ANALYSIS

Department of Human Services

Wage and Rate Study

Analyst: Gregory Jolivette

Request: Acknowledge receipt of a report on a comprehensive wage and rate study across home and community-based service delivery systems.

Analysis: The budget report for SB 5506 (2023) included a budget note directing the Department of Human Services (DHS) to conduct a comprehensive wage and rate study across home and community-based service delivery systems, with a focus on providers of in-home and residential care. DHS home and community-based services are administered by the Intellectual/Developmental Disabilities (I/DD) and Aging and People with Disabilities (APD) programs. The agency contracted with the Burns and Associates, a division of Health Management Associates to conduct the study. At the Department's request, the Emergency Board extended the due date of the report from September 2024 to December 31, 2024, with instructions that the Department report to the Joint Committee on Ways and Means during the 2025 legislative session. Highlighted below are the key findings and recommendations from the report.

Key Report Findings

- The required qualifications for direct care workers and the work they perform is similar across systems, although the specific support provided by a direct care worker will differ based on the needs of each individual served.

- Most rates for I/DD services are based on assessed needs using a single assessment tool, the Oregon Needs Assessment (ONA). In contrast, the APD program uses several different approaches for accounting for acuity across programs.

- I/DD has detailed rate models that document the staffing levels, direct care worker wages and benefits and other cost assumptions that produce the overall rate, but APD does not. Most APD rates models were established decades ago and there is no documentation about the underlying components of the rates.

- APD agency providers tend to pay lower wages than I/DD agency providers. I/DD providers generally pay higher wages than assumed in the rate model but offer less generous benefits than assumed in the rate model.

- The current collective bargaining agreement for direct care workers employed directly by individuals includes higher wages than assumed in the I/DD rate models but provides less funding for benefits than included in the rate model.

Report Recommendations

- Update existing I/DD rate models to incorporate current cost data and establish similar rate models for APD services to document cost assumptions. Rate increases would vary by service and rate but would be around 30%.

- Adopt an average direct care worker wage assumption of $23.20 per hour in the rate models for agency-delivered services and update the assumed benefits package.

- Increase the hourly base wage for direct care workers employed directly by individuals receiving services from $20 per hour to $24.50 per hour to align with the compensation included in the recommended rate models for agency-delivered services.

- Standardize the payment rate for agency-delivered in-home services across the APD and I/DD systems and standardize payment rates for assisted living facilities and residential care facilities.

- Use APD's new proposed assessment framework to establish a consistent approach to tiered rates across services and transition I/DD Adult Foster Home, Child Foster Care, and Supported Living services to tiered payment rates based on ONA.

The recommended increases to payments for agency providers and direct care workers employed directly by individuals receiving services vary, but average somewhat more than 30%. Fully implementing the recommendations would increase payments to agencies and directly employed workers by an estimated $1.3 billion annually (total funds). The table below shows how the estimated costs are distributed among the different programs and services.

Estimated Annual Fiscal Impact of Study Recommendations Total Funds, In Millions			
Service Category	**Increase**	**% Change**	**% of Total**
Collectively Bargained Services	**437.6**	**33.3**	33.6%
APD - Home Care Workers	143.4	21.4	
APD Adult Foster Homes	91.4	81.1	
I/DD - Personal Support Workers	152.1	21.3	
I/DD Adult Foster Homes	50.7	22.7	
APD - Agency Provided Services	**191.2**	**31.1**	14.7%
In-home Services	74.4	40.2	
Assisted Living Facilities	37	25.2	
Residential Care Facilities	19.4	107.9	
Memory Care Facilities	24.1	24.3	
Adult Day Services	1.1	36.9	
PACE Rates	35.2	21.7	
I/DD - Agency-Provided Services	**674.6**	**33.8**	51.8%
In-Home Services	247.4	26.4	
24 Hour Residential	339.6	42.3	
Children's Foster Homes	9.5	54.3	
Supported Living	36.3	40.3	
Day Support Services	13.7	25.5	
Employment Services	22.4	30.9	
Non-Medical Transportation	5.7	28.6	
Totals	**$1,303.4**		**100.0%**

Recommendation: The Legislative Fiscal Office recommends acknowledging receipt of the report.

Oregon
Tina Kotek, Governor

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DHS
Oregon Department
of Human Services

December 31, 2024

Senator Kate Lieber, Co-Chair
Representative Tawna Sanchez, Co- Chair
Joint Committee on Ways and Means
900 Court Street NE
H-178 State Capitol
Salem, OR 97301

RE: Oregon Department of Human Services, Rate & Wage Study

Dear Co-Chairs:

Nature of the Request

As required by Senate Bill 5506/Budget Note, the Oregon Department of Human Services (ODHS) conducted a comprehensive rate and wage study across home and community-based service delivery systems, with a focus on providers of in-home and residential care to individuals receiving services through the Office of Developmental Disabilities Services (ODDS) and the Office of Aging and People with Disabilities (APD). ODHS requested and was granted an extension to the report submission deadline from September 2024 to December 31, 2024.

Action Requested

Please find the final report and relevant attachments, including an attachment with public comments and responses from Burns & Associates, enclosed for Committee review and consideration during the 25 Session.

This report will be made available to the public shortly after this distribution. We look forward to your review and welcome invitations to present these findings to the legislature during the 2025 Session.

Context and Background

The budget note required ODHS to provide a written report to the Joint Committee on Ways and Means or Emergency Board, including:

1) the findings of the wage and rate study;

2) the different required qualifications to provide services in a particular setting; the different service delivery models and service requirements for the service delivery model; and the levels of acuity among recipients of the services provided; and

3) the costs and benefits of recommendations designed to standardize the compensation of direct care workers across programs and service delivery models.

Agency Action

ODHS contracted with the Burns & Associates, a division of Health Management Associates (HMA-Burns), to conduct the study. HMA-Burns has been supporting ODDS since 2015 and established the payment rates currently being paid for most agency-delivered services.

Major activities to date have included:

- Establishment of an advisory group comprised of service providers, trade associations, and the Service Employees International Union. The advisory group has met several times to review materials, receive project updates, and offer feedback on cross-systems issues.
- Establishment of service-specific workgroups comprised of community partners and workforce advocates for individual services or service categories (for example, in-home services, group home services, foster homes, etc.). These workgroups were convened several times to discuss service-specific issues and opportunities and to review materials.
- Development and administration of a provider survey to collect information regarding providers' costs and service designs.
- Review of documentation in other recent reports relating to wages of direct care staff in Oregon.
- Compilation of provider job postings.
- Analysis of published sources Oregon-specific data, including wage data from the Bureau of Labor Statistics and health insurance cost data from the Medical Expenditure Panel Survey.
- Opportunity for community partners to review initial findings and recommendations and provide feedback.

Legislation Affected

SB 5506

If you have questions, please direct them to:

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Sincerely,

Fariborz Pakseresht

Fariborz Pakseresht, Director, Oregon Department of Human Services

Ec: Amanda Beitel, Legislative Fiscal Office
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Kate Nass, Department of Administrative Services
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Rob Kodiriy, Oregon Department of Human Services
Roberto Gutierrez, Oregon Department of Human Services

HMA

HEALTH MANAGEMENT ASSOCIATES

SB5506 Wage and Rate Study

Study Findings and Recommendations

- PRESENTED TO -

OREGON DEPARTMENT OF HUMAN SERVICES

DECEMBER 31, 2024

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

Table of Contents

Attachments

Executive Summary

Tens of thousands of Oregonians with disabilities and older Oregonians rely on Medicaid-funded home and community-based services (HCBS) for assistance in performing activities of daily living, managing medical conditions, accessing their community, and maintaining their independence. These services are provided by direct care workers (who may be referred to as caregivers, direct support professionals, homecare workers, personal support workers, personal care attendants, and similar titles) who deliver care in a variety of settings, including service recipients' own homes, foster homes, group homes, assisted living facilities, adult day centers, individuals' workplaces, and community locations. Direct care workers are service users' primary point of contact with the HCBS service delivery system and, as a result, they have a significant impact on the quality of services and individuals' satisfaction.

Despite the challenging and critical work performed by direct care workers, they typically earn only modest wages. As a result, turnover and vacancy rates are high, which may impact the availability and stability of services. The state sets service payment rates, which many agency providers and workers argue do not offer adequate compensation for direct care workers. Additionally, payment rates across programs, services, and service delivery models in Oregon are not alighted, which can result in inequities across workers.

In response to these issues, the Oregon Legislature directed the Oregon Department of Human Services (ODHS) to undertake a comprehensive wage and rate study for services delivered through the Office of Developmental Disabilities Services and the Office of Aging and People with Disabilities. ODHS contracted with the Burns & Associates division of Health Management Associates (HMA-Burns) to conduct the study. HMA-Burns' has completed dozens of HCBS rate studies across the country and has been working with ODDS since 2015 to develop, implement, and maintain rate models for most of its agency-delivered services.

HMA-Burns designed the wage and rate study consistent with the legislative direction and federal requirements for HCBS rate-setting. To perform the study, HMA-Burns:

- Reviewed program enabling documents, regulations, and policies as well as previously commissioned reports regarding Oregon's direct care workforce to understand service and worker requirements as well as system challenges.
- Engaged provider agencies, the union representing direct care workers employed directly by individuals receiving services, and other community partners through a project advisory group, service-specific workgroups, provider site visits, provider surveys, and a public comment process.
- Identified independent cost data to document market-based cost benchmarks.
- Developed detailed and transparent rate models for agency-delivered services and made recommendations for increases to the wages paid to direct care workers employed directly by individuals receiving services.

Key findings from the wage and rate study include:

- The required qualifications for direct care workers and the work they perform is similar across systems, although the specific support provided by a direct care worker will differ based on the needs of each individual served.
- For most – though not all – of its services with rates that vary based on assessed needs, ODDS uses the Oregon Needs Assessment (ONA). APD uses different approaches for accounting for acuity across its services.

- For most of its agency-delivered services, ODDS has detailed rate models that document the staffing levels, direct care worker wages and benefits, and other cost assumptions that produce the overall rate. Most APD rates were first established decades ago so, although these rates have been regularly adjusted, there is no documentation about the underlying components of the rates.
- APD agency providers tend to pay lower wages than ODDS agency providers. Within both systems, workers providing In-Home services tend to be paid higher wages than staff who work in other settings.
- ODDS agency providers generally pay higher wages than assumed in the payment rates, but offer less generous benefits than assumed.
- The current collective bargaining agreement for direct care workers employed directly by individuals receiving services includes higher wages than assumed in the current ODDS rate models, but provides less funding for benefits than included in the rate models.

Based on these findings, the wage and rate study offered a number of recommendations, the highlights of which include:

- Update the existing ODDS rate models to incorporate current cost data and establish similar rate models for APD services to document cost assumptions.
- Adopt an average direct care worker wage assumption of $23.20 per hour ($48,000 annually) in the rate models for agency-delivered services and update the assumed benefits package.
- Increase the hourly base wage for direct care workers employed directly by individuals receiving services by $4.50 to align with the total compensation included in the recommended rate models for agency-delivered services.
- Standardize the payment rate for agency-delivered In-Home services across the APD and ODDS systems, standardize payment rates for Adult Foster Home services across the APD and ODDS systems, and standardize payment rates for assisted living facilities and residential care facilities.
- Use APD's new proposed assessment framework to establish a consistent approach to tiered rates across services, and transition ODDS' Adult Foster Home, Child Foster Care, and Supported Living services to tiered payment rates based on the ONA.

The recommended increases to payments for agency providers and direct care workers employed directly by individuals receiving services vary, but average somewhat more than 30 percent. Fully implementing the recommendations would increase payments to providers (agencies and directly employed workers) by an estimated $1.3 billion annually (accounting for both state and matching federal funds). The additional funding would be primarily intended to increase direct care worker compensation, increasing consistency across Oregon's HCBS systems and making direct care a more viable career for more workers. The goals of this investment would be reducing turnover, decreasing workers' reliance on public benefits, and promoting a more stable workforce to support access to high-quality HCBS across the state.

Given the significance of the recommended increases in payments, the wage and rate study also recommends requiring agency providers to report data on key metrics such as wages and benefits for direct care workers, supervisory staff, and clinicians; staffing ratios; training standards; and other key factors. This reporting would support accountability by measuring the impacts of any rate increases and could be used to support future rate adjustments.

Introduction

Oregon, like the country as a whole, has long struggled to attract and retain a high-quality direct care workforce to provide home and community-based services (HCBS) to Oregonians with physical, intellectual, and development disabilities and elderly Oregonians, including those who rely on Medicaid-funded supports. A 2023 report from the Bipartisan Policy Center found that "For over two decades, the United States has had a long-standing shortage of direct care workers… [that is] straining the health care system, harming care access and quality for the millions of adults and children in the United States with long-term care needs, and contributing to potentially avoidable federal and state spending."[1] Nationwide, the U.S. Department of Labor's Bureau of Labor Statistics projects that more than 900,000 direct care positions will need to be filled annually to meet the growing demand for care while addressing persistent turnover.[2]

Agencies that deliver HCBS and homecare workers and personal support workers argue that Oregon's Medicaid payment rates do not adequately compensate direct care workers. However, many current payment rates lack documentation regarding how they were developed and have been adjusted over time, preventing an accounting of what expectations have been built into the rates in terms of staffing levels, direct care worker wages and benefits, and other factors. In response, the Legislature included a budget note in the state's 2023-25 budget directing the Oregon Department of Human Services to conduct a comprehensive wage and rate study[3]:

> The Department of Human Services is directed to conduct a comprehensive rate and wage study across home and community-based service delivery systems, with a focus on providers of in-home and residential care to individuals receiving services through the Office of Developmental Disabilities Services and the Office of Aging and People with Disabilities and provide a written report on the findings and recommendations to the Joint Committee on Ways and Means or Emergency Board no later than September 2024. The report shall provide an analysis of: (1) the findings of the wage and rate study; (2) the different required qualifications to provide services in a particular setting; the different service delivery models and service requirements for the service delivery model; and the levels of acuity among recipients of the services provided; and (3) the costs and benefits of recommendations designed to standardize the compensation of direct care workers across programs and service delivery models.

The Burns & Associates division of Health Management Associates (HMA-Burns) was contracted to perform the wage and rate study. HMA-Burns' has completed dozens of HCBS rate studies across the country, spanning an array of population groups (for example, individuals with intellectual and developmental disabilities, individuals with physical disabilities,

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1 Harootunian, L., Buffett, A., O'Gara, B., Perry, K., Serafini, M., Hoagland, G. Bipartisan Policy Center. (December, 2023). Addressing the Direct Care Workforce Shortage: A Bipartisan Call to Action. Retrieved from https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2023/11/BPC-Direct-Care-Workforce-Report-Final.pdf.

2 U.S. Bureau of Labor Statistics. (September 6, 2023). Employment Projections: Occupational separations and openings, Table 1.10 Occupational separations and openings, projected 2022-32. Retrieved from https://www.bls.gov/emp/tables/ occupational-separations-and-openings.htm.

3 State of Oregon. (September 25, 2024). Analysis – Department of Human Services Rate and Wage Study. Retrieved from https://olis.oregonlegislature.gov/liz/2023R1/Downloads/CommitteeMeetingDocument/276172.

older individuals, children eligible for early intervention services, individuals with traumatic brain injuries, and individuals with behavioral health needs) and Medicaid funding authorities (including Medicaid section 1915(c) and 1115 waivers as well as Medicaid section 1915(i) and 1915(k) state plan benefits). HMA-Burns has been working with ODDS since 2015, primarily to support the development, implementation, and maintenance of rate models for most of its agency-delivered services.

Building on its extensive experience leading HCBS rate studies, HMA-Burns developed a project approach designed to meet the requirements of the budget note and to develop detailed, data-driven, and transparent recommendations to standardize direct care worker compensation across the APD and ODDS systems, across the variety of services delivered through these programs, and across both agency-delivered and individually-directed service delivery models.

This report details HMA-Burns' findings and recommendations and is organized into five sections:

- Section 1 provides an overview of the APD and ODDS programs and services included in the wage and rate study.
- Section 2 details the methodology employed to conduct the study.
- Section 3 includes recommendations related to direct care worker compensation.
- Section 4 includes recommendations related to payments for collectively-bargained services.
- Section 5 includes recommendations related to payments for agency-delivered services.

Section 1: Overview of ODHS' Home and Community-Based Services Programs

Within the Oregon Department of Human Services (ODHS), two offices manage Medicaid-funded home and community-based services: the Office of Aging and People with Disabilities (APD) and Office of Developmental Disabilities Services (ODDS).

APD administers a range of services to support adults 65 years of age and older and adults 18 years and older with a physical disability. To receive APD-funded HCBS, individuals must require assistance to perform common activities of daily living.

ODDS funds HCBS for children and adults with intellectual and developmental disabilities (I/DD) that result in a significant limitation in adaptive behavior such as communication, self-care and social skills.[4] An intellectual disability is defined as an IQ of 75 or less, verified before 18 years of age. Developmental disabilities must occur before 22 years of age and include autism, cerebral palsy, epilepsy, and other neurological conditions.

Oregon's Medicaid HCBS Authorities

The home and community-based services included in the wage and rate study are provided through Oregon's Medicaid program. Medicaid is a joint federal and state program that pays for healthcare services for individuals with limited income and resources. The federal government pays the majority of the costs of services. In Oregon, the standard federal share of costs (known as the federal medical assistance percentage, or FMAP) is 59.00 percent in fiscal year 2025. The federal government has general rules that state Medicaid programs must follow, but each state operates its own program.

State Medicaid programs may cover HCBS that allow individuals to receive services in their own homes or communities rather than institutions or other isolated settings. Examples include residential care (such as group homes, foster homes, and assisted living facilities), in-home care, adult day programs, and employment supports. Oregon is a nationally recognized leader in emphasizing HCBS, supporting Oregonians in their homes and communities rather than institutional settings.[5]

Oregon uses several Medicaid authorities to provide HCBS:

- Most of Oregon's Medicaid-funded HCBS are delivered through a Section 1915(k) state plan option (also referred to as Community First Choice programs). The federal Affordable Care Act of 2010 established Section 1915(k) to allow states to cover home and community-based attendant services through their Medicaid state plans to assist individuals with activities of daily living (ADL) and instrumental activities of daily living (IADL). Services delivered through a Section 1915(k) option receive a six percentage point increase in the federal share of costs. Oregon became the second state to adopt a

[4] Oregon Administrative Rules, Chapter 411, Division 320, Section 0080. Accessed December 2024. Retrieved from https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=300876.

[5] Wysocki, A., Murray, C., Kachalia, A., Carpenter, Al, Stepanczuk, C. Mathematica. (July 24, 2024). Trends in the Use of Spending for home and Community-Based Services as a Share of Total LTSS Use and Spending in Medicaid, 2019 – 2021. Retrieved from https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-brief.pdf.

Section 1915(k) program in 2013 and was one of nine states with a 1915(k) program as of 2020.[6]

- Oregon covers services that do not primarily involve ADL and/or IADL supports (such as employment services and case management) through several Section 1915(c) waiver programs targeted to specific populations (that is, Oregon has separate 1915(c) waivers for older individuals and adults with physical disabilities, adults with intellectual and developmental disabilities, children who are medically fragile, etc.). Congress enacted Section 1915(c) in 1981 to allow states to cover home and community-based services in their Medicaid programs as an alternative to institutional care. Most states provide the majority of their HCBS through 1915(c) waivers.
- A Section 1115 research and demonstration waiver is being implemented to expand the Oregon Project Independence (OPI) program. The OPI-Medicaid (OPI-M) program covers a variety of services – including in-home support, adult day services, and home-delivered meals – for older individuals and adults with physical disabilities. OPI-M has less restrictive financial and functional need requirements than Oregon's other Medicaid-funded HCBS programs.
- A Section 1915(i) state plan option covers personal care attendant services and adult foster home services for individuals with behavioral health conditions.

Financial and Functional Eligibility Requirements

To qualify for HCBS through APD or ODDS, individuals must meet Oregon's Medicaid financial eligibility requirements, including an individual asset limit of $2,000 for single adults[7] and a monthly income limit of 300 percent of the federal Supplemental Security Income (SSI) standard for a single individual (equal to $2,829 per month in 2024)[8]. The OPI-M program covers individuals with incomes up to 400 of the federal poverty level (equal to $5,020 per month for a single individual in 2024) and with assets of up to $87,215 in 2024. For children served by ODDS, only the child's income (if any) is considered when determining financial eligibility.

APD and ODDS also serve individuals who qualify for the Healthier Oregon Program (HOP), which provides medical care, including HCBS, to individuals who meet financial requirements but who do not have a qualifying immigration status for Medicaid services.[9]

In addition to meeting financial requirements, to qualify for HCBS, individuals must need assistance to complete activities of daily living. APD and ODDS have separate instruments to determine whether individuals meet this level of need.

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6 O'Malley Watts, M., Musumeci, M., Ammula, M. Kaiser Family Foundation. (March 4, 2022). State Policy Choices About Medicaid Home and Community-Based Services Amid the Pandemic. Retrieved from https://www.kff.org/medicaid/issue-brief/state-policy-choices-about-medicaid-home-and-community-based-services-amid-the-pandemic/.

7 Oregon Administrative Rules, Chapter 461, Division 160, Section 0015. Accessed December 2024. Retrieved from https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=316195.

8 Oregon Administrative Rules, Chapter 461, Division 155, Section 0250. Accessed December 2024. Retrieved from https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=307379.

9 Oregon Administrative Rules, Chapter 410, Division 134, Section 0000 et seq. Accessed December 2024. Retrieved from https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=7182.

Assessment for APD Services

APD uses the Client Assessment and Planning System (CA/PS) to assess an individual's eligibility. The CA/PS assesses the level and frequency of supports an individual needs with performing ADLs and IADLs. Based on CA/PS results, an individual is assigned to one of eighteen service priority levels (SPL):

1. Requires full assistance in mobility, eating, elimination, and cognition
2. Requires full assistance in mobility, eating, and cognition
3. Requires full assistance in mobility, or cognition, or eating
4. Requires full assistance in elimination
5. Requires substantial assistance with mobility, assistance with elimination and assistance with eating
6. Requires substantial assistance with mobility and assistance with eating
7. Requires substantial assistance with mobility and assistance with elimination
8. Requires minimal assistance with mobility and assistance with eating and elimination
9. Requires assistance with eating and elimination
10. Requires substantial assistance with mobility
11. Requires minimal assistance with mobility and assistance with elimination
12. Requires minimal assistance with mobility and assistance with eating
13. Requires assistance with elimination
14. Requires assistance with eating
15. Requires minimal assistance with mobility
16. Requires full Assistance in bathing or dressing
17. Requires assistance in bathing or dressing
18. Individuals assessed with ADL needs not included in SPL 1-17 or those with medical or medication management needs

Individuals assessed as meeting SPL criteria for levels 1 through 13 are eligible for Medicaid funded long-term supports and services. Individuals assessed as meeting SPLs (1) through (18) are eligible for services available through the OPI-M program. As discussed in Section 2, CA/PS results are also used to determine provider payment rates for some services.

Assessment for ODDS Services

As noted above, to quality for services through ODDS an individual must have a significant impairment in adaptive behavior, which is the degree to which an individual meets the standards of personal independence and social responsibility expected for their age and culture group.[10] In general, a significant impairment is defined as a score that is at least two standard deviations

[10] Oregon Administrative Rules, Chapter 320, Division 134. Section 0080. Accessed December 2024. Retrieved from https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=300876.

below the norm. A number of adaptive behavior tests may be used to assess whether an individual meets this standard, including the Adaptive Behavior Assessment System (ABAS), the Adaptive Behavioral Evaluation Score (ABES) for children, the Vineland Adaptive Behavior Scale, and the Scales of Independent Behavior-Revised (SIB-R).

The results of these assessments do not impact provider payment rates. Section 2 discusses the processes through which ODDS determines tiered rates for certain services.

Services in the Wage and Rate Study

Figures 1-1 and 1-2 list the services covered by APD and ODDS, respectively, included in the wage and rate study with service and spending levels between fiscal years 2021 and 2023.

