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MINNESOTA

HOME CARE MARKET ASSESSMENT



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KEY TAKEAWAYS

- **Strong public program environment:** Minnesota spends \$24,383 per capita on Home and Community Based Services over \$5,000 more per person than the national average. Additionally, Minnesota spends a greater share of its Medicaid spending on Long Term Support and Services (LTSS) than the national average and a greater share of LTSS on Home and Community Based Services than the national average. There is a long-standing commitment in the state to high quality health care and a very sophisticated nonprofit sector.
- **Increasing consumer demand:** The current home care market in Minnesota is estimated at 300,800 customers. The private pay market is estimated at approximately 50,500 customers. Minnesota's elderly population is comparable to the national proportion of elderly at 13.9% and is growing at the same rate as the national average at 9.3%. Because of this and other factors, the number of home care customers is expected to increase by 42,000 between 2017 and 2024.
- **Insufficient labor supply:** Minnesota has a healthy supply of caregivers, yet long term trends will lead to enduring demand for new caregivers. Minnesota's ratio of caregivers to those needing care is 1 to 3, far better than the national average, but 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 431,000 new caregivers to be recruited to the workforce by 2024.
- **Moderately competitive home care agency market:** The Minnesota market is moderately competitive, with 54% of home care agencies in the state earning less than \$250,000 in sales revenue. The five largest firms in the state control 36% of the market which is much higher than the national, but still allows significant space for new entrants to garner market share.
- **Cooperative opportunity:** There are not currently any home care cooperatives in Minnesota, but the state has a rich co-op history and a strong technical assistance presence. In addition, two recent developments in the marketplace might provide opportunities for a worker-centered and quality-center approach. One is the strong presence of SEIU as a potential advocacy and training partner. The other is the shift in the state to Accountable Care Organizations (ACOs) which in theory should provide an opportunity to make the case for an enhanced role for trained care givers. As in other states, in a service industry where the primary expense is personnel, Minnesota 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 a number of areas where existing home care coops operate or community groups are working to start new firms. For more information visit: www.cdf.coop or www.ica-group.org.

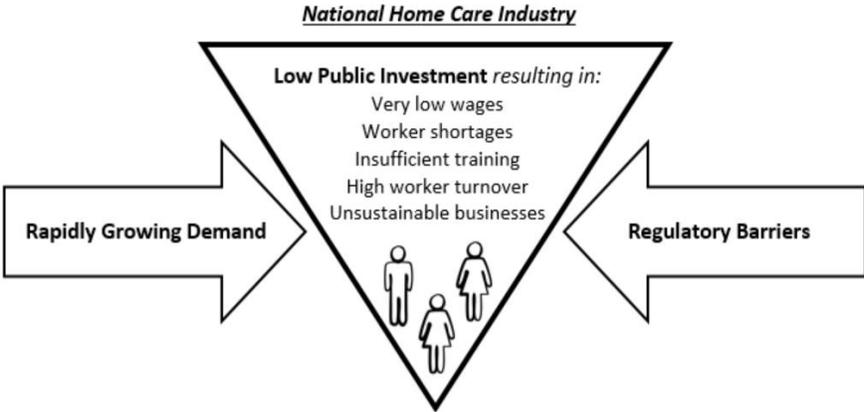
NATIONAL OVERVIEW

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



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

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 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

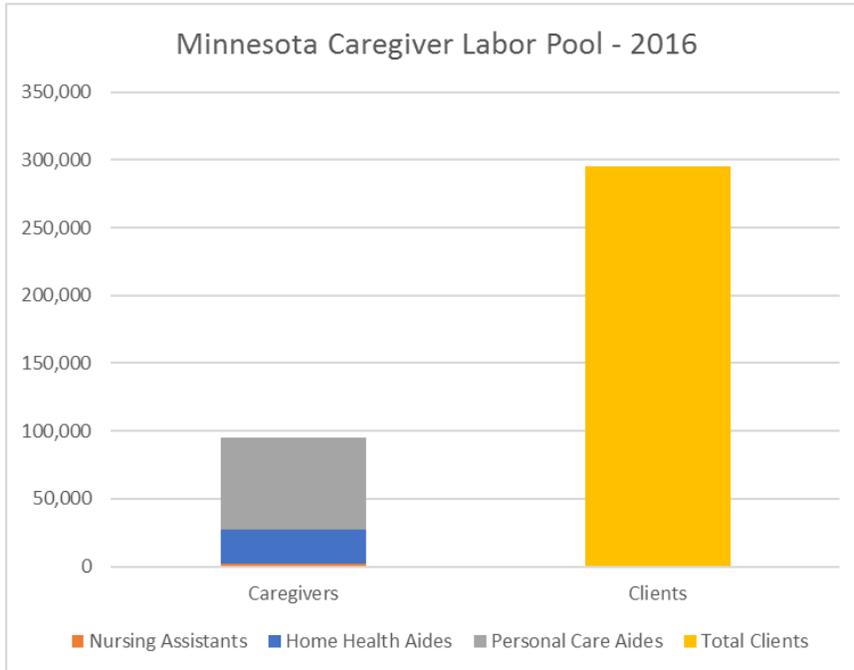
Minnesota ranks right in the middle of states in the U.S. for a number of factors affecting the market for home care cooperatives. The state has an average proportion of seniors whose ranks are growing at a yearly rate of 9.3%, slightly below the national rate of 9.7%, but a higher population of individuals living with disabilities. Adding frail elderly to those living with disabilities who need care yields an overall home care subset that is somewhat lower than the overall national average. Minnesota has a relatively high median income (12th in the nation) with a slightly above average proportion of people receiving Medicaid.

What distinguishes Minnesota is the public policy environment. Per capital spending on Home and Community Based Services at \$24,383 is about 30% above the national average, and the state devotes an admirable 75% of long term support resources to community-based services compared to an average of 53% nationally. The state continues to lead the country in a number of indicators related to support for the elderly, ranking second behind Washington state in the recent AARP Long-Term Services and Supports scorecard.² Minnesota ranked in the top five in terms of “Affordability and Access,” “Choice of Setting and Provider,” and “Quality of Life and Quality of Care” measures, and 6th in “Support for Family Caregivers,” slipping into the second quartile on only one set of measures, that of “Effective Transitions.”

Labor markets are challenging in the state however. Minnesota boasts a historically low unemployment rate (3.8% recently compared with a national rate of 4.4%) and a higher than average labor force participation rate among those of prime working age (84% compared with 81.7%). This indicates that most willing workers are already on the job somewhere, and few are left to be enticed into the labor force. This is an important consideration for any new cooperative considering the state. Thirty-six percent of market share is controlled by the five largest agencies in the state. Each of these large agencies do not work in every community in the state, but the presence of large and sophisticated competitors could make recruitment even more challenging for a small cooperative.

