OCT 2017

NEW MEXICO

HOME CARE MARKET ASSESSMENT

Cooperative Development Foundation

ICA GROUP
HOME CARE

Contents

KEY TAKEAWAYS

- **Consumer demand is growing:** New Mexico's elderly population is growing at 11.4% per year compared to the national rate of 9.7% and its population living with disabilities is double the national average. Because of this and other factors, the number of home care customers is expected to increase by almost 27,000 over the next 10 years.
- **But the market is difficult to efficiently serve:** New Mexico is a largely rural state, with significantly lower population density in urban, suburban and rural markets. It is also one of the poorest states in the nation. The current home care market in New Mexico is estimated at 150,450 customers, a relatively small base. The private pay market is an even smaller segment, estimated at approximately 25,300 customers.
- **Home care agency market is fractured, but dominated by a few large players:** The New Mexico market is highly fractured, with many small agencies; 69% of home care agencies in the state earn less than $250,000 in sales revenue. However, 41% of the market is served by just five agencies, and one in particular is many times larger than all of the others. This indicates that it is relatively easy to enter the home care market, but difficult to scale up. Only 10% of agencies are earning over $1,000,000 a year and only 1% are earning over $5,000,000 a year.
- **Public pay market is critical:** As a state with a very high Medicaid-eligible population (36.6%), public programming plays a very important role in the sector. New Mexico spends $23,000 per capita on Home and Community Based Services which is over $4,000 more per person than the national average. They also direct 74% of Medicaid Long Term spending to HCBS, significantly more than the national average of 53%. New Mexico is also primarily a managed care state.
- **Labor supply is low:** There is currently a moderately insufficient supply of caregivers to meet demand and the gap is expected to grow as demand increases. While New Mexico's ratio of caregivers to those needing care of 1 to 4.5 is better than the national ratio of 1 to 8, demand for caregivers will continue to increase in the state. The combination of high rates of turnover and increasing demand will create the need for 177,613 new caregivers to be recruited to the workforce by 2024.
- **Existing home care cooperative effort:** The state of New Mexico currently has one nascent home care cooperative, Heart is Home Cooperative in Bernalillo. The primary barriers to an organic growth strategy will be recruiting enough caregivers and reaching a sufficient number of customers in a state that is primarily rural.
- **Cooperative opportunity is challenging:** There is little existing cooperative development infrastructure in New Mexico. Organic growth will be challenging due to factors noted above; developers may want to consider augmenting start-up efforts with the option of converting an existing home care company with sufficient scale to serve public programs.

About this Report

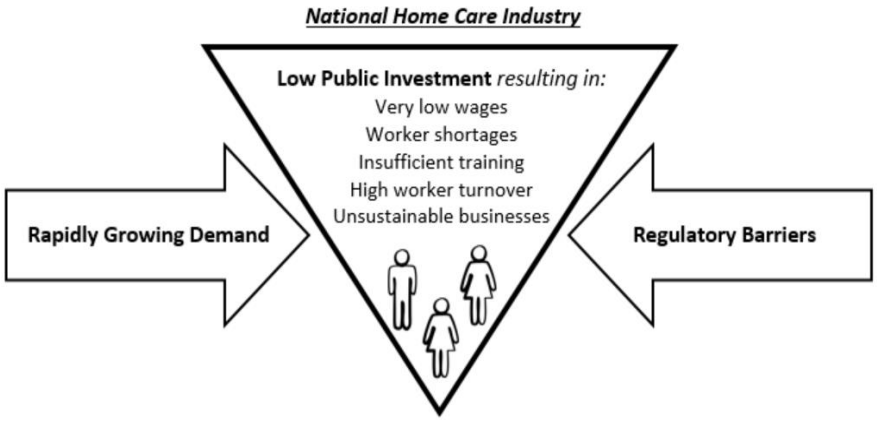
This report is part of the Cooperative Development Foundation's Socially Disadvantaged Group Grant. The ICA Group and Margaret Lund wrote this report to assist CDF in its efforts to bring home care worker cooperatives to scale across the country and to support the scale and sustainability efforts of the numerous home care cooperatives already operating. This state specific report is an in-depth market analysis for existing home care coops operating in New Mexico 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 healthcare professionals and offers a superior value for clients, this recognition has not



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

yet resulted in increased payments for services. With deep public underinvestment in home care, small and large home care cooperatives alike struggle to remain financially sustainable, let alone carve out the financial resources necessary to invest in the worker-focused benefits that differentiate a home care cooperative job from a standard home care job. Worker cooperatives have the potential to raise wages and job quality for caregivers and provide better outcomes for patients, but the business model must be first strengthened, scaled, and unified to sufficiently influence and transform the industry today.

INTRODUCTION

With a somewhat higher than average senior population (growing at a higher than average rate) and more than double the national average proportion of residents living with disabilities, home care is a vital service to the people of New Mexico. However, providing this service in the state is more challenging than in some other states. New Mexico is tied with West Virginia for the third highest proportion of individuals living in poverty, and ranks 45th in the nation in terms of median income, so relatively fewer New Mexicans have the means to pay for private care. New Mexico is also in the bottom five states in terms of population density, making providing home-base services in nearly all counties more difficult.

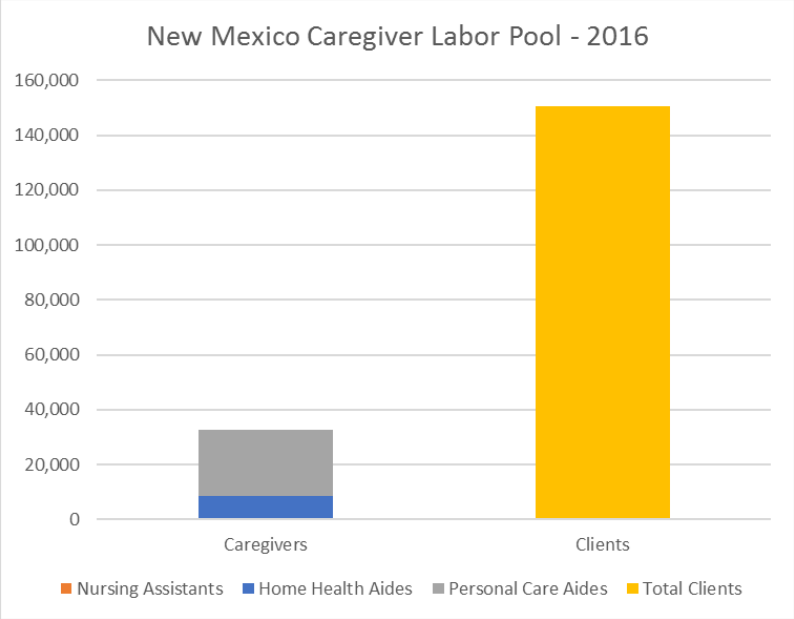
Over one-third (36.6%) of New Mexicans are currently receiving Medicaid benefits, a figure that is twice the national rate. As such, public programs necessarily play an outsized role in the New Mexico home care market. The state ranked in the middle (28th) of all states overall in the recent AARP Long-Term Services and Supports scorecard[2], a not-unencouraging sign given its challenges, and per capita spending by the state for Home and Community Based Services is 22% higher than the national average. Nonetheless, long-term trends in the aging population, caregiver shortages, and the costs of providing home care present significant challenges and few solid opportunities for current and prospective home care cooperatives in the state.

