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WEST VIRGINIA

HOME CARE MARKET ASSESSMENT



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KEY TAKEAWAYS

- **Public Program:** While West Virginia is systematically transitioning away from a fee-for-service system of care delivery to a managed care model, personal care programs are still operated under the fee-for-service model today; a target transition date of January 2017 was stalled earlier this year with a new date currently pending. State spending on home and community-based services (HCBS) is slightly lower than the national average, demonstrating a continued favorability for institutional based care.
- **Consumer Demand:** West Virginia's population is rapidly aging; by 2030, one of every four state residents will be above the age of 65. As of 2016, an estimated 164,936 West Virginia residents were categorized as "frail elderly", "self-care disabled", or "independent living disabled" and likely needing home care services.¹
- **Labor Supply:** West Virginia faces a significant home caregiver shortage with one caregiver for every 11.19 home care clients in the state. Recruiting more caregivers to the industry will continue to be difficult as West Virginia is one of only eight states in the nation where home care workers are paid less than food service and retail workers.
- **Home Care Agency Market:** West Virginia has an estimated 224 home care agencies, providing both home health and non-medical home care.² West Virginia is a highly-fragmented home care market, with the top five non-medical home care companies in West Virginia controlling only 14% of total revenues. The majority of home care operators in the state have revenue of less than \$250,000 per year³, signaling challenges in scaling and burdening the industry with inefficiencies.
- **Existing Home Care Cooperatives:** West Virginia does not currently have any home care cooperatives, but a movement towards them is beginning supported by local partner Mountain State Justice⁴
- **Cooperative Opportunity:** Today, the environment for home care business development is challenging in West Virginia. At a high level, West Virginia spends less on Medicaid per enrollee, and has a severe caregiver shortage, placing the state in the more difficult category of markets for home care in the country. Moving forward, though, there are opportunities for cooperative development as partnerships are emerging with local partners in support of home care cooperatives and the state's regulatory process is becoming more favorable to new home care businesses.

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

² Calculation excludes agencies performing skilled nursing, hospice, and dialysis.

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

⁴ Mountain State Justice. Retrieved from <https://mountainstatejustice.org/>

About this Report:

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

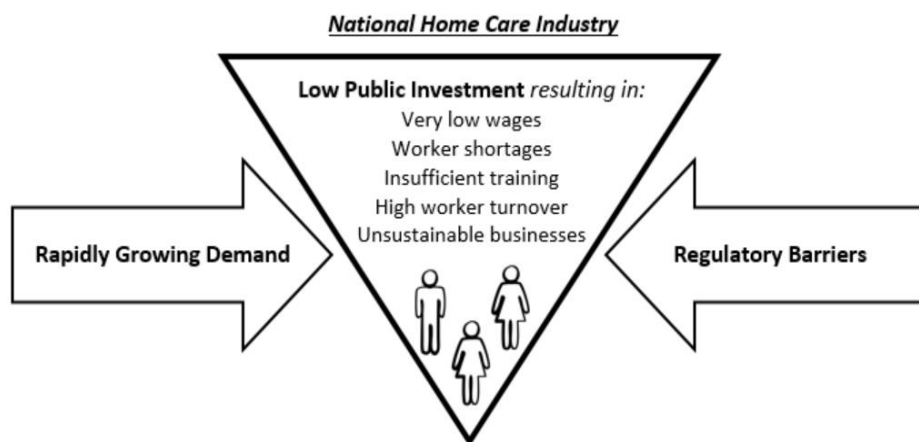
NATIONAL OVERVIEW

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

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

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

Public reimbursement rates for home care services are low, driving down wages across the industry. Unlike many other sectors in healthcare, the homecare industry does not have strong political representation and thus has been an easy target for federal cuts. Across the U.S., the hourly median wage for workers in the direct care workforce is \$10.49 per hour, only 25

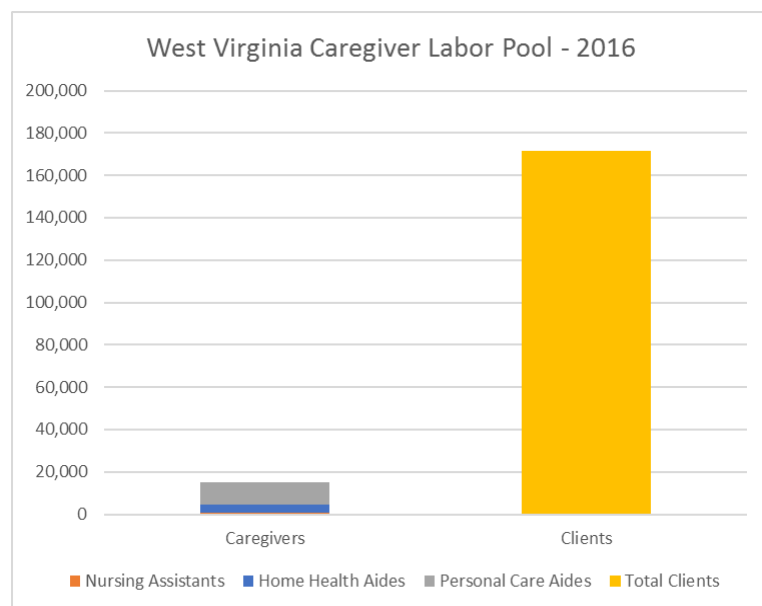


⁵ IBISWorld Industry Reports: 62161 Home Care Providers in the US

cents more than the median wage for retail and food service workers. Even though homecare is increasingly promoted by healthcare professionals and offers a superior value for clients, this recognition has not yet resulted in increased payments for services. With deep public underinvestment in home care, small and large home care cooperatives alike struggle to remain financially sustainable, let alone carve out the financial resources necessary to invest in the worker-focused benefits that differentiate a home care cooperative job from a standard home care job. Worker cooperatives have the potential to raise wages and job quality for caregivers and provide better outcomes for patients, but the business model must be first strengthened, scaled, and unified in order to sufficiently influence and transform the industry today.

INTRODUCTION

One in every six residents in West Virginia today is over the age of 65. By 2030, citizens aged 65+ will account for 25% of the state's population—or one out of every four people⁶. This high proportion of elderly in the populations is particularly pronounced in West Virginia's rural communities. West Virginia also leads the nation with the highest percentage of disabled individuals at nearly 20%⁷. Like nearly every state in the nation, West Virginia's demand for home care services is predicted to skyrocket, resulting in incredible occupational growth for direct care workers. Certainly, this demand signals potential for new home care cooperative agencies in the state. New agencies wishing to launch in the state must carefully navigate the opportunities and challenges in the state to be successful however.



Already facing a severe caregiver shortage, West Virginia will need to attract many new and diverse workers into the workforce to meet demand. The profession is unattractive to many with tiring work that often lacks prestige, limited state training requirements, poor job quality, and low pay and benefits for caregivers. Further, while the average caregiver is paid over 10% more than the average food service or retail worker nationally, at least marginally elevating the career above other entry-level professions, in West Virginia home

care workers are paid 2.33% *less* than food service and retail workers. This is a staggering statistic for an industry that already has a recruitment problem.

⁶ West Virginia Future of Aging and Caregiving Task Force Report June 2016. Retrieved from www.wvpel.org

⁷ U.S. Census, Disability Characteristics 2011-2015, American Community Survey 5-Year Estimates. Retrieved from www.census.gov

Regulatory barriers and uncertainty also exist in West Virginia. It is one of only two states that require a certificate-of-need process for the development of an in-home personal care services business, creating high regulatory barriers to entry. The state has also created uncertainty in the market by postponing the transition of personal services from the fee-for-service payment model to managed care, originally slated to occur in January 2017, but now stalled with no new transition date.

In sum, extraordinarily low compensation for caregivers, combined with prohibitive state laws and the uncertainty in the payment model for personal care services make West Virginia a challenging market for development in home care today. Moving forward, however, partnerships are emerging with local partners in support of home care cooperatives, the state will fully transition to managed care organizations to pay providers, and may even dismantle the certificate-of-need process, opening up the state for cooperative development.⁸

This report will analyze the home care market across three core dimensions including market size, labor supply, and regulatory/policy environment. We will then use this analysis to drive conclusions on the state of home care in West Virginia, how this effects current and start-up home care cooperatives in the state, and explore potential strategies for growing and nurturing home care cooperatives.

⁸ Charleston Gazette – Mail. Kabler, P., February 2017. Audit Recommends End to Certificate of Need for Hospitals. Retrieved from www.wvgazettemail.com

MARKET OVERVIEW

To understand the market for home care services in West Virginia, we use three separate lenses of analysis: customers, competition, and payers. This section provides a view into the number of potential home care customers in the West Virginia market, how home care clients pay for home care, and who is competing for these customers. Finally, we assess the regulatory and political barriers that exist in the state that may create difficulty in either starting a new home care cooperative or expanding an existing one.

