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PUERTO RICO

HOME CARE MARKET ASSESSMENT

Cooperative Development Foundation

ICA GROUP
HOME CARE

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About This Report

This report is part of the Cooperative Development Foundation's Socially Disadvantaged Group Grant. The ICA Group wrote this report to assist CDF in its efforts to scale worker ownership in home care across the United States. Specifically, this report offers an in-depth market landscape analysis for community groups working to start new home care cooperatives in Puerto Rico.

For more information visit: **www.cdf.coop** or **www.icagroup.org**.

Introduction

Demand for home care services[1] in Puerto Rico is extremely high and growing. Driven by outward migration, the island's working-age population is declining, while the elderly population makes up more of the remaining population with each passing year. These trends, combined with a significant underinvestment in home care services in Puerto Rico, and poor home care job quality, have created a significant gap between the demand for quality home care supports and the available supply.

The current home care market in Puerto Rico is not dissimilar to the rest of the United States, where the demand for care exceeds the available labor force. However, given Puerto Rico's territory status, the common difficulties experienced in the home care market on the mainland are compounded by an unequal application of federal policies and funding. With limited or non-existent federal programs and funding for home care, Puerto Rican citizens are left waiting for care, typically turning to family and community networks to fill the gaps. Furthermore, given larger economic conditions, few families can afford private, out-of-pocket care, resulting in a private pay market that is dominated by informal employment rather than by professionalized services with well-trained caregivers.

Despite this challenging landscape, opportunity exists for individuals or organizations looking to apply the cooperative model to the home care crisis. As worker-centered businesses, home care cooperatives prioritize improved working conditions including better training, higher wages, and job supports. This results in increased worker satisfaction, decreased turnover, and, ultimately, higher quality care for clients. This "cooperative difference" is a competitive advantage and those that can successfully launch and operate financially sustainable home care cooperatives can make a meaningful difference in the lives of both home care workers and consumers. In Puerto Rico, the cooperative movement is deeply rooted, and the cooperative model is understood by consumers, making this value proposition even more promising.

The following market assessment provides an in-depth look at the home care market in Puerto Rico across several key dimensions including market demand, labor supply, the regulatory environment, and other location-specific findings. With this information, individuals and organizations interested in starting a home care cooperative will gain important insight into the home care industry on the island and the conditions that will affect the success of start-up cooperative initiatives. Finally, the report discusses potential strategies for growing and nurturing successful home care cooperatives in Puerto Rico.

[1] These are medical and non-medical services for the elderly and people living with disabilities. In Spanish home care worker can be interchangeable with domestic worker, but for the purposes of this report, home care worker refers to those working in clients' homes to provide care to the elderly, those living with disabilities and others who need assistance with activities of daily living to safely remain at home.

Key Findings

- An estimated 22% of Puerto Ricans (702,334) are in the "home care subset"—individuals needing care at home. This is a combination of frail elders and people who experience difficulties with independent living.
- Due to a growing senior population and a declining workforce population, Puerto Rico has an unprecedented, unmet need for home care. With 105 potential clients for every caregiver in the workforce, Puerto Rico has a caregiver dependency ratio (105:1) that demonstrates ten times more unmet need for services than in the United States as a whole (10:1).
- The median income for individuals over 65 in Puerto Rico is $16,953 and 40% of the 65+ population live below the poverty line. Assuming a $15 hourly service rate for home care services, the out-of-pocket cost of care would be 202% of the average senior's income—an impossible expense without supplemental assistance.
- Home Health Aides and Personal Care Aides in Puerto Rico earn $0.26 less per hour on average than their retail counterparts and $0.77 less per hour than food service workers. This lack of differentiation in wage, paired with other challenging job conditions in home care such as isolation in the work and inconsistent hours, makes moving laterally across industries easier.
- The home care market in Puerto Rico is small and concentrated. Three home care agencies dominate 79% of the home care sales in Puerto Rico.

Key Challenges

- The island's outstanding debts from years of subsidizing Medicaid and Medicare shortfalls, catastrophic damages caused by Hurricanes Maria and Irma, and COVID-19 have left Puerto Rico in a state of economic crisis. The lack of capital available for the provision of basic services and recovery aid makes it difficult for public programs to prioritized investment in home care services.
- The migration of families and workers from the island has removed many family-based senior and disability supports, increasing the need for assistance with Activities of Daily Living (ADL) and personal care, which are not widely covered by existing public payers.
- Unlike in the other states, neither Medicaid nor Medicare cover any personal care services in Puerto Rico. As a result, Puerto Rico's home health care services industry is focused primarily on home health and only tangentially on personal care services, leaving a gap in the provision of needed services.
- The existence of a large informal domestic workforce, which includes home caregivers, disincentivizes the development and stability of a strong formal home care sector that can provide training and protections to caregivers and clients.

Key Opportunities

- The effort to improve the provision of quality care for seniors and people living with disabilities has a large and diverse group of supportive stakeholders because the shortage of well-trained caregivers strains so many of Puerto Rico's social systems, including health care, economic recovery and development.
- The cooperative ecosystem in Puerto Rico is rooted and thriving. Credit unions, insurance agencies, and other public services that are structured as cooperatives are more trusted by the public over their private counterparts, suggesting that a cooperative structure could provide a market advantage.
- A large group of supportive stakeholders and public approval of the cooperative model in Puerto Rico creates a conducive environment for the creation of a home care cooperative to thrive.
- The sheer magnitude of unmet demand for home care services on the island may attract socially minded foundations and granting organizations to support a cooperative home care project.

Methodology

Research for the Puerto Rico Home Care Market Landscape Assessment began in April 2021. The research included two main methods: focused interviews and quantitative data collection and analysis. Each is discussed in detail below.

In partnership with FIDECOOP, the ICA Group identified a variety of stakeholders whose work intersects with the interests of the home care industry and cooperative development in Puerto Rico. Introductions were facilitated by FIDECOOP, and interviews were conducted from June to July of 2021 by the ICA Group.

