**Objective Outcome Definitions Report**

**Automated Budget and Evaluation System of Texas (ABEST)**

**Agency Code:** 529  
**Agency:** Health and Human Services Commission

**Goal No. 1 Medicaid**

**Objective No. 1 Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients**

**Outcome No. 1 Average Medicaid and CHIP Children Recipient Months Per Month**

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**Calculation Method:** N  
**Target Attainment:** H  
**Priority:** H  
**Cross Reference:** Agy 529 084-R-S70-1 01-01 OC 02

**Key Measure:** Y  
**New Measure:** N  
**Percent Measure:** N

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**BL 2018 Definition**

This is a measure of the monthly average number of income-eligible children served in Medicaid and Children’s Health Insurance Program (CHIP).

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

Medicaid data are obtained from the Premiums Payable System (PPS). CHIP data are obtained from the Administrative Services Contractor.

**BL 2018 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 PPS 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.

**BL 2018 Purpose**

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

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529  
Agency: **Health and Human Services Commission**

Goal No. 1  
Objective No. 1  
Outcome No. 2

**Goal No. 1 Medicaid**

**Objective No. 1 Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients**

**Outcome No. 2 Average Full Benefit Medicaid Recipient Months Per Month**

**Calculation Method:** N  
**Target Attainment:** H  
**Priority:** H  
**Cross Reference:** Agy 529 084-R-S70-1 02-01 OC 01

**Key Measure:** Y  
**New Measure:** N  
**Percent Measure:** N

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**BL 2018 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).

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

Medicaid data are obtained from the Premiums Payable System (PPS).

**BL 2018 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. The quarterly average is the sum of the recipient months (managed care and non-managed care combined) for the three months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months (managed care and non-managed care combined) divided by the number of months summed.

**BL 2018 Purpose**

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

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**BL 2019 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).

**BL 2019 Data Limitations**

None

**BL 2019 Data Source**

Medicaid data are obtained from the Premiums Payable System (PPS).

**BL 2019 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. The quarterly average is the sum of the recipient months (managed care and non-managed care combined) for the three months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months (managed care and non-managed care combined) divided by the number of months summed.

**BL 2019 Purpose**
This measure reflects the average monthly number of recipient months for the named group.
OBJECTIVE OUTCOME DEFINITIONS REPORT
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code: 529  
Agency: Health and Human Services Commission
Goal No. 1  
Objective No. 1  
Outcome No. 3

Calculation Method: N  
Target Attainment: L  
Priority: H  
Cross Reference: Agy 529 084-R-S70-1 02-01 OC 04

Key Measure: N  
New Measure: N  
Percent Measure: N

BL 2018 Definition
Medicaid Acute Care Child Recipient Months per Month is the average monthly number of recipient months (managed care and non-managed care combined) for all Medicaid recipients who are under 21, including Supplemental Security Income children and STAR Health.

BL 2018 Data Limitations
None

BL 2018 Data Source
The Premium Payable System.

BL 2018 Methodology
A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. The quarterly average is the sum of the recipient months (managed care and non-managed care combined) for the three months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months (managed care and non-managed care combined) divided 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 expenditures and recipient months.

BL 2018 Purpose
This measure determines the average number of recipient months per month for the named group.

BL 2019 Definition
Medicaid Acute Care Child Recipient Months per Month is the average monthly number of recipient months (managed care and non-managed care combined) for all Medicaid recipients who are under 21, including Supplemental Security Income children and STAR Health.

BL 2019 Data Limitations
None

BL 2019 Data Source
The Premium Payable System.

BL 2019 Methodology
A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. The quarterly average is the sum of the recipient months (managed care and non-managed care combined) for the three months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months (managed care and non-managed care combined) divided 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 expenditures and recipient months.

BL 2019 Purpose
This measure determines the average number of recipient months per month for the named group.
Goal No. 1 Medicaid
Objective No. 1 Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients
Outcome No. 4 Avg Monthly Cost per Full Benefit Medicaid Client (incl Drug and LTC)

Calculation Method: N  Target Attainment: L  Priority: H  Cross Reference: Agy 529 084-R-S70-1 02-01 OC 05
Key Measure: Y  New Measure: N  Percent Measure: N

ADDITIONAL EDITS NEEDED FROM AGENCY NOVEMBER 2016. 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.

This measure involves the recipient months and costs for services. It includes STAR+PLUS Acute Care, as well as STAR+PLUS 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.

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. Dollars exclude costs for Texas Health Steps Dental and, Medicaid Transportation.

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. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures for recipient months.

This measure determines the average Medicaid acute cost per recipient month, including drug costs.

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.

This measure involves the recipient months and costs for services. It includes STAR+PLUS Acute Care, as well as STAR+PLUS 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.

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. Dollars exclude costs for Texas Health Steps Dental and, Medicaid Transportation.
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. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures for recipient months.

BL 2019 Purpose

This measure determines the average Medicaid acute cost per recipient month, including drug costs.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 1  
Objective No. 1  
Outcome No. 5

Medicaid  
Acute Care Svs (incl STARPLUS LTC) for Full-Benefit Clients  
Medicaid Rec Months: Proportion in Managed Care

Calculation Method: N  
Target Attainment: H  
Priority: H  
Cross Reference: Agy 529 084-R-S70-1 02-01 OC 06

Key Measure: Y  
New Measure: N  
Percent Measure: Y

**BL 2018 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 (beginning in FY2017) programs for the reporting period.

**BL 2018 Data Limitations**

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

**BL 2018 Data Source**

The Premium Payable System.

**BL 2018 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 by months for the given period. The resulting number is then multiplied by 100%.

**BL 2018 Purpose**

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

**BL 2019 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 (beginning in FY2017) programs for the reporting period.

**BL 2019 Data Limitations**

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

**BL 2019 Data Source**

The Premium Payable System.

**BL 2019 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 by months for the given period. The resulting number is then multiplied by 100%.

**BL 2019 Purpose**

This is a measure of the impact of implementation of managed care initiatives.
Objective Outcome Definitions Report

Automated Budget and Evaluation System of Texas (ABEST)

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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 1
Objective No. 1
Outcome No. 6

Calculation Method: N
Target Attainment: H
Priority: H
Cross Reference: Agy 529 084-R-S70-1 02-01 OC 07

Key Measure: N
New Measure: N
Percent Measure: Y

BL 2018 Definition
This measure reports the percentage of Texas Health Steps (THSteps) Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) clients receiving at least one medical check-up using the CMS-416 method.

BL 2018 Data Limitations
There are several limitations. The data reported only reflect the percentage of medical check-ups reported and completely processed as of the reporting timeframe. The THSteps (EPSDT) providers have 95 days in which to submit a claim after the date of service and if a claim is denied the provider has 180 days in which to appeal; therefore, all claims for a reporting period may not have been processed at the time of reporting. Complete data may not be available for the reporting period at the time the report is due, therefore, estimates or projections may be included based on available data.

BL 2018 Data Source
The data source, HISR303A, is generated by the Medicaid Claims Administrator. 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.

BL 2018 Methodology
The calculation is the result of dividing the number of THSteps enrolled children who received at least one initial or periodic medical check-up by the number of children enrolled in Medicaid, then multiplying by 100.

BL 2018 Purpose
The purpose of the measure is to monitor the THSteps (EPSDT) clients served for children receiving medical check-ups in Medicaid, as calculated using the CMS-416 method and indicates the extent to which EPSDT enrolled receive any initial or periodic screening services during the year, as required by the State’s periodicity schedule, prorated by the proportion of the year for which they are Medicaid enrolled.

BL 2019 Definition
This measure reports the percentage of Texas Health Steps (THSteps) Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) clients receiving at least one medical check-up using the CMS-416 method.

BL 2019 Data Limitations
There are several limitations. The data reported only reflect the percentage of medical check-ups reported and completely processed as of the reporting timeframe. The THSteps (EPSDT) providers have 95 days in which to submit a claim after the date of service and if a claim is denied the provider has 180 days in which to appeal; therefore, all claims for a reporting period may not have been processed at the time of reporting. Complete data may not be available for the reporting period at the time the report is due, therefore, estimates or projections may be included based on available data.

BL 2019 Data Source
The data source, HISR303A, is generated by the Medicaid Claims Administrator. 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.

BL 2019 Methodology
The calculation is the result of dividing the number of THSteps enrolled children who received at least one initial or periodic medical check-up by the number of children enrolled in Medicaid, then multiplying by 100.

BL 2019 Purpose

The purpose of the measure is to monitor the THSteps (EPSDT) clients served for children receiving medical check-ups in Medicaid, as calculated using the CMS-416 method and indicates the extent to which EPSDT enrolled receive any initial or periodic screening services during the year, as required by the State’s periodicity schedule, prorated by the proportion of the year for which they are Medicaid enrolled.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 1  
Objective No. 1  
Outcome No. 7

Medicaid  
Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients

Outcome No. 7  
Avg # of Members Receiving Waiver Services through Managed Care

Calculation Method: N  
Target Attainment: H  
Priority: H  
Cross Reference: Agy 529 084-R-S70-1 02-01 OC 08

Key Measure: Y  
New Measure: N  
Percent Measure: N

BL 2018 Definition  
ADDITIONAL EDITS NEEDED FROM AGENCY NOVEMBER 2016. This measure reports the monthly average number of STAR+PLUS members, enrolled in the 1915(c) component of STAR+PLUS or the Dual Demonstration, who received Medicaid Community Care services. The STAR+PLUS program integrates preventive, primary, acute care and long term care into a single managed care model.

BL 2018 Data Limitations  
This measure only includes STAR+PLUS or Dual Demonstration members who are enrolled in the 1915(c) waiver component of Long-Term Services and Supports. This measure does not describe the level, type or amount of community care received by members.

BL 2018 Data Source  
The Premiums Payable System.

BL 2018 Methodology  
Divide the sum of managed care recipient months for members receiving 1915(c) waiver community care services for all months of 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.

BL 2018 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 or Dual Demonstration. This data is a useful tool for projecting future funding needs.

BL 2019 Definition  
This measure reports the monthly average number of STAR+PLUS members, enrolled in the 1915(c) component of STAR+PLUS or the Dual Demonstration, who received Medicaid Community Care services. The STAR+PLUS program integrates preventive, primary, acute care and long term care into a single managed care model.

BL 2019 Data Limitations  
This measure only includes STAR+PLUS or Dual Demonstration members who are enrolled in the 1915(c) waiver component of Long-Term Services and Supports. This measure does not describe the level, type or amount of community care received by members.

BL 2019 Data Source  
The Premiums Payable System.

BL 2019 Methodology  
Divide the sum of managed care recipient months for members receiving 1915(c) waiver community care services for all months of 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.

BL 2019 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 or Dual Demonstration. This data is a useful tool for projecting future funding needs.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 1  
Objective No. 1  
Outcome No. 8

Calculation Method: N  
Target Attainment: H  
Priority: H  
Cross Reference: Agy 529 084-R-S70-1 02-01 OC 09

Key Measure: N  
New Measure: N  
Percent Measure: N

BL 2018 Definition
ADDITIONAL EDITS NEEDED FROM AGENCY NOVEMBER 2016. This measure reports the monthly average number of managed care members, not enrolled in the 1915(c) component of STAR+PLUS or Dual Demonstration, who received Medicaid Community Care services. The STAR+PLUS models integrate preventive, primary, acute care and long term care into a single managed care model.

BL 2018 Data Limitations
This measure does not describe the level, type or amount of community care received by members.

BL 2018 Data Source
The Premiums Payable System.

BL 2018 Methodology
Divide the sum of managed care recipient months for members receiving non waiver community care services for all months of 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.

BL 2018 Purpose
This measure shows the impact of managed care on Medicaid community care services caseloads for clients who are not enrolled in the 1915(c) waiver component of STAR+PLUS or Dual Demonstration. This data is a useful tool for projecting future funding needs.

BL 2019 Definition
This measure reports the monthly average number of managed care members, not enrolled in the 1915(c) component of STAR+PLUS or Dual Demonstration, who received Medicaid Community Care services. The STAR+PLUS models integrate preventive, primary, acute care and long term care into a single managed care model.

BL 2019 Data Limitations
This measure does not describe the level, type or amount of community care received by members.

BL 2019 Data Source
The Premiums Payable System.

BL 2019 Methodology
Divide the sum of managed care recipient months for members receiving non waiver community care services for all months of 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.

BL 2019 Purpose
This measure shows the impact of managed care on Medicaid community care services caseloads for clients who are not enrolled in the 1915(c) waiver component of STAR+PLUS or Dual Demonstration. This data is a useful tool for projecting future funding needs.
Goal No. 1 Medicaid
Objective No. 1 Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients
Outcome No. 9 Percent of Full Benefit Medicaid Eligible Population Served

Calculation Method: N Target Attainment: H Priority: H Cross Reference: Agy 529 084-R-S70-1 02-03 OC 01
Key Measure: N New Measure: N Percent Measure: Y

BL 2018 Definition
ADDITIONAL EDITS NEEDED FROM AGENCY NOVEMBER 2016. This is a measure of the percentage of the population estimated to be eligible for Medicaid that enrolls in the program.

BL 2018 Data Limitations
A portion of the data used for this measure is statistically estimated based on the results of demographics surveys that are subject tolerable/acceptable levels of sampling and non-sampling variance (error). Limited comparable data are available for the nation and the other states.

BL 2018 Data Source
Measure is estimated using demographic (population) surveys such as the Current Population Survey, the Survey of Income and Program Participation, the American Community Survey and other data from the Texas State Data Center. Data Source for actual Medicaid enrollment information is the final 8-month Medicaid enrollment files.

BL 2018 Methodology
Divide the number of persons enrolled in Medicaid on a monthly average basis, per fiscal year, by the estimated monthly average number of potential eligibles. Multiply the result by 100. As the single state agency designated to oversee and administer the state's Medicaid program, HHSC serves as the liaison to the federal government and is responsible for establishing agreements with other state agencies in carrying-out the technical operations and service delivery for the Medicaid program. This measure indicates the effectiveness of outreach efforts to eligible populations and is of increased importance with implementation of the Children's Health Insurance Program.

BL 2018 Purpose
As the single state agency designated to oversee and administer the state's Medicaid program, HHSC serves as the liaison to the federal government and is responsible for establishing agreements with other state agencies in carrying-out the technical operations and service delivery for the Medicaid program. This measure indicates the effectiveness of outreach efforts to eligible populations and is of increased importance with implementation of the Children's Health Insurance Program.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Goal No. 1 Medicaid
Objective No. 1 Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients
Outcome No. 10 Avg # Members Receiving Nursing Facility Care Through Managed Care

Calculation Method: N  Target Attainment: H  Priority: H  Cross Reference: 
Key Measure: N  New Measure: Y  Percent Measure: N

BL 2018 Definition
WAITING ON AGENCY - NOVEMBER 2016

BL 2018 Data Limitations
WAITING ON AGENCY - NOVEMBER 2016

BL 2018 Data Source
WAITING ON AGENCY - NOVEMBER 2016

BL 2018 Methodology
WAITING ON AGENCY - NOVEMBER 2016

BL 2018 Purpose
WAITING ON AGENCY - NOVEMBER 2016

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Goal No. 3 Children's Health Insurance Program Services
Objective No. 1 CHIP Services
Outcome No. 1 Percent of CHIP-eligible Children Enrolled

BL 2018 Definition
ADDITIONAL EDITS NEEDED FROM AGENCY NOVEMBER 2016. This is a measure of the percentage of children estimated to be eligible for the Children’s Health Insurance Program (CHIP) that are enrolled in the program.

BL 2018 Data Limitations
None.

BL 2018 Data Source
The source of data on the number of children eligible for the CHIP program is the March Current Population Survey (CPS) for Texas published during September-October of every year. Specifically, the identified population consists of children ages 0-18 that are not Medicaid-eligible but are from families with incomes of 200 percent of poverty or less. The data sources on the number of children enrolled in the program are the CHIP program statistical databases maintained in electronic format and compiled by HHSC on a continuous basis.

BL 2018 Methodology
1) Determine the number of children eligible from the latest available CPS. 2) Determine the number of children enrolled as of the end of the last month of the state fiscal year (i.e., the count of enrollees for the month of August). 3) Divide by the total number of children enrolled in the program by the total number of children eligible. 4) Multiply by 100.

BL 2018 Purpose
This is a measure of the effectiveness of the outreach efforts of the CHIP program. CHIP is a federal program administered by HHSC to provide health insurance to children who do not qualify for Medicaid. Federal law requires extensive outreach efforts by states to enroll eligible children.

BL 2019 Definition
This is a measure of the percentage of children estimated to be eligible for the Children’s Health Insurance Program (CHIP) that are enrolled in the program.

BL 2019 Data Limitations
None.

BL 2019 Data Source
The source of data on the number of children eligible for the CHIP program is the March Current Population Survey (CPS) for Texas published during September-October of every year. Specifically, the identified population consists of children ages 0-18 that are not Medicaid-eligible but are from families with incomes of 200 percent of poverty or less. The data sources on the number of children enrolled in the program are the CHIP program statistical databases maintained in electronic format and compiled by HHSC on a continuous basis.

BL 2019 Methodology
1) Determine the number of children eligible from the latest available CPS. 2) Determine the number of children enrolled as of the end of the last month of the state fiscal year (i.e., the count of enrollees for the month of August). 3) Divide by the total number of children enrolled in the program by the total number of children eligible. 4) Multiply by 100.

BL 2019 Purpose
This is a measure of the effectiveness of the outreach efforts of the CHIP program. CHIP is a federal program administered by HHSC to provide health insurance to children who do not qualify for Medicaid. Federal law requires extensive outreach efforts by states to enroll eligible children.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 3  
Objective No. 1  
Outcome No. 2

Objectives

Goal No. 3 Children's Health Insurance Program Services
Objective No. 1 CHIP Services
Outcome No. 2 Average CHIP Programs Recipient Months Per Month

Calculation Method: N  
Target Attainment: H  
Priority: H  
Cross Reference: Agy 529 084-R-S70-1 03-01 OC 02

Key Measure: Y  
New Measure: N  
Percent Measure: N

BL 2018 Definition
The measure provides the average Children’s Health Insurance Program (CHIP) recipient months per month, including all CHIP-enrolled children (including CHIP Phase II children, and Perinatal clients).

BL 2018 Data Limitations
None.

BL 2018 Data Source
Integrated Eligibility staff produces monthly CHIP II enrollment reports, which includes the number of all CHIP enrollees.

BL 2018 Methodology
Divide the cumulative number of CHIP recipient months (CHIP II and Perinatal clients) from the enrollment report by the number of months in the period for which the measure is reported. Perinatal 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.

BL 2018 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.

BL 2019 Definition
The measure provides the average Children’s Health Insurance Program (CHIP) recipient months per month, including all CHIP-enrolled children (including CHIP Phase II children, and Perinatal clients).

BL 2019 Data Limitations
NONE.

BL 2019 Data Source
Integrated Eligibility staff produces monthly CHIP II enrollment reports, which includes the number of all CHIP enrollees.

BL 2019 Methodology
Divide the cumulative number of CHIP recipient months (CHIP II and Perinatal clients) from the enrollment report by the number of months in the period for which the measure is reported. Perinatal 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.

BL 2019 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.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 3  
Objective No. 1  
Outcome No. 3  

Goal: Children's Health Insurance Program Services
Objective: CHIP Services
Outcome: Average CHIP Programs Benefit Cost with Prescription Benefit

Calculation Method: N  
Target Attainment: L  
Priority: H  
Cross Reference: Agy 529 084-R-S70-1 03-01 OC 04

Key Measure: Y  
New Measure: N  
Percent Measure: N

BL 2018 Definition
The measure provides the average monthly benefit cost paid to Children’s Health Insurance Program (CHIP) enrolled medical (including immunizations and including prescription drugs) and dental providers on behalf of all CHIP-enrolled children (which includes CHIP Phase II and CHIP Perinatatal). Benefit costs are understood to include amounts paid to health plans, the dental contractor, and Department of State Health Services (DSHS) to cover vaccines.

BL 2018 Data Limitations
None.

BL 2018 Data Source
Integrated Eligibility staff furnishes a monthly report to HHSC containing the caseload for which each health and dental plan will incur costs during the following month. The numbers in that report are multiplied by the premium amount to be paid to the respective plans (including the portion for drug premiums, effective March 2012). For vaccine costs, HHSC receives a quarterly invoice from DSHS (or successor agency), which shows the amount used for vaccinating CHIP-enrolled children. The data source for prescription drug costs paid via Fee-For-Service is the monthly MH 494 report, provided by the state Medicaid contractor.

BL 2018 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.

BL 2018 Purpose
This will provide an overall CHIP benefit cost per CHIP-enrolled child regardless of the eligibility category for CHIP.

BL 2019 Definition
The measure provides the average monthly benefit cost paid to Children’s Health Insurance Program (CHIP) enrolled medical (including immunizations and including 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.

BL 2019 Data Limitations
None.

