

Private Equity's Impact on Home Care Workers and Patients in New York State

September 2026

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Acknowledgements

The authors of this report would like to extend our heartfelt thanks to the people without whose guidance and support this project would not have materialized. Our Research and Advocacy Advisory Committee members took time out of their busy schedules to meet with us in person and virtually to share their expertise and support us in making important decisions about the design of our research project, data collection, and the interpretation of our findings:

Rosemary Batt, ILR School, Cornell University

Ilana Berger, New York Caring Majority

Mitch Ellmauer, 1199SEIU United Healthcare Workers East

Kim Gibson, Healthcare Workers Rising

Katia Guillaume, 1199SEIU United Healthcare Workers East

Joy Jeounghee Kim, School of Social Work, Rutgers University

Stephen Lerner, Action Center on Race & the Economy (ACRE)

Alecia McGregor, CUNY School of Public Health & Health Policy; Harvard T.H. Chan School of Public Health

Adria Powell, Cooperative Home Care Associates

Kezia Scales, PHI

Aditi Sen, Americans for Financial Reform

Heidi Siegfried, New York Association on Independent Living

Robyn Stone, LeadingAge LTSS Center @UMass Boston

Yiran Zhang, ILR School, Cornell University

We are deeply grateful to all the workers who participated in this research, including the workers who served as advisors and reviewed research materials. We owe a particular debt of gratitude to Prof. Rosemary Batt for her unstinting guidance and support in the development and execution of this research project. We would also like to thank Ana Gallego and Martha Davis from the Robert Wood Johnson Foundation who met monthly with us to provide insight and help as we developed our project. Our sample would not have been collected without the support of Meghana Reddy of Time of Day Media. A special thanks to Maeher Khosla, our student research fellow, who assisted the research process by supporting data collection and outreach, compiling annotated bibliographies, and auditing interviews. We thank Prof. Risa Lieberwitz for providing invaluable feedback on the two reports we produced for this project. We are grateful to those who shared their expertise at different stages of this project, including Keith Joseph, KC Wagner, Malini Cadambi-Daniel, and Michael Kinnucan. Norman Eng copy-edited the report and Karen Oh, creative director of HOUSEOFCAKES, created the report design and cover.

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation. The opinions, findings, and/or interpretations of data contained herein are the responsibility of the authors, and the authors take responsibility for any remaining errors and shortcomings.

Suggested citation:

Brady, A.M., West, Z., Pinto, S., Rowe, R., and Lenmark, M. 2026. *Private Equity's Impact on Home Care Workers and Patients in New York State*. ILR Worker Institute, Cornell University.

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Private Equity's Impact on Home Care Workers and Patients in New York State

EXECUTIVE SUMMARY

Our research addresses a particular form of financialization: private equity (PE)'s growing financial dealmaking in home care, with a focus on the personal care side of the industry. This report examines the working conditions of home care workers at five PE-owned agencies in New York State and the implications of the financial and management practices for workers' job quality, wellbeing, and ability to provide quality care.

This report is part of a broader research project exploring financialization and structural racism in home care and complements our first report, *Private Equity Pathways into Home Care: The Case of New York State*, published in June 2026. The first report traced private equity's growing footprint in New York State home care and showed how low pay and poor working conditions at PE-backed home care agencies are enabled by weak federal and state health and labor regulations, insufficient oversight, and opaque public and private payment systems. This creates favorable conditions for private equity and other financial actors to extract wealth from the home care system, in great part by perpetuating the exploitation of the long-devalued workforce made up predominantly of women of color.

To explore what this looks like in practice, this report presents the findings from a study of working conditions at five PE-owned home care agencies in New York State. Our analysis of the interviews conducted with 40 home care workers and key informants revealed consistent patterns across agencies:

- Private equity perpetuates poor wages and working conditions for home care workers, taking advantage of the existing business models of for-profit home care agencies that depend on workforce exploitation. The problems that persisted both before and during private equity ownership included the following:
 - Home care workers' already low wages were compounded by different forms of uncompensated work, wage theft, and payroll errors.
 - Unstable schedules and insufficient hours per week exacerbated home care workers' financial insecurity and uncertainty.
 - The nature and quality of benefits varied greatly—from no employment benefits that workers were aware of, to high-quality benefits at the one unionized home care agency included in the study.

- Management routinely neglected its responsibility to provide the support that workers needed to do their jobs well. Managerial neglect or incompetence manifested itself in two ways: severely deficient communication and coordination channels between management, workers, and clients; and agencies' failure to respond to workers' complaints about harassment and/or discrimination.
- Lack of access to agency staff often meant worse care for clients: agencies failed to adequately and accurately communicate the care needs of new clients, leaving workers to arrive with unclear, insufficient, and sometimes incorrect information about the client's condition or care plan.
- Under private equity ownership, agencies often implemented new technologies designed to automate administrative processes and streamline worker-client coordination and communication with management. This increased automation and use of technology depersonalized workers' and clients' experiences, exacerbated the problems with managerial negligence described above, and undermined workers' ability to provide quality care to clients.
- Our research also surfaced other financial actors—especially managed care organizations—whose actions appear to negatively affect job quality and standards of care.

Fixing the home care system requires bold action. Our recommendations include those that are specific to private equity practices, while some focus on addressing the general, pervasive devaluation of home care work that enables financial actors to reap profits at the expense of home care workers. But enacting our recommendations starts by changing the narrative surrounding home care—from a job that is viewed as unskilled labor that can be cheaply obtained to recognizing and respecting home care work as professional work, deserving of the full set of benefits, quality wages, and labor and social protections that professional work is accorded. To achieve this, we recommend:

Enforce and Expand Home Care Worker Rights, Protections, Representation, and Participation:

- Enact and fully fund a living wage; fund oversight and enforcement
- Convene a state task force to establish sustainable benefits and hours for home care workers
- Protect workers' right to organize and unionize
- Strengthen support and safety for home care workers
- Require agencies to provide in-person training at regular intervals

- Enforce existing laws and regulations; demand transparency and accountability
- Foster the development of mission-driven and non-profit home care agencies

Health System Policies Must Support Care Workers and De-financialize Care:

- Curb extraction of public dollars for private profits
- Make home care funding more equitable

I. INTRODUCTION

Home-based long-term care for seniors and people with disabilities is a cornerstone of our nation's care infrastructure, and it will become even more important in the coming years. Decades of advocacy efforts for the rights of older people and those with disabilities to live at home, coupled with federal and state Medicaid cost containment strategies, have led many more people to receive care at home. The overwhelming source of funding for home care comes from federal and state Medicaid dollars that are administered by the states. And as the government has increasingly shifted funding to home- and community-based services, they have become an attractive target for financial actors seeking new arenas for extracting profit.

"Financialization" refers to the heightened use of financial strategies, calculations, and actions designed to extract wealth from the companies owned by private equity (PE) and other financial actors.¹ As part of the growing privatization and subsequent financialization of the healthcare sector broadly, private equity firms have been engaging in financial dealmaking in healthcare for more than 30 years, with a sharp acceleration since 2010.² From hospitals, physician practices, and outpatient services, to nursing homes and hospice care, private equity has expanded its ownership of services across the continuum of care. Over the past 15 years, private equity has accelerated its reach into home-based care.

The extensive demand for home care and resulting growth of the industry has led to an attendant expansion of the workforce, with home care now including some of the fastest-growing occupations nationwide. And yet this workforce was—and continues to be—made up disproportionately of women of color and immigrants who labor under strenuous working conditions with low pay, few to no benefits, and limited labor rights. It grows out of a legacy of slavery and post-Civil War emancipation, when African American women continued to care for white families for low pay and no social or labor protections. That legacy informs the socially constructed racial and gendered policies, regulations, and normative practices of today, shaping who does what jobs and under what conditions.³ It helps explain not only the modern gendered division of labor, but why women of color are still more likely than other groups to hold low-wage home care jobs that are physically and emotionally demanding and feature limited benefits, job insecurity, and irregular and often insufficient hours.

The current report addresses a particular form of financialization: private equity's growing financial dealmaking in home care, with a focus on the personal care side of the industry (see box on page 14 for more on different forms of home-based care). A substantial body of research has examined the presence and impact of private equity in hospitals, physicians' practices, and skilled nursing facilities, interrogating whether the PE model comports with the goals and ethics

of healthcare delivery and documenting negative effects on the quality of care, access to care, and healthcare costs. Much less research traces the implications of private equity's growing footprint in the home care sector. Here, our research focuses specific attention on how private equity shapes the working conditions of frontline home care workers, who are predominantly women of color. While discussion of private equity's impact often centers on patients or care recipients, drawing out the implications for workers is important both from a moral standpoint and because the quality of jobs—in terms of staffing levels, training, pay, and other incentives—often determines care quality. Because labor is the largest operating cost in healthcare, private equity often targets cuts in labor costs to boost profit margins. Yet adequate staffing, training, and support of workers is vital for ensuring high-quality care. Our research therefore also examines important questions about how working conditions affect home care workers' ability to provide quality care.

This report examines the working conditions of home care workers at PE-owned agencies in New York State and the implications of the financial and management practices for workers' job quality, wellbeing, and ability to provide quality care. This report is part of a broader research project on financialization in home care⁴ and complements our first report, *Private Equity Pathways into Home Care: The Case of New York State*, published in June 2026, which traced private equity's growing footprint in New York State home care and the policy landscape that has enabled financialization.⁵ Indeed, the working conditions this report reveals at PE-owned agencies—including low pay, poor working conditions, and managerial negligence—are enabled by weak federal and state health and labor regulations, insufficient oversight, and opaque public and private payment systems. These create favorable conditions for private equity (and other financial actors) to extract wealth from the home care system, in great part by perpetuating the exploitation of the long-devalued workforce made up predominantly of women of color.

We chose New York State as a case study because it has experienced substantial private equity activity due to its total and per capita Medicaid spending on home care services, which is one of the highest in the country. Moreover, the question of private equity's impact in New York State home care has become more urgent since 2025, when Governor Kathy Hochul drove the restructuring of the New York State Medicaid Consumer Directed Personal Assistance Program (CDPAP). Through this restructuring, a PE-owned company took over administration of the program, which accounted for roughly half of the Medicaid dollars going to home care in the state.

The research findings in this report are based on 40 semi-structured interviews with home care workers at five PE-owned home care agencies in New York City and in the Buffalo-Rochester region and key informants representing unions, worker centers, industry insiders, and academics who have conducted research into financialization and healthcare (see Appendix A for more detail on our methodology). Our analysis allows us to draw out the broader implications of the findings and propose recommendations for addressing profiteering in publicly financed home care.

II. BACKGROUND

Home-based long-term care for seniors and people with disabilities has become a central focal point in discussions around the national “care crisis”—a crisis that refers to sharply rising demand for this care while there are persistent shortages in the care workforce. The demand for long-term care has risen rapidly as the population has aged, life spans are longer, people prefer to age in place, and rights for people with disabilities to be cared for at home have expanded. Home care plays a critical role in meeting people’s basic needs and surfacing health issues before they become more acute and costly while preventing unnecessary or excessively long nursing home and skilled nursing facility stays. Due to this rising demand, home care includes some of the fastest-growing occupations in the economy.

Home care should arguably be treated as one of the most important collective goods in our society. Yet reality falls far short of this ideal. Like other segments of the care economy, home care has long been dismissed as women’s work and often as “not real work.” In addition, structural racism helps explain why women of color are concentrated in home care jobs and why policymakers underinvest in supporting home care labor. The meagerness of Medicaid reimbursement rates for home care contributes to keeping home care workers’ wages stubbornly low and, in turn, to serious workforce shortages around the country. As in other domains of social policy, racism shapes a deep set of inequities and helps to explain why people from a variety of backgrounds are unable to access the social services they need.

Financialization, structural racism, and home care

We use “financialization” to refer to the heightened use of financial strategies, calculations, and actions designed to extract wealth from the companies owned by private equity and other financial actors.⁶ Given the long-standing role that structural racism has played in driving health inequities and occupational segregation in the United States, there is a need to understand how a financially driven healthcare system can entrench and perpetuate structural racism. Structural racism refers to the ways racism is produced and reproduced by laws, rules, practices, and norms within government and within our social, cultural, and economic system.⁷

Our focus on the home care industry is motivated by the aim of understanding how financialization interacts with the laws, rules, regulations, and normative practices shaped by racism to affect a workforce that is disproportionately made up of women, people of color, and immigrants. Structural racism and sexism have fundamentally shaped who does home care work in the United States and under what conditions.⁸ Home care workers perform physically and emotionally demanding labor, yet they endure low pay, job insecurity, irregular hours, and limited access to labor and social protections. The ascent of new financial actors—primarily private equity firms and insurance conglomerates, alongside other types of financial actors—into healthcare generally and

increasingly into home care specifically—has raised the specter of poor working conditions and low pay even further and raises questions about the attendant impact on the quality of care.

