Community Attendant Workforce Development Strategic Plan

As Required by

2020-21 General Appropriations Act,

House Bill 1, 86th Legislature,

Regular Session, 2019

(Article II, Health and Human

Services Commission, Rider 157)

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Table of Contents

Executive Summary

The *Community Attendant Workforce Development Strategic Plan* is submitted pursuant to 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission [HHSC], Rider 157).

The plan contains strategies and data relating to recruiting, retaining, and ensuring adequate access to the services of community attendants. More specifically, the strategic plan includes information about the community attendant workforce in Texas, feedback collected from stakeholders during a cross-agency forum and through an online survey, and HHSC's long-term goals and recommendations to address challenges faced by individuals receiving or providing community attendant care.

The 2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 207) required HHSC to submit annual reports on recruitment and retention strategies for community attendants during the 2018-19 biennium. Whereas Rider 207 gave HHSC the discretion to develop community attendant recruitment and retention strategies, Rider 157 contains specific strategies that HHSC must pursue in its development of a strategic plan in addition to any other strategies the agency deems appropriate or necessary. The full text of Rider 157 is in Appendix A.

1. Introduction

An attendant is a person who assists people with their personal care and household tasks, also known as activities of daily living (ADLs)[1] and instrumental ADLs (IADLs)[2]. Individuals receiving long-term care from attendants may have physical disabilities, chronic illness, cognitive impairment, or other complex needs and require assistance with activities such as preparing meals, bathing, dressing, and transferring, among others.

Community attendants, more specifically, help people remain active members of their local communities by assisting them with their ADLs and IADLs in home and community-based settings. Community attendants advocate for and assist hundreds of thousands of individuals in Medicaid and non-Medicaid programs across Texas. As such, community attendants play an important role in reducing more costly admissions to institutional care settings such as nursing facilities (NFs) and state supported living centers (SSLCs) and in reducing potentially preventable hospitalizations and emergency room visits.

A viable community-based long-term services and supports (LTSS) system requires a stable and trained workforce. Nationally and in Texas there are significant concerns about attendant shortages and high turnover. Factors such as high rates of turnover are aggravated by an increasingly difficult marketplace in which to hire and retain quality community attendants. With demand for community attendant services expected to increase significantly over the next decade due to an aging population, the need to strengthen this workforce will also grow.[3]

Other reported impacts on access to care for individuals receiving community attendant services through HHSC programs include:

- Residents in rural areas facing unique access challenges to quality or consistent attendant care;
- High rates of community attendant turnover and low rates of retention preventing individuals from receiving care from the same attendant on a consistent basis; and

[1] Activities of Daily Living (ADLs) are activities essential to daily personal care including bathing or showering, dressing, getting in or out of bed or a chair, using a toilet, and eating.

[2] Instrumental Activities of Daily Living (IADLs) are activities essential to independent daily living including preparing meals, shopping for groceries or personal items, performing light housework, and using a telephone.

[3] See Section 2 of the strategic plan regarding "Forecasted Demand: FY 2022-31" for more information on demand and demographic trends.

- Individuals with high medical needs or behavioral health needs often requiring attendants with specialized training and higher compensation to ensure their needs are met.

In addition to challenges for individuals needing services, an unstable workforce creates difficulties for service providers, consumer directed services option (CDS) employers, and people who work as attendants delivering Medicaid and non-Medicaid services. Community attendants in Texas and across the nation often face financial insecurity from low wages, lack of benefits such as health insurance, and high levels of part-time employment. In addition, administrative burdens and programmatic complexities add to direct care responsibilities. These factors, as well as others mentioned throughout the strategic plan, have contributed to difficulties among provider agencies and CDS employers in recruiting and retaining qualified attendants.

Addressing these and other challenges related to the community attendant workforce demands a coordinated, statewide approach. This strategic plan is an important initial step in ensuring that Texas maintains a quality attendant workforce that can serve persons in need of long-term supports in home and community-based settings.

Mission and Vision

Statements of mission and vision were created to lead the implementation and evaluation of this strategic plan for the community attendant workforce.

Mission: To develop and implement strategies to recruit, retain, and ensure adequate access to the services of community attendants.

Vision: To ensure the health, safety, and well-being of its citizens, Texas will maintain sufficient access to the services provided by community attendants through promoting the development of a sustainable attendant workforce.

As the agency works to achieve both this mission and vision, HHSC will work with other organizations and the populations served by community attendants to set forth a strategic plan.

2. Current Community Attendant Workforce in Texas

The strategic plan contains a variety of data about the current community attendant workforce in Texas. Some of this data comes from the U.S. Bureau of Labor Statistics (BLS). To make comparisons between community attendants and occupations recognized by the Standard Occupational System utilized by BLS, HHSC identified two occupational groups whose job descriptions involve performing the tasks typically associated with community attendants: personal care aides (PCAs) and home health aides (HHAs).

PCAs are generally limited in their roles to providing non-medical services. HHAs perform the same tasks as PCAs but may also perform some medical tasks such as monitoring vital signs and dispensing medications under the direction of a nurse or another healthcare practitioner.[4] As of May 2019, BLS reported 300,820 PCAs and HHAs employed in Texas, not including self-employed workers.[5]

A large number of individuals provide community attendant services on an unpaid, informal basis, such as the family members or friends of those needing services. Although these individuals collectively play an important role in the overall community attendant network, this strategic plan is focused on community attendants that provide paid services. More information on informal caregivers can be found in the February 2017 report *A Profile of Informal Caregiving in Texas*[6] with an updated report scheduled for release in December 2020. Individuals receiving community attendant care in Texas Medicaid and non-Medicaid programs often have more complex needs that require paid supports, whether in addition to or without unpaid supports.[7]

In most HHSC community attendant programs, attendants must be at least 18 years of age, have a high school diploma or equivalent, and not be the individual's primary caregiver or spouse.[8] The term "attendant" may be used interchangeably

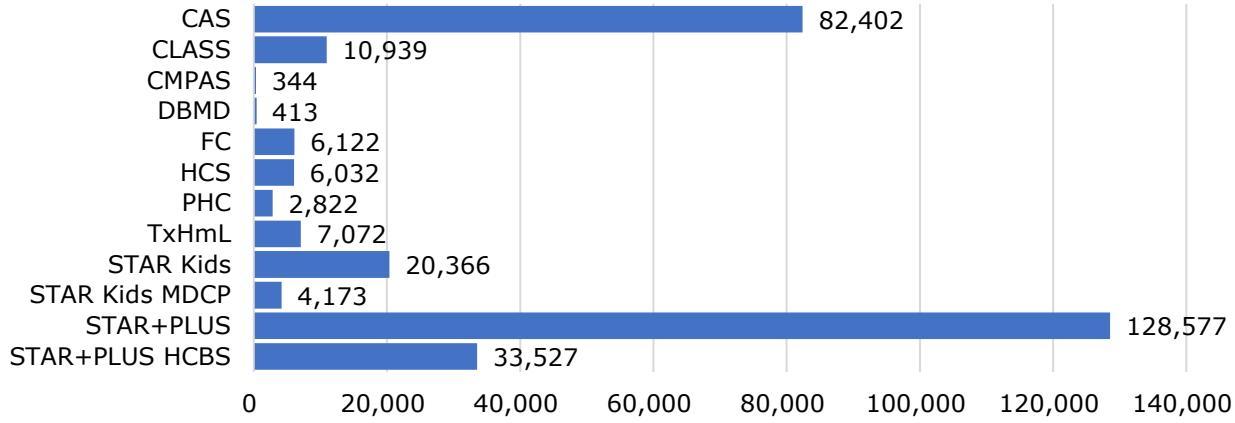
[4] U.S. Bureau of Labor Statistics. "Occupational Outlook Handbook: Home Health Aides and Personal Care Aides." https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm?view_full#tab-2
[5] U.S. Bureau of Labor Statistics. "Occupational Employment Statistics, May 2019." https://www.bls.gov/oes/tables.htm
[6] As required by Senate Bill 271, 81st Legislature, Regular Session, 2009 https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/profile-informal-caregiving-texas-feb-2017.pdf
[7] Scales, Kezia. "It's Time to Care: A Detailed Profile of America's Direct Care Workforce." PHI, 2020. https://phinational.org/resource/its-time-to-care-a-detailed-profile-of-americas-direct-care-workforce/
[8] There are some exceptions or additional requirements in certain HHSC services and programs.

with other terms such as direct care worker, direct service worker, direct support worker, and others. This strategic plan specifically focuses on community attendants, which are individuals who provide attendant services in home or community-based settings.

Populations Served

Over 300,000 people receive community attendant services through long-term services and support programs in Texas.[9] Qualified, experienced, and reliable attendants provide vital services that enable a person to thrive in a community-based setting. Figure 1 contains a breakdown by program of the number of people who receive the services of community attendants.

Figure 1. Number of People Who Receive Community Attendant Services by Program: FY 2019[10]



An attendant may be employed by a provider agency or directly by the person receiving care (or their representative). Whereas most community attendant services are delivered by provider agencies, some individuals may choose to receive their services through the CDS service delivery option.

Population in the Consumer Directed Services Option

The CDS option allows the person receiving services, or their legally authorized representative (LAR), to self-direct their services and supports. The person or LAR becomes the employer of record and hires and manages staff providing their direct

[9] Source: HHSC Center for Analytics and Decision Support

[10] These numbers reflect the total number of people receiving an attendant service. If an individual is receiving multiple attendant services, they would be counted multiple times based on the number of attendant services they received. PCS delivered through managed care is reflected in the STAR Kids count; PCS delivered through FFS is not included.

care. The CDS employer performs the following employer-related activities: selecting and hiring staff, determining wages and work schedules within the limits of their service plan, and offering staff benefits or bonuses as available in their CDS budget. An individual who elects the CDS option selects a financial management services agency (FMSA) to provide financial management services to the CDS employer. Financial management services include processing payroll, submitting payroll taxes, and billing HHSC or managed care organizations for services. The number of FMSAs the individual has to choose from often depends on which program they are enrolled in and whether they reside in an urban or rural setting.

One of the suggested strategies in Rider 157 is to increase the use of the CDS option because it allows a person needing services to employ their attendant staff directly giving them greater control and flexibility over the care they receive. And as is shown later in the strategic plan through HHSC's survey of active CDS employers, there is also a high level of satisfaction in the CDS option.[11]

Table 1 presents the number of individuals who were actively self-directing their services through the CDS option as of December 2019. As shown in Table 1, only 5.6 percent of individuals in fee-for-service programs and 1.3 percent of individuals in managed care programs were utilizing CDS as of the end of quarter 3 of fiscal year 2019. The data in Table 1 is collected by HHSC on a quarterly basis, which will allow the agency to determine if any of the recommended strategies for increasing the use of the CDS option, upon implementation, were effective.

[11] See Section 3 and Appendix B of the strategic plan.

Table 1. Unduplicated Persons Utilizing CDS: FY 2019-2020

Program	CDS Utilization Dec. 2019	CDS Utilization Dec. 2019 (% of Payment Model Total)	CDS Utilization Across Each Program (%) Q3 FY 2019
Community Care for Aged and Disabled	702	11.2%	1.0%
Comprehensive Care Program[12]	494	7.9%	N/A
Community Living Assistance and Support Services (CLASS)	2,585	41.1%	44.9%
Deaf Blind with Multiple Disabilities (DBMD)	110	1.8%	37.5%
Home and Community-based Services (HCS)	1,011	16.1%	3.7%
Texas Home Living (TxHmL)	1,387	22.1%	23.1%
Fee-for-service Total	**6,289**	**100.0%**	**5.6%**
Medicare-Medicaid Plan (MMP)	264	1.8%	0.1%
STAR Health	77	0.5%	Data unavailable
STAR Kids	3,216	22.0%	3.0%
STAR Kids Medically Dependent Children Program (MDCP)	2,813	19.2%	45.8%
STAR+PLUS	3,842	26.2%	0.3%
STAR+PLUS Home and Community Based Services (HCBS)	4,427	30.2%	3.1%
Managed Care Total	**14,639**	**100.0%**	**1.3%**
Combined Total	**20,928**		

Forecasted Demand: Fiscal Years 2022-2031

Rider 157 directs HHSC to analyze demographic trends and other relevant data to project the demand for community attendants during the fiscal years 2022-2031 period.

According to the most recent data from BLS, there were approximately 301,000 workers in Texas employed as attendants in 2019. They represented approximately 2.5 percent of all Texas workers and were paid on average $10.10 per hour compared to $24.27 per hour among all workers in the state. Currently, the minimum hourly wage in Texas is $7.25 per hour.

