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CALIFORNIA

HOME CARE MARKET ASSESSMENT

Cooperative Development Foundation

ICA GROUP
HOME CARE

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Introduction

Mirroring national trends, demand for home care services in California is high and growing. Caregiver supply is insufficient to meet demand, and given low job quality, not enough new caregivers are entering the field or staying there. Reimbursement rates for publicly supported home based care are low in the state (even lower than the national average) making it very difficult to start and operate a public pay home care agency. In contrast, given the relatively higher rates found in the private pay market, competition for private pay clients is high, and new agencies continue to enter the private pay market, particularly franchises and consolidated national chains. Despite this challenging landscape, opportunity exists for individuals and organizations looking to start cooperative home care agencies in the state. As worker-centered businesses, cooperatives prioritize improved working conditions, including better training, higher wages, and job supports, resulting in increased worker satisfaction and decreased turn over, and ultimately higher quality, consistent care for clients. This "cooperative difference" is a competitive advantage, and those that can successfully launch and operate financially sustainable home care cooperatives can make a meaningful difference in the lives of both home care workers and consumers in the state.

The following market assessment provides an in-depth look at the home care market in California across several key dimensions, including market size, labor supply, the regulatory environment, and other state specific findings. With this data, individuals and organizations interested in starting a home care cooperative in the state will get a complete picture of the state of home care in California, including how this affects new home care cooperative development. Finally, the report will discuss potential strategies for growing and nurturing home care cooperatives in the state.

Key Takeaways

- **Demand for home care services in the state is high and growing.**
  - As of 2018, an estimated 2,257,000 California residents were categorized as "frail elderly," "self-care disabled," or "independent living disabled," and likely needing home care services.[1]
  - Mirroring national trends, California's senior population is increasing rapidly. By 2026, California's 65+ age group is expected to grow by nearly **52%** adding 2.6 million individuals to the potential pool of home care clients in the state.[2]
- **California's supply of caregivers will need to grow quickly to meet rising demand.**
  - Currently, California has a caregiver ratio of **1 to 4**, meaning there is one caregiver for every four clients needing home based care; this is significantly better than the national average of 1 to 7[3], but still represents a shortage.
  - In total, there are currently about 590,000 people working in the home care industry in California, including job titles of Home Health Aides, Nursing Assistants, and Personal Care Aides. It is estimated that California needs an additional 917,000 new caregivers to enter the field by 2026 to meet demand. [4,5]
- **While demand for publicly supported home care services is high in the state, reimbursement rates are extremely low.**
  - The average per hour Medicaid reimbursement rate for home care services in California is $14.48. This rate is significantly lower than the national average of $19.01 per hour.[6] Out of this amount, agencies must pay caregiver salaries and cover all overhead expenses, making it difficult to run a financially sustainable or profitable home care agency in the public pay market without reaching adequate scale.
- **Home care workers are underpaid, a key factor driving the insufficient supply of caregivers in the state.**

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1 United States Census population estimates
2 California Department of Finance Population Projections
3 While national consensus does not exist on what an adequate supply is, the best ratios in the country hover around 3:1.
4 Bureau of Labor and Statistics
5 Not accounting for industry turnover
6 O'Malley Watts, M., Musumeci, M., (2019). Medicaid Home and Community-Based Services

- Between 2018 and 2028, Home Health Aide and Personal Care Aide are projected as the 3rd and 4th fastest-growing jobs nationally, respectively. Of the top ten fastest-growing jobs nationwide, they are also the lowest paid.[7]
- In California, the average wage of direct caregivers is $13.28 per hour; this is less than the average hourly wage retail and food services workers earn in the state. This makes recruitment and retention of caregivers and prospective caregivers even more difficult as they have employment options outside of the home care industry that are often more stable and less emotionally and physically demanding.[8]

- **California has a strong Individual Provider (consumer direct-hire) program.**
  - Under California's Medicaid funded Individual Provider (IP) program, home care consumers can direct-hire caregivers. Consumers can select their caregivers from county-based registries but often choose a family member, accounting for 92% of Individual Providers (IPs) in the state.
  - Wages for IPs are even lower than average Medicaid reimbursement rates, with average direct IP caregiver wages at a staggering $12.62 per hour. Weekly and monthly hours for reimbursable care services are restricted and leave little opportunity for IPs to thrive financially on caregiving alone.
  - IPs have no restrictions on the services they provide as the consumer is considered their direct employer.[9]
- **The average per hour rate for private pay (out-of-pocket) home care services in California is $28 per hour[10], making it a more attractive market for home care operators, but also a more competitive one.**
  - Given the significantly higher private pay rates in the state, competition among home care agencies for private pay dollars is high, and new entrants continue to enter the field (particularly franchises and national chains). However, because the largest five agencies in the state control, only 18.5% of the market, California is still considered a highly competitive market.[11]

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7 Bureau of Labor and Statistics Employment Projections 2018-2028
8 Bureau of Labor and Statistics Employment Projections 2018-2028
9 Spetz, J. (2019) Healthforce Center at UCSF
10 Genworth Cost of Care Survey 2019
11 National Establishment Time-Series (NETS) Dun and Bradstreet (n.d.).

- Given the higher rates present in the private pay market, it is more financially feasible for new entrants, including home care cooperatives, to launch and operate at a smaller scale in the private pay market.
- However, at a yearly average cost of 130% of the median income for residents 65+, out-of-pocket home care is expensive and unaffordable over the long term for most households.[12]

- **Regulatory barriers to entry are low for organizations exclusively offering custodial care (non-medical support with Activities of Daily Living and Instrumental Activities of Daily Living (ADLs and IADLs).**
  - Home Health Agencies (HHAs) and Home Care Organizations (HCOs) do not need to be *licensed* to provide non-medical care to clients.
  - HHAs and HCOs must *register* with the state, however, to provide home care services. The registration process is standardized across California by the Department of Social Services but is coordinated locally. Individual counties require every caregiver, except for IPs, to pass a background check and sign up for a registry to encourage safety and accountability among caregivers and employers.
  - Training is required for any caregiver affiliated with a home care agency or organization; at minimum, 5 hours of introductory and safety training. Training for any caregiver working independently in the private market or IP is not required.

[12] Genworth Cost of Care Survey 2019

Market Overview

Clients

As of 2018, 2,256,972 California residents were categorized as "frail elderly," "self-care disabled," or "independent living disabled," and likely needing home care services. Growth predictions expect an additional 2.6 million people 65 and older in the state by 2026. At current, California boasts one of the better caregiver to client ratios nationally at 1 to 4, versus the national average of 1 to 7. As the state's senior population grows and becomes frailer; however, unmet demand is expected to grow.

