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PENNSYLVANIA

HOME CARE MARKET ASSESSMENT



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KEY TAKEAWAYS

- **Public Program:** Pennsylvania spends over \$33,000 per capita on Home and Community Based Services -- over \$14,000 more per person than the national average indicating a strong commitment to home care.
- **Consumer Demand:** The current home care market in Pennsylvania is estimated at 882,100 customers. The private pay market is estimated at approximately 148,200 customers. Pennsylvania's population of elderly is 16.3%, compared to the national rate of 14.1%, and its population living with disabilities is double the national average. Because of this and other factors, the number of home care customers is expected to increase by 69,350 between 2017 and 2024.
- **Labor Supply:** There is currently a moderately insufficient supply of caregivers to meet demand, and the gap is estimated to grow as demand increases. While Pennsylvania's ratio of caregivers to those needing care at 1 to 6 is better than the national ratio of 1 to 8, demand for caregivers will continue to increase in the state. The combination of high rate of turnover and increasing demand will create the need for 568,400 new caregivers to be recruited to the workforce by 2024.
- **Home Care Agency Market:** The Pennsylvania market is highly competitive, with 60% of home care agencies in the state earning less than \$250,000 in sales revenue, and no dominant players. Market data in Pennsylvania State indicates that it is relatively easy to enter the home care market.
- **Existing Home Care Cooperatives:** The state of Pennsylvania currently has one home care cooperative: Home Care Associates in Philadelphia, with over 200 workers. The primary barrier to an organic growth strategy will be recruiting enough caregivers.
- **Cooperative Opportunity:** Opportunities are moderate compared with other states. In a service industry where the primary expense is personnel, Pennsylvania home care companies that can better recruit and retain caregivers will have a significant advantage.

About this Report

This report is part of the Cooperative Development Foundation's Socially Disadvantaged Group Grant. The ICA Group and Margaret Lund wrote this report to assist CDF in its efforts to bring home care worker cooperatives to scale across the country and to support the scale and sustainability efforts of the numerous home care cooperatives already operating. This state specific report is an in-depth market analysis for existing home care coops operating in Pennsylvania or community groups working to start new firms in the state. For more information visit: www.cdf.coop or www.ica-group.org.

NATIONAL OVERVIEW

Unprecedented growth in the nation's elderly population, paired with a cultural shift towards aging in place, is driving historical growth in the home care sector. In the United States, the population of citizens age 65 and over will almost double by 2050. Nine in ten seniors want to “age in place” in their current home and community, and an estimated 70 percent will need help with basic daily living activities to do so. Accordingly, millions of new home care workers will need to be hired and trained over the next few decades to meet this growing demand. Today, more than two million workers are employed by the home care industry in the U.S., a workforce that has already more than doubled in the last decade.

Despite unprecedented job growth, the work is low paid, benefits are limited, hours are inconsistent, training is insufficient, career advancement is nearly non-existent, and the job is emotionally and physically taxing. Eighteen percent of home care workers are uninsured, and of those insured 40% rely on public health care coverage (primarily Medicaid). Consequently, turnover rates within the home care sector are at an all-time high of 60% nationally, and the nation struggles with a growing caregiver shortage. Nationally there are eight clients who need home care for every one caregiver in the workforce. Many states experience significantly higher shortages. The industry wide cost of caregiver turnover is over \$6.5 billion per year, a number equivalent to 10 percent of the \$61.8 billion in Medicaid dollars spent on home care in 2016.

Nationally, home care is a \$5B+ quickly expanding, national market, expected to grow at a rate of nearly 7% year-over-year for the next five years.¹ Yet, as a direct result of underinvestment and complex state regulations, the home care industry remains highly fragmented and dominated primarily by small, independent providers. The three largest companies in the industry have a market share of only 8.7%. Industry consolidation through merger and acquisition activity has, however, accelerated in recent years as a response to low reimbursement rates driving down profits. While local, independent providers can arguably be more responsive to consumer needs, small agencies lack the profit margins necessary to increase salaries or invest in internal growth generally.

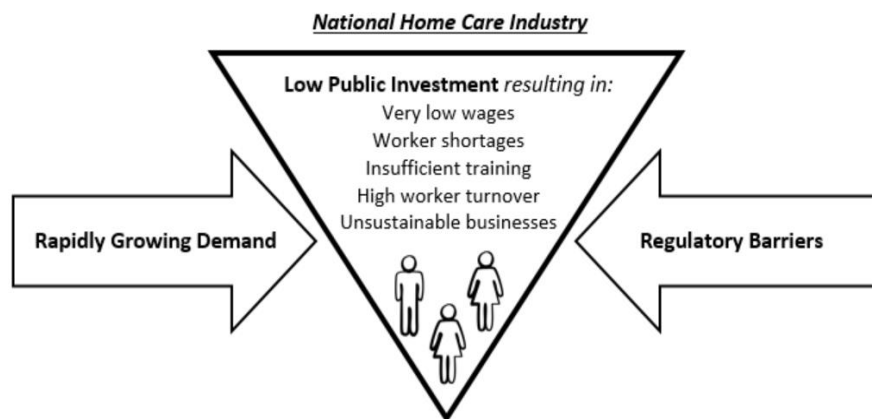
Public reimbursement rates for home care services are low, driving down wages across the industry. Unlike many other sectors in healthcare, the homecare industry does not have strong political representation and thus has been an easy target for federal cuts. Across the U.S., the hourly median wage for workers in the direct care workforce is \$10.49 per hour, only 25 cents more than the median wage for retail and food service workers. Even though homecare is increasingly promoted by healthcare professionals and offers a superior value for clients, this recognition has not yet resulted in increased payments for services. With deep public underinvestment in home care, small and large home care cooperatives alike struggle to remain financially sustainable, let alone carve out the financial resources necessary to invest in the worker-focused benefits that differentiate a home care cooperative job from a standard home care job. Worker cooperatives have the potential to raise wages and job quality for

¹ IBISWorld Industry Reports: 62161 Home Care Providers in the US

caregivers and provide better outcomes for patients, but the business model must be first strengthened, scaled, and unified to sufficiently influence and transform the industry today.

INTRODUCTION

With a somewhat higher than average senior population and more than double the national average proportion of residents living with disabilities, home care is a vital service to the people of Pennsylvania. While the state scores very well in terms of per capita spending on Home and Community Based care, it is not necessarily getting good results from this spending. Pennsylvania ranked 36 of 50 states overall in the most



recent AARP Long-Term Services and Supports scorecard,² and broke into the second quartile (#23) on only one measure, "Choice of Setting and Provider." In the other four measurement areas—"Affordability and Access," "Quality of Life and Quality of Care," "Support for Family Caregivers" and "Effective Transitions"—the state scored in the third or fourth quartile.

Pennsylvania scores very near the national average on a number of important home care market measures. Labor force participation rates and unemployment are close to average. The state has a slightly higher proportion of seniors, although the number is growing at a slightly lower than average rate. The overall measure for the total proportion of the population in the home care subset (frail elderly, self-care disabled and independent living disabled) at 6.9% of the population, is also very close to the national average of 6.19%. Pennsylvania ranks 21st among the 50 states in terms of median income and the percentage of individuals living in poverty; falling right around the middle in terms of overall ability of residents to pay for private care. Finally, 22% of Pennsylvanians currently receive Medicaid benefits, just four percentage points more than the national average of 18%.

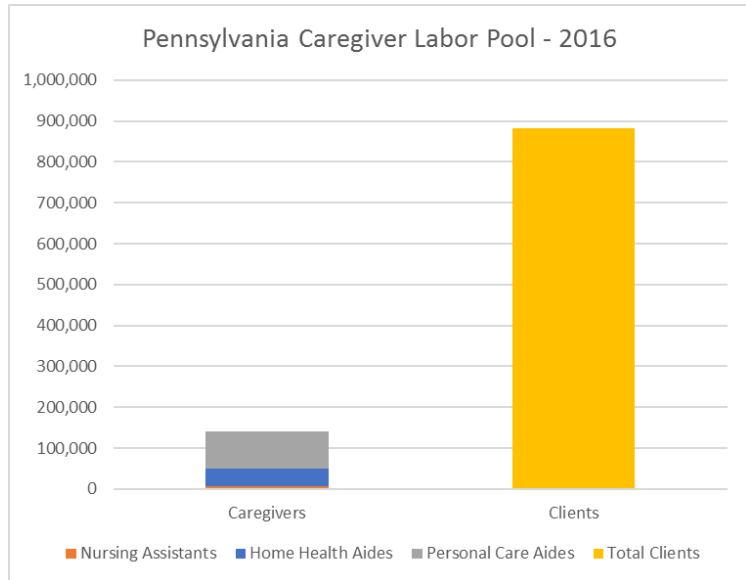
The thing that most distinguishes Pennsylvania as a market for home care services is the relative density of its population, particularly in rural areas. Pennsylvania is the 6th most populous state with over 12 million residents, and the 9th most densely populated. While the average rural square mile in the country has 19 residents, in Pennsylvania this figure is over 40 people, and this despite it being quite a large state in terms of land mass. Suburban communities, too, are much denser in Pennsylvania than average, housing close to 90 people per square mile compared with the national average of 58. This

² Long Term Services & Supports State Scorecard. Retrieved from www.longtermscorecard.org.

relative density may make it more feasible to run a home care agency in rural counties of Pennsylvania than it would be in many other states.