Analysis by the HHSC Center for Analytics and Decision Support indicates that in 2019 there were an estimated 3,280,000 Texans with a disability. Assuming that

[12] Personal Care Services (PCS) delivered through the Comprehensive Care Program.

BLS estimates of PCAs and HHAs represent community attendants only, this means that in 2019 there were approximately 11 Texans with disabilities per community attendant in the state. Using the same data sources, it is estimated that there were approximately 13 people with disabilities per community attendant in the U.S. as a whole during the same period. A general interpretation of these statistics is that, on average, the current caseload size among community attendants in Texas is slightly smaller in comparison to most of their peers' elsewhere in the country.

However, among the five most populous states (California, Texas, Florida, New York, and Pennsylvania) combined, the data indicate there were 9 people with disabilities per community attendant.

Since it is projected that Texas' population will experience significant growth between fiscal year 2022 and fiscal year 2031, it is likely that the population of persons with disabilities will also grow, especially since one of the groups projected to experience a higher than average growth rate is the group age 65 and older.[13]

This scenario implies that to maintain – or improve – the current ratio of 11 people with disabilities per community attendant during the foreseeable future, the size of the community attendant workforce will need to grow in a manner that is consistent with the projected growth trend for the population with disabilities.

HHSC analyzed U.S. Census Bureau data from the Texas sample of the 2018 American Community Survey (ACS) and population projections data produced by the Texas Demographic Center (TDC) to develop a projection of the population with disabilities in the state during the fiscal years 2022-2031 period. The ACS is a large-scale demographic and socioeconomic survey that includes representative samples from each state. The TDC works under the guidance of the Office of the State Demographer and is the official entity within Texas state government charged with producing population projections for the state.

Since the percent of the population with disabilities can vary among different demographic groups defined according to variables such as age, sex, and race/ethnicity, HHSC used data from the 2018 ACS to produce a set of baseline disabled population estimates and disability rates for 56 different demographic groups defined according to combinations of age group, sex, and race/ethnicity.

[13] Source: Texas Demographic Center, Office of the State Demographer at the University of Texas at San Antonio. Population projections based on the 2010-2015 Migration Scenario. Updated July 2019.

Using a demographic cohort-component method approach, demographic group-specific baseline disability rates were applied to year-specific population projections provided by the TDC for each of the 56 separate groups identified for the analysis. This resulted in group-specific projections of the population with disabilities for each calendar year during the fiscal years 2022-2031 period. The year and group-specific projections were aggregated (summed across) and adjusted to reflect the size of the non-institutional population to produce summary level statewide projections of the population with disabilities in the community for each year during the 2022-2031 period.

Table 2 shows the projected trend for the population with disabilities and the projected trend for the number of community attendants that would be needed, at a minimum, to:

1. maintain the current ratio of 11 people with disabilities per community attendant worker each year during the 2022-2031 period; and
2. attain and sustain a ratio of nine people with disabilities per community attendant, as observed among the five most populous states, combined, during the same period.

The projections indicate that to maintain the current Texas-specific ratio of 11 people with disabilities per worker through 2031, the community attendant workforce would need to grow from approximately 320,000 in 2022 to approximately 396,000 in 2031. They also indicate that in order to attain and sustain a ratio of 9 people with disabilities per worker throughout the projection horizon, the Texas community attendant workforce would need to grow from 301,000 in 2019 to 391,000 in 2022 and to 484,000 in 2031.

Table 2. Projected Demand for Community Attendants in Texas[14]

Calendar Year	Projected Texas Population	Projected Texas Population Age 65+	Projected Texas Population with a Disability	Projected Percent of Texas Population with a Disability	Number of Workers Needed to Maintain Current Ratio of 11 Disabled Persons per Attendant	Number of Workers Needed to Attain and Sustain a Ratio of 9 Disabled Persons per Attendant
2022	29,989,000	4,139,000	3,522,000	11.7%	320,000	391,000
2023	30,481,000	4,305,000	3,611,000	11.8%	328,000	401,000
2024	30,980,000	4,467,000	3,699,000	11.9%	336,000	411,000
2025	31,487,000	4,641,000	3,791,000	12.0%	345,000	421,000
2026	31,999,000	4,809,000	3,883,000	12.1%	353,000	431,000
2027	32,519,000	4,970,000	3,975,000	12.2%	361,000	442,000
2028	33,044,000	5,132,000	4,070,000	12.3%	370,000	452,000
2029	33,574,000	5,288,000	4,164,000	12.4%	379,000	463,000
2030	34,110,000	5,439,000	4,261,000	12.5%	387,000	473,000
2031	34,651,000	5,568,000	4,355,000	12.6%	396,000	484,000
Change 2022-2031	**4,662,000**	**1,429,000**	**833,000**	**0.9%**	**76,000**	**93,000**
Percent Change 2022-2031	**15.5%**	**34.5%**	**23.7%**	**7.0%**	**23.8%**	**23.8%**

Funding

Over the past decade, providers of community attendant services across the state have indicated there is a critical need for additional funds for direct care wages. To contextualize this matter, this section provides information on expenditures on community care programs and a history of the Texas Legislature's continued investments in community attendant services.

[14] Population estimates are for civilians/non-institutional.
Data sources:
1. U.S. Census Bureau. 2018 American Community Survey (Texas Sample)
2. Texas Demographic Center, Office of the State Demographer at the University of Texas at San Antonio. Population projections based on the 2010-2015 Migration Scenario. Updated July 2019.

Expenditures

Rider 157 directs HHSC to calculate the average cost of community care compared to NF care. To develop this comparison, HHSC first identified which programs and services are understood as "community care" in a context that is appropriate for the comparison.

Table 3 provides expenditures for home and community-based LTSS programs from fiscal year 2017 through fiscal year 2019; residential programs which involve the employment of personal attendants, such as STAR+PLUS assisted living and Home and Community-based Services 1915(c) waiver program (HCS) supported living/residential support services (SL/RSS), were also included.

Table 4 provides a comparison between the average monthly cost per client in community care versus that of NF care in both fee-for-service (FFS) and managed care combined between fiscal years 2017 and 2019.[15] Table 4 includes data on all HHSC community care programs and, separately, community care programs specifically related to diversions from NF care as opposed to diversions from intermediate care facilities for Individuals with an intellectual disability or related conditions (ICF/IID), hospitals, or other mental health facilities.

On an average monthly cost per client basis in fiscal year 2019, NF care costs were 227 percent higher than community care and 259 percent higher than community care excluding individuals with intellectual and developmental disabilities (IDD) and mental health programs.

While there is a significant difference in average costs between care received in a community program versus in a NF, there are caveats to a direct comparison. Whereas NFs provide comprehensive care, community programs differ on the levels of care provided based on setting type and individual program or service limitations or requirements.[16] And while NFs have certified nurse aides who assist with ADLs/IADLs, they are not considered attendants.

[15] The FY 2017-2019 community care costs in Table 3 are the same costs as in Table 3; however, the costs in Table 4 are less than one percent higher than those in Table 3 due to certain nuances in client-level managed care data.

Table 3. All Funds Expenditures on LTSS Community Care Programs: FY 2017-19[17]

Program[18,19]	FY 2017	FY 2018	FY 2019	Includes Personal Attendant Services
AFC	$60,988	$46,444	$43,986	No[20]
CAS	$704,561,961	$762,675,085	$821,059,828	Yes
CLASS	$266,366,755	$283,099,624	$289,390,948	Yes
CMPAS	$5,439,865	$5,602,087	$5,158,649	Yes
DAHS	$26,378,643	$25,138,170	$23,864,863	Yes
DBMD	$13,320,730	$14,491,708	$15,524,403	Yes
ERS[21]	$4,605,900	$4,623,438	$4,489,345	No
FC	$40,742,162	$40,692,275	$39,038,482	Yes
HCBS-AMH	$841,533	$4,399,715	$9,734,140	Yes
HCS	$1,098,988,009	$1,116,164,362	$1,132,522,703	Yes
HDM	$18,459,833	$18,568,840	$17,975,986	No
PACE	$41,119,784	$42,836,912	$42,104,582	Yes
PCS	$939,415	$12,572,682	$13,925,046	Yes
PHC	$13,935,042	$12,070,468	$12,409,324	Yes
RC	$2,573,693	$2,139,736	$1,780,339	Yes
SSPD	$714,906	$690,861	$276,912	Yes
TxHmL	$121,458,839	$115,808,307	$119,987,291	Yes
YES	$9,958,251	$10,713,105	$10,189,296	No
Fee-for-Service Total	**$2,370,466,309**	**$2,472,333,819**	**$2,559,476,123**	**-**
STAR Health & STAR Health MDCP[22]	$3,024,032	$1,819,522	$1,681,944	Yes
STAR Kids[23]	$667,868,548	$891,606,670	$974,802,743	Yes
STAR Kids MDCP[24]	$63,600,879	$75,924,117	$78,898,965	Yes
STAR+PLUS [25]	$1,483,279,894	$1,539,430,436	$1,539,564,508	Yes
STAR+PLUS HCBS[26]	$1,025,916,198	$1,100,683,166	$1,231,651,011	Yes
Managed Care Total[27]	**$3,243,689,551**	**$3,609,463,911**	**$3,826,599,171**	**-**
Combined Total	**$5,614,155,860**	**$6,081,797,730**	**$6,386,075,294**	**-**
Annual Growth	**-**	**8.3%**	**5.0%**	**-**

Table 4. Average All Funds Cost of LTSS Community Care Compared to Nursing Facility Care: FY 2017-19

Setting Type	FY	Avg. Monthly Client Count	Avg. Monthly Payment	Avg. Monthly Cost per Client	Monthly per Client Cost of Community Care Compared to NF (%)
Community Care[28]	2017	297,413	$471,440,145	$1,585	41.1%
	2018	308,818	$508,497,438	$1,647	42.8%
	2019	314,985	$533,325,269	$1,693	45.0%
Community Care, Excluding ICF/IID Waivers and Mental Health Programs[29]	2017	259,418	$343,801,368	$1,325	34.4%
	2018	270,611	$377,940,496	$1,397	36.3%
	2019	276,992	$399,721,791	$1,443	38.3%
NF[30]	2017	54,985	$211,853,273	$3,853	
	2018	55,686	$214,115,907	$3,845	
	2019	58,818	$221,502,266	$3,766	

[17] Some programs have costs related to institutional care, such as out-of-home respite in a nursing facility; such costs have been excluded. Costs for the Comprehensive Rehabilitation Services program and for community hospice are also excluded.
[18] See the "List of Acronyms" section of the strategic plan for definitions of program acronyms.
[19] AFC, DAHS, ERS, HDM, PCS, and PHC are also offered through managed care; these services that are separately delivered through managed care are rolled up into the appropriate managed care program costs. Although YES State Plan case management is delivered through managed care, it is not rolled into managed care costs.
[20] AFC does encompass personal attendant services, but the contracted providers deliver those services and are not considered personal attendants.
[21] Costs related to ERS in 1915(c) waiver programs (CLASS, DBMD, HCS, and TxHmL) are included in the costs for those programs and not in the ERS row.
[22] STAR Health and STAR Health MDCP costs include CDS FMS, ERS, PCS, and private duty nursing.
[23] STAR Kids costs include adult day care, CDS FMS, ERS, habilitation, HDM, home modifications, nurse delegation and supervision, nursing, occupational therapy, out-of-home respite, PAS, PCS, private duty nursing, physical therapy, PPECC, respite, speech therapy, and nursing assessment.
[24] STAR Kids MDCP costs includes the portion of the MDCP population that is still in FFS. Services included in the STAR Kids MDCP costs are adaptive aides, employment services, CDS FMS, flexible family support services, in-home respite, out-of-home respite, and peer support.
[25] STAR+PLUS costs include adaptive aides/medical supplies, AFC, AL, CDS FMS, DAHS, ERS, habilitation, HDM, home modifications, in-home respite, occupational therapy, out-of-home respite, PAS, PCS, PDN, physical therapy, and speech therapy.
[26] STAR+PLUS HCBS costs include AFC, AL, behavioral services, CDS FMS, employment services, ERS, habilitation, HDM, in-home respite, nursing, nursing assessments, occupational therapy, out-of-home respite, PAS, physical therapy, respite, speech therapy, and TAS.
[27] Includes Medicare-Medicaid Plan costs. Managed care costs in Table 3 reflect the encounter claims data that providers who contract with MCOs are billing for LTSS community care services; these costs do not reflect the costs the state is paying MCOs through capitation rates.
[28] Includes all programs listed in Table 3.
[29] Includes all programs listed in Table 3 that are directly or indirectly related to diversions from NFs, which excludes CLASS, DBMD, HCBS-AMH, HCS, TxHmL, and YES.
[30] Includes all costs associated with daily care paid through Resource Utilization Groups.

