Missouri Division of Senior and Disability Services: Summary of National Core Indicators — Aging and Disabilities and Consumer Directed Services Workforce Survey Results

September 18, 2023

The State of Missouri Department of Health and Senior Services, Division of Senior and Disability Services (DSDS) administers and oversees Missouri services for seniors and individuals with disabilities. DSDS works with Medicaid providers to offer home and community-based services (HCBS) to aged and disabled (AD) participants via two different service delivery models, the agency-based model and the consumer directed services (CDS) model. With the goal of collecting detailed workforce data to inform policy and fiscal initiatives, DSDS recently conducted separate online surveys with these two types of providers. In order to analyze the survey response data and summarize the results, DSDS contracted with Mercer Government Human Services Consulting (Mercer).

Background

The services that DSDS offers to older adults and individuals with disabilities include publicly funded services in Medicaid waivers and the Medicaid State Plan. Through these programs, DSDS authorizes and administers services for around 1,800 providers to deliver various types of HCBS services. Over the past few years, many HCBS providers have been experiencing direct service worker (DSW) staffing shortages, mainly due to challenges with attracting and retaining DSWs. In order to collect data specific to DSDS HCBS workforce issues and to inform future DSDS rate studies and value-based purchasing initiatives, DSDS recently conducted detailed agency and CDS provider surveys.

In late 2022, DSDS participated in the National Core Indicators — Aging and Disabilities (NCI-AD) Staff Stability Pilot Survey to collect data from HCBS providers that deliver agency-model personal care services in community settings, in residential care facilities (RCFs), in assisted living facilities (ALFs) and agency-model adult day care services. Since this survey did not include CDS, DSDS conducted a separate survey specific to CDS providers in early 2023. Both surveys covered various topics including, but not limited to: general provider characteristics, DSW characteristics and workforce metrics, DSW wages and benefits, and other provider costs. The surveys included questions with yes/no responses,

questions that required providers to select from pre-defined response options, and free response questions where providers submitted numerical or narrative responses.

Survey Administration

Prior to the issuance of the two surveys, DSDS engaged with various stakeholders including the Missouri Council for Independent Living, Missouri Alliance of Home Care, Missouri Council for Home Care, Missouri Assisted Living Association, and the Missouri Adult Day Services Association. DSDS discussed plans for the surveys during several monthly stakeholder meetings, during an October 2022 Missouri Medicaid Audit and Compliance provider update meeting, and during an October 2022 Missouri Assisted Living Association Conference. DSDS also issued informational memorandum Info-09-22-01 on September 8, 2022 and Info-12-22-03 on December 27, 2022 to alert agency and CDS providers, respectively, of the upcoming surveys. DSDS monitored provider responses and sent multiple email reminders during the survey timeframes to encourage provider participation. Key information on each survey is summarized in Table 1.

Table 1: Key Elements of Each Survey

Survey Name	Target Audience	# of Questions	Data Reporting Period in Survey	Survey Response Window	# of Responses	Total # of Providers
NCI-AD Staff Stability Pilot Survey	Agency-model providers who deliver: • Personal care services in the community, in RCFs, or in ALFs • Adult day services	91	January 1, 2021–December 31, 2021	September 12, 2022–November 15, 2022	222	1,081
CDS Operational Survey	CDS personal care providers	56	July 1, 2022–December 31, 2022	January 16, 2023–February 28, 2023	347	925

Provider Payment Rates for Reference

The NCI-AD and CDS surveys collected information on expenditures that providers incurred to deliver personal care services, but the surveys did not collect data on agency or CDS personal care revenues. To provide some insight into the revenue side, Table 2 includes a summary of the rates that DSDS paid providers for agency-based and CDS personal care during the survey reporting periods.

Table 2: DSDS Personal Care Payment Rates During Survey Reporting Periods

Survey Reporting Period	Model Type	Service Name	Unit Definition	FY 2021 Rate	FY 2022 Rate	FY 2023 Rate
January 1, 2021 – December 31, 2021	Agency	Personal Care/Attendant Care	15-minute	$4.59	$5.28	
		Personal Care – ALF/RCF	15-minute	$4.44	$4.86	
		Advanced Personal Care	15-minute	$5.69	$5.99	
		Advanced Personal Care – ALF/RCF	15-minute	$5.00	$5.26	
		Adult Day Care	15-minute	$2.32*	$2.44*	
July 1, 2022 – December 31, 2022	CDS	CDS Personal Care – Independent Living Waiver	15-minute			$4.32
		CDS Personal Care – State Plan	15-minute			$4.89

* The Adult Day Care 15-minute rate is a group rate, whereas all other rates in the table are per individual rates based on a 1:1 staffing ratio.

Survey Analysis and Results

Between February 2023 and March 2023, DSDS provided Mercer with two separate data extracts, one that contained the NCI-AD survey responses and one that contained CDS survey responses. The NCI-AD survey responses were de-identified, so DSDS and Mercer were unable to determine which provider submitted which response. This was not the case for the CDS survey response data, which included a provider name field. After intaking and loading the data, Mercer's analysis approach included performing validation to assess data quality, conducting analysis on the responses to each question, and summarizing results.

NCI-AD Agency Model

NCI-AD Agency Model Survey

Data Quality Assessment

In terms of the NCI-AD survey response rate, 222 providers voluntarily responded to the survey out of 1,081 total DSDS agency providers, resulting in a response rate of roughly 21%. Of the 222 responding agencies, there were 189 (or 85%) who either only provided support to older adults and/or individuals with disabilities or who could limit their reporting to DSWs who work exclusively with these populations.

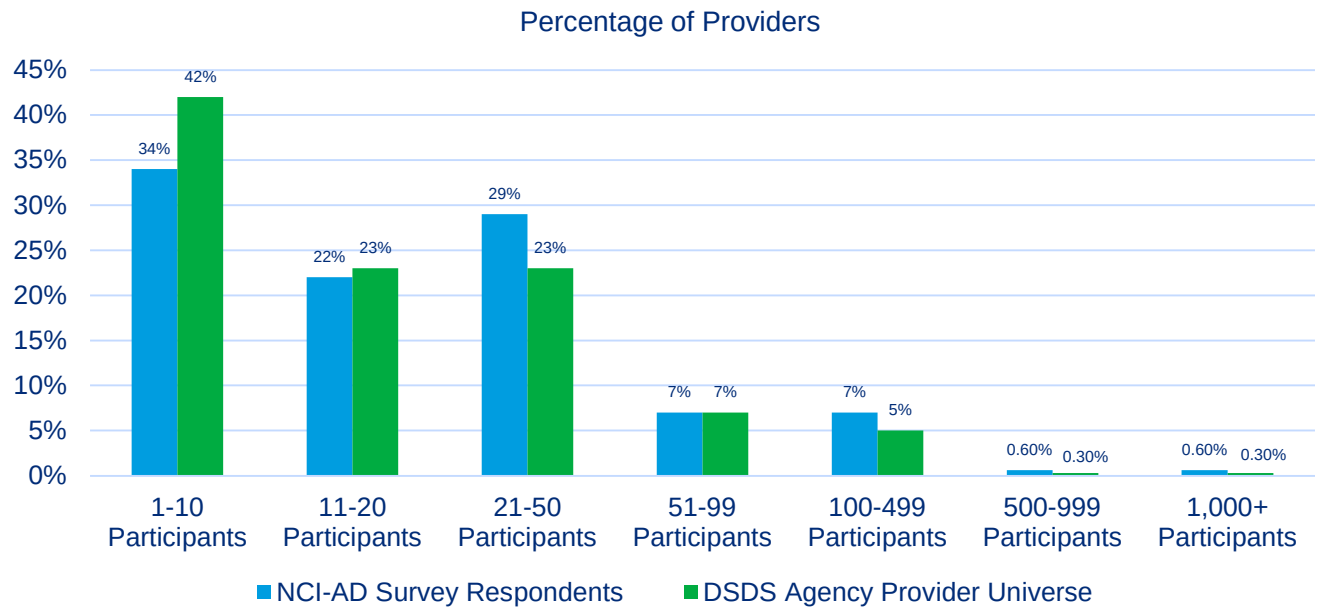
NCI-AD Agency Model

The remaining 33 agencies were not able to limit their data to the AD population. Since these 33 providers were serving additional populations beyond AD participants, there is a chance that their experience was not representative of the typical DSDS AD agency provider. Based on this, Mercer and DSDS agreed to exclude these responses from the analysis and focus on the responses from the 189 agencies whose survey responses were specific to the AD population.

