DHSS Rate Study — Questions and Feedback Submitted after October 16, 2024 Stakeholder Meeting

Submission #1: Thank you for the opportunity to provide feedback on the 2024 rate methodology. We realize that there is a lot of thought put into this process and countless hours to analyze the **information and develop a model. We sincerely appreciate it. There are several topics we'd like to make you aware of, that we believe should impact changes to the current draft model. We are also** cognizant that it is late in this process and unlikely that significant changes will be implemented. **However, it is important to provide you with our perspective as part of the evolutionary process of developing a rate methodology. We believe we have a shared goal of getting this as accurate as** possible.

As we commented in our feedback to the Rate Study presentation in August, we believe that the ERE amounts/percentages are appropriate. This part of the rate is the most understandable/ verifiable because the different components within this category are clearly delineated. Generally, all other parts of the rate model are not easy to verify and provide DHSS with feedback because there is no **breakdown of the individual components within each category. This leaves us with more questions than answers and little ability to provide alternative considerations.**

Response: DHSS and Mercer appreciate this feedback. To increase transparency and provide additional detail about how the rate study was performed for agency and CDS State Plan Basic Personal Care services, Mercer created Attachment 1. Attachment 1 shows how the Personal Care rate study assumptions discussed at the stakeholder meetings were factored together to develop the Personal Care modeled rate ranges.

It is important to note that each provider's actual costs may differ from the individual assumptions utilized in the rate study; however, Mercer and DHSS believe the overall modeled rate ranges are reasonable based on service delivery requirements and current market conditions.

- **Productivity: In both the 2019 Mercer Study and 2024 Mercer Study, it is unclear how productivity is incorporated into the rate development (see further discussion at the end).**
    - **It is unclear if paid time off is considered a benefit under ERE, or an expense under productivity.**
    - **For 2024 this is especially important if Proposition A passes on November 5th, which** mandates one hour of sick leave for each 30 hours worked. This is an added expense **effective 1/1/25 that needs to be incorporated into the rate model.**

  Response: As shown on slides 19, 22, and 23 from the October 16, 2024 presentation, paid time off was considered within the productivity assumption for agency model services. Rows L–P of Attachment 1 illustrate how the productivity component was factored into the development of the modeled rate ranges.

After Proposition A was passed on November 5, 2024, DHSS and Mercer reviewed the enacted language and considered it in the rate study. For all agency model services, the paid time off assumption for part-time direct care staff was increased from five days per year to seven days per year, which resulted in increases to the modeled rate ranges for various agency model services. DHSS does not believe that Proposition A will impact the CDS model, so no changes to CDS assumptions were made related to Proposition A. Please refer to Appendix C of the rate study report for the updated modeled rate ranges.

- **Compensation: In the 2024 Mercer Study, it is unclear how supervisory costs are incorporated** into the rate model.
    - **The October 16th, 2024 presentation (slide 16) describes that DSW Supervisor and Nurse Oversight are not included in the CDS personal care compensation. Based on this comment, the CDS compensation rate should be different (and lower) than the agency care compensation. Because both compensation amounts ($17.48) are the** same, it is hard to understand how supervisory costs are included.
    - **Similar to the Mercer Study's finalization and publication in 2020, an election-determined change regarding mandatory minimum wage (Proposition A in 2024) will come into play after the bulk of the research has been completed on the current rate study. If passed in November, Proposition A will raise the mandatory minimum wage** from $12.30 to $13.75 on 1/1/25, nearly a 12% increase. This will undoubtedly in**fl**uence hourly rates in the labor market.
    - **The DHSS/Mercer Q & A and PowerPoints describe applying a 4% annual inflationary factor to BLS data in its projections. Is it possible to historically look at how minimum** wage increases in Missouri have subsequently impacted BLS data, so it can be used to **project inflationary increases forward and be included in this rate study?**

Response:
The $17.48 DSW/PCA lower bound hourly wage is the same for both agency and CDS model Basic Personal Care services. The $26.19 supervisor hourly wage and the $39.08 nursing oversight hourly wage from slide 26 of the August 7, 2024 presentation were factored in for agency Personal Care services using the ratios on slide 16 of the October 16, 2024 presentation. Refer to Rows A–G of Attachment 1, which show that one tenth of the supervisor hourly wage and 1/25th of the nurse hourly wage were included in the rate study for agency Personal Care services.

After Proposition A was passed on November 5, 2024, DHSS and Mercer reviewed the enacted language and considered it in the rate study. Because the SFY 2026 modeled wages assumed in the rate study were significantly higher than the $13.75 minimum wage effective January 1, 2025 and also higher than the $15.00 per hour minimum wage effective January 1, 2026, it was determined that no adjustment to the rate study wage assumptions was necessary.

