Missouri Division of Senior and Disability Services: Summary of Year 3 National Core Indicators — Aging and Disabilities and Consumer Directed Services Workforce Survey Results

July 25, 2025

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 model and the consumer directed services (CDS) model. One of DSDS's ongoing priorities is working with providers to address the direct service workforce crisis; this is critical to enabling seniors and individuals with disabilities to access the services needed to remain in their homes and avoid or delay institutionalization.

In order to gather data on direct service workforce issues, DSDS asks agency model and CDS providers to participate in an annual direct service workforce survey. For agency model providers, DSDS utilizes the National Core Indicators — Aging and Disabilities (NCI-AD) State of the Workforce Survey. For CDS providers, DSDS utilizes a CDS Operational Survey via REDCap (a secure web application with survey capabilities). 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 to a large number of providers who deliver various types of HCBS. Over the past few years, providers have experienced workforce challenges including direct service worker (DSW) staffing shortages and difficulties attracting and retaining staff with the necessary skill sets and qualifications needed to deliver certain DSDS services. To collect data that provides more information on these issues, DSDS asks providers to participate in an annual provider workforce survey process.

The annual workforce surveys were initially piloted a few years ago, and DSDS recently completed the third iteration. The NCI-AD State of the Workforce Survey collects data from HCBS providers that deliver agency model personal care services in community settings, personal care services in residential care facilities (RCFs) and assisted living facilities (ALFs), and adult day care services. The CDS Operational Survey collects data from HCBS providers that deliver CDS. Both surveys cover 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 include questions with yes/no responses, questions that require providers to select from pre-defined response options, and free response questions where providers submit numerical or narrative responses.

Survey Administration

Prior to the issuance of the two surveys, DSDS engaged with various stakeholders including the Missouri Assisted Living Association, Missouri Council for Independent Living, Missouri Alliance for Care at Home, and Missouri Council for In-Home Services. DSDS discussed plans for the surveys during conferences, monthly stakeholder meetings, and during the Missouri Medicaid Audit and Compliance (MMAC) provider update meetings. DSDS also issued various informational memorandums to alert agency model and CDS providers about the upcoming surveys (INFO 07-24-04 on July 22, 2024, INFO 09-24-03 on September 9, 2024, INFO 12-24-03 on December 9, 2024, and INFO 01-25-01 on January 1, 2025). DSDS monitored provider responses and sent multiple email reminders during the survey timeframes to encourage provider participation. In addition, DSDS offered a $2,000 incentive payment to providers who fully and accurately completed each survey. 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 State of the Workforce Survey Year 3	Agency model providers who deliver: • Personal care services in the community, in RCFs, or in ALFs • Adult day services	68	January 1, 2023–December 31, 2023 (CY 2023)	September 18, 2024–November 15, 2024	197	804
CDS Operational Survey Year 3	CDS personal care providers	31	July 1, 2024–December 31, 2024	January 2, 2025–February 28, 2025	404	984

Provider Payment Rates for Reference

While the Year 3 NCI-AD and CDS surveys collected information on expenditures that providers incurred to deliver personal care services, they did not collect data on agency model 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 model 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 2023 Rate*	FY 2024 Rate*	FY 2025 Rate*
January 1, 2023– December 31, 2023	Agency	Personal Care/Attendant Care	15-minute	$7.63	$8.14	
		Personal Care — ALF/RCF	15-minute	$7.07	$7.66	
		Advanced Personal Care	15-minute	$7.66	$8.17	
		Advanced Personal Care — ALF/RCF	15-minute	$7.09	$7.68	
		Adult Day Care	15-minute	$3.12**	$3.32**	
July 1, 2024– December 31, 2024	CDS	CDS Personal Care — Independent Living Waiver	15-minute			$4.63
		CDS Personal Care — State Plan	15-minute			$5.23

* Grayed out sections are not applicable to each survey's reporting period.

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

Survey Analysis and Results

In January 2025 and March 2025, DSDS provided Mercer with two separate data extracts, one that contained the NCI-AD survey responses and one that contained CDS survey responses. After intaking and loading the data, Mercer's analysis approach included performing data validation checks, assessing data quality, applying data cleaning adjustments, and conducting analysis on the responses to each question. Since three cycles of survey data were available, Mercer made year-over-year comparisons for certain data metrics and noted trends observed across the three survey years.

For certain questions, Mercer analyzed responses in total across all providers and also separately by provider size groupings. For the agency model survey, provider size was based on the number of enrolled AD individuals as of December 31, 2023. For the CDS survey, provider size was based on the number of enrolled CDS participants as of December 31, 2024. Provider size was defined as follows:

Provider Size Category	Number of Individuals/Participants Enrolled with Provider
Small	1–10 people
Medium	11–50 people
Large	More than 50 people

NCI-AD Agency Model (CY 2023 Survey Reporting Period)

NCI-AD Agency Model Survey

Data Quality Assessment

For the NCI-AD survey, 197 providers voluntarily responded out of 804 DSDS agency model providers who were sent the survey, resulting in a response rate of roughly 25%. Of the 197 Year 3 responses, 37 were excluded due to one of the following reasons:

- Provider did not have any AD DSWs on payroll or they only used contract DSWs (11 providers)
- Provider could not limit their data to the AD population (21 providers)
- Provider left the majority of the questions blank (two providers)
- Provider failed multiple data checks bringing into question the overall accuracy of their response (three providers)

The survey analysis focused on the remaining 160 responses that were specific to the AD population and were fully complete.

Upon reviewing the results of the data validation checks, Mercer determined that the quality of the 160 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.

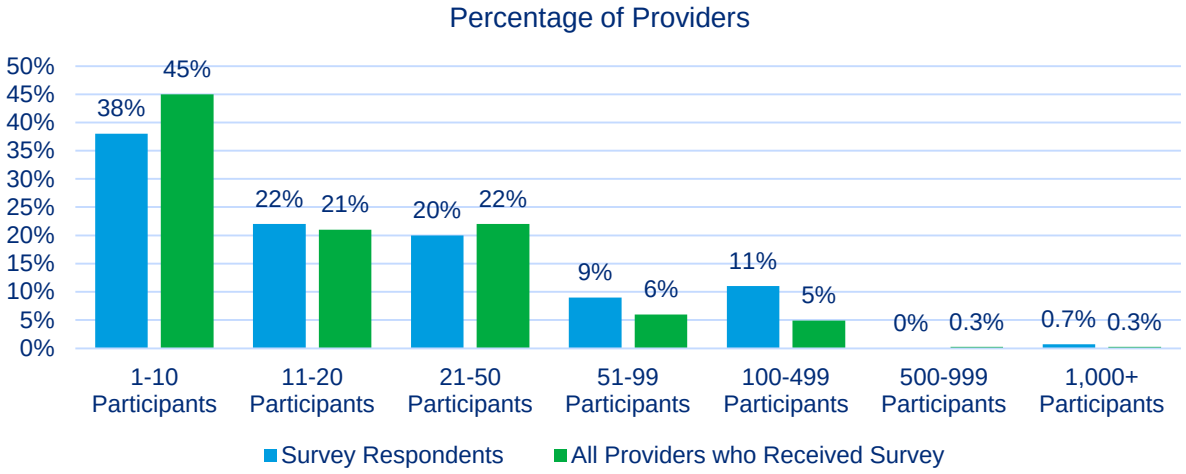
Mercer identified a few potential concerns within the response data including instances where a large number of providers left a certain question blank, a few questions where outlier values were reported that did not appear reasonable, and a few instances where it appeared that providers did not report on a consistent basis (e.g., some providers reported annual training hours for a single DSW, whereas others

NCI-AD Agency Model (CY 2023 Survey Reporting Period)

reported annual training hours across all DSWs). Given some questions either had a small response size or contained unreasonable outlier values, Mercer either did not include those questions in the analysis or caveated that the results should be reviewed with caution.

As shown in Figure 1, Mercer found that the size distribution of the 160 responding providers was somewhat similar to the size distribution of all DSDS providers who received the survey; this was similar to Year 1 and Year 2. In Year 3, the percentage of small providers (defined as those serving 1–10 participants) who responded to the survey was lower than the percentage of small providers who received the survey, and a larger percentage of providers with 100–499 participants responded to the survey compared to the percentage who received the survey.

Figure 1: Size Distribution of Year 3 Responding Providers



DSW Characteristics

Within the survey, DSWs were defined as paid workers whose primary responsibility is to provide direct care and support to the AD population. Across the survey responses, providers reported employing a total of 4,161 DSWs. On average, the ratio of DSWs to participants was roughly 1 DSW to 1.8 participants. This metric aligns with the Year 1 survey results and is an increase from Year 2, when the ratio was 1 DSW to 1.4 participants. Note that the staffing ratios did vary by provider size, as follows:

- Small providers: 1 DSW for every 0.8 participant
- Medium providers: 1 DSW for every 1.5 participants
- Large providers: 1 DSW for every 2.1 participants

The majority of providers reported staffing ratios under 1 DSW to 6 participants. However, one large provider reported a large staffing ratio of 1 DSW to 10 participants, which appears to be an outlier and should be reviewed with caution.

NCI-AD Agency Model (CY 2023 Survey Reporting Period)

Figure 2 shows that the vast majority of DSWs identified as either black (or African American) or white which is similar to prior survey years.