Interviewees included:

- Laura Núñez Ramírez, graduate nurse for Nemecio Canales Residential Center for the Aged, a recovery facility for the elderly
- Natalia Hernández, Clinical Research Manager (and by proxy, Dr. Ismael Toro Grajales, Chairman and Geriatrician) of SANACOOP, a cooperative of physicians and healthcare providers focused on serving the elderly
- Alexa Paola Figueroa, Cooperative Consultant for the municipality of Toa Baja City, previously organized a home care cooperative in San Juan
- Luiz Irizarry Vélez, Director of the Job Connection Center at Humacao City
- Heriberto Martínez Otero, Executive Director of the Puerto Rican Ways and Means Committee
- José Acarón, Executive Director of AARP Puerto Rico
- Rubén Colón Morales, lawyer and Professor of Cooperative Law, University of Puerto Rico

In addition to the qualitative information collected through interviews, research was conducted to collect quantifiable data to further inform our analysis and findings. Key data sources included the U.S. Census, Bureau of Labor Statistics, AARP of Puerto Rico, Medicaid and CHIP Payment and Access Commission (MACPAC), the Puerto Rico Chamber of Commerce, and the Congressional Research Service.

Background: Population Changes

Puerto Rico is experiencing significant population changes that are impacting many parts of the island's economic and social systems. All but one of the 78 municipalities in Puerto Rico experienced population declines between 2010 and 2019, and the populations of the five largest municipalities decreased by an average of 17.7%. Hurricane Maria in 2017 was a large contributing factor to these declines, although Puerto Rico has long had a cyclical migration trend with the mainland United States where younger generations leave to find work and older generations return to be with families.

	Puerto Rico 2010	Puerto Rico 2019	Percent Change 2010-2019
Total Population	3,762,322	3,318,447	-11.8%
Median Age	35.9	41.7	+16.2%
Total Senior Pop.	517,957	653,736	+26.2%
Senior Pop. as Percentage	13.8%	19.7%	+5.9%

While the overall population declined by 11.8% over the past decade, the 65+ population increased by 26.2%, growing from 13.8% to 19.7% of the total population, a dramatic increase compared to the more moderate and gradual population changes seen in the mainland.

Looking to the future, Puerto Rico's total population is expected to continue to decline. The island's 65+ population, however, is projected to increase through at least 2040. In the year 2030, it is estimated that a full 25%[2] of the population will be 65 years or older,[3] adding more potential home care clients to an already unsupported market.

Rural and Urban Considerations

Interviewees emphasized the distinct differences in accessing home care and other social services between urban and rural communities. While access to services is difficult in both areas, each faces its own unique barriers.

For both urban and rural populations constraints include:

- High demand
- Cost of services
- Availability of caregivers
- Limited training

5 Largest Municipios in Puerto Rico			
	Municipio[4]	Population	Pop. Change 2010-2019
1.	San Juan Municipio	318,441	-19.5%
2.	Bayamón Municipio	169,269	-18.7%
3.	Carolina Municipio	146,984	-16.8%
4.	Ponce Municipio	131,881	-20.7%
5.	Caguas Municipio	124,606	-12.8%

[2] Currently 21% of the population

[3] https://www.populationpyramid.net/puerto-rico/

[4] 2019 US Census ACS data

Rural communities also struggle with transportation and the distances between home care clients and providers. Ideally home care businesses work to optimize caregiver time because long distances increase costs in two ways. First, it increases direct costs from "unproductive" time where caregivers are not providing services that offset the cost of their wage. Second, overhead costs can increase if an agency provides travel reimbursements. If a home care business does not have the volume of clients or service rates needed to offset those additional costs, serving rural communities can be very difficult.

Market Overview

Home care providers rely on the balance between three key variables: client demand, workforce supply, and payer rates to deliver consistent quality care. Fluctuations in any variable impacts the others, requiring constant vigilance on the part of home care business operators to monitor and manage these variables for optimization. The following sections outline how these and other variables manifest at the macro level in Puerto Rico and what external variables help or hinder their development.

Home Care Clients

Demand for Home Care Services

Because not every elderly or disabled individual needs home care, the ICA Group creates an estimate of people called the "home care subset"—people who need assistance with activities of daily living to safely remain at home. The home care subset includes people categorized as "frail elderly"[5] (136K), adults over 18 who are living with a Self-Care Difficulty[6] (153K); and adults over 18 who are living with an Independent Living Difficulty[7] (413K). Using these parameters and U.S. Census data, an estimated 702,334 of Puerto Ricans (22% of the population) can be considered part of the "home care subset."

Home Care Client Subset: Percent of Total Population, 2019		
	% of Puerto Rico Population	% of United States Population
Frail Elderly	4.2%	3.2%
Self-Care and Independent Living Difficulty	17.7%	6.7%
Home Care Subset	**22%**	**10%**

[5] The "frail elderly" population is calculated as 20% of all people 65 and over

[6] Having difficulty with Activities of Daily Living (ADLs) such as bathing, dressing, or toileting

[7] Because of a physical, mental, or emotional problem, having difficulty doing errands alone such as visiting a doctor's office or shopping.

In each of these categories, Puerto Rico has higher population percentages than the U.S. Most notably, Puerto Rico's adult disability population is 17.7% of the total population, in comparison to only 6.7% of the total U.S. population. The higher proportion of 65+ and disability populations contribute to a high need for home care services and create a market of high demand.

Workforce: Caregivers

Labor Pool

There are two primary caregiver roles in home care: Home Health Aide (HHA) and Personal Care Aide (PCA),[8] both provide care inside the home, but to differing degrees.[9] Typically, HHAs provide what is described as "skilled care" or "medical care" and PCAs provide "unskilled care" or "non-medical care."