Private Equity in Healthcare

Between 2010 and 2020, private equity deals in the healthcare sector—including hospitals, nursing homes, clinical and outpatient services, medical groups, pharmaceuticals, hospices, home health, and others—totaled \$750 billion. That level of activity has continued in the current decade, with 2025 the second-highest year on record for private equity deals in healthcare.⁹

In healthcare as in other sectors, PE firms generally acquire healthcare companies through “leveraged buyouts” that are heavily debt financed (see box below for a brief snapshot of how the PE model works). Private equity has been at the forefront of merger and acquisition (M&A) activity in healthcare, often leading to consolidation across different companies and segments. While PE firms tout the efficiencies and economies of scale enabled by such consolidation, a growing number of critics argue that the resulting concentration of market power enables anticompetitive behavior.¹⁰ In physician practices and other parts of the healthcare sector, PE ownership has been associated with higher prices for consumers.¹¹

How the private equity model works¹²

The private equity business model centers on the leveraged buyout (LBO)—the use of significant debt (leverage) to buy a company in order to extract wealth through the management and sale of that company, promising investors outsized returns on a relatively short timeline.¹³ To make such acquisitions, PE firms sponsor investment funds that raise capital from investors (“limited partners”), who may be institutional investors (such as pension funds, endowments, sovereign wealth funds) and/or wealthy individuals. Most of the capital invested in the PE fund (typically 98%) comes from these limited partners, while the “general partner”—a committee of partners and principals from the PE firm—usually provides only 2% of the equity. The general partner makes decisions about which companies the fund will buy and then acquires companies through an LBO. In an LBO, high levels of debt—often 70% of the purchase price—are used to acquire a company, using that company’s assets as collateral for the debt; the remaining 30% is paid in equity from the investment fund. The acquired portfolio company then becomes responsible for paying back this debt.

The promise to yield high returns for investors on a short timeline creates incentives for PE firms to take significant risks, including the extensive use of debt. However, these risks are mainly borne by their portfolio companies and investors, while PE firms are largely shielded. PE firms generally seek to hold on to acquisitions for only four to seven years, before exiting through sale of the portfolio company to another company or PE firm (the latter being termed a “secondary

buyout"); through an initial public offering (IPO) on the stock exchange; or by "spinning off" a company into a separate business entity. Upon sale of the portfolio company, PE firms generally take "carried interest" that amounts to 20% of the profits above a certain threshold of return.¹⁴ The short timeline of PE ownership—along with the fact that most of the capital they deploy is not their own—can motivate PE firms to pursue strategies that undermine the long-term stability and performance of portfolio companies.

Private-equity-backed LBOs are distinct from other types of private capital investment in that they generally entail the PE firm(s) taking full ownership or a majority stake in their portfolio companies, which provides a high level of control over company operations and an ability to more directly shape strategies for boosting short-term profit. This can entail placing principals of the PE firm on the portfolio company's board of directors, hiring and firing the CEO and other executives, and driving plans for restructuring operations including site closures and layoffs. Leaders at PE firms often promise substantial performance-based pay incentives to top management of portfolio companies if they meet the firm's targets, and frequently replace these managers if the targets are not met.¹⁵

Private equity owners extract financial gain through operational changes that cut costs or increase the valuation of their portfolio companies (and thereby boost their profit upon exit) and financial engineering strategies. Financial engineering includes not only excessive use of debt in buyouts but dividend recapitalizations (loading more debt onto a company and using that for PE dividends), asset sales, and fees assessed on investors and portfolio companies.¹⁶

Private equity's penchant for consolidation combined with its focus on earning short-term profits has also been linked to a variety of adverse consequences for care access and quality. While leaders of PE firms point to their ability to make needed capital investments, little research supports this assertion. In fact, research shows that PE firms *disinvest* in companies they own by failing to invest in infrastructure maintenance or the skills and training of the workforce.¹⁷ Moreover, the short time horizon of PE ownership—and the overriding orientation around financial gain—have been shown to introduce greater instability into health systems, leading to disproportionately higher levels of bankruptcies and closures and substantially lower staffing levels and patient care.¹⁸ These include rural hospitals and "safety net" hospitals in urban communities of color where communities are already underserved.¹⁹ In nursing homes, the most comprehensive econometric study showed that for-profit nursing homes that were taken over by private equity had substantially lower nurse staffing levels and 50% higher use of anti-psychotic drugs. This led to a 10% higher mortality rate (22,500 lives) over a 12-year period, along with an 11% increase in patient expenditures.²⁰ In hospitals, a recent Harvard academic study found that compared to for-profit hospitals, those acquired by private equity had a 25.4% increase in

hospital-acquired conditions, a 27.3% increase in falls, and a 37.7% increase in associated bloodstream infections.²¹

Though workers are usually not the focal point in research around private equity's growing presence and impact in the healthcare sector, evidence shows they are negatively affected in many ways. Understaffing in healthcare is widespread, but it is far worse in PE-owned entities, as noted in the studies above. Excessive cuts to staffing levels is a primary PE strategy, and understaffing leads to higher rates of workplace injuries, workplace violence, and quit rates.²² Moreover, the higher financial distress and bankruptcy rates in PE-owned facilities lead to higher rates of job and income loss for workers.

Taking Stock of Private Equity in Home Care

At first glance, home care may appear to be an unattractive target for private equity buyouts. Home care workers perform individualized services across dispersed client homes. Thus, short of radical automation, staffing cuts are not practicable in home care to the same degree that they are in institution-based settings, removing a key channel through which PE firms have cut costs and extracted wealth elsewhere. And as noted earlier, Medicaid-funded personal care services have low reimbursement rates, which should limit the financial attractiveness of this sector.

How home-based care works in New York State

New York's home-based care system touches many lives. Across different programs, hundreds of thousands of people receive home-based care through the publicly funded system.

Home-based care consists of two types of services with different sources of government funding: home care and home health care.

- 1) **Home care** services, also referred to as personal care services—our focus in this report—are a form of long-term care for individuals who need assistance with activities of daily living (ADLs) such as bathing, dressing, grooming, and mobility. Medicaid can cover the cost of home care for eligible beneficiaries, who can select their own caregiver (who may be a friend or family member) through a consumer-directed program or have home care aides assigned to them through a licensed home care agency. Those ineligible for Medicaid must pay out of pocket or through private long-term-care insurance.
- 2) **Home health care**, on the other hand, is the provision of specialized medical care in the home (e.g., by a registered nurse or an occupational, physical, or speech therapist). This type of care is usually short term and prescribed by a doctor. Home

healthcare is delivered through certified home health agencies and paid for by Medicare parts A and B. Medicare Advantage plans also cover home healthcare, though coverage may differ depending on the state.

Medicaid beneficiaries in New York can obtain home care services through two main options: through the agency model, where a private agency—a licensed home care services agency (LHCSA)—assigns an aide to the beneficiary from the agency’s pool of home care employees, or through the Consumer Directed Personal Assistance Program (CDPAP), where the Medicaid beneficiary is responsible for selecting, hiring, and training the aide, with payroll and enrollment supported by a fiscal intermediary; through CDPAP, care recipients may select a family member or friend to be their caregiver.²³ Our study focuses on the private agency model, which covers roughly half of Medicaid home care services in New York State.

Still, the data show that PE firms have been rapidly increasing their footprint in the home-based care sector. Over the past 15 years, PE firms have substantially expanded their activity both in home health care (where the provision of specialized medical care results in relatively high reimbursement rates from Medicare) as well as home care (non-medical personal care services).²⁴ After years of heavy spending on acquisitions in the home care industry—almost \$70 billion since 2020—private equity firms now own some of the largest companies in that sector.²⁵ Americans for Financial Reform (AFR) estimated that approximately 10% of the home health and home care sector in the United States was PE-backed as of 2025.²⁶

Several factors may be driving private equity’s interest in home-based care. The demand for home-based care is growing rapidly, and yet it remains virtually unregulated when compared with other healthcare segments, including nursing homes.²⁷ Home-based care has also historically been a fragmented market, presenting an attractive opportunity for private equity to drive consolidation through their “platform and add-on” strategy, which entails PE firms buying an initial home care business that becomes the platform for acquiring a series of additional businesses to add on—leading to large national chains.²⁸ Such consolidation enables private equity to attain concentrated market power, have better access to debt, dramatically cut costs on administrative and HR functions, and sell the company for profits that are greater than the sum of its parts.²⁹ Some reports suggest that financial actors have come to view the personal care side of home-based care as potentially less risky than home health care because annual Medicare rate changes for home health, as set by the Centers for Medicare & Medicaid Services (CMS), introduce significant economic uncertainty.³⁰

A snapshot of the New York home care workforce

In line with patterns of demand, job titles in home-based care—including home health aides (HHAs) and personal care aides (PCAs)—constitute the largest and fastest-growing occupational category in the state. In 2023, New York State had 566,160 home health aides and personal care aides—a number projected to increase by nearly 200,000 new jobs by 2030.³¹ Women of color make up the vast majority of the workforce. Among home care workers in New York, 87% were women and 81% were people of color (including 31% Hispanic/Latine, 27% Black or African American, 18% Asian or Pacific Islander, and 5% “other” race/ethnicity). Immigrants are also disproportionately represented in the workforce, with 66% of home care workers in New York being foreign-born (including 37% U.S. citizens by naturalization and 29% not U.S. citizens).³²

Home care work is archetypically precarious. New York home care workers generally experience more economic hardship than in many other states, as PHI ranks it 31st out of 51 on its economic index of direct care workers.³³ They found median annual earnings for home care workers in New York in 2023 was \$25,738, with 33% in low-income households, 46% housing cost burdened, 39% in or near poverty, and 61% relying on some social assistance.³⁴ In New York City, the comptroller reports that in 2021, home health aides averaged \$25,000 and personal care aides \$23,000 annually, when the median income of non-care workers was \$51,000; 18% of all direct care workers were in households at or below 100% of the federal poverty line, compared to 9% of non-care workers.³⁵

While reimbursement rates are lower for home care (personal care) services, Medicaid funding provides a steady, predictable revenue stream that PE firms depend on to help service the debt they load on their companies. Large PE-owned chains also generally provide both home health care and home care services, giving them access to multiple revenue streams (Medicaid and Medicare) and reflecting a strategy of providing services across the “care continuum.”³⁶ Despite the challenges posed by the home-based care market, such consolidation may enable PE firms to extract profit by streamlining administrative functions and finding ways to leverage their market dominance.

In New York, increased market penetration by private equity follows a larger privatizing push: since the 1970s, the government has been contracting out publicly run home care programs to private agencies. This trend has led to the separation of the home care workforce, made up disproportionately of women of color, from the benefits and protections of those classified as public sector employees.³⁷ This reflects a decades-long national trend of increasing privatization within the publicly funded home care system, opening the door for private equity and other financial actors to move into the industry. Public funding for home care comes from a mix of federal, state, and local sources, with substantial variation across different states. Management

and administration is also divided across different levels of government, with state officials generally playing a large role in establishing benefits levels, eligibility criteria, and provider pay rates within the parameters established by the federal government. With home- and community-based services viewed as a less costly alternative to institutionally based forms of long-term care, many policymakers have regarded privatization as a tool for advancing efficiency and cost containment at two levels: the administration of home care programs at the state level, and the management and delivery of home care services on the ground.

Private equity in NYS home care: Overview of findings from our first report

The first report published for this research project examined private equity's growing footprint in New York State's home care industry over the past decade and traced the federal and state policy landscape that has enabled this financialization.³⁸ Key findings from the first report contextualize the qualitative research findings in this second report.

As in other states, much of private equity's growing market share in New York has come about through the consolidation of existing private for-profit agencies into multistate PE-backed chains.³⁹ Among the largest national home care chains that are backed by private equity, many currently operate agencies in New York. Private equity activity in New York State home care has accelerated over the past decade, with PE firms engaging in a steady clip of deals including leveraged buyouts of home care agencies, growth investments, and financial engineering such as dividend recapitalizations used to pay themselves and their investors dividends and/or to buy out additional agencies.

Our analysis found that PE ownership drives frequent ownership changes and leadership churn, with PE-owned home care agencies operating in New York State being sold every five years, on average. From 2016 to 2025, the largest number of private equity exits in New York State home care were secondary buyouts, reflecting a pattern of PE firms buying and selling companies to each other. Even when PE firms do not flip their companies to peers, they often sell to other financial actors, like national chains owned by large Medicare Advantage insurers such as Optum/UnitedHealth Group and Humana/CenterWell.

Our analysis of 2022 cost report data submitted by agencies to the NYS Department of Health indicate that PE-backed agencies received more than 7.6% of the Medicaid home care revenue reported by home care providers in that year—a figure that undercounts private equity's true market presence as it excludes some PE-backed agencies that provided incomplete cost report data or no data at all.⁴⁰

Private equity's footprint in New York State home care grew dramatically in 2025, after Governor Kathy Hochul drove the controversial restructuring of the state's Consumer Directed Personal Assistance Program (CDPAP), touting the change as a way to curb increased Medicaid home care spending.⁴¹ The change transferred administration of this Medicaid home care program—which accounted for over 50% of personal care services delivered in New York that year⁴²—from hundreds

of companies and non-profit organizations serving as fiscal intermediaries to a single, statewide fiscal intermediary: PE-owned Public Partnerships LLC (PPL). State lawmakers held a public hearing that identified a range of serious problems that emerged in the transition, including caregivers who went without pay or were paid incorrectly, limited health coverage for workers, and procurement irregularities. In late June 2026, PPL faced a class-action lawsuit alleging it had systematically underpaid home care workers and failed to provide adequate health insurance, settling the case for \$162 million.⁴³ Possibly the largest wage-and-hour class-action settlement in New York's history, the settlement will be paid out to approximately 200,000 home care workers.⁴⁴

Private equity firms' drive to generate outsized profits as quickly as possible raises concerns about cost-cutting measures that diminish care quality, job quality, and compliance with regulations, as reflected in the PPL example. As detailed in our first report, PE-backed home care agencies in New York State and across national chains have been penalized for harmful practices—including wage theft, fraud, and serious safety violations. New York's home care industry is rife with labor and compliance violations, including rampant wage theft that puts the industry among the worst violators in New York City and the state. Some PE firms have also acquired New York State-based agencies with records of labor violations and fraud, raising concerns about the implications for driving down standards in the industry.