Figure 1-1: Service Levels and Spending for APD Services Included in the Wage and Rate Study, Fiscal Years 2021-2023

Service	Supported Individuals			Spending (in millions)		
	2021	2022	2023	2021	2022	2023
In-Home (Agency)	4,832	4,764	5,703	$82.3	$88.6	$124.8
In-Home (Home Care Worker)	16,937	16,783	16,326	$369.0	$362.4	$373.6
Adult Foster Care	3,281	3,352	3,256	$121.9	$140.1	$152.0
Assisted Living Facility	5,796	5,880	5,904	$118.1	$139.1	$164.5
Res. Care Facility, Standard	1,131	1,092	1,199	$14.1	$16.1	$17.8
Specific Needs Contract Facility	799	863	918	$68.4	$87.5	$112.0
Memory Care Facility	4,072	4,114	4,291	$122.5	$141.5	$177.1
Specialized Living	245	244	219	$13.3	$14.1	$19.0
Adult Day Services	-	211	244	-	$1.1	$1.9

Figure 1-2: Service Levels and Spending for ODDS Services Included in the Wage and Rate Study, Fiscal Years 2021-2023

Service	Supported Individuals			Spending (in millions)		
	2021	2022	2023	2021	2022	2023
In-Home (Agency)	6,428	7,772	10,227	$177.9	$260.0	$503.6
In-Home at Job (Agency)	27	31	36	$0.1	$0.2	$0.3
In-Home (PSW)	10,631	10,209	9,574	$303.5	$301.4	$291.5
Adult Foster Care	3,328	3,279	3,105	$212.7	$220.2	$215.3
Child Foster Care	475	403	344	$25.4	$22.5	$19.8
Attendant Care (Adult Foster)	128	131	125	$2.3	$2.8	$2.7
Host Homes	4	9	9	$0.0	$0.4	$0.4
Adult 24 Hour Res. (Group Home)	3,287	3,437	3,700	$417.1	$465.5	$648.1
Child 24 Hour Res. (Group Home)	212	200	205	$41.0	$40.4	$39.9
Supported Living	848	882	878	$58.6	$64.9	$79.0
Day Support Activity	3,022	3,430	3,811	$13.8	$23.7	$40.4
Employment Path	1,102	996	974	$4.3	$4.6	$5.9
Small Group Employment	535	612	621	$4.8	$5.7	$7.0
Discovery	131	157	134	$0.3	$0.3	$0.3
Job Development	20	21	20	$0.0	$0.0	$0.0
Job Coaching	1,783	2,220	2,419	$24.9	$35.3	$43.8
Non-Medical Transportation	-	925	910	-	$0.6	$1.7

Considering only the services included in the wage and rate study:

- In both the APD and ODDS systems, the largest numbers of individuals receive In-Home services with spending on these services totaling nearly $1.3 billion in fiscal year 2023.
- Full-time residential care represents the next largest category in terms of service levels, with per-person spending figures significantly higher than for In-Home services. Within the APD system, most full-time residential care occurs in generally larger assisted living and residential care facilities; within the ODDS system, group homes are most common. More than 3,000 individuals in each system receive care in a foster home setting.
- Spending on all services other than in-home supports and full-time residential care accounts for only six percent of spending on in-scope services.

In-Home (APD and ODDS)

In-Home services cover personal care and assistance with ADLs and IADLs for individuals in their own home or in the home of a family member or friend. The number of hours of support an individual may receive are based on an individual's assessed needs. For individuals served through APD, hours are based on CA/PS results. ODDS is in the process of allotting service hours based on the Oregon Needs Assessment discussed in Section 2.

Services are provided by agency providers as well as directly hired homecare workers and personal support workers.

Agencies hire, train, and supervise direct care employees. Wages and benefits are based on each agency's wage scales and policies. ODDS has defined two types of agency providers:

- *Community living support (CLS)* providers must meet basic service standards.
- *Standard model agencies* are paid a higher rate and must meet higher standards, including providing an additional 12 hours of annual training for direct support professionals (DSPs), developing policies to minimize worker cancelations, having an on-call supervisor available when DSPs are working scheduled shifts, and developing protocols for medical and behavioral risks.

Nearly all providers have been designated as standard model agencies. Due to the additional requirements, ODDS pays these agencies a higher rate. APD has not established similar distinctions for its In-Home services agencies.

Although the specific supports provided will vary based on the needs of the individual supported, In-Home services are broadly equivalent across the APD and ODDS systems. However, payment rates have not been aligned and the APD rate is currently about 10 percent lower than ODDS' standard model agency rate.

HCWs and PSWs are employed and managed by the supported individual or their representative. HCW and PSW wages, benefits, and employment terms and conditions are defined in a collective bargaining agreement between the Oregon Home Care Commission (OHCC) on behalf of the state of Oregon and the Service Employees International Union (SEIU) Local 503. OHCC also provides training for HCWs and PSWs.

Pursuant to HB4129 passed during the 2024 legislative session, ODHS is in the process of developing an agency with choice model for In-Home services in which APD and ODDS will contract with up to two agencies to serve as the employer of direct support workers with responsibility for recruitment, hiring, training, and payment. Since the requirements for this

service delivery model have not been finalized, the agency with choice option was not considered in the wage and rate study.

Foster Care (APD and ODDS)

Adult foster homes (AFH) provide full-time residential care for up to five individuals in a private home. AFH services cover a variety of operating models. For example, many AFH providers deliver care in their own home and may be assisted by others such as family members or outside staff they employ. Other homes operate similarly to group homes with shift staff overseen by the AFH provider who does not live in the home.

Payment rates for Adult Foster Home services are negotiated between the state and SEIU.

ODDS also covers Child Foster Home (CFH) services. CFH services are not bargained, but ODDS determines payment rates similar to the process used for AFH services although CFH rates are somewhat lower. CFH standards are the same as ODHS' child welfare standards, but CFH rates are generally higher than paid by the child welfare system.

Host Homes (ODDS)

ODDS host homes are family homes for children with an in-home caregiver serving in a parental role. Unlike CFHs that are paid directly by the state, ODDS contracts with agencies that oversee host home families. The agencies have contracts with the host homes, pay the host homes, provide oversight, and offer supports such as respite. Host Homes are limited to two placements.

Assisted Living and Residential Care Facilities (APD)

Assisted Living Facility (ALF) and Residential Care Facility (RCF) services are provided in community-based residential settings that provide a range of supports on a 24-hour basis to meet the daily living, health, and social needs of residents. ALFs and RCFs are licensed to care for six or more individuals. ALF have a median licensed capacity of 68 beds while RCFs have a median capacity of 30 beds. The primary difference between these facilities is that ALFs have self-contained individual living units while RCFs may have shared units.

Staff may include paraprofessional caregivers, activity staff, food service staff, and clinicians (such as nurses), but licensing rules do not set specific staffing levels. ALFs and RCFs may contain separately endorsed memory care units designed to provide specialized services for individuals with identified memory care needs.

Adult Day Services (APD)

Adult Day services are structured, comprehensive non-residential programs that provide health, social, and related support services during a portion of the day, usually to older adults. Programs must have at least one staff for every six supported individuals, or one staff for every four individuals if more than half of those served require a full assist in three or more activities of daily living. Providers must provide one meal per day if an individual is present during a typical mealtime as well as snacks between meals.

24-Hour Residential Services (ODDS)

Adult 24-Hour Residential and Child 24-Hour Residential services are provided in group homes that usually serve five or fewer individuals. Approximately 70 percent of adults live in a three-person home. Homes are primarily staffed by direct support professionals, but rules do not set specific staffing levels. Within the ODDS system, individuals in group homes typically have higher support needs, but residents have a variety of support needs and it is not expected or required that each home support individuals with similar levels of need.

Supported Living (ODDS)

Supported Living services support individuals in a community residence of their choosing, which include provider-owned and controlled homes. Supports are intended to be one-to-one without shared staffing, and are provided both as scheduled and as needed. The number of funded hours in the monthly rate established for each individual is currently determined by the Adult Needs Assessment (ANA) discussed in Section 2, but rules do not require agencies to provide that amount of direct support. Most individuals do not receive 24-hour direct supports, but agencies must be available 24 hours per day. In addition to direct face-to-face supports, agencies often provide remote support and coordination activities such as scheduling appointments on behalf of individuals.

Day Support Activities (ODDS)

Day Support Activities (DSA) services emphasize instrumental activities of daily living competencies, generally in a group setting. Services may be provided in both center-based and community settings; in fiscal year 2023, 67 percent of billed hours were in the community. Individuals must have measurable goals documented in their service plan related to developing or maintaining skills for participating in the community. Programs must have at least one staff for every six supported individuals.

Non-Medical Transportation (ODDS)

Non-Medical Transportation services are provided in the area surrounding the home of an individual to access community services and activities that are not medical in nature. Examples include grocery shopping, attending worship services, or meeting friends.

Employment Services (ODDS)

Employment services assist individuals with attaining, maintaining, and advancing in competitive integrated employment. Vocational Rehabilitation (VR) generally provides employment services for individuals with disabilities. ODDS funds employment services when not available through VR (for example, when a waiting list is in place) as well as longer-term supports. ODDS and VR generally utilize the same provider pool and work together to deliver employment services for individuals with I/DD. To support continuity of services and predictability for providers, ODDS and VR have historically aligned payment rates.

ODDS offers an array of employment services:

- *Discovery* is a comprehensive, time-limited service to help an individual seeking employment and their job developer understand their strengths, interests, abilities, skills and support needs.

- *Employment Path* provides learning and work experiences, including volunteer opportunities, to help an individual develop skills that will contribute to employability in an integrated setting. Employment Path is generally provided in a group setting and is intended to be time-limited. Services may be provided in both center-based and community settings. In fiscal year 2023, 91 percent of billed hours were delivered in the community.
- *Job Development* covers support for an individual to obtain employment in an integrated, community job. ODDS is only responsible for Job Development when not available through Vocational Rehabilitation.
- *Job Coaching* provides support for an individual to maintain or advance in competitive integrated employment after they have successfully gained employment. VR and ODDS have consistent provider requirements so agencies approved for one program can be approved for the other, ensuring individuals can be supported by the same agency from initial job placement through long term job coaching.
- *Small Group Supported Employment* includes services and training activities provided in a regular business community setting for two to eight individuals to promote integration between participants and people without disabilities in the workplace.

Service Providers

As in most states, most home and community-based services in Oregon are provided by contracted service providers – both agencies and individually-contracted workers. Agencies range in size from small local organizations to large national companies operating in multiple states, and are diverse in terms of organizational structure (for-profit and non-profit), type of services delivered, and areas served.

Agencies typically serve only one population – only 2 percent provided services to individuals in both the APD and ODDS systems. Most agencies specialize in a single service. All APD providers generate at least 90 percent of their revenue from one service, as do 85 percent of ODDS providers. As Figures 1-3 and 1-4 show, the number of agencies increased in both the APD and ODDS systems between fiscal years 2021 and 2023.

Figure 1-3: APD Provider Counts (excludes HCWs and AFHs), Fiscal Years 2021-2023

	FY2021	FY2022	FY2022 vs. FY2021	FY2023	FY2023 vs. FY2022
All Agencies[a]	**515**	**532**	**3%**	**549**	**3%**
In-Home Care (Agency)	63	64	2%	63	(2%)
Assisted Living Facility	194	191	(2%)	189	(1%)
Residential Care Fac., Standard	31	33	6%	37	12%
Specific Needs Contract Facility	83	84	1%	105	25%
Memory Care Facility	171	178	4%	185	4%
Specialized Living	12	11	(8%)	13	18%
Adult Day Services	**-**	**13**	**-**	**13**	0%

[a] Because facilities are individually licensed and bill under separate IDs, the counts for ALFs and RCFs represent licensed sites rather than corporate organizations.

About 550 agencies provided APD services in fiscal year 2023 compared to about 515 in fiscal year 2021. Most growth was associated with Residential Care Facilities.

Figure 1-4: ODDS Provider Counts (excludes HCWs and AFHs), Fiscal Years 2021-2023

	FY2021	FY2022	FY2022 vs. FY2021	FY2023	FY2023 vs. FY2022
All Agencies[a]	**494**	**597**	**21%**	**726**	**22%**
Attendant Care (Agency)	226	226	0%	219	(3%)
Attendant Care at Job (Agency)	18	21	17%	25	19%
Host Homes	1	1	0%	1	0%
Adult 24 Hour Res. (Group Home)	245	334	36%	437	31%
Child 24 Hour Res. (Group Home)	17	18	6%	29	61%
Supported Living	59	61	3%	63	3%
Day Support Activity	140	147	5%	143	(3%)
Employment Path	74	75	1%	69	(8%)
Small Group Employment	30	30	0%	31	3%
Discovery	33	41	24%	33	(20%)
Job Development	10	11	10%	12	9%
Job Coaching	104	105	1%	104	(1%)
Non-Medical Transportation	-	72	-	98	36%

About 725 agencies provided ODDS services in fiscal year 2023 compared to about 500 in fiscal year 2021. The most significant growth over this period has been in adult group homes.

Figure 1-5 includes agency provider counts based on fiscal year 2023 payments from APD and ODDS.

Figure 1-5: Counts of Agency Providers by Fiscal Year 2023 APD or ODDS Payments

APD or ODDS Payments	APD Providers		ODDS Providers	
	Count	% of Total	Count	% of Total
$0-$100K	71	13%	139	19%
$100K-$250K	56	10%	81	11%
$250K-$500K	83	15%	149	21%
$500K-$1.0M	138	25%	168	23%
$1.0M-$2.5M	157	29%	94	13%
$2.5M-$5.0M	29	5%	33	5%
$5.0M-$10.0M	13	2%	37	5%
$10.0M-$25.0M	1	0%	18	2%
$25.0M or More	1	0%	7	1%

Although a few providers are very large – 27 agencies received APD or ODDS payments greater than $10 million in fiscal year 2023 – median annual Medicaid payments were about $700,000 for APD providers and $500,000 for ODDS providers.

ODDS providers are more likely to rely on Medicaid-funded HCBS. ODDS provider agencies that participated in the provider survey administered as part of the wage and rate study reported that Medicaid accounts for an average of 85 percent of their revenues. In comparison, assisted living facilities reported that Medicaid represents an average of only 44 percent of their revenues.

As shown in Figure 1-6, the number of adult foster homes has been stable in recent years, but the number of ODDS child foster homes has decreased 24 percent in recent years.

Figure 1-6: Foster Home Counts, Fiscal Years 2021-2023

	FY2021	FY2022	FY2022 vs. FY2021	FY2023	FY2023 vs. FY2022
APD Adult Foster Homes	1,062	1,086	2%	1,071	(1%)
ODDS Adult Foster Homes	1,272	1,248	(2%)	1,209	(3%)
ODDS Child Foster Homes	302	261	(14%)	231	(11%)

As discussed earlier, individuals may choose to receive In-Home services through a provider agency or through directly hired homecare workers and personal support workers Homecare workers and personal support workers generally work with a single individual. HCWs worked a median of 916 hours in fiscal year 2023 while PSWs worked a median of 1,121 hours.

After accounting for differences in individual acuity, individuals supported by HCWs and PSWs tend to receive more hours of support than individuals served by agencies, as shown in Figures 1-7 and 1-8.

Figure 1-7: In-Home Utilization Based on Provider Type, Individuals Served by APD, Fiscal Yar 2023

Tier[a]	Individuals Served by Agencies		Individuals Served by HCWs	
	Count	Avg. Hours	Count	Avg. Hours
Tier 1	35	400	46	451
Tier 2	294	588	878	703
Tier 3	758	950	3,415	1,157
Tier 4	471	1,517	2,865	1,785
Tier 5	256	2,320	1,636	2,601

[a] Based on APD's proposed assessment framework described in Section 2.

Figure 1-8: In-Home Utilization Based on Provider Type, Individuals Served by ODDS, Fiscal Yar 2023

Svc. Grp.[a]	Individuals Served by Agencies		Individuals Served by HCWs	
	Count	Avg. Hours	Count	Avg. Hours
1	196	500	173	700
2	807	709	1,136	1,079
3	1,518	1,603	2,559	1,785
4	1,167	2,224	1,716	2,527
5	1,098	3,090	1,203	3,235

[a] Based on Oregon Needs Assessment service groups described in Section 2.

The number of staff working as HCWs and PSWs declined between fiscal years 2021 and 2023 with decreases of 12 percent and 13 percent, respectively. Figure 1-9 reports the number of workers that stopped delivering services each year and the number that began deliver services.

Figure 1-9: Change in Number of HCWs and PSWs, Fiscal Years 2021-2023

	Homecare Workers			Personal Support Workers		
	FY2021	FY2022	FY2023	FY2021	FY2022	FY2023
Prior Year Total		19,866	19,194		15,323	14,650
Departed Staff		(4,200)	(4,819)		(2,338)	(2,345)
New Staff		3,528	3,345		1,665	1,219
Fiscal Year Total	**19,866**	**19,194**	**17,720**	**15,323**	**14,650**	**13,524**

As the table shows, between 15 and 25 percent of HCWs and PSWs stopped delivering services each year. These attrition rates are lower than what is often reported for agency-employed workers. For example, ODDS In-Home agencies participating in the provider survey reported an average turnover rate of 29 percent (APD In-Home providers reported an average turnover rate of 93 percent, but that was based on only six responses). However, the numbers of new HCWs and PSWs have been lower than the numbers of departing workers. As a result, there were about 3,900 fewer total HCWs and PSWs in fiscal year 2023 than in fiscal year 2021.

Individuals served by HCWs and PSWs who stopped providing services prior to fiscal year 2023 tended to transition to another HCW or PSW, as shown in Figure 1-10. Fewer than a quarter of individuals transitioned to an in-home agency provider.

Figure 1-10: Fiscal Year 2023 Services Received by Individuals Who Had Been Served by an HCW or PSW Who Stopped Providing Services Prior to Fiscal Year 2023

	APD	ODDS
Received In-Home Services from Other HCW/ PSW	39%	41%
Received In-Home Services from Agency	10%	33%
Received Services Other than In-Home	6%	7%
Received No Services	44%	19%

Payment Rates

Federal Medicaid statutes and regulations establish several requirements related to payment rates for service providers. Payments must be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that Medicaid beneficiaries have comparable access to services as the general population.[11] Additionally, states are expected to be able to describe the underlying cost factors and assumptions used to establish rates, and to regularly review their rate-setting methodologies.

[11] Section 1902(a)(30)(A) [42 U.S.C. 1396a]. Accessed December 2024 at https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

However, APD has not conducted a comprehensive review of payment rates for APD services in more than 20 years. As a result, APD does not possess documentation of the cost factors or assumptions used to establish current rates. For example, the current rates are not based on a specific, identifiable wage assumption for direct care workers. APD provider rates have been increased over the years based on legislative determination.

Most ODDS payment rates are based on rate models with detailed cost assumptions. Initial rate models were created through ODDS' Restructuring Budgets, Assessments and Rates (ReBAR) initiative funded through a 2005 federal systems transformation grant. Current rate models were developed with support from HMA-Burns through a multi-stage rate study process beginning in 2015. These rate models are based on a review of service requirements, independent cost data, and provider input. Final rate models were published in 2021. The resulting rates, with small updates in 2023 based on legislated funding increases, have been fully implemented.

APD and ODDS agency payment rates have received substantial increases since July 1, 2019 as shown in Figure 1-11.

Figure 1-11: Agency Payment Rate Increases Since 2019

Service	Increase
APD In-Home Care	47%
Assisted Living Facility	47%
Residential Care Facility, Standard	47%
Memory Care	47%
ODDS Attendant Care	54%
Adult 24-Hour Residential*	30%
Child 24-Hour Res. (comp. to 9/2019)*	11%
Day Support Activity*	33%
Employment Path*	20%
Small Group Employment*	31%
Job Coaching*	18%

* Effective increase is understated because the transition to the Oregon Needs Assessment resulted in individuals generally being assigned to higher rate categories, meaning agencies received higher payments for serving the same individuals.

As described in Section 4, the rate methodologies outlined in the collective bargaining agreement for Adult Foster Home services differ for APD and ODDS AFHs. Overall, APD AFH rates have increased 30 percent since July 1, 2019. ODDS AFH rate increases since July 1, 2019 have varied, but have generally been around 20 percent.

Base hourly pay rates are the same for HCWs and PSWs. The July 1, 2023 - June 30, 2025 collective bargaining agreement increased the base wage for HCWs and PSWs by $2.23 per hour, to a total of $20.00 per hour, effective January 2025. Additionally, the agreement creates an experience-based pay scale that gives workers a $1.00 increase in their base pay for each

accumulation of 2,000 hours worked since January 1, 2023, excluding overtime hours. HCWs and PSWs with at least 8,000 worked hours are assigned to the highest step and receive a base wage of $24.00.

The current base wage for HCWs and PSWs has increased 33 percent since July 2019, excluding the scheduled $0.50 increase on January 1, 2025. The effective increase is understated because it excludes the experienced-based pay scale. For example, the base wage for someone at step 3 would be 47 percent higher than the July 2019 base wage.

Finally, the agreement includes a number of pay differentials that HCWs and PSWs may receive based on their training or the significant needs of the individual they serve. These differentials are detailed in Section 3.

Section 2: Wage and Rate Study Methodology

Drawing on its experience successfully completing dozens of home and community-based services rate studies across the country, HMA-Burns designed the wage and rate study to comply with the terms of the SB5506 budget note. The study evaluated staff qualifications across systems, services, and service delivery models and offered recommendations to standardize direct care worker compensation.

The study also considered how individual acuity is assessed and impacts payment rates. Study recommendations incorporate changes to assessment frameworks developed by APD as well as ODDS' intent to transition additional services to payment rates tied to the Oregon Needs Assessment.

To develop its recommendations, HMA-Burns researched service requirements; considered data collected directly from service providers as well as from independent, published sources; and sought input from community partners. Based on this research, analysis, and input, HMA-Burns developed detailed, transparent rate models meant to reflect the reasonable costs providers incur to deliver services consistent with the state's requirements. These models are designed to reflect estimated fiscal year 2026 costs and would need to be updated to remain current in future years.

Wage and Rate Study Approach

"Setting sufficient HCBS rates is key to ensuring individuals receive quality care and have access to an adequate pool of providers" according to the federal Centers for Medicare and Medicaid Services (CMS).[12]

As a result, CMS expects states to regularly review payment rates. In addition to the statutory requirement that all Medicaid payment rates are consistent with efficiency, economy, and quality of care as well as sufficient to enlist enough providers so that service recipients have access to services comparable to access amongst the general population, CMS has outlined a number of other expectations related to HCBS rate setting. States must document the rate methodology used for each service and identify how stakeholders were involved in the rate setting process.[13] Rates should also be based on validated data sources that may include paid claims data from the state's MMIS system, benchmark rates from similar programs in the state or in other states, publicly-available data sources, cost and wage surveys from providers, and other data sources.[14]

[12] Centers for Medicare and Medicaid Services. (n.d.). Ensuring Rate Sufficiency: Rate Review and Revision Strategies. Retrieved from https://www.medicaid.gov/medicaid/home-community-based-services/downloads/rate-sufficiency.pdf.

[13] Centers for Medicare and Medicaid Services, "Engaging Stakeholders in the Rate-Setting Process," May 2019, https://www.medicaid.gov/sites/default/files/2019-12/rate-setting-process.pdf.

[14] Centers for Medicare and Medicaid Services. (n.d.). HCBS Waiver Rate Setting Data Validation. Retrieved from https://www.medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-1d-data-validation-training.pdf.

Principles and Key Considerations

Consistent with CMS' requirements and expectations, HMA-Burns' approach to this wage and rate study included the following key tenets:

- *Independent rate-setting approach.* Rather than depending on a single source of information, data from multiple sources was considered. This approach is intended to ensure payment-related recommendations reflect market-based costs – including competitive compensation for direct care staff – to support an accessible and quality provider network.
- *Transparency.* Payment-related recommendations detail the factors, values, and calculations that produce the overall rate. By providing detailed and transparent rate models, system stakeholders are provided with a clear and well-supported framework for understanding what has been assumed in the recommended rates.
- *Community partner input.* Providers, provider representatives, and other stakeholders were involved throughout the wage and rate study. Key engagement activities included meetings with an advisory group and multiple service-specific workgroups, conducting provider site visits, administering a provider cost survey, and facilitating a public comment process. These strategies ensured that community partner feedback was considered throughout the study, although not all suggestions were adopted.
- *No budget targets.* Payment-related recommendations were developed based on the results of the research and analysis conducted as part of the wage and rate study rather than a targeted funding level. Ultimately, available funding will determine the rates that can be implemented, but the rate-setting process itself aims to reflect the reasonable costs that providers incur to deliver services consistent with the state's requirements.

Additionally, the wage and rate study was designed to meet the requirements of the SB5506 budget note, including:

- *Cross-system, cross-service, and cross-service delivery modality.* The wage and rate study evaluated wages and payments across the APD and ODDS systems, considering services delivered both by contracted agencies and by homecare workers and personal support workers. In addition to in-home and residential services, the study included day program services and ODDS employment supports because of the overlap in the workforce.
- *Staff qualifications.* The study considered the documented requirements for direct care workers across systems and services. The results of this evaluation are discussed in Section 3.
- *Service recipient acuity.* The study considered how acuity is determined across systems and services. Acuity-related considerations are discussed below.