Puerto Rico's relationship with home care work and workers is often limited to only medical home care services. Home care workers are nurses and HHAs who visit the homes of individuals with chronic or long-term illnesses or disabilities and are reimbursed for their care through a formal payer like the Puerto Rican government or a Managed Care Organization. Their scope of work is focused on immediate medical needs such as dispensing and adjusting medications, replacing medical devices, and assessing a patient's overall state in accordance with a doctor's care plan. Personal care services are rarely identified as standalone or professional positions.

The Bureau of Labor Statistics reports that there are approximately 6,700 direct-care workers formally employed in the home care industry in Puerto Rico. This is composed of 6,640 HHAs and PCAs and 59 Nursing Assistants.[10]

ICA estimates that there are currently 105 potential clients[11] for everyone worker currently employed in the home care workforce in Puerto Rico, creating a client to caregiver dependency ratio of 105:1. For comparison, the national client to caregiver dependency ratio is 10:1, revealing ten times more unmet need for services in Puerto Rico than in the United States as a whole. This statistic tells us that there is significant unmet demand for services in Puerto Rico's home care marketplace, a fact that was emphasized by many of the people interviewed for this study. While this might suggest the existence of a significant workforce opportunity and favorable conditions for new businesses entering the market, there are two reasons for caution: the

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[8] Distinct home care roles are often conflated into the singular term of "home care worker". While this is convenient for conversation, institutional payers for home care work (government programs and insurance companies) require a clear distinction between roles and services provided to reimburse for those services accordingly.

[9] Personal Care Aides are restricted to services such as cleaning, preparing meals, bathing, grooming, and medication reminders. Home Health Aides can do all the same tasks performed by a PCA but have additional training that allows them to measure vital signs, administer medication, or assist with medical equipment.

[10] The number of Nursing Assistants is calculated based on an estimate that 7.14% of all Certified Nursing Assistants in the workforce provide in-home care.

[11] Potential clients are those in the "home care subset," which is an estimate of the number of people who need assistance with activities of daily living to safely remain at home. It includes the "frail elderly" and adults between the ages of 18-75 who are living with a Self-Care Difficulty or an Independent Living Difficulty.

nationwide caregiver recruitment and retention crisis and out-migration of the working age population in Puerto Rico.

With low pay, few benefits, and inconsistent hours, the home care industry does not attract enough workers to meet the demand for services. Annual industry caregiver turnover rates are high (between 64% and 82% in recent years), which intensifies and increases the recruitment challenge.[12] These two trends created a national caregiver crisis, in which home care businesses across the United States are struggling to attract and retain caregivers. The crisis has been greatly exacerbated by the global COVID-19 pandemic. The factors contributing to the caregiver shortage are amplified in Puerto Rico given the larger economic and industry context on the island. The caregiver turnover rate for Puerto Rico is unavailable, but the extreme caregiver dependency ratio suggests that the field is not attracting or retaining enough workers. Interviewees reported that it can be difficult to find or retain employees because of a reduced working age population and poor work conditions including the prevalence of contracted positions over more reliable longer-term employment.

Wages

Nationally, caregiving wages are on par with retail and food service jobs, which enables caregivers to move laterally amongst low paying jobs. In Puerto Rico, food service and retail jobs pay an average of $0.26 and $0.77 more per hour than HHA and PCA jobs. While some people do not find them as fulfilling, jobs in the food or retail industry typically offer more and consistent hours, safety, less physically and emotionally demanding tasks, less isolated work environments, and better opportunities for job advancement. When compared with wages and conditions in food service and retail jobs, there are not enough incentives to draw people into the home care workforce.

Puerto Rico Wage Comparison[13]

Occupation	Wage	Difference to HHA/PCA
Food Services	$9.08	+$0.26
Retail	$9.59	+$0.77
HHA and PCA	$8.82	N/A

HHA and PCA jobs in Puerto Rico pay an average hourly wage of $8.82, which is $3.31 less per hour than the average wage in the rest of the U.S., likely exacerbating the migration of the caregiving labor force to the U.S. mainland.

[12] 2020 Home Care Pulse Benchmarking Survey

[13] Bureau of Labor and Statistics, Puerto Rico data

Occupation [14]	Puerto Rico	United States	Difference
HHA and PCA	$8.84	$12.15	**-$3.31**
Nursing Assistant	$8.89	$14.26	**-$5.37**

Taken all together, this data suggests that the high and growing need for home care services is confronting a challenging labor market. Puerto Rico's home care businesses, and any new entrants to that industry, will have the challenging task of recruiting workers from a shrinking labor pool into an industry with unappealing work conditions. While this serves as a caution, it also suggests that a cooperative agency, offering improved working conditions to individuals desiring a career in caregiving, could have an advantage in this challenging hiring landscape.

Home Care Providers

The exact number of businesses offering home care services in Puerto Rico is unknown, but the ICA Group was able to gather general and financial information on 53 agencies in Puerto Rico using Dun and Bradstreet as a data source.[15] Ninety-six businesses were identified as being physically based in Puerto Rico and classified as "home health care services" businesses. However, the ICA Group performed quality checks and eliminated those that no longer appear to exist or offer home health care services, which left a list of 53 credible businesses for which sales data was available. In this dataset, 35 agencies offering home health aide services are registered with Medicare.[16] It was determined that 14 of the 53 listed businesses provide personal care services (26%), 20 do not provide personal care services (38%), and there was not enough information available for 19 businesses to indicate whether personal care services are offered (36%).

Sales Volume	# Of Companies	% Of Companies	% Of Sales (Market Share)
Less than $500K	26	49%	2%
$500K to $1 Million	12	23%	4%
$1 to $4 million	10	19%	10%
$4 to $10 million	2	4%	5%
$10 to $25 million	2	4%	17%
Over $100 million	1	2%	62%

[14] Bureau of Labor and Statistics, National data

[15] Information was sourced from a proprietary dataset, Mergent Intellect, which sources data from Dun and Bradstreet. This dataset includes the names and estimates of annual sales of companies that are classified as "home health care services" businesses under the NAICS code 62160 and Standard Industrial Classification (SIC) codes. This designation includes business that provide home health, hospice, and personal care services

[16] Center for Medicaid and Medicare Services (CMS), https://data.cms.gov/provider-data/dataset/6jpm-sxkc

The 14 businesses that offer personal care services account for 22% of total revenue. Because many of the businesses that offer personal care services also offer home health services, it is fair to assume that personal care accounts for less than 20% of the total home health care market in Puerto Rico.