Figure 2: DSW Race/Ethnicity Identification

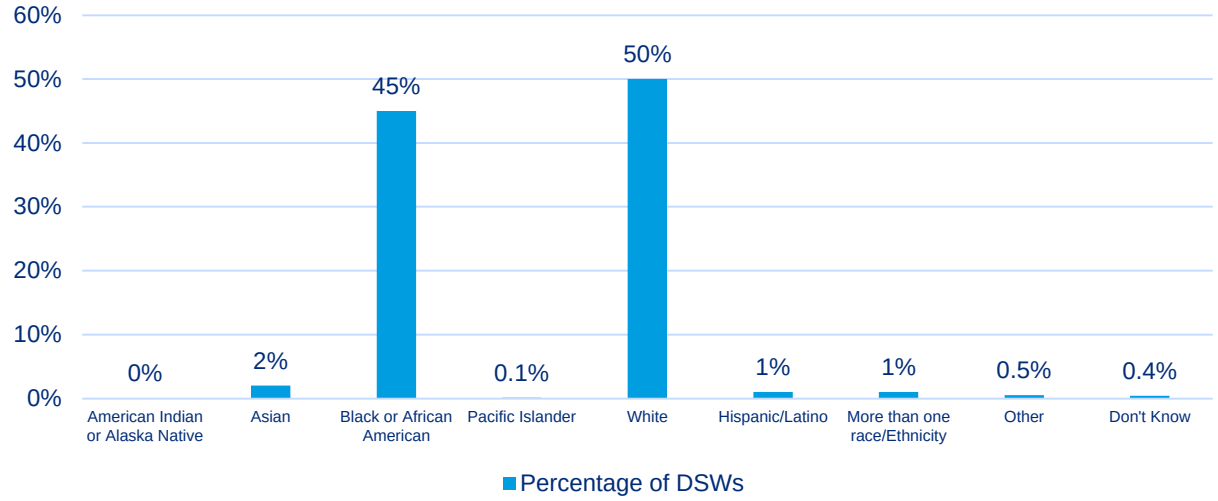
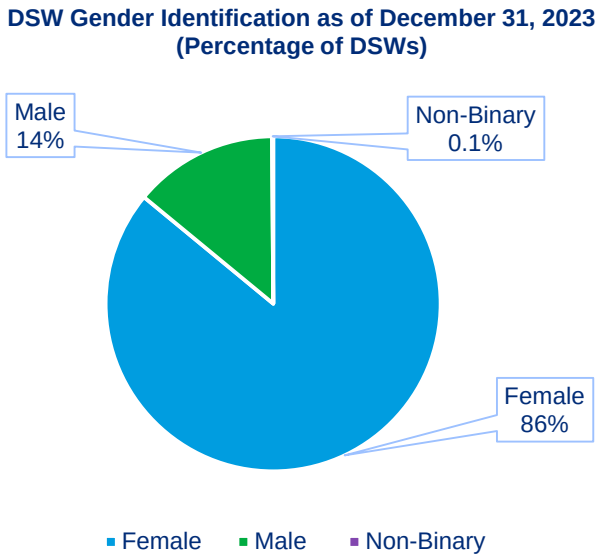
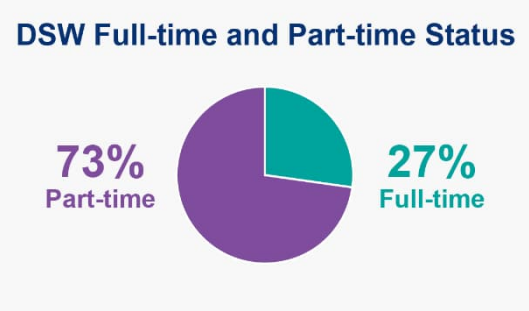


Figure 3 shows that the majority of DSWs identified as female, which was similar to Year 1 and Year 2.

Figure 3: DSW Gender Identification

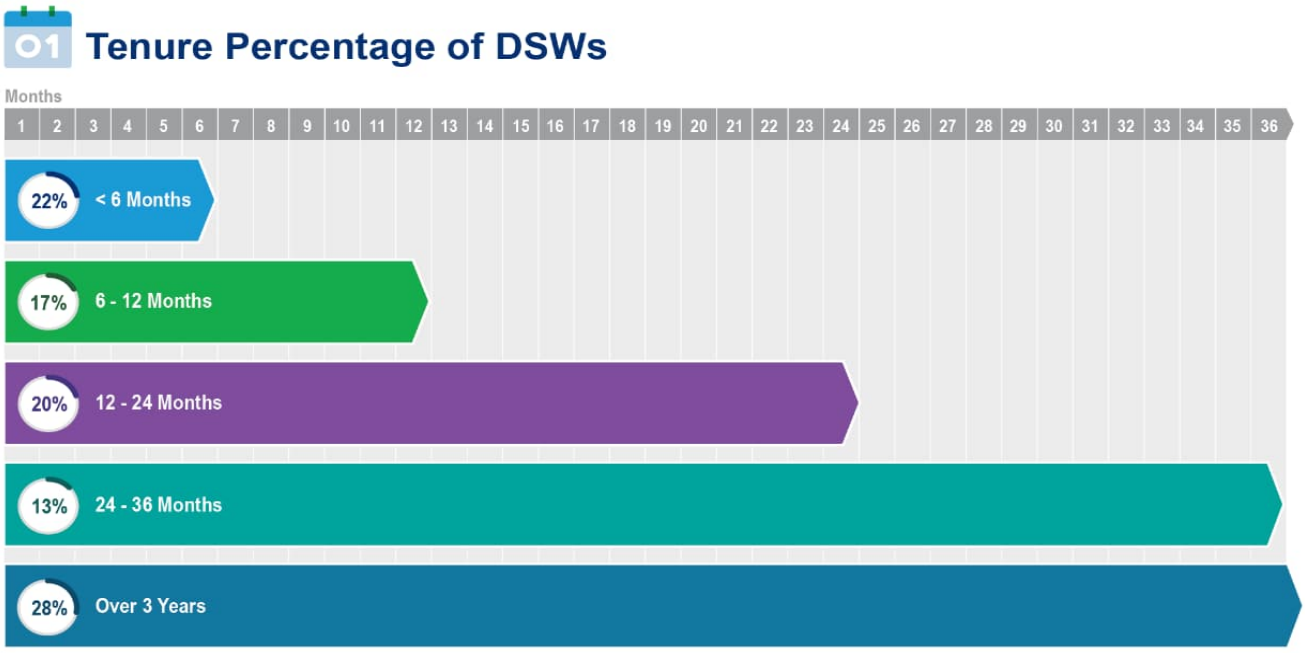


NCI-AD Agency Model (CY 2023 Survey Reporting Period)



Mercer analyzed various DSW workforce metrics including full-time/part-time distribution, tenure lengths, turnover rates, and vacancy rates. About 53% of providers were able to distinguish between full-time and part-time DSW positions. For the providers who could differentiate DSW status, many of them (62%) tended to employ more part-time DSWs than full-time DSWs. On average, roughly 73% of DSWs had a part-time employment status (compared to 71% in Year 1 and 65% in Year 2).

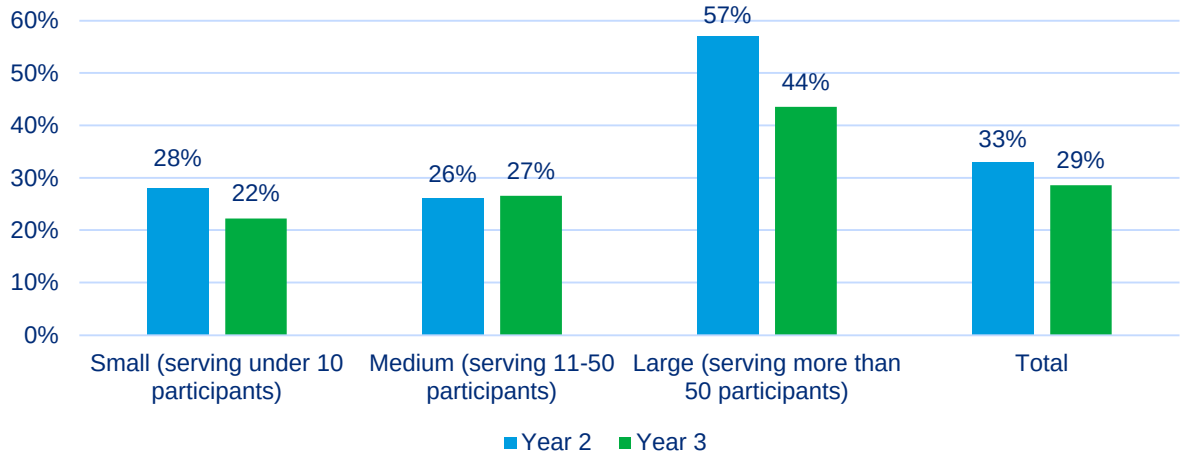
In terms of DSW tenure, Mercer observed that roughly 40% of DSWs had been employed for one year or less, while almost 30% had been employed for over three years. These results were generally similar to the results from Year 1 and Year 2.



NCI-AD Agency Model (CY 2023 Survey Reporting Period)

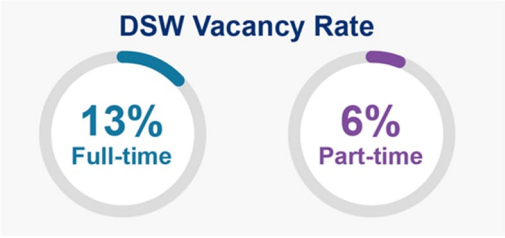
The median DSW turnover rate across providers was 29%, which was a bit lower than the 34% median rate in Year 1 and the 33% median rate in Year 2. There were some providers with extremely high turnover rates (100%–300%) that pulled the average turnover rate up to 48%. As shown in Figure 4, median turnover rates varied by provider size with large providers having the highest turnover rate. Note that a higher percentage of large providers (compared to small and medium-sized providers) gave sign-on bonuses to DSWs, which could potentially be related to the higher turnover rate experienced by large providers.

Figure 4: Median DSW Turnover Rate by Provider Size



During calendar year (CY) 2023, 74% of the DSWs who left their jobs had less than one year of tenure with the agency (compared to 79% in Year 2 and 70% in Year 1). Compared to small and medium providers, large providers reported a lower percentage of departing DSWs with less than one year of tenure. The vast majority of departing DSWs left voluntarily (as opposed to being laid off or fired).

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 13% and an average part-time DSW vacancy rate of 6% (a decrease compared to the vacancy rates in Year 1 and Year 2). Due to DSW staffing issues, 36% of providers had to turn away or stop accepting new service referrals in 2023, a significant improvement from the 57% and 53% values reported in Year 1 and Year 2, respectively. The improvements in these metrics suggest that providers may have experienced fewer staffing challenges in CY 2023 compared to prior years.



NCI-AD Agency Model (CY 2023 Survey Reporting Period)

DSW Wages and Benefits

Wages

During the January 1, 2023–December 31, 2023 survey reporting period, providers reported DSW hourly wages ranging from $10.00 per hour to $19.75 per hour, with an average starting hourly wage of $13.90 per hour and an average hourly wage regardless of tenure of $14.40 per hour[1]. The Year 3 DSW wage figures increased, on average, about $1.20 per hour compared to the wages reported in the Year 2 survey. Mercer observed 12 of 160 providers who reported either an average hourly starting wage or an average hourly wage regardless of tenure below the $12.00 minimum wage that was in place during 2023. Figure 5a shows a distribution of the average DSW wage reported by providers.

Year 3 Range of Hourly Wages: $10.00 to $19.75

Year 3 (CY 2023) Average Hourly Wage Regardless of Tenure: $14.40

Year 2 (CY 2022) Average Hourly Wage Regardless of Tenure: $13.19

for DSWs across all service types

Figure 5a: DSW Average Hourly Wage Regardless of Tenure — Survey Year 2 versus Year 3

[1] The Agency Model Personal Care fee schedule rates were increased effective July 1, 2023 (halfway through the CY 2023 NCI-AD survey reporting period) to support a $16.10 DSW hourly wage.