The rate study utilizes hourly wage assumptions that are significantly higher than historical and future Missouri minimum wage levels. Given that, DHSS and Mercer believe that the 4% annual inflationary factor is appropriate.

- Other service-related costs: Without having an itemized breakdown of this category, it is difficult to provide feedback. For example, the DHSS Rate Study PPT #1 August 7, 2024, (Slide **14) describe a median EVV cost of $174 per participant per year. Each provider has a different number of participants to apply this EVV value to, so it is unknown what value was** used as a statewide average roll-up number. Furthermore, because this value is not known, it **is also not known how much of the 2% for CDS and 5% for Agency is being attributed** exclusively to EVV costs. The 2019 rate model allocated $.35 for EVV and the 2024 appears to allocate $.47 total for other service-related costs in CDS. Without knowing how much EVV is **counting towards the $.47, a reasonable assumption could be that 75% of service-related costs in CDS are attributable to EVV.**

  Response: The CDS Operational Survey data showed that EVV costs represented roughly 0.8% of total CDS costs (based on the median survey response). This was considered in the 2% other service-related cost assumption outlined on slide 27 from the October 16, 2024 presentation. Based on stakeholder feedback related to other service-related costs, this assumption was increased to 3% after to the October 16, 2024 meeting. Please refer to Rows Q–T of Attachment 1 to see how this was factored into the rate ranges on a dollar per unit basis.

- **Administration/Overhead: We appreciate utilizing any standard for this component, but do** believe that 15% is significantly undervaluing the costs of delivering quality services.
  - **Utilizing the Proposition A (if passed) example cited above, administrative staff will receive an increase due to the minimum wage increase, in addition to new sick leave** benefits. This increase will not be incorporated into the rate methodology in any way **and will reduce any available administrative funds.**
  - **It is unclear if the OMB rule is applicable to the administrative overhead of 15% in the** rate methodology. OMB cost principles (2 CFR 200.414) typically provide guidance for **indirect costs not administrative costs. The terms "indirect costs" and "administrative** costs" can technically differ slightly, with "indirect costs" referring to any cost that **can't be directly tied to a specific project or activity, while "administrative costs" usually encompass the costs associated with managing an organization.**

  Response: The Administration/Overhead cost component includes consideration for administrative staff (e.g., C-suite positions, Human Resource specialists, finance staff, clerical staff). We do not anticipate that Proposition A will have a material impact on total administrative staff costs due to the expected low prevalence of administrative staff who are being paid at or close to minimum wage or who are not already receiving paid sick time. In addition, the 15% administrative/overhead assumption utilized in the rate study was 5% higher than the assumption used in the prior rate study.

Based on industry standards and Mercer's experience performing rate studies in other states, administrative/overhead assumptions for efficiently-run organizations typically fall in the 10%-15% range. This aligns with historical expectations communicated by CMS and the OMB Circular guidance on indirect costs. It also aligns with recent guidance communicated by CMS in the Access Rule, which indicates that providers will need to spend at least 80% of their Medicaid personal care revenues on DSW/PCA-related expenditures, which leaves less than 20% for other service-related costs and administrative/overhead costs. In the CDS Operational Survey, roughly half of provider respondents reported that administrative/overhead costs represented 15% or less of their total expenses. Given these factors, DHSS and Mercer believe that the 15% administration/overhead assumption is reasonable.

Conclusion

The most important piece of information we would like you to takeaway gets at the crux of the burden of running both models, and where the current rate methodology is falling short.

- **If the assertion is that running an agency model is more administratively burdensome, more expensive and therefore justifies a higher rate of reimbursement, it should be reflected either:**
    - **In the compensation amount as supervisory oversight costs and/or productivity are** included.
    - **In the administrative amount, which should be variable in response to increased administrative costs (ie: wages for non-DSW staff).**

Response: As described in the October 16, 2024 presentation and shown in Attachment 1, there are cost components that exist in the agency Personal Care model, but are not applicable to the CDS Personal Care model. The cost components that do not apply to the CDS model include DSW supervisory and nursing oversight costs, DSW ERE, DSW productivity, and some other service-related costs. As a result, the modeled rate ranges for agency Personal Care are higher than the modeled rate ranges for CDS Personal Care.

Submission #2: Do you have any thoughts on Proposition A (will be on the November 5th ballot) in regards to the rate study? I don't know what the survey results showed as far as if or how much sick **time agencies were giving PCAs? If this would pass, I assume this would be an additional expense on** more providers?

Response: Please refer to the response to Submission #1.

Submission #3: I am writing to provide feedback on the Mercer Rate Study.

