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DEPARTMENT OF HUMAN SERVICES

Legislative Report

HCBS Labor Market Reporting 2022

Disability Services Division

March 2022

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Contents

I. Executive summary

This report delivers the findings of a survey about direct support professionals (DSPs) of home and community based services (HCBS) providers in 2021. This report fulfills the reporting requirement in Minnesota Statutes 2021, section 256B.4914, subdivision 10a, paragraph (g) through (i) and data collection requirement in Minnesota Statutes 2021, section 256B.4912, subdivision 1a.

The data collected includes most HCBS provider types and programs in Minnesota. We also collected broad data about direct support workers from financial management service providers (FMS) in the HCBS self-direction programs.

DHS collected data for calendar year 2020 during the spring and summer of 2021. Providers were given at least six weeks to submit their data, during which a statistically significant amount of providers responded. The information collected from each provider about their direct support professionals (DSP), included:

- Number of full- and part-time workers
- Wages
- Access to and cost of other benefits
- Retention and job vacancy.

Survey findings

We used stratified random sampling to identify the 315 organizations, which provide HCBS services, that completed the labor market survey. The 12,654 HCBS self-direction employers were represented by 11 FMS providers that submitted data for self-directed services. These respondents are representative across geographical regions and service types. The sample exceeded the necessary size for statistically significant results at a 95% confidence level with a 5% margin of error. All data collected was for the calendar year 2020.

Findings included:

- The majority of the workforce was part time, with 52% of DSPs in this market working part time and 48% working full time
- The statewide median starting wage was $14.32 for part-time workers and $13.50 for full-time workers
- Only 53% of workers were offered health insurance by their employer.

The findings of the survey indicate multiple challenges in the DSP labor market. The average wage for a DSP is lower than the wage considered adequate by the Minnesota Department of Employment and Economic Development (DEED) to meet basic needs. Data showed that 47% of the surveyed HCBS

providers did not offer health insurance to full-time DSPs. Turnover in the health care and social services industry reached 45%, nationally. Additional data collection will increase the understanding of the DSP workforce in Minnesota. Additional study and reporting about the health of the direct support labor market is critical for informing and monitoring future legislative investments in this workforce.

II. Legislation

Minnesota Statutes 2021, section 256B.4914, subdivision 10a, paragraph (g) through (i) requires DHS to take theses actions and submit a report on the findings:

> (g) Providers enrolled to provide services with rates determined under section 256B.4914, subdivision 3, shall submit labor market data to the commissioner annually on or before November 1, including but not limited to:
>
> (1) number of direct care staff;
> (2) wages of direct care staff;
> (3) overtime wages of direct care staff;
> (4) hours worked by direct care staff;
> (5) overtime hours worked by direct care staff;
> (6) benefits provided to direct care staff;
> (7) direct care staff job vacancies; and
> (8) direct care staff retention rates.
>
> (h) The commissioner shall publish annual reports on provider and state-level labor market data, including but not limited to the data obtained under paragraph (g).
>
> (i) The commissioner may temporarily suspend payments to the provider if data requested under paragraph (g) is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

Minnesota Statutes 2021, section 256B.4912, subdivision 1a requires the DHS to take of these actions and analyze the findings:

Subd. 1a. **Annual labor market reporting**.

> (a) As determined by the commissioner, a provider of home and community-based services for the elderly under chapter 256S and section 256B.0913, home and community-based services for people with developmental disabilities under section 256B.092, and home and community-based services for people with disabilities under section 256B.49 shall submit data to the commissioner on the following:
>
> (1) number of direct-care staff;
> (2) wages of direct-care staff;
> (3) hours worked by direct-care staff;
> (4) overtime wages of direct-care staff;
> (5) overtime hours worked by direct-care staff;
> (6) benefits paid and accrued by direct-care staff;

(7) direct-care staff retention rates;
(8) direct-care staff job vacancies;
(9) amount of travel time paid;
(10) program vacancy rates; and
(11) other related data requested by the commissioner.

(b) The commissioner may adjust reporting requirements for a self-employed direct-care staff.

(c) For the purposes of this subdivision, "direct-care staff" means employees, including self-employed individuals and individuals directly employed by a participant in a consumer-directed service delivery option, providing direct service provision to people receiving services under this section. Direct-care staff does not include executive, managerial, or administrative staff.

