Health and Human Services Commission Strategic Plan for Fiscal Years 2023 to 2027, Part I

As Required by
Texas Government Code
Chapter 2056

Health and Human Services Commission

June 1, 2022

TEXAS
Health and Human Services

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Agency Vision and Mission

Vision: Making a positive difference in the lives of the people we serve.

Mission: We serve Texas.

The Health and Human Services Commission (HHSC) delivers hundreds of services and supports to millions of Texans through the efforts of more than 38,000 employees across the state. We provide for those who need assistance to buy necessities, eat nutritious foods, and pay for healthcare costs, by administering programs such as: Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Program for Women, Infants and Children (WIC), Medicaid, and the Children's Health Insurance Program (CHIP).

The agency operates and oversees 13 state-owned supported living centers, which provide direct services and supports to people with intellectual and developmental disabilities. HHSC also operates nine state hospitals, which serve people who need inpatient psychiatric care, and a residential treatment facility for youth in Waco. In 2022, the Dunn Center – a new hospital in Houston operated by UTHealth Houston – joined the HHSC state hospital system. These 24 facilities operate all hours of the day, all days of the year.

HHSC also regulates childcare, acute care, and long-term care providers, and provides a multitude of additional mental health and substance use services, help for people with special healthcare needs, community supports and services for older Texans, disaster relief assistance, and resources to fight human trafficking.

Building on the transformational changes required by Senate Bill 200, 84th Legislature, Regular Session, 2015, HHSC continues to improve how it provides services and supports, enhancing coordination and efficiency to improve the experience of Texas residents who rely on our services.

HHSC is appropriated approximately $78.8 billion in All Funds for the 2022-23 biennium, which accounts for about one-third of the state budget. Approximately 91.0 percent of appropriations is for grants and client services, while 3.0 percent is for state-operated, facility-based services, 3.7 percent is for administrative services, and 2.3 percent is for other programs.[a] Administrative services and other programs include eligibility determination services, contract management, financial services, information technology, regulatory services, and oversight.

[a] Amounts do not include funds outside the agency's bill pattern.

Agency Goals and Action Plan

Below are HHSC's four operational goals, their objectives, and their action items. Dates are subject to change due to contingencies such as required federal approvals, procurement timelines, operational readiness, and other factors.

Goal 1. Improve and support health outcomes and well-being for individuals and families.

Objective 1.1. Enhance quality of direct care and value of services.

- **Action Item 1.1.1. Managed Care Organization (MCO) Benchmarks.** Implement quality of care and cost efficiency benchmarks for MCOs participating in Medicaid and CHIP. (September 2022)
- **Action Item 1.1.2. STAR+PLUS Pilot Program.** Implement a STAR+PLUS pilot program to test the delivery of fee-for-service long-term services and supports through the managed care model. (September 2023)
- **Action Item 1.1.3. Medicaid for Breast and Cervical Cancer Treatment.** Improve survival rates for women diagnosed with breast or cervical cancer by reducing application processing times by approximately three days by digitizing the Medicaid for Breast and Cervical Cancer application form to start Medicaid treatment earlier. (January 2024)
- **Action Item 1.1.4. Community Attendants.** Promote the community attendant role by expanding workforce development opportunities for attendant-like positions, including at the regional and local level. (December 2024)

Objective 1.2. Prevent illness and promote wellness through public- and population-health strategies.

- **Action Item 1.2.1. Engaging Older Adults.** Assess and grow social engagement opportunities for older adults by expanding program options, such as the Know Your Neighbor campaign, by 10 percent. (January 2025)
- **Action Item 1.2.2. Addressing Opioid Harm.** Reduce negative health outcomes for opioid use by increasing the number of successful opioid overdose reversals by 20 percent. (August 2025)
- **Action Item 1.2.3. Mental Health First Aid Training.** Increase Mental Health First Aid training sessions by 20 percent. (August 2025)

Objective 1.3. Encourage self-sufficiency and long-term independence.

- **Action Item 1.3.1. Family Violence Survivor Support.** Increase the number of family violence survivors served from 15,398 to 17,500. (August 2023)

How Goal 1 Supports Each Statewide Objective

Accountability

HHSC continuously works to improve accountability for responsible expenditures in the administration and oversight of all programs to improve the overall health, safety, and well-being of Texans. One example of how HHSC will ensure accountability is the implementation of benchmarks for Medicaid and CHIP MCOs, to hold those organizations accountable for quality of care at efficient cost.

For more information about HHSC's commitment to accountability, see the Accountability discussion under Goal 4: Continuously enhance efficiency and accountability.

Efficiency

HHSC continuously seeks more efficient ways to operate and deliver services, looking to maximize each dollar invested and provide the highest quality services to Texans who rely on HHSC programs. Finding efficiencies ensures HHSC is a good steward of taxpayer resources, maximizes services to those who rely on them, and allows HHSC to be better prepared for the rapid population growth that is projected for Texas. Specific examples of HHSC's commitment to efficiency include:

- The STAR+PLUS pilot, also called SP3, will test a managed care delivery model for long-term services and supports for people with intellectual and developmental disabilities, traumatic brain injuries, acquired brain injuries, and similar functional needs. The information gained through the pilot will explore increased efficiency through the managed care model, the standard for Medicaid and CHIP service delivery, while ensuring quality of care.
- Digitizing the application form for the Medicaid for Breast and Cervical Cancer will improve efficiency and reduce processing times by approximately three days.

Effectiveness

Effectiveness of service, as measured by improved outcomes, is the core of Goal 1. Each action item aims to strengthen the health and well-being of individuals and families. An approach that focuses on the individual is at the heart of many HHSC programs, from those that serve children to those that serve older adults, to ensure the provision of truly effective services that meet the needs of the clients served. Highlights include:

- Improving efficiency in the Medicaid for Breast and Cervical Cancer application form will increase effectiveness by allowing treatment to start earlier for qualified applicants.
- Strengthening the workforce of community attendants will support effective care for the more than 300,000 people who receive community attendant services through long-term services and support programs in Texas.

- Engaging older adults in their communities effectively supports their health and well-being by addressing isolation and loneliness, which is shown to decrease the likelihood of mortality by 26 percent and the incidence of depression, diabetes, suicide, and clinical dementia by 64 percent. To meet this need, The Know Your Neighbor campaign gives clear guidance to inspire Texans to reach out to older neighbors, while taking appropriate safety precautions during the COVID-19 pandemic.
- Improving health outcomes includes other targeted programs such as:
    - The Texas Targeted Opioid Response (TTOR) program is a public health initiative addressing the opioid crisis. TTOR strategies span the behavioral health continuum of care, coordinating prevention, treatment, and recovery services, as well as integrated projects, across the state.
    - Mental Health First Aid training introduces participants to signs and symptoms of mental health and substance use concerns, builds understanding of their impact, and gives an overview of common treatments and resources, thus empowering people to support others who show signs of needing mental health treatment. Public school employees and employees of public and private higher education institutions can receive Mental Health First Aid training for free through their Local Mental Health Authority or Local Behavioral Health Authority.
    - The Family Violence Program promotes self-sufficiency, safety, and long-term independence of adult and child victims of family violence and victims of teen dating violence. Through a network of service providers, the program provides emergency shelter and supportive services to victims and their children, educates the public, and provides training and prevention support to various organizations across Texas. All services are provided for free and there is no income verification for eligibility.

Excellence in Customer Service

HHSC strives for excellence in customer service by taking a tailored approach to service delivery. Specifically, Goal 1 action items support excellence in customer service in the following ways:

- HHSC's procedures work to support excellence in customer service by requiring all areas to provide program-level inquiry and complaint information via the Ombudsman's Agency Monthly Contact Reporting process. This data is analyzed for systemic trends and shared with executive leadership on a quarterly basis.

- The TTOR provides excellence in customer service with strategies spanning the behavioral health continuum of care, treating the whole person.

Transparency

HHSC uses several strategies to support the statewide objective of transparency.

- HHSC publishes several types of information to track performance and to empower clients to make an informed decision when choosing a managed care organization:
  - Managed Care Report Cards
  - Managed Care Organization Sanctions (contract-related)
  - Medicaid & CHIP Financial Statistical Reports
  - Texas Healthcare Learning Collaborative (public access to a variety of quality measures)
- The TTOR program publishes an annual Program Report Card to show progress in its work.
- HHSC shares information, including testimonials, on the Mental Health First Aid page of the HHSC website.

Goal 2. Ensure efficient access to appropriate services.

Objective 2.1. Empower Texans to identify and apply for services.

- **Action Item 2.1.1. Community Partner Program.** Expand the current Community Partner Program from 187 counties to all 254 counties to ensure the program benefits Texans statewide. (September 2022)
- **Action Item 2.1.2. Women, Infants, and Children (WIC) Program.** Increase the participation in the WIC program by 5 percent, or 34,000 clients, to improve health outcomes for both mothers and young children. (August 2027)

Objective 2.2. Provide seamless access to services for which clients are eligible.

- **Action Item 2.2.1. Extended Postpartum Coverage.** Extend postpartum coverage period to six months for Medicaid for Pregnant Women to further reduce adverse postpartum health outcomes. (November 2022)
- **Action Item 2.2.2. Healthy Texas Women.** Transition Healthy Texas Women from fee-for-service to managed care to enhance continuity of care and increase access to preventive health care and breast and cervical cancer services. (November 2024)
- **Action Item 2.2.3. State Hospital System Capacity.** Increase the number of available beds by 40 percent in the state hospital system through construction and staffing of additional capacity. (August 2027)

Objective 2.3. Ensure people receive services and supports in the most appropriate, least restrictive settings, considering individual needs and preferences.

- **Action Item 2.3.1. State Supported Living Center Quality.** Demonstrate improved quality of care provided to approximately 2,600 residents of the state supported living centers. (August 2027)
- **Action Item 2.3.2. Individualized Skills and Socialization.** Launch a new Individualized Skills and Socialization service to replace day habilitation to increase community access, increase supports to achieve competitive, integrated employment, and provide greater choice and control over service delivery and personal resources. (March 2023)
- **Action Item 2.3.3. Child Advocacy Centers of Texas.** Increase access to behavioral health services for children served by Child Advocacy Centers of Texas by 10 percent, or an additional 2,360, for a total of 25,969 children served. (August 2023)
- **Action Item 2.3.4. Early Intervention Services.** Improve the quality of care for children with disabilities and developmental delays by increasing the retention rate of personnel who deliver early intervention services by five percent. (August 2027)

Objective 2.4. Strengthen consumers' access to information, education, and support.

- **Action Item 2.4.1. 2-1-1 Texas.** Redesign the 2-1-1 Texas interactive voice response to enrich customer service and to increase by 10 percent the number of customers who receive the information they want without being transferred to a customer call center agent. (January 2023)
- **Action Item 2.4.2. Servicemember Support.** Implement universal screening for servicemember status to allow for aggregate reporting and planning to improve person-centered referrals and servicemember outcomes. (August 2025)

How Goal 2 Supports Each Statewide Objective

Accountability

HHSC is continuously working to improve accountability in the administration and oversight of all programs while increasing access to services, all to improve the overall health, safety, and well-being of Texans.

- HHSC is committed to accuracy in eligibility determination to ensure that only qualified applicants receive services.
- Expanding the Community Partner Program statewide supports accountability for serving Texans throughout the state, ensuring service in all 254 counties.
- For more information about HHSC's commitment to accountability, see the Accountability discussion under Goal 4, Continuously enhance efficiency and accountability.

Efficiency

HHSC continuously seeks more efficient ways to ensure clients access our programs and services while maximizing each dollar invested and providing the highest quality services to Texans who rely on HHSC programs.

- The Community Partner Program supports efficiency through collaboration with community agencies, as those agencies' staff members augment the HHSC workforce in supporting people in applying for HHS services.

- Supporting the health and well-being of mothers and children is an efficient investment, as it decreases their likelihood of dependency on health and human services later in life. HHSC has several initiatives to increase this investment, including:
  - Increasing participation in WIC,
  - Increasing access to behavioral health services for children served by Child Advocacy Centers of Texas, and
  - Stabilizing the workforce that delivers early intervention services.
- Improving the 2-1-1 Texas interactive voice response will meet customer needs efficiently, saving time for both callers and call center agents.

Effectiveness

All action items under Goal 2 support HHSC's improved effectiveness at fulfilling its core functions of providing necessary services to qualified applicants, whether by serving more clients in need, serving clients for longer time periods to meet their needs, or serving clients better.

- In Medicaid waiver programs for individuals with intellectual and developmental disabilities, the Individualized Skills and Socialization service will replace day habilitation services, per federal requirements, providing a more effective approach that maximizes clients' integration and participation in the community.
- HHSC is committed to supporting the health and well-being of past and present military members and their families through a variety of initiatives. For example:
  - The Long-Term Action Plan to Prevent Veteran Suicides extends beyond individual veterans to include their families in a public health approach to preventing suicide. Current service members are included as well to prepare them to identify and overcome suicidal ideations and behavior during or after their transition to veteran status.
- Extended postpartum coverage will support both maternal health and child health and well-being.

Excellence in Customer Service

HHSC strives for excellence in customer service by taking a tailored approach to service delivery and focuses on ensuring clients receive the right services when and where they need it.

- HHSC's Health and Specialty Care System is working with academic partners across Texas to design new state hospitals and with community providers and resources to ensure continuity of care. These partnerships will join cutting-edge research with operational expertise to create a more customer-centered, effective healing environment.
- Individualized Skills and Socialization will support the person-centered plan for each client, thus improving customer service, one client at a time.
- Enriching customer service is at the core of redesigning the 2-1-1 interactive voice response system, to give callers the information they want in the simplest way.
- Universal screening for servicemember status will empower HHSC to better support servicemembers with person-centered referrals, enhancing their experience as well as their later outcomes.

Transparency

Transparency about HHSC operations improves efficient access to information and to appropriate services. As an example:

- HHSC recently redesigned its public website, hhs.texas.gov, so clients and partners have an easier, quicker time learning about HHSC and finding the information they need.
- HHSC has developed and implemented a process to routinely review website content to ensure accurate, timely, and necessary information is available to the public.

Goal 3. Protect the health and safety of vulnerable Texans.

Objective 3.1. Optimize preparation for and response to disasters, disease threats, and outbreaks.

- **Action Item 3.1.1. Emergency Broadcasting to Regulated Entities.** Implement an emergency broadcast system across the Regulatory Services Division (RSD) to allow program areas to send emergency notifications,

request feedback from providers, and provide reporting capability. (August 2027)

Objective 3.2. Prevent and reduce harm through improved education, monitoring, inspection, and investigation.

- **Action Item 3.2.1. Focus on High-Risk Facilities.** Enhance the focus on high-risk facilities when planning and conducting on-site audits, inspections, investigations, and reviews. (January 2024)
- **Action Item 3.2.2. Harm Reduction in Regulated Facilities.** Reduce the number of recurring serious violations in nursing facilities, acute care facilities, and childcare operations by five percent through consistent and efficient processes for licensing, surveying, and enforcement. (August 2026)
- **Action Item 3.2.3. Safe Child Day Care Capacity.** Increase capacity in child day care operations by five percent through community engagement activities aimed at identifying individuals who need to be regulated as well as individuals who want to provide childcare, which will strengthen health and safety protections for children in out-of-home care. (August 2026)

How Goal 3 Supports Each Statewide Objective

Accountability

A crucial role of HHSC is to protect the most vulnerable populations in Texas. RSD and the Office of Inspector General (OIG) support this goal by holding facilities and contractors accountable for the care and services provided to clients. To ensure funding for health and human services are spent properly, OIG uses audits, investigations, inspections, and reviews to detect, deter, and prevent fraud, waste, and abuse within the state health care delivery system. Specifically:

- Through proactive efforts, during the first two quarters of fiscal year 2022, the OIG:
  - Recovered more than $198 million
  - Identified nearly $424 million in potential future recoveries, and

    - Achieved more than $79 million in cost avoidance by deterring potentially questionable spending before it could occur.
- In enhancing the focus on high-risk facilities, OIG holds itself accountable for the best use of the funding allocated to it for its work.
- For more information about HHSC's commitment to accountability, see the Accountability discussion under Goal 4, Continuously enhance efficiency and accountability.

Efficiency

HHSC enhances protection of Texans living in regulated facilities and focuses on improving efficiency in the following ways:

- The RSD Emergency Alert and Notification System will give HHSC the ability to rapidly disseminate information to regulated providers across the state, including critical information during emergencies or disasters. The system will also enable HHSC to quickly gather information from regulated providers about their operational status and needs during an emergency or disaster. This information can then be shared with response partners in the State Operations Center to allow for more rapid deployment of resources and assistance during a disaster.
- RSD will continue the push toward consistency and efficiency in processes, bringing about the promise of HHS transformation, as diverse business areas collaborate to improve the way they do business.
- OIG's focus on greatest risk of financial loss or member harm ensures efficiency in all areas of its work.

Effectiveness

All action items under Goal 3 support HHSC's improved effectiveness at fulfilling its core functions.

- RSD works to obtain better outcomes for people receiving services through clear communication and continual evaluation of provider compliance.
- In an emergency, timeliness of communications is critical to an effective response. The new emergency broadcasting system will more quickly get key information to providers who need it, possibly saving lives.
- OIG's work allows money recovered from fraud, waste, and abuse to be used to support the intended purpose of HHS programs.

- Improved efficiency of regulatory processes will enhance team members' ability to conduct licensing, surveying, and enforcement activities, thus reducing harm in regulated facilities, including nursing facilities, acute care facilities, and childcare operations.
- Increased capacity in regulated child day care operations will improve health and safety protections for children in communities across the state.

Excellence in Customer Service

HHSC seeks to enhance customer service to Texans in a variety of ways relating to long-term care facilities, other medical facilities, and childcare operations. Specific future efforts to improve customer service include:

- In RSD, the emergency broadcasting will be a two-way communications system, inviting feedback from providers that will help HHSC improve services.
- RSD's improved consistency of processes will continue to improve the experience for regulated entities and providers.
- To increase capacity in child day care operations, RSD will engage communities to find childcare providers and people who want to provide childcare, working with them as customers and partners, to strengthen the network and quality of care.

Transparency

The public relies on transparency when faced with making choices about care facilities. HHSC makes information available to support informed choices.

- On the HHSC website, overview information and links to a variety of resources are published for:
  - Long-Term Care
    - ◊ Long-term Care Credentialing
    - ◊ Long-term Care Providers (licensing and registration)
  - Child Care Regulation
  - Health Care Regulation
    - ◊ Health Care Facilities Regulation
    - ◊ Professional Licensing, Certification, and Compliance

- The OIG submits quarterly reports to statewide leadership and publishes quarterly reports, audits, and inspections on this Reports page on the OIG website.
- RSD submits reports to state leadership and publishes them on the HHS website. A recent example includes: Quality Monitoring Early Warning System for Long-Term Care Facilities.

Goal 4. Continuously enhance efficiency and accountability.

Objective 4.1. Promote and protect the financial and programmatic integrity of HHS.

- **Action Item 4.1.1. Focus on High-Risk Contracts.** Establish a complex-contracts audit team to identify and audit vendors of high-risk contracts to determine whether vendors complied with key financial and programmatic contract provisions. (March 2024)
- **Action Item 4.1.2. Cybersecurity.** Defend against cybersecurity threats to protect agency assets and citizens' confidential data. (August 2027)
- **Action Item 4.1.3. SNAP Fraud Framework Grant.** Increase detection of potentially fraudulent SNAP claims by 10 percent. (December 2024)
- **Action Item 4.1.4. Group Purchasing Organizations.** Adopt administrative rules to expand the agency's use of group purchasing organizations to realize improved efficiencies in procurement operations, faster lead times, and overall cost savings to the agency and the State. (September 2023)

Objective 4.2. Strengthen, sustain, and support a high-functioning, efficient workforce.

- **Action Item 4.2.1. State Facilities Staffing.** Improve services to clients of state facilities by strengthening staffing through improved recruitment, hiring processes, and training. (August 2025)
- **Action Item 4.2.2. Critical Position Staffing.** Conduct an agency-wide market salary data analysis and increase salaries of certain health and

human services employees in critical, hard-to-fill positions with high turnover and vacancy rates. (December 2022)

Objective 4.3. Continuously improve business strategies with optimized technology and a culture of data-driven decision-making.

- **Action Item 4.3.1. Identifying Trends and Outliers.** Apply advanced data analysis techniques to quickly identify trends and outliers for audits, inspections, investigations, and reviews. (September 2023)
- **Action Item 4.3.2. Improved Contract Management.** Implement or enhance the functionality of information technology systems to improve efficiencies in processing requisitions and managing, monitoring, and reporting contracts for the agency. (August 2025)
- **Action Item 4.3.3. Medicaid Enterprise System.** Modernize the Texas Medicaid Enterprise System, a highly complex network of interconnected systems that support Texas' Medicaid delivery system, to increase efficiencies and better support the managed care model. (September 2023)
- **Action Item 4.3.4. Data Quality and Maturity.** Enhance the value of data by establishing policies to document data management/data stewardship roles and responsibilities required to enable clean, consistent data across HHSC sources and systems. (September 2023)
- **Action Item 4.3.5. Self-Service Data Quality.** Provide technology, tools, and automation for curated or self-service data analytics and reporting, in coordination with the Data Governance & Performance Management council. (December 2024)

How Goal 4 Supports Each Statewide Objective

Accountability

HHSC is committed to accountability in all its work, to ensure funding is spent efficiently and wisely. Highlights for 2023–2027 include minimizing program fraud, improving procurement operations, and protecting information assets on behalf of HHSC and the people it serves.

Minimizing Program Fraud

- OIG will identify high-risk contracts and will use data analytics to identify trends and outliers quickly, so OIG can nimbly focus on eliminating the greatest risks to financial and program integrity.
- In addition to OIG's efforts, within HHSC the department of Access and Eligibility Services (AES) will be working to increase fraud detection in SNAP.

Procurement Operations

- HHSC's expanded use of group purchasing organizations will avoid costs, allowing HHSC to get the best value for the funds entrusted to the agency.

Cybersecurity to Protect Valuable Assets

- HHSC's Information Technology Division (IT) is accountable for protecting agency information resources as valuable assets, and for safeguarding citizens' confidential data, to shield them from cybercrime or other harm. IT will continue to improve at defending against these threats, which continue to evolve.
- All HHSC team members are required to complete annual cybersecurity training, and HHSC confirms its compliance with the cybersecurity training required under Texas Government Code Sections 2054.5191 and 2054.5192.

Efficiency

HHSC is committed to continuous improvement and efficiency in all its work, to ensure it is spending tax- and fee-payer money efficiently and wisely.

In Fighting Fraud

- OIG's use of data analytics to focus its work will ensure an efficient return on investment and help identify fraud, waste, and abuse early.
- Using federal grant funding to fight SNAP fraud allows federal and state funding to stretch further.

In Purchasing and Contracting

- Since HHSC purchases large quantities of materials to do its work, and since it conducts much of its business through contracts, Procurement and Contracting Services (PCS) plays a key role in continuous improvements,

including efficiency. Expanding the use of group purchasing organizations will save money and improve operations, with faster lead times as one result.

- PCS partners with the Office of Chief Counsel, the Chief Financial Officer, the Office of Transformation and Innovation, and other internal stakeholders to make multiple improvements in processes and resources to enhance efficiency.

In Better Technology

- IT is responsible for the development and delivery of innovative IT services, including technology strategy planning, services that support operational needs of HHS business areas, and effective security for agency systems and data. This work ensures efficient operations of the many technologies HHSC relies on to do its work, while promoting the goals and policies of the State Strategic Plan for Information Resources Management.
- Using technology better will enhance multiple aspects of requisition processing and contract management.
- The Medicaid Enterprise System will increase efficiencies by modernizing the complex network of IT systems that support Medicaid service delivery.

In a Stronger Workforce

- Enhancing and stabilizing the workforce will increase efficiency in teams across the state, while also avoiding costs of hiring and training new employees.

Effectiveness

HHSC will continue to enhance effectiveness by maintaining a strong, stable, and supported workforce, equipping team members with sufficient training, and ensuring that leadership has sufficient and reliable data to support decision-making. Specific gains to be realized in effectiveness include:

- In addition to auditing vendors for financial compliance and accountability, OIG reviews whether vendors complied with complex contract provisions to help ensure programmatic integrity. The identification of these complex financial and programmatic issues facilitates more complete compliance with contract requirements by state vendors.
- Strengthening the workforce, especially in positions with high turnover and vacancy rates, will improve the quality of services across HHSC.

- Better contract management drives more effective service provision. This improvement comes not only from improved use of technology but also from ensuring that all HHSC contract managers stay current with appropriate training, including maintaining Certified Texas Contract Manager status with the Texas Comptroller of Public Accounts.
- The Medicaid Enterprise System will better support the managed care model.
- The availability of accurate data across HHSC sources and systems will support better decisions, so HHSC will invest time to be clear about internal roles and responsibilities in data management. HHSC also empowers team members with access to data by making tools available for them to use on their own or with support.

Excellence in Customer Service

HHSC encourages excellence in customer service through a variety of measures and will continue to search for ways to better serve internal and external stakeholders.

- Residents of HHSC state facilities deserve excellence in the services they receive. For excellence in direct care services, HHSC will continue to strengthen the workforce by recruiting and hiring the best people we can and training them for success in their work.
- In areas where staff shortages exist, excellent customer service is at risk, so HHSC will gather data to plan for salaries to address critical positions with high vacancy rates.

Transparency

Many of the efforts described above support transparency within and across HHSC and the larger HHS system. Specifically:

- The OIG submits quarterly reports to statewide leadership and publishes quarterly reports, audits, and inspections on this Reports page on the OIG website.
- Improved contract management includes transparency in reporting contracts, published on the Contracts Awarded by HHS page on the HHSC website, including contracts by both HHSC and the Department of State Health Services.

Redundancies and Impediments

At this time, HHSC reports no redundancies or impediments.

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June 2022

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Schedule A: Budget Structure – Goals, Objectives, and Performance Measures

This budget structure is taken from the Health and Human Services Commission (HHSC) portion of the Conference Committee Report for the 2022–23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC).

Goal 1. Medicaid Client Services

Administer the state Medicaid system efficiently and effectively, using a comprehensive approach to integrate Medicaid client health services with other direct service delivery programs.

Objective 1.1. Acute Care Services (including STAR+PLUS Long-Term Care) for Full-Benefit Clients

Administer programs that provide medically necessary health care in the most appropriate, accessible, and cost-effective setting.

- Outcome 1.1.1. Average Medicaid and Children's Health Insurance Program (CHIP) Children Recipient Months Per Month
- Outcome 1.1.2. Average Full Benefit Medicaid Recipient Months Per Month
- Outcome 1.1.3. Average Monthly Cost Per Full Benefit Medicaid Client (Including Drug and Long-Term Care)
- Outcome 1.1.4. Medicaid Recipient Months: Proportion in Managed Care
- Outcome 1.1.5. Average Number of Members Receiving Waiver Services through Managed Care
- Outcome 1.1.6. Average Number Members Receiving Nursing Facility Care through Managed Care
- Outcome 1.1.7. Average Number Served per Month: Medically Dependent Children Program (MDCP)

Related Strategic Plan Goals

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
- Goal 2. Ensure efficient access to appropriate services.

Strategy 1.1.1 Aged and Medicare-Related Eligibility Group

Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to aged and Medicare-related Medicaid-eligible persons.

- Efficiency 1.1.1.1. Average Aged and Medicare-Related Cost Per Recipient Month
- Output 1.1.1.1. Average Aged and Medicare-Related Recipient Months Per Month: Total

Related Strategic Plan Goals and Action Items

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
  - Action Item 1.1.2. STAR+PLUS Pilot Program.

Strategy 1.1.2. Disability-Related Eligibility Group

Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting for disability-related Medicaid-eligible adults and children.

- Efficiency 1.1.2.1. Average Disability-Related Cost Per Recipient Month
- Output 1.1.2.1. Average Disability-Related Recipient Months Per Month: Total

Related Strategic Plan Goals and Action Items

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
  - Action Item 1.1.2. STAR+PLUS Pilot Program.
- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.3.2. Individualized Skills and Socialization.

Strategy 1.1.3. Pregnant Women Eligibility Group

Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting for Medicaid-eligible pregnant women.

- Efficiency 1.1.3.1. Average Pregnant Women Cost Per Recipient Month
- Output 1.1.3.1. Average Pregnant Women Recipient Months Per Month

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.2.1. Extended Postpartum Coverage.

Strategy 1.1.4. Other Adults Eligibility Group

Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to adults who are principally income-level eligible (non-pregnant, non-Medicare, non-disability-related).

- Efficiency 1.1.4.1. Average Other Adult Cost Per Recipient Month
- Output 1.1.4.1. Average Other Adult Recipient Months Per Month

Strategy 1.1.5. Children Eligibility Group

Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to newborn infants and Medicaid-eligible children who are not receiving SSI disability-related payments.

- Efficiency 1.1.5.1. Average Income-Eligible Children Cost Per Recipient Month
- Efficiency 1.1.5.2. Average STAR Health Foster Care Children Cost Per Recipient Month
- Output 1.1.5.1. Average Income-Eligible Children Recipient Months Per Month
- Output 1.1.5.2. Average STAR Health Foster Care Children Recipient Months Per Month

Strategy 1.1.6. Medicaid Prescription Drugs

Provide prescription medication to Medicaid-eligible recipients as prescribed by their treating physician.

- Efficiency 1.1.6.1. Average Cost/Medicaid Recipient Month: Prescription Drugs

Related Strategic Plan Goals and Action Items

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
  - Action Item 1.1.2. STAR+PLUS Pilot Program.

Strategy 1.1.7. Texas Health Steps Early and Periodic Screening, Diagnosis and Treatment Dental

Provide dental care in accordance with all federal mandates.

- Efficiency 1.1.7.1. Average Cost per Texas Health Steps Early and Periodic Screening, Diagnosis, and Treatment Dental Recipient Months per Month
- Output 1.1.7.1. Average Texas Health Steps Early, Periodic, Screening, Diagnosis, and Treatment Dental Recipient Months Per Month

Strategy 1.1.8. Medical Transportation

Support and reimburse for non-emergency transportation assistance to individuals receiving medical assistance.

- Efficiency 1.1.8.1. Average Nonemergency Transportation Cost Per Recipient Month

Objective 1.2. Community Services and Supports — Entitlement

Provide Medicaid-covered supports and services in home and community settings to enable aging individuals, individuals with disabilities, and others who qualify for nursing facility care, but can be served at home or in the community, to maintain their independence and avoid institutionalization.

Related Strategic Plan Goals

- Goal 2. Ensure efficient access to appropriate services.

Strategy 1.2.1. Community Attendant Services

Provide attendant care services to Medicaid-reimbursed subgroup of Primary Home Care eligible individuals that must meet financial eligibility of total gross monthly income less than or equal to 300 percent of the SSI federal benefit rate.

- Efficiency 1.2.1.1. Average Monthly Cost Per Individual Served: Community Attendant Services
- Output 1.2.1.1. Average Number of Individuals Served Per Month: Community Attendant Services

Strategy 1.2.2. Primary Home Care

Provide Medicaid-reimbursed, non-technical, medically related personal care services prescribed by a physician to eligible individuals whose health problems limit their ability to perform activities of daily living.

- Efficiency 1.2.2.1. Average Monthly Cost Per Individual Served: Primary Home Care
- Output 1.2.2.1. Average Number of Individuals Served Per Month: Primary Home Care

Strategy 1.2.3. Day Activity and Health Services

Provide daytime services five days a week to individuals residing in the community as an alternative to placement in nursing facilities or other institutions.

- Efficiency 1.2.3.1. Average Monthly Cost Per Individual Served: Day Activity and Health Services
- Output 1.2.3.1. Average Number of Individuals Per Month: Day Activity/Health Services

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.3.2. Individualized Skills and Socialization.

Strategy 1.2.4. Nursing Facility Payments

Provide payments that will promote quality care for individuals with medical needs that require nursing facility care.

- Efficiency 1.2.4.1. Net Nursing Facility Cost Per Medicaid Fee-for-Service Resident Per Month
- Output 1.2.4.1. Average Number Receiving Medicaid-Funded Fee-for-Service Nursing Facility Services Per Month
- Output 1.2.4.2. Average Number Receiving Personal Needs Allowance Per Month

Strategy 1.2.5. Medicare Skilled Nursing Facility

Provides payments for individuals in dually qualified certified facilities (certified for both Medicaid and Medicare).

- Efficiency 1.2.5.1. Net Medicaid/Medicare Copay Per Individual Nursing Facility Services
- Output 1.2.5.1. Average Number Receiving Nursing Facility Copayments Per Month

Strategy 1.2.6. Hospice

Provide palliative care consisting of medical, social, and support services for individuals.

- Efficiency 1.2.6.1. Average Net Payment Per Individual Per Month for Hospice
- Output 1.2.6.1. Average Number of Individuals Receiving Hospice Services Per Month

Strategy 1.2.7. Intermediate Care Facilities for Individuals with Intellectual Disability

Provide or contract for residential facilities of four or more beds for 24-hour care for the intellectual and developmentally disabled residents.

- Efficiency 1.2.7.1. Monthly Cost per Intermediate Care Facility for Individuals with Intellectual Disability Medicaid-Eligible Individual
- Output 1.2.7.1. Average Number of Persons in Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition Medicaid Beds per Month

Objective 1.3. Long-Term Care — Non-Entitlement

Provide supports and services through Medicaid waivers in home and community settings to enable aging individuals, individuals with physical or mental disabilities, and others who qualify for institutional care to maintain their independence and avoid institutionalization.

Strategy 1.3.1. Home and Community-Based Services

Provide individualized services to individuals with intellectual disability living in their family's home, their own homes, or other settings in the community.

- Efficiency 1.3.1.1. Average Monthly Cost Per Individual Served: Home and Community-Based Services (HCS)
- Efficiency 1.3.1.2. Average Monthly Cost Individual Served: HCS Residential
- Efficiency 1.3.1.3. Average Monthly Cost Individual: HCS Non-Residential
- Explanatory 1.3.1.1. Number Individuals Receiving Services at the End of the Fiscal Year: HCS
- Explanatory 1.3.1.2. Percent of HCS Recipients Receiving Residential Services
- Output 1.3.1.1. Average Number Individuals Served Per Month: HCS

Strategy 1.3.2. Community Living Assistance and Support Services

Provide home and community-based services to persons who have a "related condition" diagnosis qualifying them for placement in an intermediate care facility. A related condition is a disability other than intellectual and/or developmental disability which originates before age 22 and which substantially limits life activity. Such disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and other diagnoses, are said to be "related to" intellectual and/or developmental disability in their effect upon the individual's functioning.

- Efficiency 1.3.2.1. Average Monthly Cost Per Individual: Community Living Assistance and Support Services (CLASS) Waiver
- Explanatory 1.3.2.1. Number of Persons Receiving Services at the End of the Fiscal Year: CLASS Waiver

- Output 1.3.2.1. Average Number of Individuals Served Per Month: CLASS Waiver

Strategy 1.3.3. Deaf-Blind Multiple Disabilities

Provide home and community-based services to adult individuals diagnosed with deafness, blindness, and multiple disabilities.

- Efficiency 1.3.3.1. Average Monthly Cost Per Individual: Deaf-Blind with Multiple Disabilitites (DBMD) Waiver
- Explanatory 1.3.3.1. Number of Persons Receiving Services at the End of the Fiscal Year: DBMD Waiver
- Output 1.3.3.1. Average Number of Individuals Served Per Month: DBMD Waiver

Strategy 1.3.4. Texas Home Living Waiver

Provide individualized services, not to exceed $17,000 per year, to individuals with an intellectual disability living in their family's home, their own homes, or other settings in the community.

- Efficiency 1.3.4.1. Average Monthly Cost Per Individual Served: Texas Home Living Waiver
- Explanatory 1.3.4.1. Number of Individuals Receiving Services at the End of the Fiscal Year: Texas Home Living Waiver
- Output 1.3.4.1. Average Number of Individuals Served Per Month: Texas Home Living Waiver

Strategy 1.3.5. Program of All-Inclusive Care for the Elderly

Provide community-based services to frail and elderly individuals who qualify for nursing facility placement. Services include in-patient and outpatient medical care and social/community services at a capitated rate.

- Efficiency 1.3.5.1. Average Monthly Cost Per Recipient: Program for All Inclusive Care (PACE)
- Explanatory 1.3.5.1. Number of Persons Receiving Services End of Fiscal Year: PACE

- Output 1.3.5.1. Average Number of Recipients Per Month: PACE

Objective 1.4. Other Medicaid Services

Provide policy direction and management of the state's Medicaid program and maximize federal dollars.

Strategy 1.4.1. Non-Full Benefit Payments

Provide payments for medically necessary healthcare to eligible recipients for certain services not covered under the insured arrangement, including undocumented persons, school health, women's health, and other related services.

- Efficiency 1.4.1.1. Average Emergency Services for Non-Citizens Cost Per Recipient Month
- Output 1.4.1.1. Average Monthly Number of Non-Citizens Receiving Emergency Services

Strategy 1.4.2. For Clients Dually Eligible for Medicare and Medicaid

Provide accessible premium-based health services to certain Title XVIII Medicare-eligible recipients.

- Efficiency 1.4.2.1. Average Supplemental Medical Insurance Benefits (SMIB) Part B Premium Per Month
- Output 1.4.2.1. Average SMIB Part B Recipient Months Per Month

Strategy 1.4.3. Transformation Payments

Maximize federal funding to provide supplemental Medicaid reimbursement for uncompensated care and delivery system reform incentives under the 1115 waiver. Historically provided children's hospital upper payment limit match.

Goal 2. Medicaid and Children's Health Insurance Program Contracts and Administration

Administer efficient and effective Medicaid and CHIP programs, set overall policy direction of the state Medicaid program and CHIP program, and manage interagency initiatives to maximize federal dollars.

Objective 2.1. Medicaid and Children's Health Insurance Program Contracts and Administration

Improve the quality of Medicaid services by serving as the single state Medicaid agency.

Related Strategic Plan Goals

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
- Goal 2. Ensure efficient access to appropriate services.
- Goal 4. Continuously enhance efficiency and accountability.

Strategy 2.1.1. Medicaid Contracts and Administration

Administer efficient and effective Medicaid program, set the overall policy direction of the state Medicaid program, and manage interagency initiatives to maximize federal dollars.

Related Strategic Plan Goals and Action Items

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
  - Action Item 1.1.1. MCO Benchmarks.
  - Action Item 1.1.2. STAR+PLUS Pilot Program.
  - Action Item 1.1.4. Community Attendants.
- Goal 2. Ensure efficient access to appropriate services.

- Action Item 2.2.2. Healthy Texas Women.
- Action Item 2.3.2. Individualized Skills and Socialization.

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.3.3. Medicaid Enterprise System.

Strategy 2.1.2. Children's Health Insurance Program Contracts and Administration

Administer efficient and effective CHIP program, including contracted administration, and set overall policy direction of CHIP programs.

Related Strategic Plan Goals and Action Items

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
  - Action Item 1.1.1. MCO Benchmarks.

Goal 3. Children's Health Insurance Program Services

Ensure health insurance coverage for eligible children in Texas.

Objective 3.1. Children's Health Insurance Program Services

Ensure health insurance coverage for eligible children in Texas.

- Outcome 3.1.1. Average CHIP Programs Recipient Months Per Month
- Outcome 3.1.2. Average CHIP Programs Benefit Cost with Prescription Benefit

Related Strategic Plan Goals

- Goal 1: Improve and support health outcomes and well-being for individuals and families.

Strategy 3.1.1. Children's Health Insurance Program

Provide healthcare to uninsured children who apply and are determined eligible for insurance through CHIP.

- Efficiency 3.1.1.1. Average CHIP Children Benefit Cost Per Recipient Month
- Output 3.1.1.1. Average CHIP Children Recipient Months Per Month

Strategy 3.1.2. Children's Health Insurance Program Perinatal Services

Provide healthcare to perinates whose mothers apply and are determined eligible for insurance through CHIP.

- Efficiency 3.1.2.1. Average Perinatal Benefit Cost Per Recipient Month
- Output 3.1.2.1. Average Perinatal Recipient Months Per Month

Strategy 3.1.3. Children's Health Insurance Program Prescription Drugs

Provide prescription medication to CHIP-eligible recipients (includes all CHIP Programs) as provided by their treating physician.

- Efficiency 3.1.3.1. Average Cost/CHIP Recipient Month: Pharmacy Benefit

Strategy 3.1.4. Children's Health Insurance Program Dental Services

Provide dental healthcare services to uninsured children who apply and are determined eligible for insurance through CHIP.

- Efficiency 3.1.4.1. Average Monthly Cost of the Dental Benefit Per Chip Program Recipient

Goal 4. Provide Additional Health-Related Services

Improve the physical and mental health of children, women, families, and individuals and enhance the capacity of communities to deliver healthcare services.

Objective 4.1. Provide Primary Health and Specialty Care

Develop and support primary healthcare and specialty services to children, women, families, and other qualified individuals through community-based providers.

- Outcome 4.1.1. Percent of Early Childhood Intervention (ECI) Clients Enrolled in Medicaid

Related Strategic Plan Goals

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
- Goal 2. Ensure efficient access to appropriate services.
- Goal 4. Continuously enhance efficiency and accountability.

Strategy 4.1.1. Women's Health Programs

Women's Health Programs.

- Efficiency 4.1.1.1. Average Monthly Cost Per Healthy Texas Women (HTW) Client Receiving Services
- Efficiency 4.1.1.2. Average Monthly Cost Per Family Planning Client Receiving Services
- Explanatory 4.1.1.1. Number of Certified Clinical Providers Enrolled in HTW Program
- Explanatory 4.1.1.2. Number of Clinical Providers Enrolled in Family Planning
- Output 4.1.1.1. Average Monthly Number Women Enrolled in Services through HTW Program
- Output 4.1.1.2. Average Monthly Number of Family Planning Clients Receiving Services
- Output 4.1.1.3. Average Monthly Number of Women Receiving HTW Services

Related Strategic Plan Goals and Action Items

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
  - Action Item 1.1.3. Medicaid for Breast and Cervical Cancer Treatment.

- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.2.1. Extended Postpartum Coverage.
  - Action Item 2.2.2. Healthy Texas Women.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 4.1.2. Alternatives to Abortion.

Provide pregnancy support services that promote childbirth for women seeking alternatives to abortion.

- Output 4.1.2.1. Number of Persons Receiving Services as Alternative to Abortion
- Output 4.1.2.2. Number of Alternatives to Abortion Services Provided

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.2.2. Healthy Texas Women.
  - Action Item 2.4.2. Servicemember Support.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 4.1.3. Early Childhood Intervention Services

Administer a statewide comprehensive system of services to ensure that eligible infants, toddlers, and their families have access to the resources and support they need to reach their service plan goals.

- Efficiency 4.1.3.1. Average Monthly Cost Per Child: Comprehensive Services/State and Federal
- Explanatory 4.1.3.1. Average Monthly Number of Hours of Service Delivered Per Child Per Month

- Output 4.1.3.1. Average Monthly Number of Children Served in Comprehensive Services
- Output 4.1.3.2. Average Monthly Number of Referrals to Local Programs
- Output 4.1.3.3. Average Monthly Number of Eligibility Determinations Completed
- Output 4.1.3.4. Average Monthly Number of Children Determined Eligible for ECI Services
- Output 4.1.3.5. Average Monthly Number of Children Newly Enrolled in ECI

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.3.4. Early Intervention Services.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 4.1.4. Ensure Early Childhood Intervention Respite Services and Quality Early Childhood Intervention Services

Serves families with children in the ECI program. Provides respite services to help preserve the family unit and prevent out-of-home placements. Provides technical assistance to parents and service providers serving in the ECI program.

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.3.4. Early Intervention Services.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 4.1.5. Children's Blindness Services

Provide information and training for blind and visually impaired children and their families so these children have the skills and confidence to live as independently as possible.

- Efficiency 4.1.5.1. Average Monthly Cost Per Child: Children's Blindness Services
- Output 4.1.5.1. Average Monthly Number of Children Receiving Blindness Services

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.2. Critical Position Staffing.

Strategy 4.1.6. Autism Program

To provide services to Texas children ages 3–15 diagnosed with autism spectrum disorder.

- Efficiency 4.1.6.1. Average Monthly Cost Per Child Receiving Focused Autism Services
- Output 4.1.6.1. Average Monthly Number of Children Receiving Focused Autism Services

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 4.1.7. Children with Special Health Care Needs

Administer service program for children with special healthcare needs (CSHCN).

- Efficiency 4.1.7.1. Average Monthly Cost Per Children with Special Health Care Needs (CSHCN) Clients Receiving Services

- Output 4.1.7.1. Average Monthly Number of CSHCN Clients Receiving Services

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 4.1.8. Title V Dental and Health Services

Title V dental and health services.

- Output 4.1.8.1. Number of Infants <1 and Children Age 1–21 Years Provided Services
- Output 4.1.8.2. Number of Women over Age 21 Provided Title V Services

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.2.1. Extended Postpartum Coverage.
  - Action Item 2.2.2. Healthy Texas Women.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 4.1.9. Kidney Health Care

Administer service programs for kidney healthcare (KHC).

- Efficiency 4.1.9.1. Average Annual Cost Per Kidney Health Care Client
- Output 4.1.9.1. Number of Kidney Health Clients Provided Services

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 4.1.10. Additional Specialty Care

Deliver specialty care services including service programs for epilepsy and hemophilia, as well as provide leadership and direction to the statewide umbilical cord blood bank and health information technology initiatives.

- Explanatory 4.1.10.1. Number of Epilepsy Program Clients Provided Services
- Explanatory 4.1.10.2. Number of Hemophilia Assistance Program (HAP) Clients

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 4.1.11. Community Primary Care Services

Develop systems of primary and preventive healthcare delivery in underserved areas of Texas.

- Efficiency 4.1.11.1. Average Cost Per Primary Health Care Client
- Output 4.1.11.1. Number Primary Health Care Clients Receiving Services

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 4.1.12. Abstinence Education

Increase abstinence education programs in Texas.

- Output 4.1.12.1. Number of Persons Served in Abstinence Education Programs

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Objective 4.2. Provide Community Behavioral Health Services

Support services for mental health and for substance abuse prevention, intervention, and treatment.

- Outcome 4.2.1. Percent Adults Receiving Community Mental Health Services Whose Functional Level Improved
- Outcome 4.2.2. Percent Children Receiving Community Mental Health Services Whose Functional Level Improved
- Outcome 4.2.3. Percent Receiving Crisis Services Who Avoid Psychiatric Hospitalization within 30 days
- Outcome 4.2.4. Percent Adults Who Complete Treatment Program and Report No Past Month Substance Use
- Outcome 4.2.5. Percent Youth Who Complete Treatment Program and Report No Past Month Substance Use
- Outcome 4.2.6. Percent of Adults With Opioid Use Disorder Receiving Medication-Assisted Treatment

Related Strategic Plan Goals

- Goal 1. Improve and support health outcomes and well-being for individuals and families.

Strategy 4.2.1. Community Mental Health Services for Adults

Provide services and supports in the community for adults with serious mental illness.

- Efficiency 4.2.1.1. Average Monthly Cost Per Adult: Community Mental Health Services
- Output 4.2.1.1. Average Monthly Number of Adults Receiving Community Mental Health Services

Strategy 4.2.2. Community Mental Health Services for Children

Provide services and supports for emotionally disturbed children and their families.

- Efficiency 4.2.2.1. Average Monthly Cost Per Child Receiving Community Mental Health Services
- Output 4.2.2.1. Average Monthly Number of Children Receiving Community Mental Health Services

Related Strategic Plan Goals and Action Items

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
  - Action Item 1.2.3. Mental Health First Aid Training.

Strategy 4.2.3. Community Mental Health Crisis Services

Community Mental Health Crisis Services.

- Efficiency 4.2.3.1. Average General Revenue Spent Per Person for Crisis Residential Services
- Efficiency 4.2.3.2. Average General Revenue Spent Per Person for Crisis Outpatient Services
- Output 4.2.3.1. Number Persons Receiving Crisis Residential Services Per Year Funded by General Revenue
- Output 4.2.3.2. Number Persons Receiving Crisis Outpatient Services Per Year Funded by General Revenue

Strategy 4.2.4. Substance Abuse Prevention, Intervention, and Treatment

Implement prevention services to reduce the risk of substance use, abuse, and dependency. Implement intervention services to interrupt illegal substance use by youth and adults and reduce harmful use of legal substances by adults. Implement a continuum of community and family-based treatment and related services for chemically dependent persons. Optimize performance quality and cost efficiency through the managing and monitoring of contracted services for substance abuse.

- Efficiency 4.2.4.1. Average Monthly Cost Per Youth for Substance Abuse Prevention Services
- Efficiency 4.2.4.2. Average Monthly Cost Per Adult for Substance Abuse Intervention Services
- Efficiency 4.2.4.3. Average Monthly Cost Per Youth for Substance Abuse Intervention Services
- Efficiency 4.2.4.4. Average Monthly Cost Per Adult Served in Treatment Programs for Substance Abuse
- Efficiency 4.2.4.5. Average Monthly Cost Per Youth Served in Treatment Programs for Substance Abuse
- Output 4.2.4.1. Average Monthly Number of Youth Served in Substance Abuse Prevention Programs
- Output 4.2.4.2. Average Monthly Number of Youth Served in Treatment Programs for Substance Abuse
- Output 4.2.4.3. Average Monthly Number of Adults Served in Substance Abuse Intervention Programs
- Output 4.2.4.4. Average Monthly Number of Youth Served in Substance Abuse Intervention Programs
- Output 4.2.4.5. Average Monthly Number of Adults Served in Treatment Programs for Substance Abuse

Related Strategic Plan Goals and Action Items

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
  - Action Item 1.2.2. Addressing Opioid Harm.

Strategy 4.2.5. Behavioral Health Waiver and Plan Amendment

Provide intensive community-based services for emotionally disturbed children and their families and for adults with serious mental illness.

- Efficiency 4.2.5.1. Average Monthly Cost Per Client Served in Home and Community-Based Services - Adult Mental Health (HCBS-AMH) Program
- Efficiency 4.2.5.2. Average Monthly Cost Per Client Served in Youth Empowerment Services (YES) Waiver

- Output 4.2.5.1. Average Monthly Number of Clients Served in HCBS-AMH Program
- Output 4.2.5.2. Average Monthly Number of Clients Served in YES Waiver

Strategy 4.2.6. Community Mental Health Grant Programs

Administer grant programs to support community mental health programs for veterans and their families, support community mental health programs for individuals experiencing mental illness, and to reduce recidivism, arrest, and incarceration of individuals with mental illness.

Objective 4.3. Build Community Capacity

Develop and enhance capacities for community clinical service providers and regionalized emergency healthcare systems.

Related Strategic Plan Goals

- Goal 2. Ensure efficient access to appropriate services.
- Goal 4. Continuously enhance efficiency and accountability.

Strategy 4.3.1. Indigent Health Care Reimbursement (University of Texas Medical Branch)

Reimburse the provision of indigent health services through the deposit of funds in the State-Owned Multi-categorical Teaching Hospital Account.

Strategy 4.3.2. County Indigent Health Care Services

Provide support to local governments that provide indigent healthcare services.

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - 4.2.2. Critical Position Staffing.

Goal 5. Encourage Self-Sufficiency

HHSC will encourage and promote self-sufficiency, safety, and long-term independence for families.

Objective 5.1. Financial and Other Assistance

Provide appropriate support services that address the employment, financial, and/or social service needs of eligible persons.

Related Strategic Plan Goals

- Goal 2. Ensure efficient access to appropriate services.
- Goal 4. Continuously enhance efficiency and accountability.

Strategy 5.1.1. Temporary Assistance for Needy Families Grants

Provide TANF grants to low-income Texans.

- Efficiency 5.1.1.1. Average Monthly Grant: TANF Basic Cash Assistance
- Efficiency 5.1.1.2. Average Monthly Grant: State Two-Parent Cash Assistance Program
- Output 5.1.1.1. Average Number of TANF Basic Cash Assistance Recipients Per Month
- Output 5.1.1.2. Average Number of State Two-Parent Cash Assistance Recipients Per Month

Strategy 5.1.2. Provide Special Supplemental Program for Women, Infants, and Children Services: Benefits, Nutrition Education, and Counseling

Provide Special Supplemental Program for Women, Infants, and Children (WIC) services including benefits, nutrition education, and counseling.

- Output 5.1.2.1. Number of WIC Participants Provided Nutritious Supplemental Food

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.1.2. Women, Infants, and Children (WIC) Program.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 5.1.3. Disaster Assistance

Provide financial assistance to victims of federally declared natural disasters.

Goal 6. Community and Independent Living Services and Coordination

Provide programs and support services to encourage self-sufficiency and healthier living in the community.

Objective 6.1. Long-Term Care Services and Coordination

Provide non-Medicaid services and supports in home and community settings to enable aging individuals and individuals with disabilities to maintain their independence and prevent institutionalization.

Related Strategic Plan Goals

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
- Goal 4. Continuously enhance efficiency and accountability.

Strategy 6.1.1. Guardianship

Provide full or limited authority over an incapacitated aging or disabled adult who is the victim of validated abuse, neglect, exploitation, or of an incapacitated minor in Child Protective Services' conservatorship.

- Output 6.1.1.1. Average Number of Wards Receiving Guardianship Services

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - 4.2.2. Critical Position Staffing.

Strategy 6.1.2. Non-Medicaid Services

Provide services to individuals ineligible for Medicaid services, in their own home or community. Services include family care, home-delivered meals, adult foster care, Day Activities and Health Services (Title XX of the Social Security Act (XX)), emergency response, and personal attendant services.

- Output 6.1.2.1. Average Number of Individuals Served Per Month: Non Medicaid Community Care (Title XX/General Revenue)

Strategy 6.1.3. Non-Medicaid Developmental Disability Community Services

Provide services, other than those provided through the Medicaid waiver programs, to individuals with intellectual or developmental disabilities who reside in the community, including independent living, employment services, day training, therapies, and respite services.

- Efficiency 6.1.3.1. Average Monthly Cost Per Individual Receiving Community Services
- Output 6.1.3.1. Average Monthly Number of Individuals with IDD Receiving Community Services

Objective 6.2. Provide Rehabilitation Services to Persons with General Disabilities

To provide quality vocational rehabilitation services to eligible persons with general disabilities. Additionally, to provide quality consumer-directed independent living services to persons with significant disabilities who have been determined eligible.

Related Strategic Plan Goals

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
- Goal 2. Ensure efficient access to appropriate services.

- Goal 4. Continuously enhance efficiency and accountability.

Strategy 6.2.1. Independent Living Services (General, Blind, and Centers for Independent Living)

Provide quality, statewide consumer-directed independent living services that focus on acquiring skills and confidence to live as independently as possible in the community for eligible people with significant disabilities. Work with the State Independent Living Council to develop the State Plan for Independent Living.

- Output 6.2.1.1. Number People Receiving Services from Centers for Independent Living
- Output 6.2.1.2. Number of People Receiving HHSC Contracted Independent Living Services

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.1.1. Focus on High-Risk Contracts.
  - Action Item 4.2.2. Critical Position Staffing.

Strategy 6.2.2. Blindness Education, Screening, and Treatment Program

Provide screening, education, and urgently needed eye-medical treatment to prevent blindness.

- Output 6.2.2.1. Number of Individuals Receiving Treatment Services in the Blindness Education, Screening and Treatment (BEST) Program
- Output 6.2.2.2. Number of Individuals Receiving Screening Services in the BEST Program

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 6.2.3. Provide Services to People with Spinal Cord / Traumatic Brain Injuries

Provide consumer-driven and counselor-supported Comprehensive Rehabilitation Services for people with traumatic brain injuries or spinal cord injuries.

- Output 6.2.3.1. Average Monthly Number of People Receiving Comprehensive Rehabilitation Services

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services
  - Action Item 2.4.2. Servicemember Support.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.1.1. Focus on High-Risk Contracts.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 6.2.4. Provide Services to Persons Who Are Deaf or Hard of Hearing

Ensure continuity of services, foster coordination and cooperation among organizations, facilitate access to training and education programs, and support access to telephone systems to individuals who are deaf or hard of hearing. To increase the number of persons (who are deaf or hard of hearing) receiving quality services by 10 percent each biennium.

- Output 6.2.4.1. Number of Interpreter Certificates Issued
- Output 6.2.4.2. Number of Equipment/Service Vouchers Issued

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.1.1. Community Partner Program.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.1.1. Focus on High-Risk Contracts.
  - Action Item 4.2.2. Critical Position Staffing.

- Action Item 4.3.2. Improved Contract Management.

Objective 6.3. Other Community Support Services

Promote safety, self-sufficiency, and long-term independence for those living with domestic violence or other adverse circumstances.

Related Strategic Plan Goals

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
- Goal 2. Ensure efficient access to appropriate services.
- Goal 4. Continuously enhance efficiency and accountability.

Strategy 6.3.1. Family Violence Services

Provide emergency shelter and support services to victims of family violence and their children, educate the public, and provide training and prevention support to institutions and agencies.

Related Strategic Plan Goals and Action Items

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
  - Action Item 1.3.1. Family Violence Survivor Support.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.1.1. Focus on High-Risk Contracts.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 6.3.2. Child Advocacy Programs

Train, provide technical assistance, and evaluate services for Children's Advocacy Centers of Texas, Inc. and Texas Court Appointed Special Advocates, Inc.

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.

- Action Item 2.3.3. Child Advocacy Centers of Texas.

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.1.1. Focus on High-Risk Contracts.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 6.3.3. Additional Advocacy Programs

Provide support services for interested individuals (Healthy Marriage, Community Resource Coordination Group Adult/Child, Texas Integrated Funding Initiative, Office of Acquired Brain Injury, Office of Disability Prevention for Children, Office of Minority Health Statistics and Engagement).

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.1.1. Community Partner Program.
  - Action Item 2.4.2. Servicemember Support.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.1.1. Focus on High-Risk Contracts.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.

Goal 7. Mental Health State Hospitals, State Supported Living Centers, and Other Facilities

Provide specialized assessment, treatment, support, and medical services in state supported living centers (SSLCs), state mental health hospitals, and other facilities.

Objective 7.1. State Supported Living Centers

Provide specialized assessment, treatment, support, and medical services in SSLC programs for intellectual and developmentally disabled residents.

Related Strategic Plan Goals

- Goal 2. Ensure efficient access to appropriate services.

- Goal 4. Continuously enhance efficiency and accountability.

Strategy 7.1.1. State Supported Living Centers

Provide direct services and support to individuals living in SSLCs. Provide 24-hour residential services for individuals who are medically fragile or severely physically impaired or have severe behavior problems, and who choose these services or cannot currently be served in the community.

- Efficiency 7.1.1.1. Average Monthly Cost Per Campus Resident
- Output 7.1.1.1. Average Monthly Number of State Supported Living Center Campus Residents
- Output 7.1.1.2. Number Unfounded Abuse/Neglect/Exploitation Allegations Against State Supported Living Center Staff
- Output 7.1.1.3. Number Confirmed Abuse/Neglect/Exploitation Incidents at State Supported Living Centers

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.3.1. State Supported Living Center Quality.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.1. State Facilities Staffing.
  - Action Item 4.3.5. Self-Service Data Quality.

Objective 7.2. Mental Health State Hospital Facilities and Services

Provide inpatient mental health services for adults and children.

Related Strategic Plan Goals

- Goal 2. Ensure efficient access to appropriate services.
- Goal 4. Continuously enhance efficiency and accountability.

Strategy 7.2.1. Mental Health State Hospitals

Provide specialized assessment, treatment, and medical services in state mental health facility programs.

- Efficiency 7.2.1.1. Average Daily Cost Per Occupied State Mental Health Facility Bed
- Output 7.2.1.1. Average Daily Census of State Mental Health Facilities

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.2.3. State Hospital System Capacity.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.1. State Facilities Staffing.

Strategy 7.2.2. Mental Health Community Hospitals

Provide inpatient treatment, crisis assessment, and medical services to adults and children served in community hospitals.

- Efficiency 7.2.2.1. Average Daily Cost Per Occupied Mental Health Community Hospital Bed
- Output 7.2.2.1. Average Daily Number of Occupied Mental Health Community Hospital Beds

Objective 7.3. Other Facilities

Provide specialized assessment, treatment, support, and medical services at other state medical facilities (Corpus Christi Bond Homes and Rio Grande State Center Outpatient Clinic).

Related Strategic Plan Goals

- Goal 2. Ensure efficient access to appropriate services.
- Goal 4. Continuously enhance efficiency and accountability.

Strategy 7.3.1. Other State Medical Facilities

Provide program support to SSLCs, state mental health hospitals, and other facilities (Corpus Christi Bond Homes and Rio Grande State Center Outpatient Clinic).

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate services.

- Action Item 2.3.1. State Supported Living Center Quality.

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.1. State Facilities Staffing.

Objective 7.4. Facility Program Support

Provide program support to SSLCs, state mental health hospitals, and other facilities (Corpus Christi Bond Homes and Rio Grande State Center Outpatient Clinic).

Related Strategic Plan Goals

- Goal 2. Ensure efficient access to appropriate services.
- Goal 4. Continuously enhance efficiency and accountability.

Strategy 7.4.1. Facility Program Support

Provide program support to SSLCs, state mental health hospitals, and other facilities (Corpus Christi Bond Homes and Rio Grande State Center Outpatient Clinic).

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.2.1. State Facilities Staffing.

Strategy 7.4.2. Capital Repair and Renovation at State Supported Living Centers, State Hospitals, and Other

Conduct maintenance and construction projects critical to meeting accreditation/certification standards and to ensuring the safety of consumers and Master Lease Purchase Program.

Related Strategic Plan Goals and Action Items

- Goal 2. Ensure efficient access to appropriate service.
  - Action Item 2.2.3. State Hospital System Capacity.

Goal 8. Regulatory, Licensing, and Consumer Protection Services

Provide licensing, certification, contract enrollment services, financial monitoring, and complaint investigation, to ensure that residential facilities, home and community support services agencies, and persons providing services in facilities or home settings comply with state and federal standards, and that individuals receive high-quality services and are protected from abuse, neglect, and exploitation.

Objective 8.1. Long-Term Care and Acute Care Regulation

Provide licensing, certification, contract enrollment services, financial monitoring, and complaint investigation, to ensure that residential facilities, home and community support services agencies, and persons providing services in facilities or home settings comply with state and federal standards, and that individuals receive high-quality services and are protected from abuse, neglect, and exploitation.

Related Strategic Plan Goals

- Goal 3. Protect the health and safety of vulnerable Texans.

Strategy 8.1.1. Health Care Facilities and Community-Based Regulation

Provide licensing, certification, contract enrollment services, financial monitoring, and complaint investigation to ensure that residential facilities and home and community support services agencies comply with state and federal standards and individuals receive high-quality services.

- Efficiency 8.1.1.1. Average Daily Caseload Per Worker Provider Investigations
- Output 8.1.1.1. Number of Long-Term Care and Health Care Regulation Licenses Issued
- Output 8.1.1.2. Number of Long-Term Care Regulation and Health Care Regulation Contacts

Related Strategic Plan Goals and Action Items

- Goal 3. Protect the health and safety of vulnerable Texans.

- Action Item 3.1.1. Emergency Broadcasting to Regulated Entities.
- Action Item 3.2.1. Focus on High-Risk Facilities.
- Action Item 3.2.2. Harm Reduction in Regulated Facilities.

Strategy 8.1.2. Long-Term Care Quality Outreach

Provide quality monitoring and rapid response team visits to access quality and promote quality improvement in nursing facilities.

Objective 8.2. Childcare Regulation

Provide a comprehensive system of consultation, licensure, and regulation to ensure maintenance of minimum standards by daycare and residential childcare facilities, registered family homes, child-placing agencies, facility administrators, and child-placing agency administrators.

Related Strategic Plan Goals

- Goal 3. Protect the health and safety of vulnerable Texans.

Strategy 8.2.1. Childcare Regulation

Provide a comprehensive system of consultation, licensure, and regulation to ensure maintenance of minimum standards by daycare and residential childcare facilities, registered family homes, child-placing agencies, facility administrators, and child-placing agency administrators.

- Efficiency 8.2.1.1. Average Monthly Day Care Caseload Per Monitoring Worker
- Efficiency 8.2.1.2. Average Monthly Residential Caseload Per Monitoring Worker
- Output 8.2.1.1. Number of Child Care Facility Inspections
- Output 8.2.1.2. Number of Completed Non-Abuse/Neglect Investigations
- Output 8.2.1.3. Number of Child Care Regulatory Permits Issued

Related Strategic Plan Goals and Action Items

- Goal 3. Protect the health and safety of vulnerable Texans.
  - Action Item 3.1.1. Emergency Broadcasting to Regulated Entities.
  - Action Item 3.2.1. Focus on High-Risk Facilities.

- Action Item 3.2.2. Harm Reduction in Regulated Facilities.
- Action Item 3.2.3. Safe Child Day Care Capacity.

Objective 8.3. Professional and Occupational Regulation

Provide credentialing, training, and enforcement services to qualify individuals to provide services to long-term care facility and home healthcare agency individuals in compliance with applicable law and regulations.

Related Strategic Plan Goals

- Goal 3. Protect the health and safety of vulnerable Texans.

Strategy 8.3.1. Credentialing/Certification of Health Care Professionals and Others

Provide credentialing, training, and enforcement services to qualify individuals to provide services to long-term care facility and home healthcare agency individuals in compliance with applicable law and regulations.

- Output 8.3.1.1. Number of Licenses/Credentials Issued
- Output 8.3.1.2. Number of Investigations Completed

Related Strategic Plan Goals and Action Items

- Goal 3. Protect the health and safety of vulnerable Texans.
  - Action Item 3.1.1. Emergency Broadcasting to Regulated Entities.
  - Action Item 3.2.2. Harm Reduction in Regulated Facilities.

Objective 8.4. Texas.gov. Estimated and Nontransferable

Texas.gov. Estimated and Nontransferable.

Strategy 8.4.1. Texas.gov. Estimated and Nontransferable

Texas.gov. Estimated and Nontransferable.

Goal 9. Program Eligibility Determination and Enrollment

Provide accurate information on and timely eligibility and issuance services for financial assistance, medical benefits, and food assistance.

Objective 9.1 Eligibility Operations

Provide accurate and timely eligibility and issuance services for financial assistance, medical benefits, and Supplemental Nutrition Assistance Program (SNAP) benefits.

Related Strategic Plan Goals

- Goal 4. Continuously enhance efficiency and accountability.

Strategy 9.1.1. Integrated Financial Eligibility and Enrollment

Provide accurate and timely eligibility and issuance services for financial assistance, medical benefits, and SNAP benefits.

- Output 9.1.1.1. Average Monthly Number of Eligibility Determinations

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.1.3. SNAP Fraud Framework Grant.

Objective 9.2. Community Access and Supports

Determine eligibility for, promote access to, and monitor long-term care services and supports.

Related Strategic Plan Goals

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
- Goal 2. Ensure efficient access to appropriate services.

Strategy 9.2.1. Intake, Access, and Eligibility to Services and Supports

Determine functional eligibility for long-term care services, develop individual service plans based on individual needs and preferences, authorize service delivery, and monitor the delivery of services (Medicaid and non-Medicaid).

- Outcome 9.2.1. Percent Long Term Care Ombudsman Complaints Resolved or Partially Resolved
- Output 9.2.1.1. Average Monthly Number Individuals w/IDD Receiving Assessment and Service Coordination

Related Strategic Plan Goals and Action Items

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
  - Action Item 1.1.2. STAR+PLUS Pilot Program.
  - Action Item 1.2.1. Engaging Older Adults.
- Goal 2. Ensure efficient access to appropriate services.
  - Action Item 2.1.1. Community Partner Program.
  - Action Item 2.4.1. 2-1-1 Texas.

Objective 9.3. Texas Integrated Eligibility Redesign System

Texas Integrated Eligibility Redesign System (TIERS).

Related Strategic Plan Goals

- Goal 4. Continuously enhance efficiency and accountability.

Strategy 9.3.1. Texas Integrated Eligibility Redesign System and Supporting Tech

TIERS and eligibility supporting technologies capital.

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.

- Action Item 4.1.2. Cybersecurity.
- Action Item 4.2.2. Critical Position Staffing.

Strategy 9.3.2. Texas Integrated Eligibility Redesign System Capital Projects

TIERS capital projects.

Goal 10. Provide Disability Determination Services within Social Security Administration Guidelines

Enhance service to persons with disabilities by achieving accuracy and timeliness within the Social Security Administration Disability Program guidelines and improving the cost-effectiveness of the decision-making process in the disability determination services.

Objective 10.1. Increase Decisional Accuracy and Timeliness of Determinations

To achieve annually the decisional accuracy of 90.6 percent and timeliness of 125 days as measured by Social Security Administration Disability Program guidelines.

Strategy 10.1.1. Determine Federal Supplemental Security Income and Social Security Disability Insurance Eligibility

Determine eligibility for federal SSI and Social Security Disability Insurance benefits.

- Output 10.1.1.1. Number of Disability Cases Determined

Goal 11. Office of Inspector General

Office of Inspector General (OIG).

Objective 11.1. Client and Provider Accountability

Improve Health and Human Services (HHS) programs and operations by protecting them against fraud, waste, and abuse.

- Outcome 11.1.1. Net State Dollars Recovered Per Dollar Expended from All Funds

Related Strategic Plan Goals

- Goal 3. Protect the health and safety of vulnerable Texans.
- Goal 4. Continuously enhance efficiency and accountability.

Strategy 11.1.1. Office of Inspector General

OIG.

- Output 11.1.1.1. Number of Completed Provider and Recipient Investigations
- Output 11.1.1.2. Number of Audits and Reviews Performed
- Output 11.1.1.3. Number of Nursing Facility Utilization Reviews
- Output 11.1.1.4. Number of Hospital Utilization Reviews
- Output 11.1.1.5. Total Dollars Recovered (Millions)
- Output 11.1.1.6. Referrals to Office of the Attorney General (OAG) Fraud Control Unit
- Output 11.1.1.7. Total Medicaid Overpayments Recovered with Special Investigation Units (SIU)
- Output 11.1.1.8. Average Number of Clients in the Inspector General Lock-in Program
- Output 11.1.1.9. Total Dollars Identified (Millions)

Related Strategic Plan Goals and Action Items

- Goal 3. Protect the health and safety of vulnerable Texans.
  - Action Item 3.2.1. Focus on High-Risk Facilities.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.1.1. Focus on High-Risk Contracts.

Strategy 11.1.2. Office of Inspector General Administrative Support

OIG Administrative Support.

- Output 11.1.2.1. Number of Trainings Presented by Office of Inspector General Staff

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.3.1. Identify Trends and Outliers.

Goal 12. Health and Human Services Enterprise Oversight and Policy

Improve the effectiveness and efficiency of the delivery of health and human services in Texas through the oversight and coordination of a prompt, accurate, and comprehensive service delivery system.

Objective 12.1. Enterprise Oversight and Policy

Improve the business operations of the HHS System to maximize federal funds, improve efficiency in system operations, improve accountability and coordination throughout the system, and ensure the timely and accurate provision of eligibility determination services for all individuals in need of HHS System programs.

Related Strategic Plan Goals

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
- Goal 4. Continuously enhance efficiency and accountability.

Strategy 12.1.1. Enterprise Oversight and Policy

Provide leadership and direction to achieve an efficient and effective HHS System.

Related Strategic Plan Goals and Action Items

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
  - Action Item 1.1.2. STAR+PLUS Pilot Program.
- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.1.4. Group Purchasing Organizations.
  - Action Item 4.3.1. Identify Trends and Outliers.
  - Action Item 4.3.2. Improved Contract Management.
  - Action Item 4.3.3. Medicaid Enterprise System.
  - Action Item 4.3.4. Data Quality and Maturity.

Strategy 12.1.2. Information Technology Capital Projects Oversight and Program Support

Information technology capital projects and program support.

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.1.2. Cybersecurity.
  - Action Item 4.2.2. Critical Position Staffing.
  - Action Item 4.3.2. Improved Contract Management.
  - Action Item 4.3.5. Self-Service Data Quality.

Objective 12.2. Program Support

Program support.

Related Strategic Plan Goals

- Goal 1. Improve and support health outcomes and well-being for individuals and families.
- Goal 2. Ensure efficient access to appropriate services.
- Goal 3. Protect the health and safety of vulnerable Texans.
- Goal 4. Continuously enhance efficiency and accountability.

Strategy 12.2.1. Central Program Support

Central program support.

Related Strategic Plan Goals and Action Items

- Goal 4. Continuously enhance efficiency and accountability.
  - Action Item 4.1.1. Focus on High-Risk Contracts.
  - Action Item 4.3.2. Improved Contract Management.

Strategy 12.2.2. Regional Program Support

Regional program support.

Goal 13. Texas Civil Commitment Office

Texas Civil Commitment Office.

Objective 13.1. Administer Texas Civil Commitment Program

Administer Texas Civil Commitment Program.

Strategy 13.1.1. Texas Civil Commitment Office

Texas Civil Commitment Office.

- Output 13.1.1.1. Number of Sex Offenders Provided Treatment and Supervision

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Schedule B: List of Measure Definitions

This budget structure is taken from the Health and Human Services Commission (HHSC) portion of the Conference Committee Report for the 2022–23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC).

Goal 1. Medicaid Client Services

Objective 1.1. Acute Care Services (including STAR+PLUS Long-Term Care) for Full-Benefit Clients

Administer programs that provide medically necessary health care in the most appropriate, accessible, and cost-effective setting.

Outcome 1.1.1. Average Medicaid and Children's Health Insurance Program (CHIP) Children Recipient Months Per Month

Definition

This is a measure of the monthly average number of income-eligible children served in Medicaid and CHIP.

Purpose

This measure reflects the total average monthly number of income-eligible children receiving services in Medicaid and CHIP.

Data Source

The Premium Payable System.

Methodology

Sum the total number of children and newborn perinatal clients from the CHIP enrollment report with the total number of income-eligible children from Premium Payable System and divide that number by the number of months in the reporting period. Children under age 19 in Medicaid as Pregnant Women or Supplemental Security Income (SSI) clients are not included in this count. Recipient months are

accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Outcome 1.1.2. Average Full Benefit Medicaid Recipient Months Per Month

Definition

Medicaid Acute Care Recipient Months per Month is the average monthly number of recipient months (managed care and non-managed care combined) for Medicaid recipients (in the Aged and Medicare Related, Disability Related, Pregnant Women, Other Adults, or Children strategies).

Purpose

This measure reflects the average monthly number of recipient months for the named group.

Data Source

The Premium Payable System.

Methodology

A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations,

retroactive decisions, and post and prior eligibility periods. If data are incomplete, estimates will be made based on completion ratios and other forecasting techniques. This measure is the sum of the total number of recipient months for all full benefit clients for the given period divided by the number of months in the reporting period.

Data Limitations

None

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Outcome 1.1.3. Average Monthly Cost Per Full Benefit Medicaid Client (Including Drug and Long-Term Care)

Definition

Average Medicaid Cost per Recipient Month (for managed care and non-managed care combined) is the average amount paid for each recipient month incurred in the Aged and Medicare Related, Disability Related, Pregnant Women, Other Adults, Children and Medicaid Prescription Drugs strategies. Includes Long Term Services and Supports in STAR+PLUS, Dual Demonstration, and STAR Kids.

Purpose

This measure determines the average Medicaid cost per recipient month, including drug costs and Long Term Services and Supports.

Data Source

Data source for this measure are the monthly STMR/STRR 650/750 statistical reports and the Mental Health series drug reports compiled by the state Medicaid contractor, the Premium Payable System, and Health Maintenance Organization (HMO) rates.

Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates, which include administration fees in the total, by the number of incurred recipient months during the reporting period. The measure will include managed care and non-managed care for the named group. Dollars exclude costs for Texas Health Steps Dental and Medicaid Transportation. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures for recipient months.

Data Limitations

This measure involves the recipient months and costs for Acute Care and Long Term Services and Supports. Data is on an incurred basis. If data is incomplete, estimates will be made based on completion ratios and other forecasting techniques.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Outcome 1.1.4. Medicaid Recipient Months: Proportion in Managed Care

Definition

The measure gives the proportion of recipient months for Medicaid clients enrolled in managed care plans compared to the total Medicaid full benefit population during the reporting period. Total Medicaid Recipients Months is the number of recipient months (managed care and non-managed care combined) for Medicaid recipients in the Aged and Medicare Related, Disability-Related, Pregnant Women, Other Adults, and Children strategies. Managed care recipient months are the total number of recipient months for the above named strategies in the STAR, STAR+PLUS, STAR Health, Dual Demonstration or STAR Kids programs for the reporting period.

Purpose

This is a measure of the impact of implementation of managed care initiatives.

Data Source

The Premium Payable System.

Methodology

A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. If data is incomplete, estimates will be made based on completion ratios and other forecasting techniques. The proportion of Medicaid caseload in managed care is calculated for the given period by summing the managed care recipient months for the reporting period and dividing by the total Medicaid Full Benefit recipient months for the reporting period. The result is then multiplied by 100.

Data Limitations

HHSC is not directly responsible for enrolling clients in the STAR+PLUS program.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Outcome 1.1.5. Average Number of Members Receiving Waiver Services through Managed Care

Definition

This measure reports the monthly average number of members enrolled in the 1915(c) component of STAR+PLUS, STAR Kids, STAR Health, or the Dual Demonstration, who received Medicaid Community Care services through a managed care model. The STAR+PLUS program integrates preventive, primary, acute care, and long term care into a single managed care model.

Purpose

This measure shows the impact of managed care on community care caseloads for clients who are enrolled in the 1915(c) waiver component of STAR+PLUS, STAR Kids, STAR Health, or Dual Demonstration. This data is a useful tool for projecting future funding needs.

Data Source

The Premiums Payable System.

Methodology

Sum of the managed care recipient months for members receiving 1915(c) Home and Community-Based Services (HCBS) or Medically Dependent Children Program (MDCP) waiver community care services for all months of the reporting period divided by the number of months in the reporting period. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

This measure only includes members who are enrolled in the 1915(c) waiver component of Long-Term Services and Supports through a managed care model. This measure does not describe the level, type, or amount of community care received by members.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Outcome 1.1.6. Average Number Members Receiving Nursing Facility Care through Managed Care

Definition

This is the average monthly number of Nursing Facility clients enrolled in a Medicaid managed care health plan. This includes both the STAR+PLUS and Dual Demonstration programs.

Purpose

This measure reflects the average monthly number of Nursing Facility residents receiving services through Medicaid managed care.

Data Source

The Premiums Payable System.

Methodology

Sum of the managed care recipient months for Nursing Facility residents for all months of the reporting period divided by the number of months in the reporting period. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Outcome 1.1.7. Average Number Served per Month: Medically Dependent Children Program (MDCP)

Definition

This measure reports the monthly average unduplicated number of individuals who received one or more services under the MDCP Waiver. This measure aligns with the MDCP risk group within STAR Kids.

Purpose

This measure reflects the total average monthly number of Medicaid children eligible for services that are enrolled in the MDCP Waiver under the STAR Kids program.

Data Source

The Premium Payable System.

Methodology

Sum the total number of recipient months for the given period and divide by the number of months in the reporting period. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. If data are incomplete, estimates will be made based on completion ratios and other forecasting techniques.

Data Limitations

None

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 1.1.1 Aged and Medicare-Related Eligibility Group

Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to aged and Medicare-related Medicaid-eligible persons.

Efficiency 1.1.1.1. Average Aged and Medicare-Related Cost Per Recipient Month

Definition

The average monthly cost paid per Aged and Medicare-Related recipient month.

Purpose

This measure reflects the amount paid for each recipient month for the named group.

Data Source

PREM report (currently with incurred data). The PREM consists of data from the monthly STMR 650/750 (non-managed care) and STRR 650/750 (managed care) statistical reports compiled by the Medicaid contractor, the Premiums Payable System, and HMO capitation rates. Dollars include STAR+PLUS premiums for long term services and supports. Dollars exclude costs for Texas Health Steps Dental, prescription drugs, and Medical Transportation Program.

Methodology

The average monthly cost for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates, which include administration fees in the total, by the number of projected recipient months to be incurred. The measure will include managed care and non-managed care for the named group. Completion factors may be applied to the incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Output 1.1.1.1. Average Aged and Medicare-Related Recipient Months Per Month: Total

Definition

The average monthly number of Aged and Medicare Related recipient months, including managed care. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

Purpose

This measure reflects the average monthly number of recipient months for the named group.

Data Source

The Premiums Payable System.

Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Managed care and fee-for-service are included. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 1.1.2. Disability-Related Eligibility Group

Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting for disability-related Medicaid-eligible adults and children.

Efficiency 1.1.2.1. Average Disability-Related Cost Per Recipient Month

Definition

The average monthly expenditure per Disability-Related recipient month.

Purpose

This measure reflects the amount paid for each recipient month for the named group.

Data Source

PREM report (currently with incurred data). The PREM consists of data from the monthly STMR 650/750 (non-managed care) and STRR 650/750 (managed care) statistical reports compiled by the Medicaid contractor, the Premiums Payable System, and HMO capitation rates. Dollars exclude costs for Texas Health Steps Dental, prescription drugs, and Medical Transportation Program. Dollars include STAR+PLUS and STAR Kids long term support and services.

Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates which include administration fees in the total by the number of projected recipient months during the reporting period. The measure will include managed care and non-managed care for the named group. Completion factors may be applied to the incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Output 1.1.2.1. Average Disability-Related Recipient Months Per Month: Total

Definition

The average monthly number of Disability-Related recipient months, including managed care program clients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

Purpose

This measure reflects the average monthly number of recipient months for the named group.

Data Source

The Premiums Payable System.

Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Managed care and fee-for-service are included. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 1.1.3. Pregnant Women Eligibility Group

Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting for Medicaid-eligible pregnant women.

Efficiency 1.1.3.1. Average Pregnant Women Cost Per Recipient Month

Definition

The average monthly expenditure per Pregnant Women recipient month.

Purpose

This measure reflects the amount paid for each recipient month for the named group.

Data Source

PREM report (incurred data). The PREM consists of data from the monthly STMR 650/750 (non-managed care) and STRR 650/750 (managed care) statistical reports compiled by the Medicaid contractor, the Premiums Payable System, and HMO capitation rates. Dollars exclude costs in Texas Health Steps Dental, Medical Transportation Program, and prescription drug.

Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates which include administration fees by the number of projected recipient months to be incurred. Managed care and fee-for-service are included. Completion factors may be applied

to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Output 1.1.3.1. Average Pregnant Women Recipient Months Per Month

Definition

The average monthly number of Pregnant Women recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

Purpose

This measure reflects the average monthly number of recipient months for the named group.

Data Source

The Premiums Payable System.

Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Managed care and fee-for-service are included. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 1.1.4. Other Adults Eligibility Group

Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to adults who are principally income-level eligible (non-pregnant, non-Medicare, non-disability-related).