Upon reviewing the results of the data validation checks, Mercer determined that the quality of the survey responses was generally high. Most providers responded to all questions, and the reported values were typically reasonable. There was also high inter-relational validity across linked questions. Mercer identified a few potential concerns within the response data including instances where a large number of providers left a question blank and questions that were only applicable to a small subset of the providers, resulting in a low number of responses submitted. As a result, Mercer either did not include those questions in our analysis or we caveated that the results should be reviewed with caution.

As shown in Figure 1, Mercer found that the size distribution of the 189 responding providers was relatively similar to the size distribution of the 1,081 DSDS agency providers. A lower percentage of providers serving 1–10 participants responded to the survey compared to the percentage in the DSDS agency universe, and a larger percentage of providers with 21–50 participants responded to the survey compared to the percentage in the DSDS universe. Percentages for providers of other size ranges were relatively comparable. The vast majority of respondents (roughly 85%) provided services to 50 or fewer AD participants.

Figure 1: Size Distribution of Responding Providers



NCI-AD Agency Model

DSW Characteristics

Providers reported employing a total of 4,728 DSWs. On average, the ratio of DSWs to participants was roughly 1 DSW to 1.8 participants. Figure 2 and Figure 3 show that the vast majority of DSWs identified as either black (or African American) or white and as female.

Figure 2: DSW Race/Ethnicity Identification

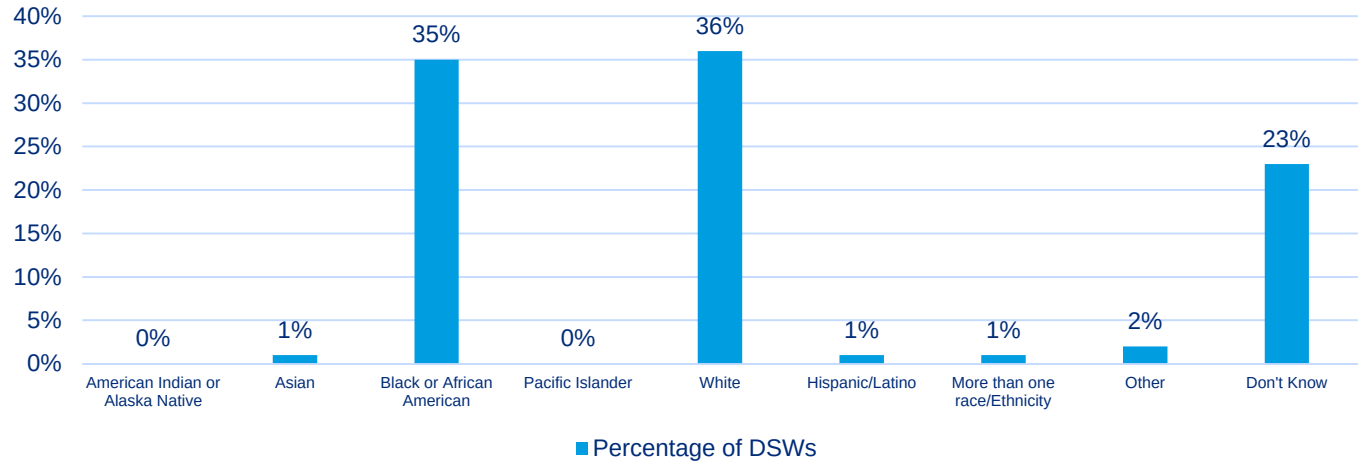
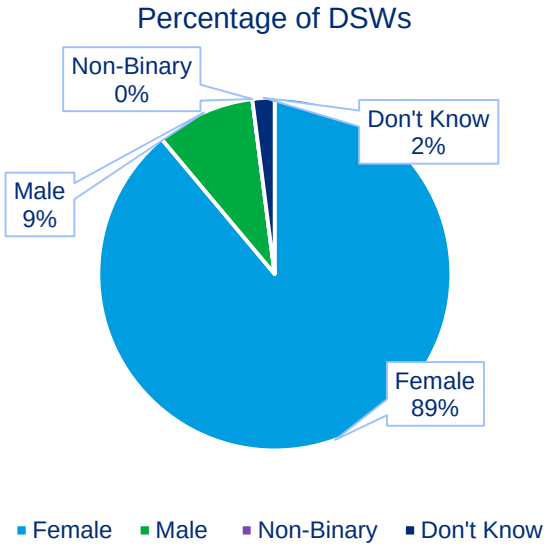
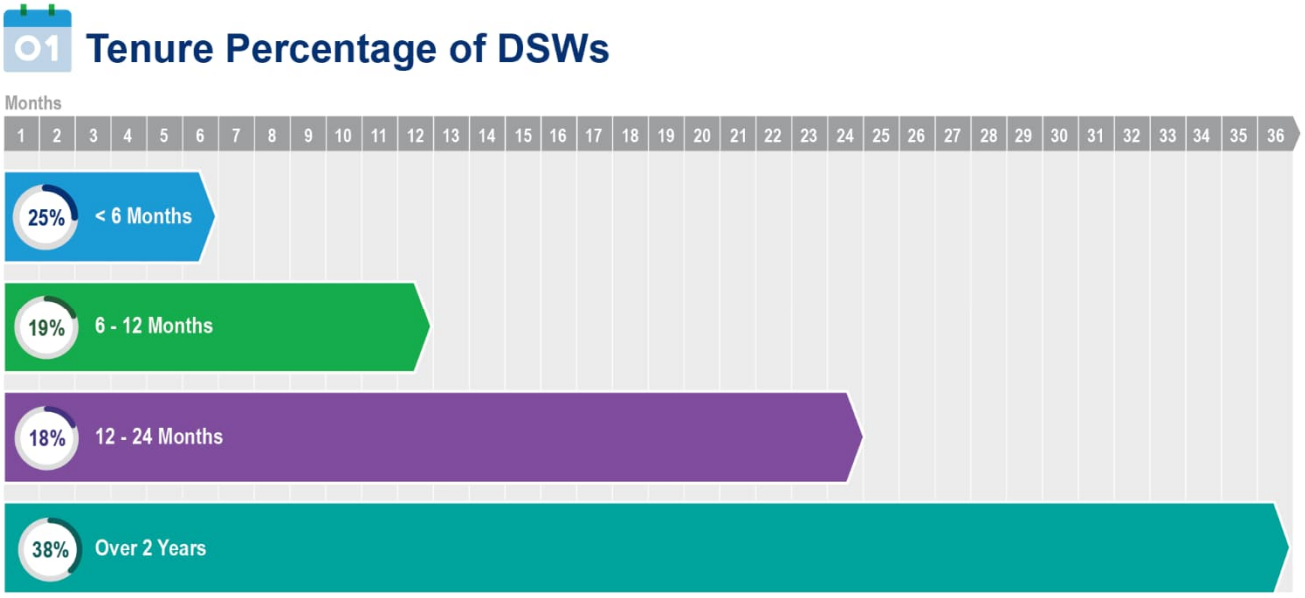