Based on considerations of comparability of service and staff requirements and service recipient acuity, the wage and rate study also evaluated the appropriateness of standardizing direct care compensation and provider payments generally.

Standardization does not necessarily translate to identical payments as there may be differences that impact costs. For example, both agencies and personal support workers and homecare workers deliver In-Home services, but these service delivery models have different cost structures. Agencies must provide supervision and manage administrative tasks such as hiring, training, and billing. For PSWs and HCWs, however, these tasks are the responsibility of

the family and financial management agent services vendors. Additionally, there are differences in the activities that can be billed. For example, PSWs and HCWs may bill for time spent on certain travel and training activities while agencies cannot. Since agencies cannot bill for this time directly, related costs must be incorporated in the rate for billable activities. Thus, while the wage and rate study recommends standardizing direct care compensation across agency providers and PSWs and HCWs as discussed in Section 4, the total hourly payment varies because such compensation is only part of agencies' total expenses.

During the course of the wage and rate study, CMS finalized its *Medicaid Program; Ensuring Access to Medicaid Services* rule (the "Access rule").[15] This expansive rule contains a number of provisions related to provider payments, including:

- Requiring that providers of homemaker, home health aide, and personal care services spend a minimum of 80 percent of Medicaid payments on compensation for direct care workers. This provision includes clinical supervisors in the definition of direct care and excludes certain travel, training, and personal protective equipment (PPE) costs from the calculation. This requirement does not become effective until July 2030 and does not apply to habilitative services. States may establish a different standard for small providers meeting state-defined criteria and may develop hardship exemptions for providers facing extraordinary circumstances.
- In preparation for enforcing the 80 percent requirement summarized in the previous bullet, requiring states to report in 2027 on their readiness to collect data regarding the percentage of payments for homemaker, home health aide, personal care, and habilitation services spent on direct care worker compensation. States must begin reporting these percentages in 2028.
- Requiring states to publish all Medicaid fee-for-service payment rates on a publicly available and accessible website.
- Requiring states to establish an advisory group for direct care workers, beneficiaries, beneficiaries' authorized representatives, and other interested parties to meet at least every two years, and advise and consult on payment rates paid to direct care workers for personal care, home health aide, homemaker, and habilitation services.

CMS will be releasing additional guidance to assist states in implementing these requirements, including defining the services subject to the 80 percent requirement. For example, some services include both personal care supports (which are subject to the requirement) and habilitative supports (which are not subject to the requirement) and it is not clear whether and how CMS might expect such supports to be separately delineated. This may be further complicated in Oregon because most services are defined as attendant care under the state's Section 1915(k) authority. Additionally, states require specific definitions of clinical supervision and the costs excluded from the 80 percent calculation.

Because the minimum spending threshold is not effective until 2030 and due to the remaining uncertainties regarding the applicability of the rule and the details of how to calculate the percentage of payments spent on direct care worker compensation, the wage and rate study does not include specific recommendations related to compliance with the Access rule. However, the establishment of rate models with detailed cost assumptions and the

[15] Federal Register, Volume 89, No. 92. (May 10, 2024). Medicaid Program; Ensuring Access to Medicaid Services (to be codified at 42 CFR Parts 431, 438, 441, and 447). Retrieved from https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08363.pdf.

recommended reporting requirements discussed in Section 5 provide a strong foundation for ODHS and community partners to evaluate how funding levels and provider spending compare to the Access rule requirements.

Broadly, the independent rate modeling approach seeks to reflect the reasonable costs providers incur to deliver services consistent with the state's requirements and individuals' service plans. To ensure these cost assumptions reflect market-based costs, data from multiple sources was considered, including documented service requirements in regulations, policies, and agreements; conclusions from previous reports about the state of the direct care workforce in Oregon; data collected through the provider survey and a review of provider job postings; published cost data (such as Bureau of Labor Statistics wage data); and community partner input.

Community Partner Engagement Strategies

The wage and rate study employed several strategies to collect community partner perspectives, including:

- *A wage and rate study advisory group*. ODHS identified a group of key stakeholders in provider payments – including provider trade groups, individual providers, SEIU, and advocacy groups – to provide input throughout the study. The group met eight times during the project. Areas of focus included study methodology and cross-system issues (for example, considering direct care worker compensation across programs and service delivery models).
- *Wage and rate study workgroups.* To allow for focused discussions of individual services, APD and ODDS identified participants for eight different workgroups, covering In-Home Services, Adult Foster Homes, Assisted Living Facility and Residential Care Facility services, APD Adult Day Services, ODDS 24-Hour Residential, ODDS Day Support Activities, and Employment services. Participants included provider trade groups, individual providers, SEIU, and advocacy groups. The groups were convened three-to-four times between Fall 2023 and Summer 2024 to discuss service-specific issues as well as the provider survey.
- *Provider survey.* A provider survey was developed and administered as part of the rate study to collect data directly from agency providers about their programs operations and expenses. The provider survey is described in greater detail below.
- *Provider site visits.* In July 2024, HMA-Burns and ODHS representatives conducted on-site visits with four assisted living facilities, residential care facilities, and APD adult foster homes. These visits allowed the team to observe the programs firsthand and engage in in-depth discussions regarding program operations.
- *Public comments.* Based on its research and analysis activities, including stakeholder input, HMA-Burns published initial recommendations in October 2024, including draft rate models and supporting materials. HMA-Burns recorded and published a series of webinars that walked through the rate proposals. The comments received resulted in a number of changes to the initial recommendations. The public comment process and the resulting changes to wage and rate study recommendations are described in greater detail below.

Recommended Rate Models and Reporting Requirements

The wage and rate study culminated with the development of rate models for agency-provided services and adult foster homes, consistent with CMS' expectations that states document the underlying cost factors and assumptions for HCBS rates. As noted in Section 1, ODDS already has detailed rate models for most services. For these services, the rate study recommends updating cost assumptions and making targeted adjustments. For services without existing rate models – APD services, Adult Foster Home services, and ODDS' Supported Living service – the study includes recommended rate models.

The rate models outline assumptions for key cost drivers, including direct care worker wages, benefits, and productivity; other direct costs such as mileage and facility expenses; worker supervision; and other administrative and operating expenses. These assumptions are not meant to dictate agencies' operations and, for any given agency, it is expected that some costs will be lower than assumed and others will be higher. Rate model assumptions are intended to reflect typical and reasonable costs, but agencies must have the flexibility to design their programs to meet the needs of their workers and the people they serve. For example, a provider may choose to pay higher wages than assumed in the model, but offer less generous benefits.

Although the assumptions incorporated in the rate models do not prescribe agencies' operations, the use of independent rate models offers a number of benefits, including:

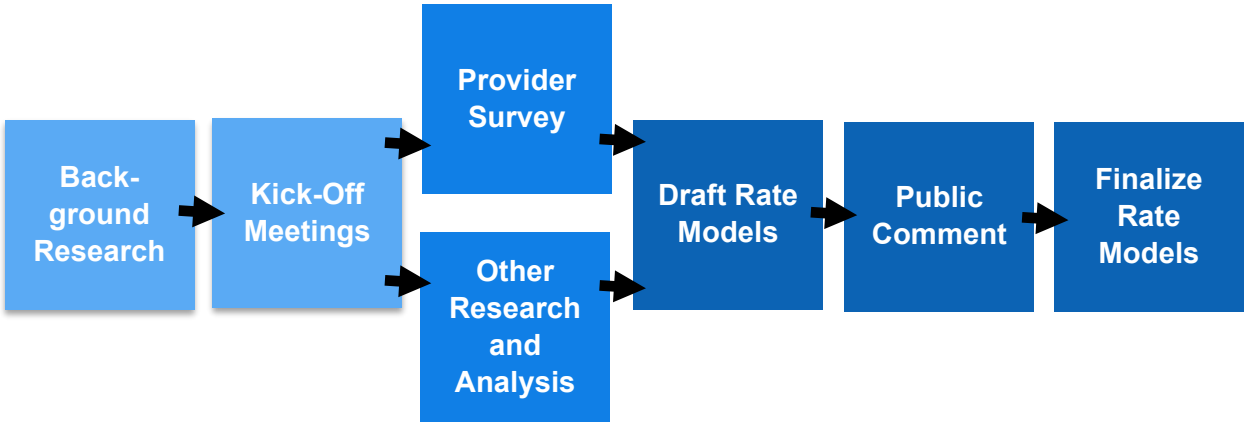
- *A shared understanding of what is funded in the rates.* For example, if asked what wage level is assumed in current payment rates, ODDS can provide an answer for most services based on its existing rate models, but APD generally cannot as their payment framework was developed decades ago and adjustments have been based on overall rates rather than specific cost components.
- *An ability to support programmatic goals.* Targeted adjustments can be made to cost assumptions to advance policy goals and objectives. For example, if ODHS decides to increase training expectations for direct care workers, the specific assumption related to staff training can be adjusted to account for the increased cost.
- *An efficient means to maintain rates over time.* Rate model cost assumptions can be updated as new cost data becomes available. For example, cost assumptions related to direct care worker wages and benefits are based on published cost data. When more current data becomes available, the new values can be easily substituted into the rate models to recalculate the overall rate.
- *A foundation for accountability measures.* Although agencies are not expected to manage to rate model assumptions, these assumptions can serve as benchmarks for agency spending.

To evaluate the ongoing appropriateness of rate model cost assumptions, the wage and rate study recommends the modification or establishment of reporting requirements to inform future rate adjustments. For example, such reporting could show that agencies have had to increase worker wages above what is assumed in the models or that they are not delivering the level of supervision that is assumed. Although some differences between rate model cost assumptions and agencies' actual operations are expected, significant variances could suggest the need to adjust the rate models. This recommendation is discussed in greater detail in Section 5.

Wage and Rate Study Process

Figure 2-1 illustrates the major tasks in the wage and rate study.

Figure 2-1: Wage and Rate Study Tasks



As the graphic demonstrates, the wage and rate study encompassed three phases:

- *Phase I: Research and Documentation* included detailed reviews of program regulations, policies, and other materials, and consultation with internal and external stakeholders to understand service requirements, existing strengths and challenges, and system goals.
- *Phase II: Data Collection and Analysis* included the collection of data regarding providers' service designs and expenses as well as research and analysis of other data to inform cost benchmarks.
- *Phase III: Rate Model Development* included the design of initial payment-related recommendations, a public comment process to solicit feedback on these proposals, and finalization of recommendations.

Background Research and Kick-Off Meetings

In the initial phase of the wage and rate study, HMA-Burns researched and documented existing service requirements and practices.

HMA-Burns first reviewed program materials – including Oregon's Medicaid state plan and waiver authorities for services covered by the wage and rate study, APD and ODDS regulations and policies, collective bargaining agreements for In-Home and Adult Foster Home services, and related documents – to develop an understanding of service requirements, including staff qualifications. This is a critical element of effective HCBS rate studies due to the wide discretion states have in setting service standards. That is, state HCBS programs typically cover similar arrays of services, but service requirements can vary significantly across programs. For example, most HCBS programs cover an adult day care and/or day habilitation service, but service requirements vary significantly from program-to-program in terms of staffing ratios, transportation, meals, and community participation. While reviewing program materials, HMA-Burns documented key cost drivers such as direct care worker qualifications, staffing levels and staffing ratios, required ancillary supports, definitions of billable activities, and similar factors.

HMA-Burns additionally reviewed several direct care worker compensation-related studies conducted in Oregon in recent years, including:

- A 2022 PHI study of the direct care workforce in Oregon.[16] The study evaluated wage and income data from the Bureau of Labor Statistics, industry and occupational employment forecasts from the Projections Management Partnership, employment and income data from the U.S. Census Bureau's American Community Survey, and occupational descriptions from the O*Net Program. The data was coupled with a review of direct care workforce policies and programs that had been implemented within the previous five years in Oregon. The report included a number of recommendations designed to strengthen direct care workforce recruitment and retention in Oregon.
- A 2022 study conducted by the Institute on Aging (IOA) at Portland State University that focused on wages for staff employed by assisted living and residential care facilities.[17] The study fulfilled a legislative requirement directing ODHS to evaluate the cost of care for ALF and RCF residents, the sufficiency of the Medicaid payment rates, and staff wages.[18] The study included a survey of 199 ALFs and RCFs across Oregon (out of 606 total licensed sites, a 32.8 percent overall response rate).
- The 2023 NCI-IDD State of the Workforce Survey, which collects comprehensive data from provider agencies and the DSP workforce serving adults with I/DD across the country.[19] A total of 26 states, including Oregon and the District of Columbia, administered the survey to providers. Nationwide, nearly 4,000 providers responded, reporting information representing more than 325,000 direct support professionals.

Key direct care worker compensation-related findings from these reports are discussed in Section 3.

HMA-Burns also evaluated current rate schedules and claims data to understand current utilization levels and trends.

After conducting this background research, HMA-Burns facilitated project kick-off meetings with ODHS' project teams as well as the external project advisory group and the service-specific workgroups. The meetings with the state team focused on discussion of the review of service requirements and any needed clarifications, how individual acuity is assessed in the APD system, and any identified challenges related to payment rates and practices. In the kick-off meetings with the advisory group and the workgroups, HMA-Burns provided an overview of the project, answered questions, and solicited input about issues of concern and areas of system strengths.

Insights gained as part of these initial tasks informed data collection efforts as well as subsequent recommendations.

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[16] Scales, K. PHI. (2023). Strengthening and Stabilizing the Direct Care Workforce in Oregon. Retrieved from https://olis.oregonlegislature.gov/liz/2023R1/Downloads/CommitteeMeetingDocument/264559.

[17] Tunalilar, O., Dys, S., Carder, P., Jacoby, D. Portland State University. (February 2023). Wage and Cost Study of Oregon Assisted Living and Residential Care Providers, 2022. Retrieved from https://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=1125&context=aging_pub.

[18] Senate Bill 703 (81st Oregon Legislative Assembly – 2021). See https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/SB703/Enrolled.

[19] National Core Indicators Intellectual and Developmental Disabilities. (2024). State of the Workforce Survey Report – 2023. Retrieved from https://idd.nationalcoreindicators.org/wp-content/uploads/2024/11/2023-NCI-IDD-SoTW_241126_FINAL.pdf.

Provider Survey

HMA-Burns developed provider surveys to collect data directly from agency providers and adult foster homes regarding their programs' operations and expenses. The surveys, which were designed in Microsoft Excel, included forms that captured details such as:

- Wage and benefit costs for direct care staff
- Non-staff operating expenses, such as costs associated with facilities, office equipment and supplies, insurance, professional services, etc.
- Direct care staff productivity, which measures the amount of time staff spend providing direct services and engaging in non-billable activities such as training, travel between service encounters, and recordkeeping
- Caseloads, staffing levels, and staffing ratios
- Typical lengths of service encounters
- Miles driven transporting recipients or traveling between service encounters

Survey drafts were shared and reviewed with the project advisory group and the service-specific workgroups. The HMA-Burns team incorporated a number of changes based upon feedback from these groups. Notably, the level of detail requested for employees that do not provide direct care was significantly reduced due to concerns regarding the confidentiality of submitted surveys. Additionally, the survey for Adult Foster Home services was substantially revised and converted to a fillable Adobe PDF format.

The surveys were accompanied by brief instructions that offered guidance beyond what was embedded in the survey instruments. Additionally, HMA-Burns recorded and published online webinars walking through each survey form-by-form. Finally, HMA-Burns provided contact information for a team member to answer questions and offer technical assistance.

APD and ODDS emailed providers informing them that they would be asked to complete the survey and published other communications explaining the purpose of the survey and requesting participation. HMA-Burns subsequently emailed the survey to all providers between January 30 and February 1, 2024. The original March 15 deadline for submitting the survey was extended to March 29 in response to requests from provider representatives. Surveys submitted after that date were also accepted.

Figure 2-2 reports survey participation. As the table shows, HMA-Burns received surveys from 171 agency providers, including 156 agencies that could be matched to fiscal year 2023 claims data. Participating agencies represented about 12 percent of all agencies, but accounted for 28 percent of paid claims for these services in fiscal year 2023 (the most recent fiscal year for which claims data were available at the time of analysis). Although nearly 100 adult foster homes submitted a survey, this represents a response rate of less than four percent.

Figure 2-2: Provider Survey Response Rates

Service	Total Providers (FY2023 Claims)	Total Payments (FY2023 Claims, $ in mil.)	Total Respon-dents	Respon-dents with Claims	Response Rate (% of Agencies)	Response Rate (% of Claims)
Aging and People with Disabilities – Agency-Provided Services						
In-Home Supp.	77	$124.5	9	9	12%	28%
Assisted Living	189	$164.5	33	33	17%	21%
Res. Care Fac.	105	$17.8	6	4	4%	6%
Memory Care	185	$177.1	12	10	5%	6%
Specific Needs	37	$112.0	0	0	0%	0%
Adult Day Svcs.	13	$1.9	3	3	23%	33%
Total	**606**	**$597.8**	**63**	**59**	**10%**	**14%**
Office of Developmental Disabilities Services – Agency-Provided Services						
Attendant Care	324	$506.3	32	47	15%	12%
Job Attend. Care	25	$0.3	10	11	44%	37%
Adult 24-Hour	437	$648.1	57	58	13%	49%
Child 24-Hour	29	$39.9	6	7	24%	51%
Day Support	143	$40.4	36	46	32%	39%
Employ. Path	69	$5.9	21	29	42%	29%
Small Grp. Emp.	31	$7.0	12	14	48%	66%
Discovery	33	$0.3	21	29	42%	29%
Job Develop.	12	$0.1	12	2	17%	36%
Job Coach.	104	$44.2	34	39	38%	45%
Total	**796**	**$1,292.3**	**108**	**97**	**12%**	**34%**
Adult Foster Homes						
APD AFHs	1,175	$152.0	57	55	5%	5%
ODDS AFHs	1,366	$222.3	36	34	2%	2%
Total	**2,541**	**$374.3**	**93**	**89**	**4%**	**3%**

HMA-Burns reviewed all submitted surveys and, when clarification was needed due to unclear or potentially erroneous responses, reached out directly to providers. No survey responses were changed unless expressly requested by providers through the follow-up process.

HMA-Burns compiled and analyzed submitted survey data. For most survey questions, the analysis presented several values: averages with and without outliers (defined as two standard deviations from the mean value), weighted averages (based on ODHS payment levels or the number of reported staff hours) with and without outliers, and medians.

The provider survey analysis was presented to the project advisory group and the service-specific workgroups. Although these presentations did not change the results (as the reported

values are only a summarization of what providers reported) the overviews gave providers and other community partners an opportunity to provide context for the results.

Provider cost surveys always have certain limitations, so caution should be taken in the use and interpretation of the results. Since the surveys requested actual cost data, the results are backwards-looking and may not reflect current costs. To mitigate this issue, the survey included a form for providers to report significant cost changes since their reporting period. Additionally, provider costs are often a function of current payment rates, particularly if a provider relies substantially on Medicaid funding. As a result, reported costs such as direct care worker wages and spending on support positions may not reflect what spending should be to support sustainable and high-quality services. Since providers were not required to participate, the surveys effectively rely on a convenience sample and it is unknown whether the respondents are representative of the overall provider community. Further, the relatively low participation rate prevented more detailed analyses such as analyzing differences in providers' costs based on size or area served.

As noted above and emphasized throughout the project, wage and rate study recommendations were always meant to be informed by information from a variety of sources. The provider surveys were only one of these sources. As discussed in subsequent sections, most rate model cost assumptions are based on broader data sources as well as community partner input from ODDS' previous rate-setting efforts. Nonetheless, the provider surveys offered important context regarding providers' current service delivery and costs, and results were used as a benchmark for many assumptions in the recommended rate models. Key findings from the surveys are discussed in the context of specific rate model recommendations discussed in Sections 3, 4, and 5. The provider survey analyses are included as Attachment 3.

Review of Job Postings

To supplement data from the provider survey, HMA-Burns identified job postings by agencies recruiting direct care workers for the services included in the wage and rate study. Research was conducted in June and July 2024 and included job postings on both agency websites and recruiting platforms such as Impact Oregon and Indeed.com. The search (which included key terms such as 'caregiver,' 'direct care worker,' and 'direct support professional') yielded results from 35 job postings from APD agency providers and 33 job postings from ODDS agency providers.

Job postings both offered insights into the defined responsibilities of staff and provided more current data regarding the pay offered by agencies. Unlike the provider survey, which sought to capture average wages across all workers in a given job title (including overtime, shift differentials, and other premium pay), the job postings generally reflect only starting base pay for new employees. Key findings from the review of job postings are presented in Section 3.

Identification and Analysis of Other Data Sources

HMA-Burns identified data from independent published sources to inform rate model cost assumptions. By using data from credible sources outside of the APD and ODDS programs, the rates aim to reflect reasonable, market-based costs. Key independent data sources included:

- Oregon-specific occupation-level wage data from the federal Bureau of Labor Statistics (BLS) to establish wage assumptions for each position identified in a rate model.
- Oregon-specific data related to historic growth in Oregonians' net earnings from the federal Bureau of Economic Analysis (BEA) to establish wage inflation estimates.

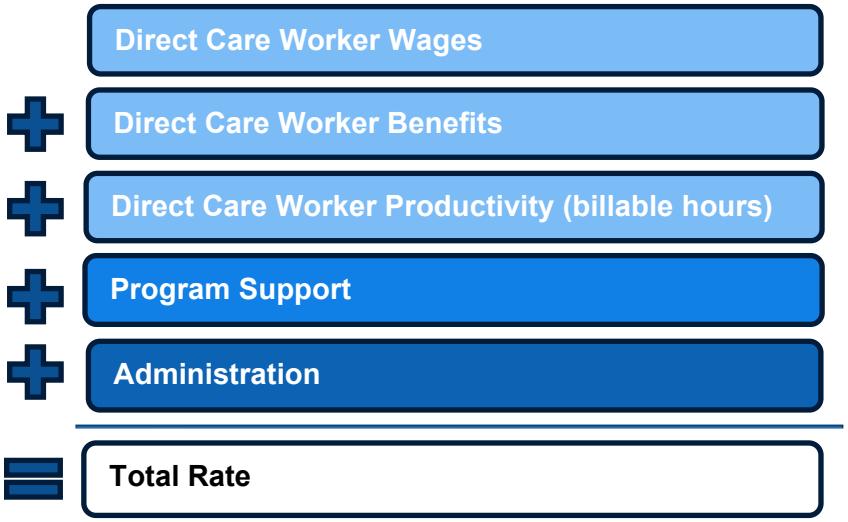
- Oregon-specific health insurance data from the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey (MEPS) to establish assumptions related to take-up rates, mix of plan types, and employer costs.
- The Internal Revenue Service's standard mileage rate to establish cost assumptions for vehicle-related operating expenses.

HMA-Burns gathered the most current versions of all data sources available at the time the recommended rate models were published.

Draft Recommended Rate Models

Based on findings from the preceding research and data collection and analysis tasks, HMA-Burns developed initial recommended rate models for the agency-provided services included in the wage and rate study as well as Adult Foster Home services. To support transparency in the development of payment rates, these models detailed the assumptions related to individual cost drivers used to establish overall rates. Nearly every rate model includes five key factors as illustrated in Figure 2-3.

Figure 2-3: Illustration of Rate Model Components



As depicted in the graphic, the five major cost drivers fall into three general categories: direct care worker expenses, program support, and administration.

Direct care worker compensation represents the largest expense in the delivery of home and community-based services. The rate models include an assumed average hourly wage expense for the direct care worker. As detailed in Section 3, assumptions are based on Oregon-specific wage estimates published by the BLS for occupations with comparable educational requirements, training, and job duties. Benefit-related cost assumptions for direct care workers are also described in Section 3 and include payroll taxes, health insurance, and discretionary benefits.

Productivity refers to the proportion of a direct care worker's paid hours that their employer can bill. Although direct care workers generally spend most of their time providing services that can be billed, they also spend time on activities that cannot be billed such as traveling between members, attending training, completing required documentation, engaging in employment-

related tasks such as attending staff meetings, and using paid time off. These non-billable activities represent a cost to the employer (that is, agencies must still pay the direct care worker for these hours even though they cannot bill for them). To account for these costs, the rate models include a productivity adjustment factor based on the assumed proportion of worked hours that can be billed. For example:

- An employee earning $30 per hour (in wages and benefits) and working 40 hours per week earns $1,200 per week ($30 per hour multiplied by 40 hours).
- However, if the employer can only bill for 32 hours per week, the employer's billable rates requires a productivity adjustment of 1.25 (40 paid hours divided 32 billable hours).
- Thus, the agency must be able to bill $37.50 per service hour ($30 per hour multiplied by the 1.25 productivity factor) to cover the cost of wages and benefits

Rate model assumptions for productivity vary by service. Additional details regarding productivity assumptions are discussed in Section 5 and detailed in Appendix C of the rate model packets.

