OCT 2017

WASHINGTON

HOME CARE MARKET ASSESSMENT

Cooperative Development Foundation

ICA GROUP
HOME CARE

Contents

KEY TAKEAWAYS

- **Acclaimed Public Program:** Washington State is a recognized leader in providing long-term care to its residents through public programs. As of 2015, 31,000 of the 66,587 workers in the direct-care workforce in Washington were part of the consumer-directed Medicaid reimbursement program offered by Washington State's Department of Social and Health Services.
- **Increasing Consumer Demand:** The current home care market in Washington State is estimated at 440,000 customers. The private pay market is estimated at approximately 74,000 customers. The growth rate of Washington's elderly population is 13.3% compared to the national growth rate of 9.7%. Because of this and other factors, the number of home care customers is expected to increase by 95,000 between 2017 and 2024.
- **Low Labor Supply:** There is currently an insufficient supply of caregivers to meet demand and the gap is estimated to grow as demand increases. In Washington, the ratio of caregivers to those needing care is 1 to 12 compared to the national ratio of 1 to 8. The combination of high rate of turnover and increasing demand will create the need for 154,000 new caregivers to be recruited to the workforce in the next 5-10 years.
- **Competitive Home Care Agency Market:** The Washington market is highly competitive with two-thirds of home care agencies in the state earning less than $250,000 in sales revenue, and no large players. Market data in Washington State indicates that it is relatively easy to enter the home care market, but scaling up to a $1,000,000 a year company is difficult. Any new Washington state based home care agency must operate for at least three years in the private pay market before it can consider entering the public pay market.
- **Existing Home Care Cooperatives:** The state of Washington currently has three home care cooperatives, two in operation (Peninsula Home Care Cooperative in Port Townsend and Circle of Life Cooperative in Bellingham) and one to begin operations in fall 2017 (Capital Homecare Cooperative in Olympia). The primary barrier to an organic growth strategy will be recruiting enough caregivers. Grassroots outreach and partnership development with local schools, career development organizations, alternative staffing agencies or other community agencies could help spur interest in the career. An acquisition strategy may be an effective way for existing home care operators to reach scale and/or enter the Medicaid market.
- **Cooperative Opportunity:** In a service industry where the primary expense is personnel, Washington home care companies that can better recruit and retain caregivers will have a significant advantage.

About this Report:

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

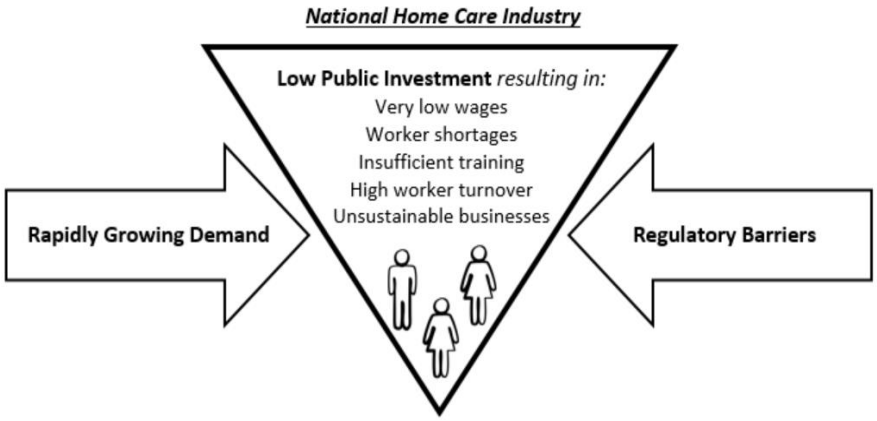
NATIONAL OVERVIEW

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

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

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

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



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

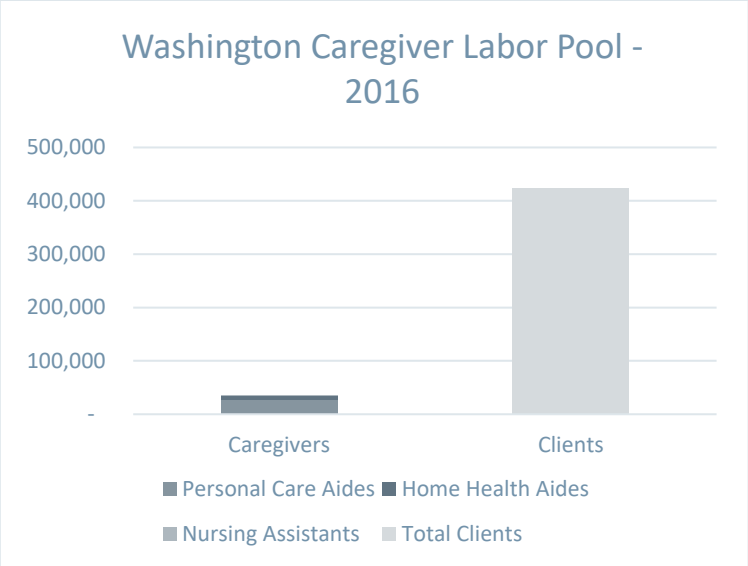
healthcare professionals and offers a superior value for clients, this recognition has not yet resulted in increased payments for services. With deep public underinvestment in home care, small and large home care cooperatives alike struggle to remain financially sustainable, let alone carve out the financial 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

Washington state is a recognized leader in providing long-term care to its residents through public programs. Washington is ranked 1st overall in the AARP's Long-Term Services and Supports scorecards and is ranked 2nd in Choice of Setting & Provider, 3rd in effective transitions, and 5th in Support for Family Caregivers[2]. Despite this success, long-term trends in the aging population, caregiver shortages, and the costs of providing home care present significant challenges and opportunities for current and prospective home care cooperatives in the state.

While Washington is a leader in funding and providing home care services to its residents, there are significant barriers to home care agencies successfully operating businesses that rely on Medicaid reimbursements. Eligibility requirements and low reimbursement rates are a challenge for small agencies and cooperatives, pushing most cooperatives to pursue the smaller, but more the feasible private pay market. At the same time, few Washington residents have the financial wherewithal to pay privately for home care over the long term, and will eventually come to rely on publicly funded sources to meet their home care needs.

There is a growing gap between the number of caregivers in Washington and the increasing population of state residents needing in home care. Washington's senior population grew



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

at a rate of 13.3% from 2012 to 2015[3], and there is currently one caregiver in Washington for every 11.75 seniors.

While these trends create a much wider market for home care agencies in the state, it means that recruiting and retaining quality employees will become not only more difficult, but a key competitive advantage for those agencies that can do it well.