Efficiency 1.1.4.1. Average Other Adult Cost Per Recipient Month

Definition

The average monthly expenditure per Other Adult recipient month. The Other Adults group includes Temporary Assistance for Needy Families (TANF)-Level Adults, Medically Needy clients, and Medicaid for Breast and Cervical Cancer clients.

Purpose

This measure reflects the amount paid for each recipient month for the named group.

Data Source

PREM report. The PREM consists of data from the monthly STMR 650/750 (non-managed care) and STRR 650/750 (managed care) statistical reports compiled by the Medicaid contractor, the Premiums Payable System, and HMO capitation rates. Dollars exclude Texas Health Steps Dental, Medical Transportation Program, and prescription drug. Dollars include STAR+PLUS long term support and services for Breast and Cervical Cancer clients.

Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates, which include administration fees in the total, by the number of projected recipient months to be incurred. The measure will include managed care and non-managed care costs and caseloads for TANF Adults, Medically Needy, and Breast and Cervical Cancer clients. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Output 1.1.4.1. Average Other Adult Recipient Months Per Month

Definition

The average monthly number of TANF-Level Adult, Medically Needy, and Medicaid for Breast and Cervical Cancer. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

Purpose

This measure reflects the average monthly number of recipient months for the named group.

Data Source

The Premium Payable System.

Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed.

Managed care and fee-for-service are included. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 1.1.5. Children Eligibility Group

Provide medically necessary health care in the most appropriate, accessible, and cost-effective setting to newborn infants and Medicaid-eligible children who are not receiving SSI disability-related payments.

Efficiency 1.1.5.1. Average Income-Eligible Children Cost Per Recipient Month

Definition

The average monthly expenditure per child recipient month for clients in the Children strategy, excluding STAR Health children. The Children group includes all age-group related children. It does not include SSI children, medically needy children, children in the STAR Health program or members under age 19 in the Pregnant Women risk group.

Purpose

This measure reflects the amount paid for each recipient month for the named group.

Data Source

PREM report. The PREM consists of data from the monthly STMR 650/750 (non-managed care) and STRR 650/750 (managed care) statistical reports compiled by the Medicaid contractor, the Premiums Payable System, and HMO capitation rates. Dollars exclude costs for Texas Health Steps Dental, Medical Transportation and prescription drug.

Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates which include administration fees by the number of projected recipient months to be incurred. Managed care and non-managed care are included for the age-based Children's groups in the non-disabled children strategy. (This excludes SSI kids and STAR Health.) Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Efficiency 1.1.5.2. Average STAR Health Foster Care Children Cost Per Recipient Month

Definition

Average monthly expenditure per Foster care children recipient months in STAR Health.

Purpose

This measure reflects the amount paid for each recipient month for the named group.

Data Source

PREM report (currently with incurred data). The PREM consists of data from the statistical reports (STMR/STRR 650/750) compiled by the Medicaid contractor, the Premiums Payable System, and HMO capitation rates. Costs exclude prescription drugs and Medical Transportation Program. Because STAR Health premiums include dental costs, dental is included in this measure.

Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from HMO capitation rates by the total recipient months to be incurred. The measure includes managed care for the Foster Care Children served in the statewide STAR Health program. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Output 1.1.5.1. Average Income-Eligible Children Recipient Months Per Month

Definition

The average monthly number of recipient months for clients in the Children strategy, excluding STAR Health children. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. The Children group includes all age-group related children. It

does not include SSI children, medically needy children, and children in the STAR Health program or members under age 19 in the Pregnant Women risk group.

Purpose

This measure reflects the average monthly number of recipient months for the named group.

Data Source

The Premiums Payable System.

Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Managed care and fee-for-service are included for the age-based Children's groups in the non-disabled children strategy. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Output 1.1.5.2. Average STAR Health Foster Care Children Recipient Months Per Month

Definition

The average monthly number of foster care children in statewide managed care recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

Purpose

This measure reflects the average monthly number of recipient months for the named group.

Data Source

The Premiums Payable System.

Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months. Managed care only is included; these children are foster care children served in the statewide managed care STAR Health program.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 1.1.6. Medicaid Prescription Drugs

Provide prescription medication to Medicaid-eligible recipients as prescribed by their treating physician.

Efficiency 1.1.6.1. Average Cost/Medicaid Recipient Month: Prescription Drugs

Definition

This measure is the total Medicaid prescription cost incurred divided by the total number of recipient months incurred in the reporting period for a given state fiscal year.

Purpose

Captures the total prescription cost incurred divided by the total number of recipient months incurred in the reporting period.

Data Source

PREM report. Drug costs for drugs paid fee-for-service comes from monthly MH 492 reports provided by the Medicaid contractor. Costs for HMO clients are based on caseload from the Premiums Payable System and capitation rates set by HHSC. Other drug expenditures include payments to managed care organizations (MCOs) for pass-through payments for dual-eligible clients enrolled in STAR+PLUS and non-risk based payments for high cost medications. Reports come from the Vendor Drug Program via the Medicaid claims contractor.

Methodology

This measure is the total Medicaid prescription cost (for fee-for-service and managed care clients) incurred divided by the number of recipient months for the reporting period. Managed care and non-managed care are included for all full benefit Medicaid clients. Because data are reported on an incurred basis, the most recent data are completed using completion ratios. Forecasting models and trends are used to project future costs and caseload.

Data Limitations

The Medicaid Prescription Drug dollars do not include any rebates or clawback expenses.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 1.1.7. Texas Health Steps Early and Periodic Screening, Diagnosis and Treatment Dental

Provide dental care in accordance with all federal mandates.

Efficiency 1.1.7.1. Average Cost per Texas Health Steps Early and Periodic Screening, Diagnosis, and Treatment Dental Recipient Months per Month

Definition

This is the average cost per recipient month per month of Texas Health Steps Early, Periodic, Screening, Diagnosis, and Treatment of dental and orthodontic recipients eligible for dental and orthodontic services during the reporting period. Measure excludes STAR Health Clients as their dental is part of STAR Health capitation.

Purpose

Measures the average cost per eligible for Texas Health Steps Early, Periodic, Screening, Diagnosis, and Treatment dental and orthodontic services.

Data Source

The STM650 report compiled monthly by the state Medicaid contractor is used for fee-for-service dental costs, and the Premium Payable System and rates set by HHSC is used for Dental Maintenance Organization dental costs (starting March 2012).

Methodology

This cost is calculated by dividing the total dental and orthodontic expenditures in the reporting period by the total number of Texas Health Steps Dental recipient

months in the same reporting period. (Texas Health Steps Dental recipient months are the same group of eligible persons as the Texas Health Steps Orthodontic recipient months, so do not sum). Clients eligible include all Medicaid children under age 21 excluding foster care children in the STAR Health program. (STAR Health includes dental care.) Recipient months are accounted for under an incurred basis and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Because data are reported on an incurred basis, recipient month figures are completed using completion ratios. Forecasting models and trends are used to project future counts.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 1.1.7.1. Average Texas Health Steps Early, Periodic, Screening, Diagnosis, and Treatment Dental Recipient Months Per Month

Definition

This is the average monthly number of recipient months for Texas Health Steps recipients eligible for dental and orthodontic services during the reporting period. Excludes STAR Health clients as their dental is part of the overall program benefits and capitation.

Purpose

This measure reflects the average monthly number of recipient months for the named group.

Data Source

The Premium Payable System.

Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Managed care and fee-for-service are included. Recipient months are accounted for under an incurred basis and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 1.1.8. Medical Transportation

Support and reimburse for non-emergency transportation assistance to individuals receiving medical assistance.

Efficiency 1.1.8.1. Average Nonemergency Transportation Cost Per Recipient Month

Definition

Nonemergency medical transportation cost per recipient month is the average amount paid for nonemergency medical transportation for each recipient month incurred. It is a blended per-member-per-month for all fee-for-service and managed care model costs.

Purpose

This measure determines the average cost per recipient month.

Data Source

Medicaid recipient month data are obtained from the Premiums Payable System for managed care, nonemergency medical transportation cost data is calculated from Premium Payable System enrollment and rates set by HHSC. Fee-for-service cost data is from claims administrator reports and the accounting system.

Methodology

This measure is the total nonemergency medical transportation cost (for fee-for-service and managed care) incurred divided by the number of recipient months for the reporting period. Managed care and fee-for-service are included. Because data are reported on an incurred basis, the most recent data are completed using completion ratios. Forecasting models and trends are used to project future costs and caseload.

Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on the data available.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Objective 1.2. Community Services and Supports — Entitlement

Provide Medicaid-covered supports and services in home and community settings to enable aging individuals, individuals with disabilities, and others who qualify for nursing facility care, but can be served at home or in the community, to maintain their independence and avoid institutionalization.

Strategy 1.2.1. Community Attendant Services

Provide attendant care services to Medicaid-reimbursed subgroup of Primary Home Care eligible individuals that must meet financial eligibility of total gross monthly income less than or equal to 300 percent of the SSI federal benefit rate.

Efficiency 1.2.1.1. Average Monthly Cost Per Individual Served: Community Attendant Services

Definition

This measure reports the average cost of Medicaid non-waiver Community Services and Supports Community Attendant Services per individual per month. Expenditures are defined as payments made to providers for services delivered to individuals as well as amounts incurred for services delivered but not yet paid. The average monthly number of Medicaid non-waiver community attendant services individuals is defined under Output 1.2.1.1. Average Number of Individuals Served per Month: Community Attendant Services.

Purpose

This measure reports the average cost of Medicaid non-waiver Community Services and Supports Community Attendant Services per individual per month.

Data Source

Month-of-service to-date data that reports, by type-of-service, the number of individuals for whom claims have been approved-to-pay, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from claims payment data provided by the Medicaid claims administrator that is accessed and reported through an agency-developed application that utilizes COGNOS software.

Methodology

Expenditures are based on units of service per client served and costs per unit. Total expenditures are then divided by the total number of projected recipient months to be incurred for the reporting period. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months. Services delivered through Consumer Directed Services have not been historically considered as part of the measure.

Data Limitations

Completion factors must be used to estimate data for months that have not been closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 1.2.1.1. Average Number of Individuals Served Per Month: Community Attendant Services

Definition

This measure reports the monthly average number of individuals who, based upon approved-to-pay claims, received the Medicaid-funded non-waiver Community Services and Supports, Community Attendant Services (formerly referred to as Frail Elderly).

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of individuals served with the funding that has been appropriated.

Data Source

The number of individuals authorized to receive Community Attendant Services services, as well as the number of units of service authorized, are obtained from the commission's Service Authorization System by means of ad hoc query. Month-of-service to-date data that reports, by type-of-service, the number of individuals for whom claims have been approved-to-pay, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application that utilizes COGNOS software.

Methodology

The monthly average for the reporting period is calculated by dividing the sum of the monthly number of individuals for all months of the reporting period, by the number of months in the reporting period.

Data Limitations

Completion factors must be used to estimate data for months that have not been closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 1.2.2. Primary Home Care

Provide Medicaid-reimbursed, non-technical, medically related personal care services prescribed by a physician to eligible individuals whose health problems limit their ability to perform activities of daily living.

Efficiency 1.2.2.1. Average Monthly Cost Per Individual Served: Primary Home Care

Definition

This measure reports the average cost of Medicaid non-waiver Community Services and Supports Primary Home Care services per individual per month. Expenditures are defined as payments made to providers for services delivered to individuals as well as amounts incurred for services delivered but not yet paid. This is a fee-for-service only. The average monthly number of Medicaid non-waiver primary home care individuals is defined under output measure 1 of this strategy.

Purpose

This measure quantifies the unit cost for providing eligible individuals with services available under this strategy. This unit cost is a tool for projecting future funding needs.

Data Source

Month-of-service to-date data that reports, by type-of-service, the number of individuals for whom claims have been approved-to-pay, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from claims payment data provided by the Medicaid claims administrator that is accessed and reported through an agency-developed application that utilizes COGNOS software.

Methodology

Expenditures are based on units of service per client served and costs per unit. Total expenditures are then divided by the total number of projected recipient months to be incurred for the reporting period. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months. Services delivered through Consumer Directed Services have not been historically considered as part of the measure.

Data Limitations

Completion factors must be used to estimate data for months that have not been closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 1.2.2.1. Average Number of Individuals Served Per Month: Primary Home Care

Definition

This measure reports the monthly average number of individuals who, based upon approved-to-pay claims, received Medicaid-funded non-waiver Community Services and Supports, Primary Home Care. This is a fee-for-service only.

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of individuals served with the funding that has been appropriated.

Data Source

The number of individuals authorized to receive Primary Home Care services, as well as the number of units of service authorized, are obtained from the Commission's Service Authorization System by means of ad hoc query. Month-of-service to-date data that reports, by type-of-service, the number of individuals for whom claims have been approved-to-pay, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application that utilizes COGNOS software.

Methodology

Individual counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly individual count (as described above) for all months of the reporting period, by the number of months in the reporting period.

Data Limitations

Completion factors must be used to estimate data for months that have not been closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 1.2.3. Day Activity and Health Services

Provide daytime services five days a week to individuals residing in the community as an alternative to placement in nursing facilities or other institutions.

Efficiency 1.2.3.1. Average Monthly Cost Per Individual Served: Day Activity and Health Services

Definition

This measure reports the average cost of Medicaid non-waiver Community Services and Supports Day Activity and Health Services (Title XIX) per individual per month. Expenditures are defined as payments made to providers for services delivered to individuals as well as amounts incurred for services delivered but not yet paid. This is a fee-for-service only. The average monthly number of Medicaid non-waiver day activity and health services individuals is defined under output measure 1 of this strategy.

Purpose

This measure reports the average cost of Medicaid non-waiver Community Services and Supports Day Activity and Health Services (Title XIX) per individual per month.

Data Source

Month-of-service to-date data that reports, by type-of-service, the number of individuals for whom claims have been approved-to-pay, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from claims payment data provided by the Medicaid claims administrator that is accessed and reported through an agency-developed application that utilizes COGNOS software.

Methodology

Expenditures are based on units of service per client served and costs per unit. Total expenditures are then divided by the total number of projected recipient months to be incurred for the reporting period. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

Completion factors must be used to estimate data for months that have not been closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 1.2.3.1. Average Number of Individuals Per Month: Day Activity/Health Services

Definition

This measure reports the monthly average number of individuals who, based upon approved-to-pay claims, received Medicaid-funded non-waiver Community Services and Supports Day Activity and Health Services (XIX).

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of individuals served with the funding that has been appropriated.

Data Source

The number of individuals authorized to receive the above services, as well as the number of units of service authorized, are obtained from the commission's Service Authorization System by means of ad hoc query. Month-of-service to-date data that reports, by type-of-service, the number of individuals for whom claims have been approved-to-pay, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from claims payment data provided by the Medicaid claims administrator that is accessed and reported through an agency-developed application that utilizes COGNOS software. Month-of-service to-date data that reports, by type-of-service, the number of individuals for whom claims have been approved-to-pay, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from claims payment data provided by the Medicaid claims administrator that is accessed and reported through an agency-developed application that utilizes COGNOS software.

Methodology

Individual counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly individual count for all months of the reporting period by the number of months in the reporting period.

Data Limitations

Completion factors must be used to estimate data for months that have not been closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 1.2.4. Nursing Facility Payments

Provide payments that will promote quality care for individuals with medical needs that require nursing facility care.

Efficiency 1.2.4.1. Net Nursing Facility Cost Per Medicaid Fee-for-Service Resident Per Month

Definition

This measure reports the average net nursing facility cost per Medicaid nursing facility resident (individual) per month. This is a measure of fee-for-service only.

Purpose

This measure is important because it is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the total unit cost to HHSC for providing Medicaid reimbursed services in a nursing facility. This data is a useful tool for projecting future funding needs.

Data Source

Month-of-service to-date data that reports, by type-of-service, the number of individuals for whom claims have been approved-to-pay, the number of units of service approved-to-pay, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved-to-pay are obtained from claims payment data provided to the agency by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application which utilizes TM1 software.

Methodology

The average daily nursing home rate for the reporting period less the applied income per day for the reporting period equals the net cost per Medicaid resident per day for each month in the reporting period. The net cost per day is then multiplied by the calendar days in the month to obtain the total net costs per month.

Data Limitations

Because it takes up to 36 months to close out 100 percent of the days of service billed for a month of service, the Medicaid payments as well as the amount of individual income contribution ultimately incurred for months that have not yet closed out must be estimated based upon approved-to-pay claims data to-date.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 1.2.4.1. Average Number Receiving Medicaid-Funded Fee-for-Service Nursing Facility Services Per Month

Definition

This measure reports the monthly average number of individuals receiving Medicaid-funded nursing facility services during the reporting period. This is a fee-for-service only.

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of individuals receiving the service that expends the majority of funding appropriated to this strategy. This count is an indication of service demand and is a useful tool for projecting future funding needs.

Data Source

Month-of-service to-date data that reports, by type of service, the number of individuals for whom claims have been approved-to-pay, the number of units of service approved to-pay, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application which utilizes TM1 software.

Methodology

Data are computed by taking the number of Medicaid days of nursing facility services ultimately incurred for a month of service and dividing by the number of calendar days in the month to derive an average daily census. This result is the average number of individuals receiving services during the month. The reported data are calculated by dividing the sum of the monthly number of individuals receiving Medicaid-funded nursing facility services for all months of the reporting period, by the number of months in the reporting period.

Data Limitations

Completion factors must be used to estimate data for months that have not been closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 1.2.4.2. Average Number Receiving Personal Needs Allowance Per Month

Definition

This measure reports the monthly average unduplicated number of Medicaid eligible, SSI institutional individuals who received a 100 percent state-funded payment to enhance their "Personal Needs Allowance" (PNA) above the SSI standard payment amount. The PNA is the amount of funds an individual is allowed to retain in order to pay for incidentals that are not provided by the institution. The

standard SSI payment for a individual in an institution is only $30 per month. This is a fee-for-service only. All eligible individuals receive a supplemental payment of $15 per month.

Purpose

This measure is important because it quantifies the number of individuals who receive this service, which was mandated by the Texas Legislature.

Data Source

Individual counts are obtained from the commission's Centralized Accounting and Payroll/Personnel System (CAPPS) Financials. The payment amount is established by rule and does not vary by individual.

Methodology

Monthly individual counts for this measure are derived each month by dividing the monthly amount expended for this service by $15. The monthly average for the reporting period is calculated by dividing the sum of the monthly individual counts for all months in the reporting period, by the number of months in the reporting period.

Data Limitations

Does not apply.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 1.2.5. Medicare Skilled Nursing Facility

Provides payments for individuals in dually qualified certified facilities (certified for both Medicaid and Medicare).

Efficiency 1.2.5.1. Net Medicaid/Medicare Copay Per Individual Nursing Facility Services

Definition

This measure reports the net monthly payment per individual receiving co-paid Medicaid/Medicare nursing facility services. The department pays the daily Medicare skilled nursing facility co-insurance payments for individuals who are eligible for both Medicare and Medicaid. This is a fee-for-service only.

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to providing services in this strategy. It quantifies the unit cost for the Medicare co-payment for eligible nursing facility residents. This data is a tool for projecting future funding needs.

Data Source

Month-of-service to-date data that reports, by type of service, the number of individuals for whom claims have been approved-to-pay, the number of units of service approved to-pay, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application which utilizes TM1 software.

Methodology

Expenditures are based on units(days) of service per client served and costs per unit(day), net cost per unit/day is then based off the Centers for Medicare and Medicaid Services (CMS) determined Medicare co-pay rate less average applied income per client. Total expenditures are based on the above net cost per day times the total number of Medicaid covered days. Total net costs are summed for the months in the reporting period and are divided by the sum of the number of individuals receiving Medicare co-pays for all months of the reporting period.

Data Limitations

Completion factors must be used to estimate data for months that have not been closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 1.2.5.1. Average Number Receiving Nursing Facility Copayments Per Month

Definition

This measure reports the monthly average number of persons receiving co-paid Medicaid/Medicare nursing facility services during the reporting period. The department pays the daily Medicare skilled nursing facility co-insurance payments for persons who are eligible for both Medicare and Medicaid. This is a fee-for-service only.

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of persons receiving one of the services funded under this strategy. This count is an indication of service demand and is a useful tool for projecting future funding needs.

Data Source

Month-of-service to-date data that reports, by type of service, the number of individuals for whom claims have been approved-to-pay, the number of units of service approved to-pay, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application which utilizes TM1 software.

Methodology

The data are calculated by dividing the sum of the monthly number of persons receiving co-paid Medicaid/ Medicare nursing facility services for all months of the reporting period by the number of months in the reporting period.

Data Limitations

Completion factors must be used to estimate data for months that have not been closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 1.2.6. Hospice

Provide palliative care consisting of medical, social, and support services for individuals.

Efficiency 1.2.6.1. Average Net Payment Per Individual Per Month for Hospice

Definition

This measure reports the average net cost per individual per month for Hospice Services. Expenditures are defined as payments made to providers for services delivered to clients, as well as incurred amounts for services delivered but not yet paid. The average monthly number of Medicaid Hospice clients is defined under output measure 1.

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the total unit cost to the agency for providing Medicaid reimbursed hospice services. This data is a useful tool for projecting future funding needs.

Data Source

Month-of-service to-date data that reports by type-of-service, the number of clients for whom claims have been approved-to-pay, the number of units of service approved-to-pay, the amounts approved-to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application which utilizes COGNOS software.

Methodology

Expenditures are based on units of service per client served and costs per unit. Total expenditures are then divided by the total number of projected recipient months to be incurred for the reporting period. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

Completion factors must be used to estimate data for months that have not been closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 1.2.6.1. Average Number of Individuals Receiving Hospice Services Per Month

Definition

This measure reports the average of the unduplicated monthly number of individuals receiving Hospice services during the reporting period.

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It provides a count of individuals receiving one of the services funded under this strategy. This count is an indication of service demand and is a useful tool for projecting future funding needs.

Data Source

Month-of-service to-date data that reports, by type of service, the number of clients for whom claims have been approved-to-pay, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application which utilizes COGNOS software.

Methodology

The data are calculated by dividing the sum of the monthly number of persons receiving Hospice services for all months of the reporting period by the number of months in the reporting period.

Data Limitations

Completion factors must be used to estimate data for months that have not been closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 1.2.7. Intermediate Care Facilities for Individuals with Intellectual Disability

Provide or contract for residential facilities of four or more beds for 24-hour care for the intellectual and developmentally disabled residents.

Efficiency 1.2.7.1. Monthly Cost per Intermediate Care Facility for Individuals with Intellectual Disability Medicaid-Eligible Individual

Definition

This efficiency measure is the average monthly cost per individual in Community Intermediate Care Facilities for Individuals With an Intellectual Disability or Related Conditions (ICFs/IID).

Purpose

This measure allows the agency to track the cost, over time, of ICF/IID services provided to individuals served by state operated and non-state operated providers.

Data Source

Month-of-service to-date data that reports, by facility size, the number of individuals for whom claims have been approved-to-pay, the number of units of

service approved to-pay, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application which utilizes TM1 software. In addition, the numbers of individuals authorized to receive ICF/IDD services by facility size are obtained from the commission's Service Authorization System .

Methodology

The average daily ICF/IID rate for the reporting period less the applied income per day for the reporting period equals the net cost per day for each month in the reporting period. The net cost per day is then multiplied by the calendar days in the month to obtain the total net costs per month. Total net costs are summed for the months in the reporting period and are divided by the sum of the number of individuals receiving ICF/IID services for all months of the reporting period.

Data Limitations

Because it takes several months to close out 100 percent of the days of service billed for a month of service, the Medicaid payments as well as the amount of individual income contribution ultimately incurred for months that have not yet closed out must be estimated based upon approved-to-pay claims data to-date.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 1.2.7.1. Average Number of Persons in Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition Medicaid Beds per Month

Definition

This output measure is the average number of Medicaid-funded individuals who reside in all Community ICFs/IID.

Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate ICF/IID Medicaid beds with related costs and outcomes.

Data Source

Month-of-service to-date data that reports, by facility size, the number of individuals for whom claims have been approved-to-pay, the number of units of service approved to-pay, the amount of patient's "applied income" associated with approved-to-pay claims, and the amounts approved to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application which utilizes TM1 software. In addition, the numbers of individuals authorized to receive ICF/IID services by facility size are obtained from the commission's Service Authorization System .

Methodology

The number of individuals served is defined as an "average daily census”, i.e., the number of days of service incurred in a month divided by the number of calendar days in that month. Data includes all bed size groupings; small (6 beds or less), medium (7 to 14 beds), and large (15 beds or more). Census values estimated through the “completion factor” method are over-ridden for service months in which fewer than three payment periods of data is available (or additional months if necessary). For these service months, the census values are estimated by using the historical ratio of individuals served (based upon claims data) to individuals authorized to receive the service (per the Service Authorization System).

Data Limitations

Completion factors must be used to estimate data for months that have not been closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Objective 1.3. Long-Term Care — Non-Entitlement

Provide supports and services through Medicaid waivers in home and community settings to enable aging individuals, individuals with physical or mental disabilities, and others who qualify for institutional care to maintain their independence and avoid institutionalization.

Strategy 1.3.1. Home and Community-Based Services

Provide individualized services to individuals with intellectual disability living in their family's home, their own homes, or other settings in the community.

Efficiency 1.3.1.1. Average Monthly Cost Per Individual Served: Home and Community-Based Services (HCS)

Definition

This measure captures the average cost per month for serving Medicaid HCS individuals.

Purpose

This measure quantifies the unit cost for providing eligible individuals with services for which funding has been appropriated. It allows the agency to track the cost of HCS waiver-funded services over time, helps to maintain the fiscal integrity of the program by ensuring the availability of funds within appropriated resources and is a tool for projecting future funding needs.

Data Source

Month-of-service to-date data that reports the number of individuals for whom claims have been approved-to-pay, and the amounts approved-to-pay are obtained from a claims payment report provided by HHSC enterprise, using data from the Client Assignment and Registration (CARE) system.

Methodology

The average monthly expenditure for the named group is calculated by summing the total monthly expenditures incurred in the reporting period and dividing by the sum of the number of individuals served in each month in the reporting period.

Data Limitations

Original claims for services provided may be submitted by providers of waiver services up to 95 days after the end of the service month. Therefore, for the current quarter, the numerator is an estimated expenditure amount based on prior period billing data, and the denominator is the number of actual enrollments for the current quarter.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Efficiency 1.3.1.2. Average Monthly Cost Individual Served: HCS Residential

Definition

This measure captures the average cost per month for serving Medicaid Non-Residential HCS individuals.

Purpose

This measure quantifies the unit cost for providing eligible individuals with services for which funding has been appropriated. It allows the agency to track the cost of HCS waiver-funded services over time, helps to maintain the fiscal integrity of the program by ensuring the availability of funds within appropriated resources and is a tool for projecting future funding needs.

Data Source

This measure is derived from enrollment and billing data, which are provided on a monthly basis. The calculation uses the average billing rate per individual from the HCS billing system for the Residential slot type. Since there is a 95-day billing window for the waiver programs, the average billing rate is an average of the prior months that are complete. The calculation also uses the monthly number of individuals enrolled from the CARE system for the Residential slot type. The enrollment report provides the number of individuals entering and leaving by slot type. The ending enrollment balance at the end of the month represents the

beginning balance for the next month by slot type. This combination of enrollments and average billing rates is used rather than utilizing the billing system alone because of the 95 day billing window for submitting claims.

Methodology

For the Residential slot type within the HCS program, the average billing rate for each month is multiplied by the number enrolled for those same months to determine a monthly expenditure amount. The monthly expenditure amount and number of individuals enrolled for the Residential slot type within HCS are aggregated into a total monthly expenditure amount and total number of individuals enrolled during the reporting period. Then the expenditure amount is divided by the aggregated number of individuals enrolled for an average monthly cost per individual for the reporting quarter.

Data Limitations

Original claims for services provided may be submitted by providers of waiver services up to 95 days after the end of the service month. Therefore, for the current quarter, the numerator is an estimated expenditure amount based on prior period billing data, and the denominator is the number of actual enrollments for the current quarter.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Efficiency 1.3.1.1.3. Average Monthly Cost Individual: HCS Non-Residential

Definition

This measure captures the average cost per month for serving Medicaid Non-Residential HCS individuals.

Purpose

This measure quantifies the unit cost for providing eligible individuals with services for which funding has been appropriated. It allows the agency to track the cost of HCS waiver-funded services over time, helps to maintain the fiscal integrity of the program by ensuring the availability of funds within appropriated resources and is a tool for projecting future funding needs.

Data Source

This measure is derived from enrollment and billing data, which are provided on a monthly basis. The calculation uses the average billing rate per individual from the HCS billing system for the Non-Residential slot type. Since there is a 95-day billing window for the waiver programs, the average billing rate is an average of the prior months that are complete. The calculation also uses the monthly number of individuals enrolled from the CARE system for the Non-Residential slot type. The enrollment report provides the number of individuals entering and leaving by slot type. The ending enrollment balance at the end of the month represents the beginning balance for the next month by slot type. This combination of enrollments and average billing rates is used rather than utilizing the billing system alone because of the 95 day billing window for submitting claims.

Methodology

For the Non-Residential slot type within the HCS program, the average billing rate for each month is multiplied by the number enrolled for those same months to determine a monthly expenditure amount. The monthly expenditure amount and number of individuals enrolled for the Non-Residential slot type within HCS are aggregated into a total monthly expenditure amount and total number of individuals enrolled during the reporting period. Then the expenditure amount is divided by the aggregated number of individuals enrolled for an average monthly cost per individual for the reporting quarter.

Data Limitations

Original claims for services provided may be submitted by providers of waiver services up to 95 days after the end of the service month. Therefore, for the current quarter, the numerator is an estimated expenditure amount based on prior period billing data, and the denominator is the number of actual enrollments for the current quarter.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Explanatory 1.3.1.1. Number Individuals Receiving Services at the End of the Fiscal Year: HCS

Definition

This measure provides an unduplicated workload count of priority population eligible individuals receiving intellectual disability Medicaid HCS funded services at the end of the fiscal year.

Purpose

Due to the high demand for these services, as indicated by the number of individuals waiting for waiver services, it is critical for the department to monitor how many individuals are receiving the service annually in order to determine the service level that will be carried into the next Fiscal Year and/or Biennium.

Data Source

The providers of HCS waiver services submit Medicaid claims for the services provided during each month. The numbers of individuals served is taken from a standard production report.

Methodology

This is a simple unduplicated count of individuals that received HCS waiver services at the end of the fiscal year.

Data Limitations

Original claims for services provided may be submitted by providers of waiver services up to 95 days after the end of the service month. If the original claim is rejected for payment for any reason, the provider has up to 180 days from the end of the original service month to correct the claim and re-bill it. Since the documentation of a service being provided to an individual is based on these claims, accurate counts of numbers served during a fiscal year may not be available for several months past the fiscal year. Values reported in the Automated Budget and Evaluation System of Texas (ABEST) can be updated when the appropriation year closes and the LBB reopens the system.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Explanatory 1.3.1.2. Percent of HCS Recipients Receiving Residential Services

Definition

This measure reports the number of HCS recipients, per month, who are receiving residential services, expressed as a percentage of all individuals receiving HCS services.

Purpose

This measure is a mechanism for tracking the percentage of those individuals in the HCS program that choose to live in a residential setting, as opposed to other alternatives.

Data Source

Month-of-service data that reports the number of individuals for whom claims have been approved-to-pay are obtained from a claims payment report provided by HHSC, using data from the CARE system. This report breaks down the data into individuals who received residential services vs. individuals who received services in non-residential settings.

Methodology

The measure is calculated by dividing the number of individuals who received HCS residential services by the total number of individuals who received any HCS service, based upon claims payment data.

Data Limitations

Because it takes several months to close out 100 percent of the claims for a month of service, completion factors may be applied to incomplete data for months that have not yet closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Output 1.3.1.1. Average Number Individuals Served Per Month: HCS

Definition

This measure captures the unduplicated count of priority population eligible individuals who receive HCS funded services on a monthly basis.

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It reflects the system-wide level of activity occurring over time and allows the agency to associate HCS waiver-funded services with related costs and outcomes.

Data Source

Two types of data are used to calculate this measure. The number of individuals authorized to receive HCS services is obtained from the commission's CARE system. Month-of-service to-date data that reports the number of individuals for whom claims have been approved-to-pay, and the amounts approved-to-pay are obtained from a claims payment report provided by HHSC enterprise, using data from the CARE system .

Methodology

Average individuals served per month is calculated by summing the named group's individuals served per month and dividing by the number of months summed.

Data Limitations

Because it takes several months to close out 100 percent of the claims for a month of service, completion factors may be applied to incomplete data for months that have not yet closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 1.3.2. Community Living Assistance and Support Services

Provide home and community-based services to persons who have a "related condition" diagnosis qualifying them for placement in an intermediate care facility. A related condition is a disability other than intellectual and/or developmental disability which originates before age 22 and which substantially limits life activity. Such disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and other diagnoses, are said to be "related to" intellectual and/or developmental disability in their effect upon the individual's functioning.

Efficiency 1.3.2.1. Average Monthly Cost Per Individual: Community Living Assistance and Support Services (CLASS) Waiver

Definition

This measure reports the average cost of Medicaid Related Conditions Waiver (CLASS) services per individual per month. Expenditures are defined as payments made to providers for services delivered to individuals, as well as incurred amounts for services delivered but not yet paid. The average monthly number of CLASS individuals is defined under Output 1.3.2.1, Average Number of Individuals Served per Month: Community Living Assistance and Support Services Waiver.

Purpose

This measure quantifies the unit cost for providing eligible individuals with services for which funding has been appropriated. It allows the agency to track the cost of CLASS waiver-funded services over time, helps to maintain the fiscal integrity of the program by ensuring the availability of funds within appropriated resources and is a tool for projecting future funding needs.

Data Source

Month-of-service to-date data that reports by type-of-service the number of individuals for whom claims have been approved-to-pay and the amounts approved-to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application that utilizes COGNOS software.

Methodology

The average monthly expenditure for the named group is calculated by summing the total monthly expenditures incurred in the reporting period and dividing that by the sum of the number of individuals served in each month in the reporting period.

Data Limitations

Because it takes several months to close out 100 percent of the days of service billed for a month of service, the expenditures ultimately incurred for months that have not yet closed out must be estimated based upon approved-to-pay claims data to-date.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Explanatory 1.3.2.1. Number of Persons Receiving Services at the End of the Fiscal Year: CLASS Waiver

Definition

This measure reports the number of individuals who, based upon approved-to-pay claims, received one or more services under the CLASS waiver during the last month of the fiscal year being reported.

Purpose

By reporting the number of persons served at the end of the fiscal year, this measure allows the State to determine the service level that will be carried into the next fiscal year and/or biennium.

Data Source

Two types of data are used to report this measure. The number of individuals authorized to receive CLASS waiver services is obtained from the commission's Service Authorization System by means of ad hoc query. Month-of-service to-date data that reports the number of individuals for whom claims have been approved-to-pay, and the amounts approved-to-pay are obtained from the commission's Claims Management System by means of ad hoc query.

Methodology

This is a simple unduplicated count of individuals who received CLASS waiver services during the last month of the fiscal year being reported.

Data Limitations

Because it takes several months to close out 100 percent of the claims for a month of service, completion factors may be applied to incomplete data for months that have not yet closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 1.3.2.1. Average Number of Individuals Served Per Month: CLASS Waiver

Definition

This measure reports the monthly average unduplicated number of individuals who, based upon approved-to-pay claims by month of service, received services under the CLASS Waiver. CLASS offers people of all ages, who have severe disabilities, the opportunity to live in their own home and to work and socialize in their communities. CLASS is a cost effective alternative to institutional care with a service array that includes case management, habilitation, respite care, physical therapy, occupational therapy, speech therapy, nursing services, psychological services, adaptive aids/supplies, minor home modifications, and unlimited prescriptions.

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It reflects the system-wide level of activity occurring over time and allows the agency to associate CLASS waiver - funded services with related costs and outcomes.

Data Source

Two types of data are used to report this measure. The number of individuals authorized to receive CLASS waiver services is obtained from the commission's Service Authorization System by means of ad hoc query. Month-of-service to-date data that reports the number of individuals for whom claims have been approved-to-pay, and the amounts approved-to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application that utilizes COGNOS software.

Methodology

Individual counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly individual counts (as described above) for all months of the reporting period, by the number of months in the reporting period.

Data Limitations

Because it takes several months to close out 100 percent of the claims for a month of service, completion factors may be applied to incomplete data for months that have not yet closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 1.3.3. Deaf-Blind Multiple Disabilities

Provide home and community-based services to adult individuals diagnosed with deafness, blindness, and multiple disabilities.

Efficiency 1.3.3.1. Average Monthly Cost Per Individual: Deaf-Blind with Multiple Disabilitites (DBMD) Waiver

Definition

This measure reports the average cost of Deaf-Blind with Multiple Disabilities Waiver services per individual per month. Expenditures are defined as payments made to providers for services delivered to individuals, as well as incurred amounts for services delivered but not yet paid. The average monthly number of DBMD Waiver individuals is defined under output measure 1 of this strategy.

Purpose

This measure quantifies the unit cost for providing eligible individuals with services for which funding has been appropriated. It allows the agency to track the cost of DBMD waiver-funded services over time, helps to maintain the fiscal integrity of the program by ensuring the availability of funds within appropriated resources, and is a tool for projecting future funding needs.

Data Source

Month-of-service to-date data that reports by type-of-service the number of individuals for whom claims have been approved-to-pay and the amounts approved-to-pay are obtained claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application that utilizes COGNOS software.

Methodology

The average monthly expenditure for the named group is calculated by summing the total monthly expenditures incurred in the reporting period and dividing that by the sum of the number of individuals served in each month in the reporting period.

Data Limitations

Because it takes several months to close out 100 percent of the days of service billed for a month of service, the expenditures ultimately incurred for months that have not yet closed out must be estimated based upon approved-to-pay claims data to-date.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Explanatory 1.3.3.1. Number of Persons Receiving Services at the End of the Fiscal Year: DBMD Waiver

Definition

This measure reports the number of individuals who, based upon approved-to-pay claims, received one or more services under the Medicaid DBMD waiver during the last month of the fiscal year being reported.

Purpose

By reporting the number of individuals served at the end of the fiscal year, this measure allows the State to determine the service level that will be carried into the next fiscal year and/or biennium.

Data Source

Two types of data are used to report this measure. The number of individuals authorized to receive services are obtained from the commission's Service Authorization System by means of ad hoc query. Month-of-service to-date data that reports the number of individuals for whom claims have been approved-to-pay and the amounts approved to-pay are obtained from the commission's Claims Management System by means of ad hoc query.

Methodology

This is a simple unduplicated count of individuals who received Medicaid DBMD waiver services during the last month of the fiscal year being reported.

Data Limitations

Because it takes several months to close out 100 percent of the claims for a month of service, completion factors may be applied to incomplete data for months that have not yet closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 1.3.3.1. Average Number of Individuals Served Per Month: DBMD Waiver

Definition

This measure reports the monthly average unduplicated number of individuals who, based upon approved-to-pay claims, received one or more services under the DBMD Waiver.

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It reflects the system-wide level of activity occurring over time and allows the agency to associate Medicaid DBMD Waiver-funded services with related costs and outcomes.

Please note that using an alternate method of estimation for periods with relatively few payment periods is consistent with actuarial standards of practice.

Data Source

Two types of data are used to report this measure. The number of individuals authorized to receive services are obtained from the commission's Service Authorization System by means of ad hoc query. Month-of-service to-date data that reports the number of individuals for whom claims have been approved-to-pay and the amounts approved to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application that utilizes COGNOS software.

Methodology

Individual counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly individual counts (as described above) for all months of the reporting period, by the number of months in the reporting period.

Data Limitations

Because it takes several months to close out 100 percent of the claims for a month of service, completion factors may be applied to incomplete data ultimately served for months that have not yet closed out, by using "completion factors" specific to each service applied to the number of individuals approved-to-pay to-date. The concept of completion factors is that data, as of a given number of claims processing months after the month of service, can be considered a certain percent complete based upon historical patterns. Therefore, for a given month of service, the number of individuals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 1.3.4. Texas Home Living Waiver

Provide individualized services, not to exceed $17,000 per year, to individuals with an intellectual disability living in their family's home, their own homes, or other settings in the community.

Efficiency 1.3.4.1. Average Monthly Cost Per Individual Served: Texas Home Living Waiver

Definition

This measure captures the average cost per month for serving Texas Home Living (TxHmL) Waiver individuals.

Purpose

This measure quantifies the unit cost for providing eligible individuals with services for which funding has been appropriated. It allows the agency to track the cost of TxHmL waiver-funded services over time, helps to maintain the fiscal integrity of

the program by ensuring the availability of funds within appropriated resources and is a tool for projecting future funding needs.

Data Source

Month-of-service to-date data that reports the number of individuals for whom claims have been approved-to-pay, and the amounts approved-to-pay are obtained from a claims payment report provided by HHSC enterprise, using data from the CARE system.

Methodology

The average monthly expenditure for the named group is calculated by summing the total monthly expenditures incurred in the reporting period and dividing that by the sum of the number of individuals served in each month in the reporting period.

Data Limitations

Because it takes several months to close out 100 percent of the claims for a month of services, completion factors may be applied to incomplete data for a the months that claims have not been closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Explanatory 1.3.4.1. Number of Individuals Receiving Services at the End of the Fiscal Year: Texas Home Living Waiver

Definition

This measure provides an unduplicated workload count of priority population eligible individuals receiving TxHmL waiver funded services at the end of the fiscal year.

Purpose

Due to the very high demand for these services, as indicated by the number of individuals waiting for TxHmL waiver services, it is critical that the commission monitors how many individuals are receiving the service annually.

Data Source

The providers of waiver services submit Medicaid claims for the services provided during each month. The numbers of individuals served is taken from a standard production report.

Methodology

This is a simple unduplicated count of individuals that received TxHmL waiver services at the end of the fiscal year.

Data Limitations

Original claims for services provided may be submitted by providers of waiver services up to 95 days after the end of the service month. If the original claim is rejected for payment for any reason, the provider has up to 180 days from the end of the original service month to correct the claim and re-bill it. Since the documentation of a service being provided to an individual is based on these claims, accurate counts of numbers served may not be available for several months past the fiscal year. Updates to the values reported in ABEST will be available when the appropriation year closes.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 1.3.4.1. Average Number of Individuals Served Per Month: Texas Home Living Waiver

Definition

This measure captures the unduplicated count of priority population eligible individuals who receive TxHmL Waiver funded services on a monthly basis.

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. It reflects the system-wide level of activity occurring over time and allows the agency to associate TxHmL waiver-funded services with related costs and outcomes.

Data Source

Two types of data are used to calculate this measure. The number of individuals authorized to receive Texas Home Living services is obtained from the commission's CARE system. Month-of-service to-date data that reports the number of individuals for whom claims have been approved-to-pay, and the amounts approved-to-pay are obtained from a claims payment report provided by HHSC enterprise, using data from the CARE system.

Methodology

Average individuals served per month is calculated by summing the named group's individuals served per month and dividing by the number of months summed.

Data Limitations

Because it takes several months to close out 100 percent of the claims for a month of service, completion factors may be applied to incomplete data for months that have not yet closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 1.3.5. Program of All-Inclusive Care for the Elderly

Provide community-based services to frail and elderly individuals who qualify for nursing facility placement. Services include in-patient and outpatient medical care and social/community services at a capitated rate.

Efficiency 1.3.5.1. Average Monthly Cost Per Recipient: Program for All Inclusive Care (PACE)

Definition

This measure reports the average cost for providing a month of care for a PACE individual. PACE provides community-based services for frail and aging individuals who would qualify for nursing facility placement. A comprehensive care approach is used to provide an array of medical, functional, and day activity services for a capitated monthly fee that is below the cost of comparable institutional care.

Purpose

This measure is important because it provides the unit cost associated with providing long-term care and acute care services to PACE recipients. This data is a useful tool for projecting future funding needs.

Data Source

Two types of data are used to report this measure. The number of individuals authorized to receive PACE services are obtained from the commission's Service Authorization System by means of ad hoc query. Month-of-service to-date data that reports the number of individuals for whom claims have been approved-to-pay and the amounts approved-to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application that utilizes COGNOS software.

Methodology

The average monthly expenditure for the named group is calculated by summing the total monthly expenditures incurred in the reporting period and dividing that by the sum of the number of individuals served in each month in the reporting period.

Data Limitations

Because it takes several months to close out 100 percent of the claims for a month of service, completion factors may be applied to incomplete data for months that have not yet closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Explanatory 1.3.5.1. Number of Persons Receiving Services End of Fiscal Year: PACE

Definition

This measure reports the number of individuals who, based upon approved-to-pay claims, received one or more services under PACE during the last month of the fiscal year being reported.

Purpose

This measure provides a count of individuals served through the agency's PACE project. This data is a useful tool for projecting future funding needs.

Data Source

The source for expenditure and recipient data is approved-to pay data from the Claims Management System by means of ad hoc query.

Methodology

This is a simple unduplicated count of individuals who received PACE services during the last month of the fiscal year being reported.

Data Limitations

Because it takes several months to close out 100 percent of the claims for a month of service, the number of individuals ultimately served must be estimated for months that have not yet closed out, by using "completion factors" specific to each service applied to the number of individuals approved-to-pay to-date and/or the number of individuals authorized to receive services and the payment amounts approved-to-pay to-date. The concept of completion factors is that data, as of a given number of claims processing months after the month of service, can be considered a certain percent complete based upon historical patterns. Therefore, for a given month of service, the payment amounts approved-to-pay to-date divided by the appropriate completion factor equals the estimated expenditures ultimately incurred.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 1.3.5.1. Average Number of Recipients Per Month: PACE

Definition

This measure reports the monthly average number of individuals who are enrolled in a PACE managed care model. PACE is a national demonstration project that provides community-based services to frail and aging individuals who qualify for nursing facility placement. It uses a comprehensive care approach, furnishing an array of services for a monthly fee that is below the cost of comparable institutional care. All PACE individuals are dually eligible (Medicare and Medicaid) long-term-care utilizers.

Purpose

This measure provides a count of individuals served through the agency's PACE project. This data is a useful tool for projecting future funding needs.

Data Source

Two types of data are used to report this measure. The number of individuals authorized to receive PACE services are obtained from the commission's Service Authorization System by means of ad hoc query. Month-of-service to-date data that reports the number of individuals for whom claims have been approved-to-pay and the amounts approved-to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application that utilizes COGNOS software.

Methodology

Individual counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly individual counts for all months of the reporting period, by the number of months in the reporting period.

Data Limitations

Because it takes several months to close out 100 percent of the claims for a month of service, completion factors may be applied to incomplete data for months that have not yet closed out.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Objective 1.4. Other Medicaid Services

Provide policy direction and management of the state's Medicaid program and maximize federal dollars.

Strategy 1.4.1. Non-Full Benefit Payments

Provide payments for medically necessary healthcare to eligible recipients for certain services not covered under the insured arrangement, including undocumented persons, school health, women's health, and other related services.

Efficiency 1.4.1.1. Average Emergency Services for Non-Citizens Cost Per Recipient Month

Definition

The average monthly costs of providing Medicaid to non-citizens residing in the United States, who are in need of medical services due to an emergency condition. Type 30 eligible persons are aliens residing in the United States who do not meet citizenship requirements for TANF or other medical programs. These persons are non-immigrants, undocumented persons, and certain legal permanent residents. This measure involves Type 30 program recipient months and expenditures.

Purpose

Captures the average monthly cost of providing Medicaid to Type 30 non-citizens residing in the United States (U.S.), who are in need of medical services due to an emergency condition.

Data Source

The Premiums Payable System and the STMR 647A provided by the state Medicaid Contractor.

Methodology

The total Type 30 expenditures incurred are divided by the total number of Type 30 recipient months. Data is provided on an incurred basis. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Output 1.4.1.1. Average Monthly Number of Non-Citizens Receiving Emergency Services

Definition

This measure reflects the number of Type 30 aliens residing in the United States who have an emergency medical condition and meet all Medicaid eligibility criteria except citizenship. Type 30 eligible persons are aliens residing in the United States who do not meet citizenship requirements for TANF or other medical programs. These persons are undocumented aliens and certain legal permanent resident aliens. This measure includes all Type 30 program recipient months.

Purpose

This measure reflects the average monthly number of Type 30 aliens residing in the U.S. who have an emergency medical condition covered by Medicaid.

Data Source

The Premium Payable System.

Methodology

The Average Number of Undocumented Persons Recipient Months Per Month is the sum of the monthly Type 30 recipient months divided by the number of months summed. Data is provided on an incurred basis. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Strategy 1.4.2. For Clients Dually Eligible for Medicare and Medicaid

Provide accessible premium-based health services to certain Title XVIII Medicare-eligible recipients.

Efficiency 1.4.2.1. Average Supplemental Medical Insurance Benefits (SMIB) Part B Premium Per Month

Definition

The average monthly premium paid for SMIB Part B Premium for Medicare eligible Medicaid clients. The SMIB Part B premium is set by the Social Security Administration and is effective for each calendar year.

Purpose

HHSC pays the Social Security Administration a premium for coverage of physician and other related services.

Data Source

Social Security Act and report MF 232-01.

Methodology

The average is calculated by taking the total estimated dollar value of claims projected to be incurred for this type of client and dividing the total by the number of projected recipient months to be incurred. The SMIB Part B premium is set by the Social Security Administrations and is effective for each calendar year. Caseload data is accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional eleven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

This measure includes Qualified Medicare Beneficiary Qualifying Individuals (QMB Ql-1s). The MF 232-01 report, a source document for this measure, provides both SMIB and QMB Ql-1 recipient months. No distinction is made between the two types in this report. QMB Ql-1s are a subset of the SMIB population, and both have the same calendar year premiums.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Output 1.4.2.1. Average SMIB Part B Recipient Months Per Month

Definition

The average monthly number of recipient months of eligibility for which a premium payment is made for SMIB Part B coverage. Medicare Part B is medical insurance

that helps pay for physician services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A. This measure includes both full-benefit and qualified partial-benefit clients.

Purpose

HHSC pays the Social Security Administration a premium for Medicare Part B coverage for Qualified Medicare Beneficiary (QMB) Program, and Specified Low-Income Medicare Beneficiaries, which covers physician and other related services.

Data Source

Monthly MF 232-01 report, which provides the number of premiums for each month on an incurred basis.

Methodology

The average is the sum of the monthly recipient months in the reporting period divided by the number of months summed. Data is accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional eleven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

This measure includes QMB QI-1s. The MF 232-01 report, a source document for this measure, provides both SMIB and QMB QI-1 recipient months. No distinction is made between the two types in this report. QMB QI-1s are a subset of the SMIB population, and both have the same calendar year premiums.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 1.4.3. Transformation Payments

Maximize federal funding to provide supplemental Medicaid reimbursement for uncompensated care and delivery system reform incentives under the 1115 waiver. Historically provided children's hospital upper payment limit match.

Goal 2. Medicaid and Children's Health Insurance Program Contracts and Administration

Administer efficient and effective Medicaid and CHIP programs, set overall policy direction of the state Medicaid program and CHIP program, and manage interagency initiatives to maximize federal dollars.

Objective 2.1. Medicaid and Children's Health Insurance Program Contracts and Administration

Improve the quality of Medicaid services by serving as the single state Medicaid agency.

Strategy 2.1.1. Medicaid Contracts and Administration

Administer efficient and effective Medicaid program, set the overall policy direction of the state Medicaid program, and manage interagency initiatives to maximize federal dollars.

Strategy 2.1.2. Children's Health Insurance Program Contracts and Administration

Administer efficient and effective CHIP program, including contracted administration, and set overall policy direction of CHIP programs.

Goal 3. Children's Health Insurance Program Services

Ensure health insurance coverage for eligible children in Texas.

Objective 3.1. Children's Health Insurance Program Services

Ensure health insurance coverage for eligible children in Texas.

Outcome 3.1.1. Average CHIP Programs Recipient Months Per Month

Definition

The measure provides the average CHIP recipient months per month, including all CHIP-enrolled children (including CHIP Phase II children, and Perinatal clients).

Purpose

To provide an overall average monthly CHIP caseload across all CHIP categories (CHIP II, and Perinatal clients) regardless of the method of finance or eligibility.

Data Source

The Premiums Payable System.

Methodology

Divide the cumulative number of CHIP recipient months (CHIP II and Perinatal clients) for the reporting period by the number of months in the reporting period. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Outcome 3.1.2. Average CHIP Programs Benefit Cost with Prescription Benefit

Definition

The measure provides the average monthly benefit cost paid to CHIP enrolled medical (including immunizations and prescription drugs) and dental providers on behalf of all CHIP-enrolled children (which includes CHIP Phase II and CHIP Perinatal). Benefit costs are understood to include amounts paid to health plans, the dental contractor, and Department of State Health Services (DSHS) to cover vaccines.

Purpose

This will provide an overall monthly CHIP benefit cost per CHIP-enrolled child regardless of the eligibility category for CHIP.

Data Source

CHIP Premiums Payable System data (caseloads and historical costs) and CHIP managed care medical and prescription benefit premium rates. For vaccine costs, HHSC receives a quarterly invoice from DSHS (or successor agency), which shows the amount used for vaccinating CHIP-enrolled children.

Methodology

The amounts incurred by HHSC in relation to the health and dental carriers and to DSHS (or successor agency) for benefit expenditures related to all CHIP-enrolled children (CHIP II and CHIP Perinatal) are totaled for the reporting period. This total is divided by the total number of CHIP-enrolled children (CHIP II and CHIP Perinatal) during the reporting period. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Strategy 3.1.1. Children's Health Insurance Program

Provide healthcare to uninsured children who apply and are determined eligible for insurance through CHIP.

Efficiency 3.1.1.1. Average CHIP Children Benefit Cost Per Recipient Month

Definition

This measure is the average monthly cost per recipient month of health premiums plus newborn screening and vaccine costs (excluding prescription drugs) for the CHIP for a reporting period.

Purpose

The measure provides the average monthly benefit cost paid to CHIP enrolled medical (including immunizations and excluding prescription drugs) providers on behalf of CHIP federally funded clients.

Data Source

The Administrative Services Contractor furnishes a monthly report to HHSC containing the costs each health plan have incurred during the month. For vaccine and newborn screening costs, HHSC receives a quarterly invoice from DSHS.

Methodology

The amounts owed to the health carriers are totaled for the reporting period. This total is divided by the number of recipient months in the CHIP II program during the reporting period. This measure does not include prescription drugs and CHIP Perinatal costs or recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Output 3.1.1.1. Average CHIP Children Recipient Months Per Month

Definition

This measure is the average monthly recipient months in the CHIP Phase II program.

Purpose

Measures the average number of Traditional CHIP recipient months.

Data Source

The Premiums Payable System.

Methodology

The measure is calculated by totaling the recipient months for CHIP II eligibles from the enrollment report and dividing that number by the number of months in the period covered by the report. This measure does not include CHIP Perinatal recipient months. Recipient months are accounted for on an incurred basis and are estimated using completion factors. Forecasting models and trends are used to project future counts.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 3.1.2. Children's Health Insurance Program Perinatal Services

Provide healthcare to perinates whose mothers apply and are determined eligible for insurance through CHIP.

Efficiency 3.1.2.1. Average Perinatal Benefit Cost Per Recipient Month

Definition

This measure is the average monthly cost of health premiums (excluding dental and prescription drugs) for the CHIP Perinatal program for a reporting period.

Purpose

Captures the average cost of CHIP Perinatal recipients per month, excluding dental and drug costs.

Data Source

HHSC programs furnish a monthly report showing the costs each health plan has incurred during the month. For vaccine and newborn screening costs, HHSC receives a quarterly invoice from DSHS.

Methodology

The amounts owed to the health carriers are totaled for the reporting period. Prescription drugs are excluded. Divide the total cost by the total number of CHIP Perinatal recipient months (both pre-and post-natal) in the same reporting period. Recipient months are accounted for under an incurred basis and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Because data are reported on an incurred basis, recipient month figures are completed using completion ratios. Forecasting models and trends are used to project future counts.

Data Limitations

Data is on an incurred basis. If data is incomplete, estimates will be made based on completion ratios and other forecasting techniques.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Output 3.1.2.1. Average Perinatal Recipient Months Per Month

Definition

This measure is the average monthly number of children enrolled in coverage under the CHIP Perinatal program for a reporting period.

Purpose

Captures the average number of CHIP Perinatal recipients month.

Data Source

The Premiums Payable System.

Methodology

The measure is calculated by totaling the number of CHIP Perinatal recipient months (both pre- and post-natal) from the enrollment report and dividing that number by the number of months in the period covered by the report. Recipient months are accounted for under an incurred basis and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Because data are reported on an incurred basis, recipient month figures are completed using completion ratios. Forecasting models and trends are used to project future counts.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 3.1.3. Children's Health Insurance Program Prescription Drugs

Provide prescription medication to CHIP-eligible recipients (includes all CHIP Programs) as provided by their treating physician.

Efficiency 3.1.3.1. Average Cost/CHIP Recipient Month: Pharmacy Benefit

Definition

This measure is the total CHIP prescription costs (which includes CHIP, and Perinatal clients) incurred during the reporting period divided by the total number of recipient months incurred during the reporting period.

Purpose

The measure captures the total CHIP prescription cost incurred divided by the total number of CHIP recipient months.

Data Source

CHIP PREM. Enrollment data is taken from the enrollment reports provided by the Administrative Services Contractor. All prescription drug costs in CHIP became capitated in March 2012, so drug costs are calculated based on premium rates set by HHSC.

Methodology

Divide the total CHIP prescription costs incurred during the reporting period by the total number of CHIP recipient months for traditional CHIP and CHIP Perinatal programs incurred during the reporting period. Recipient months are accounted for under an incurred basis and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Because data are reported on an incurred basis, recipient month figures are completed using completion ratios. Forecasting models and trends are used to project future counts.

Data Limitations

The CHIP prescription dollars do not include any rebates.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Strategy 3.1.4. Children's Health Insurance Program Dental Services

Provide dental healthcare services to uninsured children who apply and are determined eligible for insurance through CHIP.

Efficiency 3.1.4.1. Average Monthly Cost of the Dental Benefit Per Chip Program Recipient

Definition

This measure is the average monthly cost per recipient month of dental premiums for the CHIP program for a reporting period

Purpose

The measure provides the average monthly benefit cost paid to enrolled dental plan providers on behalf of traditional CHIP program clients.

Data Source

The Administrative Services Contractor furnishes a monthly report to HHSC containing the premiums incurred for dental during the month.

Methodology

The amounts incurred for dental services are totaled for the reporting period and divided by the number of recipient months in the CHIP program during the reporting period. This measure includes CHIP Perinatal costs or recipient months for infants in the CHIP Perinatal program.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Goal 4. Provide Additional Health-Related Services

Improve the physical and mental health of children, women, families, and individuals and enhance the capacity of communities to deliver healthcare services.

Objective 4.1. Provide Primary Health and Specialty Care

Develop and support primary healthcare and specialty services to children, women, families, and other qualified individuals through community-based providers.

Outcome 4.1.1. Percent of Early Childhood Intervention (ECI) Clients Enrolled in Medicaid

Definition

Of the average monthly number of children receiving Early Childhood Intervention (ECI) comprehensive services, the percent enrolled in Medicaid.

Purpose

This measure identifies the percent of children who have access to Medicaid. However, it is important to note that the percentage of children with Medicaid will not be the same as the percentage of funding from Medicaid, as not all types of ECI services can be billed to Medicaid.

Data Source

Local contract providers enter data into Texas Kids Intervention Data System (TKIDS). Determine the total number of unduplicated children receiving comprehensive services in each month, as indicated by cases in the enrolled disposition in the reporting period, and of those, the number with Medicaid.

Methodology

The monthly number of children for each month of the reporting period is summed, and then divided by the number of months in the reporting period to calculate the average monthly number of children for that reporting period. Divide the average monthly number of ECI children with Medicaid by the average monthly number of children who receive comprehensive intervention services through ECI service providers to calculate Percent of Clients Enrolled in Medicaid.

Data Limitations

The accuracy of local program reporting is periodically verified through monitoring. Accurate reporting requires local programs to meet timelines for data entry into TKIDS.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 4.1.1. Women's Health Programs

Women's Health Programs.

Efficiency 4.1.1.1. Average Monthly Cost Per Healthy Texas Women (HTW) Client Receiving Services

Definition

This measure reports the average monthly fee-for-service expenditure per Healthy Texas Women (HTW) client receiving services.

Purpose

This measure reflects the amount paid for each client receiving services for the named group.

Data Source

This measure consists of expenditure data from the monthly STMR 650A (non-managed care) statistical reports compiled by the Medicaid contractor and recipient month data from the Premiums Payable System.

Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from the stat report (claims) by the number of clients receiving services. The measure only includes fee-for-service costs; contract costs are not included. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and clients served.

Data Limitations

None

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Efficiency 4.1.1.2. Average Monthly Cost Per Family Planning Client Receiving Services

Definition

This measure reports the average monthly cost of providing fee-for-service family planning services to clients who receive services.

Purpose

This measure reports the average monthly cost of providing fee-for-service family planning services to clients who receive services.

Data Source

Client data are from the Medicaid claims administrator's Vision 21 Data Warehouse Ad Hoc Query Platform Claims Universe. Expenditures data are from the Health and Human Services Contract Administration and Tracking System.

Methodology

For each reporting time period, the total funds expended for family planning contracts is summed and divided by the sum of the monthly unduplicated number of clients receiving family planning services from enrolled entities. The measure only included fee-for-service costs; contract costs are not included.

Data Limitations

Complete data may not be available for the reporting period at the time the report is due.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Explanatory 4.1.1.1. Number of Certified Clinical Providers Enrolled in HTW Program

Definition

This measure reports the number of certified clinical providers enrolled and eligible to provide HTW services to HTW clients.

Purpose

This measure can be used to determine the number of certified clinical providers who can treat HTW clients and to determine multi-year trends in provider enrollment.

Data Source

Data are from the certified clinical provider universe held in the claims administrator's database or any newly developed reporting and analytic systems (e.g., Enterprise Data Warehouse).

Methodology

The provider count includes only those certified clinical providers who are certified and would perform the annual family planning exam and prescribe family planning drugs and devices. This includes physicians, physician extenders (e.g., physician assistants and advance practice nurses), Federally Qualified Health Centers (FQHCs), ambulatory surgical centers (ASCs), family planning agencies, and health clinics.

Data Limitations

Data only reports on providers who have certified and who can provide an annual women's health examination and prescribe family planning drugs and/or devices.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Explanatory 4.1.1.2. Number of Clinical Providers Enrolled in Family Planning

Definition

This measure reports the number of certified providers enrolled and eligible to provide family planning services to family planning clients.

Purpose

This measure can be used to determine the number of certified clinical providers who can treat family planning clients and to determine multi-year trends in provider enrollment.

Data Source

Data are from the certified provider universe held in the claims administrator's database or any newly developed reporting and analytic systems (e.g. Enterprise Data Warehouse).

Methodology

The provider count includes only those certified clinical providers who are certified and would perform the annual family planning exam and prescribe family planning drugs and devices. This includes physicians, physician extenders (e.g., physician assistants and advance practice nurses), FQHCs, ASCs, family planning agencies, and health clinics.

Data Limitations

Data only reports on providers who have been certified and who can provide an annual women's health examination and prescribe family planning drugs and/or devices.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Output 4.1.1.1. Average Monthly Number Women Enrolled in Services through HTW Program

Definition

This measure reports the average monthly number of HTW recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for HTW.

Purpose

This measure reflects the average monthly number of recipient months for clients enrolled in the HTW program.

Data Source

The Premium Payable System.

Methodology

Average recipient months per month is calculated by summing the named group's recipient months by month and dividing by the number of months summed. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future recipient months.

Data Limitations

None

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.1.1.2. Average Monthly Number of Family Planning Clients Receiving Services

Definition

This measure reports the average monthly number of persons receiving family planning services from contracting and/or enrolled entities funded through the HHSC Family Planning Program.

Purpose

This measure reports the average monthly number of persons receiving family planning services from contracting and/or enrolled entities funded through the HHSC Family Planning Program.

Data Source

Client data is from the Texas Medicaid Health Partnership Vision 21 Data Warehouse Ad Hoc Query Platform Claims Universe.

Methodology

The average monthly number of adults receiving family planning services is calculated by summing the monthly unduplicated client served counts and dividing by the number of summed months. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future recipient months.

Data Limitations

Complete data may not be available for the reporting period at the time the report is due.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.1.1.3. Average Monthly Number of Women Receiving HTW Services

Definition

This measure reports the average monthly number of HTW receiving a service covered under the HTW program.

Purpose

This measure reflects the average monthly number of women receiving services in HTW, this is a measure of utilization.

Data Source

Ad Hoc Query Platform Claims Universe, Medicaid claims administrator.

Methodology

Average monthly number of women receiving a service in HTW is calculated by summing the number of monthly utilizers and dividing by the number of months summed. Number of women served are accounted for based on claims data and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future recipient months.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 4.1.2. Alternatives to Abortion.

Provide pregnancy support services that promote childbirth for women seeking alternatives to abortion.

Output 4.1.2.1. Number of Persons Receiving Services as Alternative to Abortion

Definition

This measure reports the number of clients who receive services as an alternative to abortion. The Alternatives to Abortion program provides assistance which

includes providing women with pregnancy and parenting information, connecting them with mentoring and social service programs, and providing them with time-limited material goods (e.g., car seats, clothing, etc.).

Purpose

This measure reports the number of clients who receive services as an alternative to abortion. The Alternatives to Abortion program provides assistance which includes providing women with pregnancy and parenting information, connecting them with mentoring and social service programs, and providing them with time-limited material goods (e.g., car seats, clothing, etc.).

Data Source

The data source is the Alternatives to Abortion contractor's data collection system.

Methodology

The Alternatives to Abortion contractor completes and submits a standardized template with required data elements on a monthly, quarterly and annual basis. The information is derived from the contractor's data collection system. This data is re-calculated each quarter to ensure an unduplicated count of clients is reflected in the year-to-date total.

Data Limitations

HHSC must rely on the Alternatives to Abortion contractor to maintain information in their data collection system. The contractor depends on its subcontractors to timely and accurately enter data into the data collection system. Also, there is a gap between the due date for quarterly Legislative Budget Board (LBB) reporting and the date the contractor is required to submit final program reports to the contract manager. To assist HHSC in timely reporting LBB measures, the contractor provides HHSC with unfiltered information that may include duplicate client counts.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.1.2.2. Number of Alternatives to Abortion Services Provided

Definition

The number provided is an unduplicated count of services provided to clients of the Alternatives to Abortion program. The Alternatives to Abortion program provides assistance which includes providing women with pregnancy and parenting information, connecting them with mentoring and social service programs, and providing them with time-limited material goods (e.g., car seats, clothing, etc.).

Purpose

This measure indicates the number of unduplicated services provided to clients of the Alternatives to Abortion program.

Data Source

The date source is the Alternatives to Abortion contractor's data collection system.

Methodology

The Alternatives to Abortion contractor completes and submits a standardized template with required data elements on a monthly, quarterly and annual basis. The information is derived from the data collection system maintained by the contractor.

Data Limitations

HHSC must rely on the Alternatives to Abortion contractor to maintain information in their data collection system. The contractor depends on its subcontractors to timely and accurately enter data into the data collection system.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 4.1.3. Early Childhood Intervention Services

Administer a statewide comprehensive system of services to ensure that eligible infants, toddlers, and their families have access to the resources and support they need to reach their service plan goals.

Efficiency 4.1.3.1. Average Monthly Cost Per Child: Comprehensive Services/State and Federal

Definition

A monthly average of only HHSC appropriated state and federal funds expended for services divided by the monthly average of children receiving comprehensive services in the reporting period. State and federal funds are revenues ECI receives from the Texas Legislature, the U.S. Department of Education, Title XIX, and other State and Federal sources specifically for early childhood intervention services. The funds ECI contractors receive that are not directly appropriated for HHSC ECI are not included.

Purpose

This measure provides information regarding the HHSC ECI expenditures for providing comprehensive services to eligible children. This data can be used for projecting future expenditures and evaluating performance.

Data Source

CAPPS, which is reconciled to Uniform Statewide Accounting System. Quarterly and annual financial reports, financial report items: State and Federal funds, expended by quarter for ECI services. TKIDS: number served in comprehensive services.

Methodology

HHSC appropriation authority includes all funds allocated to the HHSC ECI services strategy. The numerator is the estimated total HHSC appropriation authority funds utilized to fund ECI services in the reporting period divided by the months in the reporting period. The denominator is the average monthly number of comprehensive children served in ECI services in the reporting period. The formula is numerator/denominator.

Data Limitations

The accuracy of state and federal funds expended for ECI services is verified periodically through monitoring and reviews of annual audits. State and federal funds expenditure data may not be complete as provider monthly requests for reimbursement are not submitted until 30 days after the end of the month.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Explanatory 4.1.3.1. Average Monthly Number of Hours of Service Delivered Per Child Per Month

Definition

The number of hours of service delivered per child per month for children in ECI comprehensive services.

Purpose

This measure is important because it reflects services provided to children and families to help support and promote the child's development and functioning. This data may be used to project future service, staffing, and fiscal needs.

Data Source

Local providers enter data into the TKIDS. Delivered services are those provided to the child/family according to each child's Individualized Family Service Plan. The number of children receiving comprehensive services is determined by the cases in the enrolled disposition at any time in the reporting period.

Methodology

The numerator is the total number of hours of delivered service in the reporting period divided by the number of months in the reporting period. The denominator is the average monthly number of children receiving comprehensive services for the reporting period, calculated by dividing the total unduplicated number of children

receiving comprehensive services for each month of the reporting period by the number of months in the reporting period. The formula is numerator/denominator.

Data Limitations

The accuracy of the data is dependent on accurate and timely information being entered into the TKIDS by local contractors. The accuracy of local reporting is periodically verified through monitoring. Services do not include eligibility services or other activities that occur prior to the child's enrollment in ECI, case management, or transition activities.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.1.3.1. Average Monthly Number of Children Served in Comprehensive Services

Definition

A monthly average of children who receive comprehensive intervention services (unduplicated by month) in ECI programs.

Purpose

This measure is important because it is an indication of the number of children eligible for and receiving comprehensive services. This measure is a reflection of the level of performance of the agency and local providers.

Data Source

Local contract providers enter data into TKIDS. Determine the total number of unduplicated children receiving comprehensive services monthly, as indicated by cases in the enrolled disposition in the reporting period.

Methodology

The unduplicated number of children receiving comprehensive services is summed for each month of the reporting period, and the total is divided by the number of months in the reporting period.

Data Limitations

The accuracy of the data is dependent on accurate and timely information being entered into the TKIDS by local contractors. The accuracy of local reporting is periodically verified through monitoring.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.1.3.2. Average Monthly Number of Referrals to Local Programs

Definition

The average monthly number of children referred to local ECI service providers.

Purpose

This measure is important because it aids the agency in evaluating the impact of state and local public awareness and child find activities, and because higher referrals reflect more effective outreach activities.

Data Source

Local contract providers enter data into the TKIDS. Determine the total number of unduplicated monthly referrals, as identified by cases that entered the referral disposition in the reporting period.

Methodology

The unduplicated number of referrals is summed for each month of the reporting period, and the total is divided by the number of months in the reporting period.

Data Limitations

The accuracy of the data is dependent on accurate and timely information being entered into the TKIDS by local contractors. The accuracy of local reporting is periodically verified through monitoring.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Output 4.1.3.3. Average Monthly Number of Eligibility Determinations Completed

Definition

A monthly average of children who receive comprehensive intervention services (unduplicated by month) in ECI programs.

Purpose

This measure is important because it is an indication of the number of children eligible for and receiving comprehensive services. This measure is a reflection of the level of performance of the agency and local providers.

Data Source

Local contract providers enter data into TKIDS. Determine the total number of unduplicated children receiving comprehensive services monthly, as indicated by cases in the enrolled disposition in the reporting period.

Methodology

The unduplicated number of children receiving comprehensive services is summed for each month of the reporting period, and the total is divided by the number of months in the reporting period.

Data Limitations

The accuracy of the data is dependent on accurate and timely information being entered into the TKIDS by local contractors. The accuracy of local reporting is periodically verified through monitoring.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Output 4.1.3.4. Average Monthly Number of Children Determined Eligible for ECI Services

Definition

This measure provides the average monthly number of children determined eligible for ECI services.

Purpose

This measure informs the agency with one metric of the level of effort directed towards identifying children eligible for ECI services.

Data Source

Local contract providers enter data into the TKIDS. This data includes the number of children who have received an eligibility determination disposition, and the number of those children who have been determined eligible for services.

Methodology

The average monthly number of children is calculated by taking the average of the monthly counts in the reporting period. The sum of unduplicated monthly counts of children determined eligible for ECI services in the reporting period is divided by the number of months in the reporting period.

Data Limitations

The accuracy of the data is dependent on accurate and timely information being entered into the TKIDS by local contractors. The accuracy of local reporting is periodically verified through monitoring.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.1.3.5. Average Monthly Number of Children Newly Enrolled in ECI

Definition

The average monthly number of new children enrolled in ECI services.

Purpose

This measure is important because it is an indication of the number of children newly enrolling for comprehensive services. This measure is a reflection of the level of performance of the agency and local providers.

Data Source

Local contract providers enter data into the TKIDS.

Methodology

The average monthly number of children is calculated by taking the average of the individual monthly counts in the reporting period. The sum of the unduplicated monthly counts of children newly enrolled in ECI services in the reporting period is then divided by the number of months in the reporting period.

Data Limitations

The accuracy of the data is dependent on accurate and timely information being entered into the TKIDS by local contractors. The accuracy of local reporting is periodically verified through monitoring.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 4.1.4. Ensure Early Childhood Intervention Respite Services and Quality Early Childhood Intervention Services

Serves families with children in the ECI program. Provides respite services to help preserve the family unit and prevent out-of-home placements. Provides technical assistance to parents and service providers serving in the ECI program.

Strategy 4.1.5. Children’s Blindness Services

Provide information and training for blind and visually impaired children and their families so these children have the skills and confidence to live as independently as possible.

Efficiency 4.1.5.1. Average Monthly Cost Per Child: Children's Blindness Services

Definition

Measures the average monthly cost per consumer served in the Blind Children's Vocational Discovery and Development Program.

Purpose

This measure tracks the average monthly cost per consumer served through the Blindness Services for Children strategy. It provides one indication of the efficiency of the program.

Data Source

The data sources are the program related expenditures and encumbrances during the reporting period from the HHSC Accounting System (CAPPS and the automated consumer statistical system); and the number of consumers served (Performance

Measure 04-01-05-OP-01: "Average Monthly Number of Children Receiving Blindness Services").

Methodology

The formula is numerator/denominator. The numerator is the total HHSC expenditures and encumbrances utilized during the reporting period to fund the habilitative services for children strategy. The denominator is the average monthly number of consumers receiving habilitative services (Performance Measure 04-01-05-OP-01: "Average Monthly Number of Children Receiving Blindness Services").

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.1.5.1. Average Monthly Number of Children Receiving Blindness Services

Definition

Measures the average number of consumer cases in the automated consumer statistical system for the Blind Children's Vocational Discovery and Development Program. Cases must have been in one or more of the following phases at any time during the reporting period: initial contact, application, eligibility, plan development, service delivery, or post closure services.

Purpose

This measure reports the average monthly number of clients who receive services from the Blind Children's Vocational Discovery and Development Program.

Data Source

Data are from the Blind Children's Vocational Discovery and Development Program automated consumer statistical system. Field staff who work with consumers collect, input, and update consumer data in this system.

Methodology

The Blind Children's Vocational Discovery and Development Program automated consumer statistical system assigns a unique identification number for each case. The numerator is the sum of the total unduplicated number of cases in one or more of the following phases in the Division for Blind Services (DBS) automated consumer statistical system at any time during each month of the reporting period: initial contact, application, eligibility, plan development, plan completed, service delivery or post closure services. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

Data Limitations

None

Calculation Method

Noncumulative

New Measure

Yes

Target Attainment

Currently undefined.

Strategy 4.1.6. Autism Program

To provide services to Texas children ages 3–15 diagnosed with autism spectrum disorder.

Efficiency 4.1.6.1. Average Monthly Cost Per Child Receiving Focused Autism Services

Definition

The average monthly cost per child of providing focused autism services to enrolled children with HHSC autism program funds.

Purpose

This measure allows HHSC to monitor grant funds expended and to ensure costs are in line with monthly projections.

Data Source

Data sources for this measure are 1) CAPPS Financial data and invoices, and 2) Consumer Data Report.

Methodology

For each reporting time period, the total funds expended from the Autism Program strategy is summed and divided by the sum of the monthly unduplicated number of children receiving focused autism services from contracting and/or enrolled entities.

Data Limitations

Data reliability is dependent on the accuracy of information submitted to HHSC by the autism grantees.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.1.6.1. Average Monthly Number of Children Receiving Focused Autism Services

Definition

A monthly average of unduplicated children who are receiving or who have received focused autism services in the HHSC Autism Program.

Purpose

Autism grantees establish a target for the number of children with autism to be served with focused autism services within available resources. This measure tracks progress toward meeting that target.

Data Source

Data source for this measure is the Consumer Data Report.

Methodology

Cases in open status at any time during the reporting period are included in the calculated average. The numerator is the total unduplicated number of cases receiving focused services each month in the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/ denominator.

Data Limitations

Data reliability is dependent on the accuracy of information submitted to HHSC by autism grantees.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 4.1.7. Children with Special Health Care Needs

Administer service program for children with special healthcare needs (CSHCN).

Efficiency 4.1.7.1. Average Monthly Cost Per Children with Special Health Care Needs (CSHCN) Clients Receiving Services

Definition

This measure reports the average paid for eligible Children with Special Health Care Needs (CSHCN) Services Program clients receiving services. For purposes of this measure, services include medical services, enabling services (excluding transportation), and family support services.

Purpose

This measure is used to monitor trends in the cost of care for the clients receiving services reimbursed by the CSHCN Services Program and reflects the program's ability to meet some of the needs of clients.

Data Source

The average monthly cost per client receiving services is obtained from the program’s automated data system.

Methodology

The average monthly cost per CSHCN Services Program client is calculated by dividing the amount paid for receiving services by the number of CSHCN Services Program clients who received services and averaging across the reporting period. Estimates may be included based on the data available.

Data Limitations

The number of clients with paid claims is reported based on the date of service. Providers have 95 days to file claims from the date of service and 180 days to submit appeals. Therefore, payment data for a given period may change through time. Due to the definition, the number of clients used for this measure may be duplicated in subsequent quarters. Complete data may not be available for the reporting period at the time the report is due; therefore, estimates may be included based on the data available.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.1.7.1. Average Monthly Number of CSHCN Clients Receiving Services

Definition

This measure reports the average monthly number of clients in the CSHCN Services Program who receive services paid by the program. For purposes of this measure,

services include medical services, enabling services, (excluding transportation), and family support services.

Purpose

This measure is used to monitor trends in the cost of care for clients receiving services reimbursed by the CSHCN Services Program and reflects the program's ability to meet some of the needs of clients.

Data Source

The average monthly number of clients receiving services is obtained from the program’s automated data system.

Methodology

This measure is calculated by summing the number of clients with paid claims for services in a month and averaging such across the reporting period. Estimates may be used for quarters in which claims data is incomplete.

Data Limitations

The number of clients with paid claims is reported based on the date of service. Providers have 95 days to file claims from the date of service and 180 days to submit appeals. Therefore, payment data for a given period may change through time. This measure may be affected by factors such as the number of individuals enrolled in the program, the clients' needs, and the availability of other healthcare resources. Due to the definition, the number of clients used for this measure may be duplicated in subsequent quarters. Complete data may not be available for the reporting period at the time the report is due; therefore, estimates may be included based on the data available.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 4.1.8. Title V Dental and Health Services

Title V dental and health services.

Output 4.1.8.1. Number of Infants <1 and Children Age 1–21 Years Provided Services

Definition

This measure reports the unduplicated number of infants <1 and children (ages 1 through 21) receiving dental and child health services, such as well child checkups, immunizations, newborn hearing and metabolic screenings, vision and hearing screening, and comprehensive and periodic oral health care through contracting agencies funded with Title V and/or related general revenue.

Purpose

This measure reports the unduplicated number of infants <1 and children (ages 1 through 21) receiving dental and child health services, such as well child checkups, immunizations, newborn hearing and metabolic screenings, vision and hearing screening, and comprehensive and periodic oral health care through contracting agencies funded with Title V and/or related general revenue.

Data Source

System reports for the contracting agencies. Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

Methodology

Reported data is calculated by adding the number of clients from reports for the contracting agencies.

Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on the data available. Estimates are updated in the subsequent reporting periods.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Output 4.1.8.2. Number of Women over Age 21 Provided Title V Services

Definition

This measure reports the unduplicated number of women over 21 receiving prenatal, dysplasia, and genetics, and laboratory services through contracting agencies funded with Title V and/or related general revenue.

Purpose

This measure reports the unduplicated number of women aged 21 and over receiving prenatal, dysplasia, and genetics, and laboratory services through contracting agencies funded with Title V and/or related general revenue.

Data Source

System reports for the contracting agencies. Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

Methodology

Reported data is calculated by adding the number of clients from reports for the contracting agencies.

Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on the data available. Estimates are updated in the subsequent reporting periods.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 4.1.9. Kidney Health Care

Administer service programs for kidney healthcare (KHC).

Efficiency 4.1.9.1. Average Annual Cost Per Kidney Health Care Client

Definition

This measure includes Kidney Health Care allowable chronic disease services, including medical, drug and transportation services and payment of Medicare Part D premiums. This measure is the average amount paid per Kidney Health Care client per fiscal year.

Purpose

To measure the average amount paid per Kidney Health Care client per fiscal year.

Data Source

Data are derived from the Kidney Health Care claims processing and budget reporting systems.

Methodology

The average cost per chronic disease service will be determined per client served per fiscal year by dividing the total client services expenditures by the total number of unduplicated clients.

Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on the data available.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.1.9.1. Number of Kidney Health Clients Provided Services

Definition

The measure is the total number of unduplicated clients for whom Kidney Health Care made payment(s) or reimbursements for chronic disease services received during the fiscal year. This includes medical, drugs and transportation services and payment of Medicare Part D premiums.

Purpose

The measure is the total number of unduplicated clients for whom Kidney Health Care made payment(s) or reimbursements for services received during the fiscal year.

Data Source

Data are derived from Kidney Health Care claims processing and budget reporting systems.

Methodology

The measure is the total number of unduplicated clients for whom Kidney Health Care made payment(s) or reimbursements for chronic disease services received during the fiscal year. Data are non-cumulative.

Data Limitations

Complete data may not be available at the time the report is due; therefore, projections may be included based on the data available.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 4.1.10. Additional Specialty Care

Deliver specialty care services including service programs for epilepsy and hemophilia, as well as provide leadership and direction to the statewide umbilical cord blood bank and health information technology initiatives.