Program support expenses include costs associated with service provision such as vehicle-related expenses to drive to service encounters and to transport individuals, the cost of the physical space in which services are delivered, program supplies, clinical supports, the cost of staff that train and supervise direct care workers, and other program infrastructure costs related to program design and quality assurance.

Administrative expenses include payroll costs associated with executive and administrative positions such as executive leadership, accounting staff, human resources, and other administrative functions, as well as other expenses associated with organizational operations such as general liability insurance, facility costs for administrative offices, information technology-related costs, office equipment and supplies, and other operating costs.

In total, the rate model cost assumptions seek to reflect a 'typical' agency's reasonable costs to fairly compensate providers, and neither overpay nor underpay for services. However, agencies are not expected to align their costs with rate model assumptions and, for any given agency, it is expected that some costs will be lower than assumed and other costs will be higher. For example, an agency in a more rural part of the state may incur higher travel-related expenses, but lower labor or facility-related costs. Or, if an agency finds that their staff prioritize wages over benefits, they may pay a higher average wage than assumed in a rate model, but offer less generous benefits than assumed

Several services include multiple rate models to account for differences that impact providers' costs, including:

- *Individual acuity.* More intensive staffing to support individuals with more significant needs is a clear cost driver. For example, it is more expensive to staff a program at a one-to-four ratio than at a one-to-six ratio, as the same staffing costs are spread over fewer participants. In general, shared services in which one staff supports multiple individuals – such as residential programs and day programs – have tiered rates that vary based on an individual's assessed needs and related differences in assumed staffing intensity.
- *Service setting.* To promote community integration, there are separate rate models for day program services, with higher rates for supports delivered in the community rather

than at a provider's site. These rates reflect the higher costs of delivering community-based services, including more intensive staffing and mileage-related expenses.

For most ODDS services, rate models have been previously established so these were updated with more current published cost data (such as newer Bureau of Labor Statistics data) and targeted adjustments based primarily on community partner feedback. For ODDS' Supported Living service, APD services, and Adult Foster Home services, new rate models were developed following the conventions of the existing ODDS rate models.

Since service-related payments for homecare workers and personal support workers reflect the worker's wage as well as contributions to benefit costs, rate models were not developed for HCWs and PSWs (other costs associated with supporting HCWs and PSWs, such as the cost of contracted financial management agent services, are outside of the scope of the wage and rate study). As discussed in Section 3, recommendations related to HCWs and PSWs are tied to the direct care worker compensation assumptions in the recommended rate model for In-Home services.

Public Comments

The draft recommended rate models were posted online for public comment on October 7, 2024. In addition to the rate models, a presentation that detailed the wage and rate study methodology and recommendations (included as Attachment 4), a series of recorded webinars that walked through the presentation, and the results of the provider survey analysis were published. Community partners were asked to submit any comments via email by October 28, although comments submitted after that date were also accepted.

More than 60 individuals and organizations submitted unique comments. Feedback was largely negative, with commenters objecting to both the wage and rate study process and recommendations.

In terms of process, criticisms included how community partners were involved, the level of detail requested in the provider survey and the low response rate, and the omission of tasks suggested by commenters such as a review of providers' financial statements and a comprehensive evaluation of all costs associated with supporting the HCW and PSW service delivery model.

Commenters expressed opposition to many study recommendations, although objections often conflicted. Major themes included concerns regarding the total amount of funding that would be required to fully implement the proposed rates; disagreement with equating the support needs of the APD population with the support needs of the ODDS population; disagreement with equating the work performed by staff employed by agencies and by HCWs and PSWs and the recommendation to standardize compensation across direct care workers; objections to the recommended increases to the base wages for HCWs and PSWs; objections to the recommended increases to payment rates for In-Home service agencies; and objections to how much (or how little) was assumed in the rate models for agencies' overhead expenses.

Several commenters highlighted the need for a plan to regularly update payment rates. There were also a number of questions related to the proposed assessment framework for APD services.

Additionally, more than 1,300 HCWs and PSWs submitted a form letter that argued against the recommended increase in the payment rates for agency-delivered In-Home services, while expressing support for the recommended increase in their base wages.

Several changes to the recommended rate models were made in response to public comments:

- A factor was added to the In-Home service rate model assuming that 30 percent of workers are part-time. Provider survey results showed that In-Home agencies rely on part-time staff to a greater extent than other agencies (In-Home providers for individuals served through ODDS reported that about half of direct care staff work part-time). Since part-time workers receive fewer benefits than full-time workers, this factor reduced the recommended rate.
- Since the recommendations for the increase to the base wages for homecare workers and personal support workers is tied to the total direct care worker compensation assumed in the recommended rate model for In-Home services, the change described in the preceding bullet that reduced the assumed compensation expense for agency services also resulted in a decrease in the recommended increase for HCWs and PSWs from $5.00 per hour to $4.50.
- The five percent premium for high-acuity services (Service Group 5 for ODDS services as well as Tier 5, memory care, and specific needs contracts for APD services) was increased to 10 percent.
- A recommended rate model for hourly Supported Living services (billed when the minimum threshold for billing the monthly rate is not met) delivered to individuals assigned to Service Group 5 was developed. This model includes the 10 percent premium for serving individuals with greater acuity noted in the previous bullet.
- The hourly wage assumption for supervisory staff was increased from $28.00 to $28.20.
- A specific factor for housekeeping and laundry staff was added to the recommended rate models for Assisted Living Facility and Residential Care Facility services, funded as one full-time staff for every 35 residents.
- Costs associated with activity space was added to the recommended rate models for Assisted Living Facility and Residential Care Facility services.
- For ODDS' Adult 24-Hour Residential services, separate recommended rate models were established for four-bed and five-bed homes, and a recommended rate model was established for two-bed homes. A recommended rate model for two-bed Child 24-Hour Residential services was also developed.
- For ODDS' Adult 24-Hour Residential services, funding for specialized staff in the recommended rate models for Category 3 and 4 was increased from one staff for every 25 individuals to one staff for every 20 individuals. For ODDS' Child 24-Hour Residential services, the ratio was lowered from one staff for every 30 individuals to one staff for every 20 individuals.

Responses to all public comments are included as Attachment 5.

Final Recommended Rate Models

The draft rate models were revised based on the changes made in response to public comments described above. The final recommended rate models for APD and ODDS services have been included as Attachments 1 and 2, respectively.

Assessing Individual Acuity to Inform Provider Payments

Differences in the amount and intensity of supports that an individual needs to perform activities of daily living and to manage medical and behavioral issues can impact the cost of service delivery, particularly for shared services where individuals with more significant support needs require more intensive staffing, including smaller group sizes and more individual attention. Recognizing this, the SB5506 budget note required that the wage and rate study consider levels of acuity among service recipients.

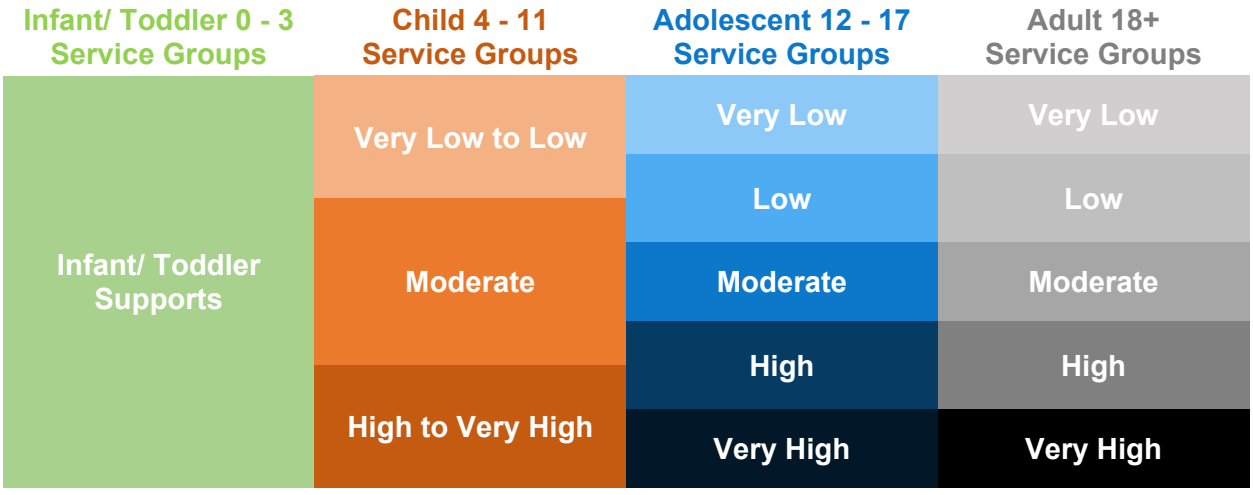
The development of new assessment frameworks is beyond the scope of the wage and rate study, but APD and ODDS initiatives to change existing frameworks have been incorporated in study recommendations.

ODDS Assessments

Pursuant to legislative direction, ODDS developed the Oregon Needs Assessment (ONA) to serve as its single functional needs assessment. ODDS contracted with Mission Analytics to develop the ONA. ODDS worked with an advisory group composed of advocates, self-advocates, families, case management entities, providers and other interested parties throughout the development process. After initial testing by Mission Analytics, ODDS contracted with the Oregon Health and Science University (OHSU) to perform additional validation and testing. Implementation of the ONA began in 2018.

The ONA measures how much assistance an individual needs to complete tasks like dressing, eating, accessing the community, managing money, and communicating, including assistance related to medical and behavioral needs. Based on an individual's age and support needs, the ONA places individuals into a service group based on age and support needs as illustrated in Figure 2-4.

Figure 2-4: ONA Service Groups



ODDS has already transitioned most services with tiered payment rates to ONA-based service groups, including Adult and Child 24-Hour Residential services, Host Home, Day Support Activities, and Employment services. For these services, providers are paid a higher rate when supporting individuals with more extensive needs to compensate for the more intensive supports these individuals require.

Three services included in the wage and rate study – Adult Foster Home, Child Foster Home, and Supported Living – have not yet transitioned to the ONA. As part of ODDS' ongoing initiative to phase-out other assessment frameworks, the recommended rate models for these services assume that rate tiers will be tied to the existing ONA-based service groups. The adoption of the ONA for these services will replace the use of other assessment tools.

ODDS developed and implemented the Adult Needs Assessment (ANA) and the Children's Needs Assessment (CNA) in 2013 when the state's Section 1915(k) program was initially adopted because federal rules require the use of functional needs assessments in these programs. ODDS continues to use a formula tied to ANA results to establish monthly payment rates for Supported Living services. Additionally, ANA and CNA results are used to determine the number of In-Home hours that may be authorized, although ODDS will begin using the ONA to determine In-Home hours in early 2025.

ODDS assesses individuals receiving Children's Foster Care or Adult Foster Home services using the Support Needs Assessment Profile (SNAP). CFC and AFH payment rates are based on SNAP results.

Figure 2-5 illustrates the distribution of service groups by residential setting.

Figure 2-5: Distribution of Individuals in ONA-Based Service Groups, by Living Setting

Setting	Group 1	Group 2	Group 3	Group 4	Group 5
Group Home	1%	7%	24%	16%	51%
Foster Care	1%	8%	34%	19%	38%
Supported Living	14%	39%	29%	7%	12%
Non-Residential	6%	20%	31%	24%	19%

As the table shows, few individuals are in Service Group 1. Group homes tend to serve individuals with the greatest needs while individuals receiving Supported Living services generally have modest needs.

APD Assessments

APD employs different approaches to account for an individual's acuity in provider payment rates for the services covered by the wage and rate study.

For Assisted Living Facility services, results from the Client Assessment and Planning System are used to assign individuals to one of five rate levels defined in administrative rules:[20]

- Level 1 – Individual is in service priority levels 1 through 13, or is in service priority levels 14 through 17 and would require institutionalization without supports within 30 days.
- Level 2 - Individual requires assistance in cognition as well as elimination, mobility, or eating.
- Level 3 - Individual requires assistance in four to six activities of daily living, or requires assistance in elimination, eating, and cognition.

[20] Oregon Administrative Rules, Chapter 411, Division 027, Section 0020. Accessed December 2024. Retrieved from https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=243996.

- Level 4 - Individual requires full assistance in one or two activities of daily living, or requires assistance in four to six activities of daily living plus assistance in cognition.
- Level 5 - Individual requires full assistance in three to six activities of daily living, or full assistance in cognition and one or two other activities of daily living.

ALF rates vary significantly across the levels; the Level 5 rate is 135 percent higher than the Level 1 rate.

For Residential Care Facility and Adult Foster Home services, individuals are assigned to a base rate that may be augmented by up to three "add-ons" defined in regulation:[21]

- Activities of daily living - Individual requires full assistance in mobility, or eating, or elimination.
- Behavioral needs - Individual demonstrates behavior that poses a risk to the individual or to others and the provider must consistently intervene to supervise or redirect.
- Medical needs - Individual's medical treatments require daily observation and monitoring with oversight performed at least quarterly by a licensed healthcare professional, and the facility has trained staff to provide these supports.

For each add-on, individuals either qualify for the full amount or they receive no additional funding. There is no recognition of a continuum of need that translates to varying intensity of supports. Additionally, the add-on amounts are modest in relation to the base rates. For AFHs, for example, the total rate for an individual who qualifies for all three add-ons is about 55 percent higher than the base rate.

The payment rate for Adult Day Services does not vary based on an individual's acuity.

To better account for individual needs and to standardize the use of assessment results across services, APD has proposed a new assessment framework to create groups (or "tiers") of individuals with similar support needs. To develop this proposed assessment framework, APD considered other states' assessment frameworks for similar populations as well as ODDS' ONA service group criteria.

The proposed framework relies on APD's existing assessment. To translate CA/PS results into tiers, APD quantified responses and created criteria for inclusion in each group. APD developed and tested multiple frameworks, considering comparisons to existing level assignments (where applicable) and the overall distributions of tiers, before finalizing its proposed framework.

APD's proposed framework assigns points to each activity of daily living and instrumental activity of daily living covered in the CA/PS based on the level of assistance needed. Recognizing that cognition and behaviors often drive the intensity of needed supports, the framework assigns substantial points when an individual requires significant support in these areas. Additionally, each assessed medical treatment is assigned one-to-three points based on the frequency of the treatment. Figure 2-6 illustrates the scoring in APD's proposed framework.

[21] Oregon Administrative Rules, Chapter 411, Division 027, Section 0025. Accessed December 2024. Retrieved from https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=243997.

Figure 2-6: Point Assignments in APD's Proposed Assessment Framework

Criteria	Points
ADLs / IADLs	
Independent	1
Minimal Assist	2
Assist	3
Substantial Assist	5
Full Assist	6
Cognition and Challenging Behaviors	
Full Assist in Any Cognition Component	10
Substantial of Full Assist in Challenging Behaviors	20
Medical Treatments	
Per Treatment	1-3

An individual's total points are used to assign them to a rate tier, as shown in Figure 2-7.

Figure 2-7: Tier Criteria in APD's Proposed Assessment Framework

Score Range	Tier	Description of Need
0 – 40	Tier 1	Low
41 – 55	Tier 2	Moderate
56 – 82	Tier 3	Moderate-High
83 – 106	Tier 4	High
107+	Tier 5	Very High

Because this is a new assessment framework, an individual's tier assignment will differ from any current classification. For example, an individual who resides in an assisted living facility and who is assigned to Level 5 today may not be assigned to Tier 5. Additionally, individuals in the same service priority level may be assigned to different rate tiers under the new framework.

Applying a standard assessment framework across services allows for comparisons of typical acuity across settings and services. Under APD's proposed framework, few individuals would be assigned to Tier 1 and most would fall into Tier 3 or 4 as demonstrated in Figure 2-8.

Figure 2-:7 Distribution of Individual Tier Assignments Based on APD's Proposed Assessment Framework, by Living Setting

Setting	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Assisted Living Facility	2%	19%	55%	20%	4%
Residential Care Facility, Standard	3%	12%	45%	28%	13%
Res. Care Facility, Specific Needs	1%	4%	26%	38%	32%
Memory Care	0%	2%	25%	45%	28%
Adult Foster Home	1%	5%	20%	28%	47%
Non-Residential	3%	21%	41%	23%	12%

As the table shows, adult foster homes tend to care for individuals with significant needs, with approximately three-quarters of AFH residents assigned to Tier 4 or 5, including nearly half in Tier 5. In comparison, ALFs serve a less acute population. Half of ALF residents would be assigned to Tier 3 and only four percent would be assigned to the highest tier. Amongst individuals who do not receive residential services, the greatest number of individuals would be assigned to Tier 3 and 85 percent would be assigned to the middle three tiers.

The overall distribution of individuals across tiers is broadly similar to the distribution of individuals in ODDS' ONA-based service groups as shown above in Figure 2-5. Overall, APD believes that the tiers in its proposed framework are broadly equivalent to ODDS' service groups. That is, individuals in APD's Tier 1 would have similar needs to those in ODDS' Service Group 1, individuals in APD's Tier 2 would have similar needs to those in ODDS' Service Group 2, etc.

For APD services for which the wage and rate study recommends tiered rates, the recommended rate models reflect APD's proposed assessment framework and the composition of individuals in each tier. If the framework is revised or an alternative approach for assigning tiers is established, the assumptions in the recommended rate models would need to be revisited, particularly those related to staffing levels.

Section 3: Recommendations for Direct Care Worker Compensation

Direct care workers are service users' primary point of contact with the HCBS service delivery system and, as a result, they have a significant impact on the quality of services and individuals' satisfaction. Additionally, wages and benefits paid to direct care workers represent the single largest expense in the delivery of home and community-based services.

Given the integral role of direct care workers in the APD and ODDS systems, the wage and rate study emphasized compensation for these staff, including the costs and benefits of standardizing compensation across systems, services, and service delivery models. Highlights of the research and analysis conducted as part of the wage and rate study and the resulting recommendations include:

- Regulations establish minimal qualifications for direct care workers in the APD and ODDS systems and for both agency staff and collectively bargained workers; there are some additional training requirements when staff support individuals with significant needs.
- ODDS service providers generally pay higher wages than APD service providers. In both the APD and ODDS systems, In-Home service providers pay higher wages than other providers. ODDS service providers spend more on direct care worker wages than assumed in the current ODDS rate models, but less than assumed for benefits (APD does not have detailed payment frameworks that allow a similar comparison).
- For agency-employed staff, the wage and rate study recommends establishing wage assumptions based on the approach incorporated in the current ODDS rate models, which use Bureau of Labor Statistics wage data for comparable positions. After accounting for estimated wage growth, the recommended direct care worker average wage is $23.20 per hour.
- For direct care worker benefits, the recommended rate models similarly build on the current ODDS rate models, including adjusting health insurance cost assumptions to account for a range of plan types.
- Considering both wages and the value of employee benefits, standardizing compensation for personal support workers and homecare workers would require increasing funding by $4.50 per hour. To support workers' choice, this increase would be added to base wage levels (which would allow workers to use the additional pay to purchase health insurance, contribute to a retirement account, cover their living expenses, etc.).

Review of Job Requirements

As is typically true for direct care staff providing home and community-based services across the country, Oregon has established minimal requirements for these workers. These standards are generally similar across programs, including:

- Meeting minimum age requirements, usually 18 years old
- Understanding written and oral communication
- Passing an approved background check
- Holding a valid driver's license for positions that require transporting individuals

Across most services, staff are required to have 12 hours of annual training covering similar topics such as CPR and first aid, core competencies, and specialized training based on population served (such as supporting people with dementia or Oregon Intervention System training on positive behavioral supports and protective physical interventions). Requirements are somewhat higher for staff providing In-Home services through ODDS standard model agencies (24 hours) and staff providing memory care services (16 hours). Staff working for APD in-home agencies as well as home care workers and personal support workers must receive a minimum of 12 hours of training every two years.

In addition to staff qualifications, the study sought to evaluate typical job duties based on reviews of service definitions and job postings. As noted earlier, most services evaluated in the wage and rate study are authorized under Oregon's 1915(k) plan so, from a federal perspective, each of these services are authorized as "attendant care" supports. Oregon's 1915(k) plan defines broad categories of direct supports, including:

- Assistance with activities of daily living such as personal hygiene, dressing, eating, toileting, bathing, ambulating, cognition, memory care, and behavior supports through hands-on assistance, supervision, and/or cueing
- Assistance with instrumental activities of daily living (such as meal preparation, light housekeeping, and laundry), through hands-on assistance, supervision, and/or cueing
- Assistance with health-related tasks through hands-on assistance, supervision, and/or cueing
- Assistance with acquisition, maintenance, and enhancement of skills necessary for individuals to accomplish ADLs, IADLs, and health-related tasks through functional skills trainings, coaching, and prompting

Statutes and regulations for each service specify covered activities that fit within the 1915(k) plan definitions; for example:

- In-Home services provided through APD are defined as services "related to activities of daily living and instrumental activities of daily living".[22] Similarly, regulations define community living supports (which includes ODDS In-Home and Day Support Activity services) as "attendant care, skills training, and relief care."[23] Further, from a regulatory perspective, these definitions apply to both collectively bargained workers and staff working for provider agencies as they are considered to be providing the same service.
- Residential care in ODDS group homes is defined as "supervision; protection; assistance while bathing, dressing, grooming or eating; management of money; transportation; recreation; and the providing of room and board."[24]
- Assisted living facilities provide a "range of supportive services available on a 24-hour basis to meet the activities of daily living, health, and social needs" of residents, and

[22] Oregon Administrative Rules, Chapter 411, Division 030, Section 0020. Accessed November 2024. Retrieved from https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=303073.

[23] Oregon Administrative Rules, Chapter 411, Division 317, Section 0000. Accessed November 2024. Retrieved from https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1802.

[24] Oregon Revised Statutes, Chapter 443, Division 400. Accessed November 2024. Retrieved from https://www.oregonlegislature.gov/bills_laws/ors/ors443.html.

"promote resident self-direction and participation in decision that emphasize choice, dignity, privacy, individuality, and independence."[25]

- Care in APD adult foster homes is defined as "assistance with activities of daily living to promote a resident's maximum independence and enhance the resident's quality of life" and includes "assistance with bathing, dressing, grooming, eating, money management, recreation, and medication management".[26] Care in ODDS adult foster homes is similarly defined as "assistance with activities of daily living and instrumental activities of daily living", "assistance with quality of life activities", and "monitoring the activities of the individual to ensure the health, safety, and welfare of the individual."[27]

In addition to program regulations, job duties listed in the review of job postings discussed in Section 2 were considered.[28] Highlights of this review include:

- All job postings listed supporting individuals with activities of daily living.
- Listed responsibilities for service planning and documentation were roughly equally common across systems.
- Helping individuals access their communities was incorporated in each posting for In-Home supports. ODDS group home providers were somewhat more likely than APD facility providers to list community integration supports.
- Fewer than half of both APD and ODDS residential job postings listed medication administration supports.
- Only a small number of job postings across systems listed behavioral support management, but such responsibilities, including the potential need for physical interventions, were somewhat more common amongst ODDS service providers.

Despite the significant similarities in the broad definitions of care across systems and services (that is, assistance with ADLs and IADLs, skill building, and health maintenance), the nature of a worker's day-to-day work will differ based on factors such as:

- *Needs of individuals served.* Individual needs vary widely in both the APD and ODDS systems. For example, supports with activities of daily living range from supervision to cueing to physical assistance. Similarly, the amount of time spent performing tasks for an individual versus training them to do the task will vary based on individual needs. Individuals may also need support to manage medical or behavioral conditions.
- *Number of individuals served.* Staff providing residential or day program services will usually be responsible for supporting multiple individuals whereas staff delivering in-home services generally provide one-to-one supports.

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[25] Oregon Administrative Rules, Chapter 411, Division 054, Section 0005. Accessed November 2024. Retrieved from https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=314992.

[26] Oregon Administrative Rules, Chapter 411, Division 049, Section 0120. Accessed November 2024. Retrieved from https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=258748.

[27] Oregon Administrative Rules, Chapter 411, Division 360, Section 0020. Accessed November 2024. Retrieved from https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=93248.

[28] Several job postings by agencies providers services to individuals served through ODDS offered narratives regarding the importance of direct support professionals in the lives of individuals with I/DD rather than more traditional listings of job duties. Job postings without identifiable job duties are not included in this summary.

- *Degree of specialization.* Larger programs may hire staff specifically for tasks such as medication management, meal preparation, and transporting individuals, while staff employed by smaller programs may perform a larger variety of tasks.
- *Access to onsite supervision and other staff.* Staff working at a provider location such as a residential or day program often work with other staff whereas staff in community settings often work independently.