Figure 3: DSW Gender Identification

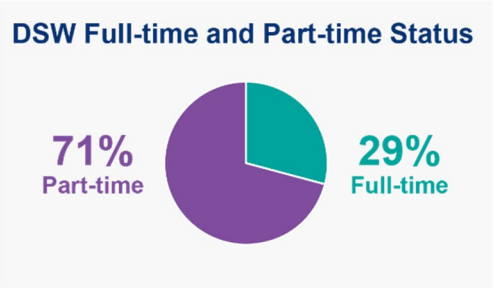


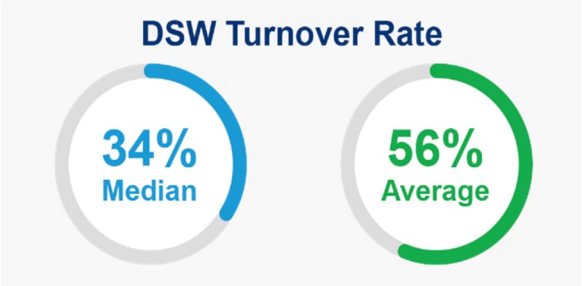
NCI-AD Agency Model

Mercer analyzed various DSW workforce metrics including tenure lengths, full-time/part-time distribution, turnover rates, and vacancy rates. Mercer observed a large percentage of DSWs (roughly 45%) were employed for one year or less, while almost 40% were employed for over two years.



About 57% of providers were able to distinguish between full-time and part-time DSW positions, and almost all required DSWs to work at least 30 hours per week to be deemed full-time. For the providers who could differentiate DSW status, many of them (60%) tended to employ more part-time DSWs than full-time DSWs. On average, roughly 70% of DSWs had a part-time employment status.

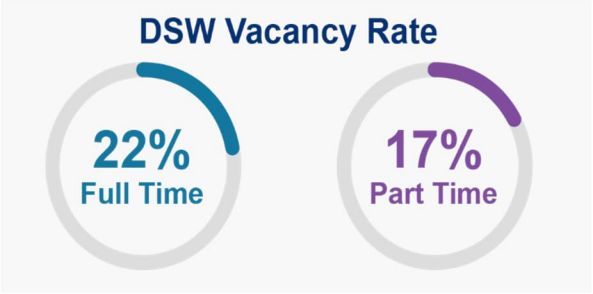




The median DSW turnover rate across providers was 34%. However, there were some providers with extremely high turnover rates (100%–400%) that pulled the average turnover rate up to 56%.

NCI-AD Agency Model

In addition to losing DSWs during the year, providers also had vacant DSW positions that they were unable to fill. Providers showed an average full-time DSW vacancy rate of 22% and an average part-time DSW vacancy rate of 17%. Due to workforce challenges and DSW staffing issues, 57% of providers had to turn away or stop accepting new service referrals in 2021.



DSW Wages and Benefits

During the January 1, 2021–December 31, 2021 survey reporting period, Missouri's minimum wage was $10.30 per hour. DSW hourly wages reported in the survey ranged from $9.00 per hour to $16.50 per hour, with a median hourly wage of $11.15 per hour and an average hourly wage of $11.71. Mercer observed 47 of 189 providers who reported an average starting hourly wage or average hourly wage less than $10.30 per hour. There was little variation between DSW starting wages and the average wage across all DSWs regardless of length of employment. There was also little variation in wages across service types (i.e., personal care delivered in the community, personal care delivered in RCFs/ALFs, adult day services).

About 29% of responding agencies indicated they provided a wage bonus to DSWs. Of those providing bonuses, 75% indicated the average bonus amount was $200 or less. DSW overtime hours were minimal, representing less than 3% of total hours worked.

In terms of benefits, generally about 20% or fewer providers made them available to DSWs (percentage varied by type of benefit). The one exception was paid vacation time, which roughly 28% of providers offered to DSWs. About half of the providers offered the benefits to all DSWs, while other providers required DSWs to work a certain amount of hours or have a minimum length of employment to be eligible to receive benefits. Figure 4 provides detail on the percentage of providers offering each type of benefit, and Figure 5 provides information on other benefits that providers indicated they offer to DSWs.

NCI-AD Agency Model

Figure 4: Benefits Offered to Some or All DSWs

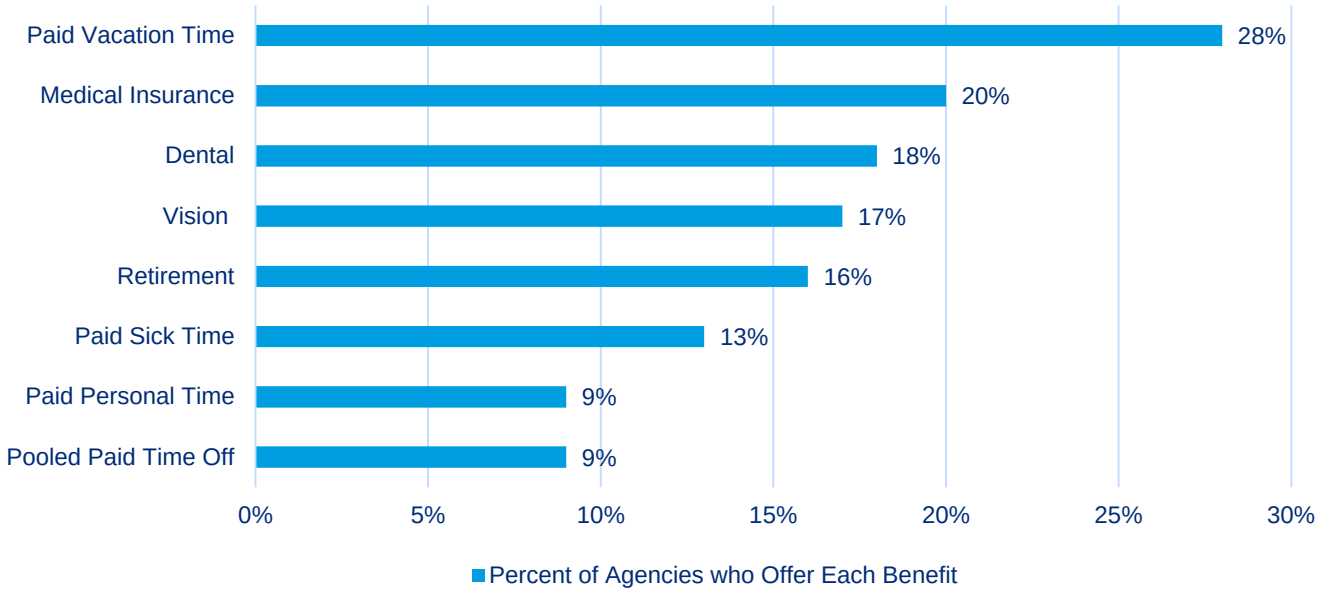
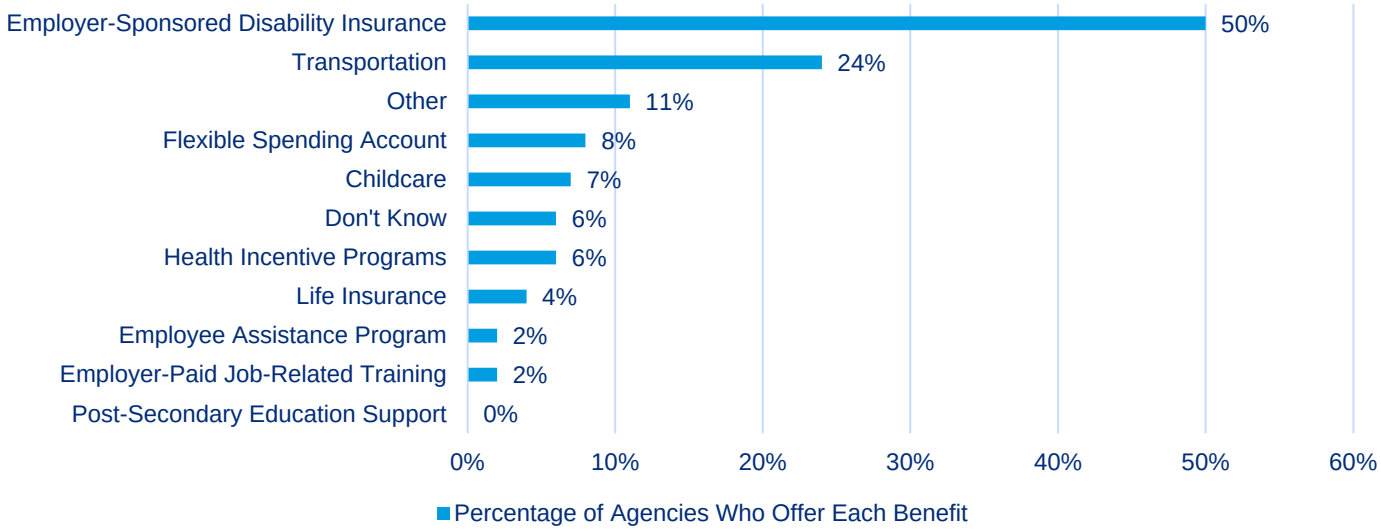