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

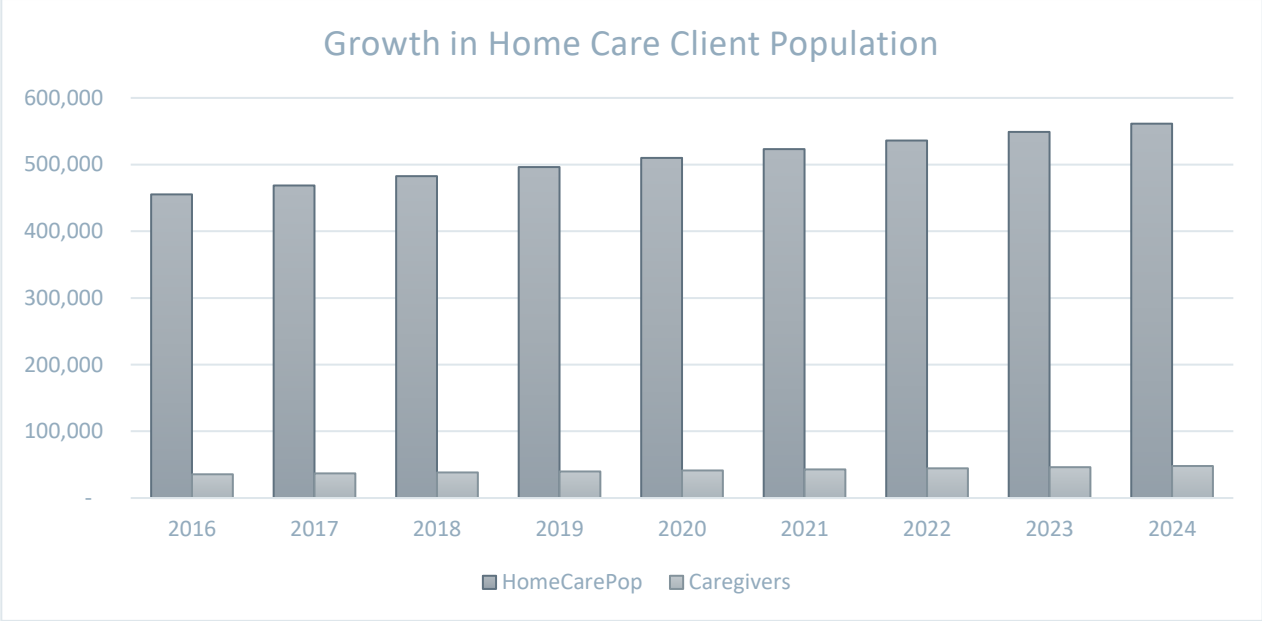
[3] U.S. Census Bureau (2016). *Monthly Population Estimates for the United States: April 1, 2010 to December 1, 2017 2016 Population Estimates*. Retrieved from www.census.gov.

MARKET OVERVIEW

To understand the market for home care services in Washington, we use three separate lenses of analysis: customers, competition, and payers. We hope this section will give you a better understanding of how many potential home clients there are in the market, how are they paying for home care, and who else is competing for these customers.

Customers

In the long term, Washington state will experience significant growth in the demographic groups that are most likely to use home care services. As of 2016, 442,382 Washington residents were categorized as frail elderly, self-care disabled, or independent living disabled[4]. While the current proportion of Washington residents in this group is comparable to the national average at just over 6%, Washington growth in its 65+ population (13.3%) is outpacing the national growth rate by over 3.5%, and the percentage of Washington residents aged 65 or over increased from 12.4% in 2012 to 13.6% in 2015. Additionally, Washington's population of individuals with disabilities is nearly double the national average at 12.8%. Over the next 5-10 years' demand for home care services will continue to grow rapidly in the state.



The primary public payer for non-medical home care is Medicaid. In Washington, 25.5% of the state's residents receive Medicaid benefits – 7.5% above the national average. This is significant for two reasons. First, the more Medicaid beneficiaries there are in a state the more public money available to pay for home care services, increasing the potential size of the state's home care market. Second, home care costs in Washington are expensive at a yearly average cost of 133% of median income for residents aged 65+, and 91% of median household income. High home care costs reduce the potential number of

[4]American Fact Finder, U.S. Census Bureau. Retrieved from www.factfinder.census.gov.

customers in the market place, but the high number of Medicaid beneficiaries in the state helps to boost some residents' ability to pay.

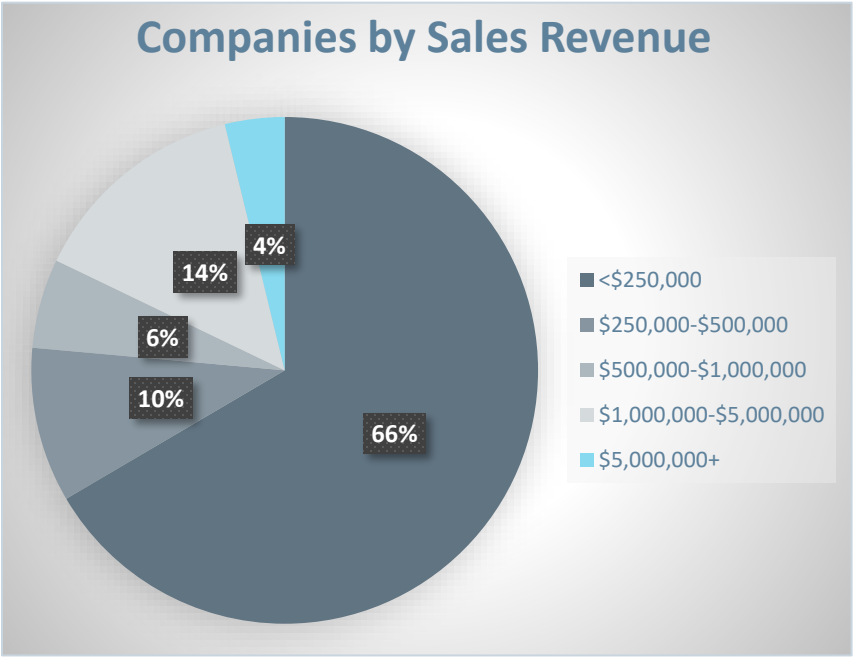
In sum, the home care client demographics in Washington are favorable towards the development of home care businesses. Long-term trends point towards a growing customer base, but high costs may reduce the potential size of the private pay market.