Turning to the policy landscape, our first report revealed how weak federal and state health and labor regulations, as well as opaque public and private payment systems, have created favorable conditions for financial actors including private equity to extract wealth from the home care system.

Nationally, Medicaid has shifted away from institutional care and toward home- and community-based services to uphold the rights and preferences of aging and disabled people and to control budgets. Yet the cost-cutting and deregulation that accompanied this transition compounded existing racialized and gendered labor inequities for long-term care workers. In New York State, Medicaid contracted with private insurers (managed care organizations) to control spending, which has reduced transparency and accountability, created incentives for cutting services and reducing the payments directed toward home care providers, and enabled public dollars to flow to financial intermediaries.

There is no uniform federal regulatory framework for home care, which leaves regulation largely to states. While New York has more regulation to cover home care workers than many states, we found that it still falls short of sufficiently safeguarding workers and improving transparency and accountability. Labor policy and regulations for home care in New York are often undermined by the persistent drive to control spending, resulting in the ongoing exploitation of a workforce with historically poor wages and working conditions.

III. THE IMPACT OF PRIVATE EQUITY IN NYS HOME CARE

Our findings for this report are primarily based on interviews with 40 home care workers and key

informants. Two-thirds of the home care workers were women, and almost all identified as Black or Hispanic/Latine (see Appendix A for more details on our methodology, including a demographic breakdown of our sample). The home care aides worked at five private-equity-owned home care agencies in New York State (five locations in New York City and two locations in Buffalo-Rochester). One-third of the interviewees had worked at the agency both before and after it was acquired by private equity. Our key informants included scholars of private equity and healthcare, researchers with expertise in home care, union leaders from healthcare unions, a private equity consultant, state government officials, a former director at a home care company acquired by a venture-capital-backed company, and a CEO of a mission-driven home care agency in New York. We also met four times with our advisory board of experts in home care and financialization to gain insights and to interpret our ongoing findings (see Appendix A for methodology).

Home care workers reported quite consistent patterns across the PE-owned non-union agencies. First, after PE firms bought out the agency, they perpetuated the already poor wages and working conditions that workers experienced. While PE firms often promise their investments will improve conditions and patient outcomes, we found that instead private equity perpetuates the existing business models of for-profit home care agencies that depend on workforce exploitation.

Second, the new PE owners often intensified or exacerbated existing problems by introducing technologies designed to automate administrative processes and streamline worker-client coordination and communication with management. But these new technologies further undermined the working conditions, replacing human interaction with automated systems that sacrificed depth and quality of interactions in the name of efficiency. This had serious implications not only for the working conditions and wellbeing of home care workers, but also for the quality of care they were able to provide.

Our research also surfaced other financial actors—especially managed care organizations—whose actions appear to negatively affect job quality and standards of care.

How Private Equity Perpetuates Workforce Exploitation

A large body of research has consistently shown that home care workers contend with low wages and poor working conditions. The median hourly wage for home care workers in New York was \$18.26 in 2024, with median annual earnings of \$25,738 in 2023.⁴⁵ Working in a weakly regulated labor market with limited oversight, they are susceptible to widespread wage theft—when

employers fail to pay the wages legally owed—and other violations.⁴⁶ Home care workers endure unstable work schedules, with low hours and little job security—nearly half of all home care workers nationally (and in New York State) work fewer than 35 hours per week, and nearly 20% are employed for only part of the year.⁴⁷ While home care workers are hired by an agency that is responsible for training aides, scheduling care shifts, and overseeing care,⁴⁸ they are often on their own in their daily work. The agency assigns them to clients who require care, and the aides then travel to private homes to provide care, organizing their own travel from one client to another. With private homes as their workplace, home care aides are vulnerable to harassment and abuse—including verbal aggression, physical assault, and sexual harassment—and often with no recourse.⁴⁹

The impact of private equity is likely to be more muted in this context of low wages, poor working conditions, and limited oversight, as noted by labor relations scholar Rosemary Batt. In fact, low job quality standards and weak regulation are factors that attract private equity or other financial actors in the first place, according to other studies in autism and mental health services.⁵⁰ In one example highlighted in our first report, the PE-backed chain Help at Home acquired two home care agencies in New York State that were subsequently found to have perpetrated a years-long fraudulent scheme to cheat thousands of workers out of millions of dollars in wages.⁵¹ In both home care and nursing homes, several key informants had observed similarly poor working conditions at “ordinary” for-profit companies and PE-owned companies.

Home care workers in our study emphasized three management and labor practices that undermined their working conditions and ability to provide decent care: excessively low wages, wage theft, and virtually no benefits; managerial negligence; and unsustainable work hours.

Low wages, wage theft, and economic insecurity

Excessively low wages, limited-to-no benefits, and wage theft are persistent problems at home care agencies in New York State. Workers we interviewed confirmed that this occurred both before and after private equity acquisitions. Respondents widely reported feeling economically insecure due to factors including low wages, wage theft, few or no benefits, and insufficient and unstable hours (as discussed below). Respondents reported earning between \$17.50 and \$22.00 per hour, with the typical wage between \$18.00 and \$19.00 per hour. This is at or near the minimum wage for home care workers at the time of the study (April 2025 to March 2026). The minimum hourly wage for home care workers rose from \$19.10 in 2025 to \$19.65 in 2026 in New York City, Long Island, and Westchester, and from \$18.10 in 2025 to \$18.65 in 2026 in the remainder of New York State.⁵²

Across the board, respondents felt their hourly wages were sharply inadequate to meet their needs, especially given the importance and demanding nature of their work, unpredictable hours, and the high costs of living. Despite their dedication to the work and their commitment to providing good care, they felt their employers did not value them or their work.

Their already low wages were compounded by different forms of uncompensated work, wage theft, and payroll errors—issues that have been widely documented in the literature on home care.⁵³ Respondents described how care obligations frequently led them to work beyond scheduled hours without being paid. This often happened when doctors appointments ran longer than expected. Or in emergencies, workers used their own money to make sure patients were taken care of:

“No, we don't get paid if we come in early, if we stay late—we don't get paid. [...] One time, I was stuck with a patient at the laundromat... She was in a wheelchair. She was going to wash her laundry. The time went over, and I called [my agency], and I asked them. They're like, 'You have to leave her there. Leave the bags there, and you have to be dismissed.' I said, 'I can't leave her here! Who is going to take her home?' So I used my own money. We had to catch a cab, a van cab, and I had to load the van cab up with her in it, and I was like, what? And then [my agency] says, 'Well, you did that on your own. You cannot get paid for that.' So I was like, okay. So, I just had to accept it.” (Agency C:24)

Respondents described instances of wage theft, when they were not paid the wages they were owed due to administrative errors, technology glitches, or the agency's failure to pay promised wage supplements. Some respondents pointed to recurring problems when their hours worked were incorrectly logged, due to the agency's flawed new technologies or apps. Workers lost hours of their own time trying to resolve payment problems, often without success. They described repeated calls that went nowhere and a lack of accountability among agency representatives:

“The payroll said they don't have nothing to do with that, to call the supervisor. They keep switching me to different supervisor, different department, different people, so it's like, it's a joke, it's a mess, they got a mess there. They don't—I don't even know who I am speaking to. At the end of the day, said they're gonna call me back, [but] they never call me back.” (Agency C:14)

In other cases, workers noted that employers' promises to provide bonuses or compensation for completing a training never materialized. They also said they had to pay out of pocket for supplies such as gloves, masks, uniforms, and cleaning supplies that should have been provided by the agency.

In addition to low wages, uncompensated work, and wage theft, workers said that unstable schedules exacerbated their financial insecurity and uncertainty. They noted how unpredictable situations with clients could lead them to suddenly lose work, such as when a client was admitted to the hospital—which could lead to long periods with fewer hours that cut deeply into their weekly pay.

Most workers we interviewed said they had few or no employment benefits that they were aware of. Here, the unionized home care workers had a substantial advantage. They reported an extensive array of benefits including paid time off, health insurance, contributions to a retirement plan, and a points system for cash bonuses. While some respondents at other agencies also reported having some benefits (paid time off, holiday pay, or health insurance), the level of those benefits and their access to them was uneven. Across the sample of workers, access to benefits depended on working a minimum number of hours per week, which our respondents often did not meet.⁵⁴

Paid time off (PTO) is a highly prized benefit for home care workers who are often the primary caregivers for their own families. But it was a source of confusion for many workers we interviewed. Some were not sure if they had it or not, while others knew they had it but did not know how many days per year or whether it was specifically vacation days or paid sick leave. For those who both knew they received PTO and could use it when they wanted, it never amounted to more than 40 hours per year. Others knew exactly how much PTO they had but said that the agency put up barriers to gaining access to it through arbitrary rules about when it could be used or how far in advance workers needed to request it.

"[My agency] don't allow us to do that [call in on the same day to ask for leave]. They don't allow us to take off days for funerals. They don't allow us to take off days for emergencies, like if we have sick children. I don't have children, but I have friends that work for [my agency] that have children that was sick... you get written up for those. That's what they do. They'll write you up." (Agency C:24)

One worker who reported having no PTO said that if they needed time off for any reason, "You just forfeit that pay" (Agency C:05). Others sometimes used PTO to maintain some of their income when a shift fell through or when a patient was admitted to a hospital and/or a rehabilitation facility, as the agencies did not cover the hours lost.

"Yeah because honestly when that happens, we can either miss a whole day or we gotta use our PTO. I feel like that's the downside of it, like when [clients] have [to be admitted to the] hospital, I feel like the aides should be covered by something because it's not due to the aide not going in, but because of certain life [events out of our control]." (Agency E:25)

Due to their very low incomes, home care workers often are eligible for Medicaid, and this is how a majority of respondents received health insurance coverage regardless of whether their agency provided an option. Most respondents were unsure if their agency offered a retirement plan.

Managerial negligence

While workers said their low wages, wage theft, and economic insecurity made them feel devalued, irresponsible management at these private-equity-owned agencies further undermined their daily work life. They felt that management routinely neglected its responsibility to provide the support they needed to do their jobs. They felt “*left out on [their] own,*” as one respondent put it—in ways that affected their own wellbeing and safety and the quality of care they were able to provide. Managerial neglect or incompetence manifested itself in two ways: severely deficient communication and coordination channels between management, workers, and clients; and a failure to respond to harassment and/or discrimination. These problems were documented at almost all agency locations and persisted under private equity ownership.

Many workers we interviewed said they simply could not reach managers and staff in their own agencies—whether it was with payroll, HR, schedulers, or supervisors. Lack of access to agency staff often meant worse care for clients: agencies failed to adequately and accurately communicate the care needs of new clients, leaving the workers to arrive with unclear, insufficient, and sometimes incorrect information about the client’s condition or care plan. One worker said her agency failed to inform her that a new client was a monolingual Spanish speaker and noted this was part of a larger pattern of neglect:

“[I was sent to a] patient and I realized that she doesn't speak English, just Spanish, and I wasn't aware prior to that, and it was a really difficult situation because the language barrier was like a major factor. We just couldn't communicate properly. I did navigate my way through, but then it wasn't as easy as it should have been. If I was told prior to that, that she speaks Spanish... so you know, those things happen sometimes. I feel like I don't get enough information on patients to help them properly.” (Agency D:23)

Agencies’ neglect or disregard of patients’ specific care needs also put workers and clients at risk, according to workers’ accounts. For example, workers were assigned to patients who required care that fell outside of their certification.

“I had a patient one time, she was bed-bound and she had a catheter in her, and I know that's not in my job description, under no circumstances [can I perform that task]. So she's looking at me and I'm looking at her like I can't do it, it's not in my job description.” (Agency E:26)

When confronted with clients who required care they were not licensed to provide, workers would try calling the main office to get clarification or to request a licensed nurse to complete

the required task. Too often, however, they were put on hold, or the requested support never arrived.

Workers we interviewed recounted many similar scenarios in which they called the agency for support when a patient's condition worsened or required specialized care, but the agency did not respond or send staff qualified to address specific client needs. These situations compelled workers to either take the risk of doing a task they were not licensed to do or to leave at the end of their shift despite the patient requiring additional care. If a family member was not present to perform a needed task, some respondents did it themselves, risking disciplinary action or loss of certification, while others managed by staying until a nurse or certified nursing assistant (CNA) finally arrived—without being paid for their time worked over the scheduled hours.

When agencies failed to respond to workers seeking support for client care, workers sometimes had to take on management tasks to ensure clients received the attention required. In one case, a home care worker called the state to report the poor health and living condition of a patient when the agency failed to respond.

"I called the state because [my agency] didn't do anything about it, you know, they're like, 'Oh, well you know, we'll have a nurse call,' or you know, and I think it was something that needed to be done in an emergency, like somebody should have come out during my shift if I'm there from 9 to 1. I think someone should have come out right away to assess the situation; to find out why she is sleeping on the floor, she doesn't have a bed, or why she doesn't have food, you know, things of that nature." (Agency B:12)

At another agency, management routinely directed home care workers to complete intake assessments for new patients even though this violated the law.

"It has to be a registered nurse [doing the intake assessment], but they [the agency] don't all the time follow the rules, and most of the time they will send a care provider to the assessment location and the care provider will write everything down, bring the documents back and then the registered nurse will sign and date it, which makes it seem like she did it or he did it, but it's not." (Agency A:22)

In other words, the agency not only provided incorrect information but pressured workers to engage in fraud.

Managerial neglect was also evident in agencies' failure to respond to workers' complaints about harassment and/or discrimination from clients and their families. Harassment and/or discrimination was a common occurrence, according to respondents, ranging from verbal abuse and inappropriate remarks to cases of inappropriate touching. Often, this discrimination and harassment is based on race or ethnicity and/or gender.

