House Human Services Committee – Interim Charge 4

Interim Charge 4: *Examine the long-term services and support system of care in Texas. Study workforce challenges for both institutional and community services, with a focus on home- and community-based services in the state's STAR+PLUS program. Review what impact funding provided by the 86th Legislature to increase the base wage for community attendant services and the increased funding for rate enhancements have on workforce retention and quality. Consider options to both stabilize and expand the workforce. Review the long-term care programs and services available to Texas' seniors, including community alternatives to institutional care available through programs like the Program of All-Inclusive Care for the Elderly. Examine the adequacy of current funding mechanisms, including Medicaid reimbursement rates and supplemental or add-on payments, to incentivize high-quality care. Consider mechanisms to promote a stable, sustainable and quality-based long-term care system to address current and future needs of the state.*

Overview

Texas offers an array of programs and services that deliver long-term care in a facility or long-term services and supports (LTSS) in the community. Individuals receiving LTSS often need help performing daily living tasks, such as eating, bathing, or grooming, or other life activities like housekeeping, working, or pursuing hobbies. Some LTSS are performed by licensed medical professionals such as nurses or therapists, while others are provided by direct care staff without medical training.

Texans who have disabilities or are older have many options for services available—including choosing where and how they receive their LTSS. The goal is to ensure individuals have seamless access to services and supports in the most appropriate, least restrictive settings based on the needs of each person. Institutional care, services in a licensed Day Activity and Health Services (DAHS) facility, and care from an attendant with activities of daily living are available through the Medicaid program and are delivered in both fee-for-service or traditional Medicaid and in Medicaid managed care.

Institutional Care

Nursing Facilities

Nursing facilities provide services to meet the medical, nursing, and psychological needs of people who have a level of medical necessity requiring nursing care on a regular basis. Nursing facilities are paid a unit rate based on the individual needs of Medicaid-eligible residents and must provide services and activities that enable people residing in the facility to attain and maintain their highest feasible level of physical, mental, psychological, and social well-being.

Assisted Living Facilities

Assisted living facilities provide individualized health and personal care assistance in a homelike setting with an emphasis on personal dignity, autonomy, independence and privacy. Facilities can be large apartment-like settings or private residences. Services include meals, bathing, dressing, toileting and administering or supervising medication. HHSC licenses assisted living facilities based on residents' physical and mental ability to evacuate the facility in an emergency and whether nighttime attendance is necessary.

Intermediate Care Facilities

Intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/ IID) provide ongoing evaluation and individual program planning as well as 24-hour supervision, coordination, and integration of health or rehabilitative services to help individuals with an intellectual disability or related condition function to their greatest ability. ICF/IID residential settings vary in size from community settings serving six to 12 individuals (currently 98 percent of ICFs/IID) to large state supported living centers (SSLCs) serving several hundred.

LTSS Community Programs

Support for home- or community-based living is made possible through waivers, state plan services, the Promoting Independence (PI) Initiative or a combination of these.

State Plan Services

State plan services are available to Texans who have eligibility for the full array of Medicaid services. LTSS offered through the Medicaid state plan are Personal Assistance Services (also called Primary Home Care), Day Activity and Health Services, and Community First Choice. The Community Attendant Services (CAS)

program is a Medicaid program providing attendant services through the Medicaid state plan for individuals who are not otherwise eligible for Medicaid but meet specific financial and functional criteria.

Personal Assistance Services

Personal Assistance Services (PAS) provide assistance with activities of daily living, instrument activities of daily living, such as assistance shopping for groceries, and escort to medical appointments. PAS is delivered through the STAR+PLUS program. If adults in the STAR or traditional Medicaid program need PAS, the service, called Primary Home Care, is coordinated by HHSC case managers and delivered by providers contracted with HHSC.

Day Activity and Health Services

Day Activity and Health Services (DAHS) are delivered to adults over age 18 and provided at facilities licensed and certified by HHSC. Services include nursing and personal assistance services, physical rehabilitative services, nutrition services including meals or snacks, transportation to and from, and other supportive services including social activities. Except for holidays, these facilities must have services available at least 10 hours a day, Monday through Friday. DAHS are prescribed by a physician who certifies the individual has a need for DAHS because of an identified chronic medical condition.

Community First Choice

Community First Choice (CFC) provides certain services and supports to individuals living in the community who are enrolled in the Medicaid program and meet CFC eligibility requirements. Eligibility requirements are: Medicaid eligibility, meeting the level of care of an institution, and needing at least one CFC service. Services include:

- activities of daily living (eating, toileting, and grooming), activities related to living independently in the community, and health-related tasks (personal assistance services);
- Emergency Response Services (ERS), an electronic monitoring system that provides a way for people to signal for help;
- acquisition, maintenance, and enhancement of skills necessary for the individuals to care for themselves and to live independently in the community (habilitation);

- providing a backup system or ways to ensure continuity of services and supports (emergency response services);
- and training people how to select, manage and dismiss their own attendants (support management).

Note: The Federal Medical Assistance Percentages (FMAPs) help determine the amount of Federal matching funds for State expenditures for assistance payments for certain social services, and State medical and medical insurance expenditures. The CFC program provides a six-percentage point increase in the FMAP.

Home and Community Based Services

Home and Community-Based Services (HCBS) 1915(c) waivers allow states to provide home and community-based services as an alternative for people who meet eligibility criteria for care in an institution (nursing facility, ICF/IID, or hospital). Texas operates four 1915(c) waivers serving adults with disabilities. Texas also offers waiver-like programs for adults with disabilities and seniors in the STAR+PLUS Home and Community-based Services program and the Program for All Inclusive Care for the Elderly. A brief description of these programs and the services delivered are provided on the following pages.

Texas Medicaid Waivers		
Waiver	**Description**	**Services Covered**
Home and Community-based Services (HCS)	HCS provides individualized services to clients of all ages who qualify for ICF/IID level of care, yet live in their family's home, their own homes, or other settings in the community.	• Adaptive aids and minor home modifications • Medical supplies • Dental services • Nursing • Respite • Professional therapies* • Employment assistance and supported employment • Day habilitation and residential services • Supported home living • Transportation • Transition assistance services

Community Living Assistance and Support Services (CLASS)	CLASS provides home and community-based services to clients who have a related condition diagnosis qualifying them for placement in an ICF/ IID. A related condition is a disability other than an intellectual or development disability, which originates before age 22 and which substantially limits life activity.	• Adaptive aids and minor home modifications • Medical supplies • Dental services • Nursing • Respite • Professional therapies* • Employment assistance and supported employment • Case management • Prevocational services • Residential habilitation transportation • Prescriptions • Support family services • Transition assistance services
Texas Home Living (TxHmL)	TxHmL provides selected services and supports for people with intellectual developmental disabilities who live in their own homes or their family's homes.	• Adaptive aids and minor home modifications • Medical supplies • Dental services • Nursing • Respite • Professional therapies* • Employment assistance and supported employment • Behavioral support • Community support • Transportation • Day habilitation

Deaf, Blind with Multiple Disabilities (DBMD)	DBMD provides home and community-based services as an alternative to residing in an ICF/IID to people of all ages who are deaf, blind or have a condition that will result in deaf-blindness and have additional disabilities.	• Adaptive aids and minor home modifications • Medical supplies • Dental services • Nursing • Respite • Professional therapies* • Employment assistance and supported employment • Case management • Day habilitation • Residential habilitation transportation • Assisted living • Prescriptions • Audiology services • Dietary services • Behavioral support • Intervener

*Professional Therapies may include: physical therapy, occupational therapy, speech and language pathology, audiology, social work, behavioral support, dietary services, and cognitive rehabilitation therapy.

STAR+PLUS Home and Community-Based Services Program

The STAR+PLUS Home and Community-Based Services (HCBS) program provides enhanced LTSS as a cost-effective alternative to living in a nursing facility to clients who are elderly or who have disabilities. To be eligible for STAR+PLUS HCBS, a member must be age 21 and older, meet income and resource requirements for Medicaid nursing facility care, and receive a determination from HHSC that they meet the medical necessity criteria to be in a nursing facility. This program delivers services to members statewide enrolled in the STAR+PLUS or the Dual Demonstration program. The Dual Demonstration is a fully integrated managed care model for individuals age 21 and older who are dually eligible for Medicare and Medicaid and required to be enrolled in the STAR+PLUS. Members receive their acute care services through Medicare or their STAR+PLUS managed care organization. STAR+PLUS HCBS services include:

- Personal assistance services (delivered through the CFC program to maximize federal funding)
- Adaptive aids
- Adult foster care home services
- Assisted living
- Emergency response services (delivered through the CFC program to maximize federal funding)
- Home delivered meals
- Medical supplies
- Minor home modifications
- Nursing services
- Respite care
- Therapies (occupational, physical, and speech-language)
- Transitional assistance services

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a comprehensive care approach providing an array of services for a capitated monthly fee below the cost of comparable institutional care. PACE participants must be age 55 and older, live in a PACE service area, qualify for nursing facility level of care, and be able to live safely in the community at the time of enrollment. PACE participants receive all medical and social services they need through their PACE provider.

PACE offers all health-related services for a participant, including inpatient and outpatient medical care, specialty services (e.g., dentistry, podiatry, physical therapy, and occupational therapy), social services, in-home care, meals, transportation, and day activity services.

PACE is available in Amarillo/Canyon, El Paso, and Lubbock. Individuals in these service areas who are also eligible for STAR+PLUS may choose to receive services either through STAR+PLUS or PACE, but not both.

Workforce Challenges

State Supported Living Centers

During fiscal year 2020, HHSC continued to improve recruitment and retention of staff across all SSLCs, though the impact of COVID-19 on retention efforts is not yet fully known.

The 86th Legislature appropriated $9,788,796 to SSLC recruitment and retention efforts, which provided market rate increases for direct care positions at SSLCs with the highest vacancy and turnover rates: San Angelo, Abilene, Corpus Christi, Lubbock, and San Antonio. Seven other centers (Austin, Brenham, Denton, Lufkin, Mexia, Richmond, Rio Grande) did not receive these market rate increases. In fiscal year 2020, the entire SSLC system saw an 8 percent decrease in Direct Support Professional (DSP) turnover: 60.5 percent in fiscal year 2019, compared to 52.5 percent (annualized through May 31) for fiscal year 2020. However, the SSLCs that received pay raises saw an averaged reduction in turnover rate of 17.4 percent. Those that did not receive pay raises averaged a 5 percent turnover rate reduction.

Other strategies to improve recruitment and retention at the SSLCs include:

- Improving communication with front-line staff through mass text-messaging services and more easily accessible newsletters.
- Establishing retention specialists at each center.
- Finding ways to streamline the new employee orientation process to ensure well-prepared staff can start work as quickly as possible.
- Examining and managing staff deployment and overtime to prevent staff burnout.
- Forming a division-wide retention workgroup to come up with best-practice solutions for employee retention at the SSLCs and state hospitals.
- Conducting staff “Think Tanks” at SSLCs to hear feedback from staff on operational changes and suggestions to improve workflow to allow staff to work smarter, not harder.

Based on historical data and findings from fiscal year 2020, the SSLCs recommend the following measures to continue to reduce turnover and vacancy rates:

- Target nursing recruitment and retention in fiscal year 2021 to reduce contract labor costs and increase fill rates for Licensed Vocation Nurse (LVN) and Registered Nurse (RN) positions. SSLCs should examine nurse market rates for these positions and adjust as necessary. SSLCs should also consider

targeted recruitment bonuses for LVNs given the relative success of the DSP recruitment bonuses in San Angelo in fiscal year 2019.

- Examine feedback and recommendations from the "Think Tank" sessions for nursing positions and implement operational changes to increase efficiency and job satisfaction.
- Continue to expand the role of retention specialists at SSLCs, measuring their success along the way, and consider whether similar positions dedicated to nursing would be beneficial.
- Create a comprehensive strategic plan on culture change and staff retention including training for managers and supervisors, ways to promote a culture of positivity and ownership, as well as ways to increase staff satisfaction and morale.
- Continue to explore strategies to ensure equitable race, ethnicity, and gender representation in leadership and management roles at the SSLCs.
- Continue to work to streamline new employee orientation to ensure staff receive the right level of training at the right time.

Community Attendants

Background

An attendant is a person who assists people with their personal care and household tasks, also known as activities of daily living (ADLs) and instrumental ADLs (IADLs). For most programs, an attendant must be at least 18 years of age, have a high school diploma or General Educational Development certificate, and not be the person's primary caregiver or spouse. There are exceptions or additional requirements in some services and programs. An attendant may be employed by a provider agency or directly by the person (or their representative). Additional terminology often utilized to reference attendants is habilitation staff or worker, direct care staff or workers, personal care attendants or assistants, home health aides, or community attendants. While nursing facilities have certified nurse aides who assist with ADLs, they are not considered attendants.

Attendant services are non-technical, medically related personal care services that are available to eligible adults and children whose health problems cause them to be functionally limited in performing ADLs or IADLs according to a practitioner's statement of medical need.

ADLs	IADLs

• Ambulation, which includes:
  ▸ helping a person move from one position to another, such as:
  ◊ standing up
  ◊ getting out of bed
  ◊ walking
• Feeding
• Dressing, which may include:
  ▸ selecting appropriate clothes
  ▸ bathing
  ▸ other personal hygiene, such as:
  ◊ helping a person brush their teeth
  ◊ providing nail and hair care
• Toileting, which can include:
  ▸ helping a person use the toilet
  ▸ cleaning after using the toilet
  ▸ changing incontinence briefs
	• Transportation, which can include:
	  ▸ grocery shopping
	  ▸ accompanying a person to events and activities such as:
	  ◊ doctor's appointments
	  ◊ organizing transportation
	• Meal Preparation
	• Light House Cleaning
	  ▸ (no supplies are brought to the home by an attendant)
	• Laundry

In some instances, ADLs/IADLs may also include helping a person with their medications. This help only includes activities in which the person can personally manage their medications, but he or she requires assistance with activities such as opening containers, gathering the supplies, etc. Attendant services in some programs may also include assisting the person with communication.

Habilitation services are attendant services designed to help people with intellectual and/or developmental disabilities (IDD) learn to perform ADLs and IADLs independently. An example of a habilitation ADL is when an attendant teaches the person to cook (including meal planning) and shop.

The Medicaid programs and services offering attendant services are listed below. Appendix A has additional information on each program or service.

- CFC
- CLASS waiver
- Consumer Managed Personal Attendant Services (CMPAS)
- DBMD waiver
- Family Care (FC) and CAS
- HCS waiver
- TxHmL waiver
- STAR Kids
- STAR Kids Medically Dependent Children Program (MDCP)
- STAR+PLUS

The following residential and facility-based programs and services also assist with ADLs and IADLs as an integral part of their programs or services. They use attendants to provide this assistance.

- DAHS
- DBMD Day Habilitation (Day Hab) and Assisted Living Services
- HCS Day Hab and Supervised Living/Residential Support Services (SL/RSS)
- ICF/IID
- Residential Care (RC)
- TxHmL Day Hab
- STAR Kids Adult Day Care
- STAR+PLUS Assisted Living/Residential Care (AL/RC)

Most attendant services are delivered by provider agencies; however, some people may choose to receive services through the Consumer Directed Services (CDS) Option. CDS is a service delivery option that allows a person to self-direct all aspects of the service. The person employs the staff providing their services and performs all the employer activities: choosing and hiring staff, determining salaries and work schedules, paying staff benefits or bonuses, etc. A person who chooses the CDS Option chooses a CDS Agency to provide financial management support services to the CDS employer, including payroll functions, submitting payroll taxes, and billing HHSC for services. Appendix A includes a list of attendant services available through the CDS Option.

Over 300,000 people receive community attendant services through LTSS programs and services in Texas. Qualified, experienced, and reliable attendants provide vital services that enable a person to thrive in a community-based setting. Appendix B includes a breakdown, by program and service, of the number of people who receive community attendant services.

Provider agencies and CDS employers face challenges in recruiting and retaining attendant staff. This problem is not exclusive to Texas but is rather a nationwide issue at the forefront of the provider industry for people receiving these services, their families, and state legislatures. Given that in many regions an attendant can earn more money working in other industries, provider agencies and CDS employers have increased competition for high-caliber staff in the job market. To recruit new attendants or retain experienced and reliable employees, employers must pay higher wages or offer benefits or bonuses to attendants. HHSC administered a survey to CDS providers and a summary of this survey will be available in the report required by the 2020-21 General Appropriations Act (GAA), House Bill (HB) 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 157), which will be published by November 1, 2020.

Texas has taken steps to assist provider agencies and CDS employers in recruiting and retaining the staff necessary to provide the quality of service people require.

Rate Setting

HHSC calculates rates based on cost report data and pro forma modeling. HHSC collects cost data in periodic reports (either a cost report or accountability report) from providers to ensure adequate financial and statistical information is available to evaluate rates. HHSC collects each provider's cost data in cost reports. Beginning in 2018, HHSC began collecting cost reports on a biennial basis.

A participating provider in the rate enhancement program must submit accountability reports when they are not required to submit full cost reports. HHSC uses accountability reports to collect a provider's cost data on attendant services to determine compliance with Attendant Compensation Rate Enhancement (rate enhancement) spending requirements. Appendix C includes the schedule and timeline of the cost report process.

Cost reports are not required for all programs or all services within a program. When historical costs are unavailable, such as in the case of a new program, reimbursement may be based on a pro-forma approach. This approach uses historical costs of delivering similar services (where appropriate data is available) and estimates the basic types and costs of products and services necessary to deliver services that meet federal and state requirements. Appendix D includes a list of rate methodologies for attendant services.

Rate Increases

The Legislature appropriated funds for general increases in payment rates for many attendant services. These increases allow provider agencies to increase wages to attendants and other staff without negatively impacting the administrative costs that support the attendant services. Administrative costs may include building costs such as rent/mortgage and utilities, supplies such as gloves and masks, and office staff such as clerks/receptionists and case managers.

Most recently, the 2020-21 GAA, HB 1, 86th Legislature, 2019 (Article II, HHSC, Rider 44) appropriated funds to increase payment rates in the HCS program and ICF/IID facilities. Rider 44 designated that appropriations for HCS be spent on an increase in a factor related to facility-based services to benefit attendants, including directly through wages; the appropriations for ICFs/IID were exclusively for the benefit of attendants. Rider 44 also appropriated funds to fund the payment rates for all DBMD services, including the attendant services, per the rate methodology.

Attendant Base Wages

Currently, the federal minimum wage is $7.25 per hour. In most locations, this is inadequate to recruit and retain the attendants necessary to provide quality attendant services for Texans. As a result, provider agencies and CDS employers must offer higher wages and benefits. Provider agencies are limited by the amount they can use to increase attendant wages as they must meet minimum administrative costs related to their license or certification, despite the administrative portion of the payment rates. CDS employers have a maximum amount they can budget for attendant wages, benefits, and bonuses, and do not have any administrative funds they can use to increase attendant wages.

To give provider agencies and CDS employers the opportunity to increase attendant wages, the Legislature appropriated funds for increases in the base hourly wage for attendants.

Table 1. Minimum Attendant Wages, Effective Dates, and Legislation

Effective Date	Minimum Attendant Wage	Legislative Reference
9/1/2013	$7.50	2014-15 GAA, Senate Bill (SB) 1, 83rd Legislature, Regular Session, 2013 (Article II, Special Provisions Applicable to all Health and Human Services (HHS) Agencies, Sec. 61)

Effective Date	Minimum Attendant Wage	Legislative Reference
9/1/2014	$7.86	2014-15 GAA, SB 1, 83rd Legislature, Regular Session, 2013, (Article II, Special Provisions Applicable to all HHS Agencies, Sec. 61)
9/1/2015	$8.00	2016-17 GAA, HB 1, 84th Legislature, Regular Session, 2015 (Article II, Special Provisions Relating to all Health and Human Services Agencies, Sec. 47)
9/1/2019	$8.11	2020-21 GAA, HB 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 45)

HHSC will continue to provide the Legislature with relevant information as they evaluate potential rate increases to increase the minimum attendant wage.