Subset of businesses that offer personal care services

Sales Volume	# Of Companies	% Of Companies	% Of Sales (Market Share)
Less than $300K	5	36%	1%
$500K to $1 million	5	36%	7%
$1 million to $5 million	2	14%	11%
$10 million to $25 million	2	14%	80%

Among the 53 businesses for which sales data was available, the majority of businesses earn less than $1 million in annual sales, but market share is largely concentrated in the biggest players. Businesses with an annual sales volume of less than $500,000 account for nearly half of the number of businesses, but only account for 2% of total sales. This reflects a common trend seen in many states, where entrepreneurs recognize the need for care in a local context and launch home care businesses to remedy the gap. This is often very helpful in the short term but can over saturate a market with too many small businesses that cannot compete with larger companies, particularly in marketing and sales, and caregiver benefits.

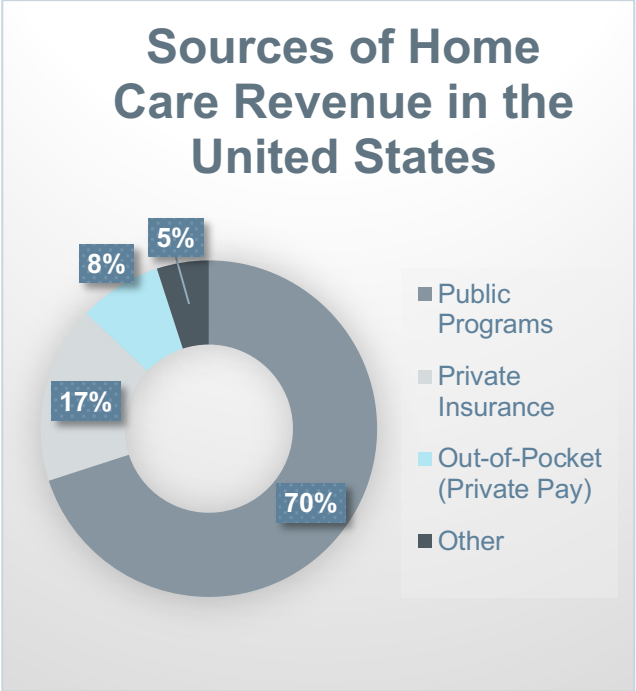
The business with the highest total annual sales ($130 million), Best Option Healthcare, accounts for 62% of total sales on the island. Best Option Healthcare offers specialized home healthcare services, including home infusion and wound care, but does not offer non-medical personal care services.

Among the 14 businesses that were determined to provide personal care services, the largest concentration (10 of 14) is among businesses with less than $1 million in annual sales. The two businesses with the highest sales account for 80% of market share. It is worth noting, however, that the business with the highest sales value ($24.5 million) offers a variety of home health services in addition to personal care assistance. If this business were excluded from the list, market share would be distributed more evenly.

Home Care Payers

Home care industry revenue comes from two primary sources. The first is from public payers, including Medicaid, Veterans Affairs, and state or municipal programs, and the second is from private payers including clients who pay out of pocket and clients who have purchased long-term care insurance. The public pay market is much larger than the private pay market nationally, but operating within this market involved challenges and barriers such as:

- Low reimbursement rates
- Licensing requirements
- Local regulations



The challenges related to the public pay market show that a private pay strategy is more feasible for many agencies, including small-scale agencies and start-ups. It is crucial for a home care agency to understand the size and scope of both markets, including both payers and clients, to match their business strategy accordingly. See Appendix 1 & 2 for a detailed explanation of Medicaid Home Care.

Public Payers

People who need home care services do not often need constant medical care or intervention. Instead, these populations typically need assistance with Activities of Daily Living (ADLs), routine activities like eating, bathing, getting dressed, toileting, mobility, and continence. Because these services are viewed as "non-medical," public payers undervalue these services with low reimbursement rates, making it difficult for home care agencies to sustainably serve this market. In Puerto Rico, Medicaid does not reimburse for non-medical services at all, creating a larger barrier to individuals being able to stay at home while they age. Due to Puerto Rico's relationship to U.S. Federal public programs, and its lack of representation in decision making, public payers each address the substantial need for care differently, creating a complex patchwork of programs that is difficult to navigate for both clients and agencies.

In April and May of 2021, the Governor of Puerto Rico, Pedro R. Pierluisi, issued executive orders establishing key working groups with missions related to the home care sector. The first is a multisector taskforce that will present proposals and strategies to the federal government for equal administration of Medicaid and Medicare.[17] The second is an Advisory Group on Public Policy of Aging and Older Adult Affairs that will be linked directly to the Governor's office and develop the 'Comprehensive Life and Active Aging Strategy for Puerto Rico.' This report will

[17] La Fortaleza Officina la Gobernador, Executive Order 2021-025, 2021.

outline policy and strategy changes for Puerto Rico's elderly population as it pertains to social, economic, labor, and health.[18] While the outcomes of these two groups has yet to be determined, the Governor's attention on these critical issues demonstrates both the need and state-wide commitment to finding solutions.