(d) This subdivision also applies to a provider of personal care assistance services under section 256B.0625, subdivision 19a; community first services and supports under section 256B.85; nursing services and home health services under section 256B.0625, subdivision 6a; home care nursing services under section 256B.0625, subdivision 7; or day training and habilitation services for residents of intermediate care facilities for persons with developmental disabilities under section 256B.501.

(e) This subdivision also applies to financial management services providers for participants who directly employ direct-care staff through consumer support grants under section 256.476; the personal care assistance choice program under section 256B.0657, subdivisions 18 to 20; community first services and supports under section 256B.85; and the consumer-directed community supports option available under the alternative care program, the brain injury waiver, the community alternative care waiver, the community access for disability inclusion waiver, the developmental disabilities waiver, the elderly waiver, and the Minnesota senior health option, except financial management services providers are not required to submit the data listed in paragraph (a), clauses (7) to (11).

(f) The commissioner shall ensure that data submitted under this subdivision is not duplicative of data submitted under any other section of this chapter or any other chapter.

(g) A provider shall submit the data annually on a date specified by the commissioner. The commissioner shall give a provider at least 30 calendar days to submit the data. If a provider fails to submit the requested data by the date specified by the commissioner, the commissioner may delay medical assistance reimbursement until the requested data is submitted.

(h) Individually identifiable data submitted to the commissioner in this section are considered private data on an individual, as defined by section 13.02, subdivision 12.

(i) The commissioner shall analyze data annually for workforce assessments and how the data impact service access.

III. Introduction

Older adults and people with disabilities in Minnesota rely on direct support professionals (DSPs) to help them with daily activities due to physical, cognitive, developmental, behavioral and/or chronic health concerns. DSPs do more than caretaking: The job also requires skills in relationship building, resource networking, communication, counseling, conflict resolution and building connections in the community. DSPs are expected to meet health, safety and care needs, while assisting their clients achieve personal goals. These goals can include finding and keeping employment, connecting with peers and becoming active community members. Survey data and personal stories show that DSPs in Minnesota earn low wages and have limited access to affordable benefits.

Without competitive wages and benefits, providers that employ DSPs are likely to lose them to other industries. Those employers may offer things like greater career advancement opportunities and a less demanding workload for equivalent, or greater, pay. This is a significant issue for policymakers because many of the organizations that provide services are reimbursed using rates set by the state.

The legislature required DHS to collect market-level information about the direct support workforce to help develop a greater understanding of the workers that support the people who use Minnesota's HCBS programs. Two distinct, but related, approaches were used to accurately collect this information.

- **2021 HCBS labor market survey**: This was a sample-based survey of direct support service providers in Minnesota HCBS programs. It yielded 315 complete surveys and represented a statistically significant sample of providers in the state.
- **2021 Self-direction reporting**: This was population-level data from FMS providers that fulfill financial tasks, billing and employer-related responsibilities for participant employers who self-direct their services. This effort yielded employer and employee data for more than 12,000 people who self-direct their services.

This report describes the findings of these efforts.

A. Information being collected

This part of the data focused on typical measures of labor market health, including wages, benefits and staff retention. DHS also collected other information to help produce a more complete analysis of the market. The following are examples of the type of information that was collected:

- Full-time and part-time employment of DSPs
- DSP wages
    - Regular and overtime
    - Service bucket specific

- Benefit access, costs and enrollment
    - Health insurance
    - Paid time off/sick/vacation
    - Other benefits
- DSP retention and job vacancy rates
- Organizational information
- Number of people served
- Revenues
- Regional location
- DSP supervisor wages, retention and direct care work
- Applicability of local ordinances (sick and safe time off, minimum wage, etc.)
- COVID-19-specific practices for employers and staff.

The 2020 workforce data also provided the unique opportunity to see if workforce or staffing practices were changed by the COVID-19 global pandemic.

B. Definitions

In order to collect consistent data about the direct support labor market, respondents were asked to utilize these definitions when answering survey questions.

Direct support professional (DSP)

An employee whose primary (greater than 50%) responsibilities include providing support, training, supervision and personal assistance to people with disabilities.

This does not include nurses and other licensed professional staff (LPN, RNs, licensed social workers, etc.). This also does not include staff who do not provide direct support (e.g. cooks, janitors, administrative staff, etc.).

Direct support professional supervisor (DSP supervisor)

Employees whose primary (greater than 50%) responsibility is the supervision of DSPs. These individuals may perform direct support tasks, but their primary duty is to supervise employees and manage programs. These individuals may or may not be licensed.