There is currently one caregiver for every three residents in need of services, a significantly better situation than the national average of 8 to 1. This ratio varies in different parts of Minnesota, however, with communities in the northern part of the state in particular having relatively fewer caregivers. In no part of the state is the ratio below the national average, however, so Minnesota is better-placed than many states in terms of the availability of individuals already in the profession. Recruiting and retaining

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



quality employees will be the single most important competitive advantage for those agencies that can do it well.

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 Minnesota, how this affects current and start-up home care cooperatives in the

state, and what are potential strategies for nurturing and growing home care cooperatives in Minnesota.

MARKET OVERVIEW

To understand the market for home care services in Minnesota, 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 Minnesota 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.

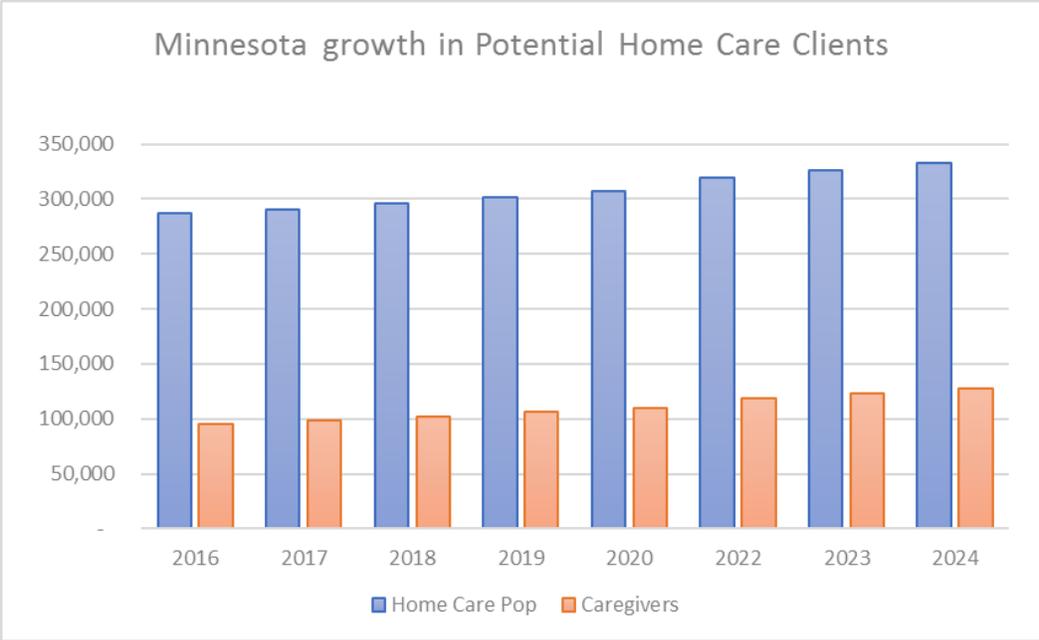
Customers

In the long term, Minnesota will experience significant growth in the demographic groups that are most likely to use home care services. As of 2016, close to 300,000 Minnesotans were categorized as frail elderly, self-care disabled, or independent living disabled.³ At 5.45% of the total state population, this is a somewhat lower proportion of the population than the national average at just over 6%. The rate of growth in Minnesota's 65+ population (9.29%) is slightly lower than the national growth rate for the senior portion of the population of 9.7%. However, the Minnesota-based population of individual living with disabilities at 11.1% is significantly higher than 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 Minnesota, 19% of the state's residents receive Medicaid benefits – just a bit more than the national average of 18%. This is significant for two reasons. First, the more Medicaid beneficiaries there are in a state, that more public money available to pay for home care services, increasing the potential size of the state's home care market. Second, home care costs in Minnesota are quite expensive at a yearly average cost of 145% of median income for residents aged 65 and over. High home care costs reduce the potential number of customers in the private pay market place, but the high number of Medicaid beneficiaries in the state helps boost the size of home health care workers' overall customer base.

In sum, the home care client demographics in Minnesota are favorable towards the development of home care businesses. Long-term trends point towards a growing customer base. High costs may dampen the potential for private pay, but this may be offset by a relatively high median state income, 12th in the nation.

³U.S. Census Bureau (2016). *Monthly Population Estimates for the United States: April 1, 2010 to December 1, 2017 2016 Population Estimates*. Retrieved from www.census.gov.



Providers

ICA estimates that there are currently 479 independent personal care and home health companies operating in Minnesota. This count includes headquarters and single location companies, but does not include branch locations. Of this group 393 are categorized as home health companies and 86 are categorized as providers of individual and family services. None of the existing agencies is organized as a cooperative.

Similar to the national market for the industry, the home care market in Minnesota has a few large companies and many small local operators – 54% of companies have revenues of less than \$250,000, which is just above the median size for state agencies overall of \$216,818⁴. On the other end of the spectrum, however are some very large players, beginning with Red Wing Regional Home Health which at revenues of over \$95 million, is bigger than many of the larger home care companies serving more populous states, and twice as large in terms of revenue as the two next largest players in the state. Together, the five largest companies in the state account for 36% of industry revenue⁵, a much higher degree of concentration than the national market where the top three companies account for only 8.7%. The Minnesota home care agency market is healthier than some however, in having a relatively robust sector of mid-sized companies as well. Twenty percent of home care companies in the state have

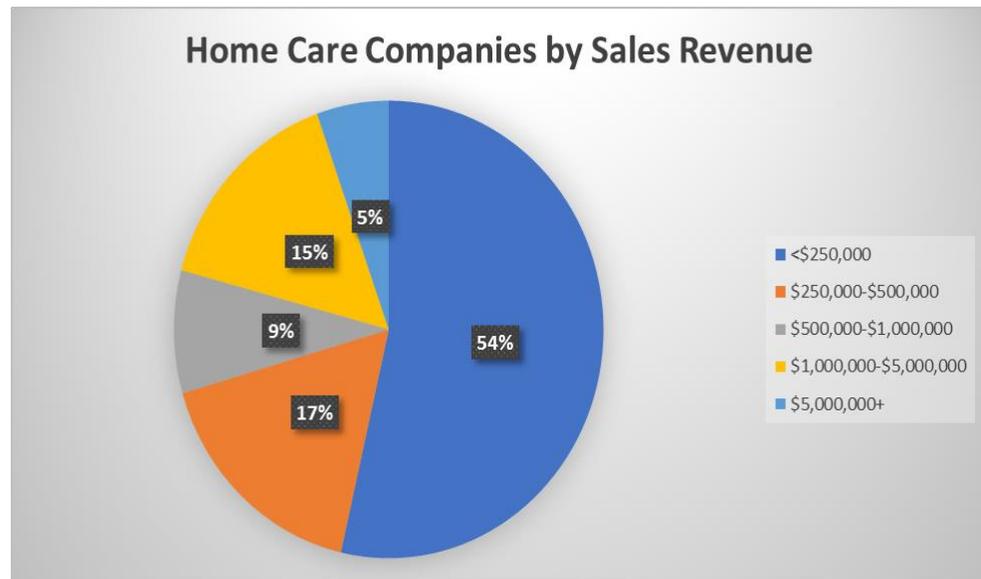
⁴ Mergent Intellect Dun and Bradstreet. (n.d.). Loblaws Inc. Retrieved from www.mergent.com.