Customers

Home care client demographics in West Virginia are favorable towards the development of home care businesses, and long-term trends point towards a growing customer base. West Virginia's population is rapidly aging. Today, one in every six residents, or nearly 300,000, are over the age of 65. By 2030, citizens aged 65+ will account for 25% of the state's population—or one out of every four people⁹. This aging trend particularly pronounced in West Virginia's rural communities. West Virginia also leads the nation with the highest percentage of disabled individuals at nearly 20%¹⁰. West Virginia's self-care (SC) and independent living (IL) disabled population is 210,630¹¹.

As of 2016, 164,936 adult West Virginia residents were categorized as “frail elderly”, “self-care disabled”, or “independent living disabled” and likely needing home care services¹². The primary source of growth in home care demand is West Virginia's “frail elderly”. The total number of individuals in these groups potentially requiring home care services, defined as the “home care subset”, is significantly higher than the national average at 9.26% (vs. 6.1 %).

Competition

West Virginia classifies home care providers under three primary categories—Home Health Agencies, Personal Care Agencies, and Personal Attendant Agencies. There are currently 54 licensed personal care agencies, 67 licensed home health agencies, and 103 personal attendant agencies registered with the West Virginia Bureau of Senior Services.

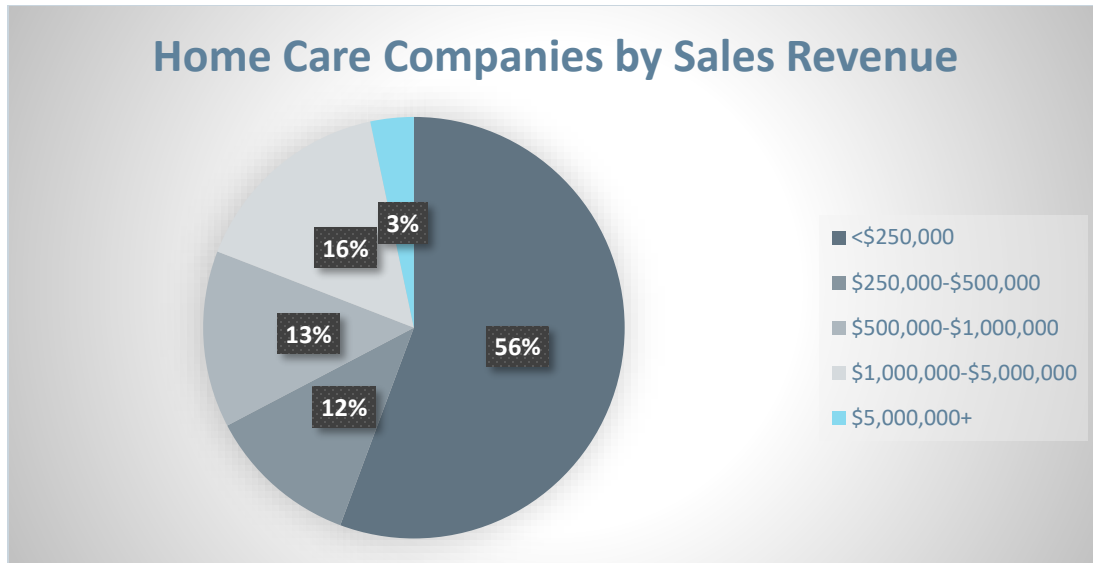
The median sales revenue for West Virginia home care companies is \$181,709, while the average revenue is \$854,108, reflecting a skew towards the large-size of the top companies in the market. Still, the majority of home care operators in the state have revenue of less than \$250,000 per year (56%), representing very small operations with highly variable management talent, operational practices, and quality levels.

⁹ West Virginia Future of Aging and Caregiving Task Force Report June 2016. Retrieved from www.wvpel.org

¹⁰ U.S. Census, Disability Characteristics 2011-2015, American Community Survey 5-Year Estimates. www.census.gov

¹¹ Erickson, W., Lee, C., & von Schrader, S. (2016). 2015 Disability Status Report: West Virginia. Ithaca, NY: Cornell University Yang Tan Institute on Employment and Disability(YTI). Retrieved from www.disabilitystatistics.org

¹² U.S. Census Bureau (2016). *Monthly Population Estimates for the United States: April 1, 2010 to December 1, 2017* 2016 Population Estimates. Retrieved from www.census.gov



The top five non-medical home care companies in West Virginia control only 14% of the total market, signaling a highly fragmented and competitive market. The top-five largest agencies are:

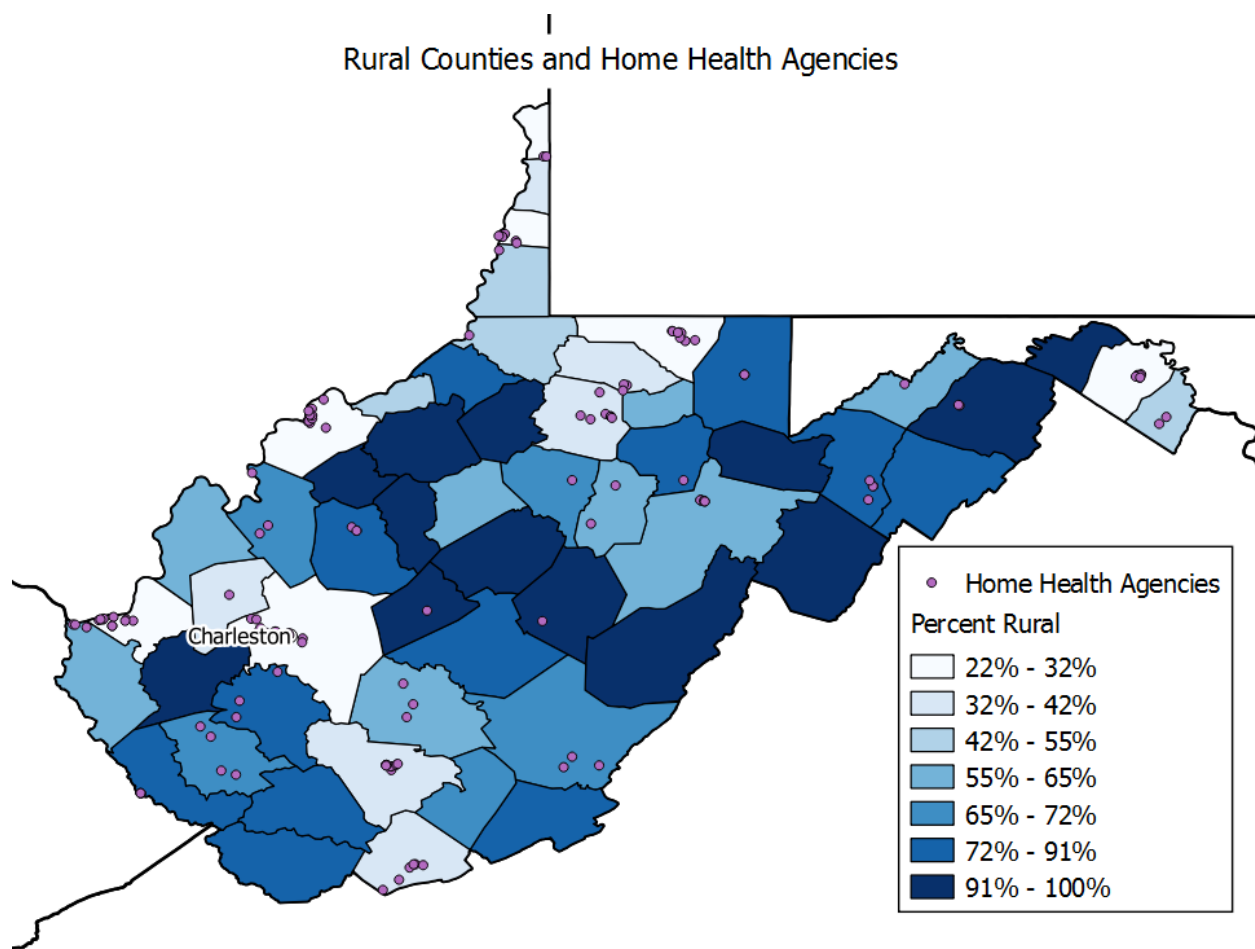
1. **Central WV Aging Services**, is a non-profit organization with annual revenues of \$18 million
2. **Loved Ones in Home Care**, a for-profit, franchise at \$15 million in annual revenues
3. **Mulberry Street Management Services** (doing business as West Virginia Select, West Virginia Choice and Coordinating Council for Independent Living), a for-profit company generating \$14 million in annual revenue
4. **Pro-Careers, Inc.**, a for-profit company earning \$7.6 million in annual revenues
5. **Coalflic Community Action Partnership** a not-for-profit earning \$7.1 million in annual revenues

Notably only three of the ten largest non-medical home care companies in the state are for-profit, which may indicate difficulty in successfully running a for-profit non-medical home care company in the state. As all three of the for-profit companies are also in the top five by market share and revenue, one can presume that these three companies are capturing a significant share of the private pay market for non-medical home care, particularly as only one of the three for-profit companies, Mulberry Street Management Services, is certified to offer Medicaid Personal Care services.

