

Home Health Labor Cost Survey

*Understanding the impact of the COVID-19 Public Health
Emergency (PHE) on home health agency labor costs*



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Understanding the impact of the COVID-19 Public Health Emergency (PHE) on home health agency labor costs

Submitted to:

Partnership For Quality Home Healthcare (PQHH)

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Executive Summary

Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) was commissioned by the Partnership for Quality Home Healthcare (PQHH) to investigate the potential impact of the COVID-19 Public Health Emergency (PHE) on the Home Health Prospective Payment System (HH PPS) market basket used to update payments in the CY 2020 – CY 2022 HH PPS final and proposed rules. Below are several highlights from the results of an appropriately anonymized and aggregated survey of home health industry participants taken in August 2021.

- Home health agencies experienced increases in wage growth as well as increased growth in costs associated with staffing and retention (benefits) in 2020 than they did in 2019. All labor-related costs for 2021 are estimated to continue to grow at a higher rate than 2019.¹
- Wages for home health staff in urban areas increased at a slightly lower rate in 2020 (an average percent increase of 3.1%) which coincides with the impact of COVID-19 on labor costs generally. In 2021, the average percent increase in wages is expected to rebound at 3.5% — an increase that is higher than the increase observed in 2019.
- In contrast to trends in wages for home health staff in urban areas, wages for home health staff in rural areas increased at a higher rate in 2020 than they did in 2019. Rural HHA wages are expected to continue to increase in 2021, although the rate of increase is estimated to be much lower than observed in 2020.
- Wages for home health staff are estimated to continue to increase in 2021 for all professions.
- Expenses on staff benefits increased by almost three times the rate in 2020 as compared to 2019. Benefits expenses are expected to continue to increase, on average, by 28.0% in 2021—more than twice the rate of increase in 2020.
- The average percent increase in administrative, general, and other expenses was 6.2% in 2020, twice the rate in 2019. This coincides with COVID-19-related increases observed in the literature. In 2021, administrative, general, and other expenses are expected to increase at a rate almost comparable but slightly higher than increases before the COVID-19 pandemic in 2019.

¹ The Labor Cost Survey was distributed to PQHH members in August 2021, thus data for January 2021-December 2021 are estimated by respondents based on year to date (YTD) information known at that time of data collection.

Executive Summary

- The results of this survey indicate that wages and associated home health industry expenses rose significantly between 2019 and 2021, yet these increases aren't adequately accounted for in current market basket updates. Instead, the HH PPS market basket update factors declined from 2.9 in CY 2020 to 2.4 in CY 2022. These results suggest that the current proxies for price inflation that CMS uses do not reflect trends in the home health industry, perhaps because they measure inflation across the broader healthcare industry.

Introduction

Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) was commissioned by the Partnership for Quality Home Healthcare (PQHH) to investigate the potential impact of the COVID-19 Public Health Emergency (PHE) on the Home Health Prospective Payment System (HH PPS) market basket used to update payments in the CY 2020 – CY 2022 HH PPS final and proposed rules. The HH PPS market basket percentage is updated annually as required under section 3401(e) of the Affordable Care Act (ACA) and it reflects price inflation for several home health cost categories for each calendar year. Cost categories are derived from Medicare cost report (MCR) data and include wages, benefits, administrative and other expenses. To determine the market basket update factor, CMS calculates a weighted inflation factor based on price proxies for inflation obtained from the Bureau of Labor Statistics from each of the cost categories. However, the price proxies CMS uses are representative of the broader healthcare industry and not specific to the home health industry. CMS updated CY 2020 payments using a market basket update factor of 2.9 in CY 2020 and CY 2021 payments using an update factor of 2.3. The proposed CY 2022 HH PPS market basket update factor is 2.4 percent—a slight increase compared to CY 2021.

In March 2020, the United States healthcare system initiated its response to the coronavirus (COVID-19) pandemic. Federal and state governments issued a PHE which resulted in changes to the use and delivery of home healthcare services. During the early stages of the PHE, home health (HH) agencies saw a decrease in client volume due to fears of contracting the virus through contact with healthcare workers.² Federal and state governments began implementing policies during the pandemic that were intended to protect essential workers from the virus by increasing access to COVID-19 supplies and resources.³ However, some healthcare workers were not designated as essential workers in all states, thus limiting agencies' ability to access PPE, cleaning supplies, and COVID-19 tests.⁴

Introduction

Fear of contracting COVID-19 also strained HH agencies' labor force. Specifically, HH agency turnover rates and staff shortages increased significantly during the pandemic.⁵ The unemployment rate in home healthcare services rose from 2.5% in March to 7.8% in April of 2020 (approximately 327,000 workers).⁶ As unemployment rates increased there was also increased competition for minimum wage workers resulting in a tight labor environment.⁷ In order to retain home healthcare workers, HH agencies began offering higher wages and retainer payments through federal disaster funding.⁸ Hazard pay was distributed through the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act; however, the distribution of funds was determined on a state by state basis.⁹ HH agencies who received funds stood a better chance of remaining competitive for healthcare labor. However, the end of hazard pay may create additional financial burden on HH agencies due to COVID-19 PHE altered labor costs.¹⁰

Federal and state governments set fixed Medicaid and Medicare reimbursement rates for recipients, thus serving as a strong influence on home healthcare workers' wages. Medicare is the largest public payer for home health services; therefore, agencies are limited in their abilities to offer competitive and comprehensive wages and benefits. Investing in funding reimbursement rates would better allow for HH agencies to retain workers at a high rate by providing more sustainable wages.¹¹ This would decrease the financial burden HH agencies are likely to face in a COVID-19 imposed labor market.

² Porter, K., Hunter, M., Mulmule, N., & Tyler, D. (2021, May 31). *COVID-19 intensifies home Care WORKFORCE Challenges: Policy Perspectives ISSUE BRIEF*. ASPE: Office of the Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/reports/covid-19-intensifies-home-care-workforce-challenges-policy-perspectives-issue-brief>.

³ Ibid.

⁴ Ibid.