BL 2019 Data Source
Integrated Eligibility staff furnishes a monthly report to HHSC containing the caseload for which each health and dental plan will incur costs during the following month. The numbers in that report are multiplied by the premium amount to be paid to the respective plans (including the portion for drug premiums, effective March 2012). For vaccine costs, HHSC receives a quarterly invoice from DSHS (or successor agency), which shows the amount used for vaccinating CHIP-enrolled children. The data source for prescription drug costs paid via Fee-For-Service is the monthly MH 494 report, provided by the state Medicaid contractor.
BL 2019 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.

BL 2019 Purpose

This will provide an overall CHIP benefit cost per CHIP-enrolled child regardless of the eligibility category for CHIP.
Objective: Provide Additional Health-related Services

Objective No. 1: Provide Primary Health and Specialty Care

Outcome No. 1: Percent of Population under Age Three Served by ECI Program

<table>
<thead>
<tr>
<th>Calculation Method:</th>
<th>Target Attainment:</th>
<th>Percent Measure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>

**BL 2018 Definition**

The number of children who received comprehensive intervention services through ECI service providers expressed as a percentage of the total number of Texas children under three years of age.

**BL 2018 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 Texas Kids Intervention Data System (TKIDS).

**BL 2018 Data Source**

Local providers enter data into TKIDS. Using TKIDS data, determine the number of children receiving comprehensive services in the fiscal year. Population projections are obtained from data files provided by the Texas State Data Center.

**BL 2018 Methodology**

Determine the total number of children served by counting the number of cases that were in the enrolled disposition anytime during the reporting period. Exclude from the count cases that were closed with a reason indicating invalid data entry and cases in which children turned three years old before the first day of the reporting period. Count only once cases that transferred from one local program to another. Determine an estimate of the Texas birth-to-three population for the year using a four-year cohort of children age 0-1, 1-2 and 2-3 for the year and children 0-1 for the following year. Divide the total number of children served by the Texas birth-to-three population estimate. Multiply by 100 to obtain a percentage.

**BL 2018 Purpose**

This performance measure is important because it evaluates progress towards serving the number of children targeted for intervention.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
<table>
<thead>
<tr>
<th>Agency Code:</th>
<th>529</th>
<th>Agency:</th>
<th>Health and Human Services Commission</th>
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<tbody>
<tr>
<td>Goal No.</td>
<td>4</td>
<td>Provide Additional Health-related Services</td>
<td></td>
</tr>
<tr>
<td>Objective No.</td>
<td>1</td>
<td>Provide Primary Health and Specialty Care</td>
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<tr>
<td>Outcome No.</td>
<td>2</td>
<td>Percent of Children Successfully Completing Services</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Key Measure:** N  
**New Measure:** N  
**Percent Measure:** Y  
**Cross Reference:** Agy 538 084-R-S70-1 01-02 OC 01

**BL 2018 Definition**

Measures the proportion of Blind Children’s Vocational Discovery and Development Program consumers exiting the program during the reporting period after a plan of services has been initiated who have successfully completed the plan of services.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

Data is from the DBS automated consumer statistical system. Field staff who work with consumers indicate in this system whether a consumer has successfully or unsuccessfully completed services.

**BL 2018 Methodology**

The total number of consumer cases closed successfully during the reporting period is divided by the total number of consumer cases closed during the reporting period after receiving planned services.

**BL 2018 Purpose**

Successfully completing program services is the desired outcome of service for each consumer. DBS establishes a projection for the percentage of consumers who successfully complete services. This measure tracks and demonstrates the progress toward meeting that projection.

**BL 2019 Definition**


**BL 2019 Data Limitations**


**BL 2019 Data Source**


**BL 2019 Methodology**


**BL 2019 Purpose**


Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 4  Provide Additional Health-related Services
Objective No. 1  Provide Primary Health and Specialty Care
Outcome No. 3  Percent of ECI Clients Enrolled in Medicaid

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 538 084-R-S70-1 01-01 OC 03

Key Measure: Y  
New Measure: N  
Percent Measure: Y

**BL 2018 Definition**

The average monthly number of children enrolled in comprehensive services during the fiscal year expressed as a percent of the average monthly number of children enrolled in comprehensive services during the previous fiscal year.

**BL 2018 Data Limitations**

The accuracy of local program reporting is periodically verified through monitoring. Accurate reporting requires local program to meet timelines for data entry into TKIDS. This measure can only be calculated on an annual basis.

**BL 2018 Data Source**

Local providers enter data into TKIDS. Determine the total number of children enrolled in comprehensive services on the last day of the month, as indicated by cases in the enrolled disposition on the last day of the month.

**BL 2018 Methodology**

Determine the monthly enrollment by counting the total number of cases in the enrolled disposition on the last day of the month. Exclude cases that were closed with a reason indicating invalid data entry, cases in which children turned three years old before or on the last day of the month, and cases that were exited and/or closed on the last day of the month. Compute the average monthly enrollment for the fiscal year. Subtract from that the average monthly enrollment for the previous fiscal year. Divide the result by the average monthly enrollment for the previous fiscal year. Multiply by 100 to obtain a percentage.

**BL 2018 Purpose**

This measure is important because it provides information on trends in the rate of growth of the number of children served from year to year. This data is essential to project future service and fiscal needs.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Objective Outcome Definitions Report
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code: 529
Agency: Health and Human Services Commission
Goal No. 4 Provide Additional Health-related Services
Objective No. 1 Provide Primary Health and Specialty Care
Outcome No. 4 Percent of ECI Program Funded by Medicaid

Calculation Method: N  Target Attainment: N  Priority: N  Cross Reference: Agy 538 084-R-S70-1 01-01 OC 04
Key Measure: Y  New Measure: N  Percent Measure: Y

BL 2018 Definition
Of the average monthly number of children receiving ECI comprehensive services, the percent enrolled in Medicaid.

BL 2018 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 Texas Kids Intervention Data System (TKIDS).

BL 2018 Data Source
Local contract providers enter data into 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.

BL 2018 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.

BL 2018 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.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 4 Provide Additional Health-related Services
Objective No. 2 Provide Community Behavioral Health Services
Outcome No. 1 HHSC-Operated or Purchased Inpatient Bed Re-admission Rate

Calculation Method: N  Target Attainment: N  Priority: Cross Reference: Agy 537 084-R-S70-1 02-02 OC 01
Key Measure: N  New Measure: N  Percent Measure: N

BL 2018 Definition

ADDITIONAL EDITS NEEDED FROM AGENCY NOVEMBER 2016. This measure is the percent of all persons discharged from any DSHS-operated or purchased inpatient bed to the community during the fiscal year who are readmitted to any DSHS-operated or purchased inpatient bed in the same fiscal year. A person may be counted more than once during a fiscal year if the person has multiple admissions during the year.

BL 2018 Data Limitations
This measure does not capture information regarding readmissions for persons discharged during any previous fiscal year.

BL 2018 Data Source
DSHS-operated or purchased inpatient facility personnel enter information about the individual into the department's data warehouse upon admission to and discharge from a DSHS-operated or purchased inpatient bed. DSHS-operated or purchased inpatient beds include state hospitals, traditional community hospitals and purchased local inpatient beds.

BL 2018 Methodology
The numerator is the number of persons admitted to DSHS-operated or purchased inpatient beds that have had a previous discharge from a DSHS-operated or purchased inpatient bed during the same state fiscal year. The denominator is the number of persons discharged from DSHS-operated or purchased inpatient beds during the state fiscal year. Readmission does not include persons that are transferred from one facility to another without an intervening stay in the community. The formula is the numerator/denominator * 100.

BL 2018 Purpose
When an individual returns to the community from an inpatient stay, the hospital and community mental health providers must effectively work together to address an individual’s needs. This measure is an indicator that a particular hospital or provider may have a problem related to the discharge process or engagement in treatment. It ensures that the department tracks trends and provides technical assistance once it is determined whether the cause is related to the discharge process, available community services or consumer engagement.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Objective Outcome Definitions Report

Automated Budget and Evaluation System of Texas (ABEST)

Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 4  
Provide Additional Health-related Services

Objective No. 2  
Provide Community Behavioral Health Services

Outcome No. 2  
% Adults Receiving Community MH Svcs Whose Functional Level Improved

Calculation Method: N  
Target Attainment: Priority: Cross Reference: Agy 537 084-R-S70-1 02-02 OC 02

Key Measure: Y  
New Measure: N  
Percent Measure: Y

BL 2018 Definition

One goal of community mental health services is to maintain or improve the consumer’s level of functioning in the community. The desired outcome of community mental health services is to improve level of functioning to the highest level of independence possible. This measure provides information about this outcome for adults receiving community mental health services through an authorized level of care as determined by the Adult Needs and Strengths Assessment.

BL 2018 Data Limitations

Collection of data is dependent upon completion of the Uniform Assessment for Texas Resilience and Recovery as prescribed.

BL 2018 Data Source

Level of functioning is measured by the Life Functioning Domain of the Adult Needs and Strengths Assessment which measures an individual’s lack of ability to function in various community settings over the past three months. This scale is used for persons with severe and persistent mental illnesses. Clinical staff are expected to administer Uniform Assessment at admission to community services, every 180 days and at planned discharges. Greater functional impairment scores reflect greater problems functioning in the community. The results of this assessment are entered into the department's data warehouse by staff at the local authority.

BL 2018 Methodology

For this calculation, the first Uniform Assessment upon admission and the latest Uniform Assessment which must have been completed at least 180 days after the initial Uniform Assessment are utilized. A decrease of 1 or more points in the second Life Functioning Domain score indicates improvement. The numerator is the number of adult consumers over the fiscal year with a minimum of two Uniform Assessments for Texas Resilience and Recovery with a decrease of 1 or more points in the second Life Functioning Domain score. The denominator is the total number of adult consumers over the fiscal year with a minimum of two Uniform Assessments for Texas Resilience and Recovery. The formula is numerator/denominator *100.

BL 2018 Purpose

Improved functioning in the community is an important indication that treatment is effective in reducing the functional deterioration associated with mental illness. There are four levels of care a mental health consumer may be assigned, level of care 1, 2, 3, or 4. Each level of care has a designated service package that the mental health consumer may receive. Persons receiving community mental health services achieve optimal benefit from those services appropriately addressing their identified needs.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Objective Outcome Definitions Report
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code: 529  Agency: Health and Human Services Commission
Goal No. 4  Provide Additional Health-related Services
Objective No. 2  Provide Community Behavioral Health Services
Outcome No. 3  % Children Receiving Community MH Svcs Whose Functional Level Improved

Calculation Method: N  Target Attainment: Y  Priority:  Cross Reference: Agy 537 084-R-S70-1 02-02 OC 03
Key Measure: Y  New Measure: N  Percent Measure: Y

BL 2018 Definition
One goal of community mental health services is to maintain or improve the consumer’s level of functioning in the community. The desired outcome of community mental health services is to improve level of functioning to the highest level of independence possible. This measure provides information about this outcome for children as measured by the Child and Adolescent Needs and Strengths assessment during the fiscal year.

BL 2018 Data Limitations
Collection of data is dependent upon completion of the Child and Adolescent Uniform Assessment for Texas Resilience and Recovery as prescribed.

BL 2018 Data Source
The evaluation instrument for this measure is the Child and Adolescent Needs and Strengths assessment which is part of the Child and Adolescent Uniform Assessment completed for all children at admission, every 90 days thereafter, and at termination of services. Level of functioning is measured by the Child and Adolescent Needs and Strengths assessment, which measures an individual’s functioning in various community settings over the past thirty days. For this calculation, the first Child and Adolescent Needs and Strengths assessment on the Child and Adolescent Uniform Assessment for Texas Resilience and Recovery and any subsequent administrations of the Child and Adolescent Needs and Strengths assessment during the fiscal year are utilized.

BL 2018 Methodology
The Reliable Change Index will be used to measure change in Child & Adolescent Needs & Strengths assessment (asst) scores. During the 1st yr of Tx Resilience & Recovery roll out, adequate data points will be collected to est the Reliable Chg Index for Child & Adolescent Needs & Strengths asst domain items. Comparing initial & subsequent Child & Adolescent Needs & Strengths asst scores will yield a Reliable Chg Index score that will or will not show statistically significant imprv on specific domain items. Calculation: Num=Total number of children/youth authorized into levels of care 1,2,3,4 or Young Child(YC) who show reliable imprv on at least one Child & Adolescent Needs & Strengths asst domain as compared to the Reliable Chg Index identified for that domain whose last two Uniform Assessments are at least 90 days apart. Den= Total number of children/youth authorized into LOC 1,2,3,4,orYC whose last two Uniform Assessments are at least 90 days apart. The formula is num/den.

BL 2018 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. There are five levels of care a mental health consumer may be assigned: 1: Medication Maintenance, 2: Targeted Srvs (counseling or skills development training), 3: Complex Srvs (counseling and skills development training), 4: Intensive Family Srvs (Wraparound Srvs), or YC. Each level of care has a flexible array of services that the consumer may receive. There may be children whose authorized level of care does not match the level of care recommended by the Child and Adolescent Needs and Strengths assessment; however, these exceptions are usually due to clinical judgment, resource issues, continuity of care per Utilization Mgmt guidelines and/or consumer refusal. Children receiving community mental health services achieve optimal benefit from those services appropriately addressing their identified needs.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
**Goal No. 4 Provide Additional Health-related Services**

**Objective No. 2 Provide Community Behavioral Health Services**

**Outcome No. 4 % Children & Adolescents Receiving Community MH Services Avoiding Rearrest**

<table>
<thead>
<tr>
<th>Calculation Method:</th>
<th>N</th>
<th>Target Attainment:</th>
<th>Priority:</th>
<th>Cross Reference:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Measure:</td>
<td>N</td>
<td>New Measure:</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

**BL 2018 Definition**

This measure is an indication of the effectiveness of treatment strategies with children and adolescents who have a history of arrest involvement with the juvenile justice system.

**BL 2018 Data Limitations**

Collection of data is dependent upon the completion of the Child and Adolescent Uniform Assessment for Texas Resilience and Recovery as prescribed.

**BL 2018 Data Source**

The evaluation instrument for this measure is the Child and Adolescent Needs and Strengths assessment which is part of the Child and Adolescent Uniform Assessment completed for all children at admission, every 90 days thereafter, and at termination of services. Staff at the local authorities enter this assessment data into the department’s data warehouse. During the first year of Texas Resilience and Recovery roll out, adequate data points will be collected to establish the Reliable Change Index for Child and Adolescent Needs and Strengths assessment domain items. Comparing initial and subsequent Child and Adolescent Needs and Strengths assessment scores will yield a Reliable Change Index score that will or will not show statistically significant improvement on specific domain items. Children who received services for one quarter or more are included in this measure.

**BL 2018 Methodology**

For this calculation, the first Child and Adolescent Needs and Strengths assessment on the Child and Adolescent Uniform Assessment for Texas Resilience and Recovery and any subsequent administrations of the Child and Adolescent Needs and Strengths assessment during the fiscal year are utilized. 

\[
\text{Numerator} = \text{The number of children and youth recommended and authorized into levels of care 1, 2, 3, 4 or Young Child, whose latest number of arrests is 0 and whose previous number of arrests is 0.}
\]

\[
\text{Denominator} = \text{All children and youths recommended and authorized into levels of care 1, 2, 3, 4 or Young Child who have at least two “number of arrests” ratings.}
\]

The formula is \((\text{numerator/denominator}) \times 100\).

**BL 2018 Purpose**

Children receiving community mental health services achieve optimal benefit from those services appropriately addressing their identified needs. Juvenile justice involvement is often related to severe emotional disturbance. This measure will provide information on the department’s efforts to provide treatment to children involved with the juvenile justice system in order to prevent further involvement with the juvenile justice system.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 4  Provide Additional Health-related Services
Objective No. 2  Provide Community Behavioral Health Services
Outcome No. 5  % Rcvng Crisis Svcs Who Avoid Psychiatric Hospitalization w/in 30 days

Calculation Method: \text{N}  
Target Attainment:  
Priority:  
Cross Reference: Agy 537 084-R-S70-1 02-02 OC 05

Key Measure: Y  
New Measure: N  
Percent Measure: Y

BL 2018 Definition

This measure reports the percent of persons (regardless of age) with one or more crisis episodes, none of which were followed by a psychiatric hospitalization at a State or Community psychiatric hospital within 30 days of the first day of each crisis episode. A crisis episode is defined as all crisis services received from Community Mental Health Centers including NorthSTAR with no break longer than 7 days. A crisis service occurring after another crisis service by 8+ days is considered a separate crisis episode. The crisis services include both residential and outpatient.

BL 2018 Data Limitations

The accuracy of the Department’s client databases is dependent upon accurate and timely information being entered into the data warehouses by Community Mental Health Centers and ValueOptions (NorthSTAR). For NorthSTAR, while the majority of paid records are available within 30 days of service, some information lags up to 90 days. Values in ABEST will be updated the quarter following the initial entry to ensure the most accurate data are available.

BL 2018 Data Source

Crisis service data are from encounter records in the DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) and NorthSTAR data warehouse. The State and Community hospitalization information is entered into the DSHS Client Assignment and Registration System (CARE).

BL 2018 Methodology

The numerator is the number of persons with one or more crisis episodes, none of which were 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.

BL 2018 Purpose

Providing less restrictive and more appropriate mental health crisis services in the community is an important function of Crisis Redesign. Appropriate interventions for persons in mental health crisis should reduce their need to access State or Community psychiatric hospitals.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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<th>Agency Code: 529</th>
<th>Agency: Health and Human Services Commission</th>
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<tbody>
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<td>Goal No. 4</td>
<td>Provide Additional Health-related Services</td>
</tr>
<tr>
<td>Objective No. 2</td>
<td>Provide Community Behavioral Health Services</td>
</tr>
<tr>
<td>Outcome No. 6</td>
<td>% of Persons Rcvng Crisis Services that is Followed by a Jail Booking</td>
</tr>
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</table>

**Calculation Method**: N  
**Target Attainment**: N  
**Priority**: N  
**Percent Measure**: Y  
**Cross Reference**: Agy 537 084-R-S70-1 02-02 OC 06

**BL 2018 Definition**

ADDITIONAL EDITS NEEDED FROM AGENCY NOVEMBER 2016. This measure reports the percent of persons (regardless of age) receiving a residential or outpatient crisis service from Community Mental Health Centers, including NorthSTAR, who had a jail booking within 7 days of a crisis service. The same crisis service lasting more than one day is considered a separate crisis service.

**BL 2018 Data Limitations**

This measure is dependent upon timely compliance to Texas Senate Bill 839, passed during the 80th Legislative Session, which requires DSHS and the Texas Department of Public Safety’s Bureau of Identification and Records to establish a contemporaneous identification system that cross-references persons booked into jails with persons in the DSHS Client Assignment and Registration (CARE) System. Thus, DSHS is not able to propose a target for this measure until compliance with Texas Senate Bill 839 is achieved.

**BL 2018 Data Source**

Crisis service data are from encounter records in the DSHS Mental Retardation and Behavioral Health Outpatient Warehouse and NorthSTAR data warehouse. Jail booking information is from local and county jails statewide and will be cross-referenced with the DSHS CARE system.

**BL 2018 Methodology**

The numerator is the number of persons with a crisis service that have a jail booking within 7 days of a crisis service. The denominator is the number of persons with one or more crisis services.

The formula is numerator/denominator * 100.

**BL 2018 Purpose**

Providing less restrictive and more appropriate mental health crisis services in the community is an important function of Crisis Redesign. Appropriate interventions for persons in mental health crisis should prevent persons from being placed in jail settings.
Goal No. 4 Provide Additional Health-related Services
Objective No. 2 Provide Community Behavioral Health Services
Outcome No. 7 % Adults Who Complete Trtmt Pgm and Report No Past Month Substance Use

Calculation Method: N Target Attainment: Priority: Cross Reference: Agy 537 084-R-S70-1 02-02 OC 07
Key Measure: Y New Measure: N Percent Measure: Y

BL 2018 Definition
ADDITIONAL EDITS NEEDED FROM AGENCY NOVEMBER 2016. The percent of adults, age 18 or above, who complete a treatment program for substance abuse and report no past month substance use at the time of discharge.

BL 2018 Data Limitations
This only reflects clients from DSHS funded programs. Completion of treatment in this measure refers only to the completion of a level of care (service) at a single service provider. Data does not necessarily reflect completion of a continuum of care, which usually includes multiple programs and levels of service (episode).

BL 2018 Data Source
Provider staff complete an end-service or discharge assessment in the Clinical Management for Behavioral Health Services system (CMBHS) between each level of care and at discharge. Data is entered by client ID number directly into CMBHS.

BL 2018 Methodology
Total number of adults, age 18 or above, who complete a treatment service for substance abuse and report no past month substance use on the end-service or discharge assessment, divided by the total number of adults who complete a treatment service.