Regions

Counties were split into three different categories to help show differences across the state: metro, regional centers and greater Minnesota. Survey results were assigned to the provider based on the county of residence (COR) of the people they serve. For regional centers, data is drawn from the urban area and the surrounding county.

- **Metro**: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington
- **Regional centers**: Blue Earth (Mankato), Clay (Moorhead), Olmsted (Rochester), St. Louis (Duluth) and Stearns (St. Cloud)
- **Greater Minnesota**: All 65 remaining counties.

Full-time/part-time employment

Full-time employment includes anyone who typically (more than 50% of the time) works 40 hours per week, or more. Part-time employees include anyone who typically works 39 hours per week, or less.

Benefits

These benefits were included in cost reporting:

- Health insurance
- Dental insurance
- Vision insurance
- Life insurance
- Short-term disability
- Long-term disability
- Retirement
- Tuition reimbursement
- Wellness programs.

HCBS programs

The following HCBS programs, and all of the services included as part these programs, are included in this data:

- Alternative Care (AC) program
- Brain Injury (BI) Waiver
- Community Access for Disability Inclusion (CADI) Waiver
- Community Alternative Care (CAC) Waiver
- Developmental Disabilities (DD) Waiver
- Elderly Waiver (EW)

- Personal care assistance (PCA) services
- Consumer Support Grant (CSG) program.

HCBS service categories

Table 1 lists the HCBS programs included in this reporting, but by defined service bucket. All services under those programs are included in this reporting.

Table 1: HCBS services by service bucket

Service type/bucket	Services included
Day services	• Adult day care services • Family adult day care services (FADS) • Day training and habilitation • Prevocational services • Structured day
PCA services	• Personal care assistant • PCA, complex • PCA extended • PCA, complex extended
Residential services	• Customized living • Corporate foster care adult/child • Daily supported living service, adult/child corporate • Daily supported living service, family, adult/child • Residential care services
Self-directed services	• Consumer directed community supports (CDCS) • Consumer Support Grants (CSG)

Service type/bucket	Services included
Unit-based services	• 24-hour emergency assistance • Chore services • Crisis respite • Homemaker/assist personal care • Homemaker/cleaning • Housing access coordination • In-home family support • Independent living skills training • Independent living skills group therapy • Independent living skills individual therapy • Individualized home support • Individualized home support remote • Night supervision • Personal support/companion care • Positive supports • Respite – in home/out of home • Supported employment • Supported living services, adult/child • Supported living services, adult own home • Supported living services, adult/child corporate.

IV. Methodology

To evaluate the state of the direct support workforce we conducted this study in five steps:

- Development of data collection instruments
- Population and sample identification
- Survey administration
- Survey respondents and response rates
- Data analysis.

Because we took two distinct data collection actions, the following sections will discuss the development and execution of both efforts separately.

For the 2021 labor market survey, DHS hired a vendor to complete some of the survey development and administration work. We note all work done by the vendor in the methodology section.

A. Development of data collection instruments

Labor market survey

We reviewed previous surveys related to the direct support labor market. DHS collaborated with the vendor to develop survey questions based on existing survey instruments, as well as lessons learned and information collected from previous surveys. New questions were also developed to address emerging policy concerns, including the COVID-19 pandemic.

Once developed, the survey questions were presented to multiple provider working groups for review and feedback. The survey was updated to reflect this feedback and was reviewed.

Self-direction reporting

DHS reviewed survey questions with FMS providers to determine what data could be collected for participant-employers and self-direction DSPs. Policy and research staff developed questions similar to those on the HCBS survey and submitted those to the FMS providers. After reviewing the questions, providers provided feedback. Staff updated the instrument to reflect the feedback and then, reviewed it again.

Population and sample identification

Labor market survey

DHS and the vendor took several steps to identify HCBS providers that should be included in reporting because they employ direct support workers.

First, DHS analyzed all HCBS services that were billed in 2019. As a result, we identified more than 10,000 providers.

Then, the agency developed minimum inclusion criteria to narrow down the number of eligible providers to those that are likely to employ DSPs. This criterion was different for each major program and was established as follows:

- EW providers qualified if they were reimbursed at least $20,000 during 2019
- PCA providers qualified if they served at least 10 people in 2019
- DWRS providers qualified if they served at least six people and reimbursed at least $150,000 during 2019.

Some providers deliver both HCBS and non-HCBS medical assistance (MA) services. Some providers could separate out data for only HCBS services and revenues to be included in the survey sample. However, many providers reported they could not separate their DWRS-specific revenue and wages. We asked these providers to complete the survey with data for all direct support employees in their organization rather than just those who provide only DWRS services.