Rural vs. Urban Conditions

Just over 38 percent (over 700,000) of West Virginia's population lives in rural areas¹³. Home health agencies, though, are largely clustered in urban areas, as is typical of most states.

¹³ Rural Health Information Hub. Retrieved from <https://www.ruralhealthinfo.org/states/west-virginia>



Population density compared between rural and urban areas in the state is quite similar (i.e., 32 residents/per square mile rural vs. 107 urban, or about 3x), revealing that West Virginia has fewer areas of concentrated population than the national average (i.e., 19/sq mile in rural compared to 1015/sq mile in urban areas, or 50x).

Rurally located home health companies in West Virginia have median sales revenue of \$517,550 as compared to urban home health companies that have median sales revenue of \$488,800; an insignificant difference.¹⁴ This seems reflective of the state's relatively flat rural and urban population density, meaning West Virginia home care companies operating in urban areas do not have a significant market advantage over rural home care companies, which is not typically the case. It is likely that rural

¹⁴ While we were unable to gather county-based data on all home care companies including personal care and home health, we do have location based data for all home health companies in the state. Using this data, we were able to calculate the relative size difference of rural versus urban based home health companies, and we will assume that these differences are reflected in the broader home care industry.

agencies must be bigger than urban agencies to maintain enough scale economies for successful operations however.

McDowell and Wyoming County

The rural county of McDowell is home to 19,600 residents, 18.14% (3,556) of which are aged 65 and above. The county's population of independent living and self-care disabled is 1,895. Median household income is less than \$25,000, and 36.72% of the county's population receives Medicaid benefits – 5% above the state average. Together with the estimated percentage of individuals that are “frail elderly”, the subset of the population likely needing home care in McDowell County is 2,606 or 13.30%.

The rural county of Wyoming is home to 22,788 residents, 16.68% (3,801) of which are aged 65 and above. The county's population of independent living and self-care disabled is 2,923. 28.09% of the county's population receives Medicaid benefits. Together with the estimated percentage of individuals that are “frail elderly”, the subset of the population likely needing home care in Wyoming County is 3,683 or 16.16%.

Both Wyoming and McDowell County have a severe shortage of home care workers, with a caregiver dependency ratio of 22.3 clients to every 1 caregiver. Each county is served by 6 home care agencies for a combined total of 12 home care agencies serving the two counties.

Payers

As is true nationally, the primary public payer for home care in West Virginia is Medicaid. 31.24% of the state's residents receive Medicaid benefits – 13.24% above the national average. The percentage of Medicaid enrollees that are “aged (65+) is 8% and disabled is 19%¹⁵. In total, West Virginia Medicaid (and CHIP) serves over 560,000 individuals annually, with spending totaling \$3.7 billion in 2016. For seniors and people with disabilities, per enrollee Medicaid spending is approximately, \$8,820¹⁶. West Virginia faces an estimated budget gap between \$300 and \$400 million in fiscal year 2018, presenting significant challenges for West Virginia's Medicaid program over the long term.

While there is a significant amount of data available on the size of the public pay market, it is much more difficult to estimate the size of private. ICA estimates that the size of the West Virginia private pay home care potential client pool to be 29,550.¹⁷ Given that home care costs in West Virginia are high relative to the state's median income for residents 65+ (\$31,776)¹⁸, 29,550 is likely an *over*-estimate of the potential market as many private pay customers may not be able to afford out-of-pocket home care costs through the long term. Home care costs as a percentage of median income for individuals 64+ in West Virginia is already 117%, two percentage points lower than the national average, but still well

¹⁵ Henry J. Kaiser Family Foundation, Distribution of Medicaid Enrollees by Enrollment, FY2014. Retrieved from www.kff.org

¹⁶ Henry J. Kaiser Family Foundation, Medicaid West Virginia: State Fact Sheet, June 2017. Retrieved from www.kff.org.

¹⁷ ICA used data available from the November 2016 IBIS world report on the national home care provider industry, and our estimate of the size of the home care client population to approximate the number of potential private pay home clients. First, our estimate of the combined frail elderly, independent disabled, and self-care disabled population in West Virginia is 175,900. This number is then multiplied by the private pay market's (out-of-pocket and private insurance) percent of the national home care industry estimated to be 16.8% by IBIS World. Using this method, we estimate that the size of the West Virginia private pay home care potential client pool to be 29,550.

¹⁸ Department of Numbers. Retrieved from <http://www.deptofnumbers.com/income/west-virginia>.

above 100%. Research by Genworth finds that non-medical home care (or homemaker) services average \$3,028 per month (assuming 44 hours per week) and home health aide services average \$3,146 per month in West Virginia, or over \$36,000 annually¹⁹.

REGULATORY & PUBLIC POLICY OVERVIEW

Medicaid Overview

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

Beginning in 2014, the Affordable Care Act allowed states the option to expand Medicaid eligibility to all non-elderly adults with income below 138% of the federal poverty line. Under “Medicaid Expansion”, the federal government absorbs a larger share of Medicaid costs for new enrollees, covering 100% of costs between 2014-2017 and gradually reducing that percentage to 90% between 2017-2020. To date 32 states and DC have expanded Medicaid²⁰.

Medicaid requires that states provide specific services at a minimum, to participate in the program. Required programs include inpatient and outpatient hospital services, physician and laboratory services, nursing home care and more recently, home health care. Above the minimum required programs, states may elect to cover additional services and/or expand services to individuals outside of the standard eligibility limits set by the Center for Medicaid and Medicare Services (CMS), the federal governing body. Typically, these additional services are provided under approved “waivers”.²¹ The number and type of waivers in each state varies widely, however common waivers include 1915 waivers, Aged and Disabled Waivers (ADW), and Intellectual Disability Waivers (ID). Home care relevant 1915 waivers include:

- 1915(c) Home and Community-Based Waivers (offered in 47 states and DC)
- 1915(i) State Plan Home and Community Based Waivers
- 1915(j) Self-Directed Personal Assistance Services Under State Plan Waivers
- 1915(k) Community First Choice Waivers²² (*see appendix A for detailed descriptions*)

1915 (c) HCBS waivers were first introduced in 1983 as a way for states to transition beneficiaries out of costly institutional care settings, and in 2005, became formal Medicaid State plan options.²³ States can

¹⁹ Genworth 2016, Cost of Care. Retrieved from <https://www.genworth.com/about-us/industry-expertise/cost-of-care.html>.

²⁰ Families USA The Voice for Health Care Consumers. Retrieved from <http://familiesusa.org/product/50-state-look-medicaid-expansion>

²¹ Congressional Budget Office, Overview of Medicaid, Retrieved from <https://www.cbo.gov/publication/44588>.

²² Medicaid, Authorities Retrieved from www.medicaid.gov/medicaid/hcbs/authorities/index.html.

²³ Medicaid, Authorities Retrieved from www.medicaid.gov/medicaid/hcbs/authorities/index.html.

offer as many 1915(c) Home and Community-Based Waivers as they elect, provided they meet the requirements set forth by CMS, and can elect what services to cover under the waivers, however home health aide, personal care aide, and homemaker services are almost always covered under these programs.²⁴ **Understanding where states fall on the spectrum of HCBS spending for their long term services and supports (LTSS) programs is an important metric for states overall preference for institutional versus home based care.**

From Medicaid's founding in 1965 until the early 1990's, Medicaid operated under a system of "fee-for-service", where providers were directly reimbursed for services provided, based on rates set by individual states. In the early 1990's however, Medicaid began a transition towards a system known as "managed care" to better manage costs, utilization, and quality. Under Medicaid managed care, state Medicaid agencies contract with independent for profit or non-profit managed care Organizations (MCOs) that accept per member per month payments for health care services, known as "capitated payments". Because payments are "capitated" MCO's are driven to balance the needs of high-need/high-cost beneficiaries with low-need/low-cost beneficiaries and provide care in the most cost effective manner possible to avoid cost overruns. Early on, managed care was implemented under 1115 Waivers, but in 1997 the Balanced Budget Act gave states more authority to implement managed care programs without waivers²⁵. As of March 2017, only 12 states did not have managed care programs in place²⁶. States that have begun transitions to managed care programs are in varying states of transition. Several states including Tennessee, Hawaii, New Hampshire, New Jersey, Rhode Island, Kentucky, Iowa, Delaware, Florida and Arizona operate almost exclusively under managed care programs (over 90% transitioned)²⁷, including home and community based services, while others are just beginning this transition. Understanding where specific states fall on this transition is important, as it is directly correlated to how service rates are set, how money flows, and the importance of strategic partnerships, scale and other factors to home care agency success in a state.