Attendant Compensation Rate Enhancement

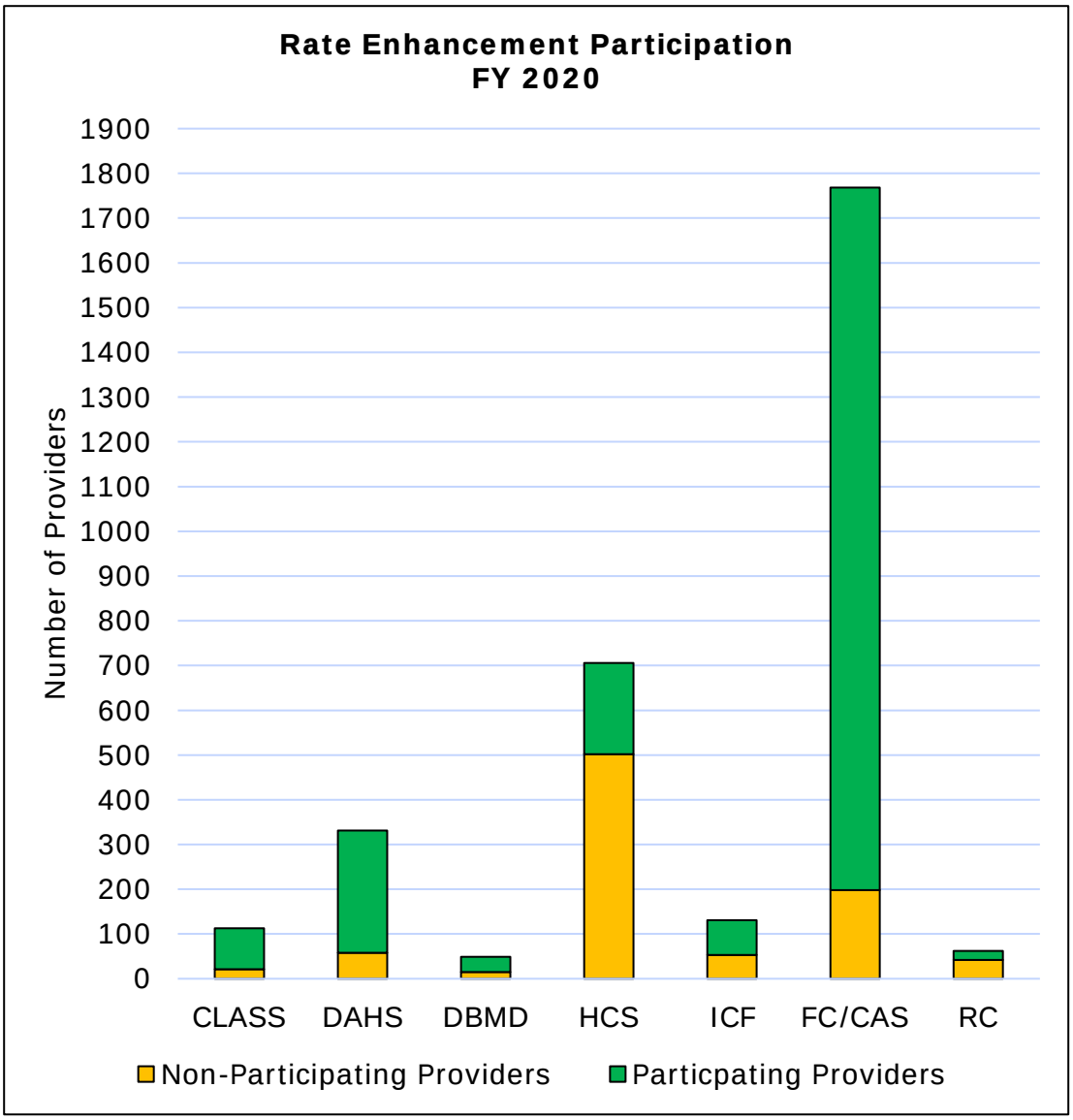
The Attendant Compensation Rate Enhancement Program (Rate Enhancement) is an optional program in which participating providers may receive additional payments to increase attendant compensation.

Attendant compensation is any payment that is passed directly to the attendant, (e.g., hourly wages, bonuses, benefits, mileage, etc.). When providers participate in the Rate Enhancement program, they agree to spend at least 90 percent of the attendant portion of the payment rate (including the additional payment) on attendant compensation. This rate enhancement gives provider agencies additional funds to hire and retain quality, reliable staff, and provide better services to people receiving attendant services.

When a provider agency chooses to participate in the Rate Enhancement program, they request a specific level (1–35, depending on the program) at which to participate, based on their spending abilities. Each level provides an additional $0.05 to the base rate for non-participating provider agencies until state fiscal year 2021. Participating provider agencies are awarded a participation level based on their requested level and available funding.

Participation in the Rate Enhancement program, which was initiated in fiscal year 2001, varies by program, and for fiscal year 2020, the percentage of participating fee-for-service (FFS) providers is presented in Chart 1.

Chart 1. Rate Enhancement Participation for Fiscal Year 2020



STAR+PLUS requires that providers have a rate enhancement program; however, they are free to design their programs as best fit their business models. Individual Managed Care Organizations have different rate enhancement programs. As a result, HHSC is unable to accurately determine the percentage of STAR+PLUS rate enhancement participation.

The 86th Legislature appropriated funds in Rider 45 to fund the Rate Enhancement program for the Community Care (CLASS, DAHS, DBMD, FC/CAS, and RC) and IDD (HCS/TxHmL and ICF/IID) programs.

In addition to the appropriations in Rider 45, the 86th Legislature also appropriated funds in Rider 44 to change the structure of the IDD Rate Enhancement program. The appropriations allow HHSC to create a new category in the Rate Enhancement program for HCS grouped by the type of billing unit.

The HCS Rate Enhancement program had two categories of rate enhancement prior to state fiscal year 2021: Day Habilitation and Non-Day Habilitation. The Non-Day Habilitation category includes both daily services (SL/RSS) and Non-Residential/Non-Day Habilitation services (SHL, Supported Employment, Employment Assistance, and Respite). SL/RSS providers must maintain staffing levels; therefore, they have multiple attendants for each billable unit of service. An hourly service has only one attendant per billable unit of service.

The appropriations in Rider 44 fund a third category in the HCS Rate Enhancement program. Effective September 1, 2020, there will be a Rate Enhancement category for Day Habilitation, SL/RSS, and Non-Residential services for state fiscal year 2021.

Currently, the add-on for the Rate Enhancement categories in HCS (Day Habilitation and Non-Day Habilitation) and ICF/IID (Day Habilitation and Residential) is $0.05 per level, regardless of the billing unit. The appropriations in Rider 44 also fund an increase in the add-on amount per level in the HCS and ICF/IID Day Habilitation categories, the ICF/IID Residential category, and the new SL/RSS category to reflect the staffing requirements for a single unit of service. Effective September 1, 2020, the add-on for the Day Habilitation categories in both HCS and ICF/IID will be $0.10 per level. The add-on for the new HCS SL/RSS category and the ICF/IID category will be $0.40 per level. These increases in the add-on reflect the higher number of attendant staff required per unit for these services. The add-on for the HCS Non-Residential services will remain at $0.05 per level.

The enrollment for the Rate Enhancement program is open from July 1 through July 31 of each year. HHSC anticipates publishing the state fiscal year 2021 enrollment information by September 30, 2020.

Data Analysis

HHSC is currently collecting and analyzing data on attendant recruitment and retention issues, including attendant wages for both provider agencies and CDS employers. Using these analyses, HHSC will be able to develop baselines and determine the impact of increased provider payment rates, attendant wages, and changes in the IDD Rate Enhancement program on attendant recruitment and retention, as well as on attendant service quality within Medicaid programs.

Rider 89 Report

In 2015, the Legislature directed HHSC to develop recruitment and retention strategies for community attendants to address the projected shortage of attendants through the 2016-17 GAA, 84th Legislature, Regular Session, 2015 (Article II, HHSC, Rider 89).

As part of HHSC's response, the Provider Finance Department (formerly known as the Rate Analysis Department) conducted surveys of providers of attendant services to collect data to be used in developing the required strategies. The survey was limited to attendant service providers and certain services. In addition to the survey, data was collected from the unaudited 2015 cost reports.

The response rate to the survey was low. Provider Finance analyzed the data for any potential trends, with the caveat that future studies with higher response rates or audited data may result in different conclusions. Appendix E includes the data analysis and a summary of the results.

Rider 207 Report

In 2017, the Legislature expanded the previous Rider 89 via Rider 207 to include a reporting requirement on recruitment and retention strategies for community attendants (2018-19 GAA, SB 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 207). In response to Rider 207, HHSC completed a report in 2018 and 2019.

Through HHSC's research for the 2018 Rider 207 report, we determined that neither HHSC nor most other state Medicaid agencies had conducted sufficient research to determine the effectiveness of any strategies developed for attendant recruitment and retention. To obtain baseline data to use in the analysis of attendant recruitment and retention strategies, Provider Finance added questions on attendant recruitment, staff turnover, wages, and the length of time staff were employed by the provider to the 2018 cost reports. The 2018 Rider 207 report can be found in Appendix F.

While researching additional sources of data as recommended in the 2018 Rider 207 report, Provider Finance identified additional data points to determine the effectiveness of HHSC's attendant recruitment and retention strategies. To gather the additional data, Provider Finance expanded the attendant recruitment questions included in the 2019 Rider 207 report to include more detailed information regarding attendant wages. The 2019 Rider 207 Report can be found in Appendix G.

Rider 157 Report

In 2019, the Legislature further expanded the reporting requirement via Rider 157 to include more comprehensive data and estimated future demands for attendant services, convened a cross-agency forum, and developed network adequacy standards for managed care organizations. Provider Finance developed a survey for CDS employers to collect their perspective on attendant care and attendant hiring over the past year. The survey also allowed CDS employers to share how the COVID-19 pandemic has impacted their situation as an employer. Provider Finance conducted the survey from June 15, 2020 through July 15, 2020. Information collected from the survey will be summarized in the Rider 157 report and published by November 1, 2020.

Quality-Based System

Until recently, few quality measures existed that focus on outcomes for Medicaid recipients enrolled in managed care who rely on LTSS. However, the Centers for Medicare and Medicaid Services (CMS) announced new measures for use by states to evaluate managed care organization (MCO) performance.

HHSC has initiated a project to calculate and report MCO results on these measures. Calculating the new measures will require MCOs to collect assessment data and HHSC plans to implement a standard data collection tool in fiscal year 2021. In fiscal year 2022, HHSC expects to have the initial results for these measures, followed by annual updates. CMS requires states to submit their results on these measures by fiscal year 2024. Regular LTSS performance results can facilitate initiatives to promote a stable, quality-based long-term care system.

HHSC incorporates MCO quality measures into a variety of programs and initiatives to hold MCOs accountable for providing quality care to their members. Initially, HHSC will hold MCOs accountable by publicly reporting their results for the new measures on its Texas Healthcare Learning Collaborative portal (THLCPortal.com). After establishing baseline performance in Texas and obtaining national benchmarks, HHSC will evaluate inclusion of these new measures in its quality-based payment programs to more effectively incentivize improved performance and promote a stable, quality-based long-term care system.

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Medicaid programs and services offering attendant services:

People enrolled in STAR+PLUS or a 1915(c) waiver program receive attendant services and Emergency Response Services through the Community First Choice (CFC) program to maximize federal funding.

The CFC attendant services are listed below:

- Community Living Assistance and Support Services 1915(c) waiver program (CLASS)- Personal Attendant Services / Habilitation (PAS/Hab)
- Deaf-Blind with Multiple Disabilities 1915(c) waiver program (DBMD)- Residential Habilitation
- Home and Community-based Services 1915(c) waiver program (HCS)- Supported Home Living (SHL)
- STAR+PLUS- Home and Community-based Services (HCBS) and non-HCBS PAS
- STAR+PLUS- HCBS and non-HCBS Habilitation services
- Texas Home Living 1915(c) waiver program (TxHmL)- Community Support Services (CSS)
- Personal Care Services (PCS) and PCS with a Behavioral Health Condition

In addition to CFC provided attendant services, the STAR PLUS and 1915(c) waiver programs offer other attendant services, as follows:

- CLASS waiver - CLASS attendant services are Habilitation Transportation and In-home Respite (IHR).
- Consumer Managed Personal Attendant Services (CMPAS) - A Title XX attendant services program in which people manage their own attendants who are employed by the CMPAS provider agency.
- Deaf-blind with Multiple Disabilities (DBMD) - DBMD attendant services are Residential Habilitation Transportation, Chore services and IHR.
- Family Care (FC) and Community Attendant Services (CAS) - Title XX (FC) and Section 1929(b) Medicaid (CAS) attendant services programs which are usually considered one program.
- Home and Community-based Services (HCS) - HCS attendant services are SHL Transportation and IHR.
- Texas Home Living (TxHmL) - TxHmL attendant services are CSS Transportation and IHR.

- STAR Kids - STAR Kids attendant services are PCS and PCS with a Behavioral Condition.
- STAR Kids Medically Dependent Children Program (MDCP) - STAR Kids MDCP attendant services are IHR provided by an attendant (with and without RN delegation) and Flexible Family Support Services (FSSS, with and without RN delegation).
- STAR+PLUS - STAR+PLUS includes State Plan attendant services for individuals age 21 or older (non-CFC). STAR+PLUS attendant services are HCBS PAS (non-CFC), non-HCBS PAS (non-CFC) and IHR.

Attendant Services in Residential and facility-based programs and services that assist with ADLs and IADLs, or both, as an integral part of the program or service, some of which use attendants to provide this assistance.

- Day Activities and Health Services (DAHS) - A Title XX and STAR+PLUS service that provides adults age 18 and older with daytime personal assistance services that support physical, mental, and social needs. DAHS is provided outside of the person's home.
- DBMD Day Habilitation – A facility-based day program that provides people with habilitation services in a group setting. A day habilitation facility uses attendants to assist with ADLs.
- DBMD Assisted Living Services - A residential service that allows people to live in a small group home in the community with up to five other people receiving DBMD waiver services. An assisted living home facility uses attendants to assist with ADLs, IADLS, and habilitation services.
- HCS Day Habilitation – A facility-based day program that provides people with habilitation services in a group setting. A day habilitation facility uses attendants to assist with ADLs.
- HCS Supervised Living/Residential Support Services (SL/RSS) - A residential service that allows people to live in a small group home in the community with up to three other people receiving HCS waiver services. SL/RSS uses attendants to assist with ADLs, IADLS, and habilitation services.
- Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition (ICF/IID) - A facility-based residential setting for people with intellectual and developmental disabilities who require 24-hour care and intervention. ICF/IID facilities use attendants to assist with ADLs.

- Residential Care (RC) - A Title XX residential program that provides 24-hour services to people who require daily access to care without nursing intervention. Services provided to people living in an RC facility include ADLs and IADLs provided by attendants. People who require daily nursing intervention are not eligible for RC.
- TxHmL Day Habilitation – A facility-based day program that provides people with habilitation services in a group setting. A day habilitation facility uses attendants to assist with ADLs.
- STAR Kids Adult Day Care - A service that provides adults age 18 and older with daytime personal assistance services that support physical, mental, and social needs. DAHS is provided outside of the person's home.
- STAR+PLUS Assisted Living/Residential Care (AL/RC) – A residential service that provides 24-hour services to people who require daily access to care. Services provided to people living in an AL/RC facility include ADLs and IADLs provided by attendants.

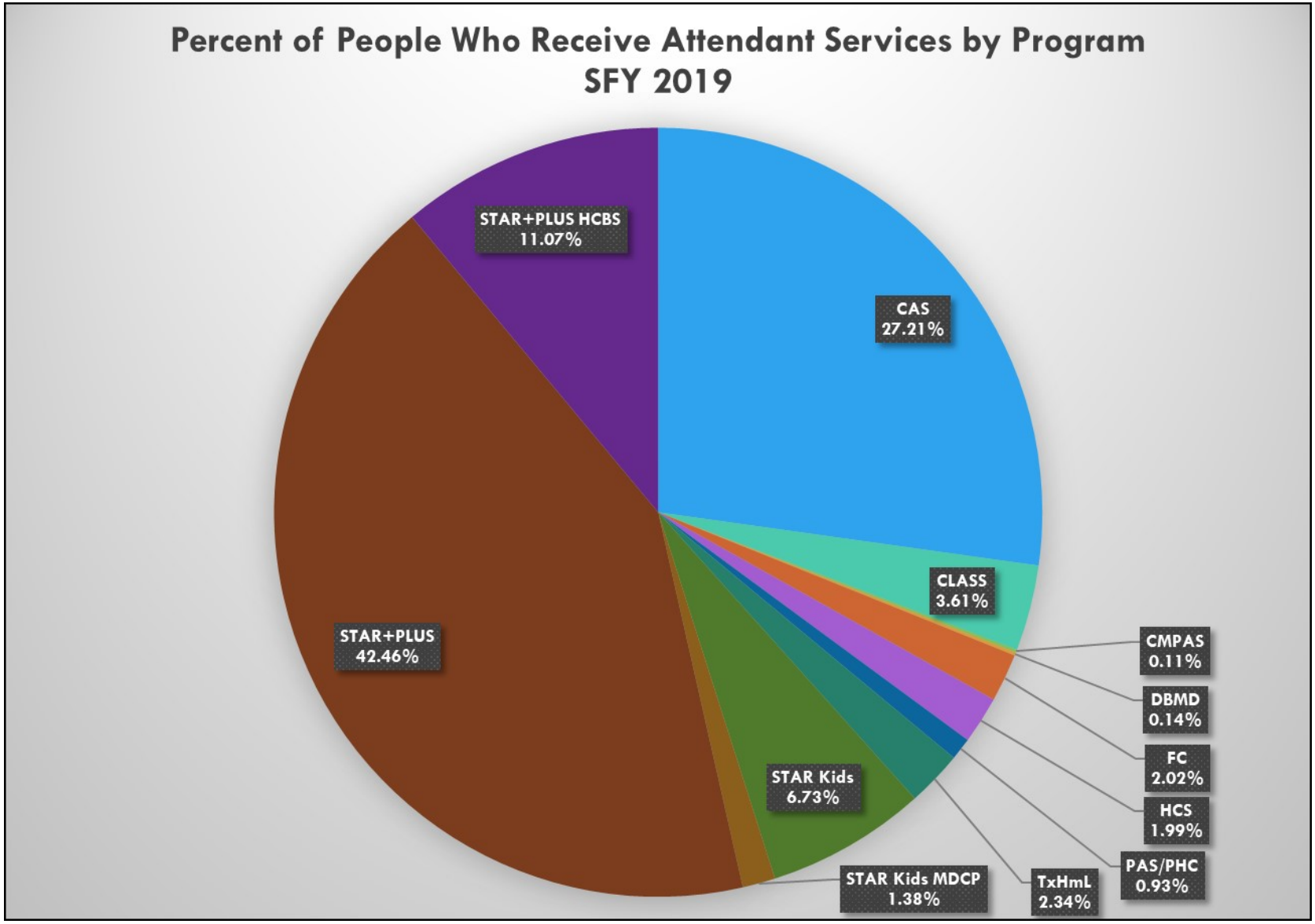
Attendant Services included in the Consumer Directed Services (CDS) Option:

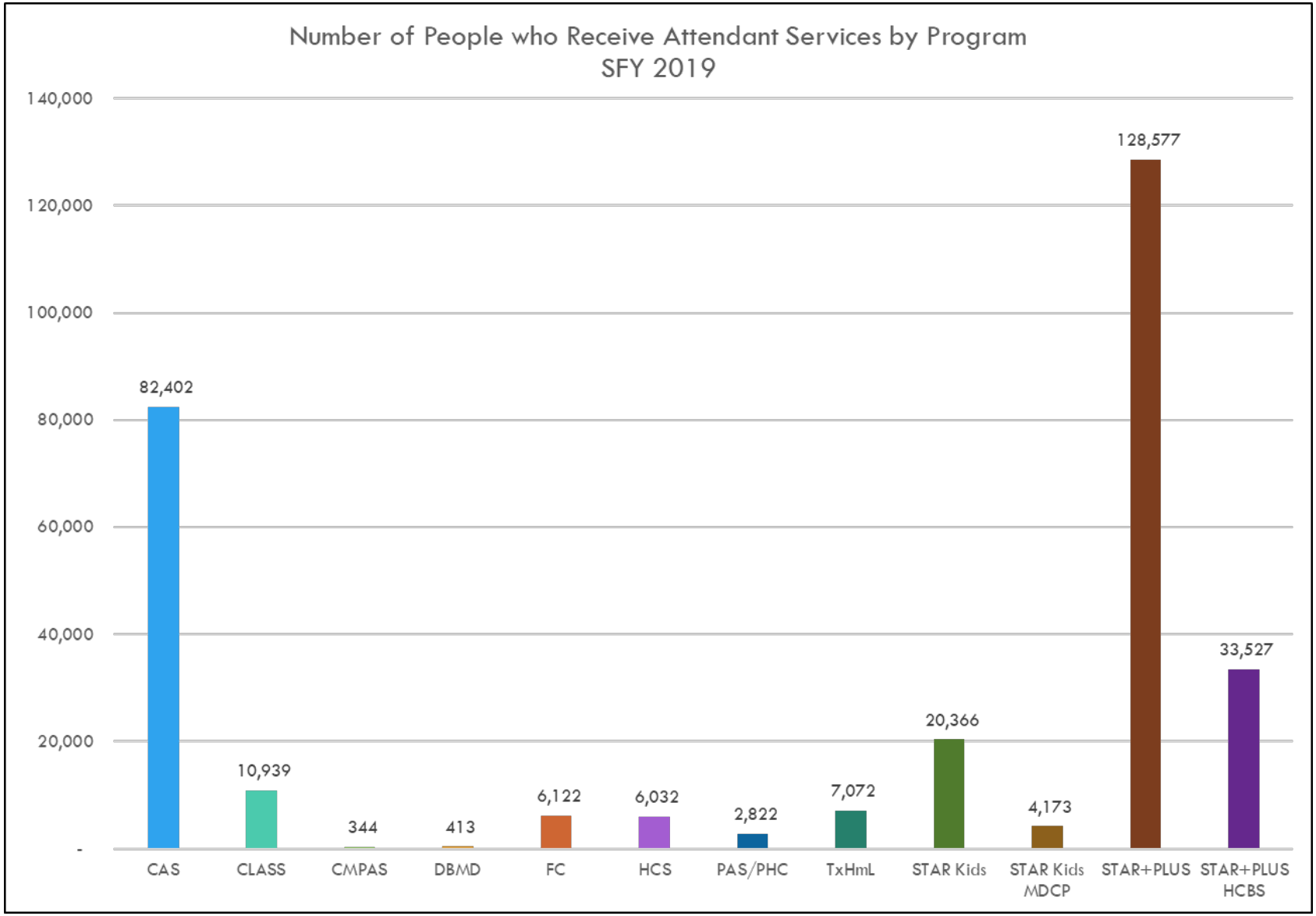
- All CFC services
- CLASS Hab Transportation and In-home Respite (IHR)
- CMPAS
- DBMD Residential Habilitation Transportation and IHR
- Family Care (FC) and Community Attendant Services (CAS)
- HCS Support Home Living (SHL) Transportation and IHR
- TxHmL CSS Transportation and IHR
- PCS and PCS with a Behavioral Condition
- STAR Kids MDCP provided by an attendant with and without Registered Nurse (RN) delegation, and Flexible Family Support Services (FSSS) with and without RN delegation
- STAR+PLUS HCBS PAS, Non-HCBS PAS and IHR

Facility- and Residential-based Services that Provide ADLs and IADLs by an Attendant that are Included in the CDS Option:

- STAR Kids Adult Day Care

- STAR+PLUS DAHS
- DBMD Day Hab
- HCS Day Hab
- TxHmL Day Hab


Percent of People Who Receive Attendant Services by Program
SFY 2019
STAR+PLUS HCBS 11.07%
CAS 27.21%
CLASS 3.61%
CMPAS 0.11%
DBMD 0.14%
FC 2.02%
HCS 1.99%
PAS/PHC 0.93%
TxHmL 2.34%
STAR Kids MDCP 1.38%
STAR Kids 6.73%
STAR+PLUS 42.46%

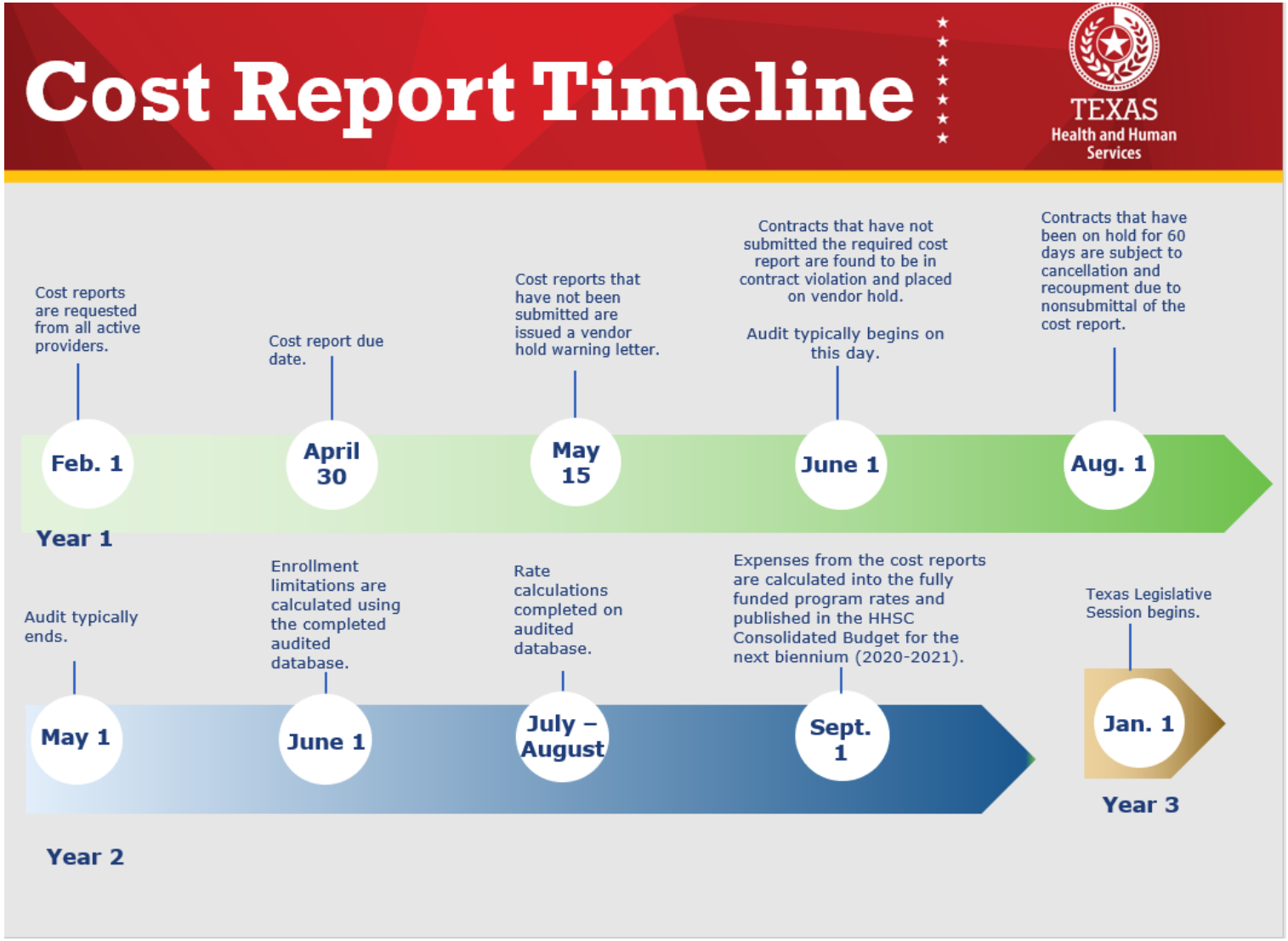

Number of People who Receive Attendant Services by Program
SFY 2019
140,000
120,000
100,000
80,000
60,000
40,000
20,000
-
82,402
10,939
344
413
6,122
6,032
2,822
7,072
20,366
4,173
128,577
33,527
CAS
CLASS
CMPAS
DBMD
FC
HCS
PAS/PHC
TxHmL
STAR Kids
STAR Kids MDCP
STAR+PLUS
STAR+PLUS HCBS

Cost and Accountability Report Collection

Cost Reporting Cycle	Report Type	Reports Collected
Even-Year Reports Beginning with 2018 reports, collected in 2019	Cost Reports	24RCC HCS/TxHmL ICF/IID NF RC
	Accountability Reports	CPC DAHS DBMD
Odd-Year Reports Beginning with 2019 reports, collected in 2020	Cost Reports	24RCC CPC DAHS

Cost Reporting Cycle	Report Type	Reports Collected
	Accountability Reports	DBMD HCS/TxHmL ICF/IID NF RC

Cost Report Timeline



Attendant services rates calculated using cost report data

- Community First Choice (CFC) Personal Assistance Services/Habilitation Services (PAS/Hab) in the Community Living Assistance and Support Services waiver program (CLASS), Home and Community-based Services waiver program (HCS), and Texas Home Living waiver program (TxHmL) waiver programs
- CFC STAR+PLUS Home and Community-based Services (HCBS) and non-HCBS PAS
- CFC STAR+PLUS HCBS and non-HCBS Service Responsibility Option (SRO)
- CFC STAR+PLUS HCBS and non-HCBS Habilitation services
- CLASS
  - Habilitation Transportation
  - In-Home Respite (IHR)
- Family Care (FC)
- Community Attendant Services (CAS)
- HCS
  - Supported Home Living (SHL) Transportation
  - IHR
- STAR+PLUS
  - HCBS PAS (non-CFC)
  - Non-HCBS PAS (non-CFC)
  - HCBS SRO (non-CFC)
  - Non-HCBS SRO (non-CFC)
  - IHR
- TxHmL
  - Communality Support Services (CSS) Transportation
  - IHR

Attendant services rates that are pro forma modeled using existing rates for the same or similar services

- CFC PAS/Hab in the Deaf-Blind with Multiple Disabilities waiver program (based on CFC CLASS PAS/Hab)
- DBMD
  - Residential Habilitation Transportation (based on CLASS Habilitation Transportation)
  - Chore services (based on Family Care / Community Attendant Services)

    - In-home Respite (based on CLASS IHR)
- STAR Kids Medically Dependent Children Program (MDCP)
    - IHR provided by an attendant (with and without RN delegation) and Flexible Family Support Services (FFSS) based on CFC STAR+PLUS HCBS and non-HCBS PAS

Attend services rates that are pro forma modeled by estimating the costs of products and services

- Consumer Managed Personal Assistance Services (CMPAS)
- STAR
    - CFC
    - Personal Care Services (PCS)
- STAR Kids
    - CFC
    - PCS
- STAR Health
    - CFC
    - PCS
- Fee-for-Service Medicaid
    - CFC
    - PCS

HHS Interim Charge 4 – Appendix E

The 2016-17 General Appropriations Act, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 89), directed the Health and Human Services Commission (HHSC) to develop recruitment and retention strategies for community attendants to address the projected shortage of attendants. As part of HHSC's response to this rider, the HHSC Rate Analysis Department (RAD) was tasked with conducting a survey of providers of community-based attendant services to collect data to be used in developing the required strategies. This document presents the results of that survey.

The Community Living Assistance and Support Services (CLASS), Primary Home Care (PHC), STAR+PLUS and Home and Community-based Services (HCS) / Texas Home Living (TxHmL) programs offer the majority of the Long Term Services and Supports (LTSS) community-based attendant services. These services are CLASS Habilitation (including Community First Choice (CFC)), PHC Priority and Non-Priority, STAR+PLUS Waiver Personal Attendant Services (PAS), STAR+PLUS Other Community Care PAS, STAR+PLUS CFC, HCS Supported Home Living (SHL) / TxHmL Community Support Services (CSS) (including CFC). The survey was limited to querying providers of these services.

With input from the Promoting Independence Advisory Committee, HHSC determined the specific data items to capture through the survey. The data items included salaries, benefits, bonuses and staff turnover rates. Data was collected through a combination of 2015 Medicaid cost report items (unaudited) and an online survey.

The specific data collected through the cost report and online survey included:

- Number of attendants hired (Cost Report);
- Number of attendant staff positions (Cost Report);
- Average hourly attendant salaries (Cost Report);
- Initial hourly attendant salaries (Survey);
- Whether the provider offers salary increases to attendants after hiring and the bases for such increases (Survey);
- Whether the provider offers salary differentials to attendants and the bases for such differentials
- Whether the provider offers bonuses to attendants and the bases for such bonuses (Survey); and
- The percentage of providers reporting benefit and mileage expenses (Cost Report).

A summary of the results is below; detailed information on the data analysis is presented in the attached tables.

- The online survey had a 41.05% overall response rate. Cost reports, being mandatory for all providers, had a 100% response rate. See Table 1.
- Annual attendant staff turnover rates ranged from 15% (HCS / TxHmL CFC) to 64.03% (CLASS Habilitation). See Table 2.
- The average hourly salary was $8.61 for CLASS, STAR+PLUS and PHC attendants, $10.65 for HCS / TxHmL attendants, and $8.64 overall. See Table 3.
- The initial hourly salary for CLASS, STAR+PLUS and PHC attendants was $8.54, and for HCS / TxHmL was $9.51. See Table 4.
- The majority of all providers (81.16 %) offer wage increases to attendants after hiring. See Table 5.
- The majority of all providers (71.15%) offer salary differentials to attendants. See Table 6.
- Fewer than half of all providers (42.16%) offer bonuses to attendants. See Table 7.
- Very few providers reported benefits and mileage expenses on the 2015 cost report (9.43% CLASS, STAR+PLUS and PHC, 7.77% HCS / TxHmL and 8.73% overall). See Table 8.

Table 1 - Survey Response Rate[1]

	HCS	CPC	Total
Surveys Requested	502	1,218	1,720
Responses	185	521	706
Percent Response	36.85%	42.78%	41.05%

Table 2 - Attendant Staff Turnover[2]

Staff Type	Total Staff Employed	Total FTEs	Percent Turnover
CLASS Habilitation	3,812	2,324	64.03%
CLASS (Community First Choice) CFC	480	297	61.62%
PHC Priority	2,806	2,013	39.39%
PHC Non Priority	71,878	49,337	45.69%
STAR+PLUS Waiver Personal Attendant Services (PAS)	55,440	37,692	47.09%
STAR+PLUS Other Community Care PAS	87,571	62,448	40.23%
STAR+PLUS CFC	1,401	1,013	38.30%
HCS Supported Home Living (SHL) / TxHmL Community Support Services (CSS)	5,092	3,851	32.23%
HCS SHL / TxHmL CFC (Attendant and Habilitation)	3,940	3,426	15.00%

Table 3 - Average Hourly Wage for all attendant services[2,3]

	Total Salaries	Total Hours	Average
CLASS, STAR+PLUS and PHC (CPC)[5]	$1,752,618,546	203,449,234	$8.61
HCS / TxHmL	$28,079,027	2,636,789	$10.65
All Attendant Services	$1,780,697,573	206,086,023	$8.64

Table 4 - What is the initial hourly wage you pay attendant staff?[4]

Cost Report Type	Average
CLASS, STAR+PLUS and PHC (CPC)[5]	$8.54
HCS / TxHmL	$9.51

Table 5 - Do you offer wage increases for attendant staff?[4]

	Yes	No	Total	Percent Yes
Total	616	143	759	81.16%

If "Yes", please select all applicable reasons for wage increases.	Number	Percent[6]
Additional Training Completed	159	20.95%
Length of Employment	437	57.58%
Merit	336	44.27%
Positive Client Feedback	285	37.55%
Other Wage Increase Basis[7]	207	27.27%

Table 6 - In addition to your attendant base wages, do you offer differential wages to attendants?[5]

	Yes	No	Total	Percent Yes
Total	540	219	759	71.15%

If "Yes", please select all applicable reasons for differential wages.	Number	Percent[6]
Consumer Need	286	37.68%
Varying Skill Requirements	200	26.35%
Environmental Issues (specific to service delivery location, e.g., dangerous er	108	14.23%
Geographic (different areas of the state)	261	34.39%
Remote Area Allowance	177	23.32%
Employee Performance	223	29.38%
Variation Between Public and Private Sectors (e.g., provider delivers Medicaid	54	7.11%
Work Shifts	197	25.96%
Other Differential Wage Basis[7]	77	10.14%

Table 7 - Do you offer bonuses?[5]

	Yes	No	Total	Percent Yes
Total	320	439	759	42.16%

If "Yes", please select all applicable reasons for bonuses.	Number	Percent[6]
Sign-on	17	2.24%
Retention	122	16.07%
Other[7]	231	30.43%

Table 8 - Percent of Providers Reporting Benefits and Mileage Expenses[2,8]

	Number of Cost Reports	Number Reporting Benefits and Mileage Expenses	Percent
CLASS, STAR+PLUS and PHC (CPC)[5]	1,771	167	9.43%
HCS / TxHmL	1,287	100	7.77%
All Attendant Services	3,058	267	8.73%

1 - The response rate data listed here is for the surveys only. Since the CLASS, PHC, STAR+PLUS and HCS / TxHmL providers are required to submit annual cost reports, there was a 100% response rate for the cost reports.
2 - From 2015 Unaudited Cost Reports. This data is subject to change.
3 - Includes salaries only. This does not include any contract staff costs.
4 - From Survey of all CLASS, PHC, STAR+PLUS and HCS/TxHmL providers required to submit a cost report.
5 - CLASS, STAR+PLUS and PHC costs are included on a single cost report called the CPC Cost Report.
6 - The percent of reasons for wage increases and differential wages, and types of bonuses may add up to more than 100% as a provider may have more than one reason or type of increase, differential wage or type of bonus.
7 - Other bases for wage increases and differential wages, and other types of bonuses vary and do not show any preponderance of a particular response.
8 - This represents the percent of providers with benefits and mileage expenses reported on the 2015 cost report. This does not represent the percent of providers who have a policy for offering benefits to attendant staff.

Community Attendant Recruitment and Retention Strategies

As Required by

Rider 207 of the 2018-19

General Appropriations Act

Texas Health and Human

Services Commission

August 2018

TEXAS
Health and Human
Services

Table of Contents

Executive Summary

The *Community Attendant Recruitment and Retention Strategies* report is submitted pursuant to Rider 207 of the 2018-19 General Appropriations Act, Senate Bill (S.B.) 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission).

Rider 207 is an expansion of Rider 89 of the 2016-17 General Appropriations Act, House Bill (H.B.) 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission).The Health and Human Services Commission (HHSC) is required to submit a report annually, by August 31, to the Legislative Budget Board and the Governor on recruitment and retention strategies for community attendants that outlines actual expenditures, cost savings, and accomplishments implementing these strategies.

HHSC has prepared financial and non-financial strategy proposals that may potentially improve community attendant recruitment and retention in Texas. HHSC has analyzed data on employment and wages, and evaluated strategies used by Medicaid agencies in other states. Also included are plans for further research to be conducted within the next fiscal year.