Workers often shrugged off these incidents as if it was a part of the job. They absorbed the abuse individually, as they viewed notifying management as a useless exercise. According to one worker:

"...at the beginning [when I first started], I did talk about it a lot. I had filed a series of complaints. But then I just realized that it's a normal thing, it's something everybody has gotten used to. So, I just stopped talking about it, and now I just go with whatever happens." (Agency D:23)

Another worker reported that clients had verbally abused and thrown objects at him, but seeking support from the agency was futile:

"So, in most of the situations, it's basically you yourself who needs to take care of the situation or the event that's taking place. [But] yeah, there is a number that [the agency] has which is basically a supervisor, a direct hotline you can call. But you can't expect much help from that because the first thing they're going to tell you is that, well, either you can leave or you can take care of the situation yourself. They're not going to try to diagnose it, they're not going to try to troubleshoot it, they're not going to try to intervene in any way, or manner, or fashion. So yeah, those helps are there, but they're not actually helpful, right?" (Agency A:22)

And in another case of reported harassment and discrimination, the agency just said "We'll look into it" and then took no further action (Agency B:17).

In certain cases, workers who reported harassment or unsafe conditions were told by the agency that they could stop working with that client. In most of these cases, they did not believe that the agency took action to address the incident with the client or to warn home care workers who were subsequently assigned to the case. One worker we interviewed described being sent to care for a client without being informed that there were around 10 men (her brothers and sons) who lived with her. She became uncomfortable and scared when the men were intoxicated and made passes at her, so she called her agency and asked if she could leave the job. When she told the agency staff which client she was with, they responded knowingly and said she could leave, giving her the impression that this was a recurring unsafe situation that they did not address or warn aides about (Agency C:01).

One agency previously had a policy of telling aides not to leave when they reported feeling unsafe at a client's home, according to a worker we interviewed. After a tragic incident where a home care worker employed at this agency in another state was killed on the job and the agency was found liable, workers at the agency complained about the policy and it was finally changed. Yet, even while an aide reporting a safety issue now had an easier path to leaving the case, the agency would seek a replacement without alerting the new aide about the complaint (Agency

D:21).

Unsustainable hours

Private equity owners often seek to cut labor costs in their portfolio companies across various healthcare segments by cutting administrative staff and frontline healthcare workers. While our findings suggest potential evidence of administrative staff being reduced in home care, layoffs of home care aides are not a viable cost-cutting strategy because home care workers provide one-on-one care at clients' homes. Agencies can increase revenues by expanding their client base, but each client requires a worker to provide individualized client care during each shift, which limits staffing cuts. By contrast, in nursing homes, hospitals, or clinics, the number of patients assigned to a nurse or aide may be raised without additional staff—work is simply intensified.

Still, our findings suggest that agencies find other ways to shift risk and insecurity to workers. Many aides reported that a lack of full-time hours was a serious problem that undermined their income stability. Most workers we interviewed said they struggled to get more than 20 or 25 hours per week of work. Agencies appeared to recruit large numbers of workers as a surplus labor pool to ensure adequate coverage of clients. Many workers we interviewed said they weren't able to secure a full 40-hour work week, with most working part-time hours at their agencies. The low wages combined with part-time and unpredictable work hours led to unsustainably low incomes for respondents: *"I feel like maybe they can go up on the pay rate or give me more hours so I would at least have 40 hours a week."*

To supplement their earnings, many workers took cases at multiple agencies or worked second jobs in other industries.⁵⁵ Yet it was often difficult for workers to pick up additional cases because of timing and location. Shifts that were only two hours in length and required traveling an hour each way were not generally worth picking up, given the time and the money spent on transportation to and from client homes—a cost that agencies did not cover. Workers received overtime pay for hours worked over 40 per week, but this occurred rarely.

Existing research and interviews with key informants confirmed that low and unpredictable work hours are a major threat to the income stability of home care workers across the board. This is largely due to agencies' strategy of recruiting and maintaining a surplus labor pool to ensure that they have the labor flexibility to add clients as they become available. They match the supply of workers to client demand, which is variable, and workers absorb the risk of this variation and the accompanying low and unpredictable income. Client demand for home care workers is generally concentrated in the morning, according to key informants and research by Nisbet and Morgan.⁵⁶ This creates a spike of need for home care workers for short shifts in the morning, and

far less demand at other times of day. Nisbet and Morgan's research also highlighted home care employers' view that managed care drove a reduction in authorized hours (a point explored in the section below), while pointing to other dynamics that made scheduling difficult as well. They found that employers sought to limit workers to a maximum of 40 hours per week in order to avoid paying overtime pay rates (1.5x), as employers did not expect managed care organizations to increase reimbursements adequately to match increased labor costs. And although it is illegal for companies to deliberately cap staff hours below full-time thresholds to avoid paying mandatory benefits, home care employers may also be engaging in this practice.⁵⁷

While the problem of insufficient and unpredictable working hours is widespread, it may be exacerbated under private equity ownership. One of the large PE-owned chains in our sample had particularly unsustainable practices when it came to hiring a surplus labor pool, according to a key informant who had observed this at their locations in the Midwest. This agency would hire new workers, require them to complete an unpaid training, and then fail to give them any assignments—all while long-tenured workers were seeking additional hours.

Private Equity Exacerbates Poor Conditions Through Automation

Under private equity ownership, agencies often implemented increased automation and use of technology for administrative operations, according to workers we interviewed. Workers' descriptions of the changes illustrated how this increased automation and use of technology depersonalized workers' and clients' experiences and exacerbated the problems with managerial negligence described above.

Within the home care industry, AI and other technological tools have promised to transform a wide range of work processes, including both administrative tasks and home care aides' work processes. In our interviews with home care workers at PE-owned agencies, the main forms of automation and increased use of technology they had seen being implemented were in the areas of scheduling (through the use of apps and algorithmic scheduling systems), communication systems (diverting communication to an app and reducing workers' ability to have live communication with agency staff), and training (switching from in-person to online training for workers).

While strategies such as automation and consolidation appear to be happening across the industry at both financialized home care businesses and "regular" for-profit agencies with the goal of cutting costs and boosting efficiency, scholars Rosemary Batt and Charlene Harrington noted that financial actors such as PE firms have access to more capital than "regular" for-profits,

enabling them to more easily drive aggressive consolidation and automation strategies.⁵⁸ PE firms commonly drive automation and increased adoption of new technologies within their portfolio companies, with the goal of improving efficiency and cutting costs—and therefore increasing companies’ profitability and overall valuation. The roll-up strategy—whereby a PE firm buys a platform company and subsequently “rolls up” additional acquisitions to add on to the platform, consolidating them into a large chain—allows PE owners to dramatically cut costs on administrative and human resources operations across the chain, according to a key informant at a PE firm. Another key informant described how a version of this administrative cost-cutting occurred when a national home care company was taken over by a venture-capital-backed company and many of the administrative leadership staff were laid off, cutting programs for innovation, training, and data collection.

Below we describe how increased implementation of technology and automation in the areas of scheduling, communication, and training exacerbated some of the problems described in the section above. Overall, respondents at three agencies related that they experienced more use of technology and automated systems and less communication with agency staff after private equity acquired their agency.⁵⁹

Automated scheduling

Scheduling is a persistent challenge for home care providers, as it requires a complex logistical matching process between the desired and authorized care hours of clients, the availability of home care workers, and the geographic constraints that workers navigate in traveling from one client to the next. On top of the logistical complexity, the preferences, skills, and experience of home care aides should be considered alongside the particular care needs of the clients. It has thus been an area where home care providers are eager to find solutions to better navigate this complexity. Home care agencies have generally handled scheduling through hiring schedulers who assign home care workers to cases, often communicating with workers by phone about availability and fit. When scheduling becomes automated, schedules are moved into an app where home care workers can view their assigned schedules and take on additional shifts, instead of speaking with a live scheduler. Increasingly, automation also includes implementation of algorithmic scheduling software that aims to match workers’ availability with clients’ needs, accounting for geographic proximity and, at times, specific skills and care needs as well.

Automation of scheduling, while ostensibly a simple administrative change, can have consequential effects on workers’ and clients’ experience. As an atomized workforce that spends the vast majority of their working hours in individual homes, home care workers’ main connection to their agency is often through communication with schedulers. This relationship can therefore

strongly shape workers' experience of working at that agency, as described by one key informant. In a job that is already isolating for workers, when scheduling moves primarily to an automated platform, it can further depersonalize workers' relationship with the agency and staff, as scholar Rosemary Batt noted, reducing flexibility and accommodations for workers.

Automated scheduling can also erode both job quality and the quality of care when it does not allow for the intentional matching of clients' needs with home care aides' particular experience and skills, according to several key informants. They described how, in some cases, standardization of the scheduling process enables agencies to more efficiently match the demand for hours but not the demand for skills. One noted how the dominant work culture of an agency can shape *how* they implement such technologies. For example, when introducing algorithmic scheduling platforms, agencies that essentially treat aides as disposable are more likely to rely solely on those platforms to match schedules on the basis of logistics (hours and geographic location) only, as was the case in our findings for this study. But within agencies with higher standards for valuing workers, an algorithmic scheduling platform could be used as a starting point, with the clients' care needs and workers' skills and preferences being considered alongside hours and geographic location.

Workers we interviewed described using apps for clocking in and out of shifts and completing electronic visit verification (EVV);⁶⁰ for viewing their assigned schedules; and for taking on additional shifts.

They described the automated scheduling systems as more rigid. When direct communication with schedulers was replaced with algorithmic scheduling and apps, workers had less ability to communicate their preferences and availability, and the issues of poor communication described above were exacerbated.

"Yeah, after the management change, they started using the automated scheduling. [Agency staff] used to personally call and check with us about availability. [...] I prefer the other [scheduling system]. They [schedulers]... show more care, and there should be more flexibility." (Agency B:15)

Echoing the key informants' points above, one worker described how the automated system did not consider the full scope of clients' needs, often failing to match clients with aides who had the appropriate experience or language (Agency B:17). Several workers we interviewed noted that the inability to speak with a human scheduler often led to surprises when arriving at a home, tension with having to manage a situation a respondent was not prepared for, and frustration with an inability to adequately meet the patient's needs as a result.

In some instances, workers described the system as providing limited (“bare minimum”) information that potentially omitted critical information about clients’ conditions and care needs.

“So what happens is it's an app and you'll go through, you'll see a list of clients, it'll just show what they pay you for the client. It might show what the client requires, [but] you might have to go there to see what the client needs. But every day, it would be like someone new, so you'll have to learn how to do something with this one client.” (Agency C:01)

When asked how her employer could help her better meet clients’ care needs, this worker elaborated, *“I would say at least having [the agency] put on the app what the client may need... or [the app] might notify you like, oh, they're bedbound, so at least just a little forewarning.”*

Increased use of technology proved challenging for some workers who were less tech literate, and any issues with using the technology potentially created compliance problems for workers. For example, the problems and administrative burden of Electronic Visit Verification (EVV) apps have been well documented,⁶¹ and respondents in our study described such problems with clocking in and out, sometimes leading to payroll problems (which were compounded by an inability to communicate with payroll staff to get the issue resolved, as described below). Training on how to use the app was not offered, with workers instead having to “figure it out for themselves.” Similarly, the key informant from the venture-capital-backed home care company described how the increased reliance on technology after the acquisition was not accompanied by increased support for workers in navigating the technology—instead, there was reduced tolerance and support for workers who were less tech savvy. A key informant from a union representing home care workers at PE-owned agencies in the Midwest also flagged problems with automated systems and EVV apps for workers at those agencies; he noted that when PE-owned agencies roll out systems that create problems or erode standards, the scale of the problem becomes larger because of the size of PE-owned chains.

Deficient communication

Workers in our study described how the increased use of technology to automate and standardize an agency’s administrative system after private equity acquisition worsened the problems with communication described in the section on managerial negligence. One key informant described it succinctly: “People are just using the technology and not remembering that there's got to be a human side to this, too.”

Workers described changes to agencies’ communication systems that reduced aides’ ability to speak with agency staff on the phone, as more scheduling and communication moved to apps.

"...I felt disconnected from the agency and the communication wasn't as smooth [as it was prior to the ownership change]." (Agency B:15)

At one agency, a worker described how previously aides could call staff members at specific extension lines, but after the ownership change, aides could only call a general phone line and it became more difficult to speak with HR, payroll, or schedulers (Agency C:28).

Because workers could not easily access staff through the automated system, HR, payroll, schedulers, or coordinators were slow to address their concerns or problems.

"One of my client's condition had suddenly changed. They started showing some signs of confusion, and she seemed a bit off. I didn't really understand [what was happening] so I tried to contact the agency. It's very important to report it and ask them what to do because it's protocol, I have to do that. But I couldn't reach anyone for several hours. I left voicemails. I sent a text. But no one followed until much later that day. It took a long time for them to reply which was really stressful because I wanted to make sure that I was doing the right thing. Situations like this make me feel like I'm alone in the field." (Agency B:15)

One agency had an app with a "feed" where the company could make posts and workers could comment. Many workers posted complaints in the feed, according to a worker we interviewed, with one of the most common complaints being the agency's lack of responsiveness to workers reporting client or employment issues. She noted that, in general, the agency did not respond meaningfully to these complaints (Agency D:21).