⁵ Industries in which the top five firms control 60 % or more of the market are generally considered non-competitive.

revenues of over \$1 million, generally considered a benchmark for efficient operations in the industry.

Another 9% are in the \$500k - \$1 million band. It appears that there is some ability in the state to scale operations to a workable level.

Interestingly, unlike in some other states which, like Minnesota, have a single major metropolitan area,



several of the largest players work across Greater Minnesota, serving the smaller cities of St. Cloud, Red Wing, Rochester, Marshall and Mankato. The average revenue size for rural and urban agencies in Minnesota are relatively similar at \$402,500 for rural areas and \$360,000 for urban, which also approximately match national figures. So, in general, despite the presence of some very large companies in the industry, the market appears to be quite competitive and open to new players in both rural and urban communities.

Rural vs. Urban Conditions

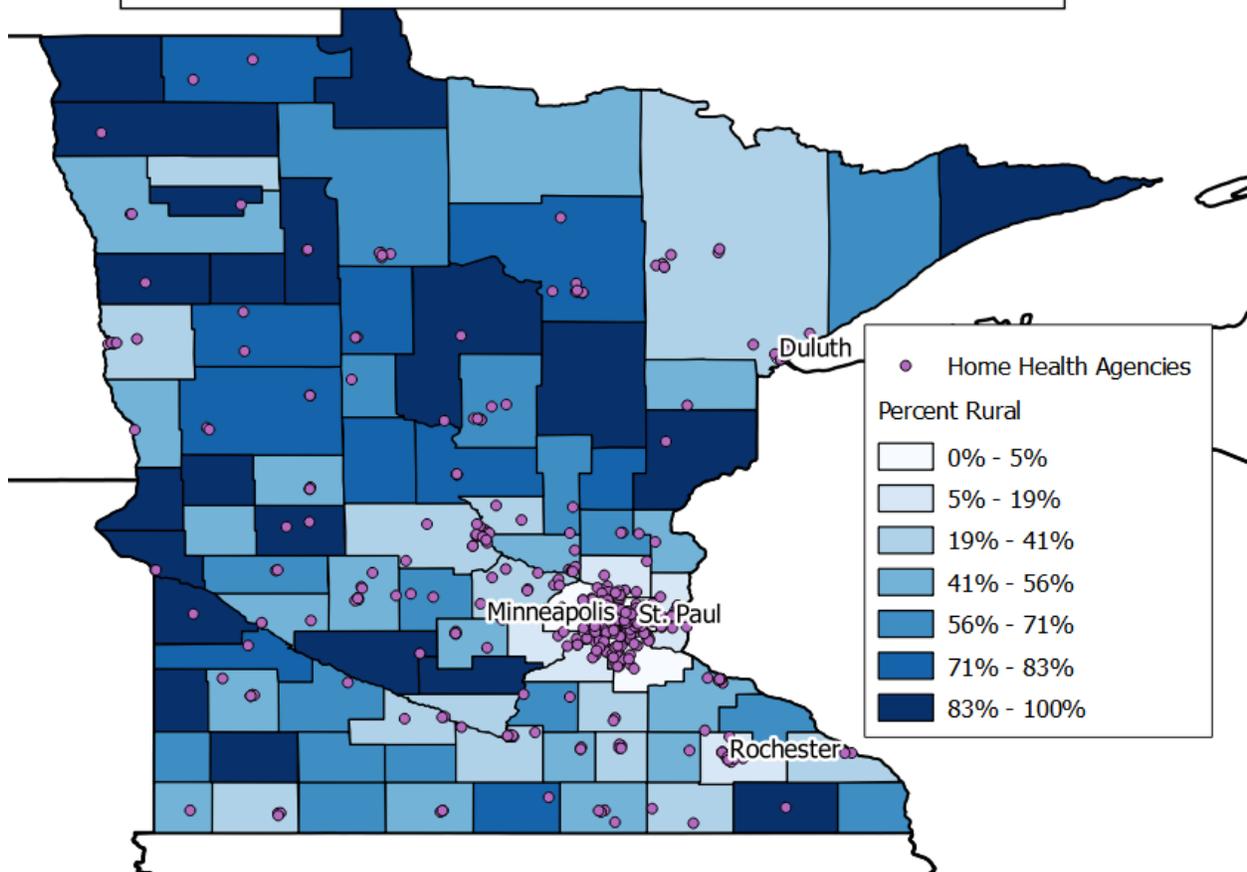
Minnesota is not a highly densely populated state, with an overall population of about 70 people per square mile versus a national figure of 91. Urban areas in particular are significantly less dense than elsewhere in the country. The state's rural areas however, are fairly similar to the rural population nationally, at 15 people per square mile compared with a national median of 19.

While the overall proportion of the state's population 65+ is about 15%, this proportion is much higher in some rural areas. Half a dozen rural counties have senior populations of over 25%, and in one remote county the proportion of the population 65 or over is 30%.

While 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. Nationally, rural homecare companies have 15% higher sales revenue than urban companies (which is true in Minnesota as well), suggesting that there are higher variable costs to operating in rural locations, possibly due to travel expenses, leading to lower margins that must be overcome by generating higher sales revenue.

As the chart below indicates however, some rural areas of the state are much better served than others, with North Minnesota in particular showing a dearth of agency resources.

Rural Counties and Home Health Agencies



Payers

The homecare industry's revenue comes from two sources. The first is from public payers, typically Medicaid. The second is from private payers, which includes both clients who pay out of pocket and clients that have long-term care insurance. The public pay market is much larger than the private pay market in both Minnesota 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.