BL 2018 Purpose
Abstinence is an objective of ongoing recovery for addiction.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 4  
Provide Additional Health-related Services

Objective No. 2  
Provide Community Behavioral Health Services

Outcome No. 8  
% of Youth Successfully Completing a Substance Abuse Prevention Pgm

Calculation Method: N  
Target Attainment: N  
Priority: N  
Cross Reference: Agy 537 084-R-S70-1 02-02 OC 08

Key Measure: N  
New Measure: N  
Percent Measure: Y

BL 2018 Definition
This measures the percentage of youth enrolled that successfully completed a substance abuse prevention program. Successful completion among youth will evidence reduced identified risk(s) and/or increased protective factors that minimize their probabilities of getting involved in the use of alcohol, tobacco and other drugs.

BL 2018 Data Limitations
Youth prevention programs and related activities are voluntary. The success rate may be limited by the number of youth that attended the required number of prevention education sessions and maintained or improved scores on the pre/posttests. Although a high rate of participation in testing is expected, circumstances beyond the providers’ control may affect this rate (e.g., school regulations disallowing testing, low youth participation in voluntary testing).

BL 2018 Data Source
Providers will report the Curriculum Outcome Reports in the Clinical Management for Behavioral Health Services system. The reports include: the number of youth enrolled, the number of youth who are pre- and post-tested, the number of youth who complete the program, and the number of youth who complete the programs successfully.

BL 2018 Methodology
The formula is numerator/denominator * 100.

BL 2018 Purpose
To measure program effectiveness in reducing substance abuse risk factors and increasing protective factors.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
### Agency Code: 529  
**Agency:** Health and Human Services Commission

<table>
<thead>
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<th>Goal No.</th>
<th>Objective No.</th>
<th>Outcome No.</th>
<th>Calculation Method</th>
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<td>Agy 537 084-R-S70-1 02-02 OC 09</td>
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</tbody>
</table>

### BL 2018 Definition

ADDITIONAL EDITS NEEDED FROM AGENCY NOVEMBER 2016. The percent of youth, age 17 or below, who complete a treatment service for substance abuse and report no past month substance use at the time of discharge.

### BL 2018 Data Limitations

This only reflects clients from DSHS funded programs. Completion of treatment in this measure refers only to the completion of a level of care (service) at a single service provider. Data does not necessarily reflect completion of a continuum of care, which usually includes multiple programs and levels of service (episode).

### BL 2018 Methodology

Provider staff complete an end-service or discharge assessment in The Clinical Management for Behavioral Health Services system (CMBHS) between each level of care and at discharge. Data is entered by client identification number directly into CMBHS.

### BL 2018 Purpose

Abstinence is an objective of ongoing recovery for addiction.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology

### BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 4  
Provide Additional Health-related Services

Objective No. 2  
Provide Community Behavioral Health Services

Outcome No. 10  
Percent of Youth Completing Treatment Who Are Attending School

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 537 084-R-S70-1 02-02 OC 10

Key Measure: N  
New Measure: N  
Percent Measure: Y

BL 2018 Definition

The percent of youth, age 17 or below, who complete a treatment service for substance abuse and report improvement in school attendance at discharge.

BL 2018 Data Limitations

This only reflects clients from DSHS funded programs. Completion of treatment in this measure refers only to the completion of a level of care (service) at a single service provider. Data does not necessarily reflect completion of a continuum of care, which usually includes multiple programs and levels of service (episode).

BL 2018 Data Source

Provider staff complete an end-service or discharge assessment in The Clinical Management for Behavioral Health Services system (CMBHS) between each level of care and at discharge. Data is entered by client identification number directly into CMBHS.

BL 2018 Methodology

Total number of youth, age 17 and below, who complete a treatment service for substance abuse and report being in school on the end-service or discharge assessment, divided by the total number of youth who complete a treatment service.

BL 2018 Purpose

Reduction in absenteeism is highly correlated to recovery from substance abuse.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Objective: Encourage Self Sufficiency

Outcome: Percent of Total Children in Poverty Receiving Cash Assistance

BL 2018 Definition
This measure reports the number of children receiving Temporary Assistance for Needy Families (TANF) and the State Two-Parent Cash Assistance program benefits expressed as a percent of all children in Texas living in poverty.

BL 2018 Data Limitations
The estimated number of children in poverty is subject to change as a result of updates/revisions to the population estimates and projections.

BL 2018 Data Source
The number of children receiving TANF and State Two-Parent Cash Assistance is from ad hoc computer runs against the Warrant history file. The number of children under age 18 in poverty is estimated using baseline family income information obtained from the last two March Current Population Surveys administered by the U.S. Census Bureau. The baseline information is extrapolated using standard demographic and other statistical techniques that rely on data provided by the population estimates and projections program of the Texas State Data Center.

BL 2018 Methodology
Data are computed by dividing the monthly average number of children receiving TANF and State Two-Parent Cash Assistance by the total number of children in Texas under 18 years of age whose family's income is at or below 100 percent of poverty, and then multiplying this result by 100.

BL 2018 Purpose
This measure is an expression of the percent of need being met as it pertains to providing financial assistance through the TANF and State Two-Parent Cash Assistance programs to children who are living in poverty. It is an indicator of the impact the agency is having on reaching this target population (children in poverty).

BL 2019 Definition
This measure reports the number of children receiving Temporary Assistance for Needy Families (TANF) and the State Two-Parent Cash Assistance program benefits expressed as a percent of all children in Texas living in poverty.

BL 2019 Data Limitations
The estimated number of children in poverty is subject to change as a result of updates/revisions to the population estimates and projections.

BL 2019 Data Source
The number of children receiving TANF and State Two-Parent Cash Assistance is from ad hoc computer runs against the Warrant history file. The number of children under age 18 in poverty is estimated using baseline family income information obtained from the last two March Current Population Surveys administered by the U.S. Census Bureau. The baseline information is extrapolated using standard demographic and other statistical techniques that rely on data provided by the population estimates and projections program of the Texas State Data Center.

BL 2019 Methodology
Data are computed by dividing the monthly average number of children receiving TANF and State Two-Parent Cash Assistance by the total number of children in Texas under 18 years of age whose family's income is at or below 100 percent of poverty, and then multiplying this result by 100.

BL 2019 Purpose
This measure is an expression of the percent of need being met as it pertains to providing financial assistance through the TANF and State Two-Parent Cash Assistance programs to children who are living in poverty. It is an indicator of the impact the agency is having on reaching this target population (children in poverty).
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 5  
Objective No. 1  
Outcome No. 2

Objective: Encourage Self Sufficiency  
Outcome: Financial and Other Assistance  
Outcome: Number of Adults Exhausting Cash Assistance Benefits

Calculation Method: N  
Target Attainment: L  
Priority: H  
Cross Reference: Agy 529 084-R-S70-1 04-01 OC 02  
Key Measure: N  
New Measure: N  
Percent Measure: N

BL 2018 Definition
This measure reports the unduplicated number of adult Temporary Assistance for Needy Families (TANF) and the state Two-Parent Cash Assistance clients who exhausted their eligibility for state or federal time-limited benefits during the fiscal year. TANF clients who exhausted their time limited benefits and continue to receive TANF and the state Two-Parent Cash Assistance because of personal or economic hardship are not included in the counts. State time limits are 12, 24, or 36 months, depending on education and work history. Federal time limits are 60 months.

BL 2018 Data Limitations
None.

BL 2018 Data Source
Ad hoc computer runs using benefit and client eligibility files.

BL 2018 Methodology
Data run results represent the cumulative numbers who have exhausted their time limited benefits if they have 0 months remaining and are inactive. To determine the number exhausting time limited benefits for the applicable fiscal year, the cumulative number through the end of the prior fiscal year is subtracted from the cumulative number through the applicable fiscal year.

BL 2018 Purpose
This measure quantifies the adult population who may need but no longer are eligible for financial assistance through the TANF block grant and the state Two-Parent Cash Assistance because they have utilized the maximum number of service months for which they were eligible to receive benefits as stipulated in welfare reform legislation. This data is useful in projecting future funding needs.

BL 2019 Definition
This measure reports the unduplicated number of adult Temporary Assistance for Needy Families (TANF) and the state Two-Parent Cash Assistance clients who exhausted their eligibility for state or federal time-limited benefits during the fiscal year. TANF clients who exhausted their time limited benefits and continue to receive TANF and the state Two-Parent Cash Assistance because of personal or economic hardship are not included in the counts. State time limits are 12, 24, or 36 months, depending on education and work history. Federal time limits are 60 months.

BL 2019 Data Limitations
None.

BL 2019 Data Source
Ad hoc computer runs using benefit and client eligibility files.

BL 2019 Methodology
Data run results represent the cumulative numbers who have exhausted their time limited benefits if they have 0 months remaining and are inactive. To determine the number exhausting time limited benefits for the applicable fiscal year, the cumulative number through the end of the prior fiscal year is subtracted from the cumulative number through the applicable fiscal year.

BL 2019 Purpose
This measure quantifies the adult population who may need but no longer are eligible for financial assistance through the TANF block grant and the state Two-Parent Cash Assistance because they have utilized the maximum number of service months for which they were eligible to receive benefits as stipulated in welfare reform legislation. This data is useful in projecting future funding needs.
Objective: Encourage Self Sufficiency

Outcome: % TANF Caretakers Leaving Due to Increased Employment Earnings

Calculation Method: N
Target Attainment: H
Priority: H
Cross Reference: Agy 529 084-R-S70-1 04-01 OC 03

Key Measure: N
New Measure: N
Percent Measure: Y

BL 2018 Definition
This measure reports the number of Temporary Assistance for Needy Families (TANF) and State Two-Parent Cash Assistance caretakers who are denied TANF and State Two-Parent Cash Assistance during the fiscal year because of increased employment earnings expressed as a percent of the total number of caretakers who leave the program during the same time period.

BL 2018 Data Limitations
Time-limited benefits and implementation of full family sanctions impact this measure. The measure is impacted by the level of activity of Local Workforce Development Boards and the state of the economy.

BL 2018 Data Source
Data is obtained from reports in the eligibility determination system.

BL 2018 Methodology
Data is computed by taking the total number of TANF and State Two-Parent Cash Assistance families who leave the TANF and State Two-Parent Cash Assistance programs per year because of increased employment earnings, including those denied for earnings and those transferred to transitional Medicaid because of earnings. This number is divided by the total number of TANF and State Two-Parent Cash Assistance families who leave the TANF and State Two-Parent Cash Assistance programs during the same time period, and then multiplied by 100 to obtain the reported percentage.

BL 2018 Purpose
This measure assesses the impact of the agency's efforts to effectively move clients from welfare to work.

BL 2019 Definition
This measure reports the number of Temporary Assistance for Needy Families (TANF) and State Two-Parent Cash Assistance caretakers who are denied TANF and State Two-Parent Cash Assistance during the fiscal year because of increased employment earnings expressed as a percent of the total number of caretakers who leave the program during the same time period.

BL 2019 Data Limitations
Time-limited benefits and implementation of full family sanctions impact this measure. The measure is impacted by the level of activity of Local Workforce Development Boards and the state of the economy.

BL 2019 Data Source
Data is obtained from reports in the eligibility determination system.

BL 2019 Methodology
Data is computed by taking the total number of TANF and State Two-Parent Cash Assistance families who leave the TANF and State Two-Parent Cash Assistance programs per year because of increased employment earnings, including those denied for earnings and those transferred to transitional Medicaid because of earnings. This number is divided by the total number of TANF and State Two-Parent Cash Assistance families who leave the TANF and State Two-Parent Cash Assistance programs during the same time period, and then multiplied by 100 to obtain the reported percentage.

BL 2019 Purpose
This measure assesses the impact of the agency's efforts to effectively move clients from welfare to work.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 5  
Objective No. 1  
Outcome No. 4

Goal: Encourage Self Sufficiency  
Objective: Financial and Other Assistance  
Outcome: Percentage of Eligible WIC Population Served

Calculation Method: N  
Target Attainment: N  
Priority: N  
Cross Reference: Agy 537 084-R-S70-1 02-01 OC 01

Key Measure: Y  
New Measure: N  
Percent Measure: Y

BL 2018 Definition

This measure represents the percent of potentially eligible clients that are provided services during the most recent month for which data are available. To be certified and participate in the WIC program, infants, children, and pregnant, postpartum, and breast-feeding women shall reside within the jurisdiction of the state, meet certain income and nutritional risk criteria.

BL 2018 Data Limitations

Most recent data available is used at reporting deadlines.

BL 2018 Data Source

Participation is reported in the output measure "Number of WIC Participants Provided Supplemental Food per Month". Potential eligibles come from the Texas WIC Program County Potential Eligible Estimates Report, which is produced by the Texas Department of State Health Services. Potential eligibles are an estimate of the number of pregnant, postpartum or breast-feeding women, as well as children up to the age of 5 whose family incomes are at or below 185% of the Federal Poverty Level.

BL 2018 Methodology

The percentage is calculated by dividing the most recent month's number of WIC participants by the estimated number of persons eligible for WIC services at the time the report is due. This calculation is based on a federal fiscal year.

BL 2018 Purpose

Measures the percentage of eligible WIC population served.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Objective Outcome Definitions Report
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 6  
Community & Independent Living Services & Coordination

Objective No. 1  
Long-term Care Services & Coordination

Outcome No. 1  
Avg # of Indiv Served Per Mo: Total Non-Medicaid Community Svcs & Supp

Key Measure: N  
New Measure: N  
Percent Measure: N

BL 2018 Definition
This measure reports the monthly average unduplicated number of individuals who, based upon approved-to-pay claims, received one or more of the following non-Medicaid Community Services and Supports: adult foster care, individual managed attendant care, day activity and health services (funded through Social Services Block Grant), emergency response services, home delivered meals (XX funded), family care, special services for individuals with disabilities, residential care, respite care and In-home Family Support. Also included are community services consisting of assessment and service coordination, vocational and training services, respite, specialize therapies and In-home and Family Support.

BL 2018 Data Limitations
This measure does not include services provided by the Area Agencies on Aging. Data for these services are reported as annual unduplicated counts that cannot be combined with the monthly averages reported for each of the other services. For other data limitations, refer to output measure 1 under strategy 1.4.4, output 2 under strategy 1.4.2 and explanatory measure 2 under strategy 1.4.1.

BL 2018 Data Source
Specific data sources are detailed under each of the measures that comprise this "roll-up" measure. See output measure 1 under strategy 1.4.4, output measure 2 under strategy 1.4.2, and explanatory measure 2 under strategy 1.4.1.

BL 2018 Methodology
This measure is the sum of output measure 1 under strategies 1, 2, 4, and output measure 2 of strategy 2 of this objective.

BL 2018 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 funding that has been appropriated.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
<table>
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<tr>
<th>Agency Code: 529</th>
<th>Agency: Health and Human Services Commission</th>
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<tr>
<td>Goal No. 6</td>
<td>Community &amp; Independent Living Services &amp; Coordination</td>
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<tr>
<td>Objective No. 1</td>
<td>Long-term Care Services &amp; Coordination</td>
</tr>
<tr>
<td>Outcome No. 2</td>
<td>Avg Mo Cost Per Indiv Served: Total Non-Medicaid Community Svcs &amp; Supp</td>
</tr>
</tbody>
</table>

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 01-04 OC 02  
**Key Measure:** N  
**New Measure:** N  
**Percent Measure:** N

**BL 2018 Definition**

This measure reports the average cost of non-Medicaid Community Services and Supports 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 non-Medicaid Community Services and Supports individuals is defined under outcome measure 1.

**BL 2018 Data Limitations**

This measure does not include services provided by the Area Agencies on Aging (AAA). Average cost data for these services are based on annual unduplicated individual counts that cannot be combined with the monthly averages reported for each of the other non-Medicaid Community Services and Supports. Specific data limitations for each of these other services are identified under efficiency measure 1 of strategy 1 and 4, and efficiency measures 1 and 2 of strategy 2, of this objective.

**BL 2018 Data Source**

Specific data sources are detailed under each of the measures that comprise this measure. See efficiency measure 1 under strategies 1 and 4, and efficiency measures 1 and 2 of strategy 2.

**BL 2018 Methodology**

The sum of monthly expenditures for non-Medicaid Community Services and Supports by month-of-service for all months in the reporting period is divided by the average monthly number of non-Medicaid Community Services and Supports individuals for the months of the reporting period; this is then divided by the number of months in the reporting period.

**BL 2018 Purpose**

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

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Goal No. 6 Community & Independent Living Services & Coordination
Objective No. 1 Long-term Care Services & Coordination
Outcome No. 3 Avg # Persons on Interest List Per Mo: Non-Medicaid Comm Svcs & Supp

**BL 2018 Definition**

This measure reports the sum of the average monthly number of individuals who have requested one or more non-Medicaid Community Services and Supports but are placed on an interest list for requested service(s) due to funding constraints. Interest lists are maintained for Title XX funded services, for GR funded services, for all In-home and Family Support services, and for Community Services. The count only includes those individuals on the list who are in “open” status (i.e., it excludes those individuals who are being processed for eligibility to begin receiving the service.) The count includes individuals who are waiting for one or more non-Medicaid Community Services and Supports while receiving other Community Services and Supports. See explanatory measure 1 under strategies 1.4.1. and 1.4.4., and explanatory measure 3 under strategy 1.4.2. for the detail of the component measures that comprise this “total” measure.

**BL 2018 Data Limitations**

See explanatory measure 1 under strategies 1.4.1. and 1.4.4., and explanatory measure 3 under strategy 1.4.2. for the detail of the component measures that comprise this “total” measure.

**BL 2018 Data Source**

Specific data sources are identified under each of the measures that are included in this count. See explanatory measure 1 under strategies 1.4.1. and 1.4.4., and explanatory measure 3 under strategy 1.4.2. for the detail of the component measures that comprise this “total” measure.

**BL 2018 Methodology**

This measure is the sum of explanatory measure 1 under strategies 1.4.1. and 1.4.4., and explanatory measure 3 under strategy 1.4.2.

**BL 2018 Purpose**

This measure is important because it is an indicator of the unmet need for services provided under non-Medicaid Community Services and Supports as currently funded by this strategy.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Goal No. 6  Community & Independent Living Services & Coordination
Objective No. 3  Other Community Support Services
Outcome No. 1  % of Adult Victims of Family Violence Denied Shelter

Calculation Method: N  Target Attainment: N  Priority:  Cross Reference: Agy 529 084-R-S70-1 04-02 OC 01
Key Measure: N  New Measure: N  Percent Measure: Y

BL 2018 Definition
This measure reports the percent of adult victims of family violence who requested shelter and were denied due to lack of space in the shelter they contacted. Adult victims denied shelter at an original site may find shelter (with assistance from the original site) at another location. A family member, friend, or another shelter may fill the need. Victims denied shelter may receive non-residential services.

BL 2018 Data Limitations
In rare instances, this count may be duplicated when a victim denied shelter at the original site seeks services in another location and is denied again due to lack of space. Data does not include walk-in clients or nonresidential clients who are seeking shelter.

BL 2018 Data Source
Data are obtained from the automated data collection system maintained by the Family Violence Program. Contractors not able to participate in this system submit their data manually to the Family Violence Program where it is combined with the automated data for reporting.

BL 2018 Methodology
Staff receives data from the automated system maintained by the Family Violence Program and queries data according to program requirements to obtain the total denied due to lack of space.

BL 2018 Purpose
This measure is an indicator of the need for shelter services.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
### Agency Code: 529  
### Agency: Health and Human Services Commission

<table>
<thead>
<tr>
<th>Goal No.</th>
<th>Objective No.</th>
<th>Outcome No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
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</table>

**Goal No. 7 Mental Health State Hospitals, SSLCs and Other Facilities**  
**Objective No. 1 State Supported Living Centers**  
**Outcome No. 1 Avg # Days SSLC Residents Wait for Community Placement**

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-08 OC 01  
**Key Measure:** N  
**New Measure:** N  
**Percent Measure:** N

---

#### BL 2018 Definition

As campus residents are recommended for community placement, the Health and Human Services Commission (HHSC) begins a process of locating and/or developing community locations. Placement is a dynamic process with the individual, family or guardian and community providers involved in the placement process. There is high variability in the amount of time needed for actual community placement due to the uniqueness of the individual's needs and the location preferences of the individual and family or guardian.

#### BL 2018 Data Limitations

With the implementation of the standardized instrument for recommending that individuals currently residing in state ID campus-based facilities be placed in the community, the data collected for this measure should have inter-rater reliability.

#### BL 2018 Data Source

The recommendation for placement in the community is from each individual's annual review. Recommendations for community placements are entered into the commission’s Client Assignment and Registration (CARE) system with the recommended movement code 5 (move from campus to community). Actual placement in the community is entered into the CARE system with the Assignment/Absence code of CP (Community Placement). Persons employed by the SSLCs enter the annual review recommendations into the department's CARE system.

#### BL 2018 Methodology

For the numerator, the sum of days between community placement recommendation and actual placement for each state ID campus resident recommended for community placement and placed in the community during the fiscal year are added together. The denominator is the number of individuals placed in community during the fiscal year. The formula is numerator/denominator.