The acquisition of a large national home care provider by a venture capital (VC) backed company provides another example of financial actors driving an increased reliance on technology to cut costs and drive efficiency, ultimately leading to worse working conditions and care quality.⁶² The model of this VC-backed company was to operate most administrative functions through its technology platform; for example, scheduling and communications among clients, home care workers, and the agency were meant to mainly happen through an app. When operations could not be fulfilled through the app, the company relied on a centralized team that handled communications. The key informant we interviewed contrasted this with the previous model, where clients and aides worked with particular schedulers or specific staff in the field. Whereas home care aides had previously found the company mostly responsive when they called for support, after the ownership change, they found it difficult to speak with anyone at the company, noting that nobody returned their calls when they reached out for support. Clients of the company found it challenging that they no longer engaged consistently with the same staff but instead encountered different agency staff constantly. This key informant described how it initially seemed like a "selling point" that the VC-backed company had a whole team of regional

people in the corporate office, but that the reality of this centralized model created problems for both clients and caregivers because it broke down the consistency and relational continuity that underpinned their care relations. Such conditions were likely to negatively affect workforce and client retention, according to several key informants.

Reduced investment in training

Training is another area where private equity owners seemed to implement a greater reliance on technology as a cost-cutting measure, according to our interviews with workers. To cut the cost of training their labor force, home care agencies may switch from providing in-person training sessions to online training, or they may move from using a robust online training platform to a cheaper one.

Workers at three agencies in our study reported that in-person training had been replaced by online training after private equity took ownership of the agency.⁶³ Multiple agencies in our study appear to use the online training platform Nevvon, which allows home care workers to complete training programs through an app on their mobile phone and promises to save agencies time and money.⁶⁴ Workers described completing a range of training programs on their phones, including annual in-service training requirements and modules on sexual harassment or specialized patient care. Training programs that were once held in person were moved online and, in most cases, accessed through an app on the respondent's phone. *"Well, mostly all the trainings are online. [...] They're not very long. It's like hospice—10 minutes. Sexual harassment—20 minutes. It's like that."* (Agency B:08)

Some workers expressed disappointment that the opportunity to engage in person with fellow home care workers and agency staff was lost when the transfer to online training took place. In a work environment where workers often expressed feelings of isolation, the in-person training was an opportunity to feel connected to the agency instead of feeling on their own in the field. Finally, while the time spent completing mandatory training courses was compensated for some workers we interviewed, others were not compensated for this time.

In the case of the VC-backed company that took over a national home care chain (described above), the new owners also targeted investment in training as a cost-cutting measure. Previously, the company had provided in-person training sessions or had offered online training through a sophisticated learning management system (LMS) that had a series of modules with multimedia content. While the new ownership expressed interest in improving the training, they laid off a director who was preparing to roll out a large training program, and they implemented what this key informant described as a "completely different" and less effective training program that relied on PowerPoint presentations that home care aides could view online.

The Growth of Financial Actors in NYS Home Care

While our research focused primarily on private equity ownership, interviews with key informants surfaced the role of other financial actors—including venture capital firms and managed care organizations—in extracting profits from publicly financed home care and driving down labor and care standards in New York State. The changes wrought at a home care chain under venture capital ownership, described above, echoed the behavior of private equity in driving cost-cutting and automation. Scholars Rosemary Batt and Charlene Harrington noted that other financial actors—such as venture capital firms in home-based care and real estate investment trusts (REITs) in nursing home care—have started behaving more like private equity when it comes to the level of operational control they exert over portfolio companies.

Managed care organizations (MCOs) stood out as financial actors playing a significant role in driving down standards and extracting profits in New York’s Medicaid home care system. Since New York’s shift to Medicaid managed long-term care, home care is largely delivered through Managed Long-Term Services and Supports (MLTSS) plans administered through MCOs.⁶⁵ As was detailed in our first report, *Private Equity Pathways into Home Care: The Case of New York State*, the lack of transparency and oversight surrounding both private equity and MLTSS makes it difficult to examine how they interact and how they may shape each other’s profit-seeking strategies.

Managed care organizations receive a set monthly rate per plan member from the state, and home care providers must negotiate contracts for plans and reimbursement rates with MCOs. This creates an incentive for MCOs to reduce the service prices paid to home care providers and cut services in order to reap greater profits from state Medicaid payments. The problems of MCOs’ general practices and at times fraudulent strategies to increase their profits extracted from Medicaid have been well documented. Yet the lack of transparency and oversight in MLTSS prevents a full accounting of their practices and the implications for service prices, care quality, and access to care.

Key informants in our study described how the MCOs administering New York’s MLTSS plans pushed unsustainably low reimbursement rates to home care providers and channeled a greater volume of clients to providers willing to accept lower rates. They noted the persistent problem of MCO reimbursement rates being insufficient to cover wages, benefits, and wage parity requirements for home care workers, thus undermining the effect of policies meant to raise home care workers’ wages and improve benefits.⁶⁶ In order to make these low reimbursement rates work, home care providers have to somehow lower their cost of providing home care service, which in some cases can lead to low-road actors choosing to skim workers’ wages and benefits.

In this way, MCOs may be encouraging and rewarding low-road behavior (and potentially violations) in New York's home care industry.

Managed care organizations have also adopted financial strategies that drive short hours of work and unsustainable scheduling. Since the introduction of managed care in New York State long-term care, key informants observed that MCOs were authorizing lower hours for clients while also making it difficult for providers to take on high-need patients who required more hours of care. This pattern has been affirmed in research, including in a 2020 U.S. Government Accountability Office study that identified a range of serious problems.⁶⁷ For example, the study noted that in 2018, "New York found that an MCO had inappropriately reduced personal care services for 88 percent of cases reviewed." Because of the per-member monthly rate the MCOs receive from state Medicaid, longer-hour cases are less profitable for MCOs. Key informants feared that this was not only negatively affecting scheduling practices but also potentially making it more difficult for providers to take on higher-need clients who require more hours of care.

Nisbet and Morgan (2019) also highlighted home care employers' view that managed care drove a reduction in authorized hours, while pointing to other dynamics that made scheduling difficult as well.⁶⁸ Employers sought to limit workers to a maximum of 40 hours per week in order to avoid paying overtime pay rates (1.5x); employers did not expect MCOs to increase reimbursements adequately to match increased labor costs. And although it is illegal for companies to deliberately cap staff hours below full-time thresholds to avoid paying mandatory benefits, home care employers may also be engaging in this practice.⁶⁹

IV. RECOMMENDATIONS

The findings in this report document how home care agencies and financial actors make profits at the expense of a workforce that is predominantly women and people of color. The evidence from our research shows what working conditions look like at five private-equity-owned home care agencies—from management and labor practices that create unsustainable working conditions to managerial neglect undermining the ability of workers to provide quality care and compromising their safety and wellbeing. These poor working conditions are perpetuated by private equity owners, who have found home care agencies to be an attractive target for wealth extraction precisely due to an existing business model based on exploiting labor in the context of little or no regulation and oversight. Our findings also show that private equity owners, who buy out and consolidate small agencies into larger chains, increase the use of technology and automation in ways that depersonalize communication between workers and clients. This exacerbates existing problems of managerial neglect, including lack of communication, coordination, and responsiveness to workers when they have serious problems serving clients in their homes. And while our research focused on private equity as a specific form of financialization, our findings also surfaced the role of managed care organizations as financial actors driving down labor standards and extracting profits in New York’s Medicaid home care system.

Our first report argued that weak federal and state health and labor regulations, as well as opaque public and private payment systems, create favorable conditions for private equity (and other financial actors) to extract wealth from the home care system, in great part by perpetuating the long-standing exploitation of the workforce.⁷⁰ The following recommendations draw directly on our findings from both reports and leverage and build on the insights of the workers, advocates, scholars, and policymakers who have been advocating for change on these issues in home care. Some recommendations are specific to private equity practices, while some focus on addressing the general, pervasive devaluation of home care work that enables financial actors and other low-road employers to reap profits at the expense of home care workers.

I. Enforce and Expand Home Care Worker Rights, Protections, Representation, and Participation

Amid a widely recognized care crisis in the United States, home care workers perform labor that is socially necessary yet deeply devalued. Structural racism and sexism have fundamentally shaped who does home care work in the United States and under what conditions, upholding the perception of home care work as unskilled labor that can be cheaply obtained. Private equity and other financial actors have taken advantage of this, perpetuating low wages and poor

working conditions that undermine the provision of care as they extract profits from Medicaid dollars. To confront this, the narrative surrounding home care must be transformed: home care work must be recognized and respected as *professional work* that is deserving of the full set of benefits, wages, protections, and training that professional work is accorded. When caregiving is not considered “real work” and the workforce is devalued, it is easier for employers and the broader home care system to organize the work without regard for home care workers’ needs and economic security.

Raising standards and strengthening protections for home care workers can help to curb practices that allow financial actors and low-road employers to reap profits based on routine exploitation of a workforce that is largely made up of immigrants and women of color. It is also a critical part of dismantling structural racism in our care system. States play an important role in strengthening labor protections in home care, even more so after the Trump administration moved to eliminate the hard-won 2013 rule that included home care workers in the Fair Labor Standards Act (FLSA)’s minimum wage and overtime protections.⁷¹ While New York State has taken steps to raise standards for home care workers, far stronger action is necessary to value home care workers’ labor and make home care a sustainable job.⁷² Our recommendations include the following:

Enact and fully fund a living wage; fund oversight and enforcement

- Raise New York State’s entry-level home care wage to a living wage—currently \$29.89—indexed annually to inflation and adjusting for regional cost of living.⁷³
- Legislate to ensure the wage increase is fully funded—and accounting for benefits and associated payroll costs—and that annual increases are linked to corresponding increases in reimbursement rates, ensuring that funds are channeled primarily to care.
- In the absence of FLSA coverage, reinstate a floor of protections for home care workers at the state level by putting in place minimum wage and overtime protections.⁷⁴ We also urge support for measures (such as the Fair Wages for Home Care Workers Act) to reinstate these protections at the federal level.⁷⁵
- Eliminate 24-hour shifts and the 13-hour rule.⁷⁶ This will require New York State to change the system for authorizing home care hours to require—and fund—such care to be provided in two 12-hour shifts.
- Corresponding oversight and enforcement must be fully funded and staffed to ensure compliance with the law.

These recommendations build on demands by existing campaigns and proposed legislation in New York State. The Fair Pay for Home Care Act,⁷⁷ for example, would raise the wage floor above

existing wage parity and home care wages in New York State and tie the increase to reimbursements that fully cover wages, benefits, and related payroll expenses. While in 2022 New York legislators passed a budget that raised the home care worker minimum wage, the actual implementation of it was severely undermined by delays, subsequent policy changes, inadequate reimbursements, and an outsized focus on cost containment.⁷⁸ New legislation must learn from these mistakes—in particular, by ensuring increases are fully funded and that funds are channeled toward care⁷⁹—as well as address existing weaknesses in New York State’s current wage parity law.⁸⁰

Moreover, we recommend that any policy changes should be developed with participation from unions, workers, and employer representatives. For example, decisions made on how wages and reimbursements are calculated must be a participatory, transparent process.⁸¹

Convene a state task force to establish sustainable benefits and hours for home care workers

Increasing wages alone will not improve home care workers’ economic wellbeing if their corresponding hours are not secure. Many workers in our study had too few hours and not enough income, due to the widespread practice of agencies maintaining a surplus labor pool of home care workers who are not owed any minimum number of hours—a practice that appears to be worsened by financial actors such as managed care organizations.⁸² The insufficient hours and unstable schedules drove economic insecurity for home care workers and often prompted workers to question the long-term viability of this work. Requiring stronger benefits for home care workers is similarly important to making home care a sustainable occupation. Those performing the physically and emotionally arduous work of providing care should not be left without access to care and rest.

To design policy solutions that can effectively account for the complexity of how home care is currently organized, delivered, and reimbursed, we recommend the state convene a task force of stakeholders—including worker representatives and high-road employers—to establish systems-level reorganization of scheduling and benefits in home care.

We recommend that this task force create a plan for New York State to establish:

- Standard shifts and/or guaranteed hours. This should build on existing models and pilots for providing home care workers with guaranteed hours.
- A guaranteed minimum set of benefits that employers must provide home care workers that includes a retirement plan; a viable, affordable, quality health insurance plan;⁸³ and paid vacation and paid sick leave that exceeds New York’s Paid Sick Leave law.

Importantly, any such requirements must be tied to funding and reflected in reimbursement rates to providers.

Protect workers' right to organize and unionize

Strengthening worker voice and representation is critical to securing quality wages and benefits, improving working conditions, and ensuring workers' voice and interests shape our care system at the enterprise and industry level. Unions and worker organizations are also critical to supporting oversight and compliance with the law, as they can help to curb wage theft and other labor violations that home care workers experience with alarming frequency. Moreover, worker centers and unions are important sites for an atomized workforce to come together and build solidarity and to gain access to important training and other educational opportunities. In short, unionization of the home care workforce is critical to ensure the success of the recommendations presented in this report. We therefore recommend:

- Bolster home care workers' right and ability to unionize as an important way to raise standards and create formal channels for worker voice and representation. This should include specific outreach efforts targeting home care workers to provide resources on their workplace rights and right to unionize.
- Enforce workers' right to unionize with legitimate unions by enforcing the law that bans company unions that are brought in by management.⁸⁴

Because their workplaces are private homes, home care workers face particular barriers in upholding their rights and unionizing. The newly established NYC Mayor's Office of Worker Power provides one example of a government initiative that aims to proactively help workers understand their rights, access resources, and get connected with unions and worker organizations.⁸⁵ The Paid Care Division within the NYC Department of Consumer and Worker Protection (DCWP) also offers an example of government efforts to address the specific challenges care workers face.⁸⁶ New York State should build on these examples at the state level to expand strategic efforts to bolster home care workers' rights and ability to unionize. At the time of publication, 1199SEIU United Healthcare Workers East petitioned the National Labor Relations Board to hold an election for workers in the Consumer Directed Personal Assistance Program (CDPAP) to vote on whether to join the union.⁸⁷ The union collected nearly 70,000 signed union cards from CDPAP caregivers to file for the election and nearly 190,000 workers would be eligible to vote in the election, making the scale of the unionization drive historic.