- **Slide 16 of the 10/16 presentation notes that supervisory oversight for the CDS program is not** accounted for due to the delivery model. However, case managers who facilitate the CDS **program require supervisory oversight, which should be factored into the rate considerations.**
- **Slide 24 of the 10/16 presentation does not currently account for training time for PCAs under the assumption that the consumer provides this training. However, agencies are responsible for training the consumer on program regulations to ensure that the PCA remains compliant, which does require agency staff time.**

- **Slide 33 of the 10/16 presentation estimates only 12 hours per year of case management per consumer. In practice, monthly calls alone may take about an hour, including documentation, while additional time may be spent playing phone tag and documenting those interactions. Additionally, the required annual in-person visit includes potentially significant travel time, a one-to-two-hour visit, and documentation. The current 12-hour annual estimate appears low and may not fully represent the actual time commitment needed.**

Response: DHSS and Mercer thank you for these comments. To clarify, the footnote on slide 16 of the October 16, 2024 presentation was specific to supervisors of direct care staff delivering Personal Care to individuals; this job position exists in the agency Personal Care model, but not in the CDS model. Similarly, slide 24 of the October 16, 2024 presentation was specific to DSW training, which exists in the agency model, but is not applicable under the CDS model due to the consumer being responsible for PCA training as part of the consumer's employer role. See the next paragraph for an explanation of how costs associated with new consumer and attendant paperwork, as well as provider orientation for the consumer and their attendant, were considered. Lastly, the 12 hour per year assumption mentioned on slide 33 of the October 16, 2024 presentation was specific to the standalone Case Management service in the Independent Living Waiver (T2024 U6).

DHSS and Mercer confirm that the types of costs you mention (monthly case management, annual face-to-face visit, and new consumer and attendant orientation) were considered in the rate study for CDS Personal Care. Please refer to slide 27 from the October 16, 2024 presentation, which shows that a 2% other service-related cost assumption was included to account for monthly case management, annual face-to-face monitoring, new consumer and attendant paperwork, provider orientation for the consumer and their attendant, and EVV software/system. This assumption was based on provider-reported data collected in early 2024 through the CDS Operational Survey. Based on stakeholder feedback related to other service-related costs, this assumption was increased to 3% after the October 16, 2024 stakeholder meeting.

Submission #4: I feel the Private Duty Nursing (PDN) proposed rates are heading in the right direction. I would like to see these increase with rate differentials, overtime/holiday pay/reimbursement for training nurses on ventilators, or orientating them on a new case. These are all costs providers have to absorb right now but are required to sta**ff** cases. These costs should be reimbursed by Medicaid and not be a burden on the agency. **Nurses who come from facilities expect a rate differential when** working nights or weekends. **If we have to pay overtime for a case or pay a nurse to work a holiday, then we should be reimbursed at the same time and in half, just as we must pay the nurse…. Massachusetts and Louisiana have rates broken out, as I describe above. Massachusetts and IL also pay for orientation. Since no nurses are trained on ventilators because they are not allowed to touch them in a facility, we must train them at our cost to work a ventilated case.** We need to be paid for this training as we should not eat this cost, but it would also guarantee that agencies are given the proper **amount of training for nurses to work with clients who have ventilators, which promotes safety and better outcomes for the client.**

Response: DHSS and Mercer appreciate this feedback and confirm these types of costs (nurse overtime, holidays, and training) were considered in the rate study for PDN services. Slide 17 from the

October 16, 2024 presentation shows that an 8% assumption was included for nurse overtime based on survey data that DHSS collected from PDN providers in August 2024. Regarding holidays, slide 23 from the October 16, 2024 presentation shows that consideration was included for paid time off (vacation, sick time, and holidays). In terms of training time, slide 24 from the October 16, 2024 presentation shows that 19 hours per year were included for new nurses and 12 hours per year were included for nurses annually thereafter. The training assumptions were informed by PDN provider responses to an August 2024 survey.

Providers can make a business decision to pay employees evening, weekend, or holiday differentials. This was considered in the rate study through the use of average wage assumptions. DHSS does not plan to modify the rate structure to include separate rates for specific circumstances (e.g., separate rates for overtime hours, holiday pay, or training time).

Submission #5: The CDS personal care rate is about 36% less than the agency personal care rate. Please explain the variant between the CDS and agency models.

Response: There are cost components that exist in the agency Personal Care model but are not applicable to the CDS Personal Care model. The cost components that do not apply to the CDS model include DSW supervisory and nursing oversight costs, DSW ERE, DSW productivity, and some other service-related costs. As a result, the modeled rate ranges for agency Personal Care are higher than the modeled rate ranges for CDS Personal Care. Please refer to the response to Submission #1 above and Attachment 1 for additional information on the rate study assumptions and process utilized to develop the modeled rate ranges for these two services. Attachment 1 specifically shows how the rate study assumptions differ between these two services.