#### BL 2018 Purpose

Ideally, campus residents recommended for community placement would be placed within 180 days. (Movement within 180 days of an individuals recommendation for community placement is a requirement of the Promoting Independence Plan.) A shorter average wait indicates success in developing community placements for campus residents who can benefit from community placement.

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#### BL 2019 Definition

#### BL 2019 Data Limitations

#### BL 2019 Data Source

#### BL 2019 Methodology

#### BL 2019 Purpose
### Agency Code: 529  
**Agency:** Health and Human Services Commission  

<table>
<thead>
<tr>
<th>Goal No.</th>
<th>Objective No.</th>
<th>Outcome No.</th>
<th>Calculation Method:</th>
<th>Target Attainment:</th>
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<td>N</td>
<td>N</td>
<td>Agy 539 084-R-S70-1 01-08 OC 02</td>
</tr>
</tbody>
</table>

**Key Measure:** N  
**New Measure:** N  
**Percent Measure:** N

### BL 2018 Definition

This outcome is based on individuals with intellectual and developmental disabilities who prefer community placement obtaining such placement. It is actually a measure of the availability of Medicaid Waiver funded services (Home and Community-based Services and any others directly administered by the Health and Human Services Commission (HHSC) in the future) and ICF/IID funding for new capacity. Movement from campus (i.e. state ID facilities which are large self-contained areas where individuals live and receive 24-hour supervised care) to community tends to be from one type of residential setting to another residential setting.

### BL 2018 Data Limitations

None.

### BL 2018 Data Source

Movement of individuals served by the HHSC campus-based system is recorded in the commission’s data warehouse system by staff at the facilities. The source of data is the “CAM3 Campus-Based Discharge/Community Placement” Client Assignment and Registration (CARE) system from which indicates actual date of community placement. These forms are located in records available from the State Supported Living Centers. The Community Placement Living Plan is available in the clinical record and projects a date for community placement that may be changed based on a variety of factors. Assignment/Absence codes are used for these movements in the CARE system. The Community Placement (CP) code is used to indicate a community placement from a state ID facility.

### BL 2018 Methodology

This is a simple count of persons with an Assignment/Absence code of CP over the fiscal year.

### BL 2018 Purpose

The implementation of the Governor's Executive Order, RP 13 and the Health and Human Services Commission's Promoting Independence Plan should have significant impact on this measure. Persons residing in state ID facilities that want community placement and for whom staff recommends community placement should have the opportunity for community placement.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology

### BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 7  
Mental Health State Hospitals, SSLCs and Other Facilities

Objective No. 1  
State Supported Living Centers

Outcome No. 3  
% Consumers Expressed Satisfaction with Ombudsman's Resolution of Issue

<table>
<thead>
<tr>
<th>Calculation Method: N</th>
<th>Target Attainment:</th>
<th>Priority:</th>
<th>Cross Reference: Agy 539 084-R-S70-1 01-08 OC 03</th>
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</thead>
<tbody>
<tr>
<td>Key Measure: N</td>
<td>New Measure: N</td>
<td>Percent Measure: Y</td>
<td></td>
</tr>
</tbody>
</table>

**BL 2018 Definition**
This measure reports the percentage of residents, families and advocates expressing satisfaction with the resolution from the Ombudsman.

**BL 2018 Data Limitations**
Data for this measure is available and updated on the 15th of each month.

**BL 2018 Data Source**
The number of residents, families and advocates who filed a concern, Consumer Rights and Services (CRS) Ombudsman Reports, with the Ombudsman.

**BL 2018 Methodology**
The percentage of consumers who expressed satisfaction is based on final evaluation of the case.

**BL 2018 Purpose**
This measure is a satisfaction indicator of the reform effort to provide more oversight and protection for the residents of the living centers.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 7  
Mental Health State Hospitals, SSLCs and Other Facilities

Objective No. 2  
Mental Health State Hospital Facilities and Services

Outcome No. 1  
Patient Satisfaction with State Mental Health Facility Treatment

BL 2018 Definition

A primary goal for inpatient treatment is to assure that quality psychiatric services are provided that meet or exceed the needs and expectations of consumers and their families. This measure is obtained from the consumers (and family members as appropriate) and provides consumer self-report information as an indication of satisfaction.

BL 2018 Data Limitations

The Mental Health Statistical Improvement Project Inpatient Consumer Survey is a voluntary survey. The collection of data from survey questionnaires is dependent upon the consumers' completion and submission of the survey. Since not all consumers will complete the survey, this measurement of satisfaction is not able to fully reveal consumer satisfaction.

BL 2018 Data Source

All adults and adolescents (13 years of age and older) are offered the Mental Health Statistical Improvement Project Inpatient Consumer Survey at discharge, but participation is strictly voluntary. The survey instrument asks for agreement/disagreement ratings along a five-point scale for 28 statements. The survey results are entered into a stand-alone section of the MyAvatar application. The surveys are extracted and submitted as part of the National Research Institute submission where the results are tabulated.

BL 2018 Methodology

The measure is calculated by averaging the items scored for all adolescent and adult patients combined who completed the Mental Health Statistical Improvement Project Inpatient Consumer Survey during the current fiscal year.

BL 2018 Purpose

A positive degree of satisfaction is one indicator reflecting success in addressing consumer needs and preferences. This includes achieving desired outcomes and is associated with compliance with treatment.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529  Agency: Health and Human Services Commission

Goal No. 7  Mental Health State Hospitals, SSLECs and Other Facilities
Objective No. 3  Other Facilities
Outcome No. 1  % Cases of TB Treated at TCID as Inpatients - Patients Treated to Cure

**Calculation Method:** N  **Target Attainment:** N  **Priority:** N  **Percent Measure:** Y  **Cross Reference:** Agy 537 084-R-S70-1 03-01 OC 01

**BL 2018 Definition**
Percent of cases of tuberculosis treated at the Texas Center for Infectious Disease (TCID) as inpatients in which the patients are treated to cure.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
Discharge summary prepared to document physician authorization to discharge patient from hospitalization at TCID is logged and data is compiled for the reporting period. “Treatment to cure” is defined as the organism being completely eradicated in those patients who must be more expensively hospitalized to complete their treatment.

**BL 2018 Methodology**
Ratio of total TCID discharged patients who have completed treatment to cure to total number of patients admitted to TCID for the reporting period.

**BL 2018 Purpose**
Measures the controllable outcome expected by HSC13.031 for TCID services.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 8  
Objective No. 1  
Outcome No. 1

**Objective No. 1 Regulation of Facilities and Consumer Products**

**Outcome No. 1 Percentage of Licenses Issued within Regulatory Timeframe**

**Calculation Method: N  
Target Attainment: N  
Priority: N  
Cross Reference: Agy 537 084-R-S70-1 04-01 OC 02**

**Key Measure: Y  
New Measure: N  
Percent Measure: Y**

**BL 2018 Definition**
Percentage of individuals credentialed and entities licensed within regulatory timeframes (mandated by statute and listed in specific program rules).

**BL 2018 Data Limitations**
The Regulatory Automation System (RAS) reports the total consecutive number days from the fiscal remittance date to the date an application is approved. However, the report does not take into account periods of time when time frames are suspended per regulations when an applicant fails to submit a complete application and/or payment.

**BL 2018 Data Source**
Application records and the Regulatory Automation System (RAS).

**BL 2018 Methodology**
This efficiency measure reflects the annual percentage of individuals credentialed and entities licensed within regulatory timeframes. Calculated using the total number of individuals and entities licensed/credentialed within the established timeframes divided by the total number of individuals and entities licensed/credentialed during the reporting period.

**BL 2018 Purpose**
Measures the efficiency of licensing activities to ensure compliance with regulatory timeframes.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Goal No. 8 Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Outcome No. 2 Percent of Investigations with a High Risk Finding

BL 2018 Definition

An investigation is conducted when a report is received that alleges a licensed or registered operation has failed to comply with the law, administrative rules, or minimum standards. Each minimum standard has been assigned a weight based on the risk a violation of that standard would present to children in care. Standards that present the most risk to children in care when violated have been assigned a high weight. All administrative rules and laws are weighted high. Children are considered to be at risk when violations of law, rules, or standards with a high weight occur.

BL 2018 Data Limitations

None.

BL 2018 Data Source

Child care investigators enter the results of their investigations into the Child-care Licensing Automation Support System (CLASS). Information is obtained from queries on investigation information contained in the CLASS investigation tables.

BL 2018 Methodology

Divide the number of non-abuse/neglect investigations and abuse/neglect investigations that were completed during the reporting period that have a finding of non-compliance for a law, rule, or standard with a high weight (numerator) by the total number of investigations that were completed within the reporting period (denominator) and multiply by 100 to achieve a percentage.

BL 2018 Purpose

The purpose of this measure is to evaluate the agency's success in protecting children in care from those situations that pose the highest risk. It is an important measure in determining whether the program is meeting its objective.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 8  
Regulatory, Licensing and Consumer Protection Services

Objective No. 1  
Regulation of Facilities and Consumer Products

Outcome No. 3  
Percent of Licensed/Certified Professionals with No Recent Violations

<table>
<thead>
<tr>
<th>Calculation Method: N</th>
<th>Target Attainment: N</th>
<th>Priority: N</th>
<th>Cross Reference: Agy 537 084-R-S70-1 04-01 OC 03</th>
</tr>
</thead>
</table>

**Key Measure:** N  
**New Measure:** N  
**Percent Measure:** Y

**BL 2018 Definition**
Percent of the total licensed, certified, registered, permitted or documented professionals at the end of the reporting period who have not incurred a violation within the current and preceding two years (three years total).

**BL 2018 Data Limitations**
The numbers of violations are dependent on the number of complaints filed and the nature of those violations investigated. The agency has no control over either of these two factors. The agency also has no control over the number of individuals who meet the requirements for professional credentialing and/or professionals who choose to renew their licenses.

**BL 2018 Data Source**
The total number of professionals and the number of professionals who received a sanction is obtained from Regulatory Automation System (RAS).

**BL 2018 Methodology**
The percentage is calculated by dividing the total number of individuals currently licensed, registered, permitted, certified, or documented who have not incurred a violation within the current and preceding two years by the total number of individuals currently licensed, registered, permitted, certified, or documented by the agency.

**BL 2018 Purpose**
Licensing, certifying, registering, permitting, and documenting individuals helps ensure that practitioners meet legal standards for professional education and practice, which is a primary program goal. This measure is an indication of the percentage of individuals who have not committed violations of the laws, and/or rules governing the profession. This measure is important because it indicates how effectively the agency's activities deter violations of professional standards established by statute and rule.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 8  Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Outcome No. 4 Percent of Licensed Facilities with No Recent Violations

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:**  
**Cross Reference:** Agy 530 084-R-S70-1 05-01 OC 02

**Key Measure:** N  
**New Measure:** N  
**Percent Measure:** Y

**BL 2018 Definition**

An operation is said to be operating in compliance with minimum standards when no violations are observed during an inspection by a licensing representative.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

Child care licensing representatives enter into the Child-care Licensing Automation Support System (CLASS) the violations of minimum standards which they observe during inspections, non-abuse/neglect investigations or abuse/neglect investigations. A record is kept of the violations that occur at each operation by the date on which they were observed and cited. Data to calculate the numerator and denominator are taken from CLASS.

**BL 2018 Methodology**

Divide the result of subtracting the total number of licensees and registrants operating at the end of the reporting period that had violations anytime during the previous two-year period from the total number of licensees and registrants operating at the end of the reporting period (numerator) by the total number of licensees and registrants operating at the end of the reporting period (denominator) and multiply the result by 100 to achieve a percentage.

**BL 2018 Purpose**

The purpose of this measure is to determine what percent of regulated facilities are operating in compliance with agency minimum standards. The information can be used to target facilities that need more regulatory attention, i.e., those which do not fall into this group.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529  
Agency: Health and Human Services Commission  
Goal No. 8  Regulatory, Licensing and Consumer Protection Services  
Objective No. 1  Regulation of Facilities and Consumer Products  
Outcome No. 5  % of Licensed/Certified AHCF Meeting St/Fed Regulations at Survey  

**BL 2018 Definition**

With the outcome measure of percentage of licensed/certified acute health care facilities (AHCF), including free standing emergency medical care facilities, meeting state/federal regulation at survey, the comparison will be made on a yearly basis between the number of acute care facility and free standing emergency medical care facilities surveys conducted and the number of those surveys which found the facilities to be in compliance with state/federal regulations.

**BL 2018 Data Limitations**

The number of compliance surveys is provided through manual computation.

**BL 2018 Data Source**

The number of compliance surveys is provided through manual computation. The facilities found to be out of compliance are maintained in a database file in an automated computer system(s) of the health facility compliance program.

**BL 2018 Methodology**

The percentage is calculated by dividing the number of acute care facilities found out of compliance with state and federal regulations during surveys by the total number of compliance surveys conducted. This number is subtracted from 1 and then multiplied by 100%.

**BL 2018 Purpose**

The goal is to demonstrate an increase in the compliance rate being an indicator of improved health care delivery to the citizens of Texas by DSHS regulated health care facilities.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Calculating the Percent of Facilities with a Remedial Action:

Remedial actions may occur as a result of a violation, but more often the operation is cited, given a date by which to achieve compliance, and re-inspected to be sure the correction has been made. Only the most serious violations, several non-compliances that create an endangering situation or patterns of repeated non-compliances result in remedial actions. Remedial actions are those that Licensing may impose if an operation is deficient in a minimum standard, rule, law, a specific term associated with the operation's permit, or a condition of evaluation, probation, or suspension. The four types of remedial actions are corrective, adverse, judicial and monetary. Agency homes and CPA branches are not eligible for remedial actions.

### BL 2018 Data Limitations
Remedial actions not within the agency's jurisdiction are not entered in CLASS. Each facility will be counted only once per fiscal year, regardless of the number of remedial actions it received during the reporting period.

### BL 2018 Data Source
Remedial actions within the agency's jurisdiction are entered into the Child-care Licensing Automation Support System (CLASS) with the date the action occurred.

### BL 2018 Methodology
Divide the number of facilities with one or more remedial action (numerator) by the total number of eligible facilities during the reporting period (denominator) and multiply the result by 100 to achieve a percentage.

### BL 2018 Purpose
The purpose of this measure is to determine the percentage of facilities with remedial actions. This will assist licensing staff in identifying the most serious violators.
Agency Code: 529  
Agency: Health and Human Services Commission  
Goal No. 8  Regulatory, Licensing and Consumer Protection Services  
Objective No. 1  Regulation of Facilities and Consumer Products  
Outcome No. 7  % Facilities Complying with Stds at Inspection Licen-Medicare/Medicaid  
Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 539 084-R-S70-1 02-01 OC 01  
Key Measure: Y  
New Measure: N  
Percent Measure: Y  

BL 2018 Definition  
This measure reports the number of facilities (nursing facilities, Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), assisted living facilities, adult day care facilities, and Prescribed Pediatric Extended Care Centers (PPECC) complying with standards at time of inspection expressed as a percent of all of these facilities (nursing facilities, ICFs/IID, assisted living facilities, adult day care facilities, and PPECC). Complying with standards is defined as a recommendation to continue/renew licensure and/or certification. An inspection is defined as a standard survey of a nursing facility, a re-certification survey of an ICF/IID, or a licensing inspection. Licensing inspections conducted in conjunction with a standard or an annual survey are counted as one activity.  

BL 2018 Data Limitations  
Does not apply.  

BL 2018 Data Source  
Data are obtained from the Regulatory Services Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing all of the data elements needed to perform the necessary calculations. The report will be titled “% Facilities Complying with Standards at Inspection Licen-Medicare/Medicaid” in the future.  

BL 2018 Methodology  
The percentage of facilities complying with standards during the state fiscal year is calculated by dividing the number of inspections determined to be in compliance at the time of inspection (numerator) by the total number of inspections completed (denominator) during the reporting period, and multiplying this result by 100.  

BL 2018 Purpose  
This measure quantifies the achievement of the program's objective while also indicating public accountability of facilities.  

BL 2019 Definition  

BL 2019 Data Limitations  

BL 2019 Data Source  

BL 2019 Methodology  

BL 2019 Purpose
This measure reports the percentage of facilities (nursing facilities, Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), assisted living facilities, adult day care facilities, and Prescribed Pediatric Extended Care Centers (PPECC)) that have corrected adverse findings/actions by the time of the first follow-up visit. The first follow-up visit is defined as the visit conducted for the purpose of determining correction of deficiencies/violations cited at the time of inspection or investigation. This visit is the first visit conducted for this purpose. A second, third, or subsequent visit would not be counted under this measure. Adverse findings are defined as recommendations other than to continue/renew licensure and/or certification.

BL 2018 Data Limitations
Does not apply

BL 2018 Data Source
Data are obtained from the Central Data Repository (CDR) that pulls nursing facility only data from the Compliance, Assessment, Regulation, Enforcement System (CARES) and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed to make the necessary calculations. The report will be titled “Facilities Correcting Adverse Findings by 1st Follow-up Visit” in the future.

BL 2018 Methodology
The percentage of facilities correcting adverse findings by time of the first follow-up visit after inspection or investigation is calculated by dividing the number of inspections determined to be in compliance with standards at the time of the first follow-up visit (numerator) by the total number of such visits conducted during the reporting period (denominator), and multiplying this result by 100. Data are reported for the state fiscal year.

BL 2018 Purpose
This measure quantifies the achievement of the program's objective while also indicating public accountability of facilities.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
<table>
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<td>Goal No.</td>
<td>8</td>
<td>Regulatory, Licensing and Consumer Protection Services</td>
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<tr>
<td>Objective No.</td>
<td>1</td>
<td>Regulation of Facilities and Consumer Products</td>
<td></td>
</tr>
<tr>
<td>Outcome No.</td>
<td>9</td>
<td>% NF with More Than Six On-site Monitoring Visits Per Year</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Percent Measure:** Y  
**Cross Reference:** Agy 539 084-R-S70-1 02-01 OC 03

**BL 2018 Definition**

This measure reports the percentage of nursing facilities that have more than six regulatory visits per year. A regulatory visit is defined as any on-site licensure inspection, certification survey, complaint and incident investigation, or follow-up to inspections, surveys and investigations. Licensure inspections conducted in conjunction with a certification survey are counted as one regulatory visit for purposes of this measure. However, if during a regulatory visit, more than one type of activity is performed (a licensure inspection, a follow-up and an investigation) each type of activity is counted separately for reporting this measure.

**BL 2018 Data Limitations**

Does not apply

**BL 2018 Data Source**

Data are obtained from the Central Data Repository (CDR) that pulls data from the Compliance, Assessment, Regulation, Enforcement System (CARES) and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed to make the necessary calculations. The report will be titled “% NF with More Than Six on-site Monitoring Visits Per Year” in the future.

**BL 2018 Methodology**

The percentage of nursing facilities with more than six regulatory visits is calculated by determining the number of nursing facilities with more than 6 visits per year (numerator) and dividing by the average number of nursing facilities licensed and/or certified (denominator) during the reporting period, and multiplying the result by 100

**BL 2018 Purpose**

This measure quantifies the achievement of the program's objective while indicating the public accountability of nursing facilities.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 8  
Objective No. 1  
Outcome No. 10  

Objective: Regulation of Facilities and Consumer Products
Outcome: Rate (1000) Substantiated Complaint Allegations of Abuse/Neglect: NF

Calculation Method: N  
Target Attainment: N  
Priority: N  
Cross Reference: Agy 539 084-R-S70-1 02-01 OC 04

Key Measure: N  
New Measure: N  
Percent Measure: N

BL 2018 Definition
This measure reports the rate of substantiated complaint allegations of resident abuse and/or neglect in nursing facilities (NFs) per 1,000 residents during the state fiscal year. A substantiated complaint allegation is defined as an allegation received as a complaint from a resident, family member, or the public that is determined to be a violation of standards. Regional Regulatory Services survey/investigation staff determine whether allegations are substantiated after a thorough investigation. Abuse and neglect are defined by state and federal regulations. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Abuse and neglect of children residing in nursing facilities is defined by Texas Family Code, Section 261.001.

BL 2018 Data Limitations
Does not apply

BL 2018 Data Source
Data are obtained from the Central Data Repository (CDR) that pulls data from the Compliance, Assessment, Regulation, Enforcement System (CARES) and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled “Rate (1000) Substantiated Complaint Allegations of Abuse/Neglect: NF” in the future. The data for the number of residents in nursing facilities is reflective of facility census data collected at the last Regulatory Services onsite visit and entered into CARES. The census data may range from several weeks to more than one year old.

BL 2018 Methodology
This measure is computed by dividing the number of substantiated complaint allegations of abuse/neglect in nursing facilities during the months of the reporting period by the total number of residents in nursing facilities, and then multiplying this result by 1,000.