Strengthen support and safety for home care workers

Managerial negligence was a pervasive problem in our findings, with home care workers reporting a stark lack of support in addressing race- and gender-based harassment and discrimination. Workers who reported instances of harassment and/or discrimination found agency management non-responsive. This managerial negligence extended to the health and safety of the worker too. Our recommendations are in the spirit of preventing workplace hazards, ensuring a safe and healthy work environment that should include the agency, the worker, the client and where relevant, the client's family. We therefore recommend:

- Mandate that home care agencies' new client intake protocol include an assessment of potential safety risks to home care aides. As part of the safety assessment and new client orientation, mandate that the client and their family receive and sign a document certifying that they received and understood health and safety guidelines and information on the law protecting workers from any form of discrimination and harassment. This will include the steps the agency will take to review and resolve any reported instances. When home care workers report problems with health and safety, discrimination, or harassment, require their agency employer to immediately conduct a visit to the client's home to reassess health and safety and address problems with harassment and discrimination.
- Mandate that all agency employees are made aware of their rights to a safe and harassment-free work environment. The agency must provide information (including the hotline phone numbers) to file a complaint with the NYC Commission on Human Rights and the New York State Division of Human Rights, as well as information about local, community-based organizations that provide support and advocacy. This information will be provided in different languages.
- Improve the required training materials on workplace health and safety and prevention of harassment and discrimination for Home Health Aides and Personal Care Aides. While the workers must be made aware of their rights to protection, so too must the employer be made aware of their responsibility in ensuring their workers are protected and safe in a client's home.
- The state should create advanced home care roles designed to support the broader home care workforce. In addition to providing direct, responsive support to home care workers, such positions can also help to enhance care delivery and serve as a career ladder opportunity. This could build on existing pilot programs in New York City and in other states.⁸⁸

Require agencies to provide in-person training at regular intervals

Our findings suggest that automation and increased reliance on new technologies to manage and communicate with workers are trends in the home care industry that may be particularly driven by financial actors such as private equity and venture capital seeking to cut costs. Such practices are often touted by financial actors as good for efficiency, and in some cases, they may help to address challenging issues such as the logistics of scheduling. Yet our research has shown that such strategies can depersonalize workers' and clients' experiences and undermine job and care quality. The areas being impacted by this increased reliance on technology include training and support. In addition to the recommendations above for strengthening support infrastructure for home care workers—which are critical to reversing the pattern of managerial negligence we found—we also recommend:

- Require home care agencies to provide in-person training at regular intervals. Require workers' time participating in training to be fully compensated—and ensure this requirement is fully funded and reflected in reimbursement rates.
- Require agencies to provide extensive training for new technologies and ongoing IT support for workers.

Enforce existing laws and regulations; demand transparency and accountability

Our findings point to the many ways in which labor protections on their own fail to protect workers because they are not enforced. There is little oversight, transparency, and accountability, eroding the effectiveness of existing protections. As noted above, unionization and collective representation are critical tools for enforcing worker protections; the state must also be adequately resourced to support enforcement.

New York State has some of the better labor protections compared to other states. And yet, the state's serious limitations in enforcing the existing regulations make it too easy for private equity to extract money by accessing the cheap labor of an exploited workforce. The severe underfunding and understaffing of agencies charged with enforcement is a widely documented problem nationally.⁸⁹ We therefore recommend:

- Fully fund and staff the agencies responsible for oversight and enforcement—including the NYS Department of Labor and the NYC Department of Consumer and Worker Protection (DCWP)—to fulfill their mandated role. Enforcement agencies should look to the recent vigorous enforcement efforts of DCWP to expand enforcement activity in home care.⁹⁰

- Enforcement agencies should engage stakeholders—including worker representatives and high-road employers—to design more effective strategies for boosting compliance and to create stronger consequences for violations.
- Where an agency is not in compliance with the law, the agency will be fined and sanctioned, and re-investigated until the agency is deemed in compliance. In the meantime, this information must be made public on the NYS Department of Labor’s website, naming the agency alongside the corresponding violations.
- Clarify legislatively that the ultimate parents of any investor-owned home care agencies or chains (including PE-owned) will also be subject to the funding conditions and enforcement measures recommended in this report. This will require training enforcement agencies to collect and analyze the relevant information and to build investigations that can look at parent entities and can take actions that include clawing back funds.

Foster the development of mission-driven and non-profit home care agencies

It is time to recognize and reward the agencies that place quality work and quality care at the forefront of their mission and their actions, helping to lay the groundwork for wider development of high-road models for home care. This includes worker-owned cooperatives, mission-driven non-profit agencies, and other models. At the same time, it is important to recognize that, within a privatized and financialized system, cooperatives and non-profit agencies are forced to compete with for-profit actors that drive a race to the bottom both in job quality and access to quality care. To address this, we recommend the following:

- Create a rating system based on the quality of work and quality of care provided by an agency.
- Lift up and reward the cooperative model and other mission-driven and non-profit home care agencies by channeling better reimbursement rates to them as a reward for investing in the quality of jobs and care delivery and centering the voice and wellbeing of workers and other stakeholders.
- Build financing mechanisms that leverage public funding and mission-aligned private funding to support the development of worker cooperatives and other high-road models in the home care sector.
- Develop publicly funded training, awareness-raising, and technical assistance programs for workers and owners/managers interested in converting home care agencies to worker ownership and/or starting up new cooperative enterprises.

Paving the high road: Bronx-based Cooperative Home Care Associates

As an important example of a high-road model in the home care sector, New York is home to Bronx-based Cooperative Home Care Associates, the largest worker cooperative in the country, with around 1,500 members. Founded in 1985, CHCA was created with the goal of building a scalable model that could improve job quality for home care workers while providing access to high-quality care. The organization started with a dozen workers and employed 60 by the end of its first year, gradually growing its footprint.

The structure of governance at CHCA amplifies worker voice. Workers hold a majority of seats on the board of directors, which oversees the activities of the co-op's senior management team. All members are eligible to vote for these representatives, and workers also have a direct line of communication with the CEO, who holds regular office hours. A 2018 study comparing CHCA with other for-profit and non-profit agencies of similar size found that CHCA workers reported higher levels of participation in work-related decisions, trust in management, and overall job satisfaction.⁹¹

CHCA engages in a range of efforts to improve conditions for its own workers and the home care workforce more broadly. Upon joining CHCA, workers have access to peer mentoring. The organization is recognized as a leader in workforce development, providing free-of-cost training to hundreds of New Yorkers each year. In 1990, CHCA shepherded the creation of PHI, a leading research and advocacy organization that disseminates best practices in the Long-Term Services and Supports sector, pushing to improve conditions for home care and nursing home workers around the country.

Nearly 20 years after its founding, in 2003, workers at CHCA unionized with the healthcare union 1199SEIU. After navigating some early growing pains in their relationship, the co-op and union have developed a partnership.⁹² The union's political muscle helps to provide backing for some of the co-op's advocacy goals, where both organizations are aligned, and the co-op serves as a model employer embodying the kinds of practices the union would like to institutionalize more widely across the industry. In recent years, CHCA and 1199SEIU have worked together in successful coalition efforts to improve pay for home care workers across New York State.⁹³

CHCA has looked to expand the reach of the co-op model within the home care industry. Leaders at the organization provided strategic support for the development of Home Care Associates (HCA), a cooperative founded in 1993 that today employs around 200 workers.⁹⁴ Closer to home, CHCA was looking to become a fiscal intermediary in New York's CDPAP system until private-equity-backed Public Partnerships LLC was awarded a statewide contract to administer the

program in 2024. Currently, CHCA is looking to expand its footprint in the private-pay market. Recognizing the challenges they face competing with well-resourced, profit-driven actors across different segments of the market, CHCA and other home care co-ops are working with other allied organizations to develop a shared services cooperative that supports the success of their model nationally.⁹⁵

II. Health System Policies to Support Care Workers and De-financialize Care

Curb extraction of public dollars for private profits

Our long-term care system has been designed in a way that allows the extraction of private profit from public systems. Reversing the privatization and financialization of home care is a large project, and New York can take concrete steps to move in that direction. As outlined above, we must build up the public sector and invest in and reward good actors—including cooperatives and mission-driven non-profits—while sanctioning the bad actors. In addition, we recommend the following:

- New York State should prohibit extractive tactics that financial actors use to siphon profits from public dollars—such as dividend payouts, management and monitoring fees, and stock buybacks—for any entity that is receiving Medicaid funding to provide home care or administer home- and community-based services.⁹⁶

Make home care funding more equitable

In order to fulfill the recommendations above, it is imperative to confront the persistent drive to curb Medicaid spending on home care. As long as Medicaid is the primary payer in home care, then it must be funded sufficiently to build a system that meets care recipients' and care workers' needs.⁹⁷ Our findings and the recommendations above make it clear that the persistent drive to curb Medicaid spending undermines standards in the home care sector. We therefore recommend:

- Increase Medicaid funding to match demand for Medicaid. For home care, this includes guaranteeing adequate hours of care to home care recipients.
- As long as long-term care is financed primarily through Medicaid, make it a guaranteed benefit—not a benefit via a waiver. This would create parity with nursing home care—no restrictions, no waiting lists, and no limits on populations.

- Increase funding to expand access to quality work through higher pay, better benefits, and improved working conditions as an important way to improve care quality.

The state must take seriously the short-sighted nature of the fixation on containing Medicaid costs: a robust care system that is capable of meeting the rapidly growing demand for long-term care is an investment that pays dividends not only for workers, care recipients, and their families, but also in the long term for the health of our communities, our healthcare system, and our economy.

At the same time, the influx of private managed care organizations contracted to provide Long-Term Services and Supports for Medicaid beneficiaries has established yet another avenue for financial actors to divert public dollars away from care and toward profit-making, creating incentives for low-road labor practices while reducing the amount of care authorized for care recipients. We therefore recommend:

- Remove managed care from the long-term care system in New York (whether part of Medicaid or financed and provided by an alternative policy instrument).

Indiana was the first state to remove managed care for Medicaid's long-term care patients. Twenty-four other states—including New York—have similar bills before their legislatures; in New York, the Home Care Savings and Reinvestment Act would eliminate the managed long-term care program.⁹⁸ In the meantime, as long as managed care is still part of New York's long-term care system, the recommendations above make it clear that measures for transparency and minimum reimbursement requirements must be instated to prevent managed care organizations from diverting public dollars away from care and driving low-road labor and care provision practices.⁹⁹

V. CONCLUSION

Evidence has shown that when private equity acquires essential public goods, such as hospitals and nursing homes, the quality of care declines, resulting in increased adverse health and morbidity outcomes. But few studies have explored the relationship between financialization, *working conditions*, and quality care. As private equity has expanded to capture services across a continuum of care, including home-based care, what happens to the quality of work and how this influences the ability of home care workers to provide quality care remains an understudied area. This report has sought to address these gaps in the research.

Moreover, the financialization of healthcare generally, and home care specifically, shines a light on the way privatization and subsequent financialization of key public services perpetuates a long-standing tradition of structural racism. Our findings show how policies, rules and regulations, and normative practices in home care that are built on a foundation of structural racism will only continue to perpetuate a harmful system unless they are explicitly transformed.

Home care proves an attractive site for private equity. As we have moved from caring for aging adults and people with disabilities in institutional settings to providing care in the home through home- and community-based services, public funding for those eligible is only set to increase as our population ages. On top of this, the lack of oversight and enforcement of existing labor protections, weak labor and social protections, and opaque payment systems make it easy to exploit an already exploited workforce for financial gain. The poor working conditions we found in our study are enabled by these inadequate protections and insufficient oversight.

Our study found that private equity owners took advantage of the worker exploitation that is prevalent across home care, perpetuating poor working conditions including low wages and wage theft, managerial negligence, and unsustainable hours. We also found that under private equity ownership, agencies often implemented increased automation and use of technology that depersonalized workers' and clients' experiences and exacerbated the problems with managerial negligence. Other financial actors—particularly managed care organizations—also played a role in driving down standards.

The findings in this study point to what happens when an industry can flourish without oversight and accountability on one hand and when workers lack the necessary social and labor protections on the other. Absent a wholesale removal of private enterprise from the provision of public services, our recommendations are intended to focus our efforts on curbing opportunities for profit extraction, and in doing so, break the systems in place that undergird exploitation and structural racism in home care.

APPENDIX A: METHODOLOGY

Our research objective was to explore whether and how financialization—specifically, the expanded activity of private equity firms—exacerbates the already challenging working conditions for women of color in home care jobs in New York, thereby reinforcing structural racism. We also sought to examine how this, in turn, affects workers’ ability to provide quality care.

We posed the following four research questions:

- To what extent does private equity ownership of home care agencies result in changes to the quality of jobs for home care workers—including wages, working conditions, staffing levels, scheduling, job security, and occupational health and safety?
- Do the labor practices in PE-owned home care agencies affect home care workers’ economic security, physical and mental wellbeing, and their ability to meet personal needs and provide for their own families? Are these experiences different for workers in unionized, PE-owned home care agencies?
- How do changes in job conditions affect home care workers’ ability to provide quality care in PE-owned home care agencies?
- To what extent do the labor practices of PE-owned home care agencies exploit structural racism? In what ways does this manifest itself?