Even more so than in other states, in New Mexico, Medicaid offers the greatest opportunity for growth and scale. Yet, as in many states, there are significant barriers to home care agencies successfully operating businesses that rely on Medicaid reimbursements. Eligibility requirements and low reimbursement rates can be daunting for small agencies and cooperatives; pursuing the smaller, but more feasible private pay market can work in some areas, but with New Mexico's modestly-sized and broadly-scattered population, this strategy may not work in many communities. And even those residents with the financial wherewithal to pay privately for home care in the beginning, may eventually come to rely on publicly funded sources to meet their home care needs in the long term. The dominant role played in the market place by a single corporation (Ambercare) also means that small agencies will likely compete for labor with a well-funded competitor, and have scant opportunity to exert influence on local labor markets.

Labor availability is the key impediment to growth in New Mexico, as in the rest of the country. While not as extreme as in some states, there is nonetheless a growing gap between the number of available caregivers in New Mexico and the increasing population of state residents needing home care. New

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

Mexico's senior population grew at a rate of 11.4% from 2012 to 2015[3] compared with national rates of 9.7%, and there is currently one caregiver for every 4.6 residents in need of services, significantly better than the national average of 8 to 1. This situation may not last, however, as competing sectors of the economy with a high proportion of entry-level work (retail and food service) pay essentially the same wages as home care in New Mexico, for easier work with far less stress. Recruiting and retaining quality employees will be the single most important competitive advantage for those agencies that can do it well.



This report will analyze the home care market across several key dimensions including market size, labor supply, the regulatory environment, and other state specific findings. We will then use this analysis to offer conclusions on the state of the home care market, and how these factors are likely to affect potential strategies for nurturing and growing worker-owned home care cooperatives New Mexico.

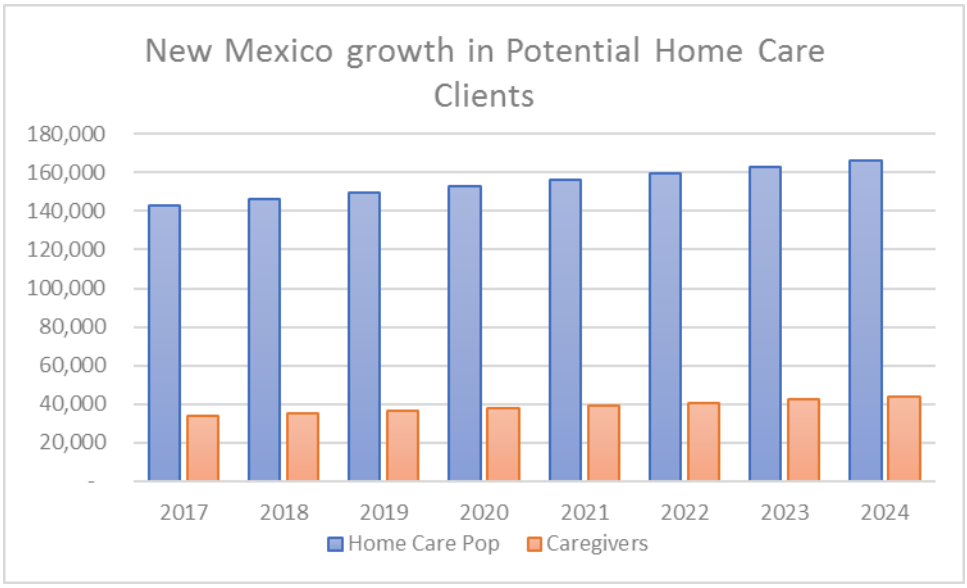
[3] U.S. Census Bureau (2016). *Monthly Population Estimates for the United States: April 1, 2010 to December 1, 2017 2016 Population Estimates*. Retrieved from www.census.gov.

MARKET OVERVIEW

To understand the market for home care services in New Mexico, we use three separate lenses of analysis: customers, competition (existing providers), and payers. This section provides a view into the number of potential home care customers in the New Mexico market, how home care clients pay for home care in the state, and who is competing for these customers. Finally, we explore key stakeholders in the state focused on the home care and cooperative industries.

Customers

In the long term, New Mexico will experience significant growth in the demographic groups that are most likely to use home care services. As of 2016, about 150,000 New Mexico residents were categorized as frail elderly, self-care disabled, or independent living disabled[4]. At 7.23%, this is a somewhat larger proportion of the population than the national average at just over 6%. The rate of growth in New Mexico's 65+ population (11.4%) is also outpacing the national growth rate for the senior portion of the population of 9.7%. Additionally, the New Mexico population of individuals living with disabilities at 14.8% is more than double the national average of 6.8%. Over the next 5-10 years' demand for home care services will clearly continue to grow rapidly in the state.



s.

The primary public payer for non-medical home care is Medicaid. In New Mexico, 36.57% of the state's residents receive Medicaid benefits – double the national average of 18%. 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 New Mexico are expensive at a yearly average cost of 130% of median income for residents aged 65 and over. High home care costs reduce the potential number of customers in the market place, but the high number of Medicaid beneficiaries in the state helps to boost some residents' ability to pay.

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

In sum, the home care client demographics in New Mexico are favorable towards the development of home care businesses. Long-term trends point towards a growing customer base, but high costs coupled with low median income in the state may reduce the potential size of the private pay market.

Providers

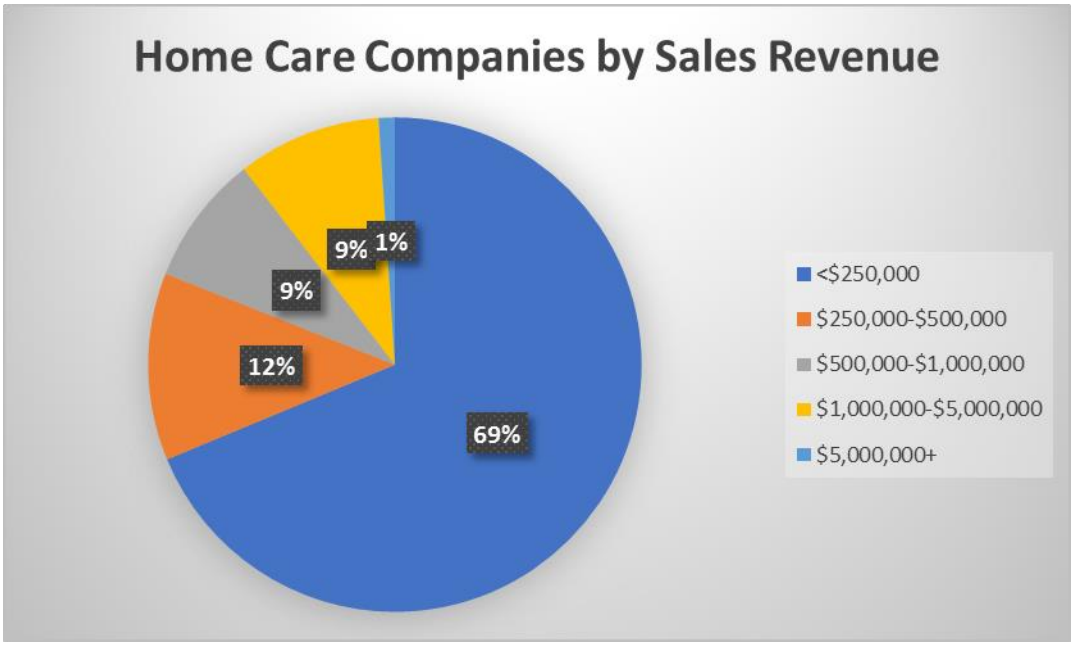
ICA estimates that there are currently 535 independent personal care and home health companies operating in New Mexico. This count includes headquarters and single location companies, but does not include branch locations. Of this group 311 are categorized as home health companies and 224 are categorized as providers of individual and family services[5]. There is one home care cooperative currently in development in New Mexico that will serve Sandoval and Lea counties.