Public Pay

Minnesota is a Managed Care state, and payments for a wide variety of public programs are run through one of nine managed care organizations. State law mandates that 72.5% of every dollar paid by the state for Personal Care Assistance (PCA) services must be spent on wages or benefits for workers, and cannot include training, fees, or administrative overhead in this figure. From a worker perspective, this is certainly a win, although any new cooperative agency would have to be able to operate effectively within this limited overhead environment.

The state also offers a number of consumer-directed personal care options for clients, whereby clients can either work through a traditional agency selecting their own PCA worker, or if approved, may assume full responsibility for recruitment, scheduling, evaluation and documentation of their hired aides, working with an approved PCA Choice agency only for such technical details as taxes and billing.

SEIU recently won the right to organize home care workers in Minnesota, and their recent contract covers about 27,000 home care workers in the state who work in one of the state's three consumer-directed choice programs. The contract included a new minimum wage of \$12 an hour, an increase in Paid Time Off, as well as a training benefit for 5,000 workers who opt to upgrade their skills.

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 Minnesota is 300,800. 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 Minnesota private pay home care potential client pool to be 50,500. Given that home care costs in Minnesota are high relative to the state's median income this may be an over estimate of the potential market as some may not be able to afford out of pocket home care costs.

Key stakeholders

SEIU: This union has negotiated with the state to cover a portion of the publicly-paid PCA workforce since first winning the right to bargain for this group in 2015.

LeadingAge Minnesota: This is the largest association of organizations serving Minnesota's seniors and host of the annual Workforce Solutions conference devoted to exploring the recruitment, retention and development of the workforce serving seniors.

REGULATORY & PUBLIC POICY OVERVIEW

This section will breakdown the regulatory and political barriers in Minnesota that may create difficulty in starting a new home care cooperative or expanding an existing one. In addition, this section will review how Medicaid works nationally and in Minnesota, with a focus on Home and Community Based Services 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.⁶

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.”⁷ 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 Waivers⁸

See Appendix 3 for detailed waiver descriptions

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.⁹ 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

⁶ A 50-State Look at Medicaid Expansion, Families USA. Retrieved from www.familiesusa.org.

⁷ Congressional Budget Office, Overview of Medicaid. Retrieved from www.cbo.gov.

⁸ Medicaid, Authorities. Retrieved from www.medicaid.gov.

⁹ Medicaid, Authorities. Retrieved from www.medicaid.gov.

aide, personal care aide, and homemaker services are almost always covered under these programs.¹⁰ 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," where providers were directly reimbursed for services provided, based on 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 per member per month payments 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. 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.¹¹ As of March 2017, only 12 states did not have Managed Care programs in place.¹² 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),¹³ 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 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.¹⁴ The goal of ACOs 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.¹⁵

¹⁰ Medicaid, Home and Community Based Services, 1915c Waiver. Retrieved from www.medicaid.gov.

¹¹ 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.

¹² Kaiser Family Foundation, Total MCO's, March 2017. Retrieved from www.kff.org.

¹³ Kaiser Family Foundation, Share of Medicaid Population Covered Under Different Delivery Models, July 2016. Retrieved from www.kff.org.

¹⁴ Center for Health Care Strategy, Inc. Medicaid ACO's: Status Update, June 2017. Retrieved from www.chcs.org.

¹⁵ Center for Health Care Strategy, Inc. Medicaid Accountable Care Organization Programs: State Profiles. Brief: October 2015. Retrieved from www.chcs.org.

Minnesota Medicaid Overview

Medical Assistance (MA) is Minnesota's Medicaid program. The Minnesota Department of Human Services (DHS) is the state's lead Medicaid agency and, as such, is responsible for administering MA. It has, in turn, delegated various responsibilities to counties, tribal governments, and managed care organizations.

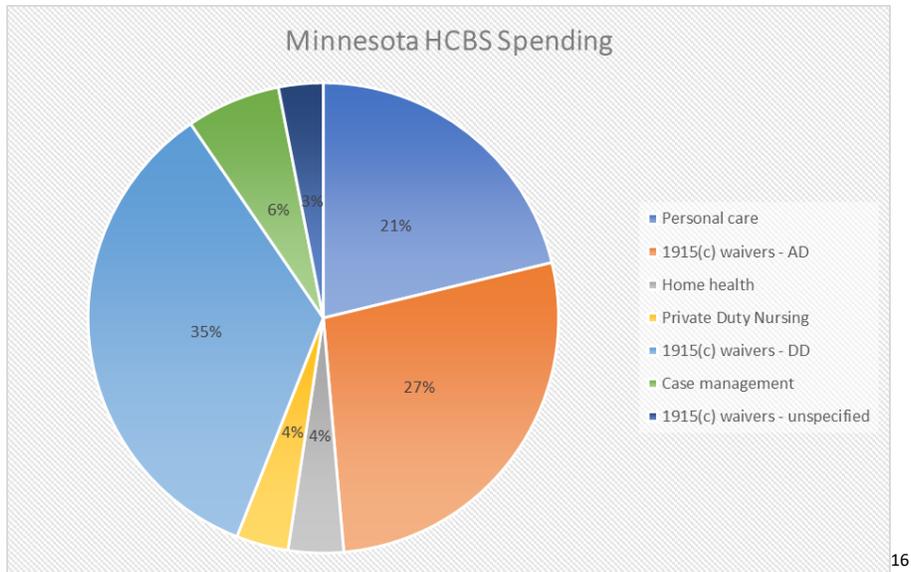
In early 2017, the Legislative auditor's office released a report on HCBS spending, concluding, among other things, that the state did not collect adequate financial data from Home and Community-Based Service providers, and that financial oversight of HCBS programs overall was lax. A previous auditor's report in 2009 identified several instances of fraud in the PCA market resulted in additional oversight of these workers, but this oversight did not extend to HHA or other workers providing similar services in the home. The new 2017 report recommends that oversight be extended to other direct care workers, and that the legislature direct the Department of Human Services to regularly collect data on direct care staff in HCBS settings, with an eye toward the looming staff shortages that Minnesota, along with every other state in the country, is likely to incur. It is unclear at this point what specific affect this report will have on the future market for home care, but it is likely that at a minimum, additional financial oversight of agencies will result, and possibly additional regulation as well.

As noted above, Minnesota is one of ten states that is experimenting with creating Accountable Care Organizations (ACOs) in an effort to enhance quality and save funds. To date, the experiments have focused on integrating Long Term Care and Acute Care in a single financial model, but have reportedly not yet really turned to integrating services from a care delivery perspective. While in theory, an empowered and well-trained direct care worker would have a significant role to play in an effective Accountable Care team, it appears that time has not yet arrived in Minnesota. Home care workers are still not generally considered as part of the medical care team, even for individuals they care for on a daily basis. In the future, however, there may be a role for quality-focused home care in the ACO system and a sophisticated worker-owned cooperative in Minnesota would be well-placed to take on that role.