Home Care Client Pool: Percent of Total Population		
	California	*National*
65+ Population	14.33%	15.93%
Individuals with Disabilities	10.6%	12.6%
Home Care Subset[13]	5.71%	6.4%

Providers

In California, there are over 1,500 registered home care agencies locations (or organizations, using California state terminology) in operation. To analyze these agencies by revenue we matched the list of registered home care agencies to the 2014 National Established Time Series (NETS) database[14]. Between those two lists we matched 769 agencies. Of those 769 registered agencies, 373 agencies were categorized as either unique individual establishments or the headquarters of multi-branch agencies.

Of the 373 registered home care agencies analyzed in California, the top five largest players occupy 18.15% of the known $313 million home care market. As is true in most states, the largest players are concentrated in specific geographic areas with high client demand, such as urban centers.[15]

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[13] Home Care Subset includes 20% of 65+ population and disabled populations potentially needing home care supports.
[14] ICA Group was able to collect location and revenue data from existing home care agencies in California from the 2014 National Established Time Series (NETS). The NETS data provided an ample list that was cross-referenced with the state's registry of licensed agencies that produced a sample-size of agencies currently solvent and in operation. A key consideration in this list is that of the 769 establishments operating in California; 373 of them were categorized as either unique individual establishments or the headquarters of multi-branch agencies. Annual revenue was collected from the 373 agencies as headquarters aggregate annual sales to one location. If a caregiver is not affiliated with a home care agency or home care organization, California does not require an individual caregiver to be licensed or registered because they are the direct employee of the client. While this data is difficult to confirm, it can be assumed that there is a pool of caregivers operating as individual providers working exclusively in the private pay market.
[15] Industries in which the top five firms control 60% or more of the market are generally considered non-competitive.

Similar to national trends, California has relatively few large companies and primarily consists of small local operators. The national median sales for home care companies is $1,835,000, which is only slightly lower than the Pacific region median of $1,841,000.[16] Based on the agency pool analyzed California's mean sales revenue is $841,461 and median sales revenue is $333,990, suggesting that the larger home care companies operate at a far greater scale that overshadow the state's smaller operators. The agency sample demonstrates this in that the majority, or 63% of agencies, make $500,000 or less in annual revenue each year[17], and 22% of those agencies make less than $250,000.

Home Care Agency Market Share by Revenue[18]	
Revenue Range	*% of Market*
<$250,000	22%
$250,000-$500.000	41%
$500,000-$1 Million	17%
$1 Million-$5 Million	16%
>$5 Million	3%

[16] Pulse Benchmark Survey Spring 2018, pg. 72, 74
[17] National Establishment Time-Series (NETS) Dun and Bradstreet (n.d.).
[18] Of the 373 Agencies ICA Group has revenue data on

Rural vs. Urban Conditions

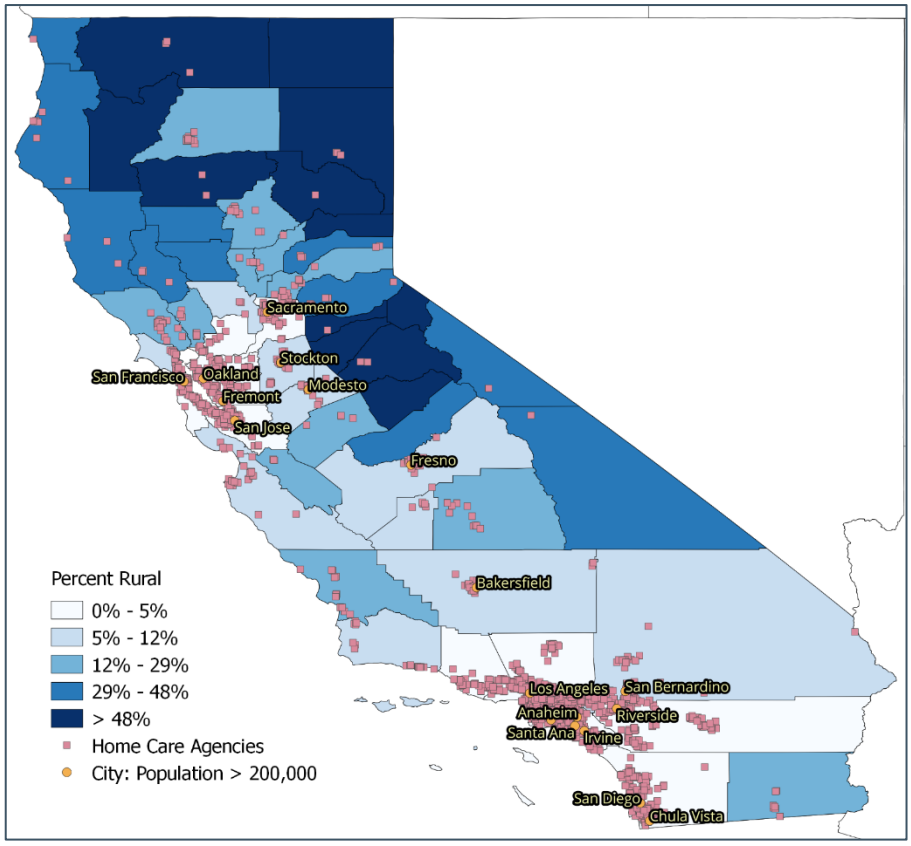
As is true nationally, home care companies in California operate at different scales in rural versus urban counties. As the third-largest state in the country and the most populated, California has both very rural areas and highly urbanized areas. The average population density of rural designated counties in California is only 8 people per square mile. Suburban areas are not much denser at 5.2 residents per square mile. In contrast, urban counties in California have an average population density of 1,026 residents per square mile. Similar to the national population, rural and suburban counties have a larger percent of the population aged 65+ at 19% and 21%, respectively, as compared to urban counties at 13%. Despite having a higher percentage of older residents, there are comparatively few agencies headquartered in rural areas, and agencies headquartered in and/or servicing rural areas are significantly larger.

Home care agency revenue by branch			
	Median	Mean	Total
Urban	$316,300	$1,237,263	$2,870,450,618
Suburban	$503,150	$1,011,300	$28,316,402
Rural	$488,750	$615,016	$4,920,125

Based on our analysis of all home care agencies headquarters and branch offices in California operating in 2014[19], we found that both rural and suburban agencies had a higher *median revenue* than agencies located in urban areas. Since rural agencies have thinner margins from higher travel expenses they need to operate at a larger size to break-even, but further growth is often capped by the smaller market. This is backed up by the fact that agencies headquartered in urban counties had an *average revenue* that was slightly higher than the revenue of suburban agencies and almost double the revenue of rural agencies. What we found in California is reflective of the broader market. To succeed in rural and suburban market agencies need to enter the market at a larger size as compared to an urban agency. Agencies in urban markets, though, have more growth opportunities explaining the larger average size as the very larger agencies are all located in urban markets.