Submission #6: The CDS rate does not cover the expected wage and the providers' cost…I feel we need **to further delve deeper into the overhead amount and the true administration of the CDS program to fi**nd the exact disconnect.

Response: Please refer to the response to Submission #1 above and Attachment 1 for additional information on the assumptions and process utilized to model the State Plan CDS Personal Care (T10109 U2) rate range. Each provider's actual costs may differ from the individual assumptions utilized in the study; however, Mercer and DHSS believe the overall modeled rate range for CDS is reasonable given service delivery requirements and current market conditions.

Submission #7: How is the Passage of Proposition A going to work for HCBS providers? Are we going to have to eat the costs of the vacation time accrued and paid to CDS attendants?

Response: DHSS does not believe that Proposition A will impact the CDS model. Please refer to the response to Submission #1 for an explanation of the considerations for Agency model services.

MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES

Mercer

Attachment 1

	Key Cost Components		DHSS Rate Study: SFY 2026 Modeled Rate Ranges			
			State Plan Personal Care - Basic Level (T1019)		State Plan CDS Personal Care (T1019 U2)	
			Lower Bound	Upper Bound	Lower Bound	Upper Bound
A	Staff Wages	Direct Service Worker (DSW) Hourly Wage	$ 17.48	$ 19.93	$ 17.48	$ 19.93
B		Direct Service Worker Staffing Ratio	1:1	1:1	1:1	1:1
C		Supervisor Hourly Wage	$ 26.19	$ 30.18		
D		Supervisor to DSW Ratio	1:10	1:10		
E		Nursing Oversight (RN) Hourly Wage	$ 39.08	$ 42.93		
F		Nurse to DSW Ratio	1:25	1:25		
G		**Total Adjusted Hourly Cost:**	**$ 21.66**	**$ 24.66**	**$ 17.48**	**$ 19.93**
H	Health, Retirement, STD/LTD/Life	Percent of Staff Hourly Cost	9%	8%		
I	FICA, FUTA/SUTA, Workers Compensation	Percent of Staff Hourly Cost	11%	11%	11%	11%
J	Total Employee Related Expenses (ERE)	Total ERE	121%	120%	111%	111%
K		**Staff Hourly Cost and ERE: (G * J)**	**$ 26.11**	**$ 29.49**	**$ 19.47**	**$ 22.18**
L	Productivity	Annual Paid Time Off	27 Days for FT Staff and 7 Days for PT Staff			
M		Annual DSW Training Time	13 Hours for New DSWs; 6 Hours Annually Thereafter			
N		Daily DSW Productivity	7.5 Billable Hours in an 8 Hour Work Day (94%)			
O		**Total Productivity Adjustment**	**113%**	**113%**		
P		**Productivity Adjusted Hourly Cost: (K * O)**	**$ 29.56**	**$ 33.38**	**$ 19.47**	**$ 22.18**
Q	Other Service-Related Costs	Percent of Total Modeled Rate	5%		3%	
R	Administration/Overhead	Percent of Total Modeled Rate	15%		15%	
S	Subtotal	**Percent of Total Modeled Rate**	**20%**		**18%**	
T		**Total Modeled Hourly Cost: *(P / [1 - S])***	**$ 36.95**	**$ 41.73**	**$ 23.74**	**$ 27.05**
U	**Unit of Service**		Per 15 Minutes		Per 15 Minutes	
V	**Modeled Rate Per Unit of Service: *(T / 4)***		**$ 9.24**	**$ 10.43**	**$ 5.94**	**$ 6.76**

Notes and Caveats:

The information in this exhibit is based on the DHSS rate study that was conducted in 2024. Refer to the rate study report for an explanation of the assumptions and rate modeling process. The report is titled: Missouri DHSS: Rate Study for 1915(c) Waiver and Select State Plan Services dated January 13, 2025.

The purpose of this attachment is to share the SFY 2026 modeled rate ranges for two select DHSS services. It is not appropriate for any other use. In some cases, totals may not sum due to rounding.

When performing this work, Mercer relied on publicly available market data, data submitted by providers, and information provided by DHSS. Mercer has reviewed the data and information for internal consistency and reasonableness, but did not audit it. The suppliers of data are solely responsible for its validity and completeness. If the data or information are incomplete or inaccurate, the assumptions may need to be revised accordingly.

Please note that all estimates (including the assumptions and projections developed for this analysis) are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.