Like most states, long-term trends in the aging population, caregiver shortages, and the costs of providing home care all present significant challenges for current and prospective home care cooperatives in Pennsylvania, and the state has a way to go in terms of being an effective partner for problem-solving to meet long term care needs. This report will analyze the home care

market across a few key dimensions including market size, labor supply, the regulatory environment, and other state specific findings. We will then use this analysis to drive conclusions on the state of home care in Pennsylvania, how this affects current and start-up home care cooperatives in the state, and potential strategies for nurturing and growing home care cooperatives in Pennsylvania.



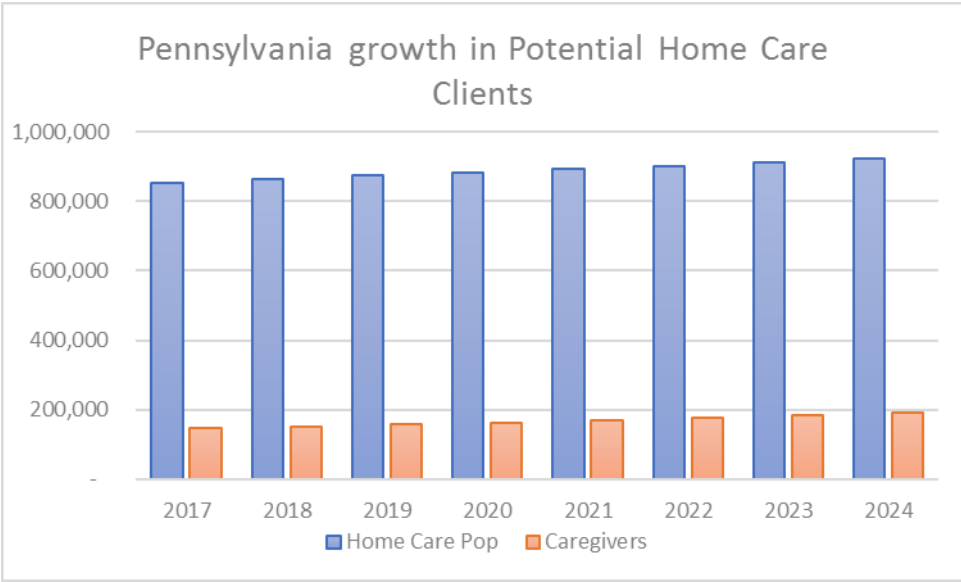
MARKET OVERVIEW

To understand the market for home care services in Pennsylvania, we use three separate lenses of analysis: customers, competition, and payers. This section provides a view into the number of potential home care customers in the Pennsylvania market, how home care clients pay for home care in the state, and who is competing for these customers. Finally, we explore key stakeholders in the state focused on the home care and cooperative industries.

Customers

In the long term, Pennsylvania will experience significant growth in the demographic groups that are most likely to use home care services. As of 2016, over 882,000 Pennsylvanians were categorized as frail elderly, self-care disabled, or independent living disabled,³ roughly 7% of the total state population, and a slightly higher than average proportion.

The rate of growth in Pennsylvania’s 65+ population (5.68%) is lower than the national growth rate for the senior population (9.7%). However, its share of elderly as a percent of the population, at 16.3% is higher than the average state rate of 14.10%, and,



significantly, the Pennsylvania population of individuals living with disabilities at 14% is more than twice the national average of 6.8%. Over the next 5-10 years, demand for home care services will clearly continue to grow rapidly in the state.

The primary public payer for non-medical home care is Medicaid. In Pennsylvania, 22.38% of the state’s residents receive Medicaid benefits – higher than the national average of 18%. In a state like Pennsylvania with a large population base, this is a lot of people. The more Medicaid beneficiaries there are in a state, the more public money there will be to pay for home care services, increasing the potential size of the state’s home care market.

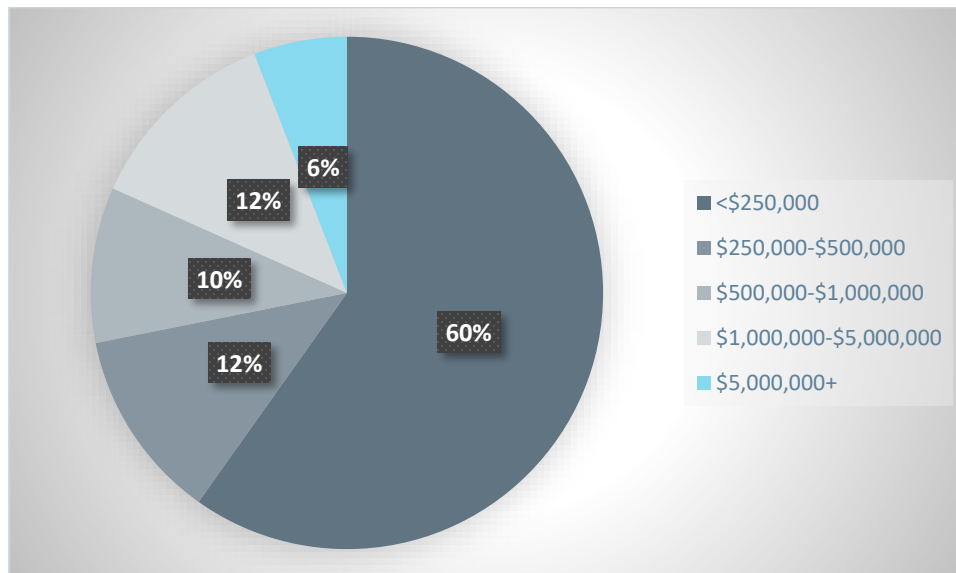
In summary, the home care client demographics in Pennsylvania are generally favorable towards the development of home care businesses. Long-term trends point towards a growing customer base.

³American Fact Finder, U.S. Census Bureau. Retrieved from www.factfinder.census.gov.

Providers

ICA estimates that there are currently 988 independent personal care⁴ and home health companies operating in Pennsylvania. This count includes headquarters and single location companies, but does not include branch locations. Of this group 867 are categorized as home health companies and 121 are categorized as providers of individual and family services. One of the existing agencies is organized as a cooperative, Home Care Associates (HCA) of Philadelphia. The five largest home care companies in Pennsylvania are:

- Main Line Health Homecare and Hospice (\$52.2 M annual sales revenue)
- Messiah Lifeways at Home (\$43.5 M annual sales revenue)
- Celtic Healthcare of Carlisle, Inc. (\$43.4 M annual sales revenue)
- Comhar Visting Nurses, Inc. (\$40.4 M annual sales revenue)
- Three Rivers for Independent Living, Inc. (\$29.5 M annual sales revenue)



Similar to the national market for the industry, the home care market in Pennsylvania has a few large companies and many small local operators – 60% of companies have revenues of less than \$250,000, and the mean revenue base for all companies in the state was only \$172,512. On the other end of the spectrum, the five largest home care companies were in the \$30 – 50 million range. Together, these companies account for only about 17% of revenues, however, so the marketplace is highly diversified amongst the state’s close to 1,000 firms. Data show a relatively robust sector of mid-sized companies as well. Eighteen percent of home care companies in the state have revenues of over \$1 million, generally considered a benchmark for efficient operations in the industry. Another 10% are in the \$500k - \$1 million band. It appears that there is some ability in the state to scale operations to a workable level.