[19] Those most recent in which we had complete revenue data

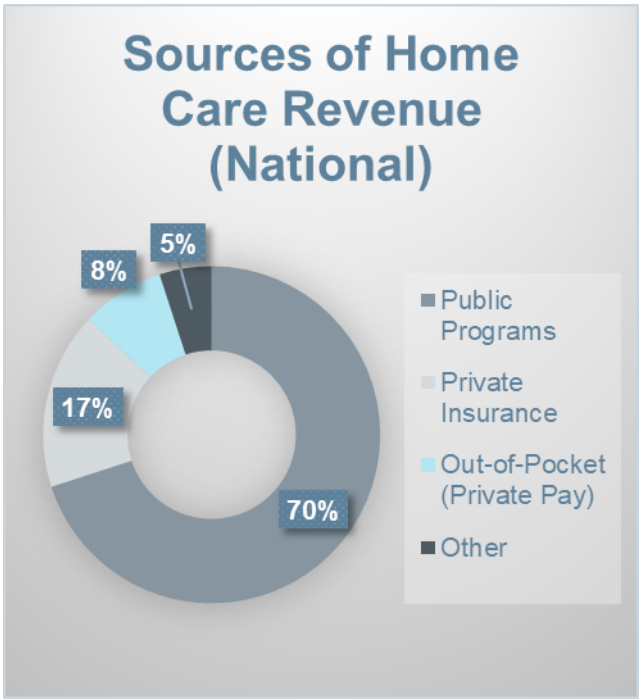
For prospective home care co-ops in California, geographic location will substantially change the size and appropriate strategy of the business venture. While urban agencies will have more potential clients and lower travel expenses, there will also be increased competition for the relatively smaller proportion of seniors in the urban market. Rural and suburban agencies will have more challenges in reaching financial sustainability, but once reaching a certain size, these agencies will have less competition.



Payers

Homecare industry revenue comes from two primary sources. The first is from public payers, typically state distributed Medicaid, and the second is from private payers, including clients who pay out of pocket and clients who have purchased long-term care insurance. The public pay market is much larger than the private pay market both nationally and within California, but often includes barriers such as:

- Low reimbursement rates
- Licensing requirements
- State specific regulations



The challenges experienced from operating within the public pay market means that a private pay

strategy is more feasible for many agencies, including small-scale agencies and start-ups. It is crucial for a home care agency to understand the size and scope of both markets to match their business strategy to both the correct payers and clients for that business. *See Appendix 2 Medicaid Overview for a detailed explanation of Medicaid Home Care.*

Median home care costs (as an average of medical and nonmedical services) are $64,041 per year in the state for full-time care.[20] California's median household income is $67,169, while the median income of the population 65 years and older is only $49,126. At a yearly average cost of 130% of median income for residents, home care costs are a formidable expense for households in California. High home care costs reduce the potential number of customers in the private pay marketplace and over the long-term pushes many home care clients into the Medicaid market as their assets are spent down.

Public Pay Market

Medicaid Overview

California's Medicaid system, known as Medi-Cal, is the largest in the nation with regards to both total beneficiaries enrolled and overall spending. In FY19, California allocated a total of $99 billion to serve 13 million Medi-Cal beneficiaries. In total, $4.2 billion was spent on programs created specifically to keep residents in their homes and out of institutionalized care facilities.

While some states have fully transitioned to systems of managed care, many others, like California, continue to operate both Fee-For-Service (FFS) and Managed Care Medicaid systems (via Managed Care Organizations, MCOs), while continuing to transition. Currently, California runs four long-term service and supports programs (LTSS): Home and Community-Based Services (HCBS), In-Home Supportive Services (IHSS)—the state's Independent Provider (IP) programs[21], Community First Choice (CCT), and the Multipurpose Senior Services Program (MSSP).[22]

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[20] Calculated at 44 hours per week at 52 weeks per year

[21] California's In-Home Supportive Services (IHSS)—the state's Independent Provider (IP) programs include the Personal Care Services Program (PCSP), Community First Choice Option Program (CFO), IHSS Plus Option Program (IPO), and the IHSS Residual Program (IHSS-R).

[22] Medi-Cal Facts and Figures, (2019). Pg. 38 www.chcf.org/wp-content/uploads/2019/02/MediCalFactsFiguresAlmanac2019.pdf

In the chart to the right we can see that Medi-Cal beneficiaries that receive FFS are higher costs, and it seems likely that FFS programs are serving higher needs clients. On average, in FY18, Medi-Cal spent $5,452 per Medicaid beneficiary.[23] For the primary population of home care clients, spending for seniors 65+ cost an average of $14,108 per year/per person, and care for people with disabilities totaled an average of $19,597 per year/per person.[24] Given the high level spending on these two populations, home care cooperatives entering the public pay market will likely have a significant portion of their clients receiving FFS reimbursements from Medi-Cal as opposed to working with managed care plans.

	% of Medi-Cal Spending	% of Medi-Cal Beneficiaries
Medi-Cal Managed Care Plan	49%	51%
Fee-For-Service Plans	51%	18%

Interestingly, in California most Long-Term Care services are "carved out"[25] from the required services that MMCPs must provide to their beneficiaries. As a result, County Based Health Plans typically facilitate the In-Home Supportive Services (IHSS) and Multipurpose Senior Services Program (MSSP) programs under fee-for-service plans to coordinate home based care for residents hoping to stay in their homes.

In-Home Supportive Services

As of September 2019, 610,457 total consumers were participating in the In-Home Supportive Services (IHSS) programs.[26] IHSS programs allow consumers to directly hire, train, supervise, and fire, their caregivers. As a program of the Department of Social Services, the consumer is qualified and evaluated by a social worker who then identifies a specific set of approved daily tasks that should be provided by the selected caregiver and for which the caregiver will be reimbursed directly.[27] After qualification, the consumer can hire anyone, including siblings, adult children, nieces, nephews, friends, and spouses, or a caregiver from a county based registry.[28]

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[23] Children: $2,127; Families: $2,438; Pregnant Women: $4,366; Adults: $4,668
[24] Medi-Cal Facts and Figures, (2019), pg. 41 www.chcf.org/wp-content/uploads/2019/02/MediCalFactsFiguresAlmanac2019.pdf
[25] Unless residing in one of 7 counties (San Mateo, Santa Clara, Los Angeles, Orange, Riverside, San Bernadino, San Diego) that participate in the Coordinated Care Initiative which merges Medicare Long Term Services with Medi-Cal.
[26] IHSS September Data Dashboard
[27] House cleaning, meal preparation, laundry, grocery shopping, personal care services, accompaniment to medical appointments and protective supervision for the medically impaired.
[28] 5 Ways to Get Paid as a Family Caregiver in California. (2019). Retrieved from https://www.payingforseniorcare.com/paid-caregiver/california.html