Similar to the national market for the industry, the home care market in New Mexico has a few large companies and many small local operators – 70% of companies have revenues of less than $250,000 and the median figure is half that, meaning there are many very small operators in New Mexico. On the other end of the spectrum, however are some very large players, beginning with Ambercare Corporation which at revenues of over $90 million annually, is bigger than many of the larger home care companies serving more populous states, and almost four times as large in terms of revenue as the next biggest player in New Mexico. It also, interestingly, advertises itself as employee-owned. Together, the five largest companies in the state account for over 40% of industry revenue[6], a much higher degree of concentration than the national market where the top three companies account for only 8.7%.

This data suggests that while smaller operators can exist in the New Mexico home care market, they will compete directly for workers and for business with larger and much more sophisticated entities. While it appears relatively easy to enter the home care market in New Mexico, scaling up operations to become a $1,000,000 a year company is much more difficult, with only 10% of companies in the state reaching that important benchmark.

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

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



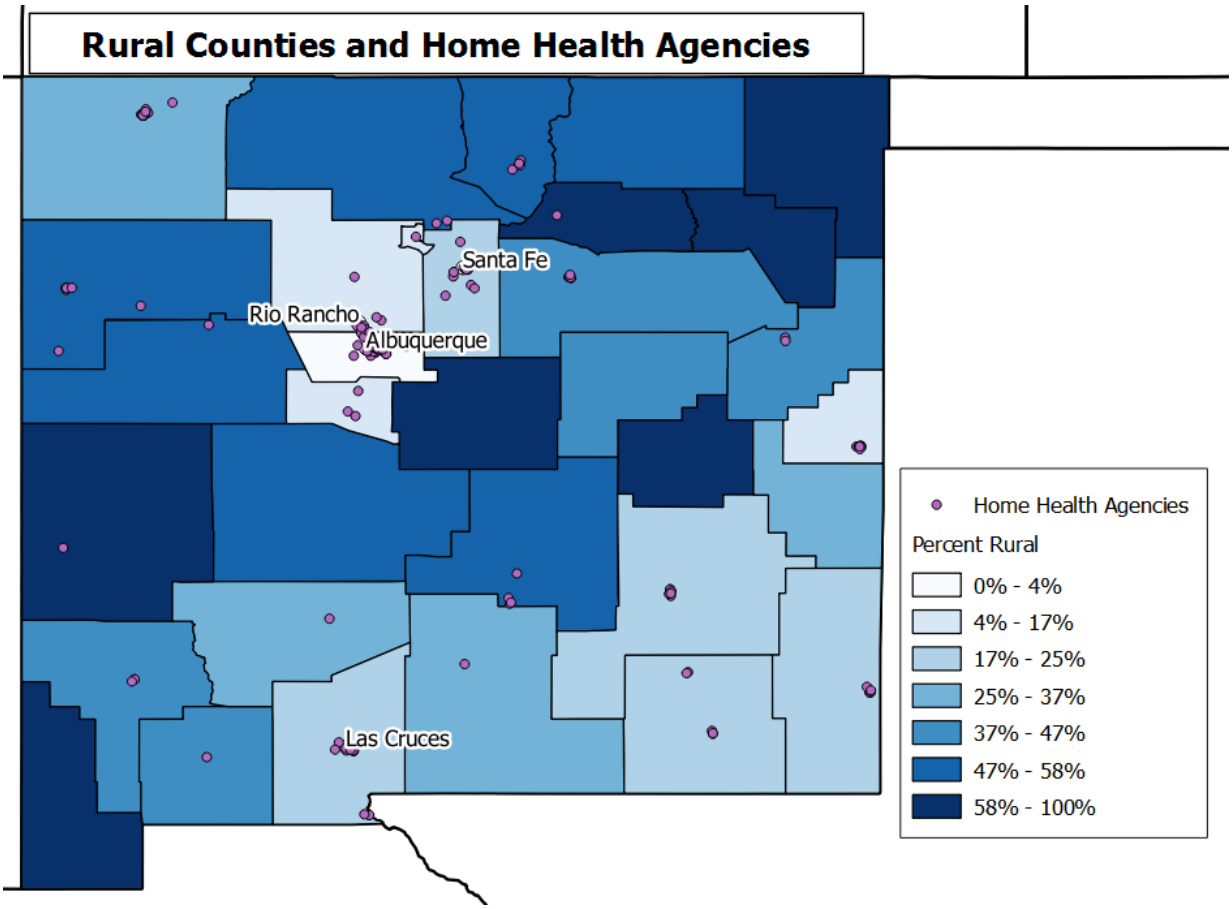
Rural vs. Urban Conditions

New Mexico is one of the least densely populated states in the country, a fact that impacts the prospects for home care companies significantly. Not only in rural areas, but also in urban and suburban markets in New Mexico, population density is significantly lower than national medians. For example, rural areas nationwide have a population density of 19 people per square mile – in New Mexico, there are not even four people per square mile. Urban areas nationwide house over 1,000 people per square mile on average, but in New Mexico this figure is only 122 people, indicating that even in urban markets, significant challenges are present to serving clients in an efficient manner.

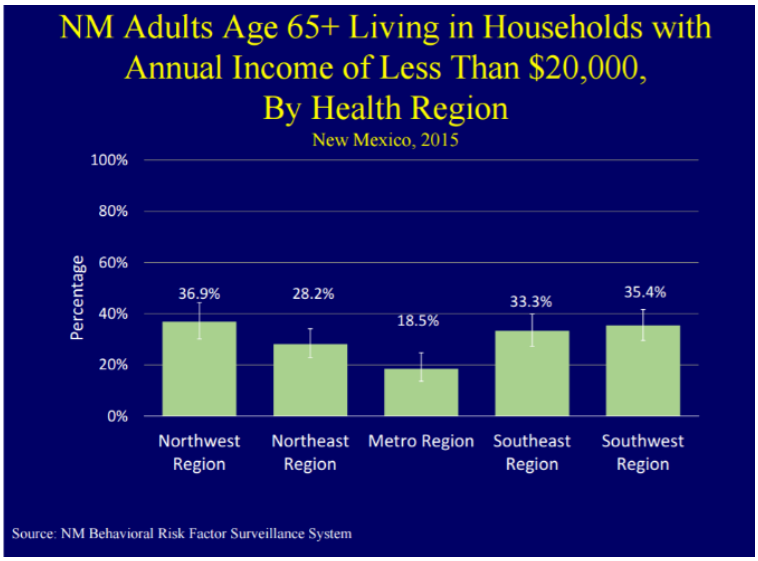
Nationally, rural homecare companies have 15% higher sales revenue than urban companies, suggesting that there are higher variable costs to operating in rural locations, possibly due to travel expenses, leading to lower margins that must be overcome by generating higher sales revenue. In New Mexico, average revenues for urban and rural companies are virtually the same, indicating that differences between urban communities and some rural markets are not that significant – all are challenging to serve[7].

As the chart below indicates however, some rural areas of the state are much better served than others.

[7] 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.



Rural areas in New Mexico also have a higher proportion of low income seniors, making public programs an even more vital part of these markets



Payer Composition

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 long-term care insurance. The public pay market is much larger than the private pay market in both New Mexico 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

The primary public payer for home care nationally and in New Mexico is Medicaid. In New Mexico, 36.57% of the state's residents receive Medicaid benefits– well above the national average of 18%. The percentage of "aged" Medicaid enrollees is 8%, while the percentage of "disabled" enrollees is 12%[8]. New Mexico spends nearly $5.4 billion on Medicaid annually[9]. New Mexico expanded Medicaid under the Affordable Care Act in January 2015, adding over 243,000 new Medicaid beneficiaries as of Q1, 2016[10]. While this was a boon for hospitals and insurers such as UnitedHealthcare, the costs of expansion were hefty — total expenditures in 2015 were expected to balloon by $1 billion. While the federal government is footing the bill for Medicaid costs for another year, New Mexico will be on the hook for some of those costs starting in 2017, an estimated $120 million[11]

In 2015, New Mexico allocated 22% of Medicaid funding to Long Term Services and Supports (LTSS) programs, less than the national average of 32%. The state allocated 79% of LTSS to Home and Community Based Services (HCBS) programs however, significantly higher than the national average of 53%, spending nearly $700 million on home-based supportive services.