Explanatory 4.1.10.1. Number of Epilepsy Program Clients Provided Services

Definition

Number of epilepsy program clients provided outreach activities, case management, and (direct) medical services by HHSC funded contractors.

Purpose

Measures the number of epilepsy program clients provided services which include outreach activities, case management, and (direct) medical services.

Data Source

Information is obtained from the Epilepsy Contractor Quarterly Reports.

Methodology

The number of persons receiving epilepsy services through funded programs is derived from a quarterly tabulation based on information obtained from the Epilepsy Contractor Quarterly Reports.

Data Limitations

None

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Explanatory 4.1.10.2. Number of Hemophilia Assistance Program (HAP) Clients

Definition

Number of Hemophilia Assistance Program (HAP) clients that receive financial assistance for blood factor products through HHSC approved providers.

Purpose

Measures the number of HAP clients that receive financial assistance for blood factor products through HHSC approved providers.

Data Source

HAP history files.

Methodology

The measure is the total number of unduplicated clients for whom the HAP made payment for services received during the fiscal year.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 4.1.11. Community Primary Care Services

Develop systems of primary and preventive healthcare delivery in underserved areas of Texas.

Efficiency 4.1.11.1. Average Cost Per Primary Health Care Client

Definition

This measure reports the average cost per Primary Health Care client provided access to primary care services. The cost includes service and administrative dollars spent by contractors.

Purpose

Measures average cost per Primary Health Care clients provided access to primary care services per year.

Data Source

The sources for this measure are the contractor monthly and annual reports.

Methodology

Average cost per Primary Health Care client provided access to primary care services per year is calculated by dividing the unduplicated number of clients who receive services into the available contract funding for the fiscal year.

Data Limitations

Complete data may not be available for the reporting period at the time the report is due.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.1.11.1. Number Primary Health Care Clients Receiving Services

Definition

This measure is the unduplicated number of Primary Health Care clients provided primary care services.

Purpose

Measures the number of Primary Health Care Program clients provided primary health care services.

Data Source

The sources for this measure are the contractor monthly and annual reports.

Methodology

This is the unduplicated number of Primary Health Care clients receiving services as reported by contractors.

Data Limitations

Complete data may not be available for the reporting period at the time the report is due.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 4.1.12. Abstinence Education

Increase abstinence education programs in Texas.

Output 4.1.12.1. Number of Persons Served in Abstinence Education Programs

Definition

Number of Persons receiving services delivered by the Abstinence Education Program.

Purpose

Measures the number of persons receiving services.

Data Source

Summary report derived from bi-annual activity reports. Numbers served will be totaled from the data reports from the Abstinence Education program.

Methodology

The total number of persons served will be the unduplicated count of individuals receiving services from contractors, parents in state-wide services, teachers and community members in coalitions and trainings, and students in youth clubs or leadership camps during the reporting period.

Data Limitations

Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Objective 4.2. Provide Community Behavioral Health Services

Support services for mental health and for substance abuse prevention, intervention, and treatment.

Outcome 4.2.1. Percent Adults Receiving Community Mental Health Services Whose Functional Level Improved

Definition

This measure captures the percent of adults receiving community mental health services who show improvement in level of functioning.

Purpose

Improved functioning in the community is an important indication that treatment is effective in reducing the functional deterioration associated with mental illness.

Data Source

Clinical staff are expected to administer assessments at admission to community services, every 180 days and at planned discharges. The results of these assessments are entered into HHSC's data warehouse system by staff at the Local Mental Health Authorities/Local Behavioral Health Authorities.

Methodology

The Reliable Change Index will be used to measure change in Adult Needs and Strengths Assessment scores. Comparing initial and subsequent Adult Needs and Strengths Assessment scores will yield a Reliable Change Index score that will allow for the determination of statistically significant improvement on specific domain items. The numerator is the total number of adults authorized into a full level of care who show reliable improvement on at least one Adult Needs and Strengths Assessment domain as compared to the Reliable Change Index identified for that domain whose last two assessments are at least 180 days apart. The denominator is the total number of adults authorized into a full level of care whose last two assessments are at least 180 days apart. The formula is numerator/denominator * 100.

Data Limitations

The accuracy of the HHSC data is dependent upon accurate and timely information being entered into the data warehouse system by the Local Mental Health Authorities/Local Behavioral Health Authorities.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Outcome 4.2.2. Percent Children Receiving Community Mental Health Services Whose Functional Level Improved

Definition

This measure captures the percent of children receiving community mental health services who show improvement in level of functioning.

Purpose

Stabilized or improved functioning in the community is an important indication that treatment is effective in reducing the functional deterioration associated with mental illness.

Data Source

Clinical staff are expected to administer assessments at admission to community services, every 90 days and at planned discharges. The results of these assessments are entered into HHSC's data warehouse system by staff at the Local Mental Health Authorities/Local Behavioral Health Authorities.

Methodology

The Reliable Change Index will be used to measure change in Child and Adolescent Needs and Strengths assessment scores. Comparing initial and subsequent Child and Adolescent Needs and Strengths assessment scores will yield a Reliable Change Index score that will allow for the determination of statistically significant improvement on specific domain items. The numerator is the total number of children authorized into a full level of care who show reliable improvement on one of the following Child and Adolescent Needs and Strengths assessment domains/modules: Child Strengths, Behavioral and Emotional Needs, Life Domain Functioning, Child Risk Behaviors, Adjustment to Trauma, School Performance or Substance Abuse. The denominator is the total number of children authorized into a full level of care whose last two assessments are at least 75 days apart. The formula is numerator/denominator * 100.

Data Limitations

The accuracy of the HHSC data is dependent upon accurate and timely information being entered into the data warehouse system by the Local Mental Health Authorities/Local Behavioral Health Authorities.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Outcome 4.2.3. Percent Receiving Crisis Services Who Avoid Psychiatric Hospitalization within 30 days

Definition

This measure captures the percent of persons with one or more crisis episodes not followed by a psychiatric hospitalization at a State or Community psychiatric hospital within 30 days of the first day of each crisis episode.

Purpose

Appropriate interventions for persons in mental health crisis should reduce their need to access State or Community psychiatric hospitals.

Data Source

Contractually required services are submitted by the Local Mental Health Authorities/Local Behavioral Health Authorities and the Hospitals to the Behavioral Health Services data warehouse system.

Methodology

This measure is an annual percent of persons who avoid hospitalization for at least 30 days after a crisis episode. The numerator is the number of persons with one or more crisis episodes not followed by a State or Community psychiatric hospitalization within 30 days of the first day of each crisis episode. The denominator is the number of persons with one or more crisis episodes. The formula is numerator/denominator * 100.

Data Limitations

The accuracy of the HHSC data is dependent upon accurate and timely information being entered into the data warehouse system by the Local Mental Health Authorities/Local Behavioral Health Authorities.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Outcome 4.2.4. Percent Adults Who Complete Treatment Program and Report No Past Month Substance Use

Definition

This measure captures the percent of persons who complete an adult substance abuse program and report no past month substance use at the time of discharge.

Purpose

Abstinence is an objective of ongoing recovery for addiction.

Data Source

Contractually required services are submitted by the providers to the Behavioral Health Services data warehouse system.

Methodology

This measure is an annual percent of persons who complete an adult substance abuse treatment program and report abstinence. The numerator is the total number of persons who complete an adult substance abuse treatment service and report no past month substance use on the end-service or discharge assessment. The denominator is the total number of persons who complete an adult substance abuse treatment service. The formula is numerator/denominator * 100.

Data Limitations

Completion of treatment in this measure refers only to the completion of a level of care (service) at a single service provider. Data do not necessarily reflect completion of a continuum of care, which usually includes multiple programs and levels of service (episode). Accuracy of the data is dependent upon accurate and timely information’s being entered into the data warehouse system by providers.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Outcome 4.2.5. Percent Youth Who Complete Treatment Program and Report No Past Month Substance Use

Definition

This measure captures the percent of persons who complete a youth substance abuse treatment program and report no past month substance use at time of discharge.

Purpose

Abstinence is an objective of ongoing recovery for addiction.

Data Source

Contractually required services are submitted by the providers to the Behavioral Health Services data warehouse system.

Methodology

This measure is an annual percent of persons who complete a youth substance abuse treatment program and report abstinence. The numerator is the total number of persons who complete a youth substance abuse treatment service and report no past month substance use on the end-service or discharge assessment. The denominator is the total number of persons who complete a youth substance abuse treatment service. The formula is numerator/denominator * 100.

Data Limitations

Completion of treatment in this measure refers only to the completion of a level of care (service) at a single service provider. Data do not necessarily reflect completion of a continuum of care, which usually includes multiple programs and levels of service (episode). Accuracy of the data is dependent upon accurate and timely information’s being entered into the data warehouse system by providers.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Outcome 4.2.6. Percent of Adults With Opioid Use Disorder Receiving Medication-Assisted Treatment

Definition

This measure captures the percent of Opioid Use Disorder clients who receive Medication-Assisted Treatment during the fiscal year.

Purpose

This measure is used to determine efficiency and cost effectiveness of the programs over time.

Data Source

Contractually required services are submitted by the providers to the Behavioral Health Services data warehouse.

Methodology

The numerator is the number of unique clients who file a claim for Medication-Assisted Treatment service during the fiscal year. The denominator is the number of unique clients with an Opioid Use Disorder who file a claim during the fiscal year. The formula is numerator/denominator*100.

Data Limitations

The accuracy of the HHSC data is dependent upon accurate and timely information being entered into the data warehouse system by the providers.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.[1]

Strategy 4.2.1. Community Mental Health Services for Adults

Provide services and supports in the community for adults with serious mental illness.

Efficiency 4.2.1.1. Average Monthly Cost Per Adult: Community Mental Health Services

Definition

This measure captures the HHSC appropriation authority monthly cost per adult receiving community mental health services in a full level of care.

Purpose

This measure is used to determine efficiency and cost effectiveness of the programs over time.

Data Source

Contractually required services are submitted by the Local Mental Health Authorities/Local Behavioral Health Authorities to the Behavioral Health Services data warehouse system.

Methodology

The cost for providing adult community mental health services in each month of the quarter is averaged. The numerator is the total HHSC appropriation authority funds utilized to fund adult mental health community services/the number of months in the reporting period. The denominator is the average monthly number of adults receiving mental health community services that are served with HHSC appropriation authority funds. The formula is numerator/denominator.

[1] Please note action item 1.2.2. on page 4 indicates that HHSC will increase overdose reversals by 20 percent.

Data Limitations

The accuracy of the commission's data is dependent upon accurate and timely information being entered into data warehouse system by the Local Mental Health Authorities/Local Behavioral Health Authorities.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.2.1.1. Average Monthly Number of Adults Receiving Community Mental Health Services

Definition

This measure captures the average monthly unduplicated count of eligible adults whose services are funded with HHSC appropriation authority funds and who receive mental health community services through a full level of care service package as part of Texas Resilience and Recovery.

Purpose

Monthly number of persons served reflects the system-wide level of activity occurring over time and allows the agency to associate this activity with related costs.

Data Source

Contractually required services are submitted by the Local Mental Health Authorities/Local Behavioral Health Authorities to the Behavioral Health Services data warehouse system.

Methodology

To obtain the number of adults served with HHSC appropriation authority funds, the percentage of total expenditures that were funded through the commission's appropriation authority in the previous fiscal year is calculated. This percentage is applied to the average monthly number served for the specified quarter to yield the average monthly number served for the specified quarter with HHSC appropriation

authority funds. The numerator is the sum of the number of adults receiving community Mental Health services through a full level of care service package as part of Texas Resilience and Recovery levels of care each month of the reporting period * state funded percentage. The state funded percentage is the expenditures financed through the HHSC appropriation authority for any adult Mental Health community service/total expenditures for any adult Mental Health community service * 100. The denominator is the number of months in the period. The formula is numerator/denominator.

Data Limitations

The accuracy of the commission's client database is dependent upon accurate and timely information being entered into the data warehouse by the Local Mental Health Authorities/Local Behavioral Health Authorities.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 4.2.2. Community Mental Health Services for Children

Provide services and supports for emotionally disturbed children and their families.

Efficiency 4.2.2.1. Average Monthly Cost Per Child Receiving Community Mental Health Services

Definition

This measure captures the HHSC appropriation authority monthly cost per child receiving community mental health services in a full level of care.

Purpose

This measure captures the HHSC appropriation authority monthly cost per child receiving community mental health services in a full level of care.

Data Source

Contractually required services are submitted by the Local Mental Health Authorities/Local Behavioral Health Authorities to the Behavioral Health Services data warehouse.

Methodology

The cost for providing child community mental health services in each month of the quarter is averaged. The numerator is the total HHSC appropriation authority funds utilized to fund child mental health community services/ the number of months in the reporting period. The denominator is the total monthly number of children receiving mental health services in the community that are served with HHSC appropriation authority funds. The formula is numerator/denominator.

Data Limitations

The accuracy of the HHSC data is dependent upon accurate and timely information being entered into the data warehouse system by the Local Mental Health Authorities/Local Behavioral Health Authorities.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.2.2.1. Average Monthly Number of Children Receiving Community Mental Health Services

Definition

This measure captures the average monthly unduplicated count of eligible children (under age 18) whose services are funded with HHSC appropriation authority funds and who receive mental health community services through a full level of care service package as part of Texas Resiliency and Recovery (levels of care 1,2,3,4, or Young Child) on a monthly basis. The mental health services in the levels of care may be provided on a monthly or quarterly basis depending upon the service.

Purpose

Monthly number of children served reflects the system-wide level of activity occurring over time and allows the agency to associate this activity with related costs.

Data Source

Contractually required services are submitted by the Local Mental Health Authorities/Local Behavioral Health Authorities to the Behavioral Health Services data warehouse system.

Methodology

To obtain the number of children served with HHSC appropriation authority funds, the percentage of total expenditures that were funded through the commission's appropriation authority in the previous year is calculated. This percentage is applied to the average monthly numbers served for the specified quarter to yield the average monthly number served for the specified quarter with HHSC appropriation authority funds. The numerator is the sum of the number of children receiving community Mental Health services through a full level of care service package as part of Texas Resilience and Recovery each month of the reporting period * state funded percentage. The state funded percentage is the expenditures financed through the HHSC appropriation authority for any child's community Mental Health services / total expenditures for any child's community Mental Health services *100. The denominator is the number of months in the period. The formula is numerator/denominator.

Data Limitations

The accuracy of the commission's data is dependent upon accurate and timely information being entered into data warehouse system by the Local Mental Health Authorities/Local Behavioral Health Authorities.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 4.2.3. Community Mental Health Crisis Services

Community Mental Health Crisis Services.

Efficiency 4.2.3.1. Average General Revenue Spent Per Person for Crisis Residential Services

Definition

This measure captures the average amount of General Revenue spent per person for a crisis residential services (i.e., respite, crisis residential, crisis stabilization unit, extended observation, or inpatient psychiatric room and board) during the fiscal year.

Purpose

This measure is used to determine efficiency and cost effectiveness of the programs over time.

Data Source

Contractually required services are submitted by the Local Mental Health Authorities/Local Behavioral Health Authorities to the Behavioral Health Services data warehouse.

Methodology

The numerator is the total year-to-date General Revenue expenditures for crisis residential services. The denominator is the unduplicated year-to-date number of persons who receive a crisis residential service funded by General Revenue.

Data Limitations

The accuracy of the HHSC data is dependent upon accurate and timely information being entered into the data warehouse system by the Local Mental Health Authorities/Local Behavioral Health Authorities.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Efficiency 4.2.3.2. Average General Revenue Spent Per Person for Crisis Outpatient Services

Definition

This measure captures the average amount of General Revenue spent per person for a crisis outpatient services (i.e., mobile crisis outreach team, walk-in crisis, or crisis follow-up) during the fiscal year.

Purpose

This measure is used to determine efficiency and cost effectiveness of the programs over time.

Data Source

Contractually required services are submitted by the Local Mental Health Authorities/Local Behavioral Health Authorities to the Behavioral Health Services data warehouse.

Methodology

The numerator is the total year-to-date General Revenue expenditures for crisis outpatient services. The denominator is the unduplicated year-to-date number of persons who receive a crisis outpatient service funded by General Revenue. The formula is numerator/denominator.

Data Limitations

The accuracy of the HHSC data is dependent upon accurate and timely information being entered into the data warehouse system by the Local Mental Health Authorities/Local Behavioral Health Authorities.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.2.3.1. Number Persons Receiving Crisis Residential Services Per Year Funded by General Revenue

Definition

This measure captures the unduplicated year-to-date number of persons (regardless of age) who receive a crisis residential services (i.e., respite, crisis residential, crisis stabilization unit, extended observation, or inpatient psychiatric room and board), and whose services are funded by General Revenue.

Purpose

Providing mental health crisis residential services as alternatives to service in more restrictive and less appropriate settings (e.g., Emergency Room, psychiatric hospital, and jail) is an important function. This measure provides an unduplicated count of the number of individuals served in residential crisis services as less restrictive and more appropriate alternatives per year.

Data Source

Contractually required services are submitted by the Local Mental Health Authorities/Local Behavioral Health Authorities to the Behavioral Health Services data warehouse.

Methodology

The unduplicated number of persons who receive a residential crisis service, where the source of funding was General Revenue, is summed for the fiscal year.

Data Limitations

The accuracy of the HHSC data is dependent upon accurate and timely information being entered into the data warehouse system by the Local Mental Health Authorities/Local Behavioral Health Authorities.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.2.3.2. Number Persons Receiving Crisis Outpatient Services Per Year Funded by General Revenue

Definition

This measure captures the unduplicated year-to-date number of persons (regardless of age) who receive a crisis outpatient services (i.e., mobile crisis outreach team, walk-in crisis, or crisis follow-up) , and whose services are funded by General Revenue.

Purpose

Providing mental health crisis outpatient services as alternatives to service in more restrictive and less appropriate settings (e.g., Emergency Room, psychiatric hospital and jail) is an important function. This measure provides an unduplicated count of the number of individuals served in outpatient crisis services as less restrictive and more appropriate alternatives per year.

Data Source

Contractually required services are submitted by the Local Mental Health Authorities/Local Behavioral Health Authorities to the Behavioral Health Services data warehouse.

Methodology

The unduplicated number of persons who receive an outpatient crisis service , where the source of funding was General Revenue, is summed for the fiscal year.

Data Limitations

The accuracy of the HHSC data is dependent upon accurate and timely information being entered into the data warehouse system by the Local Mental Health Authorities/Local Behavioral Health Authorities.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 4.2.4. Substance Abuse Prevention, Intervention, and Treatment

Implement prevention services to reduce the risk of substance use, abuse, and dependency. Implement intervention services to interrupt illegal substance use by youth and adults and reduce harmful use of legal substances by adults. Implement a continuum of community and family-based treatment and related services for chemically dependent persons. Optimize performance quality and cost efficiency through the managing and monitoring of contracted services for substance abuse.

Efficiency 4.2.4.1. Average Monthly Cost Per Youth for Substance Abuse Prevention Services

Definition

This measure captures the monthly cost per person receiving HHSC funded youth substance abuse prevention services.

Purpose

This measure is used to determine efficiency and cost effectiveness of the programs over time.

Data Source

Contractually required services are submitted by the providers to the Behavioral Health Services data warehouse.

Methodology

The numerator is the sum of prevention service expenditures reported by providers. The denominator is the number served. The formula is numerator/denominator. The number served is the total number of persons receiving HHSC-funded youth substance abuse prevention services.

Data Limitations

The accuracy of HHSC's data is dependent upon accurate and timely information being entered into the data warehouse system by the providers.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Efficiency 4.2.4.2. Average Monthly Cost Per Adult for Substance Abuse Intervention Services

Definition

This measure captures the monthly cost per person receiving HHSC funded adult substance abuse intervention services.

Purpose

This measure is used to determine efficiency and cost effectiveness of the programs over time.

Data Source

Contractually required services are submitted by the providers to the Behavioral Health Services data warehouse.

Methodology

The sum of direct service expenditures and HHSC non-service expenditures for the intervention programs divided by the total number of persons served. Number served is the total number of persons receiving HHSC-funded adult substance abuse intervention services.

Data Limitations

The accuracy of HHSC's data is dependent upon accurate and timely information being entered into the data warehouse system by the providers.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Efficiency 4.2.4.3. Average Monthly Cost Per Youth for Substance Abuse Intervention Services

Definition

This measure captures the monthly cost per person receiving HHSC funded youth substance abuse intervention services.

Purpose

This measure is used to determine efficiency and cost effectiveness of the programs over time.

Data Source

Contractually required services are submitted by the providers to the Behavioral Health Services data warehouse.

Methodology

The sum of direct service expenditures and HHSC non-service expenditures for the intervention programs divided by the total number of persons served. Number served is the total number of persons receiving youth intervention services.

Data Limitations

The accuracy of HHSC's data is dependent upon accurate and timely information being entered into the data warehouse system by the providers.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Efficiency 4.2.4.4. Average Monthly Cost Per Adult Served in Treatment Programs for Substance Abuse

Definition

This measure captures the monthly cost per person receiving HHSC funded adult substance abuse treatment services.

Purpose

This measure is used to determine efficiency and cost effectiveness of the programs over time.

Data Source

Contractually required services are submitted by the providers to the Behavioral Health Services data warehouse.

Methodology

The sum of substance abuse treatment claims divided by the total number of persons served. Number served is the total number of persons receiving adult substance abuse treatment services.

Data Limitations

The accuracy of HHSC's data is dependent upon accurate and timely information being entered into the data warehouse system by the providers.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Efficiency 4.2.4.5. Average Monthly Cost Per Youth Served in Treatment Programs for Substance Abuse

Definition

This measure captures the monthly cost per person receiving HHSC funded youth substance abuse treatment services.

Purpose

This measure is used to determine efficiency and cost effectiveness of the programs over time.

Data Source

Contractually required services are submitted by the providers to the Behavioral Health Services data warehouse.

Methodology

The sum of substance abuse treatment claims divided by the total number of persons served. Number served is the total number of persons receiving youth substance abuse treatment services.

Data Limitations

The accuracy of HHSC's data is dependent upon accurate and timely information being entered into the data warehouse system by the providers.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.2.4.1. Average Monthly Number of Youth Served in Substance Abuse Prevention Programs

Definition

This measure captures the average monthly count of persons served through HHSC funded youth substance abuse prevention program service types.

Purpose

Monthly number of youth served reflects the system-wide level of activity occurring over time and allows the agency to associate this activity with related costs.

Data Source

Contractually required services are submitted by the providers to the Behavioral Health Services data warehouse system.

Methodology

The total number of persons served with HHSC youth substance abuse prevention funds in each month of the quarter is averaged. The numerator is the sum of the number of persons served in HHSC funded youth substance abuse prevention services each month of the reporting period. The denominator is the number of months in the period. The formula is numerator/denominator.

Data Limitations

The accuracy of HHSC's data is dependent upon accurate and timely information being entered into the data warehouse system by the providers. Program measures are aggregate reports and not based on individual level services for each strategy. Due to the nature of the prevention activities within each of the strategies, it is not possible to capture an unduplicated count of the services provided.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.2.4.2. Average Monthly Number of Youth Served in Treatment Programs for Substance Abuse

Definition

This measure captures the average monthly unduplicated count of persons served through HHSC funded youth substance abuse treatment program service types.

Purpose

Monthly number of youth served reflects the system-wide level of activity occurring over time and allows the agency to associate this activity with related costs.

Data Source

Contractually required services are submitted by the providers to the Behavioral Health Services data warehouse system.

Methodology

The total number of persons served with HHSC youth substance abuse treatment funds in each month of the quarter is averaged. The numerator is the sum of the number of persons served in HHSC funded youth substance abuse intervention services each month of the reporting period. The denominator is the number of months in the period. The formula is numerator/denominator.

Data Limitations

The accuracy of HHSC's data is dependent upon accurate and timely information being entered into the data warehouse system by the providers.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.2.4.3. Average Monthly Number of Adults Served in Substance Abuse Intervention Programs

Definition

This measure captures the average monthly count of persons served through HHSC funded adult substance abuse intervention program service types.

Purpose

Monthly number of adults served reflects the system-wide level of activity occurring over time and allows the agency to associate this activity with related costs.

Data Source

Contractually required services are submitted by the providers to the Behavioral Health Services data warehouse system.

Methodology

The total number of persons served with HHSC adult substance abuse intervention funds in each month of the quarter is averaged. The numerator is the sum of the number of persons served in HHSC funded adult substance abuse intervention services each month of the reporting period. The denominator is the number of months in the period. The formula is numerator/denominator.

Data Limitations

The accuracy of the HHSC's data is dependent upon accurate and timely information being entered into the data warehouse system by the providers. Program measures are aggregate reports and not based on individual level services for each strategy. Due to the nature of the intervention activities within each of the strategies, it is not possible to capture an unduplicated count of the services provided.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.2.4.4. Average Monthly Number of Youth Served in Substance Abuse Intervention Programs

Definition

This measure captures the count of persons served through HHSC funded youth substance abuse intervention program service types.

Purpose

Monthly number of youth served reflects the system-wide level of activity occurring over time and allows the agency to associate this activity with related costs.

Data Source

Contractually required services are submitted by the providers to the Behavioral Health Services data warehouse system.

Methodology

The total number of persons served with HHSC youth substance abuse treatment funds in each month of the quarter is averaged. The numerator is the sum of the number of persons served in HHSC funded youth substance abuse intervention services each month of the reporting period. The denominator is the number of months in the period. The formula is numerator/denominator.

Data Limitations

The accuracy of the HHSC's data is dependent upon accurate and timely information being entered into the data warehouse system by the providers. Program measures are aggregate reports and not based on individual level services for each strategy. Due to the nature of the intervention activities within each of the strategies, it is not possible to capture an unduplicated count of the services provided.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 4.2.4.5. Average Monthly Number of Adults Served in Treatment Programs for Substance Abuse

Definition

This measure captures the count of persons served through HHSC funded adult substance abuse treatment program service types.

Purpose

Monthly number of adults served reflects the system-wide level of activity occurring over time and allows the agency to associate this activity with related costs.

Data Source

Contractually required services are submitted by the providers to the Behavioral Health Services data warehouse system.

Methodology

The total number of persons served with HHSC adult substance abuse treatment funds in each month of the quarter is averaged. The numerator is the sum of the number of persons served in HHSC funded adult substance abuse treatment services each month of the reporting period. The denominator is the number of months in the period. The formula is numerator/denominator.

Data Limitations

The accuracy of HHSC's data is dependent upon accurate and timely information being entered into the data warehouse system by the providers.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 4.2.5. Behavioral Health Waiver and Plan Amendment

Provide intensive community-based services for emotionally disturbed children and their families and for adults with serious mental illness.

Efficiency 4.2.5.1. Average Monthly Cost Per Client Served in Home and Community-Based Services - Adult Mental Health (HCBS-AMH) Program

Definition

The average monthly cost paid per client served in Home and Community-Based Services - Adult Mental Health (HCBS-AMH) Program.

Purpose

This measure reflects the amount paid for each participant served per month for the named group.

Data Source

Clinical Management for Behavioral Health Services (CMBHS)

Methodology

The average monthly cost for the named group is calculated by dividing the total estimated dollars from HCBS claims for the reporting period by the sum of the monthly number of estimated clients served for the reporting period. The measure will include Medicaid Billable and Non-Medicaid Billable for the named group. Completion factors may be applied to the incomplete data. Forecasting models and trends are used to project future expenditures/clients served including months with data too incomplete to report.

Data Limitations

Records are currently kept manually. The implementation of an automated system is in process. Due to a lag in Claims data, initial quarter reporting will include estimated clients served and costs for all 3 months.

Calculation Method

Noncumulative

New Measure

Yes

Target Attainment

Currently undefined.

Efficiency 4.2.5.2. Average Monthly Cost Per Client Served in Youth Empowerment Services (YES) Waiver

Definition

The average monthly cost paid per utilizer served in YES during the reporting period. A utilizer is a participant who received at least one YES service during the reporting month.

Purpose

This measure reflects the amount paid for each participant receiving at least one YES service per month for the named group.

Data Source

Clinical Management for Behavioral Health Services (CMBHS)

Methodology

The average monthly cost for the named group is calculated by dividing the total estimated dollars from claims for the reporting period by the sum of the monthly number of estimated participants who received at least one YES service during each month of the reporting period. Completion factors may be applied to the incomplete data. Forecasting models and trends are used to project future expenditures/clients served including months with data too incomplete to report.

Data Limitations

The claims report in CMBHS has experienced issues that include missing data elements and require manual reviews for data accuracy. Due to a lag in Claims data, initial quarter reporting will include estimated participants served at least one YES service and costs for all three months.

Calculation Method

Noncumulative

New Measure

Yes

Target Attainment

Currently undefined.

Output 4.2.5.1. Average Monthly Number of Clients Served in HCBS-AMH Program

Definition

This measure captures the average monthly unduplicated count of individuals served in the HCBS-AMH Program. An individual who received at least one HCBS-AMH service during the reporting month is included in this measure.

Purpose

This measure reflects the average monthly number of clients receiving services for the named group.

Data Source

CMBHS

Methodology

Average monthly number of clients served per month is calculated by summing the monthly number of clients who received at least one service during the reporting period months and dividing by the number of months in the reporting period. Client served counts are subject to revisions to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Forecasting models and trends are used to project future month served client counts.

Data Limitations

Records are currently kept manually. The implementation of an automated system (CMBHS) is in process. Due to a lag in Claims data, initial quarter reporting will include estimated clients served for all 3 months.

Calculation Method

Noncumulative

New Measure

Yes

Target Attainment

Currently undefined.

Output 4.2.5.2. Average Monthly Number of Clients Served in YES Waiver

Definition

This measure captures the average monthly utilizer count of participants served in the YES Waiver. A utilizer is a participant who received at least one YES service during the reporting month.

Purpose

This measure reflects the average monthly number of participants receiving at least one YES service for the named group.

Data Source

Clinical Management for Behavioral Health Services (CMBHS)

Methodology

Average monthly number of participants served per month is calculated by summing the monthly number of participants who received at least one YES service during the reporting period months and dividing by the number of months in the reporting period. Participants served counts are subject to revisions to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Forecasting models and trends are used to project future month served client counts.

Data Limitations

Due to a lag in Claims data, initial quarter reporting will include estimated participants served at least one YES service for all 3 months.

Calculation Method

Noncumulative

New Measure

Yes

Target Attainment

Currently undefined.

Strategy 4.2.6. Community Mental Health Grant Programs

Administer grant programs to support community mental health programs for veterans and their families, support community mental health programs for individuals experiencing mental illness, and to reduce recidivism, arrest, and incarceration of individuals with mental illness.

Objective 4.3. Build Community Capacity

Develop and enhance capacities for community clinical service providers and regionalized emergency healthcare systems.

Strategy 4.3.1. Indigent Health Care Reimbursement (University of Texas Medical Branch)

Reimburse the provision of indigent health services through the deposit of funds in the State-Owned Multicategorical Teaching Hospital Account.

Strategy 4.3.2. County Indigent Health Care Services

Provide support to local governments that provide indigent healthcare services.

Goal 5. Encourage Self-Sufficiency

HHSC will encourage and promote self-sufficiency, safety, and long-term independence for families.

Objective 5.1. Financial and Other Assistance

Provide appropriate support services that address the employment, financial, and/or social service needs of eligible persons.

Strategy 5.1.1. Temporary Assistance for Needy Families Grants

Provide TANF grants to low-income Texans.

Efficiency 5.1.1.1. Average Monthly Grant: TANF Basic Cash Assistance

Definition

This measure reports the dollar amount of the average monthly TANF Basic grant per recipient for the federally funded TANF program. The TANF Basic program provides a monthly financial assistance payment to eligible families with children and with no or one certified adult.

Purpose

This measure provides the unit cost of one of the service components funded under this strategy.

Data Source

Data is obtained from the "TANF Warrant History" file, based on eligibility determination system.

Methodology

This measure is calculated by dividing the total dollar amount of grants to TANF Basic recipients in reporting period by total number of TANF Basic recipients per month for the same period. Because data are reported on an incurred basis, the most recent data are completed using completion ratios. Forecasting models and trends are used to project future estimates.

Data Limitations

Data are incomplete at initial reporting due to cancellations and supplemental payments.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Efficiency 5.1.1.2. Average Monthly Grant: State Two-Parent Cash Assistance Program

Definition

This measure reports the dollar amount of the average monthly State Two-Parent Cash Assistance Program grant per recipient. The State Two-Parent Cash Assistance Program provides a monthly financial assistance payment to eligible families with two certified adults.

Purpose

This measure provides the unit cost of one of the service components funded under this strategy.

Data Source

Data is obtained from the 'TANF Warrant History' file, based on eligibility determination system.

Methodology

Data is derived by dividing total dollar amount of grants to State Two Parent Cash Assistance Program recipients in reporting period by the total number of State Two Parent Cash Assistance Program recipients per month for the same period. Because data are reported on an incurred basis, the most recent data are completed using completion ratios. Forecasting models and trends are used to project future estimates.

Data Limitations

Data are incomplete at initial reporting due to cancellations and supplemental payments.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Output 5.1.1.1. Average Number of TANF Basic Cash Assistance Recipients Per Month

Definition

This measure reports the monthly average number of persons who received a TANF grant from the federally funded TANF program during the reporting period. The TANF program provides a monthly financial assistance payment to low income families with children and with no or one certified parent.

Purpose

This measure provides an average monthly count of persons receiving federally funded TANF cash assistance.

Data Source

Data is obtained from the "TANF Warrant History" file based on an eligibility determination system.

Methodology

The number of TANF recipient month in the reporting period are totaled (numerator) and then divided by the number of months in the reporting period (denominator). Recipients are counted in each month they receive a grant; hence, this measure does not report an unduplicated count of recipients over time. Because data are reported on an incurred basis, the most recent data are completed using completion ratios. Forecasting models and trends are used to project future estimates.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Output 5.1.1.2. Average Number of State Two-Parent Cash Assistance Recipients Per Month

Definition

This measure reports the monthly average number of persons who received a State Two-Parent Cash Assistance Program grant during the reporting period. The State Two-Parent Cash Assistance program provides a monthly financial assistance payment to eligible families with two certified adults.

Purpose

This measure reports the monthly average number of persons who received a State Two-Parent Cash Assistance Program grant during the reporting period.

Data Source

Data is obtained from the 'TANF Warrant History' file based on an eligibility determination system.

Methodology

The number of State Two Parent Cash Assistance Program recipient months for each month in the reporting period are totaled (numerator) and then divided by the number of months in the reporting period (denominator). Recipients are counted in each month they receive a grant. Because data are reported on an incurred basis, the most recent data are completed using completion ratios. Forecasting models and trends are used to project future estimates.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 5.1.2. Provide Special Supplemental Program for Women, Infants, and Children Services: Benefits, Nutrition Education, and Counseling

Provide Special Supplemental Program for Women, Infants, and Children (WIC) services including benefits, nutrition education, and counseling.

Output 5.1.2.1. Number of WIC Participants Provided Nutritious Supplemental Food

Definition

Actual state-wide monthly participation determined by the number of WIC clients provided with supplemental foods for a particular month.

Purpose

To track WIC participation trends.

Data Source

Participation counts are collected through TXIN, the WIC management information system.

Methodology

The United States Department of Agriculture (USDA) and HHSC define WIC client participation as: the sum of the number of persons who have received supplemental foods or food instruments plus the number of totally breastfed infants (i.e., receiving no supplemental foods or food instruments) whose mothers were WIC participants and received food benefits during the reporting period plus the number of breastfeeding women who did not receive supplemental foods or food instruments but whose infant received supplemental foods of food instruments during the reporting period. The most recent available monthly participation count at the time the report is due will be reported for both the quarterly and year-to-date performance. This calculation is based on a federal fiscal year.

Data Limitations

Most recent data available is used at reporting deadlines.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 5.1.3. Disaster Assistance

Provide financial assistance to victims of federally declared natural disasters.

Goal 6. Community and Independent Living Services and Coordination

Provide programs and support services to encourage self-sufficiency and healthier living in the community.

Objective 6.1. Long-Term Care Services and Coordination

Provide non-Medicaid services and supports in home and community settings to enable aging individuals and individuals with disabilities to maintain their independence and prevent institutionalization.

Strategy 6.1.1. Guardianship

Provide full or limited authority over an incapacitated aging or disabled adult who is the victim of validated abuse, neglect, exploitation, or of an incapacitated minor in Child Protective Services' conservatorship.

Output 6.1.1.1. Average Number of Wards Receiving Guardianship Services

Definition

The measure shows the count of wards for which guardianship has been established through court order. The count includes both new and on-going guardianships that will be served by the HHSC staff and contracted private guardianship programs. On-going guardianships refers to guardianships initiated in previous months and without closure dates.

Purpose

The purpose of this measure is to show the average number of adults for whom HHSC was directly serving as guardian during the reporting period. It indicates part of the workload volume in the guardianship program.

Data Source

Using Guardianship Online Database (GOLD), the data are gathered by counting HHSC's cases and contracted private guardianship cases open during the reporting period and cases closed during the reporting period, the number of cases as documented on the guardianship detail table in which wards' guardianship letters were issued on or before the end of the report month and the event activity type was coded as 'GUA' (numerator). The count includes direct-delivery and contracted guardianships. The denominator is the sum of months in the reporting period. The IMPACT detail table was replaced with a report from GOLD system.

Methodology

Divide the numerator by the denominator. When calculating the second quarter, third quarter, and fourth quarter, the year-to-date total is recalculated.

Data Limitations

Documentation can be delayed by the volume of work, which is impacted by vacancies, sick leave, vacation leave, turnover, GOLD system downtime, etc.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 6.1.2. Non-Medicaid Services

Provide services to individuals ineligible for Medicaid services, in their own home or community. Services include family care, home-delivered meals, adult foster care, Day Activities and Health Services (Title XX of the Social Security Act (XX)), emergency response, and personal attendant services.

Output 6.1.2.1. Average Number of Individuals Served Per Month: Non Medicaid Community Care (Title XX/General Revenue)

Definition

This measure reports the monthly average unduplicated number of individuals who received one or more of the following Non Medicaid Community Care (Title XX/General Revenue) services: adult foster care, client managed personal assistance services, day activity and health services, emergency response services, home-delivered meals, personal assistance services (Family Care), residential care, and special services for persons with disabilities.

Purpose

This measure provides a count of eligible individuals who are receiving Non-Medicaid Community Care (Title XX/General Revenue) service that contributes to enabling them to remain in their own home as opposed to being placed in another more restrictive setting.

Data Source

Month-of-service to-date data that reports the unduplicated number of individuals for whom claims have been approved-to-pay are obtained from claims payment data provided by the Medicaid claims adjudicator that is accessed and reported through an agency-developed application that utilizes COGNOS software.

Methodology

For the most part, the number of individuals ultimately receiving services are estimated by the "completion factor" method explained above, applied to claims data to-date. However, because of the normal amount of variation which occurs in processing billings from month-to month, the estimated census values estimated

through the "completion factor" method are over-ridden for service months in which fewer than three payment periods of data is available. (Or additional months if necessary, based upon analyst judgment.) For these service months, the census values are estimated by using the historical ratio of individuals served (based upon claims data) to individuals authorized to receive the service (per the Service Authorization System).

Please note that using an alternate method of estimation for periods with relatively few payment periods is consistent with actuarial standards of practice.

Data Limitations

Because it takes several months to close out 100 percent of the claims for a month of service, the number of individuals as well as cost per individual per month ultimately served must be estimated for months that have not yet closed out, by using "completion factors" specific to each service applied to the number of individuals approved-to-pay to-date and/or the number of individuals authorized to receive services, the units of service approved-to-pay to-date, and the payment amounts approved-to-pay to-date. The concept of completion factors is that data, as of a given number of claims processing months after the month of service, can be considered a certain percent complete based upon historical patterns. Therefore, for a given month of service, the payment amounts approved-to-pay to-date divided by the appropriate completion factor equals the estimated expenditures ultimately incurred.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 6.1.3. Non-Medicaid Developmental Disability Community Services

Provide services, other than those provided through the Medicaid waiver programs, to individuals with intellectual or developmental disabilities who reside in the community, including independent living, employment services, day training, therapies, and respite services.

Efficiency 6.1.3.1. Average Monthly Cost Per Individual Receiving Community Services

Definition

This measure captures information regarding what it costs the state each month, on average, to provide community IDD services to each individual who is assigned to these services regardless of age. It measures the HHSC appropriation authority cost per individual as defined by the companion output measure.

Purpose

This measure captures HHSC appropriation authority cost per person for adult and child community IDD services.

Data Source

At the end of each quarter, staff of the local authorities input expenditure information into the CARE portion of the data warehouse system. The local authority indicates the fund sources used to finance the expenditures. The method of finance includes funds that are part of the HHSC appropriation authority as well as other local funds, grant funds, and earned revenues.

Methodology

HHSC appropriation authority funds include all general revenue and federal funds allocated through the performance contract. Also included are administrative claiming funds that the local authority receives following the submission of quarterly cost reports. The number of months in the reporting period is 3 for each quarter and either 3, 6, 9, or 12 for year to date. The numerator is the total HHSC appropriation authority funds utilized to fund IDD community services as reported in CARE / the number of months in the reporting period. The denominator is the average monthly number of individuals with intellectual or developmental disabilities receiving community services that are served with HHSC appropriation authority funds. The formula is numerator/denominator.

Data Limitations

The accuracy of the commission’s database is dependent upon accurate and timely information being entered into the data warehouse system by the local authorities. If the local authority does not provide accurate data for the quarter, this measure will not be accurate. (At the end of the fiscal year, community centers report preliminary expenditure information, which is used for reporting in the Automated Budget and Evaluation System of Texas (ABEST). Final expenditure information

may be entered into the CARE system up to four months following the end of the fiscal year. Therefore, end-of-year values for efficiency measures can be updated in ABEST when the information is available. The LBB determines whether to reopen ABEST to allow for these updates.)

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 6.1.3.1. Average Monthly Number of Individuals with IDD Receiving Community Services

Definition

This measure captures the unduplicated count of priority population eligible adults and children whose services are funded with the HHSC appropriation authority funds and who receive IDD community services. IDD community services include vocational services, training services, respite services, specialized therapies and excludes residential services. Quarterly and year-to-date performance is stated as the average of the months in the reporting period.

Purpose

Monthly number of adults and children served reflects the system-wide level of activity occurring over time and allows the agency to associate this activity with related costs.

Data Source

As individuals enter the community programs, registration info is entered into the CARE portion of the data warehouse system by staff of the local authority. When an individual is assigned to a specific program, this information is also entered into the data warehouse system. Production reports of individuals served are issued quarterly based on the information in the data warehouse system. The total unduplicated number of individuals assigned to receive any IDD community service each month is calculated. To obtain an unduplicated number of individuals, each individual is counted only once each period regardless of the number of different

community services to which assigned. For each quarter of the fiscal year, the unduplicated number of individuals served in each month of the quarter is averaged. The production report lists total number of adults and children assigned to a particular service each month regardless of how the services for the individuals were funded.

Methodology

To obtain the number of individuals served with HHSC appropriation authority funds, HHSC uses a production report which reflects the numbers of priority population individuals served each month with general revenue funds and required local match. The numerator is the sum of the number of individuals receiving IDD community service each month of the reporting period. The denominator is the number of months in the period. The formula is numerator/denominator.

Data Limitations

The accuracy of the commission's CARE system is dependent upon accurate and timely information being entered into the data warehouse system by the local authorities. The Data Verification Criteria Manual provides general guidance regarding timelines for closure of assignments to specific services.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Objective 6.2. Provide Rehabilitation Services to Persons with General Disabilities

To provide quality vocational rehabilitation services to eligible persons with general disabilities. Additionally, to provide quality consumer-directed independent living services to persons with significant disabilities who have been determined eligible.

Strategy 6.2.1. Independent Living Services (General, Blind, and Centers for Independent Living)

Provide quality, statewide consumer-directed independent living services that focus on acquiring skills and confidence to live as independently as possible in the community for eligible people with significant disabilities. Work with the State Independent Living Council to develop the State Plan for Independent Living.

Output 6.2.1.1. Number People Receiving Services from Centers for Independent Living

Definition

Number of people receiving services from HHSC-supported Centers for Independent Living as reported in monthly reports received from HHSC-supported Centers for Independent Living.

Purpose

HHSC provides funds to centers through contracts in order for them to provide independent living core services within their catchments areas. The volume of consumers receiving services is an indicator that centers are achieving their intended purpose.

Data Source

Data collected by the Centers is sent to HHSC monthly.

Methodology

Centers are responsible for maintaining demographics on consumers served and monthly reports submitted provide a total count served for the month and on a fiscal year-to-date basis.

Data Limitations

Timeliness and accuracy of center data entry.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Output 6.2.1.2. Number of People Receiving HHSC Contracted Independent Living Services

Definition

Number of consumers receiving services from Independent Living Center contractors.

Purpose

The purpose of the Independent Living Services is to increase the independence of people with disabilities in their daily activities. The measure shows the number of consumers provided services.

Data Source

Independent Living Data Reporting System.

Methodology

Count of consumers with plan or waived plan in the Independent Living Data Reporting System for the reporting period. The served count, in accordance with the Rehabilitation Services Administration 704 State Independence Living Services Annual Performance Report, is all consumers who have a signed or waived plan, including those who have closed with goals met as well as those who have closed without plan goals met. This will include individuals who have a signed or waived plan but are waiting for one or more purchased services.

Data Limitations

Reporting is dependent on timeliness and accuracy of contractor data entry.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 6.2.2. Blindness Education, Screening, and Treatment Program

Provide screening, education, and urgently needed eye-medical treatment to prevent blindness.

Output 6.2.2.1. Number of Individuals Receiving Treatment Services in the Blindness Education, Screening and Treatment (BEST) Program

Definition

Measures the number of individuals receiving treatment services during the reporting period through the Blindness Education, Screening and Treatment (BEST) program.

Purpose

BEST establishes a projection for the population in need of BEST services that can reasonably be served within the available resources. This measure tracks and demonstrates progress toward meeting the projected target.

Data Source

Data for the treatment services comes from HHSC's automated consumer statistical system.

Methodology

This is a count of the number of individuals receiving eye treatment services during the reporting period.

Data Limitations

Reporting is impacted by timeliness and accuracy of data entry.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Output 6.2.2.2. Number of Individuals Receiving Screening Services in the BEST Program

Definition

Measures the number of individuals receiving screening services during the reporting period through the BEST program.

Purpose

BEST establishes a projection for the population in need of BEST services that can reasonably be served within the available resources. This measure tracks and demonstrates progress toward meeting the projected target.

Data Source

Contractor monthly reporting.

Methodology

This is a count of the number of individuals receiving eye screenings as reported by the contractor during the reporting period.

Data Limitations

Reporting is impacted by timeliness and accuracy of data entry.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 6.2.3. Provide Services to People with Spinal Cord / Traumatic Brain Injuries

Provide consumer-driven and counselor-supported Comprehensive Rehabilitation Services for people with traumatic brain injuries or spinal cord injuries.

Output 6.2.3.1. Average Monthly Number of People Receiving Comprehensive Rehabilitation Services

Definition

A monthly average of people receiving Comprehensive Rehabilitation Services as reported by automated caseload statistical system.

Purpose

The measure demonstrates provision of critical rehabilitation services to eligible Texans. It is important because an estimated 80 percent of the consumers age 16 and above who suffer and survive a traumatic spinal cord or traumatic brain injury do not have the resources necessary to pay for inpatient and outpatient comprehensive rehabilitation services and Post Acute Brain Injury rehabilitation services. Research indicates that those who have access to appropriate rehabilitation services tend to experience greater independence and productivity over their lifetime. This results in lowered dependence on public services and an overall savings to the public.

Data Source

HHSC automated caseload system.

Methodology

The numeric average of unduplicated people served. For each quarter of the fiscal year, the number of people served in each month of the quarter is averaged. For the second, third, and fourth quarters, year-to-date calculations are also obtained. The numerator is the total unduplicated number of people receiving Comprehensive Rehabilitation Services each month in the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator. People served is defined as consumers noted in the consumer statistical system whose status in the reporting period was:

- Successful closure,
- Post closure,

- Post closure completed,
- Unsuccessful closure plan initiated with funds allocated, or
- Plan initiated with funds allocated.

Data Limitations

Timeliness and accuracy of data entry.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 6.2.4. Provide Services to Persons Who Are Deaf or Hard of Hearing

Ensure continuity of services, foster coordination and cooperation among organizations, facilitate access to training and education programs, and support access to telephone systems to individuals who are deaf or hard of hearing. To increase the number of persons (who are deaf or hard of hearing) receiving quality services by 10 percent each biennium.

Output 6.2.4.1. Number of Interpreter Certificates Issued

Definition

This measures the number of interpreter certificates issued during a fiscal year.

Purpose

To increase the availability and skill levels of interpreters to eliminate communication barriers and to guarantee equal access for people who are deaf or hard of hearing.

Data Source

Agency database documenting the effective date and the expiration date of a certificate.

Methodology

Sum the number of certificates issued.

Data Limitations

None

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Output 6.2.4.2. Number of Equipment/Service Vouchers Issued

Definition

This measures the number of financial assistance vouchers issued by the agency during the fiscal year to eligible clients enabling them to purchase adaptive equipment or services necessary to access the telephone system.

Purpose

To ensure equal access to the telephone system for persons with a disability.

Data Source

Agency database documenting voucher print date is the data source.

Methodology

Agency database generates a count of vouchers issued for financial assistance.

Data Limitations

This measure does not provide an accurate account of the number of multiple vouchers issued for replacement of lost or expired vouchers.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Objective 6.3. Other Community Support Services

Promote safety, self-sufficiency, and long-term independence for those living with domestic violence or other adverse circumstances.

Strategy 6.3.1. Family Violence Services

Provide emergency shelter and support services to victims of family violence and their children, educate the public, and provide training and prevention support to institutions and agencies.

Strategy 6.3.2. Child Advocacy Programs

Train, provide technical assistance, and evaluate services for Children's Advocacy Centers of Texas, Inc. and Texas Court Appointed Special Advocates, Inc.

Strategy 6.3.3. Additional Advocacy Programs

Provide support services for interested individuals (Healthy Marriage, Community Resource Coordination Group Adult/Child, Texas Integrated Funding Initiative, Office of Acquired Brain Injury, Office of Disability Prevention for Children, Office of Minority Health Statistics and Engagement).

Goal 7. Mental Health State Hospitals, State Supported Living Centers, and Other Facilities

Provide specialized assessment, treatment, support, and medical services in state supported living centers (SSLCs), state mental health hospitals, and other facilities.

Objective 7.1. State Supported Living Centers

Provide specialized assessment, treatment, support, and medical services in SSLC programs for intellectual and developmentally disabled residents.

Strategy 7.1.1. State Supported Living Centers

Provide direct services and support to individuals living in SSLCs. Provide 24-hour residential services for individuals who are medically fragile or severely physically impaired or have severe behavior problems, and who choose these services or cannot currently be served in the community.

Efficiency 7.1.1.1. Average Monthly Cost Per Campus Resident

Definition

This measure captures information regarding what it costs the HHSC each month, on average, to provide State Supported Living Centers (SSLC) and State Center services.

Purpose

This measure allows the agency to track the cost of an occupied bed at an SSLC campus over time. This is of particular importance in light of increased health care costs due to the complex medical and behavioral needs of the current SSLC residents.

Data Source

Funding for SSLC campus residential services includes the federal portion of Medicaid, Medicare, other federal interagency grants and reimbursements, third party/patient fees, state general revenue match for Medicaid, and other funds. The commission's accounting system contains all expenditure data for the state facilities. Costs include both facility administrative and residential operations. Excluded costs include depreciation, employee benefits paid by the Employee Retirement System, Central Office administrative costs and statewide administrative costs.

Methodology

The numerator is the total expenditures paid for by HHSC for SSLC campus residential services for each month in the reporting period divided by the number of months in the reporting period. The denominator is the average monthly number of state ID campus residents. The formula is numerator/denominator.

Data Limitations

Data must be current and accurate in HHSC's electronic health record system as of the date the reports are produced.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 7.1.1.1. Average Monthly Number of State Supported Living Center Campus Residents

Definition

This measure provides the number of individuals enrolled in SSLC campus residential services each month on average. Enrollment is defined as the total number of individuals residing at the facility or absent for such purposes as home visits, hospitalizations, etc. with the intention of returning to the facility. Intellectual and developmental disability campus services are provided at SSLCs.

Purpose

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate the utilization of SSLC campus services with related costs and outcomes.

Data Source

This is average monthly enrollment. Enrollment is the census plus all absences (individuals are expected to return to the facility). Enrollment data is obtained from the commission's electronic health record system.

Methodology

The numerator is the total number of individuals absent or present in all SSLC facilities for each month in the reporting period. The denominator is the number of months in the reporting period, quarter, or year to date. The formula is numerator/denominator.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 7.1.1.2. Number Unfounded Abuse/Neglect/Exploitation Allegations Against State Supported Living Center Staff

Definition

This measure reports the number of unfounded allegations as reported by victims or others against SSLC staff. An allegation is defined as a report by an individual suspecting or having knowledge that a person served at a SSLC has been or is in a state of abuse, neglect, or exploitation (A/N/E). Victim is defined as a person served who is alleged to have been abused, neglected, or exploited under TAC, Title 40, Part 19, Rule §711.3 (41).

Purpose

This measure is a mechanism for tracking unfounded allegations against SSLC staff.

Data Source

Information Management Protecting Adults and Children in Texas (IMPACT) at Department of Family and Protective Services (DFPS).

Methodology

The measure is calculated by totaling the number of A/N/E allegations as reported by victims or others deemed unfounded at all SSLCs by Department of Family and Protective Services investigators during a fiscal year.

Data Limitations

The source data for this measure is supplied by the DFPS. To ensure confidentiality, DFPS can provide data quarterly in aggregate for the entire SSLC system. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Output 7.1.1.3. Number Confirmed Abuse/Neglect/Exploitation Incidents at State Supported Living Centers

Definition

This measure reports confirmed allegations against SSLC staff. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

Purpose

This measure is a mechanism for assessing confirmed allegations of A/N/E at all State Supported Living Centers.

Data Source

Information Management Protecting Adults and Children in Texas (IMPACT) at the DFPS.

Methodology

The measure is calculated by totaling the number of confirmed allegations of A/N/E at each State Supported Living Center by Department of Family and Protective Services investigators during a fiscal year.

Data Limitations

These data are supplied by DFPS, and HHSC will work cooperatively with DFPS to provide the data for compilation. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Objective 7.2. Mental Health State Hospital Facilities and Services

Provide inpatient mental health services for adults and children.

Strategy 7.2.1. Mental Health State Hospitals

Provide specialized assessment, treatment, and medical services in state mental health facility programs.

Efficiency 7.2.1.1. Average Daily Cost Per Occupied State Mental Health Facility Bed

Definition

This measure captures information regarding what it costs the HHSC, on average, per occupied state mental health facility bed.

Purpose

This measure allows the commission to estimate the funding necessary to provide the number of state mental health facilities beds needed by its consumers.

Data Source

The expenditures for facility operations are entered into the commission's accounting system for each mental health facility.

Methodology

This is the projected average daily HHSC cost, averaged by quarter and year-to-date, for an occupied bed in the state mental health facility program. Costs include both facility and agency administrative and residential operations. Excluded costs include depreciation and employee benefits paid by the Employee Retirement System. The numerator is the total projected expenditures (less exclusion as above) paid by HHSC for state mental health facilities in the reporting period / total number of inpatient psychiatric bed days in the reporting period. The denominator

is the average daily census of state mental health facilities for the reporting period. The formula is numerator / denominator.

Data Limitations

Data must be current and accurate in the commission's accounting system as of the date reports are produced.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 7.2.1.1. Average Daily Census of State Mental Health Facilities

Definition

The state mental health facilities provide services to persons with severe mental illnesses for both acute episodes and longer-term care. The census of the facilities includes persons who have been admitted and not discharged. This measure provides information about the number of persons in state mental health facilities each day on average.

Purpose

The census of state mental health facilities provides information about the utilization of these facilities. In order to ensure maximum occupancy and ensure availability of beds to meet needs, managers require information about current utilization and utilization trends over time.

Data Source

As persons are admitted to and discharged from state mental health facilities, this movement activity is entered into the commission's electronic medical record. Production reports of consumer movement are issued monthly based on the information in the electronic medical record. Quarterly information is calculated based on these monthly reports.

Methodology

This is an average daily census by quarter where census is defined as the total number of persons occupying a campus bed on any given day. Total bed days are obtained by multiplying the number of persons hospitalized for inpatient services during the reporting period by the number of days each person is hospitalized. The numerator is the total number of bed days for state mental health facilities for the reporting period. The denominator is the number of days in the reporting period. The formula is numerator/denominator.

Data Limitations

Data is accurate to the extent that it is correctly entered into the data warehouse system.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 7.2.2. Mental Health Community Hospitals

Provide inpatient treatment, crisis assessment, and medical services to adults and children served in community hospitals.

Efficiency 7.2.2.1. Average Daily Cost Per Occupied Mental Health Community Hospital Bed

Definition

This measure captures the average daily cost per consumer receiving inpatient services at a Community Mental Health Hospital each day whose services are funded by the HHSC.

Purpose

This measure allows HHSC to estimate the funding necessary to provide the number of Community Mental Health Hospital beds needed by its consumers.

Data Source

Contractually required services are submitted by the Local Mental Health Authorities/Local Behavioral Health Authorities to the Behavioral Health Services data warehouse system.

Methodology

The numerator is the total HHSC provided funding for Community Hospitals utilized to fund Community Hospital inpatient services as reported in the data warehouse /divided by the number of days in the reporting period. The denominator is the average daily number of persons receiving Community Hospital inpatient services. The formula is numerator/denominator.

Data Limitations

The accuracy of HHSC's data is dependent upon accurate and timely information being entered into the data warehouse system by the Local Mental Health Authorities/Local Behavioral Health Authorities.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 7.2.2.1. Average Daily Number of Occupied Mental Health Community Hospital Beds

Definition

This measure captures the average number of consumers receiving inpatient services at a Community Mental Health Hospital each day whose services are funded by the HHSC.

Purpose

The census of Community Mental Health Hospitals provides information about the utilization of these facilities. In order to ensure maximum occupancy and ensure availability of beds to meet needs, managers require information about current utilization and utilization trends over time.

Data Source

Contractually required services are submitted by the Local Mental Health Authorities/Local Behavioral Health Authorities to the Behavioral Health Services data warehouse system.

Methodology

This is an average daily census by quarter where census is defined as the total number of persons occupying a facility bed on any given day, as financed by HHSC. Total bed days are obtained by multiplying the number of persons who are resident at the facility during the reporting period by the number of days each person is resident at the facility. The numerator is the total number of bed days for Community Mental Health Hospitals for the reporting period. The denominator is the number of days in the reporting period. The formula is numerator/denominator.

Data Limitations

The accuracy of HHSC's data is dependent upon accurate and timely information being entered into the data warehouse system by the Local Mental Health Authorities/Local Behavioral Health Authorities.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Objective 7.3. Other Facilities

Provide specialized assessment, treatment, support, and medical services at other state medical facilities (Corpus Christi Bond Homes and Rio Grande State Center Outpatient Clinic).

Strategy 7.3.1. Other State Medical Facilities

Provide program support to SSLCs, state mental health hospitals, and other facilities (Corpus Christi Bond Homes and Rio Grande State Center Outpatient Clinic).

Objective 7.4. Facility Program Support

Provide program support to SSLCs, state mental health hospitals, and other facilities (Corpus Christi Bond Homes and Rio Grande State Center Outpatient Clinic).

Strategy 7.4.1. Facility Program Support

Provide program support to SSLCs, state mental health hospitals, and other facilities (Corpus Christi Bond Homes and Rio Grande State Center Outpatient Clinic).

Strategy 7.4.2. Capital Repair and Renovation at State Supported Living Centers, State Hospitals, and Other

Conduct maintenance and construction projects critical to meeting accreditation/certification standards and to ensuring the safety of consumers and Master Lease Purchase Program.

Goal 8. Regulatory, Licensing, and Consumer Protection Services

Provide licensing, certification, contract enrollment services, financial monitoring, and complaint investigation, to ensure that residential facilities, home and community support services agencies, and persons providing services in facilities or home settings comply with state and federal standards, and that individuals receive high-quality services and are protected from abuse, neglect, and exploitation.

Objective 8.1. Long-Term Care and Acute Care Regulation

Provide licensing, certification, contract enrollment services, financial monitoring, and complaint investigation, to ensure that residential facilities, home and community support services agencies, and persons providing services in facilities or home settings comply with state and federal standards, and that individuals receive high-quality services and are protected from abuse, neglect, and exploitation.

Strategy 8.1.1. Health Care Facilities and Community-Based Regulation

Provide licensing, certification, contract enrollment services, financial monitoring, and complaint investigation to ensure that residential facilities and home and community support services agencies comply with state and federal standards and individuals receive high-quality services.

Efficiency 8.1.1.1. Average Daily Caseload Per Worker Provider Investigations

Definition

This measure provides the average daily caseload for Provider investigators.

Purpose

This measure is an indicator of an average amount of work handled each day by investigators.

Data Source

IMPACT (case counts) and CAPPS (investigator counts).

Methodology

Divide the numerator (sum of all daily case counts) for the reporting period by the denominator (sum of all daily investigator counts) during the reporting period.

Data Limitations

Data from CAPPS is point-in-time at the end of the month, so only the last record for the month is captured.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 8.1.1.1. Number of Long-Term Care and Health Care Regulation Licenses Issued

Definition

A license is a license, certification, registration, listing, compliance certificate, or any other written authorization granted by Licensing to operate a Long Term Care Facility, Health Care entity, or Home and Community Support Services Agency. This measure provides the number of new, Change of Ownership, and renewed licenses that were issued during the reporting period. A license is issued when all of the requirements for issuance are met.

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. These counts can be used to determine the volume of licensing in the Long Term Care and Health Care industry and in forecasting future trends, growths, and/or declines in the health care industry as well as showing the significant workload of the programs. This data is useful in projecting future funding needs.

Data Source

Long Term Care Regulation (LTCR) licensing data is entered in Texas Unified Licensure and Information Portal (TULIP). Health Care Regulation (HCR) data is tracked both manually and in VERSA.

Methodology

The number of Long Term Care and Health Care facility licenses issued for each of the components during the months of the reporting period are totaled. The components are then summed.

Data Limitations

The number of facilities and persons that apply is market-driven and is outside the agency's control. This measure does not reflect the number of licensed entities at any given time. In addition, this process is cyclical. There are two and three year licenses. One year may have much heavier activity in the renewal cycle based on this cyclical behavior.

Calculation Method

Cumulative

New Measure

Yes

Target Attainment

Currently undefined.

Output 8.1.1.2. Number of Long-Term Care Regulation and Health Care Regulation Contacts

Definition

A contact is an initial or follow-up, inspection, investigation, review, visit, or survey at an on-site operating or non-operating operation for the purposes of determining whether it is in compliance with the licensing law, administrative rules, and minimum standards. Inspections may be made in the following circumstances: routine monitoring, licensing receives an allegation that an operation is operating illegally; a person submits an application to become licensed or registered. For HCR, the number of contacts conducted is defined as the total number of investigations under state and federal regulations performed by staff and the total number of self-investigated complaints by abortion facilities, ambulatory surgical centers, birthing centers, chemical dependency treatment facilities, community mental health centers, comprehensive out-patient rehabilitation facilities, end stage renal disease facilities, free standing emergency medical care facilities, general hospitals, private psychiatric hospitals and crisis stabilization units, special hospitals, laboratories, Clinical Laboratory Improvement Amendments, and narcotic treatment programs, portable X-Ray services, rural health clinics, and special care facilities, which are documented by an appropriate investigative report. For LTCR this includes contacts in all provider facilities including Nursing Facility, Assisted Living Facility, Day Activity and Health Services, Home and Community Support Services Agencies, mental health or intellectual disability, or physical disability settings, which may include SSLCs, state hospitals, state centers, private ICF-IID facilities, community centers, HCS homes, and community providers.

Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy. These counts can be used to determine the volume of licensing in the Long Term Care and Health Care industry and in forecasting future trends, growths, and/or declines in the health care industry as well as showing the significant workload of the programs. This data is useful in projecting future funding needs.

Data Source

Due to the variety of contacts in this measure, multiple systems are used to determine individual counts which are summed for the total result.

Methodology

The measure is calculated by summing the totals for each contact type, quarterly, from the different reporting systems that are used to document the different contact types. The counts are equal to the count of completed contacts each month of the reporting period. Values reported in ABEST are updated each year-end ("Fifth" Quarter) up to and including the close of the appropriation year. Values reported in ABEST are also updated as required to ensure that data reflected is accurate and reliable.

Data Limitations

Depending on contact type, minor changes in totals may happen after the reporting period to allow for due process on contested findings.

Calculation Method

Cumulative

New Measure

Yes

Target Attainment

Currently undefined.

Strategy 8.1.2. Long-Term Care Quality Outreach

Provide quality monitoring and rapid response team visits to access quality and promote quality improvement in nursing facilities.

Objective 8.2. Childcare Regulation

Provide a comprehensive system of consultation, licensure, and regulation to ensure maintenance of minimum standards by daycare and residential childcare facilities, registered family homes, child-placing agencies, facility administrators, and child-placing agency administrators.

Strategy 8.2.1. Childcare Regulation

Provide a comprehensive system of consultation, licensure, and regulation to ensure maintenance of minimum standards by daycare and residential childcare facilities, registered family homes, child-placing agencies, facility administrators, and child-placing agency administrators.

Efficiency 8.2.1.1. Average Monthly Day Care Caseload Per Monitoring Worker

Definition

This measure provides the average monthly caseload handled by a day care licensing monitoring worker. Day care monitoring worker caseloads consist of facility and investigation assignments for child care centers, licensed and registered child-care homes.

Purpose

This measure is an indicator of an average amount of work handled by day care licensing monitoring workers, and is useful for determining and comparing staffing levels based on workload.

Data Source

Facility and investigation assignments for licensed child care centers, licensed child care homes, and registered child-care homes are captured in the Child-care Licensing Automation Support System (CLASS). The actual number of workers in the calculation is the number of worker classifications charged in CAPPS Human Resources to Program Activity Code (PAC) 247(Day Care Licensing) identified as CCL Inspector I-V (5040C, 1323A, 1324A) and CCL Specialist Generalist Investigator I-IV (5026U, 5024V, 5026V, 5025U, 5023U, 5024U, 5023V). Inspector trainees with less than 31 days of service are not counted. Inspectors with 31-90 days of service are counted as half a worker. Inspectors with 91 or more days of services are counted as full time. Due to possible modifications in the DFPS fiscal system, PACs, service codes and/or worker classification codes are subject to change. Should this occur, the current equivalent codes will be substituted and documented in the performance folder.

Methodology

Count the number of facility and investigation assignments associated with day care monitoring workers in PAC 247 during the reporting period (numerator) and divide

by the number of day care monitoring workers in PAC 247 with active assignments during the reporting period (denominator). When calculating 2nd, 3rd, and 4th quarters the year-to-date total is recalculated.

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Efficiency 8.2.1.2. Average Monthly Residential Caseload Per Monitoring Worker

Definition

This measure provides the average monthly caseload for a residential child care licensing monitoring worker.

Purpose

This measure is an indicator of an average amount of work handled by residential child care licensing monitoring workers, and is useful for determining and comparing staffing levels based on workload.

Data Source

Facility and investigation assignments are captured in the CLASS. The data includes CCL residential care licensing investigators identified as RCCL Inspector IV-VI (1323D, 1324D, 1325D) and RCCL Specialist Investigator I-II (5026E, 5026D, 5027V). Inspector trainees with less than 61 days of service are not counted. Inspectors with 61-120 days of service are counted as half a worker. Inspectors with 121 or more days of service are counted as full time. Due to possible modifications in the DFPS fiscal system, PACs, service codes and/or worker classification codes are subject to change. Should this occur, the current equivalent codes will be substituted and documented in the performance folder.

Methodology

Count the number of facility and investigation assignments associated with residential licensing monitoring workers during the reporting period (numerator) and divide by the number of residential monitoring workers with facility or investigation assignments during the reporting period (denominator).

Data Limitations

None.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Output 8.2.1.1. Number of Child Care Facility Inspections

Definition

An inspection is an on-site visit to an operating or non-operating operation or family home for the purposes of determining whether it is in compliance with the licensing law, administrative rules, and minimum standards. Inspections may be made in the following circumstances: routine monitoring, licensing receives an allegation that an operation is operating illegally, a person submits an application to become licensed or registered. Inspections conducted as part of an abuse/neglect investigation and inspections conducted as part of a non-abuse/neglect investigation are not included in the calculation.

Purpose

To achieve quality services.

Data Source

When a licensing representative inspects an operation, the date of the inspection and deficiencies with licensing law, administrative rules, or minimum standards that were observed during the inspection are entered into the Child-care Licensing Automation Support System. A record is kept by facility of the number and the date of all inspections that are conducted. The inspections are coded based upon the

purpose as monitoring, investigation, follow-up or other. Information is counted from CLASS.

Methodology

From CLASS, add together the total number of inspections made by licensing representatives of all regulated and non-regulated child care facilities within the reporting period. Exclude inspections conducted as part of non-abuse/neglect investigations or abuse/neglect investigations, attempted inspections, and assessments.

Data Limitations

None.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Output 8.2.1.2. Number of Completed Non-Abuse/Neglect Investigations

Definition

A non-abuse/neglect investigation occurs when a report is received that alleges a violation of licensing law, administrative rules, or minimum standards. This includes the following types of operations: those which are subject to regulation, licensed or certified for day care and residential care, registered and listed family homes, and foster and adoptive homes verified by Child Placing Agencies. This is a count of all non-abuse/neglect investigations completed during the reporting period.

Purpose

The purpose of this measure is to track the number of times that Licensing staff responds to reports from the public about the quality of child care.

Data Source

When licensing staff receives a report alleging violations of the licensing law, administrative rules or minimum standards, the date it was received is entered into the CLASS. When the non-abuse/neglect investigation is completed, staff enters their findings and a completion date. All reports received by the agency are resolved in some manner, but the number of reports received is outside the agency's control. Information is obtained from CLASS.

Methodology

Sum the total number of non-abuse/neglect investigations completed within the reporting period (numerator) and divide by the number of residential monitoring workers with facility or investigation assignments during the reporting period (denominator).

Data Limitations

None.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Output 8.2.1.3. Number of Child Care Regulatory Permits Issued

Definition

A permit is a license, certification, registration, listing, compliance certificate, or any other written authorization granted by Licensing to operate a child-care facility, child-placing agency, listed family home, temporary shelter or employer-based child care. This also includes an administrator's license. This measure provides the number of Initial, Full and renewed permits that were issued during the reporting period. A permit is considered issued when all of the requirements for issuance are met.

Purpose

The purpose of this measure is to track the volume of operations and administrators in the child care system as a predictor of workload. It is important in projecting the need for regulatory resources.

Data Source

When licensing staff issue a permit to an operation or administrator license, registration, or listing, they enter the date of the issuance into the CLASS.

Methodology

For the reporting period, sum the number of new and renewed permits that were issued to operations and administrators.

Data Limitations

The number of facilities and persons that apply is market-driven and is outside the agency's control.

Calculation Method

Cumulative

New Measure

Yes

Target Attainment

Currently undefined.

Objective 8.3. Professional and Occupational Regulation

Provide credentialing, training, and enforcement services to qualify individuals to provide services to long-term care facility and home healthcare agency individuals in compliance with applicable law and regulations.

Strategy 8.3.1. Credentialing/Certification of Health Care Professionals and Others

Provide credentialing, training, and enforcement services to qualify individuals to provide services to long-term care facility and home healthcare agency individuals in compliance with applicable law and regulations.

Output 8.3.1.1. Number of Licenses/Credentials Issued

Definition

This measure reports the number of health care professionals, licensed chemical dependency counselors, nursing facility administrators, nurse aides, medication aides, and any other occupational category in LTCR and HCR that are credentialed, licensed, permitted, certified, registered, and/or entered on a registry.

A credential includes any credential, license, permit, certification or addition to any registry. This output measure reflects the cumulative total (both initial and renewals) of LTCR and HCR individuals licensed, permitted, certified, registered, documented, or placed on a registry.

Purpose

This output measure reflects the cumulative total (both initial and renewals) of individuals licensed, permitted, certified, registered, documented, or placed on a registry.

Data Source

This measure is a count of licenses issued or renewed and does not provide any insight into the unit’s performance. Additionally, since many licenses renew biennially year-to-year comparisons provide inconclusive information.

Methodology

This output measure reflects the cumulative total (both initial and renewals) of individuals who are credentialed, licensed, permitted, certified, registered, and/or entered on a registry.

Data Limitations

This data is cyclical in nature and not controlled by HHSC. Because of two and three year licenses, activity numbers may spike and lull depending on how many licenses are issued when.

Calculation Method

Cumulative

New Measure

Yes

Target Attainment

Currently undefined.

Output 8.3.1.2. Number of Investigations Completed

Definition

This measure reports the total number of complaints and referrals that were resolved during all months of the reporting period. This includes complaints and referrals of nursing facility administrators, nurse aides, medication aides, direct care and professional complaint investigations. Complaints and referrals are resolved by the HHSC, either administratively by the Professional Credentialing Enforcement branch or through formal hearings conducted by the commission's Legal Division. Uncredentialled staff are all direct care personnel not licensed by another state agency in long-term care facilities licensed by the HHSC. The investigations are initiated upon notification of possible violations of state laws or rules.

Purpose

This measure quantifies the agency's workload as it pertains to implementing the provisions funded under this strategy. This is useful data for projecting future funding needs.

Data Source

This information is both manually collected and reported from systems of record. Manual collections of data are pen and paper tabulations of information manually pulled from computer based records. Systems sources include Nurse Aide Registry, Medication Aide Registry, and Nursing Facility Administrator licensing system.

Methodology

Data are computed by totaling the number of complaints and referrals dismissed by the Commission and number of cases resolved through formal hearing or settlement during the months of the reporting period.

Data Limitations

Does not apply.

Calculation Method

Cumulative

New Measure

Yes

Target Attainment

Currently undefined.

Objective 8.4. Texas.gov. Estimated and Nontransferable

Texas.gov. Estimated and Nontransferable.

Strategy 8.4.1. Texas.gov. Estimated and Nontransferable

Texas.gov. Estimated and Nontransferable.

Goal 9. Program Eligibility Determination and Enrollment

Provide accurate information on and timely eligibility and issuance services for financial assistance, medical benefits, and food assistance.

Objective 9.1 Eligibility Operations

Provide accurate and timely eligibility and issuance services for financial assistance, medical benefits, and Supplemental Nutrition Assistance Program (SNAP) benefits.

Strategy 9.1.1. Integrated Financial Eligibility and Enrollment

Provide accurate and timely eligibility and issuance services for financial assistance, medical benefits, and SNAP benefits.

Output 9.1.1.1. Average Monthly Number of Eligibility Determinations

Definition

This measure reports the average monthly number of eligibility determinations for Temporary Assistance for Needy Families and State Two Parent Cash Assistance,

Supplemental Nutrition Assistance Program, Medicaid for the Elderly and People with Disabilities, Medicaid and CHIP. Determining eligibility refers to actions taken to determine the eligibility status of applicants or ongoing cases: approved, denied, or open/closed applications, and sustained or denied complete reviews.

Purpose

This measure is useful for comparing, over time, the principal workload drivers for Eligibility Determination, the largest sub-strategy within the Integrated Eligibility and Enrollment Strategy.

Data Source

Data are obtained from Datamart.

Methodology

Data are computed by totaling, over all months in the reporting period, the number of eligibility determinations performed and dividing by the number of months in the reporting period.

Data Limitations

There may be more than one eligibility determination for a case during the reporting period. Data may be collected from different systems.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Objective 9.2. Community Access and Supports

Determine eligibility for, promote access to, and monitor long-term care services and supports.

Outcome 9.2.1. Percent Long Term Care Ombudsman Complaints Resolved or Partially Resolved

Definition

The percent of Long Term Care (LTC) Ombudsman Program complaints resolved or partially resolved is defined as the percent of complaints received by the LTC Ombudsman Program and resolved either totally or partially to the satisfaction of the complainant. A complaint is defined as a concern brought to, or initiated by, the certified ombudsman for investigation and action by or on behalf of one or more residents of a long-term care facility relating to health, safety, welfare, or rights of a resident. A resident is an individual living in a nursing home or assisted living facility.

Purpose

This outcome measure analyzes LTC Ombudsman Program effectiveness in responding to complaints made by or on behalf of residents of nursing facilities and assisted living facilities. The measure allows decision-makers and state agency staff to identify trends of the program. State agency staff may also identify opportunities for training and technical assistance to the local LTC Ombudsman Programs.

Data Source

Data is reported by local LTC Ombudsman Programs in the format specified by HHSC.

Methodology

The percentage is calculated by dividing the number of resolved complaints by the total number of complaints that were closed. When closed, the three disposition categories are: 1. Partially or fully resolved to the satisfaction of the resident, resident representative, or complainant, 2. Withdrawn or no action needed by the resident, resident representative, or complainant; and 3. Not resolved to the satisfaction of the resident, resident representative, or complainant.

Data Limitations

All complaints received by the LTC Ombudsman Program are documented in the statewide-operated database. Only complaints reported as closed and with a disposition status are included in the calculation.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Strategy 9.2.1. Intake, Access, and Eligibility to Services and Supports

Determine functional eligibility for long-term care services, develop individual service plans based on individual needs and preferences, authorize service delivery, and monitor the delivery of services (Medicaid and non-Medicaid).

Output 9.2.1.1. Average Monthly Number Individuals w/IDD Receiving Assessment and Service Coordination

Definition

This measure captures the unduplicated count of priority population, as defined by Local Authorities Performance Contract, eligible individuals whose services are funded with the HHSC funds and who receive IDD community assessment and/or service coordination services. Assessment services are monthly services. Service coordination services may occur quarterly but are most frequently monthly services. Quarterly and year-to-date performance is stated as the average of the months in the reporting period, regardless of how the services for the individuals were funded.

Purpose

Monthly number of individuals served reflects the system-wide level of activity occurring over time and allows the agency to associate this activity with related costs.

Data Source

Month-of-service to-date data that reports, by type-of-service, the number of individuals for whom claims have been approved-to-pay, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from the commission's Claims Management System by means of ad hoc query.

Methodology

To obtain the number of individuals served with HHSC appropriation authority funds, the numerator is the sum of the number of individuals receiving IDD assessment and/or service coordination services each month of the reporting period; the denominator is the number of months in the period. The formula is numerator/denominator.

Data Limitations

Because it takes 365 days to close out 100 percent of the claims for a month of service, the number of individuals ultimately served must be estimated for months that have not yet closed out, by using "completion factors" specific to each service applied to the number of individuals approved-to-pay to-date and/or the number of individuals authorized to receive services. The concept of completion factors is that data, as of a given number of claims processing months after the month of service, can be considered a certain percent complete based upon historical patterns. Therefore, for a given month of service, the number of persons on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of persons ultimately served.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Objective 9.3. Texas Integrated Eligibility Redesign System

Texas Integrated Eligibility Redesign System (TIERS).

Strategy 9.3.1. Texas Integrated Eligibility Redesign System and Supporting Tech

TIERS and eligibility supporting technologies capital.

Strategy 9.3.2. Texas Integrated Eligibility Redesign System Capital Projects

TIERS capital projects.

Goal 10. Provide Disability Determination Services within Social Security Administration Guidelines

Enhance service to persons with disabilities by achieving accuracy and timeliness within the Social Security Administration Disability Program guidelines and improving the cost-effectiveness of the decision-making process in the disability determination services.

Objective 10.1. Increase Decisional Accuracy and Timeliness of Determinations

To achieve annually the decisional accuracy of 90.6 percent and timeliness of 125 days as measured by Social Security Administration Disability Program guidelines.

Strategy 10.1.1. Determine Federal Supplemental Security Income and Social Security Disability Insurance Eligibility

Determine eligibility for federal SSI and Social Security Disability Insurance benefits.

Output 10.1.1.1. Number of Disability Cases Determined

Definition

Total number of cases determined as reported by the National Disability Determination Services System (NDDSS). A case is established on an individual and may include multiple claims.

Purpose

The purpose of this measure is to determine whether persons who apply to the Social Security Administration (SSA) for disability benefits are eligible for benefits.

Data Source

The NDDSS is the SSA management information system for all state DDS's. The DDS's on a weekly basis report workload and staffing information to SSA. This system is found on SSA's DALNET (Dallas SSA Regional Office intranet).

Methodology

Total number of cases determined and cleared as reported by the National Disability Determination Services System. Figures are cumulative.

Data Limitations

Data is collected through NDDSS.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Currently undefined.

Goal 11. Office of Inspector General

Office of Inspector General (OIG).

Objective 11.1. Client and Provider Accountability

Improve Health and Human Services (HHS) programs and operations by protecting them against fraud, waste, and abuse.

Outcome 11.1.1. Net State Dollars Recovered Per Dollar Expended from All Funds

Definition

This measures the state fund return on investment achieved by the Office of the Inspector General (OIG) relative to the agency's costs. State fund Recoveries include all General Revenue dollars or Earned Federal Funds collected, recouped, or otherwise recovered as a result of OIG activities with the exception of dollars

recovered by the Medicaid Recovery Audit Contractor (RAC). Cost savings and dollars identified for recovery that have not yet been collected (such as negotiated settlements and court-ordered restitutions) are not included in this measure.

Purpose

This is a measure of the effectiveness of the IG's efforts to maximize recoveries as required by Texas Government Code §§ 531.102(b),(p); 531.103(a); 531.1131; 531.1132; and 531.117.

Data Source

The sources of recovery data include OIG case management systems, the claims administrator system and databases, and data reported from other HHS programs who directly recover funds based on OIG activities. OIG Operating expenditure data is extracted from the HHS CAPPS Financial System. OIG staff compile recovery data from the respective source systems and activities in a consolidated IG-wide tracking system on a monthly basis, and that data is then compared to total expenditure data across the OIG for the same reporting period.

Methodology

For the given reporting period, the sum of estimated state dollars recovered from all IG divisions (including Investigations, Inspections, Audit, and Litigation) is reduced by total IG expenditures (in General Revenue) and by estimated General Revenue collected by the RAC. This quantity is then divided by total OIG expenditures in All Funds. The result is then reported as a dollar figure. Calculation: (Recoveries - Expenditures) / Expenditures, expressed as a percentage. The percentage is then converted to a dollar figure (e.g. 30Percent ROI = $1.30 Recovered per $1 Expended).

Data Limitations

No limitations.

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Strategy 11.1.1. Office of Inspector General

OIG.

Output 11.1.1.1. Number of Completed Provider and Recipient Investigations

Definition

This is a measure of the Medicaid Program Integrity and the General Investigations sections of OIG that is responsible for investigating allegations, complaints, and referrals of Medicaid, Temporary Assistance for Needy Families, and Supplemental Nutrition Assistance Program fraud, abuse, or waste.