In-Home Supportive Services (IHSS) Programs		
	% of Total Recipients	Average Hours Per Recipient Per Month
Personal Care Services Program (PCSP)	51%	69
Community First Choice Option Program (CFO)	44%	157
IHSS Plus Option Program (IPO)	2.5%	44.8
IHSS Residual Program (IHSS-R)	2.1%	98.9

Caregivers, known as Individual Providers (IPs) working for consumers in the IHSS programs, are paid directly by the state but must adhere to set restrictions of total authorized hours for specifically identified tasks over a week or month.[29] [30] On average, IPs in the IHSS program make $12.62[31] per hour with wages spanning $12.00 to $16.00 per hour depending on the county they operate within (See Appendix 4 for full list of rates).[32] [33] Almost all IPs (99.8%) are classified as "Live-In" caregivers. The IHSS program does not reimburse for 24-hour care, unauthorized tasks, or for additional hours a task may take, concluding that 92%[34] of relatives, parents, or spouses that are IPs receive supplemental income to care for their family member rather than operating as a caregiver exclusively.[35]

Multipurpose Senior Services Program

The Multipurpose Senior Services Program (MSSP) is administered by the California Department of Aging and acts as a case management system for helping Medi-Cal residents identify, coordinate and manage their Long-Term Care services, including but not limited to home care. Most Californian MSSP participants are consumers in the IHSS program, as well. *See Appendix 3 for a detailed explanation of Medicaid programs in California.*

[29] 283 hours a month
[30] Domestic chores, 6 hours per month; laundry services, 1 hour per week; Food shopping, 1 hour per week; Shopping and errand, .5 hours per week.
[31] Averaged across 59 counties
[32] California Department of Social Services: IHSS Wages By County https://www.cdss.ca.gov/agedblinddisabled/res/CoIPWages/IPWages.pdf
[33] IHSS September Data Dashboard
[34] Relatives, parents, or spouses
[35] IHSS September Data Dashboard

Private Pay Market

While there is a significant amount of data available on the size of the public pay market, it is more difficult to estimate the size of the private pay market. Using data available from the August 2017 IBIS World report on the national home care provider industry and estimates of the size of the home care client population, ICA Group approximated the number of potential private pay home care clients in California. First, we estimated that as of 2018, the combined frail elderly, independent disabled, and self-care disabled population of California to be an 2,256,000 people. This number was subsequently multiplied by 20.4%--IBIS World's estimate of the private pay market's contribution to the national home care industry--including out-of-pocket and private insurance. Using this method, ICA Group estimates the size of the California private-pay home care client pool to be 460,422 people. Survey estimates conclude that the average hourly cost for homemaker and home health aide services can cost $28 an hour in the state of California.[36]

Labor Overview

Current Labor Trends

On average, there is 1 caregiver for every 7 people needing home care in the United States. In California, that ratio is lower with 1 caregiver for every 4 people needing care, presenting overall more favorable conditions for those needing care and those naturally positioned to provide care. Considering other factors including very low Medicaid home care reimbursement rates, it is likely that the state's strong independent provider (IHHS) programs which provide financial supports for family members, friends and neighbors to provide care is the primary driver behind California's better ratio caregiver to client ratio. It is important to consider, however, how this ratio will be impacted as more residents age and the subset of people needing care increases. California's home care market suffers from most of the same poor labor conditions present in the national market, which is reflected in the Pacific region's high turnover rate of 69%. This rate is only slightly lower than the national rate of 82% and does not negate the need for a nationwide investment in recruitment and retention strategies for caregivers.[37]

Nationally, caregiving wages are on par with retail and foodservice jobs, highlighting the ability of caregivers to move laterally amongst low paying jobs. While arguably not as fulfilling,

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[36] Genworth Cost of Care Survey 2019
[37] 2018 Home Care Pulse Benchmarking Survey

comparable jobs in these industries typically offer more and consistent hours, safer and less physically demanding and isolating work environments, and often better opportunities for job advancement. On average, California caregivers receive $.60 **less** per hour than the state's retail and foodservice employees, a worse condition than the national average. While caregiver wages are currently higher than the state's $11.00 minimum wage, this difference is marginal. It will be important to monitor impacts to the pool of caregivers with the state's gradual plan to increase minimum wage to $15.00 an hour by 2023.[38,39]

Caregiver and Retail/Food Wage Comparison[40]			
	Direct Care	*Retail/Food*	*Difference*
National Average	$12.21	$12.27	-$0.05
California	$13.28	$13.88	-$.60

Low pay rates in the private sector, and even lower pay rates in the public market for both agencies and independent providers creates a precarious environment for the caregiving profession in California. When a large pool of trained and experienced caregivers is undervalued and isolated in their work, the factors that keep them engaged in their employment deteriorate over time and are eventually unable to compete with a labor market that favors other low-skill labor. Centering caregivers and their need to thrive can transform the industry by creating satisfied and engaged caregivers that provide better care overall.

Future Labor Trends

The caregiving workforce is expected to experience rapid growth over the next ten years. Occupational growth data for the caregiving workforce includes the positions of personal care aide, home health aide, and 7.14% of certified nursing assistants that work in home care services or with individual family services.[41] Overall, California will need an additional 260,000 additional caregivers by 2026 to meet the estimated 40% industry growth rate by 2026 for the state. A key consideration when assessing future labor trends is that presented figures do not typically factor in the industry turnover rate of 69% regionally and 82% nationally. In actuality, the total number of caregivers needed is higher when factoring in caregivers who are terminated or voluntarily exit the industry. These positions still need to be replaced in

[38] For businesses with fewer than 25 employees
[39] California Department of Industrial Relations
[40] Bureau of Labor and Statistics
[41] Bureau of Labor Statistics https://www.bls.gov/oes/current/oes311014.htm#nat

conjunction with the estimated 5.5% annual growth rate, resulting in an even higher demand for caregivers.

California's Home Care Workforce Growth[42]		
	Annual Job Growth Rate	*Annual Growth*
Personal Care Aide	3.99%	1,090
Home Health Aide	4.1%	24,800
Nursing Assistant[43]	1.5%	112
Annual Caregiver Needs	4%	26,002

Regulatory Environment

Agency Licensing

Home Care Organizations (HCOs), non-medical home care agencies, provide custodial care (ADL's and IADL's). HCO's are required to be licensed with the Home Care Services Bureau to be listed on the county-based registry of providers. If HCOs function only as brokers connecting clients with independent home care workers, and do not directly employ caregivers, they are not required to be licensed.

Home Health Agencies (HHAs) are required to be licensed by the California Department of Public Health (CDPH) since they provide medical care via licensed nurses, therapists, and social service professionals.