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. First, our estimate of the combined frail elderly, independent disabled, and self-care disabled population in New Mexico is 150,450. 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 New Mexico private pay home care potential client pool to be 25,300. Given that home care costs in New Mexico are high relative to the state's median income this may be an over estimate of the potential market as some may not be able to afford out of pocket home care costs.

Key stakeholders

New Mexico Direct Caregivers Coalition (NMDCC)

The New Mexico Direct Caregivers Coalition (NMDCC) was formed in 2009 to enhance and promote family and professional direct care workers, supporting their professional development and advancing issues of importance to the field of long-term and direct care. The Coalition is led by a Board of Directors

[8] Medicaid Enrollees by Enrollment Group, The Henry J. Kaiser Family Foundation. Retrieved from www.kff.org.
[9] Total Medicaid Spending, The Henry J. Kaiser Family Foundation. Retrieved from www.kff.org.
[10] The Henry J. Kaiser Family Foundation. Medicaid in New Mexico. June 2017. Retrieved from www.kff.org
[11] Christ, Sal. Albuquerque Business First. Year in review: New Mexico's biggest health care issues of 2015. December 8, 2015. Retrieved from http://www.bizjournals.com/albuquerque/news/2015/12/08/year-in-review-new-mexicos-biggest-health-care.html

who are themselves direct caregivers, with input and guidance from people who are elderly and/or disabled.

The New Mexico Association for Home & Hospice Care
A membership-based organization of 150 varied agencies, the NMAHHC provides advocacy, networking, education and communication about best practices for home care, hospice, and related home health services.

REGULATORY & PUBLIC POLICY OVERVIEW

Whether private pay or public pay, agencies wishing to operate in New Mexico 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 New Mexico specifically, discusses the states 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 private pay and public pay agencies that wish to operate in the state. Finally, this section discusses any regulatory or political barriers to operating a home care agency 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[12].

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". [13] The number and type of waivers in each state varies widely, however common waivers include 1915 waivers,

[12] A 50-State Look at Medicaid Expansion, Families USA. Retrieved from www.familiesusa.org.
[13] Congressional Budget Office, Overview of Medicaid. Retrieved from www.cbo.gov.

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

See Appendix for detailed waiver descriptions[14]

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.[15] 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.[16] 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[17]. As of March 2017, only 12 states did not have Managed Care programs in place[18]. 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)[19], 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

[14] Medicaid, Authorities. Retrieved from www.medicaid.gov.
[15] Medicaid, Authorities. Retrieved from www.medicaid.gov.
[16] Medicaid, Home and Community Based Services, 1915c Waiver. Retrieved from www.medicaid.gov.
[17] 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.
[18] Kaiser Family Foundation, Total MCO's, March 2017. Retrieved from www.kff.org.
[19] Kaiser Family Foundation, Share of Medicaid Population Covered Under Different Delivery Models, July 2016. Retrieved from www.kff.org.

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[20]. 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 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.[21]

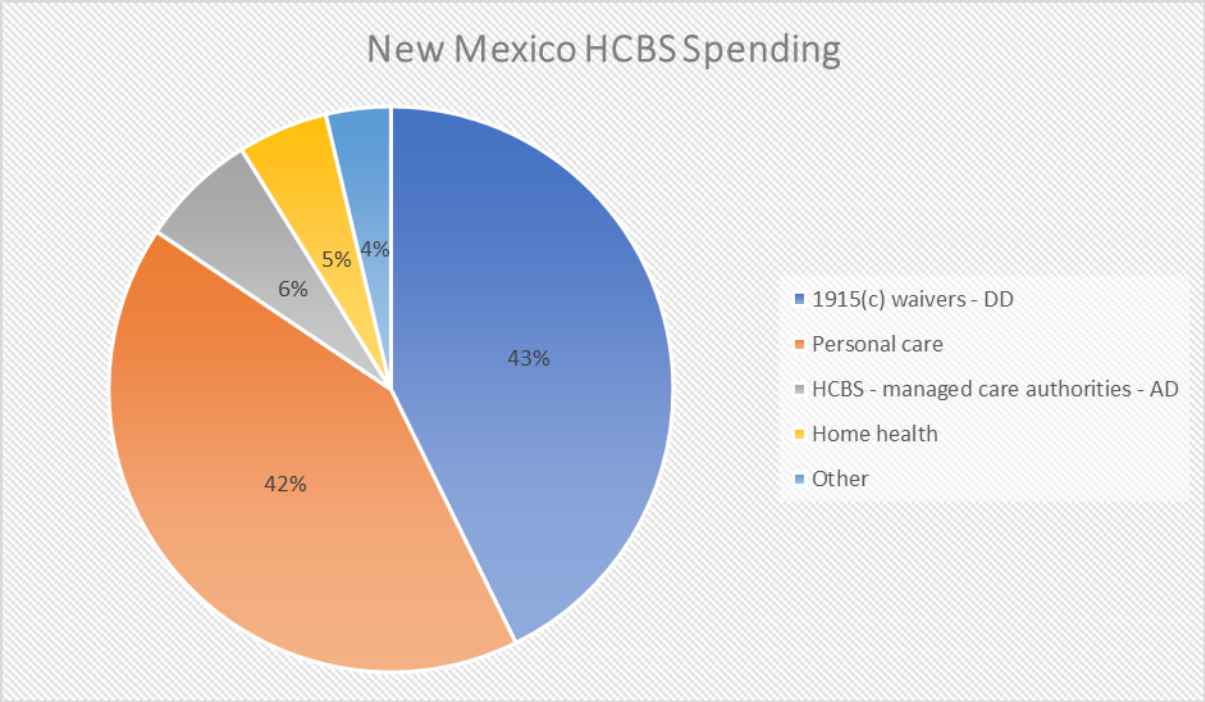
New Mexico Medicaid

New Mexico's Medicaid program is Centennial Care. Centennial Care began on January 1, 2014 with services provided by four managed care organizations (MCO's). These services include physical health, behavioral health, long-term care and community benefits. New Mexico's four MCO's are: Molina Health Care of New Mexico, Blue Cross Blue Shield of New Mexico, Presbyterian Healthcare Services, and United Healthcare. 88% of New Mexico Medicaid beneficiaries are in managed care plans [22].

As part of Centennial Care, long-term care services for the elderly that are provided outside of nursing homes are provided through a program entitled Community Benefit. Community Benefit's suite of services have been specifically chosen to help the elderly remain living in their homes or "in the community". Services include adult day health, respite care, and personal care services, including assistance with daily tasks such as hygiene, meals, and mobility. The program supports both Agency-Based Community Benefit (ABCB) care, as well as Self-Directed Community Benefit (SDCB) care. The difference between these two options is with Agency-Based the administering organization chooses the care providers. With Self-Directed, the program participant has the flexibility to choose their care providers. For personal care or other unskilled services, participants can elect to hire a family member or friend to provide care. Having said that, the managed care organization (MCO) will make the final decision on whether the person is qualified and capable of providing the needed care.