⁵ Galewitz, P. (2021, June 30). *With workers in short supply, Seniors often wait months for home health care*. NPR. <https://www.npr.org/sections/health-shots/2021/06/30/1010328071/with-workers-in-short-supply-seniors-often-wait-months-for-home-health-care>.

⁶ Bhandari, N., Batra, K., Upadhyay, S., & Cochran, C. (2021). Impact of COVID-19 on Healthcare Labor Market in the United States: Lower Paid Workers Experienced Higher Vulnerability and Slower Recovery. *International journal of environmental research and public health*, 18(8), 3894. <https://doi.org/10.3390/ijerph18083894>.

⁷ Woods, B. (2019, April 9). America's \$103 billion home health-care system is in crisis as worker Shortage worsens. CNBC. <https://www.cnbc.com/2019/04/09/us-home-healthcare-system-is-in-crisis-as-worker-shortages-worsen.html>.

⁸ Porter, K., Hunter, M., Mulmule, N., & Tyler, D. (2021, May 31). *COVID-19 intensifies home Care WORKFORCE Challenges: Policy Perspectives ISSUE BRIEF*. ASPE: Office of the Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/reports/covid-19-intensifies-home-care-workforce-challenges-policy-perspectives-issue-brief>.

⁹ Ibid.

¹⁰ Kinder, M., Stateler, L., & Du, J. (2021, March 17). The COVID-19 hazard continues, but the hazard pay does not: Why AMERICA'S essential workers need a raise. Brookings. <https://www.brookings.edu/research/the-covid-19-hazard-continues-but-the-hazard-pay-does-not-why-americas-frontline-workers-need-a-raise/>.

¹¹ Essential, Undervalued, and Underpaid: Home Health Care Workers in the United States during the COVID-19 Pandemic. (n.d.). <https://global.lehigh.edu/sites/global.lehigh.edu/files/11%20Home%20Health%20Care%20Workers%20in%20the%20United%20States%20during%20the%20COVID-19%20Pandemic.pdf>.

Introduction

To assess the impacts of the COVID-19 PHE on home health agencies' labor, Dobson | DaVanzo, in collaboration with PQHH board members, developed a Labor Cost Survey with the purpose of collecting data from PQHH members about factors that influence their labor costs which are otherwise not available. The goal of the survey was to collect real-time and trending data from the PQHH membership and use the aggregated data to highlight the increasing costs of labor in the home health industry and to document the unusual churn in the labor market that is affecting the operations of home health agencies, all of which can promote industry advocacy and public policy discussions about the accurate reflection of such costs in federal reimbursement rates.

Consistent with applicable federal antitrust compliance guidelines, all individual agency survey responses are confidential and accessible only to Dobson | DaVanzo as an independent third party. Only aggregated data are being reported, and only questions for which at least 5 agencies responded are included in the results. No individual provider's data represents more than 25 percent on a weighted basis of any statistic that is reported, as either this threshold was not exceeded and/or further weighting was done to take into account the size dispersions among all home health providers nationally. As such, all information is aggregated such that it would not permit recipients to identify the price charged, compensation paid by, or any expected trend projected by any particular agency.

All recipients of this report are also reminded that the information contained in this report should be used solely for its intended and appropriate purpose and in compliance with all applicable antitrust laws. Recipients should not discuss, suggest, or agree to any coordination of their individual business decisions or disclose or discuss any of their competitively sensitive non-public information outside their organizations. Recipients should consult their individual legal counsel with any questions about appropriate antitrust compliance.

Methodology

The survey tool was designed to assess the factors which impacted labor supply and demand in the home health industry based on a review of available literature as well as input from PQHH leadership and member agencies. The questions were developed in an iterative process with the feedback of PQHH representatives. In addition, PQHH provided input to ensure that survey recipients would find it as feasible as possible to report the requested data.

The survey tool was administered through Survey Monkey with a mix of questions aimed at gathering the nuances that can affect the market basket index. The questions were designed to obtain basic information about the PQHH member agencies, demographic information about their labor, recent changes in the mix of labor and their wages, and the factors affecting these changes (such as labor retention strategies, as well as administrative and benefits costs). Questions requested both data, selection from multiple options, and open-ended comments..

A confidential survey link was emailed on August 6, 2021 to thirteen PQHH member agencies with instructions not to share their individual links with any other respondent. Dobson | DaVanzo followed-up to obtain confirmation of receipt. Members were initially given four business days to complete the survey, but this deadline was extended by an additional four business days to allow agencies to provide the most accurate and complete data available. Technical assistance was provided by Dobson | DaVanzo via email and phone throughout this duration to ensure consistency in reporting and to support a higher response rate. Agencies which could not complete the survey in the given timeframe were also offered an abbreviated survey with 5 key questions, focusing on those that were directly used for determining market basket projections.

Survey data was downloaded by Dobson | DaVanzo in an Excel file from Survey Monkey and quality checks were performed. We also followed up with agencies with aberrant or missing data via phone and email to determine data completion and accuracy. All data analysis was conducted using Microsoft Excel.

Survey Results

Results Overview

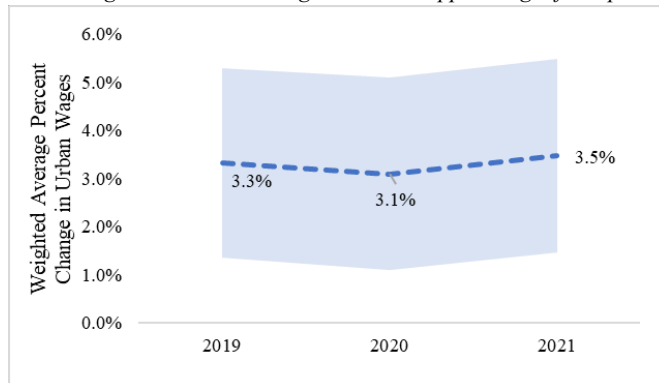
In total, ten PQHH members responded to the 2021 Labor Cost survey, although not all respondents answered each question. Responding members represented home health agencies in 44 of the 50 states.