Personal Attendant Base Wage

The Texas Legislature implemented a required base wage for service providers who employ or contract with individuals providing personal attendant services to ensure that all community attendants are paid above the federal minimum wage. The programs and services that are required to pay attendants a base wage are defined in Title 1 of the Texas Administrative Code (1 TAC) §355.7051, relating to Base Wage for a Personal Attendant. The 84th Legislature (2015) provided funding to increase the personal attendant base wage from $7.84 per hour to $8.00 per hour. The 86th Legislature (2019) provided additional appropriations to increase the personal attendant base wage for $8.00 to $8.11. Currently, Medicaid and non-Medicaid rates support a personal attendant base wage of $8.11 per hour.

Rate Enhancement Programs

Attendant Compensation Rate Enhancement and Direct Care Staff Enhancement, collectively known as rate enhancement, are voluntary programs for contracted providers of certain HHSC LTSS programs.[31] Providers enrolled in rate enhancement elect to receive additional funds to supplement attendant or direct care wages and benefits. Each participating provider is required to demonstrate compliance with spending requirements and is otherwise recouped of rate enhancement funds if HHSC determines the funds were not properly spent on attendant or direct care wages.

Table 5 shows the participation of FFS contracts in rate enhancement. While all managed care organizations (MCOs) are required to offer rate enhancement to their contracted providers who offer attendant services, each MCO can design its program to best fit its business model. As such, HHSC cannot provide details on rate enhancement participation in the STAR+PLUS and STAR Kids managed care programs.

[31] Attendant Compensation Rate Enhancement is for community care programs and programs for individuals with intellectual and developmental disabilities. Direct Care Staff Enhancement is for NFs.

Table 5. SFY 2021 HHSC FFS Provider Participation in Rate Enhancement as of October 2020

Program	Provider Contracts (n)	Rate Enhancement Participants (%)	Rate Enhancement Non-participants (%)
CAS/FC/PHC	1,752	88.5%	11.5%
CLASS	111	83.8%	16.2%
DAHS	321	85.1%	15.0%
DBMD	48	72.9%	27.1%
HCS	704	30.3%	69.7%
ICF/IID	131	60.3%	39.7%
NF	1,139	79.4%	20.6%
RC	60	33.3%	66.7%
Total	**4,270**	**74.1%**	**25.9%**

There are separate appropriations for rate enhancement programs related to IDD versus all other community-based programs. Through the 2020-21 General Appropriations Act (Article II, HHSC, Rider 45), the 86th Legislature committed to fully funding the rate enhancement programs for providers of IDD and community care services, which gives rate enhancement participants access to the highest participation levels in each program. And through the 2020-21 General Appropriations Act (Article II, HHSC, Rider 44), the 86th Legislature made significant investments in rate enhancement for IDD services. The Legislature directed HHSC to create separate rate enhancement categories in the HCS program to allow additional wage support for attendants providing community services in group home settings.

Texas Community Attendant Workforce Data

Rider 157 directs HHSC to collect comprehensive data regarding attendants providing home and community-based services in both FFS and managed care. HHSC collected most of this data through its long-term services and supports cost reports and through FFS and managed care billing data. Attendant recruitment and retention data has been collected through HHSC cost reports since 2019, beginning with fiscal year 2018 cost reports.

Wage Data

Table 6 provides HHSC Medicaid cost report data on historical wages for attendants in community-based programs between fiscal years 2015-2018, with each year's

data adjusted for personal consumption expenditures (PCE) inflation to the 2022-23 biennium. This data includes wages only; other components of compensation such as payroll taxes are not included. As Table 6 shows, reported wages have not kept up with inflation over the given period, which has led to a reduced level of real income among attendants and therefore reduced purchasing power.

Table 6 also presents the lowest-paying programs according to cost report data. It reveals that the lowest average wage rates for community attendant services are for the following:

- in-home respite attendants in the Community Living Assistance and Support Services (CLASS) program,
- non-priority attendants who serve individuals with lower needs and priority attendants who serve individuals with higher dependence on immediate and ongoing services in Community Attendant Services (CAS),
- attendants in the Family Care (FC), and Primary Home Care (PHC) programs, and
- attendants and drivers in the Day Activity and Health Services (DAHS) program.

Without an adjustment for inflation, the average hourly wages for these attendants per fiscal year 2017 cost report data are $8.22 for CLASS in-home respite attendants, $9.00 for CAS/FC/PHC non-priority attendants, $9.23 for CAS/FC/PHC priority attendants, $9.35 for DAHS attendants, and $9.03 for DAHS drivers.

Turnover Data[32]

Tables 7 - 9 reflect attendant turnover data provided by providers' cost report preparers; this data is self-reported and cannot currently be verified by the agency. Across the data collected from HHSC cost reports in fiscal year 2018 and fiscal year 2019, a total of 198,467 part-time attendants and 59,340 full-time attendants were represented (Table 7, Table 8). If these attendant totals are compared to the BLS total of 300,820 PCAs and HHAs in Texas in May 2019, these attendants represent 85.7 percent of the PCA/HHA workforce; however, duplicates may exist among the totals as some attendants may be employed with multiple agencies.

Furthermore, drivers are counted in the attendant totals in the DAHS, AL, and RC programs, and although these are considered "attendants" for cost reporting

[32] In Tables 7 - 8, FFS data is represented in CLASS, HCS, PHC, RC, and TxHmL; managed care data is represented in STAR+PLUS AL and the former CBA program as providers of former CBA services are now STAR+PLUS HCBS providers; managed care and FFS data are represented in DAHS.

purposes, drivers may not fall under the definition of PCA or HHA per the Standard Occupational Classification System utilized by the BLS.[33]

Table 6. Median Hourly Wages from FY 2015-2018 HHSC Cost Reports Adjusted for Inflation to FY 2022-23[34,35]

Program[36]	Attendant Type[37]	FY 2015 Wage	FY 2016 Wage[38]	FY 2017 Wage[39]	FY 2018 Wage[40]	Total % Change in Real Income
AL	Attendant	$11.00	$11.18	$11.15	$10.98	(0.2%)
	Driver	$11.27	$11.76	$11.35	$11.26	(0.1%)
	Medication aide	$11.94	$13.23	$13.25	$12.77	6.9%
CAS/FC/PHC	Non-priority attendant	$10.49	$10.56	$10.36	-	(1.3%)
	Priority attendant	$10.77	$10.73	$10.52	-	(2.3%)
CLASS	CFC PAS/HAB attendant	$12.11	$11.97	$11.71	-	(3.3%)
	In-home respite attendant	$9.65	$9.50	$9.23	-	(4.3%)
DAHS	Attendant	$10.86	$11.05	$10.62	-	(2.2%)
	Driver	$10.72	$10.72	$10.45	-	(2.5%)
HCS	SL/RSS attendant	$11.01	$10.81	$11.11	$10.91	(0.9%)
	Day habilitation attendant	$11.71	$11.53	$11.56	$11.15	(4.8%)
	CFC PAS/HAB attendant	$12.87	$12.53	$12.68	$12.01	(6.7%)
	Respite attendant	$12.13	$11.93	$11.56	$10.83	(10.7%)
RC	Attendant	$10.47	$10.63	$11.15	$10.83	3.5%
	Driver	$12.16	$11.65	$12.00	$11.44	(5.9%)
	Medication aide	$13.30	$13.60	$13.30	$13.58	2.1%

[33] 1 TAC §355.112(b)(3)(A)
[34] Costs were inflated to the FY 2022-23 biennium using PCE price index data from the U.S. Bureau of Economic Analysis and forecasted with data from IHS Markit.
[35] This data reflects attendant employee wages only and not total compensation (payroll taxes and benefits) or contracted attendant wages. Managed care costs are reflected in AL and DAHS only.
[36] See the "List of Acronyms" section of the strategic plan for definitions of program acronyms.
[37] Community First Choice (CFC) PAS/HAB attendants include habilitation transportation attendants.
[38] On September 1, 2015, DAHS attendant compensation base rates were raised 1.8%, HCS residential daily attendant compensation base rates were raised 1.7%, PHC non-priority hourly attendant compensation base hourly rates were raised 1.6%, and RC daily attendant compensation base rates were raised 1.5%.
[39] On August 1, 2017, HCS CFC PAS/HAB hourly attendant compensation base rates were lowered 10.9%.
[40] 2018 cost report data for CLASS, DAHS, and PHC is not available due to the HHSC Provider Finance Department implementation of cost report reform which moved the cost reporting cycle from every year to every two years.

Table 7. Community Attendant Workforce Data from FY 2018 HHSC Cost Reports

Programs	Annual Attendant Turnover Rate in CY 2018		Number of Attendants Employed on 12/31/18		% of Attendant Positions with Vacancies on 12/31/18		Number of Providers [41]
	Res.	Non-res.	Res.	Non-res.	Res.	Non-res.	
AL, RC [42]	99.3%	-	1,600	-	4.1%	-	156
HCS, TxHmL [43]	60.7%	34.5%	13,880	7,776	10.0%	6.1%	447

Table 8. Community Attendant Workforce Data from FY 2019 HHSC Cost Reports

Programs	Annual Attendant Turnover Rate in CY 2019		Number of Attendants Employed on 12/31/19		% of Attendant Positions with Vacancies on 12/31/19		Number of Providers [41]
	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	
CLASS, CAS/FC/PHC, STAR+PLUS PAS/HAB [44]	36.8%	20.9%	182,604	48,981	2.3%	1.5%	1,260
DAHS [42]	31.3%	22.7%	383	2,583	7.5%	2.4%	327

Table 9. Attendants from FY 2019 HHSC Cost Reports Paid Above the Base Wage[45]

Programs	Number of Attendants Paid at or Below $8.00/hour on 12/31/19		Number of Attendants Paid Above $8.00/hour on 12/31/19	
	Part-time	Full-time	Part-time	Full-time
CLASS, CAS/FC/PHC, STAR+PLUS PAS/HAB [44]	23,644	6,185	158,960	42,796
DAHS [42]	8	328	375	2,262
Total	**23,652**	**6,513**	**159,335**	**45,058**
% of Total	**12.9%**		**87.1%**	

[41] The number of providers is not representative of all providers with contracts for each program, but rather the number of providers who completed cost reports and provided adequate data on workforce turnover.
[42] Includes attendants and drivers.
[43] Residential (res.) settings for HCS include SL/RSS; non-residential settings (non-res) for both HCS and TxHmL include HCS day habilitation, respite, personal assistance services, and habilitation.
[44] STAR+PLUS PAS/HAB providers that submit HHSC cost reports include those that provide PAS, waiver PAS, CFC PAS, and CFC Habilitation.
[45] FY 2019 cost reports asked for information on the base wage rate of $8.00 per hour, which was the base wage rate prior to the base wage increase on September 1, 2019 to $8.11 per hour.

The fiscal year 2019 workforce data in Table 9 does not include data about numbers of attendants paid at the former $8.00 per hour attendant minimum wage threshold because the cost reporting attendant workforce section was updated after the fiscal year 2018 cost reports were administered. Another update that occurred after the fiscal year 2018 cost reports involved splitting the attendant workforce data into full-time and part-time attendants; all of these updates are reflected in the fiscal year 2019 data.

As is shown in Table 7 and Table 8, the AL and RC programs experienced the highest rates of attendant turnover among the programs represented in this data, with an annual turnover rate of 99 percent for both part-time and full-time attendants combined. Meanwhile, there is high variance in turnover rates between programs, with DAHS having the lowest overall rate of turnover of 24 percent for full-time and part-time attendants combined. Turnover rates are lower among full-time attendants than they are with part-time attendants.

Regarding vacancy rates, there is high variance in attendant position vacancy rates between programs, with HCS residential attendant positions containing the highest vacancy rates at 10 percent, inclusive of both part-time and full-time positions. Among the programs represented in this data, providers of CLASS, CAS/FC/PHC, and STAR+PLUS PAS and CFC habilitation services combined have the lowest vacancy rates, with rates of 2.3 percent vacancy for part-time and 1.5 percent vacancy for full-time. Although vacancy rates are not adjusted for seasonality, the cost reports capture vacancy rates on exactly December 31 of each year to ensure that data across providers is captured on precisely the same date; this controls for differences in provider reporting periods.

Furthermore, in fiscal year 2019 most attendants were paid above the personal attendant base wage threshold of $8.00 per hour; the personal attendant base wage was raised to $8.11 in September 2019. The increase to $8.11 will be reflected in the fiscal year 2020 cost reports collected in April 2021 and is not captured in the data presented in this report as it is not yet available.