Purpose

This measures the effectiveness of a major activity of OIG as required by Tex. Gov't Code 531.102, 531.103, 531.113(d-1) (House Bill 2292, 78th Legislature).

Data Source

OIG case management systems.

Methodology

The total unduplicated number of full-scale investigations that are closed during the reporting period. It is based on allegations, complaints, and referrals of fraud, abuse, or waste that are reflected in the OIG case management systems.

Data Limitations

No limitations.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Output 11.1.1.2. Number of Audits and Reviews Performed

Definition

This measures the total number of reports issued by or on behalf of the OIG audit division and by federal contractors for audits of HHS System and DFPS programs, providers, and contractors.

Purpose

This is a measure of work performed by the Office of the Inspector General pursuant to Texas Government Code §§531.102, 531.102(h)(4), 531.1025(a), and 531.113(d-1).

Data Source

OIG audit staff compile data on the reports issued on a monthly basis. The data is entered in the OIG Audit Division's internal tracking database. The final number reported for this measure is entered in the Performance Data Compiler (PDC) maintained by the OIG Budget Division.

Methodology

Total sum of audits and non-audit engagements conducted.

Data Limitations

None.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Output 11.1.1.3. Number of Nursing Facility Utilization Reviews

Definition

This is a measure of the number of on-site or utilization reviews to assure nursing facilities submit accurate data which reflects actual resident conditions.

Purpose

Nursing Facility Utilization reviews determine the level of care provided by nursing facilities to Medicaid residents and the relationship of such care to the charges (billing) to the state as required by Texas Government Code §531.1591 and §531.912, 1 TAC §§371.212-371.216, Social Security Act §1902(a)(30), and 42 CFR Section 456.3.

Data Source

Nurse reviewers and/or administrative enter into the agency's database information collected during the on-site reviews into the Nursing Facility Utilization Review (NFUR) application then upload it to the MFADS/NFUR Repository from which various performance reports are run. State office staff collects and accumulates all regions' information and enter it into the Performance Data Compiler (PDC).

Methodology

Nurse reviewers enter data in the field indicating the number of reviews performed, and this data is summed up for the state for the reporting period.

Data Limitations

No limitations.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Output 11.1.1.4. Number of Hospital Utilization Reviews

Definition

This measures the count of hospital inpatient admissions reviewed and closed during the reporting period.

Purpose

This measure addresses the scope of worked performed by the OIG pursuant to Texas Government Code §531.102(a-5), §531.1024, 1 TAC §§371.200-371.210,

Social Security Act §1902(a)(30), and 42 CFR §456.3. Inpatient utilization reviews are required by Public Law 92-603 to be conducted in all Title XIX participating hospitals.

Data Source

Nurse reviewers and/or administrative assistants enter information collected into the Hospital Utilization Review (HUR) application, then upload it to the MFADS/HUR Repository from which various performance reports are run. State office staff collects and accumulates all regions' information and enters it in the Performance Data Compiler (PDC).

Methodology

The methodology includes utilization reviews which may be of a statistically valid random sample or a focused case selection of hospital medical records for admissions, readmission, outliers, transfers, appropriate Diagnoses Related Groups (DRG), and quality of care. Nurse reviewers enter the number of reviews performed into the HUR application, and this data is summed for the reporting period.

Data Limitations

No limitations.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Output 11.1.1.5. Total Dollars Recovered (Millions)

Definition

This is a measure of the total monetary recoveries resulting from activities of the OIG at the end of each quarter and fiscal year. These recoveries include cash collected as well as completed offsets. Offsets, or recoupments, are payments that are set up out of future benefit allotments. Refer to Accountability Rider Report dated February 1, 2018.

Purpose

This measure addresses the efforts of OIG to maximize recoveries in all HHS programs as required by Tex. Gov't Code §§531.102(b), (p), (t)(5); 531.103(a); 531.1131; 531.1132; 531.117.

Data Source

Below are the sources in which OIG staff collects data on recoveries monthly and enters the information in the Performance Data Compiler (PDC). Refer to Accountability Rider dated February 1, 2018.

The following sources are used to collect the data: Accounts Receivable Tracking System (ARTS); Automated System for Office of Inspector General (ASOIG); Hospital Utilization Review (HUR) System; Medicaid Fraud and Abuse Detection System PI Case Tracker (Case Tracker) ; Medicaid/CHIP Administrative Tracking System (MCATS); Reports from the Medicaid claims administrator; Office of Attorney General Cash Medical Support reports; reconciliation with HMS reports; Nursing Facility Utilization Review (NFUR) System; Premium Payment System; Texas Integrated Eligibility Redesign System (TIERS); and Electronic Benefits Transfer WIC Information Network (EBTWIN). NOTE: Recovery data also used in OC-1 Net State Dollars Recovered Per Dollar Expended from All Funds.

Methodology

The sum of dollars recovered (Dollars actually recovered through cash collections or offsets) by each section of OIG for the reporting period. Refer to the Accountability Rider Report dated February 1, 2018.

Data Limitations

OIG is dependent upon other agencies and vendors (such as the Medicaid claims administrator; HHS Fiscal Management, Health Management Systems, Inc. (HMS), HHSC Accounts Payable, CMS; IRS; MCOs; etc.) for the timeliness of reporting and actual recovery of some of the funds involved in the measure.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Output 11.1.1.6. Referrals to Office of the Attorney General (OAG) Fraud Control Unit

Definition

This is a measure of the number of cases involving a suspicion of fraud that are referred to the Office of the Attorney General (OAG) for investigation and potential presentation for prosecution.

Purpose

This measure identifies the effectiveness of the Office of Inspector General in promptly and accurately identifying and referring cases of Medicaid fraud suitable for criminal or civil prosecution as required by 42 CFR 455.21 and Texas Government Code §§531.102(b), 531.103, and 531.104.

Data Source

OIG case management system. All referrals made to the OAG are entered into the case management system and monitored on a monthly basis. Upon acceptance of a referral for investigation, the OAG notifies OIG through a letter of acceptance. OIG staff enters and maintains the status of the referral into the case management system and enters the number of referrals in the Performance Data Compiler (PDC).

Methodology

Sum of cases involving a suspicion of fraud referred to the OAG during the reporting period.

Data Limitations

No limitations.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Output 11.1.1.7. Total Medicaid Overpayments Recovered with Special Investigation Units (SIU)

Definition

This is a measure of the total monetary Medicaid recoveries collected by OIG resulting from a fraud and abuse referral from an MCO SIU. This is the OIG portion (50 Percent) of recoveries collected pursuant to Government Code, Sec. 531.1131, as a result of either a MCO SIU or a collaboration between the OIG and MCO SIU. This measure does not include recoveries retained by the MCOs. These recoveries are also included in OP-5 Total Dollars Recovered (Millions).

Purpose

This measure reflects recoveries collected by OIG related to fraud and abuse recovery efforts by MCO SIUs or by the OIG in collaboration with MCO SIUs. Amounts recovered by an MCO or by an MCO in collaboration with OIG are allocated between the MCO and the OIG pursuant to Government Code Sec. 531.1131. The OIG portion of these recoveries are also reported in OP 5 - Total Dollars Recovered (Millions).

Data Source

The data source for Medicaid recoveries collected by OIG based on MCO SIU referrals is the OIG Performance Data Compiler (PDC). The PDC records recoveries from fraud, waste, and abuse cases that have reached final disposition.

Methodology

Medicaid recoveries collected by OIG are based on MCO SIU referrals. OIG used the Case Tracker system to track MCO SIU referrals and recoveries. Once cases are finalized, the recoveries are reported in the PDC. The PDC is the source for recoveries reported in this measure.

Data Limitations

OIG Recoveries are dependent upon MCO SIU recovery collections and MCO SIU self-reporting to OIG on their collections.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Output 11.1.1.8. Average Number of Clients in the Inspector General Lock-in Program

Definition

The measure establishes the number of clients enrolled in the Lock-In program, illustrates capacity, and is used as a factor to calculate cost avoidance and resource utilization.

Purpose

The key measure reports the number of clients enrolled in the Lock-In program, illustrates capacity, and is used as a factor to calculate cost avoidance and resource utilization.

Data Source

Data comes from TIERS's MN 432 reports after Medicaid cut-off monthly processing based on clients with open Lock-In segments for that month.

Methodology

The sum of clients in the Lock-In program each month is recorded and averaged by the 12 months of the Fiscal Year; and is calculated quarterly and reported annually. The sum of clients in the Lock-In program varies due to factors described in data limitations. Growth cannot be predicted due to these variables.

Data Limitations

The number of clients in the Lock-In program is dependent on eligibility and number of assigned months for the Lock-In period. Clients may lose eligibility, enter a nursing home or enroll in a non-participating Lock-In program type, expire, complete their Lock-In term; or added as a newly enrolled Lock-In client based on referrals from MCO's, the public, and providers.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Output 11.1.1.9. Total Dollars Identified (Millions)

Definition

This is a measure of the total potential overpayments resulting from activities of the OIG. These potential overpayments have not actually been collected at this point (and notice not necessarily sent to providers, contractors and/or MCOs). These potential overpayments are estimates prior to further analysis or additional information submitted by the subject of the potential recovery.

Purpose

This measure addresses the efforts of OIG to maximize recoveries in all HHS programs as required by Tex. Gov't Code 531.102(b), (p), (t)(5); 531.103(a); 531.1131; 531.1132; 531.117.

Data Source

Below are the sources in which OIG staff collects data on potential overpayments monthly and enters the information in the PDC. The following sources are used to collect the data: Accounts Receivable Tracking System (ARTS); Automated System for Office of Inspector General (ASOIG); Hospital Utilization Review (HUR) System; Medicaid Fraud and Abuse Detection System PI Case Tracker (Case Tracker); Medicaid/CHIP Administrative Tracking System (MCATS); Nursing Facility Utilization Review (NFUR) System; Premium Payment System; Texas Integrated Eligibility Redesign System (TIERS); and Electronic Benefits Transfer WIC Information Network (EBTWIN) system.

Methodology

The potential overpayments are estimated by each section of OIG as resulting from work efforts; such as Audits, Investigations, Utilization Reviews and Inspections. These potential overpayments have not actually been collected at this point (and notice not necessarily sent to providers and/or MCOs). These potential overpayments are estimates prior to further analysis or additional information submitted by the subject of the potential recovery.

Data Limitations

Potential overpayments are dependent upon the number of investigations, audits or inspections that are completed by the OIG . The potential overpayment is preliminary and in many instances will not be collected. For example, when a provider elects to litigate a matter, they may develop new legal theories or supply additional facts not considered in the preliminary identification. Furthermore, federal law recognizes that companies may go bankrupt or simply go out of business. See 42 C.F.R. 433.316.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Lower than target is desirable.

Strategy 11.1.2. Office of Inspector General Administrative Support

OIG Administrative Support.

Output 11.1.2.1. Number of Trainings Presented by Office of Inspector General Staff

Definition

This is the number of core skills trainings presented by OIG staff or external entities to internal staff, and training presented by OIG staff to external stakeholders.

Purpose

This measure tracks OIG staff development programs that reinforce program oversight and integrity, and strengthen internal skills to audit, inspect, review, and investigate fraud, waste, and abuse; and helps to educate external entities on the role of the OIG in preventing fraud, waste, and abuse in the HHS programs.

Data Source

Data is collected from the OIG PD’s internal tracking system. OIG PD coordinates the development, implementation, and monitoring of internal training programs.

Methodology

The calculation is the cumulative sum of all core skills trainings presented by OIG staff or external entities to internal staff engaged in the audit, review, investigation, inspection, and other complex health and human services programs; and training presented by OIG staff to external stakeholders.

Data Limitations

No data limitations.

Calculation Method

Cumulative

New Measure

No

Target Attainment

Higher than target is desirable.

Goal 12. Health and Human Services Enterprise Oversight and Policy

Improve the effectiveness and efficiency of the delivery of health and human services in Texas through the oversight and coordination of a prompt, accurate, and comprehensive service delivery system.

Objective 12.1. Enterprise Oversight and Policy

Improve the business operations of the HHS System to maximize federal funds, improve efficiency in system operations, improve accountability and coordination throughout the system, and ensure the timely and accurate provision of eligibility determination services for all individuals in need of HHS System programs.

Strategy 12.1.1. Enterprise Oversight and Policy

Provide leadership and direction to achieve an efficient and effective HHS System.

Strategy 12.1.2. Information Technology Capital Projects Oversight and Program Support

Information technology capital projects and program support.

Objective 12.2. Program Support

Program support.

Strategy 12.2.1. Central Program Support

Central program support.

Strategy 12.2.2. Regional Program Support

Regional program support.

Goal 13. Texas Civil Commitment Office

Texas Civil Commitment Office.

Objective 13.1. Administer Texas Civil Commitment Program

Administer Texas Civil Commitment Program.

Strategy 13.1.1. Texas Civil Commitment Office

Texas Civil Commitment Office.

Output 13.1.1.1. Number of Sex Offenders Provided Treatment and Supervision

Definition

The number of current sex offenders who have been civilly committed, receiving treatment and supervision, who have not been in prison for the entire reporting period.

Purpose

To determine the number of current sex offenders who have been civilly committed and are receiving treatment and supervision.

Data Source

Civilly Committed Sex Offender database

Methodology

A report will be run to capture the total number of civilly committed sex offenders as of the last day of the reporting period. From the number of all current, civilly committed sex offenders, those who resided in prison for the entire reporting period will be subtracted. This number will be the number of sex offenders provided treatment and supervision. Data is non-cumulative.

Data Limitations

Available data is point-in-time data. Databases provide placement at the time of the query; they do not capture changes in civilly committed sex offender placement status across time (i.e., the databases do not track the movement of a civilly committed sex offender among community placements and locked facilities).

Calculation Method

Noncumulative

New Measure

No

Target Attainment

Currently undefined.

Schedule C: Historically Underutilized Businesses Plan

The Historically Underutilized Businesses Plan, found on the following pages, was developed by the HHSC Division of Procurement and Contracting Services, in accordance with Texas Government Code Section 2161.123.

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Health and Human Services System Strategic Plans 2023–2027

Schedule C: Historically Underutilized Businesses Plan

As Required by

Tex. Gov't Code Sec. 2161.123

Health and Human Services Commission

Department of State Health Services

May 2022

TEXAS
Health and Human Services

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1. Introduction

The Health and Human Services (HHS) System administers programs to encourage participation by historically underutilized businesses (HUBs) in all contracting and subcontracting by HHS agencies. The HHS System's HUB Programs are designed to enhance the ability of HUBs to compete for HHS System contracts, increase agencies' awareness of such businesses, ensure meaningful HUB participation in the procurement process and assist HHS System agencies in achieving their HUB goals.

Each state agency is required to include in its strategic plan a HUB plan. The section below describes, in its entirety, a coordinated HUB plan that covers the HHS System's HUB programs as a whole.

2. Goal

The goal of the HHS System HUB Plan is to promote fair and competitive business opportunities that maximize the inclusion of minority, woman and service-disabled veteran-owned businesses that are certified HUBs in the procurement and contracting activities of HHS System agencies.

3. Objective

The HHS System strives to meet or exceed the Statewide Annual HUB Utilization Goals and/or agency-specific goals that are identified each fiscal year (FY) in the procurement categories related to the HHS System's current strategies and programs.

4. Outcome Measures

In accordance with Texas Government Code Section 2161(d)(5) and the State's Disparity Study, state agencies are required to establish their own HUB goals based on scheduled fiscal year expenditures and the availability of HUBs in each procurement category. The HHS System has adopted the Statewide HUB Goals as the agency-specific goals.

In procuring goods and services through contracts, the HHS System, as well as each of its individual agencies, will make a good-faith effort to meet or exceed the statewide goals, as described in Table 1, for contracts the agency expects to award in a fiscal year.

Table 1: Statewide HUB Goals by Procurement Categories, Fiscal Year 2022

PROCUREMENT CATEGORIES	UTILIZATION GOALS
Heavy Construction	11.20%
Building Construction	21.10%
Special Trade Construction	32.90%
Professional Services Contracts	23.70%
Other Services Contracts	26.00%
Commodity Contracts	21.10%

Source: Data from FY 2022 Statewide HUB Report, Texas Comptroller of Public Accounts.

The HHS System will collectively use the following outcome measure to gauge progress:

- Total expenditures and the percentage of purchases awarded directly and indirectly through subcontracts to HUBs under the procurement categories.

Each HHS System agency may track additional outcome measures.

5. HHS System Strategies

The HHS System maintains and implements policies and procedures, in accordance with the HUB statute and rules, to guide the agencies in increasing the use of HUBs by contracting directly and/or indirectly through subcontracting.

The HHS System employ several additional strategies, such as:

- Implementing policies to ensure good faith effort requirements are performed and maintained from the development of the solicitation through the duration of the contract
- Utilizing the Centralized Master Bidders List and HUB Directory to solicit bids from HUBs
- Maintaining a HUB Program Office of HUB Coordinators at HHSC headquarters for effective coordination for all HHS agencies
- Developing and implementing reporting practices to provide updates to the Executive Commissioner, Chief Operating Officer, Deputy Executive Commissioners and Associate Commissioners on HHS HUB Program activities, related initiatives, and projects
- Developing target-marketing strategies inclusive of web-based training to provide guidance on HHS System procurements
- Maintaining an active upcoming Procurement Forecast schedule on website to provide notices of opportunities prior to posting to encourage HUB participation
- Increasing awareness of the HUB Program across the HHS System by providing information to all new employees and how they may assist in the efforts to increase HUB utilization
- Enhancing outreach efforts internally and externally by promoting access, awareness, and accountability through education and training
- Increasing HUB participation in Spot Bid purchases by mandating the agency solicit a HUB for purchases starting at $5,000 to $10,000

6. Output Measures

The HHS System will collectively use and individually track the following output measures to gauge progress:

- The total number of bids received from HUBs
- The total number of contracts awarded to HUBs
- The total amount of HUB subcontracting expenditures
- The total amount of HUB Procurement Card expenditures
- The total number of mentor-protégé agreements
- The total number of HUBs provided assistance in becoming HUB certified.

Additional output measures which may be used by specific System agencies:

- The total number of outreach initiatives such as HUB forums attended and sponsored
- The total number of HUB training provided to the vendor community as well as internally to agency staff.

7. HUB External Assessment

According to the Comptroller of Public Accounts, the HHS System collectively awarded 10.46% in FY 2020, and 3.45% in FY 2021 to HUBs. Tables 2 and 3 reflects utilization for HHSC and DSHS total spending with HUBs directly and indirectly through subcontracting use.

Table 2: HHS System Expenditures with Historically Underutilized Businesses, by Agency, Fiscal Year 2020

AGENCY	TOTAL EXPENDITURES	TOTAL SPENT WITH ALL CERTIFIED HUBS	PERCENT
HHSC	$1,089,159,032	$173,706,727	15.95%
Department of State Health Services	$846,435,410	$28,828,218	3.41%
Total	$1,935,594,443	$202,534,945	10.46%

Source: Data from FY 2020 Statewide Annual HUB Report, Texas Comptroller of Public Accounts.

Table 3: HHS System Expenditures with Historically Underutilized Businesses, by Agency, Fiscal Year 2021

AGENCY	TOTAL EXPENDITURES	TOTAL SPENT WITH ALL CERTIFIED HUBS	PERCENT
HHSC	$1,254,096,820	$197,668,652	15.76%
Department of State Health Services	$5,815,625,383*	$46,517,933	0.80%
Total	$7,069,722,203	$244,186,585	3.45%

Source: Data from FY 2021 Statewide Annual HUB Report, Texas Comptroller of Public Accounts.
***Note: In FY 2021, DSHS expenditures increased from $846 million in FY2020 to $5.8 billion. A substantial portion of the $5.8 billion was expended on the state's response to the COVID pandemic which were made using the emergency procurement process which resulted in the decrease in percentage spent with certified HUBs.**

The HHS System agencies continuously strive to make internal improvements to meet or exceed HUB goals. HHS System agencies continued outreach efforts to educate HUBs and minority businesses about the procurement process.

Other areas of progress include:

- Maintaining relationships with the Texas Association of African-American Chambers of Commerce and the Texas Association of Mexican-American Chambers of Commerce among other organizations focused on small minority, women, and/or service-disabled veteran-owned businesses
- Conducting post-contract-award meetings with contractors to discuss HUB Subcontracting Plan compliance and monthly reporting requirements

Additional goals include:

- Enhancing minority/woman/services-disabled veteran-owned business participation in HHS System-sponsored HUB Forums where exhibitors may participate in trade-related conferences
- Enhancing HHS System HUB reporting capabilities

- Expanding HHS System mentor-protégé program vision to maximize the state's resources through cooperation and assistance from other public entities and corporate businesses
- Promoting and increasing awareness of HHS System procurement opportunities for direct and indirect capacity.

Schedule D: Statewide Capital Plan

The statewide capital plan for the Health and Human Services Commission will be submitted once approved.

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Schedule E: Health and Human Services Strategic Plan

The Health and Human Services System Coordinated Strategic Plan will be submitted it by its statutory deadline of October 1.

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Schedule F: Agency Workforce Plan

The Health and Human Services System Workforce Plan, found on the following pages, was developed by the Department of Human Resources, Division of System Support Services, Health and Human Services Commission, in accordance with Texas Government Code Section 2056.0021.

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Strategic Staffing Analysis and Workforce Plan For the Planning Period 2023-2027

As Required by
Texas Government Code
Section 2056.0021

Health and Human Services System
May 2022

TEXAS
Health and Human Services

Table of Contents

1. Executive Summary

The Health and Human Services (HHS) System Strategic Staffing Analysis and Workforce Plan is an integral part of HHS' staffing plan. Workforce planning is a business necessity due to many factors, including:

- constraints on funding;
- increasing demand for HHS services;
- increasing number of current employees reaching retirement age resulting in fewer, less experienced workers available as replacements; and
- increasing competition for highly skilled employees.

HHS agencies are proactively addressing this challenge by preparing for the future and reducing risks. Designed for flexibility, the HHS System Strategic Staffing Analysis and Workforce Plan allows HHS executive management to make staffing adjustments according to the changing needs of HHS agencies.

State leaders in Texas recognize the importance of workforce planning. As part of their strategic plans, state agencies are required under the Texas Government Code, Section 2056.0021, to develop a workforce plan in accordance with the guidelines developed by the State Auditor's Office (SAO). To meet these requirements, this HHS Workforce Plan – a Schedule attachment to the HHS System Strategic Plan for the Fiscal Years 2023–2027 - analyzes the following key elements for the entire HHS System:

- **Current Workforce Demographics** – Describes how many employees work for the HHS agencies, where they work, what they are paid, how many of them are return-to-work retirees, how many have left HHS, how many may retire, and whether minority groups are underutilized when compared to the state Civilian Labor Force (CLF) for Equal Employment Opportunity (EEO) job categories. The workforce is examined by gender, race, age and length of state service.
- **Expected Workforce Challenges** – Describes anticipated staffing needs based on population trends, projected job growth and other demographic trends. A detailed examination of each identified shortage occupation was conducted to identify and understand retention and recruitment problems.

- **Strategies to Meet Workforce Needs** – Describes recruitment and retention strategies that address expected workforce challenges for shortage occupation jobs.

The following is the detailed HHS System Strategic Staffing Analysis and Workforce Plan.

2. Health and Human Services

The Health and Human Services System, as reflected in Article II of the General Appropriations Act, consists of the two agencies described below:

- Health and Human Services Commission (HHSC). HHSC began services in 1991. HHSC provides leadership to the HHS agencies, manages the day-to-day operations of state supported living centers and state hospitals, and administers programs that deliver benefits and services, including:
  - Medicaid for families and children.
  - Long-term care for people who are older or who have disabilities.
  - Supplemental Nutrition Assistance Program food benefits and Temporary Assistance for Needy Families cash assistance.
  - Behavioral health services.
  - Services to help keep people who are older or who have disabilities in their homes and communities.
  - Services for women.
  - Services for people with special health needs.

The agency also oversees regulatory functions including:

  - Licensing and credentialing long-term care facilities, such as nursing homes and assisted living.
  - Health care facilities regulation.
  - Licensing child-care providers.

- Department of State Health Services (DSHS). DSHS includes programs previously administered by the Texas Department of Health, the Texas Commission on Alcohol and Drug Abuse, and the Health Care Information Council. The agency began services on September 1, 2004 and continues to administer programs to promote and protect public health by creating better systems that include prevention, intervention and effective partnerships with communities across the state. The agency works to:
  - Improve health outcomes through public and population health strategies, including prevention and intervention.

- Optimize public health response to disasters, disease threats, and outbreaks.
- Improve and optimize business functions and processes to support delivery of public health services in communities.
- Enhance operational structures to support public health functions of the state.
- Improve recognition and support for a highly skilled and dedicated workforce.
- Foster effective partnership and collaboration to achieve public health goals.
- Promote the use of science and data to drive decision-making and best practices.

HHS Vision

Making a positive difference in the lives of the people we serve.

HHS Mission

Improving the health, safety and well-being of Texans with good stewardship of public resources.

3. Workforce Demographics

With a total of 36,991 full-time and part-time employees, the HHS workforce has decreased by approximately seven percent (2,552 employees) in the period from August 31, 2019 to August 31, 2021.[1] [2] [3]

Figure 1: HHS System Workforce for FY 19 - FY 21

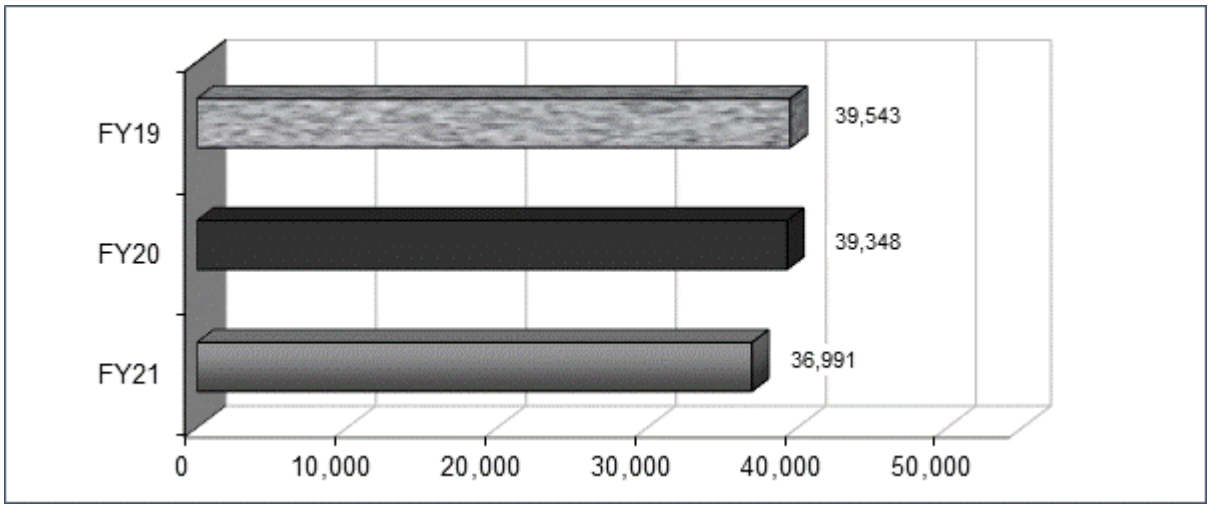
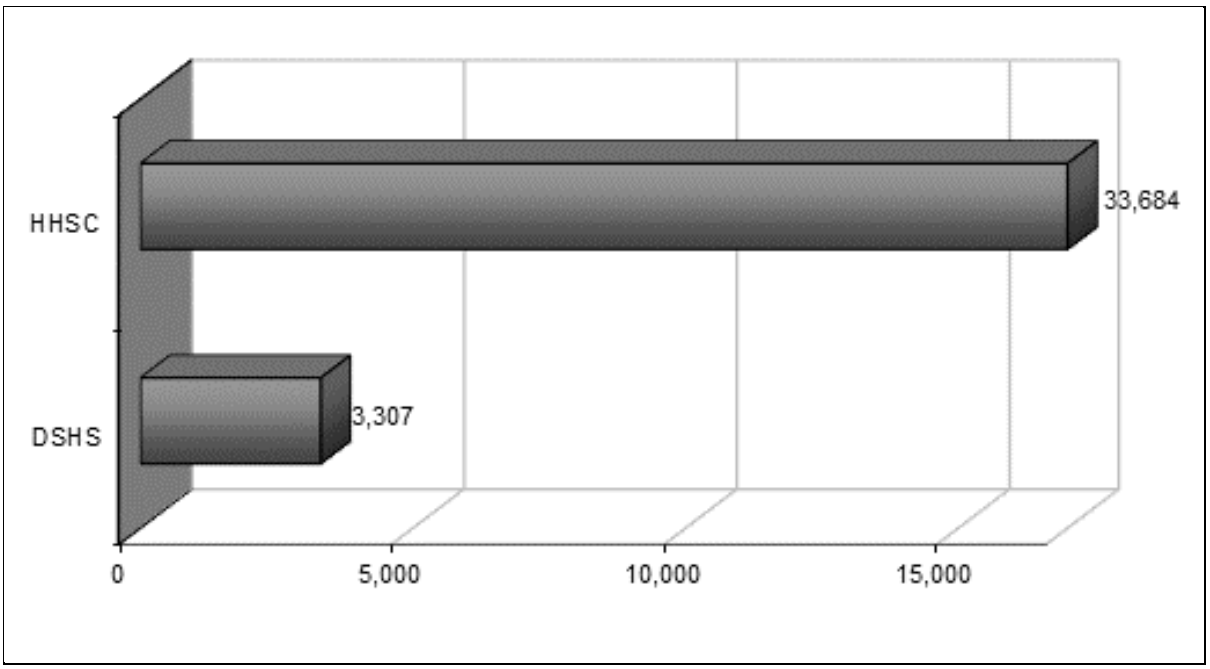


Figure 2: HHS System Workforce by Agency for FY 21



Job Families

Approximately 80 percent of HHS employees (29,676 employees) work in 23 job families.[4]

Table 1: Largest Program Job Families

Job Family	Number of Employees
Direct Care Workers[5]	6,623
Eligibility Workers[6]	4,978
Clerical Workers	3,108
Program Specialists	2,207
Registered Nurses (RNs)[7]	1,965
Managers	1,204
Licensed Vocational Nurses (LVNs)	870
Program Supervisors	876
Rehabilitation Technicians	864
System Analysts	764
Food Service Workers[8]	748
Inspectors	740
Custodial Workers	598
Directors	577
Maintenance Workers	566
Investigators	529
Contract Specialists	413
Security Workers	404
Accountants	376
Claims Examiners	373
Public Health Technicians	328
Training Specialists	315

Gender

Most HHS employees are female, making up approximately 72 percent of the HHS workforce. This breakdown is consistent across all HHS agencies.[9]

Table 2: HHS System Workforce Gender for FY 19 – FY 21[10] [11] [12]

Gender	FY 19	FY 20	FY 21
Male	27.4%	27.8%	27.8%
Female	72.6%	72.2%	72.2%

Figure 3: HHS System Workforce by Gender for FY 21

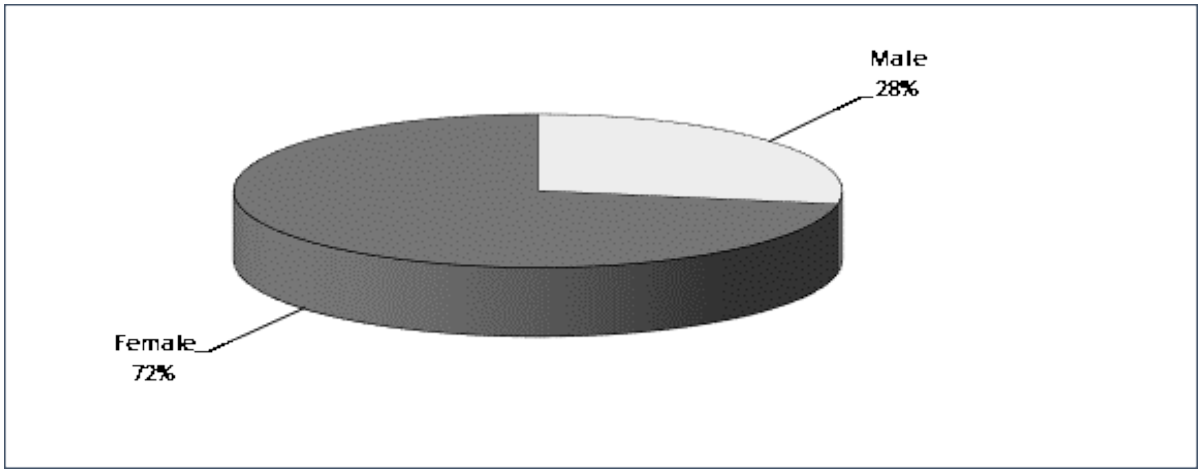


Table 3: HHS Agencies by Gender

Agency	Percentage Male	Percentage Female
HHSC	27.9%	72.1%
DSHS	27.8%	72.2%

Ethnicity

The workforce is diverse, with approximately 37 percent White, 31 percent Hispanic, 27 percent Black, and six percent Other.[13] This breakdown is consistent across all HHS agencies.[14]

Table 4: HHS System Workforce Ethnicity for FY 19 – FY 21[15] [16] [17]

Race	FY 19	FY 20	FY 21
White	37.5%	37.1%	37.1%
Black	28.7%	27.8%	26.5%
Hispanic	29.9%	30.4%	30.8%
Other	3.5%	4.7%	5.6%

Figure 4: HHS System Workforce by Ethnicity for FY 21

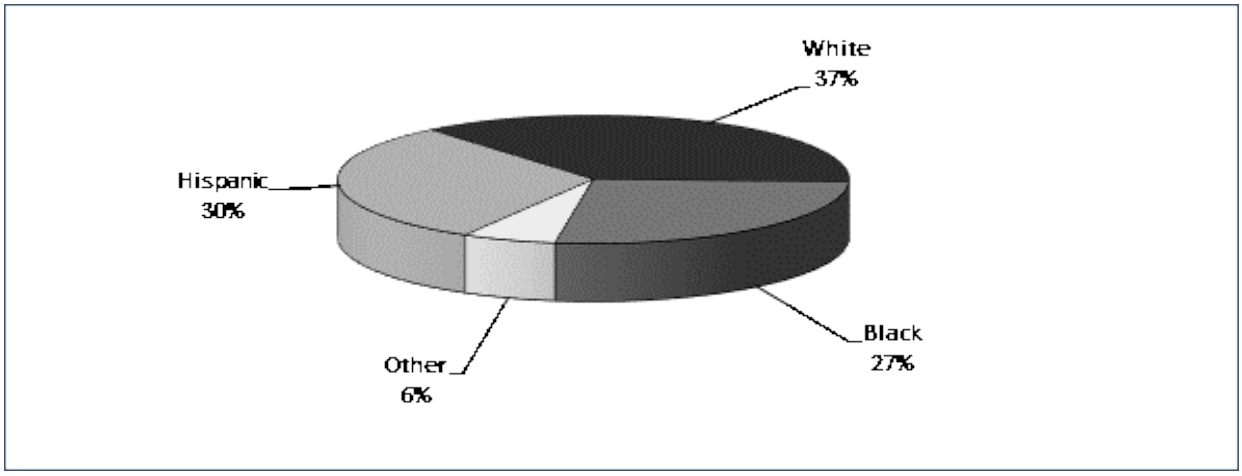


Table 5: HHS Agencies by Ethnicity[18]

Agency	Percentage White	Percentage Black	Percentage Hispanic	Percentage Other
HHSC	36.4%	27.7%	30.6%	5.3%
DSHS	44.7%	14.8%	32.3%	8.3%

Age

The average age of an HHS worker is 45 years. This breakdown is consistent across all HHS agencies.[19]

Table 6: HHS System Workforce Age for FY 19 – FY 21[20] [21] [22]

Age	FY 19	FY 20	FY 21
Under 30	14.6%	14.4%	12.3%
30-39	23.7%	23.5%	23.4%
40-49	25.1%	25.2%	25.8%
50-59	24.6%	24.7%	25.5%
60 and Over	12.0%	12.2%	13.1%

Figure 5: HHS System Workforce by Age for FY 21

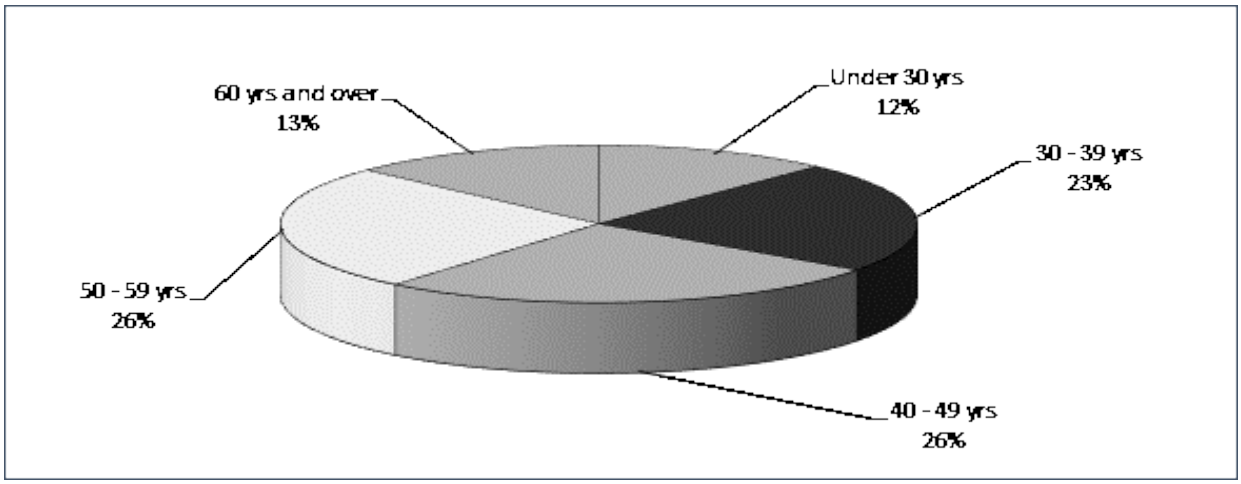


Table 7: HHS Agencies by Age[23]

Agency	Percentage Under 30	Percentage 30-39	Percentage 40-49	Percentage 50-59	Percentage 60 and over
HHSC	12.3%	23.1%	25.9%	25.6%	13.0%
DSHS	11.6%	26.4%	23.9%	23.8%	14.3%

Utilization Analysis

Texas law requires that each state agency analyze its workforce and compare the number of Blacks, Hispanics and females employed by the agency to the available state Civilian Labor Force (CLF) for each job category.

The utilization analysis was conducted for each HHS agency using the 80 percent rule. This rule compares the actual number of employees to the expected number of employees based on the available state CLF for Black, Hispanic and Female employees. For purposes of this analysis, a group is considered potentially

underutilized when the actual representation in the workforce is less than 80 percent of what the expected number would be based on the CLF.

The HHSC Civil Rights Office (CRO) reviewed and conducted analyses for each individual agency's workforce to identify potential underutilization.

The utilization analysis of the HHS agencies for fiscal year 2021 indicated potential underutilization in the HHSC workforce. The following table summarizes the results of the utilization analysis for the HHS System.

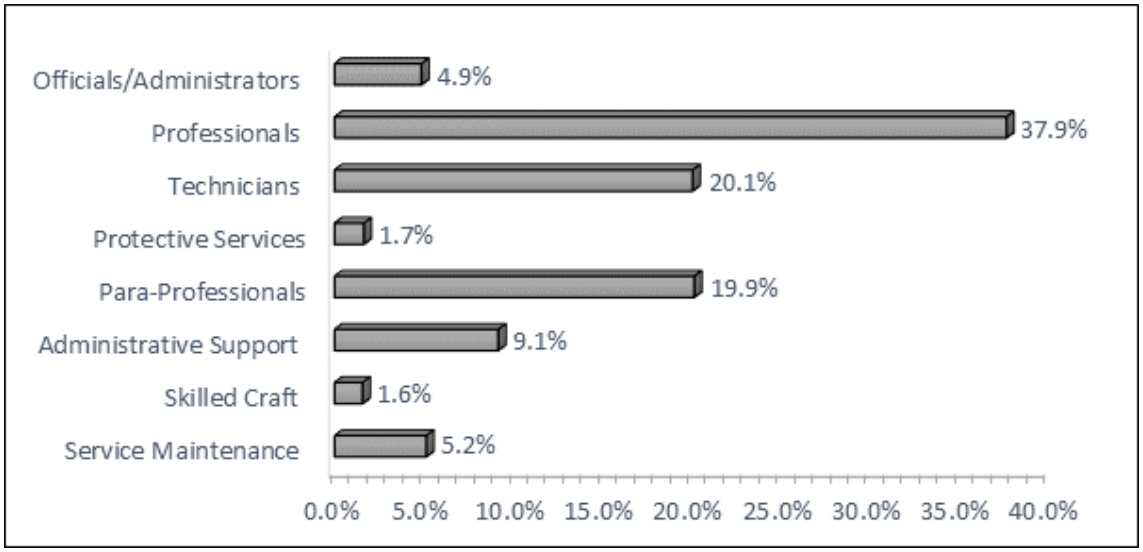
Table 8: HHS System Utilization Analysis Results[24] [25] [26]

Job Category	HHS System	HHSC	DSHS
Officials/Administrators	No	No	No
Professionals	No	No	No
Technicians	No	No	No
Protective Service	No	No	N/A
Administrative Support	No	No	No
Skilled Craft	Black Hispanic Female	Black Hispanic Female	N/A N/A N/A
Service Maintenance	Hispanic	Hispanic	Black

Although potential underutilization was identified in the Skilled Craft job category, it should be noted that the job category comprises 1.6% of the HHS System workforce.

The other job category showing potential underutilization is Service Maintenance, which comprises 5.2% of the HHS System workforce.

Figure 6: HHS System – Percent of Employees by Job Category



Veterans

About four percent of the workforce (1,646 employees) are veterans.

Table 9: HHS System Workforce by Veterans Status[27]

Agency	Number of Veterans	FY 21 Percentage
HHSC	1,432	4.3%
DSHS	214	6.5%
HHS System	1,646	4.4%

State Service

Approximately 40 percent of the workforce has 10 or more years of state service. About 19 percent of the workforce have been with the state for less than two years. This breakdown is consistent across all HHS agencies.[28]

Table 10: HHS System Workforce Length of State Service for FY 19 – FY 21[29] [30] [31] [32]

State Service	FY 19	FY 20	FY 21
less than 2 years	25.4%	23.8%	18.5%
2-4 years	16.5%	17.8%	19.9%
5-9 years	20.7%	20.5%	21.9%
10 years or more	37.4%	37.9%	39.7%

Figure 7: HHS System Workforce by Length of State Service[33]

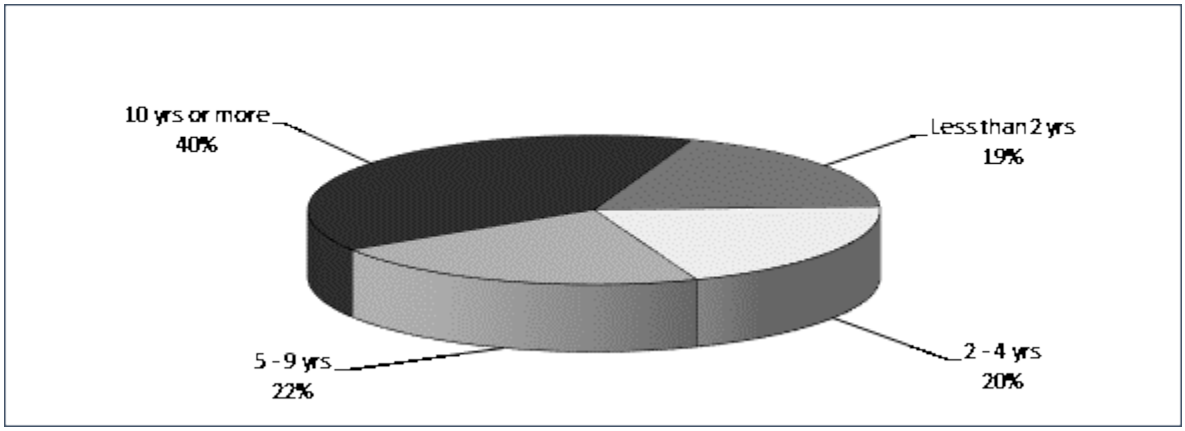


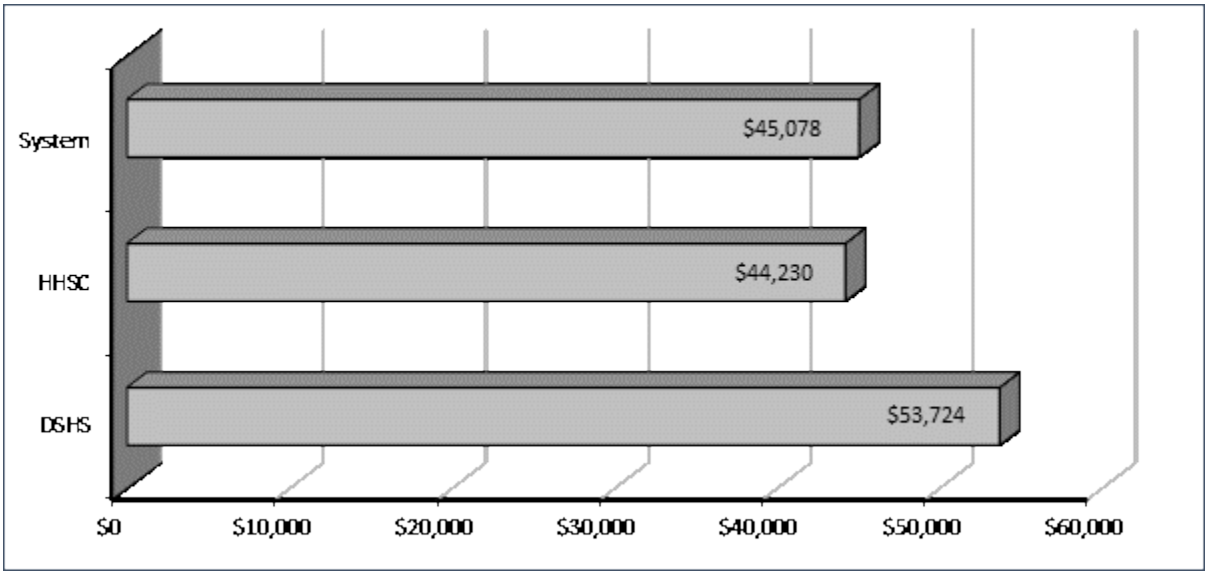
Table 11: HHS Agencies by Length of State Service[34]

Agency	Percentage Less than 2 yrs.	Percentage 2-4 yrs.	Percentage 5-9 yrs.	Percentage 10 yrs. or more
HHSC	18.4%	19.9%	22.0%	39.7%
DSHS	19.0%	19.8%	21.0%	40.2%

Average Annual Employee Salary

On average, the annual salary for an HHS System employee is $45,078.[35]

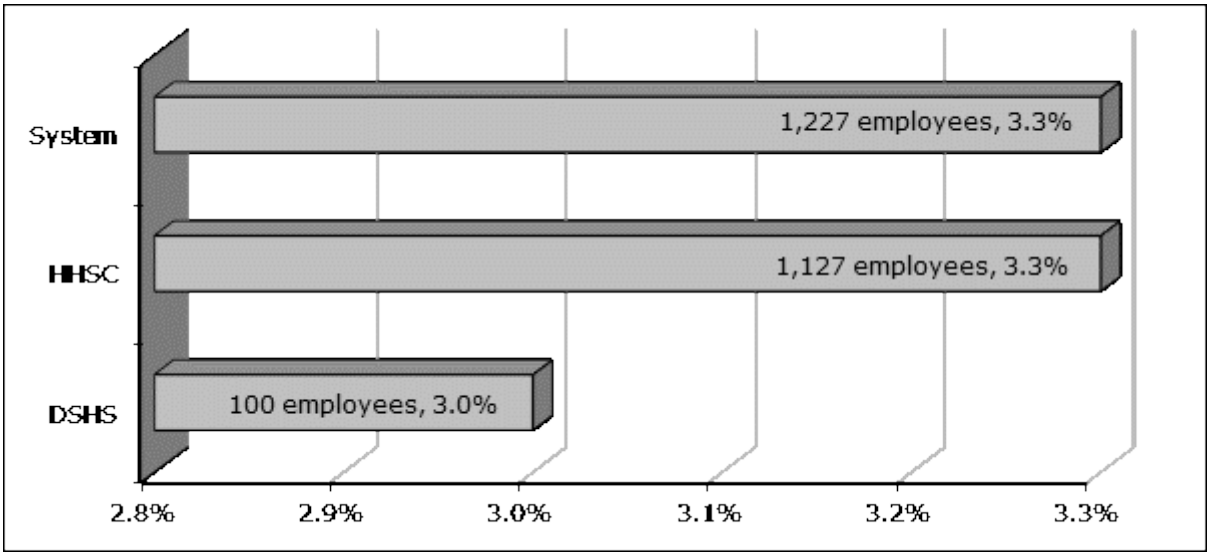
Figure 8: HHS Average Annual Salary by Agency



Return-to-Work Retirees

HHS agencies hire retirees to support both ongoing operational needs and to assist in implementing new initiatives. When recruiting for shortage occupations, special skill required positions or for special projects, retirees provide a good source of relevant program-specific knowledge. Rehired retirees constitute about three percent of the total HHS workforce.[36]

Figure 9: HHS Return-to-Work Retirees by Percent of Workforce



HHS management understands that demographic trends over the next decade will increasingly impact recruitment from typical sources. Retired workers who have institutional knowledge will be needed to pass their expertise to others.

Dealing with an aging workforce will require HHS agencies to attract more people to apply for work, encourage them to work longer and help make them more productive. Creative strategies are being planned to keep older workers on the job, such as hiring retirees as temporary status employees; letting employees phase into retirement by working part time; having experienced workers mentor younger employees; promoting telecommuting, flexible hours and job-sharing; and/or urging retirement-ready workers to take sabbaticals instead of stepping down.

4. Turnover

The HHS System turnover rate for fiscal year 2021 was 26.1 percent, about five percent higher than the statewide turnover rate of 21.5 percent.[37] [38]

Table 12: HHS System Workforce - Turnover for FY 19 – FY 21 (excludes inter-HHS agency transfers)[39]

Agency	FY 19	FY 20	FY 21
HHS System	27.6%	24.2%	26.1%

Of the two HHS agencies, HHSC experienced the highest turnover rate (27.1 percent).[40]

Table 13: Turnover by HHS Agency for FY 21 (includes inter-HHS agency transfers and excludes legislatively mandated transfers)

Agency	Average Annual Headcount	Total Separations	Turnover Rate
HHSC	37,199	10,085	**27.1%**
DSHS	3,386	517	**15.3%**
Grand Total	**40,585**	**10,602**	**26.1%**

Turnover at HHS agencies was highest for Males at HHSC (at 28.4 percent) and lowest for Females at DSHS (at 15.1 percent). Turnover across ethnic groups ranged from a high of 32.7 percent for Black employees to a low of 23.5 percent for White and Hispanic employees.[41]

Table 14: HHS Agency Turnover by Gender for FY 21 (includes inter-HHS agency transfers and excludes legislatively mandated transfers)

Agency	Gender	Average Annual Headcount	Total Separations	Turnover Rate
HHSC	Female	26,770	7,134	26.6%
	Male	10,373	2,951	28.4%
DSHS	Female	2,443	370	15.1%
	Male	934	147	15.7%
HHS System	**Female**	**29,213**	**7,504**	**25.7%**
	Male	**11,307**	**3,098**	**27.4%**

Table 15: HHS Agency Turnover by Ethnicity for FY 21 (includes inter-HHS agency transfers and legislatively mandated transfers and excludes legislatively mandated transfers

Agency	White	Black	Hispanic	Other[42]
HHSC	24.5%	33.1%	24.6%	28.8%
DSHS	14.7%	23.1%	11.9%	18.3%
HHS System	**23.5%**	**32.7%**	**23.5%**	**27.5%**

Of the total losses during fiscal year 2021, approximately 79 percent were voluntary separations and 20 percent were involuntary separations.[43] [44] Voluntary includes resignation, transfer to another agency and retirement. Involuntary includes dismissal for cause, resignation in lieu of separation, and separation at will.[45]

Table 16: Reason for Separation

Type of Separation	Reason	Separations	Percentage[46]
Voluntary	Personal reasons	6,824	64.01%
	Transfer to another agency	531	4.98%
	Retirement	1,046	9.81%
Involuntary	Termination at Will	47	.44%
	Resignation in Lieu of Termination	171	1.60%
	Dismissal for Cause	1,954	18.33%

Certain job families have significantly higher turnover than other occupational series, including direct care workers[47] at 53.2 percent, food service workers[48] at 43.8 percent, laboratory technicians at 22.0 percent, and licensed vocational nurses (LVNs) at 28.6 percent.[49]

Table 17: FY 21 Turnover for Significant Job Families[50]

Job Title	Average Annual Headcount	Separations	Turnover Rate
Direct Care Workers[51]	8,472	4,509	53.2%
Food Service Workers[52]	881	386	43.8%
Licensed Vocational Nurses (LVNs)	994	284	28.6%
Social Workers	263	72	27.4%
Registered Nurses (RNs)[53]	1,738	431	24.8%
Psychologists[54]	227	56	24.7%
Laboratory Technicians	50	11	22.0%
Eligibility Workers[55]	5,332	1,123	21.1%
Eligibility Clerks[56]	949	192	20.2%
Guardianship Specialists	72	14	19.4%
Epidemiologists	132	25	18.9%
CCL and RCCL Specialists[57]	409	75	18.3%
Health Physicists	57	10	17.5%
Veterinarians	18	3	16.7%
Dentists	32	5	15.7%
Physicians	100	13	13.0%
Microbiologists[58]	148	19	12.8%
Registered Therapists[59]	312	36	11.5%
Nurse Practitioners[60]	89	10	11.3%
Psychiatrists	124	13	10.5%
Chemists	58	5	8.6%
Sanitarians	128	11	8.6%

5. Retirement Projections

Currently, about 11 percent of the HHS workforce is potentially eligible to retire and leave state employment. About 2.6 percent of the eligible employees retire each fiscal year. If this trend continues, approximately 13 percent of the current workforce is expected to retire in the next five years.[61]

Table 18: HHS System Retirements - Percent of Workforce (FY 17 – FY 21)

Fiscal Year	Retirement Losses	Retirement Turnover Rate
2017	989	2.4%
2018	1,175	2.9%
2019	1,069	2.6%
2020	956	2.3%
2021	1,045	2.6%

Table 19: HHS System First-Time Retirement Eligible Projection (FY 21 – FY 26)

Agency	FY 21		FY 22		FY 23		FY 24		FY 25		FY 26	
HHSC	582	1.7%	830	2.5%	852	2.5%	983	2.9%	1003	3.0%	1052	3.1%
DSHS	64	1.9%	80	2.4%	91	2.8%	94	2.8%	103	3.1%	113	3.4%
Grand Total	**646**	**1.7%**	**910**	**2.5%**	**943**	**2.5%**	**1077**	**2.9%**	**1106**	**3.0%**	**1165**	**3.1%**

The loss of this significant portion of the workforce means the HHS agencies will lose some of their most knowledgeable workers, including many employees in key positions. Effective succession planning and employee development will be critical in ensuring there are qualified individuals who can replace those leaving state service.

6. Critical Workforce Skills

The current climate of the information age, advances in technology, increasing population for the state, consolidation of services, right-sizing and outsourcing will continue to place increased emphasis on the demand for well-trained and skilled staff.

The outsourcing and self-service automation of major HR functions, such as employee selection, have made it critical for HHS managers and employees to improve and commit to a continual learning of human resource policy, employee development, conflict resolution, time management, project management and automation skills.

It is important for HHS to employ professionals who have the skills necessary for the development, implementation and evaluation of the health and human services programs. These skills include:

- analytic/assessment skills;
- policy development/program planning skills;
- communication skills;
- cultural competency skills;
- basic public health sciences skills;
- financial planning and management skills;
- contract management skills; and
- leadership and systems-thinking skills.

As the Spanish speaking population in Texas increases, there will be an increased need for employees with bilingual skills, especially Spanish-English proficiency.

In addition, most management positions require program knowledge. As HHS continues to lose tenured staff, effective training will be needed to ensure that current employees develop the skills necessary to transfer into management positions.

To promote this staff development, HHS must continue to grow the skills and talents of managers as part of a plan for succession. HHS has demonstrated this belief by establishing the HHS Leadership Academy, a formalized interagency

training and mentoring program that provides opportunities to enhance the growth of high-potential managers as they take on greater responsibility in positions of leadership. The primary goals of the academy are to:

- prepare managers to take on higher and broader roles and responsibilities;
- provide opportunities for managers to better understand critical management issues;
- provide opportunities for managers to participate and contribute while learning; and
- create a culture of collaborative leaders across the HHS system.

Through this planned development of management skills and the careful selection of qualified staff, HHS will continue to meet the challenges posed by increased retirements.

7. Environmental Assessment

COVID-19

In early 2020, the nation experienced both a public health emergency and an economic crisis as the novel coronavirus (COVID-19) spread across the country. The federal government declared COVID-19 a national emergency on March 13, 2020,[62] and government entities at the state and local levels took measures to help stop the spread of the virus. Every state declared a state of emergency, and the majority put stay-at-home orders in place.

The effects of the pandemic struck the economy almost immediately in 2020: Over 22 million jobs were lost from February to April of that year.[63] In response to these challenges, Congress passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act (2020) on March 25, 2020. CARES provided direct financial assistance to families, workers, and small businesses.[64]

Subsequently, as positive COVID-19 cases fell across the country, consumer confidence grew and employment levels increased.[65] Employment rose by 428,000 jobs in March 2022 and the unemployment rate for the country currently stands at 3.6 percent.[66]

The Texas Economy

Texas, which had sustained years of positive job growth, and added over 250,000 jobs in 2019,[67] lost 1.4 million jobs between February and April of 2020[68] due to the initial stages of the pandemic. The unemployment rate reached a high of 12.9 percent in April 2020, but the rate dropped to 6.9 percent for the year. In 2021, the annual average unemployment rate for Texas fell to 5.7 percent.[69]

Texas' economy began to bounce back as COVID cases decreased in 2021. Texas added approximately 657,300 jobs from June 2020 to June 2021 and by December 2021 all the jobs lost during the pandemic were recovered.[70] In addition, the Federal Reserve Bank of Dallas predicts employment to grow 3.3 percent in 2022.[71] The Texas Leading Index rose 17 times in the last 19 months, which shows consumer confidence in spending and saving. This also suggests strong job growth in the future.[72]

Poverty in Texas

As the number of families living in poverty increases for the state, combined with the challenges created by the pandemic, the demand for services provided by the HHS System will continue to increase.

The U.S. Department of Health and Human Services defined the poverty level for 2021 according to household/family size as follows:

- $26,500 or less for a family of four;
- $21,960 or less for a family of three;
- $17,420 or less for a family of two; and
- $12,880 or less for individuals.[73]

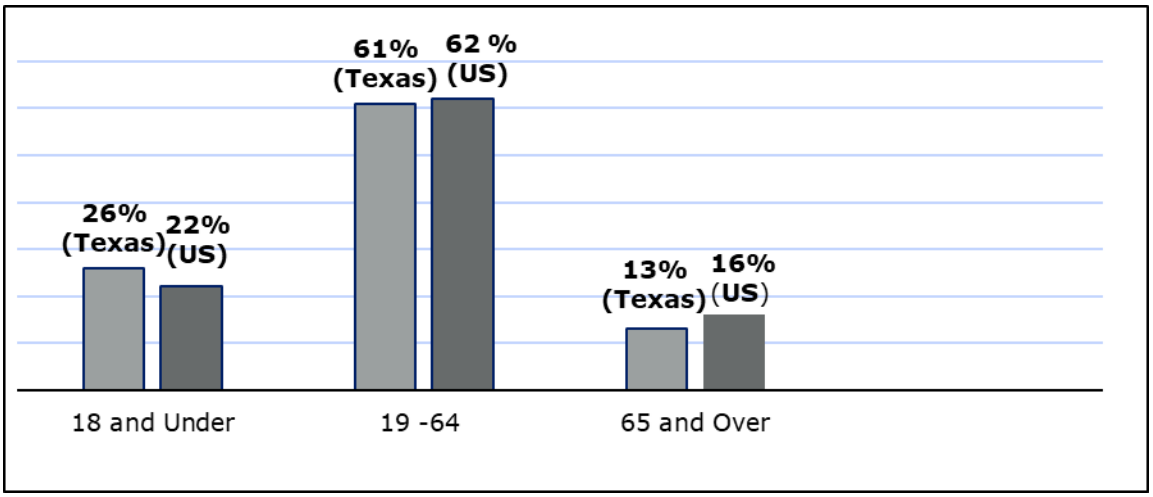
It is estimated that 13.4 percent of Texas residents live in families with annual incomes below the poverty level. This rate is slightly higher than the national poverty rate of 11.4 percent.[74]

Population Growth

According to the 2020 United States Census Bureau, as of July 2021, the estimated population of Texas was over 29 million people, which represents a 1.3 percent increase from 2020 and 15.9 percent increase from the census count in April 2010.[75]

The distribution of age groups in Texas closely mirrors that of the nation, with the largest percentage of Texas residents (61 percent) being between ages 19 to 64, followed by those 18 and under (26 percent) and those 65 and over (13 percent).[76]

Figure 10: Population Distribution by Age[77]



According to long term population projections by the Texas State Data Center, it is estimated that by 2050, Texans older than age 65 will triple in size from 2010-2050, approaching 8.3 million.[78]

8. Expected Workforce Challenges

HHS will need to continue to recruit and retain health and human services professionals. Certain jobs will continue to be essential to the delivery of services throughout the HHS System. Many of the jobs are low paying, highly stressful and experience higher than normal turnover.

Additionally, the demand for certain public health positions is expected to increase as the response to the COVID-19 pandemic continues.

Direct Care Workers (Direct Support Professionals and Psychiatric Nursing Assistants)

There are approximately 6,624 direct care workers employed within HHS. The direct care worker group is made up of direct support professionals in state supported living centers and psychiatric nursing assistants in the state hospitals. Though these positions require no formal education to perform the work, employees must develop interpersonal skills to effectively engage with residents and patients. The physical requirements of the position may be challenging due to the nature of the work and the pay is low.[79]

The overall turnover rate for employees in this group is very high, at about 53 percent annually.[80] State supported living centers and state hospitals have historically had trouble in both recruiting and retaining these valuable workers.

Direct Support Professionals at State Supported Living Centers

There are 4,418 direct support professionals in state supported living centers across the state, representing approximately 18 percent of the System's total workforce.[81] These employees provide 24-hour direct care to residents in state supported living centers. They directly support these individuals by providing services including basic hygiene needs, dressing, and bathing, general health care, and dining assistance. They support life-sustaining medical care such as external feeding and lifting individuals with physical challenges. A trained and experienced direct care staff is essential to ensure resident safety, health, and well-being.

There are no formal education requirements to apply for a job in this series; however, extensive on-the-job training is required. It takes six to nine months for a new direct support professional to become proficient in the basic skills necessary to carry out routine job duties.

A typical HHS direct support professional is 40 years of age and has about seven years of state service.[82]

Turnover for direct support professionals is over twice the state average at 55 percent, which is one of the highest turnover rates of any job category in the System. During fiscal year 2021, the System lost about 3,131 direct support professionals. Within this job family, entry-level Direct Support Professional Is experienced the highest turnover at approximately 72 percent. Turnover rates by location ranged from 38 percent at Austin State Supported Living Center to 77 percent at the San Angelo State Supported Living Center.[83] [84]

The vacancy rate for these professionals is 35 percent, and it often takes up to five months to fill vacant positions.

The State Auditor's Office (SAO) 2020 market index analysis found the average state salary for Direct Support Professional Is and IIIs to range from four to seven percent behind the market rate, contributing to challenges in recruitment.[85]

Psychiatric Nursing Assistants at State Hospitals

There are approximately 2,206 psychiatric nursing assistants employed in HHS state hospitals across Texas.[86]

Some of their daily essential job functions include assisting licensed nurses with medication administration or treatment in addition to monitoring patients' vital signs to ensure their health and safety. At times, psychiatric nursing assistants are the first to intervene during crisis situations and act as the frontline staff most likely to de-escalate situations to avoid the need for behavioral interventions. These critical positions also have a higher potential for on-the-job injuries, both from lifting requirements and intervention during crisis situations. They also may be required to work throughout the day and night.

The SAO 2020 market index analysis found the average state salary for a Psychiatric Nursing Assistant Is and IIIs to be seven to 12 percent behind the market rate, increasing existing challenges to recruitment.[87] [88]

The average psychiatric nursing assistant is about 39 years of age and has an average of seven years of service.[89]

Turnover for psychiatric nursing assistants is very high at about 50 percent, reflecting the loss of 1,378 workers during fiscal year 2021. Within this job family, Psychiatric Nursing Assistant Is experienced the highest turnover at 67 percent. Turnover rates vary by location, from 33 percent at Terrell State Hospital to 66 percent at the Big Spring State Hospital.[90]

HHS is currently having trouble filling vacant psychiatric nursing assistant positions, as there are 873 vacancies in this job family. Vacant positions are going unfilled an average of four months.[91]

Food Service Workers

HHS employs approximately 748 food service workers.[92]

The average hourly rate paid to food service workers is $11.51.[93] The turnover rate for food service workers is very high, at about 44 percent.[94] The SAO 2020 market index analysis found the average state salary for Food Service Workers ranged eight to 11 percent behind the market rate; Food Service Managers ranged from six to 15 percent behind the market rate; and Cooks ranged from nine to 11 percent behind the market rate.[95]

Retention and recruitment of these workers remains a major challenge for the System.

Food Service Workers at State Supported Living Centers

There are 449 food service workers employed in HHS state supported living centers throughout Texas.[96] The typical food service worker is about 46 years of age and has an average of approximately nine years of service.[97]

Turnover in these food service worker positions is very high, at 49 percent. By location, turnover rates range from 35 percent at Richmond State Living Center to 87 percent at Lubbock State Living Center.[98]

Food Service Workers at State Hospitals

There are 289 food service workers employed at HHS state hospitals and centers throughout Texas.[99]

The typical food service worker is about 46 years of age and has an average of about eight years of service.[100]

Of the state hospitals with over 20 food service workers, turnover rates range from 16 percent at Rio Grande State Hospital Center to 56 percent at Rusk State Hospital.[101]

Food Service Workers at Texas Center for Infectious Disease

There are 10 food service workers employed in the Texas Center for Infectious Disease (TCID).[102]

The typical food service worker is about 46 years of age and has an average of approximately seven years of service.[103]

At 26 percent, turnover for these food service worker positions is high and slightly above the state average of 21.5 percent.[104] [105]

Dietetic and Nutrition Specialists

There are 56 dietetic and nutrition specialists employed by HHS, with the majority (55 percent) classified as Dietetic and Nutrition Specialists IIIs.[106] These specialists facilitate/direct operations of nutrition care services, serve as a member of the patient's recovery team, and plan special therapeutic menus for patients.

Dietetic and nutrition specialists work in state hospitals, state supported living centers, and in Health, Developmental and Independence Services (HDIS). The typical system dietetic and nutrition specialist is 45 years of age and has nine years of service. Thirty-four percent of these specialists have 10 or more years of service.[107]

The average salary for the dietetics and nutrition specialists is $57,229, which is below both the national average wage of $65,620 and Texas average wage of $64,560.[108] [109]

Turnover is about the same as the state average at 21 percent, which represents a total loss of 13 employees.[110] [111] The vacancy rate is 15 percent, and it can take over five months to fill these vacancies.[112]

According to the Bureau of Labor Statistics, employment of dietitians and nutritionists is projected to grow 11 percent from 2020 to 2030. This is faster than the average for all occupations.[113]

Dietetic and Nutrition Specialists at State Supported Living Centers

There are 22 Dietetic and Nutrition Specialist IIs and IIIs at state supported living centers across Texas.[114]

On average, these specialists are about 45 years of age and have 10 years of service.[115]

The turnover rate for these dietetic and nutrition specialists is high at 17 percent (representing four total losses), with a high vacancy rate of approximately 24 percent.[116] [117]

Dietetic and Nutrition Specialists at State Hospitals

There are 13 dietetic and nutrition specialists employed in the state hospital system, which the slight majority working as Dietetic and Nutrition Specialist IIIs (seven specialists).[118]

The typical specialist at these facilities is about 50 years of age and has an average of nine years of service.[119]

Only the San Antonio State Hospital experienced turnover in the group, as they lost only one employee. The vacancy rate is 24 percent and it often takes over six months to fill a position.[120] [121]

Dietetic and Nutrition Specialists in Health, Developmental and Independence Services

About 21 percent of dietetic and nutrition specialists (12 employees) work in HDIS.[122]

The typical dietetic and nutrition specialist in HDIS is about 35 years of age and has an average of five years of service. Over eight percent of these specialists are currently eligible to retire.[123]

The average turnover rate for dietetic and nutrition specialists is currently high 23 percent, which is higher than the state average rate of 21.5 percent.[124] [125]

Eligibility Services Staff

Across the state, there are about 4,978 eligibility advisors within the Access & Eligibility Services (AES) area accounting for about 13 percent of the HHS System workforce.[126]

Most of these individuals (4,199 employees or 84 percent) are employed as Texas Works advisors with the remaining made up of Hospital-Based advisors and Medical Eligibility specialists.[127]

Overall turnover for these workers is high at 21 percent, with Texas Works advisors and Medical Eligibility specialists experiencing the highest turnover at 21 percent, followed by hospital-based workers at 15 percent.[128]

Texas Works Advisors

There are approximately 4,199 Texas Works advisors within AES that make eligibility determinations for the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needly Families (TANF), Medicaid for children, families, and pregnant women, and the Children's Health Insurance Plan (CHIP). The typical Texas Works advisor is 42 years of age and has an average of seven years of service.[129]

Turnover for these employees is high at 21 percent, representing a loss of 963 workers in fiscal year 2021. Certain regions of Texas experienced higher turnover than others, including the Northeast area of the state at 28 percent, and the

Metroplex area at 27 percent. Entry-level Texas Works Advisor Is experienced the highest turnover at 52 percent.[130]

In addition, AES has encountered difficulties finding qualified candidates for new eligibility advisor positions. Due to this shortage of qualified applicants, vacant positions go unfilled for an average of over four months, with vacant positions in the Houston area remaining unfilled for an average of a little more than six months.[131]

Medical Eligibility Specialists

Within AES, there are 526 Medical Eligibility specialists determining financial eligibility for Medicaid for Elderly and People with Disabilities (MEPD). Medical Eligibility specialists have, on average, eight years of service, with an average age of 43.[132]

Turnover for these specialists is high at about 21 percent, representing the loss of 118 employees in fiscal year 2021. Entry-level Medical Eligibility Specialist Is experienced the highest turnover, at 58 percent, which is 15 percent higher than fiscal year 2019.[133]

Hospital Based Workers

AES has about 253 Hospital-Based advisors stationed in nursing facilities, hospitals, and clinics. These advisors determine eligibility for the SNAP, TANF, Medicaid and CHIP programs.[134]

These tenured advisors have an average of 13 years of service and over 56 percent of these employees have 10 or more years of service, with an average age of 46.[135]

Turnover for these employees is currently below the state average at 15 percent.[136] [137]

Community Care Workers

HHS employs about 412 Community Care workers within AES. These workers conduct home visits, determine needs for services, develop service plans, and refer individuals for appropriate services.[138]

The typical Community Care worker is 47 years of age and has an average of 12 years of service.[139]

Community Care workers make an average salary of $33,679, which is below both the national average wage of $40,460 and Texas average wage of $39,630.[140] [141]

The turnover rate for AES Community Care workers is moderately high at 14 percent, representing the loss of about 61 employees.[142] The vacancy rate for these positions is well-managed at six percent, with these positions often remaining unfilled for about five weeks.[143]

Child Care Licensing and Residential Child Care Licensing Specialists

There are 406 Child Care Licensing (CCL) and Residential Child Care Licensing (RCCL) specialists employed within the System who monitor, investigate and inspect child day-care facilities and homes, residential child-care facilities, child-placing agencies and foster homes.[144] [145] In addition, they conduct child abuse/neglect investigations of children placed in 24-hour childcare facilities and child placing agencies licensed or certified by Residential Child Care Licensing.

The typical specialist is 41 years of age and has an average of nine years of service. About 34 percent of these employees have 10 or more years of service.[146]

CCL and RCCL specialist turnover is high at 18 percent, though slightly below the state average rate of 21.5 percent. Within this group, the highest turnover was experienced by RCCL Inspector IIIs at 36 percent and RCCL Investigator and Compliance Specialist IIs at 21 percent.[147] [148]

Guardianship Staff

The HHS System employs 81 guardianship specialists and guardianship supervisors who are responsible for providing guardianship services to eligible clients.[149] Staff continuously assess and determine whether guardianship is the most appropriate and least restrictive alternative necessary to ensure the consumer's health and safety.

Retention continues to be a challenge, since these positions require specialized skills and salaries are not comparable with that paid by other agencies and the private sector.

Guardianship Specialists

There are 69 guardianship specialists employed at HHS.[150]

HHS guardianship specialists are about 46 years of age and have an average of 10 years of service.[151]

The turnover rate for guardianship specialists is high at about 19 percent annually, which is slightly below the state average turnover rate of 21.5 percent.[152] [153]

About 16 percent of these tenured employees will be eligible to retire in the next five years.[154]

Guardianship Supervisors

There are 12 guardianship supervisors working for HHS.[155]

HHS guardianship supervisors has an average of about 18 years of service, with an average age of 52 years.[156]

Though the turnover rate for these highly tenured guardianship supervisors is currently well-managed at about eight percent, HHS may face significant recruitment challenges in the next few years to replace these tenured employees who are eligible for retirement. With about 25 percent of these employees currently eligible to retire, this rate is expected to increase in the next five years to about 67 percent.[157] [158]

Architects

These are 16 Architect IIs employed within the Chief Policy and Regulatory Office (CPRO). These architects perform architectural plan reviews and conduct initial and annual surveys and complaint/incident investigations on state licensure, and (when applicable) federal certification requirements for nursing facilities, assisted living facilities, Day Activity and Health Services facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities, and in-patient Hospice facilities.[159]

These HHS Architect IIs have, on average, 10 years of service, with an average age of 59 years of age. Over 85 percent of these employees have five or more years of service.[160]

The SAO 2020 market index analysis found the average state salary for Architect IIs is $75,786. The SAO 2020 market index analysis found that the average state salary for Architect IIs to be four percent behind the market rate.[161]

Though the turnover rate for these employees is only 11 percent, with a vacancy rate of 20 percent, vacant positions often go unfilled for over seven months due to a shortage of qualified applicants available for work.[162]

Though only 13 percent of these employees are currently eligible to retire, over 56 percent will be eligible to retire in the next five years.[163]

HHS needs to expand their recruitment strategies to replace these highly skilled workers.

Contract Specialists

There are 413 contract specialists employed within the HHS System. These specialists utilize various levels of technical expertise related to procurement, contract development, contract management, and program performance to meet agency needs for goods and services. Contract specialists may also consult and communicate with various community stakeholders and state and local authorities to evaluate the effectiveness of programs to meet the agency's needs. In addition, contract specialists may be responsible for monitoring contract performance, administering billing and tracking expenditures, and facilitate meetings between the System and vendors.[164]

System contract specialists are, on average, 45 years of age and have about 12 years of service. Over 50 percent of these employees have 10 or more years of service.[165]

The average salary for contract specialists is $54,892 a year.[166] The SAO market index analysis found that state Contract Specialist IIIs and IVs make two to seven percent less than the market rate.[167]

Turnover for these specialists is above the state average at 26 percent.[168] [169] With a vacancy rate of about 13 percent, vacant positions often go unfilled for over four months due to a shortage of qualified applicants available for work.[170]

Contract Specialists in DSHS Program Operations

The Program Operations (PO) area of DSHS employs 59 Contract Specialist IVs and Vs. These contract specialists have an average of 12 years of service and are about 46 years of age. Over 45 percent of this group have over 10 years of service.[171]

The turnover rate for these contract specialists is currently well-managed at four percent, though the vacancy rate is high at 19 percent.[172] [173] With over 30 percent of these Contract Specialist Vs eligible to retire in the five years, HHS will need to focus on competitive recruitment strategies.[174]

Contract Specialists in Procurement and Contracting Services

In HHSC Procurement and Contracting Services (PCS), there are 46 Contract Specialist IVs and Vs. The average contract specialist in this group is, on average, 47 years of age, with 12 years of service.[175]

The total turnover rate for these contract specialists is moderately high at 14 percent, though it often takes over five months to fill vacancies with qualified candidates.[176] [177]

Contract Specialists in Health, Developmental and Independence Services

There are 42 contract specialists in HDIS. On average, these contract specialists are about 46 years of age, with an average of 11 years of service. Forty-three percent of this group have over 10 years of service.[178]

The turnover rate for these contract specialists is currently well below the state average at 12 percent, it can take up to six months to fill vacancies.[179] [180] [181]

Contract Specialists in Intellectual & Developmental Disability & Behavioral Health Services

Intellectual & Developmental Disability & Behavioral Health Services (IDD-BH) employs 54 Contract Specialist IVs and Vs. These contract specialists have an average of 11 years of service and are about 47 years of age. Fifty-two percent of this group has at least 10 years of service.[182]

The turnover rate for these specialists is below the state average at 16 percent, though the vacancy rate is high at 21 percent.[183] [184] Over 29 percent of these contract specialists are eligible to retire in the next five years.[185] [186]

Purchasers

There are 97 purchasers employed within HHSC PCS. With 32 employees, Purchaser IVs make up over half of the group.[187] Purchasers perform functions such as assisting with procurements, receiving and tracking vendor responses, as well as distributing responses to assigned buyers. They may also assist with identifying provider resources and evaluating information supplied by bidders. Advanced employees, such as Purchaser VIs, identify purchasing related issues and work with management, requesters, subject matter experts, and outside stakeholders.[188]

The average salary for this group of PCS purchasers is $50,554.[189] In the SAO market report index for fiscal year 2020, state Purchaser IVs make 13 percent below the state market index rate.[190]

These tenured purchasers are, on average, 48 years of age and have an average of 12 years of service. Over 43 percent of these employees have more than 10 years of service.[191]

Though the turnover rate for this group is high at 15 percent, the vacancy rate is very low at five percent.[192] [193] On average, it can take over four months to fill these vacancies.[194]

Financial Analysts

There are 117 financial analysts employed in the HHS System. These employees perform advanced financial analysis, examine and investigate accounting records,

as well as conduct regulatory work related to revenue collections and budget appropriations.[195]

The average financial analyst is 46 years of age with about 12 years of service. Almost 30 percent of these employees will be eligible to retire in the next five years.[196] [197]

Turnover is well-managed for these positions, as the rate is well below the state average at nine percent.[198] [199]

The SAO's report on market index for fiscal year 2020 found the market index rate salary for financial analysts to be four to seven percent below the market index, which may account for the high vacancy rate at 18 percent. It can take up to three months to fill these vacancies.[200] [201]

Financial Analysts in the DSHS Program Operations

There are 17 Financial Analyst Is, IIs, and IIIs in the PO Division of DSHS. The average PO financial analyst is 37 years of age and has about six years of service.[202]

Turnover for this group is high with a turnover rate of 32 percent.[203] The vacancy rate is also high at 15 percent.[204]

Financial Analysts in the HHSC Chief Program and Services Office

In the CPSO, there are 11 Financial Analyst Is, IIs, IIIs, and IVs. The average CPSO financial analyst has about 11 years of service and is 48 years of age.[205]

Turnover is low for this group, and the vacancy rate is only eight percent, but it can take up to a year to fill vacant positions.[206] [207]

Social Workers

There are 234 social workers employed in the HHS System, with the majority (58 percent) housed in state hospitals across the state.[208]

Turnover for these social workers is high at 27 percent.[209]

High turnover may be due to the large disparity between private sector and HHS salaries. The average annual salary for system Social Worker I through V is $46,567, which falls significantly below the market rate. The SAO 2020 market index analysis found that the average state salary for Social Worker IIs and IIIs ranged from eight to nine percent behind the market rate. In addition, the average annual salary for social workers is below the national ($62,310) and state ($64,480) averages.[210] [211]

These problems are expected to worsen as tenured employees approach retirement. Though only nine percent of these employees are currently eligible to retire, this number is expected to increase to about 21 percent in the next five years.[212]

Social Workers at State Supported Living Centers

Approximately 12 percent of HHS social workers (27 employees) work at state supported living centers across the state.[213] These employees serve as liaisons between the resident's legally authorized representative and others to assure ongoing care, treatment, and support using person-centered practices. They gather information to assess a resident's support systems and service needs, support the assessment of the resident's rights and capacity to make decisions, and assist with the coordination of admissions, transfers, transitions, and discharges.

The typical social worker at these facilities is about 51 years of age and has an average of 13 years of service.[214]

The average turnover rate for these social workers is very high at 39 percent, much higher than the state average rate of 21.5 percent, with positions often remaining unfilled for an average of over five months before being filled.[215] [216] [217]

Social Workers at State Hospitals

There are 135 social workers at HHS state hospitals.[218] These employees are critical to managing patient flow in state hospitals and taking the lead role in communicating with patient families and community resources. Social workers provide essential functions within state hospitals that include conducting psychosocial assessments, therapeutic treatment and case coordination for individuals receiving services from HHS in-patient psychiatric hospitals and the Waco Center for Youth.

State hospital social workers are about 42 years of age and have an average of nine years of service.[219]

The overall turnover rate for these social workers is high at around 29 percent, with the Kerrville State Hospital experiencing turnover of more than 68 percent.[220]

Public Health Social Workers

There are 61 Public Health Region social workers across the state.[221] These employees provide case management consultation for families with children who have health risks, conditions, or special healthcare needs.

The typical public health social worker is about 44 years of age and has an average of nine years of service.[222]

The average turnover rate for these social workers is high at 20 percent, though slightly below the state average rate of 21.5 percent.[223] [224] Of the regions with two or more employees, the Arlington area experienced the highest rate at 36 percent and the South Texas area had the lowest at 12 percent.[225]

With a high vacancy rate of 24 percent, and with nearly 20 percent of these employees being eligible for retirement within the next five years, recruitment and retention of these workers remains a challenge.[226]

Social Workers in the Chief Program and Services Office

The CPSO employs 11 Social Worker IIIs.[227] Some of their essential job functions include providing case management, collecting and analyzing information to determine care eligibility, and providing resource facilitation. They may also develop and maintain relations with community referral sources and stakeholders.