Wages for Home Health Staff in Urban¹² Areas

Exhibit 1 shows the average weighted overall percent change in wages for field staff and clinical supervisors in urban areas from 2019 to 2021. Interestingly, wages for home health staff in urban areas increased at a slower rate in 2020 (an increase of 3.1% in 2020 as compared to 3.3% in 2019) which coincides with the impact of COVID-19 on the labor market generally. In 2021, the percent increase in wages is expected to rebound to 3.5%..

Exhibit 1: Average Percent Change in Urban Wages for Field Staff and Clinical Supervisors, 2019-2021

Light blue shading indicates the average lower and upper ranges for reported values



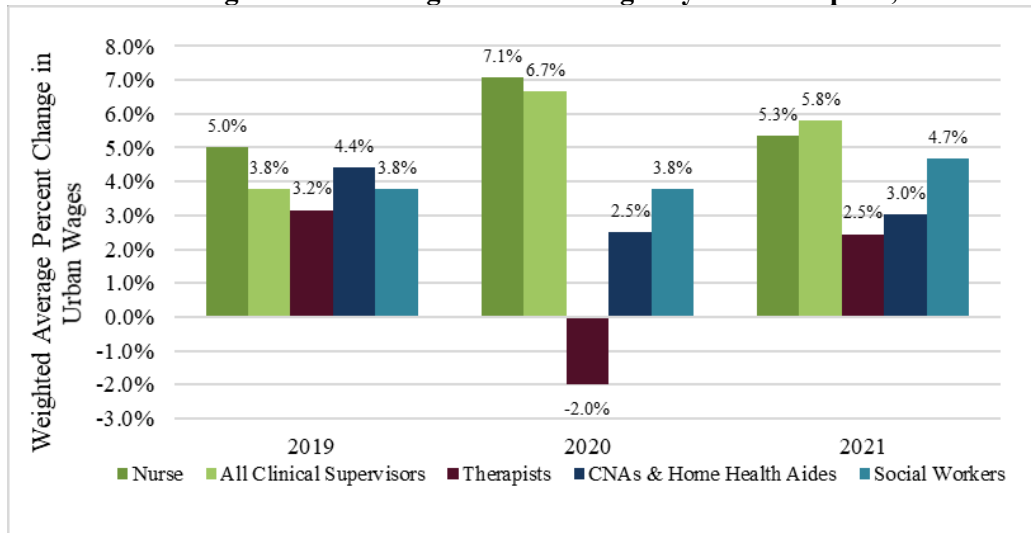
¹² Note that we defined urban areas as counties that are part of Metropolitan Statistical Areas (MSAs).

Survey Results and Discussion

Wages for Home Health Staff in Urban Areas by Discipline

The observed reduction in the average weighted percent increase in wages for home health staff in urban areas in 2020 is likely primarily driven by the decline in wages for therapy professions (which declined by 2.0% from 2019 to 2020 as shown below). The observed decrease in wages for therapy professions in 2020 is likely a result of the change in payment system away from one which incentivized therapy utilization to one which does not. Wages for nurses and clinical supervisors increased at a higher rate in 2020 compared to 2019. Wages for social workers increased at the same rate in 2020 as in 2019, while wages for CNAs and home health aides increased at a lower rate in 2020 as compared to 2019. Wages for HHA staff in urban areas are estimated to increase in 2021 for all disciplines.

Exhibit 2: Average Percent Change in Urban Wages by Staff Discipline, 2019-2021



Survey Results and Discussion

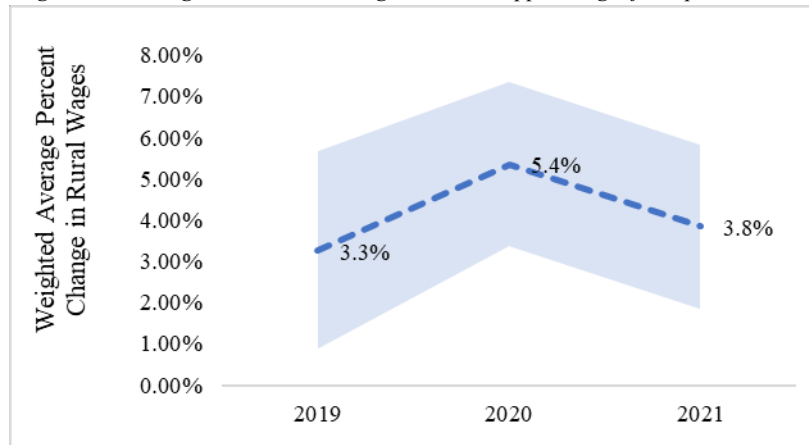
Wages for Home Health Staff in Rural¹³ Areas

Exhibit 3 shows the average weighted overall percent change in wages for field staff and clinical supervisors in rural areas from 2019 to 2021.

In contrast to trends in wages for home health staff in urban areas, wages for home health staff in rural areas increased at a higher rate in 2020 than they did in 2019. Rural HHA wages are expected to continue to increase in 2021, although the rate of increase is estimated to be lower than observed in 2020. Wages for HHA staff in rural areas increased by 3.3% in 2019, 5.4% in 2020, and 3.8% in 2021, as shown below.

Exhibit 3: Average Percent Change in Rural Wages for Field Staff and Clinical Supervisors, 2019-2021

Light blue shading indicates the average lower and upper ranges for reported values



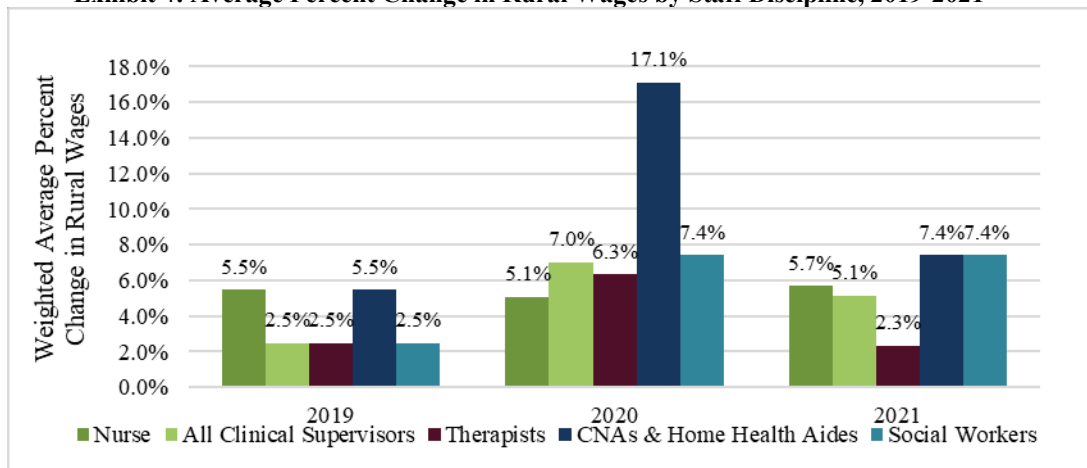
¹³ Rural areas are defined as counties that are not part of a Metropolitan Statistical Area (MSA).