Providers

ICA estimates that there are currently 263 independent personal care and home health companies operating in Washington state. This count includes headquarters and single location companies, but does not include branch locations. Of this group 189 are categorized as home health companies and 74 are categorized as providers of individual and family services. The state of Washington currently has three home care cooperatives, two in operation (Peninsula Home Care Cooperative in Port Townsend and Circle of Life Cooperative in Bellingham) and one (Capital Homecare Cooperative in Olympia) set to begin operations in fall 2017. Additionally, as of 2015 31,000 of the 66,587 workers in the direct-care workforce in Washington were individual providers who provide Medicaid reimbursed home care services through a state run program[5]. In comparison to the 26,000 personal care and home health aides working at home care agencies, individual providers have a significant portion of the Washington home care market.

Similar to the national market for the industry, the home care market in Washington has relatively few large companies and primarily consists of small local operators. ICA estimates that 31.9% of sales revenue for home care in the state goes to the top five largest operators, leaving just under 70% of sales revenue going to the remaining companies. Additionally, the median sales revenue for Washington state home care companies is $111,589, far below the national median of $216,243. This suggests that smaller operators can have success in the Washington home care market.

[5] Washington: Size of Direct-Care Workforce, 2015, PHI. Retrieved from www.phinational.org.



On the other hand, there are significant differences between large operators and small operators in Washington. While the median sales revenue is $111,589 the average revenue is $789,206 which suggests that the larger home care companies are an order of magnitude larger than small operators. Of the 263 home care operators in the state 66% have revenue of less than $200,000 per year. All of this indicates that it is relatively easy to enter the home care market in Washington, but scaling up operations to become a $1,000,000+ a year company is much more difficult.

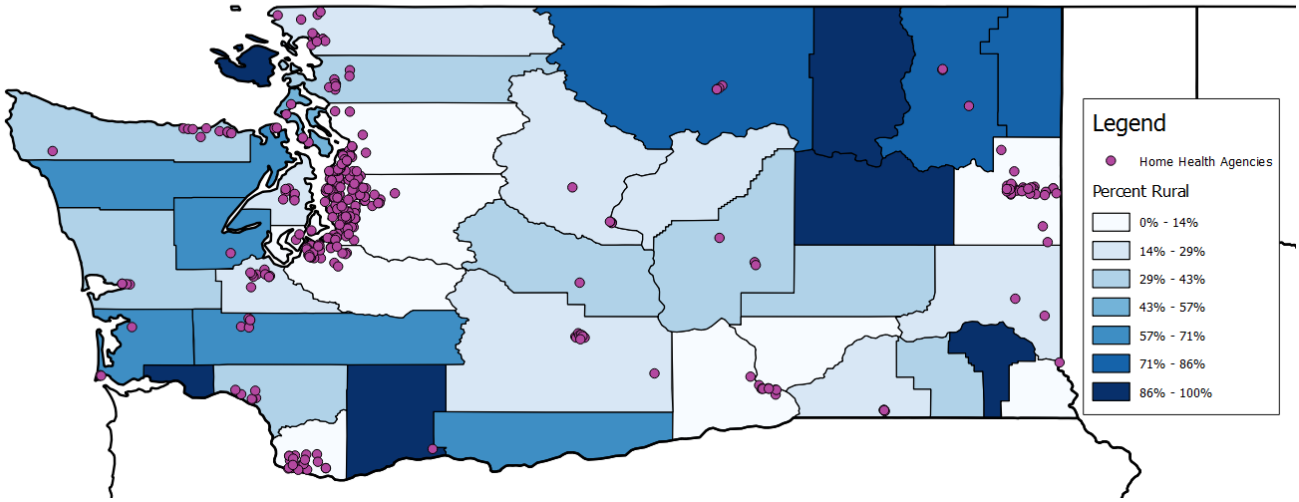
Rural vs. Urban Conditions

While Washington's population density is comparable to the national average, home care companies in Washington operate at dramatically different sizes in rural versus urban counties[6]. Rurally located home health companies have median sales revenue of $1,006,300 as compared to urban home health companies that have median sales revenue of only $316,300. This suggests that there are higher variable costs to operating in rural locations, possibly due to travel expenses, leading to lower margins that must be overcome by generating higher sales revenue. Nationally, rural homecare companies have 15% higher sales revenue than urban companies, but in Washington the median rural home care company is over 300% larger[7] than their urban counterparts. Due to the smaller number of rural home care companies, this analysis was swayed by outliers. Despite this, if we combine counties categorized as suburban and rural the median sales revenue is still $862,500, significantly higher than the sales revenue of urban based home care companies.

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

[7] National Establishment Time Series (NETS). *NETS is a proprietary database developed by Walls & Associates that converts Dun and Bradstreet (D&B) archival establishment data into a time-series database of establishment information.*

Rural Counties and Home Health Agencies



Payers

The homecare industry's revenue comes from two different sources. The first is from public payers, typically Medicaid, and the second is from private payers which includes both clients who pay out of pocket and clients that have private-pay or long-term care insurance. The public pay market is much larger than the private pay market in both Washington and national markets, but low reimbursement rates, licensing requirements, and regulatory complexity in the public pay market means that a private pay strategy might be more feasible for some agencies. It is important for a home care agency to understand the size and scope of both markets in order to match a business strategy to both the correct payers and clients for that business.

Public Pay Market

Given that most home care services are reimbursed through Medicaid it is important to understand how Medicaid reimbursed home care operates in Washington. As of fiscal year 2016, the Washington state budget for Medicaid was $10.935 billion with just over $3 billion allocated to fee-for-service care and just over $6 billion to managed care. Home health and personal care spending accounts for over 70% of the fee-for service spending or $2.151 billion[8] in the state. Washington does have a managed care long term support and services program but it is quite small with only 4,834 enrollees. More details on the framework for understanding how Medicaid works in Washington can be found in the regulatory overview beginning on page 8 of this report.

Private Pay Market

While there is a significant amount of data available on the size of the public pay market, it is much more difficult to estimate the size of the private pay market. Using data available from the November 2016 IBIS world report on the national home care providers industry, and our estimate of the size of the home care client population we can approximate the number of potential private pay home clients.

[8] Distribution of Medicaid Spending by Services, The Henry J. Kaiser Family Foundation. Retrieved from www.kff.org.

First, our estimate of the combined frail elderly, independent disabled, and self-care disabled population in Washington is 440,000. 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 Washington private pay home care potential client pool to be 74,300. Given that home care costs in Washington are high relative to the state's median income this may be an overestimate of the potential market as some may not be able to afford out of pocket home care costs.