In addition to the transition to managed care, states are increasingly transitioning Medicaid to "value-based" care models by implementing Accountable Care Organizations (ACO's). To date, ten states (MA, VT, NY, OR, UT, CO, MN, NJ, RI) have implemented ACO programs²⁸. The goal of ACO's is to "(1) enhance the patient experience of care; (2) improve the health of the population; and (3) reduce the per capita cost of health care". What differentiates an ACO from an MCO is innovative, values-based payment structures and carefully defined and tracked data and quality metrics to assess and confirm established value outcomes. The transition to value based care via the ACO model is an important one

²⁴ Medicaid, Authorities Retrieved from www.medicaid.gov/medicaid/hcbs/authorities/1915-c/index.html.

²⁵ Kaiser Family Foundation, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011. Retrieved from www.kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf.

²⁶ Kaiser Family Foundation, Total MCO's, March 2017. Retrieved from www.kff.org.

²⁷ Kaiser Family Foundation, Share of Medicaid Population Covered Under Different Delivery Models, July 2016. Retrieved from www.kff.org.

²⁸ Center for Health Care Strategy, Inc. Medicaid ACO's: Status Update, June 2017. Retrieved from www.chcs.org

for cooperative home care agencies and developers to watch, as higher quality care is a hallmark of cooperative homecare agencies, and could be an important market differentiator.²⁹

West Virginia Medicaid Overview

Like most states, particularly those that are heavily reliant on Medicaid funding to meet population medical needs (31.24% of state residents receive Medicaid), West Virginia is systematically transitioning away from a fee-for-service system of care delivery to a managed care model. West Virginia's Medicaid managed care Program is called "Mountain Health Trust". Mountain Health Trust is managed by the West Virginia Department of Health and Human Services, Bureau for Medical Services (BMS). West Virginia is home to four Managed Care Organizations--Aetna Better Health of West Virginia, The Health Plan of the Upper Ohio, Unicare, and West Virginia Family Health. All four MCO's cover all counties in WV. One additional MCO, CareSource, was contracted in 2016 but has not yet begun providing care. All MCO's fall under the state's overarching Medicaid mandatory managed care programs: Mountain Health Trust (MHT) and West Virginia Health Bridge. West Virginia Health Bridge is West Virginia's Medicaid expansion program, which expanded care in 2013, and was serving a total of 180,500 additional state residents as of Q1 2016³⁰.

Because West Virginia is in the process of fully transitioning to managed care, several programs are still operated under the fee-for-service model, including personal care services. Personal Care Services were slated to transition to managed care in January 2017, but this plan was stalled, and a new date for transition has not yet been set. This will be an important transition to watch. Fee for service payment amounts are set and non-negotiable, making the market less competitive in regards to payment.³¹

Recipients eligible for personal care services under West Virginia's Medicaid program can receive care through Traditional Agency Services or through Personal Options, though participation in Personal Options is very low in West Virginia compared to other states with less than 1000 participants. New or existing home care agencies interested in providing Medicaid in-home personal care or home health services are required to apply for and be approved for a Certificate of Need (CON) from the West Virginia Health Care Authority. Personal *attendant* agencies however do not need a CON to provide services.

Home and Community Based Programs (HCBS)

In fiscal year 2016, West Virginia spent nearly \$3.7 billion³² dollars serving 564,400 Medicaid beneficiaries. Of this 43 percent of funds were spent on Long Term Services and Supports (LTSS), with a little less than half (48%) of LTSS funds directed to Home and Community Based Services (HCBS).³³ State spending on LTSS is slightly higher than the national average in West Virginia, reflective of the state's

²⁹ Center for Health Care Strategy, Inc. Medicaid Accountable Care Organization Programs: State Profiles. Brief: October 2015. Retrieved from www.chcs.org.

³⁰ Henry J. Kaiser Family Foundation, Medicaid West Virginia: State Fact Sheet, June 2017. Retrieved from www.kff.org.

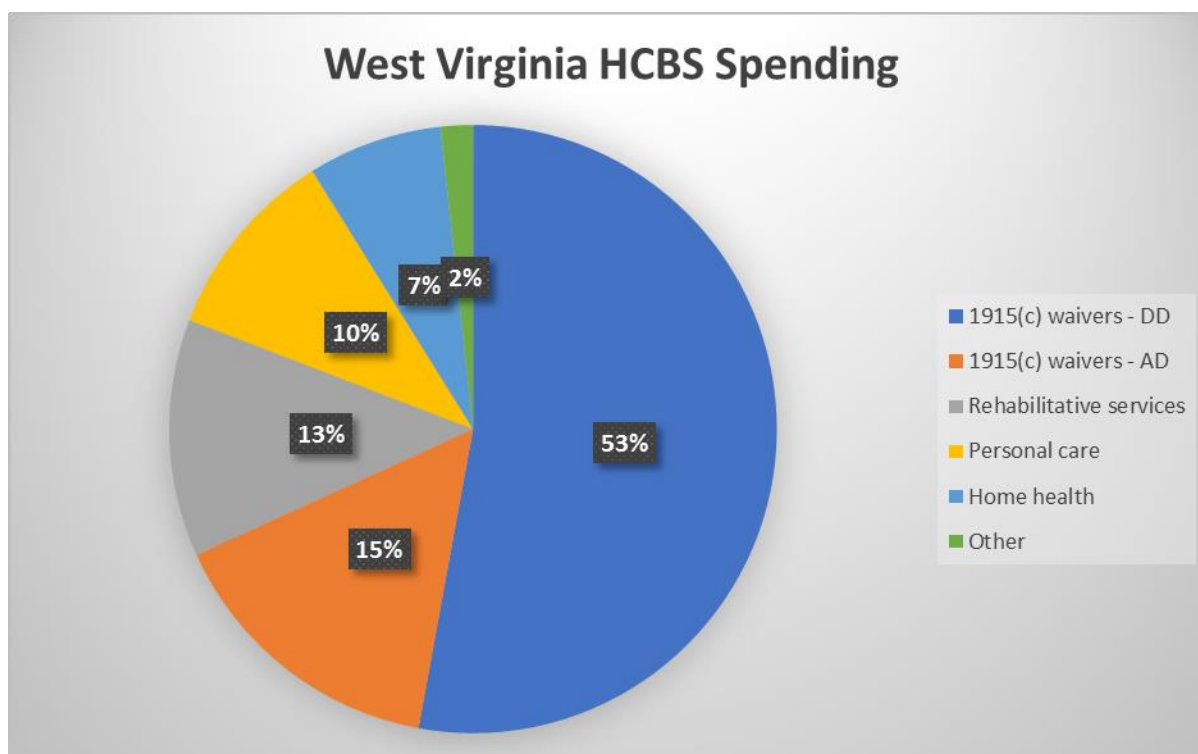
³¹ All fee-for-service payments are currently processed by Molina the fiscal agent of WV's fee-for-service (FFS) program, a for-profit company contracted by the state. Another for-profit company, KEPRO, is contracted by the state as the utilization management contractor.

³² West Virginia directly contributed 22.3% and the Federal Government contributed 77.7%

³³ Medicaid. Retrieved from www.medicaid.gov/medicaid/ltss/downloads/evolution-ltss-expenditures.pdf.

population, however spending on HCBS is slightly lower, demonstrating a continued favorability for institutional based care.

West Virginia’s HCBS programs are managed by the Bureau for Medical Services, Office of HCBS. Ten distinct programs including three waivers make up the suite of HCBS in West Virginia—Personal Care, Home Health, Hospice, Behavior Health Services, Private Duty Nursing, Children with Disabilities Community Services, Take Me Home demonstration grant (MFP demonstration), Aged and Disabled Waiver (AD), Intellectual and Developmental Disabilities Waiver (DD), and the Traumatic Brain Injury Waiver (TBIW). In terms of annual spending, the Developmental Disabilities Waiver is the largest program at 52.87% or \$360,653,048 million, followed by the Aged and Disabled Waiver at 15.34% or \$104,636,308 million. In terms of number of individuals served however Behavior Health Services (also referred to as “rehabilitation services” (which serves nearly 90K individuals annually) is the largest program, followed by Personal Care (7,872 individuals served in 2015), Home Health (7,820 individuals served) and the Aged and Disabled Waiver (AD) (6,450 individuals served in 2015).