[20] Center for Health Care Strategy, Inc. Medicaid ACO's: Status Update, June 2017. Retrieved from www.chcs.org.
[21] Center for Health Care Strategy, Inc. Medicaid Accountable Care Organization Programs: State Profiles. Brief: October 2015. Retrieved from www.chcs.org.
[22] The Henry J. Kaiser Family Foundation. Medicaid in New Mexico. June 2017. Retrieved from www.kff.org

Home and Community Based Services



Home and Community Based Service (HCBS) programs are Long Term Services and Supports (LTSS) programs that allow Medicaid recipients who are age 65+ and those living with physical disabilities to receive support with activities of daily living (ADL's) and instrumental activities of daily living (IADL's) at home or in their community, rather than in institutional settings. New Mexico's total spending on Home and Community Based Services in 2014 was $699,523,404 about 74% of the State's total Long Term Support and Service (LTSS) budget and 16.4% of the state's total Medicaid budget.

As of 2014, 1915(c) waiver Intellectual/developmental disabilities accounted for 42.7% of New Mexico HCBS spending, Personal care was 41.72% of spending, HCBS managed care authority spending was 6.7% of spending, home health was 5.2% of spending, and 3.7% of spending went to other programs. New Mexico currently has six 1915 (c) waiver programs in operation with a total budget of just under $340 million in 2014, totaling 45% of HCBS Spending.

Licensing

The New Mexico Health Facility Licensing & Certification Bureau is responsible for the monitoring of licensed and certified home health care services throughout the state. The State of New Mexico does not require a license for providing non-medical, in-home services which are defined by the state as "homemaker" services. These include cleaning, meal preparation, laundry and shopping. A background check is required of all individuals providing home care service however, which is provided by the New Mexico Division of Health Improvement.[23]

[23] Senior Resources and News. Retrieved from http://www.seniorresourcesandnews.com/New_Mexico/New_Mexico_In_Home_Care_Agencies.html

Training

There are no formal education requirements for personal care aides, but most aides have a high school diploma. Aides working in/for an agency must pass a competency test given by their employer and approved by the state. Home health aides working in/for certified (licensed) home health or hospice agencies must complete formal training and pass a standardized test. A trainee must complete a total of 75 hours of training; at least 16 of them must be practical training with supervision. Home Health Aides must also possess:

- Good communication skills
- Record keeping and reading ability
- Knowledge to ensure continued health of the patient
- Emergency technique awareness
- Proper knowledge of client rights
- The ability to be constantly changing according to the demands of the home health agency.

There are two college training programs recommended by the state for Home Health Aide work: Vista College, Associate Degree Program, Patient Care Technician; and Central New Mexico Community College's (CNM) Home Health Aide Worker Program[24].

CNM was awarded a federal grant to establish the above program as one strategy to try to address the shortage of health care workers in New Mexico. Many students are receiving scholarship assistance, and career coaches, in partnership with Workforce Development. The grant continues through March 2018[25]

[24] Vista College's Patient Care Technician program includes a broad range of practical and theoretical components that prepare graduates for employment in a nursing home, residential care facility, hospital, home health care agency or other healthcare setting. Specific topics include medical terminology, anatomy, emergency care procedures and time management. Practical skills covered include blood and specimen collection, rhythm strip documentation, electrocardiogram administration and other routine activities associated with patient care. The 40-week program includes a 180-hour externship in which students will learn to apply their skills in a practical setting. Upon successful completion of both classroom and externship components, students are awarded a diploma.

CNM's program prepares students on two levels: a foundational training for Personal Care Assistants (Home Health Attendant Foundation Skills: Personal Care Assistant, 45 practicum hours) and more advanced training for Home Health Aides (Home Health Aide Advanced Skills, 45 practicum hours). Completion of the program meets or exceeds the New Mexico Department of Health requirements for each level of training, and successful graduates receive a Home Health Aide Certificate of Achievement. Both courses at CNMCC carry a $5.00 program registration fee, however students must be enrolled as Undergraduate students at the college.

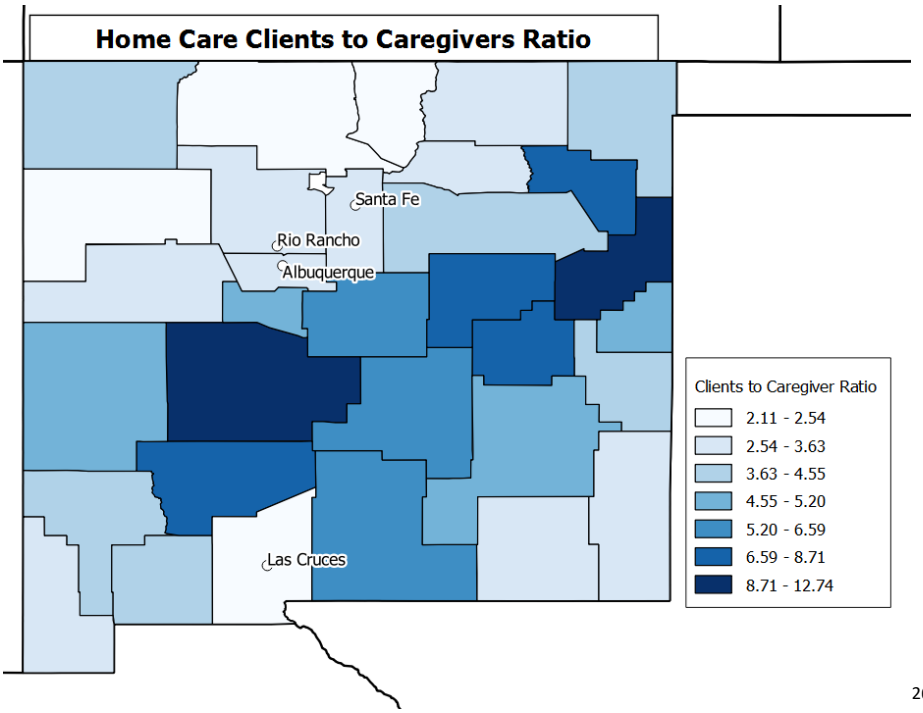
[25] . http://www.kob.com/albuquerque-news/central-new-mexico-community-college-cnm-federal-grant-health-care-workers-shortage/4374694/

LABOR OVERVIEW

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

Current Labor Pool

Home care agencies in New Mexico face some significant barriers in recruiting and retaining caregivers, although the situation is (relatively speaking) not as dire as in some states. The prime age (25-55) labor force participation rate in New Mexico is currently ten percentage points below the national average, indicating the potential, albeit small, for some staffing through untapped labor markets. The unemployment rate is also 50% higher than national rates, so there are additional potential workers in the market. For every one caregiver in New Mexico, there are currently 4.6 people categorized as frail elderly, independent living disabled, or self-care disabled needing care. While this is a significantly better ratio than the national caregiver dependency ratio of 8 to 1, the distribution of workers is not even across the state, with certain parts of the state suffering from a much higher caregiver to client ratio than others.