Caregiver Licensing

All caregivers working in California to provide assistance with ADL's and IADL's are not required to be licensed to do so. Home Health Aides are required to be certified with CDPH but operate unlicensed because they coordinate the non-medical components of a patient's medically designated care plan. Personal care aides additionally can operate unlicensed, and because they are not formally integrated into a patient's medically defined care plan, they do not require such high certification standards. All caregivers wishing to be paired with clients through the state caregiver registry, either through an HCO or directly hired by a consumer, must first apply and be approved by the state.

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[42] Projections Central: Long Term Occupational Projections 2016-2026

[43] It Is estimated that 7.14% of all Certified Nursing Assistants In the workforce provide in-home care. These numbers reflect that percentage.

Training Requirements

Training requirements for home care workers in California can be outlined under two designations—Skilled Care and Custodial Care. Skilled care includes medical services provided in the home or an institution by licensed Home Health Agencies. Custodial Care is care that focuses on supporting instrumental daily activities (IADLs) and activities of daily living (ADLs); custodial care can be provided in the home through Home Health Agencies (HHAs), Home Care Organizations (nationally referred most commonly as non-medical Home Care or Personal Care Agencies) and the direct employment of a caregiver.

As noted earlier, Home Health Aides employed by Home Health Agencies supplement the medically designated care plans of patients and are therefore required to complete a more robust curriculum of training to serve more high needs clients. They must complete 120 hours of training around topics of personal care services such as nutrition, cleaning, care tasks in the home and interpreting the medial and social needs of people being served. They also are required to certification every two years and acquire continuing education units (CEUs).

If caregivers are employed by, or work through, an HCO to be placed in client's homes, then they are required to complete an initial five hours of training consisting of a two-hour orientation and 3 hours of safety training in conjunction with a minimum of 5 hours of continued training every year.

Independent caregivers who work directly with a consumer to coordinate care are not required to complete training or licensing requirements as they operate privately. However, if a caregiver is employed by a consumer participating in the state's IHSS program, then they must complete an orientation around program regulations, fraud, wage and hours regulations, and how to complete timesheets.

Types of Home Care and Home Health Workers in California[44]				
	Type of Care	Primary type of Employer	Education/ Training	Certification/ Registration
Home Health Aide	Personal care specified by a treatment plan	Home Health Agency	120 hours	Certified by California Department of Public Health (CDPH)
Registered home care aide: "affiliated"	Personal care	Home care organization	5 hours	Registered by Home Care Services Bureau (HCSB)
Registered home care aide: "independent	Personal care	Consumer	5 hours	Registered by Home Care Services Bureau (HCSB)
Unregistered home care aide	Personal care	Consumer	None	None
In-home support services provider	Personal care, paramedical services	Consumer	Orientation	Optional to be registered by HCSB

Cooperative Opportunity

Mobilizing a marginalized workforce in a high demand industry through the cooperative-ownership model can improve outcomes for both caregivers and clients. By centering workers, cooperatives can:

- Elevate the quality of care clients, and families receive by providing better trained, engaged and committed caregivers;
- Increase caregiver engagement and commitment by stabilizing wages and benefits;
- Foster community development and a culture of participation through democratic decision making.

Opportunities

- The state's growing elderly population will continue to drive demand for high quality, consistent home care.
- California's caregiver to client ratio of 1 to 4 demonstrates a higher concentration of available caregivers than most states.
- Family/Friend/Neighbor caregivers who function as IPs represent a strong potential pool of cooperative agency caregivers, either as previous family/friend/neighbor caregivers looking to formalize a profession in caregiving, or as a method for IPs to

[44] Spetz, J. (2019). Healthforce Center at UCSF

either access more caregiving hours or greater caregiving supports. Many family caregivers will likely stop providing care once their loved one non longer needs in-home care, but some caregivers may want to continue in the profession, and some individual providers already work professionally and may want more hours.

- California has limited training requirements and no licensing mandates for non-medical services or caregivers, resulting in low barriers to entering the home care market.
- Turnover costs an estimated $2,600 per employee. Leveraging the benefits of the cooperative model to retain caregivers offers a significant opportunity for market differentiation and competitive advantage. Inconsistency of care is a significant challenge faced by home care clients nationally, and with annual turnover rate of 69% in the Pacific Coast, a better caregiver to client ratio does not necessarily mean industry stability.
- As worker-centered businesses, home care cooperatives are positioned to provide better caregiving jobs, increased representation, and occupational growth in an industry that suffers from chronic turnover and job dissatisfaction.
- Current and former independent providers (IPs) who are trained and experienced in caregiving but could additionally benefit from the supplemental income of secondary employment, would be the most immediate and viable "opportunity workforce" for a cooperative. Because working in the private sector is not restricted by the IHSS program, expanding into private caregiving would provide IPs the ability to supplement their income without compromising the care they provide to their loved ones. In fact, a cooperative of IPs would be the most qualified employer to understand the unique scheduling needs of this workforce.

Challenges

- A result of the low barriers to entering the market, means California's home care market is highly fragmented with many small services providers, creating a highly competitive market for attracting both clients and caregivers.
- Given the high level of competition, strong marketing, and the ability to sell the "cooperative difference/value" in home care is essential. Marketing and sales capacity and funds need to be earmarked upfront.
- Medi-Cal provides residents the ability to choose and hire their caregivers directly, keeping the majority of the public pay market flooded with independently operating

caregivers. This is the most critical challenge for home care cooperatives wishing to serve the public pay market traditionally by assisting in coordinating care.