Key stakeholders

Area Agencies on Aging: As mandated by the Older American's Act of 1965, Washington operates 13 area agencies on aging (AAA), which provide a suite of services to promote independence for persons 60+ with a primary focus on frail, rural and low-income minority individuals. AAA's contract with other agencies to provide services including homemaker services.

Northwest Cooperative Development Center: For existing or prospective cooperatives interested in operating in the state, the Northwest Cooperative Development Center (NWCDC), located in Olympia, assists new and existing cooperatives through training, business planning, market research, strategic planning, and other technical assistance.

SEIU 775NW: The Service Employees Union (SEIU) 775NW represents the 31,000 caregivers who work as individual providers under the state administered Medicaid reimbursed home care program.

REGULATORY & PUBLIC POLICY OVERVIEW

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

Medicaid Overview

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

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

Medicaid requires that states provide specific services at a minimum, to participate in the program. Required programs include inpatient and outpatient hospital services, physician and laboratory services, nursing home care and more recently, home health care. Above the minimum required programs, states may elect to cover additional services and/or expand services to individuals outside of the standard eligibility limits set by the Center for Medicaid and Medicare Services (CMS), the federal governing body. Typically, these additional services are provided under approved "waivers". [10] The number and type of waivers in each state varies widely, however common waivers include 1915 waivers, Aged and Disabled Waivers (ADW), and Intellectual Disability Waivers (ID). Home care relevant 1915 waivers include:

- 1915(c) Home and Community-Based Waivers (offered in 47 states and DC)
- 1915(i) State Plan Home and Community Based Waivers
- 1915(j) Self-Directed Personal Assistance Services Under State Plan Waivers
- 1915(k) Community First Choice Waivers[11]

See Appendix D for detailed waiver descriptions

[9] A 50-State Look at Medicaid Expansion, Families USA. Retrieved from www.familiesusa.org.
[10] Congressional Budget Office, Overview of Medicaid. Retrieved from www.cbo.gov.
[11] Medicaid, Authorities. Retrieved from www.medicaid.gov.

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

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

In addition to the transition to managed care, states are increasingly transitioning Medicaid to "value-based" care models by implementing Accountable Care Organizations (ACO's). To date, ten states (MA, VT, NY, OR, UT, CO, MN, NJ, RI) have implemented ACO programs[17]. The goal of ACO's is to "(1) enhance the patient experience of care; (2) improve the health of the population; and (3) reduce the per capita cost of health care". 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 for

[12] Medicaid, Authorities. Retrieved from www.medicaid.gov.
[13] Medicaid, Home and Community Based Services, 1915c Waiver. Retrieved from www.medicaid.gov.
[14] Kaiser Family Foundation, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011. Retrieved from www.kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf.
[15] Kaiser Family Foundation, Total MCO's, March 2017. Retrieved from www.kff.org.
[16] Kaiser Family Foundation, Share of Medicaid Population Covered Under Different Delivery Models, July 2016. Retrieved from www.kff.org.
[17] Center for Health Care Strategy, Inc. Medicaid ACO's: Status Update, June 2017. Retrieved from www.chcs.org.

cooperative home care agencies and developers to watch, as higher quality care is a hallmark of cooperative homecare agencies, and could be an important market differentiator.[18]

Washington Medicaid Overview

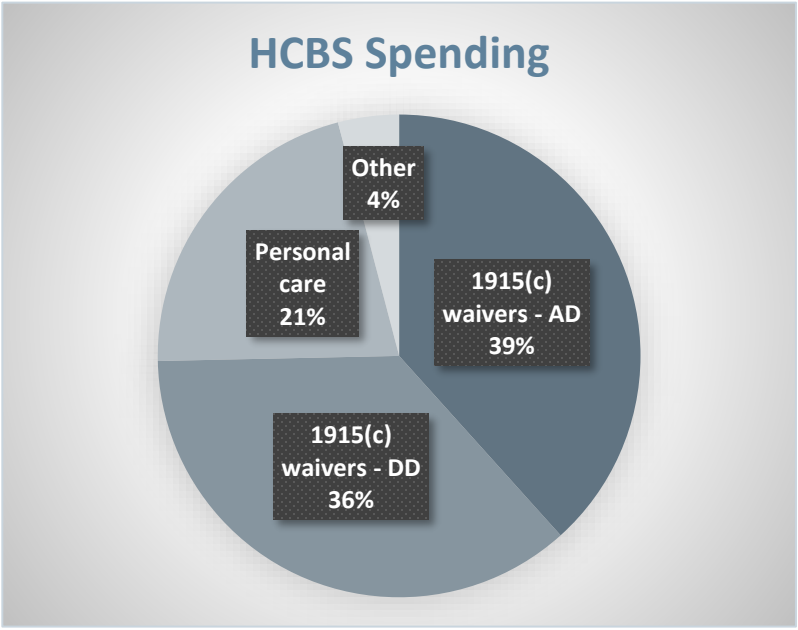
Whether private pay or public pay, agencies wishing to operate in Washington must have a basic understanding of the regulatory environment in the state. This section describes the overall system of Medicaid and home and community based services in Washington. Washington is primarily a managed care state with 85% of the Medicaid population enrolled in a managed care plan. Long term care, including home care, though, operates on a fee-for-service basis through Apple Health and is covered directly through the state and not a health plan[19].

Home and Community Based Services (HCBS)

Washington's Home and Community Based Services (HCBS) Program operates under the Department of Social and Health Services (DSHS) under either the Aging and Long-Term Services Administration (ALTSA) or the Developmental Disabilities Administration (DDA). As of 2014, 1915(c) waivers for Aged and Disabled and Intellectual/developmental disabilities accounted for 74.7% of Washington state HCBS spending, personal care accounted for 21.3% of spending, and the remaining programs totaled less than 5% of spending. Washington currently has eight 1915(c) waiver programs in operation with a total budget of $1.3 billion in 2014. The three largest waiver programs in the state were the Community Options Program Entry System (COPES) ($668 million), the Washington state Core Waiver programs ($386 million), and the Basic Plus Waiver ($197 million)[20]. Under these programs, eligible Washington residents can access home care services among other home and community based service supports.[21]

[18] Center for Health Care Strategy, Inc. Medicaid Accountable Care Organization Programs: State Profiles. Brief: October 2015. Retrieved from www.chcs.org.
[19] First-timers' Guide to Washington Apple Health (Medicaid), Washington Apple Health. Retrieved from https://www.hca.wa.gov/assets/free-or-low-cost/19-024.pdf.
[20] Medicaid Expenditures for Section 1915 (c) Waiver Programs in FY2014, Eiken, S., Burwell, B, Sredl,K., Saucier, P. Retrieved from www.medicaid.gov.
[21] Improving the Balance, The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014, Wenzlow, A., Eiken, S., Stredl, K., June 2016. Retrieved from www.medicaid.gov.