Based on the inclusion criteria and regional and program stratification, 1,721 organizations were eligible for the survey. Table 2 has more details on the eligible providers.

Table 2: 2021 eligible provider population by primary service type and region

Provider type	Greater Minnesota	Metro	Regional center
PCA	49	382	23
DWRS	386	459	147
EW	139	98	35

DHS randomly selected a sample of providers, from all of those that were identified, to complete the survey. A sample of 315 responses were needed to achieve a 95% confidence interval with a 5% margin of error. In addition, the sample must include at least 10 providers in each regional category to maintain equity among those groups during analysis. To meet these minimums, seven additional providers were added to the sample (five PCA providers in regional centers and two EW providers in regional centers). This increased the minimum number of responses to 325. Based on the assumed response rate, surveys were sent to 381 organizations. Table 3 shows the number of providers that returned the survey and were included in the sample group. Asterisks mark where providers were added to maintain power in analysis.

Table 3: Distribution of providers in the final sample

Provider type	Greater Minnesota	Metro	Regional center
PCA	11	85	10*
DWRS	83	99	32
EW	30	21	10*

During reporting, 21 providers were removed from the sample for several reasons, including closure and duplicate identification numbers. The final survey sample included 360 providers.

Self-direction reporting

DHS worked with FMS providers to collect de-identified employer and employee records. This meant survey sampling was not needed because all data was available directly.

DHS determined working directly with FMS providers to collect workforce data was an efficient way to collect information because all people who self-direct their services are required to utilize an FMS provider. Since these people act as the employer, this kept data collection efforts from burdening people that utilize supports through these programs.

Data collection administration

Labor market survey

The survey opened May 6, 2021, and closed June 30, 2021. The vendor used Snap Survey, a secure online survey platform, to administer the survey. Providers contacted the vendor if they needed assistance. The vendor held regular meetings with DHS to solve more in-depth issues that providers identified. DHS sent five reminders to complete the survey via email during the survey period.

Self-direction reporting

DHS sent a self-reporting template to FMS providers on May 21, 2021. The submission deadline was July 16, 2021. Data was collected with a spreadsheet workbook that providers completed and returned to DHS. This method was chosen due to provider feedback. Providers contacted DHS if they needed assistance. These FMS providers received four reminders to complete and return the workbook during the collection period.

Respondents and response rate

Labor market survey

The vendor received 315 completed surveys that were returned by the time the survey closed, following four weeks of extensions. This was an 87.5% response rate from the required providers, which meets the response goal of 315 for statistical significance.

These responses are representative and do not include all providers throughout the state.

Table 4: Survey respondents by program and region

Type	Greater Minnesota	Metro	Regional center	Total
PCA	73	73	9	155
DWRS	75	82	26	183
EW	23	15	8	46

Self-direction reporting

Submissions from FMS providers included 12,654 participant employers who employ 26,737 people. This data should include all FMS participant employers and workers that provide services through HCBS self-directed programs in Minnesota.

Data analysis

In almost all cases, DHS analyzed the results of the survey and self-direction reporting together. This allowed DHS to determine the number of full- and part-time employees, median wages and employee access to benefits, when possible.

The response rate for the survey was high, but many surveys were incomplete. As a result, several questions did not have enough data to analyze. The report will note where data from 2020 was not sufficient for analysis. DHS has taken measures to create a survey that will not allow partial submissions for future reports.

Due to this problem with survey responses, DHS analyzed all topics separately and did not use comparative analysis. However, DHS plans that future report data will allow for comparative analysis.

V. Survey findings

The combination of survey results and data collection shows that direct support professionals (DSPs) in HCBS service programs have relatively low wages and benefit access. These findings illustrate a labor market that does not offer competitive compensation compared to competing employers and remains in crisis. Results from each category will be reviewed in detail, below.

All data was from the 2020 calendar year. Survey results are representative of all regions and service types and have a 95% confidence interval with a 5% margin of error.

Data collected from 11 FMS providers includes all members of the self-directed workforce.

Size of the workforce

DHS estimates there are more than 100,000 HCBS DSP workers in Minnesota. Precise estimates are difficult because of the large number of providers and various definitions of a DSP.

A little more than 26,700 people are part of the HCBS self-direction workforce for the included services. It is possible to determine a more exact number of workers because all the data regarding these programs was collected.

Employment type

Statewide, 52% of DSPs were employed part time and 48% were employed full time. For these purposes, full time was defined as working 40 hours, or more, per week.