Financial Incentives

Rider 157 directed HHSC to identify any financial incentives that are passed directly to community attendants. In addition to funds related to rate enhancement, other financial incentives that are passed directly to community attendants include benefits and mileage reimbursements. The distribution of providers that offered benefits and paid for mileage reimbursements according to fiscal year 2019 cost reports are outlined in Table 10.

Table 10. Percentage of Providers Offering Benefits to Community Attendants: FY 2019 Cost Reports

Benefit Type	Attendants for CLASS, PHC, CAS, FC, STAR+PLUS PAS/HAB[46]		Attendants for DAHS	
	Part-time	Full-time	Part-time	Full-time
Medical Insurance	4.3%	17.0%	2.1%	11.3%
Dental Insurance	2.1%	6.8%	1.5%	3.1%
Vision Insurance	1.0%	4.4%	0.9%	2.4%
Mileage Reimbursement	5.1%	4.1%	1.2%	2.1%
Retirement	1.6%	3.4%	2.1%	2.7%
Paid Sick Leave	1.6%	6.5%	7.0%	25.0%
Paid Vacation	1.8%	8.4%	9.2%	54.0%
Total providers	**1,260**		**327**	

Per the breakdown of benefits in Table 10, only a small percentage of providers that submitted fiscal year 2019 cost reports reported offering the listed benefits to their attendants, with the only exception being that a majority of DAHS providers (54%) offered paid vacation to their full-time attendants (but not part-time attendants).

[46] STAR+PLUS PAS/HAB providers that submit HHSC cost reports include those that provide PAS (Non-HCBS), PAS (HCBS), Community First Choice (CFC) PAS (HCBS and Non-HCBS), and CFC Habilitation (HCBS and Non-HCBS).

3. Stakeholder Feedback

HHSC has received stakeholder feedback about community attendant workforce items for over a decade.[47] More recently, the tone of this feedback is increasingly urgent. Stakeholders report compensation for Medicaid community attendants has not been increasing at a rate that sustains an adequate or high-quality workforce, which poses challenges for clients who receive community attendant care through Medicaid and non-Medicaid programs. As time passes, an aging population is placing pressure on the supply of available attendants to provide care.

Attendees of the February 2020 cross-agency forum and respondents to the Summer 2020 CDS survey provided valuable insight to identify current challenges and goals related to recruitment and retention of community attendants and the ripple effects that workforce issues have on service provision and access to care.

Cross-agency Forum

On February 19-20, 2020, HHSC hosted the Community Attendant Cross-agency Strategic Planning Forum in Austin, Texas.

In addition to representatives for HHSC, representatives for the following state agencies attended the cross-agency forum: the Texas Department of State Health Services, the Texas Board of Nursing, the Texas Higher Education Coordinating Board, the Texas Department of Housing and Community Affairs, Texas Department of Family and Protective Services, Texas Department of Insurance, the Office of the Inspector General, and Texas Workforce Commission (TWC).

Other attendees included health plans, public colleges and universities (Austin Community College, Texas A&M University, the University of Texas at Austin), national research organizations (PHI and Applied Self-Direction), and community organizations and councils that represent individuals with disabilities.

Over the course of two days, stakeholders at the forum worked together to identify opportunities to improve the retention and recruitment of community attendants and formulated these opportunities into a list of goals. The goals formulated by

[47] Texas Health and Human Services Commission. "Stakeholder Recommendations to Improve Recruitment, Retention, and the Perceived Status of Paraprofessional Direct Service Workers in Texas." Texas Direct Service Workforce Initiative. June 2008. https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/dsw-june2008.pdf

external stakeholders, which include community organizations and councils that represent individuals with disabilities, are listed as follows and are not in any order of priority.

Stakeholder Goal 1. Provide a Living Wage

The primary goal identified by stakeholders was for the state to provide a living wage for community attendants. Stakeholders attending the cross-agency forum reported that many community attendants in Texas are receiving various forms of public assistance given the low average wages for community attendants; as such, they believe investing in a living wage would cumulatively lower their dependence on public assistance. Although the state would most likely realize savings from lifting community attendants out of public assistance dependence, it is not known at the time of writing what the estimated net savings would amount to and would require extensive research to estimate.

1.1. Compensation

- Compensate at levels appropriate to cost of living, which may vary geographically.
- Compensate at levels appropriate to the marketplace of unskilled labor.

1.2. Allow spending flexibility

- Allow provider flexibility with future spending in case attendants prefer benefits over a pay increase.

1.3. Establish insurance pools

- Establish insurance pools for CDS employers and providers to give attendants access to benefits.

1.4. Training recognition

- Consider implementing a tiered payment rate system that recognizes certifications and training.
- Implement a “badge system” linked to an online learning portal which rewards training with pay incentives and which codes specializations to protect HIPAA information.

Stakeholder Goal 2. Reduce Administrative Burdens in Consumer Directed Services Hiring Process

Stakeholders at the forum indicated that CDS employers currently face heavy administrative burdens during the hiring process and identified some ways that HHSC could make improvements in this area.

2.1. Improve orientation process

- Streamline and/or shorten the current lengthy orientation packet.
- Allow portability of orientation completion so that an attendant that has completed generic orientation can be hired by another person or agency without undergoing the lengthy process again.

2.2. Improve criminal background check process

- Increase the efficiency of criminal background check processes, as they currently cause delays in hiring and thus delays in care.
- Allow a grace period for a criminal background check in an emergency situation where a family member or friend is identified to assist but has not completed a criminal background check.

Stakeholder Goal 3. Workforce Development

Through workforce development, the attendant labor pool can be expanded and improved in quality. Several workforce development ideas were examined during the cross-agency forum, some of which were conceived after a presentation by representatives from the Texas A&M University PATHS certificate program, short for Postsecondary Access and Training in Human Services.[48] The PATHS program and the E4Texas program are educational programs administered by Texas A&M University and the University of Texas at Austin, respectively, that train individuals with or without disabilities to become caretakers such as attendants.[49] PATHS program representatives provided a detailed look at the program's accomplishments since its inception in 2012 and some of the challenges it is currently facing, such as with financial sustainability and transportation issues for students.

[48] PATHS is a "two-semester certificate program prepares graduates for employment in a career serving people with disabilities or working with children." https://paths.tamu.edu/
[49] E4Texas is a 3-semester post-secondary program in which students learn the main aspects of independent living, receive their caretaker certification, and are supported as they find jobs in their final semester. https://disabilitystudies.utexas.edu/e4texas

3.1. Amplify programs like the PATHS certificate program and E4Texas program

- Find ways to sustain or expand funding for programs like PATHS and E4Texas, for example:
  - Integrate funding for continuing education programs (CEP) with college credit courses, as the current system does not allow CEP to obtain certain streams of education funding, or
  - Fund programs through identified sources of revenue in Goal 5 of this section.
- Replicate the PATHS and E4Texas program model in more communities.
- Engage the Texas Education Agency and Regional Education Service Centers in:
  - Spreading awareness about the availability of the PATHS program, E4Texas, and other programs that train individuals in special education as vocational career paths; and
  - Engaging high school students ages 18+ to participate in such programs.

3.2. Expand workforce development opportunities

- Consider tuition subsidies for community college students serving as community attendants.
- Develop an all-online training program for direct care work.
  - This could be established through community colleges.
  - This could benefit seniors, family, friends, and others who need further education to provide direct service worker supports.

3.3. Create a one-stop online resource center for community attendant work

- The website would include a job board, educational resources, information about opportunities like PATHS and E4Texas, helpful links, tools, and templates.
  - This type of resource would potentially expand the attendant workforce pool by reducing current barriers to become an attendant.
  - This would be a standalone website or build off of a current resource like TWC's WorkInTexas.

3.4. Elevate the role of community attendant work in the eyes of the public

- May involve something similar to a public relations campaign in collaboration with TWC.

Stakeholder Goal 4. Data Collection

Stakeholders indicated that strengthening the amount of available data on the community attendant workforce was a critical next step. Some of the specific data collection goals formulated during the forum are outlined below.

4.1. Complete studies on return on investment of higher compensation of community attendants

- Study the distribution and amounts of public assistance dependence among Medicaid community attendants and compensation thresholds that would lift attendants off of each form of public assistance.
- Study rates of potentially preventable events and potentially preventable readmissions among individuals receiving community attendant care through comparisons of compensation.
- Study the rates of entrance or reentrance to institutional or facility-based care specifically because community attendant resources were insufficient.[50]

4.2. Complete a study on an attendant standby program

- Study the outcomes and costs to establish and maintain an attendant standby program that provides attendants on short notice.

4.3. Collect data on gaps in care related to hospitalizations

- Collect data on how often individuals receiving community attendant care are admitted to the hospital and also consequently have a gap in attendant care.
- Collect data on loss of compensation for employed attendants resulting from hospitalization-related gaps in attendant care.

4.4. Measure pay equity

- Measure and compare levels of compensation among community attendants, institutional attendants, and jobs with similar functions in pursuit of equitable compensation.

Stakeholder Goal 5. Pursue Alternative Sources of Revenue

Forum attendees came up with several alternative sources of revenue for the Legislature, HHSC, or other Texas state agencies, to consider pursuing.

[50] This data could potentially be sourced from HHSC Provider Investigations, Adult Protective Services, FMSAs, MCOs, case managers, and/or providers of institutional/facility-based care.

5.1. Texas Lottery

- Evaluate the feasibility of tapping into lottery revenue to help fund community attendant compensation and/or programs like PATHS and E4Texas.

5.2. Identify and reinvest savings for rate increases

- Consider potential reinvestment of MCO savings/profits (for instance, savings from potentially preventable events) to fund increased wages for community attendants.
- Dedicate money collected from administrative penalties or other fines levied based on regulatory reviews; for instance, Office of the Inspector General recoupments for fraud could fund increased community attendant compensation.
- Consider consolidating SSLCs and reinvesting savings to community attendant compensation.

Consumer Directed Services Employer Survey

As part of the development of this strategic plan, HHSC conducted a one-time voluntary survey for people who self-direct their attendant services using the CDS option. The survey included questions for CDS employers regarding their experiences with hiring attendants, attendant turnover rates, characteristics about themselves and their attendants. The survey gave opportunities to submit feedback about the CDS option. The survey was available in an online-only format from June 15, 2020 through July 15, 2020.

This section of the strategic plan includes key takeaways and selected data from the CDS survey. For expanded information on methods and results of the CDS survey, including data about how the COVID-19 pandemic has affected employers, see Appendix B.[51]

Instances of "respondents" in this section of the strategic plan refer to CDS employers that completed the survey.[52] For survey questions regarding information about CDS employers' attendants, CDS employers with multiple attendants were asked to respond regarding the person who provides the most paid hours of services.

[51] Given that this survey was conducted during the COVID-19 pandemic, an optional question about how the pandemic has created new challenges or altered the circumstances of CDS employers was included.
[52] The survey was to be taken from the perspective of the individual receiving CDS attendant services and the survey results were validated to exclude respondents that were not active employers of CDS attendant services at the time the survey was conducted.

Demographics

Figure 2 and Figure 3 reflect the demographic distribution of respondents and their attendants. As shown in Figure 2, most respondents' attendants are female (82.9%) and most respondents' attendants are younger than 45 years old (53.4%). This data conforms with nationwide averages for similar positions according to 2019 data from BLS, in which 85.6 percent of PCAs are female and 48.9 percent of PCAs are younger than 45 years old.[53]

Figure 3 shows that half of the respondents indicated they are under the age of 35 (49.1%), including 14 percent under the age of 18; whether this age distribution among respondents is reflective of the age distribution of all Texas CDS employers could not be verified at the time of writing, but this result either indicates that CDS employers are generally younger or may potentially be skewed toward younger ages by the fact that the survey was administered online only.[54] Among respondents, there were significantly more women than men at the age of 35 and older, and more men than women under the age of 35.