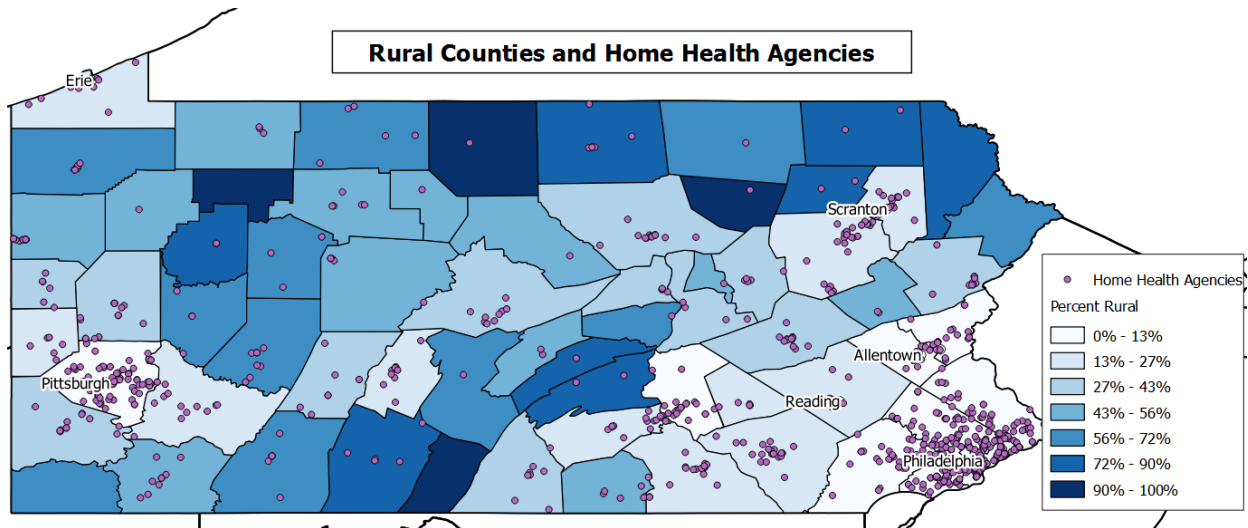
⁴ Mergent Intellect Dun and Bradstreet. (n.d.). Loblaws Inc. Retrieved from www.mergent.com.

Rural vs. Urban Conditions

Pennsylvania is quite a densely populated state, with an overall population of about 286 people per square mile versus a national figure of 91. While the national population density in rural areas is 19 residents per square mile, in Pennsylvania this figure is over 40 people. Suburban communities, too, are much denser in Pennsylvania than average, housing close to 90 people per square mile compared with the national average of 58.

The average revenue size for urban agencies in Pennsylvania, at \$460,000, is quite close to the national median of \$374,000. Rural agencies in the state are much larger however, averaging over \$800,000 in revenue compared with the national average for rural home care agencies of \$431,000⁵. In many states, home care companies serving rural areas find it necessary to operate at a large scale in order to gain administrative efficiencies sufficient to offset the relative inefficiency of catering to a widespread client base. Nationally, rural homecare companies have 15% higher sales revenue than urban companies. Therefore, despite the advantage of higher rural population density, it still may be necessary to achieve scale in order to operate effectively in Pennsylvania's rural markets.

As the map below demonstrates, Pennsylvania has quite a well-distributed market, with at least one home health company in almost every one of its 67 counties, and many rural counties hosting several. While this would indicate some existing level of competition for any new home care cooperative entering a rural market in the state, it also shows that existing companies are able to serve these markets with some degree of financial success.



Payers

The homecare industry's revenue comes from two different sources. The first is from public payers, typically Medicaid, and the second is from private payers which includes both clients who pay out of

⁵ Although we were unable to gather county based data on all home care companies including personal care and home health, we do have location based data for home health companies. Using this data, we were able to calculate the relative size difference of rural vs. urban based home health companies, and we will assume that these differences are reflected in the broader home care industry.

pocket and clients that have private-pay or long-term care insurance. The public pay market is much larger than the private pay market in both Pennsylvania and national markets, but low reimbursement rates, licensing requirements, and regulatory complexity in the public pay market means that a private pay strategy might be more feasible for some agencies. It is important for a home care agency to understand the size and scope of both markets in order to match a business strategy to both the correct payers and clients for that business.

Public Pay

The primary public payer for home care nationally and in Pennsylvania is Medicaid. In Pennsylvania, 22.38% of the state's residents Medicaid benefits (nearly 3 million)—slightly above the national average of 18%. The percentage of “aged” Medicaid enrollees is 10%, while the percentage of “disabled” enrollees is 28%⁶. Given the state's size and population, Pennsylvania ranks fourth nationally for total Medicaid spending at over \$27 billion dollars annually⁷. Pennsylvania expanded Medicaid under the Affordable Care Act in January 2015, adding over 700,000 new Medicaid beneficiaries as of Q1, 2016⁸.

In 2015, Pennsylvania allocated 37% of Medicaid funding to Long Term Services and Supports (LTSS) programs, marginally more than the national average of 32%. The state allocated 56% of LTSS to Home and Community Based Services (HCBS) programs, slightly higher than the national average (53%); spending \$3,793,376,441 on home-based supportive services.

Private Pay

While there is a significant amount of data available on the size of the public pay market, it is much more difficult to estimate the size of the private pay market. Using data available from the November 2016 IBIS world report on the national home care providers industry and our estimate of the size of the home care client population, we can approximate the number of potential private pay home clients. First, our estimate of the combined frail elderly, independent disabled, and self-care disabled population in Pennsylvania is 882,100. This number is then multiplied by the private pay market's (out-of-pocket and private insurance) percent of the national home care industry, estimated to be 16.8% by IBIS World. Using this method, we estimate that the size of the Pennsylvania private pay home care potential client pool to be 148,200. Given that home care costs in Pennsylvania are high relative to the state's median income, this may be an over estimate of the potential market, as many potential clients may not be able to afford out of pocket home care costs.

Key stakeholders

Home Care Associates:

Home Care Associates (HCA) is a 20-year old, 200-person worker-owned home care company serving Philadelphia. After CHCA in New York, it is the largest worker-owned home care cooperative in the country.

⁶ Medicaid Enrollees by Enrollment Group, The Henry J. Kaiser Family Foundation. Retrieved from www.kff.org.

⁷ Total Medicaid Spending, The Henry J. Kaiser Family Foundation. Retrieved from www.kff.org.

⁸ The Henry J. Kaiser Family Foundation. Medicaid in Pennsylvania. June 2017. Retrieved from www.kff.org

Pennsylvania Home Care Association:

Pennsylvania is also home to an active industry association, which gives the sector an advocacy presence at the state capitol, and also provides access to some useful shared services.

Pennsylvania also has two cooperative development centers, the **Philadelphia Area Cooperative Alliance (PACA)**, serving Philadelphia, and the **Keystone Development Center**, headquartered in York, serving primarily rural Pennsylvania. Neither has a particular concentration in home care, but both can provide general information and support for cooperative enterprises.

REGULATORY & PUBLIC POLICY OVERVIEW

Whether private pay or public pay, agencies wishing to operate in Pennsylvania must have a basic understanding of the regulatory and policy environment in the state. This section provides an overview of Medicaid generally as well as Pennsylvania specifically, discusses the states commitment to home and community based services for long term service and support needs, provides an overview of specific programs, and discusses both licensing and worker training requirements that need to be met by private pay and public pay agencies that wish to operate in the state. Finally, this section discusses any regulatory or political barriers to operating a home care agency in the state.

Medicaid Overview

Dually funded by the federal government and individual states, Medicaid provides financial support for health care services for low-income individuals, including elderly and disabled individuals requiring long term care (accounting for over 60% of Medicaid spending). Under Medicaid, the federal government provides a base match of 50% for approved Medicaid provided services, with low income states eligible for higher reimbursement rates. To be eligible for Medicaid benefits, individuals must meet federally mandated financial and asset criteria.

Beginning in 2014, the Affordable Care Act allowed states the option to expand Medicaid eligibility to all non-elderly adults with income below 138% of the federal poverty line. Under “Medicaid Expansion,” the federal government absorbs a larger share of Medicaid costs for new enrollees, covering 100% of costs between 2014-2017 and gradually reducing that percentage to 90% between 2017-2020. To date, 32 states and DC have expanded Medicaid.⁹

Medicaid requires that states provide specific services at a minimum, to participate in the program. Required programs include inpatient and outpatient hospital services, physician and laboratory services, nursing home care and more recently, home health care. Above the minimum required programs, states may elect to cover additional services and/or expand services to individuals outside of the standard eligibility limits set by the Center for Medicaid and Medicare Services (CMS), the federal governing body. Typically, these additional services are provided under approved “waivers.”¹⁰ The number and type of

⁹ A 50-State Look at Medicaid Expansion, Families USA. Retrieved from www.familiesusa.org.