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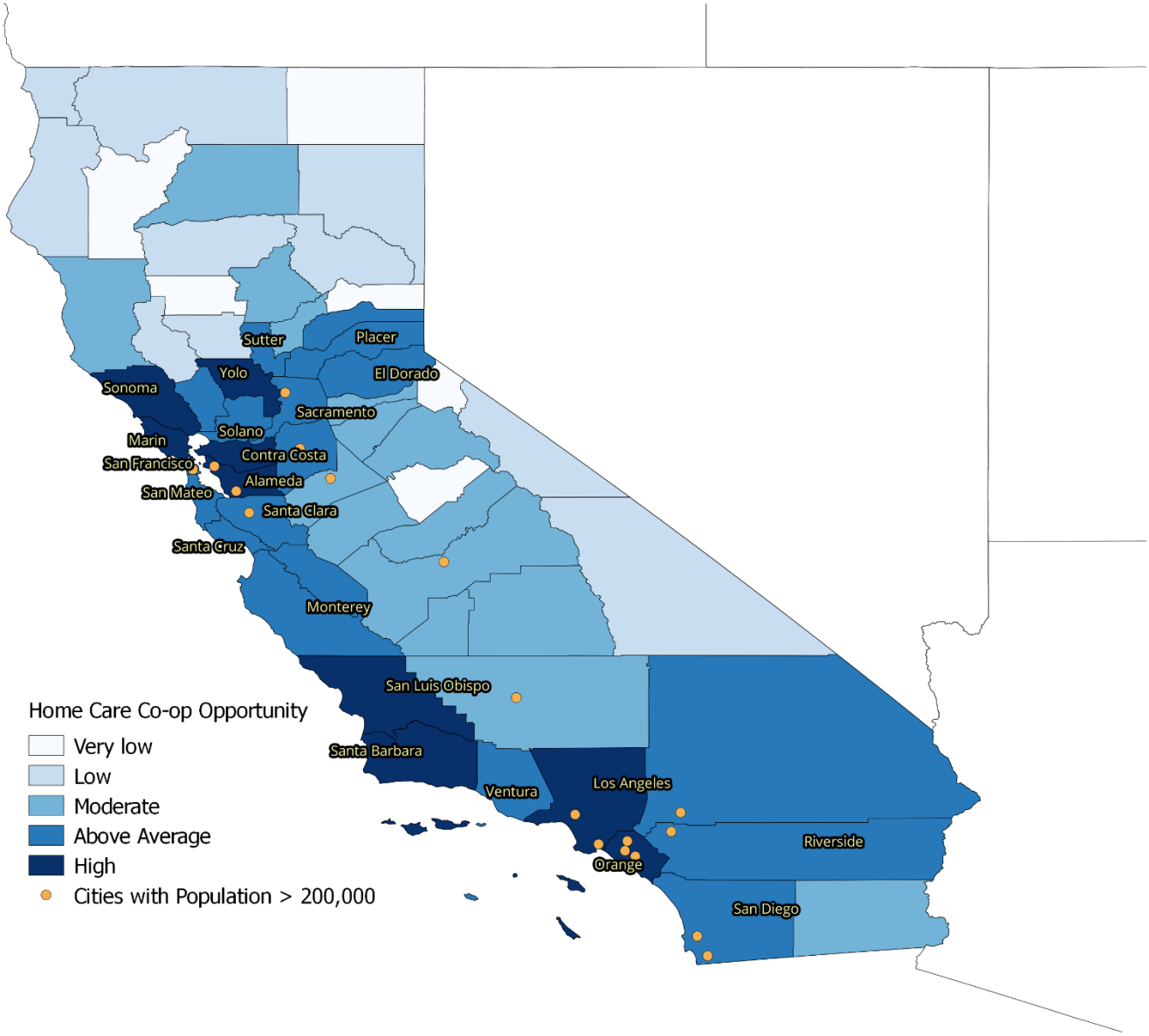
- Given the prominent division between independent caregivers and those working for home care agencies in the private market, home care start-ups will need to able to provide higher salaries and/or meaningful opportunities for ownership and engagement to attract and retain caregiver-members.



Market opportunity is defined by counties that are in the highest percentiles for client to caregiver ratio, number of home care clients, and median income. Counties in California with the most favorable home care markets are labeled on the map

Strategy and Steps

As noted throughout this market assessment, despite high demand, a favorable labor market, and low regulatory barriers, home care cooperative start-up in the public pay market in California would be difficult if not impossible without outside subsidy. However, for groups interested in launching in the public pay market acquisition and conversion of an existing public pay agency would be a viable path to consider. For groups interested and open to launching a cooperative home care agency in the private pay market, entry will be easier but will require identification of localized markets with clients who both need home care services and have the ability to pay for those services out of pocket, as well as a strong marketing and sales plan to get started. Both conversions and start-ups will need to define and maintain competitive differentiators to be successful and survive in the market long term.

As a next step for start-up initiatives, a strong business plan should be developed identifying:

- Viable town/city/county level markets. Using the opportunity map on the previous page will be a useful starting point.
- Appropriate organizational and legal structures
- Operational needs including staffing and systems
- A caregiver recruitment plan
- Financial needs including start-up and operational costs including working capital and marketing &
- Potential risks and mitigation plans/strategies

For groups interested in acquisition and conversion, partnership with a national organization specializing in conversions to worker ownership is recommended.

Conclusion

The cooperative model in home care is a proven model to combat recruitment and retention challenges and ensure high-quality, consistent care to home care clients. While unquestionably a challenging task, launching (or converting) a successful home care cooperative is possible with the right planning and supports. The home care cooperative industry is supported by a dedicated network of organizations from across the country, committed to strengthening and growing worker-ownership in home care and transforming the home care industry for both caregivers and clients. This network of support is a unique advantage that gives home care cooperatives a competitive edge. While there is more work to be done, home care cooperatives are an immediate, incremental and improved solution to the systemic underinvestment at the

state and federal level in home care work. While representing only .1% of the home care market today, at scale, home care cooperatives have the ability to meaningfully impact policies that will transform the livelihoods of caregivers and improve the quality and consistency for home care.

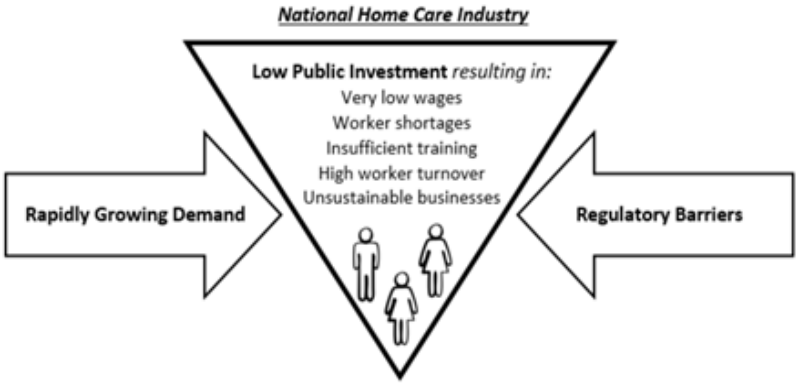
Appendix

Appendix 1: National Home Care Industry Overview

Unprecedented growth in the nation's elderly population, paired with a cultural shift towards aging in place, is driving historical growth in the home care sector. According to US Census projections, a quarter of the national population will be 65 and older and by 2060, 19.7% of this group will be 85 or older. Nine in ten seniors want to "age in place" in their current home and community, and an estimated 70% will need help with basic daily living activities to do so. Nationally speaking, there are seven[45] clients who need home care for everyone caregiver in the workforce. Many states experience significantly higher shortages.

Accordingly, millions of new home care workers will need to be hired and trained over the next few decades to meet this growing demand. Today, more than three million workers are employed by the home care industry in the U.S., a workforce that has already more than doubled in the last decade. Home Health Aide is the 3rd fastest growing job in the nation, and Personal Care Aide is ranked 4th[46]. Despite unprecedented job growth, the work is low paid, benefits are limited, hours are inconsistent, training is insufficient, career advancement is nearly non-existent, and the job is emotionally and physically taxing. Home care providers have rated caregiver shortages as the number one threat to their businesses for the last three years[47].