The typical social worker in this group is about 43 years of age and has an average of six years of service.[228]

The average turnover rate for these social workers is well-managed at 10 percent, although the vacancy rate is high at 27 percent. Positions often remain vacant for an average of over two months before being filled.[229] [230]

Case Managers

There are 58 case managers employed by HHS, with the majority (91 percent) housed in state hospitals across the state.[231] Case managers assume an advocate role for both acute and chronically disabled psychiatric patients, coordinating functions to ensure patients actively involve themselves in those activities which will promote acquisition of skills to enhance their ability to function more independently and successfully in the community.

The typical case manager is about 41 years of age and has an average of 11 years of service.[232]

Turnover for the case managers is high at 24 percent. Turnover rates by location ranged from 0 percent at Big Springs State Hospital to 50 percent at the Rio Grande State Center.[233]

This high turnover may be due to the large disparity between private sector and HHS salaries. The average annual salary for HHS Case Manager I through V is $33,666, which falls below the market rate.[234] The SAO 2020 market index analysis found that the average state salary for Case Manager Is and IIIs to be seven percent behind the market rate.[235]

These problems are expected to worsen as tenured employees approach retirement. About 16 percent of these employees will be eligible to retire in the next five years.[236]

Claims Examiners

HHS employs 373 claims examiners in AES. Over 99 percent of these examiners work in the Division for Disability Services (DDS), which is under AES. These employees research and verify DDS jurisdiction to process incoming disability cases for adjudication. The typical claims examiner is 43 years of age and has 11 years of service.[237]

The average turnover rate for Claims Examiner IIs, IIIs, and IVs is high at 18 percent, though slightly below the state average rate of 21.5 percent. With a turnover rate of 45 percent, Claims Examiners II positions are the most challenging to retain and therefore contribute the highest number of vacancies.[238] [239]

Claims Examiner IIs earn an average annual salary of $38,880.[240] This salary falls significantly below the market rate. The SAO 2020 market index analysis found Claims Examiner IIs to be 10 percent below the market index rate.[241]

This disparity may contribute to HHS' ability to recruit qualified applicants, as Claims Examiners IIs experience the highest vacancy rate at 70 percent. With over 200 vacant Claims Examiners positions, it often takes over six months to fill the vacancies.[242]

Registered Therapists

There are 295 registered therapists employed at HHS state hospitals and state supported living centers. [243] [244] They specialize in various areas, such as audiology, speech-language pathology, physical therapy, and certified occupational therapy. This group also includes licensed physical therapy assistants (LPTA). Registered therapists provide essential care to the citizens of Texas and are critical workers for direct-care services.

The average salary for all registered therapists is $75,609, which is above the national average wage of $65,030 and Texas average wage of $67,520.[245] [246]

Occupational therapists earn, on average, $89,715 a year. This is comparable to the national average wage of $89,740, but below the Texas average wage of $96,100. [247] [248]

The national average salary for physical therapists of $92,920 is also comparable to the system average of $92,076. The average salary for physical therapists in Texas is higher at $98,340. [249] [250]

System speech language pathologists' average salary of $84,306 is commensurate with national average wage of $85,820 and the Texas average wage of $82,940. [251] [252]

The turnover rate for all registered therapists is low at 12 percent. Registered Therapist IIs experienced the highest turnover at 18 percent. They also have the highest vacancy rate at 23 percent, with it often taking almost six months to fill vacant Therapist II positions.[253] [254]

HHS will need to strengthen their recruitment efforts for these critical workers, as 23 percent of these employees will be eligible to retire in the next five years.[255]

Registered Therapists at State Supported Living Centers

HHS employs 231 registered therapists in state supported living centers across Texas.[256] These employees have, on average, nine years of service, with an average age of 48.[257]

The turnover for all registered therapists in state supported living centers is below the state average at 11 percent. El Paso State Supported Living Center has the highest turnover rate at 54 percent, followed by Mexia State Supported Living Center at 32 precent.[258] [259]

HHS may face significant recruitment challenges in the next few years to replace these employees who will be eligible for retirement. Though only about eight percent of these employees are currently eligible to retire, approximately 21 percent will be eligible in the next five years.[260]

Registered Therapists at State Hospitals

There are 54 registered therapists working in state hospitals across Texas. These employees have, on average, 12 years of service, with an average age of 45. Fifty percent of the therapists have 10 or more years of service.[261]

The turnover for all registered therapists in the state hospitals is high at 17 percent, though slightly below the state average rate of 21.5 percent. North Texas State Hospital experienced the highest turnover rate at 30 percent. Of state hospitals with at least 10 registered therapists, San Antonio State Hospital experienced the lowest at eight percent.[262] [263]

Like the state supported living centers, HHS may face recruitment challenges in the next few years to replace these tenured employees who will be eligible for retirement. Thirteen percent of these employees are currently eligible to retire, and approximately 33 percent of them will be eligible in the next five years.[264]

Full staffing of these positions is critical to direct-care services.

Registered Therapy Assistants

There are 12 registered therapy assistants employed in HHS state hospitals.[265] These assistants write therapy summary reports, assure therapeutic interventions

are consistent with optimal client function, and maintain therapy space, materials, and equipment. Under the supervision of a registered therapist, they may also plan and facilitate therapeutic groups and activities.

The average registered therapy assistant is 47 years of age and has an average of seven years of service. Seventy-five percent of these employees work at the Austin State Hospital, with the remaining 25 percent at San Antonio State Hospital.[266]

Registered therapy assistants earn an average salary of $51,585, which is below the national average wage of $60,740 and Texas average wage of $69,470. [267] [268]

Turnover for registered therapy assistants is high at 18 percent, though vacancies are currently well-managed, as all positions for their group are filled.

Registered Nurses

Registered nurses (RNs) constitute one of the largest healthcare occupations. With over three million jobs in the U.S., job opportunities for RNs are expected to grow nine percent from 2020 to 2030, about as fast as the average for all occupations. About 194,500 openings for registered nurses are projected each year, on average, over the decade.[269] [270]

HHS employs approximately 1,581 RNs across the state.[271] [272] As the demand for nursing services increases, the recruitment and retention of nurses will continue to be a challenge, and the need for competitive salaries will be critical.

Currently, the average annual salary for HHS System RNs is $63,856.[273] This salary falls below both national and state averages for these occupations. Nationally, the average annual earnings for RNs in 2020 was $82,750.[274] In Texas, the average annual earnings for RNs in 2020 was $ 79,120.[275] In addition, the SAO 2020 market index analysis found the average state salary for Nurse II-IVs ranged from five to 10 percent behind the market rate and 10 percent behind the market rate for Public Health Nurse IIs.[276] Posted vacant positions are currently taking about six months to fill.[277]

To address these difficulties, HHS may consider requesting additional funding to increase salary levels for these positions.

Registered Nurses at State Supported Living Centers

About 42 percent of System RNs (664 RNs) work at HHS state supported living centers across Texas.[278]

The typical state supported living center RN is about 48 years of age and has an average of approximately nine years of service.[279]

The turnover rate for these RNs is considered high at about 21 percent. Turnover is especially high at the El Paso State Supported Living Center at approximately 41 percent and the San Antonio State Supported Living Center at about 34 percent.[280]

In addition, HHS finds it difficult to fill these vacant nurse positions. With a vacancy rate of approximately 18 percent, RN positions often remain open for more than six months before being filled. Some facilities are experiencing even longer vacancy durations. At the Brenham and Denton state supported living centers, it takes about nine months to fill a vacancy.[281]

Registered Nurses at State Hospitals

About 41 percent of System RNs (649 RNs) work at state hospitals across the Texas, providing frontline medical care of patients. They provide medications, primary health care and oversee psychiatric treatment.[282]

System nurses at state hospitals are generally required to work varied shifts and weekends. The work requires special skills and staff often work long hours with minimal staffing. The work is also physically demanding, making it increasingly more difficult for the workforce to keep up with these work demands. All of these job factors contribute to higher-than-average turnover rates. Turnover for these RNs is considered very high at about 32 percent. Turnover is over 40 percent at the El Paso Psychiatric Center, the Rusk State Hospital, the Terrell State Hospital, and the Waco Center for Youth.[283]

The typical RN at a System state hospital is about 48 years of age and has an average of approximately 10 years of service.[284]

At these state hospitals, there are always vacant nursing positions that need to be filled. These RN positions often remain open for about six months before being filled. Some hospitals are experiencing longer vacancy durations. At the Big Spring

State Hospital, the Rusk State Hospital, and the Waco Center for Youth, it takes about eight months to fill a position.[285]

Public Health Registered Nurses

Approximately 57 System RNs provide direct care and population-based services in the many counties in Texas that have no local health department, or where state support is needed. [286] [287] These RNs are often the individuals who are on the frontline in the delivery of public health services to rural communities throughout the state. These nurses serve as consultants and advisors to county, local, and stakeholder groups, and educate community partners. These RNs assist in communicable disease investigation, control and prevention, and are critical to successful public health preparedness and response throughout the state.

Public Health RNs have, on average, seven years of service, with an average age of 48 years.[288]

Overall turnover for these RNs is about 19 percent. Certain areas of Texas experienced higher turnover than others, including those in the Lubbock area at 44 percent and the El Paso area at 67 percent.[289]

Licensed Vocational Nurses

There are 870 licensed vocational nurses (LVNs) employed by HHS. The majority of these employees (about 97 percent) work at state hospitals and state supported living centers across Texas.[290] [291]

About three percent work in Public Health Regions and central office program support, assisting in communicable disease prevention and control and the delivery of population-based services to individuals, families, and communities.[292]

On average, HHS LVNs are 47 years of age and have nine years of service.[293]

As with RNs, the nursing shortage is also impacting the HHS' ability to attract and retain LVNs. Turnover for LVNs is currently high at about 29 percent.[294]

Currently, the average annual salary for System LVNs during fiscal year 2021 was $42,444.[295] This salary falls below both national and state averages for this occupation. Nationally, the average annual earnings for licensed practical nurses and LVNs is $ 51,850, and $ 50,220 in Texas.[296] The SAO 2020 market index

analysis found the average state salary for LVN Is was 14 percent behind the market rate, and the salary for LVN IIs were 13 percent behind the market rate.[297]

Recruitment and retention of these highly skilled employees remains a significant challenge.

Licensed Vocational Nurses at State Supported Living Centers

There are 469 LVNs employed at HHS state supported living centers across Texas. These LVNs are, on average, 47 years of age and have an average of approximately nine years of service.[298]

Turnover for LVNs at state supported living centers is very high at about 30 percent. The state supported living centers experienced the loss of 166 LVNs in fiscal year 2021. Turnover is extremely high at the El Paso State Supported Living Center at 72 percent and the Corpus Christi Bond Homes at 57 percent.[299]

With a very high vacancy rate of about 35 percent, vacant positions often go unfilled for over seven months. Some centers are experiencing even longer vacancy durations. At the Brenham, Denton, and San Angelo state supported living centers it takes about 10 months to fill a position.[300]

Licensed Vocational Nurses at State Hospitals

There are approximately 372 LVNs employed at HHS state hospitals and centers across Texas.[301]

On average, a state hospital LVN is about 47 years of age and has nine years of service.[302]

Turnover for these LVNs is high at about 27 percent. Turnover is especially high at Rusk State Hospital (at 43 percent) and the San Antonio State Hospital at 35 percent.[303]

State hospitals continue to experience difficulty in recruiting and retaining qualified staff which can be attributed to a shortage in the qualified labor pool. Market competition and budget limitations significantly constrain the ability of state hospitals to compete for available talent.

Licensed Vocational Nurses in Public Health Roles

About three percent of System LVNs (29 LVNs) work in the Public Health Regions across Texas.[304]

They have, on average, 11 years of service, with an average age of about 50 years.[305] The overall turnover for these LVNs is high, at about 17 percent, though slightly below the state average rate of 21.5 percent.[306] [307]

Retention is expected to remain an issue as employment of LVNs is projected to grow nine percent from 2020 to 2030, about as fast as the average for all occupations. Budgetary limitations will continue to make it difficult for the System to offer competitive salaries.[308]

Nurse Practitioners

HHS employs 90 nurse practitioners throughout the System.[309] [310] Under the supervision of a physician, 51 of these nurse practitioners are responsible for providing advanced medical services and clinical care to individuals at state hospitals and those who reside in state supported living centers across Texas.[311]

These highly skilled employees have, on average, 10 years of service, with an average age of 49. Approximately 40 percent of these employees have 10 years or more of service.[312]

System nurse practitioners earn an average annual salary of $118,202.[313] This salary falls slightly below the market rate. The SAO 2020 market index analysis found the average state salary for nurse practitioners was about 10 percent behind the market rate for the Advanced Practice Registered Nurse I and about four percent behind the market rate for the Advanced Practice Registered Nurse II.[314] Recruitment and retention of nurse practitioners continue to be challenging for state supported living centers, which are also competing with private sector salaries.

The turnover rate for nurse practitioners is well-managed at about 11 percent.[315] About 11 percent of nurse practitioners are currently eligible to retire, with this number increasing to 22 percent in the next five years.[316]

Nurse Practitioners at State Supported Living Centers

HHS employs 38 nurse practitioners at state supported living centers across Texas.[317] These highly skilled employees have, on average, eight years of service, with an average age of 47.[318]

The overall turnover rate for these nurse practitioners is high at about 19 percent.[319]

Nurse Practitioners at State Hospitals

HHS employs 51 nurse practitioners at state hospitals across Texas.[320]

These employees have, on average, 11 years of service, with an average age of 50.[321]

About 10 percent of these highly skilled employees are currently eligible to retire. This number will increase to approximately 26 percent retirement eligibility in the next five years.[322]

Expansion projects at certain state hospitals will require additional clinical and non-clinical professional staff in Kerrville, San Antonio and at the North Texas State Hospital - Vernon Campus. These projects are expected to increase the demand for employees in positions that are already at critical shortage levels.

Pharmacists

HHS employs 105 pharmacists, with an average annual salary of $106,766.[323] This salary falls significantly below the market rate. The average annual salary for pharmacists nationally is $125,690 and $127,320 in Texas.[324] In addition, the SAO 2020 market index analysis found the average state salary for Pharmacist Is 15 percent behind the market rate, and Pharmacist IIs at five percent behind the market rate.[325] This disparity is affecting the System's ability to recruit qualified applicants for open positions. Pharmacist positions often remain unfilled for over three months.[326]

Though pharmacist turnover is only moderately high at 14 percent, a significant number of pharmacists are nearing retirement age (or have already retired and returned to work), and over 20 percent will be eligible to retire in the next five

years.[327] [328] Recruitment and retention of these highly skilled employees will continue to be a problem for the System.

Pharmacists at State Supported Living Centers

About 45 percent of System pharmacists (47 employees) work at HHS state supported living centers. The typical pharmacist at these facilities is about 47 years of age and has an average of seven years of service.[329]

Turnover for these pharmacists is currently moderately high at about 12 percent, though some Centers are experiencing much higher turnover, including the Lufkin State Supported Living Center at 75 percent and the Abilene State Supported Living Center at 25 percent.[330]

HHS may face significant recruitment challenges in the next few years to retain these highly skilled employees who will be eligible for retirement. Though only six percent of these employees are currently eligible to retire, 17 percent them will be eligible in the next five years.[331]

Pharmacists at State Hospitals

There are 33 System pharmacists working in state hospitals across Texas. These highly skilled employees are essential to the timely filling of prescribed medications for patients in state hospitals. The majority of these employees are in Pharmacist II positions (23 employees or 70 percent).[332]

These pharmacists play a key role in the monitoring of costs and inventory of medications, and in the ongoing monitoring of in-patients' medication histories, needs and potential adverse drug issues. They provide important clinical consultation to psychiatrists and physicians regarding complex medical and psychiatric conditions that may be intractable to traditional medication treatment interventions.

The typical pharmacist at a state hospital is about 48 years of age and has an average of 10 years of service. About 39 percent of these employees have 10 or more years of service.[333]

Turnover for these pharmacists is currently high at about 22 percent, with positions often remaining unfilled for nearly four months before being filled.[334] [335] Some state hospitals are experiencing much higher turnover.

With 22 percent of these pharmacists currently eligible to retire, and 38 percent eligible to retire in the next five years, HHS will need to develop creative recruitment strategies to replace these skilled and highly tenured employees.[336]

Pharmacy Technicians

There are 73 pharmacy technicians in HHS, with the majority (99 percent) employed in state hospitals and state supported living centers across the state.[337] These employees assist pharmacists in various technical aspects of preparation of non-routine medication orders for passes, furloughs and discharges. They fill medication carts, maintain required medication stock for after-hours pre-packaging and labeling unit-dose and multiple dose medication orders, perform courier and drug delivery duties, and inspect medication rooms for out-of-date merchandise and appropriateness of stock.

System pharmacy technicians earn an average annual salary of $29,057, which is below the average national wage of $37,970, and lower than the Texas average wage of $38,330.[338] [339] This salary also falls below the market rate. The SAO 2020 market index analysis found the average state salary for Pharmacy Technician Is to be 14 percent behind the market rate and Pharmacy Technician IIs to be seven percent behind the market rate.[340]

Turnover for these pharmacy technicians is very high at 37 percent.[341] With a high vacancy rate of 41 percent, pharmacy technician positions often remain unfilled for over five months before being filled.[342]

Pharmacy Technicians at State Supported Living Centers

About 48 percent of HHS pharmacy technicians (35 employees) work at state supported living centers across Texas.[343]

The typical pharmacy technician at these facilities is about 45 years of age and has an average of nine years of service.[344]

Turnover for these pharmacy technicians is high at about 26 percent, reflecting the loss of about 10 workers during fiscal year 2021. Turnover rates by location ranged from 0 percent at the San Antonio State Supported Living Center to 100 percent at the Lufkin State Supported Living Center.[345]

Pharmacy technician positions often remain open for months before being filled. At the Denton State Supported Living Center, positions have remained vacant for an average of six months.[346]

Pharmacy Technicians at State Hospitals

There are 37 pharmacy technicians working at HHS state hospitals, with about 68 percent employed in Pharmacy Technician II positions.[347]

These employees have, on average, nine years of service, with an average age of 43.[348]

Turnover for these pharmacy technicians is very high at about 32 percent. Big Springs State Hospital experienced one of the highest turnover rates at 73 percent.[349]

The vacancy rate for these positions is high, at about 18 percent, with positions often remaining unfilled for over five months.[350]

HHS may face significant recruitment challenges in the next few years, as 16 percent of these employees will be eligible for retirement in the next five years.[351]

Dentists at State Supported Living Centers

The demand for dentists nationwide is expected to increase as the overall population ages. Employment of dentists is projected to grow by eight percent through 2030.[352]

The System employs a total of 30 dentists across the state.[353] Of the 30 dentists employed by the System, a little over half (53 percent) provide advanced dental care and treatment for residents living at the HHS supported living centers across Texas. The typical dentist at these facilities is about 55 years of age and has an average of 12 years of service.[354]

Facility dentists earn an average salary of $143,074, which is below the national average wage of $167,160, and lower than the Texas average wage of $150,060.[355] [356]

Turnover for these dentists is high at about 27 percent.[357] State supported living centers face challenges competing with private sector salaries to fill current vacancies.

It is anticipated that HHS will face significant recruitment challenges in the next few years to replace these highly skilled employees who will be eligible for retirement. About 19 percent of these employees are currently eligible to retire, and this number will increase to about 38 percent in the next five years.[358]

Dental Assistants

There are 21 Dental Assistant Is and IIs working in the state hospitals and state supported living centers, with IIs make up 86 percent of the total.[359] These assistants prepare treatment areas, assist dentists with instrumentation, and instruct staff, guardians, or patients regarding treatment and hygiene.

Dental assistants have, on average, 11 years of service, with an average age of 47 years of age. Over 76 percent have five or more years of service.[360]

Dental assistants make an average salary of $30,727, which is below the national wage of $42,510 and state wage of $38,370 average salaries.[361]

Turnover for dental assistants is much lower than the state average, at only nine percent.[362] [363] There were no vacancies for dental assistants in fiscal year 2021.[364]

Nineteen percent of dental assistants are eligible to retire this year, and over 29 percent will be eligible to retire in five years.[365]

Physicians

There are currently about 256,670 active physicians across the country.[366]

HHS employs 95 physicians, with 71 percent employed in HHS state supported living centers, state hospitals.[367]

These highly skilled employees have, on average, nine years of service, with an average age of 57. About 37 percent of these employees have 10 years or more of service.[368]

System physicians are currently earning an average annual salary of $194,982.[369] This salary is below the average nationally wage of $231,500 and lower than the Texas average wage of $237,890.[370] The SAO 2020 market index analysis found the average state salary for Physicians to be six to 10 percent behind the market rate.[371]

Turnover for these physicians is currently moderately high at 13 percent, though positions are remaining vacant for an average of more than six months.[372] [373]

About 17 percent of these highly skilled and tenured employees are currently eligible to retire, with this number increasing to 37 percent in the next five years.[374]

Physicians at State Supported Living Centers

There are 41 physicians working at state supported living centers across Texas.[375] Full staffing of these positions is critical to direct-care services.

These physicians have, on average, eight years of service, with an average age of 58.[376] Local physicians who have established long term private practices often apply as a staff physician at state supported living centers late in their career to secure retirement and insurance benefits, thus explaining the reason for the high average age.

Turnover for these physicians is moderately high at 14 percent.[377]

To meet the health needs of individuals residing in state supported living centers, it is critical that HHS recruit and retain qualified physicians. However, due to the short supply and large demand, state supported living centers are experiencing difficulty hiring physicians, with positions remaining unfilled for an average of almost seven months.[378]

Physicians at State Hospitals

There are currently 26 physicians at HHS who are providing essential medical care in state hospitals.[379] They take the lead role in diagnosing, determining a course of treatment, making referrals to outside medical hospitals, prescribing medications and monitoring the patients' progress toward discharge. Physician services in state

hospitals are essential to the ongoing monitoring and management of an increasing number of complex chronic medical conditions, such as diabetes, seizure disorders, hypertension and chronic obstructive pulmonary disease (COPD). These employees are critical to the System's preparedness and response to medical services provided by the state and to major public health initiatives, such as obesity prevention, diabetes, disease outbreak control and others.

These physicians have, on average, 13 years of service, with an average age of about 57. Local physicians who have established long term private practices often apply as physicians at state hospitals late in their working career to secure retirement and insurance benefits, contributing to the high overall age. More than 40 percent of the full-time physicians are 50 years of age or older.[380]

Turnover for these physicians is currently low at eight percent, though it takes about nine months to fill a state hospital physician position with someone who has appropriate skills and expertise.[381] [382]

In addition, HHS may face significant challenges in the next few years to replace those employees who are eligible for retirement. About 31 percent of these highly skilled and tenured employees are currently eligible to retire. Within five years, about 46 percent will be eligible to retire.[383] If these employees choose to retire, HHS will lose some of the most experienced medical personnel – those with institutional knowledge and skills that will be difficult to match and even harder to recruit.

Psychiatrists

There are currently about 25,520 psychiatrists nationwide.[384] A 4.5 percent decrease is projected in the state government sector by 2030.[385]

HHS employs 121 psychiatrists throughout the System, with about 84 percent employed in state hospitals across Texas.[386]

These highly skilled and tenured employees have, on average, 12 years of service, with an average age of 53.[387]

System psychiatrists currently earn an average annual salary of $247,565.[388] The SAO 2020 market index analysis found the average state salary for Psychiatrist IIs and IVs ranged from 14 to 10 percent behind the market rate.[389]

Turnover for System psychiatrists is currently at about 11 percent.[390] The vacancy rate is high at about 20 percent, with positions remaining vacant for an average of seven months.[391]

About 23 percent of these highly skilled and tenured employees are currently eligible to retire, with this number increasing to 34 percent in the next five years.[392]

Psychiatrists at State Supported Living Centers

There are 16 psychiatrists assigned to state supported living centers.[393] Full staffing of these positions is critical to providing psychiatric services needed by residents.

These psychiatrists have, on average, nine years of service, with an average age of 55.[394]

With a high vacancy rate of 16 percent, vacant positions in state supported living centers go unfilled for about seven months.[395]

Psychiatrists at State Hospitals

There are currently 102 System psychiatrists providing essential medical and psychiatric care in state hospitals.[396] These highly skilled employees take the lead role in diagnosing, determining a course of treatment, prescribing medications and monitoring patient progress. Recruiting and retaining psychiatrists at the state hospitals has been especially difficult for HHS.

These psychiatrists have, on average, 13 years of service, with an average age of 53. About 53 percent of these employees have 10 or more years of service.[397]

Annual turnover for these psychiatrists is currently well-managed at about 10 percent, although much higher rates were reported for Big Springs State Hospital at 42 percent and 19 percent for North Texas State Hospital.[398]

With an overall high vacancy rate of about 20 percent, most vacant psychiatrist positions go unfilled for over seven months.[399] These challenges are expected to continue, as about 26 percent of these highly skilled and tenured employees are currently eligible to retire and may leave at any time. Within five years, this number will increase to 35 percent.[400]

State hospitals continue to face increasing difficulty in recruiting qualified psychiatrists as salaries are not competitive with the private sector, and there is a general shortage of a qualified labor pool.

Due to the complex medical and mental challenges that individuals residing in state hospitals exhibit, it is critical that HHS is able to effectively recruit and retain qualified psychiatrists.

Psychologists

There are 43 psychologists in HHS, with 72 percent employed in state hospitals across the state.[401]

System psychologists earn an average annual salary of $84,883.[402] This salary falls below the market rate. The SAO 2020 market index analysis found the average state salary for Psychologist Is to be 11 percent behind the market rate and Psychologist IIIs to be eight percent behind the market rate.[403]

Turnover for these psychologists is very high at 37 percent. With a high vacancy rate of 41 percent, psychologist positions often remaining unfilled for over five months.[404] [405]

Psychologists at State Hospitals

There are 31 psychologists working at HHS state hospitals, with about 65 percent employed in Psychologist II positions.[406] Full staffing of these positions is critical to providing needed psychological services to patients.

State hospital psychologists play a key role in the development of treatment programs for both individual patients and groups of patients. Their evaluations are critical to the ongoing management and discharge of patients receiving competency restoration services, an ever-growing patient population in the state hospitals. They also provide testing and evaluation services important to ongoing treatment, such as the administration of IQ, mood, and neurological testing instruments.

These highly skilled and tenured employees have, on average, 11 years of service, with an average age of 51.[407]

Turnover for these psychologists is very high at about 36 percent. Rio Grande State Center experienced the highest turnover at 80 percent.[408]

The vacancy rate for these positions is very high, at about 34 percent, with positions often remaining unfilled for over six months.[409]

HHS may face significant recruitment challenges in the next few years, as 13 percent of these highly skilled and tenured employees are currently eligible for retirement and may leave HHS at any time.[410]

Behavioral Health Specialists

There are 130 behavioral health specialists within HHS.[411] These specialists are employed at state supported living centers across the state, providing behavior support services, including behavior observations, data analysis, training of behavioral interventions, and the modeling of behavior support. Behavior health specialists participate as a member of individuals' interdisciplinary teams, and are responsible for assisting in the development, implementation, and evaluation of behavior support plans (including comprehensive functional behavioral assessments), staff training, data collection and reporting, and program evaluation.

On average, HHS behavioral health specialists are 40 years of age and have about eight years of service. About 28 percent of these employees have 10 or more years of service.[412]

The turnover rate for these employees is currently high at about 26 percent. Both the Lufkin State Supported Living Center and the Austin State Supported Living Center are experiencing the highest turnover rate, at 44 percent.[413]

HHS experienced difficulty filling vacant positions. With a high vacancy rate of 17 percent, vacant positions often go unfilled for over four months.[414]

With 15 percent of these employees eligible to retire in the next five years, HHS will need to develop creative recruitment strategies to replace these skilled employees.[415]

Mental Health Specialists

There are 33 mental health specialists within HHS.[416] These specialists are employed at state hospitals across the state, performing psychological testing, assessments, group therapies, counseling, reporting and data collection. They participate in Program Recovery Teams, with duties of coordinating recovery planning.

On average, HHS mental health specialists are 41 years of age and have about eight years of service. About 21 percent of these employees have 10 or more years of service.[417]

The turnover rate for HHS mental health specialists is high at about 21 percent, reflecting the loss of about eight specialists during fiscal year 2021. Turnover rates by location ranged from 0 percent at the Austin State Hospital to 45 percent at the North Texas State Hospital.[418]

With a very high vacancy rate of 31 percent, vacant positions often go unfilled for more than six months.[419]

With 18 percent of these employees eligible to retire in the next five years, HHS will need to develop creative recruitment strategies to replace these skilled employees.[420]

Epidemiologists

HHS employs 127 epidemiologists who provide services in the areas of infectious disease and injury control, chronic disease control, emergency and disaster preparedness, disease surveillance and other public health areas.[421] They provide critical functions during disasters and pandemics and other preparedness and response planning.

As of May 2021, there were approximately 8,180 epidemiologist jobs in the U.S., with a projected job growth rate of 10 percent by 2030.[422]

On average, System epidemiologists have about six years of service, with an average age of approximately 35 years.[423]

Turnover for System epidemiologists is currently high at about 19 percent. This rate is much higher for experienced Epidemiologist IIIs, at about 22 percent.[424]

Low pay is a contributing factor in the inability to attract qualified epidemiologist applicants. System epidemiologists are currently earning an average annual salary of $60,312.[425] This salary is significantly below the average national wage of $86,740, and also lower than the Texas average wage of $82,810.[426] In addition, the SAO 2020 market index analysis found that the average state salary for epidemiologists range from 11 percent (for Epidemiologist Is) to 12 percent (for Epidemiologist IIIs) behind the market rate.[427]

Currently, only about seven percent of these employees are eligible to retire and this rate will increase in the next five years to 16 percent.[428]

Surveillance functions involving preparedness, response and monitoring will need more qualified public health professionals i.e., Epidemiologists. Emerging threats will require continuous and agile learning for Epidemiologists in areas such as disease prevention and population health. HHS will need to closely monitor this occupation due to the nationally non-competitive salaries and a general shortage of professionals performing this work.

Sanitarians

There are 126 sanitarians employed with HHS, with 73 percent employed within the DSHS Division for Consumer Protection.[429] HHS registered sanitarians inspect all food manufacturers, wholesale food distributors, food salvagers in Texas, as well as all retail establishments in the 188 counties not covered by local health jurisdictions and conduct a multitude of environmental inspections such as children's camps, asbestos abatement, hazardous chemicals/products and many others. Sanitarians are instrumental in protecting the citizens of Texas from food-borne illness and many dangerous environmental situations and consumer products, including imported foods, drugs and consumer products. The U.S. Food and Drug Administration (FDA) and the Consumer Products Safety Commission (CPSC) have little manpower and therefore depend on the state programs to protect citizens. System sanitarians also respond to a variety of emergencies, including truck wrecks, fires, tornados, floods, and hurricanes. They are the first line of defense against a bioterrorist attack on the food supply.

On average, HHS sanitarians are 44 years of age and have about 11 years of service. About 44 percent of these employees have 10 or more years of service.[430]

Though the turnover rate for HHS sanitarians is currently low at about nine percent, HHS has experienced difficulty filling vacant positions, with vacant positions often going unfilled for over seven months due to a shortage of qualified applicants available for work.[431] [432]

Historically, HHS has faced special challenges filling vacancies in both rural and urban areas of the state. In addition, the state requirement for sanitarians to be registered and have at least 30 semester hours of science (in addition to 18 hours of continuing education units annually) has made it increasingly difficult to find qualified individuals.

With 14 percent of sanitarians currently eligible to retire, and 21 percent eligible to retire in the next five years, HHS will need to develop creative recruitment strategies to replace these skilled and highly tenured employees.[433]

Health Physicists

Within DSHS, there are 51 health physicists, all employed within the Consumer Protection Division.[434] These employees plan and conduct complex and highly advanced technical inspections and license application review of radioactive material, nuclear medicine, industrial x-ray units, general medical diagnostic x-ray units, fluoroscopic units, mammographic units, C-Arm units, radiation therapy equipment, laser equipment, and industrial and medical radioactive materials to assure user's compliance with applicable State and Federal regulations. Health physicists are instrumental in emergency planning for the offsite response of nuclear power plants and are the the first line of defense for radiological disaster response.

Health physicists have, on average, 13 years of service, with an average age of 50 years. Over 60 percent of these employees have 10 or more years of service.[435]

HHS health physicists earn an average annual salary of $60,435 which is higher than both the average national wage of $57,560 and the Texas average wage of $48,200.[436] [437]

Turnover for HHS health physicists is high at 18 percent, though slightly below the state average rate of 21.5 percent.[438] [439] Vacant positions often go unfilled for over four months due to a small number of qualified applicants.[440]

Medical Technicians

Within HHS, there are 20 medical technicians.[441] These workers assist nursing staff with age-appropriate patient care, which includes providing for patient’s personal hygiene; making beds and assisting with preparation of unit’s and patient’s rooms for receiving new patients; taking vital signs; obtaining specimens; cleaning patient care equipment; and transporting patients to and from various departments.

Half of these medical technicians are employed at TCID, with the remaining technicians employed at HHS state hospitals and state supported living centers across Texas.

System medical technicians have, on average, 13 years of service, with an average age of 49 years. About 40 percent of these employees have 10 or more years of service.[442]

The turnover rate for all System medical technicians is high at 22 percent. This rate is 38 percent for entry-level Medical Technician Is at TCID.[443]

The vacancy rate for System medical technicians is currently high at about 17 percent, though slightly below the state average rate of 21.5 percent.[444] [445] Vacant positions often remain unfilled for three months.[446]

HHS medical technicians earn an average annual salary of $28,549.[447] The SAO 2020 market index analysis found the average state salary for medical technicians ranged from nine to 10 percent behind the market rate.[448] This disparity may be affecting HHS' ability to recruit qualified applicants for open positions.

Currently, 20 percent of these employees are eligible to retire, with 35 percent of these employees eligible in the next five years.[449]

Public Health and Prevention Specialists

Within HHS, there are 23 public health and prevention specialists employed within the DSHS' Division for Laboratory and Infectious Disease.[450] These employees provide technical consultation to local health departments, human and animal health care professionals, government officials, community action groups, and others on a number of public health areas, including disease epidemiology and surveillance to treat, prevent and control infectious diseases, sexually-transmitted diseases, and zoonotic diseases; provision of vaccines and life-saving HIV medications; and newborn screening testing.

These public health and prevention specialists have, on average, 10 years of service, with an average age of 44 years. Forty-four percent of these employees have 10 or more years of service.[451]

The overall turnover for these public health and prevention specialists is 17 percent, which is high, though slightly below the state average rate of 21.5 percent.[452] [453]

In addition, this division finds it difficult to fill these vacant public health and prevention specialist positions, which often remain open for over a year before being filled.[454]

Retention is expected to remain an issue as these employees approach retirement. Twenty-two percent of these public health and prevention specialists are currently eligible to retire, and about 30 percent will be eligible to retire in the next five years.[455]

Veterinarians

There are 18 veterinarians working for DSHS in the Consumer Protection Division, the Division for Laboratory and Infectious Disease Services, and in Public Health Regions across the state.[456] System veterinarians perform advanced veterinary work and are responsible for the day-to-day management of the Zoonosis Control Program.

These highly skilled and tenured employees have, on average, 15 years of service, with an average age of 53.[457]

System veterinarians make $91,544, which is below the average national wage of $109,920 and state wage of $113,720. [458] [459] In addition, the SAO 2020 market index analysis found that the average state salary for Veterinarian IIs to be nine percent behind the market rate.[460]

Turnover for veterinarians is high at 17 percent, though slightly below the state average rate of 21.5 percent.[461] [462]

The agency may face significant recruitment challenges in the next few years to replace these highly skilled and tenured employees who are eligible for retirement. Currently, 17 percent of veterinarians are eligible to retire, and over 50 percent of Veterinarian II's will be eligible to retire in the next five years.[463]

Laboratory Staff

DSHS operates a state laboratory in Austin and two regional laboratories, one in San Antonio and the other in Harlingen. In addition, the Austin State Hospital provides laboratory services for the other HHS state hospitals and state supported living centers.

While laboratory staff is made up of several highly skilled employees, there are four job groups that are essential to laboratory operations: chemists, microbiologists, laboratory technicians, and medical technologists.

Chemists

There are 58 chemists employed in the HHS Division for Laboratory and Infectious Disease Services, all located in Austin.[464]

HHS chemists are about 44 years of age and have an average of about 11 years of service. Most of the employees have 10 years or more of service.[465]

The turnover rate for HHS chemists is well maintained at about nine percent annually, which is significantly below the state average turnover rate of 21.5 percent.[466] [467]

Vacant HHS chemist positions often go unfilled for over seven months due to a shortage of qualified applicants available for work.[468] These vacancy problems are expected to worsen as employees approach retirement. About 17 percent of these tenured and highly skilled employees are currently eligible to retire, with that number increasing to 26 percent within the next five years.[469]

Low pay is a factor in the inability to attract qualified chemist applicants. System chemists earn an average annual salary of about $53,722.80.[470] The SAO 2020 market index analysis found the average state salary for chemists ranged from eight to 10 percent behind the market rate.[471] The average annual national wage is $89,130, and the Texas wage is $88,070.[472]

Microbiologists

There are 148 microbiologists working for HHS, with the majority at the Austin laboratory.[473] [474]

System microbiologists have, on average, 10 years of service, with an average age of about 40 years.[475]

The turnover rate for all System microbiologists is moderately high at about 13 percent, which is below the state average rate of 21.5 percent. The rate is much higher for mid-level Microbiologist IIIs at 21 percent.[476] [477]

System microbiologists earn an average annual salary of $51,865.[478] The SAO 2020 market index analysis found the average state salary for Microbiologist IIs was 13 percent behind the market rate and seven percent behind the market rate for Microbiologists IV.[479] This average annual salary also falls below the national and statewide market rates for this occupation. The average annual national wage is

$87,820, and the Texas wage is $62,350.[480] This disparity in earnings is affecting the System's ability to recruit qualified applicants for open positions. Microbiologist positions often remain unfilled for over seven months.[481]

In addition, HHS may face significant recruitment challenges in the next few years to replace these highly skilled and tenured employees who are eligible for retirement. Approximately 10 percent of these employees are currently eligible to retire, this rate will increase in the next five years to about 16 percent.[482]

Laboratory Technicians

There are 50 laboratory technicians employed at HHS.[483]

The typical laboratory technician is about 41 years of age and has an average of nine years of service.[484]

The turnover rate for System laboratory technicians is high at about 22 percent.[485]

While the vacancy rate for System laboratory technicians is low, at about six percent, vacant positions often go unfilled for about five months due to a shortage of qualified applicants available for work.[486]

Low pay is a factor in the inability to attract qualified laboratory technician applicants. HHS laboratory technicians earn an average annual salary of about $34,221.[487] The average national wage is $56,910, and the Texas wage is $53,240.[488] The SAO 2020 market index analysis found the average state salary for Laboratory Technician Is to IIs ranged from three to 11 percent behind the market rate.[489]

These problems are expected to worsen as employees approach retirement. About 24 percent of these tenured employees will be eligible to retire in the next five years.[490]

Medical Technologists

Within HHS, there are 62 medical technologists.[491] These workers perform complex clinical laboratory work and are critical to providing efficient and quality healthcare.

System medical technologists have, on average, eight years of service, with an average age of 43 years. About 29 percent of these employees have 10 or more years of service.[492]

The turnover rate for all System medical technologists is currently high at about 20 percent, though slightly below the state average rate of 21.5 percent.[493] [494]

The vacancy rate for System medical technologists is at about 10 percent, with vacant positions often going unfilled for over five months due to a shortage of qualified applicants available for work.[495]

HHS medical technologists earn an average annual salary of $49,960.[496] The SAO 2020 market index analysis found the average state salary for medical technologists ranged from nine to 15 percent behind the market rate.[497] This disparity is affecting HHS' ability to recruit qualified applicants for open positions.

Though only about seven percent of these employees are currently eligible to retire, almost 20 percent of these employees will be eligible in the next five years.[498]

Day Care Inspectors

There are 73 day care inspectors within HHS.[499] These specialists are responsible for conducting investigations and inspections of unregulated child care facilities and conducting parent and provider trainings related to the benefits of regulation.

The typical day care inspector is about 40 years of age and has an average of seven years of service. Nearly 20 percent of these employees have 10 or more years of service.[500]

These day care inspectors earn an average annual salary of $41,048.[501] This salary is below the average national wage of $78,740, and lower than the Texas wage of $76,510.[502] In addition, the SAO 2020 market index analysis found the average state salary for Inspector IIIs to be six percent behind the market rate and Inspector Vs to be two percent behind the market rate.[503] This disparity may be affecting HHS' ability to recruit qualified applicants for open positions.

Turnover for these inspectors is high at 19 percent, though slightly below the state average rate of 21.5 percent.[504] [505] With a vacancy rate of about 11 percent, vacant positions often go unfilled for about four months due to a shortage of qualified applicants available for work.[506]

Health Facility Social Services Surveyors

The HHS System employs 23 health facility social services surveyors.[507] These employees are responsible for planning, organizing, and conducting investigations

in Long Term Care facilities to determine compliance with state and federal laws, regulations, and rules.

The typical health facility social services surveyor is about 54 years of age and has an average of 11 years of service. Nearly 44 percent of these employees have 10 years or more of service.[508]

The overall turnover rate for these surveyors is high at about 25 percent annually, which is slightly above the state average turnover rate of 21.5 percent.[509] [510]

With a high vacancy rate of 23 percent, health facility social services surveyor positions often go unfilled for six months due to a shortage of qualified applicants available for work.[511] These vacancy concerns are expected to worsen as employees approach retirement. About 35 percent of these employees are currently eligible to retire, and about 39 percent of these tenured employees will be eligible to retire in the next five years.[512]

Qualified Intellectual Disability Professionals

There are 250 qualified intellectual disabilities professionals employed by HHS, with the 99 percent housed in state supported living centers across the state.[513] These qualified intellectual disabilities professionals are responsible for the development, implementation, monitoring, and revision of highly individualized Personal Support Plans for residents which promote dignity, respect, choice, and the exercising of personal rights for each person who is on their assigned caseload.

The typical qualified intellectual disabilities professional at these facilities is about 41 years of age and has an average of nine years of service. About 36 percent of these professionals have 10 or more years of service.[514]

Turnover for the qualified intellectual disabilities professional job family is high at 19 percent, reflecting the loss of 51 professional during fiscal year 2021. Turnover was highest at the Lufkin State Support Living Center at 37 percent and the Corpus Christi State Supported Living Center at 29 percent.[515]

Blind Children Specialists

HHS employs 14 Blind Children Specialist Is.[516] These specialists all work within the Rehabilitative and Independence Services section of HDIS. These specialists are responsible for assisting blind children and their families with counseling, information, support, training, and guidance that foster vocational discovery and

development using the agency's employment lifestyle philosophy while promoting the blind or visually impaired child's self-sufficiency.

The typical Blind Children Specialist I is about 40 years of age and has an average of only three years of service. Seventy-nine percent of these specialists have less than two years of service.[517]

Turnover for these specialists is high at 19 percent, though slightly below the state average of 21.5 percent.[518] [519] With a high vacancy rate of 22 percent, vacant positions often go unfilled for about four months due to a shortage of qualified applicants available for work.[520]

Since these employees require a nine-month probationary training period, all resignations are costly to the program. Their knowledge and skill level are critical to the delivery of quality services to children and families.

Rehabilitation Therapy Technicians

There are approximately 571 rehabilitation therapy technicians employed across Texas in the state hospitals and state supported living centers. Technician Vs make up most of this job family at 33 percent. Many of the technicians perform entry-level habilitative and rehabilitative therapy work. Some of their essential job functions include studying clients' behavior to determine the need for therapeutic activities and writing progress notes and assisting clients with instructions for their selected therapeutic activities such as arts, crafts, drama, music, printing, sewing and recreation. Higher level technicians at state hospitals may be responsible for developing a comprehensive, structured, hospital-wide recreational activity program.[521]

The U.S. Bureau of Labor Statistics estimates that about 11,200 openings for these types of positions are projected each year until 2030 as many of the vacancies are expected to come from workers who transfer to different occupations or retire.[522]

The average rehabilitation therapy technician is 43 years of age with, on average, 11 years of service. Forty-five percent of technicians have 10 or more years of service.[523]

The average salary for Rehabilitation Therapy Technician Is is $22,171.[524] Technician IIIs earn $27,429 per year and Technician Vs make the most at $32,306 annually.[525] Rehabilitation counselors, which is the most similar profession in U.S.

Bureau of Labor Statistics' categories, make an average national wage of $44,740, and Texas wage of $43,610.[526]

The turnover rate for these technicians is 28 percent, higher than the state average rate of 21.5 percent. [527] [528] Rehabilitation Therapy Technician Is have the highest turnover rate at 55 percent.[529] The Technician Is had the highest vacancy rate at 47 percent.[530] Over 25 percent of rehabilitation therapy technicians are eligible to retire in five years.[531]

Rehabilitation Therapy Technicians at State Hospitals

There are 293 rehabilitations therapy technicians working in state hospitals, with 34 percent classified as Technician IIs. There are 126 who work at the North Texas State Hospital; the Waco Center for Youth has the smallest group with six technicians on staff. The average technician working at the state hospitals is 42 years of age with 11 years of service.[532]

The turnover rate for state hospital rehabilitation technicians is high at 21 percent, with Kerrville State Hospital experiencing the highest turnover at 39 percent.[533] Austin State Hospital has the lowest turnover rate at 13 percent.[534] The vacancy rate is 16 percent, and it can take almost six months to fill these vacancies.[535]

Rehabilitation Therapy Technicians at State Supported Living Centers

The state supported living centers employs 571 rehabilitation therapy technicians. The Denton Sate Supported Living Center has the largest group, with 80 technicians, while the Rio Grande State Center has the smallest, with 17 technicians.[536]

On average, these rehabilitation therapy technicians are about 44 years of age and have 11 years of service.[537]

The overall turnover rate for these technicians is very high at 31 percent.[538] The vacancy rate for these positions is also high at 24 percent.[539]

Health Assistants

There are 103 health assistants employed in the HHS system, with 98 percent working in state supported living centers. The remaining two percent work at the North Texas State hospital. Some of the health assistants' essential job functions include assisting with performing diagnostic and treatment functions, assisting with research projects and program evaluations, and gathering information and data from direct care and clinical staff. They may also administer or assist with various behavioral and psychiatric assessments as deemed necessary by a specialist or analyst. The average health assistant is about 38 years of age and has an average of 10 years of service.[540]

System health assistants earn an average salary of $31,592 per year.[541] This is lower than the national average wage of $35,850 and Texas average wage of $34,660.[542]

Turnover for health assistants is 22 percent, slightly higher than the state average rate of 21.5 percent, reflecting a loss of 24 workers during fiscal year 2021. Richmond State Supported Living Center had the highest turnover rate at 61 percent, followed by San Angelo State Supported Living Center at 56 percent.[543] [544]

The vacancy rate for health assistants is well-managed at 11 percent. Denton State Supported Living Center had the highest vacancy rate at 25 percent. It often takes over four months to fill vacant positions in that area.[545]

Human Services Specialists

There are 83 human services specialists employed within the system. Over 42 percent work in HDIS. The specialists have various responsibilities, including determining eligibility and need for Personal Care Services and Community First Choice. They may provide case management consultation, assessment and services for children and families who have health risks, conditions, or special health care needs.[546]

The typical human services specialist is about 48 years of age and has an average of 11 years of service. Over 70 percent of these specialists have five or more years of service.[547]

Human services specialists earn an average salary of $43,926, with Human Services Specialist VIIs, who make up 63 percent of this group, earning $45,848.[548]

According to the Bureau of Labor Statistics, the average national wage for health education specialists and community health workers is $48,140.[549]

The average turnover rate for this group is moderately high at 12 percent, though lower than the state average rate of 21.5 percent, with Human Services Specialist IVs experiencing the highest turnover at 27 percent.[550] [551] With a high vacancy rate of 15 percent, vacant positions have remained unfilled for over six months.[552]

HHS will need to prepare recruitment strategies for these specialists, as 16 percent of them are currently eligible to retire, and 28 percent will be eligible in the next five years.[553]

Human Services Technicians

There are 24 human services technicians employed within the Health and Specialty Care System (HSCS), with the 75 percent housed in Corpus Christi Bond Homes.[554] These technicians are responsible for the daily supervision and care of assigned individuals, and focus on training, implementing, and monitoring assigned Person Support Plan activities. These technicians also support and encourage families during the treatment process, performing work as a family partner, engaging families during the admission process, answering questions about the process, encouraging participation in treatment and helping families make informed decisions about recovery.

The typical HSCS human services technician is about 49 years of age and has an average of 10 years of service. Fifty percent of these technicians have 10 or more years of service.[555]

Turnover for these technicians is very high at 30 percent, with all these losses occurring at Corpus Christi Bond Homes.[556]

This high turnover may be due to the large disparity between private sector and HHS salaries. The average annual salary for HSCS Human Services Technician I through III is $26,328, which falls below the market rate.[557] The SAO 2020 market index analysis found that the average state salary for Human Services Technician IIs to be 10 percent behind the market rate.[558]

These problems are expected to worsen as tenured employees approach retirement. About 17 percent of these employees are currently eligible to retire, with that number increasing to 38 percent in the next five years.[559]

Research Specialists

HHS employs 125 research specialists throughout the System.[560] These research specialists are responsible for providing statistical and programming work critical to supporting the services the agencies provide.

These employees have, on average, 11 years of service, with an average age of 42. Approximately 47 percent of these employees have 10 years or more of service.[561]

HHS research specialists earn an average annual salary of $59,588.[562] The SAO 2020 market index analysis found the average state salary for research specialists ranged from about eight to 13 percent behind the market rate for Research Specialists I - III.[563] Recruitment and retention of research specialists continue to be challenging for HHS, who is also competing with other public and private sector salaries.

The turnover rate for research specialists is about 18 percent, with turnover slightly higher in the DSHS Division for Laboratory and Infectious Disease at 22 percent.[564] The vacancy rate for research specialists is high at approximately 17 percent, with positions remaining unfilled for over three months.[565]

About 12 percent of research specialists are currently eligible to retire, with this number increasing to 22 percent in the next five years.[566]

Training Specialists

There are 17 Training Specialist IIIs, IVs, and Vs employed within HDIS. They develop, implement, and evaluate training programs, as well as develop methods for assessing and evaluating the effectiveness of training. About 53 percent of these employees are Training Specialist Vs.[567]

Training specialists in this area have, on average, nine years of service, with an average age of 48. Over 64 percent of these employees have five or more years of service.[568]

These training specialists earn an average annual salary of $57,399, which is, according to the SAO's most recent classification report, up to 14 percent behind the market rate.[569] [570]

Human Resources Specialists

HHS employs 37 human resources specialists who provide support services to over 36,000 HHS employees.[571] Human Resources (HR) is a core business area of HHS and has quickly established itself as an HHS strategic business partner.

HR has evolved and now plays an important role in strategic planning, employee engagement, recruitment and onboarding, legal and regulatory compliance, a change agent, training partner, and data steward.

Although the role of human resources has evolved, the average annual salary paid to HHS human resources staff falls below the average annual salary of many of the same classified positions in other state agencies of similar size and organizational structure. HHS human resources specialists are currently earning an average annual salary of $55,941.[572] The SAO 2020 market index analysis found that the average state salary for human resources specialists range from seven percent for Human Resources Specialist IIIs to fifteen percent for Human Resources Specialist IIs behind the market rate.[573] In addition, the salary paid to HHS human resources specialists is significantly below the average national wage of $70,720, and also lower than the Texas average wage of $69,360.[574]

As of May 2021, there were approximately 674,800 human resources specialist jobs in the U.S., with a projected job growth rate of 10 percent from 2020 to 2030, about as fast as the average for all occupations.[575]

On average, HHS human resources specialists have about eleven years of service, with an average age of approximately 47 years.[576]

Turnover for HHS human resources specialists is currently high at about 25 percent, with System Support Services Division experiencing the highest turnover rate at 23 percent.[577]

Currently, about 11 percent of these employees are eligible to retire. This rate is expected to increase in the next five years to about 22 percent.[578]

Administrative Assistants

HHS employs 1,213 administrative assistants who provide office support services to the various HHS program areas.[579]

The turnover rate for HHS administrative assistants is moderately high at about 16 percent.[580] Although the overall vacancy rate is high at 14 percent, AES experienced the highest vacancy rate at 31 percent, with positions remaining unfilled for over five months.[581] [582]

The average annual salary paid to HHS administrative assistants falls below the average annual salary of many of the same classified positions in other state agencies of similar size and organizational structure. HHS administrative assistants are currently earning an average annual salary of $33,944.[583] The SAO 2020 market index analysis found that the average state salary for administrative assistants range from six percent for Administrative Assistant IVs to 12 percent for Administrative Assistant Is behind the market rate.[584] In addition, the salary paid to HHS administrative assistants is significantly below the average national wage of $42,250, and also lower than the Texas average wage of $38,110.[585]

On average, HHS administrative assistants have about 13 years of service, with an average age of approximately 48 years.[586]

About 17 percent of these employees are currently eligible to retire. This rate is expected to double to about 34 percent within the next five years.[587]

Managers

Managers perform a variety of high-level task throughout the system. There are 1,204 managers employed by the system, with a moderately high turnover rate of 13 percent.[588] [589]

Though turnover is consistent for managers throughout the system, there are certain areas that vary, both higher and lower.

In DSHS's Community Health Improvement Division, the turnover rate was high at 23 percent (nine separations), higher than the state average rate of 21.5 percent. Other areas of note include the DSHS Laboratory and Infectious Disease Services Division at 19 percent (seven separations); Information Technology (IT) at 16 percent (nine separations), and System Support Services at only seven percent (two separations).[590] [591]

The vacancy rate for System managers is 10 percent, which is also consistent among most areas, but with a few notable exceptions. In the Regulatory Division, the vacancy rate is much lower, at five percent, with only seven losses. On the other hand, IT had a higher than average vacancy rate at 19 percent.[592]

IT Business Analysts

Within the IT Division, there are 20 Business Analyst IIs and IIIs.[593] This group of business analysts provide critical support to the agency and some of their responsibilities include the gathering, assessment and validation of business requirements, while providing assistance to development team members and support to application users.

These business analysts have, on average, six years of service, with an average age of 46 years. About 50 percent of these employees have five or more years of service.[594]

IT Business Analyst IIs and IIIs earn an average annual salary of $79,327.[595] This is below the national average wage of $102,210 and Texas average wage of $105,130.[596] This disparity may be affecting HHS' ability to recruit qualified applicants for open positions.

The turnover rate for these business analysts is moderately high at 16 percent.[597]

The vacancy rate for these positions is 13 percent, with positions remaining unfilled for over three months. [598]

IT System Analysts

The IT Division employs 465 system analysts.[599] This group of system analysts provide technical support, analyze business requirements and procedures, and collaborate with vendors, business providers, and application teams. These positions provide critical support to the IT division and HHS system.

This group of analysts are, on average, 50 years of age and have an average of 12 years of service. Over 45 percent of these employees have 10 or more years of service.[600]

Turnover for these analysts is currently well-managed at 10 percent, though with a vacancy rate of 16 percent, it often takes up to four months to fill vacant positions.[601] [602]

These system analysts earn an average annual salary of $77,960.[603] This is below the national average wage of $102,210 and Texas average wage of $105,130.[604]

HHS will need to focus on creative recruiting and retention strategies, since 30 percent of employees will be eligible to retire in the next five years.[605]

System Support Specialists

Within the IT Division, there are 57 System Support Specialist IVs.[606] These workers perform various functions, such as software installations, troubleshooting/diagnosing complex hardware, software, and network performance problems, in addition to interpreting technical documents for users. This group of employees provide essential technical support to the agency.

These System Support Specialist IVs have, on average, 17 years of service, with an average age of 46 years. Over 63 percent of these employees have 10 or more years of service.[607]

The turnover rate for System Support Specialist IVs is below the state average at 12 percent.[608] [609] The vacancy rate is currently low at eight percent, though vacant positions often remain unfilled for four months.[610]

IT System Support Specialist IVs earn an average annual salary of $47,328.[611] The SAO 2020 market index analysis found the average state salary for System Support Specialist IVs to be $58,800.[612] This disparity may be affecting HHS' ability to recruit qualified applicants for open positions in a timely manner.

Currently, 16 percent of these employees are eligible to retire, and over 42 percent will be eligible within the next five years.[613]

Cybersecurity Analysts

There are 10 cybersecurity analysts employed within the IT Division.[614] These employees provide direction and guidance in strategic and tactical cybersecurity operations. They protect cybersecurity assets, deliver cybersecurity incident detection, and monitor cybersecurity alerts using advanced information systems. Cybersecurity analysts play a critical role in protecting the agency's data.

Cybersecurity analysts have, on average, eight years of service, with an average age of 48 years of age. Over 30 percent of these employees have 10 or more years of service.[615]

HHS cybersecurity analysts earn an average annual salary of $110,978 which is below the average national wage of $113,270, but higher than the Texas average wage of $101,800.[616] [617]

The turnover for cybersecurity analysts is high at 19 percent, though slightly below the state average of 21.5 percent.[618] [619]

HHS will need to develop creative retention strategies to keep these highly skilled employees in a competitive field.

Database Administrators

There are 29 database administrators working in the IT Division.[620] Some of their job responsibilities include designing, developing, maintaining, and improving database solutions for the agency. They also are responsible for performing advanced logical database administration and development. These workers provide critical support to various areas of the agency.

These highly skilled employees have, on average, nine years of service, with an average age of 52.[621]

HHS database administrators earn an average annual salary of $93,487, which is below the national average wage of $96,550 and Texas average wage of $98,910.[622] [623]

Turnover for database administrators is high at 17 percent, though slightly below the state average rate of 21.5 percent.[624] [625] In addition, the vacancy rate for these positions is also high at 22 percent, with position often going unfilled for almost three months.[626]

Due to the high vacancy rate, the agency will need to make special efforts to recruit adept workers in Texas' growingly competitive IT field.

Information Technology Security Analysts

There are 20 IT security analysts within the IT Division.[627] These are key positions that strategically plan and execute HHS's Information Security Risk roadmap. Many of them are subject matter experts on IT Security Risk and Assurance related topics and lead internal security and compliance assessments for assurance purposes. Information technology security analysts help facilitate and promote security awareness within the agency.

HHS IT security analysts earn an average annual salary of $96,034, which is well below the national average wage of $113,270 and Texas average wage of $101,800.[628] [629]

The typical IT security analyst is 48 years of age and has an average of 11 years of service. Nearly half of these of these employees have 10 or more years of service.[630]

Turnover for these analysts is high at 17 percent, though slightly below the state average rate of 21.5 percent.[631] [632] With a vacancy rate of about 17 percent, vacant positions often go unfilled for over two months due to a shortage of qualified applicants available for work.[633]

Programmers

There are 51 Programmer IVs, Vs, and VIs employed within the IT Division.[634] These skilled programmers perform functions such as computer programming, analysis, and development of complex business processes and system solutions. These employees code, test, and debug programs that are in development, as well as provide technical direction and guidance to technical staff in related programming activities.

These programmers are, on average, 47 years of age and have an average of five years of service. Over 27 percent of these employees have less than two years of service.[635]

The turnover rate for this group is well below the state average at six percent, although the vacancy rate is high at 27 percent. [636] [637] [638] On average, it can take up to four months to fill these vacancies.[639]

9. Development Strategies to Meet Workforce Needs

Recruitment Strategies

General Strategies

- Continue to advertise job postings in relevant schools, colleges and professional listings and organizations.
- Continue to advertise job postings on agency approved social media outlets, using LinkedIn and occupation-specific association job boards.
- Mention staffing needs when networking with professionals in the field.
- Hold in-person and virtual job fairs in various regions across Texas and provide conditional job offers on-site.
- Utilize hiring "sprints" to expedite the recruitment process by filling multiple positions at a time.
- Create college campus flyers for distribution to local colleges and universities.
- Notify existing staff of job postings to encourage recruitment of qualified candidates.
- Host internships to recruit from local colleges and universities.
- Continue to promote a positive workforce culture, which leads to word-of-mouth advertising from current employees to their friends and acquaintances.
- Establish "promote from within" as a first principle when looking for, and filling, internal leadership roles. For example, post senior positions internally for a period of time before posting externally.
- Continue to inform applicants of state benefits, including job stability, medical/dental/vision insurance options for the employee and family members, career advancement, and defined benefit retirement plans.
- Continue to inform applicants of job incentives, including flexible schedules, compressed workweek schedule options, telework options, and other site-specific benefits (e.g., cafeteria, gym, etc.).

- Advertise the Public Service Loan Forgiveness (PSLF) program to potential applicants and that HHS agencies are qualifying employers and provide information regarding PSLF program requirements to new employees.
- Explore expanding opportunities for flexible work schedules, telework, mobile work, and alternative offices.
- Place work-from-home policies in job postings and job descriptions.
- Use functional titles in job postings instead of more general position titles.
- Broaden experience requirements to attract a larger pool of applicants.
- Explore increasing entry level salaries to be competitive in a market where qualified applicants are in short supply.
- Post and hire at mid-range or higher salary for key positions in order to compete with other public and private employers.
- Continue to submit salary exception requests for approval of salary offers greater than the HHS allowable amount when appropriate.
- Review and update position classifications as necessary.
- Identify positions that could benefit from the Texas Workforce Commission's Veteran's Direct Hire Process.

State Supported Living Centers and State Hospitals

- Continue to provide sign-on bonuses for select critical shortage positions, including direct support professionals, psychiatric nursing assistants, and registered nurses.
- Pilot flexible schedules, part-time positions within facilities, particularly for direct support professionals and psychiatric nursing assistants.
- Procure a Practice Match recruiting tool subscription to help recruit physicians, psychologists, dentists, psychiatrists, registered nurses, and other specialties who have a provider identification number.
- Coordinate with the Office of Communications to explore:
  - Developing individual facility landing pages to help aid in recruiting but also communication with current staff.

    - Purchasing targeted Facebook Ads for recruiting select critical shortage and hard to fill positions.
    - Obtaining social media access for all recruitment specialists.
    - Creating social media pages for facilities.
- Renew CareerArc recruiting tool to increase visibility for open positions.
- Continue to use salary increase plans for all facility staff.
- Develop compensation plans by discipline to further support a unified strategy to compensate employees.
- Explore the potential use of locality pay based on geographical location.
- Pilot different shift patterns to provide better work-life balance.
- Evaluate expanded use of the tuition reimbursement program.
- Explore hiring a recruitment specialist at each facility, primarily focusing on talent acquisition.
- Implement the first-step application to assist with making more immediate contact with potential candidates and assist them with completing the state of Texas application.
- Enhance internship program options.
- Develop or procure leadership training to promote an improved workplace culture.
- Through the Health and Specialty Care System (HSCS) Recruitment and Retention Workgroup, develop HSCS workforce initiatives, strategic planning for workforce-related challenges, and establish priorities for workforce-related policy development or changes, statutory initiatives, or implementation.
- Use the Recruitment Specialist Workgroup to share recruitment best practices, discuss facility recruitment needs, learn from facility successes in recruiting efforts, and strategize to promote and evolve recruitment efforts.
- Implement a Compensation Workgroup to explore the possibility of designing a competitive, automated, and equitable compensation plan for new and tenured staff.

Access and Eligibility Operations

- Updated initial screening criteria for eligibility advisors to increase pool of candidates by reducing customer service requirement to one year and removing screening disqualifications for travel and work hours.
- Explore hiring part-time employees who have previous Texas Works (TW) and Medicaid for the Elderly and People with Disabilities (MEPD) experience (i.e., retirees), and work with The Office of Veteran Affairs Services Coordinators.
- Inform applicants of the opportunity for career advancement and promotion of internal hiring preferences to program specialist and management positions.
- Speak at local colleges and universities in rehabilitation, social work and medical schools.
- Interview applicants at local high-traffic eligibility offices.

Intellectual & Developmental Disability & Behavioral Health Services

- Explore the development of a career ladder for program specialists and contract specialists.
- Establish partnerships with universities such as the University of Texas-Steve Hicks School of Social Work to provide interns during fall and spring semesters.
- Distribute notifications of job openings through state and national outlets such as the National Association of State Mental Health Program Directors, Substance Abuse and Mental Health Services Administration, and state professional organizations such as the Texas Counseling Association.

Health, Developmental, and Independence Services

- Continue to use a hybrid virtual and in-person work model to attract applicants for contract specialist, financial analyst, and training specialist positions.

- Explore reclassifying lower-level positions for contract specialists, reimbursement officers, financial analysts, training specialists.
- Explore the development of career ladders for social workers, blind children specialists and human services specialists.
- Continue to encourage internal staff to apply for higher level positions within the program.
- Continue to increase visibility to skilled workers by speaking at the Executive Leadership Academy (ELA), as well as state and industry conferences.

Policy and Regulatory

- Explore increasing salaries for architects, engineers, and investigators.
- Explore establishing market rates for Regulatory positions.

Medicaid and CHIP Services

- Evaluate which positions are appropriate to shift to regional full-time equivalents to overcome salary versus cost-of-living barriers.
- Continue implementation of the MCS Professional Internship Program.
- Develop and improve onboarding tools for staff, including interview questions aligned to MCS mission and values, a sample onboarding calendar and checklist, a one-page document on hiring processes, and other guides to help managers with virtual onboarding process.

Chief Operating Officer

- Offer full-time telecommuting for more Information Technology (IT) positions.
- Continue to utilize the IT Workforce Support Team for assistance with job postings, and recruitment and hiring activities.
- Continue to use the HHSC Procurement and Contracting Services (PCS) promotion-from-within model to recruit and retain staff.
- Continue to advertise vacant Human Resources (HR) positions on association web sites, such as Texas State Human Resources Association, as well as on external job boards.

- Use data analytics to assist agency leadership in making data-driven informed decisions.
- Expand the use of agency-wide market salary data analysis to help support the funding of increased salaries in certain positions that are hard-to-fill and retain.
- Upgrade the telecom system to enable Operations and Support Services operators to telework.

Office of Inspector General

- Explore the development of a career ladder for Audit division staff.
- Present the Officer of Inspector General (OIG) mission and work at universities to help proactively recruit students.

Consumer Protection Division

- Increase the number of interns performing programmatic work to help introduce public health work as a career choice to college students.
- Explore strategies to improve the starting salary structures to align more closely with those provided by state, federal and private entities.

Center for Public Health Policy and Practice

- Continue advertising job postings in public health schools and professional listings, as well as non-public health schools (to target students with more intense policy and administration expertise).
- Host virtual outreach events to faculty and students to highlight and market careers in public health.

Community Health Improvement

- Send job postings for certain positions (epidemiologists, registered and public health nurses, research specialists, and manager positions) to different state and national organizations, such as Public Health departments in universities, the U.S. Health Resources & Services Administration (HRSA), the Association of Maternal & Child Health Programs (AMCHP), and the American College of Obstetricians and Gynecologists (ACOG).

- Explore bringing up the starting salary for registered and public health nurses to 75 percent of the maximum of the salary range.
- Explore bringing up the starting salary for public health and prevention specialists to the mid-range or greater of the salary range.

Laboratory and Infectious Disease Services

- Re-evaluate Pharmacy Unit positions to identify those under market rate for equity adjustments and ensure that pay is comparable to other salaries within the same geographic area.
- Explore increasing the starting salary for research specialist positions to be competitive with those with statistical or programing experience in the private sector.
- Explore the development of a career ladder for veterinarian and social worker positions.
- Upgrade specific entry level positions to be commensurate with other programs in the agency.

Regional and Local Health Operations

- Explore the development of a career ladder for social worker positions.
- Explore aggressive marketing and direct recruiting through the implementation of an agency-level staffing services contract.

DSHS Program Operations

- Accept more diversity in education for financial analyst positions (e.g., public health or social services degree in addition to accounting and finance), while not requiring a specified amount of college level accounting coursework.
- Increase entry-level salaries for contract specialist and financial analyst positions to be competitive in a market where qualified applicants are in short supply.
- Continue to use the COVID Grants Hiring Team, made up of three Hiring Specialists who support DSHS managers with all aspects of the hiring activities.

- Establish a team to support DSHS by developing recruitment strategies and programs, conduct studies, and increase/strengthen partnership with HHSC and other state agencies on best practices.
- Explore setting up a contract with a staffing agency to provide open-position marketing and candidate sourcing for all vacant COVID grant-funded positions.

Retention Strategies

General Strategies

- Focus more resources on succession planning activities.
- Explore opportunities to mentor professional staff.
- Ensure workloads are evenly and effectively distributed.
- Establish "promote from within" principles to retain top talent by showing them a clear and attainable career path within the organization.
- Award merits when funding is available.
- Explore expanding opportunities for flexible work schedules, telework, mobile work, and alternative offices.
- Pay certification/licensure fees and training opportunities when funds are available.
- Encourage staff to apply for internal promotion opportunities.
- Continue to provide advanced and ongoing training opportunities.
- Continue to provide staff with leadership training opportunities, including the HHS Executive Leadership Academy (ELA) and the Aspiring Leaders Academy (ALA), and other state and national leadership academies.
- Continue to cross-train staff.
- Establish focus groups to hear retention ideas directly from staff.
- Survey staff about their needs and design engagement opportunities based on their feedback.
- Continue to engage staff through activities such as all staff meetings, newsletters and management meetings.

- Develop a management forum and other tools to assist individuals with the technical skills transition and be successful in positions that require both technical and management skills.
- Identify ways for staff to feel more connected through team building activities.
- Explore engaging staff in the full spectrum of cross-program activities and collaborations.
- Continue to provide regular performance and career discussions to start proactively identifying, evaluating, and fostering emerging leaders.
- Continue to foster a culture that is meaningful and rewarding by increasing team member job satisfaction by providing ownership of building and planning programs out using their own creativity, and providing meaningful guidance and feedback, and one-on-one assistance as needed.
- Continue to recognize and reward employees who make significant contributions.
- Hold staff appreciation events on a regular basis.
- Continue to use administrative leave to reward staff when expectations are exceeded.
- Create shared resources for teams to improve their performance and experience (e.g., memo writing guides, etc.).
- Continue to use technology such as Microsoft Teams in lieu of travel for onsite meetings/monitoring, where possible.
- Consider requesting additional funding to increase salary levels for high turnover and hard-to-fill positions and large salary discrepancies compared to the Texas labor market and other Texas state agencies.

State Supported Living Centers and State Hospitals

- Pilot flexible schedules, part-time positions within facilities, particularly for direct support professionals and psychiatric nursing assistants.
- Hire a retention specialist at each facility.
- Enhance internship program options.
- Continue to use salary increase plans for HSCS staff.

- Develop compensation plans by discipline to further support a unified strategy to compensate employees.
- Explore the potential use of locality pay based on geographical location.
- Pilot different shift patterns to provide better work-life balance.
- Evaluate expanded use of the tuition reimbursement program.
- Explore a program in which childcare assistance is provided to staff.
- Explore ride-share options for facility staff.
- Expand texting service to facility level support staff.
- Host quarterly Town Hall meetings.
- Establish routine meetings with division and facility leadership for routine information sharing.
- Provide training targeted for non-standard shift staff, and to complement existing work schedules.
- Develop or procure leadership training to promote an improved workplace culture.
- Develop on-the-job training programs to support ongoing coaching and mentoring of new hires.
- Use the HSCS Recruitment and Retention Workgroup to develop workforce initiatives, strategic planning for workforce-related challenges, and establish priorities for workforce-related policy development or changes, statutory initiatives, or implementation.
- Use the Retention Specialist Workgroup to share retention best practices and current data, discuss facility needs and collaborations with other local teams and learn from facility successes in retention efforts.
- Use the Workplace Violence Workgroup to develop strategies that can be implemented to reduce, address, and respond to workplace violence.
- Use the Reducing Staff Injuries Workgroup to develop strategies to reduce staff injuries in restraint or other related incidents.
- Use the Compensation Workgroup to explore the possibility of designing a competitive, automated, and equitable compensation plan for new and tenured staff.

- Use the Health and Wellness Workgroup to develop and expand strategies to foster overall employee wellness and ensure employee's needs (emotional, physical, mental) are being met through trauma informed care approaches.

Access and Eligibility Operations

- Explore providing equity adjustments for Eligibility Advisor Is and claims examiners.
- Explore expanded use of retention bonuses for claims examiners.

Intellectual & Developmental Disability & Behavioral Health Services

- Explore the development of career ladders for program specialists and contract specialists.
- Explore feasibility of increased funding for positions and opportunities for advancement and/or regular increases in salary.
- Utilize job audits to keep experienced staff.
- Examine pay equity and formulate strategies to address disparities in wages amongst peers in like roles across the division.
- Explore covering the costs for professional licensing and renewals.
- Support a pro-team environment by using a "buddy system."
- Encourage one-on-one meetings with all staff, not just direct reports.
- Implement findings identified from IDD-BH responses to the Survey of Employee Engagement.
- Leverage interns as a retention as well as recruitment strategy.

Health, Developmental, and Independence Services

- Explore the development of career ladders for social workers, blind children specialists and human services specialists.
- Explore feasibility of increased funding for positions and opportunities for advancement and/or regular increases in salary.

- Create an internal structure for awarding merits.
- Explore salary equity assessments.
- Explore increasing the percent of new staff participating in HDIS New Employee Orientation.
- Explore increasing the percent of directors, managers, and supervisors completing Crucial Conversations training.
- Continue ongoing recognition for extraordinary work, award administrative leave, encourage team building activities, developed "'A' Team" recognition for staff that exhibit positive teamwork and support to peers.
- Continue to use the ECI Office Employee Engagement Committee at the state office level, which plans activities to help promote connection and community, frequently shares available training and professional development opportunities, and encourages participation in those opportunities for ECI staff.

Policy and Regulatory

- Work with the HHSC budget team to identify funds to increase salaries for existing staff.
- Develop "stay surveys" to determine what employee needs are before staff begin looking for new positions.

Medicaid and CHIP Services

- Continue hosting bi-monthly MCS Immersion sessions, which provide new staff with information about the work MCS does, its structure and culture. This allows new staff to immediately learn more about the division and encourages staff to make connections with other new hires.
- Continue to host quarterly all-staff meetings to gather (virtually) as a group to share good news and current agency priorities from MCS leadership.
- Continue to communicate consistently with staff through the weekly MCS newsletter, which includes updates on projects, staff members, engagement opportunities, and helpful resources.
- Launch an academy for staff to participate in a cohort-model program to improve on both hard and soft skills necessary to succeed in the division.

Chief Operating Officer

- Explore the development of career ladders for HR staff.
- Expand the use of agency-wide market salary data analysis to help support the funding of increased salaries in certain positions that are hard-to-fill and retain.
- Continue to review budget reports on a regular basis to determine if funds are available to award regular or one-time merit awards, administrative leave, development opportunities, and tuition reimbursement to staff meeting eligibility requirements in an effort to enhance retention.
- Continue to review HR positions and reclassify to a more appropriate classification and salary group.
- Use data analytics to assist agency leadership in making data-driven informed decisions.
- Offer full-time telecommuting for IT positions where possible.
- Explore expanding telework opportunities for HR positions that are not traditionally eligible to telework due to location or nature of the job.
- Utilize LinkedIn Learning licenses that have been purchased to create learning paths for positions that are at risk of turnover or high vacancies. This will give employees a roadmap to learn the skills necessary to advance to the next level in their classification.
- Expand training and development opportunities for HR team members and create leads within teams to assist with training new team members and providing support to managers with large teams.
- Reassign administrative work away from key IT staff.
- Create an internship program within IT for paid and unpaid interns to assist in generating a pipeline of candidates and market HHSC IT job opportunities.

Office of Inspector General

- Explore the development of a career ladder for Audit division staff.

Consumer Protection Division

- As part of the regular audit process for health physicist and sanitarian positions, assess the federal and private sector compensation packages for comparison, and make recommendations on pay scales as appropriate.
- Establish a salary entry point for health physicist and sanitarian positions that encourages qualified applicants to apply, along with a protocol to increase compensation that is tied to ongoing training and subject matter expertise.
- Continue to internally promote the DSHS Shine Awards, an agency-wide awards and recognition program.
- Ensure, to the extent possible, that the workplace reflects continuous upgrades and improvements, especially in the areas of IT and communication technologies.

Laboratory and Infectious Disease Services

- Explore the development of a career ladder for veterinarian and social worker positions.
- Continue to assess salaries as compared with market levels for chemists, microbiologists, laboratory technicians, public health prevention specialists, and managers.
- Explore increasing the pay for epidemiologists to coincide with the increase in the Austin metropolitan area cost of living, and to remain competitive with national salaries.
- Explore offering shift differential pay for chemists, medical technologists, and molecular biologists who work weekends.
- Review supervisory-level veterinarian jobs for appropriateness and for reclassification to the Veterinarian IV and/or director series.
- Increase funding for positions and opportunities for advancement (position) and/or regular increases in salary.
- Explore allowing managers to telework or manage from regional offices.

Regional and Local Health Operations

- Explore the development of a career ladder for social worker positions.

- Work with Certified Nursing Assistant (CNA) programs to develop and promote CNA (Medical Technicians) tracks with rotations at the Texas Center for Infectious Disease (TCID).
- Explore equity adjustments for staff serving in the Specialized Health and Social Services (SHSS) Program.

DSHS Program Operations

- Establish a team that will support DSHS by developing retention strategies and programs, conducting studies, and increasing/strengthening partnerships with HHSC and other state agencies on best practices.
- Work internally to cross-train team members and document processes for each area of oversight.
- Decrease travel for staff with increased remote work.

References

[1] HHSAS Database, as of 8/31/19.
[2] HHSAS Database, as of 8/31/20.
[3] HHSAS Database, as of 8/31/21.
[4] Ibid.
[5] Direct care workers include direct support professionals and psychiatric nursing assistants.
[6] Eligibility workers includes Texas works advisors, hospital-based workers and medical eligibility specialists within Access and Eligibility Services (AES).
[7] RNs include public health nurses, nurse surveyors, and direct care nurses.
[8] Food service workers include food service workers, managers and cooks.
[9] HHSAS Database, as of 8/31/21.
[10] HHSAS Database, as of 8/31/19.
[11] HHSAS Database, as of 8/31/20.
[12] HHSAS Database, as of 8/31/21.
[13] Ethnicity "Other" includes American Indian, Alaska Native, Asian, Native Hawaiian, Other Pacific Islander and two or more races.
[14] Ibid.
[15] HHSAS Database, as of 8/31/19.
[16] HHSAS Database, as of 8/31/20.
[17] HHSAS Database, as of 8/31/21.
[18] Ibid.
[19] Ibid.
[20] HHSAS Database, as of 8/31/19.
[21] HHSAS Database, as of 8/31/20.
[22] HHSAS Database, as of 8/31/21.
[23] Totals may not equal 100% due to rounding.
[24] HHS System workforce data is from CAPPS-HCM Database as of 8/31/2021.
[25] CLF data for underutilization percentages comes from the "Equal Employment Opportunity and Minority Hiring Practices Report Fiscal Years 2017-2018" published by the Texas Workforce Commission (TWC). Note: CLF data from TWC did not include Para-Professionals as a job category and did not indicate if members of that category were counted as part of any other categories - as a result, it is not included in the above table.
[26] "N/A" for Protective Service is due to that workforce being integrated into HHSC as part of Transformation. "N/A" for Skilled Craft indicates the number of employees in that job category was too small (less than 30) to test any differences for statistical significance.
[27] Ibid.
[28] HHSAS Database, as of 8/31/21.
[29] Totals may not equal 100% due to rounding.
[30] HHSAS Database, as of 8/31/19.
[31] HHSAS Database, as of 8/31/20.
[32] HHSAS Database, as of 8/31/21.
[33] Ibid.
[34] Ibid.
[35] Ibid.
[36] Ibid.
[37] HHS turnover calculations do not consider interagency transfers due to legislatively mandated transfers as separations. All other interagency transfers were counted as separations since these separations significantly impact HHS agencies.
[38] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," October 2020 Report No. 21-107 web page https://sao.texas.gov/reports/main/21-701.pdf, last accessed

4/11/22. Note: The State Auditor's Office does not consider transfers between state agencies as a loss to the state and therefore does not include this turnover in their calculations.

[39] HHSAS Database for FY 2019-2021. Note: Legislative transfers are not considered separations.

[40] HHSAS Database for FY 2021. Note: Legislative transfers are not considered separations.

[41] Ibid.

[42] Ethnicity "Other" includes American Indian, Alaska Native, Asian, Native Hawaiian, Other Pacific Islander and two or more races.

[43] Death accounted for .83% of separations.

[44] HHSAS Database for FY 2021.

[45] Ibid.

[46] Death accounted for .83% of separations (88 separations).

[47] Direct care workers include direct support professionals and psychiatric nursing assistants.

[48] Food service workers include food service workers, managers and cooks.

[49] HHSAS Database for FY 2021.

[50] HHSAS Database for FY 2021. Note: Legislative transfers are not considered separations.

[51] Direct care workers include direct support professionals and psychiatric nursing assistants.

[52] Food service workers include food service workers, managers and cooks.

[53] RNs include public health nurses and direct care nurses.

[54] Psychologists include behavioral health specialists and behavioral analysts.

[55] Eligibility workers includes Texas works advisors, hospital-based workers and medical eligibility specialists within Access and Eligibility Services (AES).

[56] Eligibility clerks includes clerical, administrative assistant, and customer service representative positions within AES.

[57] CCL and RCCL specialists include CCL inspectors and specialists and RCCL inspectors and investigators.

[58] Microbiologists include molecular biologists.

[59] Registered therapists include registered audio, speech, occupational, licensed, certified, and physical therapists at state supported living centers and state hospitals.

[60] Nurse practitioners include nurse practitioners at state supported living centers and state hospitals.

[61] Includes return-to-work-retirees. HHSAS Database.

[62] Exec. Order No. 85 FR 15337 - Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak Federal Register. Presidential Proclamation 9994. Wednesday, March 18, 2020., 3 C.F.R.