The wage and rate study considered the impact that these factors could have on worker wages. Both APD and ODDS serve individuals with significant needs in all settings and through both agency-managed and self-directed services so any adjustment to assumed wages would be based on the individual rather than assumed to apply to an entire population or service. The other factors do not suggest that worker wages should vary based on the population supported or the service provided. For example, staff working in residential programs may be responsible for caring for multiple individuals, but they generally work as part of a team whereas staff delivering in-home services usually provide one-to-one supports, but they work without assistance from other staff. Thus, given the commonalities in required staff qualifications and broad similarities in job duties, the wage and rate study recommends standardizing direct care worker compensation assumptions across systems, services, and delivery models. Establishing consistency in compensation increases equity across workers regardless of the population served, the setting in which they work, and who they choose to work for.

Many ODDS provider agencies have expressed disagreement with this recommendation, arguing that individuals with I/DD have greater needs than individuals served through the APD system and that the supports they provide emphasize community integration, relationship building, critical thinking skills, empowerment, and self-advocacy whereas APD service providers focus on health, wellness, and physical supports. These providers also argued that direct support professional wages should be higher than those of personal support workers because DSPs provide comprehensive support in all aspects of a person's life compared to PSWs that focus on only one or two objectives.

Despite this feedback, the wage and rate study continues to recommend standardizing direct care worker compensation funding rather than financially valuing one population over another, one service setting over another, or one employment model over another.

Agency Direct Care Worker Wages

After determining that direct care worker compensation should be standardized across systems, services, and service delivery models, the wage and rate study considered what an appropriate compensation package would include. Existing reports were reviewed and additional research and analysis was conducted to understand current wages and benefits offered by agency providers. Recommendations for compensation assumptions within the proposed payment models reflect broader data sources intended to reflect competitive, forward-looking wages and benefits to support a high-quality workforce.

Review of Previous Reports

Wages earned by direct care workers have been an issue of significant focus in Oregon and nationally for a number of years, with a number of reports providing information about the state of this workforce.

The 2022 PHI study commissioned by APD to evaluate Oregon's direct care workforce and to offer recommendations to strengthen and stabilize the workforce analyzed Bureau of Labor Statistics data and found that direct care worker wages increased 8.9 percent on an inflation-adjusted basis between 2011 and 2021 to a median of $15.38 per hour.[29] Despite this increase in real wages, however, PHI's analysis found that direct care workers earned substantially less than workers in "competitive occupations" such as food service and retail who earned a median hourly wage of $18.12. This report also found that nearly half of direct care workers in Oregon relied on some form of public assistance, primarily food assistance and/or Medicaid.

Providers that participated in the survey administered by Portland State University as part of its 2022 assisted living and residential care facility wage and cost study reported an average resident assistant wage of $17.40 per hour.[30] The report analyzed wages based on geographic region using the zones established for the purpose of the state's minimum wage. Reported wages were highest in the Portland Metro area at $17.90 per hour, compared to $17.40 per hour in standard areas and $16.20 per hour in non-urban areas. Nonprofit organizations tended to offer higher wages, paying an average of $18.20 per hour compared to an average of $17.40 paid by for-profit providers.

According to the 2023 NCI-IDD State of the Workforce Survey, Oregon providers reported an overall weighted average hourly wage of $21.69 , while the unweighted average was $19.80, and the median was $19.55.[31] By service type, the lowest wages were reported for residential DSPs (with an unweighted average hourly wage of $19.12) followed by non-residential supports such as day programs ($20.79) and in-home supports ($21.09). Providers reported an average (unweighted) starting wage of $18.88 per hour. Additionally:

- Most Oregon providers are small; approximately three-quarters reporting employing 20 or fewer direct support professionals and more than 60 percent reported serving 10 or fewer individuals.
- Oregon providers reported that 71.8 percent of DSPs work full-time, slightly higher than the overall average of 70.8 percent across all participating providers.
- Oregon providers reported an average turnover rate of 39.5 percent, nearly identical to average across all participating providers.
- Oregon providers reported an 11.3 percent full-time vacancy rate, somewhat less than the overall average of 12.2 percent.
- Oregon providers reported an average of one frontline supervisor for every eight DSPs.

Wage and Rate Study Provider Survey

To collect more current data using a consistent methodology across providers, the wage and rate study included the design and administration of a provider survey, as described in Section 2. Providers were asked to report total hours by direct care staff and the total salaries and

[29] Scales, K. PHI. (2023). Strengthening and Stabilizing the Direct Care Workforce in Oregon. Retrieved from https://olis.oregonlegislature.gov/liz/2023R1/Downloads/CommitteeMeetingDocument/264559.

[30] Tunalilar, O., Dys, S., Carder, P., Jacoby, D. Portland State University. (February 2023). Wage and Cost Study of Oregon Assisted Living and Residential Care Providers, 2022. Retrieved from https://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=1125&context=aging_pub.

[31] National Core Indicators Intellectual and Developmental Disabilities. (2023). National Core Indicators Intellectual and Developmental Disabilities State of the Workforce in 2022 Survey Report. https://idd.nationalcoreindicators.org/survey-reports-insights/.

wages paid to these staff, inclusive of base wages and all other reportable income such as overtime, shift differentials, and bonuses in order to calculate an overall effective hourly wage cost.

Figure 3-1 lists the median and average reported wages reported through the provider survey.

Figure 3-1: Direct Care Worker Wages Reported by Provider Survey Respondents

	Number of Respondents	Weighted Average w/o Outliers	Median
ODDS Attendant Care	28	$23.39	$22.66
ODDS On the Job Attendant Care	10	$20.07	$22.04
ODDS Adult 24-Hour Residential	47	$20.91	$20.81
ODDS Children 24-Hour Residential	4	$22.12	$22.43
ODDS Adult Foster Care	12	$20.56	$17.79
ODDS Day Support Activities	36	$20.34	$20.77
ODDS Employment Path	19	$20.21	$20.81
ODDS Small Group Supported Employment	12	$20.49	$22.40
ODDS Discovery	11	$21.85	$21.56
ODDS Job Development	10	$24.96	$23.45
ODDS Job Coaching	34	$21.40	$21.56
APD In-Home Services	6	$21.94	$22.50
APD Assisted Living	21	$19.19	$18.79
APD Residential Care	5	$19.90	$20.22
APD Memory Care	6	$19.17	$18.61
APD Adult Foster Care	26	$19.98	$20.14
APD Adult Day Services	3	$17.80	$17.56
OHA Adult Foster Care	2	$14.58	$17.25

As the table shows, ODDS service providers generally reported paying direct care workers approximately $20.50 to $21.00 per hour, excluding In-Home services for which providers reported paying an average of more than $23.00. Additionally, approximately 13 percent of agencies that participated in the provider survey noted they had increased direct care worker wages since the survey reporting period. The average reported increase was about five percent.

These wages exceed the wage assumptions funded in the current rate models. ODDS providers appear to be paying higher wages by, in part, spending less on benefits than assumed in the current rate models, as shown in Figure 3-2.

Figure 3-2: Comparison of Direct Support Professional Compensation Assumptions in ODDS Rate Models to Provider Survey Reporting

	Current Rate Model Assumption	Provider Survey Result[a]	Difference
Wages[b]	$18.38	$21.43	**$3.05**
Social Security/ Medicare	$1.41	$1.64	**$0.23**
Federal Unemployment Insurance	$0.02	$0.02	**$0.00**
State Unemployment Insurance	$0.50	$0.38	**($0.12)**
Workers' Compensation	$0.42	$0.30	**($0.12)**
Paid Time Off[c]	$1.70	$1.46	**($0.24)**
Health Insurance	$2.57	$1.85	**($0.72)**
Retirement	$0.37	$0.28	**($0.09)**
Other Benefits	$0.14	$0.23	**$0.09**
Total[d]	**$25.51**	**$27.59**	**$2.08**

[a] Provider survey results reflect weighted averages without outliers for full-time staff only (reported benefits for part-time staff were significantly lower).

[b] The ODDS rate models for some services include tiered rates with higher wage assumptions for supporting individuals assigned to the most assessed needs (Service Group 5). For simplicity, the table lists only the standard wage assumption.

[c] Paid time off is recognized as a productivity adjustment in the rate models, but is translated to a benefit cost here for completeness.

[d] Total differs slightly from the rate models due to rounding.

Overall, the value of the benefits reported by ODDS service providers – discussed in greater detail below – are about $1.00 per hour less than funded in the rate models. Total compensation reported by providers for full-time staff exceeds the rate model assumptions by approximately $2.00 per hour. As discussed previously, rate model assumptions are not meant to dictate providers' operations as the needs of the staff employed and individuals served vary from one agency to the next. Providers are likely employing a variety of strategies to direct additional funding to direct care worker compensation, such as relying on a combination of full-time staff and lower cost part-time staff (survey respondents reported that about one-third of direct care staff work part-time and receive minimal benefits), spending less than assumed in the rate model for other expenses (such as supervision and administration), and/or subsidizing their I/DD services with revenue from other sources (such as fundraising or other programs they operate).

APD service providers reported lower wages than ODDS providers, generally ranging from $18.00 to $19.00 per hour, excluding in-home services. Because APD does not have documentation detailing cost assumptions, these values cannot be compared to funding levels in current payment rates.

Both ODDS and APD service providers reported paying staff delivering in-home services about $2.00 per hour more than staff delivering other services. However, reported benefits for staff providing in-home services were generally lower than for those in other service areas. Additionally, compared to providers of other services, in-home service providers in both the APD and ODDS systems reported substantially greater reliance on part-time staff with few benefits.

Review of Job Postings

To both validate reporting through the provider survey and to collect real-time information regarding wages currently being offered, HMA-Burns evaluated advertised wages in a sampling of provider job postings. Advertised wages were somewhat lower than those reported in the provider survey. This difference was expected, however, as job postings typically represent entry-level wages, whereas the provider survey captured average wages across all staff, including premium pay such as overtime, shift differentials, and bonuses. Other highlights of this review included:

- For ODDS service providers, advertised wages mostly ranged from $19.00 to $20.00 per hour for residential and day services, and approximately $23.00 per hour for in-home services.
- Overall, wages advertised by APD service providers were generally lower than those advertised by ODDS agencies. Specifically, assisted living and memory care facilities listed wages around $17.50 per hour, residential care facilities listed wages around $18.50, and in-home services agencies listed wages around $19.25.

Recommendations for Agency Rate Model Direct Care Worker Wage Assumptions

Payroll and benefits costs for direct care workers represent the single largest category of expenses for HCBS providers. In the current ODDS rate models, these costs account for between 56 and 78 percent of total expenses (the lower ratios reflect group-based day programs where the cost of the direct care staff is spread over multiple individuals). As a result, spending in these areas tends to be subject to the greatest constraints when payment rates do not reflect market costs. Thus, although current wage and benefit levels are informative, the wage and rate study relies on independent, published sources of market wage data for comparable positions to ensure cost assumptions reflect current economic realities, the varied responsibilities of direct care workers, and expected wage growth.

The existing ODDS rate models rely on Oregon-specific wage data published by the Bureau of Labor Statistics for more than 800 standard occupational classifications (SOCs). The BLS describes its wage data as the "only comprehensive source of regularly produced occupational employment and wage rate information for the U.S. economy, as well as States, the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Islands, and all metropolitan and nonmetropolitan areas in each State."[32] This statement highlights several features of the BLS data that makes it particularly useful for setting wage assumptions, including:

- *It is comprehensive.* BLS wage data is representative of 1.2 million establishments and about 57 percent of the employment in the United States.
- *It is regularly produced.* BLS wage data is published on an annual basis, allowing rate model assumptions to be regularly reviewed and updated.
- *It is cross-industry.* BLS wage data is not limited to a single industry so estimates for a given occupation are representative of the overall labor market for that occupation; this is particularly important when considering wage levels for underfunded programs.

[32] United States Bureau of Labor Statistics. (n.d.). Frequently Asked Questions. Retrieved from https://www.bls.gov/oes/oes_ques.htm.

- *It is state- (and local-) specific.* BLS wage data is reported for individual states and sub-state areas so that assumptions are tailored to the state in which rates are being developed.

Given the comprehensiveness of the BLS' annual wage data, many states use it when developing payment rates for home and community-based services. A report conducted by HMA-Burns on behalf of the American Network of Community Options and Resources (ANCOR, a national trade association for providers supporting individuals with I/DD) to evaluate the methodologies that states use to establish direct support professional wage assumptions in payment models for HCBS for individuals with I/DD found that 20 of 24 states (83 percent) with identifiable wage assumptions rely on BLS data.[33]

As in the existing ODDS rate models, the recommended rate models use Oregon-specific BLS data to set direct care worker wage assumptions. Utilizing BLS data requires two key decisions. First, the data should be updated to make it current and, second, the appropriate BLS occupation or occupations must be selected as a benchmark for direct care workers.

Although the BLS wage data is published annually, it is always backwards looking. The BLS releases data in March or April of each year, with the dataset representing May of the previous year. Thus, the most recent BLS dataset available at the time of the publication of this report was released in April 2024 and reflects May 2023.

Data from the U.S. Department of Commerce's Bureau of Economic Analysis (BEA) was used to estimate wage inflation. According to the BEA as of September 2024, the ten-year compound annual growth rate for net earnings in Oregon was 5.8 percent.[34] Based on this annual growth rate, all BLS wage estimates were increased 15.68 percent to project wages for January 2026, the midpoint of the first full fiscal year in which the rates could potentially be implemented.[35]

As noted above, the BLS publishes data for more than 800 occupations. Direct care workers providing home and community-based services are primarily classified as home health and personal care aides (SOC 31-1120).[36] The BLS provides the following description for this occupation:

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[33] Health Management Associates. (July 6, 2022). Review of States' Approaches to Establishing Wage Assumptions for Direct Support Professionals When Setting I/DD Provider Rates. Retrieved from https://www.ancor.org/wp-content/uploads/2022/08/august_2022_dsp_wage_assumptions_in_state_idd_service_rate_setting-1.pdf.

[34] Bureau of Economic Analysis. (n.d.). 10-year compound annual growth rate for net earnings in Oregon for 2013 – 2023. Accessed October 2024 from https://apps.bea.gov/regional/bearfacts/.

[35] HMA-Burns also considered a wage adjustment to account for Oregon's increasing minimum wage using the same methodology employed in the current ODDS rate models. The calculated adjustment was lower than the inflation-based increases described in the report so the minimum wage adjustment has not been detailed, A detailed description of HMA-Burns' methodology for estimating the impact of minimum wage adjustments can be found in a report commissioned by the American Network of Community Options and Resources in 2021 and available at https://www.ancor.org/wp-content/uploads/2022/09/Estimating-the-Impact-of-an-Increased-Federal-Minimum-Wage-on-IDD-Providers.pdf.

[36] The classification is evident in nationwide employee counts by industry. Home health and personal care aides represent 1,872,690 positions out of 2,276,120 in the industry of services for the elderly and persons with disabilities (North American Industry Classification System 624120,

> This occupation includes the 2018 SOC occupations 31-1121 Home Health Aides [Monitor the health status of an individual with disabilities or illness, and address their health-related needs, such as changing bandages, dressing wounds, or administering medication. Work is performed under the direction of offsite or intermittent onsite licensed nursing staff. Provide assistance with routine healthcare tasks or activities of daily living, such as feeding, bathing, toileting, or ambulation. May also help with tasks such as preparing meals, doing light housekeeping, and doing laundry depending on the patient's abilities.] and 31-1122 Personal Care Aides [Provide personalized assistance to individuals with disabilities or illness who require help with personal care and activities of daily living support (e.g., feeding, bathing, dressing, grooming, toileting, and ambulation). May also provide help with tasks such as preparing meals, doing light housekeeping, and doing laundry. Work is performed in various settings depending on the needs of the care recipient and may include locations such as their home, place of work, out in the community, or at a daytime nonresidential facility.].[37]

This description describes aspects of the work that direct care workers perform, but it arguably does not fully represent the responsibilities of staff who are expected to provide training and support to maintain or increase individuals' independence and to manage often challenging behaviors. When establishing the existing ODDS rate models, ODDS worked with provider representatives to identify other BLS classifications that represent the work of direct support professionals. Based on this input, the rate models ultimately relied on a weighting of 60 percent based on home health and personal care aides and 40 percent based on social and human services assistants (SOC 21-1093)[38], which are described as having the following responsibilities:

> Assist other social and human service providers in providing client services in a wide variety of fields, such as psychology, rehabilitation, or social work, including support for families. May assist clients in identifying and obtaining available benefits and social and community services. May assist social workers with developing, organizing, and conducting programs to prevent and resolve problems relevant to substance abuse, human relationships, rehabilitation, or dependent care.

The wage and rate study recommends maintaining this weighting of BLS occupations for setting direct care wage assumptions in rates models for agency services; Figure 3-3 demonstrates the resulting wage assumption.

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https://www.bls.gov/oes/current/naics5_624120.htm) and 256,160 positions out of 378,590 in residential intellectual and developmental disability facilities (NAICS 623210, https://www.bls.gov/oes/current/naics5_623210.htm).

[37] United States Bureau of Labor Statistics. Occupational Employment and Wages (31-1120 Home Health and Personal Care Aide). Retrieved from https://www.bls.gov/oes/current/oes399021.htm and https://artifacts.casetext.com/artifacts/20222018200112_abr.

[38] There are minor variations across individual rate models, but most services (measured by payment volume) use the weighting of BLS occupations described in this report. As part of the standardization of direct care worker staff compensation, most of these services were updated to include the same weighting. Services with a specific employment focus (Employment Path, Discovery, Job Development, and Job Coaching) use different BLS weightings.

Figure 3-3: Development of Direct Care Worker Base Wage Assumption

BLS Standard Occupational Classification	Weighting	Median Wage (Inflated)
Social and Human Service Assistant (21-1093)	40%	$25.90
Home Health and Personal Care Aide (31-1120)	60%	$21.40
Weighted Average		**$23.20**

As the table demonstrates, the recommended wage assumption uses the median BLS wage values, representing the wage at which half of the staff in the occupation earn more and half earn less. Based on the inflated BLS median wage values and the weighting of BLS job classifications in the existing ODDS rate models, this methodology produces an assumed wage of $23.20 per hour, or more than $48,000 annually for full-time worker. This wage is close to the overall 2023 median wage for all workers in Oregon and significantly more than the $39,300 average annual salary earned by Oregonians with only a high school degree in 2023 (the required level of education for direct care workers).[39]

In addition to this base wage assumption, the rate study considered potential adjustments for employment-related supports, services for individuals with more significant needs, and for services delivered in high-cost areas of the state.

The existing ODDS rate models for employment-related services (Employment Path, Small Group Supported Employment, Discovery, Job Development, and Job Coaching) assume higher direct care worker wages based on different mixes of BLS occupations. These higher wages were established to support Oregon's commitment to ensuring that employment is prioritized as the first option when supporting individuals with disabilities, to recognize the differing skillsets needed for providing employment supports, and to provide agencies the resources needed to hire and retain staff with more experience and training.

Regulations require additional training for staff providing employment supports, but qualifications are otherwise similar to those for other direct care workers. As illustrated above in Figure 3-1, the provider survey administered as part of the wage and rate study found that providers generally do not pay staff delivering employment supports much more than those delivering other services. For example, providers reported an average hourly wage of $21.56 for Job Coaching staff, more than reported for staff delivering Adult 24-Hour Residential ($20.81) and Day Support Activity ($20.77), but less than reported for staff delivering In-Home Attendant Care ($22.66). This wage, however, is consistent with the assumed wage in the current rate models ($21.17), which may be limiting agencies' ability to pay higher wages.

As with the assumed mix of BLS occupations in the recommended rate models for non-employment direct care workers, the recommended rate models for employment supports maintain the assumed mix of BLS occupations in the current ODDS rate models. These assumptions continue to produce higher wage assumptions for employment services – including $29.19 per hour for staff providing Job Coaching – as Oregon remains committed to employment first principles and the nature of these services can result in recruiting challenges (as, for example, overall service volumes are often lower than for other services and service

[39] United States Census Bureau, American Community Survey. (n.d.). Table B20004 - Median Earnings in the Past 12 Months (in 2023 Inflation-Adjusted Dollars) by Sex by Educational Attainment for the Population 25 Years and Over for Oregon. Retrieved from data.census.gov.

encounters may offer fewer hours or occur outside of traditional working hours based on participants' work schedules).

Regulations generally do not establish many additional requirements for staff working with individuals with more significant needs. As noted above, there are modest additional training requirements for staff working in memory care units or when supporting individuals with significant behavioral challenges. Further, few agencies that participated in the provider survey reported paying acuity-based differentials. For example, only about a quarter of ODDS service providers reported separate pay scales or policies to offer additional pay for staff working with individuals with more significant support needs.

Despite the lack of formal requirements, the existing ODDS rate models for services with tiered rates include a five percent assumed wage premium for the highest rate tier. In response to feedback from service providers, the recommended rate models increase that premium to 10 percent, consistent with the average differential reported through the provider survey by those agencies with acuity-based differentials. The 10 percent wage premium increases the $23.20 per hour wage assumption to $25.52 in the Category 4 rates (covering ONA Service Group 5) for applicable ODDS services, Tier 5 rates for applicable APD services, memory care services, and specific needs contracts for residential care facilities.

The recommended 10 percent wage premium, which increases the assumed wage by $2.32 per hour, remains somewhat less than suggested by some ODDS service provider representatives who noted that the collective bargaining agreement for homecare workers and personal support workers provides for an additional $3.00 per hour when caring for individuals eligible for the exceptional differential. However, the exceptional differential applies to a narrower group of individuals than those assigned to the highest support levels. For example, in June 2024, 0.4 percent of personal support workers received the exceptional differential while 28 percent of ODDS enrollees had been assessed as ONA Service Group 5. PSWs and HCWs must also receive additional training and be certified to receive the exceptional differential. The broader enhanced differential available to PSWs and HCWs who have the required certification and work with eligible individuals is only $1.00 per hour.

Neither APD nor ODDS currently have payment rates that vary based on the region of the state in which the service was delivered. When developing the current ODDS rate schedule, regionally-differentiated rates were considered, but ultimately rejected for reasons including administrative and operational challenges, such as defining appropriate rates for services that cross wage boundaries and addressing potential distortions for providers operating near those boundaries. This issue was nevertheless reconsidered as part of this wage and rate study.

Wages are higher in the Portland metro area. The Legislature recognized this when establishing minimum wage requirements, setting the minimum wage $1.25 higher than the "standard" minimum wage (and $2.25 higher than the minimum wage set for non-urban counties). BLS wage data also demonstrates these differences. Considering home health and personal care aides (as discussed above, this is how most direct care workers are classified), the median hourly wage in the Portland metropolitan statistical area (MSA) is $19.22, which is between 3 and 12 percent greater than the median wage in the other geographic regions.

However, because Portland is the state's largest employment center, statewide figures are heavily influenced by this area's labor costs. For home health and personal care aides, the Portland MSA accounts for more than half of the statewide workforce. As a result, the Portland MSA's median wage for this occupation is only 3.9 percent greater than the statewide median (and the difference is even smaller for social and human service assistants, the other position in

the BLS occupation mix used to establish direct care worker wage assumptions). Thus, if regional wage assumptions were adopted, the assumed wage would be modestly higher in the Portland area, but would then be lower in every other region of the state. Given the modest impact that regional rates would have on Portland-area providers (that already have the benefit of a larger service population), the negative impact on rates in greater Oregon, and the administrative and operational challenges, the wage and rate study recommends maintaining statewide rates rather than regional rates.

Agency Direct Care Worker Benefits

In addition to market-based wages, the recommended rate models for agency-provided services include a comprehensive benefits package intended to support providers in the attraction and retention of a qualified and stable workforce.

The recommended rate models include the following standard employer-paid payroll taxes:

- Social Security – 6.20 percent of total wages[40]
- Medicare – 1.45 percent of total wages[41]
- Federal unemployment insurance – 0.60 percent on the first $7,000 in wages paid[42]
- State unemployment insurance – 2.40 percent on the first $52,800 wages paid[43]
- Paid Leave Oregon – 0.40 percent of total wages[44]
- Workers' compensation – 2.18 percent of total wages[45]

The existing ODDS rate models include funding to account for the assumed cost of the employer's share of an employee-only health insurance plan. ODDS service providers have argued that the rate model should account for a mix of health insurance options, which they need to offer to meet the needs of their staff. Based on this feedback, the recommended rate models reflect a range of health insurance plan types: employee-only, employee-plus-one, and family plans. Assumptions related to take-up rates, distribution across plan

Figure 3-4: Health Insurance Assumptions for Direct Care Workers in Recommended Rate Models

Coverage Type	Participation Rate	Employer Cost
Employee Only	43.1%	$625.00
Employee + One	13.0%	$1,025.00
Family	17.0%	$1,700.00
All Coverages	**73.1%**	**$691.63**

[40] Internal Revenue Service. (2024). Publication 15 (2024), Circular E, Employer's Tax Guide. Retrieved from https://www.irs.gov/publications/p15.