Table 5: Employment type by program

Service/type	Full time	Part time
Statewide	**48%**	**52%**
AC/EW	54%	46%
CAC/CADI/BI/DD	55%	45%
PCA	37%	63%
Self-direction	11%	88%

In many occupations, full-time workers have higher wages and greater access to benefits than part-time workers. Larger wage and benefit disparities between part- and full-time DSPs are more likely to occur in Minnesota because most of these people only work part time.

A. Direct support wages

Wages are commonly used as the measuring stick that determines job market health in a particular industry. This is no different for Minnesota's direct support workforce. In many cases, a lack of competitive wages will cause employers to lose people to other industries where they can get paid an equal, or better, wage, and enjoy greater advancement opportunities in a less demanding environment. Many DSP positions are low paying because they are considered entry-level jobs that require minimal qualifications. This issue is important for policymakers because many organizations that provide HCBS services are reimbursed utilizing rates set by the state.

Statewide median wage for full- and part-time workers

The starting median wage for a full-time direct support worker in Minnesota is $13.50 per hour. Full-time DSPs who have been with their employer for more than a year earn a median wage of $13.25 per hour. Part-time DSPs were paid a higher median wage than full-time workers, starting at $14.32 per hour. The median wage of workers with one year of employment is $14.00 per hour. These particular values average the median wages for all employment types, service location and service types.

DHS was unable to determine why median wages for part-time DSPs were higher than full-time workers or why the median starting wage for a DSP is higher than the median wage for employees with at least one year of experience. The unexpected results may indicate that wages for DSPs are rising quickly or that there is a problem with the data collected.

Regardless of the reason for the unexpected results, median wages are up when compared to data from previous reports. The average full-time wage among employees supporting the four disabilities waiver programs was $12.82 per hour in 2019. The result is a 3.4% increase from 2018 to 2020.

Table 6: Regular Hourly Wages

Category	Full-time starting wage	Full-time wage (more than one year experience)	Part-time starting wage	Part-time wage (more than one year experience)
Overall	**$13.50/hr.**	**$13.25/hr.**	**$14.32/hr.**	**$14.00/hr.**
PCA	$13.50/hr.	$13.06/hr.	$14.92/hr.	$14.25/hr.
CAC/CADI/BI/DD	$13.25/hr.	$13.25/hr.	$14.00/hr.	$13.91/hr.
AC/EW	$13.89/hr.	$13.50/hr.	$14.75/hr.	$14.00/hr.

Self-direction wages

Comparatively, self-direction workers saw much higher wages than traditional service providers. However, there was a wider range of wages being paid that may have led to a higher median wage. Full-time workers had a median wage of $17.27 per hour, while part-time workers (majority of workforce) had a median wage of $16.50 per hour. The data collection did not distinguish between wages for DSPs with no previous experience and those with more than one year of experience.

Wages by service type

Respondents to the survey may serve people through multiple service types and programs. Each service category, or collection of similar services, has at least one payment rate for services. Waiver categories may have more than one rate because of different rate methodologies used for different programs. Differences in reimbursement rates and service requirements may cause wage variations for direct support workers that perform several types of service. Sometimes this can result in different wages paid to DSPs working for the same employer. Table 7 shows the median part- and full-time wages for people with more than one year of experience, compared to DWRS wage assumptions and overall rate per hour.

Note: These wages may differ from median program wages because DHS did not ask providers to report the proportion of their business dedicated to each category of services. Self-direction data is not included here because rates and wages are not standardized, or controlled by the state.

Table 7: Wages by reported service type

Service type	Median full-time wage after one year	Median part-time wage after one year	Direct support worker wage component in DWRS rate with workforce factor ([1])
Day services	$13.50/hr.	$13.00/hr.	$16.02/hr.
Residential services	$14.68/hr.	$14.42/hr.	$14.17/hr.
Unit-based services ([2])	$14.00/hr.	$13.50/hr.	$12.85-$19.16/hr.
PCA services	$13.25/hr.	$13.00/hr.	N/A ([3])

Comparing DSP wages

To understand DSP wages relative to cost of living in the state, we compared wages to DEED's statewide cost of living([4]). This analysis determines the hourly wage needed to achieve simple living standards that meet a person's basic needs for health and safety. In 2020, the statewide basic needs wage was $18.85 per hour for a family of three, with two adults working full time. For a single adult, the basic needs wage was $15.85 per hour.