Figure 5: Additional Benefits Offered to DSWs



NCI-AD Agency Model

Frontline Supervisors

The survey defined frontline supervisors as staff who supervise DSWs working with the AD population and also engage in direct support as part of their duties. When responding to these questions, the survey requested that providers focus on frontline supervisors who spend more than half their time on supervisory tasks.

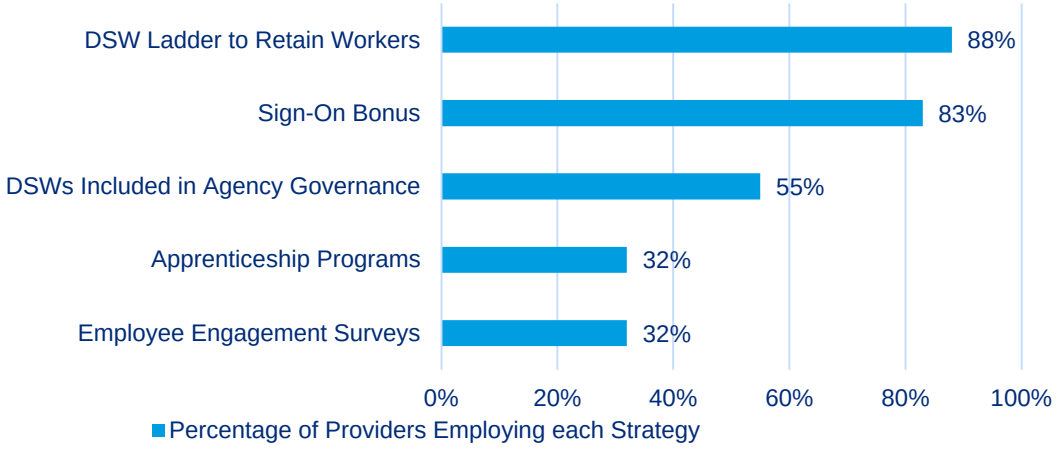
Across all providers, there was a total of 418 frontline supervisors. On average, providers employed about one frontline supervisor for every 11 DSWs. This varied widely by provider; some providers indicated they did not employ any frontline supervisors and others employed one supervisor for every two or three DSWs. The vast majority of frontline supervisors identified as female and as either black (or African American) or white; these results were similar to the DSW responses to these questions.

There was variation amongst providers on whether they paid their frontline supervisors on an hourly or salaried basis. About 40% indicated they pay their supervisors on an hourly basis, 40% pay on a salaried basis, and 20% pay some of their supervisors on an hourly basis and others on a salaried basis. The majority of providers (84%) indicated their supervisors did not receive additional pay/wages for overtime (i.e., hours worked beyond 40 in a week).

Provider Recruitment and Retention Strategies

In an attempt to reduce DSW workforce challenges, providers utilized several different types of recruitment and retention strategies. Most agencies indicated using at least one recruitment or retention strategy, with the top five most popular strategies displayed in Figure 6.

Figure 6: Top 5 Most Popular DSW Recruitment and Retention Strategies



NCI-AD Agency Model

Key Takeaways

The NCI-AD survey data highlighted various workforce challenges that DSDS agency providers are facing including DSW staffing shortages, short DSW employment tenures, and high DSW turnover rates. The data showed that many agencies had vacant DSW positions in 2021, and over 50% of providers had to turn away or stop accepting new service referrals due to staffing issues. Providers indicated they were employing various workforce retention strategies, but given variation in turnover and vacancy rates, some agencies appear to have been more successful than others in attracting and retaining DSWs.

Wages and benefits are generally important factors in DSW recruitment and retention. The survey responses showed a great deal of variation in DSW hourly wages ranging from $9.00 to $16.50, with a median hourly wage of $11.00. There was little variation between DSW starting wages and the average wage across all DSWs regardless of length of employment. While some of the larger providers offered paid time off, health insurance, and/or retirement benefits to DSWs, this was not a consistent and widespread practice. DSDS providers are likely having to compete for DSW staff with private sector employers who could be paying higher hourly wages for other types of jobs (e.g., gas station, retail, fast food chain) and offering employee benefits. Additionally, DSDS providers may be competing for DSW staff with Missouri HCBS providers who support other populations (e.g., intellectually and developmentally disabled population). Mercer anticipates that each provider's DSW wage and benefit offerings will continue to be a key factor in their ability to attract and retain DSWs going forward.