NCI-AD Agency Model (CY 2023 Survey Reporting Period)

There was some variation between Year 3 DSW starting wages and wages regardless of tenure, but the variation wasn't significant. The survey responses also showed little variation in wages across service types (i.e., personal care delivered in the community, personal care delivered in RCFs/ALFs, adult day services).

Table 3 shows that there was some variation in DSW wages based on provider size. Small providers were generally paying lower wages than medium-sized providers, and medium-sized providers were generally paying lower wages than large providers.

Table 3: Year 3 DSW Hourly Wage Regardless of Tenure

Provider Size	Average Hourly Wage
Small	$13.61
Medium	$14.83
Large	$15.32
All Providers	**$14.40**

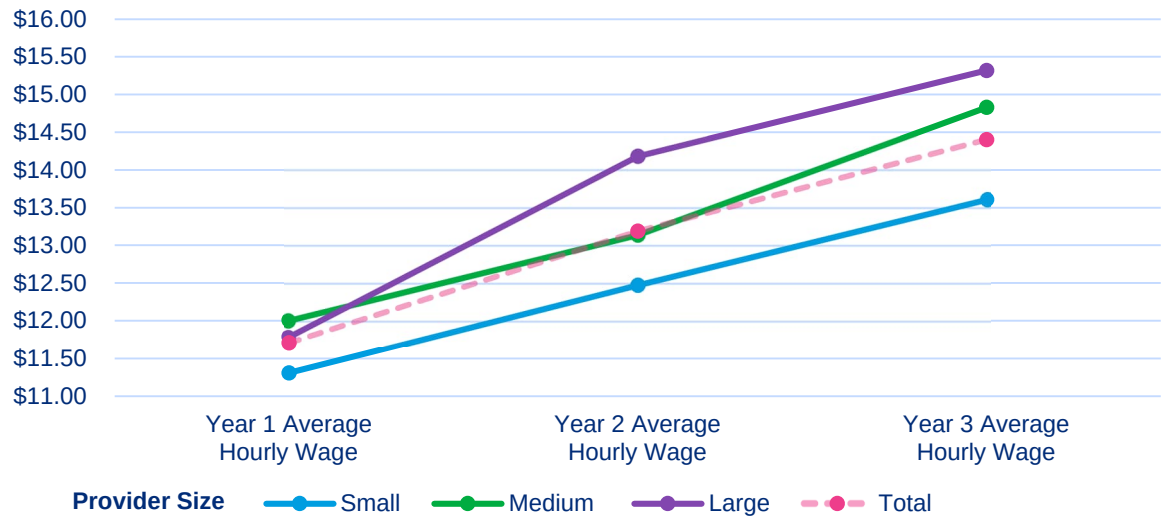
When asked how DSW wages compare for basic and advanced personal care, 37% of providers who offer both basic and advanced personal care services indicated they pay higher wages to DSWs delivering advanced personal care. As shown in Table 4, on average, these providers pay advanced personal care DSWs about $1.18 more per hour than basic personal care DSWs.

Table 4: Year 3 DSW Hourly Wages by Service Type

Service Type	Average Hourly Wage
Basic Personal Care	$14.34
Advanced Personal Care	$15.52
Across All Services/Settings	**$14.40**

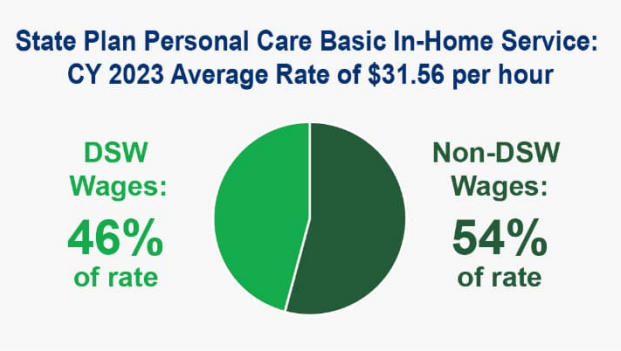
Figure 5b illustrates how the average DSW hourly wage reported by providers changed between the initial survey year (CY 2021 reporting period) and the Year 3 survey (CY 2023 reporting period). When looking at all providers in total, the DSW average hourly wage increased roughly 23% from $11.71 per hour in Year 1 to $14.40 per hour in Year 3. When looking at the DSW hourly wage increases by provider size, the trends were somewhat similar for each size category.

Figure 5b: Average DSW Hourly Wage by Provider Size and Survey Year



NCI-AD Agency Model (CY 2023 Survey Reporting Period)

During the January 1, 2023–December 31, 2023 period, NCI-AD providers were paid an average rate of $7.89 per 15-minute unit ($31.56 per hour) to deliver the State Plan Personal Care Basic In-Home service. Based on the $14.40 average DSW hourly wage reported in the survey, providers spent roughly 46% of their payment rate on DSW wages[2]. The remaining 54% was spent on non-wage cost components, which likely included DSW benefits and taxes, frontline supervisors, training materials, electronic visit verification (EVV), other service-related costs, and administration/overhead.



Bonuses

Approximately 42% of responding agencies indicated they provided a wage bonus to DSWs. This figure is significantly higher than the 29% figure observed in Years 1 and 2. This percentage varied by provider size with 30% of small providers, 49% of medium providers, and 53% of large providers indicating that they gave wage bonuses to DSWs.

Benefits

In terms of benefit offerings, results were similar to prior years. Generally, about a quarter of providers made benefits available to at least some DSWs (percentage varied by type of benefit). Approximately half of the providers required DSWs to be full-time to be eligible for the benefit, while other providers required DSWs to work a certain number of hours or have a minimum length of employment to be eligible to receive benefits.

[2] The methodology used to calculate this percentage is different from the methodology used in the Centers for Medicare & Medicaid Services (CMS) Access Rule; this is because the NCI-AD survey did not collect data on all elements needed to replicate the CMS Access Rule calculation. Therefore, this percentage cannot be compared to the 80% because it was calculated on a different basis.

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Figure 6 provides details on the percentage of providers offering each type of benefit, and Figure 7 provides information on other benefits that providers indicated they offer to DSWs.

Figure 6: Benefits Offered to Some or All DSWs

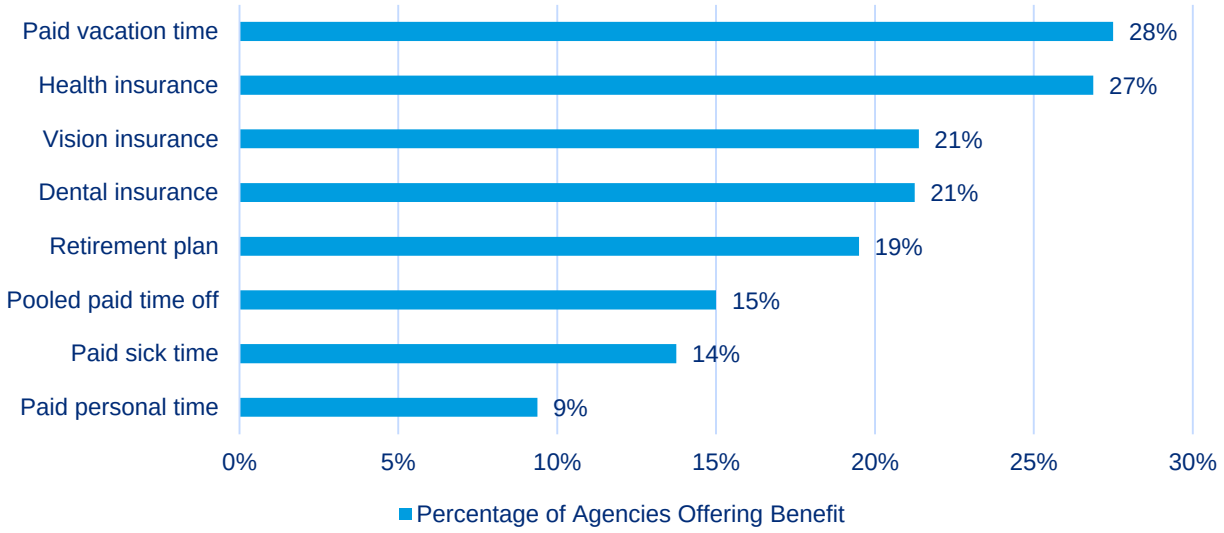


Figure 7: Additional Benefits Offered to DSWs

NCI-AD Agency Model (CY 2023 Survey Reporting Period)

Frontline Supervisors

The survey defined frontline supervisors as staff who supervise DSWs working with the AD population and often 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. The vast majority of responses indicated that frontline supervisors identified as female and as either black (or African American) or white; these results were generally similar to prior years and similar to the DSW responses to these questions.

On average, providers employed about one frontline supervisor for every 11 DSWs or a 1:11 ratio (this was aligned with the Year 1 ratio, but lower than the Year 2 ratio of one frontline supervisor for every 14 DSWs).This change could be due to the fact that fewer large providers responded to the survey in Year 3, and large providers tended to have higher supervisor ratios. The supervisor to DSW ratio varied widely, with some providers indicating they did not employ any frontline supervisors, while others reported employing one supervisor for 40 DSWs to 60 DSWs. Mercer also observed significantly different ratios based on provider size:

- Small providers employed an average of one supervisor for every six DSWs (1:6)
- Medium providers employed an average of one supervisor for every nine DSWs (1:9)
- Large providers employed an average of one supervisor for every 15 DSWs (1:15)

Providers reported frontline supervisor hourly wages ranging from $10.35 per hour to $75.00 per hour, with an average wage around $22.50 per hour. Note that medium-sized providers paid frontline supervisors the most at around $23.50 per hour, while small providers paid about $21.50 per hour, and large providers paid about $22.00 per hour. During CY 2023, 35% of providers indicated that they paid additional pay/wages to frontline supervisors for overtime hours. This was an increase over Year 1 and Year 2. Offering overtime hours to frontline supervisors varied by provider size with large providers being more likely to do so.