When the basic needs wage is compared to the median wages of part- and full-time DSPs there is a deficit as high as $5.35 per hour. The median DSP wage cannot sustain a person's basic needs in Minnesota because of this 39% deficit.

1 These wages include the 2020 direct care support worker base wages and the additional competitive workforce factor of 4.7%.

2 There are numerous rates for this service group. The wages and rates vary by each service.

3 A rate framework was passed in 2021 for this service, with a direct support worker wage component of $13.49. This rate is based on 2019 values, but was not in effect for this data collection.

4 DEED Cost of Living: https://mn.gov/deed/data/data-tools/col/.

Table 8: DSP wages to cost of living wages

Employment Type	DSP wage	Livable wage for single adult	Difference (%)	Livable wage for family of three with two working adults	Difference (%)
Full time	$13.50/hr.	$15.85/hr.	17%	$18.85/hr.	39%
Part time	$14.32/hr.	$15.85/hr.	11%	$18.85/hr.	32%

B. Direct support benefits

Sufficient benefits and accessibility to utilize them have a direct effect on retaining staff in the direct care industry. The benefits available to direct support workers vary from organization to organization, and may not be available through their employer. Part of the survey asked if a DSP's employer offered benefits, like paid time off, paid sick leave, paid vacation, health insurance and other benefits ([5]). This section summarizes DSPs access to employment benefits.

Self-direction DSPs are not included in this section because most participant employers do not offer benefits. However, participant employers may provide stipends or other funds to offset the cost for services that are included in traditional benefits packages, like health insurance.

Health insurance

Health insurance is one of the most costly benefits employers can offer, both for the organization and employee. Given the low wages of DSPs in HCBS programs, health insurance coverage can consume a large portion of earned wages. The survey found that 53% of providers offered health insurance to their DSPs. That means DSPs working for 47% of the state's providers do not have the opportunity to purchase health insurance through their employer. These percentages varied by program, with PCA services having the highest percent of employers offering health insurance.

5 In order to incorporate the current practices of all provider organizations, the survey included both paid time off, and paid sick/vacation time in the understanding that few to no organizations would be providing both.

Table 9: Providers that offer group health insurance for DSPs

Program	Health insurance offered	High deductible	Full coverage	Other plan types
Overall	**53%**	**35%**	**22%**	**15%**
PCA	57%	37%	25%	14%
CAC/CADI/BI/DD	53%	35%	20%	16%
AC/EW	50%	30%	26%	11%

Other benefits

Health insurance was the most frequently offered benefit, but some providers make other benefits available to their employees. However, the 46% of providers across all programs that do not offer benefits to DSPs is notably high. PCA service providers were most likely to offer a greater number of benefits, while EW/AC providers were most likely to offer the fewest benefits.

Table 10: DSP other benefits

Other benefits	Overall	PCA	CAC/CADI/BI/DD	EW/AC
Dental insurance	**39.8%**	44.5%	38.1%	38.1%
Vision insurance	**29.0%**	35.3%	26.0%	29.2%
Life insurance	**37.2%**	39.6%	36.3%	36.3%
Short-term disability	**27.8%**	28.5%	28.4%	24.2%
Long-term disability	**22.9%**	20.7%	23.5%	24.6%
Retirement benefits	**36.2%**	40.7%	35.7%	30.7%
Tuition reimbursement	**15.5%**	20.7%	14.6%	10.5%

Other benefits	Overall	PCA	CAC/CADI/BI/DD	EW/AC
Wellness programs	**12.9%**	10.3%	17.0%	2.8%
Other	**12.3%**	17.6%	12.0%	4.8%
None of the above	**46.3%**	38.8	48.5%	50.9%

Paid time off

Paid time off (PTO) is another benefit that a provider may offer to their DSPs. For the purpose of this report, PTO includes holiday pay, sick time, vacation time, and traditional PTO. Of all DSPs, 37% of full-time and 28% of part-time employees were offered some form of PTO.

Table 11: PTO for DSPs

Pay type	Full-time	Part-time
Overall	**37%**	**28%**
Holiday pay	53%	36%
Paid sick time	30%	19%
Vacation time	34%	23%
Traditional PTO	31%	33%

C. Direct support turnover and job vacancies

Workforce stability is critical to support older adults and people with disabilities that live independently to an adequate level. Turnover, the people that leave positions in a given year, and job vacancies, the number of positions that go un-filled, are two effective measures that help indicate the stability of a given workforce.