To answer the questions, we used a community-based participatory research (CBPR) model in the design of the qualitative research. We established a research and advocacy advisory committee that informed the design of our qualitative methodology and advocacy. This committee included home care workers, community advocates, representatives from a union and a worker center representing home care workers, and researchers with expertise in home care and/or financialization. With their input and guidance, we constructed the following methodology.

We interviewed home care workers at five home care agencies in New York State that had been acquired by private equity firms (see Table 1). We chose agencies from two distinct regions—New York City and Buffalo-Rochester—because New York City has a higher level of union density in home care compared to Buffalo-Rochester, and this difference might have spillover effects for the agencies we studied. Our sample was diverse, with 18 who identified as women and 7 who identified as men. Twenty-two identified as Black or African American, two as Hispanic/Latine, and one as South Asian. The average age of respondents was 40, with the youngest being 21

and the oldest, 61. Fifteen respondents were from the New York City area, and 10 were based in Buffalo-Rochester.

Table 1. Home care agencies included in this study

Agency	Timeline of private equity acquisition	Locations	Unionized?
Agency A	Acquired by a PE-owned national chain within the last five years	NYC	Yes, but company union
Agency B	Acquired by a PE-owned national chain within the last five years	NYC, Buffalo	No
Agency C	Acquired by a PE-owned national chain within the last five years	NYC, Buffalo, Rochester	Yes, but company union
Agency D	Acquired by PE firm 10 years ago	NYC	No
Agency E	Acquired by PE firm over 10 years ago	NYC	Yes

Of the five agencies in our study, two were not unionized at all, two were unionized with a company union (where workers were generally unaware that their agency was unionized), and one was unionized with a legitimate labor union. The one (legitimate) unionized agency included in our study allowed us to explore how unionization may affect working conditions in the context of private equity ownership.

Qualitative Interviews

We conducted 40 interviews, including 25 with home care workers and 15 with key informants. The interviews with home care workers were roughly evenly distributed across the home care agencies in New York City and the Buffalo-Rochester region. To identify changes before and after private equity acquisitions, we sought to interview home care workers who had worked at those agencies pre- and post- acquisition. About one-third of our sample comes from these workers. The remainder were hired after the PE acquisition took place and were able to describe conditions they experienced under PE ownership.

We also sought interviews with schedulers, supervisors, and managers to understand how the agencies managed operations, constructed guidelines, and enforced rules and regulations. We secured only two interviews due to what may have been fear of participating in research on internal management practices. Our interviews with key informants were helpful for this context. They included scholars of private equity and healthcare, researchers with expertise in home care, union leaders from healthcare unions, a private equity consultant, state government officials, a former director at a home care company acquired by a venture-capital-backed company, and a CEO of a mission-driven home care agency in New York.

We used social media targeted advertising to recruit the sample of home care workers, schedulers, and managers. Social media advertising is designed to target a specific population by advertising the opportunity to participate in the study on Meta social media platforms like Facebook and Instagram.¹⁰⁰ In our study, the advertisements targeted those who worked at agencies as either home care workers, schedulers, or mid-level managers. The advertisement provided an explanation of our research and a link to the intake survey. The intake survey explained the objective of the study and then asked where the person worked, what role they performed at the agency, and their contact information if they were interested in participating in an interview. If the intake information matched the profile of respondents we were seeking to interview, we contacted the person to set up an interview. We offered respondents a \$50.00 gift card to compensate for their time spent participating in the study. At two agencies, we also worked with worker organizations and a union to recruit home care workers.

Our interviews with key informants were secured through targeted outreach. Here we identified or relied on recommendations and then contacted the individuals directly to set up an interview. Key informants were not remunerated. The Cornell University Institutional Review Board reviewed our research design and deemed it “exempt,” indicating that it posed no or minimal risk to participants.

Interview topics

Interviews with home care workers lasted between 45 to 90 minutes and included questions about their tenure, trajectory, and entry into home care. We asked about job quality and working conditions before (where relevant) and after the private equity acquisition, including questions about pay; benefits; hours; scheduling; training opportunities; job security; (dis)respect; treatment by managers, supervisors, and schedulers; physical, mental, and emotional risks; discrimination and unequal treatment; and changes in staffing. We also asked whether they were aware of the ownership change. We asked respondents to compare their experience at the agency with other agencies they had worked for.

We sought to better understand how respondents defined “quality care” and asked about the degree to which respondents felt they were able to provide quality care to their patients. This included questions about the type of caregiving tasks they performed; relationships with the patients; and ways in which the agency created constraints, barriers, or opportunities to meet patients’ care needs. We also asked whether they felt valued by the agency and whether they felt they had voice in shaping their working conditions. We asked respondents whether the agency they worked for was unionized or if they belonged to a worker organization. We then asked respondents how, if at all, working conditions affected their personal lives and physical and emotional wellbeing—including feelings of financial (in)security, physical and emotional health, and access to healthcare.

Interviews with key informants covered a wide range of topics depending on their area of expertise. We sought to contextualize insights from the worker interviews by providing a more comprehensive picture of private equity’s activity in home care agencies and in long-term care and healthcare more broadly. We asked about trends in home care and long-term care generally, as well as details regarding the incentives, profit-making strategies, and impact of private equity and other financial actors.

ENDNOTES

¹ Appelbaum, E. and Batt, R. (2021). "Financialization in Health Care: The Transformation of US Hospital Systems." CEPR Working Paper 2022-1. September 9. <https://cepr.net/report/working-paper-financialization-in-health-care-the-transformation-of-us-hospital-systems/>

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³ Bailey, Z. D., Feldman, J. M., and Bassett, M. T. (2021). "How Structural Racism Works—Racist Policies as a Root Cause of US Racial Health Inequities." *New England Journal of Medicine*, 384(8), 768-773. See also Flynn, A., Holmberg, S., Warren, D. and Wong, F. (2016). *Rewrite the Racial Rules. Building an Inclusive American Economy*. Roosevelt Institute.

⁴ Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

⁵ West, Z., Rowe, R., Brady, A.M., and Lenmark, M. 2026. *Private Equity Pathways into Home Care: The Case of New York State*. ILR Worker Institute, Cornell University. <https://hdl.handle.net/1813/124545>

⁶ Appelbaum, E. and Batt, R. (2021). "Financialization in Health Care: The Transformation of US Hospital Systems." CEPR Working Paper 2022-1. September 9. <https://cepr.net/report/working-paper-financialization-in-health-care-the-transformation-of-us-hospital-systems/>

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⁹ Appelbaum and Batt, 2020; Scheffler, R. M., Alexander, L. M., and Godwin, J. R. (2021). *Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk*. Berkeley (CA): American Antitrust Institute. <https://www.antitrustinstitute.org/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL-1.pdf>; Edlich, A., Llewellyn, C., Croke, C., Schneider, R., and Teichner, W. (2026, February 10). *Private Equity: Clearer View, Tougher Terrain*. McKinsey & Company.

¹⁰ Appelbaum and Batt, 2020.

¹¹ Scheffler, R., Alexander, L., Fulton, B., Arnold, D., and Abdelhadi, O. (2023). *Monetizing Medicine: Private Equity and Competition in Physician Practice Markets*. American Antitrust Institute (AAI).

¹² This account is drawn from our first report in this research project; for more details on the private equity model, see: West, Z., Rowe, R., Brady, A.M., and Lenmark, M. 2026. *Private Equity Pathways into Home Care: The Case of New York State*. ILR Worker Institute, Cornell University. <https://hdl.handle.net/1813/124545>

¹³ Appelbaum and Batt, 2020. See also Appelbaum, E. and Batt, R. (2014). *Private Equity at Work: When Wall Street Manages Main Street*. New York: Russell Sage Foundation.

¹⁴ U.S. Department of Health and Human Services. (2025). "HHS Consolidation in Health Care Markets RFI Response." Report prepared by the HHS Office of the Secretary (OS), in consultation with the U.S. Department of Justice and the U.S. Federal Trade Commission. Private equity firms benefit from the fact that carried interest is taxed at a lower rate as capital gains rather than as income.

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- ¹⁵ Appelbaum and Batt, 2020; Appelbaum and Batt, 2014.
- ¹⁶ Ibid.
- ¹⁷ Schrier, E., et al. (2024). "Hospital Assets Before and After Private Equity." *JAMA* 332, no. 8: 669–71.
- ¹⁸ Parr, M. (2026). "Private Equity's Role in Healthcare Bankruptcies Resurfacing." Private Equity Stakeholder Project. February 25, 2026. <https://pestakeholder.org/news/private-equitys-role-in-healthcare-bankruptcies-resurfacing/>
- ¹⁹ U.S. Senate Budget Committee. (2025). "Profits over Patients: The Harmful Effects of Private Equity on the U.S. Health Care System." Senate Budget Committee Bipartisan Staff Report, U.S. Senate Budget Committee, Chair Sheldon Whitehouse (D-RI) and Ranking Member Charles E. Grassley (R-IA), Senate Finance Committee, 118th Congress, January 2025, 7–86. https://www.budget.senate.gov/imo/media/doc/profits_over_patients_the_harmful_effects_of_private_equity_on_the_ushealthcaresystem1.pdf; Organized Crime and Corruption Reporting Project (OCCRP) and *Boston Globe*. (2024). "How Private Equity and an Ambitious Landlord Put Steward Health Care on Life Support." October 9. <https://www.occrp.org/en/investigation/how-private-equity-and-an-ambitious-landlord-put-steward-healthcare-on-life-support>
- ²⁰ Gupta, A., Howell, S. T., Yannelis, C., and Gupta, A. (2021). "Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes," NBER Working Paper 28474. <https://doi.org/10.3386/w28474>
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- ²³ New York State's home care utilization trend has shifted over the past seven years, as agency-provided home care utilization declined and consumer-directed care utilization increased sharply; as of 2023, over half of Medicaid dollars spent on personal care services in New York State financed care through CDPAP. See Kinnucan, M. (2024, December 12). "How Fast is New York's Home Care Program Really Growing?" Fiscal Policy Institute. <https://fiscalspolicy.org/wp-content/uploads/2024/12/2024.12.12-How-Fast-is-Home-Care-Growing.pdf>
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- ²⁷ Bugbee et al., 2025. Unlike nursing homes, home care is not subject to a standard federal regulatory system; regulation is left to the states, which have various and typically weak standards. Private equity firms also have reportedly slowed their activity in hospitals and physician practice management in the face of heightened federal and state regulatory scrutiny—leading them to pursue acquisitions in more specialized healthcare services, such as home-based care. See Fischer, J. R. (2024, December 19). *Home-Based Care Deals Driven by Chronic Conditions*,

Aging Population, Patient-Directed Care. PE Hub. <https://www.pehub.com/home-based-care-deals-driven-by-chronic-conditions-aging-population-patient-directed-care/>

²⁸ See Salcedo et al., 2025; Moss and Valdes Viera, 2023

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³⁷ Boris, E., and Klein, J. (2012). *Caring for America: Home Health Workers in the Shadow of the Welfare State*. Oxford University Press.

³⁸ For more details on the findings in this section, see our first report: West, Z., Rowe, R., Brady, A.M., and Lenmark, M. 2026. *Private Equity Pathways into Home Care: The Case of New York State*. ILR Worker Institute, Cornell University. <https://hdl.handle.net/1813/124545>

³⁹ For details on specific New York State home care agencies' trajectories into private equity ownership, see our first report: West et al., 2026. <https://hdl.handle.net/1813/124545>

⁴⁰ See our first report, *Private Equity Pathways into Home Care*, for the full analysis of private equity's growing footprint in New York State home care. Authors' analysis of 2022 Licensed Home Care Services Agency (LHCSA) Statistical Report data, based on the number of Medicaid hours of care reimbursed. All licensed home care service agencies in New York State are required to submit annual reports to the Department of Health. 2022 is the most recent year for which we had statistical report data available for analysis. Some PE-backed agencies did not submit LHCSA statistical report data or submitted incomplete data.

⁴¹ The proposal was approved by the legislature in the spring 2024 state budget negotiations. For more on this transition, see West et al., 2026. <https://hdl.handle.net/1813/124545>

⁴² See Kinnucan, 2024, *How Fast is New York's Home Care*. "To demonstrate this shift, we rely on data provided to the State by managed care organizations participating in New York State's Partial Capitation Managed Long-Term Care program, the State's largest long-term-care Medicaid program. This data is not comprehensive (other NYS Medicaid programs also provide home care), but we estimate that it covers over 90% of all personal care in New York State."