Eighteen percent of home care workers are uninsured, and of those insured, 40% rely on public health care coverage, primarily through Medicaid. Consequently, turnover rates within the home care sector have climbed from 60% in 2017 to 82%[48] in 2019,



[45] In 2017, OES data expanded the scope for "Services for the Elderly and Persons with Disabilities" to include some positions that were previously classified under "Services in Private Households", subsequently increasing the total number of personal care aides employed nationally and decreasing the national caregiver ratio from the previous 8:1.
[46] BLS Fastest Growing Occupations https://www.bls.gov/emp/tables/fastest-growing-occupations.htm
[47] Pulse 2018 Benchmark, page 62
[48] 2019 Spring Home Care Benchmarking Study

contributing to the overall caregiver shortage. Industry wide costs of caregiver turnover was over $10 billion per year.

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.[49] 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. Even though Medicaid Home and Community Based Services (HCBS) enrolled 4.6 million people in 2017, and spent $82.7 billion for care[50], that spending is rarely reflected in the wages and employment stability of home care workers. Across the U.S., the hourly median wage for workers in the direct care workforce is $12.17 per hour, only $.10 cents more than the median wage for retail and food service workers. Even though 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. Continued neglect for the home care occupation will continue to result in the growth of recruitment needs and cost and a decrease in available quality care for the country's vulnerable aging population.

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

Appendix 2: Medicaid Overview

Representing over 70% of payments, Medicaid is the largest and most important payer of home care services nationally.[51] Dually funded by the federal government and individual states, Medicaid provides financial support for health care services for low-income individuals, including elderly and disabled individuals requiring long term care. Long term care specifically, accounts for over 60% of Medicaid spending. Under Medicaid, the federal government provides a base match of 50% for approved Medicaid provided services, with low income states eligible for higher reimbursement rates. To be eligible for Medicaid benefits, individuals must meet federally mandated means tests.

Beginning in 2014, the Affordable Care Act allowed states the option to expand Medicaid eligibility to all non-elderly adults with income below 138% of the federal poverty line. Under "Medicaid Expansion", the federal government absorbed a larger share of Medicaid costs for new enrollees, covering 100% of costs from 2014 to 2017 and gradually reducing that percentage to 90% from 2017 to 2020. To date, 36 states and the District of Columbia have expanded Medicaid, including California.[52]

Medicaid requires that states provide specific services at a minimum to participate in the program. Required programs include inpatient and outpatient hospital services, physician and laboratory services, nursing home care, and home care. Above the minimum required programs, states may elect to cover additional services and/or expand services to individuals outside of the standard eligibility limits set by the Center for Medicaid and Medicare Services (CMS), the federal governing body. Typically, these additional services are provided under approved "waivers".[53] The number and type of waivers in each state vary widely; however, common waivers include 1915 waivers, Aged and Disabled Waivers (ADW), and Intellectual Disability Waivers (ID). Home care relevant 1915 waivers include:

- 1915(c) Home and Community-Based Waivers (offered in 47 states and DC)
- 1915(i) State Plan Home and Community Based Waivers
- 1915(j) Self-Directed Personal Assistance Services Under State Plan Waivers
- 1915(k) Community First Choice Waivers 22 (See Appendix A for Waiver Details)

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[51] Medicaid, May 2019 Medicaid & CHIP Enrollment Data Highlights. Retrieved from www.medicaid.gov

[52] Medicaid Expansion in California, Fact Sheet, Updated January 2016, Kaiser Family Foundation. Accessed at: http://files.kff.org/attachment/fact-sheet-medicaid-expansion-in-California

[53] Congressional Budget Office, Overview of Medicaid. Retrieved from https://www.cbo.gov/publication/44588

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.[54] 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.[55] 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", in which providers were directly reimbursed for services provided, based on the 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 fixed and standardized payments per member per month 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.[56] As of July 2018, 11 states did not have Managed Care programs in place.[57] States that have begun transitions to managed care programs are in varying states of transition. 17 states operate almost exclusively under managed care programs (over 90% transitioned), [58,59] 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

[54] Medicaid, Home & Community Based Services Authorities. Retrieved from www.medicaid.gov.
[55] Medicaid, Home & Community-Based Services 1915(c). Retrieved from www.medicaid.gov.
[56] Kaiser Family Foundation, Five Key Questions and Answers about Section 1115 Medicaid Demonstration Waivers, 2011. Retrieved from https://www.kff.org.
[57] Kaiser Family Foundation, Total Medicaid MCOs. Retrieved from https://www.kff.org.
[58] The 17 states with over 90% transition to MCOs include Tennessee, Hawaii, Nebraska, Delaware, Kansas, New Jersey, Virginia, Texas, Arizona, Oregon, Iowa, Florida, Washington, Louisiana, Kentucky, Rhode Island, and New Mexico.
[59] Kaiser Family Foundation, Share of Medicaid Population Covered under Different Delivery Systems. Retrieved from https://www.kff.org.

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.

Appendix 3: California Medicaid Overview (Medi-Cal)

California's Medicaid program, known as Medi-Cal, was founded in 1966 just one year after Medicaid was passed, and serves 1 in 3 California residents while providing coverage for low-income children and adults, pregnant women, people with disabilities, seniors 65+, and children regardless of their immigration status. Medi-Cal is coordinated and negotiated among three main entities, the federal government, the state government and the county governments, while 8[60] individual departments ensure accountability and oversight. Medi-Cal provides a full scope of services that include primary care, specialty care, and acute care.

Medi-Cal Covers:

1. Hospitalizations
2. Ambulatory Care
3. Emergency Services
4. Prescription Drugs
5. Preventative and Wellness Services
6. Maternity and new-born care
7. Rehabilitative and Habilitative Services
8. Transportation
9. Dental/Vision
10. Home and Community-Based Services
11. Institutional care
12. Pediatric and Adult Dental Services
13. Comprehensive Behavioral Health coverage, including behavioral health treatment for children with autism spectrum disorders
14. Substances Use Disorder Treatment Services

As stated in Appendix 2, in order to receive federal funding, Medi-Cal is mandated to serve specific populations based on financial, categorical, and non-financial requirements. Additionally, California chose to extend their full scope of benefits to low-income adults under the age of 65, those in the Breast and Cervical Cancer Treatment Program, and those who receive care in a nursing facility or receive long-term support services. Medi-Cal's 8 Medical Eligibility Groups (MEGs) include: Parent/Caretaker Relative and Child (39%), ACA Expansion Adult (19-64) (30%), Seniors, Persons with Disabilities (15%), Children's Health Insurance Programs (10%), Undocumented Individuals (5%), Adoption/Foster Care (1%), Other (.08%), and Long Term Care (.03%). Eligibility for coverage under Medi-Cal must be redetermined annually.

[60] Centers for Medicare and Medicaid Services (CMS), California Health and Human Services Agency, California Department of Health Care Services, California Department of Managed Health Care, California Department of Social Services, California Department of Aging, California Department of Developmental Services.