The following is a summary of public payer home care programs and how they operate in Puerto Rico:

- **Medicaid:** Medicaid does not reimburse for any non-medical or medical in-home care services in Puerto Rico. All other Medicaid services are provided as Fee-For-Service (FFS) through the state, or through Mi Salud,[19] a managed care delivery model that provides acute and primary care services.[20]
- **Medicare:** Medicare only reimburses for medical in-home care services through Medicare Advantage, and Home Health Aides (HHA) and nurses must provide these services. These services need to be coordinated in partnership with a health care provider.
- **Veterans Affairs:** Veterans Affairs provides a Program of Comprehensive Assistance for Family Caregivers (PCAFC). This program provides stipends for caregivers that are related to a veteran and who provide in-home assistance with activities of daily living.
- **Local Government:** Municipal governments and the Department of Family Affairs attempt to address the lack of access to health and home care services with locally developed programs.[21]

Medicaid

In the 50 U.S. states, the federal government provides matching funding to state investments in Medicaid programs based on the Federal Medicaid Assistance Percentage (FMAP), a formula that considers the average per capita income for each state relative to the national average. By law, the FMAP-based federal matching funds cannot be less than 50%.[22] Unlike each of the 50 states, Puerto Rico's FMAP has been set by statute at 55%, meaning that the U.S. government will only match 55% of Puerto Rico's investment in Medicaid. If the same process that is used in the 50 states was used in Puerto Rico, the federal government would provide 83% in matching funds.

Medicaid is the largest payer for home care in the 50 states, and so the limited funding allocation for Medicaid in Puerto Rico severely impacts the provision of home care services. Puerto Rico only offers 10 of the 17 mandatory Medicaid services due to a lack of funding and

[18] La Fortaleza Officina la Gobernador, Executive Order 2021-042, 2021.

[19] A locally funded insurance program that extends Medicaid coverage for those who exceed the Medicaid income eligibility.

[20] Puerto Rico and Health Care Finance: Frequently Asked Question. Congressional Research Service, June 27, 2016

[21] Information about local programs is limited and extremely difficult to find. One program that was mentioned was "Helping Hands" for individuals living with disabilities.

[22] Kaiser Family Foundation-Federal Medicaid Assistance Program

infrastructure.[23] See Appendix 3 for a full table of covered Medicaid Services. This misalignment leaves a vacuum in the healthcare system that other payers and stakeholders are left to address.

Veterans Affairs

As a federal program that typically operates autonomously from state-based programs like Medicaid, Veterans Affairs is a keystone healthcare provider for Puerto Rico's 300K+ veterans. The VA Hospital is in San Juan and was publicly recognized for its efforts to rescue and care for veterans in their homes during Hurricanes Irma and Maria.

To provide eligible aging veterans with in-home assistance at no cost, the VA created a Program of Comprehensive Assistance for Family Caregivers (PCAFC), formerly known as the Caregiver Support Program (CSP). This program mirrors consumer-driven home care programs seen in U.S. states. The PCAFC program provides a stipend for family members who provide care to a veteran to help offset lost income from providing care.

For this program, there are two levels of care that can be reimbursed, and they depend on the veteran's ability or inability to "self-sustain in the community." A veteran is deemed "unable to self-sustain" if the veteran cannot perform 3 of the 7 activities of daily living,[24] or needs supervision, instruction, or protection on a continuous basis. After eligibility has been verified, and a caregiver is identified, stipends[25] are provided at two levels:

- Level 1: Not unable to self-sustain: 62.5% of monthly stipend
- Level 2: Unable to self-sustain: 100% of monthly stipend

Medicare Part C, Medicare Advantage (MA)

Medicare Advantage, also known as Part C, can cover home health services provided by agencies that are certified by the local state or territory Department of Health. The Medicare Advantage program is targeted at "dual-eligible" citizens—individuals who qualify for both Medicaid and Medicare.

Medicare Advantage covers:[26]

- Skilled Nursing Facilities: MA will completely cover costs for recovery following an inpatient hospital stay for up to 20 days.
- Assisted Living Communities: MA does not cover the cost of assisted living or personal care (custodial care) but will cover most medical costs for people residing in assisted living facilities.

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[23] MACPAC Mandated Report on Medicaid in PR-Chapter 5, 2017

[24] Dressing, bathing, grooming, adjusting prosthetic or orthopedic appliances, toileting, feeding oneself, mobility.

[25] Stipends are determined by taking the annual Rate for Grade 4, Step 1, based on the locality pay area in which the eligible Veteran resides, divided by 12.

[26] Medicare Benefits for Assisted Living and Long Term Care (LTC)

- In Home Care: MA will cover skilled in-home nursing care for a limited time, but not non-medical home care.
- Adult Day Care: Some MA plans will cover the cost.
- Alzheimer's/Dementia Care: Most care for Alzheimer's patients is considered non-medical personal care and, therefore, MA will not cover those costs.
- Hospice: MA will cover the cost of hospice for a maximum of 6 months for a terminally ill patient.

The home health workers who provide care under Medicare Advantage need to be employed by a Puerto Rico Department of Health licensed agency or hospital system that provides most of the care to a patient. Medicare determines visit time limits and frequency based on the primary care provider's recommendation and authorizes the home health agency for a specific number of visits per week, and a set of authorized activities. Home health agencies will then only be reimbursed by the Medicare Advantage Plan for care that is provided within the pre-authorized parameters.

Department of Family and Municipal Governments

The Puerto Rico Department of Family Affairs is primarily responsible for the care of children and their families. As an extension of their mission, they also provide services to individuals living with physical and mental disabilities along with the Corporation for the Blind, Mentally Retarded, and Other Disabled Persons (CIRIO). In partnership with municipal governments, these stakeholders work to develop programs that keep people safe while remaining in their homes and/or communities. Unfortunately, because of Puerto Rico's economic crisis and its effect on local budgets, the nature of political cycles, and the numerous needs for aid and service provision after the hurricanes in 2017, these two entities struggle to fill the gap left by the absence of federal government supported programs.

Private Pay

The median household income of Puerto Rico's 65+ population is $16,953—$3,521 less than the median household income for the total population, and 40% of people 65 years and over are living below the poverty line. Assuming an hourly direct service rate of $15-$16 per hour,[27] it is estimated that full-time care in Puerto Rico could cost individuals between $34,320 to $36,608 per year.[28] This equates to an average yearly cost of 202% to 216% of median income for those 65+, suggesting that paying for home care services out of pocket would be impossible for many Puerto Ricans without supplemental assistance from family or public programs.