State managed home care services are provided through two different channels. The first is through the state's individual provider program, which employs the majority of home health and personal care aides in the state. Clients use the Washington Home Care Referral Registry local office or have care coordinated through one of the 13 local Area Agencies on Aging (AAA). The second channel is through traditional home care agencies that must be licensed through the state. Agency care is coordinated through the local AAA or other Local Home and Community Services offices.



Licensing

All home care providers in the state of Washington must be licensed by the Department of Social and Health Services (DSHS). Home health care providers must also be licensed by the state, but under a different set of requirements than personal care agencies.

To contract with DSHS and to receive referrals for public pay clients a home care agency in Washington must meet the following requirements. First, the agency must have at least three years' in operations in Washington as a licensed home care provider. Second, the agency must provide service in a geographic area defined by the contracting Area Agency on Aging (AAA). Finally, the agency must also meet other requirements involving financial reporting, quality monitoring, staff experience, and electronic timekeeping. These requirements mean that any new Washington state based home care agency must operate for at least three years in the private pay market before it can consider entering the public pay market[22]. For home care cooperatives starting up in Washington this means that pursuing the private pay market is the only option during initial operations.

Training

Washington has significant state training requirements for homecare workers. As of 2011, all long-term care works, including in home caregivers, must pass both state and federal background checks. In addition, workers must complete 75 hours of training by their 120th day of work and pass homecare aide certification by their 150th day of work[23].

[22] In-Home Services Agencies, Washington State Legislature. Retrieved from www.app.leg.wa.gov/wac/.
[23] Training Requirements and Classes, Washington State Department of Social and Health Services. Retrieved from www.dshs.wa.gov.

LABOR OVERVIEW

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

Current Labor Pool

Home care cooperatives in Washington face some significant barriers in recruiting and retaining caregivers. The number of caregivers in the workforce significantly lags the population most likely to seek out homecare services. For every one caregiver in Washington there are just under 12 people categorized as frail elderly, independent living disabled, or self-care disabled. Washington's ratio of one caregiver to every 11.76 potential home care clients is more severe than the national ratio of eight to one. In addition, the growth rate of Washington's elderly population (13.3%) is over 3.5% greater than the national growth rate of 9.7%.

While there is a need for caregivers in Washington, recruitment also depends on how wages compare to similar entry-level service sector occupations. In Washington caregivers are paid on average $12.10 per hour, which is about 1.4% more than their counterparts in retail and food service. Nationally caregivers are paid about 4.5% more than retail or food service workers. Given the shortage of homecare workers in the state, it appears that this pay bump isn't enough to recruit enough caregivers to make up for long-term demand trends.

Caregiver and Retail/Food Service Wage Comparison			
	Direct Care	**Retail/Food**	**Difference**
National Average	$ 10.70	$ 10.24	$ 0.46
Washington	$ 12.10	$ 11.93	$ 0.16

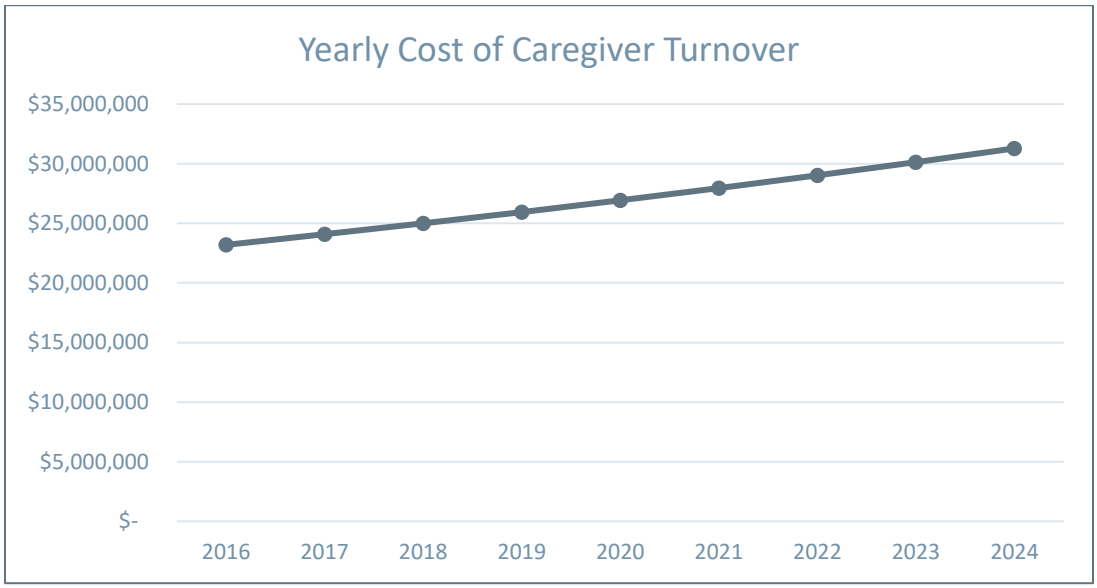
The macro employment environment in Washington is relatively average with unemployment comparable to national unemployment, and a prime age (25-55) labor force participation rate 6% below the national average. This data indicates that there is a small potential pool of untapped labor to recruit into the caregiver workforce, but a greater number of workers will need to be recruited from other industries.