BL 2018 Purpose
This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in nursing facilities. It is a tool for evaluating the program's effectiveness and accessing the accountability of facilities.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 8  
Regulatory, Licensing and Consumer Protection Services

Objective No. 1  
Regulation of Facilities and Consumer Products

Outcome No. 11  
Rate (1000) Substantiated Complaint Allegations Abuse/Neglect: ICF/IID

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 02-01 OC 05

**Key Measure:** N  
**New Measure:** N  
**Percent Measure:** N

---

**BL 2018 Definition**

This measure reports the rate of substantiated complaint allegations of abuse and/or neglect in ICFs/IID per 1,000 residents during the state fiscal year. A substantiated complaint allegation is defined as an allegation received as a complaint from a resident, family member, or the public that is determined to be a violation of standards. Abuse and neglect are defined by state and federal regulations. See outcome measure 4 for definition of abuse and neglect.

**BL 2018 Data Limitations**

Does not apply

**BL 2018 Data Source**

Data are obtained from the Central Data Repository (CDR) that pulls data from the Compliance, Assessment, Regulation, Enforcement System (CARES) and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled “Rate (1000) Substantiated Complaint Allegations Abuse/Neglect: ICF/IID” in the future. The data for the number of residents in ICFs/IID for persons with related conditions is reflective of facility census data collected at the last Regulatory Services onsite visit and entered in the CARES system. The census data may range from several weeks to more than one year old.

**BL 2018 Methodology**

This measure is computed by dividing the number of substantiated complaint allegations of abuse/neglect in ICFs/IID during the months of the reporting period by the total number of residents in ICFs/IID during this period, and then multiplying this result by 1,000

**BL 2018 Purpose**

This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in ICFs/IID. It is a tool for evaluating the program's effectiveness and accessing the accountability of facilities.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 8  
Objective No. 1  
Outcome No. 12  
Goal: Regulatory, Licensing and Consumer Protection Services  
Objective: Regulation of Facilities and Consumer Products  
Outcome: Percent of Nursing Facility Administrators with No Recent Violations

Calculation Method: N  
Target Attainment: Priority:  
Key Measure: N New Measure: N Percent Measure: Y

Cross Reference: Agy 539 084-R-S70-1 02-01 OC 06

BL 2018 Definition
This measure reports the number of nursing facility administrators who have had no recent violations expressed as a percent of all nursing facility administrators licensed by the agency.

BL 2018 Data Limitations
Does not apply

BL 2018 Data Source
Data are obtained from both automated and manual sources. The information regarding licensees with an imposed sanction within the last 24 months is collected manually. Manual collections of data are pen and paper tabulations of information manually pulled from computer files. There are no report titles or identifying numbers associated with this process. Information regarding the number of licensees at the time of reporting is collected from the automated administrators licensing database.

BL 2018 Methodology
Data are computed by dividing the number of administrators without an imposed sanction (numerator) by the number of all licensees (denominator), multiplied by 100. The numerator is derived by subtracting the number of licensees with a sanction imposed within the past 24 months from the total number of licensees at the time of reporting. The denominator is derived by tabulating the total number of licensees at the time of reporting.

BL 2018 Purpose
This measure shows the effect of the agency's program to ensure that nursing facility administrators are in compliance with legal requirements. It is a tool for assessing the program's effectiveness and the accountability of nursing facility personnel.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 8 Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Outcome No. 13 Percent of Nurse Aides and Medication Aides with No Recent Violations

Calculation Method: N Target Attainment: N Priority: N Cross Reference: Agy 539 084-R-S70-1 02-01 OC 07
Key Measure: N New Measure: N Percent Measure: Y

BL 2018 Definition
This measure reports the number of nurse aides and medication aides who have had no recent violations expressed as a percent of all nurse aides and medication aides credentialed by the commission.

BL 2018 Data Limitations
Does not apply

BL 2018 Data Source
Data are obtained from the automated Nurse Aide and Medication Aide Tracking Systems.

BL 2018 Methodology
Data are calculated by dividing the number of medication aides and nurse aides without an imposed sanction (numerator) by the number of all credentialed medication aides and nurse aides (denominator), multiplied by 100. The numerator is derived by subtracting the number of medication aides and nurse aides with sanctions imposed within the last 24 months from the total number of medication aides permitted and nurse aides in active status on the nurse aide registry at the time of reporting. The denominator is derived by tabulating the total number of medication aides permitted and nurse aides in active status on the nurse aide registry at the time of reporting.

BL 2018 Purpose
This measure shows the effect of the agency's program to ensure Medication Aides and Nurse Aides are in compliance with legal requirements. It is a tool for evaluating the program's effectiveness and assessing the accountability of nursing facility personnel.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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<tr>
<td>Goal No.</td>
<td>8</td>
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<td>Regulation of Facilities and Consumer Products</td>
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<td>Outcome No.</td>
<td>14</td>
<td>% Complaints and Referrals Resulting in Disciplinary Action: NFA</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 02-01 OC 08  
**Key Measure:** N  
**New Measure:** N  
**Percent Measure:** Y

**BL 2018 Definition**

This measure reports the number of complaints and referrals against nursing facility administrators that resulted in disciplinary action expressed as a percent of all complaints and referrals against nursing facility administrators.

**BL 2018 Data Limitations**

The Nursing Facility Administrators Advisory Committee (NFAAC) is advisory only. The commission has the ultimate authority to decide on an administrator's culpability and what sanctions, if any, are to be imposed. Therefore, the department can and routinely does amend, and in some cases dismiss, the NFAAC's recommendations. The commission must take action on a complaint/referral when the NFAAC fails to meet/review cases, such as in the past when the NFAAC was temporarily abolished.

**BL 2018 Data Source**

This information is electronically tabulated from data entered into the Complaints and Tracking System (CARTS). CARTS is an Access database maintained by the Health and Human Services Commission’s Credentialing staff. There are no report titles or identifying numbers associated with this ad hoc report.

**BL 2018 Methodology**

Data are calculated by dividing the number of sanctions imposed (numerator) by the number of referrals and complaints reviewed by the NFAAC and/or the commission (denominator), multiplied by 100. The numerator is derived by tabulating the number of sanctions imposed during the reporting period up to the time the report is prepared. The denominator is derived by tabulating the number of complaints and referrals reviewed by the NFAAC and/or department during the reporting period up to the time of reporting.

**BL 2018 Purpose**

This measure shows the effect of the agency's program to ensure nursing facility administrators are in compliance with legal requirements. It is a tool for evaluating the Program's effectiveness and assessing the accountability of nursing facility personnel.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
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<td>Objective No. 1</td>
<td>1 Regulation of Facilities and Consumer Products</td>
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<tr>
<td>Outcome No. 15</td>
<td>% Complaints and Referrals Resulting in Disciplinary Action: NA &amp; MA</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 02-01 OC 09  
**Key Measure:** N  
**New Measure:** N  
**Percent Measure:** Y

**BL 2018 Definition**  
This measure reports the number of complaints and referrals against medication aides and nurse aides that resulted in disciplinary action expressed as a percent of all complaints and referrals against nurse aides and medication aides.

**BL 2018 Data Limitations**  
Does not apply

**BL 2018 Data Source**  
This information is manually collected and tabulated. Manual collections of data are pen and paper tabulations of information manually pulled from the Nurse Aide and Medication Aide tracking systems. There are no report titles or identifying numbers associated with this process.

**BL 2018 Methodology**  
Data are calculated by dividing the number of sanctions imposed against medication aides and nurse aides (numerator) by the number of complaints and referrals received on medication aides and nurse aides (denominator), multiplied by 100. The numerator is derived by tabulating the number of sanctions imposed during the reporting period up to the time of reporting. The denominator is derived by tabulating the number of complaints and referrals received during the reporting period up to the time of reporting.

**BL 2018 Purpose**  
This measure shows the effect of the agency's program to ensure medication aides and nurse aides are in compliance with legal requirements. It is a tool for evaluating the program's effectiveness and accessing the accountability of nursing facility personnel.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 8  Regulatory, Licensing and Consumer Protection Services
Objective No. 1  Regulation of Facilities and Consumer Products
Outcome No. 16  % HCSSA Complying with Standards at Time of Inspection

Calculation Method: N  Target Attainment:  Priority:  Cross Reference: Agy 539 084-R-S70-1 02-01 OC 10
Key Measure: N  New Measure: N  Percent Measure: Y

BL 2018 Definition
This measure reports the number of Home and Community Support Services Agencies (HCSSAs) complying with standards at the time of inspection expressed as a percent of all HCSSAs inspected. Complying with standards is defined as a recommendation to continue/renew licensure and/or certification. An inspection is defined as a standard survey, a re-certification survey, or licensing inspection. Licensing inspections conducted with a standard or annual survey are counted as one activity.

BL 2018 Data Limitations
Does not apply

BL 2018 Data Source
Data are obtained from regional HCSSA staff workload input reports. Data will be contained in an ad hoc report at the end of the reporting period. This report will be titled “% HCSSAs Complying with Standards at Time of Inspection” in the future.

BL 2018 Methodology
The percentage of agencies complying with standards during the state fiscal year is calculated by dividing the number of agencies determined to be in compliance at the time of inspection (numerator) by the total number of agencies inspected (denominator) during the reporting period, and multiplying this result by 100.

BL 2018 Purpose
This measure is important because it quantifies the achievement of the program's objective, while also indicating public accountability of agencies.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Goal No. 8 Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Outcome No. 17 Rate (1000) Substantiated Compliant Allegations Abuse/Neglect: PPECC

BL 2018 Definition
This measure reports the rate of substantiated complaint allegations of resident abuse and/or neglect in Prescribed Pediatric Extended Care Centers (PPECC) per 1,000 residents during the state fiscal year. A substantiated complaint allegation is defined as an allegation received as a complaint from a resident, family member, or the public that is determined to be a violation of standards. Regional Regulatory Services survey/investigation staff determine whether allegations are substantiated after a thorough investigation. Abuse and neglect are defined by state and federal regulations. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Abuse and neglect of children residing in nursing facilities is defined by TX Family Code, Section 261.001.

BL 2018 Data Limitations
Does not apply

BL 2018 Data Source
Data are obtained from the Central Data Repository (CDR) that pulls data from the Compliance, Assessment, Regulation, Enforcement System (CARES) and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled “Rate (1000) Substantiated Complaint Allegations of Abuse/Neglect: PPECC” in the future. The data for the number of residents in PPECCs is reflective of facility census data collected at the last Regulatory Services staffs visit and entered into CARES. The census data may range from several weeks to several months old.

BL 2018 Methodology
This measure is computed by dividing the number of substantiated complaint allegations of abuse/neglect in nursing facilities during the months of the reporting period by the total number of residents in nursing facilities, and then multiplying this result by 1,000

BL 2018 Purpose
This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in PPECCs. It is a tool for evaluating the program's effectiveness and accessing the accountability of facilities.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529   Agency: Health and Human Services Commission
Goal No. 8   Regulatory, Licensing and Consumer Protection Services
Objective No. 1   Regulation of Facilities and Consumer Products
Outcome No. 18   Incidence of Facility Abuse/Neglect/Exploitation Per 1,000 Persons

Calculation Method: C   Target Attainment: N   Priority: N   Cross Reference: Agy 530 084-R-S70-1 04-01 OC 03
Key Measure: N   New Measure: N   Percent Measure: N

BL 2018 Definition
This measure compares the number of confirmed investigations of abuse, neglect, or exploitation of persons receiving mental health, intellectual disability or physical disability services, which include state supported living centers, state hospitals, state centers, community centers, private ICF-IID facilities, and community providers to the total number of persons being served by these entities.

BL 2018 Data Limitations
Due to data being gathered by another agency and reported to FPS, it is difficult to accurately project the number of persons who will be receiving services through mental health, intellectual disability or physical disability programs. CARE counts all individuals enrolled, regardless of whether or not services are received. This may inflate the denominator.

BL 2018 Data Source
IMPACT; Health and Human Services Client Assignment and Registration (CARE) system; and the Home and Community-based services (HCS) Automated Enrollment and Billing system. Due to possible modifications in HHS data systems, the data sources used to calculate this measure are subject to change. Should this occur, the current appropriate data systems will be substituted and documented in the performance folder.

BL 2018 Methodology
Divide the number of confirmed incidents by mental health, intellectual disability or physical disability service providers which are those investigations of abuse, neglect, or exploitation that are coded as 'CON' (confirmed) in IMPACT at the completion of the investigation stage during the reporting period (numerator) by the unduplicated count of clients who are receiving mental health, intellectual disability or physical disability services during the reporting period, as gathered from the CARE report system and the HCS Automated Enrollment and Billing system, or appropriate data system (denominator) and multiply the result by 1,000.

BL 2018 Purpose
Assuming that FPS investigations are prompt, thorough, and accurate, this measure is an indicator of the quality of care being provided by mental health, intellectual disability or physical disability providers.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Goal No. 8 Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Outcome No. 19 Adult Protective Services Caseworker Turnover Rate

Calculation Method: C  Target Attainment:  Priority:  Cross Reference: Agy 530 084-R-S70-1 04-01 OC 05

Key Measure: N  New Measure: N  Percent Measure: N

BL 2018 Definition
This measure is the percentage of classified regular full- and part-time APS caseworkers who voluntarily and involuntarily separate from the agency during the fiscal year. The definition is based on the methodology used by the State Auditor's Office to calculate classified employee turnover for fiscal year 2007.

BL 2018 Data Limitations
There may be some minimal loss of data due to data entry transactions occurring after calculation.

BL 2018 Data Source
The HHSAS-HR system is used to identify full- and part-time employees with job class codes that correspond to APS caseworker positions including: 5002 APS Specialist I; 5003 APS Specialist II; 5004 APS Specialist III; 5005 APS Specialist IV; and 5006 APS Specialist V.

Job Class codes are subject to change. Should this occur, current equivalent codes will be substituted and documented in the performance folder.

BL 2018 Methodology
Divide the number of separations during the fiscal year (numerator) by the average number of APS caseworkers during the fiscal year (denominator) and multiply by 100 to achieve a percentage. The average number of APS caseworkers is calculated by totaling the number of APS caseworkers (defined as someone who worked at any time during a quarter) for each quarter of the fiscal year, and then dividing this total by the number of quarters. Should the SAO methodology change, the agency will work with LBB to update the measure definition in ABEST.

BL 2018 Purpose
The purpose of this measure is to provide an annual turnover rate for APS caseworkers. The measure would allow the agency to compare turnover rates across fiscal years to assist in identifying retention trends in the APS caseworkers.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 8  Regulatory, Licensing and Consumer Protection Services
Objective No. 1  Regulation of Facilities and Consumer Products
Outcome No. 20  Percent of APS Caseworkers Retained for Six Months Following BSD

Calculation Method: C  Target Attainment:  
Priority:  
Cross Reference: Agy 530 084-R-S70-1 04-01 OC 06

Key Measure: N  New Measure: N  Percent Measure: N

BL 2018 Definition
This measure calculates the percentage of APS caseworkers retained for at least six months following the completion of Basic Skills Development (BSD) training.

BL 2018 Data Limitations
There may be some minimal loss of data due to data entry transactions occurring after calculation.

BL 2018 Data Source
Active APS caseworkers providing direct delivery services are identified by the following job class codes: 5002 APS Specialist I; 5003 APS Specialist II; 5004 APS Specialist III; 5005 APS Specialist IV; and 5006 APS Specialist V. The End Date of the training is from HHSAS-HRMS Administrator Training Database where the date is during four quarters. The four quarters would include the last two quarters of the previous fiscal year and the first two quarters of the current fiscal year. The numerator for this measure is the count of APS caseworkers who completed BSD training during the last two quarters of the previous fiscal year and the first two quarters of the current fiscal year and remained with the agency six months or more following the completion of the BSD training. The denominator for this measure is the count of APS caseworkers who completed BSD training during the last two quarters of the previous fiscal year and the first two quarters of the current fiscal year.

BL 2018 Methodology
Divide the numerator by the denominator and multiply by 100 to achieve a percentage.

BL 2018 Purpose
The purpose of this measure is to provide an annual retention rate for APS caseworkers who have completed BSD.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 9  
Program Eligibility Determination & Enrollment

Objective No. 2  
Long-term Care Eligibility Determination & Enrollment

Outcome No. 1  
Avg # of Individuals Serv Per Mth: Total Community Services & Supports

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 539 084-R-S70-1 01-01 OC 01

Key Measure: N  
New Measure: N  
Percent Measure: N

BL 2018 Definition

This measure reports the total monthly average number of individuals served through many of the agency's community services and supports programs. The different types of individuals that comprise this measure are identified under output measure 1 of strategies 1.2.1., 1.2.2., 1.2.3., 1.3.1., 1.3.2., 1.3.3., 1.3.4., 1.3.5., 1.3.6., 1.4.2., 1.4.4., 1.5.1., and 1.6.4. Output measure 1 from strategy 1.4.2 and explanatory measure 2 from strategy 1.4.1 are also included.

BL 2018 Data Limitations

This measure does not include services provided by the Area Agencies on Aging. Data for these services are based on annual unduplicated individual counts that cannot be combined with the monthly averages reported for each of the other non-Medicaid Community services and supports measures. Specific data limitations for each of these other measures are identified under output measure 1 of strategies 1.2.1., 1.2.2., 1.2.3., 1.3.1., 1.3.2., 1.3.3., 1.3.4., 1.3.5., 1.3.6., 1.4.2., 1.4.4., 1.5.1., and 1.6.4, output measure 1 of strategy 1.4.2 and explanatory measure 2 of strategy 1.4.1.

BL 2018 Data Source

Specific sources from which the data are obtained are listed under each of the output measures identified under the short definition.

BL 2018 Methodology

This measure reports the sum of the average number of individuals served per month through Medicaid entitlement programs (Primary Home Care, Community Attendant Services and Day Activity and Health Services (XIX)); Medicaid waiver programs (Community-based Alternatives, Home and Community-based Services, Community Living Assistance and Support Services, Deaf-blind with Multiple Disabilities, Medically Dependent Children Program, and Texas Home Living); non-Medicaid Title XX programs; In-Home and Family Support Services; PACE; promoting independence services; and the average number of individuals with intellectual and developmental disabilities receiving community, residential, and In-Home services.

BL 2018 Purpose

This measure is a mechanism for assessing the agency’s performance as it pertains to services provided through community services and supports programs.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529  Agency: Health and Human Services Commission

Goal No. 9  Program Eligibility Determination & Enrollment
Objective No. 2  Long-term Care Eligibility Determination & Enrollment
Outcome No. 2  Percent LTC Ombudsman Complaints Resolved or Partially Resolved

Calculation Method: N  Target Attainment: N  Priority: N  Cross Reference: Agy 539 084-R-S70-1 01-01 OC 05
Key Measure: N  New Measure: N  Percent Measure: N

BL 2018 Definition
This measure reports the sum of the average monthly number of individuals on an interest list for: Medicaid Community-Based Alternatives (CBA) Waiver services, Medicaid Home and Community-based (HCS) Waiver services, Medicaid Related Conditions (CLASS) Waiver services, Deaf-blind with Multiple Disabilities Waiver services, Medically Dependent Children Program services, non-Medicaid XX Community Services and Supports, Community Services, In-Home and Family Support Services and In-Home Services. See explanatory measures under strategies 1.3.1., 1.3.2., 1.3.3., 1.3.4., 1.3.5., 1.4.1., 1.4.2., and 1.4.4.

BL 2018 Data Limitations
See specific data limitations for each of the services that comprise this measure.

BL 2018 Data Source
Specific sources from which the data are obtained are listed under each of the component measures that comprise this measure. These measures are identified under the short definition above.

BL 2018 Methodology
This measure is derived by summing the component measures that comprise this measure. See explanatory measures under strategies 1.3.1., 1.3.2., 1.3.3., 1.3.4., 1.3.5., 1.4.1., 1.4.2., and 1.4.4.

BL 2018 Purpose
This measure is important because it is an indicator of the total unmet need for services provided.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Goal No. 10 Provide Disability Determination Services within SSA Guidelines
Objective No. 1 Increase Decisional Accuracy and Timeliness of Determinations
Outcome No. 1 Percent of Case Decisions That Are Accurate

Calculation Method: N Target Attainment: N Priority: N Cross Reference: Agy 538 084-R-S70-1 03-01 OC 01
Key Measure: Y New Measure: N Percent Measure: Y

BL 2018 Definition
The percentage of cases that can be processed without being returned to the State agency for further development or for correction of decisions based on evidence in the file as reported monthly by the SSA Office of Quality Performance.

BL 2018 Data Limitations
Quality attributes are determined by SSA policy. The cases receiving a quality review are a random sample and do not include all case categories. The guidance for this review is found in SSA's Programs Operations Manual System (POMS), Section 30005.001ff. For example, "Group I" (Decisional Errors) are the only errors that affect the DDS accuracy rate. "Group II" (Onset) and "Group III" (Technical) are not factored into the DDS's accuracy rate. The reviews are done by SSA components.

BL 2018 Data Source
Based on evidence reported monthly by the SSA Office of Quality Performance.

BL 2018 Methodology
Determined by SSA formula. Figures are non-cumulative.