Survey Results and Discussion

Wages for Home Health Staff in Rural Areas by Discipline

The observed increase in the average weighted percent change in wages for home health staff in rural areas in 2020 is likely primarily driven by the increase in wages of rural certified nursing assistants and home health aides which increased by 17.1% in 2020 as shown in **Exhibit 4**. Wages for all home health disciplines in rural areas increased at a higher rate in 2020 compared to 2019 except for nurses. Further, wages for all home health disciplines are estimated to continue to increase in 2021. Although, the estimated wage increases for therapists in 2021 are much lower than 2020.

Exhibit 4: Average Percent Change in Rural Wages by Staff Discipline, 2019-2021



Additional responses by participating PQHH members indicated that wages for field staff and clinical supervisors are expected to increase at a faster rate in 2022 than they did in 2021. Responses indicated that increasing competition for clinical staff, particularly nurses, would be a driving force for wage increases, especially as hospitals are able to pay higher salaries for nurses than home health agencies and the ongoing national shortage of nurses continues.¹⁴

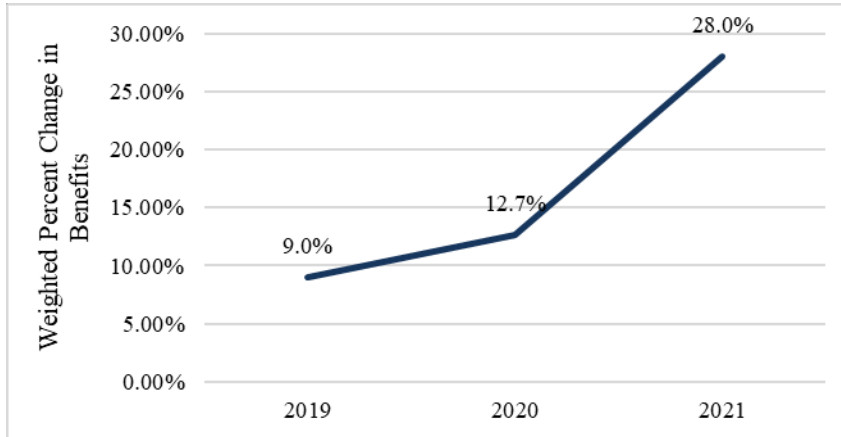
¹⁴ <https://pittsburgh.cbslocal.com/2021/08/23/local-hospitals-offer-big-sign-on-bonuses-amid-nursing-shortage/>

Survey Results and Discussion

Benefits

Exhibit 5 shows the weighted average percent change in benefits expenses. As shown below, benefits costs increased in 2020 compared to 2019. Benefits expenses are expected to continue to increase by 28.0% in 2021—more than twice the rate of increase in 2020.

Exhibit 5: Average Percent Change in Benefits, 2020-2021



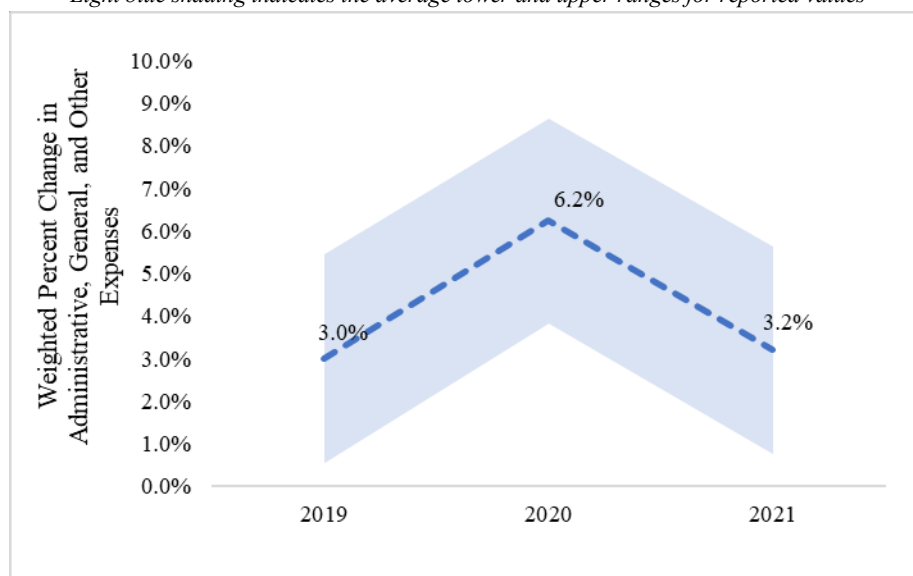
Survey Results and Discussion

Administrative, General and Other Expenses

Exhibit 6 shows the average weighted percent change in administrative, general, and other expenses from 2019 to 2021 for PQHH members operating in both urban and rural areas. We defined administrative, general, and other expenses as expenses related to administrative support, financial services, medical supplies, rubber and plastics, telephone, professional fees, other products, and other services. As shown, the average percent increase in administrative, general and other expenses more than doubled in 2020—6.2% in 2020 compared to 3.0% in 2019—coinciding with COVID-19-related increases observed in the literature. In 2021, administrative, general, and other expenses are expected to increase at a rate almost comparable although slightly higher than increases before the COVID-19 pandemic in 2019.