Although HHSC has suggested strategies to improve attendant retention and mitigate turnover, neither HHSC nor most other state Medicaid agencies have conducted sufficient research to determine the effectiveness of these provisions. HHSC has analyzed data on employment and wages, and evaluated strategies used by Medicaid agencies in other states. HHSC estimates that we will spend at least $7.9 billion on community attendant expenses during the 2020-21 biennium. This total includes wages and benefits paid to community attendants.

The report concludes with staff recommendations for further research and workgroup recommendations to be included in the next annual report. In preparation for the next annual report required under Rider 207, HHSC plans to revise questions in their regular Medicaid cost reports to better capture data on attendant turnover and retention.

1. Introduction

As of May 2017, Texas employed 196,790 personal care aides (PCAs), the second largest statewide number in the entire country.[1] According to the U.S. Bureau of Labor Statistics (BLS), home health aides (HHAs) and PCAs are forecasted to be the third and fourth fastest growing occupations in the country from 2016-2026.[2] "Employment in the health care and social assistance sector is projected to add nearly 4.0 million jobs by 2026, about one-third of all new jobs."[3] An aging population will increase the demand for these healthcare workers significantly; meanwhile, the overall labor force participation rate over this decade is expected to decline.

In Texas, like much of the country, long-term care (LTC) employers have historically struggled to hire and retain attendants.[4] The Paraprofessional Healthcare Institute's "literature reviews on this topic show turnover rates of between 45 and 65 percent, and Home Care Pulse recently surveyed private-pay home care agencies and found a national turnover rate of 66 percent in this segment of home care."[5]

Per Rider 207, this report describes recruitment and retention strategies for community attendants. HHSC staff identified both financial and non-financial strategies aimed at reducing attendant staff turnover and improving retention.

HHSC's research compares data on attendant wages and compensation in Texas with national data for other similar occupations. HHSC also surveyed other state Medicaid agencies to illustrate the degree of their community attendant turnover problems and what strategies they are pursing to improve attendant recruitment and retention.

[1] https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm#tab-6
[2] "What Home Health Aides and Personal Care Aides Do." U.S. Bureau of Labor Statistics https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm#tab-2
[3] "Employment Projections – 2016-26." U.S. Department of Labor, Bureau of Labor Statistics https://www.bls.gov/news.release/pdf/ecopro.pdf January 30, 2018.
[4] Luke, Elyse L. "Stakeholder Recommendations to Improve Recruitment, Retention, and the Perceived Status of Paraprofessional Direct Service Workers in Texas." Health and Human Services Commission. June 2008. https://hhs.texas.gov/sites/default/files//documents/doing-business-with-hhs/provider-portal/dsw-june2008.pdf
[5] "Understanding the Direct Care Workforce." Paraprofessional Healthcare Institute. https://phinational.org/policy-research/key-facts-faq/ Accessed 6/15/2018.

2. Background

Title 1 of the Texas Administrative Code (TAC) Section 355.112(b) defines an attendant as "the unlicensed caregiver providing direct assistance to individuals with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADLs)." Attendants are direct service workers that help the aged and individuals with disabilities with activities such as toileting, transferring, bathing, eating, dressing, and mobility as well as basic household services like laundry, light house work and meal preparation and accompanying to doctor's appointments. A community attendant, specifically, is an attendant that works in a non-institutional setting, assisting clients so that they can stay in their own homes or helping them maintain an active and full life in their community.

For the purposes of this report, the BLS definition of a PCA most-resembles HHSC's definition of an attendant. The BLS defines HHAs and PCAs as workers that "help people with disabilities, chronic illness, or chronic impairment by assisting in their daily living activities." Furthermore, "[PCAs]—sometimes called caregivers or personal attendants—are generally limited to providing non-medical services, including companionship, cleaning, cooking, and driving."[6]

Community attendants and other direct care workers have long faced high turnover rates and low retention. According to the Final Report from the Congressional Commission on Long-Term Care, the number of Americans requiring long-term care will double by 2050, placing greater demand for paid attendant services in the coming decades.[7] Demand for direct care workers, including community attendants, is "set to increase by 48% in the next decade, adding 1.6 million positions."[8] The report also notes retention is a problem. Workers often "have low job and industry attachment" with turnover rates well over 40% in many cases.[9]

[6] "Employment Projections – 2016-26." U.S. Department of Labor, Bureau of Labor Statistics https://www.bls.gov/news.release/pdf/ecopro.pdf January 30, 2018.
[7] "Final Report." The Congressional Commission on Long-term Care. http://ltccommission.org/ltccommission/wp-content/uploads/2013/12/Commission-on-Long-Term-Care-Final-Report-9-26-13.pdf September 18, 2013.
[8] Ibid.
[9] Ibid.

The Final Report from the Congressional Commission on Long-Term Care identifies several factors that contribute to the recruitment and retention problem including "low levels of compensation, lack of benefits, and limited opportunities for advancement that are associated with the skill levels required for the job."[10] The LTC provider industry and state Medicaid programs have struggled to address these issues. HHSC's survey of other state Medicaid agencies shows that most states are only beginning to collect the data on the challenge of reducing attendant turnover. To its credit, Texas has long sought to mitigate turnover and increase retention through its rate enhancement programs.

In 1999, the 76th Legislature established HHSC's Attendant Compensation Rate Enhancement Program (rate enhancement), a voluntary program for community-based providers (excluding Home and Community-based Services (HCS) and Texas Home Living (TxHmL) providers) that gives participating providers access to funds to increase the wages of their attendants. The purpose of this program is to "incentivize increased wages and benefits for community care attendants."[11] Providers participating in rate enhancement agree to spend ninety percent of the attendant rate component, including the rate enhancement add-on, on attendant compensation. Attendant compensation includes salaries, payroll taxes, benefits, and mileage reimbursement. In state fiscal year (SFY) 2010, the rate enhancement program was expanded to include Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICFs/IID), HCS, and TxHmL providers.[12] The Texas Legislature has demonstrated a commitment to attendant wages and reducing staff turnover through its continued funding of Rate Enhancement.

Besides the rate enhancement program, the Texas legislature has increased attendant wages and provider rates. The 83rd Legislature increased the community attendant base wage to $7.50 per hour in SFY 2014 and $7.86 per hour in SFY 2015.[13] The 84th Legislature also directed increased appropriations to community attendant wages setting the base wage for personal care attendants to $8.00 per hour in SFYs 2016 and 2017.[14]

[10] Ibid.
[11] Rider 37 of the 2000-01 General Appropriations Act, H.B. 1, 76th Legislature, Regular Session 1999 (Article II, Health and Human Services).
[12] Rider 67 of the 2010-11 General Appropriations Act, S.B. 1, 81st Legislature, Regular Session 2009 (Article II, Health and Human Services).
[13] 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 61, Information on Funding Provided for Direct Care Workers and Attendant Wages).
[14] 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2013 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 47, Information on Funding Provided for Attendant Wages).

3. State and National Data

According to the BLS, the 2017 mean hourly wage in Texas for PCAs was $9.30; meanwhile, the nationwide mean hourly wage for PCAs was $11.59.

Low wages are a key factor behind high attendant turnover, but inherently there exist other factors. To gain a better understanding of the attendant turnover problem as well as insight into how other states are addressing this issue, HHSC surveyed Medicaid agencies in other states.

Fifteen states were contacted and survey information was received from eight states: Connecticut, Florida, Louisiana, Michigan, New Mexico, Oklahoma, Washington, and Wisconsin. States were chosen based on geographic proximity (Oklahoma, Louisiana, and New Mexico), large demographic sample (Florida), and a report by the Kaiser Family Foundation that listed the states that have been addressing the attendant turnover issue through financial and/or non-financial means (Connecticut, Michigan, Washington, and Wisconsin).[15]

Most of the State survey respondents acknowledged the staffing challenges that their LTC providers face, particularly with low-wage workers. Some states have not only been tracking the issue closely but have also implemented a variety of means to alleviate high attendant turnover rates; still, none of the states we surveyed have "solved" their recruitment and retention difficulties.

The state of Washington conducts annual surveys of their provider community to acquire accurate, up-to-date data on attendant turnover. HHSC plans to add turnover questions similar to Washington's to the Medicaid cost reports that HHSC Long-term Services and Supports (LTSS) providers are already required to complete annually; this will give HHSC a more detailed picture of the turnover and retention trends in Texas.

None of the eight surveyed states stated they have a program similar to HHSC's Attendant Compensation Rate Enhancement program. Based on this information, HHSC was unable to make any comparisons to other rate enhancement programs.

[15] https://www.kff.org/report-section/medicaid-moving-ahead-in-uncertain-times-long-term-services-and-supports-reforms/

Table 1 compares the 2017 hourly mean wages of PCAs according to the BLS with 2017 state minimum wages and the 2017 living wage for a one-adult family in both Texas and the states that HHSC surveyed for this report.

Table 1. Minimum Wages and PCA Wages of Texas and Surveyed States, 2017

State	State Minimum Wage[16]	BLS Hourly Mean PCA Wages[17]	Hourly Mean PCA Wage Percentage Above State Min. Wage
Connecticut (CT)	$10.10	$13.15	+30.20%
Florida (FL)	$8.10	$10.93	+34.94%
Louisiana (LA)	$7.25[18]	$9.13	+25.93%
Michigan (MI)	$8.90	$11.09	+24.61%
New Mexico (NM)	$7.50	$9.83	+31.07%
Oklahoma (OK)	$7.25	$9.56	+31.86%
Texas (TX)	$7.25	$9.30	+28.28%
Washington (WA)	$11.00	$13.28	+20.73%
Wisconsin (WI)	$7.25	$11.15	+53.79%

Table 2 shows what other state Medicaid agencies have done to address community attendant turnover, including financial and non-financial strategies, data collection efforts, and information about their attendant rates. The hourly minimum PCA rates for other states, if any, are typically higher than that of Texas. In Texas, Day Activity & Health Services (DAHS), HCS, ICFs/IID, Community Living Assistance & Support Services (CLASS), and Primary Home Care (PHC) (with the exception of STAR+PLUS) are programs that are delivered on a fee-for-service basis.

[16] Source: "Changes in Basic Minimum Wages in Non-Farm Employment Under State Law: Selected Years 1968 to 2017", U.S. Department of Labor. https://www.dol.gov/whd/state/stateMinWageHis.htm

[17] Source: U.S. Bureau of Labor Statistics, May 2017

[18] Louisiana does not have a state minimum wage, so the federal minimum wage is listed.

Table 2. Community Attendant Rates and Turnover Strategies of Texas and Surveyed States, 2018

State	Turnover Strategies: Non-Financial[19]	Turnover Strategies: Financial	Turnover Data Collection	Fee-for-Service (FFS) or Negotiated Rates	Per Hour PCA Rate Minimum for Provider Agencies
CT	Yes	Yes	No	Union negotiates with Medicaid Agency	$14.75[20]
FL	No	No	No	Both. Managed Care Organizations (MCO) negotiate with providers for ICFs/IID. FFS for HCS[21]	$15.44 (FFS)
LA	No	No	No	FFS	None
MI	No, reviewing options	Yes	No	MCOs negotiate with Medicaid agency	$13.50-$15.50[22]
NM	No	No	No	MCOs negotiate with personal care agencies	None
OK	No, reviewing options	No, reviewing options	Yes	FFS	$15.12[23]
TX	No, reviewing options	Yes	No, reviewing options	Both. MCOs negotiate with providers for STAR+PLUS or STAR Kids. FFS otherwise	$8.00
WA	Yes	Yes	Yes	Union negotiates with Medicaid Agency	$13.75-$16.50[24]
WI	Yes	Yes	Yes	FFS	$16.40

[19] These non-financial strategies include, for instance, incentives for advanced training and certifications leading to improved workforce development.
[20] Connecticut's rate has built-in increases through July 1, 2020.
[21] The terms ICFs/IID and HCS are used with equivalence to HHSC's programs, even though Florida may have different program names.
[22] Michigan's rates are dependent on county, but there will eventually be a uniform rate.
[23] http://www.okdhs.org/services/aging/Pages/RRS.aspx
[24] Washington has tiered rates that are based on cumulative career hours. These rates went into effect on July 1, 2018 and will increase to $15.00 floor, $17.65 ceiling on January 1, 2019.

4. HHSC's Proposed Strategies

Non-Financial Strategies

Improve outreach and recruitment of attendants through local collaboration

A survey of over 34,000 community attendants was conducted between May and August 2014 by the former Department of Aging and Disability Services (DADS) in coordination with HHSC to identify strategies for improving recruitment, training, and retention efforts. [25]

Findings from the survey indicated how the attendants learned about their current jobs:

- 39% From a friend
- 29% From a family member
- 8% Internet
- 6% Newspaper
- 3% Local workforce center

The Texas Workforce Commission (TWC), Local Workforce Development Boards, community colleges, and non-profits (i.e., Volunteers of America, Centers for Independent Living) have a wealth of expertise in the needs of local job markets, workforce recruitment techniques, and training opportunities. Encouraging collaboration between such organizations and health plans and providers may yield innovative ideas for matching the need for attendants and those who might be interested.

Importantly, TWC has information on potential target populations for recruitment outreach such as Temporary Assistance for Needy Families (TANF) recipients, older workers or students seeking part-time employment. TWC operates a searchable job bank that can potentially be a source for highlighting attendant opportunities.

[25] Texas Department of Aging and Disability Services. Texas Direct Service Worker Final Report. January 2015.

Convene a cross-agency forum to develop a state workforce development plan for retention and recruitment of community attendants

Invite key stakeholders from provider associations (i.e., Personal Attendant Coalition of Texas, Texas Association of Home Care and Hospice, Providers Alliance for Community Services of Texas, Private Providers Association of Texas), the TWC, local workforce development boards, Medicaid, MCOs, clients, Consumer Directed Services (CDS) employers, researchers, and local universities to review the most recent information on direct service workforce in Texas.

Information includes healthcare industry growth, demographic trends, results from HHSC regional forums and surveys of attendants, and relevant data on attendant wages and turnover. The goal of the forum would be to develop a blueprint for attendant recruitment and retention strategies.

Require employers (both agency and CDS employers) to provide Federal Child Care and Development Fund (CCDF) program eligibility and referral information to all community attendants

CCDF is a subsidized child care program for people who meet certain income requirements. There are brochures that have been developed by TWC that describe CCDF, and they will be distributed to all community attendants. The goal of this strategy is to provide outreach information in order to help support community attendants who may need low cost child care.

Create a Strategy to expand utilization of the service responsibility option (SRO)

The service responsibility option (SRO) is a service delivery option that allows individuals greater choice and independence in how their services are provided to them. For example, an individual that selects the SRO would work with an agency to determine which staff will assist them.

The SRO is less restrictive than the agency option in which the member does not select which staff are assigned to assist them. Allowing individuals receiving services to select their attendants increases the likelihood the attendant and the individual will have greater satisfaction thus reducing attendant turnover.

The goal of this strategy is to increase participation and provider capacity. Options for outreach and education include:

- Brochures included in the enrollment packet for attendants sent by the state-contracted enrollment broker;
- Requirement of program case management, Local Intellectual and Developmental Disability Authority (LIDDA), Local Mental Health Authority (LMHA), MCO service coordinators to provide individuals with education (including an HHSC approved brochure) and option of service delivery at least annually;
- Education on SRO to traditional agencies.

Continue focus on increasing training opportunities for attendants

Increased training to community attendants has been shown to increase job satisfaction among workers and improve quality of care for older adults and people with disabilities.

The 2014 DADS survey of community attendants also found that over 70 percent of community attendants believed they were adequately trained in skills such as basic personal care, providing person-directed services, first aid and emergency training, how to lift and transfer safely, CPR and supporting people with complex medical and behavioral healthcare needs.[26] Over 70 percent also, however, indicated an interest in receiving additional training on topics such as understanding mental illness and recovery, supporting people with challenging behavior, mitigating aggressive or violent behavior, and recognizing illness or injury in persons who have difficulty communicating.

In response to the study's findings, Texas developed an online training for community attendants. Money Follows the Person (MFP) Demonstration funds were used to develop training modules designed for direct service workers and other caregivers focused on behavioral health needs, including those with co-occurring conditions (Individuals with an Intellectual Disability (IID) or mental health). MFP also sponsored in-person, regional trainings for supporting individuals who have experienced trauma, and regional trainings on dementia basics for community attendants and family caregivers. Additional funds have been allocated to develop training on other topics cited in the study.

[26] Ibid.

Explore amending policy in all programs within the scope of this report to allow attendants to live in the residence of the individuals receiving the personal assistance or habilitation services

Personal assistance services (PAS) and habilitation services are provided by community attendants who meet the following criteria:

- Employed by an MCO-contracted provider, a program provider, or the employer of record under the CDS Option;
- 18 years of age or older;
- Not the spouses or legally authorized representative of the person served or parents of a minor person served; and
- Perform all of the services available within their scope of competency and within the program service definition.

Individuals who reside with the individual receiving services are often family members and have a vested interest in the quality of care received by their loved one, who currently are not allowed to provide attendant services. Allowing family members who reside in the home to deliver attendant services could lead to less turnover.

Examine workplace culture issues to learn about tenured attendants' motivations

A key finding of HHSC's research involves the connection between worker retention and workplace culture. Low-wage employees are more likely to stay in their current job when they feel that their efforts are valued and their work contributes to a noble purpose, and providing care to the aged or individuals with disabilities can be fulfilling in such a way.[27] This kind of staff empowerment can help community attendants overcome the everyday stresses that may accompany their work routines and low wages.

Improving workplace culture often requires improving the relationship between employee and supervisor, for instance. The Paraprofessional Healthcare Institute suggests that workplace culture can be enhanced for attendant care staff by improving skills training and instituting a coaching model where supervisors work

[27] "Why They Stay: Retention Strategies for Long Term Care" Provider Magazine. November 2015. http://www.providermagazine.com/archives/2015_Archives/Pages/1115/Why-They-Stay-Retention-Strategies-For-Long-Term-Care.aspx

with direct service employees to develop problem-solving skills.[28] The coaching-supervisor model seeks to improve that relationship, and by doing so, increases the likelihood that attendant staff stay in their jobs longer. This kind of initiative, however, may have short-term costs to providers due to the time and resources required to facilitate a coaching model and to provide skills training.

HHSC is unsure whether low- or no-cost options may be available for this strategy and recommends this issue be presented to the recommended cross-agency forum for consideration and further development.

Gather comprehensive data regarding community attendant turnover

HHSC currently possesses limited data on the specific reasons community attendants are leaving employment in the LTC industry, i.e. whether they are seeking jobs in other industries or leaving the workforce altogether.

Data collection efforts can help lead to the development of more robust strategies to improve retention and assist in recruitment of quality staff. HHSC can partner with provider industries, community attendant organizations, TWC, state Medicaid agencies, health policy organizations, and other research institutions in pursuit of a more thorough understanding of the issue.

The State of Wisconsin, for instance, recently launched an initiative to distribute $60.8 million over two SFYs to direct care workers providing services to the state's LTC MCO members.[29] As part of this initiative, providers are required to complete a survey after each quarterly payment that indicates how the funding was used, why they chose to use the funding as they did, whether they know of any instances whether the additional funding made the difference in retaining or recruiting a worker, and how large of an impact they believe the funding has had on their ability to recruit and retain workers.

[28] "Creating a Culture of Retention: A Coaching Approach to Paraprofessional Supervision." Paraprofessional Healthcare Institute. https://phinational.org/wp-content/uploads/2017/07/PHI-CoachingOverview.pdf

[29] Wisconsin Direct Care Workforce Funding Initiative: https://www.dhs.wisconsin.gov/medicaid/ltc-workforce-funding-faq.htm

Financial Strategies

Explore the potential of managed care value-based payment models

In April 2018, HHSC was one of ten states selected to participate in a Centers for Medicare and Medicaid Services (CMS) Innovation Accelerator Program project on value-based payments for home and community-based services, with a project completion date of February 2019. The goal of the Texas project is to develop strategies to increase Medicaid clients' success in the community by encouraging and supporting MCO value-based payment (VBP) models focused on PCAs. The HHSC project team is exploring the potential for MCO VBP models to improve attendant recruitment and retention by rewarding a better-trained PCA workforce. The project is still in its early stages.