BL 2018 Purpose
Shows improvement in the accuracy in disability determination decisions.
### Calculation Method: N  Target Attainment:  Priority:  Cross Reference: Agy 538 084-R-S70-1 03-01 OC 02

#### Key Measure: N  New Measure: N  Percent Measure: N

#### BL 2018 Definition

Number of case processing days that are below target. The target is the case processing time goal established by the State agency (DDS). Processing time is the average number of days from the time the state agency receives the claim until the completed determination is put into the National Disability Determination Services System (NDDSS).

#### BL 2018 Data Limitations

There are reasons that cases are put on 'medical hold' in order that evaluation would follow a medical stabilization period. There are 'administrative hold' reasons for issues awaiting legislative or policy clarification. The hold process obviously increases the number of case processing days.

#### BL 2018 Data Source

Information is reported monthly by the National Disability Determination Services System. This measure is determined by internal calculations using information from NDDSS. It is not directly derived from NDDSS.

#### BL 2018 Methodology

This number is subtracted from the target to arrive at days below target. Weekends and holidays are counted. This measure is determined by subtracting the number of actual processing days to clear a case from the target. The higher the measure, the better the performance. Non-cumulative.

#### BL 2018 Purpose

The measure is useful because it focuses solely on results, serves the needs of multiple audiences, and is the basis for documenting annual performance trends. As a measure, it is a basis not only for determining aggregate divisional timeliness but also for timeliness comparisons at the director, unit and examiner level.

#### BL 2019 Definition

#### BL 2019 Data Limitations

#### BL 2019 Data Source

#### BL 2019 Methodology

#### BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 11  
Office of Inspector General

Objective No. 1  
Client and Provider Accountability

Outcome No. 1  
Net Dollars Recovered Per Dollar Expended from All Funds

**Calculation Method:** N  
**Target Attainment:** H  
**Priority:** M  
**Cross Reference:** Agy 529 084-R-S70-1 07-01 OC 01

**Key Measure:** N  
**New Measure:** N  
**Percent Measure:** N

**BL 2018 Definition**

This measures the return on investment achieved by the Inspector General relative to the agency's costs. "Recoveries" include all dollars collected, recouped, or otherwise recovered as a result of IG activities. 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.

**BL 2018 Data Limitations**

No limitations.

**BL 2018 Data Source**

The sources of recovery data include IG case management systems, the claims administrator system and databases, and data reported from IG partners who directly recover funds based on IG activities (such as DSHS WIC recoupments and certain MCO collections). IG expenditure data is reflected, in coordination with HHSC Central Budget, in the HHS financial system of record. IG 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 IG for the same reporting period.

**BL 2018 Methodology**

For the given reporting period, the sum of IG dollars recovered from all IG divisions (including Investigations, Inspections, Audit, and Litigation) is reduced by total IG expenditures in all funds. This quantity is then divided by the total IG 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. 30% ROI = $1.30 Recovered per $1 Expended).

**BL 2018 Purpose**

This is a measure of the effectiveness of the IG's efforts to maximize recoveries to HHSC programs, demonstrating how the dollars allocated to the IG's office result in an overall savings.

**BL 2019 Definition**

The return on investment of combined Federal and State dollars that fund the Office of Inspector General (OIG). "Recoveries" refers to payments received by HHSC to satisfy financial obligations due the state. Recoveries include dollars actually recovered. Recoveries are handled by various programs in OIG.

**BL 2019 Data Limitations**

No Limitation.

**BL 2019 Data Source**

The sources of data are the OIG case management system and the claims administrator system and databases. OIG staff collects data on recoveries on a monthly basis, entering the information in the appropriate system and/or database.

**BL 2019 Methodology**

For the given reporting period, the sum of OIG dollars recovered is reduced by the sum of all OIG expenditures in all funds. This quantity is then divided by the sum of all OIG expenditures in all funds. The result is then reported as a dollar figure.

**BL 2019 Purpose**

This is a measure of the effectiveness of OIG's efforts to maximize recoveries to HHSC programs.
Strategy-Related Measures Definitions
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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**Calculation Method:** N  **Target Attainment:** L  **Priority:** H  
Cross Reference: Agy 529 084-R-S70-1 02-01-01 EF 01

**Key Measure:** Y  **New Measure:** N  **Percentage Measure:** N

**BL 2018 Definition**
The average monthly cost paid per Aged and Medicare-Related recipient month.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
PREM report (currently with incurred data). The PREM consists of data from the monthly STMR 650/750 (Non Managed Care) & STRR 650/750 (Managed Care) statistical reports compiled by the Medicaid contractor, the Premiums Payable System, and Health Maintenance Organization (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.

**BL 2018 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 & 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.

**BL 2018 Purpose**
This measure reflects the amount paid for each recipient month for the named group.

**BL 2019 Definition**
The average monthly cost paid per Aged and Medicare-Related recipient month.

**BL 2019 Data Limitations**
None.

**BL 2019 Data Source**
PREM report (currently with incurred data). The PREM consists of data from the monthly STMR 650/750 (Non Managed Care) & STRR 650/750 (Managed Care) statistical reports compiled by the Medicaid contractor, the Premiums Payable System, and Health Maintenance Organization (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.

BL 2019 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 & 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.

BL 2019 Purpose

This measure reflects the amount paid for each recipient month for the named group.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 1  
Objective No. 1  
Strategy No. 1  
Measure Type EF  
Measure No. 2

Goal: Medicaid
Objective: Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients
Strategy: Aged and Medicare-related Eligibility Group
Measure: Avg Cost Per Aged & Medicare-Related Recipient Month: STAR+PLUS

Calculation Method: N  
Target Attainment: L  
Priority: H  
Cross Reference: Agy 529 084-R-S70-1 02-01-01 EF 02

Key Measure: N  
New Measure: N  
Percentage Measure: N

**BL 2018 Definition**

The average monthly capitated cost per Medicare eligible recipient month in STAR+PLUS managed care. Recipient month is defined as one month's membership in STAR+PLUS for an individual who is in the Medicare eligible category. The STAR+PLUS program integrates preventive, primary, acute care and long term care into a single managed care model. This measure does not include premiums paid for drug benefits.

**BL 2018 Data Limitations**

Premium amount does not include acute care costs. When new client groups or costs are added into STAR+PLUS capitation, the average cost will fluctuate. Acute care may be capitated for this group in FY 2016.

**BL 2018 Data Source**

The source for expenditure data is the capitation rates set by HHSC. Recipient month data is from the Premium Payment System.

**BL 2018 Methodology**

The average monthly premium per Medicare eligible recipient month is calculated by dividing the total premiums paid to the STAR+PLUS Health Maintenance Organization including administrative fees on behalf of Medicare eligible members for the reporting period by the total number of recipient months projected to be incurred in the reporting period. Data is 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.

**BL 2018 Purpose**

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

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
### Strategy-Related Measures Definitions

85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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**Cross Reference: Agy 529 084-R-S70-1 02-01-01 OP 01**

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**Strategy No. 1 Aged and Medicare-related Eligibility Group**

**Measure No. 1 Average Aged and Medicare-Related Recipient Months Per Month: Total**

**BL 2018 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.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
The Premiums Payable System.

**BL 2018 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.

**BL 2018 Purpose**
This measure reflects the average monthly number of recipient months for the named group.

**BL 2019 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.

**BL 2019 Data Limitations**
None.

**BL 2019 Data Source**
The Premiums Payable System.
BL 2019 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.

BL 2019 Purpose
This measure reflects the average monthly number of recipient months for the named group.
**Goal No. 1 Medicaid**

**Objective No. 1 Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients**

**Strategy No. 1 Aged and Medicare-related Eligibility Group**

**Measure Type OP**

**Measure No. 2 Avg Aged and Medicare-Related Recipient Months Per Month: STAR+PLUS**

**Calculation Method:** N  
**Target Attainment:** H  
**Priority:** H  
**Cross Reference: Agy 529  084-R-S70-1  02-01-01  OP 02**

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

The average monthly number of Medicare client recipient months in STAR+PLUS and the Dual Demonstration. A recipient month is defined as one month's membership in STAR+PLUS for an individual who is in the Medicare-eligible category. These managed care programs integrate preventive, primary, acute care and long term care into a single Health Maintenance Organization (HMO) managed care model.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

The Premiums Payable System.

**BL 2018 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.

**BL 2018 Purpose**

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

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**

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**BL 2019 Methodology**

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**Strategy-Related Measures Definitions**

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Automated Budget and Evaluation System of Texas (ABEST)

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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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**Goal No. 1 Medicaid**
**Objective No. 1 Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients**
**Strategy No. 2 Disability-Related Eligibility Group**
**Measure Type EF**
**Measure No. 1 Average Disability-Related Cost Per Recipient Month**

**Calculation Method:** N  
**Target Attainment:** L  
**Priority:** H  
*Cross Reference: Agy 529 084-R-S70-1 02-01-02 EF 01*

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

The average monthly expenditure per Disability-Related recipient month.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

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

**BL 2018 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 & 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.

**BL 2018 Purpose**

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

---

**BL 2019 Definition**

The average monthly expenditure per Disability-Related recipient month.

**BL 2019 Data Limitations**

None.

**BL 2019 Data Source**

PREM report (currently with incurred data). The PREM consists of data from the monthly STMR 650/750 (Non Managed Care) & STRR 650/750 (Managed Care) statistical reports compiled by the Medicaid contractor, the Premiums Payable System, and Health Maintenance Organization (HMO) capitation rates. Dollars exclude costs for Texas Health Steps dental, prescription drugs, and Medical Transportation Program. Dollars include STAR+PLUS long term support and services.
**BL 2019 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 & 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.

**BL 2019 Purpose**
This measure reflects the amount paid for each recipient month for the named group.
### Strategy-Related Measures Definitions

#### Automated Budget and Evaluation System of Texas (ABEST)

**85th Regular Session, Agency Submission, Version 1**

**Health and Human Services Commission**

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<td>Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients</td>
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<td><strong>Strategy No.</strong></td>
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<td>Disability-Related Eligibility Group</td>
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<td><strong>Measure Type</strong></td>
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<td><strong>Measure No.</strong></td>
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<td>Avg Cost/Disability-Related Recipient Month:STAR+PLUS</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 529 084-R-S70-1 02-01-02 EF 02  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

The average monthly cost paid per Disability-Related recipient month in STAR+PLUS. The Non Medicare category includes members who are aged, blind, or disabled who are not qualified for Medicare. The STAR+PLUS program integrates preventive, primary, acute care and long term care into a single managed care model. This measure does not include premiums paid for drug benefits.

**BL 2018 Data Limitations**

When new client groups or costs are added into STAR+PLUS capitation, the average cost will fluctuate.

**BL 2018 Data Source**

The source for expenditure data is the capitation rates set by the HHSC Actuarial Analysis Division. Recipient month data is from the Premium Payment System.

**BL 2018 Methodology**

The average monthly premium per non Medicare recipient month is calculated by dividing the total premiums paid to the STAR+PLUS Health Maintenance Organization (HMOs) including administrative fees on behalf of non-Medicare members for the months in the reporting period by the total number of recipient months projected to be incurred in the reporting period. Data is 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.

**BL 2018 Purpose**

The average monthly long term care cost paid per Disability-Related recipient month in STAR+PLUS. The Non Medicare category includes members who are aged, blind, or disabled who are not qualified for Medicare. The STAR+PLUS program integrates preventive, primary, acute care and long term care into a single managed care model.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Strategy-Related Measures Definitions
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Agency Code: 529
Agency: Health and Human Services Commission

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Objectives: Medicaid
Objective 1: Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients
Strategy 2: Disability-Related Eligibility Group
Measure 3: Average Cost/Disability-related Recipient Month: STAR Kids

Calculation Method: C
Target Attainment: Cross Reference: Agy 52X 084-R-S70-1 02-01-02 EF 03
Priority: N

Key Measure: N
New Measure: N
Percentage Measure: N

BL 2018 Definition
The average monthly cost paid per Disability-Related recipient month in the STAR Kids program. The STAR Kids program is scheduled to begin in September 2016, and will integrate preventive, primary, acute care and long term care into a single managed care model for children under 21. This measure does not include premiums paid for drug benefits.

BL 2018 Data Limitations
None.

BL 2018 Data Source
The source for expenditure data is the capitation rates set by the HHSC Actuarial Analysis Division. Recipient month data is from the Premium Payment System.

BL 2018 Methodology
The average monthly premium per non Medicare recipient month is calculated by dividing the total premiums paid to the STAR Kids Health Maintenance Organization (HMOs) including administrative fees on behalf of members for the months in the reporting period by the total number of recipient months projected to be incurred in the reporting period. Data is 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.

BL 2018 Purpose
The average monthly cost paid per Disability-Related recipient month in STAR Kids. This category includes members who are aged, blind, or disabled. The STAR Kids program integrates preventive, primary, acute care and long term care into a single managed care model.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
### Agency Code: 529

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#### Calculation Method: N

#### Target Attainment: L

#### Priority: H

#### Cross Reference:

#### Key Measure: N

#### New Measure: Y

#### Percentage Measure: Y

**BL 2018 Definition**

This measure reports the number of Disability-Related clients under age 21 as a percent of the state's total Medicaid population. This includes clients receiving full benefit Medicaid services only, limited benefit beneficiaries are excluded.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

Premiums Payable System

**BL 2018 Methodology**

Data are computed by totaling the number of Disability-Related recipients under 21 over all months in the reporting period, and dividing by the number of months in the reporting period to determine the average monthly number of recipients. This result is divided by the total average monthly recipients on Medicaid over the same time period and then multiplied by 100. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future recipient months.

**BL 2018 Purpose**

This measure reflects the percent of full benefit clients on Medicaid for the named group.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 1  
Objective No. 1  
Strategy No. 2  
Measure Type OP  
Measure No. 1  

BL 2018 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.

BL 2018 Data Limitations
None.

BL 2018 Data Source
The Premiums Payable System.

BL 2018 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.

BL 2018 Purpose
This measure reflects the average monthly number of recipient months for the named group.

BL 2019 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.

BL 2019 Data Limitations
None.

BL 2019 Data Source
The Premiums Payable System.
BL 2019 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.

BL 2019 Purpose

This measure reflects the average monthly number of recipient months for the named group.
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<td>Measure No.</td>
<td>2 Average Disability-Related Recipient Months Per Month: STAR+PLUS</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** H  
**Cross Reference:** Agy 529 084-R-S70-1 02-01-02 OP 02

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

The average monthly cost paid per Disability-Related recipient month in STAR+PLUS. The Non Medicare category includes members who are aged, blind, or disabled who are not qualified for Medicare. The STAR+PLUS program integrates preventive, primary, acute care and long term care into a single managed care model. This measure does not include premiums paid for drug benefits.

**BL 2018 Data Limitations**

When new client groups or costs are added into STAR+PLUS capitation, the average cost will fluctuate.

**BL 2018 Data Source**

The source for expenditure data is the capitation rates set by the HHSC Actuarial Analysis Division. Recipient month data is from the Premium Payment System.

**BL 2018 Methodology**

The average monthly premium per non Medicare recipient month is calculated by dividing the total premiums paid to the STAR+PLUS Health Maintenance Organization (?HMOs?) including administrative fees on behalf of non-Medicare members for the months in the reporting period by the total number of recipient months projected to be incurred in the reporting period. Data is 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.

**BL 2018 Purpose**

The average monthly long term care cost paid per Disability-Related recipient month in STAR+PLUS. The Non Medicare category includes members who are aged, blind, or disabled who are not qualified for Medicare. The STAR+PLUS program integrates preventive, primary, acute care and long term care into a single managed care model.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

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BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 1  
Objective No. 1  
Strategy No. 2  
Measure Type OP  
Measure No. 3  

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**Goal No. 1 Medicaid**
**Objective No. 1 Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients**
**Strategy No. 2 Disability-Related Eligibility Group**

**Measure Type OP**
**Measure No. 3 Average Disability-related Recipient Months Per Month: STAR Kids**

---

**Calculation Method: N**  
**Target Attainment: L**  
**Priority: H**  

Cross Reference: Agy 529 084-R-S70-1 02-01-02 OP 03

**Key Measure: N**  
**New Measure: N**  
**Percentage Measure: N**

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**BL 2018 Definition**

The average monthly cost paid per Disability-Related recipient month in the STAR Kids program. The STAR Kids program is scheduled to begin in September 2016, and will integrate preventive, primary, acute care and long term care into a single managed care model for children under 21. This measure does not include premiums paid for drug benefits.

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**BL 2018 Data Limitations**

None.

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**BL 2018 Data Source**

The source for expenditure data is the capitation rates set by the HHSC Actuarial Analysis Division. Recipient month data is from the Premium Payment System.

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**BL 2018 Methodology**

The average monthly premium per non Medicare recipient month is calculated by dividing the total premiums paid to the STAR Kids Health Maintenance Organization (HMOs) including administrative fees on behalf of members for the months in the reporting period by the total number of recipient months projected to be incurred in the reporting period. Data is 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.

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**BL 2018 Purpose**

The average monthly cost paid per Disability-Related recipient month in STAR Kids. This category includes members who are aged, blind, or disabled. The STAR Kids program integrates preventive, primary, acute care and long term care into a single managed care model.
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Agency: Health and Human Services Commission

Goal No. 1  Medicaid
Objective No. 1  Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients
Strategy No. 3  Pregnant Women Eligibility Group
Measure Type EF
Measure No. 1  Average Pregnant Women Cost Per Recipient Month

Calculation Method: N  Target Attainment: L  Priority: H
Key Measure: Y  New Measure: N  Percentage Measure: N

BL 2018 Definition
The average monthly expenditure per Pregnant Women recipient month.

BL 2018 Data Limitations
None.

BL 2018 Data Source
PREM report (incurred data). The PREM consists of data from the monthly STMR 650/750 (Non Managed Care) & STRR 650/750 (Managed Care) statistical reports compiled by the Medicaid contractor, the Premiums Payable System, and Health Maintenance Organization (HMO) capitation rates. Dollars exclude costs in Texas Health Steps Dental, Medical Transportation Program, and prescription drug.

BL 2018 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 & Non Managed Care for the Pregnant Women group. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

BL 2018 Purpose
This measure reflects the amount paid for each recipient month for the named group.

BL 2019 Definition
The average monthly expenditure per Pregnant Women recipient month.

BL 2019 Data Limitations
None.

BL 2019 Data Source
PREM report (incurred data). The PREM consists of data from the monthly STMR 650/750 (Non Managed Care) & STRR 650/750 (Managed Care) statistical reports compiled by the Medicaid contractor, the Premiums Payable System, and Health Maintenance Organization (HMO) capitation rates. Dollars exclude costs in Texas Health Steps Dental, Medical Transportation Program, and prescription drug.
BL 2019 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 & Non Managed Care for the Pregnant Women group. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

BL 2019 Purpose

This measure reflects the amount paid for each recipient month for the named group.
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- **Goal No.**: 1
- **Objective No.**: 1
- **Strategy No.**: 3
- **Measure Type**: OP
- **Measure No.**: 1

**Measure No. 1: Average Pregnant Women Recipient Months Per Month**

**Calculation Method:** N  
**Target Attainment:** H  
**Priority:** H  
**Cross Reference:** Agy 529 084-R-S70-1 02-01-03 OP 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 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.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
The Premiums Payable System.

**BL 2018 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.

**BL 2018 Purpose**
This measure reflects the average monthly number of recipient months for the named group.

**BL 2019 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.

**BL 2019 Data Limitations**
None.

**BL 2019 Data Source**
The Premiums Payable System.
BL 2019 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.

BL 2019 Purpose

This measure reflects the average monthly number of recipient months for the named group.
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<td>Measure No.</td>
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<td>Average TANF-Level Adult Cost Per Recipient Month</td>
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**Calculation Method:** N  
**Target Attainment:** L  
**Priority:** H

Cross Reference: Agy 529 084-R-S70-1 02-01-04 EF 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

The average monthly expenditure per TANF-Level Adult recipient month. The TANF-Level Adults group includes Medically Needy clients.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

PREM report. The PREM consists of data from the monthly STMR 650/750 (Non Managed Care) & STRR 650/750 (Managed Care) statistical reports compiled by the Medicaid contractor, the Premiums Payable System, and Health Maintenance Organization (HMO) capitation rates. Dollars exclude Texas Health Steps Dental, Medical Transportation Program, and prescription drug.

**BL 2018 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 & Non Managed Care for the TANF Adult group, including Medically Needy costs and caseload. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

**BL 2018 Purpose**

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

---

**BL 2019 Definition**

The average monthly expenditure per TANF-Level Adult recipient month. The TANF-Level Adults group includes Medically Needy clients.

**BL 2019 Data Limitations**

None.