[41] Ibid.

[42] Ibid.

[43] State of Oregon Employment Department. (November 15, 2023). Oregon Employment Department Announces 2024 Rates for Paid Leave Oregon and Unemployment Insurance. Retrieved from https://www.oregon.gov/employ/NewsAndMedia/Documents/2023-11-Tax-Contribution-Rate-Notice.pdf.

[44] Ibid.

[45] NCCI. (n.d.). Assigned Risk Rates for Classification Code 8835 (Home, Public, and Traveling Healthcare--All Employees) in Oregon as of January 1, 2024. Retrieved from https://www.ncci.com.

types, and employer contributions to premium expenses are derived from Oregon-specific data from the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey (MEPS).[46] Figure 3-4 presents the assumed distribution across plan types and the assumed provider cost for each.

Overall, these assumptions translate to an assumed employer cost of $691.63 per employee per month. This is the assumed average cost for all employees, including the assumed 26.9 percent of staff who do not participate in their employer's health insurance plan. When considering only employees who participate, the assumed cost is about $950 per employee per month.

In addition to health insurance, the recommended rate models include:

- 24 days of paid time off, inclusive of paid holidays, vacation, and sick leave. This assumption is unchanged from the existing ODDS rate models.
- A two percent contribution to a retirement plan. This assumption is unchanged from the existing ODDS rate models.
- $75 per employee per month for other discretionary benefits such as dental or life insurance, tuition reimbursement, etc. This represents an increase from the $25 per employee per month included in the existing ODDS rate models.

Overall, the benefits package assumed in the recommended rate models exceeds what providers reported in the provider survey although, as discussed above, this difference is more than offset by the higher wages reported by providers.

As is true for workers nationally, providers reported that part-time workers receive substantially fewer benefits than full-time workers. The existing ODDS rate models assume staff work full-time to provide sufficient funding to support a high-quality and stable workforce. Additionally, agencies participating in the provider survey reported that most direct care staff work full-time, but there were differences based on the services provided. For example, residential providers in both the APD and ODDS systems reported more than three-quarters of direct care workers are full-time and ODDS' day program providers reported almost 70 percent of staff work full-time.

In comparison, in-home service providers reported a greater reliance on part-time staff. For example, ODDS' in-home providers reported that nearly 50 percent of their direct care workers are part-time. In response, the recommended rate models for In-Home services include an assumption that 70 percent of staff work full-time with the full benefits package described above while the remaining 30 percent work part-time with fewer benefits. In particular, the assumed benefits package for part-time staff reduces paid leave to 48 hours of annual paid leave and eliminates the funding for health insurance and retirement contributions.

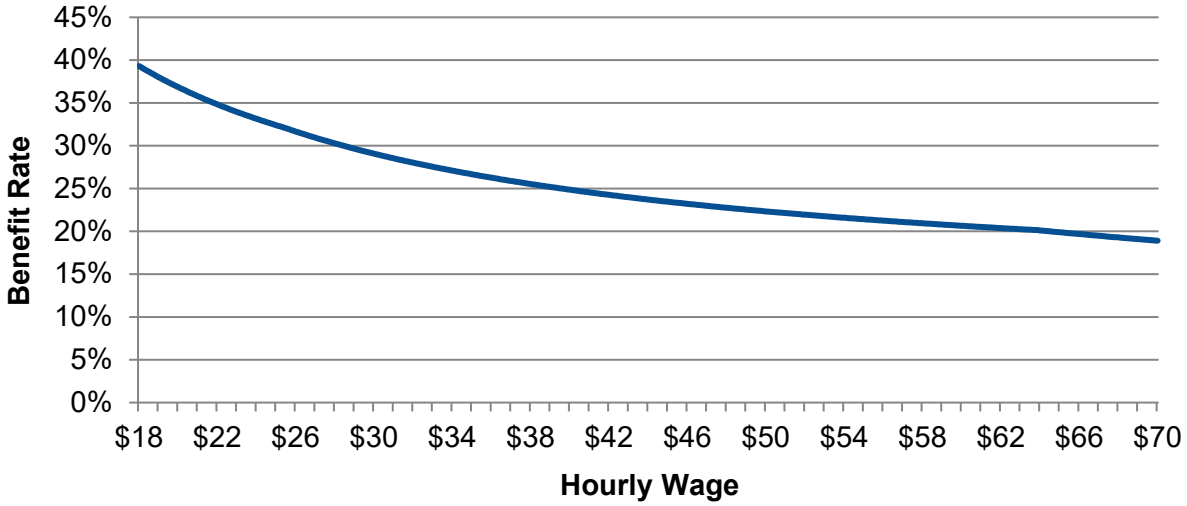
The benefits package for direct care workers is detailed in Appendix B of the rate model packets.

In the rate models themselves, the benefits package is translated to a benefit rate expressed as a percentage of the direct care worker's wage. Since certain benefit costs are assumed to be fixed (for example, the rate models provide the same $691.63 per month for health insurance for all full-time direct care workers), there is an inverse relationship between the wage of the direct

[46] United States Department of Health and Human Services Medical Expenditure Panel Survey. (2023). Retrieved from https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2023/ic23_iia_f.pdf. See Tables II.B.3.b.(1).(a), II.C.1, II.C.2, II.C.4, II.D.1, II.D.2, II.D.4, II.E.1, II.E.2, and II.E.4.

care worker and the benefit rate. That is, as the direct care wage increases, the benefit rate declines as illustrated in Figure 3-5.

Figure 3-5: Benefit Rate Assumed in Rate Models for Full-Time Staff, by Wage Level (excludes paid time off)



For a full-time direct care worker earning $20 per hour, the benefits package translates to a 36.9 percent benefit rate; for a worker earning $50 per hour, that same benefits package yields a 22.3 percent benefit rate. For the $23.20 per hour wage assumption for direct care workers described above, the full-time benefit rate is 33.8 percent. These benefit rates exclude paid time off, which is recognized in the rate models as an adjustment to worker productivity (that is, a reduction in billable hours).

Personal Support Workers and Home Care Workers Wages and Benefits

As noted in Section 1, HCW and PSW wages and benefits are determined through a collective bargaining agreement negotiated between SEIU and the state. Unlike payment rates for agency providers that do not change based on the direct care worker providing the service, payments to PSWs and HCWs vary based on a number of factors. The 2023-25 CBA includes tenure-based steps, overtime pay, and various wage differentials. As a result, developing recommendations to standardize direct care worker compensation first required analysis of the impact of these factors on the average wage earned by HCWs and PSWs.

The 2023-25 CBA established a "step"-based system that increases workers' base pay as they accumulate more worked hours, with a look-back to January 1, 2023, as shown in Figure 3-6.

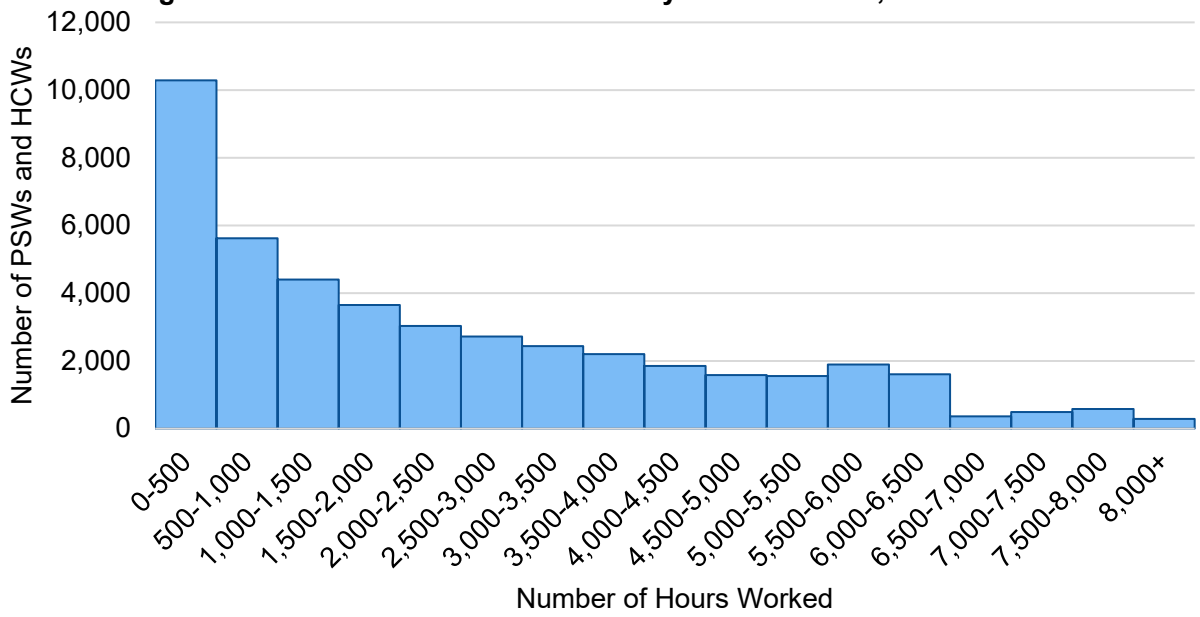
If a worker worked full-time (40 hours per week) in 2023 and 2024, they would be at step 3 on January 1, 2025 and earn a base wage of

Figure 3-6: HCW/ PSW Pay Scale Steps

Step	Hours Worked and Accumulated since January 1, 2023	January 1, 2025 Hourly Rate
1	0 < 2,000	$20.00
2	2,000 < 4,000	$21.00
3	4,000 < 6,000	$22.00
4	6,000 < 8,000	$23.00
5	8,000+	$24.00

$22.00 per hour. However, most PSWs and HCWs do not work full-time. Figure 3-7 presents the distribution of PSWs and HCWs based on the number of hours they worked over a three-year period (fiscal years 2021 through 2023).

Figure 3-7: Count of PSWs and HCWs By Hours Worked, FY2021-2023



Considering this distribution of worked hours, new PSWs and HCWs beginning at step 1, and worker turnover, it is assumed that the average base wage for PSWs and HCWs in 2026 will be around $21.00 per hour (equivalent to step 2).

The 2023-25 CBA includes several differentials for workers with specified training or who support individuals with more significant needs. Figure 3-8 lists the differentials, add-on amounts, and estimated prevalence of these differentials in June 2024.

Figure 3-8: HCW and PSW Differential Amounts and Estimated Prevalence

Differential(s)	Amount	Est. % of HCW Hours	Est. % of PSW Hours
CPR/ First Aid	$0.25	3.3%	3.2%
Professional Development Certification (w/ CPR/ First Aid)	$0.75	2.8%	1.7%
Enhanced Certification	$1.00	0.3%	0.5%
PDC (w/ CPR/ First Aid) + Enhanced Certification	$1.75	0.5%	0.4%
Exceptional Certification[a]	$3.00	0.2%	0.4%
Ventilator Dependency and Quadriplegia (APD Only)[a]	$3.00		-
Enhanced Certification + VDQ (APD Only)	$4.00	0.1%	-
Children's Intensive In-Home Services (ODDS Only)	$2.00	-	2.0%
Child. Intensive In-Home + CPR/ First Aid (ODDS Only)	$2.25	-	0.1%
Employment Specialist (ODDS Only)	$2.50	-	<0.1%
Employment Specialist + CPR/ First Aid (ODDS Only)	$2.75	-	<0.1%

[a] Since the Exceptional Certification and Ventilator Dependency and Quadriplegia differentials are identical, an analysis of payment data cannot differentiate between the two and this table provides a single estimate for the differentials in combination.

As the table shows, billing of the differentials is uncommon, partly because several apply only when the individual receiving services meets certain criteria. Every HCW and PSW, however, is eligible to receive the professional development certification. The value of this differential was therefore included when comparing the average wage for HCWs and PSWs to the direct care worker compensation assumptions in the recommended agency rate models.

In fiscal years 2021 through 2023, overtime increased workers' effective average hourly wage. For PSWs, overtime added an average of about $0.50 per hour, implying an overtime rate of about six percent. For HCWs, overtime added an average of about $0.12 per hour, implying an overtime rate of about two percent. Applying a four percent overtime rate to a $21.00 base wage would add an average of $0.42 per worked hour.

Assuming a typical $21.00 base rate (step 2), professional development certification, and a four percent overtime rate, the "typical" hourly wage for HCWs and PSWs would be $22.18, about $1.00 per hour less than the direct care worker wage assumed in the recommended rate models for agency services. However, wages are only one component of worker compensation; benefits must also be considered.

Leaving aside payroll taxes (Social Security, Medicare, federal and state unemployment insurance, Paid Leave Oregon, and worker's compensation) that are paid by the state for HCWs and PSWs (and are incorporated in the recommended rate models for agency-provided services), the CBA mandates state contributions to SEIU-managed trusts to provide benefits to HCWs and PSWs. In total, the state currently contributes $2.66 per hour worked, $1.02 to the Oregon Homecare Workers Benefit Trust and $1.64 to the Oregon Homecare Workers Supplemental Trust.[47]

Figure 3-9 compares the benefits available to HCWs and PSWs to the benefits package assumption in the recommended rate model for agency-provided In-Home services.

Figure 3-9: Comparison of Benefits Funded for HCWs and PSWs and for Direct Care Workers in the Recommended Rate Model for In-Home Services

Benefit	2023-25 Collective Bargaining Agreement for HCWs / PSWs	Recommended Rate Model for Agency-Provided In-Home Services
Paid Time Off	Maximum of 48 hours per year	FT: Assumes 192 hours per year PT: Assumes 48 hours per year
Health Insurance	Coverage of premium costs for some health insurance plans (and a share of cost for others); assistance covers only the worker (i.e., no family coverage)	FT: Includes funding to offer a range of plan types (e.g., individual-only and family plans) PT: None
Other Benefits	Access to dental, vision, and hearing insurance, as well as an employee assistance program	FT: Assumes a two percent retirement contribution and $75 per employee per month for other benefits PT: Assumes $75 per employee per month for other benefits

[47] The state also contributes to the SEIU Training Partnership, but the wage and rate study does not treat this as a fringe benefit. Training-related expenses are also incorporated in the recommended rate models for agency-provided services.

In total, the recommended rate model for In-Home services provided by agencies includes $6.13 per hour for direct care worker benefits (including paid time off and excluding payroll taxes), substantially more than the funding for benefits in the collective bargaining agreement for HCWs and PSWs. To create parity in total compensation across service delivery models, the wage and rate study recommends increasing base wages in the CBA by $4.50 per hour. Raising the base wage gives workers flexibility to determine how to use the increase. For example, they could pay for family health insurance coverage, contribute to a retirement account, or use the money to pay for living expenses.

As discussed above, ODDS service provider representatives have argued that collectively bargained workers are not equivalent to direct care workers employed by agencies and therefore objected to the recommendation to standardize total compensation. These representatives added that, if there will be an increase, the additional funding should be added to the homecare worker trusts rather than wages because the higher wages would make agencies non-competitive. However, agencies can offer less generous benefits than assumed in the rate models in order to pay higher wages (subject to legal requirements such as minimum paid leave and health insurance plan standards). SEIU and individual HCWs and PSWs have expressed support for the increase in base wages.

Section 4: Recommendations for Payments for Collectively Bargained Services

In-Home services provided by homecare workers and personal support workers as well as Adult Foster Home services are collectively bargained. Recognizing that any changes to the terms of compensation for HCWs, PSWs, and foster care providers would be subject to bargaining, the wage and rate study offers several recommendations, including:

- Increase the base wage for HCWs and PSWs by $4.50 per hour to align total compensation with the amounts included in the recommended rate models for agency-provided In-Home services. This recommendation is detailed in Section 3.
- Increase employment specialist differential for PSWs from $2.50 per hour to $6.00, consistent with the difference between the assumed wages for agency-employed direct care workers and job coaches.
- Standardize payment rates for Adult Foster Homes across systems by establishing a five-tier rate schedule that accounts for the payment to the owner/operator of the home as well as support hours provided by other staff to meet the needs of the resident. Individuals would be assigned to the appropriate tier based on APD's proposed assessment framework for individuals served through APD and based on the Oregon Needs Assessment for individuals served through ODDS.
- Update payment rates for specific needs Adult Foster Home contracts with APD, and update the exceptions process for both APD and ODDS AFHs when a home requires more hours of additional support than funded in the standard rate models.

Figure 4-1 presents the estimated increase in annual spending by service.

Figure 4-1: Estimated Fiscal Impact for Collectively Bargained Services

Service	Annual Spending Increase (Total Funds, in millions)	% Change
APD In-Home (HCWs)	$143.4	21.4%
ODDS In-Home (PSWs)	$91.4	21.3%
APD Adult Foster Homes	$152.1	81.1%
ODDS Adult Foster Homes	$50.7	22.7%
Total	**$437.6**	**33.3%**

Homecare Workers and Personal Support Workers

As detailed in Section 3, the wage and rate study recommends increasing the base wages for HCWs and PSWs delivering in-home services by $4.50 per hour, resulting in a starting (step 1) wage of $24.50. Between the step-based increases, the wage add-on for the professional development certification, and overtime earnings, the "typical" hourly wage for HCWs and PSWs would be approximately $26.80. Coupled with the state's current contributions to the benefits trusts, total compensation (excluding the value of payroll taxes) for HCWs and PSWs would be almost $30 per hour, roughly equivalent to the compensation assumptions incorporated in the recommended rate models for agency-provided In-Home services.

The wage and rate study considered other aspects of the payment framework for HCWs and PSWs, including:

- *Billable activities.* The terms of the collective bargaining agreement allow HCWs and PSWs to bill for travel time between individuals' homes or initial service-related sites (such as a pharmacy or grocery store), and for attending certain required training (training hours are paid at the worker's base rate). No changes to these standards are recommended. Agencies cannot bill for their workers' travel or training time, but these costs are incorporated in the recommended rate models as productivity adjustments.
- *Employment specialist differential.* As noted earlier in Figure 3-8, the CBA includes a $2.50 differential for PSWs who complete required training and provide Job Coaching services. The wage and rate study recommends increasing this differential to $6.00 per hour to roughly match the difference between the standard wage assumption for agency-employed direct care workers and job coaches in the recommended rate models for agency-provided services.
- *Need-based differentials.* As detailed in Section 3, the CBA provides additional pay to HCWs and PSWs who support individuals with greater support needs and who have completed specified training. The wage and rate study does not recommend specific changes to these differentials. However, given the significant recommended increase to base wages and efforts by both APD and ODDS to standardize assessment of acuity, it is recommended that the continuing need for the enhanced and exceptional differentials, the eligibility for these differentials, and the value of these differentials be re-evaluated as part of the next CBA.
- *Mileage reimbursement.* Per the CBA, HCWs and PSWs can seek reimbursement for the use of their personal vehicles for service-plan-related non-medical transportation at a rate of $0.56 per mile, the Internal Revenue Service's standard mileage rate in 2021. The recommended rate models for agency-provided services uses the IRS' standard mileage rate, which was $0.70 in 2025, to fund vehicle-related costs and the wage and rate study recommends that mileage reimbursement for HCWs and PSWs be similarly tied to the IRS' rate.
- *Maintaining compensation standardization.* Decisions regarding service payment rates across the APD and ODDS systems have often been siloed, with annual adjustments based on ODHS' funding priorities, legislative budget decisions, and the results of collective bargaining. This has resulted in differences in funded compensation levels across the APD and ODDS systems, across individual services, and across service delivery models. Assuming compensation levels are standardized as recommended, future adjustments should be consistent across all payments. For example, if the assumed wage in the rate models for agency-provided services is increased by $1.00 per hour, there should be an equal adjustment in the wages for HCWs and PSWs. Similarly, compensation increases in the CBA should be incorporated in the rate models for agency-provided services.

Adult Foster Homes

As described in Section 1, the collective bargaining agreement between SEIU and the state employs different approaches to assessing needs and establishing payment rates for foster

homes depending on whether they support individuals served through APD or though ODDS.[48] Additionally, Adult Foster Home services may be delivered through a variety of operating models. The development of payment recommendations therefore required consideration of how best to align payments with assessed needs and to account for various operational structures.

Current APD Adult Foster Home rates are based on three factors:

- A provider receives (as of January 2025) a base rate of $2,120 per individual per month, which is intended to support one-to-five care.
- A provider may receive up to three "add-ons" of $386 per month if an individual requires full assistance in mobility, eating, or elimination; has behaviors that pose a risk to themselves or others; or needs medical treatments that require oversight by a licensed healthcare professional (an individual may qualify for all three add-ons). Currently, 21 percent of individuals have zero add-ons,40 percent have one add-on, 34 percent have two add-ons, and 5 percent have three add-ons.
- A provider may request "exceptional" funding to pay for hours of additional staffing if an individual requires additional hours of service not paid for in the base rate or add-on amounts, or if the individual requires nighttime services that prevent the provider from getting at least five hours of uninterrupted sleep per night. Providers must submit a staffing plan that justifies the exception and are required to provide proof of hiring and continued employment. Currently, 56 percent of AFHs have approved exception hours.

In addition to these standard rates, APD has higher, specific needs contract rates to provide specialized care. As of December 2024, specific needs contract rates range from $3,665 to $23,647 per individual per month.

Current ODDS Adult Foster Home rates are based on the Support Needs Assessment Profile (SNAP):

- A provider receives (as of January 2025) a base rate of $1,026.53 to cover the first 47 hours of assessed needs.
- Up to $2,511.82 per month may be added to the base rate if the individual requires full or partial assistance with specified activities of daily living.
- Up to $5,050.98 per month may be added to the base rate if the individual requires full or partial assistance with specified medical support needs.
- Up to $5,026.34 per month may be added to the base rate if the individual requires staff to be within hearing and visual distance.
- Up to $2,931.35 may be added to the base rate for nighttime needs based on the frequency of needed supports due to medical or behavioral support needs.
- Funding may be added at a rate of $16.69 per hour for two-to-one support needs.

[48] The budget note mandating the wage and rate study covered only certain services provided through APD and ODDS. The collective bargaining agreement for adult foster homes included a commitment to study payment rates for individuals served through the Oregon Health Authority (OHA) as well. OHA is in the process of reviewing wage and study recommendations to determine whether the recommended approaches to tiered rates and exceptions can be adapted for its program.

The add-on amounts are calculated independently, but are subject to cumulative maximums. An individual may not receive more than $5,800 in funding across the ADL, medical, and behavioral categories while the total maximum rate before consideration of two-to-one support needs is $10,043.

These differing approaches to establishing payment rates have resulted in significant differences in average Adult Foster Home rates. In fiscal year 2023, the average APD rate (excluding specific needs contracts) was about $4,800 per individual per month compared to an average ODDS rate of $6,700. To reduce these disparities and consistent with preexisting goals within both APD and ODDS to increase standardization of assessing needs within their programs, the wage and rate study incorporates the programs' intended changes to assessing the needs of individuals in foster homes as discussed in Section 2:

- APD has developed an assessment framework intended to establish a consistent approach across services.
- Rates for ODDS AFHs would be based on the Oregon Needs Assessment service groups.

Both assessment frameworks incorporate five levels of needs so the recommended rate models for Adult Foster Home Services include five rate tiers. These rate models include two primary components:

- The funded payment for the primary caregiver (that is, the foster home owner/operator) to account for both the caregiving and administrative responsibilities of the provider. As the owner/operators are not considered hourly employees, this payment is reflected as a monthly amount.
- Assumed hours of additional staffing delivered by someone other than the primary caregiver. The rate models fund these staffing hours as if they are delivered by an employee hired by and receiving an hourly wage from the owner/operator.

Assumptions for both of these primary components are tiered based on the assessed needs of the individual, as shown in Figure 4-2.

Figure 4-2: Development of Direct Care Worker Base Wage Assumption

	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Assumed Caregiver Pay (per year)	$30,000	$36,000	$42,000	$48,000	$54,000
Assumed Caregiver Mileage (per yr.)	$1,278	$1,278	$1,278	$1,278	$1,278
Assumed Addl. Staff Hrs. (per wk.)	0	8	16	24	34
Total Annual Payment (Rounded)	**$31,278**	**$51,189**	**$71,101**	**$91,013**	**$119,579**
Annual room and board (2024 level)	$8,796	$8,796	$8,796	$8,796	$8,796

As the table demonstrates, the assumed payments to the owner/operator – excluding amounts assumed to pay for additional staff – range from $30,000 to $54,000 per individual per year. As highlighted in Section 2, about three quarters of individuals served in APD AFHs and more than half of individuals served in ODDS AFHs would be assigned to Tier 4 or 5 so the owner/operator would generally receive $48,000 to $54,000 per individual per year, which is similar to the statewide median wage in Oregon. When caring for five individuals, the owner/operator would be assumed to earn between $150,000 and $270,000 annually. Foster home provider additionally receive funding for residents' room and board. In 2024, foster homes receive about $8,800 per individual per year, or $44,000 annually for homes serving five individuals.