CDS Survey

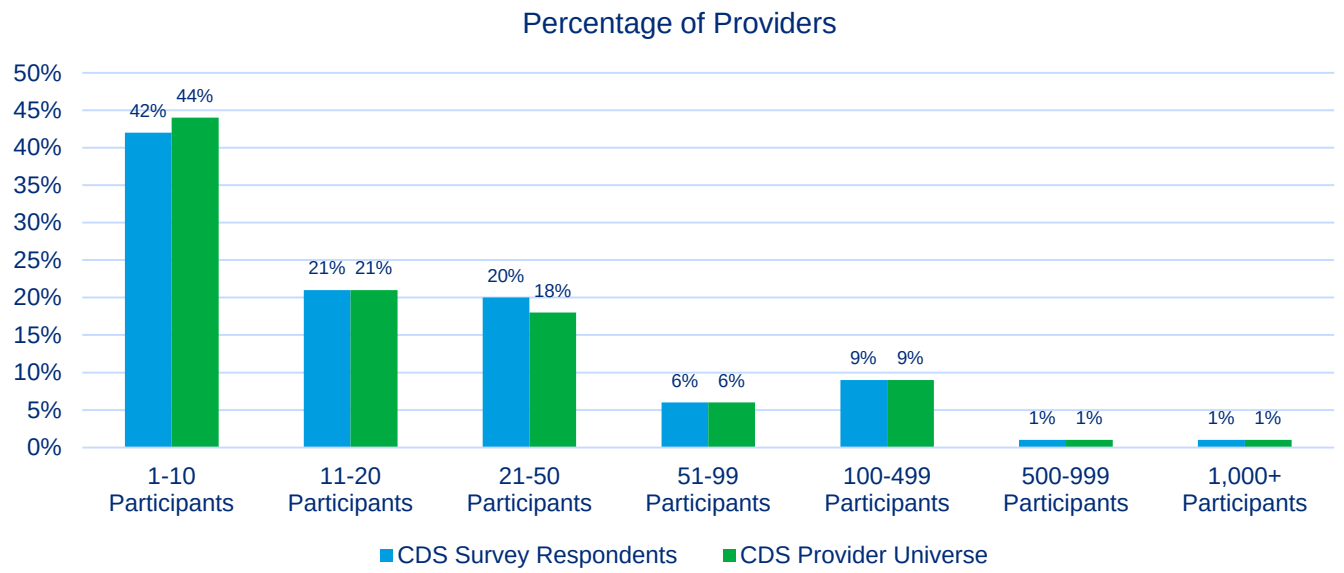
CDS Survey

Data Quality Assessment

DSDS received 347 CDS survey responses from providers who either only provided support to DSDS CDS participants or who could report data specific to the personal care attendants (PCAs) who worked exclusively with DSDS CDS participants. Out of 925 total DSDS CDS providers, the survey response rate was roughly 38%. As shown in Figure 7, Mercer found that the size distribution (based on number of participants) of the survey respondents was relatively similar to the size distribution of the total 925 CDS providers. There was also good representation in the survey responses across different population areas including providers operating in smaller areas (defined as having populations of less than 25,000 people) to providers operating in much larger areas with populations over 200,000 people.

CDS Survey

Figure 7: Size Distribution of Responding Providers



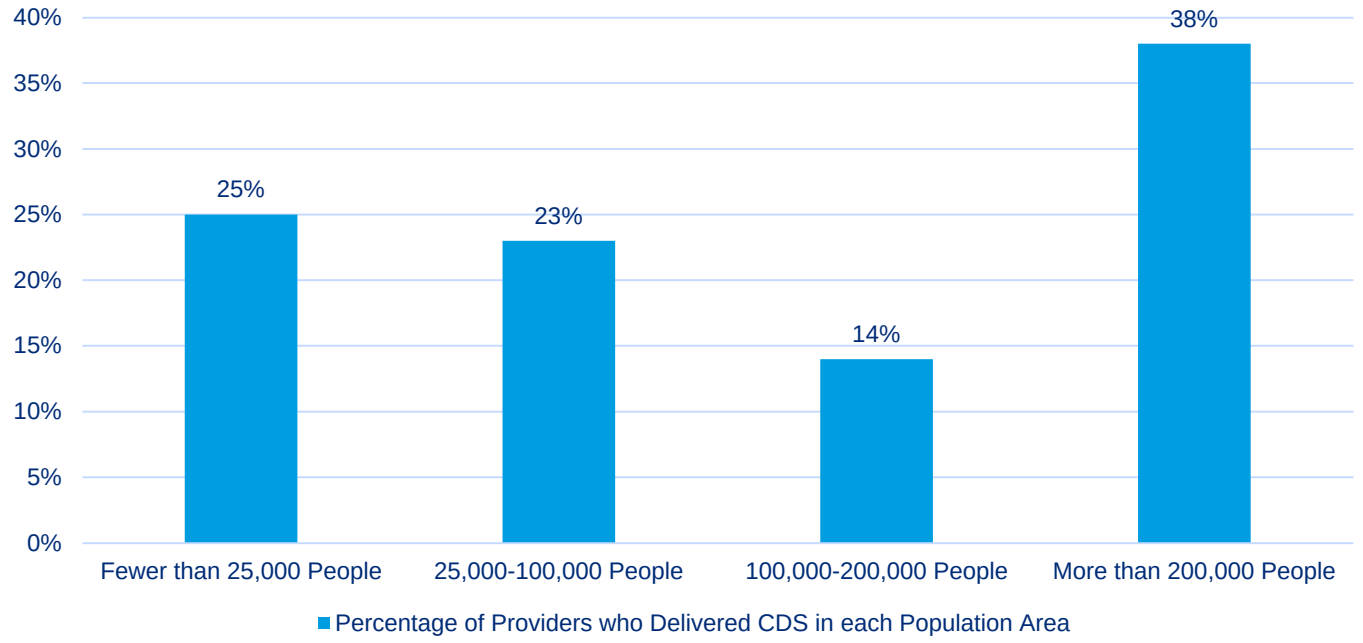
Upon reviewing the results of the data validation checks, Mercer noticed several instances where providers failed validation checks on multiple survey questions. There were also specific questions where a large number of providers failed the inter-relational validation checks, reported outlier values that did not appear reasonable, or did not report on a consistent basis (e.g., some providers reported hourly wage bonuses and others reported lump sum wage bonuses). Based on these observations, Mercer's assessment was that the data quality was somewhat low in several instances. In order to limit the impact of data quality issues, Mercer excluded 36 invalid survey responses prior to conducting statistical analysis on the remaining 311 responses.

Area(s) Served

The survey requested information from providers on the population of the area(s) in which they administered CDS. The survey provided the following four response options: fewer than 25,000 people, 25,000–100,000 people, 100,000–200,000 people, more than 200,000 people. Providers were able to select all options that applied. As shown in Figure 8, all four population areas were represented in the survey responses. Refer to the hourly wage section for commentary on wages across population areas.

CDS Survey

Figure 8: Percentage of Providers who Delivered CDS in each Population Area
(categories not mutually exclusive)



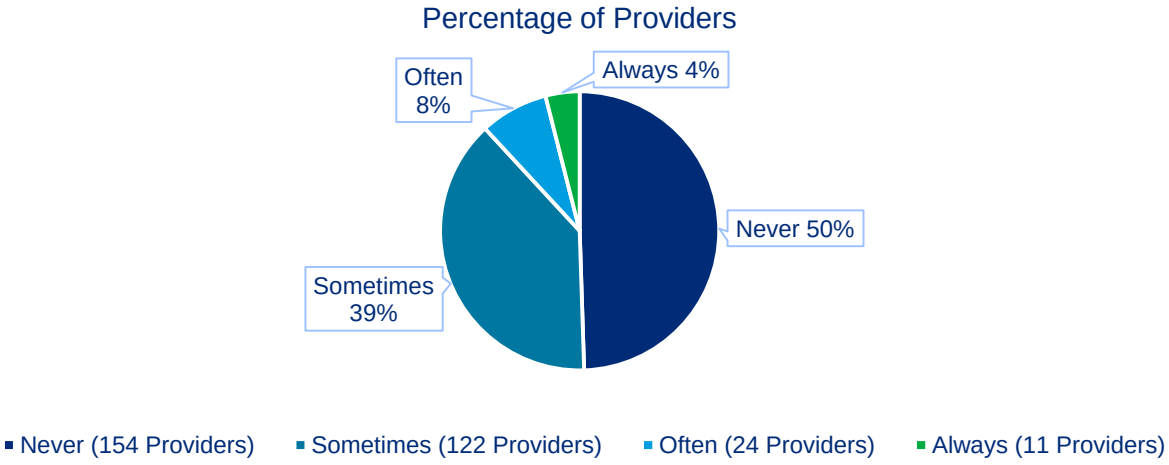
Taking on New Participants

Between July 1, 2022 and December 31, 2022, CDS providers reported new participant rates ranging from 0% to 100% (70 providers indicated they did not serve any new participants during the reporting timeframe and 21 providers indicated all the participants they served were new). The average new participant rate across CDS providers was 19%.