¹⁰ Congressional Budget Office, Overview of Medicaid. Retrieved from www.cbo.gov.

waivers in each state varies widely, however. Common waivers include 1915 waivers, Aged and Disabled Waivers (ADW), and Intellectual Disability Waivers (ID). Home care relevant 1915 waivers include:

- 1915(c) Home and Community-Based Waivers (offered in 47 states and DC)
- 1915(i) State Plan Home and Community Based Waivers
- 1915(j) Self-Directed Personal Assistance Services Under State Plan Waivers
- 1915(k) Community First Choice Waivers¹¹

See Appendix 4 for waiver details.

1915 (c) HCBS waivers were first introduced in 1983 as a way for states to transition beneficiaries out of costly institutional care settings, and in 2005, became formal Medicaid State plan options.¹² States can offer as many 1915(c) Home and Community-Based Waivers as they elect, provided they meet the requirements set forth by CMS, and can elect what services to cover under the waivers, however home health aide, personal care aide, and homemaker services are almost always covered under these programs.¹³ Understanding where states fall on the spectrum of HCBS spending for their long term services and supports (LTSS) programs is an important metric for states overall preference for institutional versus home based care.

From Medicaid's founding in 1965 until the early 1990's, Medicaid operated under a system of "fee-for-service," where providers were directly reimbursed for services provided, based on rates set by individual states. In the early 1990's however, Medicaid began a transition towards a system known as "managed care" to better manage costs, utilization, and quality. Under Medicaid managed care, state Medicaid agencies contract with independent for profit or non-profit Managed Care Organizations (MCOs) that accept per member per month payments for health care services, known as "capitated payments." Because payments are "capitated" MCO's are driven to balance the needs of high-need/high-cost beneficiaries with low-need/low-cost beneficiaries and provide care in the most cost-effective manner possible to avoid cost overruns. Early on, managed care was implemented under 1115 Waivers, but in 1997 the Balanced Budget Act gave states more authority to implement managed care programs without waivers.¹⁴ As of March 2017, only 12 states did not have Managed Care programs in place.¹⁵ States that have begun transitions to managed care programs are in varying states of transition. Several states including Tennessee, Hawaii, New Hampshire, New Jersey, Rhode Island, Kentucky, Iowa, Delaware, Florida and Arizona operate almost exclusively under managed care programs (over 90% transitioned),¹⁶ including home and community based services, while others are just beginning this transition. Understanding where specific states fall on this transition is important, as it is directly

¹¹ Medicaid, Authorities. Retrieved from www.medicaid.gov.

¹² Medicaid, Authorities. Retrieved from www.medicaid.gov.

¹³ Medicaid, Home and Community Based Services, 1915c Waiver. Retrieved from www.medicaid.gov.

¹⁴ Kaiser Family Foundation, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011. Retrieved from www.kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf.

¹⁵ Kaiser Family Foundation, Total MCO's, March 2017. Retrieved from www.kff.org.

¹⁶ Kaiser Family Foundation, Share of Medicaid Population Covered Under Different Delivery Models, July 2016. Retrieved from www.kff.org.

correlated to how service rates are set, how money flows, and the importance of strategic partnerships, scale and other factors to home care agency success in a state.

In addition to the transition to managed care, states are increasingly transitioning Medicaid to “value-based” care models by implementing Accountable Care Organizations (ACO’s). To date, ten states (MA, VT, NY, OR, UT, CO, MN, NJ, RI) have implemented ACO programs.¹⁷ The goal of ACO’s is to “(1) enhance the patient experience of care; (2) improve the health of the population; and (3) reduce the per capita cost of health care.” Differentiating an ACO from an MCO are innovative values-based payment structures and carefully defined and tracked data and quality metrics to assess and confirm established value outcomes. The transition to value based care via the ACO model is important for cooperative home care agencies and developers to watch, as higher quality care is a hallmark of cooperative homecare agencies, and could be an important market differentiator.¹⁸

Pennsylvania Medicaid Overview

The Pennsylvania Department of Human Services, Office of Medical Assistance Programs, manages Medicaid for the state. Pennsylvania is far along the transition to managed care, with 83% of Medicaid beneficiaries in the state, including 9,087 enrollees aged 64+¹⁹, enrolled in Managed Care Plans. Changes to the system are reportedly pending to be implemented in 2018, so opportunities in the public pay market may change at that time.

The state contracts with nine plans to manage care for beneficiaries, with Keystone First Health Plan maintaining the largest market share at 19%, serving nearly 429,000 individuals²⁰. Additionally, the state’s Program for the All-Inclusive Care for the Elderly (PACE), known in Pennsylvania as Living Independence for the Elderly (LIFE), provides a full continuum of acute, primary and long-term services to aged and disabled adults age 55 and older in certain regions, as well.

Home and Community Based Services

Home and Community Based Service (HCBS) programs are Long Term Services and Supports (LTSS) programs that allow Medicaid recipients who are age 65+ and those living with physical disabilities to receive support with activities of daily living (ADL’s) and instrumental activities of daily living (IADLs) at home or in their community, rather than in institutional settings. Pennsylvania’s total spending on Home and Community Based Services in 2014 was \$3,793,376,441 about 44% of the State’s total Long Term Support and Service (LTSS) budget and 37% of the state’s total Medicaid budget.

As of 2014, 1915(c) waivers for Aged and Disabled and Intellectual/developmental disabilities accounted for 90% of Pennsylvania HCBS spending, the Program for All-Inclusive Care for the Elderly (PACE) was 5%

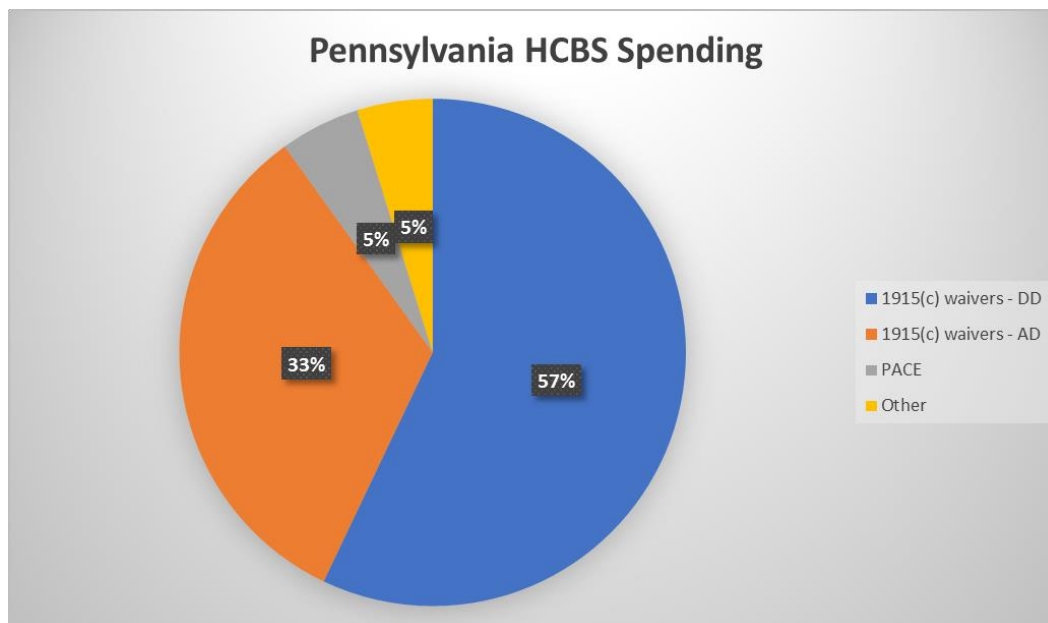
¹⁷ Center for Health Care Strategy, Inc. Medicaid ACO’s: Status Update, June 2017. Retrieved from www.chcs.org.

¹⁸ Center for Health Care Strategy, Inc. Medicaid Accountable Care Organization Programs: State Profiles. Brief: October 2015. Retrieved from www.chcs.org.

¹⁹ PA Department of Human Services Enterprise Data Warehouse. August 2017. Retrieved from <http://www.dhs.pa.gov>

²⁰ PA Department of Human Services Enterprise Data Warehouse. August 2017. Retrieved from <http://www.dhs.pa.gov>

of spending, and the remaining programs totaled less than 5% of spending. Pennsylvania currently has 10 1915 (c) waiver programs in operation²¹ with a total budget of just under \$3.5 billion in 2014.



Licensing

Home care agencies and home care registries are regulated through the Pennsylvania Department of Health. Since 2009, home care agencies have been required to be licensed by the state, and meet certain minimum requirements including background checks, TB screening and complying with all state regulations regarding training of home care workers. Licenses are renewed annually.