Given the changes to assessment frameworks and payment models, the impact of these recommendations vary by individual and by home. The proposed rates would increase total estimated payments for ODDS foster homes by an estimated 23 percent. On a home-by-home basis, total revenues would increase for an estimated 63 percent of adult foster homes.

Because current APD Adult Foster Home rates are significantly lower than current ODDS rates and a higher proportion of individuals served by APD would be assigned to the highest rate tiers, rate increases for APD foster home providers are substantially larger. An estimated 76 percent of APD foster homes would receive an overall increase in payments and total estimated payments to these providers would increase by an estimated 81 percent.

As Figure 4-2 shows, the recommended rate models include funding for additional staff hours that increase with each subsequent rate tier. The incorporation of additional staff hours into the standard rates (coupled with higher payments to the owner/operator) is meant to meet the needs of the large majority of individuals without the need for an exception. As with other full-time residential services providing 24-hour support (such as Assisted Living Facility services and Adult 24-Hour Residential services for individuals with I/DD), AFH providers receiving only standard payment rates will not be required to provide the number of staff hours assumed in the recommended rate models, but are expected to provide the level of staffing necessary to meet the needs of home residents.

For APD AFHs, incorporating additional staff hours in the standard rates should reduce the need for specific needs contracts and for exceptions. In particular, the wage and rate study recommends the elimination of the basic and advanced specific needs rates as the Tier 5 rates generally provide the level of support required in these models. For the remaining specific needs rates, recommended rate models were developed following the structure illustrated above based on contractual standards, including additional requirements such as onsite nursing support. Figure 4-3 compares the current and recommended specific needs contract rates. As the table shows, several recommended rates are lower than current rates. However, at this time, APD does not intend to implement these decreases.

Figure 4-3: Comparison of Current and Recommend Rates for APD Specific Needs Adult Foster Homes

Specific Needs Contract	January 2025 Rate	Recommended Rate Model
Complex	$12,546.00	$11,609.16
Bariatric	$9,769.00	$10,395.36
Advanced Ventilator	$24,711.00	$14,165.36
Hospice	$10,463.00	$10,224.61
Traumatic Brain Injury	$8,998.00	$8,230.63

Although the standard payment rates and the specific needs contract rates should meet the needs of most individuals, there will still be some who require more support than incorporated in their rate. Building on current APD practices, the wage and rate study recommends that adult foster homes be able to request additional funding to pay for additional staffing within the home with the following requirements:

- *Provide all hours funded in home residents' base rates.* To request an exception for more staff hours, the AFH would first have to demonstrate they are delivering the level of additional staffing (that is, supports provided by someone other than the primary caregiver) funded for all residents in the home. For example, as shown in Figure 4-2 above, the Tier 5 rate includes 34 hours of additional staffing per individual per week so, if a home has five individuals assigned to Tier 5, total funded staffing would be 170

hours per week. The AFH provider would have to document that they are delivering 170 hours of additional staffing and could only request funding for hours in excess of this amount. This approach ensures that the state does not pay for the same staff hour twice.

- *Counting additional staffing hours provided by other household members.* When demonstrating that all already-funded hours are being delivered, the AFH may count support provided by other member of the household (such as the owner/operator's spouse or adult child). Only hours during which the other household member is awake, onsite, and providing active care may be counted, and no more than 40 hours per week can be counted per other household member.
- *Billing additional staffing hours on a fee-for-service basis.* Instead of bundling authorized exceptions hours into the overall payment rate, additional staff hours would be billed on a fee-for-service basis in order to limit billing to hours of additional support that are actually provided.

The recommended rate model for these additional staff hours incorporate the same wage, benefit, and productivity assumptions for the direct care worker as incorporated in the rate models for agency-provided In-Home services, translating to an hourly rate of $33.35, significantly greater than the current APD and ODDS rates for exceptional hours (as of January 2025, $19.50 and $16.69, respectively).

Section 5: Recommendations for Payments for Agency-Provided Services

In addition to the recommendations for direct care worker compensations detailed in Section 3, highlights of recommendations for payment rates for the agency-providers services evaluated in the wage and rate study include:

- Updating existing ODDS rate models to incorporate updated published cost data with limited targeted adjustments to further specific goals, such as providing funding to facilitate activities in the community and supporting smaller group homes.
- Adopting transparent rate models for APD services similar to the existing ODDS models. The establishment of such models would ensure a shared understanding between APD, providers, and community partners regarding what has been built into payment rates.
- Aligning payment rates for In-Home services across the APD and ODDS systems.
- Standardizing payment rates for Assisted Living Facility and Residential Care Facility services.
- Transitioning ODDS' Supported Living services to tiered rates based on the Oregon Needs Assessment, and using APD's proposed assessment framework to establish tiered rates for Assisted Living Facility , Residential Care Facility, and Adult Day services.
- Creating a more consistent framework for negotiating payment rates for Specific Needs Facilities and Specialized Living programs.
- Collaborating with providers and other community partners to establish reporting requirements to regularly collect data regarding key cost drivers (such as direct care worker wages, benefits, and staffing levels) to evaluate the effectiveness of any rate increases and to inform future rate adjustments.

Figure 5-1 presents the estimated cost of adopting the recommended rate models for each service.

Figure 5-1: Estimated Fiscal Impact for Agency-Provided Services

Service	Annual Spending Increase (Total Funds, in millions)	% Change
Aging and People with Disabilities Agency-Provided Services		
In-Home Services	$74.4	40.2%
Assisted Living Facilities	$37.0	25.2%
Residential Care Facilities	$19.4	107.9%
Memory Care Facilities	$24.1	24.3%
Adult Day Services	$1.1	36.9%
PACE Rates	$35.2	21.7%
Total – APD Services	**$191.2**	**31.1%**

Figure 5-1: Estimated Fiscal Impact for Agency-Provided Services

Service	Annual Spending Increase (Total Funds, in millions)	% Change
Office of Developmental Disabilities Services Agency-Provided Services		
In-Home Support	$247.4	26.4%
24-Hour Residential	$339.6	42.3%
Children Foster Homes	$9.5	54.3%
Supported Living	$36.3	40.3%
Day Support Activities	$13.7	25.5%
Employment Services	$22.4	30.9%
Non-Medical Transportation	$5.7	28.6%
Total – ODDS Services	**$674.6**	**33.8%**

Rate Model Development Across Programs and Services

As described in Section 2, rate models were developed for each agency-provided service. These models detail cost assumptions for individual cost drivers for each service in order to establish a total assumed cost. The rate model assumptions are meant to account for the reasonable costs of service delivery, but are not meant to dictate agencies' operations. Providers are expected to structure their operations to meet the needs of individuals they serve and their employees. For example, if their employees value wages more than benefits, a provider may choose to pay more than assumed in the rate model while offering less generous benefits. Thus, for any given provider, it is expected that some costs will be higher than assumed in a model and other costs will be lower.

Since ODDS has already-established rate models that have received significant input from service providers and other community partners, the wage and rate study used those models as a starting point when developing assumptions for the five key cost factors in home and community-based services rate models illustrated earlier in Figure 2-3.

Direct Care Worker Wages, Benefits, and Productivity

As described in Section 3, the wage assumption for caregivers in the APD system and direct support professionals in the ODDS system is based on data from the Bureau of Labor Statistics inflated to account for estimated wage growth to January 2026. The recommended rate models benchmark direct care workers to the same BLS occupational classifications as used in the current ODDS rate models.

This methodology yields an assumed wage of $23.20 per hour, which is meant to reflect an appropriate overall average effective wage into 2026, recognizing that some staff will earn more and others will earn less based on education and training, tenure, and shift differentials and other premium pay.

The development of wage assumptions for services provided by other staff (job coaches, for example) as well as for other positions specifically listed in the rate models (such as supervisors and clinical staff) followed the same BLS-based approach described above. If these positions were previously incorporated in the current ODDS rate models, the same BLS benchmarks

were used. For positions not included in a current ODDS rate model (such as facility directors and kitchen staff in the recommended rate models for Assisted Living Facility and Residential Care Facility services), BLS job descriptions were evaluated to identify the most appropriate benchmark.

The BLS wage data before and after wage growth adjustments as well as the job mix assumptions are included in Appendix A of the APD and ODDS rate model packets.

The assumed benefits package for direct care workers is detailed in Section 3 and generally mirrors the assumptions included in the current ODDS rate models. Assumptions for health insurance were adjusted to provide for a mix of plan types rather than the current ODDS rate models, which only account for employee-only plans.

As discussed in Section 3, the assumed benefits package exceeds what was reported by providers that participated in the provider survey. This is particularly true for part-time staff who are reported to receive few benefits. The provider survey results suggest that spending less on benefits than assumed in the rate models has allowed agencies to spend more on wages than assumed in the models. The recommended rate models maintain a comprehensive benefits package to support the recruitment and retention of a high-quality workforce. As described later in this section, however, the wage and rate study recommends that the proposed rate increases be accompanied with additional reporting requirements, including details regarding benefit-related costs to inform any subsequent rate adjustments.

Appendix B of the APD and ODDS rate model packets details the benefit package assumptions.

Rate model productivity adjustments are designed to account for hours worked by direct care workers – and paid by their employer – that cannot be billed. For example, an agency cannot bill for time that workers spend in staff meetings or receiving feedback from their supervisor, but these activities are part of the expectation of the job and represent a real cost to the agency. Productivity adjustments effectively spread these costs over billable hours. Productivity adjustments incorporated in both ODDS' current rate models and the recommended rate models include:

- *Paid time off.* Although part of the benefits package described in Section 3, the assumed 24 days of paid time off is reflected in the rate models as a productivity adjustment since these represent paid hours that cannot be billed.
- *Training.* Assumed training hours generally exceed minimum requirements to account for agency-specific requirements. Assumptions also vary by service, based on feedback from service providers, ranging from 18 hours per year for CLS model agencies to 140 hours for Children's 24-Hour Residential services.
- *Travel time.* Services delivered in an individual's home or the community include a productivity adjustment for the time staff spend driving between service encounters and between a service encounter and the office. These adjustments are not intended to account for a worker's commuting time (that is, travel before their work day begins or after it ends). Provider site-based services such as full-time residential programs and day programs do not include travel time adjustments.
- *Employer and one-on-one supervision time.* This adjustment accounts for time spent on workers' employment-related responsibilities such as attending staff meetings, completing job-related paperwork, and meeting with their supervisor. In general, the rate models include 45 minutes per week for such activities.

- *Participating in assessment and planning meetings.* The rate models include time for direct care workers to participate in assessment and planning meetings for the individuals they support. The rate models assume that staff providing group services spend more time attending assessments and meetings.
- *Progress notes and medical records.* This adjustment captures time spent on documentation that does not occur during service provision and therefore cannot be billed. The rate models assume that staff providing group services spend more time on documentation.

The provider survey requested that providers report data regarding worker productivity. Compared to the existing ODDS rate models, providers reported that staff spend more time than assumed on some activities and less time than assumed on others. Overall, there were not consistent trends in one direction, except that reported training hours were broadly less than assumed in the rate models. Providers have also argued that current productivity may not be reflective of best practices due to staffing shortages and current payment rates that may prevent investment in non-billable activities.

Thus, the recommended rate models for ODDS services maintain the productivity adjustments included in the current rate models. For APD services, the recommended rate models generally reflect the productivity adjustments for the most comparable ODDS service (for example, productivity adjustments for Assisted Living Facility and Residential Care Facility services are tied to the assumptions in the ODDS Adult 24-Hour Residential models while APD Adult Day services are tied to the ODDS Day Support Activities models).

Since training directly impacts service quality and because the rate models include significant funding for training hours, the reporting requirement discussed later in this section should include collection of information related to the time that staff spend in training to inform future rate model revisions and, potentially, changes to regulatory training requirements.

Appendix C of the APD and ODDS rate model packets details productivity assumptions.

Program Support and Administration

Broadly, the recommended rate models include assumptions for program-specific expenses and a standard 15 percent of total costs for administrative and other overhead costs.

Program support expenses generally vary by service. For example, the recommended rate models for Assisted Living Facility and Residential Care Facility services include cost assumptions for nursing staff, kitchen staff, activity staff, and program supplies while the recommended rate models for ODDS Day Support Activity services include cost assumptions for vehicles, physical program space, and program supplies. Program support cost assumptions were informed by the existing ODDS rate models, data gathered through the provider survey, community partner input, and rate models developed in other states.

Most of the recommended rate models include an assumption for a supervisor or facility manager-type position. For non-residential services, the models fund one supervisor for every eight direct care workers. This ratio also appears generally consistent with reporting through the provider survey. When comparing the number of hours worked by staff with supervisory responsibilities to the number of hours worked by staff without such responsibilities for ODDS services, the ratios mostly ranged from one-to-seven to one-to-nine. In-Home Attendant Care services were a notable exception where reporting indicated only one supervisory hour for every 39 direct care worker hours.

The recommended rate models for agency-provided services include 15 percent of the total rate for other program support and administrative costs. When combined with the assumed supervisory cost, most of the recommended rate models include approximately 25 percent of the total rate for program support and administration. Because Assisted Living Facility and Residential Care Facility services have lower direct care worker ratios, the recommended rate models include a higher proportion of total costs allocated to program support and administration. Across the recommended rate tiers, the rate models for these services include between 32 and 42 percent for the facility director, activity staff, kitchen staff, housekeeping staff, and other administration and overhead costs.

A number of providers argued that the overhead cost assumptions are too low. However, in percentage terms, these assumptions are consistent with costs reported through the provider survey. Further, since the recommended rates represent an increase in provider reimbursement, the rates would increase providers' administrative funding (that is, the overhead *rate* is the same, but it is applied to a higher cost base, resulting in more overhead *funding*), which is intended to account for the types of increased costs reported by agencies that participated in the provider survey. For example, about six percent of responding agencies reported increasing program support and administrative staff wages by an average of almost four percent while 13 percent reported about a four percent increase in overall operating expenses due to higher costs associated with insurance, rent and utilities, and other expenses.

Recommended Rates for ODDS Service Providers

As discussed in Section 1, ODDS has developed detailed rate models to establish payment rates for most services. For services with existing rate models, the wage and rate study incorporated updated published cost data such as:

- New wage data from the Bureau of Labor Statistics, adjusted assumed wage inflation as discussed in Section 3.
- New health insurance cost data from the U.S. DHHS' Medical Expenditure Panel Survey.
- The latest standard business mileage rate from the IRS.

The wage and rate study also considered targeted adjustments to the existing rate models based on data and feedback from providers and other community partners.

For services without existing rate models, recommended rate models were developed consistent with the structures of the existing models.

Adult and Children's 24-Hour Residential

In addition to incorporating updated published cost data, the recommended rate models include several other proposed changes:

- *Home size.* Current rate models for Adult 24-Hour Residential services include separate rates for homes with three or fewer residents and for homes with four or five residents. In response to feedback from service providers, the recommended rate models include separate rates for two-person, three-person, four-person, and five-person homes. Similarly, the current model for Child 24-Hour Residential services with three-or-fewer children was divided between two-person and three-person rates.

- *Shift overlap.* The recommended rate models add 0.25 hours per shift (0.75 hours per day) to allow for a 15-minute debrief during three daily shift changes.
- *Specialized supports.* The recommended rate models increase funding for clinical staff such as registered nurses and behavior support professionals in rate categories 3 and 4 by funding one full-time equivalent position for every 20 individuals.
- *Supplies.* The recommended rate models add $20 per individual per week for costs associated with supplies related to the operation of the home (excluding personal items that are individuals' responsibility). These funds are also intended to support community engagement by, for example, covering the cost of staff to accompany individuals to activities that have a cost.
- *Mileage.* The mileage assumption in the Adult 24-Hour Residential rate models was increased from 100 miles per home per week in the existing rate models to 200 miles in the recommended rate models. The increased amount is more consistent with reporting through the provider survey and is intended to support both home operations and assisting individuals to access the community.

The staffing assumptions included in Appendices D and E in the ODDS rate model packet were also evaluated. Based on provider survey reporting, providers are delivering about 93 percent of the hours assumed in the rate models. As discussed earlier, rate models assumptions are not meant to dictate provider operations and providers may be delivering fewer hours than assumed in the models to support the higher wages they also reported. Staffing levels should continue to be monitored to determine whether rate models should be adjusted in the future.

Figure 5-2 compares the recommended rates to current rates.

Figure 5-2: Comparison of Current and Recommended Rates – Adult and Child 24-Hour Residential

Rate Category	Current Rate (per day)	Proposed Rate (per day)	$ Change	% Change
Adults, 2 Residents				
Category 1	$300.14	$623.33	$323.19	107.7%
Category 2	$410.20	$724.55	$314.35	76.6%
Category 3	$561.69	$872.15	$310.46	55.3%
Category 4	$687.54	$1,080.38	$392.84	57.1%
Adults, 3 Residents				
Category 1	$300.14	$419.44	$119.30	39.7%
Category 2	$410.20	$563.77	$153.57	37.4%
Category 3	$561.69	$770.16	$208.47	37.1%
Category 4	$687.54	$969.52	$281.98	41.0%
Adults, 4 Residents				
Category 1	$234.81	$366.16	$131.35	55.9%
Category 2	$349.85	$503.29	$153.44	43.9%
Category 3	$434.62	$634.57	$199.95	46.0%
Category 4	$561.20	$814.49	$253.29	45.1%
Adults, 5 Residents				
Category 1	$234.81	$295.64	$60.83	25.9%
Category 2	$349.85	$445.19	$95.34	27.3%
Category 3	$434.62	$561.45	$126.83	29.2%
Category 4	$561.20	$746.28	$185.08	33.0%

Figure 5-2: Comparison of Current and Recommended Rates – Adult and Child 24-Hour Residential

Rate Category	Current Rate (per day)	Proposed Rate (per day)	$ Change	% Change
Children, 2 Residents				
Category 1	$518.25	$745.31	$227.06	43.8%
Category 2	$619.65	$887.00	$267.35	43.1%
Category 3	$725.13	$1,031.51	$306.38	42.3%
Category 4	$855.73	$1,245.30	$389.57	45.5%
Children, 3 Residents				
Category 1	$518.25	$707.76	$189.51	36.6%
Category 2	$619.65	$840.24	$220.59	35.6%
Category 3	$725.13	$989.70	$264.57	36.5%
Category 4	$855.73	$1,204.54	$348.81	40.8%
Children, 4 Residents				
Category 1	$476.79	$649.82	$173.03	36.3%
Category 2	$552.11	$749.00	$196.89	35.7%
Category 3	$709.72	$964.35	$254.63	35.9%
Category 4	$812.66	$1,143.52	$330.86	40.7%
Children, 5 Residents				
Category 1	$388.85	$533.63	$144.78	37.2%
Category 2	$449.08	$612.98	$163.90	36.5%
Category 3	$576.16	$788.65	$212.49	36.9%
Category 4	$658.72	$932.63	$273.91	41.6%

As the table shows, the recommended rate models would provide much larger rate increases for the highest rate categories in dollar terms. The percentage increases are somewhat larger at the lower rate categories because of the addition of certain fixed costs noted above. For example, in percentage terms, the addition of $20 per individual per week for supplies represents a larger percentage change to the lower category rates than to the higher category rates.

Child Foster Homes and Host Homes

Although Child Foster Homes are not collectively bargained like Adult Foster Homes, payment rates for CFHs are similarly tied to the Support Needs Assessment Profile. As part of ODDS' shifting of all tiered rates to the Oregon Needs Assessment, the wage and rate study recommends adopting the same five-tiered payment framework for AFHs discussed in Section 4 for CFHs. This framework would increase payment rates for an estimated 82 percent of CFHs and would increase overall CFH payments by an estimated 53 percent.

In addition to the incorporation of updated published cost data, the recommended rate models for Host Home services increase the assumed payment to the host home provider. Given that host home providers have access to agency supports, the assumed payments to the host home providers are set somewhat less than the recommended rate model assumptions for foster home owner/operators. Figure 5-3 compares the current and recommended host home rates.

Figure 5-3: Comparison of Current and Recommended Rates – Host Homes

Rate Category	Current Rate (per day)	Proposed Rate (per day)	$ Change	% Change
Category 1	$130.46	$182.86	$52.40	40.2%
Category 2	$183.16	$238.65	$55.49	30.3%
Category 3	$257.43	$322.49	$65.06	25.3%
Category 4	$327.38	$412.15	$84.77	25.9%

In-Home Services

As discussed in Section 3, the recommended rate models for In-Home service agencies include a factor to account for the use of part-time direct care workers in the delivery of this service. Changes in the recommended rate models are otherwise limited to the incorporation of updated cost data. The recommended rate models maintain the same distinctions between standard model agencies and community living supports agencies in terms of worker productivity, mileage, and supervision.

Figure 5-4 compares the recommended rates to current rates.

Figure 5-4: Comparison of Current and Recommended Rates – In-Home Services

Rate Type	Current Rate (per hour)	Proposed Rate (per hour)	$ Change	% Change
Standard Model Agency				
1:1	$42.24	$53.39	$11.15	26.4%
1:2 (per person)	$23.23	$29.37	$6.14	26.4%
1:3 (per person)	$16.90	$21.36	$4.46	26.4%
2:1	$76.69	$97.53	$20.84	27.2%
Community Living Supports Agency				
1:1	$34.99	$44.55	$9.56	27.3%
1:2 (per person)	$19.25	$24.51	$5.26	27.3%
1:3 (per person)	$14.00	$17.82	$3.82	27.3%
2:1	$64.26	$81.81	$17.55	27.3%

Supported Living

ODDS has been working with Supported Living providers for several years to update service policies and payment models. ODDS' payment-related goals have included development of transparent rate models that document cost assumptions, transitioning to the Oregon Needs Assessment to determine support needs, and increasing alignment between payments and the level of support provided.

The recommended rate models reflect ODDS' proposed payment approach, which includes:

- *Alignment of cost assumptions.* The recommended rate models align cost assumptions such as direct care worker wages and benefits and the administration and other overhead rate with the assumptions in other ODDS models.

- *Monthly payment rate.* As with current Supported Living payments, the recommended rate model is based on a monthly service rate, which provides predictable revenue while recognizing that the amount of support delivered varies from day-to-day and month-to-month.
- *Tiered rates based on the ONA.* Supported Living is one of the few remaining services that have not been transitioned to the Oregon Needs Assessment. The recommended rate models include five rate categories based on the same ONA service groups used to establish tiered rates for other services as well as a model for individuals who require and are approved for 24 hours of daily support. The rates differ primarily based on the assumed number of hours of direct support that the individual receives with individuals with more significant needs assumed to receive more supports. Assumed direct support hours are equal to the maximum number of In-Home hours that an individual in each service group may receive.
- *Minimum service level requirement.* To bill the full monthly payment rate, providers must deliver at least 75 percent of the direct support hours funded in the model. For example, the recommended rate model for Service Group 3 funds 42 hours of direct support per week, or 182.5 hours per month so the provider would need to provide 137 hours of support (182.5 multiplied by 75 percent) to bill the full rate. Both in-person and remote direct supports can be counted towards the requirement. If the 75 percent threshold is not met, the provider bills a fixed monthly rate to cover oversight and coordination costs and an hourly rate for the number of direct support hours actually delivered.

ODDS intends to continue engaging providers and other community partners to finalize payment rules including documentation requirements and exceptions processes, as well as service-related policies.

Figure 5-5 lists the recommended rates.

Figure 5-5: Recommended Rates – Supported Living

Rate Category	Proposed 'Full' Rate (per month)	Proposed Oversight/Coord. Rate (per month) [a]	Proposed Hourly Direct Support Rate (per hour)[a]
Service Group 1	$5,858.42	$2,483.89	$48.59
Service Group 2	$7,490.53	$2,694.28	$48.59
Service Group 3	$12,138.06	$3,357.99	$48.59
Service Group 4	$22,737.88	$4,974.64	$48.59
Service Group 5	$32,726.81	$5,966.49	$52.58
24-Hour Care	$42,589.58	$7,469.31	$52.58

[a] If the provider does not meet the 75 percent threshold to bill the full rate, they bill the monthly coordination-only rate plus the hourly rate for the number of direct support hours actually provided.

The recommended rate models would increase payment rates for approximately 83 percent of individuals. Overall provider revenues would increase by an estimated 39 percent, assuming that the 75 percent threshold is met for all service months.