Figure 2. Population Pyramid of Respondents' Primary CDS Attendants

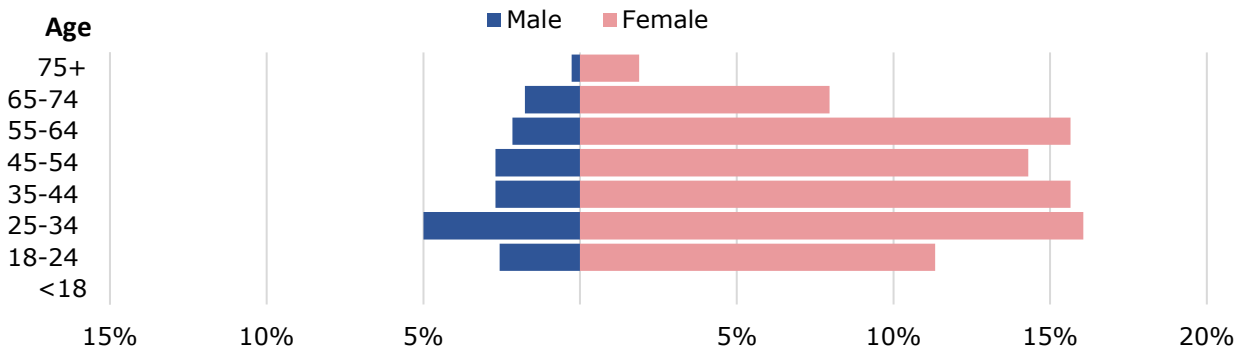
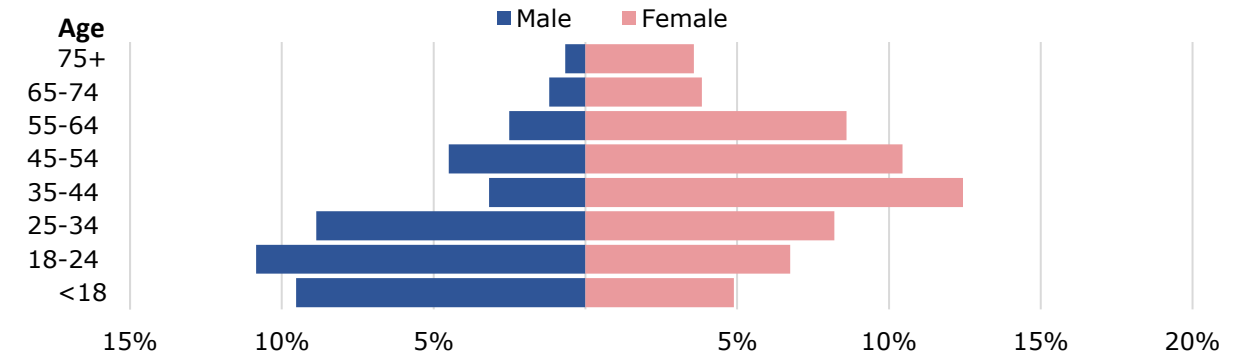


Figure 3. Population Pyramid of Respondents



[53] U.S. Bureau of Labor Statistics. Labor Force Statistics from the Current Population Survey: Demographics. Age and Women. 2019. https://www.bls.gov/cps/demographics.htm
[54] Some respondents provided answers on behalf of their children receiving services.

Lastly, when asked about household size, just 12 percent of respondents indicated that they live alone.

CDS Attendant Hiring and Turnover

The survey responses show that the employment of CDS attendants is often conditioned by the availability of family or acquaintance-related assistance. As shown in Figure 4, a large majority of respondents (78.3%) indicated that their current attendant is someone they knew before. The reliance of CDS employers on their social circles is also confirmed by the fact that 65 percent of respondents indicated they hire a friend or relative as their CDS attendant (Figure 5).

Figure 4. Respondents' Relationships to Attendants Prior to Hiring

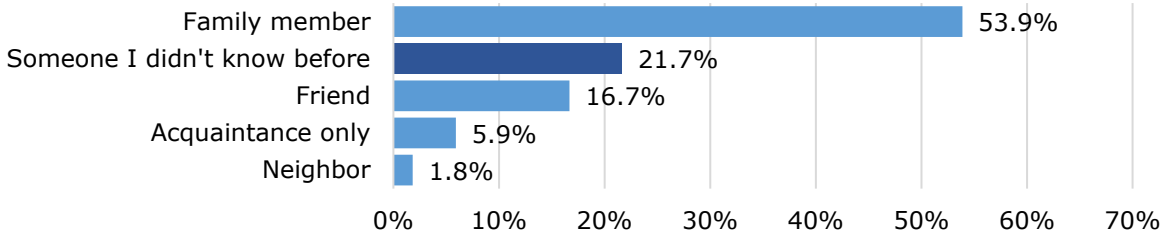
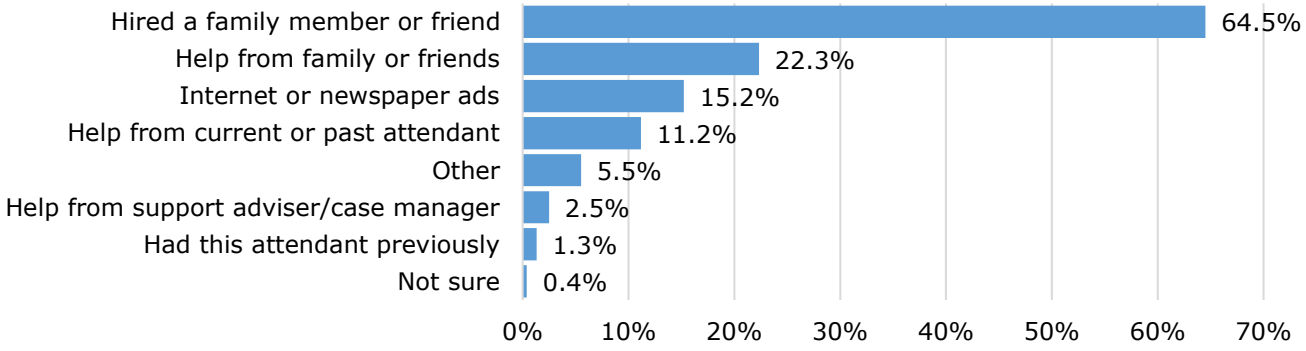


Figure 5. Methods Used by Respondents to Hire Their Most Recently Hired Attendant (multiple selection option)



In the past year, 20 percent of all respondents experienced attendant turnover, and 35 percent of all respondents hired a new attendant. Figure 6 shows that among those that hired a new attendant in the past year, the most common reason indicated for hiring a new attendant was a need for an additional attendant. The two next most common reasons for hiring are that their attendant quit (35.8%) and that their attendant moved (19.5%). Most respondents indicated they are currently employing only one attendant (52.6%); these are the individuals most at risk of not receiving services in the case that their attendant quits or moves (Figure 7).

Figure 6. Why Respondents Hired a New Attendant in the Past Year

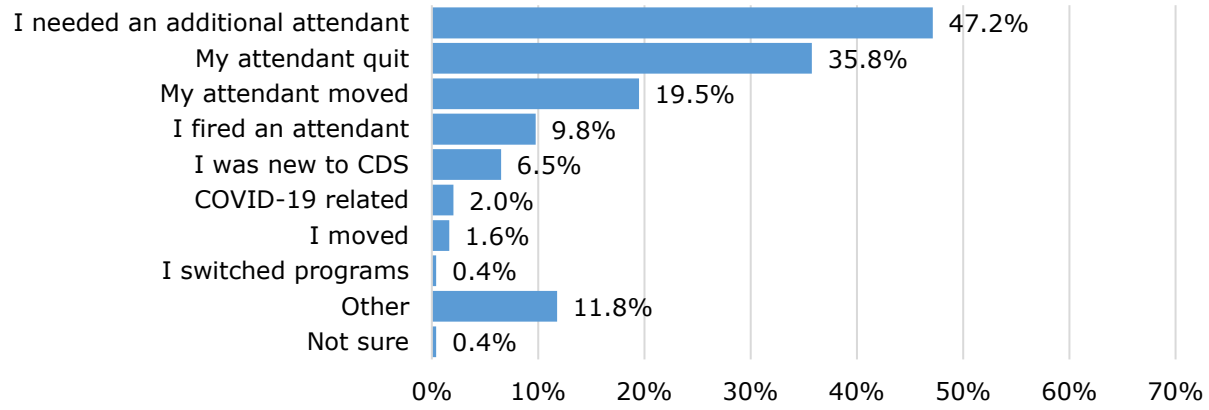
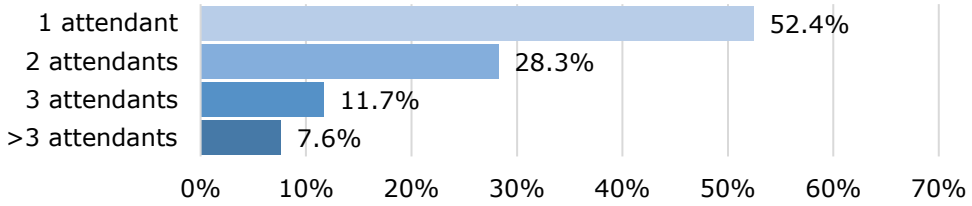
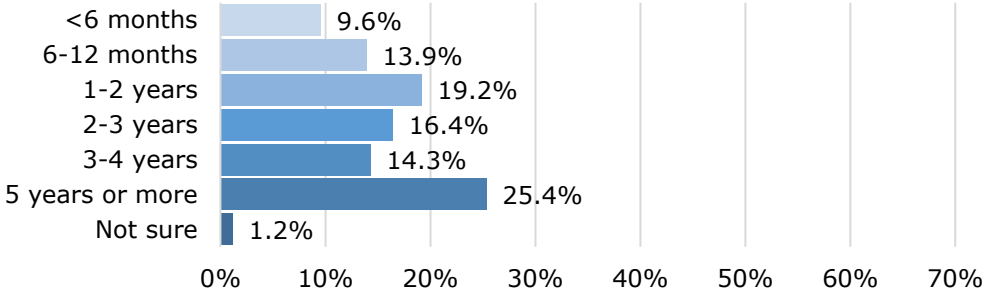


Figure 7. Respondents by Total Number of Currently Employed Attendants



There is a tendency among CDS employers toward long-term employment of attendants (Figure 8). Most respondents (56.1%) indicated that they have employed their current primary attendant for two years or longer.

Figure 8. Length of Employment of Respondents' Attendants



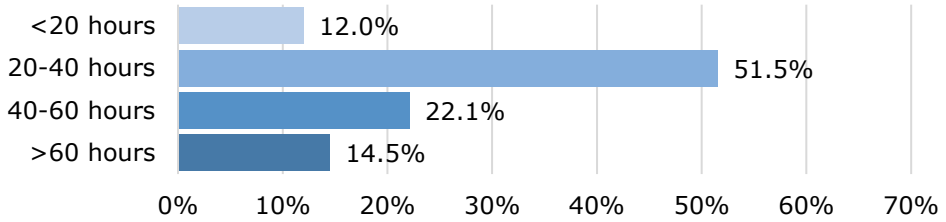
Attendants that indicated that they had hired a new attendant within the past year were asked a series of questions, one of which regards how difficult the hiring process was for them. Across the 264 respondents that hired a new attendant in the past year, the average answer on a scale of very easy (1) to very hard (5) was 3.4, or neither easy nor hard with a slight lean toward hard. Table 11 shows the levels of difficulty indicated by respondents broken down by their self-reported

HHSC CDS program, along with their levels of satisfaction with the CDS option and the quality of the attendant services they receive through CDS.

Service Utilization

Most respondents (95.0%) indicated that they utilize most or all of their hours within the CDS option. Furthermore, most respondents are authorized to receive between 20 and 40 hours of attendant care per week (Figure 9).

Figure 9. Respondents' Weekly Authorized Hours for CDS Attendant Care



Respondent Satisfaction with CDS

Per Table 11, respondents were generally satisfied or very satisfied with the CDS option and quality of attendant services they have received. On a scale from 1 to 5, where 1 is "very dissatisfied" and 5 is "very satisfied", the average satisfaction with the CDS option is 4.6 and the average satisfaction with quality of attendant services is 4.8.

Only 7 percent of respondents stated that their attendants need additional training. Among this 7 percent of respondents, 50 percent indicated that their attendant needs additional training in physical support skills, 42 percent in social/communication skills, 30 percent in organizational skills, 28 percent in food/nutrition skills, and 26 percent in housekeeping skills. Some respondents mentioned special medical knowledge, behavioral care/incidents skills, and other skills specific to their case needs.

Table 11. Respondent Satisfaction with CDS Option and CDS Services and Respondent Hiring Difficulties

Self-reported Program[55]	Avg. satisfaction with CDS option[56]	Avg. satisfaction with quality of attendant services[56]	Avg. difficulty finding a new attendant in past year[57]	Satisfaction (n)	Difficulty (n)
CAS/FC/PHC	4.8	4.8	3.2	17	6
CMPAS	4.6	4.8	3.7	153	43
CFC Services [58]	4.3	4.5	5.0 [59]	6	2
DBMD	4.6	4.5	4.3	8	4
HCS	4.6	4.7	3.4	52	28
MMP	4.5	4.9	1.8	24	5
STAR Health	4.8	4.8	3.0 [59]	6	1
STAR Kids or MDCP	4.5	4.7	3.5	217	82
STAR+PLUS or STAR+PLUS HCBS	4.6	4.8	3.2	238	78
TxHmL	4.8	4.9	2.9	34	14
Not sure	4.7	4.8	1.0 [59]	6	1
Combined Total	**4.6**	**4.8**	**3.2**	**761**	**264**

Moreover, most of the respondents (77.8%) said they always received assistance with personal activities when they needed it. Only 3 percent of respondents said they frequently did not receive the assistance needed at the past year (Table 12).