Interviewees acknowledged the presence of a private pay market for home care, though could provide little concrete detail about its practices. They did however highlight two key variables regarding the private pay market. The first is the prevalence of an informal workforce (often

[27] Average hourly rates on the mainland are $23.50 per hour. The assumed rate of $15 to $16 per hour in Puerto Rico was derived through interviews for this study.

[28] Full-time care is calculated at 44 hours per week at 52 weeks per year.

referred to as grey market or under-the-table work), including many undocumented workers from neighboring islands. Interviewees noted that it is quite common for people to hire informal caregivers directly, rather than going through an agency. The second is a shortage of trained and available caregivers even for those who can afford out-of-pocket rates, meaning there is likely demand for private pay services that could be met with a trained and coordinated workforce.

While both informal and direct-hire work can be seen as beneficial in the short term to the worker who receives the full sum of payment for the services they provide, the down sides are significant. Directly hired or informal caregivers have no job safety or job protections, sometimes leading to precarious or dangerous employment situations. Families that choose to go this route are required to provide all training and supervision to the caregiver, and have little to no recourse if something goes amiss while directly employing a caregiver. Finally, many home care workers on the mainland receive job training through their employers. The lack of agencies operating on the island not only results in a lack of available services and a lack of formal protections for caregivers and clients, but also in a lack of training programs and opportunities for the caregiving workforce.

Overall, the private pay market in Puerto Rico operates with little to no oversight, creating a market where caregivers are shuffled around, and families are in a near-constant search for a caregiver or a better caregiver. Multiple interviewees stressed that when it comes to directly hiring a caregiver, your own internal network is the most valuable asset. The names of quality caregivers are shared and referred around internal networks creating a web of information that is unavailable to those not "in the know."

Regulatory Environment

Business Licensing Requirements

Any new home care business in Puerto Rico will need to register and be licensed by the state's Registry of Corporations and Entities[29] to serve clients. Enterprises looking to be reimbursed by Medicare would additionally need to register with the Centers for Medicare and Medicaid Services (CMS) to be an approved provider.

Training and Workforce Licensure Requirements

To provide care, whether in-home or at facilities, individual health care professionals are required to maintain up-to-date licenses and certifications with the Puerto Rico Department of Public Health.[30] Recertification for most licenses is required every three years. For a home care business, this would apply to the nurses on staff who manage client care plans and to Home

[29] https://prcorpfiling.f1hst.com/CreationFilings/NameAvailability.aspx

[30] https://orcps.salud.gov.pr/Default.aspx

Health Aides who are required to maintain their certification with continuing education credits, which employers can provide. Based on our research, there are no certification or training requirements for personal care services.

Training requirements are primarily targeted for Home Health Aides (HHA) or Certified Nursing Assistants (CNA). HHA training requires 40 hours of total training and can be provided by employers or third parties. The Job Connection Center, a workforce development center with 4 locations across the island, provides training programs focused on home care to both those who are new to the profession and to existing caregivers seeking more training.

Cooperative Opportunity

The lack of consistent quality home care in Puerto Rico creates a self-perpetuating economic cycle for caregivers and clients. There is an insufficient supply of caregivers in the industry to meet the demand for care. Because of a systemic underinvestment in home care, caregivers in the industry leave for better paying, more stable, or less physically and emotionally taxing work, and new caregivers are not incentivized to enter the workforce. Together, this results in a perpetual deficit of caregivers. For clients and their families, the shortage of available, reliable, trained, and affordable caregivers results in family members having to stay home from work to care for their family members. This loss of household income then makes it harder to find affordable, quality, and available care. Across the board, the resounding effects are loss of productivity to Puerto Rico's economy from family members having to stay home to care for family members and increased costs to Puerto Rico's healthcare system as individuals transition into institutional care without adequate at-home supports.

Given this vicious cycle, an innovative intervention is needed. During market research, interviewees shined a spotlight on Puerto Rico's strong cooperative ecosystem and the inherent commitment to finding community-based solutions to help solve the home care crisis. Additionally, the last two years of difficult recovery from natural and economic crises has solidified the resolve to invest in communities and find solutions through on-the-ground collaboration. For the seniors and individuals living with disabilities that remain in Puerto Rico, that work cannot come soon enough.

Applying the cooperative model to home care in Puerto Rico provides a familiar, trusted solution to an industry in need. Without a large public payer like Medicaid to drive client referrals, or a clear and localized private pay market, a new home care cooperative will need to rely on its community connections, partnerships at the state and municipal level, philanthropic supporters, or exclusive contracts for stable revenue, client, and caregiver sources.

It's important to note that each of the 14 home care cooperatives in the U.S. states is uniquely tailored to its local context, and this would be the same for Puerto Rico. Possible cooperative and home care structures that would create jobs and provide needed care to the community could include combinations of the following:

Alzheimer's and Dementia Care Specialization: In Puerto Rico, the Alzheimer's death rate sits at 39.8%,[31] 15.6% higher than the U.S. While the Alzheimer's and dementia care opportunity was reiterated multiple times during interviews, it is contingent on well-trained caregivers. For families with members who are experiencing the degenerative effects of Alzheimer's or dementia, their primary concern when hiring caregivers is trusting that the caregiver has the training and qualifications to center their family member's dignity and safety. As such, the primary market for a specialized Alzheimer's and dementia care cooperative would be in the private market. However, if an effective training curriculum can be established, that curriculum could also be sold to other home care providers so that quality care can be provided to all Puerto Ricans living with Alzheimer's and dementia.