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 (ADLs) and instrumental activities of daily living (IADLs) at home or in their community, rather than in institutional settings. Minnesota's total spending on Home and Community Based Services in 2014 was \$3,113,337,103 about 75% of the State's total Long-Term Support and Service (LTSS) budget and 30.9% of the state's total Medicaid budget.

As of 2014, 1915(c) waivers for Aged and Disabled and Intellectual/developmental disabilities accounted for 61.9% of Minnesota HCBS spending, Personal Care was 21.2% of spending, case management was 6.5% of spending, and the remaining 10% of spending included Home Health, Private Duty Nursing, and unspecified 1915(c) waivers. Minnesota currently has five 1915 (c) waiver programs in operation with a total budget of just over \$2 billion in 2014, totaling about two-thirds of HCBS Spending.



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Licensing

Minnesota law requires that all individuals and agencies offering home care services in the state be licensed by the Minnesota Department of Health. There are two options offered to a new agency, licensure as a “basic” or “comprehensive” home care provider. Approved Basic providers may provide assistance with dress, grooming, toileting, and housekeeping and may also provide verbal or visual reminders to a client to take medication, but cannot administer the medication or provide hands-on assistance with transfer or mobility. Comprehensive providers can be approved for a wide variety of services including medication management, transfers and mobility, and a range of professional services including RN, LPN, PT, OT, speech therapy, nutrition and social work.

Training

Minnesota uses the federal CNA requirements as the basis for HHA training requirements, including 75 hours of instruction and 16 hours of clinical experience. Since 2009, workers wishing to provide PCA services in Minnesota have been required to take a nine-part, 24-hour online training and certification test which is offered free of charge and in six languages. Training must be passed before employment can begin for either an agency-based or independent provider. Training is uniform and mandatory across all state programs.

Minnesota is one of only 26 states to require agencies to provide any kind of training for PCAs and one of only eight states to mandate a minimum number of training hours. That said, several insiders have noted that the questions on the final competency test are so easy that it is possible to pass the test without completing any of the training sessions. A state task force made up of representatives from the

¹⁶ Improving the Balance, The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014, Wenzlow, A., Eiken, S., Stredl, K., June 2016. Retrieved from www.medicaid.gov.

Department of Human Resources and SEIU is currently working on recommendations for additional training resources for PCAs.

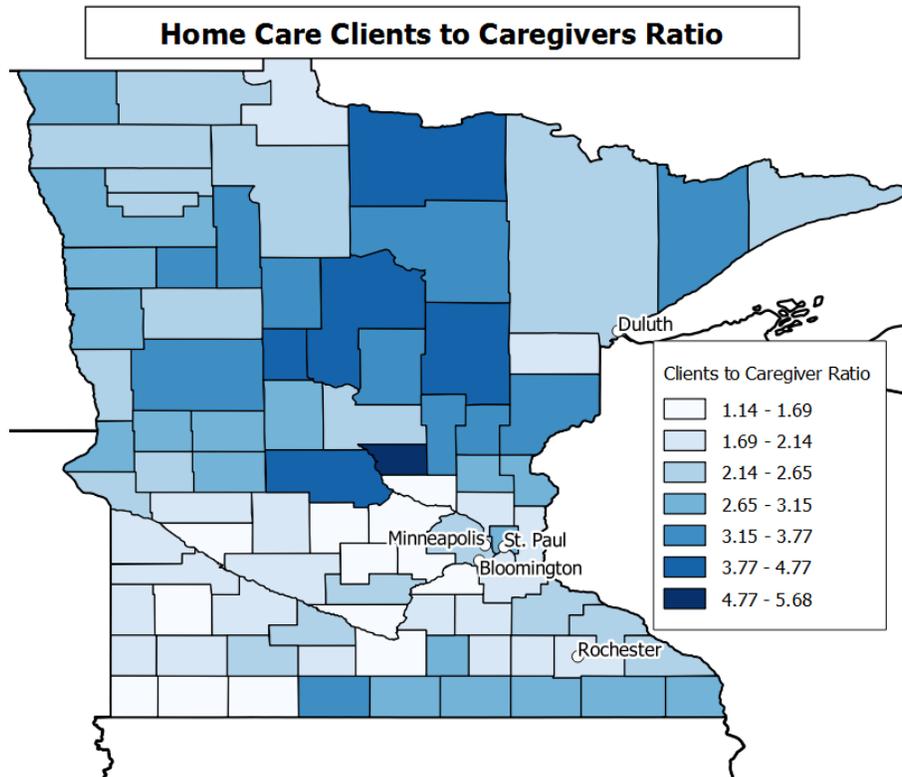
LABOR OVERVIEW

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 Minnesota 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 Minnesota is currently about 2% higher than average for the country, and the unemployment is half a percentage point lower, meaning agencies will likely have to compete with other agencies to locate staff. On the plus side, for every one caregiver in Minnesota, there are currently only three people categorized as frail elderly, independent living disabled, or self-care disabled needing care, a ratio of 3:1. This is a significantly better ratio than the national caregiver dependency ratio of 8 to 1, and indicates that there are a relatively high number of workers in Minnesota who already identify themselves as serving in direct care professions.

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 Minnesota in particular, has relative lack of care givers. In no place in Minnesota, however, is the ratio greater than 6 to 1, indicating a (again, relatively) good market for finding staff and clients in the same place.