Incentivize provider agencies to provide mentors and training opportunities for community attendants

Training and mentoring supports the stability of the provider network, and the ability of the provider and community attendant to provide quality services in the community. Mentoring and training contribute to higher community attendant job satisfaction thereby potentially increasing attendant retention. Funding would incentivize providers to:

- Compensate community attendants for spending time developing special skills and expertise through training; and
- Provide new attendants with mentors or coaches to obtain consumer-specific special needs training; this allows attendants to better care for individuals with complex medical and behavioral health needs.

Furthermore, provider agencies have indicated that an increase in the administrative/operational portion of the rate could result in increased training and mentoring opportunities.

Increase the minimum wage paid to attendants above $8.00

As stated above, the 84th Legislature (2015) provided funding to increase the attendant minimum wage from $7.84 per hour to $8.00 per hour. Medicaid and non-Medicaid rates currently support a minimum attendant wage of $8.00 per hour.[30]

[30] Per 40 TAC, Section 49.312, Providers are required to pay at least the current mandated minimum wage of $8.00 to their employee attendants.

Anecdotally, HHSC has been made aware from stakeholders that at this wage rate, providers have difficulties hiring and retaining qualified attendants. Per 40 TAC, Section 49.312, Providers are required to pay at least the current mandated minimum wage of $8.00 to their employee attendants. An additional increase to the base attendant rate to support minimum salaries greater than $8.00 per hour would potentially improve retention and recruitment among community attendants providing services to Texas' Medicaid consumers.

At this time, HHSC is unable to evaluate attendant recruitment and retention data after the most recent rate increase in support of an $8.00 minimum attendant wage because the agency lacks reliable data prior to the wage increase. HHSC is currently working to improve the reliability of its survey tools to better capture data on attendant recruitment or retention in Texas in subsequent cost reporting cycles. This will allow HHSC to evaluate changes in recruitment and retention data after any future increases or decreases to the minimum attendant wage.

Increase the levels of the Attendant Compensation Rate Enhancement Program

The rate enhancement program is a voluntary program where participating providers may choose to receive additional funds to supplement attendant wages and benefits. Increasing funding for rate enhancement programs may potentially alleviate recruitment and retention issues in Texas by increasing the attendant portion of the rate for participating providers.

There are separate appropriations for IID programs versus all other community-based programs; the current appropriations support a rate increase of $0.05 per level for up to 25 levels above the base rate for IID programs, and up to 35 levels above the base rate for all other community-based programs. In SFY 2018, HHSC maintained the currently awarded levels in rate enhancement for both IID and all other community-based programs. However, HHSC could only allow new IID rate enhancement participants to be at Level 1; there was no funding available to allow current IID program participants to increase their participation levels. Furthermore, HHSC could only allow all other community-based programs to participate at Level 13; all existing participants who were participating below Level 13 were unable to increase their participation level beyond Level 13.

Because rate enhancement participants must agree to spend ninety percent of the increased attendant rate component on attendant compensation, increasing appropriations for the rate enhancement program will directly impact the expenditures for community attendants, which include increased individual attendant wages and benefits or the hiring of additional attendants. The remaining ten percent of the attendant rate component is for providers' discretionary spending on operational expenses associated with attendant care.

5. Conclusion

LTC providers in Texas are facing difficulties recruiting and retaining the qualified community attendants necessary to provide direct care for both the aged and persons with disabilities. Both HHSC and other state Medicaid agencies that were surveyed have limited data on the scope of the attendant recruitment and retention issue.[31] In preparation for the next annual report required under Rider 207, HHSC plans to revise questions in their regular Medicaid cost reports to better capture data on attendant turnover and retention.[32] Improved data on the recruitment and retention difficulties in Texas will allow HHSC to establish a turnover baseline and provide further guidance; the agency will then be able to determine the effects of any strategies that are implemented thereafter.

Until HHSC is able to collect and analyze additional data on attendant recruitment and retention issues in Texas, it will be difficult to fully evaluate the effects of the proposed non-financial and financial strategies mentioned in this report.

[31] Some states have collected data on turnover, but they have only started collecting very recently. Washington, for instance, started collecting data in 2016, and Wisconsin in 2018.
[32] As mentioned in Rider 207 Section 3: State and National Data and Section 4: Proposed Non-Financial Strategies

List of Acronyms

Acronym	Full Name
ADL	Activities of Daily Living
BLS	United States Bureau of Labor Statistics
CCDF	Child Care and Development Fund
CDS	Consumer Directed Services
CLASS	Community Living Assistance and Support Services
CMS	Centers for Medicare and Medicaid Services
DADS	Department of Aging and Disability Services
DAHS	Day Activity and Health Services
FFS	Fee-for-Service
HHA	Home Health Aide
HHSC	Texas Health and Human Services Commission
HCS	Home and Community-based Services 1915(c) Waiver Program
IADL	Instrumental Activities of Daily Living
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) State Plan Service
IID	Individuals with an Intellectual Disability
LIDDA	Local Intellectual and Developmental Disability Authority

Acronym	Full Name
LMHA	Local Mental Health Authorities
LQ	Location Quotient
LTC	Long Term Care
LTSS	Long-term Services and Supports
MCO	Managed Care Organization
MFP	Money Follows the Person
PAS	Personal Assistance Services
PCA	Personal Care Aide
PHC	Primary Home Care (includes the Community Attendant Services and Family Care programs)
SRO	Service Responsibility Option
SFY	State Fiscal Year
TAC	Texas Administrative Code
TANF	Temporary Assistance to Needy Families
TWC	Texas Workforce Commission
TxHmL	Texas Home Living 1915(c) Waiver program
VBP	Value-based Payment

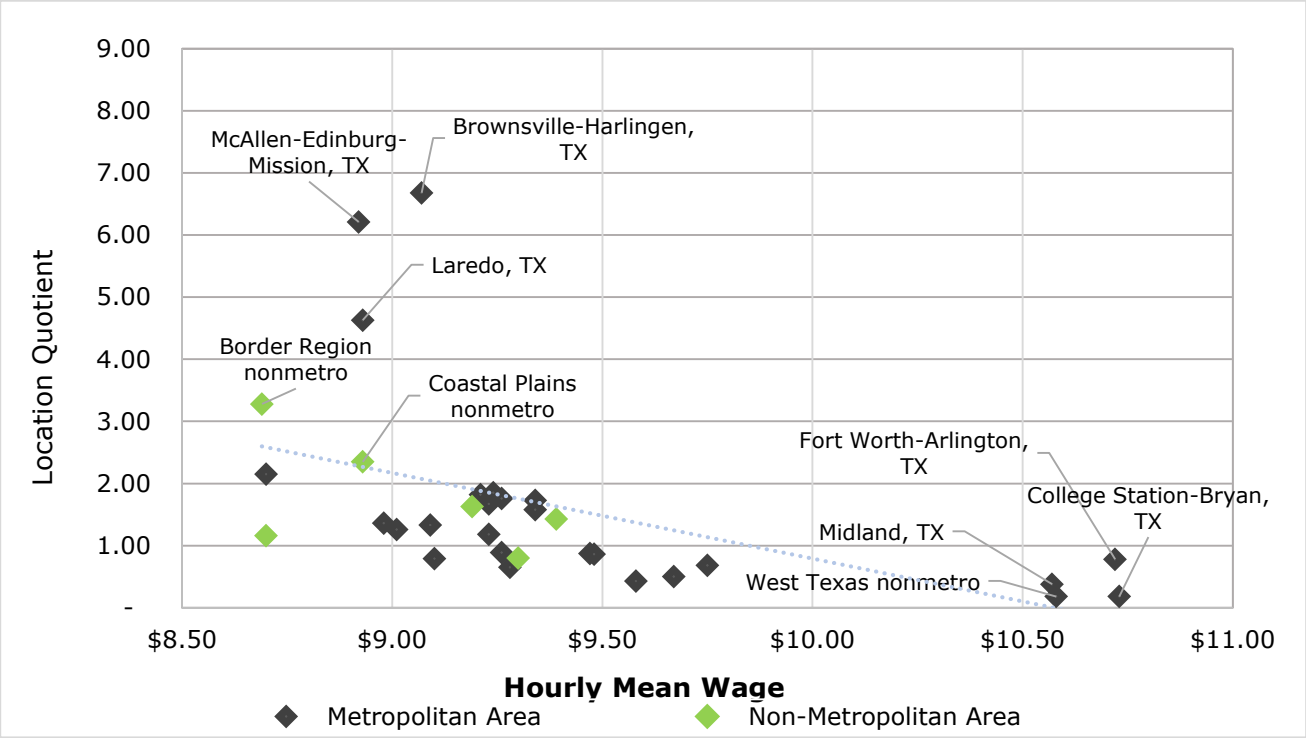
Appendix A. Location Quotient

As per the BLS, "a location quotient shows the occupation's share of an area's employment relative to the national average. For example, a location quotient of 2.0 indicates that an occupation accounts for twice the share of employment in the area than it does nationally."[33]

Furthermore, the Rio Grande Valley has the highest location quotient (LQ) for personal care aides in the entire country: Brownsville-Harlingen, TX has the highest LQ in the U.S. (6.68) and McAllen-Edinburg-Mission, TX has the second highest LQ (6.21).[34] Figure 3 shows the relationship between hourly mean wages and location quotients in each BLS Texas area.[35] See Table 4 for the data in Figure 3.

As of May 2017, Texas employs 196,790 personal care aides, the second largest statewide number in the entire country.

Figure 3. Hourly Mean Wages and Location Quotients for Personal Care Aides by Texas Area, May 2017



[33] https://www.bls.gov/oes/highlight_location_quotients.htm
[34] https://www.bls.gov/oes/current/oes399021.htm#st
[35] For metropolitan and nonmetropolitan area BLS definitions see https://www.bls.gov/oes/current/msa_def.htm

Table 4. Hourly Mean Wages and Location Quotients of Personal Care Aides, May 2017[36]

Texas Area Name[37]	PCA Hourly Mean Wage	PCA Location Quotient
Abilene, TX	$9.47	0.87
Amarillo, TX	$9.10	0.79
Austin-Round Rock, TX	$9.67	0.50
Beaumont-Port Arthur, TX	$8.98	1.36
Big Thicket Region*	$9.19	1.63
Border Region*	$8.69	3.28
Brownsville-Harlingen, TX	$9.07	6.68
Coastal Plains Region*	$8.93	2.35
College Station-Bryan, TX	$10.73	0.18
Corpus Christi, TX	$9.23	1.67
Dallas-Fort Worth-Arlington, TX	$9.75	0.68
Dallas-Plano-Irving, TX	$9.28	0.65
El Paso, TX	$8.70	2.15
Fort Worth-Arlington, TX	$10.72	0.78
Hill Country Region*	$9.30	0.80
Houston-The Woodlands-Sugar Land, TX	$9.48	0.86
Killeen-Temple, TX	$9.01	1.26
Laredo, TX	$8.93	4.63
Longview, TX	$9.21	1.82
McAllen-Edinburg-Mission, TX	$9.23	1.18

[36] Source: The U.S. Bureau of Labor Statistics, May 2017 OES Data.

[37] For metropolitan and nonmetropolitan area BLS definitions see https://www.bls.gov/oes/current/msa_def.htm

Texas Area Name[37]	PCA Hourly Mean Wage	PCA Location Quotient
Midland, TX	$10.57	0.38
North Texas Region*	$9.39	1.43
Odessa, TX[38]	-	-
San Angelo, TX	$9.34	1.73
San Antonio-New Braunfels, TX	$9.34	1.58
Sherman-Denison, TX	$9.26	1.76
Texarkana, TX	$9.09	1.33
Tyler, TX	$9.24	1.85
Victoria, TX	$9.58	0.43
Waco, TX	$8.70	1.16
West Texas Region*	$10.58	0.18
Wichita Falls, TX	$9.26	0.89

[38] May 2017 OES data on PCAs from the BLS did not include data for Odessa, TX.

Community Attendant Recruitment and Retention Strategies

As Required by

Rider 207 of the 2018-19

General Appropriations Act

Texas Health and Human

Services Commission

August 2019

TEXAS
Health and Human
Services

Table of Contents

Executive Summary

The *Community Attendant Recruitment and Retention Strategies* report is submitted pursuant to Rider 207 of the 2018-19 General Appropriations Act, Senate Bill (S.B.) 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission). The rider states:

> **207. Recruitment and Retention Strategies.** Out of funds appropriated above in Strategy L.1.1, HHS System Supports, the Health and Human Services Commission (HHSC) shall develop recruitment and retention strategies for community attendants.
>
> HHSC shall submit an annual report by August 31 to the Legislative Budget Board and the Governor reflecting actual expenditures, cost savings, and accomplishments implementing recruitment and retention strategies for community attendants. (Conference Committee Report Rider 142)

The 2019 Rider 207 report is the second report in a series of annual reports. Since the 2018 Rider 207 report, HHSC continued researching financial and non-financial strategies that may potentially improve community attendant recruitment and retention in Texas. Many of HHSC's proposals in the 2018 Rider 207 report were actively pursued, while others remain contingent on policy development and/or legislative action. The 86th Texas legislature made investments in community attendant reimbursement rates by increasing the minimum wage rate from $8.00 to $8.11. Including these additional funds, HHSC estimates that we will spend at least $8.1 billion on community attendant expenses during the 2020-21 biennium. This total includes wages and benefits paid to community attendants.

In August 2018, HHSC published the first of two annual reports directed by Rider 207 of the 2018-2019 General Appropriations Act. The 2018 report presented preliminary strategies to improve community attendant recruitment and retention, and preliminary data on the state of the direct care industry; the report concluded with plans for increased data collection and continued development of potential strategies. Since the original report, the agency has implemented workforce recruitment and retention questions in its Medicaid cost reports, strengthened its database of other state Medicaid agencies' strategies, and boosted its overall data analysis and data collaboration efforts. HHSC sought stakeholder input regarding the recruitment and retention strategies proposed in the 2018 report.

The 2019 Rider 207 report details the agency's latest data on the direct care workforce and related topics, provides status updates on strategies that were mentioned in the 2018 report, and discusses additional potential strategies that were not mentioned in the 2018 report.

The report concludes with the agency's recommendations for implementation and further research. Some of HHSC's recommendations include continuing to prioritize data collection, explore the potential for value-based payment models, promote initiatives for attendant training, and promote state and local collaboration on community attendant issues.

1. Introduction

As the Baby Boomer generation ages, the demand for long-term services and supports (LTSS) is expected to grow dramatically. Employment in healthcare occupations is projected to grow 18 percent from 2016 to 2026, much faster than the average for all occupations, adding about 2.4 million new jobs. This projected growth is mainly due to an aging population, leading to greater demand for healthcare services.[1] This demographic shift will impact the direct care worker industry considerably, which includes occupations such as personal care aides (PCAs) and home health aides (HHAs).

According to the U.S. Bureau of Labor Statistics (BLS), HHAs and PCAs are forecasted to be the third and fourth fastest growing occupations in the country from 2016-2026 with ten-year projected growth rates of 47 percent and 39 percent, respectively.[2] Meanwhile, the number of Americans requiring long-term care is projected to more than double by 2050, creating greater demand for paid attendant services in the coming decades.[3] As of May 2018, Texas employed 206,240 PCAs, the second largest statewide number in the country.[4] While demand for direct care workers both in Texas and nationwide continues to increase exponentially, long-term care (LTC) employers are already struggling to hire and retain direct care workers.

Per Rider 207, this report describes recruitment and retention strategies for community attendants. The 2019 Rider 207 report describes potential financial and non-financial strategies meant to reduce community attendant turnover and improve retention; the report includes data that is meant to aid future decision-making by both the agency and the legislature. HHSC expanded the number of state Medicaid agencies it surveyed for the 2018 Rider 207 report, collected

[1] "Healthcare Occupations" U.S. Bureau of Labor Statistics. April 12, 2019. https://www.bls.gov/ooh/healthcare/home.htm
[2] "Fastest Growing Occupations" U.S. Bureau of Labor Statistics. April 12, 2019. https://www.bls.gov/ooh/fastest-growing.htm
[3] "Final Report." The Congressional Commission on Long-term Care. September 18, 2013. http://ltccommission.org/ltccommission/wp-content/uploads/2013/12/Commission-on-Long-Term-Care-Final-Report-9-26-13.pdf
[4] "Occupational Employment and Wages, May 2018, 39-9021 Personal Care Aides." U.S. Bureau of Labor Statistics. March 29, 2019. https://www.bls.gov/oes/current/oes399021.htm

feedback on participation in the Attendant Compensation Rate Enhancement program and added new recruitment and retention questions to its Medicaid cost reports.

HHSC's research compares data on attendant wages and compensation in Texas with national data for other similar occupations. HHSC also surveyed other state Medicaid agencies to illustrate the degree of their community attendant turnover problems and what strategies they are pursuing to improve attendant recruitment and retention.

2. Background

Title 1 of the Texas Administrative Code (TAC), Section 355.112(b), defines an attendant as "the unlicensed caregiver providing direct assistance to individuals with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADLs)."[5] Attendants are direct service workers who help the aged and individuals with disabilities with activities such as toileting, transferring, bathing, eating, dressing, and mobility as well as with basic household services like laundry, light house work, and meal preparation; attendants also accompany clients to appointments with physicians. A community attendant, specifically, is an attendant that works in a non-institutional setting, assisting clients so they can stay in their own homes or helping them maintain an active and full life in their community.

For this report, the BLS definition of a PCA most-resembles HHSC's definition of an attendant. The BLS defines PCAs as workers that "help people with disabilities, chronic illness, or chronic impairment by assisting in their daily living activities."[6] Furthermore, "[PCAs]—sometimes called caregivers or personal attendants—are generally limited to providing non-medical services, including companionship, cleaning, cooking, and driving." For more details on PCAs in Texas, see Appendix E which details demographic information of PCAs in Texas from the U.S. Census Bureau's 2017 American Community Survey.

The recruitment and retention challenges that PCAs face is commonly attributed to the low staff wages, demanding day-to-day responsibilities, limited career growth opportunities, and other factors affecting this occupation. High rates of turnover lead to increased stress across the workforce and are a key barrier to the delivery of quality services.[7] Turnover of home care workers alone costs U.S. employers an estimated $6 billion annually[8], and the cost of hiring and training new direct care

[5] The phrases "direct care worker" and "attendant" are often used interchangeably; however, this report shall primarily use "attendant", particularly in the context of the phrase "community attendant."
[6] "Occupational Employment and Wages, May 2018, 39-9021 Personal Care Aides." U.S. Bureau of Labor Statistics. March 29, 2019. https://www.bls.gov/oes/current/oes399021.htm
[7] "Coverage of Direct Service Workforce Continuing Education and Training within Medicaid Policy and Rate Setting: A Toolkit for State Medicaid Agencies." Centers for Medicare & Medicaid Services. August 2013. https://www.medicaid.gov/medicaid/ltss/downloads/workforce/dsw-training-rates-toolkit.pdf
[8] "Paying the Price: How Poverty Wages Undermine Home Care in America." PHI. February 2015. https://phinational.org/wp-content/uploads/legacy/research-report/paying-the-price.pdf.

workers (institutional and community-based) is estimated at $4,872 per position.[9] PHI, a non-profit research and consulting organization dedicated to improving LTSS and improving the state of the direct care workforce, found that studies of direct care worker turnover rates are typically between 45 and 65 percent turnover; a recent Home Care Pulse survey of private-pay home care agencies found a national turnover rate of direct care workers of 66 percent.[10]

Texas has recognized the difficulties that LTSS providers face in recruiting and retaining qualified attendant staff to serve individuals needing Medicaid services. Texas has pursued multiple avenues to address attendant compensation, recruitment, and retention issues, such as through HHSC's Attendant Compensation Rate Enhancement Program (rate enhancement), past increases to attendant wages and provider rates, and through legislative riders such as the Rider 207 report.