Non-Medicaid Home Care Programs

West Virginia also sponsors three non-Medicaid funded home and community based service programs—Family Alzheimer’s In-Home Respite (FAIR), Lighthouse In-Home Service, and the Legislative Initiative for the Elderly (LIFE) Programs—which collectively serve over 22,000 individuals annually, and cost the state just under \$21M per year³⁴. All three programs are supported by West Virginia state lottery income.

³⁴ Bureau for Medical Services 2015 Report. Retrieved from www.dhhr.wv.gov.

Services are coordinated by the states county aging providers and are based on assessed medical and financial need.

Licensing Requirements

Most personal care provider agencies are required to have a Certificate of Need (CON) from the WV Health Care Authority in order to provide services in the state.³⁵ The provider must then submit and maintain documentation with the state operating agency on a broad array of operating policies and procedures, training program, and requirements, including a valid business license and maintenance of a physical office with sufficient space for confidentiality.³⁶

Regulatory & Political Barriers to Entry

While West Virginia has strong demand for home care services, there are several important considerations for any new or existing home care service provider looking to enter or scale in the state. First, as referenced above, West Virginia requires new or existing service providers interested in entering the Medicaid Personal Care market to apply for and be approved for a Certificate of Need (CON) from the West Virginia Health Care Authority. The main criteria require that all CON applicants demonstrate with specificity that:

- (1) There is an unmet need for the proposed service;
- (2) The proposed service will not have a negative effect on the community by significantly limiting the availability and viability of other services or providers; and
- (3) The proposed services are the most cost effective alternative.

CON's are reviewed and approved by the West Virginia Health Care Authority. If a CON is awarded, the agency must then secure a National Provider Identifier (NPI) number and undergo a site visit by the Bureau for Senior Services (BoSS) which is who BMS contracts with to administer the day to day operations of the Personal Care Services Program. Given the CON requirements, it is relatively difficult for new providers to enter the market. Acquisition of an existing agency is one strategy to reduce the CON burden. However, all CON's are reviewed under cases of Change of Ownership, and for new agencies without an operating history, transfer of the CON may be difficult.

Training

Overall, training for personal care aides is limited in West Virginia, inhibiting job and service quality. While there are no federal training standards for personal care aides, West Virginia's Medicaid state plan requires PCAs to complete 32 hours of training in broad topic areas. Training is typically provided by the employing personal care agency, and can thus vary greatly in quality. Nearly all training is provided for free by employing agencies in West Virginia. However, some home care workers, particularly those seeking to advance their careers to higher levels, may receive training through community college programs.

³⁵ Bureau for Medical Services 2015 Report. Retrieved from www.dhhr.wv.gov.

³⁶ Bureau for Medical Services 2015 Report. Retrieved from www.dhhr.wv.gov.

For other home care positions, like nursing and home health aides, training requirements are about average. West Virginia exceeds federal standards for nursing aides, requiring a minimum of 150 training hours, 55 of which must be clinical (versus the federal standard of 75 and 16 respectively). Training standards for home health aides (HHA's) however, are in line with federal standards which require that HHA's complete a minimum of 75 hours of training through classroom and supervised practical training, with at least 16 of those hours devoted to hands-on, clinical training. The individual being trained must complete at least 16 hours of classroom training *before* beginning the supervised practical training.³⁷

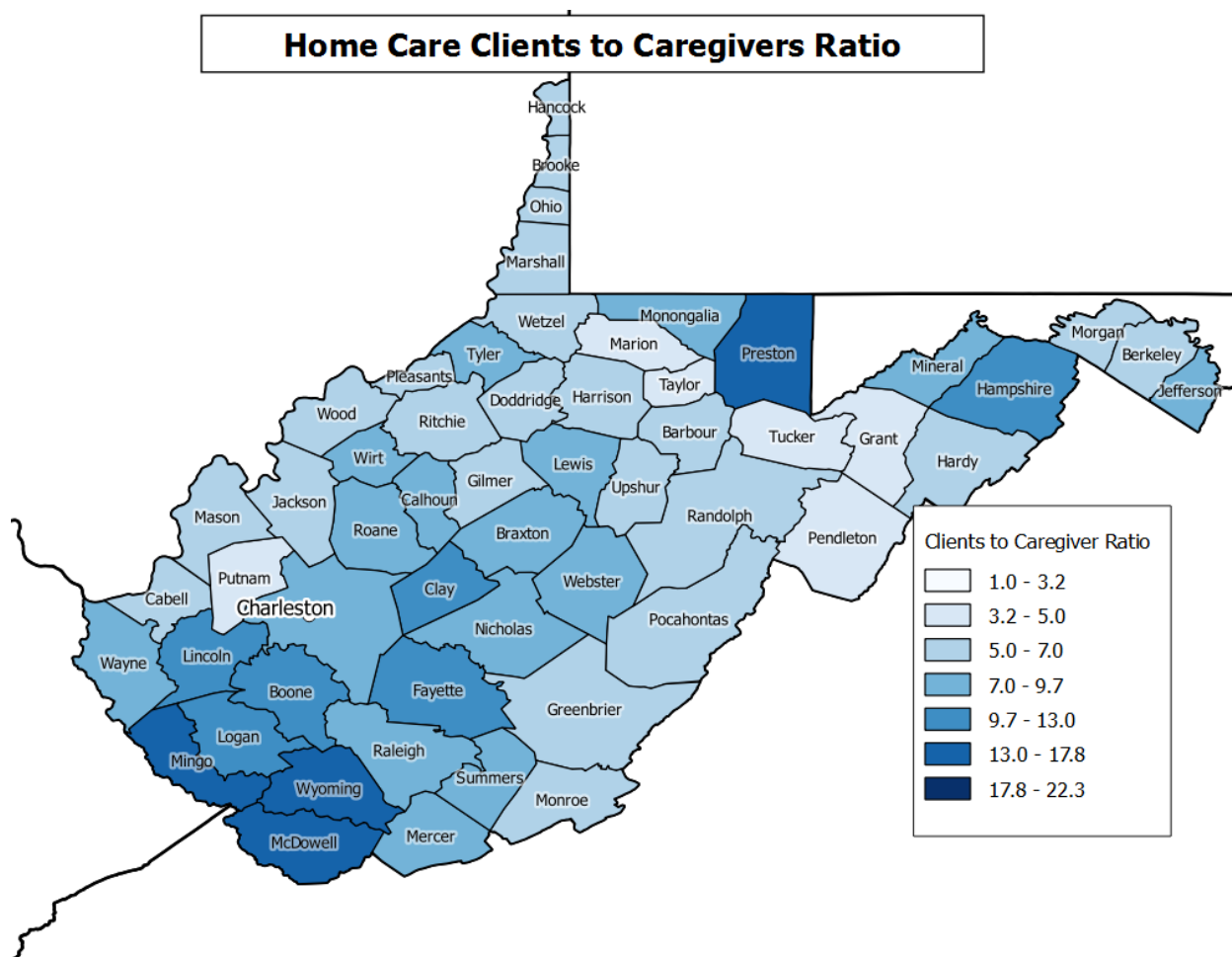
³⁷ PHI Quality Care Through Quality Jobs. Retrieved from <https://phinational.org/policy/states/west-virginia>

LABOR OVERVIEW

Current Labor Conditions

West Virginia's rapidly aging population will necessitate significant growth in the direct care workforce over the coming years to meet demand, especially since the state already faces a shortage. For every one caregiver in West Virginia there are currently 11.2 people categorized as frail elderly, independent living disabled, or self-care disabled needing care, which is significantly higher ratio than the national ratio of 8 to 1.

Further, distribution of caregivers across the state is also uneven, with rural areas facing greater worker shortages. This is particularly pronounced in rural Wyoming and McDowell Counties, which have caregiver ratios as low as 1 caregivers to every 22.3 residents needing home care services.



The median hourly wage for all occupations in West Virginia was \$16.01³⁸. Wages across all industry sectors have remained stagnant or trended downward in West Virginia in recent years and West Virginians increasingly find themselves working in low wage jobs. Health Care and Social Assistance make

³⁸ Workforce West Virginia. Retrieved from www.workforcewv.org.

up West Virginia's largest private sector industry, followed closely by retail trade and leisure and hospitality³⁹.

In 2016, West Virginia's home care market employed 10,710 personal care aides, 3,860 home health aides and about 600⁴⁰ nursing assistants⁴¹. Median hourly wages for each occupation were \$8.89, \$8.91 and \$11.07 respectively⁴². State minimum wage is \$8.75. For comparison, the average hourly wage of a retail sales associate at Walmart in West Virginia (one of the states' largest employers) is \$9.15 per hour⁴³.