[26]

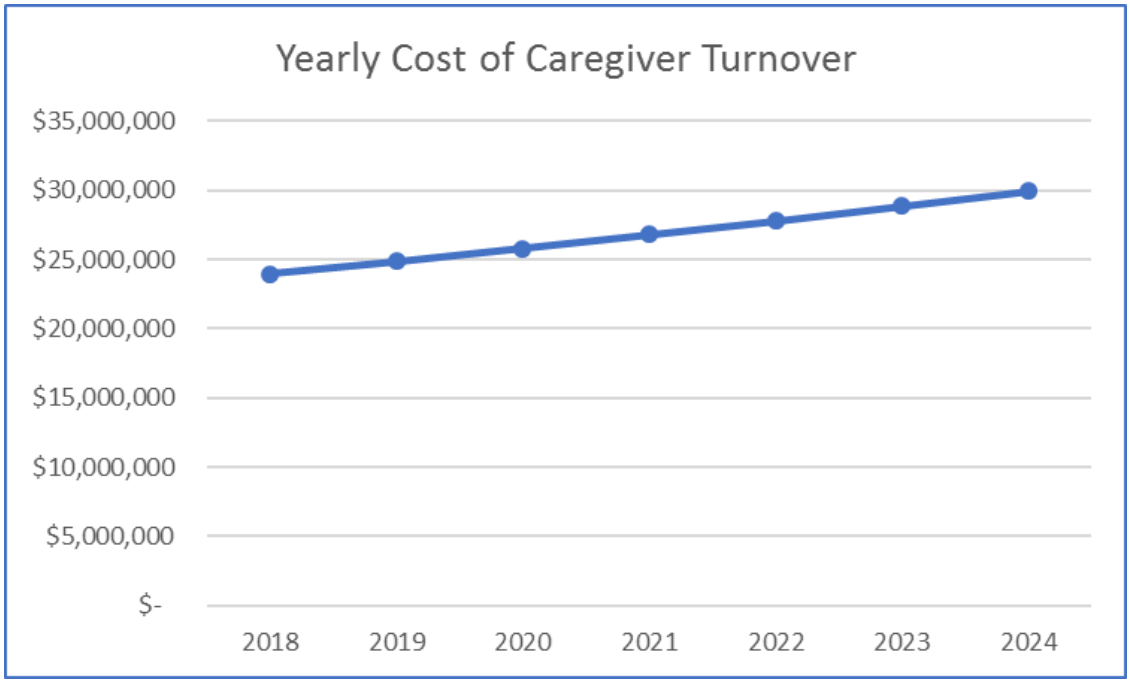
[26] American Fact Finder, U.S. Census Bureau. Retrieved from www.factfinder.census.gov.

Further, with some clients requiring 24/7 care, this ratio does not necessarily signal an adequate ratio. Finally, as the population increases and demand grows, this ratio will undoubtedly increase, putting added recruitment pressure on agencies.

While there is a need for caregivers in New Mexico, recruitment also depends on how wages compare to similar entry-level service sector occupations that might be available to a similarly-skilled person. In New Mexico, despite the stresses, difficulties and importance of their jobs, direct caregivers are actually paid less on average, than their counterparts in retail and food service. Nationally caregivers are paid about 10% more than retail or food service workers. Given this low pay, it is perhaps not surprising that the field suffers difficulties in recruiting sufficient committed staff members, or attracting non-participants into the labor force.

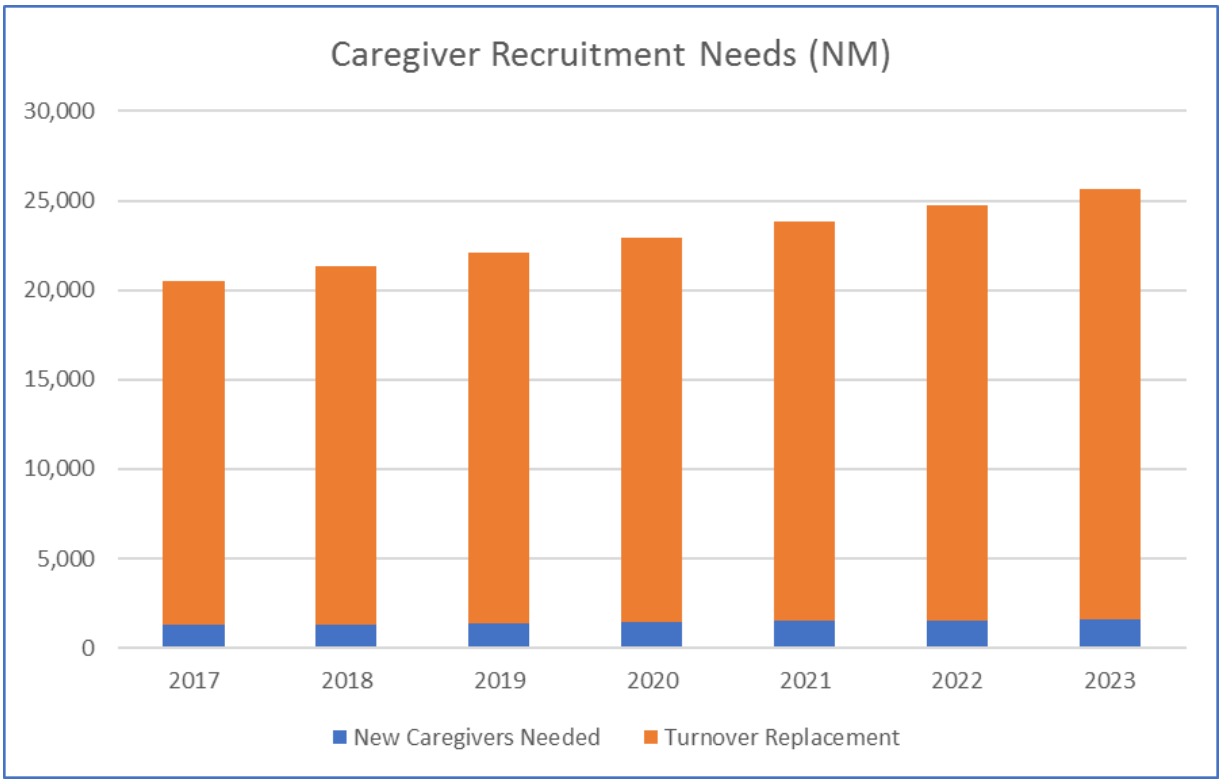
Future Labor Trends

Personal care aides and home health aides are ranked the #1 and #2 fastest growing occupations (highest estimated annual percentage change in openings) in New Mexico for the 2014-2024 time-period. Lower level medical professions make up 7 of the top 10 growing positions[27].



[27] See full table https://www.nmcareersolutions.com/vosnet/lmi/area/areasummary.aspx?enc=SgfjA5gOXyjl8J88h1RJLS0SzSyVIuhHVAo05igj+nDt/yIUrhBUV/BDiEH6ITqlbWzOoiVEyQFIYU3f9j2Gx5loHvX4cvT0mAUxyHAK5+oNYiI4twiynPmNwrSuHf9gfof5Yg2LxAlrsh5NL591SxOizE9efithzOkbgIeWkE/Jk2jzmbuZ2dmqD37EPWqa

Employment of personal care aides is projected to grow 26 percent from 2014 to 2024, much faster than the average for all occupations. Employment of home health aides is projected to grow 38 percent from 2014 to 2024, an even faster pace of growth. Because of the high rate of turnover in the industry (60% nationally and 73% for the South West region) needs driven by organic growth must be supplemented by recruitment of additional workers to replace departing ones. In total, New Mexico is expected to need over 25,000 new caregivers by 2024 to meet expected demand, should current turnover rates persist.



Caregiver and Retail/Food Service Wage Comparison			
	Direct Care	**Retail/Food**	**Difference**
National Average	$ 10.70	$ 10.24	$ 0.46
New Mexico	$ 9.51	$ 9.70	$ (0.19)

And the cost of this turnover is substantial at nearly $30M between 2017 and 2024, and is only expected to increase.