Adult Day Care: Adult day centers provide safe and supported environments for elderly citizens. They can be spaces to build community and provide needed socialization for elderly individuals who live alone or live with family members but are alone for most of the day. Adult day centers also provide supportive services like transportation to appointments, on-site personal care, rehabilitative therapy, and conveniences for other services like hairdressers. Payers for these services can come from locally established public programs or individuals who are willing to pay out of pocket.

Seniors4Seniors: Given the growing concentration of citizens who are nearing or over 65 in Puerto Rico, establishing a cooperative that both employs and serves older citizens from the community would be worth exploring. Whether it be seniors who are retired and active in the community, those who work limited hours and could benefit from supplemental income, or those who are actively seeking work, a home care cooperative made up of clients' peers would be a unique solution to the caregiving deficit in Puerto Rico.

Community membership structure: Similar to the Seniors4Seniors structure, the community membership structure finds solutions to the caregiver vacuum. A community membership structure is a longer-term solution where community members contribute nominal amounts of money over time into a community account that is intended to pay caregivers and run the operations of a home care cooperative. When a family or individual who has contributed to this community fund needs care, it can be provided at no additional cost or at minimal cost by the cooperative. These kinds of pre-paid cooperative structures gained large success internationally and in other industries such as insurance.

Respite care for family caregivers: The VA program in Puerto Rico addresses the constraints placed on family caregivers. Similarly respite care for full-time family caregivers is a welcomed intermediate solution for families who cannot afford full-time caregivers. Unlike the VA program which provides stipends to family caregivers, a new cooperative could provide respite care to allow family caregivers to work or run necessary errands away from the home. However, the VA could be a potential partner for a new home care cooperative offering this service. This

[31] Health In the Americas Puerto Rico, 2012

partnership would be dependent on the cooperative's ability to navigate and process VA billing systems and would dictate the kind of qualifications caregivers in the cooperative need. A cooperative offering this service could also operate in the private pay market with families scheduling respite hours as needed.

Conversion: A home care cooperative conversion would advance the development of a home care cooperative in Puerto Rico in a shorter time frame. In this instance, a home care agency owner who is interested in retiring or otherwise exiting their business would sell the business to their employees with the financial assistance of a Community Development Financial Institution (CDFI) or another community-oriented lender. A conversion expedites the establishment of a home care cooperative because an established client base, referral partners, and caregiving staff can be included in the sale—components that start-up cooperatives struggle to establish as new entrants. With capital, an entrepreneur or group could also lead the acquisition of an existing company with the intention of converting the business to a cooperative ownership and management structure. It is ideal to structure such an arrangement so that management agrees to stay on for a defined period of time while the company transitions to worker ownership.

Conclusion

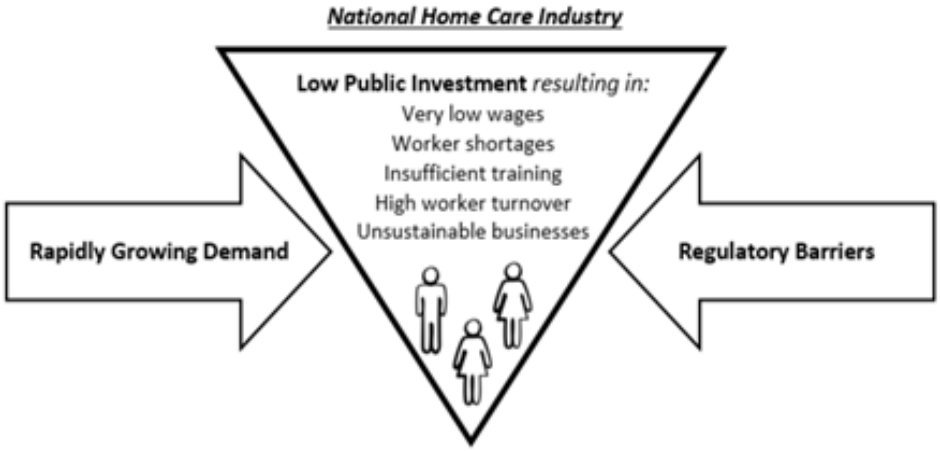
Societal undervaluing of caregiving as a profession has led to historically low wages, negative attitudes, a stigma towards caregivers, and a disregard for the issues facing caregivers and clients. Puerto Rico's status as a U.S. territory has restricted local leaders from federal programs like Medicaid that could provide much-needed employment and care for Puerto Rico's citizens. Families and community members are left to navigate a fragmented support network and fill the gaps.

Those hoping to address the immense need for home care services in Puerto Rico will confront a challenging labor market defined by a rapidly aging population and a shrinking workforce. The "cooperative difference" in home care—respect, better wages and benefits, training and career advancement, worker ownership and voice—is a competitive advantage. Those that can successfully launch and operate financially sustainable home care cooperatives can make a meaningful difference in the lives of both home care workers and consumers.

Cooperatives thrive in Puerto Rico, where community relationships and networks prevail as the most stable system of assistance. A home care cooperative that is backed by a network of trustworthy and familiar entities and is structured to provide quality training and respected job opportunities could begin to incrementally chip away at the larger issues caused by the current economic crisis and the systemic challenges facing the home care industry. Because of the familiarity with the cooperative model, and a government acknowledgement of its status as a viable and important business model, the cooperative ecosystem in Puerto Rico would be a hospitable place to start and grow a home care cooperative.

Appendix

Appendix 1: National Home Care Industry 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. According to U.S. Census projections, a quarter of the national population will be 65 and older by 2060 and 19.7% of this group will be 85 or older. Nine in ten seniors want to "age in place" in their current home and community, and an estimated 70% will need help with basic daily living activities to do so. Nationally, there are seven[32] clients who need home care for everyone caregiver in the workforce. Many states experience significantly higher shortages.

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 three 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. Home Health Aide is the 3rd fastest growing job in the nation, and Personal Care Aide is ranked 4th.[33] 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. Home care providers have rated caregiver shortages as the number one threat to their businesses for the last three years[34]. Eighteen percent of home care workers are uninsured and, of those insured, 40% rely on public health care coverage, primarily through Medicaid. Consequently, turnover rates within the home care sector have climbed from 60% in 2017 to 82%[35] in 2019, contributing to the overall caregiver shortage. The industry wide cost of caregiver turnover is over $10 billion per year.