Task that are permitted to be provided under a home care license include:

- assistance with self-administered medications;
- personal care (i.e., assistance with personal hygiene, dressing and feeding);
- homemaking (i.e., assistance with household tasks, housekeeping, shopping, meal planning and preparation, and transportation);
- companionship;
- respite care (i.e., assistance and support provided to the family); and
- other non-skilled services.

In February 2017, the state expanded the list of services that could be provided by a Home Health Aid to include limited medical tasks such as dressing wounds or catheter care, tasks that previously had required a Licensed Practical Nurse.

²¹ Medicaid.gov. Retrieved from <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>

Training

Pennsylvania follows the federal CNA requirements as the basis for HHA training requirements, including 75 hours of instruction and 16 hours of clinical experience. Personal Care Aides are required to complete an agency-based training program and demonstrate some minimum competencies, but in practice the programs and standards for PCAs in the state can vary widely by agency.

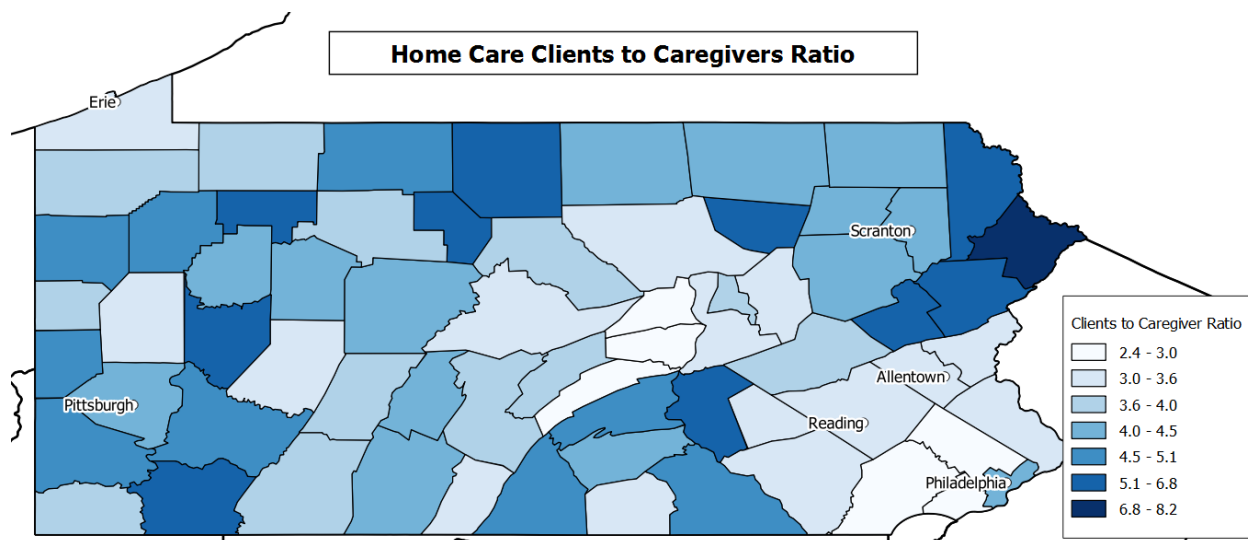
LABOR OVERVIEW

As a human centered business, recruitment and retention of enough quality home care workers is the biggest factor in the sustainability and success of any home care agency. Home care cooperatives and agencies across the country are having trouble recruiting and retaining enough caregivers to meet their business needs. This section provides an overview of the current labor pool of caregivers in the state, as well as the current labor conditions for home care workers, and a view into the future market for caregivers as demand for home care work increases.

Current Labor Pool

Home care agencies in Pennsylvania do face some significant barriers in terms of recruiting and retaining caregivers, although the situation is (relatively speaking) not as dire as in some states. The prime age (25-55) labor force participation rate in the state is currently about four percentage points below the national average, indicating the potential, albeit small, for some staffing through untapped labor markets. The unemployment rate in Pennsylvania is also somewhat higher than national rates, so there are a few additional potential workers in the market. For every one caregiver in Pennsylvania, there are currently six people categorized as frail elderly, independent living disabled, or self-care disabled needing care; this is close to the national average caregiver dependency ratio of 8 to 1.

The distribution of workers and of clients is not even however, with certain parts of the state suffering from a much higher caregiver to client ratio than others. Northern, Western, and a portion of South Central Pennsylvania all have counties with client to caregiver ratios above the state average; the city of Philadelphia also shows something of a shortage of caregivers relative to suburban markets. There is clearly a need for more caregivers in Pennsylvania. Particularly, when considering that client needs range from 24-7 care to occasional care.



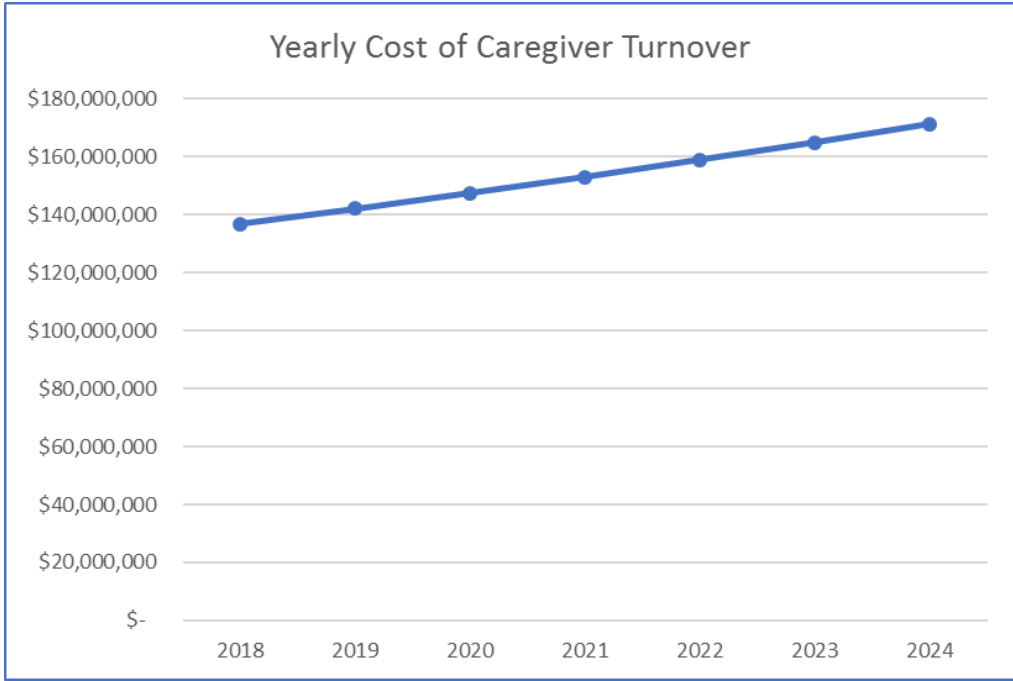
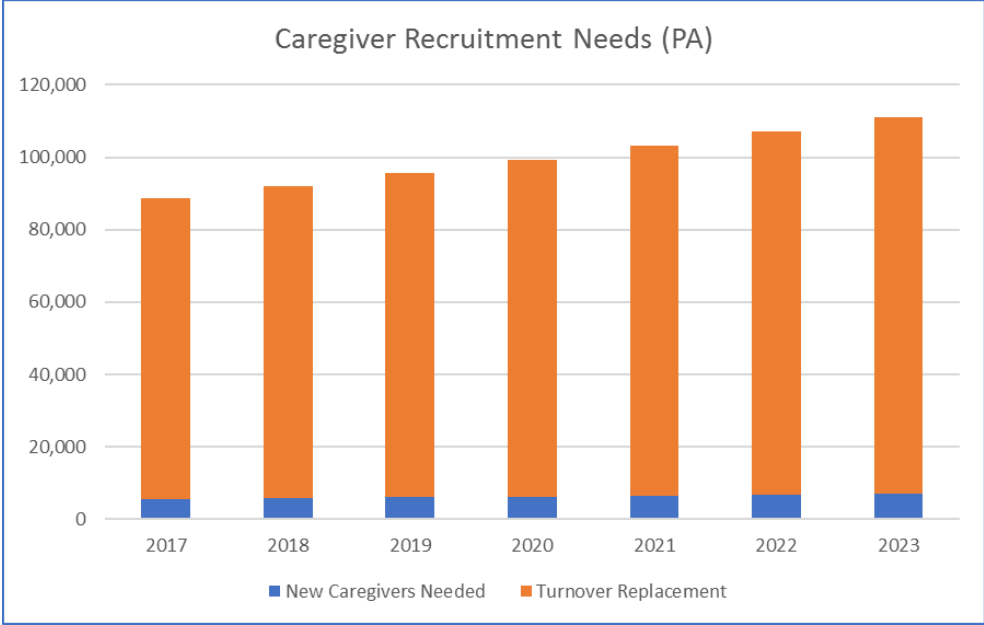
Recruitment also depends on how wages compare to similar entry-level service sector occupations that might be available to a similarly-skilled person. In the United States, the average caregiver is paid over 10% more than the average food service or retail worker. In Pennsylvania, the average wage for direct care workers is 12% more than counterparts in retail and food service. This is better than in many markets, but part of this relatively better showing is that the base wage for retail and food service workers in Pennsylvania is low. Direct care wages are still insufficient.