Exhibit 6: Average Percent Change in Administrative, General, and Other Expenses, 2019-2021

Light blue shading indicates the average lower and upper ranges for reported values



PQHH agencies indicated that they face a number of pressures in the current environment for recruiting home health labor. Most significantly, losing potential candidates to higher paying healthcare jobs was cited as the most prevalent pressure reported by the agencies. Losing potential candidates to other healthcare sectors due to safety concerns was the second most frequently cited reason by home health agencies. Current literature supports these findings.¹⁵

¹⁵ Porter, K., Hunter, M., Mulmule, N., & Tyler, D. (2021, May 31). *COVID-19 intensifies home Care WORKFORCE Challenges: Policy Perspectives ISSUE BRIEF*. ASPE: Office of the Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/reports/covid-19-intensifies-home-care-workforce-challenges-policy-perspectives-issue-brief>; Bhandari, N., Batra, K., Upadhyay, S., & Cochran, C. (2021). Impact of

Survey Results and Discussion

Limitations

- These responses reflect providers' best estimates and their interpretation of the questions. As such, accuracy and consistency of the responses may vary.
- Given the survey's quick turnaround, agencies may have been limited in the extent to which they could complete the survey.
- The sample size is limited as some providers could not participate.
- For these reasons, the results should be taken as correct in terms of direction and magnitude, but the actual numbers may be different in future analyses.
- The respondents who participated operate in different geographical areas and manners, thus any averaged or aggregated data may not necessarily be indicative of activities in all or particular areas within the United States.

Conclusion

The results of this survey indicate that labor costs and other associated home health industry expenses rose significantly between 2019 and 2021, yet these increases aren't adequately accounted for in current market basket updates. Instead, the HH PPS market basket update factors declined from 2.9 in CY 2020 to 2.4 in CY 2022. These results suggest that the current proxies for price inflation that CMS uses do not reflect trends in the home health industry, perhaps because they measure inflation across the broader healthcare industry.

Further analyses showed that these cost increases from the survey data translate into a market basket update factor that should have increased by 1.1 percentage points between CY 2019 and CY 2020 and by 1.2 percentage points between CY 2020 and CY 2021. While results from this survey provide data to derive a counterfactual market basket based on only the three top cost categories, the observed upward trends in price increases across cost categories and the overall market basket indicate that the market basket should have remained flat or risen between CY 2019 to CY 2021 instead of the observed decline. For reference, the CMS HH PPS market basket update factors decreased by 0.1 percentage points between CY 2019 and CY 2020, and further decreased by 0.6 percentage points between CY 2020 to CY 2021

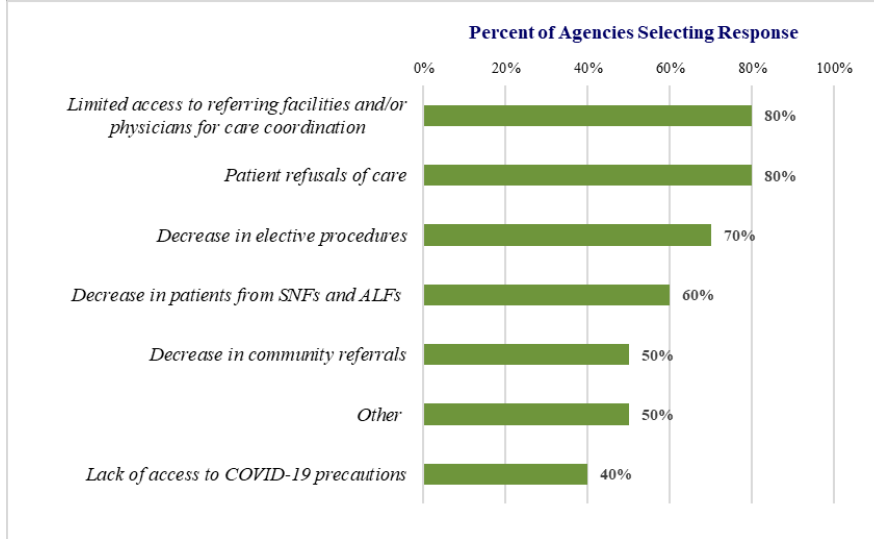
Overall, the results of this survey underscore the need for CMS to comprehensively assess all aspects of the HH PPS market basket derivation to ensure that it reasonably forecasts annual cost increases and that the price proxies accurately reflect trends in the home health industry.

Appendix

This appendix provides a summary of results from a selection of additional questions asked as part of the survey (for which we received a reportable number of responses).

Additionally, we asked questions pertaining to factors affecting geographic distribution of patient populations and percent of patients who experienced delayed starts of care due to shortage of staff, both of which resulted in fewer than five responses and are not tabulated in this report due to low sample reporting size.

Figure 1: Factors Affecting the Changes in the Number of 60-day Episodes or 30-day Periods Delivered by Home Health Agencies in CY 2020 as Compared to CY 2019



Note: PQHH Agencies were asked to select all that apply, thus totals will exceed 100.

Figure 2: Average Percent of Patient Population by Geographical Distribution

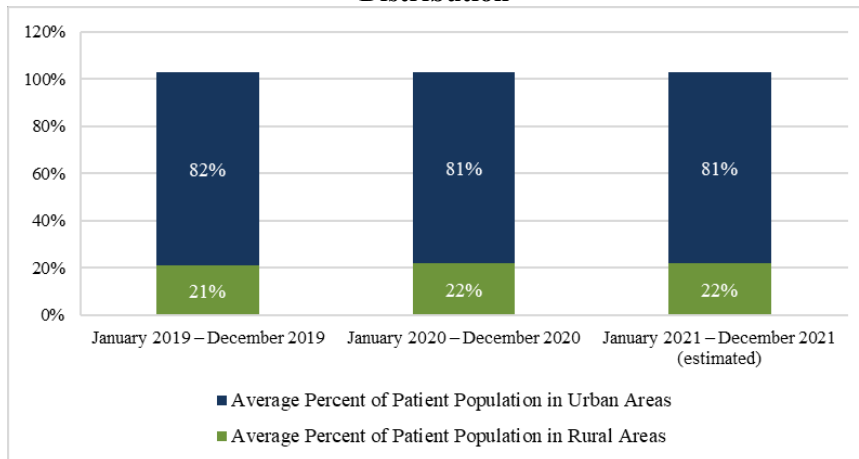


Figure 3: Average Percent of Full-Time Equivalent Field Staff and Clinical Supervisor Positions that were Terminated/Resigned or that were Filled