Table 5: Hourly Wage Paid to Frontline Supervisors

Supervisor Average Hourly Wage by Provider Size	
Small	$21.57
Medium	$23.52
Large	$21.89
All Providers	**$22.44**

Authorized Nurse Visits

The Year 3 survey asked providers about authorized nurse visits (ANVs), ANV hours delivered by a licensed practical nurse (LPN) and by a registered nurse (RN), and LPN and RN hourly wages. Of the 160 survey responses, 129 providers (81%) indicated they billed for ANVs during CY 2023. Of the total reported ANV hours, the overall distribution between LPN hours and RN hours was roughly 66% LPN and 34% RN. However, when reviewing the ANV LPN/RN hour distributions at the provider level, Mercer observed that 22 providers only used LPNs to deliver ANVs, 54 providers only used RNs, and 49

NCI-AD Agency Model (CY 2023 Survey Reporting Period)

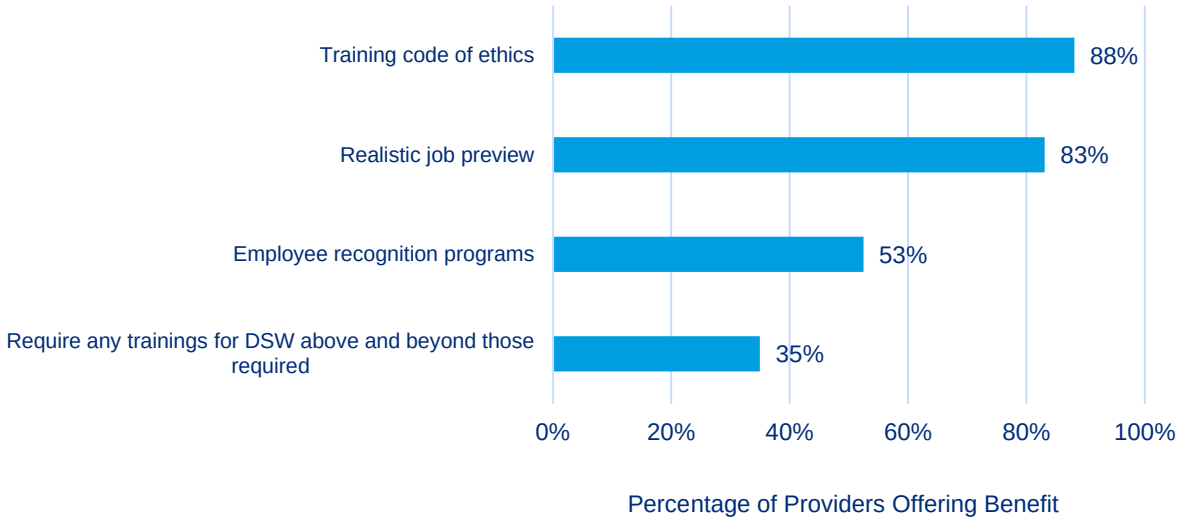
providers used a mix of LPNs and RNs. Note that these counts are specific to nurses who delivered ANVs and do not reflect all nursing staff that providers employed. Providers reported that less than 1% of the total reported ANV hours were overtime hours.

Providers reported LPN hourly wages ranging from $15.00 per hour to $50.00 per hour, with an average wage of $28.37 per hour. Providers reported RN hourly wages ranging from $20.00 per hour to $75.00 per hour, with an average wage of $36.96 per hour.

DSW 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 four most popular strategies displayed in Figure 8.

Figure 8: Top Four Most Popular DSW Recruitment and Retention Strategies



Provider Costs Incurred to Deliver Services

The Year 3 survey included a new question about provider costs to deliver services. The question collected data on CY 2023 costs that agency model providers incurred for various cost categories including:

- Compensation, benefits, and taxes for DSWs and other program staff integral to service delivery (e.g., frontline supervisors, nursing oversight)
- Other service-related costs
- Administration/overhead

In order to analyze the responses, Mercer calculated the percentage of total costs attributed to each line item. Some providers indicated they did not incur costs for certain categories, while other providers said

NCI-AD Agency Model (CY 2023 Survey Reporting Period)

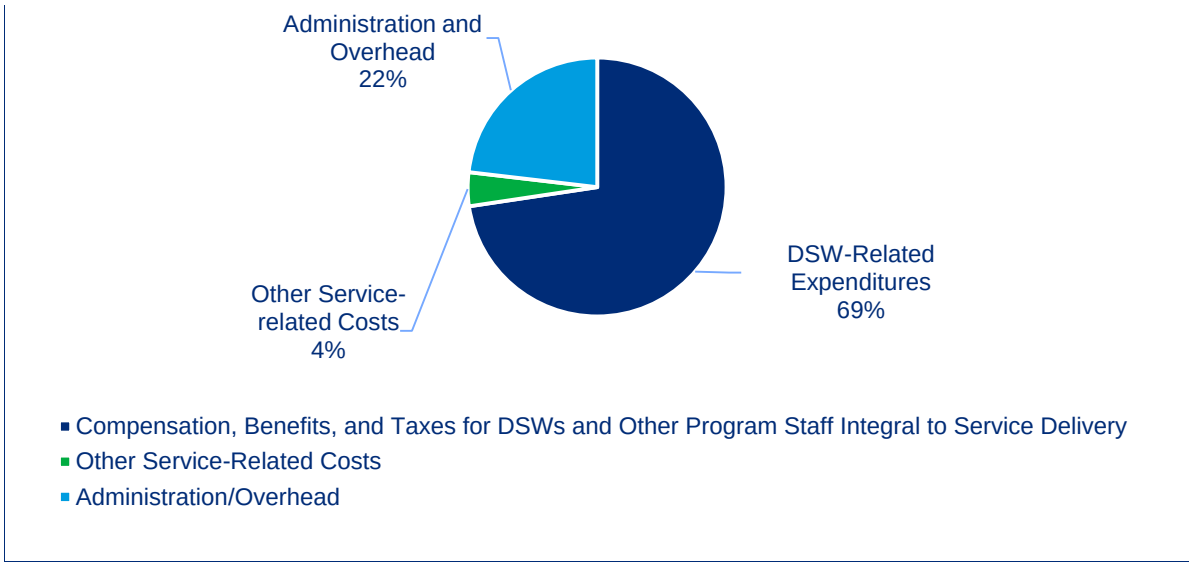
they incurred significant costs for that same category. Due to these inconsistencies and the other data quality concerns related to the responses to this question, this data should be reviewed with caution.

After calculating the cost distribution on each provider's reported values, Figure 9 shows the median cost percentage observed across providers. Roughly 69% of total agency model costs were attributed to DSWs, 4% of costs were attributed to other service-related costs, and 22% of costs were attributed to administration and overhead. Please note that a single provider does not represent the median value for all cost categories; therefore, percentages do not sum to exactly 100%.

Large and medium sized providers generally reported a larger portion of agency model costs spent on DSW-related expenditures, while small providers reported a larger percentage spent on other service-related and administrative expenditures. This is not unexpected given small providers are typically not able to take advantage of economies of scale that help medium and large providers reduce their administration/overhead cost percentage.

It is also important to note that the methodology used to calculate these percentages differs from the methodology used in the CMS Access Rule; this is because the NCI-AD survey did not collect data on all elements needed to replicate the CMS Access Rule calculation. Therefore, the 69% cannot be compared to the 80% provision in the Access Rule because they were calculated differently.

Figure 9: Percent of Total Agency Model Costs by Major Cost Category[3,4]



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[4] The methodology used to calculate these percentages differs from the methodology used in the CMS Access Rule; this is because the NCI-AD survey did not collect data on all elements needed to replicate the CMS Access Rule calculation. Therefore, the 69% cannot be compared to the 80% provision in the Access Rule.

NCI-AD Agency Model (CY 2023 Survey Reporting Period)

Key Takeaways

While the data collected in the NCI-AD Year 3 survey suggests that DSDS providers are continuing to face DSW workforce challenges, the data showed positive trends in a few key workforce statistics including a decrease in the DSW vacancy rate, a decrease in the DSW turnover rate, and an increase in the DSW average hourly wage. In addition, 36% of providers had to turn away or stop accepting new service referrals due to staffing issues, a significant decrease from both the Year 1 (57%) and Year 2 (53%) survey results.

Wages and benefits are generally important factors in DSW recruitment and retention. The Year 3 survey responses showed significant variation in DSW hourly wages ranging from $10.00 to $19.75, with an average hourly wage of $14.40 per hour[5]. The Year 3 average wage was about $1.20 per hour higher than the Year 2 average wage of $13.19. Providers paid frontline supervisors wages ranging from $10.35 per hour to $70.00 per hour, with an average wage of $22.44 per hour. While some of the providers offered paid time off, health insurance, and/or retirement benefits to DSWs, this was not a consistent or widespread practice; it was most common for large providers to offer these benefits. Some providers offered other benefits to DSWs such as bonuses, supplemental insurance, and transportation benefits.

Based on the survey responses, the majority of agency model costs were attributed to DSW-related expenditures. When looking at the median percentage across providers, roughly 69% of total agency model costs were attributed to DSWs, 4% of costs were attributed to other service-related costs, and 22% of costs were attributed to administration and overhead.

Mercer observed various instances where the provider responses to a given survey question varied significantly based on the provider's size:

- The DSW turnover rate for large providers (those serving more than 50 people) was higher than the rate for small and medium-sized providers (those serving 10 or fewer people and those serving 11-50 people, respectively)
- Large providers had a smaller portion of departing DSWs with less than one year of tenure than small or medium-sized providers
  - This is the opposite of what was seen for large providers in Year 2 and suggests that in Year 3, large providers were able to retain staff with less than one year of tenure at a higher rate than small or medium-sized providers
- Small providers had fewer participants per DSW and fewer DSWs per supervisor than medium and large providers
- On average, small providers were paying lower DSW wages than medium-sized providers, and medium-sized providers were paying lower DSW wages than large providers

[5] Note that Agency Model Personal Care fee schedule rates were increased effective July 2022 to support a $15.00 DSW hourly wage and then further increased effective July 2023.

NCI-AD Agency Model (CY 2023 Survey Reporting Period)

- Large providers were more likely to offer benefits to DSWs than small or medium-sized providers. This was true for most benefits mentioned in the survey (e.g., paid time off, medical/vision/dental insurance, employer-sponsored retirement plan, and various other benefits)

CDS Model (July 2024–December 2024 Survey Reporting Period)

CDS Survey

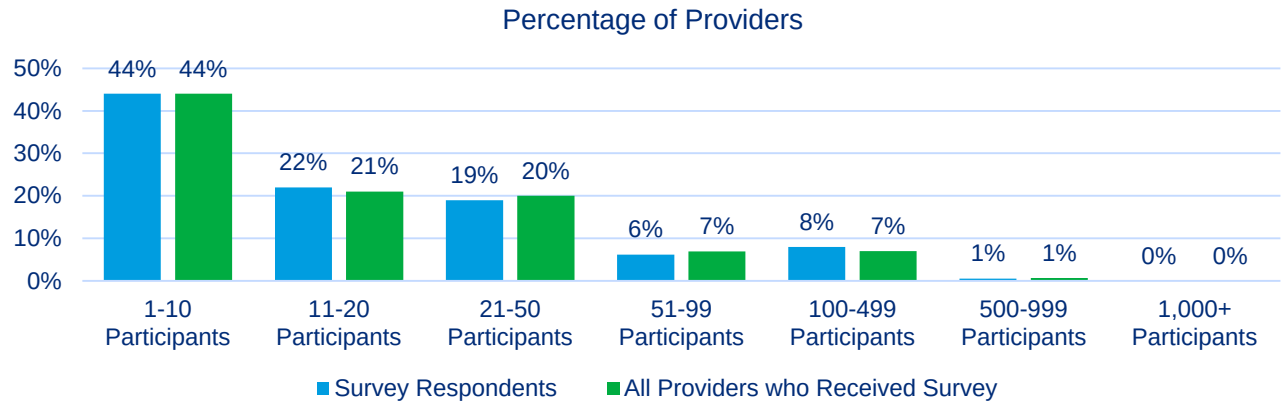
The next section of the report is specific to the CDS Operational Survey, which captures information from DSDS providers that deliver CDS model services. For the purposes of the survey, direct service workers under the CDS model are referred to as Personal Care Attendants (PCAs).