Median wages for personal care aides below entry-level retail jobs, like Wal-Mart, are especially troubling given the industry's recruitment and retention goals. West Virginia is one of only eight states in the nation where home care workers are paid less than food service and retail workers. Nationally, the average caregiver is paid over 10% more than the average food service or retail worker, in West Virginia however home care workers are paid 2.33% *less* than food service and retail workers⁴⁴. Given other challenges facing home care workers including irregular and insufficient hours, no or minimal benefits, and the emotional and physical demands of the work, there is little incentive for workers to enter or stay in the home care field.

Caregiver and Retail/Food Service Wage Comparison			
	Direct Care	Retail/Food	Difference
National Average	\$ 10.70	\$ 10.24	\$ 0.46
West Virginia	\$ 9.32	\$ 9.46	\$ (0.14)

Future Labor Trends

Occupational growth projections for the period 2016-2024 show a 38.1% growth in demand for home health aides, 25.9% growth for personal care aides and a 17.6% growth for nursing assistants⁴⁵. Taking the regional turnover rate for West Virginia at 53%⁴⁶ into account, **West Virginia will need to hire and train over 61,000 new home care workers between 2018 and 2024 to meet demand**⁴⁷.

Of note, a bill was introduced in the state legislature requesting that the Joint Committee on Government and Finance study the state's in-home direct-care workforce with the aim to improve the quality and quantity of in-home care workers so as to ensure that a trained and competent workforce would exist to care for the state's growing aged population. This bill died (HCR 65) in committee,

³⁹ State of Working West Virginia, December 12, 2016. Retrieved from www.afsc.org.

⁴⁰ Total number of Nursing assistants in the state (7,580) multiplied by the % working in home care nationally (7.5%)

⁴¹ Bureau of Labor Statistics, U.S Department of Labor, 2014. Retrieved from www.projectionscentral.com/Projections/LongTerm

⁴² PHI. Retrieved from <https://phinational.org/policy/states/west-virginia>.

⁴³ Indeed.com. Retrieved from <https://www.indeed.com/salaries/Retail-Sales-Associate-Salaries-at-Walmart,-West-Virginia>

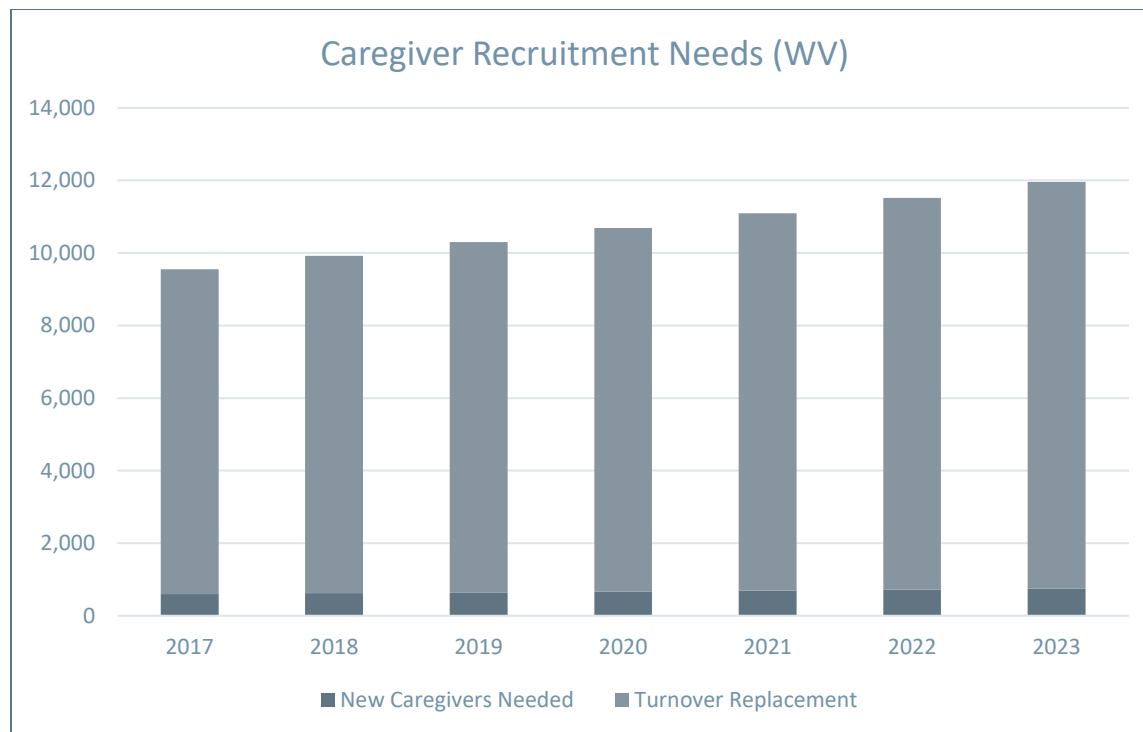
⁴⁴ Workforce West Virginia. Retrieved from <http://workforcewv.org>.

⁴⁵ Bureau of Labor Statistics, U.S Department of Labor, 2014. Retrieved from <http://www.projectionscentral.com/Projections/LongTerm>.

⁴⁶ PHI. Retrieved from <https://phinational.org/policy/states/west-virginia>.

⁴⁷ Bureau of Labor Statistics, U.S Department of Labor, 2014. Retrieved from <http://www.projectionscentral.com/Projections/LongTerm>.

however, and has not been revisited since, signaling a lack of interest in investing in home care by the state⁴⁸.



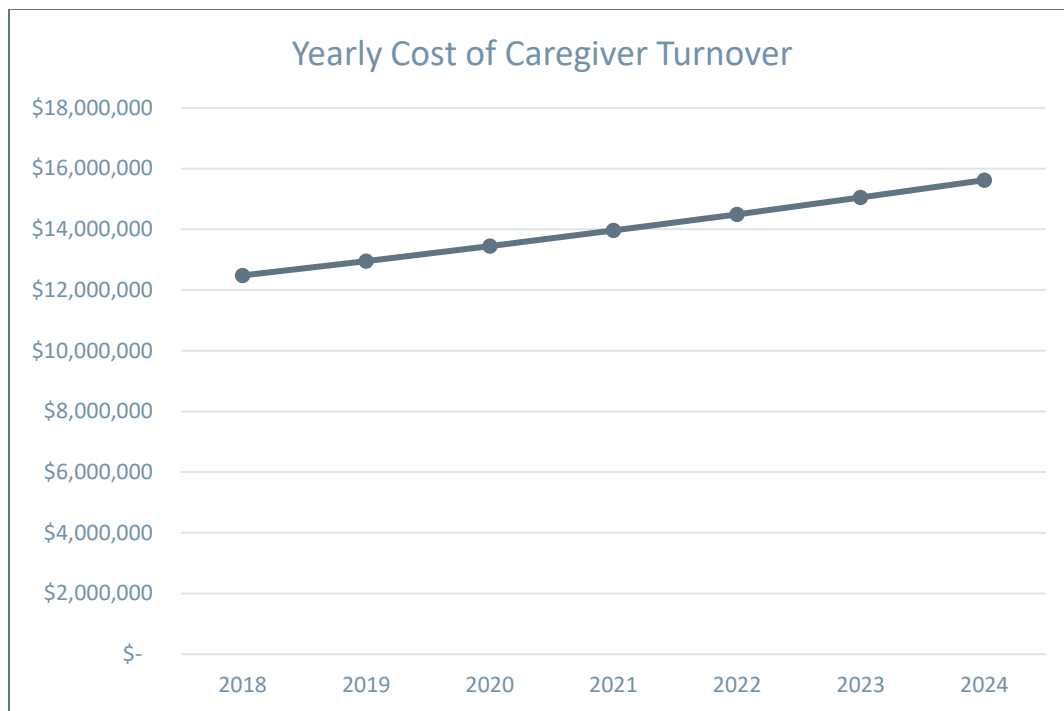
With an estimated state turnover rate of 53%, home care companies are likely to lose one caregiver for every two new that they hire each year. High turnover is common in the industry and a result of many factors, namely low pay and benefits. First, West Virginia's negative pay comparison with other entry-level jobs provides little incentive for workers to join the home care workforce. Second, West Virginia is losing population at a faster rate than any other state due to net migration loss and a greater number of deaths than births⁴⁹. West Virginia's rural counties, including McDowell and Wyoming Counties saw the largest drops in population growth at -2.2% and -1.7% respectively⁵⁰. Finally, due to a variety of factors, West Virginia boasts the nation's lowest labor force participation rate among prime-age adults, those aged 25 to 54 years (at only 72% compared to the national average of 80.6 percent)⁵¹. We estimate the annual cost of turnover for home care workers in West Virginia to exceed \$12M annually and rising, as shown below.

⁴⁸West Virginia Legislature, Bill Status – 2011 Regular Session. Retrieved from www.legis.state.wv.us.

⁴⁹ Breaking Down WV's 10,000 Resident Population Decline. Retrieved from www.wvpolicy.org.