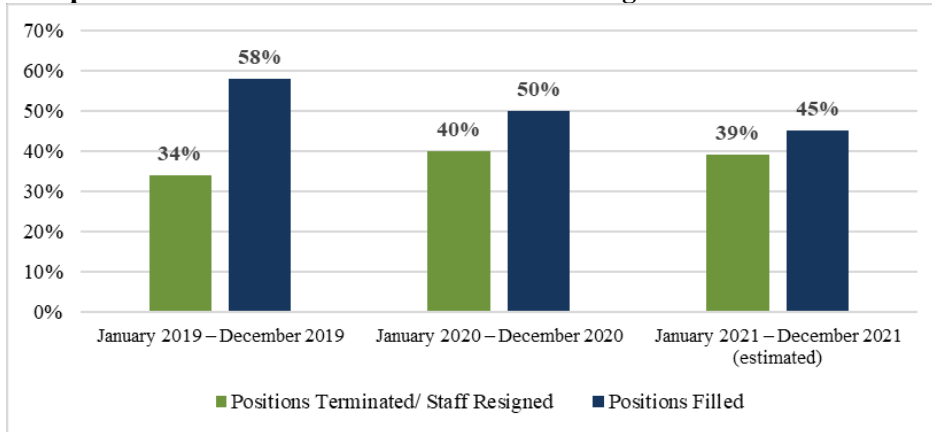
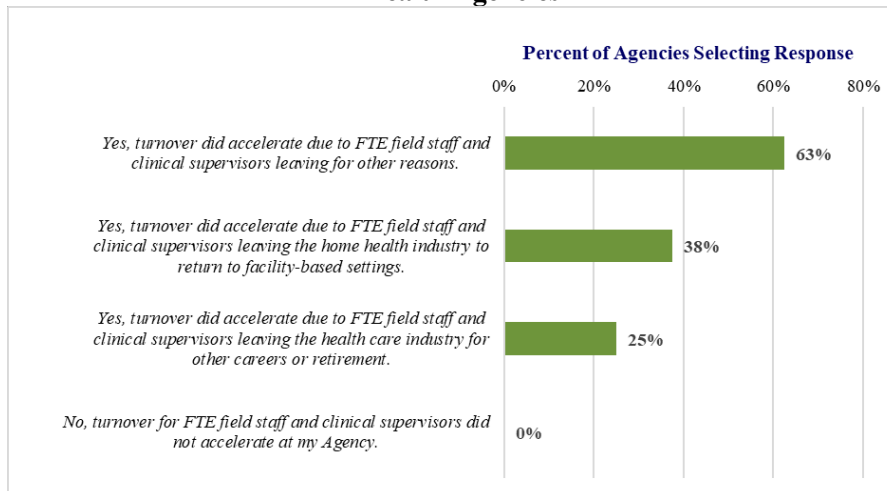
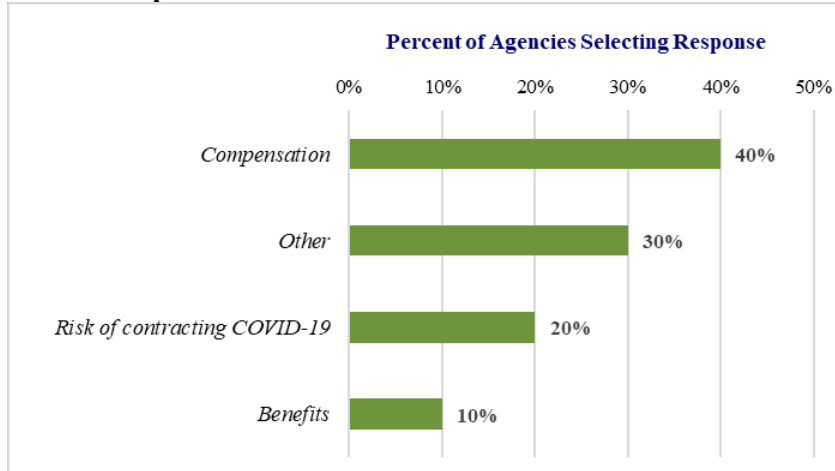


Figure 4: Reason for Turnover if Turnover for Full-Time Equivalent Field Staff and Clinical Supervisors Accelerated from CY 2019-2020 at Home Health Agencies



Note: PQHH Agencies were asked to select all that apply, thus totals will exceed 100.

Figure 5: Primary Reason if Full-Time Equivalent Field Staff and Clinical Supervisors Left for Other Healthcare Sector Jobs



Note: PQHH Agencies were asked to select all that apply, thus totals will exceed 100.

Figure 6: Average Percent of Full-Time Equivalent Field Staff and Clinical Supervisors

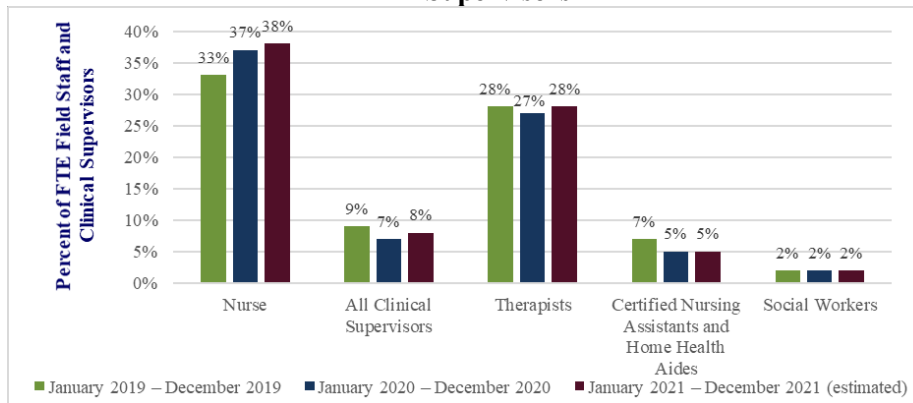


Figure 7: Average Percent of Visits Staffed by Full-Time Equivalent or Contract Field Staff and Clinical Supervisors