Data Quality Assessment

DSDS received 404 CDS survey responses from providers who either only provided support to DSDS CDS participants or who could report data specific to the PCAs who worked exclusively with DSDS CDS participants. Out of 984 total DSDS CDS providers, the survey response rate was roughly 41%. This is similar to the response rates from Year 1 and Year 2.

As shown in Figure 10, the percentage of Year 3 survey respondents falling within each size interval was closely aligned with the percentage observed across all providers who received the survey; this indicates that the size distribution of responding providers was consistent with the size distribution of all CDS providers. Between Year 2 and Year 3, there was an increase in the percentage of respondents serving 10 or fewer participants and a slight decrease in the percentage of respondents with 11–50 participants. The Year 3 survey responses also showed representation across different population areas ranging from providers operating in smaller areas (defined as having populations of less than 25,000 people) up to providers operating in much larger areas with populations over 200,000 people.

Figure 10: Size Distribution of Responding Providers



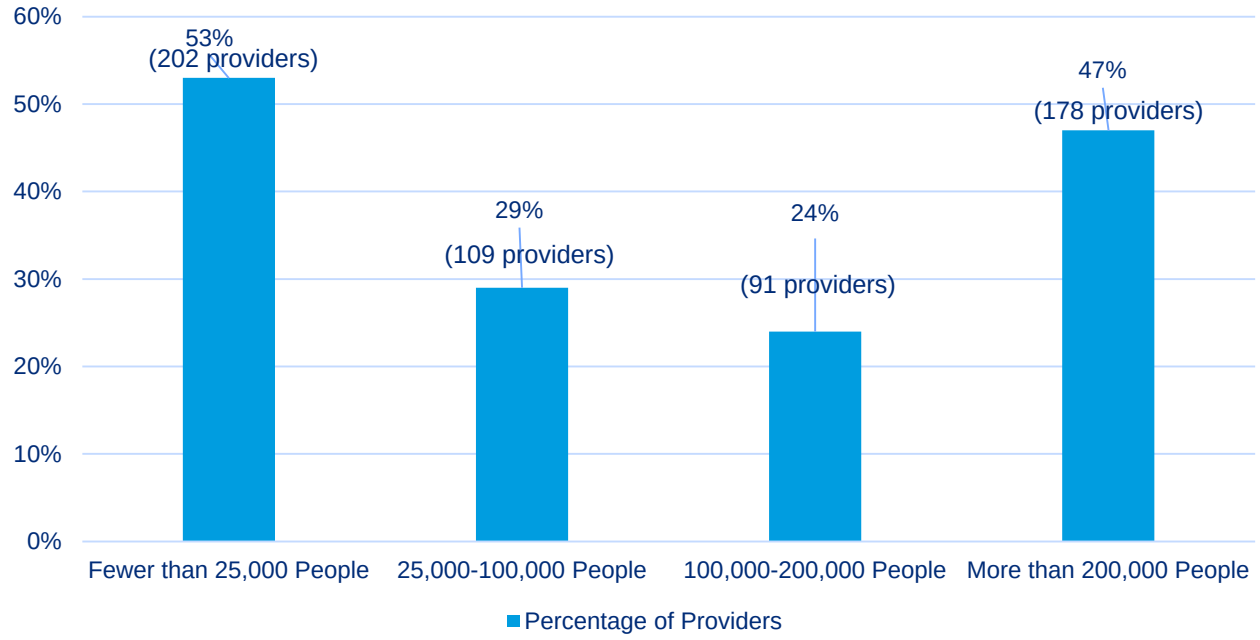
CDS Model (July 2024–December 2024 Survey Reporting Period)

In terms of data quality, Mercer observed instances where providers failed validation checks on questions, failed multiple 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 payroll hours per PCA while others reported payroll hours across all PCAs). Upon reviewing the overall data validation results, Mercer determined that the reported hourly wage data was generally reasonable. Data quality issues were mainly observed in PCA full-time and part-time counts, CDS employee full-time and part-time counts, July 2024–December 2024 reported hours by detailed CDS task, and July 2024–December 2024 reported costs by detailed CDS line item. The main concerns in these areas were providers often reporting equivalent PCA and CDS employee counts, significant variation in responses across providers, and the high number of outliers; these issues suggest that some providers may have reported incorrectly. In order to limit the impact of data quality issues, Mercer excluded 24 survey responses prior to conducting statistical analysis on the remaining 380 responses. This is an increase from Year 2, when Mercer excluded 14 responses out of 402 due to data quality concerns.

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. Roughly 73% of the providers indicated they administer CDS in just one population area, while roughly 27% administer CDS in more than one area. As shown in Figure 11, all four population areas were represented in the survey responses. Compared to Year 2 of the survey, Year 3 showed a smaller percentage of respondents operating in areas with populations below 100,000 people and a higher percentage of respondents in areas with populations above 100,000 people.

Figure 11: Percentage of Providers who Delivered CDS in each Population Area *(categories not mutually exclusive)*



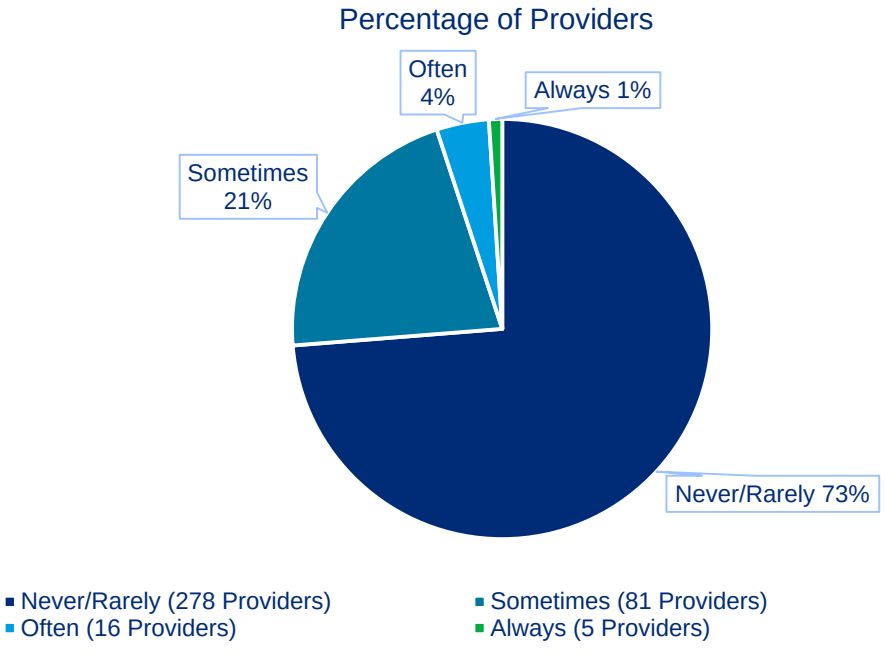
CDS Model (July 2024–December 2024 Survey Reporting Period)

Taking on New Participants

Between July 1, 2024 and December 31, 2024, providers took on differing numbers of new CDS participants. The Year 3 average new CDS participant rate was 20%, which is slightly higher than the Year 1 and Year 2 rates of 19% and 18%, respectively. Note that this percentage varied significantly across providers, with some providers indicating they did not serve any new participants during the reporting timeframe and some providers indicating all the participants they served were new. Several of the providers who said all their participants were new also reported an average PCA/participant relationship of over one year, which suggests the 100% new participant rates may not be accurate and should be reviewed with caution.

As shown in Figure 12, 73% of CDS providers indicated their CDS participants usually had a PCA in mind, which means the provider generally did not need to provide assistance with PCA matching. This was higher than the 68% value from Year 2. For the other 27% of CDS providers, about 26% indicated they sometimes or often needed to pair the participant up with a PCA, and 1% (five providers) said they always needed to find a PCA for the participant. In terms of the five providers who responded with *always*, two of them reported that a portion of their PCAs was related to the participants they were serving, which raises questions about the accuracy of the *always* response. When looking at the results by provider size, 85% of small providers reported never/rarely having to pair a participant with a PCA versus 47% of large providers.

Figure 12: Frequency of Provider Needing to Pair Participant with a PCA



CDS Model (July 2024–December 2024 Survey Reporting Period)

Impact of Staffing Issues on Services Delivered

Roughly 66% of providers reported never having to turn down referrals. About 18% of providers had either one or two participants referred to them for whom they were unable to deliver services due to staffing issues, and about 16% of providers had to turn down referrals for three or more participants. These values were generally consistent with Year 2. Note that the percentage of providers who did not have to turn any referrals varied significantly by provider size, with 75% of small providers and 67% of medium providers reporting they did not have to turn down any referrals compared to 39% of large providers.

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 2,339 PCAs. Most providers reported about one PCA for every one participant, which was consistent across provider size and consistent with the Year 1 and Year 2 survey responses. There were some outlier providers whose data showed very low or very high ratios (e.g., one provider indicated they had five PCAs serving 21 participants, which is one PCA for every 4 participants; another provider indicated they had 30 PCAs serving eight participants which would be approximately four PCAs per participant).