Future Labor Trends

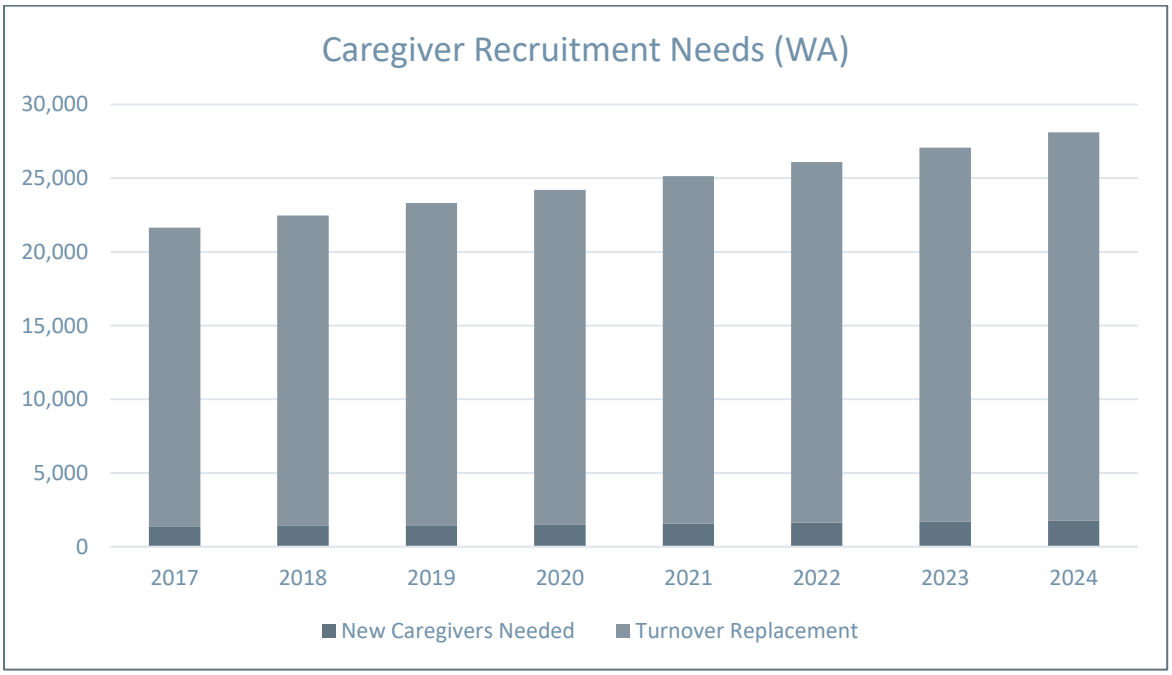
The caregiving workforce is expected to experience rapid growth over the next ten years. By 2024 the workforce of personal care aides is expected to grow by 25.9%, home health aides by 38.1%, and nursing assistants by 17.6%. In total, the state of Washington is expected to have just under 50,000 caregivers working at agencies by 2024, 15,000 more caregivers than currently work at agencies in the state[24].

[24] Long Term Occupational Projections. Retrieved from www.projectionscentral.com.

Nationally, the direct care workforce has experienced a tripling in the rate of employee turnover since 2009. Currently, the national average for yearly turnover is over 60% with states in the Pacific region experiencing average turnover of 57% in 2015[25].



Combining the growth in the workforce with the industry's high turnover rate we estimate that the state of Washington will need to recruit and train an additional 154,000 caregivers into the workforce by 2024. Even if the turnover rate was halved over the same period over 76,000 new caregivers would be needed to meet current growth rates.



[25] The 2017 Home Care Benchmarking Study. Retrieved from www.homecarepulse.com.

COOPERATIVE OPPORTUNITY

Cooperative Law

Washington State has an applicable employee cooperative statute. Washington State law chapter RCW 23.78.020 states that "any corporation organized under the laws of this state may elect to be governed as an employee cooperative under the provisions of this chapter, by so stating in its articles of incorporation, or articles of amendment filed in accordance with Title 23B RCW and Article 2 of chapter23.95 RCW. A corporation so electing shall be governed by all provisions of Title 23B RCW, except RCW 23B.07.050, 23B.13.020, and chapter 23B.11RCW, and except as otherwise provided in this chapter."[26]

Cooperative Strategy

As of 2015, Washington's elderly population totaled almost 950,000 growing over 13% since 2012, almost 10% faster than the state's overall population growth. At the same time, the state direct care workforce is insufficient to meet current and future demand for home care. The impending challenge for the state of Washington to meet its residents home care needs also represents an opportunity for home care cooperatives. To fill this large and growing demand for home care services, Washington based home care cooperatives need to surmount challenges specific to the state's market in recruiting and retaining a skilled workforce, operating in the public pay market, and operating at scale.

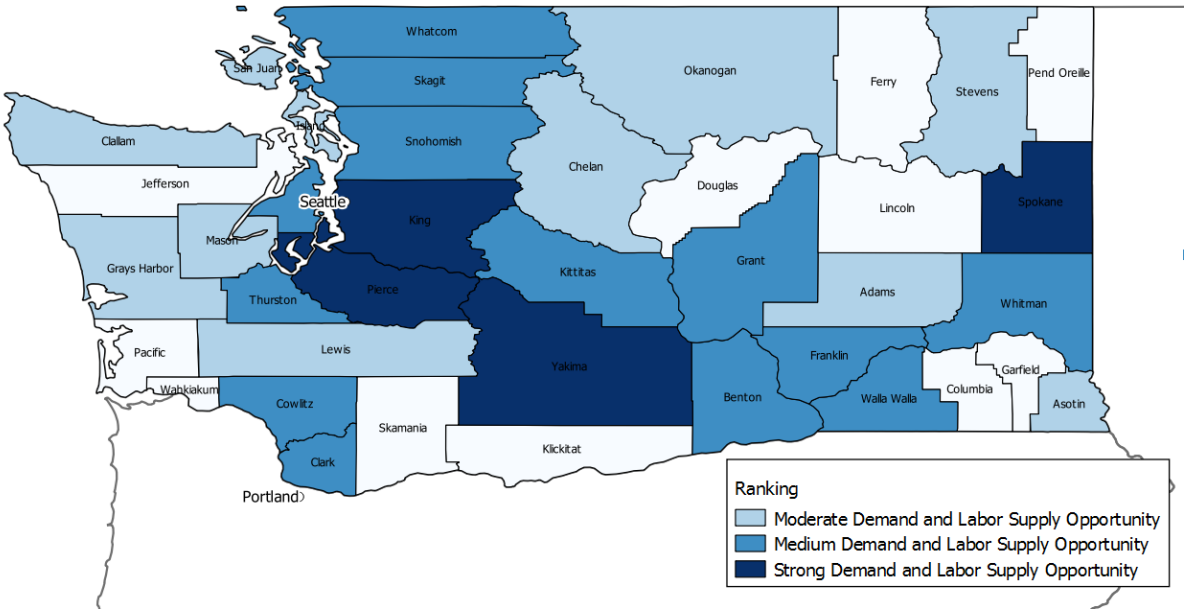
The primary challenge facing home care cooperatives in the state will be recruiting and retaining enough caregivers to meet this growing demand in an industry with low pay, demanding work, and high turnover. If industry wide turnover rates remain the same, over 150,000 new home care workers will need be recruited and trained by 2024. Additionally, pay rates for the direct care workforce in Washington are low in comparison to other service sector work. This represents an opportunity for cooperatives to develop a competitive advantage by providing better training, pay, and a more stable work environment. Reducing turnover through better training and pay decreases recruitment expenses while also leading to better quality care, an important competitive differentiator in the market.