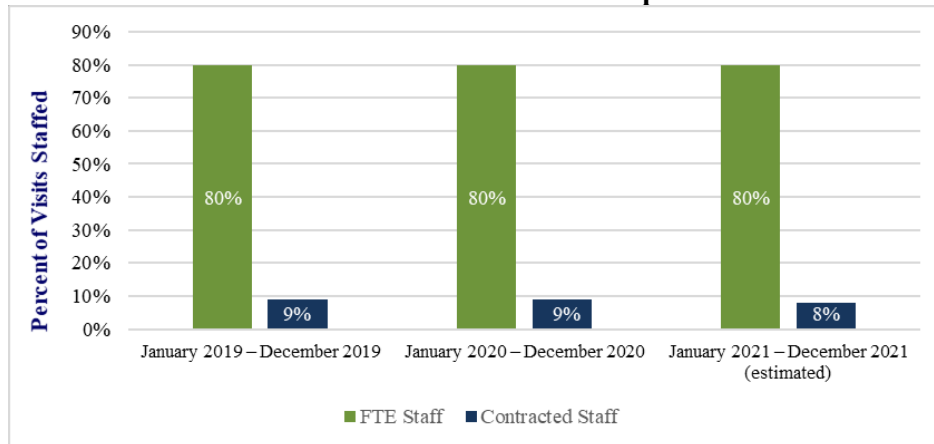
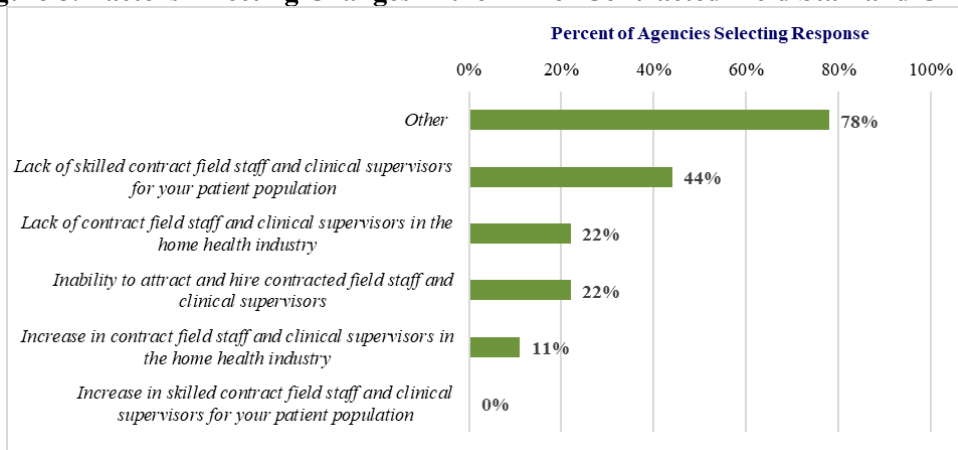


Figure 8: Factors Affecting Changes in the Mix of Contracted Field Staff and Clinical Supervisors



Note: PQHH Agencies were asked to select all that apply, thus totals will exceed 100.

Figure 9: Average Racial Distribution of Full-Time Equivalent Field Staff and Clinical Supervisors

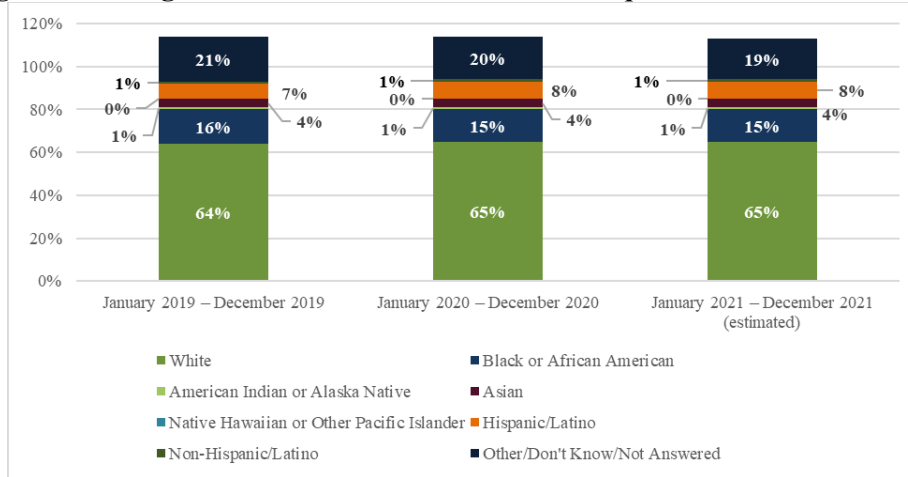


Figure 10: Average Portion of Full-Time Equivalent Field Staff and Clinical Supervisors by Gender Designation

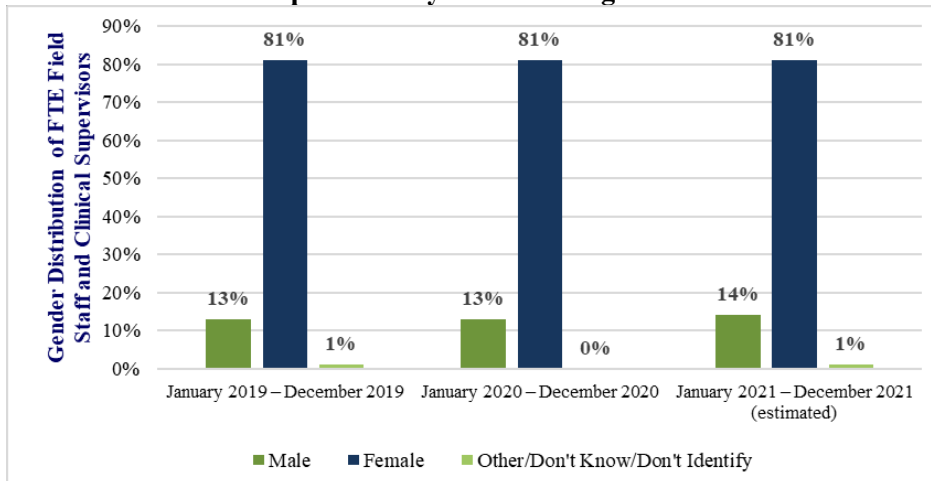


Figure 11: Average Age Distribution of Full-Time Equivalent Field Staff and Clinical Supervisors