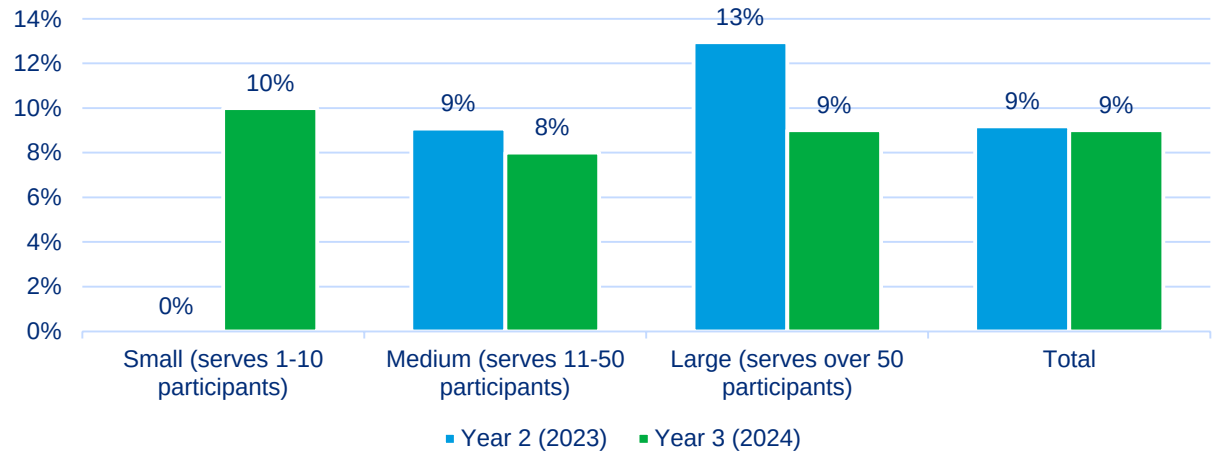
Across all providers, the median percentage of new PCAs to total PCAs was about 15%. This is a slight decrease from the Year 2 value of 17%, but higher than the Year 1 value of 14%. Small providers had a median new PCA percentage of 25%, compared to 14% for medium and large providers. The new PCA rate 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. Several of the providers who said all their PCAs were new also reported an average PCA/participant relationship of over one year, which suggests the 100% new PCA rates may not be accurate and should be reviewed with caution.

The PCA turnover rates varied across providers from 0% to 100%, with a 9% median turnover rate across all providers. There were some providers with high turnover rates (50% to 100%) that pulled the average turnover rate up to 14% (compared to the 9% median). The Year 3 median turnover rate of 9% is consistent with the Year 2 rate and slightly higher than the Year 1 value of 6%.

CDS Model (July 2024–December 2024 Survey Reporting Period)

As shown in Figure 13, large providers had a higher Year 3 median turnover rate than medium providers and a lower rate than small providers.

Figure 13: Median Turnover Rate by Provider Size



PCA Relationships with Participants

The survey also collected various types of information about the relationship between PCAs and the participants they serve. About 55% of PCAs were related to the participants they were serving, which was comparable to Year 1 and Year 2. About 34% of PCAs lived with the participants they were serving; this is an increase from the Year 1 value of roughly 29% and the Year 2 value of 32%.

In terms of the average length of time that PCAs were providing care to participants, roughly 80% of participants had been receiving care from their current PCA for over a year. This is consistent with the results observed in the Year 2 survey.

CDS Model (July 2024–December 2024 Survey Reporting Period)

PCA Wages

PCA hourly wages reported in the survey for the July 1, 2024–December 31, 2024 reporting period ranged from $8.58 per hour to $29.76 per hour, with an average starting wage of $12.95 per hour and an average wage regardless of tenure of $13.84 per hour[6]. This represents an approximately $0.50 increase from the Year 2 PCA wage regardless of tenure. Table 6 shows that PCAs were receiving a relatively similar average hourly wage regardless of provider size.

Table 6: Year 3 PCA Hourly Wage Regardless of Tenure

Provider Size	Average Hourly Wage
Small (1–10 participants)	$13.62
Medium (11–50 participants)	$13.79
Large (51+ participants)	$14.33
Total	**$13.84**

Year 3 Range of Hourly Wages:
$8.58 to $29.76

Year 3 (Jul-Dec 2024) Average Hourly Wage Regardless of Tenure:
$13.84

Year 2 (Jul-Dec 2023) Average Hourly Wage Regardless of Tenure: $13.37

for PCAs across all population areas

[6] The CDS Personal Care fee schedule rates were increased effective July 1, 2023 to support a $16.10 PCA hourly wage.

CDS Model (July 2024–December 2024 Survey Reporting Period)

Figure 14a shows the distribution of statewide average reported PCA wages regardless of tenure. Note that 55 of 378 providers reported a PCA average hourly wage regardless of tenure below the $12.30 Missouri minimum wage that was effective during the July 1, 2024–December 31, 2024 time period. In terms of provider size, 20% of small providers were paying an average PCA hourly wage above $15.00, compared to 21% of medium providers and 33% of large providers. Figure 14a also shows that there was a significant year-over-year increase in the percentage of providers paying a PCA hourly wage of $13.00 or more (percentage increased from 49% in Year 2 to 72% in Year 3).

Figure 14a: Provider Counts by PCA Average Hourly Wage

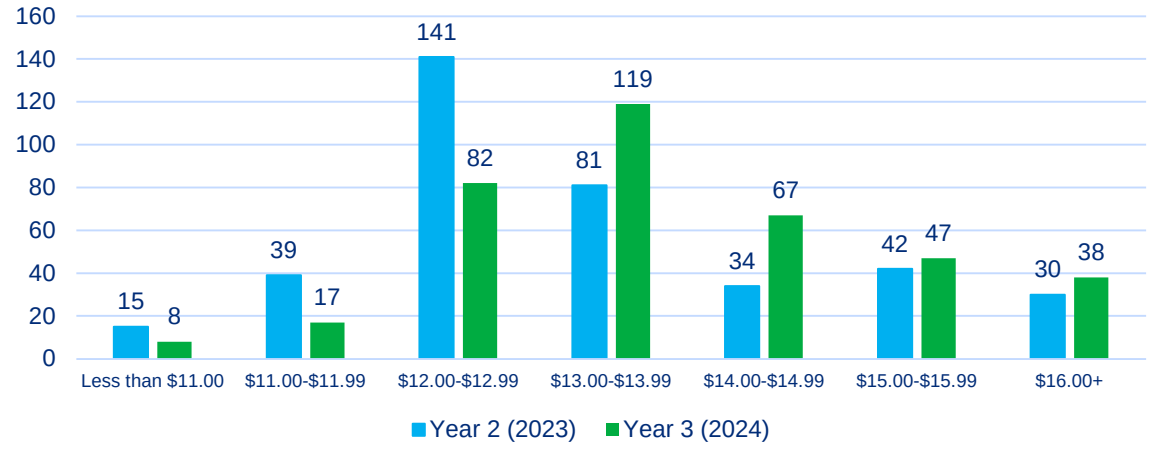
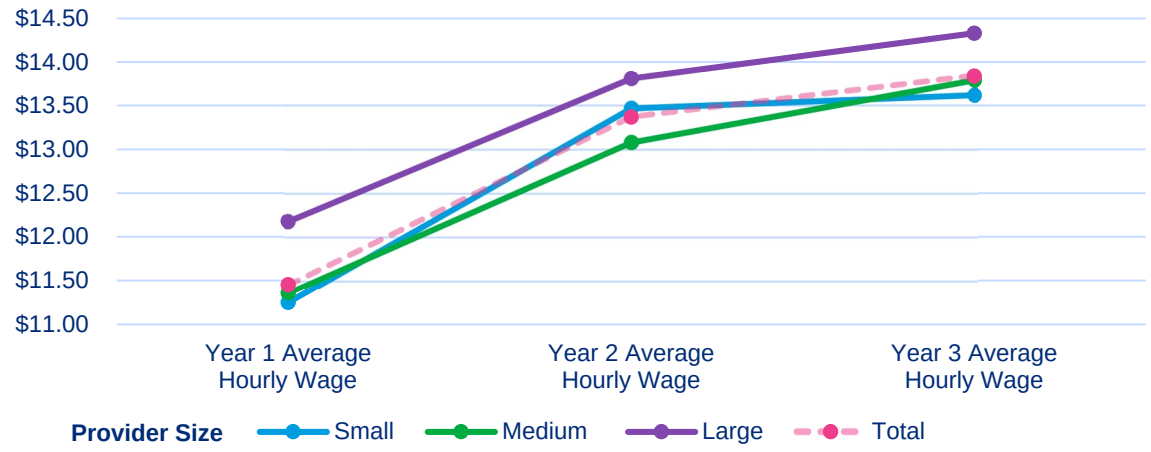


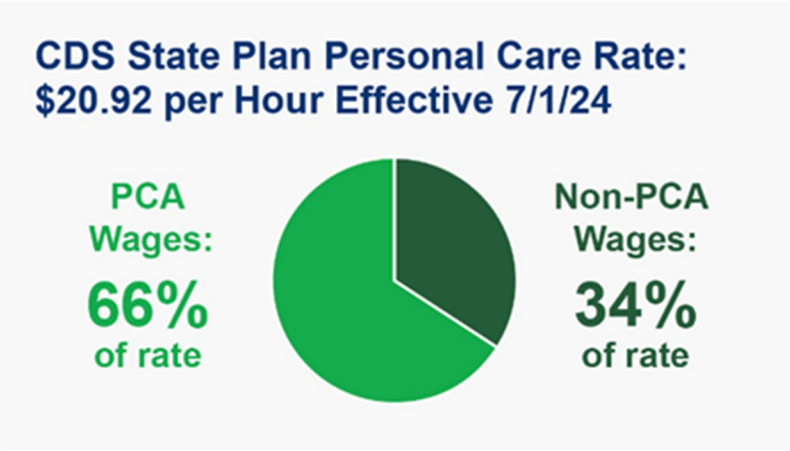
Figure 14b illustrates how the average reported PCA hourly wage changed between the initial survey year (July – December 2022 reporting period) and the Year 3 survey (July – December 2024 reporting period). When looking at all providers in total, the PCA average hourly wage increased roughly 21% from $11.45 per hour in Year 1 to $13.84 per hour in Year 3; the bulk of this wage increase occurred between Year 1 and Year 2. When looking at the PCA hourly wage increase percentages by provider size, the trends were somewhat similar for each size category.

Figure 14b: PCA Average Hourly Wage by Provider Size and Survey Year



CDS Model (July 2024–December 2024 Survey Reporting Period)

During the July 1, 2024–December 31, 2024 period, CDS providers were paid a rate of $5.23 per 15-minute unit ($20.92 per hour) to deliver the CDS State Plan Personal Care service. Based on the $13.84 average PCA hourly wage reported in the survey, providers spent roughly 66% of their payment rate on PCA wages (an increase from Year 2 when the PCA wage represented roughly 64% of the CDS State Plan Personal Care rate)[7]. The remaining 34% was spent on non-wage cost components, which likely included costs such as employer taxes (e.g., Federal Insurance Contributions Act [FICA], Federal Unemployment Tax Act [FUTA]/State Unemployment Tax Act [SUTA]), workers' compensation insurance, EVV, fiscal management services, other service-related costs, and administration/overhead).