In 1999, the 76th Legislature established HHSC's rate enhancement program, a voluntary program for community-based program providers (excluding Home and Community-based services (HCS) and Texas Home Living (TxHmL) providers at the time) that gives participating providers access to funds to increase the wages of their attendants. The purpose of this program is to "incentivize increased wages and benefits for community care attendants."[11] Providers participating in rate enhancement agree to spend 90 percent or more of the attendant rate component, including the rate enhancement add-on, on attendant compensation. Attendant compensation includes salaries, payroll taxes, benefits, and allowable mileage reimbursement. During state fiscal year 2010, the rate enhancement program was expanded to include HCS and TxHmL providers.[12] The Texas Legislature has demonstrated a commitment to attendant wages and reducing staff turnover through its continued funding of rate enhancement, including additional appropriations for the 2020-2021 biennium.

Apart from the rate enhancement program, the Texas Legislature has increased attendant wages and provider rates in the past. The 83rd Legislature increased the

[9] "Coverage of Direct Service Workforce Continuing Education and Training within Medicaid Policy and Rate Setting: A Toolkit for State Medicaid Agencies." Centers for Medicare & Medicaid Services. August 2013. https://www.medicaid.gov/medicaid/ltss/downloads/workforce/dsw-training-rates-toolkit.pdf
[10] "Understanding the Direct Care Workforce." PHI. https://phinational.org/policy-research/key-facts-faq/
[11] Rider 37 of the 2000-01 General Appropriations Act, H.B. 1, 76th Legislature, Regular Session 1999 (Article II, Health and Human Services).
[12] Rider 67 of the 2010-11 General Appropriations Act, S.B. 1, 81st Legislature, Regular Session 2009 (Article II, Health and Human Services).

community attendant base wage to $7.50 per hour in state fiscal year 2014 and $7.86 per hour in state fiscal year 2015.[13] The 84th Legislature directed increased appropriations to community attendant wages setting the base wage for personal care attendants to $8.00 per hour in state fiscal years 2016 and 2017.[14] Recently, the 86th Legislature continued this trend by providing appropriations for rates to support a personal care attendant base wage of $8.11 per hour for state fiscal years 2020 and 2021.[15]

In August 2018, HHSC published the first of two annual reports directed by Rider 207 of the 2018-2019 General Appropriations Act. The 2018 report presented preliminary strategies to improve community attendant recruitment and retention, and preliminary data on the state of the direct care industry; the report concluded with plans for increased data collection and continued development of potential strategies. Since the original report, the agency has implemented workforce recruitment and retention questions in its Medicaid cost reports, strengthened its database of other state Medicaid agencies' strategies, and boosted its overall data analysis and data collaboration efforts. HHSC sought stakeholder input regarding the recruitment and retention strategies proposed in the 2018 report. The 2019 Rider 207 report details the agency's latest data on the direct care workforce and related topics, provides status updates on strategies that were mentioned in the 2018 report, and discusses additional potential strategies that were not mentioned in the 2018 report.

[13] 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 61, Information on Funding Provided for Direct Care Workers and Attendant Wages).
[14] 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2013 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 47, Information on Funding Provided for Attendant Wages).
[15] 2020-21 General Appropriations Act, H. B. 1,86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission, Rider 45, Information on Funding Provided for Attendant Wages and Rate Enhancements).

3. Recruitment and Retention Data

Per the conclusion of the 2018 Rider 207 report, HHSC committed to prioritize data collection of the attendant workforce. Improved data collection will enable HHSC and the Texas Legislature to make better informed decisions in the future. HHSC expanded its data collection in several ways. First, the agency added critical recruitment and retention questions to its Medicaid cost reports. Second, it continued state survey research that commenced for the 2018 Rider 207 report. Finally, HHSC collected feedback on participation in rate enhancement program from the HCS providers who currently participate in rate enhancement at much lower frequency than providers in other community programs.

Texas Medicaid Community Attendant Recruitment and Retention Data

For several years, the Washington State Department of Social and Health Services has been collecting annual surveys of certain institutional providers to acquire accurate, up-to-date data on direct care worker turnover. Following correspondence with Washington state in 2018, HHSC added turnover questions to its Medicaid cost reports which were modeled after Washington's surveys. HHSC's Medicaid cost reports for the Community Living Assistance and Support Services (CLASS), Day Activity Health Services (DAHS), HCS/TxHmL, Primary Home Care (PHC), and Title XX Residential Care (RC) programs now include important questions about workforce turnover and retention.[16] Appendix A contains the questions that were added to HCS/TxHmL providers' fiscal year 2018 cost reports in January 2019.

In a separate initiative, HHSC modified its cost report submission requirements beginning in 2019 so that cost reports are submitted every other year rather than every year.[17] In April 2019, HHSC received turnover data from HCS/TxHmL and RC providers. For this report, HHSC presents pertinent attendant recruitment and retention data from the HCS/TxHmL and RC programs. With these new cost report

[16] The new recruitment and retention questions were first implemented in providers' fiscal year 2018 Medicaid cost reports and will continue to be included going forward.

[17] All LTSS program cost reports that were submitted every year are now submitted every other year, except for the 24-hour Residential Child Care program administered by the Texas Department of Family and Protective Services. HCS/TxHmL, ICF/IID, NF, and RC providers submit cost reports during even years, and CLASS, DAHS, and PHC providers submit cost reports during odd years.

questions, HHSC will be better equipped to examine turnover trends in the Texas Medicaid attendant workforce, particularly over the span of multiple years. Per Rider 157 of the General Appropriations Act for the 2020-21 biennium, HHSC will submit a state workforce strategic plan by November 1, 2020 to improve recruitment and retention of community attendants; 2019 cost report turnover data collected on CLASS, DAHS, and PHC providers will be presented at this time, in addition to other data that the agency plans to collect.[18]

Table 1 contains a preliminary summary of the data from the HCS/TxHmL and RC cost report turnover sections; the data is self-reported and is not verified by HHSC. The data in Table 1 exhibits a weak correlation between average wages and average percent turnover, and turnover amongst HCS/TxHmL non-residential attendants is notably lower than that of residential attendants. Based on the agency's preliminary review of the cost report data received in May 2019, the agency intends to modify certain turnover questions for future clarification. See Appendix B for further details on 2018 HCS/TxHmL turnover.

Table 1. Texas Attendant Turnover in HCS/TxHmL and RC, 2018

Attendant Type[19]	Average Wage	Average Percent Turnover	Average Estimated Days to Fill Vacant Positions	Average Percent Work Hours Filled with Overtime or Non-Scheduled Staff
HCS/TxHmL				
Residential Attendant	$10.38	72.4%	36	24.1%
Non-Residential Attendant	$10.81	39.8%	31	22.1%
Residential Care				
Attendant	$10.20	104.6%	13	16.5%

[18] 2020-21 General Appropriations Act, H.B. 1, 86rd Legislature, Regular Session, 2019 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 157, Community Attendant Workforce Development Strategies.

[19] The Attendant Compensation Rate Enhancement program is available for attendant services programs. Attendant services in both residential and non-residential settings are available in the HCS program; non-residential attendant services are available in the TxHmL program. Residential attendant services only are available in the RC program.

State and National Data

In pursuit of a more complete database of the progress other state Medicaid agencies are making toward remedying the attendant workforce issue, HHSC attempted to contact and survey all state Medicaid agencies that were either contacted unsuccessfully or not contacted for the 2018 Rider 207 report. All state Medicaid agencies were contacted for this year's report except for Connecticut, Florida, Louisiana, Michigan, New Mexico, Oklahoma, and Wisconsin, which were contacted for the 2018 reports; Washington state provided an update of last year's survey response because HHSC has been actively corresponding with them. Of the 41 state Medicaid agencies that were contacted, HHSC received survey responses from 16, which amounts to a two-year database of 25 states. Appendix C contains a summary table of all Rider 207 survey responses received by HHSC in 2018 and 2019.

In the survey, HHSC asked other Medicaid agencies to describe the greatest difficulties attendants are facing in their states; commonly cited difficulties include job market competition for staff, high turnover rates, staffing issues in rural areas, low availability of attendants qualified to serve individuals with complex needs, and low attendant wages. In addition, HHSC inquired about the financial and non-financial strategies other state Medicaid agencies have implemented or are considering for attendant workforce issues. Financial strategies cited by other state Medicaid agencies include tiered rates and career ladders for attendants, allocating funds for attendant training and development, value-based payment (VBP) models for the attendant workforce, increased wages, and increased wages contingent on mandatory surveys that track the effect that increased funds have had on attendant staffing; non-financial strategies cited include data collection, workforce planning requirements in managed care, electronic visit verification (EVV), ensuring access to effective supervision, training and orientation, and self-directed personal care.

Beyond the state survey results, HHSC collected information on non-surveyed state Medicaid agencies' strategies. An October 2018 Kaiser Family Foundation report reveals that North Carolina is expanding workforce opportunities with a new live-in support service and Tennessee is using test grant funding to create new education and training curriculum for direct care workers."[20]

[20] "State Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019." Kaiser Family Foundation. October 25, 2018. https://www.kff.org/report-section/states-focus-on-quality-and-outcomes-amid-waiver-changes-long-term-services-and-supports-reforms/

In the 2018 report, HHSC presented general data on PCA wages in other states compared to Texas. Table 2 expands on that data, and contains the median PCA wage, cost of living, minimum wage, and Medicaid attendant minimum wage of each of the 25 surveyed states plus the United States to show comparisons with Texas.

Table 2. Attendant Wage Comparisons of Texas and Surveyed States

State	BLS Hourly Median PCA Wage[21]	Composite Cost of Living Index (COLI)[22]	Median PCA Wage Adjusted by COLI[23]	State Min. Wage, 2019	Medicaid Attendant Base Wage, 2019
AL	$8.98	89.5	$10.03	$7.25	None
AZ	$11.39	97.7	$10.61	$11.00	None
AR	$9.38	88.4	$11.66	$9.25	None
CO	$11.68	105.5	$11.07	$11.10	None
CT	$12.48	128.8	$9.69	$10.10	$15.50
FL	$10.68	98.9	$10.80	$8.46	None
GA	$10.25	91.2	$11.24	$7.25	None
HI	$13.16	190.1	$6.92	$10.10	None
ID	$10.73	94.2	$12.60	$7.25	None
IN	$10.84	90.1	$11.39	$7.25	None
IA	$11.57	91.8	$12.03	$7.25	None
KY	$11.38	91.8	$12.40	$7.25	None
LA	$8.96	93.6	$9.57	$7.25	None
MI	$11.06	89.3	$12.39	$9.45	$9.45 or $13.50-$15.50[24]
MN	$12.38	101.5	$12.20	$9.86	$13.25
MS	$9.96	85.7	$11.62	$7.25	None
MT	$11.36	104.0	$10.92	$8.50	None
NM	$9.57	92.8	$15.74	$7.50	None
NV	$11.07	108.3	$11.32	$8.25	None
NJ	$13.87	122.5	$10.31	$8.85	$17.00
ND	$15.54	98.7	$10.22	$7.25	$20.36 or $27.96[25]
OK	$9.27	88.1	$10.52	$7.25	None
TX	**$9.30**	**91.3**	$10.19	**$7.25**	**$8.00**
WA	$13.77	109.5	$12.58	$12.00	$12.24 (entry level); $13.12 (second year)
WI	$11.43	95.8	$11.93	$7.25	$16.40
U.S.	**$11.55**	**100.0**	**$11.55**	**-**	**-**

[21] Occupational Employment Statistics, Personal Care Aides, All States and National. BLS. May 2018. BLS provides national data that does not distinguish by payer sources.
[22] 2018 Cost of Living Index (COLI). The Council for Community and Economic Research (C2ER).
[23] The values in this column are obtained by dividing the median PCA wages by the composite COLI, multiplied by 100.
[24] Agency attendants in Michigan are paid $13.50-$15.50/hour minimum depending on the county.
[25] ND minimum Medicaid attendant wages: $20.36 for individual attendant; $27.96 agency attendant.

Table 2 contains each surveyed state's median PCA wage, its cost of living index (COLI), its median wage adjusted by its COLI value, and its statewide minimum wage. The Median PCA Wage Adjusted by COLI column is meant to illustrate the purchasing power of attendants both working and living in each state by evaluating wages relative to cost of living. Hawaii, for instance, has a high median PCA wage ($13.16), but also a very high COLI (190.1); given Hawaii's very high cost of living, the median PCA wage adjusted by the COLI is very low ($6.92). Texas has both a low median PCA wage ($9.30) and low cost of living (91.3); however, regardless of the lower cost of living in Texas, the PCA median wage relative to its cost of living ($10.19) is lower than the national average ($11.55).

Rate Enhancement Participation Survey Data

In June 2018, HHSC conducted a survey of active HCS/TxHmL and ICF/IID providers, which included questions about the Day Habilitation program and rate enhancement. Of the 582 (454 HCS/TxHmL and 128 ICFs/IID) total survey responses, 355 (307 HCS/TxHmL and 48 ICFs/IID) answered that they do not participate in rate enhancement, equating to 32.4 percent rate enhancement participation for HCS/TxHmL and 62.5 percent rate enhancement participation for ICFs/IID.

If the survey respondent indicated that they do not participate in rate enhancement, they were asked to provide a written answer as to why. The written response data for why providers do not participate was manually categorized and visualized in Appendix D.

The top three reasons why surveyed non-participating HCS/TxHmL and ICF/IID providers do not participate in rate enhancement are ranked in order below:

1. Rate enhancement add-on payment is insignificant.
2. The reporting requirements and paperwork for rate enhancement are too cumbersome.
3. The provider is unfamiliar with the program and/or program benefits.

HHSC is committed to taking steps to encourage providers to participate in the rate enhancement program. To reduce the administrative and financial burdens associated with submitting cost reports every year, the agency revised its submission requirements to make cost reports due only every other year. This reform effort began with a pilot on ICF/IID cost reports in 2017 and was expanded

to all other LTSS cost reports in 2018. HHSC is also working to expand the avenues to educate providers about the benefits of rate enhancement and to clarify the process and requirements. The agency hopes that improved education and provider outreach will lead to increased provider participation in the upcoming enrollment period. In addition, the General Appropriations Act for the 2020-21 biennium appropriates funds for the creation of separate categories in the rate enhancement program for HCS/TxHmL; this will group services based on the number of attendant hours included in the billing unit in an effort to increase participation.[26]

[26] 2020-21, General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019, (Article II, HHSC, Rider 44(a)(4)).

HHSC's Proposed Strategies

Non-Financial Strategies

Convene a cross-agency forum to develop a state workforce development plan for retention and recruitment of community attendants

In October 2018, HHSC Money Follows the Person (MFP) staff hosted a two-day forum addressing the recruitment and retention of Direct Service Workers (DSWs) with forty individuals representing community-based stakeholders and other state agencies.[27] Individuals receiving HHSC services, direct care workers and representatives from advocacy organizations, provider associations and organizations, Managed Care Organizations (MCOs), researchers, HHSC, Department of State Health Services (DSHS), and the Texas Workforce Commission (TWC) attended this forum. The goals of the two-day forum were to review the most recent information on direct service workforce in Texas, and to obtain stakeholder input on recruitment and retention strategies.

The first day of the forum consisted of panel presentations on the state of recruitment and retention of DSWs in Texas, an explanation of the 2018 Rider 207 report, and staff from TWC exploring their role in addressing the DSW workforce shortage. The day concluded with stakeholders discussing the successes and failures of previous DSW recruitment and retention efforts.

The second day began with a panel of DSWs discussing their experiences in the field and what they believed could address the recruitment and retention issue. The day concluded with a gathering of stakeholders compiling and prioritizing a list of recommendations that they would like to see explored. The recommendations developed at the forum aligned with the strategies identified in the 2018 Rider 207 report.

In March 2019, a stakeholder meeting was held which included many of the same participants from the DSW forum. The focus of this meeting was on Value-Based Payments for home and community-based services (HCBS) in managed care. This

[27] The Direct Service Worker Forum was funded by the Money Follows the Person Demonstration.

meeting continued many of the conversations introduced at the forum as applicable to VBP, and the feedback will help shape how Texas implements VBP for HCBS.

Require employers (both agency and Consumer Directed Services (CDS) employers) to provide Federal Child Care and Development Fund (CCDF) program eligibility and referral information to all community attendants

Upon further research into the CCDF program, HHSC found that CCDF services are handled by 28 local CCDF board areas across Texas and thus program specifics can differ slightly depending on which county the individual lives in. As a result, a single brochure that would be accurate across Texas does not exist. HHSC capitalized on this additional opportunity to build relationships with TWC. HHSC worked with policy specialists from TWC to develop a training covering the general information about the program as well as how to find the local CCDF board that applies to a community attendant's service area.[28] HHSC coordinated a presentation of this information to STAR+PLUS managed care organizations and will do the same for fee-for-service waiver providers later this year, to include the following four IDD waivers: CLASS, Deaf Blind with Multiple Disabilities (DBMD), HCS and TxHmL. HHSC will coordinate the presentation of this information to any other groups as requested. The goal is to provide outreach information to help support community attendants who may need low-cost child care.

Create a strategy to expand utilization of self-directed services

Individuals receiving LTSS may choose the delivery model through which their services are provided. The CDS option and Service Responsibility Option (SRO) are alternatives to the provider agency model, where an agency is responsible for employing and managing the DSW.

The CDS option allows individuals to self-direct some or all of their program services, meaning that they hire and manage their service providers. The individual receiving services, or their legally authorized representative (LAR), is appointed as the CDS employer. As the CDS employer, the individual hires, trains, manages, and terminates his or her own service providers. The CDS employer may also appoint a

[28] "How to Apply for Child Care Assistance." Texas Workforce Commission. 2019. https://texaschildcaresolutions.org/financial-assistance-for-child-care/how-to-apply-for-child-care-assistance/

designated representative to assist the individual with his or her employer responsibilities.

SRO is a service delivery option that allows individuals receiving services through a provider agency greater control over how their services are provided to them. For example, an individual who selects SRO would work with an agency to determine which staff will assist them. SRO is less restrictive than the agency option in which the member does not select which staff are assigned to assist them.

To increase utilization of the CDS option, HHSC staff will travel across the state during summer and fall 2019 to provide in-person trainings for program service coordinators and case managers. Service coordinators and case managers are responsible for providing individuals with information about service delivery options upon program enrollment and annually thereafter. The trainings will include information about forms, processes, and responsibilities of service coordinators and case managers for the CDS option. They will also provide information about SRO.

Allowing individuals receiving services to select their attendants increases the likelihood the attendant and the individual will have greater satisfaction thus reducing attendant turnover. HHSC is considering the following actions to help expand utilization of self-directed services:

- Revise existing educational materials about self-direction.
- Provide information about SRO directly to provider agencies with a goal of increasing participation and provider capacity.
- Annually (or more frequently) require program case management, Local Intellectual and Developmental Disability Authority (LIDDA), Local Mental Health Authority (LMHA), and MCO service coordinators to provide individuals with education (including an HHSC approved brochure) and option of service delivery.
- Provide education on SRO to traditional agencies.

Continue focus on increasing training opportunities for attendants

Increased training of community attendants has been shown to increase job satisfaction among workers and improve quality of care for the individuals receiving attendant care.

A 2014 survey conducted by legacy Department of Aging and Disability Services (DADS) of community attendants found that over 70 percent of community

attendants believed they were adequately trained in skills such as basic personal care, providing person-directed services, first aid and emergency training, how to lift and transfer safely, CPR, and supporting individuals with complex medical and behavioral healthcare needs. Over 70 percent also, however, indicated an interest in receiving additional training on topics such as understanding mental illness and recovery, supporting people with challenging behavior, mitigating aggressive or violent behavior, and recognizing illness or injury in persons who have difficulty communicating.