⁴³ *Private Equity-Backed PPL Settles Wage Theft Case, Faces DOJ Lawsuit*. (2026, July 23). Private Equity Stakeholder Project PESP. <https://pestakeholder.org/news/private-equity-backed-ppl-settles-wage-theft-case-faces-doj-lawsuit/>

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- ⁴⁸ Our interviews focused on workers in the agency model of home care services; for the distinction between the agency model and the consumer-directed model of home care, see box "How home-based care works in New York State."
- ⁴⁹ Hanson, G. C., Perrin, N. A., Moss, H., Laharnar, N., and Glass, N. (2015). "Workplace violence against homecare workers and its relationship with workers health outcomes: a cross-sectional study." *BMC public health*, 15, 1-13.; Burnham, L., Theodore, N. (2012). "Home Economics: The Invisible and Unregulated World of Domestic Work." *National Domestic Workers Alliance*.
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- ⁵¹ See our first report, West et al., 2026, pp.32-33 for a detailed account of the violations and settlement. <https://hdl.handle.net/1813/124545>
- ⁵² NYS Department of Labor. 2024. Home Care Aide Minimum Wage. <https://dol.ny.gov/system/files/documents/2024/12/p105-home-health-aide-10-23-24.pdf>. For details on how the Home Care Worker Wage Parity Law affects compensation, see: https://www.health.ny.gov/health_care/medicaid/redesign/mrt_61.htm
- ⁵³ See, for example: Geringer-Sameth, E. (2024, September 12). *Home Care Agencies Lead New York City in Wage Theft Violations*. Crain's New York Business. <https://www.crainsnewyork.com/health-pulse/wage-theft-rampant-home-health-care-industry>; Chen, S. (2024, March 7). *Home Care Aides Fight to End 24-Hour Shifts: 'This Work Is Killing Them'*. The New York Times. <https://www.nytimes.com/2024/03/07/nyregion/home-care-aides-city-council-bill-end-24-hour-shifts.html>; Ming, J., Gong, D., Ngai, C. S. E., Sterling, M., Vashistha, A., & Dell, N. (2024). Wage Theft and Technology in the Home Care Context. *Association for Computing Machinery*, 151, 1-30.
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- ⁵⁵ Those working at agencies unionized by 1199SEIU United Healthcare Workers East can combine their hours across two unionized agencies in determining their benefits eligibility.
- ⁵⁶ Nisbet, E., and Morgan, J. C. (2019). "Where Policy Meets Practice: Employer Perspectives on Scheduling and Hours for Home Care Aides." *Journal of Applied Gerontology*, 38(11), 1615-1634.
- ⁵⁷ Intentionally cutting or suppressing an employee's hours specifically to block them from receiving established benefits can violate Section 510 of the Employee Retirement Income Security Act (ERISA). The Affordable Care Act employer mandate generally requires large employers (those with 50 or more full-time workers or full-time-equivalent employees) to offer affordable and minimum value health coverage to their full-time employees (employees who regularly work an average of at least 30 hours per week).
- ⁵⁸ Based on key informant interviews with Rosemary Batt and Charlene Harrington.
- ⁵⁹ These were the three agencies where we were able to interview respondents who had been employed at the agency both before and after it was acquired by private equity. For the other two agencies, respondents only reported on current conditions under private equity ownership.

⁶⁰ The introduction of the Electronic Visit Verification (EVV) system created a federal requirement for states to implement a data collection system for Medicaid home care services with the aim of increasing oversight and transparency. Home care workers are required to use an EVV app to clock in and clock out for their care shifts and to log the care recipient, the location, and the type of service performed.

⁶¹ EVV was mandated by the 21st Century Cures Act in 2016. On documented problems with EVV, see: Miller, J., Breslin, M. L., & Chapman, S. (2021). Impact of Electronic Visit Verification (EVV) on Personal Care Services Workers and Consumers in the United States. UCSF Health Workforce Research Center on Long-Term Care. https://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/EVV_Report_210722.pdf; Mateescu, A. (2024). Working Against the Clock: Digital Surveillance in US Medicaid Homecare Services. *Journal of Sociology*, 60(3), 560-576.

⁶² This case was described by a key informant.

⁶³ These were the three agencies where we were able to interview respondents who had been employed at the agency both before and after it was acquired by private equity. For the other two agencies, respondents only reported on current conditions under private equity ownership.

⁶⁴ See <https://www.nevvo.com/> [accessed on August 18, 2026]

⁶⁵ See our first report for a more detailed description of Medicaid managed long-term care in New York: West, Z., Rowe, R., Brady, A.M., and Lenmark, M. 2026. Private Equity Pathways into Home Care: The Case of New York State. ILR Worker Institute, Cornell University. <https://hdl.handle.net/1813/124545>

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⁶⁷ GAO (2020, November). Medicaid Long-Term Services and Supports. Access and Quality Problems in Managed Care Demand Improved Oversight. GAO-21-49, Washington DC. <https://www.gao.gov/assets/gao-21-49.pdf>

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⁶⁹ Intentionally cutting or suppressing an employee's hours specifically to block them from receiving established benefits can violate Section 510 of the Employee Retirement Income Security Act (ERISA). The Affordable Care Act employer mandate generally requires large employers (those with 50 or more full-time workers or full-time-equivalent employees) to offer affordable and minimum value health coverage to their full-time employees (employees who regularly work an average of at least 30 hours per week).

⁷⁰ West, Z., Rowe, R., Brady, A.M., and Lenmark, M. 2026. *Private Equity Pathways into Home Care: The Case of New York State*. ILR Worker Institute, Cornell University. <https://hdl.handle.net/1813/124545>

⁷¹ *Department of Labor Halts Enforcement of Minimum Wage, Overtime Rights for Home Care Workers*. (2025, July 31). Economic Policy Institute. <https://www.epi.org/policywatch/departement-of-labor-halts-enforcement-of-minimum-wage-overtime-rights-for-home-care-workers/>

⁷² Moreover, raising workers' wages has also been recognized as a critical step in recruiting enough workers to address New York State's large and growing shortage of home care workers. See, for example, Jabola-Carolus, I., Luce, S., and Milkman, R. (2021). *The case for public investment in higher pay for New York state home care workers: Estimated costs and savings*. https://academicworks.cuny.edu/gc_pubs/682/; Eisner, E. (2023, March). Workforce Report: Labor Shortage Mitigation in New York's Home Care Sector. Fiscal Policy Institute. <https://fiscalpolicy.org/workforce-report-labor-shortage-mitigation-in-new-yorks-home-care-sector>

⁷³ This amount is based on a single worker with no dependents. <https://livingwage.mit.edu/states/36>.

⁷⁴ See, for example, how Oregon instated state-level protections: <https://olis.oregonlegislature.gov/liz/2026R1/Measures/Overview/sb1518>

⁷⁵ Fair Wages for Home Care Workers Act, S.4081 (2025). <https://www.congress.gov/bill/119th-congress/senate-bill/4081/text>

⁷⁶ See our first report for more details about this rule and its impact on home care workers: West, Z., Rowe, R., Brady, A.M., and Lenmark, M. 2026. Private Equity Pathways into Home Care: The Case of New York State. ILR Worker Institute, Cornell University. <https://hdl.handle.net/1813/124545>

⁷⁷ At the federal level, the Fair Wages for Home Care Workers Act would guarantee minimum wage and overtime protections for home care workers. See US Senate Bill S.4081 - Fair Wages for Home Care Workers Act, 119th Congress (2025-2026) <https://www.congress.gov/bill/119th-congress/senate-bill/4081/text>

⁷⁸ For an analysis of the failures of the minimum wage increase, see: <https://www.phinational.org/resource/investing-in-the-home-care-workforce-a-brief-analysis-of-new-yorks-home-care-minimum-wage-increase/>

⁷⁹ New York State must develop specific accountability measures that go beyond employer attestation, which is insufficient. For example, California has implemented accountability measures for its wage pass-through laws that include facility payroll audits and provider surveys. See Yearby et al. September 2020. *Wage Pass Through Law Final Report*. The Institute for Healing Justice & Equity. https://ihje.org/wp-content/uploads/2024/02/2.28.24-Wage-Pass-Through-Law-Final-Report_Institute-of-Healing-Justice-and-Equity.pdf

⁸⁰ PHI report on wage parity rollout & critiques of shortcomings: Dawson & Rodet 2014. The Impact of Wage Parity on Home Care Aides, <https://www.phinational.org/wp-content/uploads/legacy/research-report/phi-benefitcliffs-20140623.pdf>. The Interested Parties Advisory Group (IPAG) requirement within the Medicaid Access Rule could potentially serve as a good mechanism for ensuring this transparency and input. This requirement is slated to be mandatory by 2029, but New York could follow the example of other states that have taken a head start on codifying and implementing IPAGs, like Maryland: <https://health.maryland.gov/mmcp/longtermcare/Pages/Interested-Parties-Advisory-Group.aspx>

⁸¹ See, for example, Jabola-Carolus, I., Luce, S., and Milkman, R. (2021). *The case for public investment in higher pay for New York state home care workers: Estimated costs and savings*. https://academicworks.cuny.edu/gc_pubs/682/.

⁸² While insufficient hours is a widespread problem for home care workers, as noted in the recommendation above, there are also some home care workers who endure 24-hour shifts.

⁸³ Policy design would need to address the complexities of health insurance provision for home care workers, ensuring, for example, that workers would not lose affordable coverage in exchange for inferior and/or unaffordable health insurance. For a recent example of problematic health insurance for home care workers, see Kinnucan, M. (2025, March 18). How the CDPAP Transition Could Leave Thousands of Home Care Workers Uninsured. Fiscal Policy Institute. <https://fiscalspolicy.org/how-the-cdpap-transition-could-leave-thousands-of-home-care-workers-uninsured>

⁸⁴ A company union is a worker organization that is dominated or unduly influenced by an employer and is therefore not an independent, democratically elected union. Company unions are contrary to international labor law (see ILO Convention 98, Article 2). They were outlawed in the United States by the 1935 National Labor Relations Act §8(a)(2), due to their use as agents for interference with independent unions. However, company unions persist.

⁸⁵ See Mayor's Office of Worker Power: <https://www.nyc.gov/main/mayors-office-of-worker-power>

⁸⁶ See Paid Care Division - NYC Department of Consumer and Worker Protection (DCWP). (2016). <https://www.nyc.gov/site/dca/about/paid-care-division.page>

⁸⁷ Goldstein, J. (2026, September 22). Powerful New York Labor Group Seeks to Unionize 190,000 Health Workers. *The New York Times*. <https://www.nytimes.com/2026/09/22/nyregion/powerful-new-york-labor-group-seeks-to-unionize-190000-health-workers.html>

⁸⁸ One such pilot program is the Care Connections Senior Aide and another, more recently, is the Care Integration Senior Aide. See *A Career Development Project That Improved Clinical Outcomes*. (2017, September 10). PHI. https://www.phinational.org/impact_story/career-development-improved-outcomes/; Scales, K. and Dieppa Colo, E. 2024. *Advancing Care, Advancing Careers: Implementation and Evaluation of the Care Integration Senior Aide (CISA) Home Care Role in Wisconsin*. New York, NY: PHI. <https://www.phinational.org/resource/advancing-care-advancing-careers-implementation-and-evaluation-of-the-care-integration-senior-aide-cisa-home-care-role-in-wisconsin/>. New York's Advanced Home Health Aide role could be the vehicle for this type of enhanced support,

but that position was never implemented because of insufficient funding and impractical supervision requirements; see https://www.health.ny.gov/facilities/home_care/advanced_home_health_aides/.

⁸⁹ Fine, J. (2017). "Enforcing labor standards in partnership with civil society: Can co-enforcement succeed where the state alone has failed?" *Politics and Society*, 45(3), 359–388; Galvin, D. J. (2016). "Deterring wage theft: Alt-labor, state politics, and the policy determinants of minimum wage compliance." *Perspectives on Politics*, 14(2), 324–350; Weil, D. and Pyles, A. (2005). "Why complain? Complaints, compliance, and the problem of enforcement in the US workplace," *Comparative Labor Law & Policy Journal*, 27(59).

⁹⁰ Mayor Mamdani Wins Record \$131.5 Million from DoorDash for Delivery Workers. (2026, September 22). City of New York. <http://www.nyc.gov/site/dca/news/065-26/mayor-mamdani-wins-record-131-5-million-doordash-delivery-workers>

⁹¹ Berry, D., and Bell, M. P. (2018). "Worker cooperatives: Alternative governance for caring and precarious work." *Equality, Diversity and Inclusion: An International Journal*, 37(4), 376–391.

⁹² Berry, D. P., and Schneider, S. (2011). "Improving the quality of home health aide jobs: A collaboration between organized labor and a worker cooperative." *Employee ownership and shared capitalism: New directions in research*, 59–89.

⁹³ Pinto, S. (2026). "Cooperative Home Care Associates: Worker Cooperative Development and Unionisation." In *Cooperativism at Work* (pp. 399–410). Routledge.

⁹⁴ See <https://www.phinational.org/partner/home-care-associates/>

⁹⁵ See <https://elevatecommunity.coop/>

⁹⁶ For more details on policies to curb extractive practices and strengthen transparency, see Salcedo, G., Seifert, R., & Sen, A. (2025, May). *Wall Street on Your Doorstep: Protecting Home Care From Private Equity Abuses*. Americans for Financial Reform Education Fund. <https://realbankreform.org/wp-content/uploads/2025/05/Wall-Street-on-Your-Doorstep.pdf>

⁹⁷ At the federal level, the Medicare at Home Act would create a Medicare home care benefit. See Medicare at Home Act, H.R.10020 (2025). <https://www.congress.gov/bill/119th-congress/house-bill/10020/text/ih>. At the state level, Washington State has implemented a statewide long-term-care insurance program funded through mandatory payroll contributions; legislation has also been introduced in New York State proposing a payroll-funded long-term-care trust program. See New York Long Term Care Trust Act, S1179, NY State Senate (2025). <https://www.nysenate.gov/legislation/bills/2025/s1179>; Matesky, C. (2026, September 2). *Is a Long-Term Care Tax Coming to Your State?* ACACIA Insurance. <https://www.ltcinsuranceconsultants.com/guides/taxes/long-term-care-tax/>

⁹⁸ For details on the Home Care Savings and Reinvestment Act, see Senate Bill S2332A, NY State Senate (2025). <https://www.nysenate.gov/legislation/bills/2025/S2332/amendment/A>

⁹⁹ See, for example, measures in the Fair Pay for Home Care Act.

¹⁰⁰ Schneider, D., and Harknett, K. (2022). "What's to like? Facebook as a tool for survey data collection." *Sociological Methods & Research*, 51(1), 108–140.