Due to the data collection issues mentioned in the methodology, DHS cannot report on vacancy rates or turnover for these particular programs. The discussion below is based on available state and national data.

Turnover

Turnover creates a variety of problems for providers. The costs of replacing a DSP can be high because of the time and effort to hire and train new employees. As a result, turnover impacts company performance negatively and reduces service quality. Turnover is an often used to determine the stability of a workforce because it means that employees are not staying in their positions long enough to develop the skills needed to perform their job duties in a proficient manner. High turnover can diminish the quality of service received by aging adult and people with disabilities due to less experienced and skilled employees.

Turnover rates in health care and social assistance in the United States, which includes direct support occupations, was 45% during the survey period. This is a significant increase from previous years, but may be due to factors other than workforce stability. Health care and its related fields were stressed to the breaking point during the COVID-19 pandemic. This caused a larger than expected number of people to leave health care. Within two years the current workforce will be completely replaced if current turnover rates continue.

Vacancy rates

High percentages of job vacancies indicate that there are not enough workers to fulfill the employment demand in a given industry. This means those who work that industry must attempt to complete the same amount of work that would be done by several people, otherwise. This can contribute to overworked employees and reduced productivity. During the period of this survey, the statewide job vacancy rate among all industries was 4.5%. The vacancy rate for positions similar to a DSP was 7.6%, nearly double the rate for all other types of employment.

High turnover and job vacancy rates indicate an unstable workforce. This means that employees that may not have the opportunity to master their individual position before they are pressured to take on additional duties. This cycle can lead to employee burnout and the loss of more DSPs from an already strained workforce.

D. DSP supervisors

In addition to direct support professionals, supervisors play an integral role in the success of the service systems for people with disabilities and older adults. They oversee the work of DSPs and often step in to fill gaps caused by staffing shortages. The model of supervision varies by provider, though broader measures of workforce stability could be applied. However, supervision wages were not available for 2020 due to data collection issues that were previously noted.

E. Additional self-direction workforce findings

The addition of direct support workforce data in 2021 allowed previously unavailable analysis to be performed. Greater than 26,700 Minnesota DSPs support more than 12,600 people live more independently using self-direction services. In these programs, people receiving services act as the employer for their direct support staff. They are responsible, in partnership with FMS providers, for setting and paying wages to staff members, directly. They can hire family members to provide their supports, however there are some limitations to when family are allowed to provide support.

Consumer directed community supports (CDCS) is the most utilized self-direction option. It can be used by people who are utilizing any of the four disability waivers and also can be used by people utilizing EW and AC. Currently, minors (younger than 18 years old) account for 32% of all CDCS users, while the remaining 68% are adults (18 years, and older).

Under CDCS, there are four types of supports available. Two services accounted for a majority of those provided by employees of participant employers. Personal assistance (help with activities of daily living and other person care) made up 60% of these situations while19% were treatment and training (training/skill building supports).

Paid family members

As mentioned, family members of a person who use these services can be hired to provide supports. The data shows 69% of all self-direction workers are paid family members, with most workers (65%) providing support to adults. In many cases, paid family members provided personal assistance supports.

F. Local ordinances

Outside of the normal labor market measures, the survey asked about other issues providers in the sample group had potentially faced. Local ordinances regarding minimum wage, sick time and safe time, which are set to go into effect in the near future, are the most pressing concerns currently.

Minimum wage

Minneapolis and St. Paul recently passed a $15 per hour minimum wage. Employers will need to gradually increase pay to reach the new minimum wage before within a specific timeframe. In Minneapolis, small business (less than 100 employees) will have until July 1, 2024, to comply with the higher minimum wage while larger businesses need to implement new pay structures in 2022. In St. Paul, small businesses (five to 99 employees) must meet the new standard by July 1, 2025, with larger businesses required to do so in 2023.

Currently, the median wage across the state is below the $15 minimum that continues to rollout in Minneapolis and St. Paul.