**BL 2019 Data Source**

PREM report. The PREM consists of data from the monthly STMR 650/750 (Non Managed Care) & STRR 650/750 (Managed Care) statistical reports compiled by the Medicaid contractor, the Premiums Payable System, and Health Maintenance Organization (HMO) capitation rates. Dollars exclude Texas Health Steps Dental, Medical Transportation Program, and prescription drug.
BL 2019 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 & Non Managed Care for the TANF Adult group, including Medically Needy costs and caseload. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

BL 2019 Purpose
This measure reflects the amount paid for each recipient month for the named group.
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#### Agency Code: 529

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**Goal No. 1:** Medicaid

**Objective No. 1:** Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients

**Strategy No. 4:** Other Adults Eligibility Group

**Measure Type:** OP

**Measure No. 1:** Average TANF-Level Adult Recipient Months Per Month

---

**Calculation Method:** N

**Target Attainment:** H

**Priority:** H

---

**Cross Reference:** Agy 529 084-R-S70-1 02-01-04 OP 01

**Key Measure:** Y

**New Measure:** N

**Percentage Measure:** N

---

**BL 2018 Definition**

The average monthly number of Temporary Assistance for Needy Families (TANF)-Level Adult and Medically Needy recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

The Premium Payable System.

**BL 2018 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.

**BL 2018 Purpose**

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

---

**BL 2019 Definition**

The average monthly number of Temporary Assistance for Needy Families (TANF)-Level Adult and Medically Needy recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

**BL 2019 Data Limitations**

None.

**BL 2019 Data Source**

The Premium Payable System.
BL 2019 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.

BL 2019 Purpose
This measure reflects the average monthly number of recipient months for the named group.
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Agency: Health and Human Services Commission

Goal No. 1  
Objective No. 1  
Strategy No. 5  
Measure Type EF  
Measure No. 1

**Strategy-Related Measures Definitions**

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**Calculation Method:** N  
**Target Attainment:** L  
**Priority:** H  
**Cross Reference:** Agy 529 084-R-S70-1 02-01-05 EF 01

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<th>Key Measure: Y</th>
<th>New Measure: N</th>
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**BL 2018 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 19 in the Pregnant Women risk group.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

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

**BL 2018 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 & Non Managed Care for the aged-based Children’s groups in the children strategy. (This excludes Supplemental Security Income 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.

**BL 2018 Purpose**

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

**BL 2019 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 19 in the Pregnant Women risk group.
BL 2019 Data Limitations
None.

BL 2019 Data Source
PREM report. The PREM consists of data from the monthly STMR 650/750 (Non Managed Care) & STRR 650/750 (Managed Care) statistical reports compiled by the Medicaid contractor, the Premiums Payable System, and Health Maintenance Organization (HMO) capitation rates. Dollars exclude costs for Texas Health Steps Dental, Medical Transportation and prescription drug.

BL 2019 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 & Non Managed Care for the aged-based Children’s groups in the children strategy. (This excludes Supplemental Security Income 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.

BL 2019 Purpose
This measure reflects the amount paid for each recipient month for the named group.
**Strategy-Related Measures Definitions**
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### Agency Code: 529
**Agency:** Health and Human Services Commission

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**Goal No. 1 Medicaid**

**Objective No. 1 Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients**

**Strategy No. 5 Children Eligibility Group**

**Measure No. 2 Average STAR Health Foster Care Children Cost Per Recipient Month**

**Calculation Method:** N  
**Target Attainment:** L  
**Priority:** H  

**Cross Reference:** Agy 529 084-R-S70-1 02-01-05 EF 02  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

#### BL 2018 Definition
Average monthly expenditure per Foster care children recipient months in STAR Health.

#### BL 2018 Data Limitations
None.

#### BL 2018 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 Health Maintenance Organization (HMO) capitation rates. Costs exclude prescription drugs and Medical Transportation Program. Because STAR Health premiums include dental costs, dental is included in this measure.

#### BL 2018 Methodology
The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from HMO capitation rates. 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.

#### BL 2018 Purpose
This measure reflects the amount paid for each recipient month for the named group.

#### BL 2019 Definition
Average monthly expenditure per Foster care children recipient months in STAR Health.

#### BL 2019 Data Limitations
None.

#### BL 2019 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 Health Maintenance Organization (HMO) capitation rates. Costs exclude prescription drugs and Medical Transportation Program. Because STAR Health premiums include dental costs, dental is included in this measure.
BL 2019 Methodology
The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from HMO capitation rates. 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.

BL 2019 Purpose
This measure reflects the amount paid for each recipient month for the named group.
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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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<td>Average Income-Eligible Children Recipient Months Per Month</td>
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<td>Measure Type</td>
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**Goal No. 1** Medicaid  
**Objective No. 1** Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients  
**Strategy No. 5** Children Eligibility Group  
**Measure No. 1** Average Income-Eligible Children Recipient Months Per Month

**Calculation Method: N**  
**Target Attainment: H**  
**Priority: H**  
**Cross Reference: Agy 529 084-R-S70-1 02-01-05 OP 01**

**Key Measure: Y**  
**New Measure: N**  
**Percentage Measure: N**

---

**BL 2018 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 Supplemental Security Income children, medically needy children, and children in the STAR Health program or members under 19 in the Pregnant Women risk group.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

The Premiums Payable System.

**BL 2018 Methodology**

The measure will include Managed Care & Non Managed Care for the age-based Children’s groups in the non-disabled children strategy. 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.

**BL 2018 Purpose**

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

---

**BL 2019 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 Supplemental Security Income children, medically needy children, and children in the STAR Health program or members under 19 in the Pregnant Women risk group.

**BL 2019 Data Limitations**

None.
BL 2019 Data Source
The Premiums Payable System.

BL 2019 Methodology
The measure will include Managed Care & Non Managed Care for the age-based Children’s groups in the non-disabled children strategy. 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.

BL 2019 Purpose
This measure reflects the average monthly number of recipient months for the named group.
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 1
Objective No. 1
Strategy No. 5
Measure Type OP
Measure No. 2

Calculation Method: N  Target Attainment: H  Priority: H  Cross Reference: Agy 529 084-R-S70-1 02-01-05 OP 03
Key Measure: Y  New Measure: N  Percentage Measure: N

BL 2018 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.

BL 2018 Data Limitations
None.

BL 2018 Data Source
The Premiums Payable System.

BL 2018 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.

BL 2018 Purpose
This measure reflects the average monthly number of recipient months for the named group.

BL 2019 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.

BL 2019 Data Limitations
None.

BL 2019 Data Source
The Premiums Payable System.
BL 2019 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.

BL 2019 Purpose
This measure reflects the average monthly number of recipient months for the named group.
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#### Calculation Method: N  Target Attainment: N  Priority: N  Cross Reference: Agy 529 084-R-S70-1 02-02-02 EF 01

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  - **Agency Code**: 529  **Agency**: Health and Human Services Commission
  - **Goal No.**: 1  **Objective No.**: 1  **Strategy No.**: 6  **Measure Type**: EF  **Measure No.**: 1
  - **Agency**: Health and Human Services Commission
  - **Goal No.**: 1  **Objective No.**: 1  **Strategy No.**: 6  **Measure Type**: EF  **Measure No.**: 1

#### BL 2018 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.

#### BL 2018 Data Limitations
The Medicaid Prescription Drug dollars do not include any rebates or Clawback expenses.

#### BL 2018 Data Source
PREM report. Drug costs for drugs paid fee-for-service (FFS) comes from monthly MH 492 reports provided by the Medicaid contractor. Costs for Health Maintenance Organization (HMO) clients are based on caseload from the Premiums Payable System and capitation rates set by HHSC.

#### BL 2018 Methodology
This measure is the total Medicaid prescription cost (for FFS and managed care clients) incurred divided by the number of recipient months for the reporting period. The measure will include Managed Care & Non Managed Care 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.

#### BL 2018 Purpose
Captures the total prescription cost incurred divided by the total number of recipient months incurred in the reporting period for a given state fiscal year.

#### BL 2019 Definition

#### BL 2019 Data Limitations

#### BL 2019 Data Source

#### BL 2019 Methodology
BL 2019 Purpose
### BL 2018 Definition

This is the average cost per recipient month per month of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) of dental and orthodontic recipients eligible for dental and orthodontic services during the reporting period.

### BL 2018 Data Limitations

None.

### BL 2018 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).

### BL 2018 Methodology

This cost is calculated by dividing the total dental and orthodontic expenditures in the reporting period by the total number of THSteps Dental recipient months in the same reporting period. (THSteps Dental recipient months are the same group of eligible persons as the THSteps 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, re determinations, 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.

### BL 2018 Purpose

Measures the average cost per eligible for THSteps (EPSDT) dental and orthodontic services.
BL 2019 Methodology

BL 2019 Purpose
### Strategy-Related Measures Definitions

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**Goal No. 1 Medicaid**

**Objective No. 1 Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients**

**Strategy No. 7 Health Steps (EPSDT) Dental**

**Measure Type EX**

**Measure No. 1 Percent Of Eligible Children Receiving A Dental Service**

**Calculation Method:** N  
**Target Attainment:** Cross Reference: Agy 529 084-R-S70-1 02-02-04 EX 01  
**Priority:** Y  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** Y

**BL 2018 Definition**

This measure reports the percent of eligible children under age 21 receiving at least one Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) paid dental or orthodontic service during the reporting period. This includes clients receiving full benefit Medicaid services only, limited benefit beneficiaries are excluded.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

The Premiums Payable System and the HISR303A report generated by the Medicaid Claims Administrator. 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.

**BL 2018 Methodology**

Data are computed by totaling the unduplicated number of Medicaid children receiving received at least one THSteps (EPSDT) paid dental or orthodontic service in the reporting period, and dividing by the total unduplicated number of Medicaid children under 21 eligible for dental benefits and then multiplied by 100. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future recipient months.

**BL 2018 Purpose**

This measure reflects the percent of children on Medicaid receiving a dental service.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Goal No. 1 Medicaid
Objective No. 1 Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients
Strategy No. 7 Health Steps (EPSDT) Dental
Measure Type OP
Measure No. 1 Average THSteps (EPSDT) Dental Recipient Months Per Month

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 529 084-R-S70-1 02-02-04 OP 01

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This is the average cost per recipient month per month of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) of dental and orthodontic recipients eligible for dental and orthodontic services during the reporting period.

**BL 2018 Data Limitations**

None

**BL 2018 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).

**BL 2018 Methodology**

This cost is calculated by dividing the total dental and orthodontic expenditures in the reporting period by the total number of THSteps Dental recipient months in the same reporting period. (THSteps Dental recipient months are the same group of eligible persons as the THSteps 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, re determinations, 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.

**BL 2018 Purpose**

Measures the average cost per eligible for THSteps (EPSDT) dental and orthodontic services.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 1 Medicaid
Objective No. 1 Acute Care Svcs (incl STARPLUS LTC) for Full-Benefit Clients
Strategy No. 8 Medical Transportation
Measure Type EF
Measure No. 1 Average Nonemergency Transportation (NEMT) Cost Per Recipient Month

Calculation Method: N
Target Attainment: 
Priority: 
Key Measure: Y
New Measure: N
Percentage Measure: N

BL 2018 Definition
NEMT Cost Per Recipient Month is the average (clients through 20 years of age and clients 21 years and older) amount paid for NEMT for each recipient month incurred. It is a blended per-member-per-month for all fee for service and managed care model costs.

BL 2018 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.

BL 2018 Data Source
Medicaid recipient month data are obtained from the Premiums Payable System (PPS) For managed care, NEMT cost data is calculated from Premium Payable System enrollment and rates set by HHSC. Fee-for Service (FFS) cost data is from claims administrator reports and the accounting system.

BL 2018 Methodology
For a quarterly or annual weighted cost per recipient month, sum the NEMT dollars for the given time period. Sum the NEMT care recipient months for the same time period. The quarterly or annual weighted cost per recipient month is therefore equal to the total NEMT dollar amounts (capitated and FFS) for the time period divided by the total recipient months for the time period. Medicaid recipient months are derived from the Premium Payable System. For the more recent months of data, appropriate completion factors shall be applied in order to generate total incurables.

BL 2018 Purpose
This measure determines the average cost per recipient month.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
Automated Budget and Evaluation System of Texas (ABEST)
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Strategy-Related Measures Definitions

Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 1  
Objective No. 2  
Strategy No. 1  
Measure Type EF  
Measure No. 1

Goal: Medicaid  
Objective: Community Services and Supports - Entitlement  
Strategy: Community Attendant Services

Measure: Average Mthly Cost Per Individual Served: Community Attendant Services

Calculation Method: N  
Target Attainment: Priority:

Key Measure: Y  
New Measure: N  
Percentage Measure: N

Cross Reference: Agy 539 084-R-S70-1 01-02-02 EF 01

BL 2018 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 measure 1 of this strategy.

BL 2018 Data Limitations
Because it takes several months to close out 100% of the claims for a month of service, the number of individuals ultimately served as well as cost per individual per month 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.

BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software.

BL 2018 Methodology
Units of service paid to date for a given service month are divided by the number of individuals with claims approved to pay for the month of service to yield an “average units per individual to date,” which is then adjusted by adding the avg amount of change expected to occur over the remaining payment months, using moving averages to calculate historical avg amounts of change for each additional payment period.

The amount paid for a given month is divided by the units of service paid to date for the month of service to yield an “average cost per unit to date.” Then adding the average amount of change expected to occur over the remaining payment months, using moving avgs.

The estimated expenditure: (adjusted) units of service per individual times the avg cost per unit times the number of individuals served. The sum of the expenditures for all months in the reporting period is then divided by the sum of the number of CAS individuals for all months of the reporting period.
BL 2018 Purpose

This measure quantifies the unit cost for providing eligible persons with services for which funding has been appropriated. This unit cost is a tool for projecting future funding needs.
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Calculation Method: N  Target Attainment: N  Priority: N  Cross Reference: Agy 539 084-R-S70-1 01-02-02 OP 01
Key Measure: Y  New Measure: N  Percentage Measure: N

**BL 2018 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 (CAS) (formerly referred to as Frail Elderly).

**BL 2018 Data Limitations**
Because it takes several months to close out 100% 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 individuals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

**BL 2018 Data Source**
Two types of data are used to calculate this measure. 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 (SAS) 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software.

**BL 2018 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 ind. count (as described above) for all months of the reporting period, by the number of months in the reporting period. 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 ind. served (based upon claims data) to individuals authorized to receive the service (per SAS).
BL 2018 Purpose

This measure quantifies the unit cost for providing eligible individuals with services for which funding has been appropriated. This unit cost is a tool for projecting future funding needs.
**Strategy-Related Measures Definitions**

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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 01-02-01 EF 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 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. The average monthly number of Medicaid non-waiver primary home care individuals is defined under output measure 1 of this strategy.

**BL 2018 Data Limitations**

Because it takes several months to close out 100% of the claims for a month of service, the number of individuals ultimately served as well as cost per individual per month 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.

**BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software.

**BL 2018 Methodology**

The average monthly cost per Primary Home Care (PHC) individual served can be broken down into two components: the average monthly units of service per individual, and the average cost per unit. The monthly units of service per individual are estimated as follows: The units of service paid to date for a given service month are divided by the number of individuals for whom claims have been approved-to-pay for the corresponding month of service to yield an “average units per individual to date” for a given month of service. The average units per individual to-date amounts for each service month are then adjusted by adding the average amount of change expected to occur over the remaining payment months, using moving averages to calculate historical average amounts of change for each additional payment period.

**BL 2018 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.
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 01-02-01 OP 01  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 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.

**BL 2018 Data Limitations**
Because it takes several months to close out 100% 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 individuals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

**BL 2018 Data Source**
Two types of data are used to calculate this measure. 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 (SAS) 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software.

**BL 2018 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 ind. count (as described above) for all months of the reporting period, by the number of months in the reporting period. 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 ind. served (based upon claims data) to individuals authorized to receive the service (per SAS).
BL 2018 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.
**Strategy-Related Measures Definitions**
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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**Agency:** Health and Human Services Commission

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**Goal No. 1 Medicaid**  
**Objective No. 2 Community Services and Supports - Entitlement**  
**Strategy No. 3 Day Activity and Health Services (DAHS)**

**Measure Type EF**  
**Measure No. 1 Avg Mthly Cost Per Individual Served: Day Activity and Health Services**

**Calculation Method:** N  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 01-02-03 EF 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

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**BL 2018 Definition**

This measure reports the average cost of Medicaid non-waiver Community Services and Supports Day Activity and Health Services (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. The average monthly number of Medicaid non-waiver day activity and health services individuals is defined under output measure 1 of this strategy.

**BL 2018 Data Limitations**

Because it takes several months to close out 100% of the claims for a month of service, the number of individuals ultimately served as well as cost per individual per month 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.

**BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through and agency-developed application that utilizes COGNOS software.

**BL 2018 Methodology**

The average monthly cost per Day Activity and Health Services (DAHS) individual served can be broken down into two components: the average monthly units of service per individual, and the average cost per unit. The monthly units of service per individual are estimated as follows: The units of service paid to date for a given service month are divided by the number of individuals for whom claims have been approved-to-pay for the corresponding month of service to yield an "average units per individual to date" for a given month of service. The average units per individual to-date amounts for each service month are then adjusted by adding the average amount of change expected to occur over the remaining payment months, using moving averages to calculate historical average amounts of change for each additional payment period. The average cost per unit is estimated as follows: the amount paid to date for a given service month are divided by the units of service paid to date for the

**BL 2018 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.
**Strategy-Related Measures Definitions**

85th Regular Session, Agency Submission, Version 1

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#### Calculation Method: N

#### Target Attainment:  

#### Priority:  

Cross Reference: Agy 539 084-R-S70-1 01-02-03 OP 01

#### Key Measure: Y  

#### New Measure: N  

#### Percentage Measure: N

---

**BL 2018 Definition**

This measure reports the average cost of Medicaid non-waiver Community Services and Supports - Day Activity and Health Services (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. The average monthly number of Medicaid non-waiver day activity and health services individuals is defined under output measure 1 of this strategy.

**BL 2018 Data Limitations**

Because it takes several months to close out 100% of the claims for a month of service, the number of individuals ultimately served as well as cost per individual per month 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.

**BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through and agency-developed application that utilizes COGNOS software.

**BL 2018 Methodology**

The average monthly cost per Day Activity and Health Services (DAHS) individual served can be broken down into two components: the average monthly units of service per individual, and the average cost per unit. The monthly units of service per individual are estimated as follows: The units of service paid to date for a given service month are divided by the number of individuals for whom claims have been approved-to-pay for the corresponding month of service to yield an "average units per individual to date" for a given month of service. The average units per individual to-date amounts for each service month are then adjusted by adding the average amount of change expected to occur over the remaining payment months, using moving averages to calculate historical average amounts of change for each additional payment period. The average cost per unit is estimated as follows: the amount paid to date for a given service month are divided by the units of service paid to date for the

**BL 2018 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.
**Strategy-Related Measures Definitions**
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**Agency:** Health and Human Services Commission

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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-06-01 EF 03

**BL 2018 Definition**
This measure reports the average net nursing facility cost per Medicaid nursing facility resident (individual) per month.

**BL 2018 Data Limitations**
Because it takes up to 36 months to close out 100% 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.

**BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application which utilizes TM1 software.

**BL 2018 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 Medicaid resident per day is then multiplied by the calendar days in the month to obtain the value for that service month. See efficiency measures 1 and 2 under this strategy for discussions of each of these components.

The average value for each reporting period is calculated by taking the sum of the product of the “net nursing facility cost per average daily rate” for each month in the reporting period (as calculated above), times the estimated “average number of individuals receiving Medicaid-funded nursing facilities per month” for each month of the reporting period, and dividing that sum by the sum of the estimated “average number of individuals receiving Medicaid-funded nursing facilities per month” for all months of the reporting period.

**BL 2018 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.
### BL 2018 Definition

This measure reports the average amount of the "State Supplementation for Personal Needs Allowance (PNA)" per individual per month. PNA is the amount of money 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 person in an institution is only $30 per month. All eligible individuals receive a supplemental payment of $15 per month.

### BL 2018 Data Limitations

Does not apply.

### BL 2018 Data Source

The payment amount is established by agency rule and does not vary by client.

### BL 2018 Methodology

By agency rule, all eligible individuals receive a supplemental personal needs allowance (PNA) payment of $15 per month in order to enhance their PNA above the SSI standard payment amount. Since the payment amount is established by agency rule and does not vary by individual, the reported value equals the value stated by rule.

### BL 2018 Purpose

This measure is important because it quantifies the benefit amount for individuals who receive this service, which was mandated by the Texas Legislature.
Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 1 Medicaid
Objective No. 2 Community Services and Supports - Entitlement
Strategy No. 4 Nursing Facility Payments
Measure Type OP
Measure No. 1 Number of Nursing Facility Clients per Month, Unduplicated

Calculation Method: C
Target Attainment: L
Priority: L

Key Measure: N
New Measure: Y
Percentage Measure: N

BL 2018 Definition
This is a measure of the average monthly number of clients (unduplicated clients per month) in a Nursing Facility, whether in STAR+Plus, Dual Demonstration, or Fee for Service.

BL 2018 Data Limitations
Nursing Facility client counts are measured differently in managed care and fee for service, with managed care utilizing a first of month count and fee-for-service utilizing an average daily census count. This measure is using an unduplicated count of clients in order to capture an overall picture of nursing facility clients.