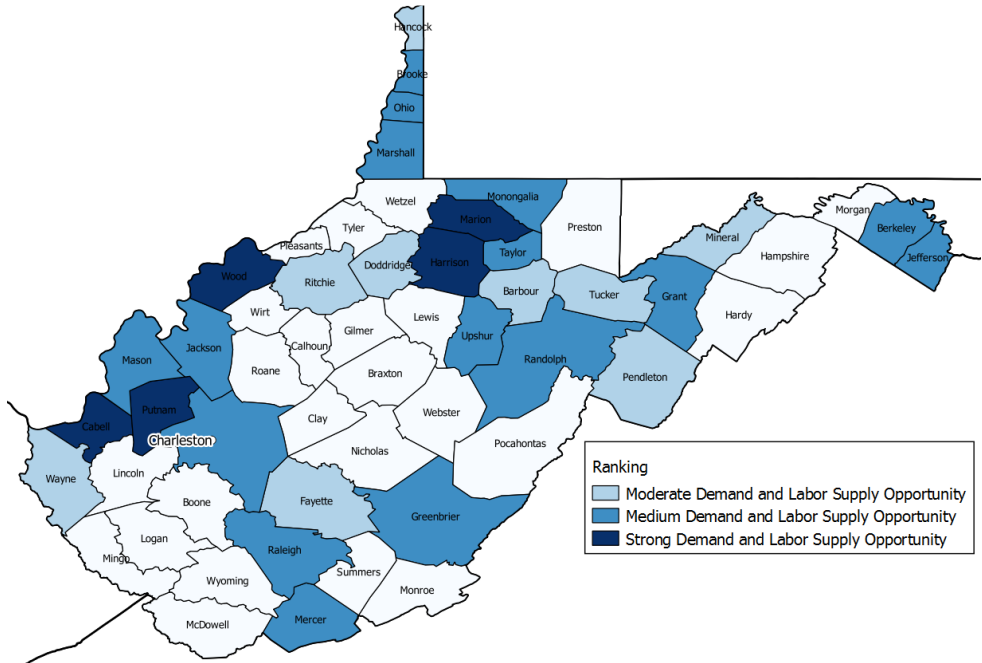
⁵⁰ West Virginia losing more people than any other state, Johnson, S. March, 2016. Retrieved from <http://wvmetronews.com>.

⁵¹ State of Working West Virginia, December 12, 2016. Retrieved from www.afsc.org



West Virginia's low labor force participation rate also presents an opportunity, however, as it points to a large potential untapped workforce. The right mix of outreach, training opportunities, wages, and benefits could entice unemployed or underemployed West Virginian's to join the home care sector. As is true nationally, a greater diversity of caregivers will need to be recruited into West Virginia's home care workforce, including notably, more men and both younger and older workers. Note the darker-colored counties on the map below indicating areas where both demand *and* potential labor supply opportunity is the greatest.

West Virginia Combined Demand and Labor Supply Opportunity



COOPERATIVE OPPORTUNITY

Cooperative Law

Recent years have seen a burgeoning cooperative movement take form, spurred by on-the-ground partners at Mountain State Justice and The West Virginia College of Law. In 2015, West Virginia passed a law expanding the state's agricultural cooperative statute to enabling all food and farm businesses, not just producers, to form cooperative businesses. While the state does not yet have a cooperative law for businesses beyond the food and farm industry, conditions seem ripe for expanding the law given the active coalition.⁵²

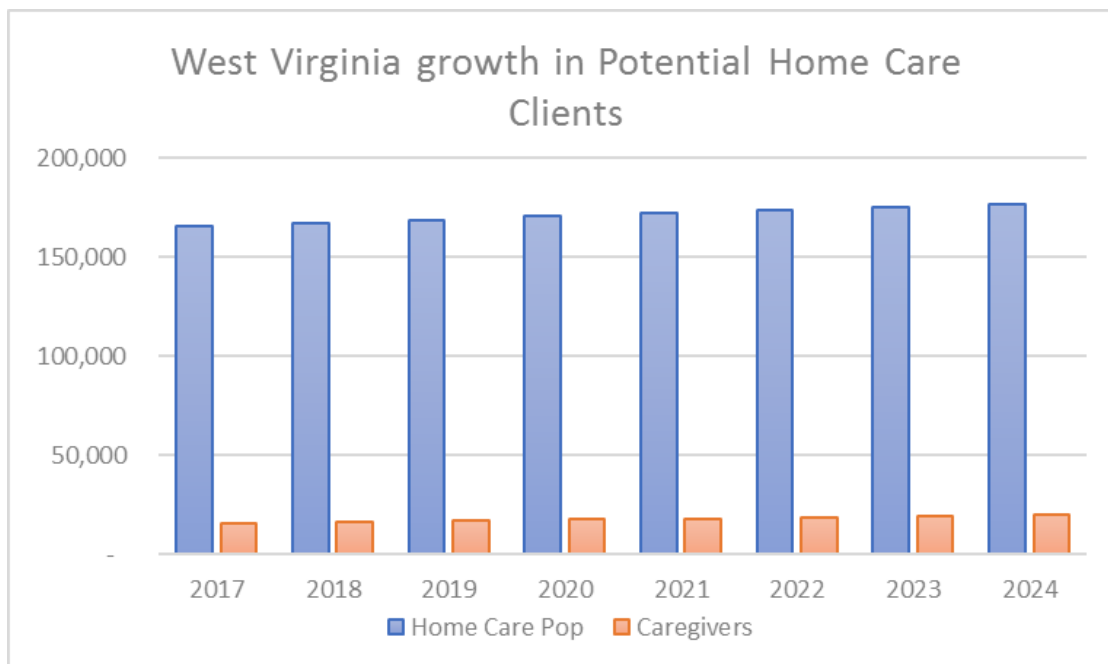
Cooperative Strategy

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

Today, the environment for home care business development is challenging in West Virginia. At a high level, West Virginia spends less on Medicaid per enrollee, and has a severe caregiver shortage, placing the state in the more difficult category of markets for home care in the country.

Looking closer, an uncertain regulatory environment with a prohibitive certificate of need process, and a Medicaid payment system in transition present additional obstacles for growth and expansion. Mediocre training requirements and an average wage for caregivers beneath retail and other entry-level professions make recruitment and retention uniquely burdensome in the state. While a rapidly aging population will certainly continue to propel demand for services, it also means that caregiver shortages will continue to intensify with fewer young people available to care for those in need. The following chart illustrates both expected growth in the market and the deep caregiver shortage West Virginia is experiencing.

⁵² West Virginia code 19-4-3 states that “a cooperative association may be organized to engage in one or more qualified activities in connection with the marketing or selling of agricultural products or the goods and services of its members or those purchased from other persons; or in connection with the manufacturing, selling or supplying to its members of machinery, equipment or supplies; or in securing and disseminating market information; or in the financing directly, through agricultural credit associations, and/or otherwise, the above-enumerated activities; or in any one or more of the activities specified herein. An agricultural credit association may be organized hereunder to finance qualified persons or to finance any cooperative association, or both, whether formed under the laws of this or any other state.”



For those that can successfully navigate entry into the home care market in West Virginia, attracting workers will be the next massive challenge. The existing caregiver shortage is seriously compounded by the state’s rapidly aging population. Here, leveraging the “cooperative difference”—greater voice and ownership in the business to start—and later— better pay and other benefits will be critical. Cooperative home care agencies that can differentiate both their employment practices and the quality of care they provide should be well positioned to gain competitive advantage through increased recruitment and retention of both home care workers and clients.

Furthermore, national home care cooperative development strategies can support the successful start-up and growth of local cooperatives. One potential strategy for operatives and partners to assist local home care cooperatives is through the development of a shared services cooperative. It can be difficult for smaller scale organizations to manage back office operations, training, and regulatory paperwork while also managing a home care business and generating new sales. A membership organization for cooperatives that provides more efficient payroll and scheduling solutions and access to high quality training can create the benefits of scale while also allowing for local control of the cooperative. An organization that can provide a pool of well-trained caregivers can significantly reduce recruitment costs and increase quality of care for cooperative members. and a membership organization is one strategy that may provide that advantage.

In West Virginia and nationwide, effecting the potential impact of cooperatives in the home care industry will require sufficient capital investment, collaboration, ingenuity, and a willingness to take risks and learn from failure. If done right, home care cooperatives can be a powerful, market-based approach creating access to dignified employment for low-wage workers in a difficult industry that has suffered from systemic underinvestment – an approach that is working for, but not waiting for, the policy solutions that are needed for larger-scale change.