In terms of how wages were initially set, the surveys included various responses including that wages were set: equivalent to minimum wage, based on a certain dollar amount above minimum wage, based on the Missouri Medicaid HCBS payment rates, based on the PCA's level of experience, based on market conditions and wage levels being paid by other providers, or based on the level of care needed by the individual. In terms of PCA wage increases, responses indicated that increases were made based on various factors including:

- Triggered by minimum wage or HCBS rate increases
- Using a set timeframe (e.g., every six months or annually)
- Based on the PCA's performance
- Based on the PCA's increased tenure/experience or additional certifications

[7] The methodology used to calculate this percentage is different from the methodology used in the CMS Access Rule; this is because the CDS survey did not collect data on all elements needed to replicate the CMS Access Rule calculation. Therefore, this percentage cannot be directly compared to the 80% because it was calculated on a different basis.

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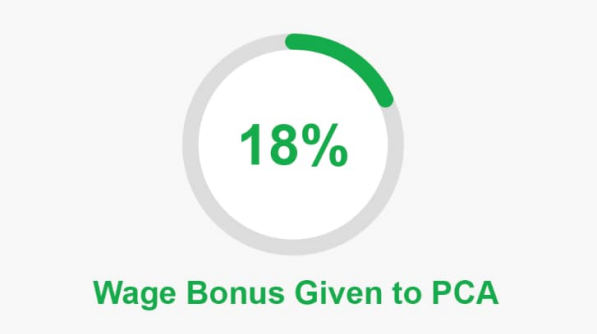
PCA Bonuses

About 18% of the survey responses (i.e., 70 providers) indicated that bonuses were given to PCAs. This is equal to the bonus percentage reported in Year 2 and is an increase from the Year 1 value of 11%. The Year 3 percentage did not vary significantly by size (i.e., 16% of small providers, 21% of medium providers, and 18% of large providers gave bonuses). Note that the Year 2 survey questions about the frequency of the bonuses and the dollar value were not included in the Year 3 survey.



PCA Payroll Hours

Productivity

The survey asked CDS providers to report total PCA payroll hours, as well as the portion of PCA payroll hours spent delivering Medicaid reimbursable services, portion of hours spent on non-Medicaid reimbursable tasks (e.g., driving time to and from the participant's home), and portion of hours taken as paid time off. The vast majority of responses showed 100% PCA productivity, meaning that all PCA payroll hours were Medicaid reimbursable. There were a few providers who reported very low PCA productivity rates (under 50%), which pulled the average down to 95% (similar to the 94% average from Year 2). It is unclear if these values were mis-reported, so the average value of 95% should be interpreted with caution.

Overtime

Consistent with Year 1 and Year 2, the majority of responses indicated overtime hours were not paid to CDS PCAs. Only 21 providers indicated that overtime hours were paid, and the number of overtime hours reported was minimal. The lack of overtime hours could be due to the fact that most PCAs were reported to have a part-time status; therefore, they would be working less than 40 hours per week.

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.

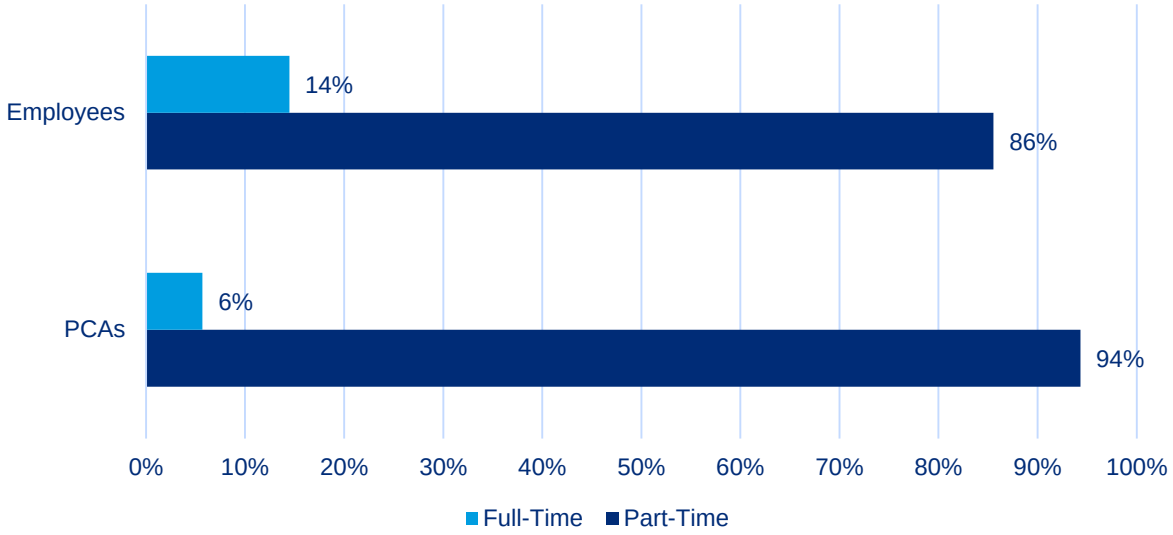
Note there were over one hundred instances where providers indicated the same full-time and part-time counts for PCAs and CDS employees. This suggests that providers may have been confused about the difference between PCAs and employees and may have pasted their PCA responses into the employee count section. Therefore, the information below should be reviewed with caution.

Figure 15 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 more common for employees than for PCAs. While the

CDS Model (July 2024–December 2024 Survey Reporting Period)

percentage of employees who were full-time decreased from Year 2 to Year 3 (22% to 14%), the percentage of PCAs who were full-time (6%) was the same in both Year 2 and Year 3. These percentages varied by provider size with small, medium, and large providers having full-time employee percentages of 12%, 2%, and 18%, respectively. There was also slight variation in reported full-time and part-time percentages for PCAs by provider size. Small providers reported 7% of PCAs were full-time, medium providers reported 5% were full-time, and large providers reported 6% of their PCAs were full-time. As noted above, these results should be reviewed with caution due to the large number of providers that may have misunderstood the question.

Figure 15: Employee and PCA Full-time and Part-Time Percentages



Benefits

Less than 15% of the responses indicated that health insurance, retirement, or life/disability insurance 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 lower for PCAs, with approximately 5% of the responses indicating that these benefits were offered to full-time or part-time PCAs. All of these results are similar to the results from Year 1 and Year 2.

In terms of paid time off, 14% of providers reported paid time off hours for employees and 3% reported paid time off hours for PCAs. These values were similar to the Year 2 survey results.

Similar to Year 1 and Year 2, roughly 5% of providers indicated they offered mileage reimbursement to full-time PCAs, and 7% of providers offered mileage reimbursement to part-time PCAs. It was more common for providers to offer this benefit to employees than PCAs, with over 13% of respondents indicating they offered this benefit to full-time and part-time employees.

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Hours Spent on Other CDS Tasks

There was a wide range of time spent by providers on various CDS tasks listed in the survey. Table 7 provides key statistics on the time that providers spent on one-time CDS activities (activities were deemed *one-time* if they are only completed upon PCA hire or new consumer onboarding) and time spent on recurring tasks completed on an ongoing basis (e.g., monthly, quarterly, or annually). Given the variation in responses and several reported outlier values, providers may have interpreted the tasks differently or may have reported incorrectly. To limit the impact of outliers, Mercer focused on the median reported value, as well as the 25th and 75th percentile values, but the results in Table 7 should still be reviewed with caution.

Additionally, in Year 3, Mercer observed a number of providers who reported hours spent on new PCA paperwork or setting up new consumers with no corresponding indication that they took on new PCAs or new participants during the reporting period. These instances were excluded from the hours calculations, and the resulting one-time tasks statistics are based on only the providers who indicated new PCAs and/or new participants during the reporting period. This was a change in methodology between Year 2 and Year 3; therefore, the year-over-year statistics cannot be directly compared to each other.

Table 7: Provider Time Spent on CDS Tasks

Task	Measurement	25th Percentile	Median	75th Percentile
One-Time Tasks				
Completing new PCA paperwork at time of hire	Hours per New PCA	2 hours	5 hours	17 hours
Setting up new consumers as employers, including all paperwork at signup and training	Hours per New Consumer	2 hours	5 hours	13 hours
Ongoing Tasks				
Checking the Employee Disqualification List and List of Excluded Individuals/Entities for CDS PCAs	Per Month per PCA	2 Minute	5 Minutes	13 Minutes
Processing PCA Payroll	Per Month per PCA	8 Minutes	23 Minutes	1 Hour and 12 Minutes
Performing Monthly Case Management Monitoring Tasks	Per Month per Consumer	10 Minutes	27 Minutes	1 Hour

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Task	Measurement	25th Percentile	Median	75th Percentile
Conducting annual face to face monitoring visits	Per Month per Consumer[8]	7 Minutes	12 Minutes	30 Minutes
Processing IRS, Department of Revenue, and Division of Employment Security Letters/changes/taxes	Per Month per PCA	3 Minutes	8 Minutes	23 Minutes
Gathering data for the MMAC Quarterly CDS Financial and Annual Service Report and the annual CDS Financial Audit	Per Month per Consumer[9]	3 Minutes	7 Minutes	23 Minutes
Reporting suspected fraud, neglect, abuse, and/or exploitation of the consumer, including providing documentation as requested	Per Month per Consumer	0 Minutes	0 Minutes	1 Minute
Certifying, Maintaining, or Correcting EVV records	Per Month per Consumer	7 Minutes	24 Minutes	1 Hour and 12 Minutes
Total Time Per Month for *Per PCA* Tasks[10]	**Per Month per PCA**	**13 Minutes**	**36 Minutes**	**1 Hour and 48 Minutes**
Total Time Per Month for *Per Consumer* Tasks[3]	**Per Month per Consumer**	**27 Minutes**	**1 Hour and 10 minutes**	**3 Hours and 6 Minutes**

Table 7 shows the median total time spent per month per PCA increased from Year 2 to Year 3 by about 38% (from a median of 26 minutes in Year 2 to 36 minutes in Year 3). Median total time spent per month per consumer saw a similar increase of about 35%, from 52 minutes in Year 2 to one hour and 10 minutes in Year 3. The main drivers of the increase between years can be attributed to three tasks: processing PCA payroll (seven minute increase in the median), performing monthly case management monitoring tasks (seven minute increase in the median), and certifying, maintaining, or correcting EVV records (seven minute increase in the median).

[8] These values are presented on a *per month* basis to allow comparison to time spent on other tasks. Converting these values to an annual basis indicates that providers spent a median of roughly two and a half hours per consumer per year on face-to-face monitoring visits (25th percentile of roughly one and a half hours and 75th percentile of six hours).