Caregiver and Retail/Food Service Wage Comparison			
	Direct Care	Retail/Food	Difference
National Average	\$ 10.70	\$ 10.24	\$ 0.46
Pennsylvania	\$ 11.01	\$ 9.82	\$ 1.18

Future Labor trends

The caregiving workforce is expected to experience incredible and rapid growth over the next ten years. The national workforce of personal care aides is expected to grow 25.9% by 2024, home health aides by 38.1%, and nursing assistants by 17.6%. By 2024, to meet demand, Pennsylvania will need to add 6,962 new caregivers per year to meet demand.

Across the country, the direct care workforce has experienced a tripling in the rate of employee turnover since 2009. Currently, the national average for annual turnover is over 60%. Should current rates of employee turnover persist, we estimate that the state of Pennsylvania will actually need to recruit and train more than 568,400 new caregivers into the workforce between 2017 and 2024 in order to meet demand, a daunting prospect. And the cost of this turnover is significant at over \$171 million, and is only expected to grow.



COOPERATIVE OPPORTUNITY

Cooperative Law

Cooperatives based in Pennsylvania can organize under Chapter 71, Title 15, Subchapter A. Any corporation may be organized on the cooperative principle by setting forth in its articles a common bond of membership among its shareholders or members by reason of occupation, residence or otherwise and that it is a cooperative corporation.²²

Cooperative Strategy

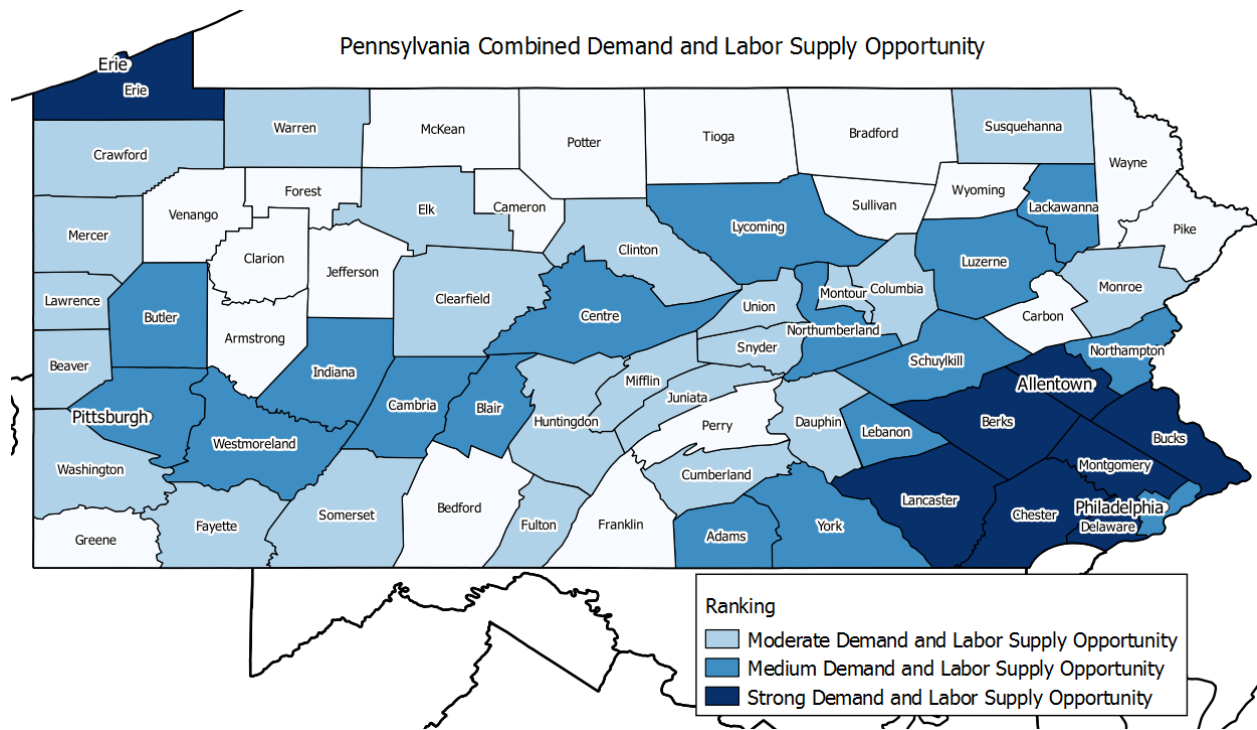
As in the rest of the country, Pennsylvania faces a pending crisis of a mismatch between the care needs of its elderly and frail residents, and the availability of a workforce to care for them. The state's senior population is growing, and its share of people living with disabilities already exceeds national averages. At the same time, the state direct care workforce is insufficient to meet current and future demand for home care.

The impending challenge for the state of Pennsylvania to meet its residents' home care requirements also represents an opportunity for home care cooperatives to successfully meet this market need. To fill this large and growing demand for home care services, Pennsylvania-based home care cooperatives would need to surmount challenges specific to the state's market in recruiting and retaining a skilled workforce in a state with a relatively low unemployment rate, working effectively in the public pay market under a pending new MCO regime, and operating at a scale sufficient to cover costs.

Of course, some geographic regions of the state also provide greater challenges than others. Below, we have overlaid a map of where the most potential homecare clients reside, with another indicating where the caregiver labor force is located to determine which portions of the state had the best match of supply and demand.

The state's suburban markets are clearly strong, as are central parts of the state, but the perimeter counties would provide a challenge to a new home care initiative.

²² Pennsylvania State Legislature <http://www.legis.state.pa.us/WU01/LI/LI/CT/HTM/15/00.071..HTM>



One potentially positive development on the horizon is pending changes in the state’s MCO structure. Home Care Associates in Philadelphia is currently participating in a demonstration program to create an “Advanced Aide” designation for workers with additional training and responsibility. If it were possible to convince the MCOs to participate in some sort of related payment for quality program, that might provide an opening for somewhat higher wages and a career track for some of Pennsylvania’s caregivers. Recent experience at HCA has shown however, that even this relatively large and sophisticated worker cooperative offering the advantages of benefits and job stability still is challenged to attract enough caregivers to meet market demand.

CONCLUSION

Cooperative developers and others interested in supporting home care cooperatives in Pennsylvania have an exciting opportunity to improve the quality of jobs, the quality of care, and access to care in the state. However, while the potential for impact is high, the road is difficult. Nationwide, independent home care agencies are struggling to survive because of the small private market, low margins on Medicaid clients, difficulty in recruitment and retention, and high training costs.

In Pennsylvania, the primary challenge facing existing and start-up home care cooperatives is recruiting and retaining enough caregivers to meet growing demand in an industry with low pay, demanding work, and high turnover. While pay rates in the state are marginally better than elsewhere, they are clearly not good enough to attract and retain sufficient caregivers to this difficult and often stressful work. Aggregate data for the state in terms of labor force participation, unemployment, caregiver dependency ratios and wages all closely align with national averages, meaning that while conditions in Pennsylvania are not significantly worse than other places in the country in terms of addressing the caregiver crisis, they are not significantly better either. Pennsylvania has few competitive advantages in this market aside from population size and density, and thus is likely to mirror the rest of the country as the caregiver shortage continues to fester and grow.

There are advantages to working in Pennsylvania, as well, however. Pennsylvania is already home to the second largest home care cooperative in the country, Home Care Associates. The market for home care in Pennsylvania is sufficiently large to support multiple home care cooperatives in the state or a single, scaled home care cooperative, and there appear to be low market barriers to entry for smaller firms. Even rural and suburban areas boast populations large enough to support independent home care agencies.