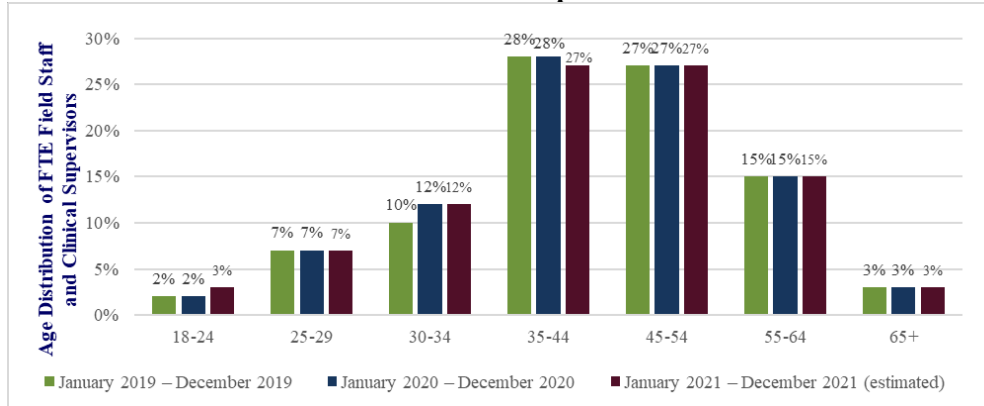


Figure 12: Average Payer Mix of Responding Member Agencies

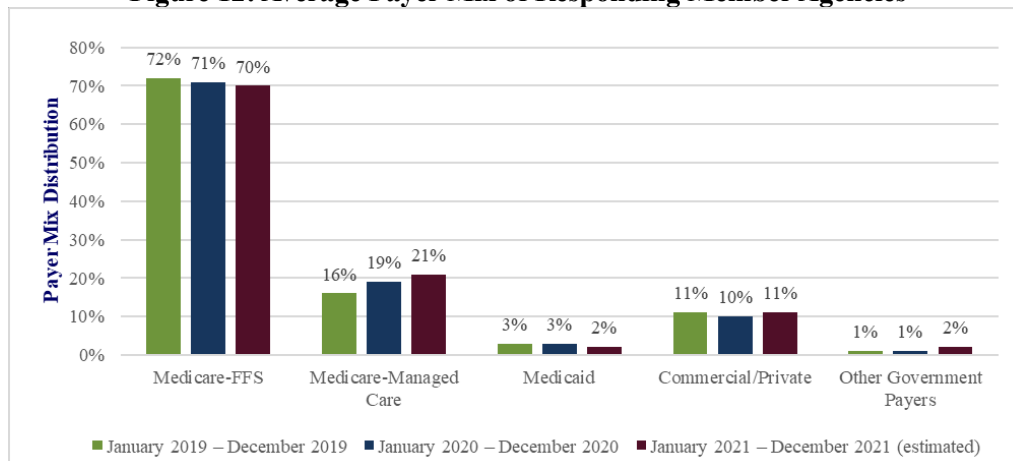


Figure 13: Percent of Unfilled Positions for Field Staff and Clinical Supervisors

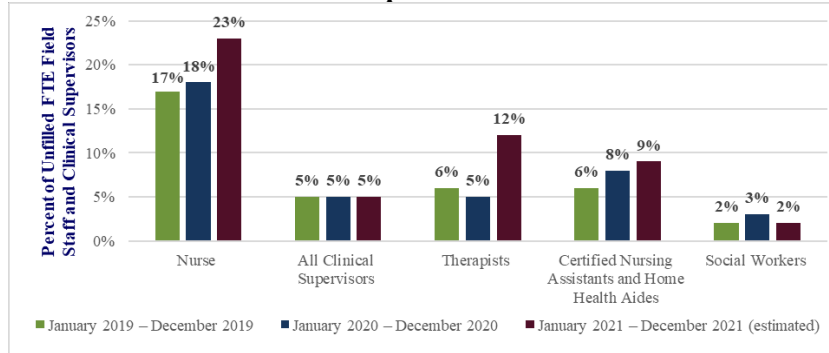


Figure 14: Percent of Annual Overtime Hours Relative to Base Salary

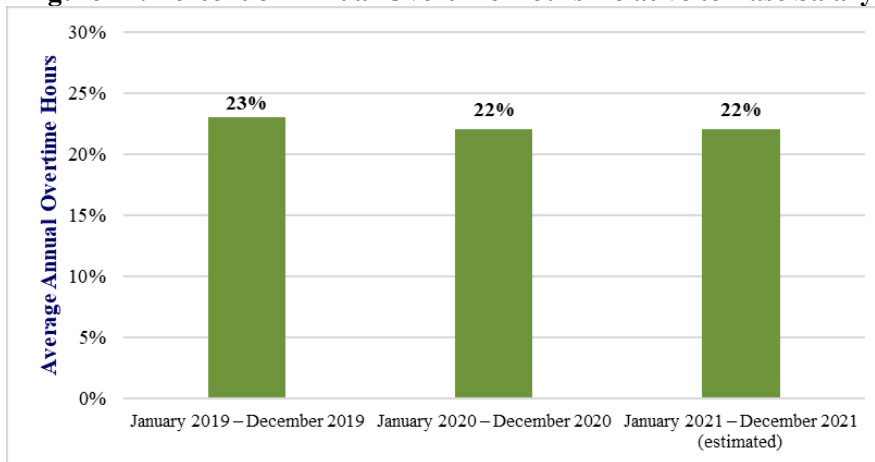


Figure 15: Average Number of Recruiters at Home Health Agencies