As shown in Figure 9, 50% of CDS providers indicated their CDS participants had a PCA in mind, which means the provider did not need to supply any assistance with PCA matching. For the other 50% of CDS providers, about 47% indicated they sometimes or often needed to pair the participant with a PCA, and 4% said they always needed to find a PCA for the participant. In terms of the 4% of providers who responded with “always”, they also reported that many of their PCAs were related to the participants they were serving, which raises questions about the accuracy of the “always” response.

CDS Survey

Figure 9: Frequency of Provider Needing to Pair Participant with a PCA

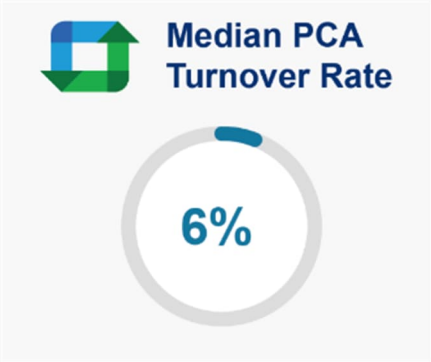


Impact of Staffing Issues on Services Delivered

Over 60% of providers reported no instances of having to turn down referrals. Around 15% of providers had either one or two participants referred to them for which they were unable to deliver services due to staffing issues, and about 20% of providers had to turn down referrals for three or more participants.

PCA Characteristics

Within the survey, PCAs were defined as participant-employed individuals providing direct services to participants. Providers reported PCA counts ranging from one PCA to 1,909 PCAs, with a total of 17,669 PCAs reported across provider respondents. Most providers reported about one PCA for every one participant. There were some outlier providers whose data showed very low or very high PCA to participant ratios (e.g., one PCA serving many participants or many PCAs serving one participant).



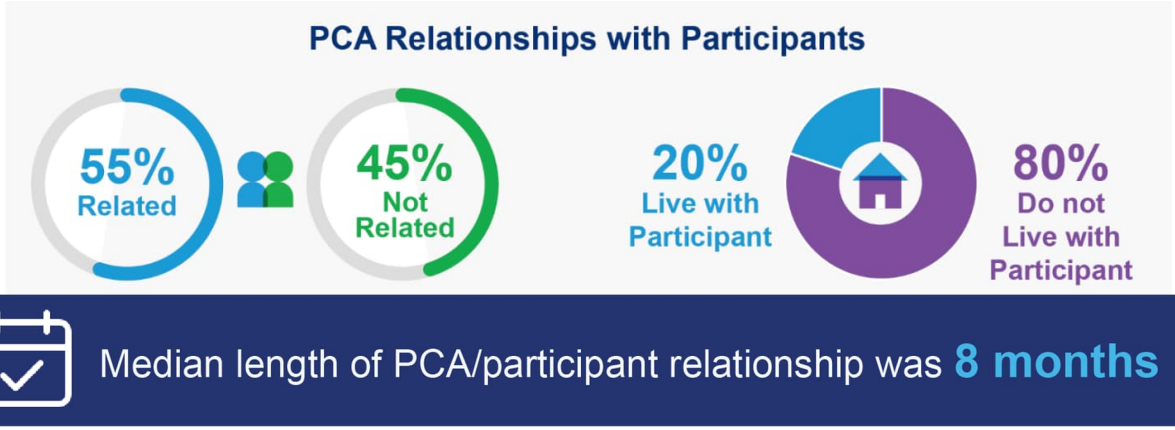
The new PCA rate ranged from 0% to 100%, meaning that some providers indicated no new PCAs started during the six-month reporting period, and a few providers indicated all PCAs were new. Across all providers, the median percentage of new PCAs to total PCAs was about 14%. The PCA turnover rates varied significantly from 0% to 86%, with a 6% median turnover rate. This indicates that

CDS Survey

the PCA turnover rates were quite low in most survey responses. In almost half of the cases where the PCA discontinued care, the PCA voluntarily left, retired, or quit.

PCA Relationships with Participants

The survey also collected various types of information about the relationship between PCAs and the participants they serve. About 50% of PCAs were related to the participants they were serving and about 20% of PCAs lived with the participants they were serving. PCAs were typically only serving one participant on a regular basis, but there were about 10% of PCAs who regularly worked with multiple participants. Most participants did not receive care from more than one PCA at the same time.

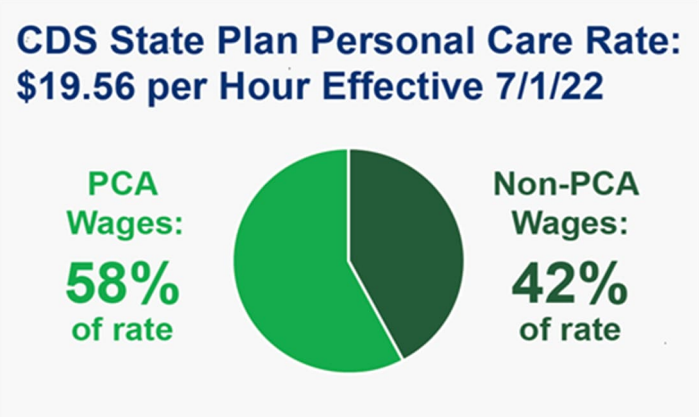


The median PCA/participant relationship duration was eight months. A few providers reported very long durations (25-30 years), which pushed the mean up to nearly two years, and several providers reported very short durations (one or two months). Given the low prevalence of very long tenures, it is challenging to know if those reported high values were accurate. In addition, some providers may have been confused at the wording of the question and reported relationship durations specific to the survey reporting period (July 1, 2022 through December 31, 2022), as opposed to the total length of the PCA and participant relationship. Based on this, this data should be interpreted with caution.

CDS Survey

PCA Wages

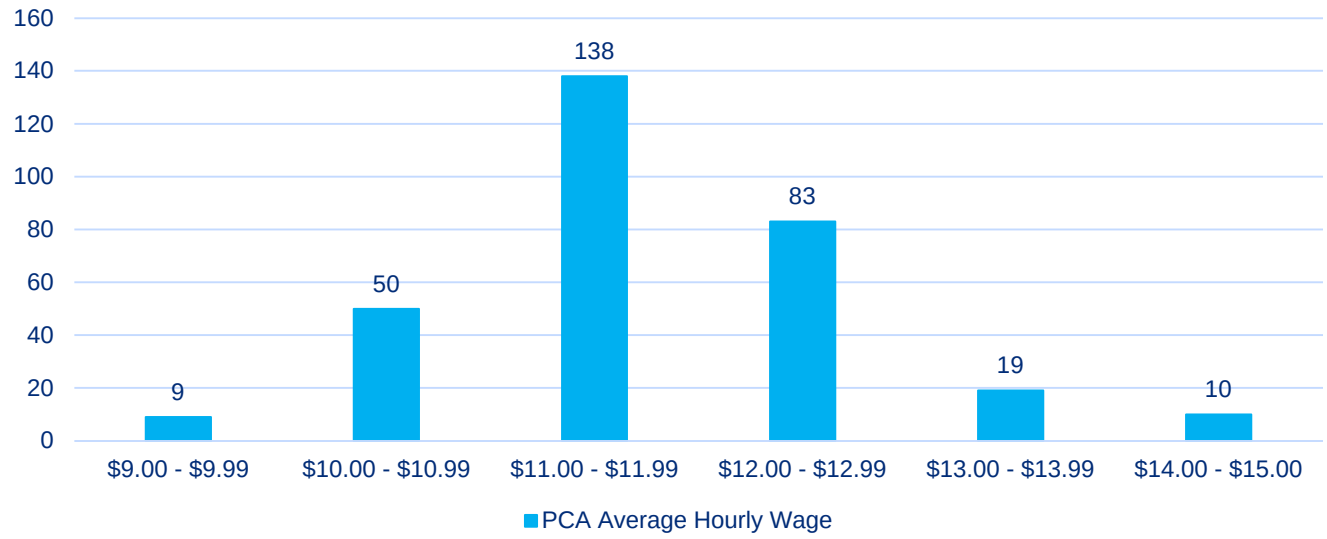
PCA hourly wages reported in the survey for the July 1, 2022–December 31, 2022 reporting period ranged from $9.00 per hour to $15.00 per hour, with a median hourly wage of $11.25 per hour and an average hourly wage of $11.45. During this timeframe, CDS providers were paid a rate of $4.89 per 15-minute unit ($19.56 per hour) to deliver the CDS State Plan Personal Care service. Based on the $11.25 median PCA hourly wage, CDS State Plan Personal Care providers spent roughly 58% of their payment rate on PCA wages. The remaining 42% was spent on non-wage cost components, which likely included costs such as employer taxes (e.g., FICA, FUTA/SUTA), workers' compensation insurance, electronic visit verification (EVV), fiscal management services, other service-related costs, and administration/overhead. In contrast, the percentage of the rate that went to non-wage cost components in the agency model was 44%. While there are different regulatory requirements for the agency model versus self-direction, there is little variation in the non-wage percentage of the rate.



