



Community Attendant Recruitment and Retention Strategies

**As Required by
Rider 207 of the 2018-19
General Appropriations Act**

**Texas Health and Human
Services Commission**

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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). 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 annually⁸, 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 Type¹⁹	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; and³⁰
- 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.utlongtermcareurse.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 Minnesota³⁴ and Wisconsin³⁵ 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

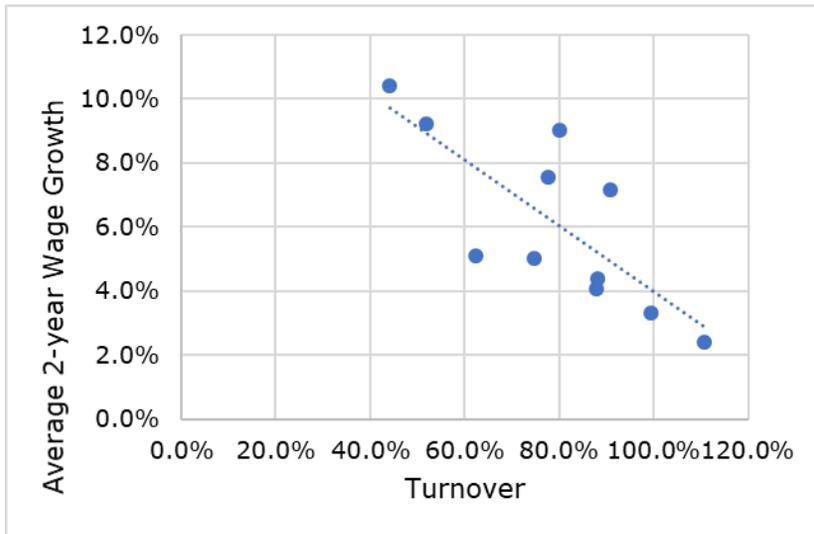


Figure B-2. HCS/TxHmL Non-Residential Attendants: Turnover vs. 2-year Wage Growth

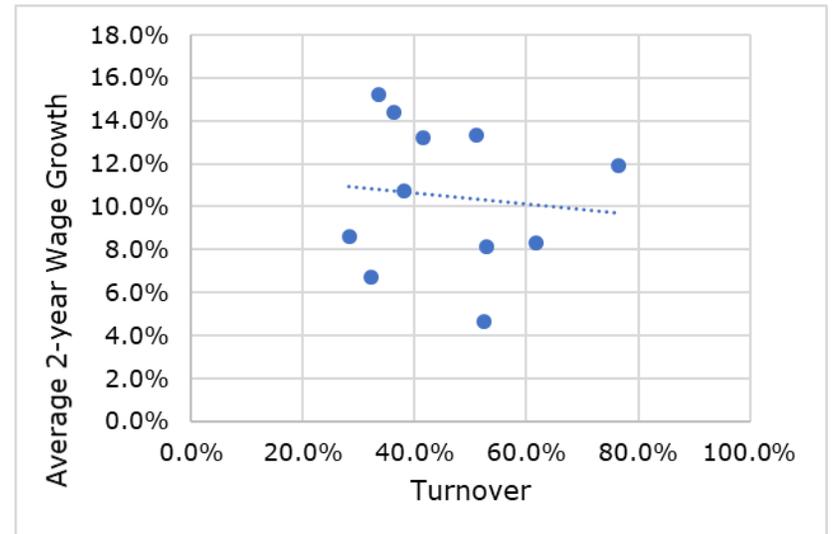


Figure B-3. Texas HHS Regions, October 2018⁴²



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. ⁹	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

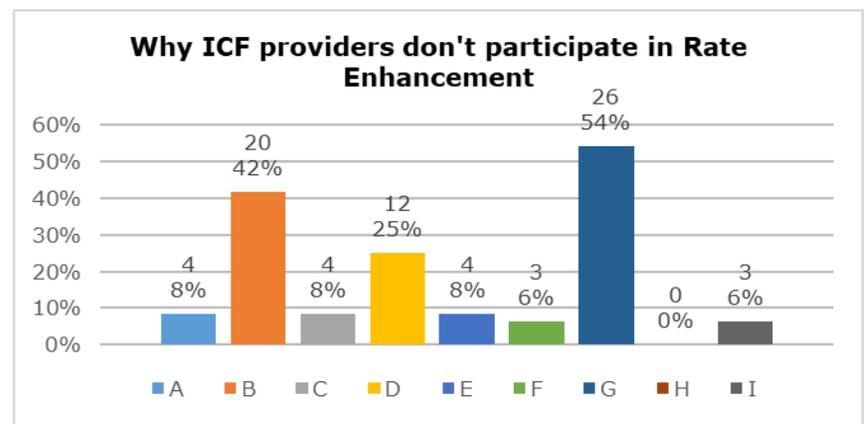
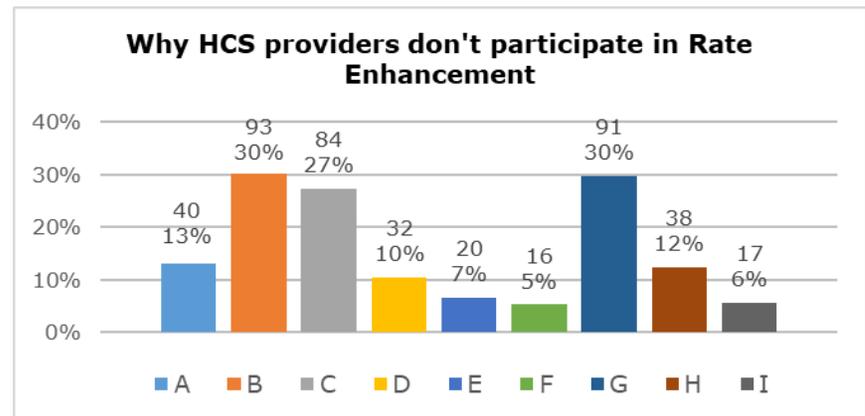
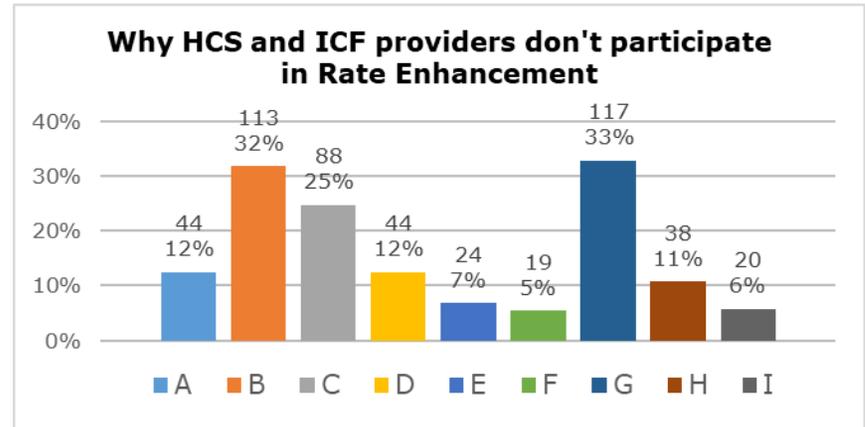
A	No applicable clients or not enough applicable clients
B	Reporting requirements/paperwork too cumbersome
C	Unfamiliar with the program/program benefits
D	Fears of recoupment
E	Requires an accountant / too small of a provider
F	Past issues with cost reporting
G	Rate enhancement is insignificant/not 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, 2017⁴³

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>