Furthermore, national home care cooperative development strategies can support the successful startup and growth of local cooperatives. One potential strategy for operatives and partners to assist local home care cooperatives is through the development of a shared services cooperative. It can be difficult for smaller scale organizations to manage back office operations, training, and regulatory paperwork while also managing a home care business and generating new sales. A membership organization for cooperatives that provides more efficient HR solutions, access to financing, high quality training and a host of other benefits, can create benefits of scale while also allowing for local control of the cooperative. An organization that can provide a pool of well-trained caregivers can significantly reduce recruitment costs and increase quality of care for cooperative members. A membership organization is one strategy that may provide that advantage. In Pennsylvania and nationwide, effecting the potential impact of cooperatives in the home care industry will require sufficient capital investment, collaboration, ingenuity, and a willingness to take risks and learn from failure. If done right, home care cooperatives can be a powerful, market-based approach creating access to dignified employment for low-wage workers in a difficult industry that has suffered from systemic underinvestment – an approach that is working for, but not waiting for, the policy solutions that are needed for larger-scale change.

Appendix

Appendix 1: Opportunity Matrix

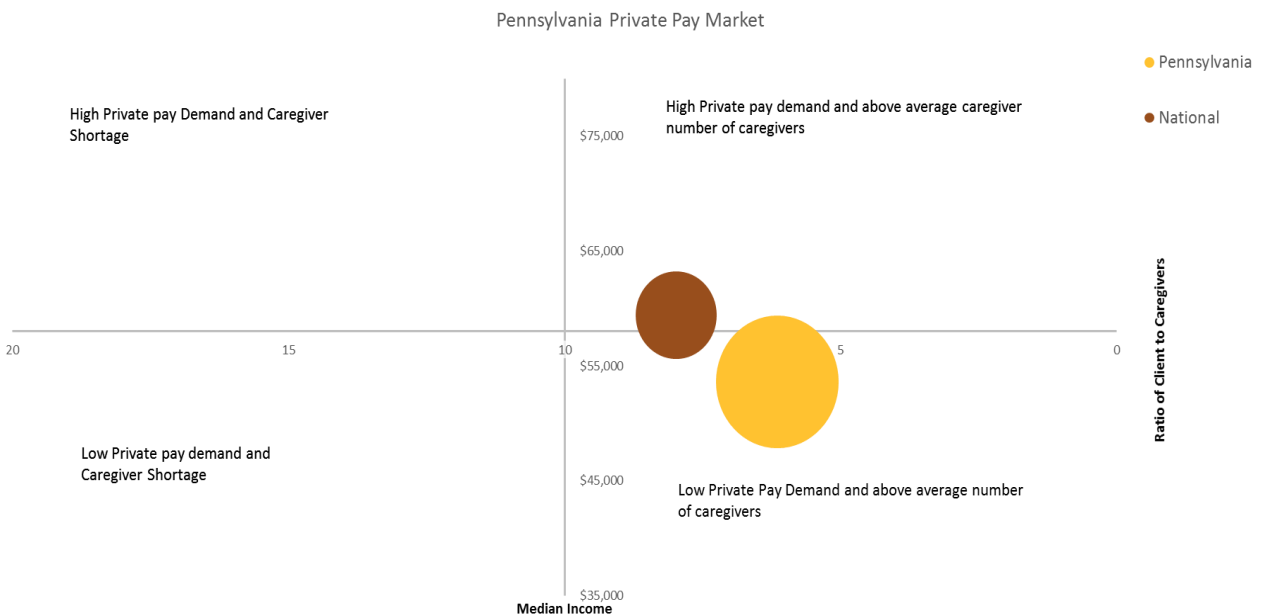
<u>Opportunity Assessment Framework</u>		
Key Metrics - Labor Supply:	<u>US Average</u>	<u>Pennsylvania</u>
<i>Assesses ease or difficulty of recruitment and retention for direct-care workforce.</i>		
Prime-Age Labor Force Participation Rate (25-55 Years of Age)	81.70%	78%
Other Entry-Level Pay Comparison (Retail and Food Service)	10.83%	12.00%
Caregiver Dependency Ratio (direct care workforce over home care subset-frail elderly/dependent)	7.98	6.14
Unemployment Rate	4.40%	4.80%
Key Metrics - Firm Barriers to Entry:		
<i>Assesses ease or difficulty of entering the home care market as a new provider</i>		
Scale Barriers	\$216,243	\$172,512
Average Sales of Home Care Companies Rural	Rural: \$431,300	Rural: \$805,000
Average Sales of Home Care Companies Urban	Urban: \$373,800	Urban: \$460,000
Scale of Service Area (as Population Density)	91.39	285.73
Rural Population Density	Rural: 19.17	Rural: 40.1
Suburban Population Density	Suburban: 57.83	Suburban: 89.7
Urban Population Density	Urban: 1015.17	Urban: 797.04
Key Metrics - Market Competitiveness		
<i>Assesses the state of market consolidation/fragmentation, and dominance of any major firms.</i>		
Total % Market Share of Top 5 Firms	8.7% (Top Three)	16.78%
Largest Provider Operating in State (Annual Sales)	Kindred	Main Line HomeCare & Hospice
Key Metrics - Client/Customer Demographics		
<i>Describes composition of population in state likely needing home care services.</i>		
Total % in Home Care Subset (Frail Elderly & Ind'l with Disabilities, IL & SC)	6.19%	6.90%
Growth in Aging Population	9.70%	5.68%
Total % Population Age 65+	14.10%	16.30%
Total % Population Individuals with Disabilities	6.81%	14.00%
Total % Population on Medicaid	18.00%	22.38%
Home Care Costs as % of Median Income of 65+ Population	119%	139%
Key Metrics - Payer Composition		
<i>Describes key customers/payers in the state, how money flows, ability of providers to negotiate for better rates, etc.</i>		
Percentage Total State Medicaid Spending on LTSS	32%	37%
Share Medicaid LTSS Spending for Devoted to HCBS	53%	56%
Self-Directed Care Program	N/A	Yes
Rate Flexibility	N/A	Fee for Services and Managed Care
Per Capita HCBS	\$18,870	\$33,115

Appendix 2: 2x2 Analysis

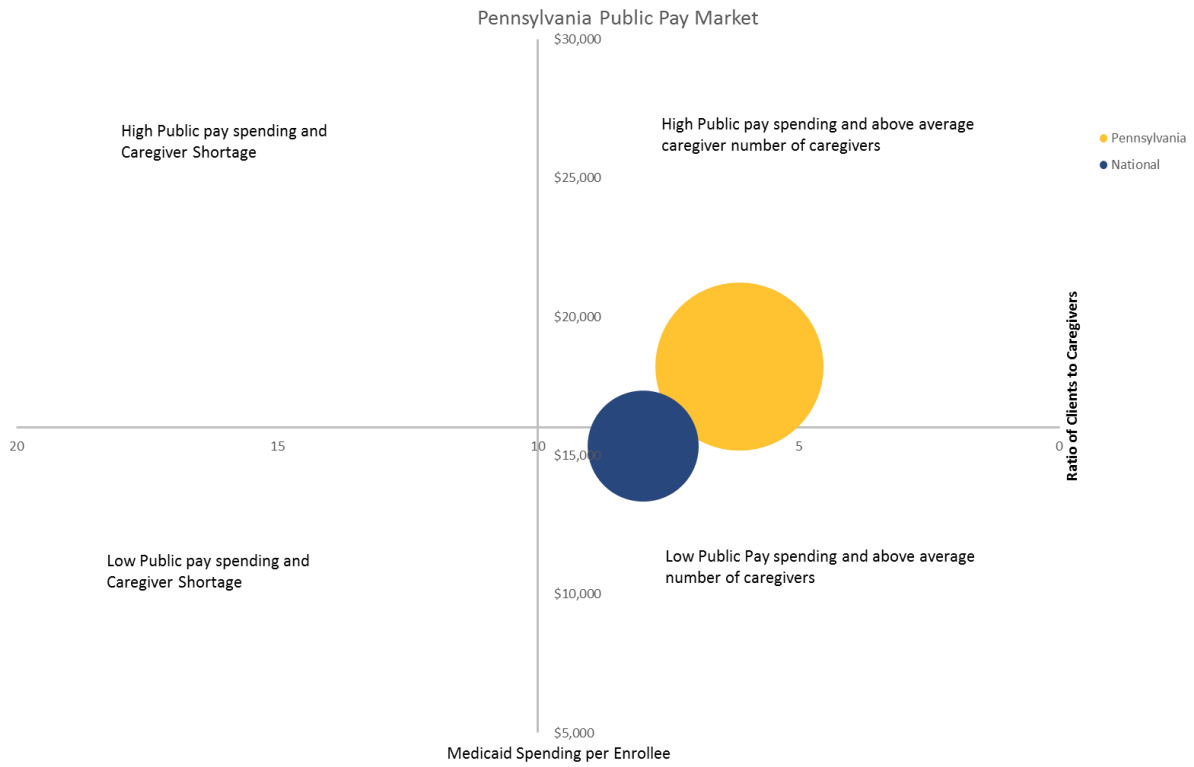
The two graphics below analyze both the private pay market and the public pay market by integrating the labor supply, the number of clients needing home care services, and the pool of money available for those services. In both charts the size of the bubble indicates the total number of potential home care clients in the state. Along the x-axis, we have the ratio of home care clients to caregivers in the state. For example, nationally, there are about eight home care clients for every one working caregiver. States to the right of the national bubble have a relatively strong supply of caregivers in the state in comparison to the national average. Finally, on the y-axis we have two different data points depending on whether we are assessing the private pay market or the public pay market. In the private pay assessment, we use the state's median income to determine the potential pool of private money available to pay for home care. In the public pay assessment, we use the state's per enrollee Medicaid spending on aged and disabled beneficiaries.