Overall, 22 percent of respondents experienced a time during the past year when their attendant could not provide services as scheduled and had to rely on someone else to provide additional support. Nearly half of these CDS employers (54.6%) whose attendant could not always provide services as scheduled found backup assistance from someone else. However, 19 percent of CDS employers needing backup assistance were unable to do so.

[55] The distribution of answers by program is approximate. This information is self-reported and can be prone to error due to differences in respondents' usage of program names versus HHSC's.
[56] Satisfaction is on a scale from 1 to 5 in which 1 is very dissatisfied, 2 is dissatisfied, 3 is neither satisfied, nor dissatisfied, 4 is satisfied, and 5 is very satisfied.
[57] Difficulty is on a scale from 1 to 5 in which 1 is very easy, 2 is easy, 3 is neither easy nor hard, 4 is hard, 5 is very hard.
[58] This program category is for respondents that at the time of the survey were receiving CFC services while on a waiver program interest list.
[59] Insignificant value because of too few cases (n) for calculating an average for this program.

Table 12. Self-reported Frequency in Which Respondents Did Not Receive Assistance with Personal Care Activities When They Needed It

Frequency of Personal Care Needs Not Being Met	%	n
Never; always received assistance when needed	77.8%	592
Rarely	10.6%	81
Sometimes	8.7%	66
Frequently	1.6%	12
Very frequently	1.3%	10
Total	**100.0%**	**761**

Recommendations for Improvement

CDS survey respondents provided valuable perspectives and recommendations on how to improve the CDS option.

The recommendations associated with improving the process of finding and hiring an attendant were provided in responses to open-ended questions and manually grouped and categorized in Table 13. Recommendations to HHSC for improving the CDS option were manually grouped and categorized in Table 14.

HHSC is evaluating the feasibility of implementing the recommendations provided during the cross-agency forum and recommendations provided in the CDS survey.

Table 13. Respondent Recommendations to Improve Process of Finding and Hiring a CDS attendant [60]

CDS Attendant Finding/Hiring Recommendation Category	%[61]	n
1. Increase or allow greater flexibility with pay, benefits, or mileage reimbursement	47.3%	98
2. Provide more resources to help employers find/screen/hire quality attendants[62]	44.9%	93
3. Streamline or simplify paperwork and application process and/or make it online	6.8%	14
4. Reduce hiring restrictions[63]	6.3%	13
5. Improve issues with customer service[64]	4.8%	10
6. Increase public outreach/awareness of CDS option availability	1.4%	3

Table 14. CDS Survey Respondent Recommendations for Improvement of CDS Service Delivery Option[65]

CDS Option Recommendation Category	%[61]	n
1. Increase or allow greater flexibility with pay, benefits, or mileage reimbursement	40.2%	74
2. Address customer service issues with FMSAs and/or case managers[64,66]	25.5%	47
3. Provide more resources or training to help employers handle operational responsibilities	14.1%	26
4. Streamline or simplify paperwork and/or make it online	9.8%	18
5. Address concerns with EVV implementation or EVV costs	8.7%	16
6. Provide more resources to help employers find/screen/hire quality attendants[62]	8.7%	16
7. Address issues with the authorizations/approvals process	3.8%	7
8. Reduce hiring restrictions[63]	3.3%	6
9. Increase public outreach/awareness of CDS option availability	2.7%	5
10. Expand CDS option to more programs/services (e.g., in HCS)	1.1%	2
11. Other[67]	5.4%	10

[60] Open-ended responses manually grouped and categorized to answer, "To improve the process of finding and hiring an attendant, HHSC can:."
[61] Total response rate >100% because some responses fell into multiple categories.
[62] Many respondents that provided this answer indicated they have difficulties or concerns with hiring strangers as unskilled caregivers.
[63] For instance, restrictions regarding hiring the following as attendants: family members; individuals below the age of 18; and individuals that have committed certain non-violent crimes.
[64] Many but not all respondents referred to FMSA customer service, specifically.
[65] Open-ended responses were manually grouped and categorized to answer, "To improve the CDS option, HHSC can:."
[66]Issues include payroll, budgeting, oversight, and FMSA monopolies over certain geographic areas.
[67] Other recommendations include creating an online platform to talk to other CDS employers, allowing attendants to drive the CDS employer's vehicle, education options, and more.

4. Long-Term Goals

HHSC determined the long-term goals outlined below after careful consideration of stakeholder feedback and analysis of data that is mentioned throughout this report. Supporting information is cited for each goal to provide context and considerations that may need to be addressed to achieve these goals.

Long-term Goal 1: Sustain and Continue Investing in Wage Increases and Rate Enhancement Programs

HHSC is committed to working with the Legislature by providing information to evaluate the need and potential fiscal impact of wage increases for attendant services. The table below outlines the estimated annual cost of increasing the current required hourly base wage of personal attendants.

Table 15. FY 2022-23 Estimated Fiscal Impact of Increasing Personal Attendant Base Wage from $8.11

Base Wage	FY 2022 AF	FY 2022 GR	FY 2023 AF	FY 2023 GR
$9.00	$446,772,123	$172,096,622	$469,087,800	$180,833,347
$10.00	$985,757,705	$378,351,278	$1,034,182,699	$397,284,733
$11.00	$1,555,624,046	$595,248,143	$1,630,907,407	$624,640,197
$12.00	$2,151,231,336	$821,498,001	$2,253,504,670	$861,405,486
$13.00	$2,774,497,721	$1,057,425,684	$2,903,806,271	$1,107,871,623
$14.00	$3,399,302,096	$1,293,853,521	$3,555,732,591	$1,354,866,607
$15.00	$4,024,106,471	$1,530,281,358	$4,207,658,911	$1,601,861,591

The fiscal estimate in Table 15 applies only to programs and services subject to a base wage for personal attendants as defined in 1 TAC §355.7051. As described above, the personal attendant base wage assumes base wages without any benefits or supplemental add-on associated with rate enhancement. Furthermore, the estimate in Table 15 is assumed to constitute the minimum necessary fiscal impact to increase base wages from the current hourly minimum wage of $8.11. HHSC recommends a base wage be divisible by four, due to potential rounding issues when services are billed in 15-minute increments, rather than hourly.

Increasing funding for rate enhancement may serve as one mechanism to potentially alleviate recruitment and retention issues in Texas. Such funding would be directed exclusively toward attendant wage rates and, as a result, may potentially increase provider participation in rate enhancement. One measure of the success of the rate enhancement program is through provider participation since higher participation by providers allows more attendants to be eligible for additional funds.

As noted in Appendix D of the 2019 Rider 207 report, the top reasons why surveyed IDD providers did not participate in rate enhancement were because the reporting requirements for rate enhancement are too burdensome and not financially worth the effort, and because the risk of recoupment from a misstep in reporting is too high.[68] Given the considerations about rate enhancement expressed by some providers, it may be prudent to examine how HHSC can improve the administration of rate enhancement. This may particularly help attendants in programs with low rates of participation in rate enhancement, such as HCS which has a fiscal year 2021 participation rate of just 30 percent of contracted providers (Table 5).

Because the pools of enrolled providers and their corresponding rate enhancement levels shift annually, an estimate of the cost to support maximum funding for rate enhancement for community attendants was not available to include in this report.

Long-term Goal 2: Improve Data Collection

As an initiative of the 2018-19 Rider 207 reports, HHSC began collecting attendant workforce recruitment and retention data in its cost reports. Although this cost report data collection initiative has garnered useful insights, HHSC has realized the limitations that come with collecting this information from cost reports and not from a separate survey dedicated to the topic of attendant workforce issues. For instance, cost report preparers are typically contracted accountants or other individuals whose purviews involve financial information and not information about hiring and turnover. And yet, these cost report preparers are the ones tasked with answering hiring and turnover questions which are not directly related to financials.

In order to collect data that is more robust and covers more providers, HHSC plans to explore other vehicles with which to collect attendant workforce recruitment and retention data.

[68] Texas Health and Human Services Commission. "Community Attendant Recruitment and Retention Strategies." August 2019. https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/community-attendant-recruitmt-retention-strat-aug-2019.pdf

Long-term Goal 3: Convene a Workforce Development Task Force

The need for a qualified and sustainable direct service workforce is paramount to the delivery of personal assistance and habilitation services to individuals receiving LTSS. State government and community organizations and councils representing individuals with disabilities have a role in furthering this goal. Many of the ideas from participants in the cross-agency forum outlined in Stakeholder Goals 3 through 5 will need long-term discussion, possible statutory changes, additional resources, and ongoing cross-agency collaboration to successfully implement. The task force would also be responsible for the oversight of the strategic plan.

Stakeholders at the cross-agency forum identified the following state agencies as important partners:

- TWC, including members of Local Workforce Development Boards;
- The Texas Higher Education Coordinating Board; and
- HHSC.

Community organizations and councils that represent individuals with disabilities and the challenges faced in recruiting and retaining attendants including the following:

- Texas Council for Developmental Disabilities;
- Coalition for Texans with Disabilities;
- Disability Rights Texas;
- Area Agencies on Aging;
- ADAPT/PACT (American Disabled for Attendant Programs Today / Personal Attendant Coalition of Texas)
- The Arc of Texas;
- Centers for Independent Living; and
- Texas Parent to Parent.

MCOs and FFS community-based provider associations also play an important role in workforce development.

The taskforce can assist HHSC and other partners with exploring and implementing goals and strategies identified at the cross-agency forum and any additional strategies for attendant workforce development such as:

- Consider options to develop internships for students in health-related fields such as medicine, nursing, occupational therapy, physical therapy, and others;
- Consider options for recruiting retired seniors to work as community attendants;
- Consider options for partnering with faith-based organizations to support community attendants and persons receiving these services; and
- Exploring alternative sources of funding for community attendant services.

Goal 3 recommends creation of a taskforce that meets several times a year to monitor the implementation of the strategic plan outlined in this report and continues researching innovative strategies and funding aimed at addressing the goal of a qualified and sustainable direct service workforce.

Long-term Goal 4: Increase Utilization of the CDS Option

Secure Additional Funding for Attendant Services in the CDS Option

Per 1 TAC §355.114, the rates for the CDS option are modeled on the payment rates paid to contracted agencies for providing services to consumers who do not participate in CDS option, and then removing from those rates amounts needed to fund CDS provider agencies' responsibilities. Moreover, the funds available for the CDS option cannot exceed, in aggregate, that which would have been paid to an agency if the consumer was not participating in CDS option.

For services that are eligible for participation in the rate enhancement program in the agency option, CDS services receive a rate enhancement add-on equivalent to participation level 4, which was the average level of rate enhancement participation when the CDS option was originally established. The Texas Legislature has provided additional appropriations in the rate enhancement program for provider agencies; however, there have not been corresponding adjustments to those CDS option services. A rate increase for CDS attendant services to the current average participation level in the agency option would require additional appropriations and may violate the limit that CDS services cannot exceed the amount paid to contracted agencies.

Strategies for Increasing Utilization in the CDS Option

To increase utilization of the CDS option, HHSC will explore opportunities to streamline the attendant hiring process for CDS employers. This includes decreasing the administrative burden on CDS employers and prospective attendants by simplifying and consolidating the required documents and forms that must be completed as part of the hiring process. HHSC will also work to develop additional resources for CDS employers related to their employer requirements and responsibilities for hiring CDS employees.

In response to Stakeholder Goal 2.2, criminal background checks are required by law prior for an attendant delivering services in all Medicaid community-based programs. While HHSC can examine ways to further streamline the process for checking criminal history, HHSC cannot authorize CDS employers and FMSAs to allow attendants without criminal history checks to begin delivering services.

HHSC is collaborating with the Texas Council on Consumer Direction (TCCD) to revise informational materials related to the CDS option. These materials, including a brochure and booklet, are resources for individuals receiving services, and their families, who may be interested in using CDS. The revised CDS brochure was printed in Fall 2019 and revisions to the booklet are in progress.[69] Development and printing of these brochures were funded by a federal Money Follows the Person (MFP) Demonstration grant.

HHSC is also working to improve and increase training resources available to service coordinators and case managers who present the CDS option to individuals receiving services. To ensure that consistent and accurate education regarding the CDS option is provided to all program recipients, HHSC provided in-person training to MCO service coordinators, local intellectual and developmental disability authority service coordinators, and case managers throughout the state in Fall 2019. Additionally, HHSC continues to explore opportunities to develop training resources on the CDS option, including online training modules for service coordinators, case managers, FMSAs, and CDS employers.