APPENDIX

Appendix A: Home Care 1915 Medicaid Waiver Descriptions

1915(c) Home and Community-Based Waiversⁱ

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

1915(i) State Plan Home and Community Based Waiversⁱⁱ

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

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

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

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

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

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

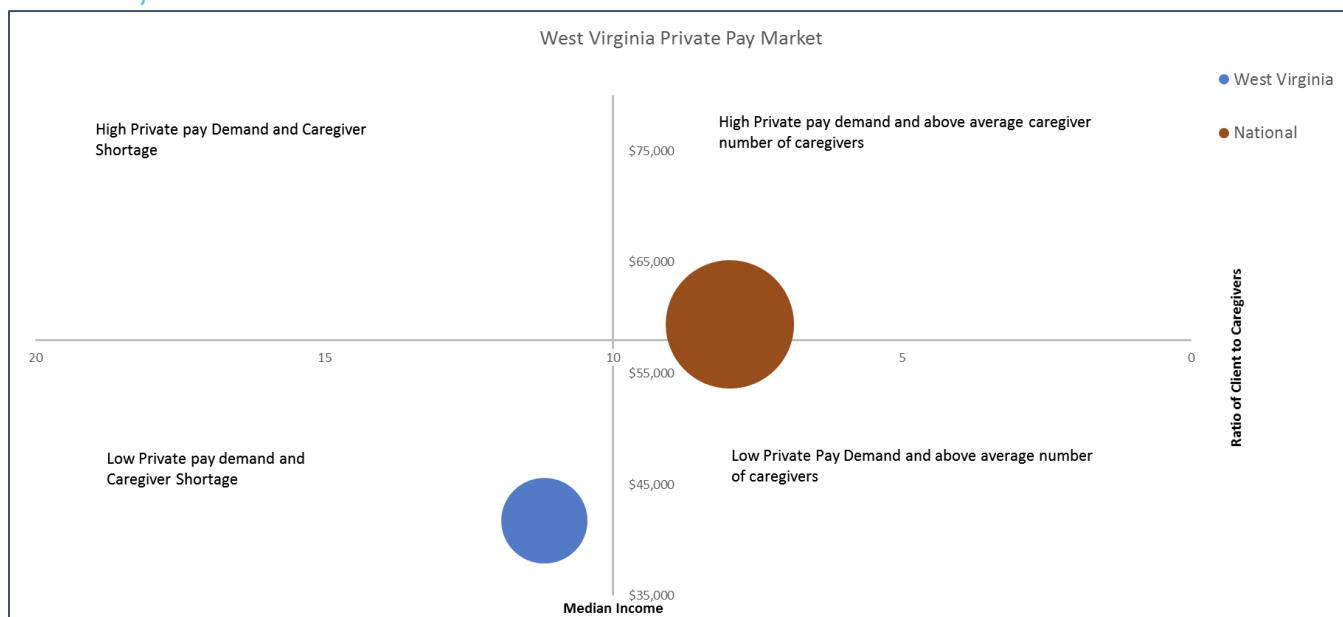
The "Community First Choice Option" allows States to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their State Plan. This State plan option was established under the Affordable Care Act of 2010.

Appendix D: 2x2 Analysis

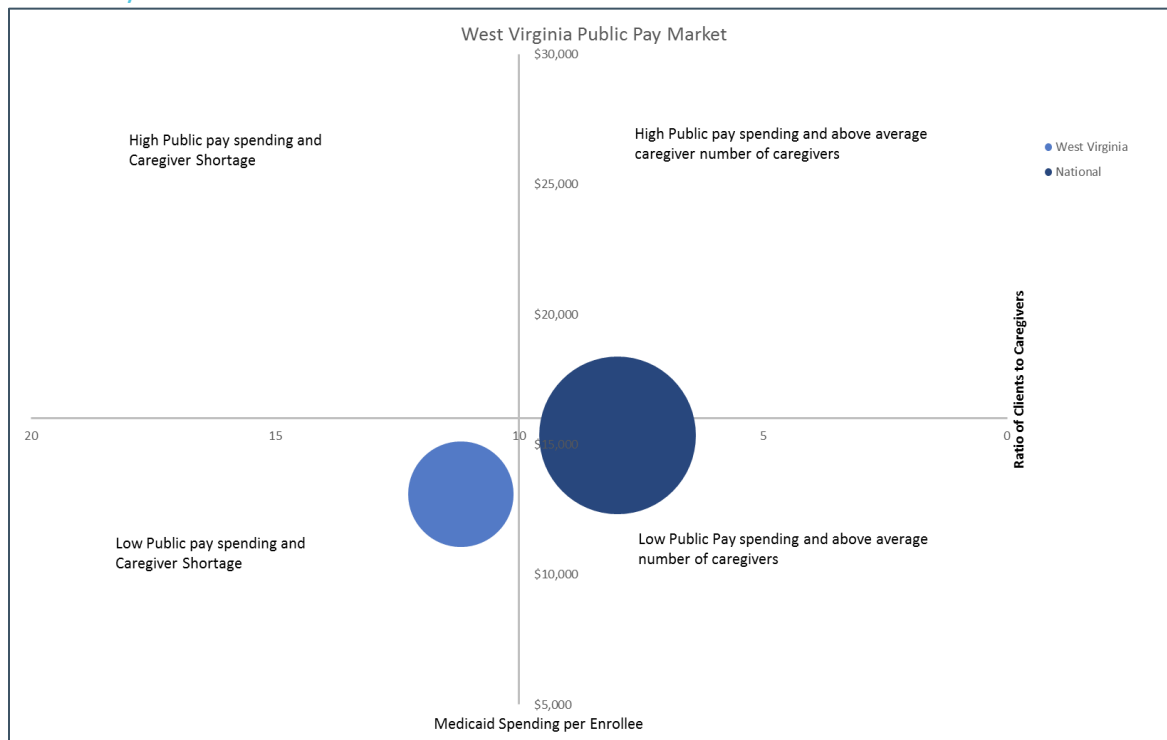
West Virginia:

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

Private Pay 2x2:



Public Pay 2x2:



Appendix C: Methodology

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

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

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

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

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

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

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

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

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

Opportunity Matrix Sources:

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Appendix E: State Opportunity Matrix

<u>Opportunity Assessment Framework</u>		
Key Metrics - Labor Supply:	<u>US Average</u>	<u>West Virginia</u>
<i>Assesses ease or difficulty of recruitment and retention for direct-care workforce.</i>		
Prime-Age Labor Force Participation Rate (25-55 Years of Age)	81.70%	72%
Other Entry-Level Pay Comparison (Retail and Food Service)	10.83%	-1.50%
Caregiver Dependency Ratio (direct care workforce over home care subset-frail elderly/dependent)	7.98	11.19
Unemployment Rate	4.40%	4.90%
Key Metrics - Firm Barriers to Entry:	<u>US Average</u>	<u>West Virginia</u>
<i>Assesses ease or difficulty of entering the home care market as a new provider</i>		
Scale Barriers	\$216,243	Median Sales: \$181,000
Average Sales of Home Care Companies Rural	Rural: \$431,300	Rural: \$517,550
Average Sales of Home Care Companies Urban	Urban: \$373,800	Urban: \$488,800
Scale of Service Area (as Population Density)	91.39	76.18 (people/sq mile)
Rural Population Density	Rural: 19.17	Rural: 32.07
Suburban Population Density	Suburban: 57.83	Suburban: 71.65
Urban Population Density	Urban: 1015.17	Urban: 170.09
Key Metrics - Market Competitiveness	<u>US Average</u>	<u>West Virginia</u>
<i>Assesses the state of market consolidation/fragmentation, and dominance of any major firms.</i>		
Total % Market Share of Top 5 Firms	8.7% (Top Three)	14.00%
Largest Provider Operating in State (Annual Sales)	Kindred	Central WV Aging Services (\$18M, Non-profit)
Key Metrics - Client/Customer Demographics	<u>US Average</u>	<u>West Virginia</u>
<i>Describes composition of population in state likely needing home care services.</i>		
Total % in Home Care Subset (Frail Elderly & Ind'l with Disabilities, IL & SC)	6.19%	9.26%
Growth in Aging Population	9.70%	6.67%
Total % Population Age 65+	14.10%	17.00%
Total % Population Individuals with Disabilities	6.81%	10.90%
Total % Population on Medicaid	18.00%	31.24%
Home Care Costs as % of Median Income of 65+ Population	119%	117%
Key Metrics - Payer Composition	<u>US Average</u>	<u>West Virginia</u>
<i>Describes key customers/payers in the state, how money flows, ability of providers to negotiate for better rates, etc.</i>		
Percentage Total State Medicaid Spending on LTSS	32%	43%
Share Medicaid LTSS Spending for Devoted to HCBS	53%	48%
Self-Directed Care Program	N/A	Yes
Rate Flexibility	N/A	Fee-for-Service--No Negotiation
Per Capita HCBS	\$18,870	\$28,220

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

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

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

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