As can be seen, the sheer size of the public payment pool provides a substantial opportunity for home care cooperatives, if payment rates can be raised sufficiently to attract workers. The private pay market appears somewhat less robust, but still substantial given the large size and density of the state population.

Private Pay 2x2:



Public Pay 2x2:



Appendix 3: Detailed Medicaid Home Care Waiver Descriptions

1915(c) Home and Community-Based Waivers²³

This waiver enables States to tailor services to meet the needs of a particular target group. Within these target groups, States are also permitted to establish additional criteria to further target the population to be served on a HCBS waiver (e.g. target by age or diagnosis such as autism, epilepsy, cerebral palsy, traumatic brain injury, HIV/AIDS; etc.). Eligible individuals must demonstrate the need for a Level of Care that would meet the State's eligibility requirements for services in an institutional setting. States choose the maximum number of people that will be served under a HCBS Waiver program. States can offer a variety of unlimited services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

1915(i) State Plan Home and Community Based Waivers²⁴

States can offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit. People must meet state-defined criteria based on need and typically get a combination of acute-care medical services (like dental services, skilled nursing services) and long-term services (like respite, case management, supported employment and environmental modifications) in home and community-based settings.

1915(j) Self-Directed Personal Assistance Services Under State Plan Waivers²⁵

Self-directed personal assistance services (PAS) are personal care and related services provided under the Medicaid State plan and/or section 1915(c) waivers the State already has in place.

- Participation in self-directed PAS is voluntary. Participants set their own provider qualifications and train their PAS providers Participants determine how much they pay for a service, support or item

The plan must include an assessment of contingencies that pose a risk of harm to participants and an "individualized backup plan" to address those contingencies, as well as a "risk management plan" that outlines risks participants are willing to assume.

²³ Medicaid. *Home and Community Based Services 1915(c)*. Retrieved from www.medicaid.gov/medicaid/hcbs/authorities/1915-c/index

²⁴ Medicaid. *Home and Community Based Services 1915(i)*. Retrieved from at www.medicaid.gov/medicaid/hcbs/authorities/1915-i/index

²⁵ Medicaid. *Home and Community Based Services 1915(j)*. Retrieved from at www.medicaid.gov/medicaid/hcbs/authorities/1915-j/index

1915(k) Community First Choice Waivers²⁶

The "Community First Choice Option" allows States to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their State Plan. This State plan option was established under the Affordable Care Act of 2010.

²⁶ Medicaid. *Home and Community Based Services 1915(k)*. Retrieved from at www.medicaid.gov/medicaid/hcbs/authorities/1915-k/index

Appendix 4: Opportunity Matrix Methodology

To better understand the opportunities and challenges of creating or expanding a home care cooperative we assessed the state on five dimensions: labor supply, barriers to entry, market competitiveness, customer demographics, and payer composition. We used multiple data points and measures to assess each category, and the sources and calculation methods for each data point is outlined in Appendix X.

Labor Supply: To evaluate the state's labor supply, we wanted to understand how difficult it is to recruit, attract, and retain homecare workers. The caregiver dependency ratio is the ratio of the number of direct care workers to the number of potential homecare customers which paints a picture of how much demand there is for homecare workers in the state. We also compare wages for homecare workers to wages for other service sector jobs to determine how easy it is to recruit homecare workers away from other entry-level work. Finally, the state labor force participation rate and unemployment rate are used to determine whether there is an available pool of workers to recruit from.

Barriers to Entry: Barriers to entering the homecare market were assessed using the National Establishment Time Series (NETS) database and the Mergent Intellect online database. These two databases were used to calculate the average size of homecare companies for rural counties, urban counties, and for the entire state. This data is useful in understanding how large a homecare company must be to successfully operate in a state. Additionally, we calculated the population density of rural, urban, and suburban counties to understand how travel time and costs may affect homecare companies operating in those counties.

Competitiveness: The market competitiveness category is an evaluation of the business environment for the home care industry in the state. We assessed the competitiveness of the homecare industry by calculating what percentage of the industry's sales revenue was captured by the five largest firms in the state. Since many of the larger homecare companies simultaneously operate personal care, home health, and nursing facility lines of business in multiple states, this measure does not have a high level of precision but does give an accurate assessment of the general level of homecare industry competitiveness in the state.

Client Demographics: This category is an assessment of the current and future demand for homecare services in a state based upon the size and growth of the customer base. Primarily using US census data, we determined the size of the state's elderly population, the growth rate of the elderly population, the size of the adult disabled population, and the size of the homecare subset (frail elderly plus individuals with disability). Additionally, we determined the client base's ability to pay for homecare services by comparing the current per capita homecare costs to the states per capita median wage. Finally, the potential size of the public pay market is estimated using the total percentage of the state's population currently on Medicaid.

Payer Composition: The payer composition category uses both qualitative and quantitative data to assess the regulatory environment, the amount of public money allocated towards homecare, and the funding streams for homecare in the state. The total amount of money available for homecare is

measured using the percent of Medicaid spending dedicated to Long-term Support and Services (LTSS) and Home and Community Based Care (HCBS). Per capita spending on HCBS is used to determine how much public money is dedicated to each homecare customer.

Labor Supply		
Data Point	Source	Calculation/Notes
Prime-Age Labor Force Participation Rate (25-55 Years of Age)	BLS	Direct from source
Other Entry-Level Pay Comparison (Retail and Food Service)	OES wage data	Average of retail and food service wages divided by average of personal care and home health aide wages
Caregiver Dependency Ratio	OES wage data and US Census (2015 American Community Survey 5-year Estimates)	Sum of nursing assistants in home care (7.9% of all nursing assistants nationally), personal care aides, and home health aides divided by sum of adults with disabilities and seniors designated as frail or dependent
Unemployment	BLS	Direct from source
Firms Barriers to Entry		
Data Point	Source	Calculation/Notes
Scale Barriers	Mergent Intellect	Median revenue of homecare companies in D&B database
Average Sales Revenue Rural Home Care Companies	NETS Data	Rural designation based county in which the company's headquarters is located
Average Sales Revenue Urban Home Care Companies	NETS Data	Urban designation based county in which the company's headquarters is located
Scale of Service Area	US Census	Direct from source
Rural Population Density	US Census	Direct from source
Suburban Population Density	US Census	Direct from source
Urban Population Density	US Census	Direct from source
Market Competitiveness		
Data Point	Source	Calculation/Notes
Total % Market Share of Top 5 Firms	Mergent Intellect cross checked with state list	Revenue of five largest homecare firms in state divided by total state homecare market revenue
Largest Provider is state by sales revenue	Mergent Intellect cross checked with state list	Direct from Source
Client Demographics		
Data Point	Source	Calculation/Notes
Total Percent in Home Care subset	US Census (2015 American Community Survey 5-year Estimates)	Sum of adults with disabilities and frail elderly population
Growth in Aging Population	US Census (2015 American Community Survey 5-year Estimates)	
Total Percent Population 65+	US Census (2015 American Community Survey 5-year Estimates)	

Total Percent Population Individuals with Disabilities	US Census (2015 American Community Survey 5-year Estimates)	
Total Percent Population on Medicaid	Kaiser State Health Facts	
Home Care Costs as Percent of Median Income of 65+ Population	US Census (2015 American Community Survey 5-year Estimates) and...	
Payer Composition		
Data Point	Source	Calculation/Notes
Percent Total Medicaid Spending on LTSS	CMS and Truven Health Analytics report	Direct from Source
Share Medicaid LTSS Spending dedicated to HCBS	CMS and Truven Health Analytics report	Direct from Source
Per Capita HCBS	Kaiser Health Foundation from 2013 based off KCMU and UCSF analysis	Total number of state Medicaid HCBS spending divides by number of participants.

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