[69] Texas Health and Human Services. "Consumer Directed Services: You have choices." https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/cds-you-have-choices.pdf

Long-term Goal 5: Enhance Network Adequacy Standards

To improve upon a service, the agency must first have a reliable measure of how well the current service is meeting the needs of the population. Stakeholders report that there are issues with finding qualified community care attendants.

Rider 157 directs HHSC to develop enhanced network adequacy standards for Medicaid MCOs ensuring sufficient member access to community care attendants. HHSC is exploring several potential measures including:

- patient-provider ratios;
- timeliness of attendant services;
- missed and late attendant visits;
- number of service hours delivered vs. the number of service hours approved;
- percentage of licensed provider (staffing agencies) contracting with Medicaid;
- complaints;
- out-of-network utilization and single case agreements;
- network gaining or losing providers; and
- utilization review.

These potential measures were presented to the Network Adequacy Steering Committee and the State Medicaid Managed Care Advisory Committee in November 2019. The data and feedback received were provided to an external entity contracted with HHSC to research network adequacy in managed care across the country and help determine which measures should be pursued in Texas. HHSC will continue to explore network adequacy measures for community care attendants with plans to add network adequacy measures for attendants to the managed care contracts effective March 1, 2021.

Long-term Goal 6: Value-Based Payment Systems in Managed Care

From April 2018 through September 2019, HHSC was one of 10 state Medicaid agencies selected to participate in a Centers for Medicare and Medicaid Services (CMS) Innovation Accelerator Program (IAP) project on Value-Based Payment (VBP) for managed care HCBS. 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 was drafted. This concept and visualization (known as a driver diagram) and a plan for VBP in managed care

HCBS were presented to several focus groups comprised of stakeholders from varying perspectives. Through the IAP, HHSC recognized that a comprehensive HCBS VBP strategy requires additional work identifying metrics relevant for attendant care services. The network adequacy measures developed through Rider 157 help build the foundation for increasing value-based payment between MCOs and providers for HCBS services.

5. Next Steps and Conclusion

HHSC is committed to the next steps as outlined below. A primary focus of HHSC is the establishment of a Workforce Development Taskforce, which would spearhead the evaluation and potential implementation of the specific stakeholder ideas, among other identified improvements. These efforts will include continued data analyses and consistent engagement with stakeholders and other state agencies as necessary to support individuals receiving community attendant services and providers of these services. The immediate next step of the strategic plan is to pursue the strategies and recommendations identified throughout this report as outlined below.

In the Next 6 Months

HHSC will take the following steps in the next 6 months:

- During the second quarter of fiscal year 2021, launch a public relations campaign in collaboration with other state agencies and stakeholders to increase awareness of the role of community attendant work and growing career opportunities in the field.
- Through the Chief Program and Services Office, dedicate resources at HHSC to coordinate and support a Workforce Development Taskforce. Engage with other state agencies and stakeholders to hold the initial taskforce meeting in March 2021.
- Add network adequacy measures for community attendants to the managed care contracts, effective March 1, 2021.
- Collaborate with the TCCD on reducing administrative burdens on CDS employers through improvements to orientation and criminal background check processes. A preliminary timeline for this work follows.
  - November 17, 2020: Explore changes with TCCD Process and Expansion Subcommittee.
  - December 1, 2020: Continue discussion with TCCD at full committee meeting with the goal of a final implementation plan at the March 2021 full committee meeting.
  - March 18, 2021: Discuss final implementation plan.
- Explore the use of MFP funding toward goals outlined in this report. On September 23, 2020, CMS announced the availability of up to $165 million in supplemental funding to states currently operating MFP demonstration programs. This funding will help state Medicaid programs build capacity to

maintain efforts to transition individuals with disabilities and older adults from institutions and nursing facilities to home and community-based settings of their choosing.

- Provider and direct service worker recruitment, education, training, technical assistance, and quality improvement activities are identified by CMS as a focus area for funding. Each state is eligible to receive up to $5 million in supplemental funding.
- CMS will accept budget requests under this funding opportunity on a rolling basis through June 30, 2021. Funds will be available for four years after the award. HHSC will work with stakeholders to identify potential options for the use of this fund.

Beyond 6 Months

HHSC will take the following steps beyond the next 6 months:

- Continue the Workforce Development Taskforce to engage stakeholders in a consistent effort to address attendant workforce issues, including creating a more detailed timeline and benchmarks for addressing stakeholder priorities addressed in the cross-agency forum.
- In collaboration with the Workforce Development Taskforce, explore securing additional funding to enhance training for community attendants including the expansion of online resources dedicated to workforce development.
- Continue data collection efforts regarding community attendant retention and turnover.
- Expand data collection and analysis efforts to study wage equity, service gaps, and other matters impacting individuals receiving community attendant services and providers of attendant services.
- Increase value-based payment between MCOs and providers of HCBS.

HHSC will work to achieve both the mission and vision outlined in this report through these next steps while working closely with the Legislature, other agencies, and stakeholders.

List of Acronyms

Acronym	Full Name
1 TAC	Title 1 of the Texas Administrative Code
ACS	American Community Survey
ADAPT	American Disabled for Attendant Programs Today
ADLs	Activities of daily living
AF	All Funds
AFC	Adult Foster Care
AL	Assisted Living
AMH	Adult metal health
Avg.	Average
BLS	U.S. Bureau of Labor Statistics
CAS	Community Attendant Services
CDS	Consumer Directed Services
CEP	Continuing education program
CFC	Community First Choice
CLASS	Community Living Assistance and Support Services
CMPAS	Consumer Managed Personal Attendant Services
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DAHS	Day Activity and Health Services
DBMD	Deaf-blind with Multiple Disabilities
ERS	Emergency Response Services

Acronym	Full Name
FC	Family Care
FFS	Fee-for-service
FMSA	Financial Management Services Agency
FY	Fiscal Year
GR	General Revenue
HCBS	Home and Community-based Services
HCS	Home and Community-based Services (Texas 1915(c) waiver program)
HDM	Home-delivered Meals
HHA	Home Health Aide
HHSC	Texas Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act of 1996
IADLs	Instrumental Activities of daily living
IAP	Medicaid Innovation Accelerator Program
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions
IDD	Individuals with an intellectual or developmental disability
LAR	Legally authorized representative
LTSS	Long-term services and supports
MCO	Managed care organization
MDCP	Medically Dependent Children Program
MFP	Money follows the person
MMP	Medicare-Medicaid plan (dual demonstration)
n	Number of cases

Acronym	Full Name
NF	Nursing Facility
PACE	Program of All-inclusive Care for the Elderly
PACT	Personal Attendant Coalition of Texas
PAS	Personal attendant services
PATHS	Texas A&M Postsecondary Access and Training in Human Services
PCA	Personal Care Aides
PCE	Personal Consumption Expenditures price index
PCS	Personal care services
PDN	Private duty nursing
PHC	Primary Home Care
Q	Quarter
RC	Residential Care
SL/RSS	Supported living/residential support services
SSLC	State supported living center
SSPD	Special Services to Persons with Disabilities
TCCD	Texas Council on Consumer Direction
TDC	Texas Demographic Center
TWC	Texas Workforce Commission
TxHmL	Texas Home Living
VBP	Value-Based payment
YES	Youth Empowerment Services (Texas 1915(c) waiver program)

Appendix A. Full Text of Rider 157

157. Community Attendant Workforce Development Strategies. Out of funds appropriated above, the Health and Human Services Commission (HHSC) shall develop strategies to recruit, retain, and ensure adequate access to the services of community attendants.

(a) These strategies shall include the following:

(1) Gathering comprehensive data regarding attendants providing home and community-based services in both fee-for-service and managed care, including:

(A) number of attendants;

(B) turnover rates for attendants;

(C) vacancy rates for attendants;

(D) number of attendants paid at the base wage rate;

(E) number of attendants paid above the base wage rate;

(F) average wage rate in the lowest-paying programs;

(G) historic wages levels in Texas community care, adjusted for inflation;

(H) any financial incentives that are passed directly to community attendants;

(I) factors that impact access to reliable attendant care;

(J) average cost of community care as compared to nursing facility care; and

(K) any other data the agency deems necessary to develop a plan to improve recruitment and retention of the community attendants and inform the Legislature about the challenges facing the provision of community attendant services.

(2) Estimating the demand for community attendant services utilizing demographic trends and any other necessary information and the required community attendant workforce capacity required to meet that demand for the period from fiscal year 2022 to fiscal year 2031.

(3) Convening a cross-agency forum to develop a state workforce strategic plan for retention and recruitment of community attendants. The plan shall include:

(A) recommendations for the Legislature to consider related to potential dedicated sources of funding for community attendants;

(B) ways to increase the use of consumer directed services;

(C) innovative ideas for recruitment and retention of community attendants, which may include the following:

(i) wage and benefit incentives;

(ii) quality-based payment systems in managed care;

(iii) training people with disabilities to be community attendants;

(iv) options to develop internships for students in health-related fields such as medicine, nursing, occupational therapy, physical therapy, and others; and

(v) recruiting retired seniors to work as community attendants.

(4) Developing enhanced network adequacy standards for Medicaid managed care organizations ensuring sufficient member access to community care attendants.

(b) HHSC may conduct surveys or other methods as necessary to collect the data described in subsection (a)(1) if it is not available from existing sources.

(c) In developing the strategic plan, HHSC shall work in consultation with the Aging and Disability Resource Advisory Committee, State Medicaid Managed Care Advisory Committee, Texas Council on Consumer Direction, and any other advisory committees and stakeholders as determined by the Executive Commissioner of HHSC.

(d) HHSC shall submit the strategic plan and recommendations for implementation of the plan by November 1, 2020 to the Governor, the Legislative Budget Board, and permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services.

Appendix B. Consumer Directed Services Employer Survey

Methods

The information in this appendix is based on an online survey conducted by HHSC between June 15, 2020 and July 15, 2020. The sample includes individuals that were actively self-directing their attendant services through the CDS option in Texas at the time the survey was conducted. The survey was open to all CDS employers and could be completed by the employer, the employer's legally authorized representative, or individuals directed by the employer to respond on their behalf, including an employer's family member, friend, or attendant.

The questionnaire was published on the online survey platform SurveyMonkey and made available for respondents through a published information letter distributed by HHSC via GovDelivery and TexConnect notices, and via distributions to FMSAs.

The questionnaire had 43 general questions and was designed to capture some of the main dimensions of CDS employers' experiences with personal attendant services. The survey began with two questions that filtered out respondents that were not active CDS employers of attendant services or representatives of active CDS employers of attendant services. Some questions allowed respondents to select multiple responses to a single question; in this appendix, results related to these questions are marked to indicate this using the language "multiple choices allowed."

The following high-level results are based on 761 fully completed questionnaires included into the final sample.

Results

The CDS survey results in this appendix are in addition to those already given in section 3 of the strategic plan; as such, a full picture of the survey results requires section 3 and this appendix combined.

The results are categorized into six sections below.

Section 1. Demographics of Respondents

Table B-1. Respondents by Age Group and Gender

Respondent age group	Female (%)	Male (%)	Total (%)	Total (n)
<18[70]	4.9%	9.5%	14.4%	109
18-24	6.7%	10.8%	17.6%	133
25-34	8.2%	8.9%	17.1%	129
35-44	12.4%	3.2%	15.6%	118
45-54	10.4%	4.5%	14.9%	113
55-64	8.6%	2.5%	11.1%	84
65-74	3.8%	1.2%	5.0%	38
75 or older	3.6%	0.7%	4.2%	32
Total	**58.7%**	**41.3%**	**100.0%**	**756**

Table B-2. Respondents by Size of Household

Respondent household Size	Female (%)	Male (%)	Total (%)	All (n)
Lives alone	7.0%	4.6%	11.5%	87
Lives with one other person	9.8%	7.0%	16.9%	128
Lives with two other people	16.6%	14.0%	30.6%	231
Lives with three or more other people	25.3%	15.6%	41.0%	310
Total	**58.8%**	**41.2%**	**100.0%**	**756**

Table B-3. Respondents by Primary Language

Respondent primary language	%	n
English	93.8%	714
Spanish	3.8%	29
Other[71]	2.4%	18
Total	**100.0%**	**761**

[70] A parent or guardian is the employer of record for an individual that is both utilizing CDS services and under the age of 18.
[71] "Other" includes nonverbal individuals.