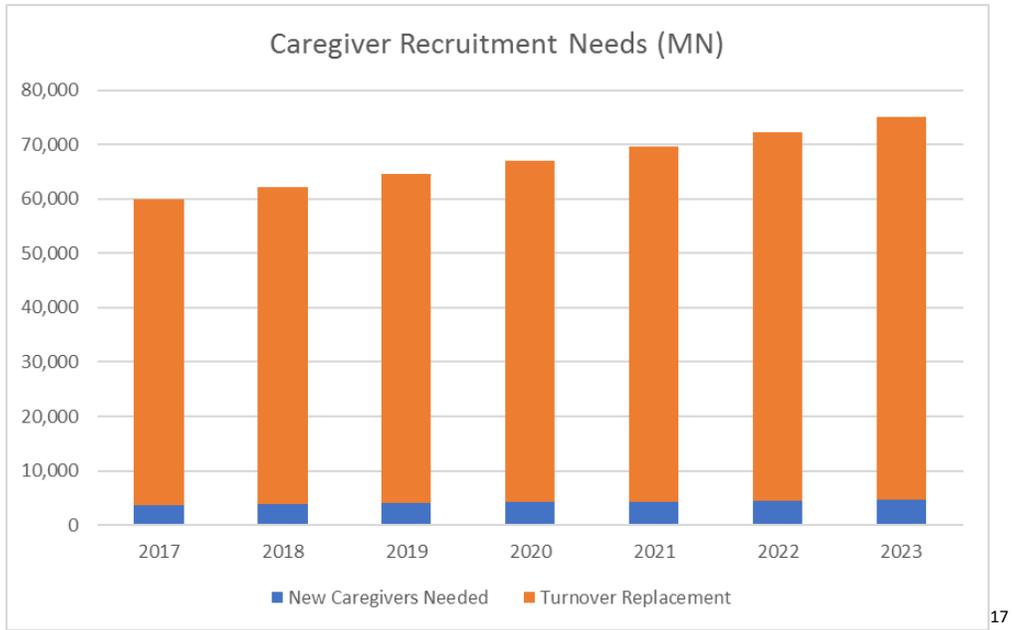


While there is a need for caregivers in Minnesota, recruitment also depends on how wages compare to similar entry-level service sector occupations that might be available to a similarly-skilled person. In Minnesota, despite the stresses, difficulties and importance of their jobs, direct caregivers are actually paid only about 15% more than their counterparts in retail and food service. This is better than in many markets, where nationally caregivers are paid only about 10% more than retail or food service workers. But it is still insufficient. The fact that the caregiver shortage and pending crisis has caught the attention of the Minnesota state legislative auditor is just one indication of the seriousness of the situation.

Caregiver and Retail/Food Service Wage Comparison			
	Direct Care	Retail/Food	Difference
National Average	\$ 10.70	\$ 10.24	\$ 0.46
Minnesota	\$ 11.74	\$ 10.07	\$ 1.67

Future Labor Trends

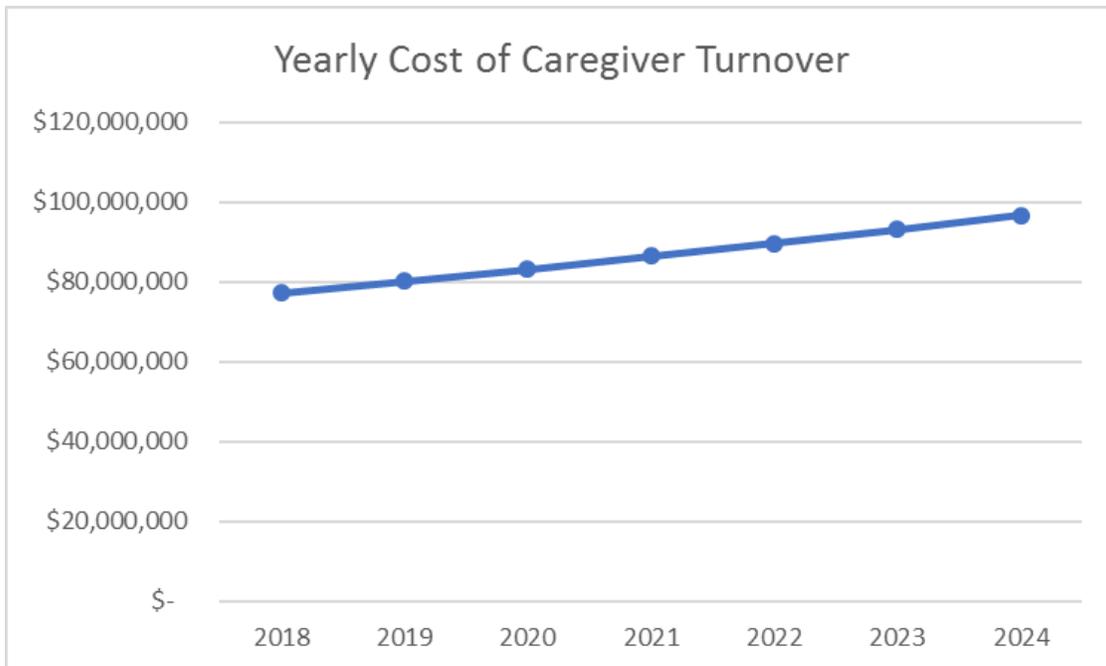
The caregiving workforce is expected to experience incredible and rapid growth over the next ten years. The national workforce of personal care aides is expected to grow 25.9% by 2024, home health aides by 38.1%, and nursing assistants by 17.6%.



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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 Minnesota will need to recruit and train an additional 430,000 caregivers into the workforce by 2024 in order to meet demand.

And the cost of this turnover is not unsubstantial, and is only expected to grow.



¹⁷ Projections Central, Long Term Occupational Projections. Retrieved from www.projectionscentral.com.

COOPERATIVE OPPORTUNITY

Cooperative Law

Minnesota has one of the most simple, comprehensive, and flexible state cooperative statutes in the nation. Organizations may form a general-purpose cooperative under Chapter 301A.101 of Minnesota State Law provided that the purpose is to conduct an agricultural, dairy, marketing, transportation, warehousing, commission, contracting, building, mining, telephone, manufacturing, mechanical, mercantile, electrical, heat, light, or power business or for any combination of these purposes or for any other lawful purposes.¹⁸ In addition, the state has a second cooperative statute, 308B, and allows cooperatives to have investor members under certain circumstances.

Cooperative Strategy

Like the rest of the country, Minnesota 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. Minnesota'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.