As mentioned previously, the PCA wages reported in the survey varied from $9.00 per hour to $15.00 per hour. Figure 10 shows the distribution of reported PCA wages, with almost 50% of the responding providers reporting an hourly wage between $11.00 and $11.99. Mercer compared the reported PCA wages to the $11.15 Missouri minimum wage that was effective during the July 1, 2022–December 31, 2022 survey reporting period. Mercer observed 144 of 311 providers who reported an average starting hourly wage or average hourly wage less than $11.15 per hour. In addition, although the CDS State Plan personal care rates were increased effective July 1, 2022 with the intent for providers to support a $15.00 per hour baseline PCA wage, nearly all CDS providers reported average hourly PCA wages below this level during the July 1, 2022 through December 31, 2022 survey reporting period.

CDS Survey

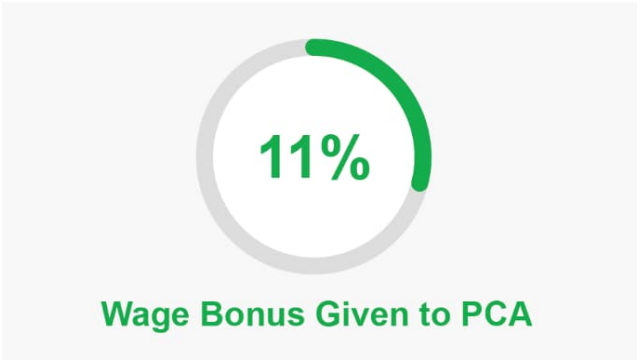
Figure 10: Provider Counts by PCA Average Hourly Wage



The survey collected data on both PCA starting wages and the average wage across all PCAs (regardless of tenure); Mercer observed little variation in the responses to these two questions. In terms of provider size, the average hourly wage for small providers was $11.31, a bit lower than the $12.18 average hourly wage reported by large providers. Providers were also asked to report wages specific to each population area (ranged from areas with fewer than 25,000 individuals up to areas with populations over 200,000 individuals); limited wage variation was seen across population areas (i.e., each population area's wages were very similar).

PCA Bonuses

About 11% of responding providers (i.e., 33 providers) indicated that wage bonuses were given to PCAs. Almost 60% of these providers indicated the bonuses were a one-time special circumstance, while about 40% indicated they were a routine business practice. Wage bonuses were typically given to a large number of the PCAs (often at least half of the PCAs), and in some cases, to all of the PCAs. The reported data on PCA bonus amounts appeared to be a mix of lump sum bonus payments and hourly wage bonuses. Due to the inconsistency in responses, Mercer was unable to make any meaningful conclusions about the wage bonus amounts paid to PCAs.



CDS Survey

PCA Hours Worked

Productivity

The survey asked CDS providers to report the total number of working hours recorded by PCAs (defined as hours spent on Medicaid reimbursable services, as well as informal supports). The survey also requested data on the portion of PCA working hours that were eligible for Medicaid reimbursement and the number of overtime hours paid to PCAs. The relationship between these two values illustrates a productivity rate. The vast majority of responses showed 100% PCA productivity, meaning that all PCA hours worked were Medicaid reimbursable. There were a few providers who reported very low PCA productivity rates, which pulled the average down to 96%. It is important to note that Mercer observed many data issues with provider responses to these questions, so the results above should be interpreted with caution.

Overtime

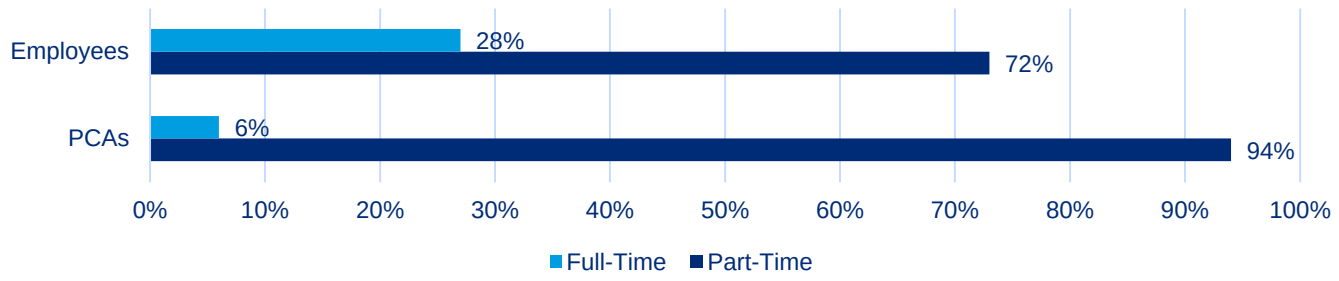
The majority of providers indicated overtime hours were not paid to CDS PCAs. Only 18 providers indicated that overtime hours were paid, and the number of overtime hours reported was minimal.

Full-Time and Part-Time Status

While most survey questions were about PCAs, there were a few questions that asked providers to supply information related to their employees. PCAs were defined as: participant-employed individuals providing direct services to participants, while employees were defined as: individuals employed by the provider to assist in business functions outside of direct services.

Figure 11 shows that employees and PCAs typically had part-time status (part-time status defined as 35 hours or fewer per week). Full-time status was much more common for provider employees than for PCAs. Note that in roughly half of the provider responses, the sum of the reported full-time and part-time PCA counts did not tie to the total number of reported PCAs. Based on this, it is unclear how reliable the data is.

Figure 11: Employee and PCA Full-time and Part-Time Percentages



CDS Survey

Benefits and Travel

Less than 16% of the responses indicated that health insurance, retirement, life insurance, disability, or continuing education benefits were offered to full-time employees, and less than 8% of the responses indicated that these benefits were offered to part-time employees. The numbers were even lower for PCAs, with less than 5% of the responses indicating that these benefits were offered to full-time or part-time PCAs. Given the low prevalence of benefits being offered, minimal benefit cost data was available. In terms of paid time off, less than 26% of the responses indicated that any type of paid time off was offered to employees, and less than 5% indicated that any type of paid time off was offered to PCAs. Given this low prevalence, minimal data on the number of paid time off days was available.