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[32] In 2017, OES data expanded the scope for "Services for the Elderly and Persons with Disabilities" to include some positions that were previously classified under "Services in Private Households", subsequently increasing the total number of personal care aides employed nationally and decreasing the national caregiver ratio from the previous 8:1.
[33] https://www.bls.gov/emp/tables/fastest-growing-occupations.htm
[34] Pulse 2018 Benchmark, page 62
[35]2019 Spring Home Care Benchmarking Study

Nationally, home care is a $5B+ national market that is quickly expanding and expected to grow at a rate of nearly 7% for the next five years.[36] 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 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 home care industry does not have strong political representation and thus has been an easy target for federal cuts. Even though Medicaid Home and Community Based Services (HCBS) enrolled 4.6 million people in 2017, and spent $82.7 billion for care,[37] that spending is rarely reflected in the wages and employment stability of home care workers. Across the U.S. the hourly median wage for workers in the direct care workforce is $12.17 per hour, only 10 cents more than the median wage for retail and food service workers. Even though home care is increasingly promoted by healthcare professionals and offers a superior value for clients, this recognition has not yet resulted in increased payments for services. Continued neglect for the home care occupation will continue to result in the growth of recruitment needs and cost and a decrease in available quality care for the country's vulnerable aging population.

[36] *IBISWorld Industry Reports: 62161 Home Care Providers in the US*
[37] https://www.kff.org/medicaid/issue-brief/medicaid-home-and-community-based-services-enrollment-and-spending/

Appendix 2: Medicaid Overview

Representing over 70% of revenue, Medicaid is the largest and most important payer of home care services nationally.[38] 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. Long-term care, specifically, accounts for over 60% of Medicaid spending. Under Medicaid, the federal government provides a base match of 50% for approved Medicaid provided services, with lower income states eligible for higher reimbursement rates. To be eligible for Medicaid benefits, individuals must meet federally mandated means tests.

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 absorbed a larger share of Medicaid costs for new enrollees, covering 100% of costs from 2014 to 2017 and gradually reducing that percentage to 90% from 2017 to 2020. To date, 39 states and the District of Columbia have expanded Medicaid.[39]

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 home 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."[40] The number and type of 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 Waivers 22

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.[41] 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. Home health aide, personal care aide, and homemaker services are

[38] Medicaid, May 2019 Medicaid & CHIP Enrollment Data Highlights. Retrieved from www.medicaid.gov
[39] Medicaid Expansion in Michigan, Fact Sheet, Updated January 2016, Kaiser Family Foundation. Accessed at: http://files.kff.org/attachment/fact-sheet-medicaid-expansion-in-michigan
[40] Congressional Budget Office, Overview of Medicaid. Retrieved from https://www.cbo.gov/publication/44588
[41] Medicaid, Home & Community Based Services Authorities. Retrieved from www.medicaid.gov.

almost always covered under these programs.[42] 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 1990s, Medicaid operated under a system of "fee-for-service" in which providers were directly reimbursed for services provided, based on the rates set by individual states. In the early 1990s, 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 fixed and standardized payments per member per month for health care services, known as "capitated payments." Because payments are "capitated," MCOs 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 and ensure company profit.

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.[43] As of July 2018, 11 states did not have Managed Care programs in place.[44] States that have begun transitions to managed care programs are in varying states of transition. 17 states operate almost exclusively under managed care programs (over 90% transitioned),[45, 46] 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 correlated to how service rates are set, how money flows, and impacts the importance of strategic partnerships, scale and other factors to home care agency success.

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[42] Medicaid, Home & Community-Based Services 1915(c). Retrieved from www.medicaid.gov.

[43] Kaiser Family Foundation, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011. Retrieved from https://www.kff.org.

[44] Kaiser Family Foundation, Total Medicaid MCOs. Retrieved from https://www.kff.org.

[45] The 17 states with over 90% transition to MCOs include Tennessee, Hawaii, Nebraska, Delaware, Kansas, New Jersey, Virginia, Texas, Arizona, Oregon, Iowa, Florida, Washington, Louisiana, Kentucky, Rhode Island, and New Mexico.

[46] Kaiser Family Foundation, Share of Medicaid Population Covered under Different Delivery Systems. Retrieved from https://www.kff.org.

Appendix 3:

TABLE 5-2. Mandatory and Optional Medicaid Benefits Covered by Puerto Rico, FY 2018

	Mandatory Medicaid benefits	Optional Medicaid benefits
Covered	• EPSDT services for individuals under age 21 • Inpatient hospital services • Laboratory and X-ray services • Medical or surgical services by a dentist • Outpatient hospital services • Physician services • Tobacco cessation for pregnant women • Family planning services • FQHC services • Rural health clinic services	• Clinic services • Dental services • Eyeglasses and prosthetics • Outpatient prescription drugs • Physical therapy and related services • Diagnostic, screening, preventive, and rehabilitative services • Inpatient psychiatric hospital services for individuals under age 21 • Inpatient hospital services for individuals age 65 or over in an IMD
Not covered	• Home health services for those entitled to nursing facility services • NEMT • Certified pediatric and family nurse practitioner services • Nurse midwife services • Nursing facility services for individuals age 21 and over • Emergency services for legalized aliens and undocumented aliens • Freestanding birth center services	• Hospice care • Private duty nursing services • Intermediate care facility for individuals with intellectual disabilities • Personal care services • Targeted case management services

Notes: EPSDT is early and periodic screening, diagnostic, and treatment. FQHC is federally qualified health center. FY is fiscal year. IMD is institution for mental diseases. NEMT is non-emergency medical transportation. Eyeglasses are provided only under the EPSDT benefit.

Source: GAO 2016.