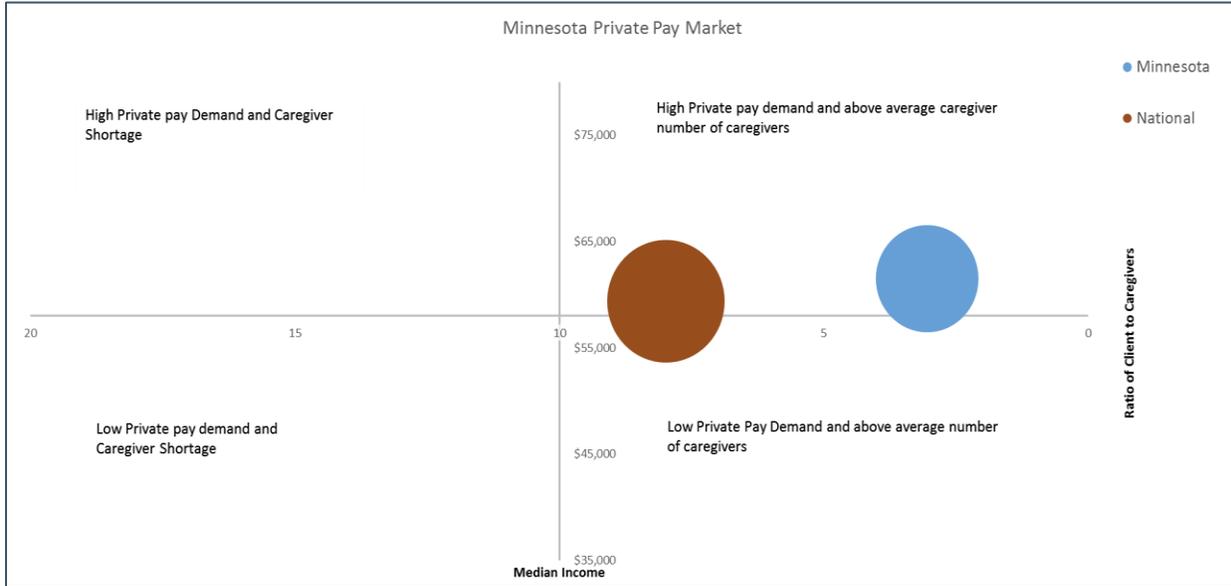
The impending challenge for the state of Minnesota to meet its residents' home care requirements also represents an opportunity for home care cooperatives to successfully meet this market need. To fill this large and growing demand for home care services, Minnesota-based home care cooperatives would need to surmount challenges specific to the state's market in recruiting and retaining a skilled workforce in a state with historically low unemployment, working effectively in the public pay market under potential new regulations, and operating at a scale sufficient to cover costs, given the statutory limitation on overhead for agencies billing public programs.

The two graphics below analyze 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.

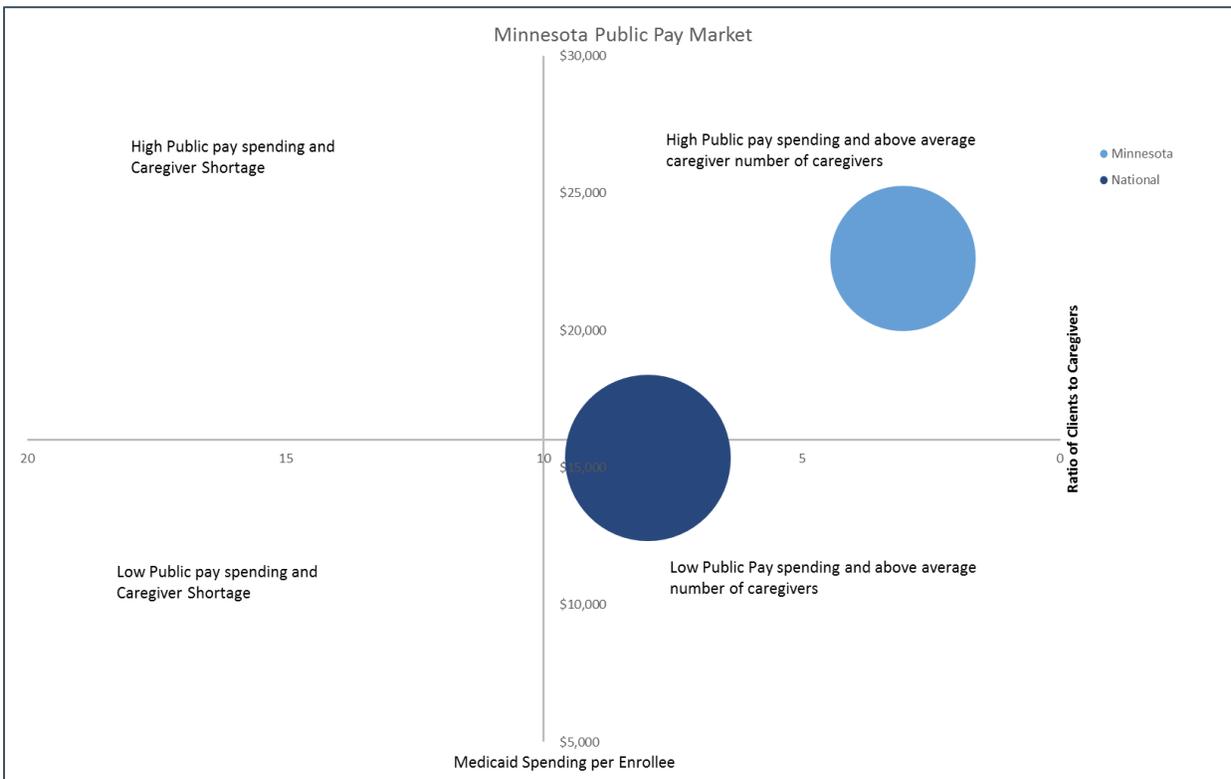
¹⁸ The Office of the Revisor of Statutes <https://www.revisor.mn.gov/statutes/?id=308A.101>

These charts indicate a (relatively) strong market for a potential new home care cooperative. State spending is strong, and median incomes area high enough on average to support a substantial private pay market.

Private Pay 2x2:



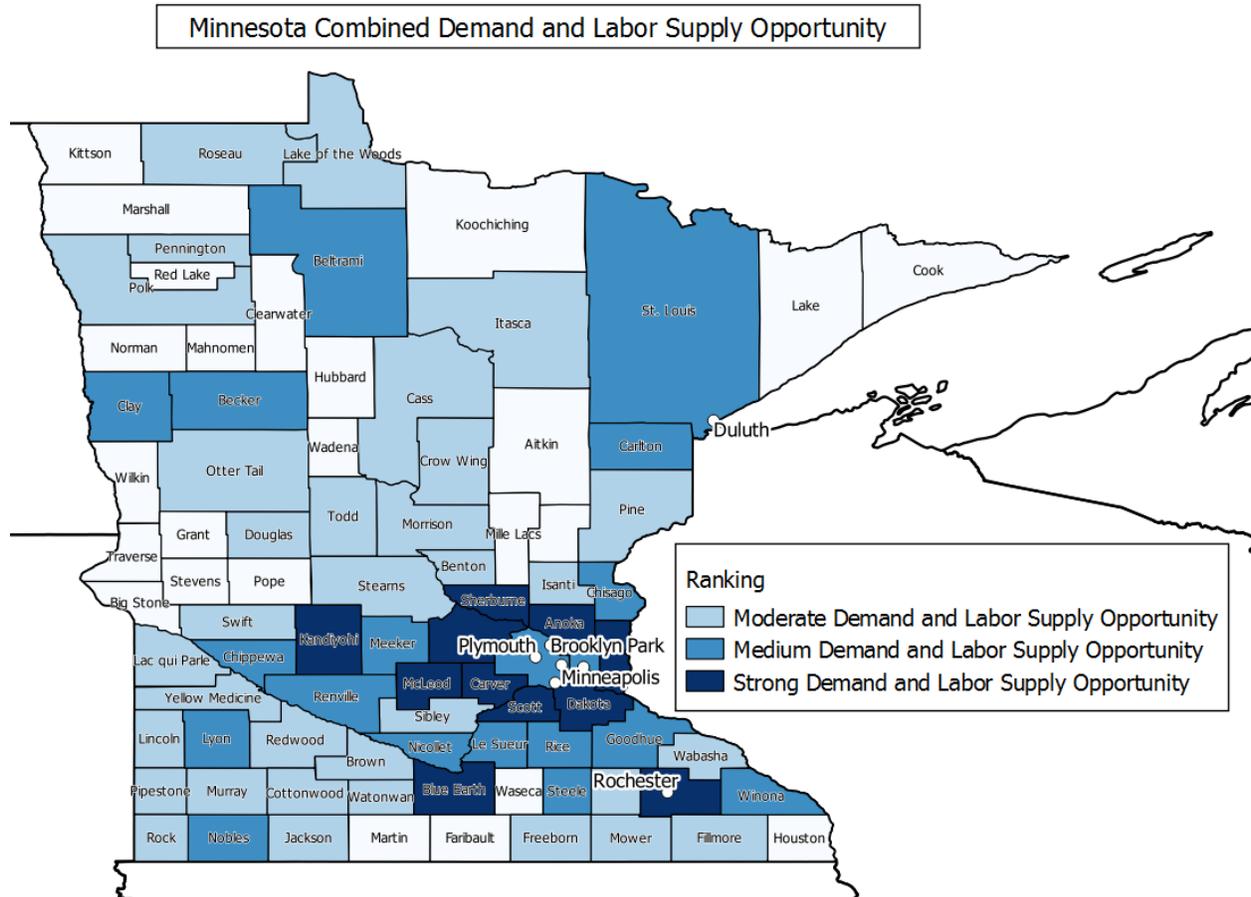
Public Pay 2x2:



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

caregivers are located to determine which portions of the state had the best match of supply and demand.

The state’s suburban markets are clearly strong, but so are a number of rural parts of Minnesota, particularly in the central and southern parts of the state.



CONCLUSION

The primary challenge facing home care cooperatives in the state will be recruiting and retaining enough caregivers to meet this growing demand in an industry with low pay, demanding work, and high turnover. While pay rates in Minnesota are somewhat better than elsewhere, they are not good enough to attract sufficient caregivers to this difficult and often stressful work for a growing market of clients. In addition, low unemployment rates and high labor force participation means that most new workers will likely have to be lured from somewhere else. This represents an opportunity for cooperatives to develop a competitive advantage by providing better training, pay, and a more stable work environment. Reducing turnover through better training and pay decreases recruitment expenses while also leading to better quality care, an important competitive differentiator in the market.

Fortunately, it appears that Minnesota has a relative strong private pay market, and that a new cooperative might succeed by starting locally with private pay clients, and building up the capacity to serve public programs at a time when they have reached scale. Low reimbursement rates—coupled in Minnesota with the admirable, but challenging requirement that 72.5% of each dollar must go to workers – make it difficult for eligible small home businesses to earn a profit on Medicaid reimbursed work. For it to be financially feasible for a home care cooperative to operate in the public pay market, the organization must reduce its operating expenses and serve enough clients so lower margins can still generate enough operating income to cover overhead expenses. It appears that in Minnesota, reaching this scale is not unachievable, as 20% of firms in the market have revenues in excess of \$1 million.

The Minnesota market is made further attractive by the presence of several sophisticated partners—SEIU as well as several nonprofit organizations focused on seniors—who have identified the workforce shortage in direct care as a problem worth solving. Coupled with a public policy environment that is generally supportive of long term care goals and a population with at least passing familiarity with the co-op model, Minnesota might well be a market worth targeting for future home care cooperative development.

Appendix

Appendix 1: Opportunity Matrix

Opportunity Assessment Framework		
Key Metrics - Labor Supply:	US Average	Minnesota
<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%	84%
Other Entry-Level Pay Comparison (Retail and Food Service)	10.83%	16.60%
Caregiver Dependency Ratio (direct care workforce over home care subset-frail elderly/dependent)	7.98	3.05
Unemployment Rate	4.40%	3.80%
Key Metrics - Firm Barriers to Entry:	US Average	Minnesota
<i>Assesses ease or difficulty of entering the home care market as a new provider</i>		
Scale Barriers	\$216,243	\$216,818
Average Sales of Home Care Companies Rural	Rural: \$431,300	Rural: \$402,500
Average Sales of Home Care Companies Urban	Urban: \$373,800	Urban: \$360,000
Scale of Service Area (as Population Density)	91.39	69.32
Rural Population Density	Rural: 19.17	Rural: 14.8
Suburban Population Density	Suburban: 57.83	Suburban: 40.4
Urban Population Density	Urban: 1015.17	Urban: 383.72
Key Metrics - Market Competitiveness	US Average	Minnesota
<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)	36.00%
Largest Provider Operating in State (Annual Sales)	Kindred	Red Wing Regional Home Health
Key Metrics - Client/Customer Demographics	US Average	Minnesota
<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%	5.45%
Growth in Aging Population	9.70%	9.29%
Total % Population Age 65+	14.10%	13.90%
Total % Population Individuals with Disabilities	6.81%	11.10%
Total % Population on Medicaid	18.00%	18.98%
Home Care Costs as % of Median Income of 65+ Population	119%	145%
Key Metrics - Payer Composition	US Average	Minnesota
<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%	41%
Share Medicaid LTSS Spending for Devoted to HCBS	53%	75%
Self-Directed Care Program	N/A	Yes
Rate Flexibility	N/A	Both Fee for Service and Managed Care
Per Capita HCBS	\$18,870	\$24,383

Appendix 2: 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 U.S. 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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Appendix 3: Detailed Medicaid Home Care Waiver Descriptions

1915(c) Home and Community-Based Waiversⁱ

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 Waiversⁱⁱ

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 Waiversⁱⁱⁱ

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.

1915(k) Community First Choice Waivers^{iv}

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.

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

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

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

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