About 5% of providers (i.e., 17 providers) indicated they offer agency vehicles for PCAs to use for CDS-related travel. This means that in most cases, PCAs need to use their own vehicles, and 5% of providers reimburse PCAs for their mileage costs in these situations. The survey response data appeared to be a mix of mileage rates and number of miles driven, which made it challenging to assess the actual mileage reimbursement rates.

Hours Spent on Other CDS Activities

There was a wide range of time spent by providers on the different types of CDS administrative activities listed in the survey. Mercer observed that small providers were generally spending more time than large providers (on a per participant or per PCA basis) performing monthly case management monitoring, processing PCA payroll, and certifying, maintaining, or correcting EVV records. Given several reported outliers and other values that appeared unreasonable, it appears that some providers reported incorrectly, and Mercer recommends caution when reviewing the results in Table 3.

Table 3: Provider Time Spent on CDS Activities

Task	Measurement Basis	Range of Responses	Median
Onboarding New PCAs	Hours per PCA	1 hour–130 hours	3 hours
Training New Consumers	Hours per Consumer	1 hour–72 hours	3 hours
Conducting Background Checks	Hours per New PCA	6 minutes–120 hours	1 hour
Performing Monthly Case Management Monitoring Tasks	Per Month per Participant*	0 minutes–60 hours	35 minutes
Processing PCA Payroll	Per Month per PCA*	0 minutes–80 hours	30 minutes

CDS Survey

Task	Measurement Basis	Range of Responses	Median
Certifying, Maintaining, or Correcting EVV Records	Per Month per Participant*	0 minutes–100 hours	43 minutes

* Converted survey responses to per PCA or per participant basis to allow comparison across providers

Specific to EVV, Personal Care providers were required to transmit their EVV data to Missouri's Electronic Aggregator Solution (EAS) effective November 8, 2021. In October 2022, DSDS notified providers that a value-based payment (VBP) would be made beginning in March 2023 to all providers who demonstrated they were meeting this requirement. Based on DSDS data, 60% of providers demonstrated compliance with the EVV requirement and obtained the VBP as of March 2023.

Key Takeaways

Although the CDS survey response rate was relatively high and the survey respondent subset appeared to provide a good snapshot of the DSDS CDS provider universe, the quality of the survey response data was low in several instances. There were several occasions where providers failed validation checks on multiple survey questions. In addition, there were specific questions where a large number of providers failed the inter-relational validation checks, reported outlier values that did not appear reasonable, or did not report on a consistent basis. Based on these observations, Mercer recommends caution when reviewing certain data metrics highlighted in this paper. To the extent that DSDS conducts a future CDS survey, Mercer is able to provide guidance on strategies that could help improve data quality.

Most providers indicated they only served DSDS CDS participants, only operated in one population area, and were serving 50 or fewer participants. In addition, most CDS providers reported a staffing ratio of one PCA for every one participant. Roughly two-thirds of CDS providers never had to turn down a new referral due to staffing issues and very few overtime hours were paid to PCAs. The lack of overtime hours could be due to the fact that most PCAs were reported to have a part-time status and therefore would not be working anywhere close to 40 hours per week. The median PCA turnover rate was relatively low at roughly 6%. Compared to the NCI-AD agency model survey data, the CDS survey data suggests that workforce and staffing challenges are less of an issue in the CDS model.

The survey responses showed DSW hourly wages ranging from $9.00 to $15.00, with a median hourly wage of $11.25. There was little variation between PCA starting wages and the average wages across all PCAs (regardless of length of employment). Mercer also observed limited variation in the PCA wages reported by small and large providers and little variation in wages across population areas. Very few survey responses mentioned that PCAs were offered wage bonuses, benefits, or paid time off.

There was a very wide range of time being spent by providers on CDS administrative activities (e.g., onboarding new PCAs, training new consumers, performing monthly case management, etc.). It is unclear how much of this variation is due to errors in survey responses versus actual differences in provider operational processes. The data showed that smaller providers were typically spending more time than larger providers (on a per participant or per PCA basis) performing monthly case management monitoring, processing PCA payroll, and certifying, maintaining, or correcting EVV records.

Next Steps

The information collected through the NCI-AD and CDS workforce surveys provides DSDS with a wealth of data that can aid in program monitoring efforts, identify provider best practices, highlight system pain points, and inform future policy and fiscal initiatives. For example, additional personal care rate increases supporting DSW and PCA baseline wages of $16.10 per hour were implemented 7/1/23 pursuant to the FY 2024 budget; as a result, DSDS plans to continue issuing workforce surveys to ensure DSW and PCA wage increases are implemented as intended. The survey data also provides insight into current agency and CDS provider cost components, which will help DSDS begin assessing potential impacts of the proposed federal Access Rule[1] published on April 27, 2023. The Centers for Medicare & Medicaid Services (CMS) included a specific provision in the Access Rule that would require states to demonstrate that at least 80% of Medicaid payments for personal care, homemaker, and home health aide waiver services were spent on direct care staff compensation. In the future, DSDS anticipates utilizing workforce surveys to demonstrate compliance with the CMS 80% compensation threshold. Lastly, it is DSDS' and Mercer's intent to utilize provider survey data as one of the data sources for future DSDS rate studies (use of the survey data as a data source requires a high level of data quality and sufficient participation rates).

In terms of rate study next steps, CMS requires states to formally review rates for 1915(c) waiver services at least once every five years. One of the key goals is to determine whether the fee schedule rates being paid to providers are reasonable and appropriate given market conditions. Rate studies consider cost components that providers incur to deliver services and that are necessary to meet state HCBS requirements. The following provides a list of cost components that are typically considered in an agency-model rate study. Due to differences in the CDS delivery model, it is common that CDS providers will not incur certain cost components listed below (e.g., PCA benefits, paid time off for PCAs); therefore, not all agency-model cost components are typically considered in CDS rate studies.

- Wages and overtime for direct care staff and other program staff integral to service delivery
- Employee-related expenses for direct care and other program staff — includes things like employee benefits, employer taxes, and workers' compensation insurance
- Productivity — includes things like paid time off, training time, and other non-billable time
- Other service-related expenses — includes things like transportation and service-specific supplies
- Administration/overhead — includes things like compensation for staff who spend time on administrative tasks and activities needed to meet state HCBS requirements and administrative building costs

[1] https://public-inspection.federalregister.gov/2023-08959.pdf

Next Steps

Independent market data sources, such as data from the Bureau of Labor Statistics, are used to price the cost components. In some cases, states may also collect provider-specific cost data to benchmark against the independent market data. Collection of provider-specific data can take various forms, but one common approach is to conduct provider surveys that include questions about different provider cost components. In order to use provider survey data in a rate study, there needs to be a sufficient amount of data to ensure credibility and the data needs to pass validation checks to ensure quality. Given some of the data quality issues observed in the NCI-AD and CDS survey responses, there are several areas where the current survey data cannot be relied upon; cleaner data would need to be collected prior to using the data as one of the rate study sources. Mercer and DSDS plan to discuss strategies that could help providers improve the quality and consistency of any future provider data survey or reporting efforts that DSDS chooses to pursue.

DSDS and Mercer will soon begin discussing a plan, timeline, and stakeholder engagement strategy for the next rate study. The NCI-AD and CDS provider surveys allowed providers an opportunity to submit detailed provider-specific data on various HCBS cost components. DSDS and Mercer anticipate engaging stakeholders throughout the next rate study in various ways to ensure an understanding of stakeholder concerns related to HCBS agency and CDS rates. More information will be shared as it becomes available.