[9] These values are presented on a *per month* basis to allow comparison to time spent on other tasks. Converting these values to a quarterly basis indicates that providers spent a median of 21 minutes per consumer per quarter on quarterly/annual MMAC reporting (25th percentile of nine minutes and 75th percentile of approximately one hour).

[10] Please note that a single provider does not represent the 25th percentile, median, or 75th percentile for all tasks; therefore, the totals in the table may differ significantly from the 25th percentile, median, and 75th percentile values across all respondents.

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Provider Costs Incurred to Deliver CDS

The Year 3 survey collected data on July 1, 2024–December 31, 2024 CDS costs that providers incurred for the various line items shown below. In order to gain an understanding of how much each provider was spending on PCA-related costs versus other CDS cost components, Mercer mapped the detailed line items into three major cost categories as shown in Table 8. The three categories included PCA-related expenditures, other service-related costs, and administration/overhead.

Table 8: Mapping Between Detailed Cost Line Items and Major Cost Categories

Detailed Line Item Cost	Major Cost Category Mapping
PCA Payroll	PCA-related expenditures
PCA Taxes (FICA/FUTA/SUTA) and Workers' Compensation Insurance	
Salaries, Benefits and Payroll Taxes of CDS Employees Providing Direct Programmatic Assistance (e.g., monthly case management activities)	Other service-related costs
EVV System Costs	
Non-Service Delivery Related Travel Costs, Salaries, Benefits, and Payroll Taxes of CDS Employees Providing Administrative Functions	Administration/overhead
Non-Service Delivery Related Travel Costs	
General and Professional Insurance and Financial Audit	
Administrative Building Occupancy (rent, mortgage, maintenance)	
Utilities, Equipment, Office Supplies, Postage, and Software other than EVV Related Items	

Mercer calculated the percentage of total costs attributed to each major cost category for each survey response. Note that some providers indicated they did not incur costs for certain line items, while other providers reported significant costs for that same line item. Due to these inconsistencies and other data quality concerns related to the responses to this question, this data should be reviewed with caution.

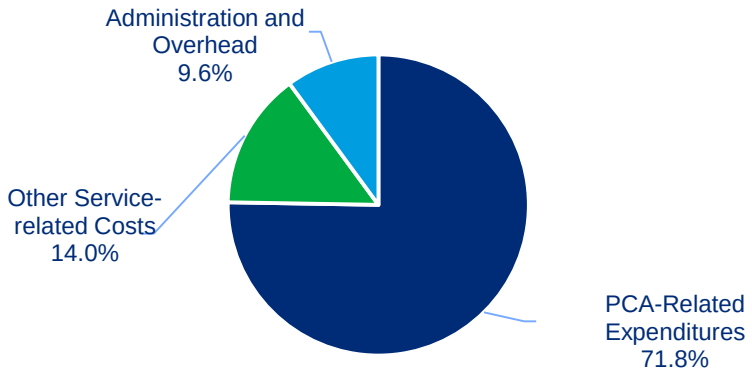
After calculating the cost distribution on each provider's reported values, Figure 16 shows the median cost percentage observed across providers. Roughly 72% of total CDS costs were attributed to PCAs

CDS Model (July 2024–December 2024 Survey Reporting Period)

(74% in Year 2)[11], 14% of costs were attributed to other service-related costs (6% in Year 2), and 10% of costs were attributed to administration and overhead (16% in Year 3). The increase in the other service-related cost percentage for Year 3 was driven by an increase in reported EVV costs, while the decrease in the administration and overhead percentage was driven by a decrease in reported payroll and benefit costs for CDS employees providing administrative functions. With only two data points (Year 2 and Year 3 surveys) available for the cost metrics, it is too early to tell if this trend will continue or if it was simply due to year-over-year data variation that may even out over time. Additionally, the number and order of reportable cost categories in the survey decreased between Year 2 and Year 3, which may have resulted in provider confusion and reporting errors. As a result, Mercer observed a number of outliers and potential reporting errors, such that these results should be reviewed with caution.

Large and medium sized providers generally reported a larger portion of CDS costs spent on PCA-related expenditures, while small providers reported larger percentages spent on administrative expenditures. This is not unexpected given small providers are typically not able to take advantage of economies of scale that help medium and large providers reduce their administration/overhead cost percentage.

Figure 16: Percent of Total CDS Costs by Major Cost Category[12, 13]



[11] The methodology used to calculate these percentages differs from the methodology used in the CMS Access Rule; this is because the CDS survey did not collect data on all elements needed to replicate the CMS Access Rule calculation. Therefore, the 72% cannot be directly compared to the 80% provision in the Access Rule.

[12] Please note that a single provider does not represent the median value for all cost categories; therefore, percentages do not sum to exactly 100%.

[13] The methodology used to calculate these percentages differs from the methodology used in the CMS Access Rule; this is because the CDS survey did not collect data on all elements needed to replicate the CMS Access Rule calculation. Therefore, the 72% cannot be directly compared to the 80% provision in the Access Rule.

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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, there were some concerns with data quality. While the reported hourly wage data was generally reasonable, there were other areas where quality issues were observed such as the equivalent PCA and CDS employee counts, July 2024–December 2024 reported hours by detailed CDS task, and July 2024–December 2024 reported costs by detailed CDS line item. The main concerns were the significant variation in responses across providers and the high number of outliers, which may suggest that some providers reported incorrectly. Based on these observations, Mercer recommends caution when reviewing certain data metrics highlighted in this paper.

A large portion of respondents 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 be working less than 40 hours per week. The median PCA turnover rate was relatively low at roughly 9%. All of these results are similar to Year 1 and Year 2. Compared to the NCI-AD agency model survey data, the survey data suggests that workforce and staffing challenges are less of an issue in the CDS model.

The survey responses showed PCA hourly wages ranging from $8.58 per hour to $29.76 per hour, with an average starting wage of $12.95 per hour and an average wage regardless of tenure of $13.84 per hour. The Year 3 average PCA hourly wage regardless of tenure was about $0.50 per hour higher than the Year 2 PCA average wage. Although PCA wages did not vary significantly based on provider size, Mercer observed the highest PCA average hourly wage for large providers (approximately $0.50 more per hour, on average, than small and medium providers). Lastly, consistent with prior years, very few surveys indicated that wage bonuses, benefits, or paid time off were offered to PCAs.

Providers reported a wide range of time spent on various CDS tasks. It is unclear how much of this variation is due to errors in survey responses versus actual differences in provider operational processes, so the data below should be reviewed with caution.

In terms of CDS one-time tasks, providers spent:

- A median of five hours completing new PCA paperwork at time of hire
- A median of five hours setting up new consumers as employers and conducting training for new consumers

CDS Model (July 2023–December 2023 Survey Reporting Period)

In terms of recurring tasks (e.g., processing payroll, monthly case management monitoring tasks, EVV, etc.):

- Providers reported spending a median[14] of 36 minutes per PCA per month on PCA-related tasks (including checking employee disqualification/exclusion lists, processing payroll, and processing IRS and other Federal PCA-related letters/requests). This is an increase from the median of 26 minutes in Year 2, but with only two data points, it is too early to tell if this trend will continue or if it was simply due to year-over-year data variation that may even out over time
- Providers reported spending a median[15] of one hour and 10 minutes per consumer per month on consumer tasks (including monthly case management monitoring; annual face-to-face monitoring visits; gathering data for MMAC-required financial reports; reporting suspected fraud, neglect, abuse and/or exploitation; certifying, maintaining, and correcting EVV records). This is an increase from the median of 52 minutes in Year 2, but with only two data points, it is too early to tell if this trend will continue or if it was simply due to year-over-year data variation that may even out over time
- When looking at all CDS tasks that providers complete, most CDS employee time was spent on performing monthly case management monitoring tasks; certifying, maintaining, or correcting EVV records; and processing PCA payroll
- In general, providers spent a relatively small amount of time on the remaining CDS tasks

Based on the survey responses, the majority of provider CDS costs were attributed to PCA-related expenditures. When looking at the median percentage across providers, roughly 72% of total CDS costs were attributed to PCAs, 14% of costs were attributed to other service-related costs, and 10% of costs were attributed to administration and overhead.

As mentioned in prior sections, there were instances where the provider responses to a given survey question varied based on the provider's size. Key observations in this area included:

- On average, small providers were paying lower PCA wages than medium-sized providers, and medium-sized providers were paying lower PCA wages than large providers
- The percentage of providers who did not have to turn down any referrals was higher for small and medium providers (75% for small and 67% for medium providers) than large providers (39%)
- Small providers had a median new PCA percentage of 25%, compared to 14% for medium and large providers
- Large and medium sized providers generally reported a larger portion of CDS costs spent on PCA-related expenditures, while small providers reported larger percentages spent on administrative expenditures. This is not unexpected given small providers are typically not able to take advantage of

[14] Note that a single provider does not represent the median for each of the different tasks; therefore, adding the medians for the Table 8 PCA-related tasks and for the consumer-related tasks may produce a different result than calculating the median across all respondents.

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economies of scale that help medium and large providers reduce their administration/overhead cost percentage

- Large and medium sized providers generally indicated a longer average length of time that participants were continuously receiving care from their PCA compared to small sized providers, 86% of large and 82% of medium sized providers indicated an average length of time greater than one year compared to 70% for small sized providers
- Large providers were more likely than small or medium sized providers to offer benefits to CDS employees. In terms of PCAs, large providers were less likely to offer certain benefits to PCAs than small or medium-sized providers

Next Steps

Next Steps

The information collected through the NCI-AD and CDS workforce surveys continue to provide DSDS with a wealth of data to support various DSDS processes outlined below.

- DSDS uses this data to monitor trends with the direct service workforce and assess opportunities for future programmatic improvement initiatives that better support the direct service workforce and to enhance the provision of quality care
- The survey data also provides insight into current agency model and CDS provider cost components, which will help DSDS assess potential impacts of the federal Access Rule[16] published in the Federal Register on May 10, 2024
  - The Access Rule includes a provision that at least 80% of Medicaid payments for personal care, homemaker, and home health aide waiver services be spent on direct care staff compensation. States must begin reporting this information to CMS in 2028 and must demonstrate they meet the 80% requirement starting in 2030. As DSDS prepares to meet this provision and all other Access Rule requirements, DSDS may refine future NCI-AD and CDS surveys in order to collect data related to the new requirements
- DSDS and Mercer utilized provider survey data as one of the data sources for the DSDS rate study conducted in 2024 (refer to report with January 13, 2025 issuance date). DSDS and Mercer intend to continue to utilize survey data for future rate studies and view the NCI-AD and CDS workforce surveys as a key component of the rate study stakeholder input process

[16] https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services