Managed Care

Medi-Cal Managed Care Plans (MCPs) cover 82%, or almost 11 million, of Medi-Cal's beneficiaries. Residents enrolled in a MMCP are eligible for one of 6 plan types that are coordinated by one of three stakeholders; a commercial insurance provider, a non-profit insurance provider, and a specific county. The top three plans account for 96% of coverage under MMCPs.

- The Two-Plan Model incorporates coverage between a public and locally run entity along with a commercial plan;
- County Organized Health System (COHS) is entirely managed by a single county;
- Geographic Managed Care is a mixture of commercial and non-profit plans.

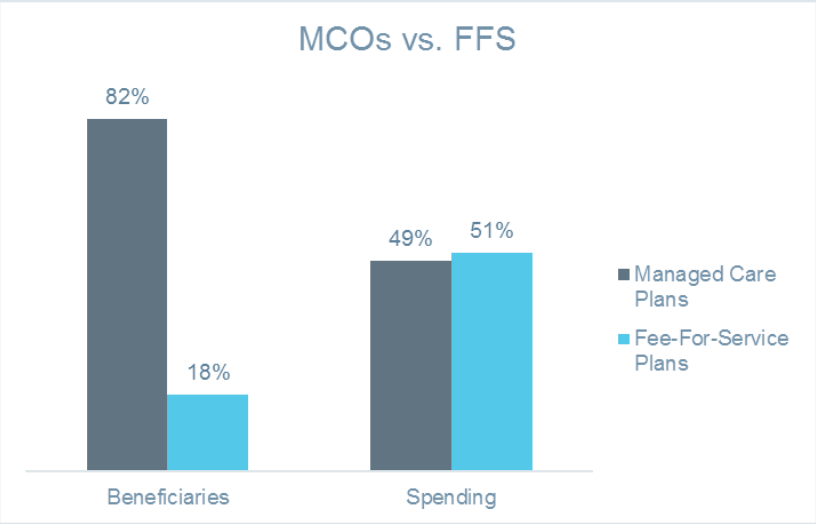
The remaining three plans types, Regional Expansion Model, Imperial Model and San Benito Model account for less than 4% of coverage for enrollees. While MCPs are mandated to provide the full scope of Medi-Cal services mentioned before, specific services, including LTSS, are allowed to be "carved out"[61] requiring beneficiaries to seek out those services through a fee-for-service plan.

Managed Care Plan	Percent of Beneficiaries
Two-Plan Model	65%
County Organized Health System (COHS)	20%
Geographic Managed Care	11%
Regional Expansion Model	8%
Imperial Model	<1.0%
San Benito Model	<1.0%

Fee-For-Service

The fee-for-service (FFS) plan directly reimburses medical and health professionals for the services provided to Medi-Cal enrollees, and it is the enrollees responsibility to identify and coordinate care with a provider directly. FFS accounts for far fewer enrollees (2.4 million) than manage care plans, but higher spending. FFS participants in California are much more likely to be people with disabilities, seniors, or both (dual-eligibles), and are much more likely to be higher cost participants.

[61] Specialty mental health services, substance use disorder services, dental services, long-term services and supports, long-term care, California children's services



California uses three types of Medi-Cal Waivers:

- Section 1915(b) Managed Care Freedom-of-Choice Waivers: beneficiaries who meet the medical necessity criteria for specialty mental health services to receive those services through their County mental Health Plan (MHP) in order to have a choice of providers.
- Section 1915(c) Home-and Community- Based Services (HCBS) Waivers: allows Medicaid programs to cover long-term care services to be delivered in community settings instead of solely in institutions such as nursing homes. Can provide traditional medical and non-medical services.
- Section 1115 Waivers: used by states to test policy innovations and implement sweeping Medicaid program reforms.

Appendix 4: IHSS Individual Providers Rated by County

County	Wages
SAN FRANCISCO	$16.50
MARIN	$14.80
SANTA CLARA	$14.00
SAN MATEO	$13.90
ALAMEDA	$13.85
MONTEREY	$13.50
SACRAMENTO	$13.00
SAN LUIS OBISPO	$13.00
SONOMA	$13.00
VENTURA	$12.96
LOS ANGELES	$12.80
SAN BENITO	$12.80
SHASTA	$12.60
ALPINE	$12.50
DEL NORTE	$12.50
MONO	$12.50
SAN DIEGO	$12.50
SOLANO	$12.50
TRINITY	$12.50
TUOLUMNE	$12.50
SANTA CRUZ	$12.46
IMPERIAL	$12.40
CONTRA COSTA	$12.25
ORANGE	$12.25
NAPA	$12.10
SANTA BARBARA	$12.10
AMADOR	$12.00
BUTTE	$12.00
CALAVERAS	$12.00

County	Wages
COLUSA	$12.00
EL DORADO	$12.00
FRESNO	$12.00
GLENN	$12.00
HUMBOLDT	$12.00
INYO	$12.00
KERN	$12.00
KINGS	$12.00
LAKE	$12.00
LASSEN	$12.00
MADERA	$12.00
MARIPOSA	$12.00
MENDOCINO	$12.00
MERCED	$12.00
MODOC	$12.00
NEVADA	$12.00
PLACER	$12.00
PLUMAS	$12.00
RIVERSIDE	$12.00
SAN BERNARDINO	$12.00
SAN JOAQUIN	$12.00
SIERRA	$12.00
SISKIYOU	$12.00
STANISLAUS	$12.00
SUTTER	$12.00
TEHAMA	$12.00
TULARE	$12.00
YOLO	$12.00
YUBA	$12.00

Appendix 5: Key Stakeholders

- **California Center for Cooperative Development (CCCD):** promotes cooperatives as a vibrant model to address the economic and social needs of California's communities. The Center's Community and Economic Development Programs specifically highlight cooperative projects that promote opportunities for people with low and moderate incomes.
- **SEIU 2015**: California's union for long term care workers. SEIU 2015 builds partnerships, embraces innovation and education, so that long term care workers can achieve quality jobs with livable wages, retirement security, respect, and the right to a union for all.[62]
- **Courage Homecare**: Courage Home care is a currently operating home care cooperative located in Los Angeles. They are a valuable partner and source of information for anyone looking to start a cooperative in California.
- **California Commission on Services to the Aging**: The commission is a 25-member bi-partisan board that advises the state's Governor, Legislature, and a diverse range of stakeholder on issues related to aging policies and programs.[63]
- **Area Agencies on Aging**: As mandated by the Older American's Act, California operates 57 county-based 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.[64]

[62] SEIU Local 2015 https://www.seiu2015.org/article/mission-statement/
[63] California Commission on Aging https://ccoa.ca.gov/
[64] California Department of Aging in Scramento, CA. https://www.agingcare.com/local/california-department-of-aging-sacramento-area-agency-on-aging-ca

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