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[82] Ibid.
[83] State Auditor's Office, "Classified Employee Turnover for Fiscal Year 2021," March 2022, Report No. 22-702 web page https://sao.texas.gov/reports/main/22-702.pdf last accessed 4/10/22.
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[94] HHSAS Database, FY 2021 data.
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[97] Ibid.
[98] HHSAS Database, FY 2021 data.
[99] HHSAS Database, as of 8/31/21.
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[101] HHSAS Database, FY 2021 data.
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[127] Ibid.
[128] Ibid.
[129] Ibid.
[130] HHSAS Database, FY 2021 data.
[131] HHSAS Database, as of 8/31/21.
[132] Ibid.
[133] HHSAS Database, FY 2021 data.
[134] HHSAS Database, as of 8/31/21.
[135] Ibid.
[136] State Auditor's Office, "Classified Employee Turnover for Fiscal Year 2021," March 2022, Report No. 22-702 web page https://sao.texas.gov/reports/main/22-702.pdf last accessed 4/10/22.
[137] HHSAS Database, FY 2021 data.
[138] HHSAS Database, as of 8/31/21.
[139] Ibid.
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[141] U.S. Department of Labor, Bureau of Labor Statistics., Selected Occupational Projections Data, web page Tables Created by BLS. Last accessed on 4/10/22.
[142] HHSAS Database, FY 2021 data.
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[144] CCL and RCCL specialists include CCL inspectors, program specialists and supervisors, and RCCL inspectors, investigators, and supervisors.
[145] HHSAS Database, as of 8/31/21.
[146] Ibid.
[147] State Auditor's Office, "Classified Employee Turnover for Fiscal Year 2021," March 2022, Report No. 22-702 web page https://sao.texas.gov/reports/main/22-702.pdf last accessed 4/10/22.
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[149] HHSAS Database, as of 8/31/21.
[150] Ibid.
[151] Ibid.
[152] HHSAS Database, FY 2021 data.
[153] State Auditor's Office, "Classified Employee Turnover for Fiscal Year 2021," March 2022, Report No. 22-702 web page https://sao.texas.gov/reports/main/22-702.pdf, last accessed 4/10/22.
[154] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
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[156] Ibid.
[157] HHSAS Database, FY 2021 data.
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[162] HHSAS Database, FY 2021
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[164] HHSAS Database, as of 8/31/21.
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[170] Ibid.
[171] HHSAS Database, as of 8/31/21.
[172] HHSAS Database, FY 2021 data.
[173] Ibid.
[174] Includes return-to-work retirees. HHSAS Database, as of 8/31/2021
[175] HHSAS Database, as of 8/31/21.
[176] HHSAS Database, FY 2021 data.
[177] HHSAS Database, as of 8/31/21.
[178] Ibid.
[179] HHSAS Database, FY 2021 data.
[180] State Auditor's Office, "Classified Employee Turnover for Fiscal Year 2021," March 2022, Report No. 22-702 web page https://sao.texas.gov/reports/main/22-702.pdf last accessed 4/10/22.
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[185] State Auditor's Office, "Classified Employee Turnover for Fiscal Year 2021," March 2022, Report No. 22-702 web page https://sao.texas.gov/reports/main/22-702.pdf last accessed 4/10/22.
[186] Includes return-to-work retirees. HHSAS Database, as of 8/31/2021
[187] HHSAS Database, as of 8/31/21.
[188] Ibid.
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[205] Ibid.

[206] HHSAS Database, FY 2021 data.
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[209] HHSAS Database, FY 2021 data.
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[211] U.S. Department of Labor, Bureau of Labor Statistics., Selected Occupational Projections Data, web page Tables Created by BLS. Last accessed on 4/10/22.
[212] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
[213] HHSAS Database, as of 8/31/21.
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[218] HHSAS Database, as of 8/31/21.
[219] Ibid.
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[224] HHSAS Database, FY 2021 data.
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[226] Includes return-to-work retirees. HHSAS Database, as of 8/31/2021
[227] HHSAS Database, as of 8/31/21.
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[236] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
[237] HHSAS Database, as of 8/31/21.
[238] State Auditor's Office, "Classified Employee Turnover for Fiscal Year 2021," March 2022, Report No. 22-702 web page https://sao.texas.gov/reports/main/22-702.pdf last accessed 4/10/22.
[239] HHSAS Database, FY 2021 data.
[240] HHSAS Database, as of 8/31/21.
[241]State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," October 2020, Report No. 21-701, web page https://sao.texas.gov/reports/main/21-701.pdf 3/30/2022.
[242] HHSAS Database, FY 2021 data.
[243] Registered therapists include registered audio, speech, occupational, licensed, certified, and physical therapists at state supported living centers and state hospitals.
[244] HHSAS Database, as of 8/31/21.
[245] Ibid.
[246] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2021; last accessed on 4/15/22.
[247] HHSAS Database, FY 2021 data.
[248] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2021; last accessed on 4/15/22.
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[251] HHSAS Database, FY 2021 data.
[252] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2021; last accessed on 4/15/22.
[253] HHSAS Database, FY 2021
[254] HHSAS Database, FY 2021 data.
[255] Includes return-to-work retirees. HHSAS Database, as of 8/31/2021
[256] HHSAS Database, as of 8/31/21.
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[258] State Auditor's Office, "Classified Employee Turnover for Fiscal Year 2021," March 2022, Report No. 22-702 web page https://sao.texas.gov/reports/main/22-702.pdf last accessed 4/10/22.
[259] HHSAS Database, FY 2021 data.
[260] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
[261] HHSAS Database, FY 2021 data.
[262] State Auditor's Office, "Classified Employee Turnover for Fiscal Year 2021," March 2022, Report No. 22-702 web page https://sao.texas.gov/reports/main/22-702.pdf last accessed 4/10/22.
[263] HHSAS Database, FY 2021 data.
[264] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
[265] HHSAS Database, as of 8/31/21.
[266] HHSAS Database, as of 8/31/21.
[267] HHSAS Database, FY 2021 data.
[268] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2021; last accessed on 4/15/22.
[269] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, web page https://www.bls.gov/ooh/healthcare/registered-nurses.htm, last accessed on 4/16/22.
[270] U.S. Department of Labor, Bureau of Labor Statistics, Selected Occupational Projections Data. Period: May 2020; web page http://www.bls.gov/emp/ep_table_110.htm, last accessed on 4/16/22.
[271] HHSAS Database, as of 8/31/21.
[272] RNs include public health nurses.
[273] HHSAS Database, as of 8/31/21.
[274] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page https://www.bls.gov/oes/current/oes291141.htm, Period: May 2020; last accessed on 4/16/22. Employees listed under the occupational title of Registered Nurses.
[275] Ibid.
[276] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," October 2020 Report No. 21-107 web page https://sao.texas.gov/reports/main/21-701.pdf, last accessed 4/16/22.
[277] HHSAS Database, as of 8/31/21.
[278] Ibid.
[279] Ibid.
[280] HHSAS Database, FY 2021 data.
[281] HHSAS Database, as of 8/31/21.
[282] Ibid.
[283] HHSAS Database, FY 2021 data.
[284] HHSAS Database, as of 8/31/21.
[285] Ibid.
[286] Ibid.
[287] Includes RN II - Vs in public health roles and public health nurses. Note: Public health nurses are also registered nurses.
[288] HHSAS Database, as of 8/31/21.
[289] HHSAS Database, FY 2021 data.
[290] HHSAS Database, as of 8/31/21.
[291] Includes Licensed Vocational Nurse II - III.

[292] HHSAS Database, as of 8/31/21.
[293] Ibid.
[294] HHSAS Database, FY 2021 data.
[295] HHSAS Database, as of 8/31/21.
[296] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page https://www.bls.gov/oes/current/oes292061.htm, Period: May 2020; last accessed on 4/18/22. Employees listed under the occupational title of Licensed Practical and Licensed Vocational Nurses.
[297] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," October 2020 Report No. 21-107 web page https://sao.texas.gov/reports/main/21-701.pdf, last accessed 4/18/22.
[298] HHSAS Database, as of 8/31/21.
[299] HHSAS Database, FY 2021 data.
[300] HHSAS Database, as of 8/31/21.
[301] Ibid.
[302] Ibid.
[303] HHSAS Database, FY 2021 data.
[304] HHSAS Database, as of 8/31/21.
[305] Ibid.
[306] State Auditor's Office, "Classified Employee Turnover for Fiscal Year 2021," March 2022, Report No. 22-702 web page https://sao.texas.gov/reports/main/22-702.pdf last accessed 4/10/22.
[307] HHSAS Database, FY 2021 data.
[308] U.S. Bureau of Labor Statistics, Occupational Outlook Handbook, website https://www.bls.gov/ooh/healthcare/licensed-practical-and-licensed-vocational-nurses.htm#tab-6.
[309] HHSAS Database, FY 2021 data.
[310] Advanced Practice RN Is and RN IIs.
[311] HHSAS Database, FY 2021 data.
[312] Ibid.
[313] Ibid.
[314] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," October 2020 Report No. 21-107 web page https://sao.texas.gov/reports/main/21-701.pdf, last accessed 03/22/2022. Note: For Advanced Practice Registered Nurse Is and IIs.
[315] HHSAS Database, FY 2021 data.
[316] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
[317] HHSAS Database, as of 8/31/21.
[318] Ibid.
[319] HHSAS Database, FY 2021 data.
[320] HHSAS Database, as of 8/31/21.
[321] Ibid.
[322] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
[323] HHSAS Database, as of 8/31/21.
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[326] HHSAS Database, as of 8/31/21.
[327] HHSAS Database, FY 2021 data.
[328] Includes return-to-work retirees. HHSAS Database, as of 8/31/2021
[329] HHSAS Database, as of 8/31/21.
[330] HHSAS Database, FY 2021 data.
[331] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
[332] HHSAS Database, as of 8/31/21.
[333] Ibid.
[334] HHSAS Database, FY 2021 data.
[335] HHSAS Database, as of 8/31/21.
[336] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.

[337] HHSAS Database, as of 8/31/21.
[338] Ibid.
[339] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2021; last accessed on 4/15/22. Note: The Employees are listed under the Occupational title of Pharmacy Technicians.
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[341] HHSAS Database, FY 2021 data.
[342] HHSAS Database, as of 8/31/21.
[343] Ibid.
[344] Ibid.
[345] HHSAS Database, FY 2021 data.
[346] HHSAS Database, as of 8/31/21.
[347] Ibid.
[348] Ibid.
[349] HHSAS Database, FY 2021 data.
[350] HHSAS Database, as of 8/31/21.
[351] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
[352] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, web page http://www.bls.gov/ooh/healthcare/dentists.htm, last accessed on 4/4/22.
[353] HHSAS Database, as of 8/31/21.
[354] Ibid.
[355] Ibid.
[356] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2019; last accessed on 4/28/20. Note: The Employees are listed under the Occupational title of Dentists, General.
[357] HHSAS Database, FY 2021 data.
[358] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
[359] HHSAS Database, as of 8/31/21.
[360] Ibid.
[361] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page https://www.bls.gov/oes/2019/may/oes291131.htm, Period: May 2021; last accessed on 4/27/20.
[362] State Auditor's Office, "Classified Employee Turnover for Fiscal Year 2021," March 2022, Report No. 22-702 web page https://sao.texas.gov/reports/main/22-702.pdf last accessed 4/10/22.
[363] HHSAS Database, FY 2021 data.
[364] HHSAS Database, as of 8/31/21.
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[366] U.S. Department of Labor, Bureau of Labor Statistics., Selected Occupational Projections Data, web page Tables Created by BLS. Last accessed on 4/15/22.
[367] HHSAS Database, as of 8/31/21.
[368] Ibid.
[369] Ibid.
[370] U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, web page http://data.bls.gov/oes/search.jsp?data_tool=OES, Period: May 2021; last accessed on 4/27/22.
[371] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," October 2020 Report No. 21-107 web page https://sao.texas.gov/reports/main/21-701.pdf, last accessed 4/15/22.
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[373] HHSAS Database, as of 8/31/21.
[374] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
[375] HHSAS Database, as of 8/31/21.
[376] Ibid.
[377] HHSAS Database, FY 2021 data.
[378] HHSAS Database, as of 8/31/21.

[379] Ibid.
[380] Ibid.
[381] HHSAS Database, FY 2021 data.
[382] HHSAS Database, as of 8/31/21.
[383] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
[384] U.S. Department of Labor, Bureau of Labor Statistics, Selected Occupational Projections Data, web page Tables Created by BLS. Last accessed on 4/10/22.
[385] U.S. Department of Labor, Bureau of Labor Statistics, Selected Occupational Projections Data, web page National Employment Matrix_IND_622202 (bls.gov) Period: May 2021; last accessed on 4/10/22. For state psychiatric and substance abuse hospitals.
[386] HHSAS Database, as of 8/31/21.
[387] Ibid.
[388] Ibid.
[389] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," October 2020 Report No. 21-107 web page https://sao.texas.gov/reports/main/21-701.pdf, last accessed 4/12/22.
[390] HHSAS Database, FY 2021 data.
[391] HHSAS Database, as of 8/31/21.
[392] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
[393] HHSAS Database, as of 8/31/21.
[394] Ibid.
[395] Ibid.
[396] Ibid.
[397] Ibid.
[398] HHSAS Database, FY 2021 data.
[399] HHSAS Database, as of 8/31/21.
[400] Includes return-to-work retirees. HHSAS Database, as of 8/31/21.
[401] HHSAS Database, as of 8/31/21. Note: Includes Psychologists I-III.
[402] HHSAS Database, as of 8/31/21.
[403] State Auditor's Office, "A Biennial Report on the State's Position Classification Plan," October 2020 Report No. 21-107 web page https://sao.texas.gov/reports/main/21-701.pdf, last accessed 4/12/21.
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[406] Ibid.
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[411] HHSAS Database, as of 8/31/21.
[412] Ibid.
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[414] HHSAS Database, as of 8/31/21.
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Schedule G: Workforce Development System Strategic Planning

Schedule G is no longer required for the Health and Human Services Commission.

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Schedule H: Report on Customer Service

The 2022 Report on Customer Service found on the following pages was developed in accordance with Texas Government Code Section 2114.002.

2022 Report on Customer Service

As Required by
Texas Government Code, §2114.002

Texas Health and Human Services
June 1, 2022

TEXAS
Health and Human Services

Table of Contents

Executive Summary

This "2022 Report on Customer Service" is prepared in response to §2114.002 of the Government Code, which requires that Texas state agencies biennially submit information gathered from customers about the quality of agency services to the Office of the Governor's (OOG) Budget and Policy Team and the Legislative Budget Board (LBB).

This report reflects the combined efforts of two Texas agencies belonging to the Texas Health and Human Services (HHS) system during the State Fiscal Year (SFY) 2020 and SFY 2021 reporting period (September 2019 to August 2021). Specifically, this report includes information from the Department of State Health Services (DSHS) and the Health and Human Services Commission (HHSC).

The HHS system mission is "We serve Texas." In pursuit of this mission, HHS agencies administer a wide array of surveys to assess the quality of HHS services. This report includes the results of 363,481 responses from 28 distinct surveys that examine customer satisfaction in various programs. HHS agencies use survey feedback to help improve customer service for individuals served in those programs.

Individual Agency Surveys

HHS agencies, divisions, and programs independently conduct surveys that include questions about customer satisfaction with specific agency programs and services. This report presents descriptions and major findings from the following surveys.

Department of State Health Services

- Community Health Improvement
  - Children with Special Health Care Needs Systems Development Group Case Management and Family Supports and Community Resources Family Satisfaction Surveys
- Consumer Protection Division
  - Business Filing and Verification Section – Customer Service Satisfaction Survey

    - Surveillance Section Customer Service Satisfaction Survey
- Laboratory and Infectious Disease
    - Human Immunodeficiency Virus Care Services Ryan White Part-B, Post Monitoring Satisfaction Survey
    - Laboratory Services Testing Customer Satisfaction Survey
    - South Texas Laboratory – Water Sample Testing Survey

Health and Human Services Commission

- Healthcare Coverage
    - STAR Child Caregiver Member Survey
    - STAR Health Caregiver Survey
    - STAR Kids Caregiver Member Survey
    - Children’s Health Insurance Program Caregiver Member Survey
    - Child Core Measures Survey
    - Medicaid and Children's Health Insurance Program Dental Caregiver Survey
    - STAR Adult Member Survey
    - STAR+PLUS Member Survey
    - Adult Core Measures Survey
    - Medical Transportation Program Member Survey
- Access and Eligibility Services
    - YourTexasBenefits.Com Survey
- Quality Reviews
    - Nursing Facility Quality Review
    - Complaint and Incident Intake Survey
- Health, Development, and Independence Services
    - Blind Children’s Vocational Discovery and Development Program Customer Service Satisfaction Survey
    - Comprehensive Rehabilitation Services Customer Service Survey
    - Early Childhood Intervention Family Survey

    - Independent Living Services Program Survey
    - Children’s Autism Program Survey
    - Your WIC Experience Client Satisfaction Survey
- Mental Health Services
    - Mental Health Statistics Improvement Program Youth Services Survey for Families
    - Mental Health Statistics Improvement Program Adult Services Survey
    - Mental Health Statistics Improvement Program Inpatient Consumer Survey

Overall, HHS agencies obtained feedback from a diverse group of customers. However, given the multitude of programs operated and customer groups served under HHS, it is possible this report only reflects a subset of all customers served. Additionally, due to the number and distinct nature of surveys administered by HHS, it can be challenging to collectively interpret survey results and present a unified picture of agency programs. Still, most respondents provided positive feedback regarding the services and supports they received through HHS programs, while a small percentage offered opportunities for improvement. These results support the HHS system mission of improving the health, safety, and well-being of Texans.

1. Introduction

This "2022 Report on Customer Service" is prepared in response to §2114.002 of the Government Code, which requires that Texas state agencies biennially submit information gathered from customers about the quality of agency services to the OOG's Budget and Policy Team and the LBB.

This report reflects the combined efforts of two Texas agencies belonging to the Texas HHS system during the SFY 2020-2021 reporting period: DSHS and HHSC.

HHS System Mission and Budget Strategies

The HHS system mission is "We serve Texas." The HHS System Strategic Plan 2021–2025 articulates specific goals and action plans for achieving the system mission, and includes a list of related budget strategies consistent with the HHS budget structure.[1] Two appendices to this report present a description of services provided to customers from each agency by strategic plan budget strategy.[2] In pursuit of the system mission and accompanying budget strategies, HHS agencies, divisions, and programs administer a range of surveys to assess the quality of HHS services and promote continuous improvement. This report presents the results of those surveys.

Previous Reports on Customer Service

HHS agencies worked collaboratively to develop a system-wide survey to assess the satisfaction of customers of each HHS agency, as required by §2114.002 of the Government Code. HHS administered the first system-wide survey in 2006; this approach was replicated in 2008. The survey questionnaire for both the 2006 and 2008 administrations included questions about service access and choice, staff knowledge, staff courtesy, complaint handling, quality of information and communications, and internet use.

For the 2010 HHS system customer satisfaction survey, HHS agencies collaborated on a system-wide survey of children with special health care needs (CSHCN)

[1] See HHS System Strategic Plan 2021–2025, Volume II, Schedule A.
[2] See Appendix A and Appendix B of this document for Customer Inventories by Agency. This information is presented in accordance with Chapter 2114.002(a) of the Government Code.

enrolled in each HHS agency.[3] At the time, the five existing HHS agencies served CSHCN customers through a variety of programs.

For the 2006 to 2010 iterations of the Report on Customer Service, HHS hired an independent contractor to administer the system-wide survey at a cost of $65,000 to $90,000 per biennium. To reduce project expenditures, HHS stopped administering the system-wide survey in 2012. Instead, HHS agencies began drawing on independently conducted surveys that included questions about customer satisfaction with specific agency programs and services, and each agency provided the results of those independent surveys to HHSC for compilation. Some surveys focused entirely on customer satisfaction while others included customer satisfaction as one of several service categories being assessed.

The 2018 report took a similar approach to the reports produced since 2012, with each HHS agency providing the results of customer surveys for their particular programs. Because many of the surveys were conducted prior to HHS system reorganization, the 2018 report was structured to reflect both the current and legacy location of each survey. The overall format of the report reflected the three HHS agencies in operation at the time—the Department of Family and Protective Services (DFPS), DSHS, and HHSC. The HHS system reorganization increased the number of programs operating under the HHS system, substantially increasing the scope and the nature of the report.

Starting in 2020, and continuing in the current report, results include customer surveys administered by programs in DSHS and HHSC, reflecting the current HHS system organization. DFPS, which became a standalone agency at the direction of House Bill (HB) 5, 85th Legislature, Regular Session, 2017, now submits its own Report on Customer Service.

[3] A 2008 Texas Pediatric Society and Texas Medical Association stakeholder forum recommended that HHS agencies survey CSHCNs to determine how well available services meet the needs of these children. The HHS agencies convened and decided to focus the 2010 HHS Enterprise Customer Satisfaction survey on CSHCN customers in each HHS agency. The 2010 questionnaire included three HHS agency-specific customer satisfaction questions that were also used in the 2006 and 2008 Customer Satisfaction surveys: overall satisfaction with the benefits or services received from the agency, the difficulty customers had in getting needed benefits or services, and the length of time customers waited to receive benefits or services. The latter two questions were selected because results from the 2008 survey showed that a lower proportion of customers were satisfied with these aspects of service delivery.

Surveys Included in 2022 Report on Customer Service

The surveys included in the 2022 Report on Customer Service are briefly described in the pages that follow (Tables 1 and 2). For the most part, surveys were administered during SFY 2020 and SFY 2021 (September 2019-August 2021), though data collection for some surveys fell slightly outside of this period. This report summarizes 363,481 responses to 28 surveys conducted by HHS agencies to assess customer satisfaction during SFY 2020 and SFY 2021. Although the goal of this report is to compile all customer service surveys administered during SFY 2020 and SFY 2021, it is possible that some existing surveys may have been unintentionally excluded.

The majority of surveys were administered during the COVID-19 public health emergency. The public health emergency modified how HHS interacted with customers, often by transitioning some or all services to online platforms. Survey response rates and results should be interpreted in light of this broader context.

Table 1. Department of State Health Services Surveys

Program Area	Name	Data Collection	SFY 2020 Sample Size (Response Rate)	SFY 2021 Sample Size (Response Rate)	Survey Population
Community Health Improvement	CSHCN Systems Development Group Case Management and Family Supports and Community Resources Family Satisfaction Surveys	09/01/2019-08/31/2021	674 (11.8%)	993 (17.2%)	Families of children and youth with special health care needs who received services from contracted providers
Consumer Protection Division	Business Filing and Verification Section – Customer Service Satisfaction Survey	09/01/2019-08/31/2021	301 (0.3%)	317 (0.4%)	Customers of the Regulatory Licensing Unit (businesses and facilities regulated by the state)
Consumer Protection Division	Surveillance Section Customer Service Satisfaction Survey	09/01/2017-08/31/2019	1 (0.0%)	20 (0.3%)	Regulated entities that interact with Surveillance Section staff
Laboratory and Infectious Disease	Human Immunodeficiency Virus Care Services Ryan White Part-B, Post Monitoring Satisfaction Survey	09/01/2019-08/31/2021	51 (88.0%)	17 (61.0%)	Ryan White Part-B and State Services funded service providers
Laboratory and Infectious Disease	Laboratory Services Testing Customer Satisfaction Survey	01/30/2020-02/28/2020; 03/17/2021-04/15/2021	70 (0.3%)	144 (0.6%)	Facilities that receive services from the Laboratory Services Section
Laboratory and Infectious Disease	South Texas Laboratory – Water Sample Testing	01/21/2020-02/29/2020	31 (36.0%)	N/A	Submitters of water samples to the South Texas Laboratory
Total			**1,128**	**1,491**	

Notes. SFY=State fiscal year (September 1-August 31); CSHCN=Children with Special Health Care Needs.

Table 2. Health and Human Services Commission Surveys

Program Area	Name	Data Collection	SFY 2020 Sample Size (Response Rate)	SFY 2021 Sample Size (Response Rate)	Survey Population
Healthcare Coverage	STAR Child Caregiver Member Survey	04/2021-09/2021	N/A	8,402 (13.0%)	Caregivers of children who received services funded through the Medicaid STAR program
Healthcare Coverage	STAR Health Caregiver Survey	06/2020-10/2020	207 (6.0%)	N/A	Caregivers of children who received services funded through the STAR Health program
Healthcare Coverage	STAR Kids Caregiver Member Survey	05/2020-10/2020	5,463 (18.5%)	N/A	Caregivers of children who received services funded through the Medicaid STAR Kids program
Healthcare Coverage	CHIP Caregiver Member Survey	04/2021-08/2021	N/A	3,609 (9.5%)	Caregivers of children who received services through CHIP
Healthcare Coverage	Child Core Measures Survey	06/2020-11/2021; 06/2021-11/2021	411 (19.6%)	302 (14.4%)	Caregivers of children who received services funded through Texas Medicaid and CHIP
Healthcare Coverage	Medicaid and CHIP Dental Caregiver Survey	07/2021-10/2021	N/A	1,751 (14.0%)	Caregivers of children receiving dental services through Medicaid and CHIP
Healthcare Coverage	STAR Adult Member Survey	05/2020-10/2020	7,439 (13.0%)	N/A	Adults who received services funded through the Medicaid STAR program
Healthcare Coverage	STAR+PLUS Adult Member Survey	05/2020-10/2020	5,067 (12.0%)	N/A	Adults with disabilities who received services through the Medicaid STAR+PLUS program

Program Area	Name	Data Collection	SFY 2020 Sample Size (Response Rate)	SFY 2021 Sample Size (Response Rate)	Survey Population
Healthcare Coverage	Adult Core Measures Survey	09/2020-11/2020	352 (10.8%)	275 (9.3%)	Adults who received services funded through the Texas Medicaid program
Healthcare Coverage	Medical Transportation Program Member Survey	03/2020-07/2020	2,437 (19.0%)	N/A	Members and their caregivers who used the Medical Transportation Program services funded through Texas Medicaid
Access and Eligibility Services	YourTexasBenefits.Com Survey[1]	01/2020-08/2021	61,660 (N/A)[2]	47,026 (N/A)[2]	Customers who used YourTexasBenefits.com to manage or enroll in benefits
Quality Reviews	Nursing Facility Quality Review[3]	05/2019-02/2020	530 (100%)	1,455 (100%)	Individuals living in Medicaid-certified nursing facilities in Texas
Quality Reviews	Complaint and Incident Intake Survey	09/01/2020-08/31/2021	N/A	5,247 (16.5%)	Callers who contacted the Complaint Intake Call Center
Health, Development, and Independence Services	Blind Children's Vocational Discovery and Development Program Customer Service Satisfaction Survey	06/01/2021-08/31/2021	N/A	237 (10.9%)	Families enrolled in the Blind Children's Vocational Discovery and Development Program
Health, Development, and Independence Services	Comprehensive Rehabilitation Services Customer Service Survey	09/17/2021-11/05/2021	N/A	94 (14.8%)	Individuals 15 or older who have a traumatic brain injury, a traumatic spinal cord injury, or both

Program Area	Name	Data Collection	SFY 2020 Sample Size (Response Rate)	SFY 2021 Sample Size (Response Rate)	Survey Population
Health, Development, and Independence Services	Early Childhood Intervention Family Survey	06/2020-07/2020; 05/2021-06/2021	2,685 (51.0%)	2,638 (46.0%)	Parents or guardians of children enrolled in the Early Childhood Intervention program, which serves children from birth to 36 months of age who have developmental delays or disabilities
Health, Development, and Independence Services	Independent Living Services Program Survey	09/01/2020-06/15/2021	N/A	57 (10.0%)	Individuals with significant disabilities that applied for or received services from a Center for Independent Living
Health, Development, and Independence Services	Children's Autism Program Survey	09/01/2020-08/31/2021	N/A	13 (2.0%)	Families whose children have completed the Children's Autism Program and exited the program, and families whose children have aged out of the Children's Autism Program.
Health, Development, and Independence Services	Your WIC Experience Client Satisfaction Survey	09/01/2019-08/31/2021	83,343 (6.0%)	114,547 (7.9%)	Adults who received nutrition education through the WIC program
Mental Health Services	Mental Health Statistics Improvement Program Youth Services Survey for Families	05/2020-08/2020; 05/2021-08/2021	436 (16.0%)	506 (14.0%)	Parents of children/adolescents age 17 or younger who receive community-based mental health services from HHSC, Behavioral Health Services

Program Area	Name	Data Collection	SFY 2020 Sample Size (Response Rate)	SFY 2021 Sample Size (Response Rate)	Survey Population
Mental Health Services	Mental Health Statistics Improvement Program Adult Mental Health Survey	05/2020-08/2020; 05/2021-08/2021	491 (29.0%)	455 (23.0%)	Adults age 18 or older who receive community-based mental health services from HHSC, Behavioral Health Services
Mental Health Services	Mental Health Statistics Improvement Program Inpatient Consumer Survey	09/2019-08/2021	2,098 (40.0%)	1,629 (42.0%)	Adolescents (ages 13-18) and adults who received services in state-run psychiatric hospitals
Total			**172,619**	**188,243**	

Notes. [1] The YourTexasBenefits.com survey is reported by calendar year, not state fiscal year. [2] The YourTexasBenefits.com survey only captures the number of individuals who initiate a survey response, not the number of individuals who are prompted to respond. Thus, the response rate for this survey cannot be calculated. [3] The recurring Nursing Facility Quality Review (NFQR) involves data collection and analysis that span multiple years. The most recent NFQR uses survey data collected in 2019-2020. SFY=State fiscal year (September 1-August 31); STAR=Medicaid managed care program that serves children, newborns, pregnant women, and some families and children; STAR Health=Medicaid managed care program that serves individuals under or transferring out of conservatorship or foster care; STAR Kids=Medicaid managed care program that serves children and adults age 20 and younger with a disability; CHIP=Children's Health Insurance Program; STAR+PLUS=Medicaid managed care program that serves people with a disability and people who are age 65 and older (including those dually eligible for Medicare and Medicaid) and women with breast or cervical cancer; WIC=The Special Supplemental Nutrition Program for Women, Infants, and Children; HHSC=Health and Human Services Commission.

2020-2022 Guidance on Agency Strategic Plans

Pursuant to Government Code §2114.002, the OOG's Budget and Policy Team and the LBB are required to jointly develop a standardized method to measure customer service satisfaction and agencies' performance. In February 2020, the OOG's Budget and Policy Team and the LBB published Instructions for Preparing and Submitting Agency Strategic Plans for SFY 2021 to 2025. This document offers updated guidance for statutorily directed strategic planning submissions to ensure long-range planning is effective and efficiently uses state resources in service of the agency's core mission. In February 2022, the OOG and the LBB published new Instructions for SFYs 2023-2027. However, there were no substantive changes to the section that addresses the Report on Customer Service.

The 2020-2022 guidance directed agencies to develop customer service standards and implement customer satisfaction assessment plans. HHS's customer service standards can be found on the Compact with Texans website. The biennial Report on Customer Service reflects one way in which HHS implements customer satisfaction assessment plans.

The 2020-2022 guidance also required agencies to include a set of eight standardized questions in all efforts to assess customer service and report on four types of measures in each agency's report on customer service: output measures, efficiency measures, outcome measures, and explanatory measures. Table 3 provides descriptions of these types of measures. Both of these requirements were new and had not been included in previous iterations of the report.

Table 3. Types of Measures Required in Reports on Customer Service

Measure Type	Indicator	Description
Output Measure	Total customers surveyed	The number of customers who receive access to surveys regarding agency services.
Output Measure	Response rate	The percentage of total customers surveyed who completed the survey.
Output Measure	Total customers served	The total number of customers receiving services through the agency's programs.
Efficiency Measure	Cost per customer surveyed	The total costs for the agency to administer customer surveys divided by the total number of customers surveyed.
Outcome Measure	Percentage of surveyed customer respondents expressing overall satisfaction with services received	The total number of agency survey respondents indicating that they are satisfied or very satisfied with the agency, divided by the total number of agency survey respondents.
Explanatory Measure	Total customer groups inventoried	The total number of unique customer groups identified for each agency program.
Explanatory Measure	Total customers identified	The total population of customers in all unique customer groups.

Standardized Questions

In May 2020, HHSC reached out to program staff that manage the majority of HHS customer service surveys regarding the feasibility of incorporating the eight LBB-required customer satisfaction questions into their existing surveys. A limited number of surveys already include items that approximate these questions; these items are reported where applicable in the 2022 Report. However, staff developing the report received consistent feedback indicating that incorporating these questions into existing program-administered surveys would be problematic and, in many cases, not possible for a number of reasons. Programs most frequently indicated that these questions could not be added because (a) the survey items are federally mandated, (b) the required questions are not applicable to the target sample, or (c) content changes would threaten instrument validity.[4] Although HHS programs noted challenges to incorporating the questions into agency surveys, the

[4] The results of these surveys are included in the Report on Customer Service because they assess customer satisfaction; however, most of these surveys were designed for a different purpose, such as to assess progress towards program-specific goals or outcomes.

2022 Report includes similar questions derived from existing surveys where available. HHSC has worked to pursue a reporting strategy that allows HHSC to speak to each measure as applicable.

Output, Efficiency, and Outcome Measures

In October 2020, HHSC reached out to all programs that submitted survey summaries for previous reports to inform them about the new requirements included in the 2020 LBB guidance. HHSC provided these programs with an updated template for submitting their summaries that included definitions of and placeholders for the output, efficiency, and outcome measures. Almost all programs were able to report on these new measures for the 2022 Report on Customer Service.

Explanatory Measures

The surveys included in the 2022 Report do not comprehensively cover the 208 customer groups collectively identified by DSHS and HHSC budget strategies. The budget strategies provide a high-level overview of how appropriation items target different customer types; however, they do not directly correspond to HHS programs or client populations.

Budget strategies often define customer groups using broad, ambiguous language; for example, the budget strategies identify "All Citizens of Texas," "Taskforces," "Committees," and "Other External Partners" as customer groups. Many customer groups therefore do not reflect individual DSHS or HHSC clients and cannot be identified through an anonymous survey. Moreover, clients are not actively tracked by the agency at the customer group level used in the agency budget strategies. HHS instead serves its customers by developing programs that address the specific needs of different client populations.

HHS programs may effectively serve multiple budgetary customer groups, or one subgroup of clients within a single budgetary customer group. For example, HHSC Budget Strategy A.1.2. serves disability-related adults and children. Customers in this group are potentially eligible for multiple programs (e.g., Medicaid STAR+PLUS, Texas Home Living, Community First Choice). Further, these customers may also be included in other budget strategies (e.g., Strategy A.1.1., Aged and Medicare-Related Eligibility Group; Strategy A.1.6., Medicaid Prescription Drugs).

Because of these challenges, it is not possible for HHSC to represent each of these customer groups in surveys on customer service; the 2022 Report therefore only reflects a subset of all customer groups served.

Summary

Although the challenges stated above prevented the program-administered surveys from fully adhering to the LBB guidelines for the 2022 Report, HHSC has attempted to organize, summarize, and evaluate the existing program-administered survey data in a manner that covers each of the questions while also providing the most program-specific customer service information available. HHSC has and will continue to work to obtain and incorporate additional input from the LBB regarding applying the 2020-2022 guidance and any future LBB guidance in a way that best addresses the unique challenges associated with surveying customer service across programs as large and diverse as those administered by Texas HHS.

Report Format

This 2022 Report on Customer Service presents summaries of the results of customer surveys conducted by DSHS and HHSC. Each summary includes the purpose, sample and survey methods, the required performance metrics, and the major findings.

Because §2114.002 of the Government Code requires that HHS agencies gather information from their customers about the quality of services, the term "customers" is used where appropriate throughout this report to indicate individuals who receive services from HHS agencies. Of note, many of the HHS agencies more commonly use the terms “consumer,” “client,” or “individual” to refer to service recipients. Appendix C presents a glossary of acronyms used in this report.

2. Department of State Health Services

DSHS conducted six surveys during SFY 2020 and SFY 2021 that collected customer satisfaction data. More than 2,600 responses were received through these surveys, primarily from families of children with special health care needs. For readability, this chapter is organized into three sections:

- Community Health Improvement
  - CSHCN Systems Development Group Case Management and Family Supports and Community Resources Family Satisfaction Surveys
- Consumer Protection Division
  - Business Filing and Verification Section – Customer Service Satisfaction Survey
  - Surveillance Section Customer Service Satisfaction Survey
- Laboratory and Infectious Disease
  - Human Immunodeficiency Virus Care Services Ryan White Part-B, Post Monitoring Satisfaction Survey
  - Laboratory Services Testing Customer Satisfaction Survey
  - South Texas Laboratory – Water Sample Testing Survey

Community Health Improvement

CSHCN Systems Development Group Case Management and Family Supports and Community Resources Family Satisfaction Surveys

Purpose

The CSHCN Systems Development Group (SDG) serves children ages 0 to 21 with special health care needs. The program works to strengthen community-based services to improve systems of care for children and youth with special health care needs by funding organizations across Texas through two different contracts: Case

Management (CASE) and Family Support and Community Resources (FSCR). CASE contractors work in partnership with children and youth with special health care needs (CYSHCN) and their families to assess needs, develop service plans, provide linkages to state and local resources, and coordinate care. FSCR contractors help CYSHCN and their families by providing a wide range of services and activities in response to community needs. Services and activities include respite assistance, educational workshops, recreational and fitness programs, parent to parent networking, and crisis prevention.

In the first quarter of SFY 2020, CSHCN SDG developed separate FSCR and CASE family experience surveys to better assess each contractor program. Previously, the survey was the same for both contracts. The new FSCR family experience survey gauges contractor responsiveness to family inquiries, respect for culture and traditions, quality of linkages to needed resources, facilitation of parent-to-parent connections, and support in helping families feel included in the community. Additionally, the CASE survey measures family satisfaction with service plan development, emergency preparedness planning, timeliness of follow-up, and shared decision-making for their child.

Sample and Methods

The CSHCN FSCR and CASE Family Satisfaction Surveys were distributed during two separate time periods, one for SFY 2020 and one for SFY 2021. CSHCN SDG contractors sought responses from all families served by their organization with CSHCN SDG funding. All families served were provided a survey at least once during the contract year. Paper and online surveys were offered in both English and Spanish. To ensure distribution, the CSHCN SDG sent each contractor printed surveys, return envelopes, and links to the online surveys. Individuals who completed a paper survey sent their response via postal mail to DSHS.

In SFY 2020, there were 558 completed FSCR responses out of 4,715 surveys distributed by the CSHCN SDG contractors (11.8 percent response rate). There were 116 completed CASE responses out of 1,004 surveys distributed by CSHCN SDG contractors (11.6 percent response rate).

In SFY 2021, there were 847 completed FSCR responses out of 4,687 surveys distributed by the CSHCN SDG contractors (18.1 percent response rate). There were 146 completed CASE responses out of 1,077 surveys distributed by CSHCN SDG contractors (13.5 percent response rate).

Performance Metrics

Table 4 provides the output measures for CSHCN FSCR and CASE Family Satisfaction Surveys.

Table 4. Output Measures for CSHCN FSCR and CASE Family Satisfaction Surveys

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	5,720	7,110	7,200
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	5,720	7,110	7,200
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	5,719	5,764	5,750
Total customers who responded to the survey	The number of customers who responded to the survey.	674	993	1,296
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	11.8%	17.2%	22.5%

Notes. CSHCN=Children with Special Health Care Needs; FSCR=Family Supports and Community Resources; CASE=Case Management; SFY=State fiscal year (September 1-August 31).

Table 5 shows the efficiency measures for the CSHCN FSCR and CASE Family Satisfaction Surveys. DSHS CSHCN SDG does not calculate the cost to distribute the surveys since the cost is minimal and dispersed between DSHS and the community-based contractors. The efficiency measures are not applicable to the CSHCN FSCR and CASE Family Satisfaction Surveys.

Table 5. Efficiency Measures for CSHCN FSCR and CASE Family Satisfaction Surveys

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	N/A	N/A	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	N/A	N/A

Notes. CSHCN=Children with Special Health Care Needs; FSCR=Family Supports and Community Resources; CASE=Case Management; SFY=State fiscal year (September 1-August 31).

Major Findings

Table 6 shows several key findings from the CSHCN FSCR and CASE Family Satisfaction Surveys.

Table 6. Findings from the CSHCN FSCR and CASE Family Satisfaction Surveys

Satisfaction Measure	SFY 2020 Proportion of Respondents[1] (N=674)	SFY 2021 Proportion of Respondents[1] (N=993)
Expressed satisfaction with DSHS staff courtesy	95.6%	96.8%
Expressed satisfaction with the timeliness of services or information DSHS provided	94.4%	94.0%
Expressed satisfaction with the ease in requesting or accessing services or information	94.4%	94.0%

Notes. [1] Proportions indicate respondents who chose responses "somewhat satisfied," "satisfied," or "very satisfied" rather than "somewhat dissatisfied," "dissatisfied," or "very dissatisfied." Those who did not answer the survey question are not counted in these proportions. CSHCN=Children with Special Health Care Needs; FSCR=Family Supports and Community Resources; CASE=Case Management; SFY=State fiscal year (September 1-August 31); N=Sample size; DSHS=Department of State Health Services.

Additional results, grouped by SFY, are presented below.

SFY 2020

FSCR and CASE Survey Results

- Most respondents (94.4 percent) reported having access to staff when they had questions or concerns about their child.
- Most respondents (95.0 percent) reported that the staff respected their culture and traditions when working with their family.
- Most respondents (91.2 percent) reported that the organization helped link them with services and resources needed for their child's care.
- Most respondents (91.6 percent) reported the organization provided resources to help them feel included in the community.
- Most respondents (96.8 percent) reported that the staff made their family feel supported and cared for.

Additional CASE Survey Results

- Most respondents (97.4 percent) reported that they were included in the planning and decisions for their child's care.
- Most respondents (93.9 percent) reported that the services provided met the needs of their child and family.
- Most respondents (94.8 percent) reported that they were happy with the services they received from the organization.

SFY 2021

FSCR and CASE Survey Results

- Most respondents (94.0 percent) reported having access to staff when they had questions or concerns about their child.
- Most respondents (96.8 percent) reported that the staff respected their culture and traditions when working with their family.
- Most respondents (94.9 percent) reported that the organization helped link them with services and resources needed for their child's care.
- Most respondents (95.5 percent) reported the organization provided resources to help them feel included in the community.

- Most respondents (97.9 percent) reported that the staff made their family feel supported and cared for.

Additional CASE Survey Results

- Most respondents (95.9 percent) reported that they were included in the planning and decisions for their child's care.
- Most respondents (93.2 percent) reported that the provided services met the needs of their child and family.
- Most respondents (95.9 percent) reported that they were happy with the services they received from the organization.

Consumer Protection Division

Business Filing and Verification Section – Customer Service Satisfaction Survey

Purpose

The Business Filing and Verification Section (BFV) serves businesses and individuals by processing and issuing certifications, licenses, and registrations to applicants, while ensuring compliance with specific program regulations to ensure the safety of Texans. The types of businesses and individuals that are served include retail stores that sell abusable volatile chemicals; asbestos abatement; hazardous products; retail consumable hemp, manufacturers, and distributors; lead abatement; youth camps; drugs and medical devices manufacturers, distributors and salvagers; food manufacturers, distributors, and salvagers; emergency medical services personnel and providers; milk and dairy; radiation producing machines and radioactive materials; industrial radiographers; retail food and school food establishments; and tattoo and body piercing studios.

The BFV staff also provide customer service to businesses and individuals via email and the telephone. In addition, staff provide answers and instructions related to the submission of licensing applications and fees.

The purpose of the BFV Customer Service Satisfaction Survey is to measure customer satisfaction with the BFV staff, the application submission experience, and the information and instructions posted on the program website pages. The survey

data and comments are also used as a quality improvement tool by managers. The information is reviewed to identify trends that could lead to improvements.

Sample and Methods

The BFV Customer Service Satisfaction Survey was available to businesses and individuals who submitted certification, licensing, or registration applications. Using SurveyMonkey, the BFV Customer Service Satisfaction Survey was accessible online via a link that is posted on all program specific website pages. Additionally, BFV staff frequently interacted with customers via email, and an invitation to complete the survey with the online link was included in the BFV staff's individual signature lines. The BFV Customer Service Satisfaction Survey was offered in English only.

Performance Metrics

Table 7 provides the output measures for the BFV Customer Service Satisfaction Survey.

Table 7. Output Measures for the BFV Customer Service Satisfaction Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	101,700	81,000	100,000
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	101,700	81,000	100,000
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	101,700	81,000	100,000
Total customers who responded to the survey	The number of customers who responded to the survey.	301	317	310
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	0.3%	0.4%	0.3%

Notes. BFV=Business Filing and Verification; SFY=State fiscal year (September 1-August 31).

Table 8 shows the efficiency measures for BFV Customer Service Satisfaction Survey. The BFV Customer Service Satisfaction Survey uses SurveyMonkey and therefore costs are minimal. Thus, BFV does not track survey administration costs

associated with the customer service survey and provided answers of "not applicable" within the table.

Table 8. Efficiency Measures for the BFV Customer Service Satisfaction Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	N/A	N/A	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	N/A	N/A

Notes. BFV=Business Filing and Verification; SFY=State fiscal year (September 1-August 31).

Major Findings

Table 9 shows the major findings from the BFV Customer Service Satisfaction Survey.

Table 9. Findings for the BFV Customer Service Satisfaction Survey

Satisfaction Measure	SFY 2020 Proportion of Respondents[1] (N=301)	SFY 2021 Proportion of Respondents[1] (N=317)
Expressed satisfaction with staff being helpful, courteous, and knowledgeable	79%	79%
Expressed satisfaction with communicating with DSHS (via telephone, mail, or electronically) and found it to be an efficient process	76%	76%
Expressed satisfaction with the DSHS website and found it to be user-friendly and contained adequate information	75%	75%
Expressed satisfaction with the ease of filing an application and the processing of it in a timely manner	82%	69%
Expressed satisfaction with the forms, instructions, and other information provided by DSHS and found them helpful and easy to understand	64%	66%

Notes. [1] Proportions indicate respondents who chose responses "somewhat satisfied," "satisfied," or "very satisfied" rather than "somewhat dissatisfied," "dissatisfied," or "very dissatisfied." Those who did not answer the survey question are not counted in these proportions.
BFV=Business Filing and Verification; SFY=State fiscal year (September 1-August 31); N=Sample size; DSHS=Department of State Health Services.

There was a decrease in the number of customers who reported their application was easy to file and processed in a timely manner, from 82 percent in SFY 2020 to 69 percent in SFY 2021. BFV staff believe that upon the state's reopening from the COVID-19 public health emergency, the significant increase in the number of application submissions across all programs led to longer processing timeframes, which was inconsistent with previously established expectations. There were no other significant changes from SFY 2020 to SFY 2021.

Surveillance Section Customer Service Satisfaction Survey

Purpose

The Surveillance Section of the Consumer Protection Division protects consumer health and safety by ensuring compliance with state and federal law and rules regulated under DSHS. Activities performed by Surveillance Section staff include inspections, product and environmental sampling, complaint investigations, and technical assistance.

The entities inspected include retail stores that sell abusable volatile chemicals or hazardous products, asbestos abatement contractors, lead abatement contractors, tattoo and body piercing studios, drugs and medical device manufacturers or distributors, food manufacturers or warehouses, food and drug salvagers, milk plants and dairy farms, entities that use and store radioactive materials, x-ray machines, and mammography machines.

The purpose of the Surveillance Section Customer Service Survey is to determine customer satisfaction of the regulated entities that interact with Surveillance Section staff and provide the regulated entities a mechanism for input into the inspections process. Additionally, the Surveillance Section Customer Service Survey data and comments can be used as a quality assurance tool by managers. The information is reviewed to identify trends that may lead to training opportunities for staff and/or regulated entities.

Sample and Methods

The Surveillance Section Customer Service Survey, conducted online through SurveyMonkey, is made available to all regulated entities who met with an inspector. The survey was made available on March 1, 2017 and has been perpetually listed for entities to complete. The link to the survey is printed on the back of inspectors' business cards. Inspectors are required to present their business cards and credentials upon entering a firm. On average, the Surveillance Section conducts approximately 40,000 inspections annually. The survey is offered online and in English only. From September 1, 2017 through August 31, 2021, 171 surveys were completed. For the reporting period of SFY 2020 and SFY 2021, a total of 21 surveys were completed. The unit conducted additional remote and

virtual inspections during this time; however, due to the COVID-19 public health emergency, lower response numbers were collected.

Performance Metrics

Table 10 provides the output measures for the Surveillance Section Customer Service Survey.

Table 10. Output Measures for the Surveillance Section Customer Service Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	53,800	69,181	61,500
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	53,800	69,181	61,500
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	53,800	69,181	61,500
Total customers who responded to the survey	The number of customers who responded to the survey.	1	20	100
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	0.00%	0.03%	0.16%

Notes. SFY=State fiscal year (September 1-August 31).

Table 11 provides efficiency measures for Surveillance Section Customer Service Survey. Because the survey was conducted through SurveyMonkey, costs are minimal. Thus, the Surveillance Section does not track costs associated with the customer service survey and provided "not applicable" in the table.

Table 11. Efficiency Measures for the Surveillance Section Customer Service Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	N/A	N/A	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	N/A	N/A

Notes. SFY=State fiscal year (September 1-August 31).

Major Findings

Table 12 presents the major findings from the Surveillance Section Customer Service Survey.

Table 12. Findings from the Surveillance Section Customer Service Survey

Measure	SFY 2020 Proportion of Respondents[1] (N=1)	SFY 2021 Proportion of Respondents (N=20)
The inspector introduced himself/herself and presented his/her credentials/ID before the inspection.	N/A	100%
The purpose of the inspection was adequately described at the beginning of the inspection.	N/A	98.2%
The on-site inspection was completed in a reasonable amount of time and did not unduly interfere with the delivery of services.	N/A	94.6%
The DSHS inspector was prepared and well organized.	N/A	98.2%
The inspection was handled in a courteous and professional manner.	N/A	98.2%
The inspector clearly explained any applicable state or federal requirements, answered questions adequately, and/or referred them to an alternate source for the information.	N/A	98.2%
I now have a better understanding or knowledge of state and/or federal requirements affecting my business.	N/A	94.6%
The inspector clearly explained their findings.	N/A	98.2%
If deficiencies, observations, or violations were found, the inspector clearly explained the timeframe and/or process for corrective action.	N/A	96.4%

Notes. [1] Results are not presented for SFY 2020 due to the small sample size (the COVID-19 public health emergency limited the number of responses collected).
SFY=State fiscal year (September 1-August 31); N=Sample size; DSHS=Department of State Health Services.

Laboratory and Infectious Disease

Human Immunodeficiency Virus (HIV) Care Services Ryan White Part-B, Post Monitoring Satisfaction Survey

Purpose

DSHS HIV Care Services Ryan White Part-B and State Services Program serves approximately 35,000 low income people living with HIV in Texas. This program provides resources and funding to access medical and support services. The program's focus is to promote improved health outcomes and reduce HIV transmission. The HIV Care Services Group conducts annual program monitoring to assess the compliance to the 27 HIV Program Service Standards of Care of each 58 funded service providers across the state. This survey summary covers SFY 2020 and SFY 2021 of the HIV Care Services Post Monitoring Survey results.

The purpose of the annual Texas HIV Care Services Post Monitoring Survey is to assess and gather feedback from program funded medical clinics and support service agencies on the monitoring process and their satisfaction with their experience. The survey, which is conducted by the HIV Care Services Groups' Quality Management Coordinator, is an annual quality management activity.

Sample and Methods

The HIV Care Services Post Monitoring Survey sought responses from 58 Ryan White Part-B and State Services funded service providers in SFY 2020 and SFY 2021.

During SFY 2021, the program implemented a burden reduction process, cutting monitoring in half by monitoring 28 service providers in SFY 2021 and the remaining 30 service providers in SFY 2022. The survey link was sent to each monitored service provider agency representative after monitoring was completed.

The study was conducted electronically using Microsoft Forms. The surveys were offered in English only. Individuals completed the survey themselves and electronically submitted their responses using a survey link with the option to self-identify or remain anonymous.

Performance Metrics

Table 13 provides the output measures for HIV Care Services Post Monitoring Survey.

Table 13. Output Measures for HIV Care Services Post Monitoring Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	58	28	30
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	58	28	30
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	58	28	30
Total customers who responded to the survey	The number of customers who responded to the survey.	51	17	27
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	87.9%	60.7%	90.0%

Notes. HIV=Human Immunodeficiency Virus; SFY=State fiscal year (September 1-August 31).

Table 14 provides the efficiency measures for HIV Care Services Post Monitoring Survey.

Table 14. Efficiency Measures for HIV Care Services Post Monitoring Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	$240	$240	$240
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	$4	$9	$8

Notes. HIV=Human Immunodeficiency Virus; SFY=State fiscal year (September 1-August 31).

Major Findings

Overall survey results for each fiscal year show high satisfaction rates with the monitoring process and the monitoring teams' performance (Table 15).

Table 15. Findings for HIV Care Services Post Monitoring Survey

Measure	SFY 2020 Proportion of Respondents (N=51)	SFY 2021 Proportion of Respondents (N=17)
The monitoring team was professional, respectful, and courteous throughout the remote monitoring process	100%	100%
The annual program monitoring process helps my agency to identify potential areas of deficiency and opportunities for improvement[1]	94%	88%

Notes. [1] The survey facilities the identification of opportunities for improvement in their respective service delivery practices in relation to compliance with the Texas HIV Service Standards of Care.
HIV=Human Immunodeficiency Virus; SFY=State fiscal year (September 1-August 31); N=Sample size.

Laboratory Services Testing Customer Satisfaction Survey

Purpose

The DSHS Laboratory Services Section (LSS) provides unique testing services for a myriad of sample types and facilities across the state. Services include testing newborn blood samples for inherited, potentially deadly disorders; testing water quality for biologic contaminants from local sources; and testing milk and meat. LSS's goal is to improve the public health and patient outcomes for all Texans and serve thousands of facilities across the state that submit samples to the laboratory.

The purpose of the DSHS LSS Survey was to allow laboratory management to gauge client satisfaction with the type of services provided, ease of use with electronic reporting systems, and experience with customer support services. The goal is to improve client satisfaction. Surveys were conducted annually by the LSS Quality Assurance Unit and included all facilities that received LSS services from 2019 through 2020.

Sample and Methods

DSHS LSS issued a survey for services rendered in 2019 and 2020 with surveys issued the following year, 2020 and 2021 respectively. Facilities were made aware of the survey opportunities through notices placed on results web portals, issued via GovDelivery or ListServ, email, and the DSHS website. The responses could be completed electronically by facility representatives for 30 days. The 2020 DSHS LSS Survey closed February 28, 2020 and the 2021 DSHS LSS Survey closed on April 15, 2021. The surveys were offered in English and were available online only.

Performance Metrics

Table 16 provides output measures for the DSHS LSS Survey. The number of customers who received access to the survey (26,323) is much larger than the number of customers served in the program for several reasons:

- The laboratory openly advertises to everyone via the laboratory website, online portals, and email distribution lists. The website can be seen by everyone, including the general public. Online portals are actively seen by a subset of active submitters (not all submitters use the online portals). The email distribution lists are open to anyone who takes the time to subscribe. The laboratory maintains seven email distribution lists and took count of the number of email addresses part of each distribution list to arrive at 26,323.
- For every active submitting entity, many supporting staff members interact with the laboratory on a regular or sporadic basis. Each submitting entity, whether it be a clinic, hospital or individual, has supporting staff including administrative, nurses, techs, etc. In the cases of hospitals and clinics, their support staff, all those who work for the submitting doctor/hospital/clinic/etc., can be large and often siloed. For instance, techs sending out specimens are in a different area from those attaching results to patient records, etc. Each has a portion of the job to ensure their patients are taken care of. Each has its own experiences when interacting with the laboratory. To get the information to the staff that needs it, the laboratory maintains email distribution lists that send out periodic alerts, reminders, etc. Customers, including all support staff, can sign up to be on any email distribution list available.

Table 16. Output Measures for the DSHS LSS Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total customers served (i.e., population)[1]	Total number of customers receiving services from the program.	5,277	4,980	4,980
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	5,277	4,980	4,980
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	26,323	26,323	26,323
Total customers who responded to the survey	The number of customers who responded to the survey.	70	144	144
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	0.3%	0.5%	0.5%

Notes. [1] The total number of customers receiving services from the programs is equivalent to the number of "active" submitters for the time frame being surveyed. To be classified as "active," the submitter/provider must have submitted at least one specimen/sample for testing within the calendar year being surveyed. All submitters that fell into the "active" submitters criteria within the 2019 calendar year were included in the total number of customers served for the 2020 survey. All "active" submitters within the 2020 calendar year were included in the 2021 DSHS LSS Survey.
DSHS=Department of State Health Services; LSS=Laboratory Services Section; SFY=State fiscal year (September 1-August 31).

Table 17 provides efficiency measures for the DSHS LSS Survey. The survey tool used, Microsoft Forms, is part of the Microsoft suite of products used for other business purposes, so no additional costs were incurred.

Table 17. Efficiency Measures for the DSHS LSS Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	N/A	N/A	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	N/A	N/A

Notes. DSHS=Department of State Health Services; LSS=Laboratory Services Section; SFY=State fiscal year (September 1-August 31).

Major Findings

Findings for the DSHS LSS Survey issued in 2020 and 2021 show that respondents were satisfied with the laboratory performance, communication, and services (Table 18). Across all measures, satisfaction ratings in 2021 were higher than those in 2020. Specifically, submitter satisfaction with the quality of service and information provided increased in the 2021 DSHS LSS Survey with submitters citing the clear communications surrounding test delays due to Winter Storm Uri with re-testing results provided quickly. Submitter concerns and dissatisfaction were most often expressed regarding the online platform where submitters access patient results. The issue noted the most was the inability to quickly reset passwords to regain access to online results and the difficulty searching for results.

Table 18. Findings for the DSHS LSS Survey

Satisfaction Measure	SFY 2020 Proportion of Respondents[1] (N=70)	SFY 2021 Proportion of Respondents[1] (N=144)
Expressed satisfaction with the quality of service or information DSHS provided	90%	96%
Expressed satisfaction with DSHS staff courtesy	88%	98%
Expressed satisfaction with the timeliness of services or information DSHS provided	90%	97%
Expressed satisfaction with the ease in requesting or accessing services or information	85%	92%

Notes. [1] Proportions indicate respondents who chose responses "satisfied", "very satisfied", "neither satisfied or dissatisfied" rather than "dissatisfied" or "very dissatisfied." Those who did not answer the survey question are not counted in these proportions.
DSHS=Department of State Health Services; LSS=Laboratory Services Section; SFY=State fiscal year (September 1-August 31); N=Sample size.

South Texas Laboratory – Water Sample Testing Survey

Purpose

The South Texas Laboratory (STL) is a branch of the Laboratory Services Section located in Harlingen, Texas. One service provided by the STL is bacterial water testing for drinking water. Testing is performed on public water systems, companies who sell bottled or vended water, and private individuals (i.e., self-owned businesses or properties with ground wells). The program also provides bacterial water testing for drinking water submitters who are required to follow the Texas Commission of Environmental Quality (TCEQ) regulations.

The purpose of the Water Sample Testing Survey is to seek feedback from the submitters. The feedback is used to improve customer service, the management system, and testing. The survey is a Quality Systems General Requirement by The National Environmental Laboratory Accreditation Program Institute and part of the TCEQ Standards. The survey, which was conducted by the STL Water Department, included all water submitters.

Sample and Methods

The study sought responses from water submitters who are current customers of the South Texas Laboratory and was conducted from January 21, 2020 through February 29, 2020. The Water Sample Testing Survey was offered in English only. Individuals completed the survey themselves. The total number of completed responses was 31 of 85 for a response rate of 36 percent.

Performance Metrics

Table 19 provides SFY 2020 output measures for Water Sample Testing Survey. Output measures for Projected SFY 2022 is estimated to be the same as SFY 2020. A survey was not conducted during SFY 2021 and is noted as "not applicable."

Table 19. Output Measures for Water Sample Testing Survey

Measure	Specification	SFY 2020	SFY 2021[1]	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	85	N/A	85
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	85	N/A	85
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	85	N/A	85
Total customers who responded to the survey	The number of customers who responded to the survey.	31	N/A	31
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	36.5%	N/A	36.5%

Notes. [1] The Water Sample Testing Survey was not conducted in SFY 2021.
SFY=State fiscal year (September 1-August 31).

Table 20 provides the SFY 2020 efficiency measures for the Water Sample Testing Survey. The efficiency measures for Projected SFY 2022 are estimated to be the same as SFY 2020. A survey was not conducted during SFY 2021 and is marked as "not applicable."

Table 20. Efficiency Measures for Water Sample Testing Survey

Measure	Specification	SFY 2020	SFY 2021[1]	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	$200	N/A	$200
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	$2	N/A	$2

Notes. [1] The Water Sample Testing Survey was not conducted in SFY 2021.
SFY=State fiscal year (September 1-August 31).

Major Findings

The findings of the Water Sample Testing Survey were as follows:

- Most submitters (94 percent) received lab reports in a timely manner (faxed, mailed, or other).
- Most submitters (94 percent) spoke with an STL staff member immediately or within 3 to 5 minutes.
- Most submitters (72 percent) indicated their water issues were resolved within minutes.
- Most submitters (94 percent) gave a highly satisfied rating.
- Most submitters (80 percent) reported well above average on customer service experience, on-time delivery of service, professionalism, quality of service, and understanding of customers' needs.
- Most submitters (65 percent) rated the STL service much higher to comparable labs.
- Most submitters (78 percent) strongly agreed that the STL staff member was knowledgeable.
- Most submitters (75 percent) rated the overall laboratory service well above average on instructing changes on the G-19 form.
- Most submitters (94 percent) reported that STL gave clear instructions on collection of water samples and clear answers to resolve issues.
- Most submitters (81 percent) expressed high satisfaction with STL responsiveness.

- Most submitters (90 percent) provided an overall rating on the process of problem resolving as “very good.”
- Many submitters (77 percent) rated the STL staff member as well above average for the following characteristics: patience, enthusiastic, listens carefully, friendly, responsive, and courteous to the water submitters.

3. Health and Human Services Commission

This chapter reports the results of 22 surveys that collected customer satisfaction data related to HHSC. A total of 360,862 responses were received through these surveys. For readability, this chapter is organized into five sections:

- Healthcare Coverage
  - STAR Child Caregiver Member Survey
  - STAR Health Caregiver Survey
  - STAR Kids Caregiver Member Survey
  - Children's Health Insurance Program Caregiver Member Survey
  - Child Core Measures Survey
  - Medicaid and Children's Health Insurance Program Dental Caregiver Survey
  - STAR Adult Member Survey
  - STAR+PLUS Adult Member Survey
  - Adult Core Measures Survey
  - Medical Transportation Program Member Survey
- Access and Eligibility Services
  - YourTexasBenefits.Com Survey
- Quality Reviews
  - Nursing Facility Quality Review
  - Complaint and Incident Intake Survey
- Health, Development, and Independence Services
  - Blind Children’s Vocational Discovery and Development Program Customer Service Satisfaction Survey
  - Comprehensive Rehabilitation Services Customer Service Survey
  - Early Childhood Intervention Family Survey
  - Independent Living Services Program Survey
  - Children’s Autism Program Survey

    - Your WIC Experience Client Satisfaction Survey
- Mental Health Services
    - Mental Health Statistics Improvement Program Youth Services Survey for Families
    - Mental Health Statistics Improvement Program Adult Services Survey
    - Mental Health Statistics Improvement Program Inpatient Consumer Survey

Healthcare Coverage

Ten surveys captured customer satisfaction information from Texas HHSC clients receiving healthcare coverage during SFY 2020 and SFY 2021. For readability, this section is organized in three subsections:

1. Child Healthcare Coverage
2. Adult Healthcare Coverage
3. Transportation Coverage

The surveys discussed in this section relate to Texas Medicaid, Children's Health Insurance Program (CHIP), and transportation services. Federal law requires state Medicaid programs to contract with an external quality review organization (EQRO) to help evaluate services. HHSC contracts with Institute for Child Health Policy (ICHP) at the University of Florida for this purpose, and ICHP conducted these surveys as part of their EQRO duties. The surveys assess members' or their caregivers' satisfaction with physical health, behavioral health, dental, or non-emergency medical transportation (NEMT) services. The questions on the surveys are primarily taken from nationally standardized survey instruments.

Child Healthcare Coverage

The surveys about services for children include:

- STAR Child Caregiver Member Survey
- STAR Health Caregiver Survey
- STAR Kids Caregiver Member Survey
- CHIP Caregiver Member Survey

- Child Core Measures Survey
- Medicaid and CHIP Dental Caregiver Survey

The EQRO used a similar survey protocol for all surveys. Evaluators sent advance notification letters written in English and Spanish to caregivers of child members in Medicaid and CHIP requesting their participation in the surveys. Then the evaluators telephoned caregivers seven days a week in both day and evening hours (generally between 9:00 a.m. and 9:00 p.m. Central) to complete the survey. Multiple attempts (up to 20 for most programs) were made to reach a family before a member's phone number was removed from the calling circuit. If a respondent was unable to complete the interview in English, evaluators referred the respondent to a Spanish-speaking interviewer for a later time.

The Child Healthcare Coverage surveys included questions from the following sources:

- The Agency for Healthcare Research and Quality's (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, a widely used instrument for measuring and reporting consumer experiences with their health plan and providers.[5]
- Items developed by the EQRO pertaining to caregiver and member demographic and household characteristics.

Additional details on these sources can be found on the Texas Healthcare Learning Collaborative portal in the Member Surveys folder under Resources.[6]

STAR Child Caregiver Member Survey

Purpose

The EQRO conducts the STAR Child Caregiver Member Survey from April to September every other year with caregivers of children who receive services funded through the Medicaid STAR program. STAR serves children in low-income families as well as adults who meet certain income and eligibility criteria. The program provides physical health, behavioral health, and dental services for children. This survey reviews physical and behavioral health, and a separate survey examines

[5] https://www.ahrq.gov/cahps/index.html
[6] https://thlcportal.com/resources/

satisfaction with dental services. Surveys for adults and children in the STAR program are conducted separately.

The purpose of the STAR Child Caregiver Member Survey is to determine the sociodemographic characteristics and health status of children enrolled in the STAR program and assess parental experiences and satisfaction with healthcare received by STAR enrollees. Specifically, the survey includes questions to address:

- The sociodemographic characteristics and health status of members
- Caregivers' satisfaction with their child's healthcare
- Access to and timeliness of care, including having a usual source of care
- Preventive care, including check-ups
- The need for and availability of specialized services
- Caregivers' experiences with their child's health plan and customer service
- Healthcare needs as children with chronic conditions transition into adulthood

Sample and Methods

Participants for the STAR Child Caregiver Member Survey were selected from a stratified random sample of beneficiaries ages 17 and younger who were enrolled in STAR for six continuous months between October 2020 and March 2021. Members having no more than one 30-day break in enrollment in the same managed care organization (MCO) during this period were included in the sampling frame. The sample was stratified to include representation from the 44 plan codes, plus a statewide sample of members in Permanency Care Assistance and Adoption Assistance. The target number of completed surveys was 200 per plan code and 300 for MCOs operating in only one service area. While the sample was drawn from the beneficiaries (children), the survey was conducted with their parents/caregivers.

Performance Metrics

Table 21 provides the output measures for the STAR Child Caregiver member Survey.

Table 21. Output Measures for STAR Child Caregiver Member Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022[2]
Total customers served (i.e., population)	Total number of customers receiving services from the program.	N/A	3,732,959[3]	N/A
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	N/A	1,457,722	N/A
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	N/A	83,144	N/A
Total customers who responded to the survey	The number of customers who responded to the survey.	N/A	8,402	N/A
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	N/A	10.1%	N/A

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2020. [2] Because this is a biennial survey, it will not be conducted in SFY 2022. [3] This number reflects the average monthly enrollment in STAR between September 2020 and August 2021. The total number of unique individuals enrolled throughout SFY 2021 is slightly higher.
Source: Medicaid 8-month Eligibility Database, HHSC.
STAR=Medicaid managed care program that serves children, newborns, pregnant women, and some families and children; SFY=State fiscal year (September 1-August 31); HHSC=Health and Human Services Commission.

Table 22 shows the efficiency measures for STAR Child Caregiver member Survey.

Table 22. Efficiency Measures for STAR Child Caregiver Member Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022[2]
Total costs	The total costs for the agency to administer customer surveys.	N/A	$259,580	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	$3	N/A

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2020. [2] Because this is a biennial survey, it will not be conducted in SFY 2022.
STAR=Medicaid managed care program that serves children, newborns, pregnant women, and some families and children; SFY=State fiscal year (September 1-August 31).

Major Findings

The EQRO presented the findings to HHSC for several domains which allows for the calculation and reporting of healthcare composites. Domains combine results for closely related survey items, providing a comprehensive, yet concise summary of results for multiple survey questions.

The scores in Tables 23 and 24 present the survey's composites. In all the satisfaction domains, the STAR Child Caregiver Member Survey results were above the 2020 AHRQ national average.

Table 23. STAR Child Caregiver Member Survey CAHPS® Composites: Percent "Always" Having Positive Experiences

Satisfaction Domain	SFY 2021 Proportion of Respondents[1]	AHRQ National Average (2020)
Getting Needed Care	67.8%	61%
Getting Care Quickly	75.6%	73%
How Well Doctors Communicate	83.8%	81%
Customer Service	81.5%	68%
Coordination of Care	64.6%	N/A[2]

Notes. [1] CAHPS® composite rates and CAHPS®-based HHSC Dashboard indicators in this report are calculated following the "top box" (percent always) method. [2] No national average available. STAR=Medicaid managed care program that serves children, newborns, pregnant women, and some families and children; CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31). AHRQ=Agency for Healthcare Research and Quality; HHSC=Health and Human Services Commission.

Table 24. STAR Child Caregiver Member Survey CAHPS® Composites: Percent Rating at "9" or "10"

Satisfaction Domain	SFY 2021 Proportion of Respondents	AHRQ National Average (2020)
Health Care Rating	81.3%	70%
Personal Doctor Rating	79.8%	78%
Specialist Rating	82.7%	74%
Health Plan Rating	82.5%	71%

Notes. STAR=Medicaid managed care program that serves children, newborns, pregnant women, and some families and children; CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31). AHRQ=Agency for Healthcare Research and Quality.

The STAR Child Caregiver Member Survey included several questions that functioned as indicators of health plan performance, which are listed on the HHSC Performance Indicator Dashboard.[7] HHSC set benchmarks (known as HHSC Performance Dashboard Indicators) for the agency's performance in several key domains. The relevant results of the STAR Child Caregiver Member Survey are reported relative to these performance indicator benchmarks in Table 25.

[7] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10-1-14.pdf

Table 25: Statewide STAR Child Member Survey Results Relative to HHSC Performance Dashboard Indicators

Performance Indicator Dashboard	SFY 2021 Proportion of Respondents	STAR Child Minimum Standard (2021)
Good Access to Urgent Care	80.4%	79%
Good Access to Specialist Appointment	63.6%	55%
Good Access to Routine Care	70.8%	68%
Members Rating Child's Personal Doctor "9" or "10"	79.8%	78%
Members Rating Child's Health Plan a "9" or "10"	82.5%	71%
How Well Doctors Communicate	83.8%	82%

Notes. STAR=Medicaid managed care program that serves children, newborns, pregnant women, and some families and children; HHSC=Health and Human Services Commission; SFY=State fiscal year (September 1-August 31).

STAR Health Caregiver Survey

Purpose

The Texas STAR Health program began in April 2008 and operates through Superior HealthPlan to provide physical health, behavioral health, dental services, and care coordination to children in foster care. This STAR Health Caregiver Survey reviews physical and behavioral health, and a separate survey examines satisfaction with dental services. The STAR Health Caregiver Survey is conducted by the EQRO every other year.

The purpose of the STAR Health Caregiver Survey is to assess the sociodemographic characteristics and health status of members and the experiences and satisfaction of caregivers with the healthcare services received by their children in STAR Health. Additionally, the survey includes questions to address:

- The sociodemographic characteristics and health status of members
- Caregivers' experiences and satisfaction with their child's healthcare, personal doctor, and health plan customer service
- The need for and availability of specialized services for members
- Caregivers' experiences with their child's care coordination
- Healthcare needs as children with chronic conditions transition into adulthood

Sample and Methods

Participants for the STAR Health Caregiver Survey were selected from a simple random sample of beneficiaries age 17 years or younger who were enrolled in the STAR Health program for at least six continuous months from December 2019 to May 2020 and have been living with their present caregiver for six months or longer. The fielding period of the survey was between June 2020 and October 2020. There were 13,083 clients identified in the sampling frame. The target number of completed surveys was 300.

The EQRO contracted with the University of Florida Survey Research Center (UFSRC) to conduct the surveys using computer-assisted telephone interviewing. UFSRC telephoned parents and caregivers of STAR Health members seven days a week between 9 a.m. and 9 p.m. Central Time. Up to 20 attempts were made to reach a family before a member's phone number was removed from the calling circuit. If a respondent was unable to complete the interview in English, UFSRC referred the respondent to a Spanish-speaking interviewer for a later time.

The EQRO sent advance notification letters written in English and Spanish to parents and caregivers of sampled STAR Health members, requesting their participation in the survey. Survey results are publicly posted online on the Texas Healthcare Learning Collaborative portal.[8]

Performance Metrics

Table 26 provides the output measures for the STAR Health Caregiver Survey.

[8] Texas Healthcare Learning Collaborative, https://thlcportal.com/survey

Table 26. Output Measures for STAR Health Caregiver Survey

Measure	Specification	SFY 2020	SFY 2021[1]	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	34,512[2]	N/A	37,527[3]
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	13,083	N/A	13,000
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	3,397	N/A	3,400
Total customers who responded to the survey	The number of customers who responded to the survey.	207	N/A	210
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	6.1%	N/A	6.2%

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2021. [2] This number reflects the average monthly enrollment in STAR Health between September 2019 and August 2020. The total number of unique individuals enrolled throughout SFY 2020 is slightly higher. [3] This number reflects the projected enrollment in STAR Health for September 2021.
Sources: Medicaid 8-month Eligibility Database, HHSC; Medicaid CHIP Data Analytics within the Office of Data, Analytics, and Performance, HHSC; Forecasting Division/Budget, HHSC.
STAR Health=Medicaid managed care program that serves individuals under or transferring out of conservatorship or foster care; SFY=State fiscal year (September 1-August 31); HHSC=Health and Human Services Commission; CHIP=Children's Health Insurance Program.

Table 27 shows the efficiency measures for STAR Health Caregiver Survey.

Table 27. Efficiency Measures for STAR Health Caregiver Survey

Measure	Specification	SFY 2020	SFY 2021[1]	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	$36,981	N/A	$41,820
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	$11	N/A	$12

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2021.
STAR Health=Medicaid managed care program that serves individuals under or transferring out of conservatorship or foster care; SFY=State fiscal year (September 1-August 31).

Major Findings

The EQRO presented the findings to HHSC for several domains which allows for the calculation and reporting of healthcare composites. These are scores that combine results for closely related survey items, providing a comprehensive, yet concise summary of results for multiple survey questions. The scores in Tables 28 and 29 present the survey's composites.

Table 28. STAR Health Caregiver Survey CAHPS® Composites: Percent "Always" Having Positive Experiences

Satisfaction Domain	SFY 2020 Proportion of Respondents[1]	AHRQ National Average (2020)
Getting Needed Care	66.9%	61%
Getting Care Quickly	79.9%	73%
How Well Doctors Communicate	89.1%	81%
Customer Service	78.7%	68%
Coordination of Care	68.4%	N/A[2]

Notes. [1] CAHPS® composite rates and CAHPS®-based HHSC Dashboard indicators in this report are calculated following the "top box" (percent always) method. [2] No national average available.
STAR Health=Medicaid managed care program that serves individuals under or transferring out of conservatorship or foster care; CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31).

Table 29. STAR Health Caregiver Survey CAHPS® Composites: Percent Rating at "9" or "10"

Satisfaction Domain	SFY 2020 Proportion of Respondents	AHRQ National Average (2020)
Health Care Rating	80.9%	70%
Personal Doctor Rating	83.9%	78%
Specialist Rating	69.4%	74%
Health Plan Rating	81.5%	71%

Notes. STAR Health=Medicaid managed care program that serves individuals under or transferring out of conservatorship or foster care; CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31); AHRQ=Agency for Healthcare Research and Quality.

The STAR Health Caregiver Survey included several questions that functioned as indicators of health plan performance, which are listed on the HHSC Performance Indicator Dashboard.[9] HHSC set benchmarks (known as HHSC Performance Dashboard Indicators) for the agency's performance in several key domains. The relevant results of the STAR Health Caregiver Survey are reported relative to these performance indicator benchmarks in Table 30.

[9] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10-1-14.pdf

Table 30. Statewide STAR Health Caregiver Survey Results Relative to HHSC Performance Dashboard Indicators

Performance Dashboard Indicator	SFY 2020 Proportion of Respondents	Minimum Standard (2020)
Good Access to Urgent Care	80.0%	79%
Good Access to Specialist Appointments	51.9%	55%
Good Access to Routine Care	79.9%	68%
Good Access to Behavioral Health Treatment or Counseling	64.1%	50%
Members Rating their Personal Doctor a "9" or "10"	83.9%	77%
Members Rating their Health Plan "9" or "10"	81.5%	65%
Good Experience with Doctor's Communication	89.1%	79%

Notes. STAR Health=Medicaid managed care program that serves individuals under or transferring out of conservatorship or foster care; SFY= State fiscal year (September 1-August 31).

STAR Kids Caregiver Member Survey

Purpose

The EQRO conducts the STAR Kids Caregiver Member Survey from May to October every other year with caregivers of children who received services funded through the Medicaid STAR Kids program. STAR Kids serves children and adults 20 and younger who have a disability and meet certain eligibility criteria. The program provides physical health, behavioral health, and dental services. This survey reviews physical and behavioral health, and a separate survey examines satisfaction with dental services.

The purpose of the STAR Kids Caregiver Member Survey is to determine the sociodemographic characteristics and health status of children enrolled in the STAR Kids program and assess parental experiences and satisfaction with healthcare received by STAR Kids enrollees. Specifically, the survey includes questions to address:

- The sociodemographic characteristics and health status of enrollees
- Caregivers' experiences of and satisfaction with their children's healthcare, personal doctor, and health plan customer service
- Access to and timeliness of care, including having a usual source of care
- Caregivers' knowledge of and experiences with service coordination provided through their health plan
- The need for and availability of specialized services for members
- Healthcare needs as children with chronic conditions transition into adulthood

Sample and Methods

Participants for the STAR Kids Caregiver Survey were selected from a stratified random sample of beneficiaries ages 17 years or younger who were enrolled in STAR Kids for six continuous months between October 2019 - March 2020. Members having no more than one 30-day break in enrollment in the same MCO or waiver during this period were included in the sample. The sample was stratified to include representation from the 28 plan codes (MCO/service areas), with a target number of 200 completed surveys per plan code and 300 completed surveys for MCOs operating in only one service area.

The EQRO contracted with UFSRC to conduct the surveys using computer-assisted telephone interviewing. UFSRC telephoned caregivers of STAR Kids members from May 2020 - October 2020, seven days a week between 9 a.m. and 9 p.m. Central Time. Up to 20 attempts were made to reach a member before a phone number was removed from the calling circuit. If a respondent was unable to complete the interview in English, UFSRC referred the respondent to a Spanish-speaking interviewer for a later time. UFSRC used an external vendor from the University of North Florida to help with time and personnel effort for this survey. The external vendor used the same survey methods and tool that was approved and used by UFSRC.

The EQRO sent advance notification letters written in English and Spanish to caregivers of sampled STAR Kids members, requesting their participation in the survey.

Performance Metrics

Table 31 provides the output measures for the STAR Kids Caregiver Member Survey.

Table 31. Output Measures for STAR Kids Caregiver Member Survey

Measure	Specification	SFY 2020	SFY 2021[1]	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	159,764[2]	N/A	166,687[3]
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	97,792	N/A	97,000
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	47,082	N/A	47,000
Total customers who responded to the survey	The number of customers who responded to the survey.	5,463	N/A	5,000
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	11.6%	N/A	10.6%

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2021. [2] This number reflects the average monthly enrollment in STAR Kids between September 2019 and August 2020. The total number of unique individuals enrolled throughout SFY 2020 is slightly higher. [3] This number reflects the projected enrollment in STAR Kids for September 2021.
Sources: Medicaid 8-month Eligibility Database, HHSC; Medicaid CHIP Data Analytics within the Office of Data, Analytics, and Performance, HHSC; Forecasting Division/Budget, HHSC.
STAR Kids=Medicaid managed care program that serves children and adults age 20 and younger with a disability; SFY=State fiscal year (September 1-August 31); HHSC=Health and Human Services Commission; CHIP=Children's Health Insurance Program.

Table 32 shows the efficiency measures for STAR Kids Caregiver Member Survey.

Table 32. Efficiency Measures for STAR Kids Caregiver Survey

Measure	Specification	SFY 2020	SFY 2021[1]	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	$274,622	N/A	$276,279
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	$6	N/A	$6

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2021.
STAR Kids=Medicaid managed care program that serves children and adults age 20 and younger with a disability; SFY=State fiscal year (September 1-August 31).

Major Findings

The EQRO presented the findings to HHSC for eight domains which allows for the calculation and reporting of healthcare composites. These are scores that combine results for closely related survey items, providing a comprehensive, yet concise summary of results for multiple survey questions. The scores in Tables 33 and 34 present the survey's composites. Notably, STAR Kids caregivers rated customer service experiences 8.3 percentage points higher than the national average.

Table 33. STAR Kids Caregiver Member Survey CAHPS® Composites: Percent "Always" Having Positive Experiences

Satisfaction Domain	SFY 2020 Proportion of Respondents[1]	AHRQ National Average (2020)
Getting Needed Care	66.0%	61%
Getting Care Quickly	75.0%	73%
How Well Doctors Communicate	81.4%	81%
Customer Service	76.3%	68%
Coordination of Care	66.6%	N/A[2]
Access to Specialized Services	52.5%	N/A[2]
Getting Needed Information	76.1%	76%
Getting Prescriptions	74.3%	69%

Notes. [1] CAHPS® composite rates and CAHPS®-based HHSC Dashboard indicators in this report are calculated following the "top box" (percent always) method. [2] No national average available. STAR Kids=Medicaid managed care program that serves children and adults age 20 and younger with a disability; CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31); AHRQ=Agency for Healthcare Research and Quality.

Table 34. STAR Kids Caregiver Member Survey CAHPS® Composites: Percent Rating at "9" or "10"

Satisfaction Domain	SFY 2020 Proportion of Respondents	AHRQ National Average (2020)
Health Care Rating	77.4%	70%
Personal Doctor Rating	79.8%	78%
Specialist Rating	82.2%	74%
Health Plan Rating	74.0%	71%

Notes. STAR Kids=Medicaid managed care program that serves children and adults age 20 and younger with a disability; CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31); AHRQ=Agency for Healthcare Research and Quality.

CHIP Caregiver Member Survey

Purpose

The EQRO conducts the CHIP Caregiver Member Survey from April to August every other year with caregivers of children who receive services funded through the CHIP program. CHIP is a partially subsidized health insurance program for children from families whose income falls below a specific threshold but exceeds the eligibility level to qualify for Medicaid. The program provides physical health, behavioral health, and dental services for children. This survey reviews physical and behavioral health.