COOPERATIVE OPPORTUNITY

Cooperative Law

New Mexico Cooperatives may incorporate under the "Cooperative Association Act" provided they include any five or more natural persons or two or more associations for the purpose of acquiring, selling, producing, building, operating, operating, manufacturing, furnishing, exchanging or distributing any type or types of property, commodities, goods or services, and for the transacting of any lawful business.[28]

Cooperative Strategy

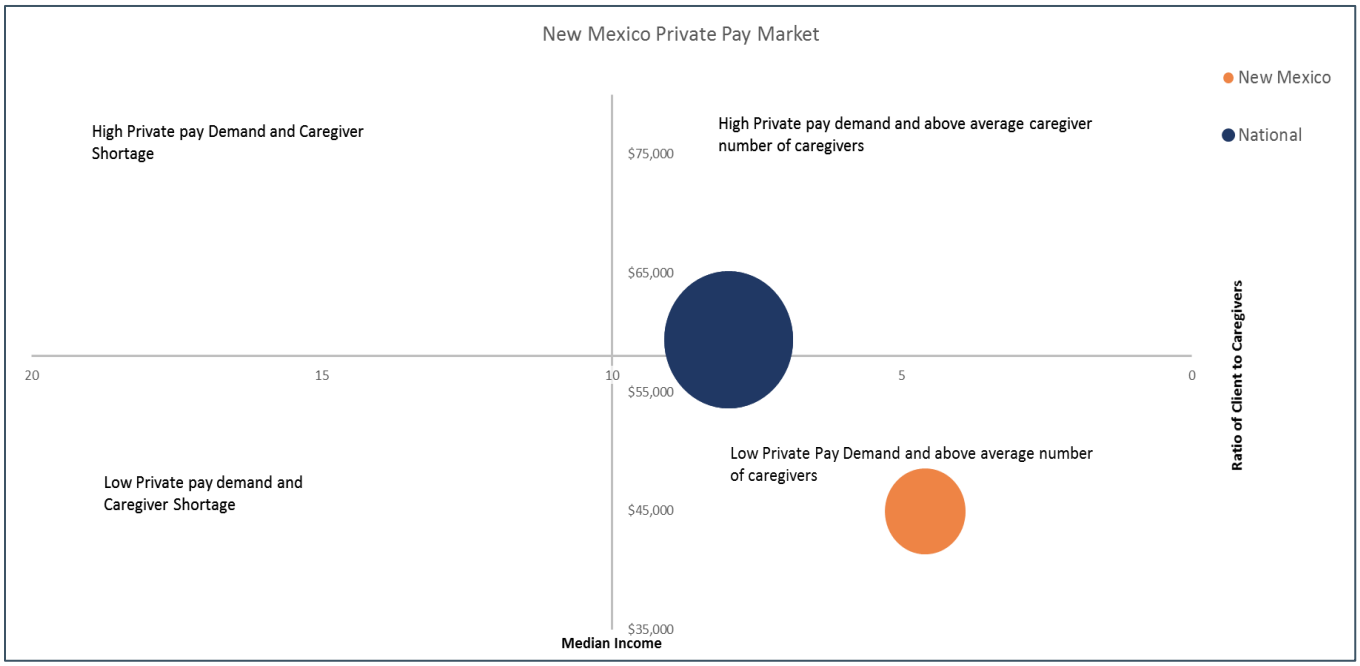
Like the rest of the country, New Mexico faces a pending crisis of a mismatch between the care needs of its elderly and frail residents, and the availability of a workforce to care for them. New Mexico's senior population is growing at a rate exceeding national averages, and its share of people living with disabilities is already twice that of the rest of the country. 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 New Mexico to meet its residents home care needs also represents an opportunity for home care cooperatives to successfully meet this market need. To fill this large and growing demand for home care services, New Mexico-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 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.

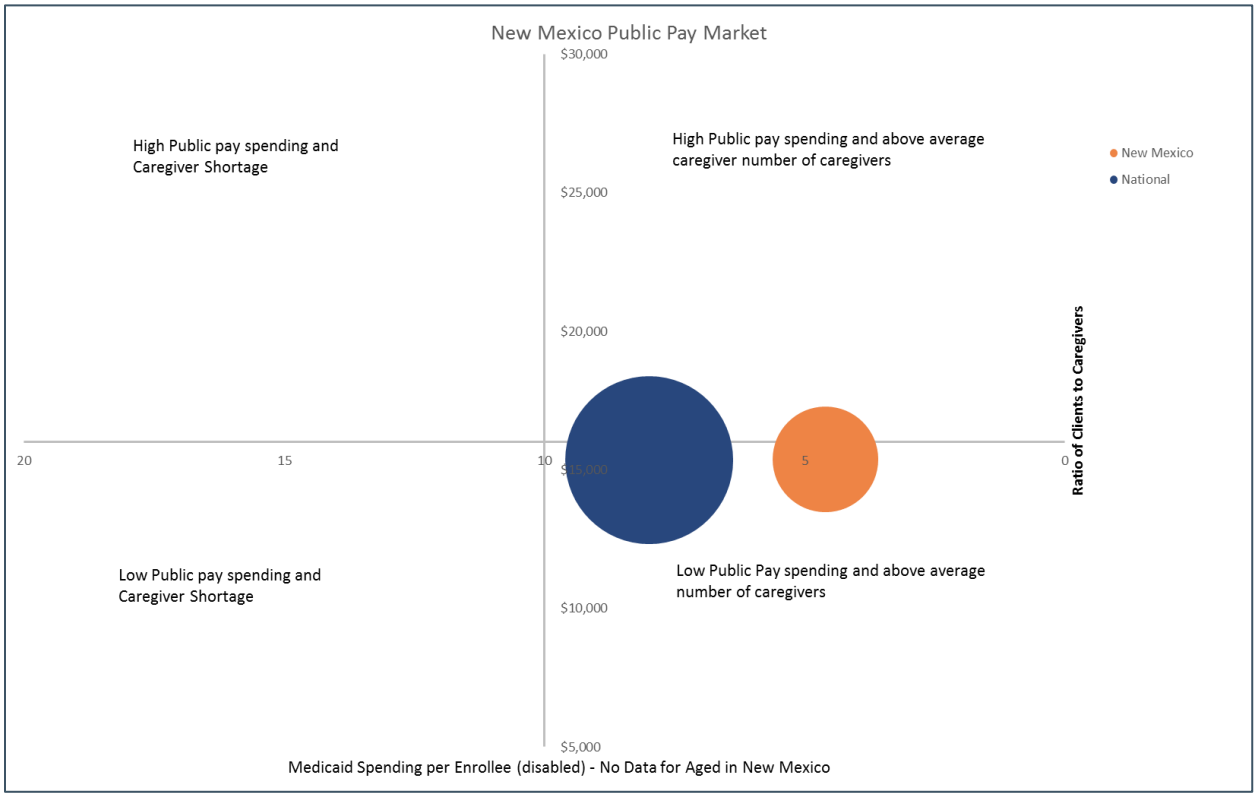
As can be seen, for various reasons relating to low median income and highly disbursed population, the private pay market is challenging in New Mexico. More long-term opportunities are likely presented in the public pay arena, though public pay in New Mexico is also challenging.

[28] New Mexico Secretary of State http://www.sos.state.nm.us/uploads/files/Corporations/ch53Art4.pdf

Private Pay 2x2:

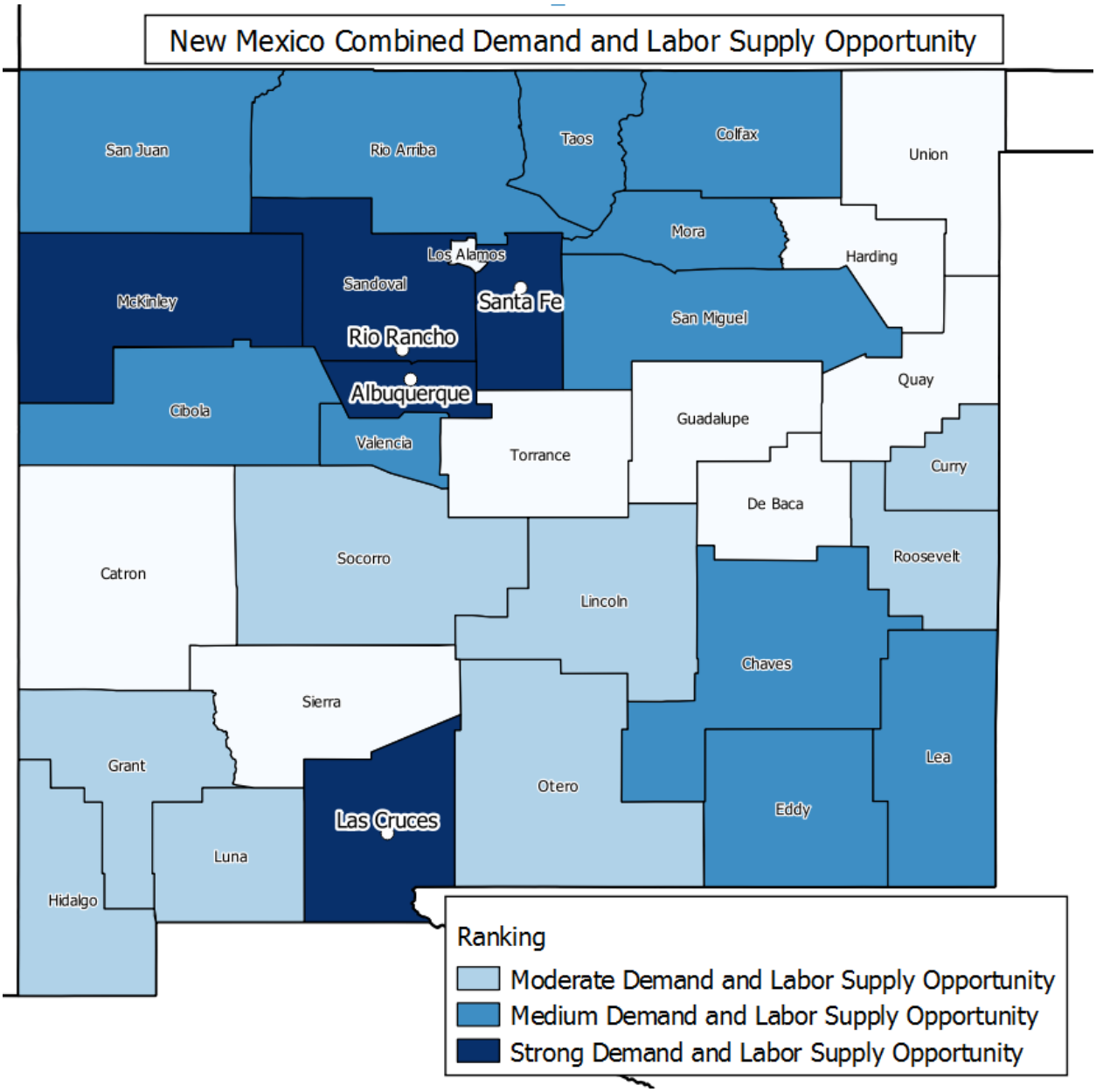


Public Pay 2x2:



Some geographic regions of the state also provide greater challenges than others. We overlay a map of where the most potential homecare clients reside, with another indicating where caregivers are located to determine which portions of the state had the best match of supply and demand.

As illustrated below, several non-metropolitan counties present potentially good opportunities for a cooperative to locate or expand. These include the two counties served by the emerging Heart is Home Cooperative, Sandoval and Lea as well as their adjacent counties, which both look like relatively good markets.



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. Additionally, pay rates for the direct care workforce in New Mexico 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. Low reimbursement rates make it difficult for eligible small home care businesses to earn a profit on Medicaid reimbursed work. For it to be financially feasible for a home care cooperative to operate in the public pay market, the organization must be able to reduce its operating expenses and serve enough clients so lower margins can still lead to enough operating income to cover overhead expenses. The discrepancy between the size the largest players and the very modest size of the median agency in New Mexico indicate that reaching scale can be difficult in this environment—only 10% of agencies have revenues exceeding $1 million, a general marker of sufficient size to absorb the cost of needed middle management. An alternate strategy to organic growth might be the acquisition through conversion of a local company which already has the scale and capacity to work in the public market. In the interim, leveraging the 'cooperative difference" to secure a significant segment of the private pay market is likely the best strategy.

CONCLUSION

Cooperative developers and others interested in supporting home care cooperatives in New Mexico 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. These same trends are true and exacerbated in New Mexico. Additionally, New Mexico's high percentage of poverty, very low population density, lower than retail/food service average wage rate, and high rate of market control by the state's largest agency present additional layers of challenge.

There are advantages to working in New Mexico, however. New Mexico's high unemployment rate and slightly lower prime age labor force participation rate mean there is a larger pool of untapped labor than many other states. The state is aware of the pending caregiver gap, and is actively investing funds in community college training programs and scholarships. The state already has one nascent home care cooperative, Heart is Home Cooperative in Bernalillo, and is home to the active New Mexico Direct Caregivers Coalition (NMDCC). While the market for home care in New Mexico is significantly smaller than most other states given its small population, growing demand will support multiple home care cooperatives. Finally, regulatory and market barriers to entry are low for small firms, though scale is difficult in the state, and would require entrance into the public pay market over the long term.

Furthermore, national home care cooperative development strategies can support the successful startup and growth of local cooperatives. One potential strategy for operatives and partners to assist local home care cooperatives is through the development of a shared services cooperative. It can be difficult for smaller scale organizations to manage back office operations, training, and regulatory paperwork while also managing a home care business and generating new sales. A membership organization for cooperatives that provides more efficient payroll and scheduling solutions and access to high quality training can create the benefits of scale while also allowing for local control of the cooperative. An organization that can provide a pool of well-trained caregivers can significantly reduce recruitment costs and increase quality of care for cooperative members. and a membership organization is one strategy that may provide that advantage. In Pennsylvania 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 1: Opportunity Matrix

Opportunity Assessment Framework		
Key Metrics - Labor Supply:	***US Average***	***New Mexico***
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%	72%
Other Entry-Level Pay Comparison (Retail and Food Service)	10.83%	1.90%
Caregiver Dependency Ratio (direct care workforce over home care subset-frail elderly/dependent)	7.98	4.60
Unemployment Rate	4.40%	6.70%
Key Metrics - Firm Barriers to Entry:	***US Average***	***New Mexico***
Assesses ease or difficulty of entering the home care market as a new provider		
Scale Barriers	$216,243	$120,510
Average Sales of Home Care Companies Rural	Rural: $431,300	Rural: $345,600
Average Sales of Home Care Companies Urban	Urban: $373,800	Urban: $345,000
Scale of Service Area (as Population Density)	91.39	17.16
Rural Population Density	Rural: 19.17	Rural: 3.68
Suburban Population Density	Suburban: 57.83	Suburban: 22.9
Urban Population Density	Urban: 1015.17	Urban: 121.72
Key Metrics - Market Competitiveness	***US Average***	***New Mexico***
Assesses the state of market consolidation/fragmentation, and dominance of any major firms.		
Total % Market Share of Top 5 Firms	8.7% (Top Three)	40.86%
Largest Provider Operating in State (Annual Sales)	Kindred	AmberCare
Key Metrics - Client/Customer Demographics	***US Average***	***New Mexico***
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%	7.23%
Growth in Aging Population	9.70%	11.40%
Total % Population Age 65+	14.10%	*14.70%*
Total % Population Individuals with Disabilities	6.81%	*14.80%*
Total % Population on Medicaid	18.00%	36.57%
Home Care Costs as % of Median Income of 65+ Population	119%	130%
Key Metrics - Payer Composition	***US Average***	***New Mexico***
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%	22%
Share Medicaid LTSS Spending for Devoted to HCBS	53%	74%
Self-Directed Care Program	N/A	Yes
Rate Flexibility	N/A	Managed care and only limited fee for service for Native American Populations
Per Capita HCBS	$18,870	$23,069

Appendix 2: Detailed Medicaid Home Care 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.

Appendix 3: 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:

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

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

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

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