Second, home care cooperatives will need to develop the capabilities to tackle both the private pay and public pay markets. While it is a smaller portion of the market, Washington based home care coops have targeted private pay customers as Medicaid reimbursement rates are low and compliance with state regulations for receiving public money has proven difficult and burdensome for these smaller organizations. For smaller cooperatives and those just entering the market, pursuing private pay clients is the best path towards earning revenue and reaching financial stability in the short-term. In the long-term however, the Washington Medicaid home care market represents billions of dollars of potential revenue and the opportunity for home care cooperatives to reach scale in the state. For home care cooperatives to operate in the public pay market, the organization must be able to reduced its operating expenses and serve enough clients so that lower margins can still lead to enough operating income to cover overhead expenses.

[26] Washington State Legislature, Chapter 23.78. Retrieved from http://app.leg.wa.gov/RCW/default.aspx?cite=23.78.020.

These two challenges have proven to be significant barriers to scaling home care businesses in Washington to date. These structural barriers have created a fragmented patchwork of small home care agencies that are not capable of reaching the size needed to meet the significant and growing gap between the supply of home care work and the demand for that work. While home care agencies in the state have average revenue of about $750,000, the median sales revenue of agencies is just over $100,000. This is the result of 166 home care agencies in the state earning less than $200,000 a year in sales revenue. The five largest home care companies in the state still garner only 33% of the market. These factors combined mean that the Washington home care industry is highly fragmented and competitive. This environment gives local home care cooperatives the opportunity to become leaders in the state, by quickly pursing scale.

Washington Combined Demand and Labor Supply Ranking



For the home care cooperatives already in operation, expansion opportunities can come in two ways. The first way is to expand internally by increasing the number of clients being served and by increasing the amount of services delivered to existing clients. In the three counties that have home care cooperatives (Jefferson, Thurston, and Whatcom), the primary barrier to increasing business will be recruiting enough caregivers. All three counties have demographic makeups that indicate that a high percentage of the population is or will need home care services in the near future. On the other hand, all three counties have high caregiver dependency ratios, indicating that there are not enough caregivers in the workforce to meet demand. Grassroots outreach and partnership development with local schools, career development organizations, alternative staffing agencies or other community agencies could help spur interest in the career.

The second method of increasing size is to pursue acquisitions and conversions of existing home care agencies. This could be especially useful for expanding into the Medicaid market more quickly. While it is difficult for new or smaller cooperatives to pursue the public pay market due to regulation and low reimbursement rates, a local cooperative or a cooperative developer that can raise the funds necessary

to acquire and convert an existing Medicaid certified agency would have an opportunity to enter a large market. According to the Washington state list of state licensed Medicaid home care agencies, there are 9 agencies in Thurston County, 7 in Whatcom County, and 3 in Jefferson county. Additionally, neighboring counties such as Pierce, Kitsap, and Clallam have higher concentrations of home care agencies and may be potential markets for conversions, but they may also be more competitive markets to operate in. In the counties with home care cooperatives, the neighboring counties of Mason, Thurston, Pierce, and Whatcom are the best opportunities for expansion as they have a low number of home care agencies relative to the potential client pool.

CONCLUSION

Cooperative developers and others interested in supporting home care cooperatives in Washington have an exciting opportunity to improve the quality of jobs, the quality of care, and access to care in the state.

However, while the potential for impact is high, the road is difficult. Nationwide, independent home care agencies are struggling to survive because of the small private market, low margins on Medicaid clients, difficulty in recruitment and retention, and high training costs. In Washington, some of these national trends are exaggerated. The increase in demand for home care market in Washington State is outpacing the national market, while the labor market is below the national ratio of caregivers to those needing care. As a result, in Washington State, a key barrier to starting and/or growing a successful home care cooperative will be recruitment and retention of caregivers. Furthermore, the pay differential for caregivers versus other, less strenuous jobs, is less than the national average.

There are advantages to working in Washington State, as well, though. Washington is home to the Northwest Cooperative Development Center, which has successfully supported the launch of two home care cooperatives and is currently supporting another start-up operation, and a strong labor union. The market for home care in Washington is sufficiently large to support home care cooperatives in the state, and there appear to be low barriers to entry for smaller firms to get into the private pay market.

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 afford and 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 Washington State 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