The purpose of the CHIP Caregiver Member Survey is to determine the sociodemographic characteristics and health status of children enrolled in CHIP and to assess parental experiences and satisfaction with healthcare received by CHIP enrollees. The survey includes questions to address:

- The sociodemographic characteristics and health status of enrollees
- Parent's experiences and satisfaction with their children's healthcare, personal doctor, and health plan costumer service
- The need for and availability of specialized services for members
- Healthcare needs as children with chronic conditions transition into adulthood

Sample and Methods

Participants for the CHIP Caregiver Member Survey were selected from a stratified random sample of beneficiaries ages 17 years or younger who were enrolled in CHIP for six continuous months between October 2020 and March 2021. Members having no more than one 30-day break in enrollment in the same MCO during this period were included in the sample. The target number of completed surveys was 200 per plan code and 300 completed surveys for MCOs operating in only one service area. While the sample was drawn from the beneficiaries (children), the survey was conducted with their parents/caregivers.

Performance Metrics

Table 35 provides the output measures for the CHIP Caregiver Member Survey.

Table 35. Output Measures for CHIP Caregiver Member Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022[2]
Total customers served (i.e., population)	Total number of customers receiving services from the program.	N/A	264,688[3]	N/A
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	N/A	97,816	N/A
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	N/A	46,407	N/A
Total customers who responded to the survey	The number of customers who responded to the survey.	N/A	3,609	N/A
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	N/A	7.8%	N/A

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2020. [2] Because this is a biennial survey, it will not be conducted in SFY 2022. [3] This number reflects the average monthly enrollment in CHIP between September 2020 and August 2021. The total number of unique individuals enrolled throughout SFY 2021 is slightly higher.
Sources: Medicaid 8-month Eligibility Database, HHSC; Medicaid CHIP Data Analytics within the Office of Data, Analytics, and Performance, HHSC; Forecasting Division/Budget, HHSC.
CHIP=Children's Health Insurance Program; SFY=State fiscal year (September 1-August 31); HHSC=Health and Human Services Commission.

Table 36 shows the efficiency measures for CHIP Caregiver Member Survey.

Table 36. Efficiency Measures for CHIP Caregiver Member Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022[2]
Total costs	The total costs for the agency to administer customer surveys.	N/A	$262,094	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	$6	N/A

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2020. [2] Because this is a biennial survey, it will not be conducted in SFY 2022.
CHIP=Children's Health Insurance Program; SFY=State fiscal year (September 1-August 31).

Major Findings

The EQRO presented the findings to HHSC for several domains which allows for the calculation and reporting of healthcare composites. These are scores that combine results for closely related survey items, providing a comprehensive, yet concise summary of results for multiple survey questions. The scores in Tables 37 and 38 present the survey's composites.

Table 37. CHIP Caregiver Member Survey CAHPS® Composites: Percent "Always" Having Positive Experiences

Satisfaction Measure	SFY 2021 Proportion of Respondents[1]	AHRQ National Average (2020)
Getting Needed Care	64.1%	62%
Getting Care Quickly	74.7%	75%
How Well Doctors Communicate	84.9%	82%
Customer Service	75.6%	67%
Coordination of Care	63.2%	N/A[2]

Notes. [1] CAHPS® composite rates and CAHPS®-based HHSC Dashboard indicators in this report are calculated following the "top box" (percent always) method. [2] No national average available. CHIP=Children's Health Insurance Program; CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31); AHRQ=Agency for Healthcare Research and Quality.

The Getting Care Quickly and the personal doctor rating composites were just under the 2020 AHRQ national average, with all other measures scoring above the national average.

Table 38. CHIP Caregiver Member Survey CAHPS® Composites: Percent Rating at "9" or "10"

Satisfaction Domain	SFY 2021 Proportion of Respondents	AHRQ National Average (2020)
Health Care Rating	77.9%	72%
Personal Doctor Rating	77.9%	78%
Specialist Rating	79.6%	74%
Health Plan Rating	75.8%	70%

Notes. CHIP=Children's Health Insurance Program; CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31); AHRQ=Agency for Healthcare Research and Quality.

Child Core Measures Survey

Purpose

The EQRO conducts the Child Core Measures Survey from June to November each year with caregivers of children who receive services funded through Texas Medicaid and CHIP. The purpose of the Child Core Measures Survey is to assess member and caregiver overall experiences with Medicaid and CHIP in Texas. Results from these surveys were used in SFY 2020 Child and Adult Core Measures reporting to the Centers for Medicare and Medicaid Services.

Sample and Methods

Participants for the Child Core Measures Survey were selected from a stratified random sample of beneficiaries ages 17 and younger who were enrolled in Medicaid (STAR, STAR Kids, STAR Health, and Fee-For-Service (FFS)) or CHIP for six or more continuous months. Targeted sample sizes were 411 for CHIP and 411 for a simple random statewide Medicaid sample from STAR, STAR Kids, and STAR Health programs.

Performance Metrics

Table 39 presents the output measures for the Child Core Measures Survey.

Table 39. Output Measures for Child Core Measures Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	3,784,427[1]	4,367,701[2]	4,083,632[3]
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	946,884	1,079,020	1,000,000
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	2,100	2,100	2,100
Total customers who responded to the survey	The number of customers who responded to the survey.	411	302	411
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	19.6%	14.4%	19.6%

Notes. [1] This number reflects the average monthly enrollment in STAR, STAR Kids, STAR Health, Medicaid FFS, and CHIP between September 2019 and August 2020. The total number of unique individuals enrolled throughout SFY 2020 is slightly higher. [2] This number reflects the average monthly enrollment in STAR, STAR Kids, STAR Health, Medicaid FFS, and CHIP between September 2020 and August 2021. The total number of unique individuals enrolled throughout SFY 2021 is slightly higher. [3] This number reflects the projected enrollment in STAR, STAR Kids, STAR Health, Medicaid FFS, and CHIP for September 2021.
Sources: Medicaid 8-month Eligibility Database, HHSC; Medicaid CHIP Data Analytics within the Office of Data, Analytics, and Performance, HHSC; Forecasting Division/Budget, HHSC.
SFY=State fiscal year (September 1-August 31); STAR=Medicaid managed care program that serves children, newborns, pregnant women, and some families and children; STAR Kids=Medicaid managed care program that serves children and adults age 20 and younger with a disability; STAR Health=Medicaid managed care program that serves individuals under or transferring out of conservatorship or foster care; FFS=Fee-for-service; CHIP=Children's Health Insurance Program; HHSC=Health and Human Services Commission.

Table 40 shows the efficiency measures for Child Core Measures Survey.

Table 40. Efficiency Measures for Child Core Measures Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.[1]	$26,310	$78,929	$115,134
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.[2]	$13	$38	$55

Notes. [1] The Child and Adult Core Measures Surveys are billed as one item in HHSC's contract with the external quality review organization. The amounts reflect costs for both the Child and Adult Core Measures Surveys. [2] These approximations reflect the joint number of customers solicited to take the Adult and Child Core Measures Surveys.
SFY=State fiscal year (September 1-August 31); HHSC=Health and Human Services Commission.

Major Findings

The EQRO presented the findings to HHSC for several domains which allows for the calculation and reporting of healthcare composites. These are scores that combine results for closely related survey items, providing a comprehensive, yet concise summary of results for multiple survey questions. Tables 41, 42, and 43 present the survey's composites.

Table 41. Child Core Measures Survey CAHPS® Composites: Percent "Always" Having Positive Experiences

Satisfaction Domain	SFY 2020 Proportion of Medicaid Respondents[1]	SFY 2020 Proportion of CHIP Respondents[1]
Getting Needed Care	64.9%	63.1%
Getting Care Quickly	72.1%	69.3%
How Well Doctors Communicate	79.4%	80.2%
Customer Service	78.4%	63.8%

Notes. [1] CAHPS® composite rates and CAHPS®-based HHSC Dashboard indicators in this report are calculated following the "top box" (percent always) method.
CAHPS®= Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31); CHIP=Children's Health Insurance Program; HHSC=Health and Human Services Commission.

Table 42. Child Core Measures Survey CAHPS® Composites: Percent Responding "Yes"[1]

Satisfaction Domain	SFY 2020 Proportion of Medicaid Respondents	SFY 2020 Proportion of CHIP Respondents
Health Promotion and Education	69.8%	71.0%
Shared Decision-Making	N/A	74.8%

Notes. [1] See https://www.ahrq.gov/cahps/index.html for a list of specific items in each domain. CAHPS®= Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31); CHIP=Children's Health Insurance Program.

Table 43: Child Core Measures Survey CAHPS® Composites: Percent Rating at "9" or "10"

Satisfaction Domain	SFY 2020 Proportion of Medicaid Respondents	SFY 2020 Proportion of CHIP Respondents
Health Care Rating	77.4%	73.3%
Personal Doctor Rating	83.3%	77.3%
Specialist Rating	N/A	N/A
Health Plan Rating	79.7%	74.7%

Notes. CAHPS®= Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31); CHIP=Children's Health Insurance Program.

Medicaid and CHIP Dental Caregiver Survey

Purpose

The EQRO conducts the Medicaid and CHIP Dental Caregiver Survey from July to October every other year with caregivers of children who receive dental services funded through Texas Medicaid and CHIP. The Medicaid programs STAR, STAR Kids, and STAR Health, as well as Medicaid FFS and CHIP, all provide dental services for children under 18 years of age.

The purpose of the Medicaid and CHIP Dental Caregiver Survey is to assess caregivers' experiences and satisfaction with the dental health services their children received in the Medicaid and CHIP programs. Specifically, the survey includes questions to address:

- The sociodemographic characteristics and health status of child enrollees receiving dental health services
- Caregiver experiences and satisfaction with their child's dentist and dental services overall, including:
  - The timeliness of getting treatment
  - The quality of dentist's communication and care
  - Getting treatment and information from the health plan
  - Receiving information about treatment options

Sample and Methods

Participants for the Medicaid and CHIP Dental Caregiver Survey were selected from a stratified random sample of beneficiaries ages 17 years or younger who were enrolled in CHIP or Medicaid for six continuous months between December 2020 to May 2021. Members having no more than one 30-day break in enrollment in the same CHIP or Medicaid dental plan during this period were included in the sample. The sample was stratified to include representation from CHIP and Medicaid with a target number of 300 completed surveys per dental plan.

Performance Metrics

Table 44 provides the output measures for the Medicaid and CHIP Dental Caregiver Survey.

Table 44. Output Measures for Medicaid and CHIP Dental Caregiver Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022[2]
Total customers served (i.e., population)	Total number of customers receiving services from the program.	N/A	4,367,701[3]	N/A
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	N/A	1,643,397	N/A
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	N/A	16,041	N/A
Total customers who responded to the survey	The number of customers who responded to the survey.	N/A	1,751	N/A
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	N/A	10.9%	N/A

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2020. [2] Because this is a biennial survey, it will not be conducted in SFY 2022. [3] This number reflects the average monthly enrollment in STAR, STAR Kids, STAR Health, Medicaid FFS, and CHIP between September 2020 and August 2021. The total number of unique individuals enrolled throughout SFY 2021 is slightly higher.
Source: Medicaid 8-month Eligibility Database, HHSC.
CHIP=Children's Health Insurance Program; SFY=State fiscal year (September 1-August 31); STAR=Medicaid managed care program that serves children, newborns, pregnant women, and some families and children; STAR Kids=Medicaid managed care program that serves children and adults age 20 and younger with a disability; STAR Health=Medicaid managed care program that serves individuals under or transferring out of conservatorship or foster care; FFS=Fee-for-service; CHIP=Children's Health Insurance Program.

Table 45 shows the efficiency measures for the Medicaid and CHIP Dental Caregiver Survey.

Table 45. Efficiency Measures for Medicaid and CHIP Dental Caregiver Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022[2]
Total costs	The total costs for the agency to administer customer surveys.	N/A	$55,696	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	$3	N/A

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2020. [2] Because this is a biennial survey, it will not be conducted in SFY 2022.
CHIP=Children's Health Insurance Program; SFY=State fiscal year (September 1-August 31).

Major Findings

The EQRO presented the findings to HHSC for several domains which allows for the calculation and reporting of healthcare composites. These are scores that combine results for closely related survey items, providing a comprehensive, yet concise summary of results for multiple survey questions. Tables 46 and 47 present the survey's composites.

Table 46. Medicaid and CHIP Dental Caregiver Survey CAHPS® Composites: Percent "Always" Having Positive Experiences

Satisfaction Measure	SFY 2021 Proportion of Medicaid Respondents[1]	SFY 2021 Proportion of CHIP Respondents[1]
In the last six months, how often were your child's dental appointments as soon as you wanted?	73.6%	72.1%
In the last six months, how often did the customer service staff at your child's dental plan treat you with courtesy and respect?	83.3%	88.7%
In the last six months, how often did your child's regular dentist explain things in a way that was easy to understand?	83.8%	88.4%
In the last six months, how often did your child's dental plan cover all of the services you thought were covered?	84.5%	62.7%
[Of those who sought information] In the last six months, how often did the 800 number, written materials or website provide the information you wanted?	61.1%	50.6%

Notes. [1] CAHPS® composite rates and CAHPS®-based HHSC Dashboard indicators in this report are calculated following the "top box" (percent always) method.
CHIP=Children's Health Insurance Program; CAHPS®= Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31).

Table 47. Medicaid and CHIP Dental Caregiver Survey CAHPS® Composites: Percent Rating at "9" or "10"

Satisfaction Measure	SFY 2021 Proportion of Medicaid Respondents	SFY 2021 Proportion of CHIP Respondents
Using any number from 0 to 10, where 0 is extremely difficult and 10 is extremely easy, what number would you use to rate how easy it was for you to find a dentist for your child?	70.3%	69.1%
Using any number from 0 to 10, where 0 is the worst dental plan possible and 10 is the best dental plan possible, what number would you use to rate your child's dental plan?	81.8%	70.8%

Notes. CHIP=Children's Health Insurance Program; CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31).

Adult Healthcare Coverage

The surveys about adult services include:

- STAR Adult Member Survey
- STAR+PLUS Adult Member Survey
- Adult Core Measures Survey

The EQRO used the same protocol for the three telephone-based surveys discussed here as was used with the similar surveys regarding services for children (advanced notification followed by telephone surveys). As with the surveys about children's services, the EQRO used CAHPS® and other survey questions approved by HHSC. The technical appendices for these reports can be found on the Texas Healthcare Learning Collaborative portal in the Member Surveys folder under Resources.[10]

STAR Adult Member Survey

Purpose

The EQRO conducts the STAR Adult Member Survey from May to October every other year with adults who received services funded through the Medicaid STAR

[10] https://thlcportal.com/resources/

program. STAR serves children in low-income families and adults who meet certain income and eligibility criteria. The program provides physical and behavioral health services for adults and children, as well as dental services for children. This survey reviews physical and behavioral health. Surveys for adults and children in the STAR program are conducted separately.

The purpose of the STAR Adult Member Survey is to determine the sociodemographic characteristics and health status of members and members' experiences and level of satisfaction in the STAR program. Specifically, the survey includes questions to address:

- The sociodemographic characteristics and health status of members
- Members' satisfaction with their healthcare
- Access to and timeliness of care, including having a usual source of care
- Preventive care, including check-ups, flu shots, and smoking cessation
- The need for and availability of specialized services
- Members' experiences with their health plan and customer service

Sample and Methods

Participants for the STAR Adult Member Survey were selected from a stratified random sample of beneficiaries ages 18 to 64 years who were enrolled in the same STAR MCO for six continuous months between September 2019 and February 2020. Members having no more than one 30-day break in enrollment in the same MCO during this period were included in the sample. The sample was stratified to include representation from 44 plan codes (MCO/service areas), with a target number of 200 completed surveys per plan code and 300 completed surveys for MCOs operating in only one service area.

Performance Metrics

Table 48 provides the output measures for the STAR Adult Member Survey.

Table 48. Output Measures for STAR Adult Member Survey

Measure	Specification	SFY 2020	SFY 2021[1]	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	2,996,929[2]	N/A	3,402,158[3]
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	199,379	N/A	200,000
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	80,225	N/A	80,000
Total customers who responded to the survey	The number of customers who responded to the survey.	7,439	N/A	7,000
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	9.3%	N/A	8.8%

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2021. [2] This number reflects the average monthly enrollment in STAR between September 2019 and August 2020. The total number of unique individuals enrolled throughout SFY 2020 is slightly higher. [3] This number reflects the projected enrollment in STAR for September 2021.
Sources: Medicaid 8-month Eligibility Database, HHSC; Medicaid CHIP Data Analytics within the Office of Data, Analytics, and Performance, HHSC; Forecasting Division/Budget, HHSC.
STAR=Medicaid managed care program that serves children, newborns, pregnant women, and some families and children; SFY=State fiscal year (September 1-August 31); HHSC=Health and Human Services Commission; CHIP=Children's Health Insurance Program.

Table 49 shows the efficiency measures for the STAR Adult member Survey.

Table 49. Efficiency Measures for STAR Adult Survey

Measure	Specification	SFY 2020	SFY 2021[1]	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	$365,700	N/A	$407,363
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	$5	N/A	$5

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2021.
STAR=Medicaid managed care program that serves children, newborns, pregnant women, and some families and children; SFY=State fiscal year (September 1-August 31).

Major Findings

The EQRO presented the findings to HHSC for several domains which allows for the calculation and reporting of healthcare composites. These are scores that combine results for closely related survey items, providing a comprehensive, yet concise summary of results for multiple survey questions. Tables 50 and 51 present the survey's composites.

Table 50. STAR Adult Member Survey CAHPS® Composites: Percent "Always" Having Positive Experiences

Satisfaction Domain	SFY 2020 Proportion of Respondents[1]	AHRQ National Average (2020)
Getting Needed Care	60.2%	55%
Getting Care Quickly	59.5%	59%
How Well Doctors Communicate	83.2%	77%
Customer Service	77.9%	69%
Coordination of Care	60.2%	N/A[2]

Notes. [1] CAHPS® composite rates and CAHPS®-based HHSC Dashboard indicators in this report are calculated following the "top box" (percent always) method. [2] No national average available.
STAR=Medicaid managed care program that serves children, newborns, pregnant women, and some families and children; CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31); AHRQ=Agency for Healthcare Research and Quality.

Table 51. STAR Adult Member Survey CAHPS® Composites: Percent Rating at "9" or "10"

Satisfaction Domain	SFY 2020 Proportion of Respondents	AHRQ National Average (2020)
Health Care Rating	64.6%	56%
Personal Doctor Rating	68.9%	69%
Specialist Rating	72.6%	69%
Health Plan Rating	65.8%	61%

Notes. STAR=Medicaid managed care program that serves children, newborns, pregnant women, and some families and children; CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31); AHRQ=Agency for Healthcare Research and Quality.

STAR+PLUS Adult Member Survey

Purpose

The STAR+PLUS program integrates acute and long-term services and supports for adults who are older and/or have disabilities. The EQRO conducts the STAR+PLUS Adult Member Survey from May to October every other year with adults who receive services funded through the Medicaid STAR+PLUS program.

The purpose of the STAR+PLUS Adult Member Survey is to determine members' level of satisfaction in the STAR+PLUS program. Specifically, the survey includes questions to address:

- The sociodemographic characteristics and health status of members
- Members' satisfaction with their healthcare
- Access to and timeliness of care, including having a usual source of care
- Preventative care, including check-ups, flu shots, and smoking cessation
- The need for and availability of specialized services
- Members' experiences with their health plan and customer service
- Members' knowledge of and experiences with Service Coordination provided by their health plan

Sample and Methods

The study sought responses from a stratified random sample of STAR+PLUS beneficiaries ages 18 to 64 years who were enrolled in the same STAR+PLUS managed care organization (MCO) for six continuous months between October 2019 and March 2020. Members having no more than one 30-day break in enrollment in the same MCO during this period were included in the sampling frame. The sample was stratified to include representation from 30 plan codes (MCO/service areas) with a target number of 200 completed surveys per plan code, and a single Breast Cancer Screening/Cervical Cancer Screening statewide quota with a target number of 250 completed surveys.

The EQRO contracted with the National Opinion Research Center (NORC) to conduct the surveys using computer-assisted telephone interviewing. NORC telephoned STAR+PLUS members from May 2020 through October 2020, seven days a week between 9 a.m. and 9 p.m. Central Time. Up to 20 attempts were made to reach a member before the member's phone number was removed from the calling circuit. If a respondent was unable to complete the interview in English, NORC referred the respondent to a Spanish-speaking interviewer for a later time.

The EQRO sent advance notification letters written in English and Spanish to sampled STAR+PLUS members, requesting their participation in the survey. Survey results are publicly posted online on the Texas Healthcare Learning Collaborative portal.[11]

Performance Metrics

Table 52 provides the output measures for the STAR+PLUS Adult Member Survey.

[11] Texas Healthcare Learning Collaborative, https://thlcportal.com/survey

Table 52. Output Measures for STAR+PLUS Adult Member Survey

Measure	Specification	SFY 2020	SFY 2021[1]	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	531,009[2]	N/A	534,641[3]
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	187,870	N/A	188,000
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	61,554	N/A	62,000
Total customers who responded to the survey	The number of customers who responded to the survey.	5,067	N/A	5,000
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	8.2%	N/A	8.1%

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2021. [2] This number reflects the average monthly enrollment in STAR+PLUS between September 2019 and August 2020. The total number of unique individuals enrolled throughout SFY 2020 is slightly higher. [3] This number reflects the projected enrollment in STAR+PLUS for September 2021.
Sources: Medicaid 8-month Eligibility Database, HHSC; Medicaid CHIP Data Analytics within the Office of Data, Analytics, and Performance, HHSC; Forecasting Division/Budget, HHSC.
STAR+PLUS=Medicaid managed care program that serves people with a disability and people who are age 65 and older (including those dually eligible for Medicare and Medicaid) and women with breast or cervical cancer; SFY=State fiscal year (September 1-August 31); HHSC=Health and Human Services Commission; CHIP=Children's Health Insurance Program.

Table 53 shows the efficiency measures for STAR+PLUS Adult Member Survey.

Table 53. Efficiency Measures for STAR+PLUS Adult Member Survey

Measure	Specification	SFY 2020	SFY 2021[1]	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	$208,631	N/A	$155,292
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	$3	N/A	$3

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2021. STAR+PLUS=Medicaid managed care program that serves people with a disability and people who are age 65 and older (including those dually eligible for Medicare and Medicaid) and women with breast or cervical cancer; SFY=State fiscal year (September 1-August 31).

Major Findings

The EQRO presented the findings to HHSC for several domains which allows for the calculation and reporting of healthcare composites. These are scores that combine results for closely related survey items, providing a comprehensive, yet concise summary of results for multiple survey questions. Tables 54 and 55 show the survey's composites.

Table 54. STAR+PLUS Adult Member Survey CAHPS® Composites: Percent "Always" Having Positive Experiences

Satisfaction Domain	SFY 2020 Proportion of Respondents[1]	AHRQ National Average (2020)
Getting Needed Care	58.3%	55%
Getting Care Quickly	62.6%	59%
How Well Doctors Communicate	80.1%	77%
Customer Service	71.9%	69%
Coordination of Care	59.2%	N/A[2]

Notes. [1] CAHPS® composite rates and CAHPS®-based HHSC Dashboard indicators in this report are calculated following the "top box" (percent always) method. [2] No national average available. STAR+PLUS=Medicaid managed care program that serves people with a disability and people who are age 65 and older (including those dually eligible for Medicare and Medicaid) and women with breast or cervical cancer; CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31); AHRQ=Agency for Healthcare Research and Quality.

Table 55. STAR+PLUS Adult Member Survey CAHPS® Composites: Percent Rating at "9" or "10"

Satisfaction Domain	SFY 2020 Proportion of Respondents	AHRQ National Average (2020)
Health Care Rating	56.3%	56%
Personal Doctor Rating	69.4%	69%
Specialist Rating	67.5%	69%
Health Plan Rating	61.2%	61%

Notes. STAR+PLUS=Medicaid managed care program that serves people with a disability and people who are age 65 and older (including those dually eligible for Medicare and Medicaid) and women with breast or cervical cancer; CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31); AHRQ=Agency for Healthcare Research and Quality.

The survey included several questions that functioned as indicators of health plan performance, which are listed on the HHSC Performance Indicator Dashboard.[12] HHSC set benchmarks (known as HHSC Performance Dashboard Indicators) for the agency's performance in several key domains. The relevant results of the STAR+PLUS Adult Member Survey are reported relative to these performance indicator benchmarks in Table 56.

[12] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10-1-14.pdf

Table 56. Statewide STAR+PLUS Adult Member Survey Results Relative to HHSC Performance Dashboard Indicators

Performance Dashboard Indicator	SFY 2020 Proportion of Respondents	Minimum Standard (2020)
Good Access to Urgent Care	65.8%	64%
Good Access to Specialist Appointments	56.5%	53%
Good Access to Routine Care	59.4%	56%
Good Access to Special Therapies	36.4%	39%
Good Access to Service Coordination	38.7%	53%
Advising Smokers to Quit	43.1%	39%
Good Access to Behavioral Health Treatment or Counseling	48.8%	47%
Members Rating their Personal Doctor a "9" or "10"	69.4%	68%
Members Rating their Health Plan "9" or "10"	61.2%	60%
Good Experience with Doctor's Communication	80.1%	76%

Notes. STAR+PLUS=Medicaid managed care program that serves people with a disability and people who are age 65 and older (including those dually eligible for Medicare and Medicaid) and women with breast or cervical cancer; HHSC=Health and Human Services Commission; SFY=State fiscal year (September 1-August 31).

Adult Core Measures Survey

Purpose

The EQRO conducted the Adult Core Measures Survey from September 2020 to November 2020 with adults who received services funded through the Texas Medicaid program. Surveys for adults and children in Medicaid were conducted separately. The purpose of the Adult Core Measures Survey is to assess overall member experiences with Medicaid in Texas. Results from these surveys were used in the SFY 2020 Child and Adult Core Measures reporting to the Centers for Medicare and Medicaid.

Sample and Methods

Participants for the Adult Core Measures Survey were selected from a stratified random sample of beneficiaries ages 18 to 64 who were enrolled in Medicaid (STAR, STAR+PLUS, STAR Kids, and FFS) for six continuous months. The target number of completed surveys was 411.

Performance Metrics

Table 57 presents the output measures for the Adult Core Measures Survey.

Table 57. Output Measures for Adult Core Measures Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	3,912,718[1]	4,595,157[2]	4,273,374[3]
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	665,625	506,495	600,000
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	3,268	2,949	3,000
Total customers who responded to the survey	The number of customers who responded to the survey.	352	275	280
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	10.8%	9.3%	9.3%

Notes. [1] This number reflects the average monthly enrollment in STAR, STAR Kids, STAR+PLUS, and Medicaid FFS between September 2019 and August 2020. The total number of unique individuals enrolled throughout SFY 2020 is slightly higher. [2] This number reflects the average monthly enrollment in STAR, STAR Kids, STAR+PLUS, and Medicaid FFS between September 2020 and August 2021. The total number of unique individuals enrolled throughout SFY 2021 is slightly higher. [3] This number reflects the projected enrollment in STAR, STAR Kids, STAR+PLUS, or Medicaid FFS for September 2021.
Sources: Medicaid 8-month Eligibility Database, HHSC; Medicaid CHIP Data Analytics within the Office of Data, Analytics, and Performance, HHSC; Forecasting Division/Budget, HHSC.
SFY=State fiscal year (September 1-August 31); STAR=Medicaid managed care program that serves children, newborns, pregnant women, and some families and children; STAR Kids=Medicaid managed care program that serves children and adults age 20 and younger with a disability; STAR+PLUS=Medicaid managed care program that serves people with a disability and people who are age 65 and older (including those dually eligible for Medicare and Medicaid) and women with breast or cervical cancer; FFS=Fee-for-service; HHSC=Health and Human Services Commission; CHIP=Children's Health Insurance Program.

Table 58 shows the efficiency measures for Adult Core Measures Survey.

Table 58. Efficiency Measures for Adult Core Measures Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.[1]	$26,310	$78,929	$115,134
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.[2]	$8	$27	$38

Notes. [1] The Child and Adult Core Measures Surveys are billed as one item in the external quality review organization contract. The amounts in this table reflect costs for both the Child and Adult Core Measures Surveys. [2] These approximations reflect the joint number of customers solicited to take the Adult and Child Core Measures Surveys.
SFY=State fiscal year (September 1-August 31).

Major Findings

The EQRO presented the findings to HHSC for several domains which allows for the calculation and reporting of healthcare composites. These are scores that combine results for closely related survey items, providing a comprehensive, yet concise summary of results for multiple survey questions. The scores in Tables 59, 60, 61, and 62 present the survey's composites.

Table 59. Adult Core Measures Survey CAHPS® Composites: Percent "Always" Having Positive Experiences

Satisfaction Domain	SFY 2020 Proportion of Respondents[1]
Getting Needed Care	53.4%
Getting Care Quickly	59.7%
How Well Doctors Communicate	84.2%
Customer Service	59.2%

Notes. [1] CAHPS® composite rates and CAHPS®-based HHSC Dashboard indicators in this report are calculated following the "top box" (percent always) method.
CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31); HHSC=Health and Human Services Commission.

Table 60. Adult Core Measures Survey CAHPS® Composites: Percent Responding "Yes"[1]

Satisfaction Domain	SFY 2020 Proportion of Respondents
Health Promotion and Education	69.3%
Shared Decision-Making	80.0%
Flu Vaccination	39.8%

Notes. [1] See https://www.ahrq.gov/cahps/index.html for a list of specific items in each domain. CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31).

Table 61. Adult Core Measures Survey CAHPS® Composites: Percent Responding "Yes"[1]

Satisfaction Domain	SFY 2020 Proportion of Respondents
Health Promotion and Education	69.8%
Shared Decision-Making	N/A[2]

Notes. [1] See https://www.ahrq.gov/cahps/index.html for a list of specific items in each domain. [2] The Shared Decision-Making domain was not included in the 2020 Adult Core Measures Survey. CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31).

Table 62: Adult Core Measures Survey CAHPS® Composites: Percent Rating at "9" or "10"

Satisfaction Domain	SFY 2020 Proportion of Respondents
Health Care Rating	59.2%
Personal Doctor Rating	71.5%
Specialist Rating	71.7%
Health Plan Rating	66.9%

Notes. CAHPS®=Consumer Assessment of Healthcare Providers and Systems; SFY=State fiscal year (September 1-August 31).

Transportation Coverage

The EQRO contracted with UFSRC to conduct the Medical Transportation Program (MTP) Member Survey using computer-assisted telephone interviewing. The EQRO used the same protocol for the MTP Member Survey as was used with the similar

surveys regarding services for children and adults (advanced notification followed by telephone surveys). Since there is no nationally standardized transportation survey to use, the EQRO developed questions based on other NEMT services. The MTP Member Survey was conducted by UFSRC.

Medical Transportation Program Member Survey

Purpose

The purpose of the MTP Member Survey is to examine member experience and satisfaction with MTP services in all transportation regions in Texas. The MTP Member Survey includes questions to assess the accessibility of transportation services as well as experience of and satisfaction with services. Survey questions focus on three types of transportation services (mass transit, demand-response, and mileage reimbursement), and two types of ancillary services (advanced funds and meals/lodging). The survey also asked about respondents' experience using the Managed Transportation Organizations' toll-free line and regional reservation line to request transportation services.

The aims of the MTP Member Survey include:

- Describing Medicaid member experiences with MTP services across all transportation regions
- Assessing member knowledge of available services in all regions
- Assessing overall member satisfaction with MTP processes and services in all regions

Sample and Methods

UFSRC telephoned members or caregivers who accessed MTP services on behalf of child or adolescent members from March to July 2020 seven days a week between 9 a.m. and 9 p.m. Central Time. Up to eight attempts were made to reach a member before a phone number was removed from the calling circuit. The average number of calls to a residence was three (2.8). If a respondent was unable to complete the interview in English, UFSRC referred the respondent to a Spanish-speaking interviewer for a later time. Approximately 19 percent of the surveys were completed in Spanish.

To facilitate inferences from the survey results to the MTP member population, results were weighted to the full set of eligible beneficiaries in the enrollment

dataset. A separate base weight was calculated for each of the plan code sampling groups, representing the inverse probability of inclusion in the final sample (the total number of eligible members in the enrollment file divided by the number of completed surveys).

Performance Metrics

Table 63 provides the output measures for the MTP Member Survey.

Table 63. Output Measures for the MTP Member Survey

Measure	Specification	SFY 2020	SFY 2021[1]	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	98,246	N/A	98,000
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	98,246	N/A	98,000
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	19,816	N/A	19,000
Total customers who responded to the survey	The number of customers who responded to the survey.	2,437	N/A	2,300
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	12.3%	N/A	12.1%

Notes. [1] Output measures for SFY 2021 were not available at the time of writing.
MTP=Medical Transportation Program; SFY=State fiscal year (September 1-August 31).

Table 64 shows the efficiency measures for MTP Member Survey.

Table 64. Efficiency Measures for the MTP Member Survey

Measure	Specification	SFY 2020	SFY 2021[1]	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	$376,641	N/A	$432,811
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	$19	N/A	$23

Notes. [1] Efficiency measures for SFY 2021 were not available at the time of writing.
MTP=Medical Transportation Program; SFY=State fiscal year (September 1-August 31).

Major Findings

The EQRO presented findings to HHSC of the percentage of members that are "Satisfied" or "Very Satisfied" with transportation services by region and service type. Table 65 presents survey results.

Table 65. Findings from the MTP Member Survey

MTP Service	SFY 2020 Proportion of Respondents[1] (N=2,437)
Mass Transit	90.1%
Demand Response	88.1%
Mileage Reimbursement	90.8%
Meals and Lodging	94.7%
Advanced Funds	93.8%
Reservation Line	93.5%
"Where's My Ride" Line	90.2%
Overall Satisfaction	89.1%

Notes. [1] Proportions indicate respondents who chose responses "satisfied" or "very satisfied."
MTP=Medical Transportation Program; SFY=State fiscal year (September 1-August 31); N=Sample size.

Access and Eligibility Services

YourTexasBenefits.com Survey

Purpose

Your Texas Benefits is one access avenue for customers to apply for or renew benefits to multiple programs. Your Texas Benefits also enables customers to upload documents, check on their case status, and view their Lone Star EBT card transaction history. Customers use the YourTexasBenefits.com website to apply for, renew benefits, check case status, report changes, view their EBT Lone Star card balance, and upload verifications needed for determining eligibility.

The purpose of this ongoing online survey is to collect data regarding customers' satisfaction and experiences with YourTexasBenefits.com.

Sample and Methods

The online YourTexasBenefits.com Survey is not program specific; rather, the survey is intended to capture the website experience, specifically regarding system modifications. Customers automatically receive the option to complete the YourTexasBenefits.com Survey after they apply for or renew benefits online. The survey is offered in English and Spanish.

In 2020, there were 61,660 completed YourTexasBenefits.com Survey responses – an average of 5,138 responses per month. In addition, 2,682 surveys were initiated but were not completed.

In 2021 (January – August 2021), there were 47,026 completed YourTexasBenefits.com Survey responses – an average of 5,878 responses per month. In addition, 1,981 surveys were initiated but were not completed.

Performance Metrics[13]

Table 66 shows the efficiency measures for the YourTexasBenefits.com Survey. Existing agency software was used to develop and distribute the survey, resulting in no additional cost to the agency to gather survey data.

Table 66. Efficiency Measures for the YourTexasBenefits.com Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	N/A	N/A	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	N/A	N/A

Notes. SFY=State fiscal year (September 1-August 31).

Major Findings

Table 67 presents the major findings of the YourTexasBenefits.com Survey.

Table 67. Findings from the YourTexasBenefits.com Survey

Measure	2020 Proportion of Respondents[1] (N=61,660)	2021 Proportion of Respondents[2] (N=47,026)
Expressed the website was easy or very easy to set up an account	81%	79%
Expressed the website on their phone or tablet was acceptable, good, or very good	92%	87%

Notes. [1] The 2020 YourTexasBenefits.com Survey covers January 2020 to December 2020. [2] The 2021 YourTexasBenefits.com Survey covers January 2021 to August 2021.
N=Sample size.

[13] Output measures for The YourTexasBenefits.com Survey are not provided because the survey only captures the number of individuals who initiate a survey response, not the number of individuals who are prompted to respond.

Quality Reviews

Nursing Facility Quality Review

Purpose

The Nursing Facility Quality Review (NFQR) is a statewide survey of people living in Medicaid-certified nursing facilities. The NFQR evaluates the quality of care received and how satisfied residents were with quality of life in their nursing facility. HHSC contracted with The University of Texas at Austin to conduct the 2019 administration of the NFQR. Between May 2019 and February 2020, nurse reviewers from the university visited 396 nursing facilities, gathering data on a total of 1,985 individuals.

The HHS Quality Monitoring Program uses NFQR data to identify opportunities for statewide improvement and to measure statewide changes in the quality of services provided across time. The NFQR examines the care provided to a sample of people living in nursing facilities to determine whether that care was clinically appropriate. The standards for appropriateness of care are evidence-based, determined from systematic reviews of the clinical research literature.

Sample and Methods

HHSC provided the university with a list of randomly selected nursing facilities, including facilities from each HHSC region. HHSC also ensured there were facilities from rural and urban areas of the state, and of different sizes (small, medium, and large). A list of randomly generated numbers was then prepared for each facility. This list, and a roster provided by the nursing facility, was used by the nurse reviewers hired by the university to select residents for the sample. For example, if the random number was five, then the fifth person on the facility's roster was selected for the sample.

Information was gathered from the medical records and face-to-face interviews, using structured survey tools provided by HHSC. If a person was unable or declined to participate in the interview, the responsible party/surrogate decision maker was contacted to obtain their input on selected interview questions. The interviews were conducted in English; however, interpreters were used as needed for the face-to-face interviews.

Performance Metrics

Table 68 provides the output measures for the 2019 administration of the NFQR. Because NFQR activities during the 2019 administration occurred during SFY 2019 and SFY 2020, information in Table 68 is presented during both SFYs.

Table 68. Output Measures for the 2019 Administration of the NFQR

Measure	Specification	SFY 2019	SFY 2020	Projected SFY 2022[1]
Total customers served[2]	People living in Medicaid-certified nursing facilities in Texas.	92,965	78,919	N/A
Total customers in sampling frame[2]	The total number of customers meeting criteria to participate in the survey.	92,965	78,919	N/A
Total customers solicited to take the survey	The number of nursing facility residents included in the random sample.	530	1,455	N/A
Total customers who responded to the survey	The number of resident-level record reviews and interviews completed.	530	1,455	N/A
Response Rate	The percentage of residents who responded to the survey out of the total number of customers solicited to take the survey.	100%	100%	N/A

Notes. [1] Data collection is not scheduled for SFY 2022. [2] This information was obtained from the HHSC Long-term Care Regulatory Annual Report for Fiscal Year 2020, "Occupancy Trends for Nursing Facilities," published March 1, 2021. The decrease in the total number of customers served from SFY 2019 to SFY 2020 may reflect a shift towards assisted living facilities, rather than nursing facilities, and/or the impact of the COVID-19 public health emergency.
NFQR activities during the 2019 administration occurred during SFY 2019 and SFY 2020.
NFQR=Nursing Facility Quality Review; SFY=State fiscal year (September 1-August 31).

Table 69 provides the efficiency measures for 2019 administration of the NFQR. To estimate NFQR-related costs, the following items were included:

- Estimates of QMP staff time spent updating the survey instruments, developing the facility and resident level samples, and for the project meetings with the university's project staff.
- Survey contract invoices, paid as outlined in the Interagency Contract with The University of Texas at Austin School of Nursing.

Table 69. Efficiency Measures for the 2019 Administration of the NFQR

Measure	Specification	SFY 2019	SFY 2020	Projected SFY 2022[1]
Total costs	The total costs for the agency to administer customer surveys.	$159,253	$173,177	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	$300	$119	N/A

Notes. [1] Data collection is not scheduled for SFY 2022.
NFQR=Nursing Facility Quality Review; SFY=State fiscal year (September 1-August 31).

Major Findings

The NFQR evaluates many clinical measures related to quality of care, as well as residents' satisfaction with the quality of care they received in the facility and with their quality of life. The findings summarized below focus on the quality of life measures and residents' satisfaction with the services they received in the nursing facility.

Overall Satisfaction

In general, residents interviewed during the on-site visits expressed satisfaction with their overall experience in the nursing facility and the care they received. This finding was not significantly different from previous surveys. Table 70 presents the Overall Satisfaction findings.

Table 70. Findings from the 2019 Administration of the NFQR: Overall Satisfaction

Satisfaction Measure	NFQR 2019 Proportion of Respondents[1] (N=1,985)
Expressed satisfaction with their experience in the nursing facility	88%
Expressed satisfaction with the healthcare services they received	92%

Notes. [1] Proportions indicate respondents who chose responses "somewhat satisfied," "satisfied," or "very satisfied" rather than "somewhat dissatisfied," "dissatisfied," or "very dissatisfied." Those who did not answer the survey question are not counted in these proportions.
NFQR=Nursing Facility Quality Review; SFY=State fiscal year (September 1-August 31); N=Sample size.

Specific Quality of Life/Consumer Satisfaction Measures

These measures include the person's satisfaction with relationships, activities, autonomy, privacy, and feelings of safety/security at the nursing facility. Several measures demonstrated statistically significant improvement or declines over time, while others remained relatively stable. Table 71 presents the findings for specific satisfaction measures.

Table 71. Findings from 2019 Administration of the NFQR: Specific Satisfaction Measures

Satisfaction Measure	NFQR 2019 Proportion of Respondents (N=1,985)
Liked the food served at the facility[1]	85%
Felt that their possessions were safe at the facility[1]	92%
Felt safe and secure at the nursing facility[1]	97%
Stated staff members treated them with respect[1]	96%
Stated they were able to choose their daily schedule[1]	70%
Stated they could choose when and how to bathe[1]	64%
Stated they participated in their care plan meeting[1]	48%
Stated they had concerns the facility did not address[2]	21%
Stated they did not express concerns due to a fear of retaliation[2]	10%

Notes. [1] Proportions indicate respondents who chose responses "sometimes," "most of the time," or "always," rather than "rarely," or "never." Those who did not answer the survey question are not counted in these proportions. [2] Proportions indicate respondents who responded "yes," rather than "no" to these questions. Those who did not answer the survey question are not counted in these proportions.
NFQR=Nursing Facility Quality Review; SFY=State fiscal year (September 1-August 31); N=Sample size.

Complaint and Incident Intake Survey

Purpose

Complaint and Incident Intake (CII) receives complaints and incidents regarding acute and long-term providers who are licensed/certified by HHSC. HHSC staff investigates these complaints and notifies the person who made the complaint

about the findings. Additionally, the CII staff provides information about HHSC services and supports through their website and hotline.

Offering call center surveys allows CII to look at call center performance and overall customer satisfaction rates. Customer feedback provides highly actionable information and insight for increasing and sustaining customer satisfaction. The CII survey results are used as a resource to identify areas of efficiencies and areas of opportunity for improvement.

The study population is comprised of callers who contacted the Complaint Intake Call Center between September 1, 2020 and August 31, 2021. Due to a change in telecommunications survey vendor, survey data from SFY 2020 was not available for this report.

Sample and Methods

The CII Survey has been collected or distributed in various formats since May 2006. Currently, an automated telephone option offers the survey to all inbound callers and then transfers those callers who agree into the survey module at the completion of the hotline call. Surveys are available in English and Spanish. The survey instrument includes six customer satisfaction questions with responses on a 5-point Likert scale of "strongly agree," "agree," "neutral," "disagree," and "strongly disagree."

Performance Metrics

Table 72 provides the output measures for the CII Survey.

Table 72. Output Measures for the CII Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022
Total customers in contact with the program	Total number of calls to the CII hotline.	N/A	50,428	51,000
Total customers in sampling frame	The total number of hotline calls answered by CII staff.	N/A	37,352	39,000
Total customers offered a survey	The number of calls where the CII survey was offered.	N/A	31,668	39,000
Total customers who responded to the survey	The number of customers who responded to at least one question on the survey.	N/A	5,247	7,020
Response Rate	The percentage of customers who responded to at least one question on the survey out of the total number of customers who had the survey offered to them.	N/A	16.6%	18.0%

Notes. [1] SFY 2020 results are not available due to a change in telecommunications survey vendor.
CII=Complaint and Incident Intake; SFY=State fiscal year (September 1-August 31).

Table 73 provides the efficiency measures for the CII Survey.

Table 73. Efficiency Measures for the CII Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	N/A	N/A	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	N/A	N/A

Notes. CII implemented the customer survey module in 2014 at a one-time cost of approximately $50,000. Ongoing maintenance costs are not charged separately and are part of HHSC's overall Telecommunications contract.
CII=Complaint Incident Intake; SFY=State fiscal year (September 1-August 31).

Major Findings

The findings of the CII Survey are presented in Table 74.

Table 74. Findings from the CII Survey

Measure	SFY 2021 Proportion of Respondents (N=434)
Complaint and Incident Intake hotline was easy to use	89.3%
Person I spoke with explained the process for handling my complaint	86.3%
Overall, I was satisfied with Complaint and Incident Intake	83.8%

Notes. CII=Complaint and Incident Intake; SFY=State fiscal year (September 1-August 31); N=Sample size.

Health, Development, and Independence Services

Blind Children's Vocational Discovery and Development Program Customer Service Satisfaction Survey

Purpose

The Blind Children's Vocational Discovery and Development Program (BCP) serves children from birth through age 21 who are blind or have a visual impairment. The program provides direct skills training, parent education, and case management in order to increase the child's independence in the home or community. Each child and family enrolled in BCP services has an individualized family service plan designed to address the personalized needs of the child. BCP services are designed to help children and families meet the following program outcomes:

- Children and families will have access and/or have the skills to access needed services.
- Parents will actively engage in their child's development, educational system, medical system, and social system.
- Children will actively engage in their community and daily living skills to their unique capacity.

The purpose of the BCP Customer Service Satisfaction Survey was to assess family satisfaction with BCP services to inform program improvements.

Sample and Methods

Responses were solicited from all BCP families in active services for longer than six months or in post-closure services who had an email address on file with the program. The survey was sent electronically with an accompanying letter that explained the purpose of the survey. Families were sent a reminder email approximately one month after the initial email. Field staff encouraged families to complete the survey. Surveys were also re-sent to families if the family or the staff member reported that they did not receive the survey or wished to receive the survey at an alternate email address.

The BCP Customer Service Satisfaction Survey was conducted using Microsoft Forms and was accessible to both mobile and PC users between June 1, 2021 and August 31, 2021 (all surveys were distributed during the COVID-19 public health emergency). The surveys were offered in English, Spanish, and Vietnamese. Surveys and letters were sent to families in the language of their preference as designated in the BCP case management system. The BCP Customer Service Satisfaction Survey is conducted biennially.

Performance Metrics

Table 75 provides the output measures for the BCP Customer Service Satisfaction Survey.

Table 75. Output Measures for the BCP Customer Service Satisfaction Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022[2]
Total customers served (i.e., population)	Total number of customers receiving services from the program.	N/A	3,275	N/A
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	N/A	2,462	N/A
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	N/A	2,182	N/A
Total customers who responded to the survey	The number of customers who responded to the survey.	N/A	237	N/A
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	N/A	10.9%	N/A

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2020. [2] Because this is a biennial survey, it will not be conducted in SFY 2022.
BCP=Blind Children's Vocation Discovery and Development Program; SFY=State fiscal year (September 1-August 31).

Table 76 shows the efficiency measures for the BCP Customer Satisfaction Survey. Existing agency software was used to develop and distribute the survey, resulting in no additional cost to the agency to gather survey data. Staff time to develop and distribute the survey was estimated to be approximately 100 hours.

Table 76. Efficiency Measures for the BCP Customer Satisfaction Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022[2]
Total costs	The total costs for the agency to administer customer surveys.	N/A	$3,000	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	$1	N/A

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2020. [2] Because this is a biennial survey, it will not be conducted in SFY 2022.
BCP=Blind Children's Vocation Discovery and Development Program; SFY=State fiscal year (September 1-August 31).

Major Findings

The BCP Customer Satisfaction Survey indicated that most families (81 percent) were satisfied or highly satisfied with the BCP. Families indicated that they agreed or strongly agreed that their blind children's specialist:

- Provided the services, resources, and referrals they need (87 percent).
- Involved them in making decisions about their child's needs (86 percent).
- Was knowledgeable about program services and visual impairments (89 percent).
- Contacted them enough for them to make progress (84 percent).

Additional results are presented in Tables 77, 78, 79, and 80.

Table 77. Findings from the BCP Customer Satisfaction Survey

Satisfaction Measure	SFY 2021 Proportion of Respondents[1] (N=237)
Respondents who indicated satisfaction with the application and eligibility determination process	84%
Respondents who indicated satisfaction with BCP staff	90%
Respondents who indicated satisfaction with BCP staff communication	88%
Respondents who indicated satisfaction with BCP internet site	59%[2]
Respondents who indicated satisfaction with BCP complaint process	40%[3]
Respondents who indicated they were satisfied about the amount of time waiting for services to begin after applying	73%
Respondents who indicated they were satisfied about BCP brochures or other printed information	72%
Respondents who indicated they were satisfied overall with BCP	81%

Notes. [1] Percent of respondents who indicated, "very satisfied" or "satisfied" versus "neither", "dissatisfied", "very dissatisfied", or "N/A." [2] A high proportion of respondents indicated "N/A" or "not applicable" to this question, indicating that they did not utilize the BCP website (29 percent). [3] A high proportion of respondents indicated "N/A" or "Not Applicable" to this question, indicating that they did not utilize the BCP complaint resolution process (45 percent). BCP=Blind Children's Vocation Discovery and Development Program; SFY=State fiscal year (September 1-August 31); N=Sample size.

Table 78. Findings from the BCP Customer Satisfaction Survey: Importance of BCP Services

Service	SFY 2021 Proportion of Respondents[1] (N=237)
Help learning a new skill (including workshops, classes, camps, community outings, support groups etc. provided or paid for by BCP)	90%
Help getting a service, equipment (for example a medical service or therapy) or other support	95%
Help communicating with their child's medical team, school team, or other service providers	88%
Help planning for their child's future	92%

Notes. [1] Percent of respondents who indicated the BCP service was "essential" "very important" or "important" to their child's progress versus "not important at all" or "a little important."
BCP=Blind Children's Vocation Discovery and Development Program; SFY=State fiscal year (September 1-August 31); N=Sample size.

Table 79. Findings from the BCP Customer Satisfaction Survey: Helpfulness of BCP for Their Child

Service	SFY 2021 Proportion of Respondents[1] (N=237)
Understand and adjust to their disability	74%
Discover their likes and dislikes	62%
Improve their communication skills	62%
Improve their motor skills and ability to travel by themselves	51%
Improve their independence in life skills at home, school, and work	59%

Notes. [1] Percent of respondents who indicated "strongly agree" or "agree" versus "strongly disagree," "disagree," "no opinion," or "N/A." A high percentage of respondents responded N/A to these questions (ranging from 6 percent to 15 percent of respondents depending on the question). This does not indicate that they are necessarily dissatisfied with the service but rather that they did not need or access that service.
BCP=Blind Children's Vocation Discovery and Development Program; SFY=State fiscal year (September 1-August 31); N=Sample size.

Table 80. Findings from the BCP Customer Satisfaction Survey: Helpfulness of BCP for Their Family

Service	SFY 2021 Proportion of Respondents[1] (N=237)
Learn skills to encourage their child to develop and learn to their fullest potential	79%
find resources to support their family in their community	70%
Know their rights	68%

Notes. [1] Percent of respondents who indicated "strongly agree" or "agree" versus "strongly disagree," "disagree," "no opinion," or "N/A."
BCP=Blind Children's Vocation Discovery and Development Program; SFY=State fiscal year (September 1-August 31); N=Sample size.

Comprehensive Rehabilitation Services Customer Service Survey

Purpose

The Comprehensive Rehabilitation Services (CRS) program enhances the quality of life for individuals 15 and older who have a traumatic brain injury, a traumatic spinal cord injury, or both. The program provides case management and funding for the individual's inpatient and outpatient rehabilitation to empower and support individuals holistically in achieving their identified short and long-term goals.

The purpose of the CRS Customer Service Survey is to provide feedback to leadership to make appropriate programmatic changes, assess participant's satisfaction with the program, and provide data to measure programmatic outcomes.

Sample and Methods

The CRS Customer Service Survey was conducted internally by the CRS program. The study population consisted of eligible persons in an active, re-opened, or closed

case from SFY 2020 and SFY 2021. The sample included 646 eligible individuals; of those, 632 received access to the survey.[14]

Potential participants were sent a cover letter and survey via email and the mailing address on the CRS case management system. Included in the cover letter was the link to the survey. A reminder email was sent to all potential participants approximately one month after the initial survey invite.

The CRS Customer Service Survey was conducted via Microsoft Forms from September 17, 2021 to November 5, 2021. The survey was offered in English, Spanish, and Vietnamese. Surveys and cover letters were sent in the language that was selected in the CRS case management system. If the individual responded to the email requesting a paper copy of the survey, the program provided a paper copy with a pre-stamped return envelope included. Staff members were encouraged to assist individuals in completing the survey if issues or concerns emerged.

Performance Metrics

Table 81 provides the output measures for CRS Customer Service Survey.

[14] Fourteen individuals did not receive the invitation to participate in the CRS Customer Service Survey due to an incorrect email and/or mailing address.

Table 81. Output Measures for the CRS Customer Service Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022[2]
Total customers served (i.e., population)	Total number of customers receiving services from the program.	N/A	646	N/A
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	N/A	646	N/A
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	N/A	632	N/A
Total customers who responded to the survey	The number of customers who responded to the survey.	N/A	94	N/A
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	N/A	14.9%	N/A

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2020. [2] Because this is a biennial survey, it will not be conducted in SFY 2022.
CRS=Comprehensive Rehabilitation Services; SFY=State fiscal year (September 1-August 31).

Existing agency software was used to develop and distribute the CRS Customer Service Survey, resulting in no additional cost to the agency to gather survey data. Staff time to develop and distribute the survey was estimated to be approximately 100 hours. This cost is reflected in Table 82.

Table 82. Efficiency Measures for the CRS Customer Service Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022[2]
Total costs	The total costs for the agency to administer customer surveys.	N/A	$2,500	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	$4	N/A

Notes. [1] Because this is a biennial survey, it was not conducted in SFY 2020. [2] Because this is a biennial survey, it will not be conducted in SFY 2022.
CRS=Comprehensive Rehabilitation Services; SFY=State fiscal year (September 1-August 31).

Major Findings

- Most respondents (86 percent) reported that their social worker was trustworthy.
- Most respondents (82 percent) reported that their social worker coordinated care as prescribed by their doctor.
- Most respondents (81 percent) reported that their social worker assisted in providing resources when a need was presented.
- The average rating for the overall satisfaction with the CRS program was 8.8 out of 10.
- Most respondents (92 percent) reported that their social worker was respectful and listened to their choices and values.
- Most respondents (87 percent) reported that their social worker asked them what they wanted their independence and quality of life to look like.

Additional results are presented in Table 83.

Table 83. Findings from the CRS Customer Service Survey

Satisfaction Measure	SFY 2021 Proportion of Respondents (N=94)
Expressed satisfaction with the CRS staff	88%
Expressed satisfaction with the program's ability to timely give support	77%
Expressed satisfaction with the CRS provider facilities	64%[1]
Expressed satisfaction with CRS communications (calls returned, access to contact numbers, text messaging, electronic mail, letters)	87%
Expressed satisfaction with the CRS website	51%[2]
Expressed satisfaction with the CRS complaint handling process	41%[3]
Indicated satisfaction with agency brochures or other printed information	57%[4]

Notes. [1] An additional 23 percent of respondents indicated "not applicable." [2] An additional 29 percent of respondents indicated "not applicable." [3] An additional 42 percent of respondents indicated "not applicable." [4] An additional 28 percent of respondents indicated "not applicable." CRS=Comprehensive Rehabilitation Services; SFY=State fiscal year (September 1-August 31); N=Sample size.

Early Childhood Intervention Family Survey

Purpose

The Early Childhood Intervention (ECI) program serves children from birth to 36 months of age who have developmental delays or disabilities, as well as their families. The program provides early intervention services to help families and caregivers strengthen their ability to improve the child's development through everyday activities in the home and community. Services are provided through a statewide system of community-based programs. The ECI Family Survey is administered to a sample of parents or caregivers every year.

The purpose of the ECI Family Survey is to measure the percentage of families who report that early intervention services have helped the family know their rights, effectively communicate their children's needs, and help their children develop and learn.

The ECI Family Survey is administered in compliance with the regulations for early intervention programs from the Office of Special Education Programs (OSEP) at the U.S. Department of Education. Statewide data are reported as part of ECI's Annual Performance Report to OSEP.

The results from this study are included in Annual Performance Report located in the data and reports section of the ECI website: ECI Data and Reports.

Sample and Methods

A stratified random sampling plan with 95 percent confidence level was used to select a sample for SFY 2020 and SFY 2021.[15] All local ECI programs were stratified with respect to geographic region and size (large versus medium/small). Families were selected from each of the seven geographic regions to ensure statewide representation. In both SFY 2020 and SFY 2021, the ECI Family Survey was conducted by ECI through the 41 contracted agencies who deliver ECI services.

The study population was parents or guardians of children who had been enrolled in the ECI program for at least six months as of April 1 of that year. This criterion was established to ensure the family had sufficient experience with the program to respond to the questions.

[15] Families were not included in more than one sample.

The ECI Family Survey was offered in English and Spanish. The SFY 2020 survey was open from June 2020 until July 2020. The SFY 2021 survey was open from May 2021 until June 2021. During each of these periods, families received a link to their surveys via email or during telehealth visits. After the survey period ended, the state office accessed the survey responses that families submitted electronically. Completed survey responses were only accessible to the state office to ensure confidentiality. Individuals provided their responses by completing the survey themselves. If families requested assistance in completing the survey, ECI service coordinators were instructed to find another community resource for this assistance so ECI staff would not be involved in completing the survey.

Performance Metrics

Table 84 provides the output measures for ECI Family Survey.

Table 84. Output Measures for the ECI Family Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	59,234	60,204	60,000
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	20,000	18,000	20,000
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	5,304[1]	5,672[2]	5,500
Total customers who responded to the survey	The number of customers who responded to the survey.	2,685	2,638	2,900
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	50.6%	46.5%	52.7%

Notes. [1] Although 7,473 families were randomly selected to respond to the ECI Family Survey in SFY 2020, 2,169 surveys were undeliverable due to changes in address, family discharging from ECI, or the service coordinator or staff member being unable to reach the family. [2] Although 6,602 families were randomly selected to respond to the ECI Family Survey in SFY 2021, 930 surveys were undeliverable due to changes in address, family discharging from ECI, or the service coordinator or staff member being unable to reach the family.
ECI=Early Childhood Intervention; SFY=State fiscal year (September 1-August 31).

Table 85 shows the efficiency measures for the ECI Family Survey. The total costs include online survey software and five percent of two HHS staff time salaries.

Table 85. Efficiency Measures for the ECI Family Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	$7,547	$7,547	$7,884
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	$1	$1	$1

Notes. ECI=Early Childhood Intervention; SFY=State fiscal year (September 1-August 31).

Major Findings

Responses to ECI Family Survey questions were combined into composite scores for the domains measured by the survey instrument, following federally recommended procedures.

Family Experiences with Services – 2020

- Most respondents (85 percent) reported that early intervention services have helped the family know their rights.
- Most respondents (88 percent) reported that early intervention services have helped the family effectively communicate their children's needs.
- Most respondents (88 percent) reported that early intervention services have helped the family help their children develop and learn.
- Most respondents (91 percent) reported that the ECI program helped them understand their child's strength, needs, and abilities.
- Most respondents (90 percent) reported that the ECI program helped them know their rights and advocate for their child.
- Most respondents (91 percent) reported that the ECI program helped their child develop and learn.
- Most respondents (83 percent) reported that they have support systems.
- Most respondents (84 percent) reported that they have access to community events and resources after leaving ECI.

Family Experiences with Services – 2021

- Most respondents (86 percent) reported that early intervention services have helped the family know their rights.
- Most respondents (89 percent) reported that early intervention services have helped the family effectively communicate their children's needs.
- Most respondents (88 percent) reported that early intervention services have helped the family help their children develop and learn.
- Most respondents (91 percent) reported that the ECI program helped them understand their child's strength, needs, and abilities.
- Most respondents (87 percent) reported that the ECI program helped them know their rights and advocate for their child.
- Most respondents (91 percent) reported that the ECI program helped their child develop and learn.
- Most respondents (79 percent) reported that they have support systems.
- Most respondents (81 percent) reported that they have access to community events and resources after leaving ECI.

Independent Living Services Program Survey

Purpose

The Independent Living Services (ILS) Program assists individuals with significant disabilities achieve greater independence in their homes and communities. The ILS Program contracts with Centers for Independent Living (CIL) to serve individuals who have significant disabilities that result in substantial barriers to their ability to live independently and who can benefit from the services of the program.[16]

Since outsourcing the ILS Program to CILs in SFY 2017, the CILs have been required to complete their own consumer satisfaction surveys and keep the results for request by HHS during monitoring reviews. In SFY 2020, the CILs continued to conduct their own survey instrument and procedures. Service provider's satisfaction survey policy, procedure and adherence to the requirements are reviewed during

[16] Centers for Independent Living are private, non-profit organizations contracted with HHSC as service providers of the Independent Living Program.

on-site contract monitoring reviews. HHSC has not tabulated results of CIL satisfaction surveys so there are no cumulative data to submit for SFY 2020.

In SFY 2021, HHSC began to conduct program satisfaction surveys and will continue in future years. The purpose of the ILS Program Survey was to obtain information on the experience of customers who have applied for or received services from a CIL and to meet the legislative requirements to obtain public input about HHS services. The survey was conducted by staff of the ILS Program.

Sample and Methods

The ILS Program population for the SFY 2021 survey was 2,333 customers listed in the ILS Data Reporting System (DRS) who were served by the ILS purchased services contracts and who had an active case any time between September 1, 2020 and June 15, 2021. The population included customers who were awaiting services, had received services, or whose case was closed for any reason during this timeframe.

The ILS Program Survey sought responses from a sample of the ILS Program population. The sample size was 533 customers and was selected based on those who had an email address in the ILS DRS to allow for electronic delivery of the survey information. The online survey was accessed through a link in the body of an email sent to the sample of customers by ILS Program staff.

The ILS Program Survey was offered in English and Spanish. Customers who reported English as their primary language accounted for 85 percent of the population and 14 percent reported Spanish as their primary language.

Individuals provided their responses by completing the survey themselves or with the help of a family member or friend of their choice.

Performance Metrics

Table 86 provides the output measures for the ILS Program Survey.

Table 86. Output Measures for the ILS Program Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	N/A	2,333	2,600
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	N/A	2,333	2,600
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	N/A	556	2,600
Total customers who responded to the survey	The number of customers who responded to the survey.	N/A	57	520
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	N/A	10.3%	20.0%

Notes. [1] No data is available for SFY 2020 because CILs developed their own survey instruments and procedures. CILs were not required to submit a summary of the results to HHSC.
ILS=Independent Living Services; SFY=State fiscal year (September 1-August 31); CIL=Center for Independent Living; HHSC=Health and Human Services Commission.

Table 87 shows the efficiency measures for the ILS Program Survey. For SFY 2021, existing software was used to develop and distribute the survey. This resulted in no additional cost to the agency to gather survey data. Staff time to develop and distribute the survey was estimated to take 150 hours. SFY 2022 is based on the budget available for contracting costs to distribute the survey and summarize the results.

Table 87. Efficiency Measures for the ILS Program Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	N/A	$8,600	$75,000
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	$15	$29

Notes. [1] No data is available for SFY 2020 because CILs developed their own survey instruments and procedures. CILs were not required to submit a summary of the results to HHSC.
ILS=Independent Living Services; SFY=State fiscal year (September 1-August 31); CIL=Center for Independent Living; HHSC=Health and Human Services Commission.

Major Findings

Major findings from the ILS Program Survey include*:*

- Most respondents (70 percent) reported satisfaction with staff of the CIL including employee courtesy, friendliness, and knowledgeable and adequate identification (such as with the use of name plates or tags for accountability).
- Most respondents (67 percent) reported satisfaction with their overall experience with the CIL.
- Some respondents (32 percent) reported dissatisfaction with the length of time between development of their Independent Living Plan and receipt of services.
- Approximately half of all respondents (49 percent) reported they may not have been informed or were not informed of their right to complain or how to file a complaint with HHSC about the services from the CIL.
- Some respondents (32 percent) requested contact from HHS related to the ILS Program Survey. All of these respondents were contacted by ILS program staff.
- Some respondents (7 percent) indicated that they had been denied a service or had not received a service for an extended period of time. HHSC followed up with the assigned CIL to inquire about these services.

Additional results are presented in Table 88.

Table 88. Findings from the ILS Program Survey

Satisfaction Measure	SFY 2021 Proportion of Respondents (N=57)
Expressed satisfaction with their experience with the Center for Independent Living	66.7%
Expressed satisfaction with the Center for Independent Living's ability to provide services timely	56.1%
Expressed satisfaction with the length of time between development of the Independent Living Plan and receipt of items or services requested.	52.6%
Expressed satisfaction with the vendor from which goods or services were purchased	61.4%

Notes. No data is available for SFY 2020 because CILs developed their own survey instruments and procedures. CILs were not required to submit a summary of the results to HHSC.
ILS=Independent Living Services; SFY=State fiscal year (September 1-August 31); N=Sample size; CIL=Center for Independent Living; HHSC=Health and Human Services Commission.

Children's Autism Program Survey

Purpose

The Children's Autism Program works in partnership with local community agencies through grant contracts to provide applied behavior analysis (ABA) services for children with autism spectrum disorder (ASD).

The Children's Autism Program services include assessments and focused ABA treatment services in the home, community, or clinic. To be eligible for these services, children 3 through 15 years of age must have a diagnosis on the autism spectrum and be a Texas resident. The survey may be provided to clients and families as they exit treatment from the Children's Autism Program.

The purpose of the Children's Autism Program Survey is to assess:

- Parent or caregiver satisfaction with the Children's Autism Program services and service providers
- Parent or caregiver satisfaction with their children's treatment progress

Sample and Methods

The Children's Autism Program Survey was not conducted in SFY 2020. In SFY 2021, the survey population included families whose children have completed or aged out of the Children's Autism Program services.

The sampling frame is the population that is eligible to take the survey. In the Children's Autism Program, only clients who are exiting the program are provided a satisfaction survey.

During SFY 2021, the service provider administered a survey to families as their children exited the program. The surveys were offered in English and Spanish. Individuals completed the survey themselves by mailing a paper survey to HHSC.

The Children's Autism Program Survey consisted of seven questions related to areas of satisfaction with the services and 12 questions related to the respondent's perception of their child's progress in specific behavioral domains (e.g., following directions, responding to requests).

Performance Metrics

The Children's Autism Program performance measures for SFYs 2021-2022 are based on the average monthly client count and average cost per client. Table 89 presents the output measures for the Children's Autism Program Survey.

Table 89. Output Measures for Children's Autism Program Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	N/A	1,169	1,295
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.[2]	N/A	593	593
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.[2]	N/A	593	593
Total customers who responded to the survey	The number of customers who responded to the survey.	N/A	13[3]	108[4]
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	N/A	2.2%	18.2%

Notes. [1] The Children's Autism Program Survey was not conducted in SFY 2020. [2] This represents the number of exits from the Children's Autism Program. [3] Low response numbers are attributed to a flux in service due to the COVID-19 public health emergency, as well as loss of access to the previous online survey platform. [4] The SFY 2022 projection is based on an anticipated return to historical figures when the new online survey platform (JotForm) is available to respondents. SFY=State fiscal year (September 1-August 31).

Table 90 shows the efficiency measures for Children's Autism Program survey. Beginning SFY 2022, the Children's Autism Program will begin utilizing a software called JotForm to allow for electronic submission of client satisfaction surveys. Electronic access should improve access to the survey, including families and providers who implement mostly telehealth protocol. The ease in return should also increase the overall response rate. There is no specific program cost to utilize this software, as Children's Autism Program use is incidental and the JotForm subscription is paid through other administrative funds.

Table 90. Efficiency Measures for Children's Autism Program Survey

Measure	Specification	SFY 2020[1]	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	N/A	N/A	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	N/A	N/A

Notes. [1] The Children's Autism Program Survey was not conducted in SFY 2020.
SFY=State fiscal year (September 1-August 31).

Major Findings

Of the 13 collected responses to the Children's Autism Program Survey, respondents did not consistently complete the entirety of survey sections. Findings in this report reflect surveys where sections were completed.

Most respondents to the survey were satisfied or very satisfied with the services their children received (Table 91) and reported their children made good or great progress in the behavioral domains specified (Table 92).

Table 91. Findings from the Children's Autism Program Survey: Parent or Caregiver Satisfaction with Services and Service Providers

Service Satisfaction	SFY 2021 Proportion of Respondents[1] (N=12)
Services provided to your child in a clinical setting	90%
Services provided to your child in the home	100%
Parent training provided to your child in another setting such as in the school, at the park, or at the store	88%
Parent training provided to you	89%
Parent training provided on how to review data and evaluate your child's progress	89%
Transition planning received prior to exiting the Children's Autism Program	81%
Your child's service provider	90%

Notes. [1] Percentage of respondents who indicated "satisfied" or "very satisfied." Those who did not answer the survey question or who indicated the survey item was "not applicable" are not counted in these proportions. Percentages should be interpreted carefully in light of the small sample size.

SFY=State fiscal year (September 1-August 31); N=Sample size.

Table 92. Findings from the Children's Autism Program Survey: Parent or Caregiver Satisfaction with Their Child's Progress

Behavioral Domain	SFY 2021 Proportion of Respondents[1] (N=11)
Following directions	64%
Responding to requests	64%
Communicating with primary caregivers	64%
Communicating with others	55%
Interacting with primary caregivers	73%
Interacting with others	60%
Play skills, such as playing with toys and taking turns	64%
Completing daily tasks without assistance, such as toileting, eating, and dressing	40%
Completing daily tasks with assistance, such as toileting, eating, and dressing	60%
Reducing disruptive behaviors, such as aggression and tantrums	30%
Participating in family activities, such as going to church, the park, and the store	55%
Overall progress on the treatment plan goals	82%

Notes. [1] Percentage of respondents who indicated "good progress" or "great progress." Those who did not answer the survey question or who indicated the survey item was "not applicable" are not counted in these proportions. Percentages should be interpreted carefully in light of the small sample size.
SFY=State fiscal year (September 1-August 31); N=Sample size.

Your WIC Experience Client Satisfaction Survey

Purpose

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federally funded, state-administered nutrition program that serves low-income pregnant women, postpartum and breastfeeding women, and infants and children up to the age of five that are at nutritional risk. Eligible participants may

receive nutrition education and counseling, breastfeeding support, nutritious foods, and healthcare referrals for other services that improve health outcomes.

The purpose of the Your WIC Experience Client Satisfaction Survey is to gather ongoing, real-time client feedback on clients' recent WIC visits. Your WIC Experience was created with the goal to provide all Texas WIC clinics with the capability to track and respond immediately and efficiently to customer feedback following a clinic visit.

Sample and Methods

The WIC state agency administers the survey using the Qualtrics Customer Experience platform (Qualtrics). This real-time survey platform allowed staff to send a short text message inviting all WIC clients who visited a local WIC clinic within the previous 24 hours to complete a short customer satisfaction survey. The survey was automatically sent in the WIC client's preferred language (English or Spanish).

Client survey responses were tied back to their local agency and further down to their specific clinic. This feature provided WIC clinic staff the ability to track and respond immediately to customer feedback following a clinic visit. Results were populated and displayed in a real-time dashboard that state and local agency users could view, analyze, and follow 24/7. Reports from the dashboard were available to provide a point-in-time snapshot upon request or at any time to other licensed Qualtrics users that worked on this project with WIC.

The study population included every WIC family who elected to click on the survey link in the text message. When a client clicked on the survey link in the text message, it took them to the Qualtrics survey online. The total number of completed responses was 83,343 between September 1, 2019 and August 31, 2020 (6.0 percent response rate) and 114,547 between September 1, 2020 and August 31, 2021 (7.9 percent response rate).

Frequencies and means were computed for quantitative Likert-scale questions. Text IQ qualitative analysis software was used to theme open-ended response questions.

Performance Metrics

Table 93 provides the output measures for the Your WIC Experience Client Satisfaction Survey.

Table 93. Output Measures for the Your WIC Experience Client Satisfaction Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022[1]
Total customers served (i.e., population)	Total number of customers receiving services from the program. Totals may include more than one member of a family (i.e., mother, infant, and child).	1,145,585	1,125,653	1,125,653
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey. Inclusion criteria are the number of English and Spanish speaking families only.	595,110	585,912	585,912
Total customers solicited to take the survey[2]	The number of customers (i.e., English and Spanish speaking families) who receive access to surveys regarding agency services.	1,399,419	1,443,798	1,443,798
Total customers who responded to the survey[2]	The number of customers (i.e., English and Spanish speaking families) who responded to the survey.	83,343	114,547	114,547
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	6.0%	7.9%	7.9%

Notes. [1] Assumes flat growth projection in SFY 2022. [2] WIC families were surveyed at each visit, which occurs approximately every three months. The WIC program was unable to de-duplicate family responses in the "total customers solicited to take the survey" and "total customers who responded to the survey."
WIC=The Special Supplemental Nutrition Program for Women, Infants, and Children; SFY=State fiscal year (September 1-August 31); N=Sample size.

Table 94 shows the efficiency measures for Your WIC Experience Client Satisfaction Survey. The cost estimate for the client satisfaction survey is based on the price of the text messages used ($0.01 per credit) plus the cost of the Qualtrics online survey software purchased for customer experience. Because the survey uses about 36 percent of all the survey responses purchased in the customer experience

portion of the license, the total cost of the software was multiplied by 0.36 to estimate cost for this survey.

Table 94. Efficiency Measures for the Your WIC Experience Client Satisfaction Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	$170,881	$137,911	$162,341
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	<$1	<$1	<$1

Notes. WIC=The Special Supplemental Nutrition Program for Women, Infants, and Children; SFY=State fiscal year (September 1-August 31).

Major Findings

Because survey questions have display and skip logic based on a client's response, not all questions have the same sample size. The sections below present the key findings of the Your WIC Experience Client Satisfaction Survey.

Happiness with WIC Visit

Most WIC clients (96 percent) reported being happy with their WIC clinic visit. Additionally, there was an increase in net promoter scores from 83 in SFY 2020 to 88 in SFY 2021.[17]

Respondents who utilized the call center were asked to indicate their level of satisfaction with the customer service they received, using a 5-point Likert scale (1=extremely dissatisfied; 5=extremely satisfied). Clients reported an average of 4.6 in SFY 2020 (N=37,298) and 4.7 in SFY 2021 (N=53,207).

Clinic Improvements

Four conditions within the survey generated a ticket for the local WIC clinic to follow up on: unhappy with WIC clinic visit, unhappy with call center, trouble/negative sentiment in open comment, request for a call back. In SFY 2020, 2,313 (2.8

[17] Net promoter score is a customer loyalty metric that gauges how willing a customer is to recommend a product or service (i.e., extremely likely to refer a friend or colleague to their WIC clinic). Net promoter score is derived by taking the percentage of respondents who are promoters (scale points 9 or 10) and subtracting the percentage of respondents who are detractors (scale points 0 through 6).

percent) of responses generated a ticket for follow up and in SFY 2021, 4,806 (4.2 percent) of responses generated a ticket for follow up.

Less than 5 percent of respondents offered feedback that suggested a need for improvement. The top four themes from this feedback are shown in Table 95.

Table 95. Findings from the Your WIC Experience Client Satisfaction Survey: Clinic Improvement Themes[1]

Theme	SFY 2020 Count (Percentage)	SFY 2021 Count (Percentage)
Wait time	1,544 (42%)	1,420 (39%)
Phone responsiveness	525 (14%)	636 (17%)
Card not updated	367 (10%)	463 (13%)
Customer service rude, unpleasant, not helpful	414 (11%)	374 (10%)

Notes. [1] Less than 5 percent of respondents offered feedback that suggested a need for improvement. Only the subset of respondents who suggested a need for improvement are included in this table.
WIC=The Special Supplemental Nutrition Program for Women, Infants, and Children; SFY=State fiscal year (September 1-August 31).

The small percentage of less favorable responses prompted the state agency to develop a hospitality policy and unique customer service trainings to build staff interpersonal skills and connection with WIC clients.

Shopping Experience

Shopping for WIC foods poses a challenge for about 50 percent of clients. Strategies to alleviate this include enhanced promotion of the shopping app, increased local agency staff training on WIC approved foods, continued vendor training on labeling applicable WIC foods, and a new WIC Participant Shopping Survey that began in November 2021.

Moreover, data from open responses revealed that clients reported a desire for more fruits and vegetables benefits and provided evidence supporting USDA's decision to allocate increased cash value benefits for fruits and vegetables for WIC participants.

Additional Feedback

Clients were asked if there is anything else they would like to report about their WIC visit. Of the 21,161 responses received in SFY 2020 and the 24,686 responses received in SFY 2021, most sentiments were positive. The top four themes from this feedback are shown in Table 96.

Table 96. Findings from the Your WIC Experience Client Satisfaction Survey: Additional Feedback Themes

Theme	SFY 2020 Count (Percentage)	SFY 2021 Count (Percentage)
Thank you, appreciative	8,212 (39%)	10,732 (43%)
Helpful/friendly	5,345 (25%)	4,672 (19%)
Fast service	854 (4%)	737 (3%)
Something is new and we like it	396 (2%)	349 (1%)

Notes. WIC=The Special Supplemental Nutrition Program for Women, Infants, and Children; SFY=State fiscal year (September 1-August 31).

Impact of the COVID-19 Public Health Emergency

The feedback from these surveys, along with the immediate service delivery changes necessitated by the COVID-19 public health emergency, justified and accelerated several technology enhancements. These enhancements included the ability to begin a WIC application online, a gateway to upload federally required documentation and health histories, the launch of a *myTexasWIC* shopping app, and the pilot of a new client facing web portal. These new tools decreased wait times at the clinic and better met the needs of busy caregivers.

In addition, Texas WIC was able to use data from the Your WIC Experience Client Satisfaction Survey to compile a document for the National WIC Association on August 17, 2020, *Client Satisfaction Survey Assesses Texas WIC Service Delivery Before and During the COVID-19 Pandemic.*

Surveys were especially helpful during the COVID-19 public health emergency. Texas WIC received open-ended feedback during the service delivery modifications that helped local agencies keep a pulse on call center wait times and increased need for WIC services. State and local WIC staff modified operations to assist in areas of Texas hit hardest by the pandemic. Surveys also provided insight into

availability of WIC foods in stores when the pandemic fueled shortages of some items.

Mental Health Services

Mental Health Statistics Improvement Program Youth Services Survey for Families

Purpose

Since 2002, Texas has conducted an annual survey of customers who receive community-based mental health services to assess their perceptions of the services they receive. These services are provided by HHSC, Behavioral Health Services. The Youth Services Survey for Families (YSSF) was designed by the federal Mental Health Statistics Improvement Program (MHSIP).

The purpose of the YSSF is to measure:

- Parental satisfaction with mental health services received through the state mental health system
- Parental perception of these services along multiple dimensions, including access to care and outcomes of services

Sample and Methods

Parents or guardians of customers age 17 or younger who received a mental health service in at least two months of a given eligibility window were eligible for inclusion in the YSSF. For the SFY 2020 survey, the eligibility window was September 2019 to February 2020, and for the SFY 2021 survey, the eligibility window was September 2020 to February 2021. For both fiscal years, a simple random sample was drawn from the eligible population to identify which parents or guardians would receive the survey requests.

HHSC contracted with a vendor to mail surveys to the identified sample across four waves between May and August in both SFYs. Participants could respond to the survey by mailing back a paper copy or by using a secure link to submit their responses online. The survey was administered in English and Spanish.

The YSSF consisted of 26 questions about mental health services the customer received over the past six months. The survey questions fell into seven groups of related questions, or domains. The domains that comprised the YSSF were:

- Satisfaction (with services)
- Access (to services)
- Participation in Treatment Planning
- Cultural Sensitivity (of staff)
- Outcomes (of services)
- Social Connectedness
- Functioning (of the child)

The domains are described in more detail in Table 99 on page 126.

Parents/guardians of customers answered each survey question using a five-point Likert scale ranging from "strongly agree" to "strongly disagree." Survey results focus on the domain "agreement rates," which means the percentage of parents/guardians that reported "agree" or "strongly agree," on average, across the items in a domain.

Performance Metrics

Table 97 provides the output measures for the YSSF.

Table 97. Output Measures for the YSSF

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	38,261	37,861	38,000
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	3,451	4,797	5,482
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	2,661	3,730	4,221
Total customers who responded to the survey	The number of customers who responded to the survey.	436	506	591
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	16.4%	13.6%	14.0%

Notes. The customers in the sampling frame were identified by a simple random sample. The number of customers solicited to take the YSSF were those in the sampling frame with a valid mailing address.
YSSF=Youth Services Survey for Families; SFY=State fiscal year (September 1-August 31).

Table 98 shows the efficiency measures for the YSSF.

Table 98. Efficiency Measures for the YSSF

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	$16,150	$22,350	$26,600
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	$6	$6	$6

Notes. The total costs measure includes envelope purchasing costs, printing costs, mailing costs, data entry costs, and online survey software subscription costs; they do not include HHSC staff time costs.
YSSF=Youth Services Survey for Families; SFY=State fiscal year (September 1-August 31); Health and Human Services Commission.

Major Findings

The results of the two most recent survey years (SFY 2020 and 2021) are shown in Table 99. The percentages indicate the average proportion of respondents who answered "agree" or "strongly agree" to questions in the stated domain.[18] For instance, on average, 81 percent of respondents agreed or strongly agreed with the items in the Satisfaction domain in SFY 2020. The majority of domain agreement rates were similar between SFY 2020 and SFY 2021, with SFY 2020 rates being slightly higher than SFY 2021 rates.

[18] For each domain, only respondents who answered two-thirds or more of the items comprising that domain were included in the calculation.

Table 99. Findings from the YSSF: Domain Agreement Rates

Domain	Description of Domain[1]	SFY 2020 Proportion of Respondents[2] (N=436)	SFY 2021 Proportion of Respondents[2] (N=506)
Satisfaction (with services)	The parent would choose these services for his/her child if there were other options available.	81%	75%
Access (to services)	Services are available when and where needed.	84%	77%
Participation in Treatment Planning	The parent feels involved in treatment decisions.	88%	84%
Cultural Sensitivity (of staff)	Staff show respect for the family's race/ethnicity/culture?	91%	88%
Outcomes (of services)	As a result of services, the child's functioning at home and school has improved and he/she has experienced fewer mental health symptoms.	63%	60%
Social Connectedness	The child feels connected to friends, family, and community.	82%	79%
Functioning (of the child)	The child's overall well-being has improved.	63%	60%

Notes. [1] Each domain represents a composite of several questions. [2] Proportions indicate respondents who chose responses "strongly agree" or "agree" rather than "neutral," "disagree," or "strongly disagree." Those who did not answer the survey question are not counted in these proportions.
YSSF=Youth Services Survey for Families; SFY=State fiscal year (September 1-August 31); N=Sample size.