In the 2018 Rider 207 report, HHSC discussed online training for community attendants developed in response to the survey's findings. Since that report these online training modules have been expanded to include three new modules designed to expand the knowledge and skills of healthcare professionals (including physicians, physician assistants, nurse practitioners, and other providers), delivering care for individuals with IDD and co-occurring behavioral health challenges. Although these newer modules are not directed toward attendants, anyone can access these modules at no cost. Additional funds have also been allocated to develop training on other topics cited in the study including communication, prevention of disease, challenging behaviors, mental health, substance abuse, dementia, Alzheimer's, and self-care.

In addition to the Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities training cited above, HHSC offers a combination of online and in-person training opportunities for community attendants including the following:

- Texas OASIS for HCBS Dementia Academy: an online academy for those working in community settings;
- Person-centered Thinking: in-person trainings by certified trainers;
- Alzheimer's Disease and Dementia Care Seminars by the National Council of Certified Dementia Practitioners;
- Trauma-informed Care: in-person trainings by certified trainers;
- Advanced Certified Nurse Aide Academy (coming soon): an online version of the face-to-face training;
- Center for Excellence in Aging Services and Long Term Care: a University of Texas School of Nursing educational platform for the delivery of geriatric and

disability best practices to nurses of all licensure levels providing care in Texas;[29]
- The LTC Quality Provider Outreach Conference day 2 breakout sessions: a free 2-day training event in August 2019 hosted by HHS and the University of Texas at Austin School of Nursing; and[30]
- Comprehensive Abuse, Neglect and Exploitation: computer-based training.

Furthermore, HHSC is developing a presentation to provide information regarding where training for community attendants can be found, how to receive updates on new trainings and encouraging them to access these trainings and maintain any certificates received.

Explore amending policy in all programs within the scope of this report to allow attendants to live in the residence of the individuals receiving the personal assistance or habilitation services

Personal assistance services (PAS) and habilitation services are provided by community attendants who meet the following criteria:

- Employed by an MCO-contracted provider, a program provider, or the employer of record under the CDS Option;
- 18 years of age or older;
- Not the spouses or legally authorized representative of the person served, or parents of a minor person served; and
- Perform all the services available within their scope of competency and within the program service definition.

Individuals who reside with the individual receiving services are often family members and have a vested interest in the quality of care received by their loved one. Allowing family members who reside in the home to deliver paid attendant services could lead to less turnover. Currently, some but not all Medicaid programs allow qualified service providers who live in the home of individuals served as eligible service providers (i.e. eligible for payment).

[29] "Center for Excellence in Aging Services and Long-Term Care." UT School of Nursing, http://www.utlongtermcarenurse.com/
[30] "2019 HHS Quality in Long-Term Care Conference." March 6, 2019. https://hhs.texas.gov/about-hhs/communications-events/news/2019/03/save-date-2019-hhs-quality-long-term-care-conference

HHSC is currently performing analysis on the feasibility of amending policy to allow qualified attendants who reside in the homes of individuals receiving Community First-Choice Personal Assistance Services / Habilitation Services (CFC PAS/HAB) as eligible paid service providers in the HCS and TxHmL programs.

Examine workplace culture issues to learn about tenured attendants' motivations

A key finding of HHSC's research involves the connection between worker retention and workplace culture. Low-wage employees are more likely to stay in their current job when they feel that their efforts are valued and their work contributes to a noble purpose, and providing care to the aged or individuals with disabilities can be fulfilling in such a way.[31] This kind of staff empowerment can help community attendants overcome the everyday stresses that may accompany their work routines and low wages.

Improving workplace culture often requires improving the relationship between employee and supervisor, for instance. PHI suggests that workplace culture can be enhanced for attendant care staff by improving skills training and instituting a coaching model where supervisors work with "direct service employees" to develop problem-solving skills.[32] The coaching-supervisor model seeks to improve that relationship, and by doing so, increases the likelihood that attendant staff stay in their jobs longer. This kind of initiative, however, may have short-term costs to providers due to the time and resources required to facilitate a coaching model and to provide skills training.

Stakeholders raised this topic in the cross-agency forum held in October 2018 and gave recommended implementation. However, low- or no-cost options may not be available for this strategy. Currently, agencies are free to implement coaching-supervisor methods on their own. HHSC continues to review for opportunities to collaborate for this purpose.

[31] "Why They Stay: Retention Strategies for Long Term Care" Provider Magazine, November 2015. http://www.providermagazine.com/archives/2015_Archives/Pages/1115/Why-They-Stay-Retention-Strategies-For-Long-Term-Care.aspx

[32] "Creating a Culture of Retention: A Coaching Approach to Paraprofessional Supervision." PHI. https://phinational.org/wp-content/uploads/2017/07/PHI-CoachingOverview.pdf

Continue to prioritize data collection

In January 2019, HHSC released its Medicaid LTSS cost reports with questions related to workforce recruitment and retention. This, however, is only an initial step toward more comprehensive data which allows for more informed decision-making.

The agency will work with the Texas Council on Consumer Direction (TCCD) to discuss the possibility of collecting attendant turnover data from CDS personal assistance providers. This data, intended to mirror the turnover data now collected via cost reports submitted by providers, would reveal the differences in turnover rates between CDS attendants and non-CDS attendants. One of the strategies discussed in this report is to promote the use of the CDS option; HHSC will be better equipped to do so if we have better insights into the difficulties that CDS employers face regarding attendant recruitment and retention relative to non-CDS employers.

Because cost reports including turnover data are collected every other year instead of every year as of 2019, HHSC is considering implementing mandatory interim turnover questions. This may be implemented through the Attendant Compensation Reports that are required for rate enhancement participants, or through other surveys which would include providers that do not participate in rate enhancement.[33]

Over the course of developing the 2019 Rider 207 report, the agency established relationships with individuals in other state Medicaid agencies and health policy organizations such as PHI and the National Association of States United for Aging and Disabilities (NASUAD). Attendant workforce turnover issues are not only endemic to Texas but are nationwide, so it is essential that HHSC continues to collaborate with other organizations that are also researching the issues addressed in this report. For instance, in 2018 PHI partnered with home care providers in both Minnesota[34] and Wisconsin[35] to transform home care jobs by "[elevating] the role of the aide" in the states' home care systems.

[33] Attendant Compensation Reports are submitted by rate enhancement participants during years that cost reports are not required in order to determine rate enhancement compliance.
[34] "PHI Launches Initiative to Transform Home Care Jobs in Minnesota." PHI. July 24, 2018. https://phinational.org/news/phi-home-care-initiative-minnesota/
[35] "New PHI Initiative Aims to Transform Home Care Jobs in Wisconsin." PHI. October 6, 2018. https://phinational.org/news/new-phi-initiative-aims-to-transform-home-care-jobs-in-wisconsin/

Improve outreach and recruitment of attendants through local collaboration

TWC, Local Workforce Development Boards, community colleges, and non-profits (i.e., Volunteers of America, Centers for Independent Living) have a wealth of expertise in the needs of local job markets, workforce recruitment techniques, and training opportunities. Encouraging collaboration between such organizations and health plans and providers may yield innovative ideas for matching the need for attendants and those who might be interested. Importantly, TWC has information on potential target populations for recruitment outreach such as Temporary Assistance for Needy Families (TANF) recipients, older workers or students seeking part-time employment. TWC operates a searchable job bank that can potentially be a source for highlighting attendant opportunities. The October 2018 forum addressed the potential benefit of computer-based resources for connecting attendants with local employment opportunities.

In addition, HHSC submitted a Community Attendant Registry Study report in 2018 in accordance with House Bill 3295, 85th Legislature, Regular Session, 2017.[36] In conducting this study, HHSC found that states report anecdotal benefits, saying that registries:

- allow individuals without personal networks or in rural areas to find a DSW and live successfully in a community setting;
- provide information for a better fit between the individual using services and the DSW; and
- increase the opportunities for DSWs to create a 40-hour workweek by working for multiple individuals or agencies.

Successful outreach and dedication of resources would be key factors in launching such a registry.

[36] "Community Attendant Registry Feasibility Study." Texas Health and Human Services. December 2018. https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/hb-3295-community-attendant-regsitry-feasibility-dec-2018.pdf

Financial Strategies

Explore the potential of managed care value-based payment models

In April 2018, HHSC was one of 10 states selected to participate in a Centers for Medicare and Medicaid Services (CMS) Innovation Accelerator Program (IAP) project on VBP for managed care HCBS, with an initial project completion date of February 2019. In collaboration with the IAP team, a concept and visual representation for the aim and drivers to support the desired outcomes for the VBP for managed care HCBS initiative in Texas has been drafted. This concept and visualization (known as a driver diagram), reflects many of the strategies outlined in this report. The driver diagram and plan for VBP in managed care HCBS was presented to several focus groups comprised of stakeholders from varying perspectives. These focus groups' feedback contained additional strategies from this report and the Texas team is working with our IAP coaches to determine how best to incorporate those strategies into the VBP for managed care HCBS in Texas project. Additionally, Texas applied for an extension of this IAP program and was awarded the extension in March of 2019. The IAP for VBP in managed care HCBS will continue until September 2019 with a goal of developing a detailed workplan for implementation of VBP in managed care HCBS for Texas.

Incentivize provider agencies to provide mentors and training opportunities for community attendants

Training and mentoring support the stability and adequacy of the provider network, and the ability of the community attendant to provide quality services in the community. Mentoring and training contribute to higher community attendant job satisfaction thereby potentially increasing attendant retention.

There are a multitude of articles, guides, and models available for providers looking to implement mentoring and training programs. However, there are cost barriers because staff training or mentoring must be paid for as part of the administrative cost for the program's direct care service.

Increased funding of the administrative/operational portion of the rate for direct services would incentivize providers to compensate community attendants for spending time developing special skills and expertise through training and provide new attendants with mentors or coaches to obtain consumer-specific special needs training; these would prepare attendants to care for individuals with complex

medical and behavioral health needs. Provider agencies have indicated that an increase in the administrative/operational portion of the rate would support increased training and mentoring opportunities.

Increase the minimum wage paid to attendants

As briefly discussed, the 86th Legislature (2019) provided $33,600,000 in General Revenue ($87,083,409 All Funds) for an increase in the base wage of personal attendants to $8.11 per hour for state fiscal years 2020 and 2021.[37] HHSC will continue to explore how increases to the minimum hourly wage for attendants affect recruitment and retention issues, particularly as the agency gathers more complete workforce data from LTSS providers and CDS employers.

Because the agency only began to collect data on the 2018 cost reports submitted by LTSS providers in April 2019, HHSC is unable to evaluate the effect of the prior rate increase to support of a $8.00 minimum attendant wage and the most recent rate increase to $8.11 minimum attendant wage has on attendant recruitment and retention data. As more data is collected from future cost reports HHSC will be able to evaluate changes in recruitment and retention data after any future increases or decreases to the minimum attendant wage.

Increase in the funding of the Attendant Compensation Rate Enhancement program

The rate enhancement program is a voluntary program in which participating providers may choose to receive additional funds to supplement attendant wages and benefits. Increasing funding for rate enhancement programs may potentially alleviate recruitment and retention issues in Texas by increasing the attendant portion of the rate for participating providers.

There are separate appropriations for IID programs versus all other community-based programs; the current appropriations support a rate increase of $0.05 per level for up to 25 levels above the base rate for IID programs, and up to 35 levels above the base rate for all other community-based programs.

Because rate enhancement participants must agree to spend ninety percent of the increased attendant rate component on attendant compensation, increasing

[37] 2020-21, General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019, (Article II, HHSC, Rider 45)

appropriations for the rate enhancement program will directly impact the expenditures for community attendants, which include increased individual attendant wages and benefits or the hiring of additional attendants. The remaining 10 percent of the attendant rate component is for providers' discretionary spending on administrative expenses associated with attendant care.

The 86th Texas Legislature (2019) appropriated $9,100,000 in General Revenue ($23,538,615 All Funds) for the 2020-21 biennium to fully fund the rate enhancement programs for community care and IID providers.[38] Providers who choose to participate in the rate enhancement program determine the participation level at which they would like to participate. Due to FY2019 funding levels, not all providers enrolled in the rate enhancement program are able to participate in the program at their requested level. The funds appropriated to fully fund the community care and IID rate enhancement programs in FY2020-21, in addition to allowing more providers to participate in the program, will allow current providers to participate at or near their requested participation levels.

For FY 2021, the 86th Texas Legislature also appropriated $6,137,103 ($16,615,210 All Funds) for HHSC to create separate categories in the HCS/TxHmL rate enhancement programs to group services based on the number of attendant hours included in the billing unit and, as funds are available, to increase participation in those rate enhancement programs. HHSC plans to develop new categories for the IID rate enhancement program by September 1, 2020.[39]

The increased legislative appropriations, revisions to the IID rate enhancement program, and expanded provider outreach efforts as described above are intended to lead to higher rate enhancement participation that will benefit community attendants in Texas. HHSC will continue to evaluate how increased funding and programmatic changes to rate enhancement impacts attendant recruitment and retention through continued data collection and analysis.

[38] 2020-21, General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019, (Article II, HHSC, Rider 45).
[39] 2020-21, General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019, (Article II, HHSC, Rider 44(a)(4) and (c)). Note that as a part of this rider, the legislature also appropriated $4,682,897 ($12,316,931 All Funds) to create separate categories of rate enhancement for the ICF/IID program.

4. Conclusion

Long-term care providers not only in Texas but nationwide are facing a mounting challenge to recruit and retain the qualified attendants necessary to provide direct care for an aging population and individuals with disabilities.

Improved data on the recruitment and retention difficulties in Texas will allow HHSC to establish a turnover baseline and provide further guidance; the agency will then be able to determine the effects of any strategies that are implemented thereafter.

As HHSC continues to collect and analyze additional data on attendant recruitment and retention issues in Texas, both the agency and the legislature will be better equipped to make critical decisions in the interest of both Medicaid community attendants and the individuals whom the attendants serve.

List of Acronyms

Acronym	Full Name
ADL	Activity of Daily Living
BLS	United States Bureau of Labor Statistics
CCDF	Child Care and Development Fund
CDS	Consumer Directed Services
CLASS	Community Living Assistance and Support Services (1915(c) Waiver Program)
CFC PAS/HAB	Community First-Choice Personal Assistance Services / Habilitation
CMS	Centers for Medicare & Medicaid Services
DADS	Department of Aging and Disability Services
DBMD	Deaf Blind with Multiple Disabilities (1915(c) Waiver Program)
DAHS	Day Activity and Health Services
EVV	Electronic Visit Verification
HAB	Habilitation
HCBS	Home and Community Based Services (federal)
HCS	Home and Community-based Services (Texas 1915(c) Waiver Program)

Acronym	Full Name
HHA	Home Health Aide
HHS	Texas Health and Human Services
HHSC	Texas Health and Human Services Commission
IADL	Instrumental Activity of Daily Living
IAP	Innovation Accelerator Program
ICF/IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities or Related Conditions (State Plan Service)
IDD	Intellectual or Developmental Disabilities
IID	Individuals with Intellectual Disabilities or Related Conditions
LIDDA	Local Intellectual and Developmental Disability Authority
LMHA	Local Mental Health Authorities
LTC	Long Term Care
LTSS	Long Term Services and Supports
MCO	Managed Care Organization
MFP	Money Follows the Person
MW	Minimum wage
PAS	Personal Assistance Services

Acronym	Full Name
PCA	Personal Care Aide
PHC	Primary Home Care
SHL/CSS	Supported Home Living / Community Support Services
SL/RSS	Supervised Living / Residential Support Services
SRO	Service Responsibility Option
TAC	Texas Administrative Code
TANF	Temporary Assistance to Needy Families
TWC	Texas Workforce Commission
TxHmL	Texas Home Living (1915(c) Waiver Program)
VBP	Value-based Payment

Appendix A. New Workforce Turnover Questions in Cost Reports

Below are new tables that were added to the HCS/TxHmL cost reports that will assist with data gathering on staff recruitment and retention, particularly for direct care workers. These tables were originally modeled from a similar section in the state of Washington's Medicaid cost reports, which was shared with HHSC while conducting research for the 2018 Rider 207 report. Equivalent tables were also added to the CLASS, DAHS, PHC, and RC cost reports, but they were tailored for program-specific staff position types.

Per a cost report reform initiative implemented on January 1, 2019, cost reports for most LTSS programs are now required every other year instead of every year. 2018 community-based cost reports were due on April 30, 2019 for HCS/TxHmL and RC providers; 2019 community-based cost reports are due on April 30, 2020 for CLASS, DAHS, and PHC providers.

For the 2019 cost reports collected in 2020, the tables shown Appendix A will be slightly refined based on the analysis of the staff recruiting information reported in the 2018 cost reports.

Staff Recruiting Information

Position Type	Difference in recruiting new staff from 1/1/2018 - 12/31/2018? Please select one option for each Position Type
Residential Attendants (Supervised Living/Residential Support Services (SL/RSS))	
Non-Residential Attendants (Supported Home Living/Community Support Services (SHL/CSS), Day Habilitation, Respite)	
Employment Services (Supervised Employment (SE), Employment Assistance (EA))	
Nurses (Registered Nurses (RNs), Licensed Vocational Nurses (LVNs))	
Specialists (Physical Therapists (PT), Occupational Therapists (OT), Dieticians, etc.)	
Central Office Staff	
Administrative and Operations Staff	

Note: the second column in the above table has drop-down lists in each row with choices 0, 1, 2, and 3

Staff Retention Information

Position Type	Number of staff (Full-time, Part-time, Temp, Medicaid, Non-Medicaid & Private Pay combined) on 12/31/2018	Number of staff who left 1/1/2018 - 6/30/2018	Number of staff who left 7/1/2018 - 12/31/2018	Number of vacancies on 12/31/2018	Percentage of work hours filled w/OT or non-scheduled staff (Estimates accepted if unknown)	Average number of days to fill vacant positions (Estimates accepted if unknown)	Current starting wage for this type of position within your agency in 2018 (Hourly Rate)	Average wage for this type of position after 2 years of employment (Hourly Rate)
Residential Attendants (SL/RSS)					%		$	$
Non-Residential Attendants (SHL/CSS, Day Hab, Respite)					%		$	$
Employment Services (SE, EA)					%		$	$
Nurses (RNs, LVNs)					%		$	$
Specialists (PT, OT, Dietary, etc.)					%		$	$
Central Office Staff					%		$	$
Administrative and Operations Staff					%		$	$

Position Type	Number of staff (Full-time, Part-time, Temp, Medicaid, Non-Medicaid & Private Pay combined) on 12/31/2018	Number of staff who left 1/1/2018 - 6/30/2018	Number of staff who left 7/1/2018 - 12/31/2018	Number of vacancies on 12/31/2018	Percentage of work hours filled w/OT or non-scheduled staff (Estimates accepted if unknown)	Average number of days to fill vacant positions (Estimates accepted if unknown)	Current starting wage for this type of position within your agency in 2018 (Hourly Rate)	Average wage for this type of position after 2 years of employment (Hourly Rate)
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Length of Time with your Agency	Using the total number of staff from above, what is the length of time they have been with your agency?
LESS than 6 months	
BETWEEN 6 and 12 months	
OVER 12 months	
Total Staff by Length of Time	**0**

Number of HCS/TxHmL clients (Medicaid, Non-Medicaid, Private Pay, etc. combined) actively enrolled on 12/31/2018	

Staff Benefits Information

In addition to wages, does your agency offer benefits to staff? If Yes, check all that apply	Full-Time Staff	Part-Time Staff
Medical Insurance (paid in whole or in part by agency)		
Dental Insurance (paid in whole or in part by agency)		
Retirement (paid in whole or in part by agency)		
Paid Sick Leave		
Paid Vacation		
Short-Term Disability		
Long-Term Disability		
Jury Duty Leave		

In addition to wages, does your agency offer benefits to staff? If Yes, check all that apply	Full-Time Staff	Part-Time Staff
Bereavement Leave		
Vision Insurance		
Employee Assistance Plan		
Life Insurance		

Appendix B. HCS/TxHmL Attendant Wages and Turnover

This table breaks the attendant data from the 2018 HCS/TxHmL cost reports down into Texas HHS Regions and by residential (SL/RSS) versus non-residential (SHL/CSS) attendants. This data was obtained from new cost report questions that are displayed in Appendix A. The data obtained is self-reported by HCS/TxHmL providers and cannot be verified by HHSC.