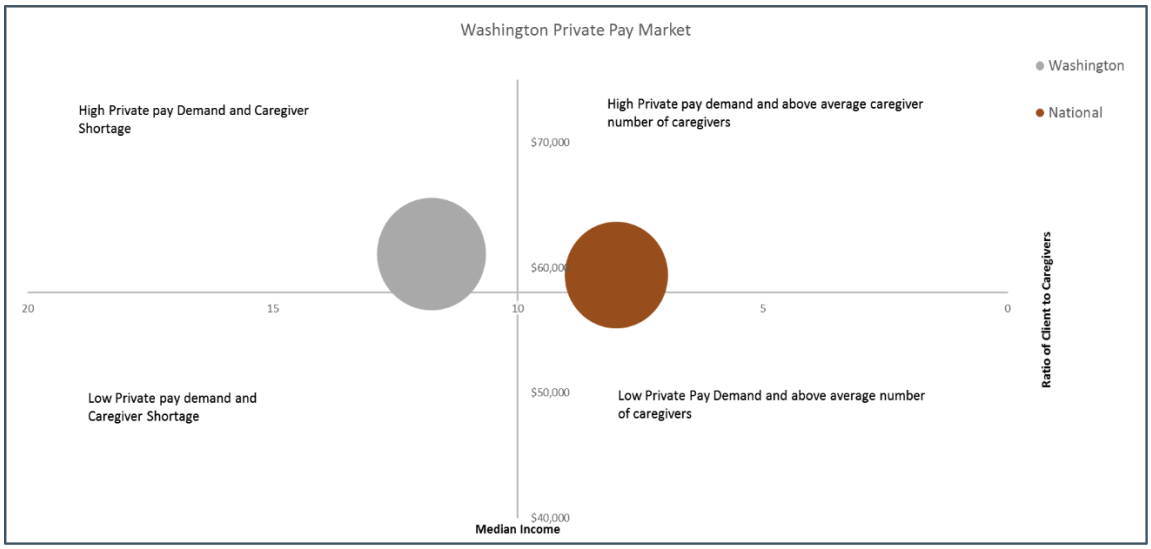
Appendix A: Opportunity Matrix

Opportunity Assessment Framework		
Key Metrics - Labor Supply:	***US Average***	***Washington***
Assesses ease or difficulty of recruitment and retention for direct-care workforce.		
Prime-Age Labor Force Participation Rate (25-55 Years of Age)	**81.70%**	**75%**
Other Entry-Level Pay Comparison (Retail and Food Service)	**10.83%**	**1.40%**
Caregiver Dependency Ratio (direct care workforce over home care subset-frail elderly/dependent)	**7.98**	**11.76**
Unemployment Rate	**4.40%**	**4.70%**
Key Metrics - Firm Barriers to Entry:	***US Average***	***Washington***
Assesses ease or difficulty of entering the home care market as a new provider		
Scale Barriers	**$216,243**	**$111,589**
Average Sales of Home Care Companies Rural	**Rural: $431,300**	**Rural: $1,150,000**
Average Sales of Home Care Companies Urban	**Urban: $373,800**	**Urban: $333,900**
Scale of Service Area (as Population Density)	**91.39**	**109.67**
Rural Population Density	**Rural: 19.17**	**Rural: 23.9**
Suburban Population Density	**Suburban: 57.83**	**Suburban: 58.1**
Urban Population Density	**Urban: 1015.17**	**Urban: 222.28**
Key Metrics - Market Competitiveness	***US Average***	***Washington***
Assesses the state of market consolidation/fragmentation, and dominance of any major firms.		
Total % Market Share of Top 5 Firms	**8.7% (Top Three)**	**31.90%**
Largest Provider Operating in State (Annual Sales)	**Kindred**	**Chesterfield Services Inc**
Key Metrics - Client/Customer Demographics	***US Average***	***Washington***
Describes composition of population in state likely needing home care services.		
Total % in Home Care Subset (Frail Elderly & Ind'l with Disabilities, IL & SC)	**6.19%**	**6.07%**
Growth in Aging Population	**9.70%**	**13.30%**
Total % Population Age 65+	**14.10%**	***13.58%***
Total % Population Individuals with Disabilities	**6.81%**	***12.80%***
Total % Population on Medicaid	**18.00%**	**25.52%**
Home Care Costs as % of Median Income of 65+ Population	**119%**	**131%**
Key Metrics - Payer Composition	***US Average***	***Washington***
Describes key customers/payers in the state, how money flows, ability of providers to negotiate for better rates, etc.		
Percentage Total State Medicaid Spending on LTSS	**32%**	**26%**
Share Medicaid LTSS Spending for Devoted to HCBS	**53%**	**66%**
Self-Directed Care Program	**N/A**	**Yes**
Rate Flexibility	**N/A**	**Managed care State, but home care is still Fee for Service**
Per Capita HCBS	**$18,870**	**$17,944**

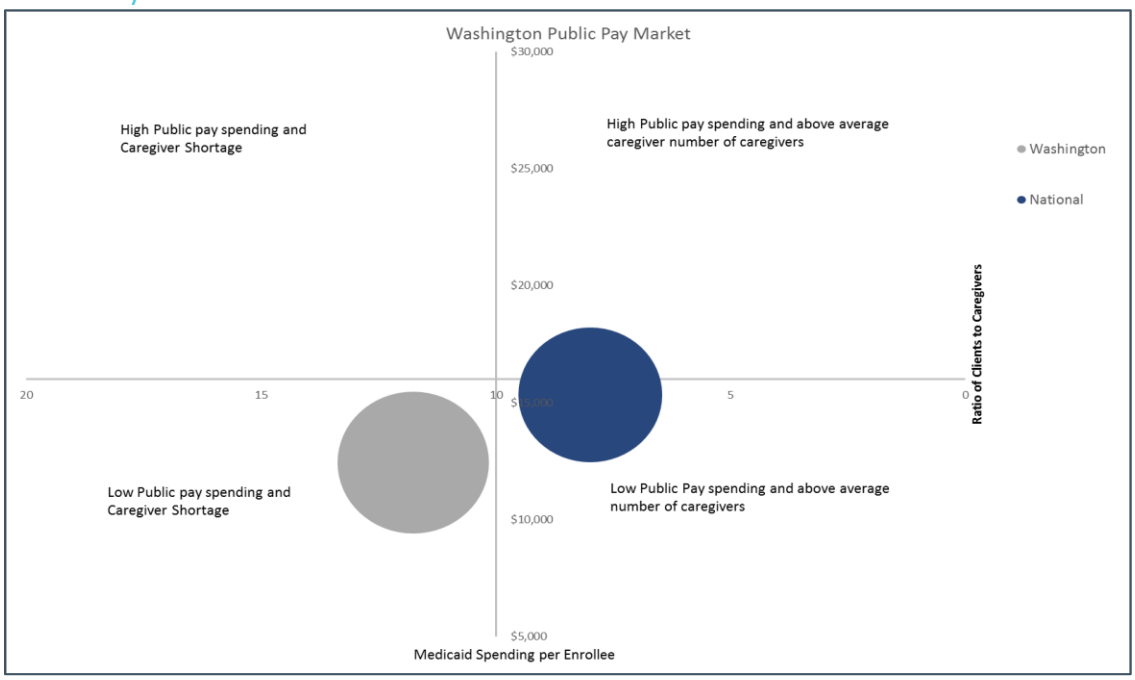
Appendix B: State Market Assessments

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: Opportunity Matrix Methodology

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

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

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

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

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

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

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

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

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

Opportunity Matrix Sources:

Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Employment Statistics*, July, 2017 Retrieved from www.bls.gov/oes/

Mergent Intellect Dun and Bradstreet. (n.d.). Loblaws Inc. Retrieved from Mergent Intellect database.

National Establishment Time Series (NETS). *NETS is a proprietary database developed by Walls & Associates that converts Dun and Bradstreet (D&B) archival establishment data into a time-series database of establishment information.*

State Health Facts. *The Henry J. Kaiser Family Foundation*, 2017. Retrieved from http://www.kff.org/statedata.

U.S. Census Bureau. *S0103 Population 65 Years and Over in the United States 2011-2015 American Community Survey 5-Year Estimates*, 2015. Retrieved from www.factfinder.census.gov.

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

Appendix D: Home Care 1915 Medicaid Waiver Descriptions

1915(c) Home and Community-Based Waivers[i]

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 Waivers[ii]

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 Waivers[iii]

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

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

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

1915(k) Community First Choice Waivers[iv]

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

[i] Medicaid. *Home and Community Based Services 1915©.* 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