Mental Health Statistics Improvement Program Adult Mental Health Survey

Purpose

Since 1997, Texas has conducted an annual survey of customers who receive community-based mental health services to assess their perceptions of the services they receive. These services are provided by HHSC, Behavioral Health Services. The Adult Mental Health (AMH) Survey was designed by the federal MHSIP.

The purpose of the AMH Survey is to measure:

- Customer satisfaction with mental health services received through the state mental health system
- Customer perception of these services along multiple dimensions, including access to care and outcomes of services

Sample and Methods

Adults age 18 years or older who received a mental health service in at least two months of a given eligibility window were eligible for inclusion in the AMH Survey. For the SFY 2020 survey, the eligibility window was September 2019 to February 2020, and for the SFY 2021 survey, the eligibility window was September 2020 to February 2021. For both fiscal years, a simple random sample was drawn from the eligible population to identify which customers would receive the survey requests.

HHSC contracted with a vendor to mail surveys to the identified sample across four waves between May and August in both SFYs. Participants could respond to the survey by mailing back a paper copy or by using a secure link to submit their responses online. The survey was administered in English and Spanish.

The AMH Survey consisted of 36 questions about mental health services the customer received over the past 12 months. The survey questions fell into seven groups of related questions, or domains. The domains that comprised the AMH Survey were:

- Satisfaction (with services)
- Access (to services)
- Participation in Treatment Planning
- Quality and Appropriateness (of services)
- Outcomes (of services)
- Social Connectedness
- Functioning

The domains are described in more detail in Table 102 on page 130.

Customers answered each survey question using a five-point Likert scale ranging from "strongly agree" to "strongly disagree." Survey results focus on the domain

"agreement rates," which means the percentage of customers that reported "agree" or "strongly agree," on average, across the items in a domain.

Performance Metrics

Table 100 provides the output measures for the AMH Survey.

Table 100. Output Measures for the AMH Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total customers served (i.e., population)	Total number of customers receiving services from the program.	109,025	114,047	119,300
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	2,168	2,639	3,571
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	1,701	2,014	2,714
Total customers who responded to the survey	The number of customers who responded to the survey.	491	455	597
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	28.9%	22.6%	22.0%

Notes. The customers in the sampling frame were identified by a simple random sample. The number of customers solicited to take the AMH Survey were those in the sampling frame with a valid mailing address.
AMH=Adult Mental Health; SFY=State fiscal year (September 1-August 31).

Table 101 shows the efficiency measures for the AMH Survey.

Table 101. Efficiency Measures for the AMH Survey

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	$10,675	$12,950	$18,000
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	$6	$6	$7

Notes. The total costs measure includes envelope purchasing costs, printing costs, mailing costs, data entry costs, and online survey software subscription costs; they do not include HHSC staff time costs.
AMH=Adult Mental Health; SFY=State fiscal year (September 1-August 31); HHSC=Health and Human Services Commission.

Major Findings

The results of the two most recent survey years (SFY 2020 and 2021) are shown in Table 102. The percentages indicate the average proportion of respondents who answered "agree" or "strongly agree" to questions in the stated domain.[19] For instance, on average, 87 percent of respondents agreed or strongly agreed with the items in the Satisfaction domain in SFY 2020. The majority of domain agreement rates were similar between SFY 2020 and SFY 2021, with SFY 2020 rates being slightly higher than SFY 2021 rates.

[19] For each domain, only respondents who answered two-thirds or more of the items comprising that domain were included in the calculation.

Table 102. Findings from the AMH Survey: Domain Agreement Rates

Domain	Description of Domain[1]	SFY 2020 Proportion of Respondents[2] (N=491)	SFY 2021 Proportion of Respondents[2] (N=455)
Satisfaction (with services)	The consumer would choose to receive these services if he or she had other options.	87%	87%
Access (to services)	Sufficient services are available when and where needed.	81%	78%
Participation in Treatment Planning	The consumer feels involved in treatment decisions	75%	72%
Quality and Appropriateness (of services)	Staff are competent and the services are professional.	86%	82%
Outcomes (of services)	The consumer has experienced improvement in work, housing, and relationships.	60%	57%
Social Connectedness	The consumer feels connected to friends, family, and community.	65%	61%
Functioning	The consumer's overall well-being has improved.	58%	56%

Notes. [1] Each domain represents a composite of several questions. [2] Proportions indicate respondents who chose responses "strongly agree" or "agree" rather than "neutral," "disagree," or "strongly disagree." Those who did not answer the survey question are not counted in these proportions.
AMH=Adult Mental Health; SFY=State fiscal year (September 1-August 31); N=Sample size.

Mental Health Statistics Improvement Program Inpatient Consumer Survey

Purpose

State psychiatric hospitals located throughout Texas serve people with psychiatric disorders who need services provided in a residential environment. The usual length of stay for civil patients, accounting for about 35 percent of the patients in state

hospitals, is short. Civil patients usually are treated for a few days or possibly weeks; the focus of services is stabilization and support of patients' return to the community. Forensic patients generally have a longer length of stay, which is determined by the court, and can vary from about 90 days for a patient on initial restoration commitment, to years for a patient commitment under the Not Guilty by Reason of Insanity commitment, or those more complicated restoration commitments.

State psychiatric hospitals provide assessment, evaluation, and treatment. Treatment involves a variety of services: psychiatry, nursing, social work, psychology, education/rehabilitation, nutrition, medical, and dental. These services are paid for through general revenue funds from the State of Texas, private payment, private third-party insurance, and Medicare and Medicaid programs.

The MHSIP Inpatient Consumer Survey (ICS) is conducted in compliance with MHSIP requirements. The ICS is distributed to individuals age 13 years or older who are discharged from one of the 10 state psychiatric hospitals, or for those with episodes lasting greater than one year.

The purpose of the MHSIP ICS is to measure individuals':

- Experience in the state psychiatric hospital, including their experience with staff, treatment, and the facility
- Participation in their treatment
- Ability to function after leaving the hospital

Samples and Methods

The study sought responses from adults served in the state psychiatric hospitals. Data were collected at 10 state psychiatric hospitals:

- Austin State Hospital
- Big Spring State Hospital
- El Paso Psychiatric Center
- North Texas State Hospital (Vernon, Vernon-South, Wichita Falls)
- Kerrville State Hospital
- Rio Grande State Center
- Rusk State Hospital

- San Antonio State Hospital
- Terrell State Hospital
- Waco Center for Youth

The ICS was conducted using a convenience sampling method. When a decision was made to discharge a patient, the patient was given an opportunity to complete the survey. This process could begin as early as three or more days prior to discharge. Patients could also be given an envelope so that the completed survey could be mailed back to the quality assurance division of the facility after discharge. The likelihood of a returned survey was greater prior to the customer leaving the facility. Patients with hospital episodes greater than one year were given a survey to complete during each annual review. For those completing surveys prior to discharge or due to annual review, they could be completed with or without staff assistance. The survey was offered on paper and was available in English and Spanish. These results are entered into an administrative section of the hospitals' electronic health record.

Performance Metrics

Table 103 provides the output measures for MHSIP ICS.

Table 103. Output Measures for the MHSIP ICS

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022[1]
Total customers served (i.e., population)	Total number of customers receiving services from the program.	6,003	4,732	4,730
Total customers in sampling frame	The total number of customers meeting criteria to participate in the survey.	5,236	3,852	3,850
Total customers solicited to take the survey	The number of customers who receive access to surveys regarding agency services.	5,236	3,852	3,850
Total customers who responded to the survey	The number of customers who responded to the survey.	2,098	1,629	1,620
Response Rate	The percentage of customers who responded to the survey out of the total number of customers solicited to take the survey.	40.1%	42.3%	42.1%

Notes. [1] Given recent changes to state hospital patient population, capacities as a result of the COVID-19 public health emergency response and staffing challenges, new construction, and other factors, predicting into SFY 2022 is a difficult challenge. The numbers provided above represent as estimate using the theory that things will stay the same and SFY 2021 rates will be maintained. If hospital capacity were to increase, we would expect the numbers served, eligible and surveyed to increase as well but it is unclear by how much.
MHSIP=Mental Health Statistics Improvement Program; ICS=Inpatient Consumer Survey; SFY=State fiscal year (September 1-August 31).

Table 104 shows the efficiency measures for MSHIP ICS.

Table 104. Efficiency Measures for the MHSIP ICS

Measure	Specification	SFY 2020	SFY 2021	Projected SFY 2022
Total costs	The total costs for the agency to administer customer surveys.	N/A	N/A	N/A
Cost per customer surveyed	Total costs divided by the total number of customers solicited to take the survey.	N/A	N/A	N/A

Notes. The MHSIP ICS is a long-standing process ingrained in day-to-day hospital operations. The costs of conducting this survey are negligible and difficult to estimate. The state hospitals do not contract for the survey. The printing is completed on contracted Xerox printers in most, if not all instances. HHSC does not track the number of surveys that are returned by mail to estimate mailing costs. HHSC does not have software subscription costs specific to the survey as it was added in electronic health records. HHSC staff time would only be involved in distributing or assisting with the survey, and minimal data entry (HHSC does not do respondent recruitment). MHSIP=Mental Health Statistics Improvement Program; ICS=Inpatient Consumer Survey; SFY=State fiscal year (September 1-August 31); HHSC=Health and Human Services Commission.

Major Findings

In general, high-level monitoring of adolescent and adult satisfaction with state psychiatric hospitals relied on an average overall score, which encompasses answers to survey questions in all five domains. In both SFY 2020 and SFY 2021, this annual average score target was exceeded by all 10 state psychiatric hospitals. Client satisfaction was fairly consistent across all five domains. Dignity scores remain the highest marks by average and the rights domain continued to be lower than the other domains. An increase in forensic population with a longer length of stay and fewer discharges were contributing factors in having fewer surveys returned but a consistent rate of return was maintained. Results for SFY 2020 and SFY 2021 are provided in Table 105.

Table 105. Findings from the MHSIP ICS

Measure	SFY 2020 Proportion of Respondents[1] (N=2,089)	SFY 2021 Proportion of Respondents[1] (N=1,629)
Outcome – Effect of the hospital stay on the customer's ability to deal with their illness and with social situations	76.9%	76.8%
Dignity – Quality of interactions between staff and customers than highlight a respectful relationship	82.3%	82.3%
Rights – Ability of customers to express disapproval with conditions or treatment and receive an appropriate response from the organization	66.0%	67.0%
Participation in Treatment – Customers' involvement in their hospital treatment as well as coordination with the customers' doctor or therapist from the community[2]	76.1%	73.7%
Facility Environment – Feeling safe in the facility and the aesthetics of the facility.	74.0%	73.8%

Notes. [1] Proportions indicate respondents who chose responses "agree," or "strongly agree," rather than "neutral," "disagree," or "strongly disagree." Those who did not answer the survey question are not counted in these proportions. [2] The change from 76.1 percent to 73.7 percent, while not an extreme shift, was noted. This could potentially be a result of the COVID-19 public health emergency which limited, at times, in person communication between treatment teams and the patient, as well as an increase in forensic population responses. In the forensic cases, a lot of the treatment decisions rely on the courts and not the hospital staff or patients. MHSIP=Mental Health Statistics Improvement Program; ICS=Inpatient Consumer Survey; SFY=State fiscal year (September 1-August 31); N=Sample size.

Conclusion

This HHS system-wide 2022 Report on Customer Service describes the results of 363,481 individual survey responses from 28 surveys conducted by the two Texas agencies belonging to the Texas HHS system during the SFY 2020-2021 reporting period. Surveyed individuals were primarily direct consumers of services and enrollees in health plans; other surveys solicited feedback from entities regulated or inspected by HHS, service providers contracted with HHS, and entities receiving HHS laboratory services.

- Thirteen projects surveyed customers of HHS services, including families of children with special needs, developmental delays, or disabilities; adults with disabilities; elderly individuals residing in nursing facilities; customers of eligibility offices; customers of complaint intake offices; adults participating in the WIC program; and children and adults who received mental health services. The largest of these surveys, the Your WIC Experience Client Satisfaction Survey, collected almost 200,000 responses. Overall, most respondents provided positive feedback regarding the services and supports received through HHS programs.
- Enrollees in STAR, STAR Kids, STAR Health, STAR+PLUS, and CHIP health plans were surveyed through 10 different surveys. Respondents included families or caregivers of enrolled children, as well as enrolled adults. Across these surveys, most quality components were rated positively. Respondents were most likely to give positive feedback related to communication with doctors, but indicated that there may be opportunities for improvement in access to specialized services. Texas's External Quality Review Organization provides more detailed findings and recommendations from member surveys in their annual Summary of Activities Report.
- Three surveys collected responses from customers of state laboratory services, including submitters to the South Texas Laboratory and providers funded by Ryan White Part-B and State Services. Surveys showed broad satisfaction related to monitoring processes, staff responsiveness, and quality of service.
- Two surveys obtained feedback from entities inspected by the state. A wide range of businesses, food service facilities, and other regulated organizations provided positive feedback on state services, including inspections and communication with staff.

Overall, the HHS system of agencies succeeded in obtaining feedback from a diverse group of customers. Although most respondents provided positive feedback regarding the services and supports received through HHS programs, some surveys identified opportunities for improvement. Feedback identifying opportunities for improvement is frequently used to inform how services are provided in the future. For example, feedback collected from health plan enrollees is used to hold managed care organizations accountable through HHSC quality programs. These results support the HHS system mission of improving the health, safety, and well-being of Texans through good stewardship of public resources.

Appendix A. Customer Inventory for the Department of State Health Services (DSHS)

Services Provided to Customers by Budget Strategy, as listed in HHS System Strategic Plan 2019–2023, Volume II, Schedule A

Objective A.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.1.1. Public Health Preparedness and Coordinated Services. Coordinate essential public health services through public health regions and affiliated local health departments. Plan and implement programs to ensure preparedness and rapid response to bioterrorism, natural epidemics, and other public health and environmental threats and emergencies.	**Citizens of Texas:** DSHS is responsible for public health and medical services during a disaster or public health emergency and ongoing surveillance for infectious disease outbreaks with statewide potential such as influenza and foodborne outbreaks. **Other Local, State, and Federal Agencies**: DSHS coordinates with local health departments (LHDs); Texas Division of Emergency Management; Regional Advisory Councils; laboratories and laboratory response networks; first responders; law enforcement; environmental, veterinary, and agricultural laboratories; hospitals; and healthcare systems. **Texas-Mexico Border Residents and Border Health Partners:** DSHS coordinates and promotes health issues between Texas and Mexico and provides interagency coordination and assistance on public health issues with local border health partners referenced in *Strategy 1.1.4. Border Health and Colonias*. **Public Health Services:** DSHS Public Health Regions (PHR) are responsible for ensuring the provision of public health services to communities across Texas where no LHD has been established or the LHD does not have the capacity or wish to provide a full range of public health services. State and federal funds are used to support DSHS Regions in the prevention of epidemics and spread of disease; protection against environmental hazards; prevention of injuries; promotion of healthy behaviors; and response to disasters. Through public health social workers, DSHS supports its statutory responsibility to link individuals who have a need for community and personal health services to appropriate community and private providers. **Committees:** DSHS provides support to the Public Health Funding and Policy Committee and Preparedness Coordinating Council.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.1.2. Vital Statistics. Maintain a system for recording, certifying, and disseminating information about births, deaths, and other vital events in Texas.	**Citizens of Texas:** DSHS provides vital records needed to access benefits and services. **Local Governments:** DSHS maintains and operates a statewide information system, Texas Electronic Vital Events Registrar (TxEVER), for use by statewide officials responsible for birth and death registration. DSHS receives information from district and county clerks responsible for registering vital event information associated with marriages, divorces, and suits affecting the family. **Funeral Directors, Funeral Home Staff, Medical Directors, and Facilities:** DSHS maintains and operates TxEVER for use by funeral directors and funeral home staff that provide death certificates as part of funeral services and to collect demographic data associated with registered deaths. Physicians, justices of the peace, medical examiners, hospitals, and hospices also contribute medical data associated with registration of death events. **Hospitals, Birthing Centers, and Midwives:** DSHS maintains TxEVER for hospitals, birthing centers, and certified and non-certified midwives that are responsible for registration of birth events.
Strategy A.1.3. Health Registries. Collect health information for public health research and information purposes that inform decisions regarding the health of Texans.	**Direct Consumers and Policymakers:** DSHS provides health-related disease registry for health planning and policy decisions. This includes the Texas Cancer Registry, Birth Defects Registry, Blood Lead Registry, Traumatic Brain Injury, Trauma and Emergency Medical Services Registries. DSHS collects, maintains, and disseminates data for all Texas residents and for policymakers. The aggregated data that is shared with a diverse group of users and stakeholders that contribute to prevention and control of diseases and conditions, and improve diagnoses, treatment, survival, and quality of life for all Texans.
Strategy A.1.4. Border Health and Colonias. Promote health and address environmental issues between Texas and Mexico through border/binational coordination, maintenance of border health data, and community-based healthy border initiatives.	**Texas-Mexico Border Residents:** DSHS coordinates and promotes health issues between Texas and Mexico and identifies resources and develops projects that support community efforts to improve border health. **Border Health Partners:** DSHS provides interagency coordination and assistance on public health issues with local border health partners; border LHDs; binational health councils; community health work groups, state border health offices in California, Arizona, and New Mexico; U.S.-Mexico Border Health Commission; U.S. EPA Border 2020 Program; U.S. Department of Health and Human Services (DHHS) Office of Global Affairs, U.S. DHHS Health Resources and Services Administration (HRSA) Office of Border Health; México Secretaria de Salud; and other state and federal agency border programs. **Committees:** DSHS provides support to the Taskforce of Border Officials.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.1.5. Health Data and Statistics. Collect, analyze, and distribute information about health and healthcare.	**Citizens of Texas:** DSHS utilizes data to help address Texas residents' concerns regarding health conditions in their neighborhoods. DSHS posts healthcare facility-level, community-level, and statewide health and healthcare workforce data on the Texas Health Data website. Texas Health Data is an interactive data website to support public health officials, educators, and students in improving service delivery, evaluating healthcare systems, and monitoring the health of the people of Texas. DSHS provides data to researchers and for other public health purposes, including inclusion in national and international documents that discuss and/or report the burden of health conditions nationally and/or internationally. This data may also be used for community health assessments, public health planning, and making informed healthcare decisions. **Other External Partners:** DSHS coordinates with the Texas Medical Association (TMA), Texas Academy of Family Physicians, Texas Midwifery Association, Association of Texas Midwives, County Medical Societies, Texas and New Mexico Hospice Organization, Texas Justice Court Training Center, Texas County Commissioners Court, County and District Clerks' Association of Texas, Texas Hospital Association (THA), Texas Society of Infection Control and Prevention, local chapters of the Association for Professionals in Infection Control and Epidemiology, Texas Tumor Registrars Association, the National Program of Cancer Registries - part of the Centers for Disease Control and Prevention (CDC), and the North American Association of Central Cancer Registries (NAACCR). **Other State Agencies:** DSHS coordinates with the Office of Attorney General, DFPS, Texas Department of Transportation, Texas Workforce Commission, HHSC, Texas Commission on Environmental Quality, Cancer Prevention and Research Institute of Texas (CPRIT), Texas Department of Housing and Community Affairs, Texas Poison Center Network, Texas Medical Board, Texas Board of Nursing, Texas Department of Agriculture, and Texas State Commission on Judicial Conduct. **Federal Agencies:** DSHS coordinates with the CDC, National Center for Health Statistics, Social Security Administration, Federal Bureau of Investigations, Food and Drug Administration (FDA), National Institute of Occupational Safety and Health, Centers for Medicare & Medicaid Services (CMS), Agency for Healthcare Research and Quality, Agency for Toxic Substances and Disease Registries, Department of Veteran Affairs, and EPA.

Objective A.2

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.2.1. Immunize Children and Adults in Texas. Implement programs to immunize children and adults in Texas.	**Direct Consumers:** DSHS operates the Texas Vaccines for Children (TVFC) and Adult Safety Net (ASN) programs to provide immunizations for eligible children, adolescents, and adults. These programs also work to educate and perform quality assurance activities with healthcare providers vaccinating these groups. DSHS maintains an electronic vaccine inventory system that enables participating providers to order vaccine stock and report on vaccines administered. DSHS maintains a statewide immunization registry (ImmTrac2) that contains millions of immunization records, mostly for children. Healthcare providers use ImmTrac to ensure timely administration of vaccines and to avoid over-vaccination. Parents may obtain immunization records for their children. DSHS also conducts surveillance, investigation, and mitigation of vaccine-preventable diseases. **Local Governments:** DSHS helps LHDs in conducting immunization programs at the local level, including providing immunizations for eligible children, adolescents, and adults; providing immunization education; and assisting with activities to increase immunization coverage levels across Texas. **Schools and Childcare Facilities:** DSHS provides education and technical assistance to school and childcare facilities on school immunization requirements. DSHS conducts an annual survey of private schools and public school districts to assess vaccination coverage. Additionally, DSHS conducts audits on schools and childcare facilities to ensure that the facilities comply with school immunization requirements. **External Partners:** DSHS works with the Texas Immunization Stakeholder Working Group, which includes representatives from TMA, Texas Pediatric Society (TPS), parents, schools, LHDs, pharmacists, nurses, vaccine manufacturers, immunization coalitions, and other organizations with a role in the statewide immunization system. **Other State Agencies:** DSHS works with Texas Education Agency, DFPS and HHSC in the delivery of immunization services.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.2.2. HIV/Sexually Transmitted Disease (STD) Prevention. Implement programs of prevention and intervention including preventive education, case identification and counseling, HIV/STD medication, and linkage to health and social service providers.	**Direct Consumers:** DSHS provides access to HIV treatment and care services, including life-enhancing medications, for low-income, uninsured, or underinsured persons. DSHS also provides ambulatory healthcare and supportive services to persons living with HIV disease through contracted providers. DSHS contracts to provide HIV counseling and testing, linkage to HIV related medical care and behavior change interventions to prevent the spread of HIV and other STDs. DSHS provides testing for HIV and STDs, medications for some STDs, and disease intervention and partner services to reduce the spread of STDs. **Local Governments:** DSHS helps local governments in the delivery of services to assure that persons diagnosed with HIV and high priority STDs are notified and linked to medical care and treatment. Assistance is provided to assure that partners of persons newly diagnosed with HIV and high priority STDs are notified and offered testing services. DSHS provides capacity building and technical assistance/training services to LHDs that provide HIV/STD prevention and treatment and care services. DSHS works with LHDs to promote HIV/STD as a health and prevention priority among medical providers and the community at large. DSHS provides local leaders and groups across Texas with information on the size and scope of HIV and STD cases in their communities, with HIV/STD-specific strategic planning tools, and with best risk reduction practices to support creation of HIV/STD prevention and services action plans. **Community-Based Organizations:** DSHS provides capacity building and technical assistance/training services to contracted providers providing HIV/STD prevention and treatment and care services. **Committee:** The Texas HIV Medication Advisory Committee advises DSHS about the Texas HIV Medication Program formulary and policies.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.2.3. Infectious Disease Prevention, Epidemiology and Surveillance. Conduct surveillance on infectious diseases, including respiratory, vaccine-preventable, bloodborne, foodborne, zoonotic diseases and healthcare associated infections. Implement activities to prevent and control the spread of emerging and acute infectious and zoonotic diseases.	**Citizens of Texas:** DSHS coordinates disease surveillance and outbreak investigations including information on the occurrence of disease, as well as prevention and control measures. DSHS conducts surveillance for and investigations of infectious diseases, recommends control measures in accordance with best practices, and implements interventions. In addition, DSHS provides information on infectious disease prevention and control to the public through the website and personal consultation. DSHS facilitates the distribution of rabies biologics to persons exposed to rabies, provides Animal Control Officer training opportunities, inspects animal rabies quarantine facilities, immunizes wildlife that can transmit rabies to humans, mobilizes community efforts such as pet neutering programs through the Animal Friendly grant, and maintains investigative response capacity. **Local Governments:** DSHS coordinates infectious disease prevention, control, epidemiology, and surveillance activities with LHDs. **Other State and Federal Agencies:** DSHS collaborates daily with the CDC to maintain consistency with national guidance on infectious disease surveillance, investigation, and mitigation. DSHS serves as the lead on a cooperative project with U.S. Department of Agriculture and Texas Military Forces. Other stakeholders are THA, Texas Health Care Association, Texas Organization of Rural & Community Hospitals (TORCH), Texas Ambulatory Surgery Center Society, End State Renal Disease (ESRD) Network of Texas, the Texas Animal Health Commission, Texas Parks and Wildlife Department, Texas Veterinary Medical Diagnostic Laboratory, U.S.-Mexico Border Health Commission, Rotary International, CDC, FDA, HRSA, schools of public health in Texas, voluntary agencies, HHSC, and federal Office of Refugee Resettlement. **Medical Community:** DSHS provides information and consultation to the human and veterinary medical communities, as well as to healthcare professionals through personal consultation and professional organizations, presentations and posters at scientific meetings, and peer-reviewed publications. **Committees:** DSHS provides support to the Task Force on Infectious Disease Preparedness and Response and the Healthcare Safety Advisory Committee. (The Healthcare Safety Advisory Committee was abolished on September 1, 2020 as per Texas Administrative Code (TAC) (25 TAC §200.40 (e)(2)(f)).

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.2.4. Tuberculosis (TB) Surveillance and Prevention. Implement activities to conduct TB surveillance, to prevent and control the spread of TB, and to treat TB infection.	**Direct Consumers:** DSHS establishes disease surveillance and outbreak investigations processes and provides information on the occurrence of TB disease in communities across Texas. DSHS implements TB disease control measures, including testing and diagnostic services and promoting adherence to treatment. DSHS also ensures that all persons residing in Texas and the Texas/Mexico border who are diagnosed with TB or Hansen's disease receive treatment regardless of ability to pay for services. In addition, DSHS provides information to the public on TB prevention and control and Hansen's disease through its website. Phone consultations are also provided to the public on TB and Hansen's disease. **Local Government:** DSHS contracts with LHDs to provide outpatient clinical and public health services for TB and Hansen's disease management. DSHS works with DSHS PHRs and LHD providers on TB binational projects and other special projects targeting individuals and groups at high risk for TB. DSHS provides medications, laboratory services, capacity building, technical assistance, and training services to contracted providers on TB and Hansen's disease. DSHS works in collaboration with LHDs and PHRs to evaluate TB screening, reporting and case management activities conducted by local jails statewide. **State Agencies:** DSHS collaborates with Texas Commission on Jail Standards to uphold standards for jails with a TB screening program. DSHS collaborates with Texas Department of Criminal Justice on TB screening, prevention, and reporting activities. **Federal Agencies:** DSHS collaborates with the CDC, the National Hansen's Disease Program, Bureau of Prisons, Immigration Customs Enforcement, U.S. Marshal's Office on disease surveillance, reporting and management. **Medical Community:** DSHS provides consultation services to healthcare professionals on TB and Hansen's disease. DSHS works in collaboration with medical partners to evaluate persons for TB, reporting and patient management activities. **Contracted Providers:** DSHS contracts with private organizations, hospitals, university medical centers and federally qualified health centers (FQHCs) to provide outpatient TB screening and diagnosis services. DSHS partners with Heartland National TB Center, a CDC Regional Training and Medical Consultation Center, to provide training to healthcare professionals and to maintain an educated TB workforce. DSHS also participates in professional organizations including conducting presentations and presenting posters at scientific meetings and submitting peer-reviewed publications.
Strategy A.2.5 Texas Center for Infectious Disease. Provide medical treatment to persons with tuberculosis and Hansen's disease.	**Hospital Services:** Through the Texas Center for Infectious Disease, DSHS provides inpatient and outpatient TB treatment and outpatient Hansen's disease evaluation and treatment.

Objective A.3

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.3.1. Health Promotion and Chronic Disease Prevention. Develop, implement, and evaluate evidence-based interventions to reduce health risk behaviors that contribute to chronic disease. Conduct chronic disease surveillance.	**Citizens of Texas:** DSHS provides awareness and educational resources/materials for diabetes, Alzheimer's disease, cancer, asthma, and cardiovascular disease (CVD). DSHS provides child safety seats to low-income families with children less than eight years of age. DSHS provides support to communities for planning and implementing evidence-based obesity prevention interventions through policy and environmental change. **Councils, Task Forces, and Collaboratives:** DSHS provides administrative support to the Texas Diabetes Council, Texas Council on Alzheimer's Disease and Related Disorders, Texas Council on CVD and Stroke, Texas CVD and Stroke Partnership, Texas School Health Advisory Committee, Stock Epinephrine Advisory Committee, and the Cancer Alliance of Texas. **Healthcare Professionals:** DSHS provides toolkits and information that include professional and patient education materials featuring self-management training, minimum standards of care, and evidence-based treatment algorithms. **Contracted entities:** DSHS contracts with various LHDs, universities, non-profits, private sector entities, and others to implement interventions and collect data to reduce the burden of chronic disease and related risk factors. **Community Diabetes Projects:** DSHS contracts with LHDs, community health centers, and grassroots organizations to establish programs for promoting wellness, physical activity, weight and blood pressure control, and smoking cessation for people with or at risk for diabetes. **Schools:** DSHS provides technical assistance on the care of students with or at risk for chronic disease. DSHS provides child safety seats and education to community partners that assist in the distribution of the safety seats to low-income families and trains nurses, police officers, and other community members to be nationally certified child passenger safety technicians. **State Agencies:** DSHS provides subject matter expertise, including research and data analysis, on topics related to chronic disease. DSHS also collaborates with the CPRIT on cancer-related activities. DSHS works with state agency worksite wellness coordinators to implement health promotion and wellness activities in Texas state agencies.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.3.2. Reducing the Use of Tobacco Products Statewide. Develop a statewide program to reduce the use of tobacco products.	**Citizens of Texas:** DSHS plays a leadership role in educating the public about the importance of tobacco prevention and cessation. DSHS also provides cessation counseling services to all Texas residents. **Healthcare Providers:** DSHS provides training and resources for healthcare providers to implement best practices for treating tobacco dependence in multiple healthcare settings. **External Partners:** DSHS works with the University of Texas at Austin, University of Texas at El Paso, University of Houston, The Council on Alcohol and Drug Abuse, Optum, Texas State University, Texas A&M University, MD Anderson Cancer Center, American Cancer Society, and American Lung Association. **Contracted Services:** DSHS contracts with a media firm; a national Quitline service provider; state institutions of higher education; and local coalitions to implement comprehensive tobacco prevention, cessation, and environmental change policies.

Objective A.4

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.4.1. Laboratory Services. Provide analytical laboratory services in support of public health program activities.	**Citizens of Texas:** DSHS tests specimens for infectious diseases such as HIV, STD, and TB; screens for lead in children; tests bay water and milk samples for contamination; tests for rabies; screens every newborn for 54 metabolic and genetic disorders; and identifies organisms responsible for disease outbreaks throughout Texas. DSHS also provides testing for chemical and biological threats. **Other Local, State, and Federal Agencies:** DSHS coordinates with LHDs and their laboratories; laboratories that are part of CDC Laboratory Response Network; first responders; law enforcement; environmental, veterinary, and agricultural laboratories; vector control programs; and animal control programs. **Public Water Systems:** DSHS provides testing of water samples as part of the EPA Safe Drinking Water Act. **External Partners:** DSHS works with the Texas Newborn Screening Advisory Committee, THA, TMA, TPS, and other professional associations.

Objective B.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy B.1.1. Maternal and Child Health. Provide easily accessible, quality, and community-based maternal and child health services to low-income women, infants, children, and adolescents.	**Direct Consumers:** DSHS provides contracted clinical, educational, and support services to Texas residents who meet specific eligibility requirements. DSHS provides preventive oral health services to children in low-income schools and provides training and certification for vision and hearing screening. In addition, DSHS makes audiometers available to schools and day care centers for their staff to conduct screenings. DSHS also provides preventive and primary care, medical and limited dental services, and case management to low-income pregnant women and children through contracts with Title V funds. In the public health regions, DSHS participates in community assessment and provides a variety of Maternal and Child Health related special projects and community health promotion interventions to improve the health of families and the community. Limited genetics services are also provided through contracts. DSHS notifies primary care physicians and families of newborns with out-of-range newborn screening results to ensure clinical care coordination to prevent development delays, intellectual disability, illness, or death. DSHS also provides education to providers and the public regarding genetics. **Contracted Providers:** DSHS provides professional education to dental, medical, and case management providers through online provider education and in-person training opportunities. DSHS contracts with nonprofit organizations including LHDs, hospital districts, university medical centers, FQHCs, and other community-based organizations. **Certified Individuals:** DSHS provides oversight of the training and certification requirements for promotoras/community health workers and training instructors. **Schools:** DSHS contracts with entities that provide primary and preventive services through school-based health centers. DSHS also provides training and technical assistance to school administrators, school nurses, and parents on the provision of health services within the school setting. **Other State Agencies:** DSHS provides subject matter expertise, including research and data analysis, on topics related to maternal and child health populations. DSHS also collaborates with the CPRIT on cancer-related activities. Under authority of Title XIX of the Social Security Act (SSA), Chapters 22 and 32 of the Human Resource Code and an Interagency Cooperation Agreement (IAC) with HHSC, DSHS provides for administrative functions related to periodic medical and dental checkups for Medicaid-eligible children 0 through 20 years of age and case management for children 0 through 20 years of age and pregnant women with health risks or health conditions. **External Partners:** DSHS interacts with the American Cancer Institute, TPS, Texas Dental Association, TMA, THA, TORCH, March of Dimes, Children's Hospital Association of Texas, Head Start programs, independent school districts, and healthcare providers. **Committees:** DSHS provides administrative support to the Newborn Screening Advisory Committee, Promotor(a)/Community Health Worker (CHW) Training and Certification Advisory Committee, Sickle Cell Task Force, and the Maternal Mortality and Morbidity Review Committee.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy B.1.2. CSHCN. Administer population health initiatives for children with special health care needs.	**Direct Consumers:** DSHS is responsible for public health initiatives for children with special health care needs and their families and people of any age with cystic fibrosis. Regional staff also provide case management, eligibility determination, and enrollment services. DSHS community-based initiatives for the CSHCN population include medical home, transition to adult care, and community integration through contractors. Through community-based contracts, family supports and community resources are provided and case management is available for CSHCN who are not part of Medicaid. **External Partners:** DSHS actively participates on a variety of advisory groups including but not limited to the Children's Policy Council and the Texas Council for Developmental Disabilities. DSHS interacts with professional organizations, including Children's Hospital Association of Texas, THA, TMA, and TPS, and advocacy/support groups, including Texas Parent to Parent, Every Child, Inc., and Disability Rights Texas. DSHS facilitates the Medical Home Learning Collaborative, Transition to Adult Care Learning Collaborative and participates in the STAR Kids Advisory Council, the Texas Respite Coalition, the statewide Community Resource Coordination Group (CRCG), and the ECI Advisory Committee.

Objective B.2

Budget Strategy	Stakeholder Groups/Services Provided
Strategy B.2.1. Emergency Medical Services (EMS) and Trauma Care Systems. Develop and enhance regionalized emergency healthcare systems.	**Citizens of Texas:** DSHS ensures a coordinated statewide Emergency Medical Services (EMS) and trauma system and designates trauma and stroke facilities in Texas. DSHS regulates and sets standards for EMS professionals and providers. **Emergency Medical Services:** DSHS sets standards and maintains oversight of EMS providers, EMS education providers and EMS personnel. **Healthcare Facilities:** DSHS sets standards and maintains oversight of a system of designations for hospitals in trauma, stroke, neonatal care. **Regional Advisory Councils (RACs)**: DSHS contracts and coordinates with 22 RACs that are tasked with developing, implementing, and monitoring a regional emergency medical service trauma system plan, for the purpose of improving and organizing trauma care. **External Partners:** DSHS interacts with professional organizations including Texas Ambulance Association, Texas Fire Chiefs Association, Texas EMS Alliance, Texas Hospital Association, Texas Medical Association, Texas Organization of Rural and Community Hospitals, and Texas EMS Trauma and Acute Care Foundation. **Committees:** DSHS provides administrative support for the Medical Advisory Board and the Governor's EMS and Trauma Advisory Council (GETAC).

Budget Strategy	Stakeholder Groups/Services Provided
Strategy B.2.2. Texas Primary Care Services. Develop systems of primary and preventive healthcare delivery in underserved areas of Texas.	**Local Health Departments:** DSHS may recommend areas where local health entities operate for federal designation as Health Professional Shortage Areas and Medically Underserved Areas. **Schools of Public Health and Universities:** DSHS partners with these entities in recruitment activities for the National Health Service Corps and Texas Conrad 30 J-1 Visa Waiver Program. **Other Organizations:** DSHS works with communities and nonprofit organizations to develop and expand FQHCs in Texas.

Objective C.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy C.1.1. Food (Meat) and Drug Safety. Design and implement programs to ensure the safety of food, drugs, and medical devices.	**Citizens of Texas:** DSHS protects Texas residents from contaminated, adulterated, and misbranded foods by enforcing food safety laws and regulations and investigating foodborne illness outbreaks to identify sources of contamination. DSHS also protects Texas residents from adulterated or misbranded foods, consumable hemp products, drugs, medical devices, cosmetics, and tattoo and body-piercing procedures through regulation. DSHS protects school-age children by inspecting school cafeterias. **Local and State Entities:** DSHS interacts with Texas Department of Agriculture, the Texas Board of Pharmacy, U.S. Department of Agriculture, and U.S. Food and Drug Administration.
Strategy C.1.2. Environmental Health. Design and implement risk assessment and risk management regulatory programs for consumer products, occupational and environmental health, and community sanitation.	**Citizens of Texas:** DSHS provides protection and handles compliance over a broad range of commonly used consumer items including automotive products, household cleaners, polishes and waxes, paints and glues, infant items, and children's toys. DSHS also protects and promotes the physical and environmental health of Texans from asbestos, and lead. DSHS protects children attending private and university-based summer youth camps by requiring completion of certain trainings and inspections. **Committees:** DSHS provides administrative support from the Youth Camp Advisory Committee.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy C.1.3. Radiation Control. Design and implement a risk assessment and risk management regulatory program for all sources of radiation.	**Citizens of Texas:** DSHS protects Texas residents from unnecessary exposure to radiation sources by enforcing radiation laws and regulations and investigating events related to radiation sources. DSHS also responds to emergency response when there is a potential risk of exposure to radiation sources. **Other State Agencies:** DSHS coordinates with the Texas Division of Emergency Management, local governments and other state agencies as part of the DSHS responsibility for Annex D, Radiological Emergency Response, of the State of Texas Emergency Management Plan. DSHS also interfaces with Texas Commission on Environmental Quality, the Texas Railroad Commission, the U.S. FDA, and the U.S. Nuclear Regulatory Commission. **Committees:** DSHS provides administrative support for the Texas Radiation Advisory Board.
Strategy C.1.4. Texas.Gov. Estimated and Nontransferable. Texas.Gov. Estimated and Nontransferable.	**Regulated Entities:** DSHS is statutorily permitted to increase license, permit, and registration fees imposed on licensees by an amount sufficient to cover the cost of the subscription fee charged by TexasOnline.

Objective D.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy D.1.1. Agency Wide Information Technology Projects. Provide data center services and a managed desktop computing environment for the agency.	**DSHS Employees:** DSHS provides information technology support for DSHS employees and programs.

Objective E.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy E.1.1. Central Administration. Central administration. **Strategy E.1.2. Information Technology Program Support.** Information Technology program support. **Strategy E.1.3. Other Support Services.** Other support services. **Strategy E.1.4. Regional Administration.** Regional administration.	**DSHS Employees:** DSHS provides administrative support for DSHS employees and programs.

Appendix B. Customer Inventory for the Health and Human Services Commission (HHSC)

Services Provided to Customers by Budget Strategy, as listed in HHS System Strategic Plan 2019–2023, Volume II, Schedule A

Objective A.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.1.1. Aged and Medicare-Related Eligibility Group. Provide medically necessary healthcare in the most appropriate, accessible, and cost-effective setting to aged and Medicare-related Medicaid-eligible persons.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides healthcare to Medicaid aged and Medicare-related persons. **MCOs/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
Strategy A.1.2. Disability-Related Eligibility Group. Provide medically necessary healthcare in the most appropriate, accessible, and cost-effective setting for disability-related Medicaid-eligible adults and children.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides healthcare to eligible disability-related adults and children. **MCOs/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
Strategy A.1.3. Pregnant Women Eligibility Group. Provide medically necessary healthcare in the most appropriate, accessible, and cost-effective setting for Medicaid-eligible pregnant women.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides healthcare to women who are pregnant and eligible for Medicaid. **MCOs/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
Strategy A.1.4. Other Adults Eligibility Group. Provide medically-necessary healthcare in the most appropriate, accessible, and cost-effective setting to adults who are principally income-level eligible (non-pregnant, non-Medicare, non-disability-related).	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides healthcare to eligible TANF-level adults, medically needy, and other adults who are principally income-level eligible. **MCOs/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.1.5. Children Eligibility Group. Provide medically necessary healthcare in the most appropriate, accessible, and cost-effective setting to newborn infants and Medicaid-eligible children who are not receiving SSI disability-related payments.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides healthcare to Medicaid eligible child recipients.
Strategy A.1.6. Medicaid Prescription Drugs. Provide prescription medication to Medicaid-eligible recipients as prescribed by their treating physician.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides prescription medication benefits to Medicaid recipients. **MCOs/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
Strategy A.1.7. Texas Health Steps (THSteps) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Dental. Provide dental care in accordance with all federal mandates.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides access to periodic dental exams, diagnosis, prevention, and treatment of dental disease to Medicaid eligible children. **MCOs/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
Strategy A.1.8. Medical Transportation. Support and reimburse for non-emergency transportation assistance to individuals receiving medical assistance.	**Medicaid Consumers:** HHSC provides transportation for Medicaid recipients. **Providers:** The Medical Transportation Program contracts with Managed Transportation Organizations (MTOs) and Full Risk Brokers for the provision of medical transportation services. The program sets policy and provides oversight for the services.

Objective A.2

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.2.1. Community Attendant Services. Provide attendant care services to Medicaid-reimbursed subgroup of Primary Home Care eligible individuals that must meet financial eligibility of total gross monthly income less than or equal to 300 percent of the Supplemental Security Income (SSI) federal benefit rate.	**Direct customer groups include:** • Individuals of any age who meet specific eligibility requirements including income and resources, who have a practitioner's statement of medical need and meet functional assessment criteria.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.2.2. Primary Home Care. Provide Medicaid-reimbursed, non-technical, medically related personal care services prescribed by a physician to eligible individuals whose health problems limit their ability to perform activities of daily living.	**Direct customer groups include:** • Individuals 21 years of age and older; • Individuals who meet eligibility requirements including Medicaid eligibility; • Individuals who have a practitioner's statement of medical need; and • Individuals who meet functional assessment criteria.
Strategy A.2.3. Day Activity and Health Services (DAHS). Provide daytime services five days a week to individuals residing in the community as an alternative to placement in nursing facilities or other institutions.	**Direct customer groups include:** • **Title XIX:** Individuals age 18 or older who receive Medicaid and meet eligibility requirements, which include having a functional disability related to a medical condition, a need for a personal care task, and a medical diagnosis and physician's orders requiring care or supervision by a licensed nurse. • **Title XX:** Individuals age 18 or older who meet specific eligibility requirements including income and resources and who have a functional disability related to a medical condition, a need for a personal care task, and a medical diagnosis and physician's orders requiring care or supervision by a licensed nurse.
Strategy A.2.4. Nursing Facility Payments. Provide payments that will promote quality care for individuals with medical needs that require nursing facility care.	**Direct customer groups include:** • Individuals with medical needs meeting medical necessity requirements and are eligible for Medicaid. The individuals must reside in a nursing facility for 30 consecutive days.
Strategy A.2.5. Medicare Skilled Nursing Facility. Provides payments for individuals in dually qualified certified facilities (certified for both Medicaid and Medicare).	**Direct customer groups include:** • Individuals who receive Medicaid and reside in Medicare (XVIII) skilled nursing facilities, • Medicaid/Quality Medicare Beneficiary (QMB) recipients and • Medicare only QMB recipients.
Strategy A.2.6. Hospice. Provide palliative care consisting of medical, social, and support services for individuals.	**Direct customer groups include:** • Individuals eligible for Medicaid who are terminally ill and no longer desire curative treatment and who have a physician's prognosis of six months or less to live. • Individuals under the age of 21 may continue to receive curative treatments while receiving hospice services.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.2.7. Intermediate Care Facilities - for Individuals with Intellectual Disability (ICFs/IID). Provide or contract for residential facilities of four or more beds for 24-hour care for the intellectual and developmentally disabled residents.	**Direct customer groups include:** • Individuals with intellectual and/or developmental disabilities who would benefit or require 24-hour supervised living arrangements and qualify for Medicaid.

Objective A.3

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.3.1. Home and Community-Based Services (HCS). Provide individualized services to individuals with intellectual disability living in their family's home, their own homes, or other settings in the community.	**Direct customer groups include:** • Individuals of any age who have a determination/diagnosis of intellectual disability or related condition, who meet Medicaid eligibility, resource and level of care criteria, and who choose HCS services instead of the ICF/IID program.
Strategy A.3.2. Community Living Assistance and Support Services (CLASS). Provide home and community-based services to persons who have a "related condition" diagnosis qualifying them for placement in an Intermediate Care Facility. A related condition is a disability other than intellectual and/or developmental disability which originates before age 22 and which substantially limits life activity. Such disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and other diagnoses, are said to be "related to" intellectual and/or developmental disability in their effect upon the individual's functioning.	**Direct customer groups include:** • Individuals of any age with a diagnosis of developmental disability other than intellectual disability who meet specific eligibility requirements including Medicaid eligibility and functional need and who choose waiver services instead of institutional services.
Strategy A.3.3. Deaf-Blind Multiple Disabilities (DBMD). Provide home and community-based services to adult individuals diagnosed with deafness, blindness, and multiple disabilities.	**Direct customer groups include:** • Individuals of any age who are deaf, blind, and have a third disability, who meet specific eligibility requirements including Medicaid eligibility and functional need and who choose waiver services instead of institutional services.
Strategy A.3.4. Texas Home Living (TxHmL) Waiver. Provide individualized services, not to exceed $17,000 per year, to individuals with an intellectual disability living in their family's home, their own homes, or other settings in the community.	**Direct customer groups include:** • Individuals of any age who have a determination/diagnosis of intellectual disability or related condition, who meet specific eligibility requirements including Medicaid eligibility, resource and level of care criteria, and who choose waiver services over ICF/IID.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.3.5. Program of All-Inclusive Care for the Elderly (PACE). Provide community-based services to frail and elderly individuals who qualify for nursing facility placement. Services include inpatient and outpatient medical care and social/community services at a capitated rate.	**Direct customer groups include:** • Individuals age 55 or older who qualify for nursing facility services and receive Medicare and/or Medicaid.

Objective A.4

Budget Strategy	Stakeholder Groups/Services Provided
Strategy A.4.1. Non-Full Benefit Payments. Provide payments for medically necessary healthcare to eligible recipients for certain services not covered under the insured arrangement, including undocumented persons, school health, and other related services.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides healthcare to Medicaid eligible recipients for specific services not covered. **MCOs/Providers**: The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
Strategy A.4.2. For Clients Dually Eligible for Medicare and Medicaid. Provide accessible premium-based health services to certain Title XVIII Medicare-eligible recipients.	**Medicaid Consumers:** HHSC Medicaid/CHIP division provides premium-based health services to Medicaid-eligible aged and disability related persons who are also eligible for Title XVIII Medicare coverage. **MCOs/Providers:** The HHSC Medicaid/CHIP division contracts with MCOs for the provision of health services. The Medicaid/CHIP division sets policy and provides oversight for the program.
Strategy A.4.3. Transformation Payments. Maximize federal funding to provide supplemental Medicaid reimbursement for uncompensated care and delivery system reform incentives under the 1115 waiver. Historically provided children's hospital upper payment limit match.	**Hospitals/Providers:** States may receive federal funding to provide hospitals supplemental payments to cover inpatient and outpatient services that exceed regular Medicaid rates.

Objective B.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy B.1.1. Medicaid Contracts and Administration. Administer efficient and effective Medicaid program, set the overall policy direction of the state Medicaid program, and manage interagency initiatives to maximize federal dollars.	**Other HHS Agencies:** HHSC provides the leadership and policy planning for administration of the state Medicaid Office across the HHS system.
Strategy B.1.2. CHIP Contracts and Administration. Administer efficient and effective CHIP program, including contracted administration, and set overall policy direction of CHIP programs.	**Federal Government:** HHSC Medicaid/CHIP division provides direction, guidance, and policy making for the Children's Health Insurance Program, a federal program administered through states. **MCOs:** The HHSC Medicaid/CHIP division contracts with Managed Care Organizations for the provision of the Children's Health Insurance Program. The Medicaid/CHIP division sets policy and provides oversight for the CHIP program. **Children and Families:** The CHIP program exists to serve Texas children and families, providing health insurance to children in families with incomes up to 200 percent of the federal poverty level.

Objective C.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy C.1.1. CHIP. Provide healthcare to uninsured children who apply and are determined eligible for insurance through CHIP. **Strategy C.1.2. CHIP Perinatal Services.** Provide healthcare to perinates whose mothers apply and are determined eligible for insurance through CHIP. **Strategy C.1.3. CHIP Prescription Drugs.** Provide prescription medication to CHIP-eligible recipients (includes all CHIP programs), as provided by their treating physician. **Strategy C.1.4. CHIP Dental Services.** Provide dental healthcare services to uninsured children who apply and are determined eligible for insurance through CHIP.	**Federal Government:** HHSC Medicaid/CHIP division provides direction, guidance, and policy making for the Children's Health Insurance Program, a federal program administered through states. **MCOs:** The HHSC Medicaid/CHIP division contracts with Managed Care Organizations for the provision of the Children's Health Insurance Program. The Medicaid/CHIP division sets policy and provides oversight for the CHIP program. **Children and Families:** The CHIP program exists to serve Texas children and families, providing health insurance to children in families with incomes up to 200 percent of the federal poverty level.

Objective D.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy D.1.1. Women's Health Program. Women's Health Program.	**Non-Pregnant Low Income Women:** HHSC provides family planning services, related health screening, and birth control to low-income women who are 18 through 44 years of age. Providers are required to complete an HTW certification every year they participate.
Strategy D.1.10. Additional Specialty Care. Deliver specialty care services including service programs for epilepsy and hemophilia, as well as provide leadership and direction to the statewide umbilical cord blood bank and health information technology initiatives.	**Direct Consumers:** HHSC provides clinical and support services through contracted providers to Texas residents with epilepsy or seizure-like symptoms who meet specific eligibility requirements. HHSC provides financial assistance for people with hemophilia to pay for their blood factor replacement products. **Contracted Providers:** HHSC contracts with a university medical center, hospital district, and nonprofit organizations for epilepsy services. Local health entities, schools of public health, and universities may be contracted providers. HHSC contracts with pharmacies for hemophilia services. **External Partners:** HHSC interacts with professional organizations, including TMA, THA, and with statewide epilepsy entities. HHSC interacts with professional organizations, including hemophilia treatment centers, TMA, and THA, and with statewide hemophilia networks.
Strategy D.1.11. Community Primary Care Services. Develop systems of primary and preventive healthcare delivery in underserved areas of Texas.	**Direct Consumers:** HHSC/DSHS provides clinical services through contracted providers to Texas residents who meet specific eligibility requirements. **Contracted Providers:** HHSC/DSHS contracts with nonprofit organizations such as LHDs, hospital districts, university medical centers, FQHCs, and other community-based organizations. **Local Health Departments:** HHSC/DSHS may recommend areas where local health entities operate for federal designation as Health Professional Shortage Areas and Medically Underserved Areas. **Schools of Public Health and Universities:** HHSC/DSHS partners with these entities in recruitment activities for the National Health Service Corps and Texas Conrad 30 J-1 Visa Waiver Program. **Other Organizations:** HHSC/DSHS works with communities and nonprofit organizations to develop and expand FQHCs in Texas.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy D.1.12. Abstinence Education. Increase abstinence education programs in Texas.	**Adolescents and Parents:** HHSC provides abstinence education in Spanish and English through brochures, toolkits, workbooks, curricula, and online as well as service learning opportunities and leadership summit opportunities for youth in grades 5-12, and resources for parents in Spanish and English online and through booklets and DVDs. **Contractors:** HHSC contracts with providers to provide abstinence education curricula and service learning projects during in-school and after-school interventions. **School Districts:** HHSC provides workshops, webinars, trainings, toolkits, brochures, and workbooks for school districts across Texas. **Community, Faith-based, and Health Organizations:** HHSC provides toolkits, brochures, and workbooks for organizations.
Strategy D.1.2. Alternatives to Abortion. Nontransferable. Provide pregnancy support services that promote childbirth for women seeking alternatives to abortion.	**Pregnant Women and Children:** HHSC contracts for the delivery of pregnancy support services. These services include information regarding pregnancy and parenting (brochures, pamphlets, books, classes, and counseling), referrals to existing community services and social service programs (childcare services, transportation, low-rent housing, etc.), support groups in maternity homes, and mentoring programs (classes on life skills, budgeting, parenting, counseling, and obtaining a GED).
Strategy D.1.3. Early Childhood Intervention Services. Administer a statewide comprehensive system of services to ensure that eligible infants, toddlers, and their families have access to the resources and support they need to reach their service plan goals.	**Children with Disabilities & Their Families:** HHSC serves families with children birth to 36 months with developmental disabilities or delays and must provide early childhood intervention services to all eligible children.
Strategy D.1.4. Ensure ECI Respite Services and Quality ECI Services. Ensure that resources are identified and coordinated to provide respite service to help preserve the family unit and prevent costly out-of-home placements.	**Children with Disabilities & Their Families:** HHSC provides respite services to families served by the ECI program.
Strategy D.1.5. Children's Blindness Services. Provide information and training for blind and visually impaired children and their families so these children have the skills and confidence to live as independently as possible.	**Blind or Visually Impaired Consumers & Their Families:** HHSC provides services necessary to assist blind children to achieve self-sufficiency and a fuller richer life.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy D.1.6. Autism Program. To provide services to Texas children ages 3-15 diagnosed with autism spectrum disorder.	**Children with Autism & Their Families:** HHSC provides treatment services to children with a diagnosis of autism.
Strategy D.1.7. CSHCN. Administer service program for children with special health care needs, in conjunction with DSHS.	**Direct Consumers:** HHSC/DSHS provides services to children with special health care needs and their families and people of any age with cystic fibrosis. Services are provided through community-based contractors, entities that provide direct healthcare services and case management. Staff also provides case management. **External Partners:** HHSC/DSHS actively participates on a variety of advisory groups including but not limited to the Children's Policy Council and the Texas Council for Developmental Disabilities. HHSC/DSHS interacts with professional organizations, including Children's Hospital Association of Texas, THA, TMA, and TPS, and advocacy/support groups, including Texas Parent to Parent, Every Child, Inc., and Disability Rights Texas. HHSC/DSHS facilitates the Medical Home Workgroup, Transition Workgroup, and participates in the STAR Kids Advisory Council, the Texas Respite Coalition, the statewide CRCG, and the ECI Advisory Committee.
Strategy D.1.8. Title V Dental and Health Services. Provide easily accessible, quality and community-based dental services to low-income infants, children, and adolescents.	**Children and Families:** HHSC provides dental services to children through contracts with Title V funds. Services are provided through community-based contractors, entities that provide direct healthcare services.
Strategy D.1.9. Kidney Health Care. Administer service programs for kidney health care.	**Direct Consumers:** HHSC provides benefits to persons with end-stage renal disease who are receiving a regular course of renal dialysis treatments or have received a kidney transplant. **External Partners:** External partners include professional associations, including the ESRD Network and the Texas Kidney Foundation, to provide information and training and to receive information about the population served.

Objective D.2

Budget Strategy	Stakeholder Groups/Services Provided
Strategy D.2.1. Community Mental Health Services for Adults. Provide services and supports in the community for adults with serious mental illness.	**Contracted Services:** HHSC contracts with local mental health authorities to provide services to adults with diagnoses such as schizophrenia, bipolar disorder, major depression, post-traumatic stress disorder, schizoaffective disorder, obsessive-compulsive disorder, anxiety disorder, attention deficit disorder, delusional disorder, and eating disorders who are experiencing significant functional impairment. Additionally, HHSC contracts with community behavioral health providers to provide mental health services. Community services for adults may include: • psychiatric diagnosis; • pharmacological management; • training; and • support; • education and training; • case management; • supported housing and employment; • peer services; • therapy; • and rehabilitative services.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy D.2.2. Community Mental Health Services for Children. Provide services and supports for emotionally disturbed children and their families.	**Contracted Services:** HHSC contracts with local mental health authorities to provide services to children ages 3–17 with serious emotional disturbance (excluding a single diagnosis of substance use disorder, intellectual or developmental disability, or autism spectrum disorder) who have a serious functional impairment or who: 1) are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms, or 2) are enrolled in special education because of a serious emotional disturbance. Additionally, HHSC contracts with community behavioral health providers to provide mental health services. Community services for children may include: • community-based assessments, including the development of inter-disciplinary, recovery-oriented treatment plans, diagnosis, and evaluation services; • family support services, including respite care; • case management services; • pharmacological management; • counseling; and • skills training and development.
Strategy D.2.3. Community Mental Health Crisis Services (CMHCS). CMHCS.	**Contracted Services:** HHSC contracts with local mental health authorities to provide crisis services to persons whose crisis screening and/or assessment indicate that they are an extreme risk of harm to themselves or others in their immediate environment or to persons believed to present an immediate danger to self or others or their mental or physical health is at risk of serious deterioration. Additionally, HHSC contracts with community behavioral health providers to provide mental health services. Crisis services are designed to provide timely screening and assessment to individuals in crisis to divert them from unnecessary treatment in restrictive environments such as jails, emergency rooms, and state hospitals. Statewide crisis services include crisis hotlines, mobile crisis outreach teams and crisis facilities.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy D.2.4. Substance Abuse Prevention, Intervention, and Treatment. Implement prevention services to reduce the risk of substance use, abuse, and dependency. Implement intervention services to interrupt illegal substance use by youth and adults and reduce harmful use of legal substances by adults. Implement a continuum of community and family based treatment and related services for chemically dependent persons. Optimize performance quality and cost efficiency through the managing and monitoring of contracted services for substance abuse.	**Contracted Services:** HHSC contracts with local community providers to provide substance abuse prevention, intervention, and treatment services. Substance Abuse Prevention is targeted to school-age children and young adults. HIV Outreach and HIV Early Intervention programs provide information and education for substance-abusing adults at risk for HIV or who are HIV positive. Pregnant, Post-Partum Intervention Services provide case management, education, and support for pregnant and post-partum women at risk for substance abuse. HHSC contracts with state licensed programs to deliver treatment services to adolescents and adults who meet DSM-V criteria for substance abuse or dependence. Each region provides a continuum of care that includes outreach, screening, assessment, and referral; specialized services for females; residential and outpatient treatment for adults and youth; pharmacotherapy; and treatment for co-occurring disorders. HHSC also funds recovery support services such as housing, employment, and recovery coaching in order to develop long-term recovery in communities around the state.
Strategy D.2.5. Behavioral Health Waivers. Provide intensive community-based services for emotionally disturbed children and their families and for adults with serious mental illness.	**Children and Families:** HHSC provides services to children in Medicaid age 3 to 18 who have serious emotional disturbance to prevent acute psychiatric hospitalization. To support long-term recovery and success in an individual's community of choice, HHSC also provides intensive services in the home or community to adults with a serious mental illness who have had long tenures in an inpatient psychiatric hospital, frequent discharges from correctional facilities, or numerous emergency department visits.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy D.2.6. Community Mental Health Grant Programs. Behavioral health grant programs that support communities providing mental health and/or behavioral health services to meet the needs of specific Texas populations.	**Contracted Services:** HHSC contracts with local mental health authorities and other entities to support community collaboratives to improve and increase the availability and access to critical behavioral health services and treatment for individuals experiencing mental illness. Community Service Grants may include programs to assist: • Individuals who may need help coordinating mental health care services with other transition support services. • Juveniles encountering the criminal justice system. • Adults who have been arrested and incarcerated for the commission of a crime. • Homeless individuals' transition to integration in the community. • Veterans and their families.

Objective D.3

Budget Strategy	Stakeholder Groups/Services Provided
Strategy D.3.1. Indigent Health Care Reimbursement (UTMB). Reimburse the provision of indigent health services through the deposit of funds in the State-owned Multicategorical Teaching Hospital Account.	**University of Texas Medical Branch at Galveston (UTMB):** HHSC transfers funds for unpaid healthcare services provided to indigent patients.
Strategy D.3.2. County Indigent Health Care Services. Provide support to local governments that provide indigent healthcare services.	**Local Governments:** HHSC provides technical assistance to counties regarding program compliance and assistance with Supplemental Security Income and Medicaid claim submission.

Objective E.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy E.1.1. Temporary Assistance for Needy Families (TANF) Grants. Provide Temporary Assistance for Needy Families grants to low-income Texans.	**Children and Families:** The TANF grants provide capped entitlement services, non-entitlement services, one-time payments, child support payments and payment support for grandparents to children and families.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy E.1.2. Provide WIC Services: Benefits, Nutrition Education, and Counseling. Provide WIC services including benefits, nutrition education, and counseling.	**Direct Consumers:** HHSC provides services to low-income pregnant and post-partum women, infants, and children up to age five who meet certain eligibility requirements. **Citizens of Texas:** HHSC provides funding and support to communities through a competitive process to implement population level, evidence-based approaches to obesity prevention. **Contracted Providers:** HHSC contracts with LHDs, public health districts, hospitals, and nonprofit organizations to provide the WIC Program. **External Partners, Healthcare Professionals, and Other State Agencies:** HHSC provides subject matter expertise to a variety of external partners.

Objective F.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy F.1.1. Guardianship. Provide full or limited authority over an incapacitated aging or disabled adult who is the victim of validated abuse, neglect, exploitation, or of an incapacitated minor in Child Protective Services' (CPS) conservatorship.	**Direct customer groups include:** • Individuals with diminished capacity who are older and who meet specific eligibility requirements; • Individuals with diminished capacity who have a disability and who meet specific eligibility requirements; and • Individuals with diminished capacity who are aging out of CPS conservatorship.
Strategy F.1.2. Non-Medicaid Services. Provide services to individuals ineligible for Medicaid services, in their own home or community. Services include family care, home-delivered meals, adult foster care, Day Activities and Health Services (Title XX), emergency response, and personal attendant services.	**Direct customer groups include:** • Non-Medicaid community (Title XX and general revenue funded) services are provided to individuals 18 years of age or older who meet specific eligibility requirements including income, resource, and functional assessment criteria. • Older Americans Act (OAA) services are provided to individuals age 60 or older, their family caregivers and other caregivers caring for an eligible person.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy F.1.3. Non-Medicaid Developmental Disability Community Services. Provide services, other than those provided through the Medicaid waiver programs, to individuals with intellectual or developmental disabilities who reside in the community, including independent living, employment services, day training, therapies, and respite services.	**Direct customer groups include:** • Individuals with a determination/diagnosis of intellectual disability who reside in the community.

Objective F.2

Budget Strategy	Stakeholder Groups/Services Provided
Strategy F.2.1. Independent Living Services (General, Blind, and Centers for Independent Living). Provide quality, statewide consumer-directed independent living services that focus on acquiring skills and confidence to live as independently as possible in the community for eligible people with significant disabilities. Work with the State Independent Living Council to develop the State Plan for Independent Living.	**Blind or Visually Impaired Consumers:** HHSC is responsible for providing services that assist Texans with visual disabilities to live as independently as possible. **Consumers with Disabilities Other than Blindness:** HHSC provides people with significant disabilities, who are not receiving vocational rehabilitation services, with services that will substantially improve their ability to function, continue functioning, or move toward functioning independently in the home, family, or community.
Strategy F.2.2. Blindness Education, Screening, and Treatment (BEST) Program. Provide screening, education, and urgently needed eye-medical treatment to prevent blindness.	**Texans:** HHSC provides public education about blindness, screenings, and eye exams to identify conditions that may cause blindness and treatment procedures necessary to prevent blindness.
Strategy F.2.3. Provide Services to People with Spinal Cord/Traumatic Brain Injuries. Provide consumer-driven and counselor-supported CRS for people with traumatic brain injuries or spinal cord injuries.	**Consumers with Traumatic Brain or Spinal Cord Injuries:** HHSC provides adults who have suffered a traumatic brain or spinal cord injury with comprehensive inpatient or outpatient rehabilitation and/or acute brain injury services.
Strategy F.2.4. Provide Services to Persons Who Are Deaf or Hard of Hearing. Ensure continuity of services, foster coordination and cooperation among organizations, facilitate access to training and education programs, and support access to telephone systems to individuals who are deaf or hard of hearing. To increase the number of persons (who are deaf or hard of hearing) receiving quality services by 10 percent each biennium.	**Deaf or Hard of Hearing Consumers:** HHSC, through a network of local service providers at strategic locations throughout the state, provides communication access services including interpreter services and computer-assisted real-time transcription services, information and referral, hard of hearing services, and resource specialists' services.

Objective F.3

Budget Strategy	Stakeholder Groups/Services Provided
Strategy F.3.1. Family Violence Services. Provide emergency shelter and support services to victims of family violence and their children, educate the public, and provide training and prevention support to institutions and agencies.	**Children and Families:** HHSC's Family Violence Program contracts with local agencies to provide shelter, nonresidential, and special nonresidential services. Shelter centers' services include, but are not limited to, 24-hour emergency shelter, 24-hour crisis hotline services, referrals to existing community services, community education and training, emergency medical care and transportation, intervention, educational arrangements for children, cooperation with criminal justice officials, and information regarding training and job placement. Nonresidential centers provide the same services as shelter centers with the exception of the 24-hour emergency shelter component. Special nonresidential services address unmet needs or underserved populations such as immigrants or populations with limited English proficiency.
Strategy F.3.2. Child Advocacy Programs. Train, provide technical assistance, and evaluate services for Children's Advocacy Centers of Texas, Inc. (CACTX) and Texas Court Appointed Special Advocates, Inc. (Texas CASA).	**Children:** HHSC contracts with a statewide organization to provide training, technical assistance, evaluation services, and funds administration to support local children's advocacy center programs and court-appointed volunteer advocate programs.
Strategy F.3.3. Additional Advocacy Programs. Provide support services for interested individuals (Healthy Marriage, CRCG Adult/Child, TIFI, Office of Acquired Brain Injury, Faith and Community-Based Initiative, Center for the Elimination of Disproportionality).	**Children, Families and Adults:** HHSC helps connect couples to premarital education classes through the Healthy Marriage Program, provides education, awareness and prevention information for brain injury survivors, families and caregivers through the Office of Acquired Brain Injury, and provides education and outreach to prevent developmental disabilities in infants and young children through the Office of Disability Prevention for Children.

Objective G.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy G.1.1. SSLCs. Provide direct services and support to individuals living in state supported living centers. Provide 24-hour residential services for individuals who are medically fragile or severely physically impaired or have severe behavior problems, and who choose these services or cannot currently be served in the community.	**Direct customer groups include:** • Individuals who have a determination/diagnosis of intellectual disability who are medically fragile or who have behavioral problems.

Objective G.2

Budget Strategy	Stakeholder Groups/Services Provided
Strategy G.2.1. Mental Health State Hospitals. Provide specialized assessment, treatment, and medical services in state mental health facility programs.	**Direct Consumers:** HHSC directly provides statewide access to court-directed specialized inpatient services in nine state psychiatric hospitals (including a psychiatric unit at the Rio Grande State Center) for persons who are seriously mentally ill and are a risk to themselves or others or show a substantial risk of mental or physical deterioration of the person's ability to function independently. Individuals are on civil or forensic judicial commitments or are accepted on voluntary admissions. HHSC also provides services at the Waco Center for Youth, a psychiatric residential treatment center that admits children ages 13-17 who have a diagnosis of being emotionally disturbed, who have a history of behavior adjustment problems, and who need a structured treatment program in a psychiatric residential facility.
Strategy G.2.2. Mental Health (MH) Community Hospitals. Provide inpatient treatment, crisis assessment, and medical services to adults and children served in community hospitals.	**Contracted Services:** HHSC contracts with local mental health authorities, county governments, and universities to provide specialized inpatient services in their communities for persons who are seriously mentally ill and are a risk to themselves or others or show a substantial risk of mental or physical deterioration of the person's ability to function independently. Individuals are on civil or forensic judicial commitments or are accepted on voluntary admissions.

Objective G.3

Budget Strategy	Stakeholder Groups/Services Provided
Strategy G.3.1. Other State Medical Facilities. Provide program support to State Supported Living Centers, State Mental Health Hospitals, and other facilities (Corpus Christi Bond Homes and Rio Grande State Center Outpatient Clinic).	**Contracted Services:** HHSC provides administrative support for contracted services and programs.

Objective G.4

Budget Strategy	Stakeholder Groups/Services Provided
Strategy G.4.1. Facility Program Support. Provide program support to SSLCs, State Mental Health Hospitals, and other facilities (Corpus Christi Bond Homes, Texas Center for Infection Disease, and Rio Grande State Center Outpatient Clinic).	**Contracted Services:** HHSC provides administrative support for contracted services and programs.
Strategy G.4.2. Capital Repair and Renovation at State Supported Living Centers (SSLCs), State Hospitals, and Other. Conduct maintenance and construction projects critical to meeting accreditation/certification standards and to ensuring the safety of consumers and Master Lease Purchase Program.	**Direct Consumers:** HHSC funds projects, SSLCs, State Hospitals, and other facilities that are in need of ongoing repairs and maintenance. Projects include compliance with life safety and accessibility codes; physical plant changes that help prevent suicide; utility repairs; grounds upkeep; hazardous material remediation and abatement; and roofing, heating, ventilation, and air conditioning repairs.

Objective H.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy H.1.1. Health Care Facilities and Community-Based Regulation. Provide licensing, certification, contract enrollment services, financial monitoring, and complaint investigation to ensure that residential facilities and home and community support services agencies comply with state and federal standards and individuals receive high-quality services.	**Direct customer groups include:** • Providers of long-term care services that meet the definitions of a nursing facility, assisted living facility, day activity and health services facility, private intermediate care facility for persons with an intellectual disability, prescribed pediatric extended care center or home and community support services agency; • Persons receiving services in facilities or from agencies regulated under this strategy; • Persons eligible to receive services under TxHmL and HCS waiver contracts; and • Family and community members of persons receiving services in facilities or agencies regulated under this strategy who may obtain assurance that regulated facilities and agencies meet the minimum standard of care required by statute and regulation.
Strategy H.1.2. Long-Term Care Quality Outreach. Provide quality monitoring and rapid response team visits to assess quality and promote quality improvement in nursing facilities.	**Direct customer groups include:** Staff in nursing homes, SSLCs, ICFs, Assisted Living Facilities, and the people who live in these settings. Quality Monitoring Program (QMP) staff provide in-services which are attended by the people who live there, as well as their family members.

Objective H.2

Budget Strategy	Stakeholder Groups/Services Provided
Strategy H.2.1. Child Care Regulation. Provide a comprehensive system of consultation, licensure, and regulation to ensure maintenance of minimum standards by day care and residential child care facilities, registered family homes, child-placing agencies, facility administrators, and child-placing agency administrators.	**Children and Families:** HHSC helps ensure the health, safety, and well-being of children in child day care and 24-hour residential child care settings by developing and regulating compliance with minimum standards and investigating reports of abuse and neglect in child care facilities. **Other State Agencies:** Child care regulation involves support and participation by Texas Workforce Commission, DSHS, DFPS, and other regulatory agencies. **Local Governments:** HHSC regulation of child care facilities involves the network of child care providers managed by local workforce boards. It also includes local health agencies and fire inspectors. **External Partners:** HHSC regulation of child care facilities includes listed family homes, registered child care homes, licensed child care centers and homes, licensed residential child care facilities, and licensed child placing agencies. Other external partners in ensuring safety of children in childcare settings include parents, schools, licensed child care administrators, and children's advocates.

Objective H.3

Budget Strategy	Stakeholder Groups/Services Provided
Strategy H.3.1. Credentialing/Certification of Health Care Professionals and Others. Provide credentialing, training, and enforcement services to qualify individuals to provide services to long-term care facility and home health care agency individuals in compliance with applicable law and regulations.	**Direct customer groups include:** • Persons employed or seeking employment as nursing facility administrators, nurse aides and medication aides benefit from training and from assurance that people working in the field meet minimum standards; • Providers of long-term care services that meet the definitions of nursing facility, assisted living facility, day activity and health services facility, private intermediate care facility for persons with an intellectual disability, prescribed pediatric extended care center or home and community support services agency benefit from training programs for employees, from monitoring of certification of employees and from access to misconduct registry for unlicensed or unregistered employees; • Employers of nurse aides and medication aides, including long-term care service and related providers who benefit from public access to information in the Nurse Aide Registry (NAR) and Employee Misconduct Registry (EMR) to enhance pre-employment verification of employability; • Persons receiving services in facilities or from agencies regulated by HHSC benefit from having a more highly qualified workforce as caregivers and administrators; and • Family and community members of persons receiving services in facilities or agencies regulated under this strategy who may obtain assurance that caregivers meet minimum standards through licensing and credentialing.

Objective H.4

Budget Strategy	Stakeholder Groups/Services Provided
Strategy H.4.1. Texas.gov. Estimated and Nontransferable.	**Regulated Entities:** HHSC is statutorily authorized to increase the occupational license, permit, and registration fees imposed on licensees by an amount sufficient to cover the cost of the subscription fee charged by the Texas.Gov authority.

Objective I.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy I.1.1. Integrated Financial Eligibility and Enrollment. Provide accurate and timely eligibility and issuance services for financial assistance, medical benefits, and Supplemental Nutrition Assistance Program (SNAP) benefits.	**Children & Families:** The functions involved in both centralizing and conducting eligibility determination for HHS programs will apply to children and families seeking to participate in the Medicaid, CHIP, TANF, SNAP, Texas Women's Health Program and other health and human services programs.

Objective I.2

Budget Strategy	Stakeholder Groups/Services Provided
Strategy I.2.1. Intake, Access, and Eligibility to Services and Supports. Determine functional eligibility for long-term care services, develop individual service plans based on individual needs and preferences, authorize service delivery, and monitor the delivery of services (Medicaid and non-Medicaid).	**Direct customer groups include:** • Individuals who are older who meet specific eligibility requirements; • Individuals with physical, intellectual, and/or developmental disabilities who meet specific eligibility requirements; and • Family members and caregivers of individuals who are older and those with disabilities who meet specific eligibility criteria.

Objective I.3

Budget Strategy	Stakeholder Groups/Services Provided
Strategy I.3.1. Texas Integrated Eligibility Redesign System (TIERS) and Supporting Tech. Texas Integrated Eligibility Redesign System and eligibility supporting technologies capital.	**Other HHS Agencies:** HHSC provides the leadership to assist the HHS agencies in developing the TIERS system. **Children & Families:** HHSC ensures the accessibility of TIERS to children and families across Texas.
Strategy I.3.2. TIERS Capital Projects. TIERS capital projects.	**Other HHS Agencies:** HHSC provides the leadership to assist the HHS agencies in developing the TIERS system. **Children & Families:** HHSC ensures the accessibility of TIERS to children and families across Texas.

Objective J.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy J.1.1. Determine Federal SSI and Social Security Disability Insurance (SSDI) Eligibility. Determine eligibility for federal SSI and SSDI benefits.	**Texans Applying for SSI or SSDI:** HHSC determines whether persons who apply for Social Security Administration (SSA) disability benefits meet the requirements for "disability" in accordance with federal law and regulations. **Federal Government:** HHSC assists SSA in making disability determination decisions for this federal program in a quick, accurate, and cost-effective manner.

Objective K.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy K.1.1. Office of Inspector General (OIG). OIG.	**Citizens of Texas/Taxpayers:** OIG serves as the lead agency for the investigation of fraud, abuse, and waste in health and human services; and administers the Medicaid Fraud and Abuse Detection System technology services contract, which uses technology to identify and deter fraud, abuse and waste in the Medicaid program throughout the state. **Medicaid Providers:** OIG provides training to Medicaid providers on how to detect, prevent and report Medicaid provider fraud; and provides training on Resource Utilization Group for nursing facilities. **Medicaid Consumers:** OIG investigates fraud, abuse, and waste in health and human services-related programs, ensuring integrity and efficiency in programs and the highest quality services for beneficiaries. **Residents of Facilities:** OIG monitors Utilization Review activities in Medicaid contract hospitals to ensure program integrity and improve the quality of services delivered to residents of Medicaid facilities.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy K.1.2. OIG Administrative Support. Administrative support for the Office of Inspector General.	**Citizens of Texas/Taxpayers:** OIG serves as the lead agency for the investigation of fraud, abuse, and waste in health and human services; and administers the Medicaid Fraud and Abuse Detection System technology services contract, which uses technology to identify and deter fraud, abuse and waste in the Medicaid program throughout the state. **Medicaid Providers:** OIG provides training to Medicaid providers on how to detect, prevent and report Medicaid provider fraud; and provides training on Resource Utilization Group for nursing facilities. **Medicaid Consumers:** OIG investigates fraud, abuse, and waste in health and human services-related programs, ensuring integrity and efficiency in programs and the highest quality services for beneficiaries. **Residents of Facilities:** OIG monitors Utilization Review activities in Medicaid contract hospitals to ensure program integrity and improve the quality of services delivered to residents of Medicaid facilities.

Objective L.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy L.1.1. Enterprise Oversight and Policy. Provide leadership and direction to achieve an efficient and effective Health and Human Services System.	**Oversight Agencies and Legislative Leadership:** HHSC coordinates and monitors the use of state and federal money received by HHS agencies; reviews state plans submitted to the federal government; monitors state health and human services agency budgets and programs, and makes recommendations for budget transfers; conducts research and analyses on demographics and caseload projections; and directs an integrated planning and budgeting process across five HHS agencies. **Other HHS Agencies:** HHSC provides the leadership to assist the HHS agencies in developing customer-focused programs and policy initiatives that are relevant, timely, and cost-effective. **Citizens of Texas:** HHSC ensures that state and federal funds allocated to HHS agencies are coordinated and monitored, and spent in the most efficient manner.

Budget Strategy	Stakeholder Groups/Services Provided
Strategy L.1.2. Information Technology Capital Projects Oversight and Program Support. Information Technology Capital Projects and program support.	HHSC provides information technology support for all programs. All stakeholder groups would be included for this strategy.

Objective L.2

Budget Strategy	Stakeholder Groups/Services Provided
Strategy L.2.1. Central Program Support. Central program support.	**HHS Employees:** HHSC provides central support services for HHS employees. Services include accounting, budget, and contract and grant administration, internal audit, external relations and legal.
Strategy L.2.2. Regional Program Support. Regional program support.	**Other HHS Agencies:** HHSC provides the leadership to assist the HHS agencies in developing in providing to support to regional programs.

Objective M.1

Budget Strategy	Stakeholder Groups/Services Provided
Strategy M.1.1. Texas Civil Commitment Office. Texas Civil Commitment Office.	The civil commitment of sexually violent predators function was transferred to a new agency, the Texas Civil Commitment Office, effective September 1, 2015.

Appendix C. List of Acronyms

Acronym	Full Name
ABA	Applied Behavior Analysis
AHRQ	Agency for Healthcare Research and Quality
AMH	Adult Mental Health
ASD	Autism Spectrum Disorder
ASN	Adult Safety Net
BCP	Blind Children's Vocational Discovery and Development Program
BEST	Blindness Education, Screening, and Treatment
BFV	Business Filing and Verification Section
CACTX	Children's Advocacy Centers of Texas, Inc.
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CASE	Case Management
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CII	Complaint and Incident Intake
CIL	Center for Independent Living
CLASS	Community Living Assistance and Support Services
CMHCS	Community Mental Health Crisis Services
CMS	Centers for Medicare and Medicaid Services
CPRIT	Cancer Prevention and Research Institute of Texas
CPS	Child Protective Services
CRCG	Community Resource Coordination Group
CRS	Consumer Rights and Services
CSHCN	Children with Special Health Care Needs
CVD	Cardiovascular Disease
CYSHCN	Children and Youth with Special Health Care Needs
DAHS	Day Activity and Health Services
DBMD	Deaf-Blind Multiple Disabilities
DFPS	Department of Family and Protective Services

Acronym	Full Name
DHHS	U.S. Department of Health and Human Services
DRS	Data Reporting System
DSHS	Department of State Health Services
ECI	Early Childhood Intervention
EMR	Employee Misconduct Registry
EMS	Emergency Medical Services
EPA	Environmental Protection Agency
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
ESRD	End State Renal Disease
FDA	Food and Drug Administration
FFS	Fee-for-Service
FQHC	Federally Qualified Health Centers
FSCR	Family Support and Community Resources
GETAC	Governor's EMS and Trauma Advisory Council
HB	House Bill
HCS	Home and Community-based Services
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
IAC	Interagency Cooperation Agreement
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability
ICHP	Institute for Child Health Policy
ICS	Inpatient Consumer Survey
ILS	Independent Living Services
LBB	Legislative Budget Board
LHD	Local Health Departments
LSS	Laboratory Services Section
MCO	Managed Care Organization
MH	Mental Health

Acronym	Full Name
MHSIP	Mental Health Statistics Improvement Program
MTO	Managed Transportation Organization
MTP	Medical Transportation Program
NAACCR	North American Association of Central Cancer Registries
NAR	Nurse Aide Registry
NEMT	Non-Emergency Medical Transportation
NFQR	Nursing Facility Quality Review
NORC	National Opinion Research Center
OAA	Older Americans Act
OIG	Office of Inspector General
OOG	Office of the Governor
OSEP	Office of Special Education Programs
PACE	Program for All-Inclusive Care for the Elderly
PHR	Public Health Regions
QMB	Qualified Medicare Beneficiary
QMP	Quality Monitoring Program
RAC	Regional Advisory Councils
SDG	Systems Development Group
SFY	State Fiscal Year
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Act
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSLC	State Supported Living Centers
STD	Sexually Transmitted Disease
STL	South Texas Laboratory
TAC	Texas Administrative Code
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TCEQ	Texas Commission of Environmental Quality

Acronym	Full Name
Texas CASA	Texas Court Appointed Special Advocates
THA	Texas Hospital Association
THSteps	Texas Health Steps
TIERS	Texas Integrated Eligibility Redesign System
TMA	Texas Medical Association
TORCH	Texas Organization of Rural & Community Hospitals
TPS	Texas Pediatric Society
TVFC	Texas Vaccines for Children
TxEVER	Texas Electronic Vital Events Registrar
TxHmL	Texas Home Living program
UFSRC	University of Florida Survey Research Center
UTMB	University of Texas Medical Branch at Galveston
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children
YSSF	Youth Services Survey for Families