Table 12: Minneapolis and St. Paul $15/hour minimum wage implementation timeline

Date	Minneapolis large business (more than 100 employees)	St. Paul large business (100-9,999 employees)	Minneapolis small business (100 or fewer employees)	St. Paul small business (5-99 employees)	St. Paul micro business (5 or fewer employees)*
July 1, 2019	$12.25	---	$11.00	---	---
July 1, 2020	$13.25	$11.50	$11.75	$10.00	$9.25
July 1, 2021	$14.25	$12.50	$12.50	$11.00	$10.00
July 1, 2022	$15.00	$13.50	$13.50	$12.00	$10.75
July 1, 2023	City Rate	$15.00	$14.50	$13.00	$11.50
July 1, 2024	City Rate	City Rate	$15.00	$14.00	$12.25
July 1, 2025	City Rate	City Rate	City Rate	$15.00	$13.25
July 1, 2026	City Rate	City Rate	City Rate	City Rate	$14.25
July 1, 2027	City Rate	City Rate	City Rate	City Rate	$15.00

*Business size not applicable under Minneapolis wage ordinance

Sick and safe time

Similar to the minimum wage ordinances, Minneapolis, St. Paul and Duluth have all passed ordinances that require most employers to provide paid time off for employees. These rules went into effect between 2018 and 2020. These requirements have the potential to create more issues in the DSP labor market. The survey shows 22% of DSPs worked for an employer that is required to provide sick and safe time. It also showed that roughly one-third of all full-time DSPs, and more than half of part-time workers, didn't have access to paid time off (including sick, vacation or traditional PTO).

G. COVID-19

Throughout 2020, and into 2021, there were many questions about the pandemic's impact on the labor market. Data from 2020 provided the unique opportunity to understand how a public health emergency affected providers and DSPs. In general, we found that COVID-19 affected some decisions regarding the service workforce. However, provider organizations reported that the pandemic was not the primary reason for changes in the industry. As the pandemic continues, it is worth tracking changes in each of the topics discussed in this report to determine the pandemic's long-term impact on this workforce.

Note: Questions in our survey regarding COVID-19 practices allowed providers to check all that applied, so individual responses to the question may add up to a total greater than 100%.

Compensation for DSPs

The data suggest recent wage increases were not solely due to policy changes in response to the pandemic. Providers reported that most wage increases (55%) were due to unrelated rate changes, cost of living adjustments or to comply with local ordinances.

Many of the surveyed providers (about 46%) reported hiring and retention as the primary driver of wage increases. However, it is unclear if these situations were in response to the pre-pandemic workforce shortage or shortages caused by the pandemic. Regardless of cause, staffing shortages continue to be a major problem for this industry.

Temporary rate increases or hazard pay as a direct response to the COVID-19 pandemic was selected by 36% of the providers as a reason for higher DSP wages.

Many providers used, and continue to utilize, bonuses or other financial incentives to provide additional compensation for DSPs during the pandemic. Roughly 35% of new bonuses were reported as a direct response to the COVID-19 pandemic.

Table 13: Reasons for new DSP bonuses in 2020

New bonuses offered	Percent of providers that offered
Staff appreciation bonuses	22%
COVID-19 shift bonuses	18%
Hazard pay bonuses	17%
Retention bonuses	12%
Hiring bonuses	10%
Vaccination bonuses	4%
Other	4%
Profit-sharing bonuses	< 1%

Staffing changes

Throughout 2020, providers reported fairly consistent staffing from month to month. Nine months had a median number of 20 DSPs. The other three months (July, October and December) had a median number of 21 DSPs. Because all providers did not answer this question, this data could reflect only the experiences of the providers sampled. Large staffing fluctuations during 2020 may have signaled volatility in the workforce, however it appears to have been relatively stable throughout the year.

Despite the consistency seen in the workforce month-to-month during 2020, providers reported many reasons why staffing levels changed throughout the year. In this case, policy changes caused by the pandemic did seem to play a significant role behind changes that were reported.

Table 14: Reasons for staffing level changes in 2020

Reason	Percent of changes
COVID-19 staff leave	20%
Changes to comply with COVID-19 regulations	18%
Change in demand for services	17%
COVID-19 cases at facility	8%
Staffing costs	7%
Change in services offered	7%
Other	5%
Change in ownership (e.g., merger)	1%

VI. Conclusion

The HCBS labor market reporting provides a new and unique collection of data about the direct support labor market in Minnesota. Policymakers can track the health of the labor market year over year to get a better understanding of outcomes due to further investment or policy changes. The findings will add context for future conversations regarding benefit access and wages for DSPs. The data also may be useful in the broader discussion about the direct support workforce crisis in the United States.

During this first year of reporting, DHS learned how to engage providers and collect this information in a consistent and clear manner. In 2022, DHS will collect this data internally to provide a better experience for providers as they complete and submit responses for analysis.

Potential changes include:

- Revised survey instructions to provide clarity for all provider types
- Updated survey content based on provider feedback
- Additional trainings about labor market reporting.

DHS plans to continue tracking trends in the workforce in 2022, and beyond.