Day Support Activity, Employment Path, and Small Group Supported Employment

The recommended rate models maintain the current approach of varying payment rates based on the service group to which an individual is assigned and whether the service is delivered in a provider's facility or in the community (Small Group Supported Employment rates only vary based on an individual's service group). The recommended rate models do not include changes to the staffing ratios assumed for each rate category and setting.

In addition to incorporating updated published cost data, the recommended rate models include several other proposed changes:

- *Overhead cost alignment.* Because the ODDS rate models were done in stages, different approaches were taken to incorporating program support and administrative costs. The current rate models for these services include $10 per individual per day for program support and 20 percent of the total rate for other administrative and overhead costs. There are no specific assumptions related to supervision. The rate models developed later for in-home and residential services include cost assumptions for supervision and 15 percent of the total rate for other administrative and overhead costs.

  For consistency, the recommended rate models for Day Support Activity, Employment Path, and Small Group Supported Employment include an assumption for supervision at a one-to-eight ratio and 15 percent of the total rate for other overhead costs. This approach produces a similar level of total funding for overhead costs for these services; some rates are somewhat higher than they would be if the current overhead funding approach was maintained and other rates are somewhat lower.

- *Supplies.* The recommended rate models for Day Support Activity and Employment Path services increase the assumed cost of program supplies from $1.00 per day per member to $2.00.

- *Program space.* The recommended rate models for Day Support Activity and Employment Path services increase the assumed cost of program space from $11.25 per square foot to $20.00.

Figure 5-6 compares the recommended rates to current rates.

Figure 5-6: Comparison of Current and Recommended Rates – Day Support Activity, Employment Path, and Small Group Supported Employment

Rate Category	Current Rate (per person per hour)	Proposed Rate (per person per hour)	$ Change	% Change
Day Support Activity, Community-Based				
Category 1	$17.11	$20.05	$2.94	17.2%
Category 2	$21.33	$25.68	$4.35	20.4%
Category 3	$29.77	$36.95	$7.18	24.1%
Category 4	$39.76	$51.66	$11.90	29.9%
1:1 (by Exception)	$41.82	$53.78	$11.96	28.6%
2:1 (by Exception)	$71.24	$90.72	$19.48	27.3%

Figure 5-6: Comparison of Current and Recommended Rates – Day Support Activity, Employment Path, and Small Group Supported Employment

Rate Category	Current Rate (per person per hour)	Proposed Rate (per person per hour)	$ Change	% Change
Day Support Activity, Center-Based				
Category 1	$11.99	$13.47	$1.48	12.3%
Category 2	$15.75	$18.61	$2.86	18.2%
Category 3	$19.50	$23.78	$4.28	21.9%
Category 4	$28.39	$37.00	$8.61	30.3%
1:1 (by Exception)	$38.59	$50.85	$12.26	31.8%
2:1 (by Exception)	$67.64	$87.48	$19.84	29.3%
Employment Path, Community-Based				
1:1 Svcs. (Solo)	$42.29	$57.31	$15.02	35.5%
Category 1	$21.28	$26.67	$5.39	25.3%
Category 2	$24.66	$31.38	$6.72	27.3%
Category 3	$29.71	$38.41	$8.70	29.3%
Category 4	$39.83	$53.80	$13.97	35.1%
1:1 (by Exception)	$41.71	$56.16	$14.45	34.6%
2:1 (by Exception)	$71.01	$95.07	$24.06	33.9%
Employment Path, Center-Based				
Category 1	$13.48	$16.14	$2.66	19.7%
Category 2	$17.32	$21.69	$4.37	25.2%
Category 3	$22.46	$29.11	$6.65	29.6%
Category 4	$28.27	$38.38	$10.11	35.8%
1:1 (by Exception)	$38.44	$53.08	$14.64	38.1%
2:1 (by Exception)	$67.37	$91.67	$24.30	36.1%
Small Group Supported Employment				
Category 1	$22.46	$27.80	$5.34	23.8%
Category 2	$25.97	$32.72	$6.75	26.0%
Category 3	$31.45	$40.36	$8.91	28.3%
Category 4	$42.50	$57.36	$14.86	35.0%
1:1 (by Exception)	$43.91	$59.07	$15.16	34.5%
2:1 (by Exception)	$73.76	$99.13	$25.37	34.4%

Discovery and Job Development

As with the recommended rate models for Day Support Activity, Employment Path, and Small Group Supported Employment services, the models for Discovery and Job Development

services have been revised to align the overhead cost structure with the other ODDS rate models. The recommended rates models were also revised with updated published cost data.

Discovery and Job Development payments are based on "milestones". For Discovery, agencies are paid a single rate upon completion of the Discovery Profile. For Job Development, agencies receive a payment once an individual is successfully placed in a job and a second payment if the individual remains in the job for at least 90 days. The wage and rate study considered updating the number of hours assumed in the milestone payments, but the provider survey did not produce adequate data to support changes. Further, since Vocational Rehabilitation (VR) typically covers Job Development services, any changes should be coordinated with that program.

Figure 5-7 compares the recommended rates to current rates.

Figure 5-7: Comparison of Current and Recommended Rates – Discovery and Job Development

Rate Category	Current Rate	Proposed Rate	$ Change	% Change
Discovery (Completed Discovery Profile)				
Category 1	$2,184.54	$2,854.25	$669.71	30.7%
Category 2	$2,496.61	$3,262.00	$765.39	30.7%
Category 3	$2,808.69	$3,669.75	$861.06	30.7%
Category 4	$2,808.69	$3,669.75	$861.06	30.7%
Job Development (Placement Milestone)				
Category 1	$2,429.86	$3,216.80	$786.94	32.4%
Category 2	$3,037.33	$4,021.00	$983.67	32.4%
Category 3	$3,644.80	$4,825.20	$1,180.40	32.4%
Category 4	$3,644.80	$4,825.20	$1,180.40	32.4%
Job Development (90-Day Retention Milestone)				
Category 1	$1,518.67	$2,010.50	$491.83	32.4%
Category 2	$1,822.40	$2,412.60	$590.20	32.4%
Category 3	$2,429.86	$3,216.80	$786.94	32.4%
Category 4	$2,429.86	$3,216.80	$786.94	32.4%

Job Coaching

Rather than paying providers based on the number of direct support hours delivered, ODDS pays Job Coaching service providers based on the number of hours the supported individual works in competitive integrated employment. This approach incentivizes two key goals. Agencies are incentivized to assist the individual in increasing their work hours (thereby increasing the agency's billable hours) while fading unnecessary supports (because their revenue is not directly tied to the number of hours of support delivered).

To establish the Job Coaching rate models, ODDS had to develop assumptions related to the ratio of the number of hours that an individual works to the number of hours of support provided by the agency. These ratios are used to determine the appropriate rate to bill for each hour worked by the individual. For example, if the cost per staff hour is $50 and individuals require

supports for an average of 70 percent of the hours they work, the billable rate per work hour would be $35 ($50 multiplied by 70 percent). The amount of support an individual requires is assumed to vary based on two factors:

- *Assessed needs.* The rate models assume that individuals with more significant needs require more support to maintain their jobs. As with other services with tiered rates, an individual's needs are determined through the Oregon Needs Assessment.
- *Time on the job.* The rate models assume that the amount of support an individual needs should diminish as they gain more experience in their job. The rate models recognize three employment phases: the initial phase (the first six months on the job), the ongoing phase (the next 18 months), and the maintenance phase (all support beyond two years on the job).

When negotiating this payment model, the Centers for Medicare and Medicaid Services required that these ratios be based on an analysis of actual support levels. The agreement with CMS requires that these ratios be reviewed at least every five years with the analysis covering the five previous years. This review will occur in 2026 so the recommended rate models incorporate the current ratios, but preliminary analysis shows that actual support levels are less than assumed in the many of the rate models. If the final analysis produces the same result, the ratios will be reduced, which will decrease the rates. At this time, however, the recommended rate models incorporate updated published cost data and the adjustments to overhead funding described above for Day Support Activity, Employment Path and Small Group Employment.

Figure 5-8 compares the recommended rates to current rates.

Figure 5-8: Comparison of Current and Recommended Rates – Job Coaching

Rate Category	Current Rate (per individual worked hour)	Proposed Rate (per individual worked hour)	$ Change	% Change
Initial Phase				
Category 1	$32.07	$42.25	$10.18	31.7%
Category 2	$49.82	$65.46	$15.64	31.4%
Category 3	$71.73	$95.18	$23.45	32.7%
Category 4	$71.73	$95.18	$23.45	32.7%
Ongoing Phase				
Category 1	$25.66	$33.80	$8.14	31.7%
Category 2	$49.82	$65.46	$15.64	31.4%
Category 3	$71.93	$95.18	$23.25	32.3%
Category 4	$71.93	$95.18	$23.25	32.3%
Maintenance Phase				
Category 1	$19.24	$25.35	$6.11	31.8%
Category 2	$49.82	$65.46	$15.64	31.4%
Category 3	$71.93	$95.18	$23.25	32.3%
Category 4	$71.93	$95.18	$23.25	32.3%

Recommended Rates for APD Service Providers

As discussed in Section 1, APD does not have rate models comparable to those established by ODDS. As a result, there is no documentation regarding what current payment rates are designed to cover in terms of staffing levels, direct care worker wages and benefits, agency administration and overhead, or any other factor.

To improve transparency and to guide future rate adjustments, the wage and rate study recommends the establishment of rate models for the APD services covered by this report. As with the ODDS rate models that have been in place for many years, cost assumptions are based on a variety of data sources meant to reflect reasonable, market-based expenses, but are not intended to dictate how agency providers manage their operations.

Assisted Living Facilities and Residential Care Facilities

As detailed in Section 2, APD currently has substantially different approaches to assigning payment rates for Assisted Living Facility and Residential Care Facility services:

- *Assisted Living Facilities.* Individuals are assigned to one of five rate levels based on CA/PS assessment results. The rates range from $1,922 to $4,513 per individual per month. Based on the distribution of level assignments and the current rates, the average ALF payment is $3,873.
- *Residential Care Facilities.* Payment rates are structured similarly to Adult Foster Home service rates. There is a base payment rate of $2,393 and an individual may qualify for up to three add-ons of $466 each based on support needs associated with activities of daily living, medical conditions, or behavioral issues. Based on the current distribution of add-ons and the current rates, the average RCF payment is $2,606. In addition to these standard rates, APD frequently negotiates "specific needs" contracts to pay higher rates to facilities designed to address specific populations such as those with extensive medical and/or extensive behavioral needs.

As discussed in Section 1, ALFs and RCFs are very similar and primarily differ on whether an individual has a private room. However, the average RCF rate is 33 percent less than the average ALF rate.

Due to the similarities in service requirements and expectations, the wage and rate study recommends standardizing payment rates for ALFs and RCFs. The recommended rate models have five tiers based on APD's new proposed assessment framework discussed in Section 2.

The primary difference across the tiered rates is the assumed level of direct care staffing. The staffing assumptions rely on findings from the Portland State University's 2024 Community-Based Care report. PSU's analysis of staffing data reported by responding providers found that ALFs and RCFs delivered a median of 2.49 care hours per individual per day.[49] This figure used a broad definition of care staff, including nurses and social workers. Personal care workers, certified nursing assistants (CNAs), certified medication assistants (CMAs), and activity staff (including the activity director) represented 93 percent of staff. When establishing assumed caregiver ratios (inclusive of personal care workers, CNAs, CMAs, and activity staff), the wage and rate study reduced the reported median by 10 percent (since the activity director is separately funded in the recommended rate models). As discussed in Section 2, the largest

[49] The provider survey conducted as part of the wage and rate study also considered. Results from that survey suggested somewhat lower staffing levels, but participation was lower than for the PSU survey.

number of individuals in ALFs and RCFs would be assigned to Tier 3. The recommended Tier 3 rate model therefore assumes caregiver staffing of 2.25 hours per individual per day (15.75 hours per week), equal to the adjusted median staffing figure from the PSU study. The assumed staffing level moves up or down by 0.25 hours per day with each subsequent rate tier, as shown in Figure 5-9.

Figure 5-9: Assumed Caregiver Staffing Levels in the Recommended Rate Models for Assisted Living Facilities and Residential Care Facilities

Rate Tier	Caregiver Hours per Resident per Week	Implied Caregiver Staffing Ratio
Tier 1	12.25	1:14
Tier 2	14.00	1:12
Tier 3	15.75	1:11
Tier 4	17.50	1:10
Tier 5	19.25	1:9

As the table shows, the assumed staffing levels translate to staffing ratios of one caregiver for every 9 to 14 residents (calculated on a 24-hour basis; it is likely that staffing is greater during daytime hours and lower overnight). As with all recommended rate models generally, assumed staffing levels are meant to reflect providers' typical operations and costs so actual staffing is expected to vary based on the needs of each facility's residents.

In addition to caregivers, the recommended rate models include specific assumptions for a variety of clinical and operational staff, as detailed in Figure 5-10.

Figure 5-10: Assumed Staffing Ratios for Clinical and Operational Positions in the Recommended Rate Models for Assisted Living Facilities and Residential Care Facilities (full-time staff : individuals)

Rate Tier	Registered Nurse	Lic. Practical Nurse	Activity Director	Kitchen Staff	Housekeeping Staff
Tier 1	1:70	1:70	1:50	1:16	1:35
Tier 2	1:60	1:60	1:50	1:16	1:35
Tier 3	1:50	1:50	1:50	1:16	1:35
Tier 4	1:40	1:40	1:50	1:16	1:35
Tier 5	1:30	1:30	1:50	1:16	1:35

The positions detailed in the recommended rate models do not include all staff associated with the operation of ALFs and RCFs. As with all of the rate models, the funding assumed for administrative and other overhead costs is intended to cover other operational staff.

Figure 5-11 lists the recommended rates for ALFs and RCFs.

Figure 5-11: Recommended Rates – Assisted Living Facilities and Residential Care Facilities

Rate Tier	Proposed Rate
Tier 1	$3,851.45
Tier 2	$4,238.13
Tier 3	$4,648.88
Tier 4	$5,101.83
Tier 5	$5,944.94

The recommended rates are not directly comparable to current payment rates because of the impacts of APD's proposed changes to the assessment process used to assign individuals to a rate. In particular, APD's new assessment framework would place fewer individuals into the highest rate categories, meaning that the population of individuals in the

current Level 5 are not the same as the population of individuals in the future Tier 5. If the assessment framework was not changing, all of the recommended rates would be lower.

Overall, the recommended rates would increase provider revenues. All RCFs with standard rates would experience an increase in their revenues and total payments to these facilities would more than double. An estimated 99 percent of ALFs would receive greater payments under the recommended rates and total payments to these facilities would increase 25 percent.

In addition to the standard rates, recommended rate models were developed for Memory Care services and Specific Needs Facility services. The recommended rate models for these programs include more intensive staffing than assumed in the standard rate models as demonstrated in Figure 5-12.

Figure 5-12: Assumed Staffing Levels in the Recommended Rate Models for Memory Care Units and Specific Needs Facilities

Rate Tier	Care-giver (Hrs. /Wk.)	Reg. Nurse (Ratio)	Lic. Prac. Nurse (Ratio)	Behav. Supp. (Ratio)	Activity Director (Ratio)	Kitchen Staff (Ratio)	House-keeping Staff (Ratio)
Memory Care	28.00	1:40	1:40	-	1:40	1:16	1:35
Behavior	40.25	1:30	1:25	1:20	1:30	1:16	1:35
Medical	40.25	1:25	1:25	1:30	1:30	1:16	1:35
Behavior + Medical	47.25	1:20	1:20	1:30	1:30	1:16	1:35
Enhanced Care	21.00	1:13	-	-	1:20	1:16	1:35

Figure 5-13 lists the recommended rates for ALFs and RCFs.

The recommended rate for Memory Care services represents a 22 percent increase compared to the current rate. Since APD currently negotiates rates for Specific Needs Facility services, the comparison of current and recommended rates vary across providers. However, for most specific needs facilities, the recommended rates would result in a reduction. As a result, APD intends to apply these rates for new providers, but does not intend to reduce current providers' rates.

Figure 5-13: Recommended Rates – Memory Care Units and Specific Needs Facilities

Rate Tier	Proposed Rate
Memory Care	$7,635.50
Behavior	$11,031.39
Medical	$10,983.37
Behavior + Medical	$12,658.63
Enhanced Care	$7,291.53

In addition to the standard and specific needs rates, APD will continue to have a need to establish rates for individual facilities in some limited circumstances, most commonly to deliver very specialized services to a targeted population. To support these negotiations, a "customizable" rate model has been developed. The prospective facility and APD would negotiate a staffing plan across various staffing categories (including caregivers, registered nurses, licensed practical nurses, social workers, drug and alcohol counselors, behavioral support professionals, dieticians, and others). The agreed-upon staffing hours would be input into the customizable model, which would then price these supports using the same

methodologies as included in all of the recommended rate models. For example, the same benefits package would be assumed for these staff. This approach is intended to increase consistency in negotiated rates across facilities and to promote equity across providers and staff (by funding the same level of benefits for staff regardless of whether they work for a facility with a negotiated rate, for example).

Specialized Living

Given the diversity of Specialized Living programs, the wage and rate study does not recommend a fixed rate schedule. Instead, as described above for Specific Needs Facility services, a customizable rate model is recommended. The prospective provider and APD would negotiate a staffing plan across various staffing categories. The agreed-upon staffing hours would be input into the customizable model, which would then price these supports using the same methodologies as included in all of the recommended rate models.

In-Home Services

Despite covering the same types of supports, APD's current payment rate for In-Home services is about 10 percent less than ODDS' current payment rate for standard model agencies. The wage and rate study recommends standardizing the payment rate across programs, resulting in a larger increase for APD providers.

The recommended rate model is based on the existing ODDS model, adjusted to account for updated published cost data. Additionally, as explained in Section 3, the recommended rate model for In-Home services was revised to include a factor to recognize In-Home service providers' more significant reliance on lower-cost part-time workers compared to other services.

Figure 5-14 compares the recommended rates to current rates.

Figure 5-14: Comparison of Current and Recommended Rates – In-Home Support Services

Current Rate (per hour)	Proposed Rate (per hour)	$ Change	% Change
$38.08	$53.39	$15.31	40.2%

Adult Day Services

APD currently pays a single daily rate for Adult Day services regardless of the assessed needs of the individual, the location of services, or the length of the program day. The recommended rate models would adopt a framework similar to ODDS' Day Support Activities to support several goals:

- *Account for individual acuity.* The current one-size-fits-all rate pays the same rate regardless of individual need although, individuals with greater needs generally require more intensive supports. The recommended tiered payment rates are intended to reflect the higher costs providers incur to serve individuals with greater needs. An individual would be assigned to a payment tier based on the new APD assessment framework described in Section 2.
- *Encourage more integrated activities.* The recommended rate models would establish higher rates for services delivered in the community compared to those delivered at a provider's site. These higher rates are designed to reflect providers' costs for vehicles

and more intensive staffing, and to provide financial incentives for community-based activities.

- *Fairly pay providers based on the amount of service delivered.* The establishment of hourly payment rates ensures that providers that deliver more services receive higher pay.

In general, the tiered rates differ primarily based on the assumed staffing ratio. Figure 5-15 reports the assumed ratio in the recommended rate models.

Figure 5-15: Assumed Staffing Ratios and Recommended Rates – Adult Day Services

Rate Tier	Expected Avg. Group Size	Proposed Rate (per hour)
Facility-Based		
Tier 1-2	1:6	$15.86
Tier 2	1:4	$21.26
Tier 3	1:3	$26.68
Tier 4	1:2	$40.45
Community-Based		
Tier 1-2	1:4	$22.85
Tier 2	1:3	$28.64
Tier 3	1:2	$40.24
Tier 4	2:3	$55.28

Based on an analysis of the assessment results for individuals receiving services and provider survey reporting regarding service locations and the length of program days, it is expected all providers would experience an increase in revenues under the recommended rate models and overall provider payments would increase by 37 percent.

Section 6: Recommendations to Measure and Sustain Rate Impacts

The adoption of the wage and rate study recommendations would represent a historic investment in Oregon's home and community-based services. The recommended increases are primarily intended to enhance direct care workers' compensation. To ensure than any additional funding achieves this purpose and is sustained over time, the wage and rate study recommends the adoption of agency reporting requirements and regular updates to payment rates.

Recommended Reporting Requirements

As highlighted in Figure 5-1, fully implementing the recommended payment rates would increase agency providers' total annual revenues by nearly $800 million. Recommended increases in direct care worker compensation – for both wages and benefits – drive the majority of this cost. Given the significance of this investment and the importance of the direct care workforce in delivering high-quality services, the wage and rate study recommends increasing provider reporting requirements.

Existing reporting may serve as a foundation for the establishment of this requirement. For example, as noted above, nursing facilities must submit an annual cost report and, beginning in 2024, all ODDS agency providers were required to participate in the National Core Indicators State of the Workforce Survey.[50] After inventorying existing reporting requirements for APD and ODDS providers and identifying reporting structures both within and outside of Oregon, the details of a reporting framework should be developed in consultation with providers and other community partners. At a minimum, the following topics should be covered:

- *Wages* for direct care staff as well as other key staff included in the recommended rate models, including supervisors and clinical staff.
- *Benefits* for direct care staff. The reporting should be detailed enough to allow for a meaningful understanding of the benefits offered to staff and the associated costs.
- *Staffing levels,* including staff-to-consumer ratios and supervisor-to-staff ratios.
- *Training* for direct care workers.

Reporting would produce several benefits, including:

- *Evaluating the effectiveness of any rate increase.* The recommendations are meant to further several goals, including investing in the direct care workforce in terms of competitive wages and benefits and adequate training. Collecting data regarding providers' costs would allow policymakers and community partners to compare providers' operations and costs to the assumptions included in the rate models.
- *Increasing transparency and accountability.* The rate models provide detailed assumptions about the allocation of funds across major cost drivers, but there is not similar detail regarding the actual use of funds.
- *Preparing for implementation of the 2024 Access rule.* As discussed in Section 2, CMS' 2024 Access rule includes requirements that certain providers allocate a specified percentage of their payments to direct care worker compensation. These provisions are not effective until 2030 and states will require significant additional guidance regarding

[50] Oregon Administrative Rules, Chapter 411, Division 323, Section 0055. Accessed December 2024. Retrieved from https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=305650.

appliable services and implementation-related issues, but developing a reporting framework now will allow Oregon to begin building needed infrastructure.

- *Informing future rate adjustments.* Reported data will allow policymakers to identify the need for potential rate adjustments.

As noted several times in this report, rate models are not designed to dictate providers' operations. Rate model assumptions are meant to represent reasonable costs to deliver services consistent with service requirements, but for any given provider, it is expected that some costs will be higher than assumed and other costs will be lower. However, if there are widespread and significant disconnects between assumed and actual costs, payment rate adjustments should be considered. For example, if providers need to pay staff more than assumed in the rate models, wage assumptions may need to increase. Or, if providers are not delivering the level of training or supervision funded in the rate models, those assumptions may need to be reduced. Collecting this data on a regular basis will allow for ongoing review of the appropriateness of payment rates.

Maintaining Rate Adequacy Over Time

The recommended rate models have been designed to approximate the costs providers will incur in fiscal year 2026. Since costs increase every year, the rate models would need to be revised in subsequent years to remain current. It is not feasible for states to conduct a comprehensive review of payment rates – such as this wage and rate study – every year. For example, CMS expects states to conduct comprehensive review of rate methodologies in states' Section 1915(c) HCBS waiver programs every five years. In the interim period between such comprehensive reviews, the wage and rate study recommends that ODHS review and update the rate models during each biennial budget.

As discussed above, a key benefit to the establishment of detailed and transparent rate models is the ease with which they can be updated. For example, new published wage estimates from the BLS or the IRS' annual update to the standard mileage rate can be easily incorporated into the models. In addition to incorporating the most recent available data, any rate model updates should consider findings from the data collected from providers as part of the recommended reporting requirements discussed below.

Regularly updating the rate models will result in modest year-to-year increases rather than larger increases that will be needed if updates do not occur regularly. Such an approach is also consistent with regular reviews that occur for other Medicaid services in Oregon. For example, ODHS reviews and revises Medicaid-funded nursing facility rates annually based on facility cost reporting.[51] Most importantly, maintaining the currency of the rate models ensures that payment continue to reflect market-based costs, supporting high-quality services and a sustainable provider network.

[51] See: Oregon Administrative Rules, Chapter 411, Division 070, Section 0300. Accessed December 2024. Retrieved from https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=90696 and Oregon Administrative Rules, Chapter 411, Division 070, Section 0452. Accessed December 2024. Retrieved from https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=293150.