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

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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.

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[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]

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[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]

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[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

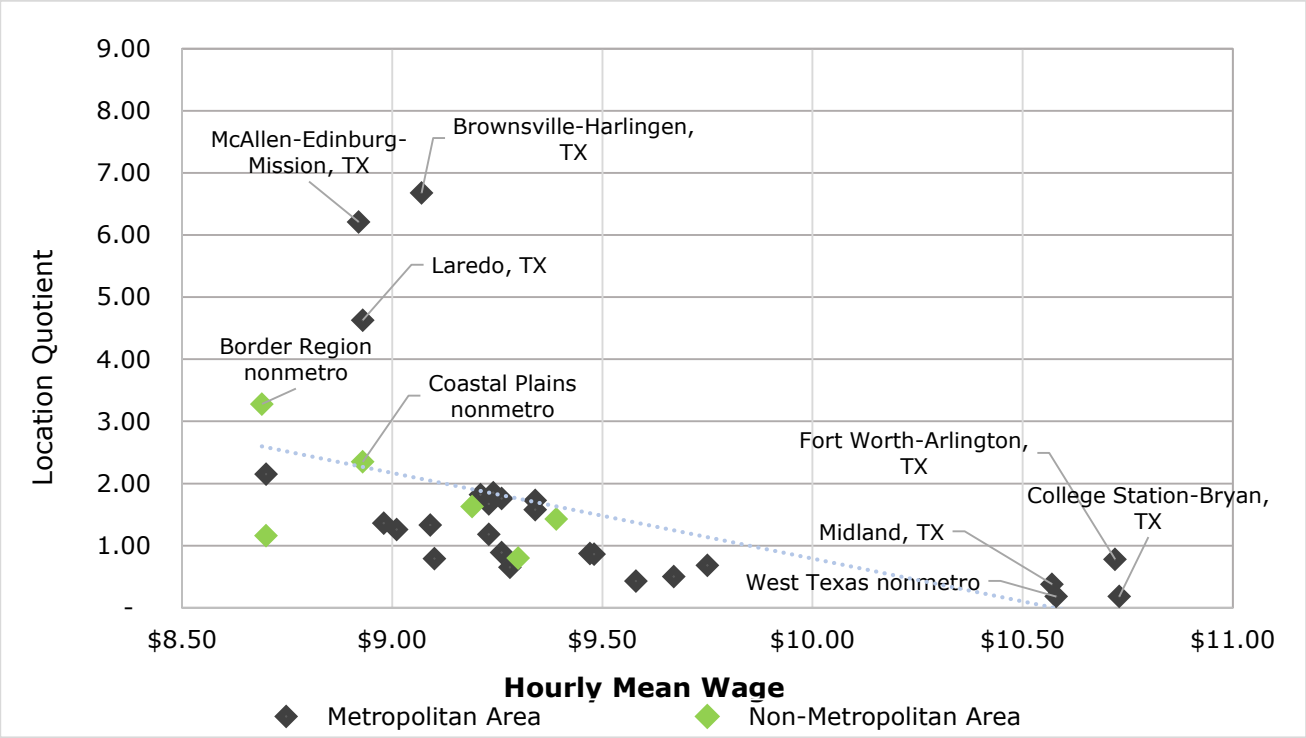
Appendix A. Location Quotient

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.