Table B-1. HCS/TxHmL Attendant Wages and Turnover, 2018

Texas HHS Regions[40]	Residential Average Wage	Residential Average Percent Turnover	Residential Average Wage Growth After 2 Years[41]	Non-Residential Average Wage	Non-Residential Average Percent Turnover	Non-Residential Average Wage Growth After 2 Years
Region 1	$10.44	87.8%	4.1%	$10.72	51.1%	13.3%
Region 2	$10.05	110.6%	2.4%	$10.55	61.7%	8.3%
Region 3	$10.76	77.6%	7.6%	$11.30	38.1%	10.7%
Region 4	$10.36	74.6%	5.0%	$10.70	41.6%	13.2%
Region 5	$10.10	62.3%	5.1%	$11.18	32.2%	6.7%
Region 6	$10.39	44.2%	10.4%	$11.24	36.3%	14.4%
Region 7	$10.31	90.9%	7.2%	$10.96	52.9%	8.2%
Region 8	$10.58	80.2%	9.0%	$10.46	33.7%	15.2%
Region 9	$11.24	99.5%	3.3%	$11.70	76.5%	11.9%
Region 10	$9.07	88.2%	4.4%	$8.98	52.5%	4.7%
Region 11	$9.58	51.9%	9.2%	$9.93	28.3%	8.6%
Total Avg.	**$10.38**	**72.4%**	**7.7%**	**$10.81**	**39.8%**	**11.7%**

[40] Health and Human Services (HHS) Offices by County. October 2018. https://hhs.texas.gov/sites/default/files/documents/about-hhs/hhs-regional-map.pdf

[41] This is the difference between the average starting wage of an attendant and the average wage after two years of employment in the same position.

Although a positive correlation exists between higher wage growth and lower percent turnover for residential attendants, the correlation is weaker for non-residential attendants. This is illustrated in the figures below in Figure B-1 and Figure B-2. The relationship between wage growth and turnover is one of many factors that may be examined via data from the new cost report turnover questions.

Figure B-1. HCS/TxHmL Residential Attendants: Turnover vs 2-year Wage Growth

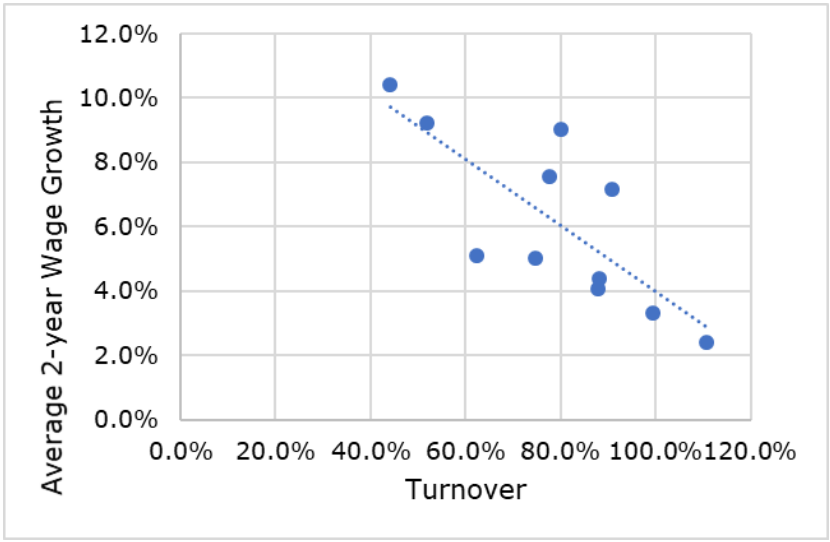


Figure B-2. HCS/TxHmL Non-Residential Attendants: Turnover vs. 2-year Wage Growth

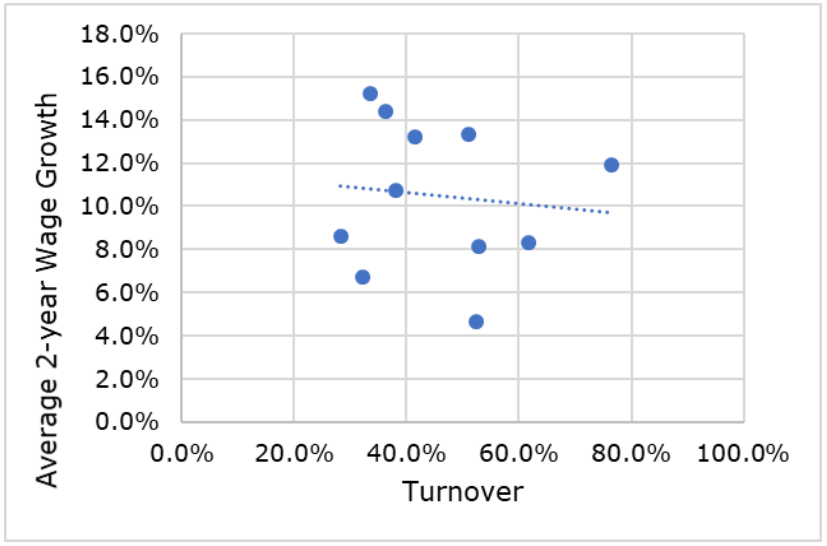


Figure B-3. Texas HHS Regions, October 2018[42]

Figure B-3 displays the Texas HHS Regions used for Table B-1.

[42] Health and Human Services (HHS) Offices by County. October 2018. https://hhs.texas.gov/sites/default/files/documents/about-hhs/hhs-regional-map.pdf

Appendix C. State Medicaid Agency Survey Data

Table C-1. State Medicaid Agency Survey Data, 2018-2019.

State[a]	Attendant Program Difficulties	Financial Strategies	Non-financial Strategies	Attendant Workforce Data Collection	State and Attendant Hourly Minimum Wage (MW), 2019[b]
AL	Turnover; recruitment in rural areas.	None	1915(j) self-directed allows waiver client to choose and pay their own worker.	None	State MW: $7.25[c]
AZ	State's 2017 minimum wage increase from $8.05 to $10.00 amplified market competition for staff.	Differential adjusted payment (DAP) initiative, which currently provides one-time time limited increase to HCBS providers for EVV services, is being considered for attendant workforce development / retention. VBPs under consideration by MCOs for workforce/retention. State legislature approved one-time funding for an incentive payment for HCBS providers who service IDD individuals if they participate in surveys conducted by MCOs.	Three workforce planning requirements implemented into managed care contracts: designate Workforce Development Administrator, collect workforce data, provide technical assistance to providers for workforce stability. Also implemented a "Long Term Care Workforce Advisory Committee."	Beginning data collection of workforce turnover in 2019 via EVV.	State MW: $11.00[d]
AR	Recruitment, especially in rural areas.	None	None	None	State MW: $9.25
CO	Overhead costs; recruitment in rural areas.	Evaluating rates to include travel time.	Initial stages of collaborating with other state agencies to develop plans/strategies.	None	State MW: $11.10

State[a]	Attendant Program Difficulties	Financial Strategies	Non-financial Strategies	Attendant Workforce Data Collection	State and Attendant Hourly Minimum Wage (MW), 2019[b]
CT*	Unknown	Training and upgraded funds available for those who wish to pursue coursework.	Required orientation.	None	State MW: $10.10 Attendant MW: $15.50[e]
FL*	Unknown	None	None	None	State MW: $8.46
GA	Wages; travel expenses.	Career ladders under development.	Recruitment and training	Yes, via national core indicators for some programs.	State MW: $7.25
HI	Job market competition for staff.	None	None	None	State MW: $10.10
ID	Recruitment and turnover, especially in rural areas; market competition for staff.	Reimbursement increase and reevaluation of methodology.	None	None	State MW: $7.25
IN	Job market competition for staff.	Closest equivalent is VBPs for CNAs in SNFs.	None	Yes, via cost reports, but only for SNFs	State MW: $7.25
IA	Attendants available only via 1915(c) HCBS waivers, none via state plan.	None	None	None	State MW: $7.25
KY	Recruitment and retention.	Conducting a rate study across all waiver programs.	Training	None	State MW: $7.25
LA*	Unknown	None	None	None	State MW: $7.25[d]

State[a]	Attendant Program Difficulties	Financial Strategies	Non-financial Strategies	Attendant Workforce Data Collection	State and Attendant Hourly Minimum Wage (MW), 2019[b]
MI*	Issues with retention, rates, and implementing strategies (such as training requirements and differential pay based upon training) for managed care programs.	None	None	None	State MW: $9.45 Attendant MW: $9.45 individual attendants; $13.50-$15.50 agency attendants[f]
MN	Low rates; turnover; staff shortages.	Developing a rate methodology that considers wages in comparable occupations; promote use of existing training and development options.	Ensure access to effective supervision to increase job satisfaction; identify and promote use of technology solutions; enhance data collection to monitor workforce issues.	Yes, via voluntary provider survey; currently seeking legislative authority to mandate survey.	State MW: $9.86 Attendant MW: $13.25 floor
MS	Recruitment and retention in rural areas.	None	None	None	State MW: $7.25[d]
MT	Recruitment issues (especially in rural areas) via market competition, low unemployment, and variable work schedules.	State legislature granted bonuses/wage increases, and reimbursements for CFC/PAS providers who provide health insurance coverage to workers.	None	None	State MW: $8.50
NM*	Unknown.	None	None	None	State MW: $7.50
NV	Low availability in rural areas; lack of EVV.	Legislative rate increase requests.	EVV	None	State MW: $8.25

State[a]	Attendant Program Difficulties	Financial Strategies	Non-financial Strategies	Attendant Workforce Data Collection	State and Attendant Hourly Minimum Wage (MW), 2019[b]
NJ	Not enough staff to meet needs.	Increased rates.	Considering: shared ride services to address transportation issues; career paths for home care workers' permitting pilot efforts by MCOs to build in VBPs; monitoring supply/demand to ensure sufficient capacity.	None	State MW: $8.85 Attendant MW: $17.00
ND	Recruitment in rural areas; availability of attendants qualified to serve complex needs, especially in rural areas.	Legislative rate increase requests.	MFP for addressing recruitment and retention.	Yes, turnover data has been collected continuously since the 1980s.	State MW: $7.25 Attendant MW: $20.36 individual attendants $27.96 agency attendants
OK*	Unknown	None	Collaborative planning with providers and other stakeholders for reducing staff turnover.	Yes, via optional provider portal for reporting turnover data (63% response rate in FY17)	State MW: $7.25
TX	Attendant turnover; low wages	Legislative requests for attendant minimum wage increase and rate enhancement rate increase, considering VBPs to improve attendant recruitment and retention.	Strengthening data collection; annually presenting several options for consideration by TX Legislature such as increasing training opportunities.	Yes, via cost reports beginning January 2019. Considering consumer-directed services data collection.	State MW: $7.25 Attendant MW: $8.00

State[a]	Attendant Program Difficulties	Financial Strategies	Non-financial Strategies	Attendant Workforce Data Collection	State and Attendant Hourly Minimum Wage (MW), 2019[b]
WA	Hiring and retention related to competing wages and job markets.	Replaced hourly rates with tiered rates (January 1, 2019) to allow providers more flexibility in how they provide services.	Data collection	Yes, via annual provider survey in Developmental Disability Community Residential settings.	State MW: $12.00 Attendant MW: $12.24 (entry level), $13.12 (second year)
WI*	Unknown	Direct workforce funding initiative for two state fiscal years that requires that providers complete a survey after each quarterly payment about: 1. how they used funding 2. why they chose to use funding as they did 3. whether they know of instances where the additional funding made the difference in retaining or recruiting a worker, and 4. how large of an impact they believe the funding has had on their ability to recruit and retain workers.[g]	Unknown	Yes, via direct workforce funding initiative mentioned in Financial Strategies.	State MW: $7.25 Attendant MW: $16.40 ($4.10/15 mins)

[a] Any state with an asterisk (*) was last surveyed in 2018 for the 2018 Rider 207 report and has not been surveyed again since.

[b] Statewide minimum wage data source: Consolidated Minimum Wage Table. U.S. Department of Labor https://www.dol.gov/whd/minwage/mw-consolidated.htm

[c] Alabama, Louisiana, and Mississippi do not have state minimum wages, so the federal minimum wage is listed.

[d] Arizona's state minimum wage will increase to $12.00 on January 1, 2020.

[e] Connecticut has built in increases for attendant wages that will eventually reach $16.25/hour on January 1, 2021.

[f] Attendants in Michigan are typically family and/or friends of the individual receiving attendant services and are paid minimum wage. Agency attendants, on the other hand, are paid $13.50-$15.50/hour minimum depending on the county.

[g] Wisconsin also has a program for NFs called WisCaregiver Careers (a grant program from Civil Money Penalty funding), which provides free training and testing for up to 3,000 students to become caregivers in WI NFs, plus a $500 retention bonus from participating NFs after six months on the job.

Appendix D. Rate Enhancement Participation Data

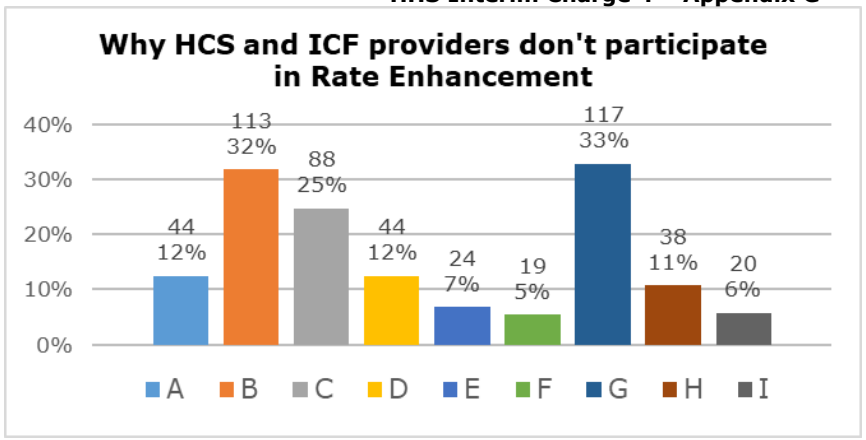
A	No applicable clients or not enough applicable clients
B	Reporting requirements/paperwork too cumbersome
C	Unfamiliar with the program/program benefits
D	Fears of recoupment
E	Requires an accountant / too small of a provider
F	Past issues with cost reporting
G	Rate enhancement is insignificant/not worth it
H	N/A or Choice
I	Wants to participate

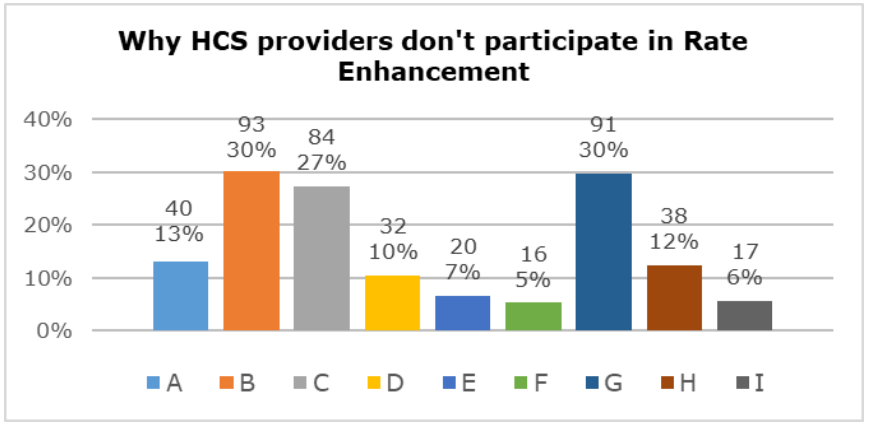
N = 355 (ICFs = 48, HCS = 307).

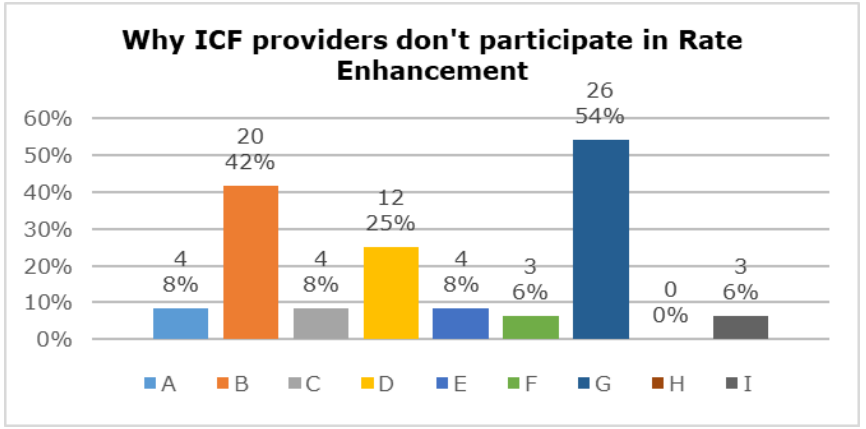
Data is based on two write-in questions in a June 2018 survey of HCS/TxHmL and ICF/IID providers: "*Why don't you participate in the Rate Enhancement program?*" and "*What would incentivize you to participate in the Rate Enhancement program?*" Around 36% of providers stated multiple grievances with rate enhancement, so each individual category is out of 100%.

Of the 582 (454 HCS/TxHmL and 128 ICFs/IID) total survey responses, 355 (307 HCS/TxHmL and 48 ICFs/IID) answered that they do not participate in rate enhancement, equating to 32.4% rate enhancement participation for HCS/TxHmL survey respondents and 62.5% rate enhancement participation for ICFs/IID survey respondents.

The first of the following charts is HCS/TxHmL and ICF/IID data combined, and then the second and third are broken down by HCS/TxHmL and ICF/IID responses alone, respectively.







Appendix E. Demographics of Personal Care Aides in Texas

Table E-1. Demographics of Personal Care Aides in Texas, 2017[43]

Category	Factor	Number	Percent
Total sample		**1,426**	**100.0**
Sex	Male	180	12.6
	Female	1,246	87.4
Race/Ethnicity	Non-Hispanic White	398	27.9
	Black	308	21.6
	Hispanic	547	38.4
	Asian	34	2.4
	Other	139	9.7
Age	18-24 years	149	10.4
	25-44 years	394	27.6
	45-64 years	674	47.3
	65 years and over	209	14.7
Employment type	Part-time (1-34 hours/week)	619	51.3
	Full-time (35 hours and over/week)	588	48.7
Class of worker	For-profit employee	1,074	75.3
	Not-for-profit employee	80	5.6
	Government employee	121	8.5
	Self-employed	139	9.7
	Other	12	0.8
Receiving public assistance	Yes	223	15.6
	No	1,203	84.4

The table above contains the demographics of PCAs in Texas, obtained from the U.S. Census Bureau. As of 2017, PCAs in Texas are majority female (87.4%), majority black or Hispanic (60.0%), and the median age is 50 years old. Over half of PCAs in Texas work part-time (51.3%), the majority work for a for-profit business (75.3%), and 15.6% receive some type of public assistance.

[43] 2017 American Community Survey 1-year Public Use Microdata Sample. U.S. Census Bureau. https://www.census.gov/programs-surveys/acs/data/pums.html