Table B-4. Respondents by Race (multiple choices allowed)

Respondent race	%	n
White	62.0%	472
Hispanic / Latino	28.1%	214
Black (African American)	13.9%	106
Asian	2.6%	20
American Indian / Alaska Native	0.9%	7
Other	2.5%	19

Table B-5. Respondents by Highest Attained Level of Education[72]

Respondent education level	%	n
Less than high school diploma or equivalent (e.g. GED)	27.0%	203
High school diploma or equivalent	33.8%	254
Some college	15.2%	114
Technical or vocational diploma	2.8%	21
Associate degree	5.3%	40
Bachelor's degree	10.5%	79
Advanced degree	5.5%	41
Total	**100.0%**	**752**

Table B-6. Respondents by Self-reported HHSC program

Self-reported program	%	n
CMPAS	20.1%	153
Currently receiving CFC services while on a waiver program interest list	0.8%	6
DBMD	1.1%	8
HCS	6.8%	52
MMP	3.2%	24
PHC / FC / CAS	2.2%	17
STAR Health	0.8%	6
STAR Kids or MDCP	28.5%	217
STAR+PLUS or STAR+PLUS HCBS	31.3%	238
TxHmL	4.5%	34
Not sure	0.8%	6
Total	**100.0%**	**761**

[72] Does not include respondents that declined to respond.

Section 2. Demographics of Respondents' Primary CDS Attendants

Table B-7. Respondents' Attendants by Age Group and Gender[73]

Attendant age group	% of total number of attendants			Number of attendants		
	Female	Male	Total	Female	Male	Total
18-24	11.3%	2.6%	**13.9%**	84	19	**103**
25-34	16.1%	5.0%	**21.1%**	119	37	**156**
35-44	15.7%	2.7%	**18.4%**	116	20	**136**
45-54	14.3%	2.7%	**17.0%**	106	20	**126**
55-64	15.7%	2.2%	**17.8%**	116	16	**132**
65-74	8.0%	1.8%	**9.7%**	59	13	**72**
75 or older	1.9%	0.3%	**2.2%**	14	2	**16**
Total	**82.9%**	**17.1%**	**100.0%**	**614**	**127**	**741**

Table B-8. Respondents' Attendants by Primary Language

Attendant primary language	%	Total (n)
English	92.8%	706
Spanish	5.9%	45
Other	0.9%	7
I don't know	0.4%	3
Total	**100.0%**	**761**

[73] Excludes the responses "I don't know" and "Prefer not to answer."

Table B-9. Primary Relationship of Respondents to Their Attendants by Attendant Gender

Relationship to Attendant	Female	Male	Prefer not to say	Total (%)	Female	Male	Prefer not to say	Total (n)
Family member	43.8%	9.3%	0.8%	**53.9%**	333	71	6	**410**
Someone I didn't know before	18.3%	3.3%	0.1%	**21.7%**	139	25	1	**165**
Friend	13.1%	3.0%	0.5%	**16.7%**	100	23	4	**127**
Acquaintance only	4.9%	0.8%	0.3%	**5.9%**	37	6	2	**45**
Neighbor	1.4%	0.3%	0.1%	**1.8%**	11	2	1	**14**
Total	**81.5%**	**16.7%**	**1.8%**	**100.0%**	**620**	**127**	**14**	**761**

Table B-10. Type of Family Member of Attendant for Respondents that Indicated that the Person Providing the Most Paid Hours of Attendant Services is a Family Member

Attendant family member type	%	Total number
Parent	25.1%	103
Son or daughter	23.7%	97
Grandparent	15.4%	63
Aunt or uncle	7.1%	29
In-law	4.6%	19
Cousin	3.9%	16
Grandchild	2.2%	9
Other family	18.0%	74
Total	**100.0%**	**410**

Table B-11. Respondents' Attendants by Race (multiple choices allowed)

Attendant race	%	n
White	52.7%	401
Hispanic or Latino	32.6%	248
Black or African American	17.0%	129
Asian	1.7%	13
American Indian / Alaska Native	0.9%	7
Other	2.5%	19

Section 3. Hiring and Turnover of Respondents' CDS Attendants

Data on respondent levels of difficulty hiring in the past year are located in section 3 of the strategic plan. In addition to this, HHSC identified several statistically significant correlations between responses to particular questions in the CDS survey using the Pearson correlation coefficient.[74] Higher levels of difficulty hiring over the past year, in particular, are correlated with:

- Higher numbers of weekly authorized CDS hours;
- Lower levels of satisfaction with the quality of their attendant services;
- Lower levels of satisfaction with the CDS option;
- Higher frequencies of personal care needs not being met during the past year;
- Indications that the attendant needs more training;
- Lower utilization of authorized CDS hours; and
- Higher numbers of attendants hired during the past year.

Table B-13. Respondents' Attendants by Length of Employment

Attendant length of employment	%	n
<6 months	9.6%	73
6-12 months	13.9%	106
1-2 years	19.2%	146
2-3 years	16.4%	125
3-4 years	14.3%	109
More than 5 years	25.4%	193
Not sure	1.2%	9
Total	**100.0%**	**761**

[74] Correlations are statistically significant at the 0.01 level (2-tailed).

Table B-12. Respondents by Self-Reported Program and Number of Attendants Currently Employing

Self-reported Program	Number of Attendants Currently Employing					
	1	2	3	4 or more	Total (%)	Total (n)
CAS/FC/PHC	41.2%	47.1%	11.8%	-	100%	17
CMPAS	30.1%	42.5%	14.4%	13.1%	100%	153
Currently receiving CFC services while on a waiver program interest list	66.7%	16.7%	16.7%	-	100%	6
DBMD	25.0%	50.0%	12.5%	12.5%	100%	8
HCS	32.7%	28.8%	26.9%	11.5%	100%	52
MMP	83.3%	8.3%	4.2%	4.2%	100%	24
STAR Health	66.7%	-	16.7%	16.7%	100%	6
STAR Kids or MDCP	58.5%	27.6%	10.1%	3.7%	100%	217
STAR+PLUS or STAR+PLUS HCBS	63.0%	21.0%	8.8%	7.1%	100%	238
TxHmL	50.0%	26.5%	11.8%	11.8%	100%	34
Not sure	83.3%	16.7%	-	-	100%	6
Total	**52.4%**	**28.3%**	**11.7%**	**7.6%**	**100%**	**761**

Table B-15. Respondents by Whether They Hired an Attendant in the Past Year

Hired attendant in past year	%	n
Yes [75]	34.4%	259
No	64.8%	487
Not sure	0.8%	6
Total	**100.0%**	**752**

[75] Excludes missing values.

Table B-16. Number of Respondents' Attendants that Left in the Past Year[76]

Number of attendants that left	%	n	% of all respondents
1	59.9%	91	12.0%
2	23.7%	36	4.7%
3	10.5%	16	2.1%
4 or more	5.9%	9	1.2%
Total	**100.0%**	**152**	**20.0%**

Table B-17. Respondent Reasons Why They Hired a New Attendant if They Hired an Attendant in the Past Year (multiple choices allowed if hired multiple attendants)

Reason for Hiring New Attendant	%	n
I needed an additional attendant	47.2%	116
My attendant quit	35.8%	88
My attendant moved	19.5%	48
I fired my attendant	9.8%	24
New to CDS / recently joined	6.5%	16
COVID-19 related	2.0%	5
I moved	1.6%	4
Switched programs	0.4%	1
Other reasons	11.8%	29
Not sure	0.4%	1

Table B-18. Respondent Length of Time to Hire Most Recently Hired Attendant from the Time They Started Searching

Length of time to hire	%	n
<1 month	45.9%	349
1-3 months	23.4%	178
4-6 months	7.0%	53
7-9 months	2.1%	16
10 months or more	3.5%	27
Not sure	16.8%	128
N/A	1.3%	10
Total	**100.0%**	**761**

[76] Excludes one response of "not sure."

Table B-19. Respondent Method Used to Hire Most Recently Hired Attendant
(multiple choices allowed)

Category	%	n
Hired a family member or friend	64.5%	491
Help from family or friends	22.3%	170
Internet or newspaper advertisements	15.2%	116
Help from a current or past attendant	11.2%	85
Help from support adviser or case manager	2.5%	19
Had this attendant previously	1.3%	10
Other	6.6%	50
Not sure	0.4%	3

Section 4. Respondent Utilization of CDS Services

Table B-20. Respondent Utilization of CDS Services and Number of Weekly Authorized CDS Hours

Category	<20 hours	20-40 hours	40-60 hours	>60 hours	Row Total
I utilize all of my hours	73.6%	81.1%	80.4%	76.4%	**79.4%**
I utilize most of my hours	15.4%	13.5%	17.3%	20.9%	**15.6%**
I utilize some of my hours	9.9%	4.8%	2.4%	1.8%	**4.5%**
I do not utilize any of my hours	1.1%	0.5%	-	0.9%	**0.5%**
Column Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
% of Total	**12.0%**	**51.5%**	**22.1%**	**14.5%**	**100.0%**
Total (n)	**91**	**392**	**168**	**110**	**761**

Section 5. Respondent Satisfaction with Services

Table B-21. Satisfaction with the CDS Service Delivery Option

Satisfaction level with CDS	%	n
Very dissatisfied	1.1%	8
Dissatisfied	2.4%	18
Neither satisfied, nor dissatisfied	3.4%	26
Satisfied	23.4%	178
Very satisfied	69.8%	531
Total	**100.0%**	**761**

Table B-22. Satisfaction with Quality of Services Provided by Attendant

Satisfaction level with attendant services	%	n
Very dissatisfied	-	-
Dissatisfied	0.1%	1
Neither satisfied, nor dissatisfied	1.6%	12
Satisfied	21.4%	163
Very satisfied	76.9%	585
Total	**100.0%**	**761**

Table B-23. Attendant Needs More Training Based on Respondent's Specific Needs and Health Conditions

More training needed for attendant	%	n
Yes	6.6%	50
No	93.2%	709
Not sure	0.3%	2
Total	**100%**	**761**

Table B-24. Areas in Which Attendant Needs Additional Training if Respondent Indicated That More Training is Needed (multiple choices allowed)

Attendant needs training category	Selected (%)	Selected (n)
Physical supports skills	50.0%	25
Social/communication skills	42.0%	21
Organization skills	30.0%	15
Food/nutrition skills	28.0%	14
Housekeeping skills	26.0%	13
Medical knowledge	10.0%	5
Behavioral care / incidents skills	6.0%	3
Specific needs	6.0%	3
Other	10.0%	5

Table B-25. When your attendant could not provide services as scheduled in the past year, did you successfully find backup assistance from someone else?

Response	% excluding N/A	n	% including N/A
Yes, always	54.6%	291	38.2%
Yes, sometimes	25.5%	136	17.9%
No, never	19.1%	102	13.4%
Not sure	0.8%	4	0.5%
N/A	-	228	30.0%
Total	**533**	**761**	**100.0%**

Section 6. Respondent Feedback

The survey included three open-ended questions that allowed respondents to write feedback on the CDS service delivery option, feedback on the quality of their attendant services, and feedback on how the COVID-19 pandemic has created new challenges or altered the circumstances of respondents. The results of the first two open-ended questions are located in Table 13 and Table 14 in Section 3 of the strategic plan; the results of the COVID-19 impact question are in Table B-26, below.

Approximately 36 percent of respondents answered the optional open-ended question about how the COVID-19 pandemic has created new challenges or altered their circumstances as a CDS employer. The common challenges among respondents were manually grouped and categorized in Table B-26.

Table B-26 How the COVID-19 Pandemic Has Created New Challenges or Altered the Circumstances of CDS Survey Respondents[77]

COVID-19 Impact Category	%[78]	n
1. New fear, anxiety, or stress about allowing attendants into home or being exposed to COVID-19	27.1%	74
2. Increased difficulties hiring/retaining attendants or otherwise obtaining appropriate care	22.3%	61
3. Reduced or suspended community-based activities (e.g., PAS/HAB or day habilitation) and/or therapies	16.8%	46
4. Reduced or suspended utilization of in-home attendant care[79]	15.0%	41
5. Increased needs for or reliance on attendant care	13.2%	36
6. Difficulties finding or paying for personal protective equipment and/or infection control supplies	10.6%	29
7. New reliance on family member(s) or household to provide attendant care to reduce outside exposure	6.2%	17
8. Regression(s) in behavior or skills from lack of community-based activities	4.0%	11
9. Adapting to fewer community activities with new in-home or otherwise safe activities	2.9%	8
10. Urgency for hazard pay for attendants	1.5%	4
11. Other	13.2%	36

[77] Open-ended responses were manually grouped and categorized to answer, "Other than following minimum recommended health protocols for all individuals in Texas, the employer is dealing with:."
[78] The total response rate is over 100% because some responses to the open-ended question fell into multiple categories.
[79] Such as to limit COVID-19 infection risk or other reasons.