BL 2018 Data Source
Premiums Payment System; SAS System

BL 2018 Methodology
Unduplicated clients are calculated by summing the number of managed care clients each month (technically recipients months) with the number of unduplicated clients in a Medicaid paid nursing facility bed on any given day of a month, and dividing by the total number of months summed. Unduplicated clients 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. The quarterly average is the sum of the unduplicated clients for the three months in the specified quarter divided by 3. The year to date average is the sum of the monthly unduplicated clients divided by the number of months summed.

BL 2018 Purpose
This measure reflects the average monthly number of unduplicated clients for the named group.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**

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**Goal No. 1: Medicaid**
**Objective No. 2: Community Services and Supports - Entitlement**
**Strategy No. 4: Nursing Facility Payments**

**Measure No. 2: Average Number Receiving Medicaid-funded Nursing Facility Services/Mo**

**Calculation Method:** N
**Target Attainment:**
**Priority:**

**Cross Reference:** Agy 539 084-R-S70-1 01-06-01 OP 01

**Key Measure:** Y
**New Measure:** N
**Percentage Measure:** N

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**BL 2018 Definition**

This measure reports the monthly average number of individuals receiving Medicaid-funded nursing facility services during the reporting period.

**BL 2018 Data Limitations**

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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application which utilizes TM1 software.

**BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application which utilizes TM1 software.

**BL 2018 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. For the most part, the days of service ultimately incurred are estimated by the “completion factor” method explained above. 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.

**BL 2018 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.
### BL 2018 Definition

This measure reports the monthly average unduplicated number of Medicaid eligible, Supplemental Security Income (SSI) institutional individuals who received a 100% 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 an individual in an institution is only $30 per month. All eligible individuals receive a supplemental payment of $15 per month.

### BL 2018 Data Limitations

Does not apply.

### BL 2018 Data Source

Individual counts are obtained from the department’s Health and Human Services Administrative System (HHSAS) Financials. The payment amount is established by rule and does not vary by individual.

### BL 2018 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.

### BL 2018 Purpose

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

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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 01-06-01 OP 02  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N
BL 2018 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.

BL 2018 Data Limitations
Since it takes several months to close out 100% of the days of service billed, the Medicaid payments as well as the amount of individual income contribution ultimately incurred, data for months that have not yet closed out must be estimated using "completion factors". 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 claims approved-to-pay to date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application which utilizes TM1 software.

BL 2018 Methodology
The monthly units of service per individual: the units of service paid to date for a given service month are divided by the number of individuals for whom claims have been approved-to-pay to yield an “average units per individual to date,” which is then adjusted by adding the avg amount of change expected over the remaining payment months, using moving averages to calculate historical average amounts of change for each additional payment period.
For each service month, the average net cost per day of service is calculated by subtracting the average amount of client income per patient day from the Medicare co-payment rate (set by Medicare).
The estimated expenditure per month is calculated: the (adjusted) units of service per individual times the average cost per unit times the number of individuals served. The sum of the monthly expenditures for all months in the reporting period is then divided by the sum of the number of SNF individuals for all months of the reporting period.

BL 2018 Purpose
The average monthly net payment per individual receiving co-paid Medicare/Medicaid Skilled Nursing Facility Services (SNF) can be broken down into two components: the average monthly days of service per individual, and the average net cost per day of service. Further, the average net cost per day of service can be broken down into the daily Medicare co-payment rate less the average amount of client applied income per patient day.

The monthly units of service per individual are estimated as follows: the units of service paid to date for a given service month are divided by the number of individuals for whom claims have been approved-to-pay for the corresponding month of service to yield an “average units per individual to date” for a given month of service.

This measure quantifies the unit cost for the Medicare co-payment for eligible nursing facility residents. This data is a useful tool for projecting future funding needs.
Strategy-Related Measures Definitions
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 1 Medicaid
Objective No. 2 Community Services and Supports - Entitlement
Strategy No. 5 Medicare Skilled Nursing Facility
Measure Type OP
Measure No. 1 Average Number Receiving Nursing Facility Copayments/Mo

Calculation Method: C Target Attainment: 
Priority: 
Cross Reference: Agy 539 084-R-S70-1 01-06-02 OP 01

Key Measure: Y New Measure: N Percentage Measure: N

**BL 2018 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.

**BL 2018 Data Limitations**
Because it takes several months to close out 100% 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.

**BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application which utilizes TM1 software.

**BL 2018 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. For the most part, the number of individuals served is estimated by the “completion factor” method. 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 four payment periods of data is available. (Or additional months if necessary.) For these service months, the census values are estimated by using the “completion factor”-generated estimate from the preceding month, plus the average monthly change for the two prior years.

Using an alternate method of estimation for periods with relatively few payment periods is consistent with actuarial standards of practice.

**BL 2018 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.
### BL 2018 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.

### BL 2018 Data Limitations

Because it takes several months to close out 100% 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 individuals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

### BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application which utilizes COGNOS software.

### BL 2018 Methodology

Units of service paid to date for a given service month are divided by the number of individuals with claims approved-to-pay for the month of service to yield an “average units per individual to date,” which is then adjusted by adding the avg amount of change expected to occur over the remaining payment months, using moving averages to calculate historical avg amounts of change for each additional payment period.

The amount paid for a given month is divided by the units of service paid to date for the month of service to yield an “average cost per unit to date.” Then adding the average amount of change expected to occur over the remaining payment months, using moving avgs.

The estimated expenditure: (adjusted) units of service per individual times the avg cost per unit times the number of individuals served. The sum of the expenditures for all months in the reporting period is then divided by the sum of the number of Hospice individuals for all months of the reporting period.
**BL 2018 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.
**Strategy-Related Measures Definitions**

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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 01-06-03 OP 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

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**BL 2018 Definition**

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

**BL 2018 Data Limitations**

Because it takes several months to close out 100% 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 individuals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

**BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application which utilizes COGNOS software.

**BL 2018 Methodology**

The reported data are calculated by dividing the sum of the monthly number of individuals receiving Hospice services for all months of the reporting period by the number of months in the reporting period. For the most part, the number of individuals ultimately receiving services is estimated by the “completion factor” method explained above. 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 four 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 “completion factor”-generated estimate from the preceding month, plus the average monthly change for the two prior years.

**BL 2018 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.
**BL 2018 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 (ICF/IID).

**BL 2018 Data Limitations**

Because it takes several months to close out 100% 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.

**BL 2018 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 TMHP (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-ID services by facility size are obtained from the commission's Service Authorization System (SAS).

**BL 2018 Methodology**

For each facility size grouping, the average daily rate for the reporting period less the applied income per patient day for the reporting period equals the net cost per resident per day for each month in the reporting period. The net cost per resident per day is then multiplied by the calendar days in the month to obtain the value for that service month. See efficiency measures 1 and 2 under Strategy 1.6.1 for discussions of each of these components. The average value for each reporting period is calculated by taking the sum of the product of the "monthly (net) cost per ICF-IID individual" for each month in the reporting period (as calculated above), times the estimated "number of (Medicaid-funded) persons in ICF/IID Medicaid beds" (as defined in 1.7.1 Output Measure 1)" for each month of the reporting period, and dividing that sum by the sum of the estimated "number of (Medicaid-funded)

**BL 2018 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**

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**Goal No. 1 Medicaid**  
**Objective No. 2 Community Services and Supports - Entitlement**  
**Strategy No. 7 Intermediate Care Facilities - for Individuals w/ ID (ICF/IID)**  
**Measure Type EX**  
**Measure No. 1 Number ICF/IID Individuals with Residential Length of Stay 0-12 Months**

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**

Cross Reference: Agy 539 084-R-S70-1 01-07-01 EX 02

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

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**BL 2018 Definition**

This measure relates to the length of stay for an individual in an ICF/IID and reports the number of individuals whose length of stay is one year or less. A length of stay is defined as date of authorization to date of an absence from the facility for more than 30 days.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

Information about individual movement is entered into the commission's Client Assignment and Registrations (CARE) system. Movement includes admission, absence and discharge. From this CARE system, the number of days from admission (date of authorization) to present can be calculated.

**BL 2018 Methodology**

This measure is calculated for individuals residing in an ICF/IID on the last day of the fiscal year. For all persons residing in the facilities who have not been absent from their facility for more than 30 days during the year, the total days from the date of authorization to the end of the reporting period are counted. From this total count of individuals, the number of individuals in an ICF/IID for one through 365 days is counted.

**BL 2018 Purpose**

These facilities are intended to provide long-term services and supports for individuals with intellectual and developmental disabilities that need or desire 24-hour supervised living environments. The number of individuals with shorter lengths of stay is relatively insignificant. These facilities have a stable number of residents and new admissions to facilities are dependent upon a bed becoming available.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

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<td>Measure Type</td>
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**Calculation Method:** N
**Target Attainment:**
**Priority:**
Cross Reference: Agy 539 084-R-S70-1 01-07-01 EX 03
**Key Measure:** N
**New Measure:** N
**Percentage Measure:** N

**BL 2018 Definition**
This measure relates to the length of stay for an individual in an ICF/IID and reports the number of individuals whose length of stay is 366 days through 730 days. A length of stay is defined as date of authorization to date of an absence from the facility for more than 30 days.

**BL 2018 Data Limitations**
None

**BL 2018 Data Source**
Information about individual movement is entered into the commission's Client Assignment and Registration (CARE) system. Movement includes admission, absence and discharge. From this CARE system, the number of days from admission (date of authorization) to present can be calculated.

**BL 2018 Methodology**
This measure is calculated for individuals residing in an ICF/IID on the last day of the fiscal year. For all persons residing in the facilities who have not been absent from their facility for more than 30 days during the year, the total days from the date of authorization to the end of the reporting period are counted. From this total count of individuals, the number of individuals in an ICF/IID for 366 through 730 days is counted.

**BL 2018 Purpose**
These facilities are intended to provide long-term services and supports for individuals with intellectual and developmental disabilities that need or desire 24-hour supervised living environments. The number of individuals with shorter lengths of stay is relatively insignificant. These facilities have a stable number of residents and new admissions to facilities are dependent upon a bed becoming available.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

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Goal: Medicaid  
Objective: Community Services and Supports - Entitlement  
Strategy: Intermediate Care Facilities - for Individuals w/ ID (ICF/IID)  
Measure Type: EX  
Measure No.: Number ICF/IID Individuals with Residential Length of Stay 24+ Months

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 539 084-R-S70-1 01-07-01 EX 04

Key Measure: N  
New Measure: N  
Percentage Measure: N

**BL 2018 Definition**

This measure relates to the length of stay for an individual in an ICF/IID and reports the number of persons whose length of stay is 731 days or more. A length of stay is defined as date of authorization to date of an absence from the facility for more than 30 days.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

Information about individual movement is entered into the commission's Client Assignment and Registration (CARE) system. Movement includes admission, absence and discharge. From this CARE system, the number of days from admission (date of authorization) to present can be calculated.

**BL 2018 Methodology**

This measure is calculated for individuals residing in an ICF/IID on the last day of the fiscal year. For all individuals residing in the facilities who have not been absent from their facility for more than 30 days during the year, the total days from the date of authorization to the end of the reporting period are counted. From this total count of individuals, the number of individuals in an ICF/IID for 731 days or more is counted.

**BL 2018 Purpose**

These facilities are intended to provide long-term services and supports for individuals with intellectual and developmental disabilities that need or desire 24-hour supervised living environments. The number of individuals with shorter lengths of stay is relatively insignificant. These facilities have a stable number of residents and new admissions to facilities are dependent upon a bed becoming available.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This explanatory measure is the average monthly number of individuals who reside in community ICFs/IID that have eight beds or less.

### BL 2018 Data Limitations

ICF/IID providers are allowed to submit claims no longer than 365 days from the month service was provided in order for the claims to be paid. Although most providers do not delay submission of claims for this amount of time, any delay in submission of claims beyond the period being reported will result in this measure being understated.

### BL 2018 Data Source

The number of persons served in any period is based on service authorization data, which is made at the time an individual is approved for ICF/IID placement/reimbursement. Service authorization information is entered into the commission's Client Assignment and Registration (CARE) system. A monthly Health and Human Services Commission (HHSC) production report (ICF-IID Program Data Report) is generated from the database and provides information about number of persons with service authorizations by size of facility and level of need.

### BL 2018 Methodology

Number of persons served is defined as number of service authorizations. The number of service authorizations each month of the period for ICFs/IID with eight beds or less is counted. The numerator is the sum of the monthly number of service authorizations for ICF/IID for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

### BL 2018 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.

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### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source
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<td>Measure No.</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 01-07-01 EX 06  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This explanatory measure is the average monthly number of individuals who reside in community ICFs/IID that have eight beds or less.

**BL 2018 Data Limitations**
ICF/IID providers are allowed to submit claims no longer than 365 days from the month service was provided in order for the claims to be paid. Although most providers do not delay submission of claims for this amount of time, any delay in submission of claims beyond the period being reported will result in this measure being understated.

**BL 2018 Data Source**
The number of persons served in any period is based on service authorization data, which is made at the time an individual is approved for ICF/IID placement/reimbursement. Service authorization information is entered into the commission's Client Assignment and Registration (CARE) system. A monthly Health and Human Services Commission (HHSC) production report (ICF-IID Program Data Report) is generated from the database and provides information about number of persons with service authorizations by size of facility and level of need.

**BL 2018 Methodology**
Number of persons served is defined as number of service authorizations. The number of service authorizations each month of the period for ICFs/IID with eight beds or less is counted. The numerator is the sum of the monthly number of service authorizations for ICF/IID for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

**BL 2018 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
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**Goal No. 1: Medicaid**

**Objective No. 2: Community Services and Supports - Entitlement**

**Strategy No. 7: Intermediate Care Facilities - for Individuals w/ ID (ICF/IID)**

**Measure Type: EX**

**Measure No. 6: Average Monthly Number of Individuals in ICF/IID, 9-13 Beds**

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  

**Cross Reference:** Agy 539 084-R-S70-1 01-07-01 EX 07

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

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**BL 2018 Definition**

This explanatory measure is the average monthly number of individuals who reside in community ICFs/IID that have more than eight beds but less than 14 beds.

**BL 2018 Data Limitations**

ICF/IID providers are allowed to submit claims no longer than 365 days from the month the service was provided in order for the claims to be paid. Although most providers do not delay submission of claims for this amount of time, any delay in submission of claims beyond the period being reported will result in this measure being understated.

**BL 2018 Data Source**

The number of individuals served in any period is based on service authorization data, which is made at the time an individual is approved for ICF/IID placement/reimbursement. Service authorization information is entered into the department's Client Assignment and Registration (CARE) system. A monthly Department of Aging and Disability Services (DADS) production report (ICF/IID Program Data Report) is generated from the database and provides information about number of persons with service authorizations by size of facility and level of need.

**BL 2018 Methodology**

Number of individuals served is defined as number of service authorizations. The number of service authorizations each month of the period for ICFs/IID with more than eight beds but less than fourteen beds is counted. The numerator is the sum of the monthly number of service authorizations for ICFs/IID for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

**BL 2018 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.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 01-07-01 EX 08  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This explanatory measure is the average cost per individual in community ICFs/IID that have more than eight beds but less than 14 beds.

**BL 2018 Data Limitations**
Original claims for services provided may be submitted by providers of ICF/IID services up to 365 days after the end of the service month. Therefore, for the current fiscal year, the numerator is an estimated expenditure amount based on prior period billing data and the denominator is actual service authorizations for the current quarter.

**BL 2018 Data Source**
The measure is derived from service authorizations and billing data provided on a monthly basis. The calculation uses the average billing rate per individual from the Claims Management System (CMS). The actual billing rates are already net of applied income. Since there is a full twelve-month billing window, the average billing rate is an average of the prior months that are complete. The calculation also uses the monthly number of service authorizations from the Client Assignment and Registration (CARE) system. This combination of service authorizations and average billing rates is used rather than utilizing the billing system alone because of the twelve month billing window for submitting claims.

**BL 2018 Methodology**
The average billing rate for each month is multiplied by the number of service authorizations to determine a monthly expenditure amount. The monthly expenditure amount for each of the three months in the reporting quarter is summed. The number of service authorization for each of the three months in the reporting quarter is also summed. The quarterly expenditure amount is divided by the quarterly number of service authorizations for an average monthly cost per individual for the reporting quarter. Due to the large billing window in this program, the values reported in the Automated Budget and Evaluation System of Texas (ABEST) will not be updated to reflect actual average monthly billing rates from the billing system alone until a year later. In ABEST, the reported values for each quarter of the previous fiscal year will be updated upon submission of either the Operating Budget or the Legislative Appropriations Request (LAR) document.

**BL 2018 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.

**BL 2019 Definition**

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BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
**BL 2018 Definition**

This explanatory measure is the average monthly number of individuals who reside in community ICFs/IID which have 14 beds or greater.

**BL 2018 Data Limitations**

ICF/IID providers are allowed to submit claims no longer than 365 days from the month the service was provided in order for the claims to be paid. Although most providers do not delay submission of claims for this amount of time, any delay in submission of claims beyond the period being reported will result in this measure being understated.

**BL 2018 Data Source**

The number of individuals served in any period is based on service authorization data, which is made at the time an individual is approved for ICF/IID placement/reimbursement. Service authorization information is entered into the department's Client Assignment and Registration (CARE) system. A monthly Health and Human Services Commission (HHSC) production report (ICF/IID Program Data Report) is generated from the database and provides information about number of individuals with service authorizations by size of facility and level of need.

**BL 2018 Methodology**

Number of individuals served is defined as number of service authorizations. The number of service authorizations each month of the period for ICFs/IID with fourteen or more beds is counted. The numerator is the sum of the monthly number of service authorizations for ICFs/IID for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

**BL 2018 Purpose**

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

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
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**Target attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-07-01 EX 10  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**  
This explanatory measure is the average cost per individual in community ICFs/IID that have 14 or more beds.

**BL 2018 Data Limitations**  
Original claims for services provided may be submitted by providers of ICF/IID services up to 365 days after the end of the service month. Therefore, for the current fiscal year, the numerator is an estimated expenditure amount based on prior period billing data and the denominator is actual service authorizations for the current quarter.

**BL 2018 Data Source**  
The measure is derived from service authorizations and billing data provided on a monthly basis. The calculation uses the average billing rate per individual from the Claims Management System (CMS). The actual billing rates are already net of applied income. Since there is a full twelve-month billing window, the average billing rate is an average of the prior months that are complete. The calculation also uses the monthly number of service authorizations from the Client Assignment and Registration (CARE) system. This combination of service authorizations and average billing rates is used rather than utilizing the billing system alone because of the twelve month billing window for submitting claims.

**BL 2018 Methodology**  
The average billing rate for each month is multiplied by the number of service authorizations to determine a monthly expenditure amount. The monthly expenditure amount for each of the three months in the reporting quarter is summed. The number of service authorizations for each of the three months in the reporting quarter is also summed. The quarterly expenditure amount is divided by the quarterly number of service authorizations for an average monthly cost per individual for the reporting quarter. Due to the large billing window in this program, the values reported in the Automated Budget and Evaluation System of Texas (ABEST) will not be updated to reflect actual average monthly billing rates from the billing system alone until a year later. In ABEST, the reported values for each quarter of the previous fiscal year will be updated upon submission of either the Operating Budget or the Legislative Appropriations Request (LAR) document.

**BL 2018 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.

**BL 2019 Definition**
BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This explanatory measure is the average number of certified beds in community ICFs/IID that have eight beds or less.

### BL 2018 Data Limitations

None.

### BL 2018 Data Source

The Department of Aging and Disability Services (DADS) maintains a database within the Client Assignment and Registration (CARE) system of all ICF/IID providers that contains information about location and size of each facility. The agency certifies beds for the purpose of Medicaid reimbursement. The number of certified beds determines the size of the facility.

### BL 2018 Methodology

The number of Medicaid certified beds in ICFs/IID with eight beds or less each month is determined for the last day of the month. The measure is the average number of beds each month as calculated for the reporting quarter and year-to-date. The numerator is the sum of the monthly bed count for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

### BL 2018 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.
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  

Cross Reference: Agy 539 084-R-S70-1 01-07-01 EX 12  

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This explanatory measure is the average number of certified beds in community ICFs/IID which have greater than eight beds but less than 14.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

DADS maintains a database within the Client Assignment and Registration (CARE) system of all ICF/IID providers that contains information about location and size of each facility. The agency certifies beds for the purpose of Medicaid reimbursement. The number of certified beds determines the size of the facility.

**BL 2018 Methodology**

The number of Medicaid certified beds in ICFs/IID with nine to thirteen beds each month is determined for the last day of the month. The measure is the average number of beds each month as calculated for the reporting quarter and year-to-date. The numerator is the sum of the monthly bed count for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

**BL 2018 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.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
Agency Code: 529  
Agency: Health and Human Services Commission  
Goal No. 1  
Medicaid  
Objective No. 2  
Community Services and Supports - Entitlement  
Strategy No. 7  
Intermediate Care Facilities - for Individuals w/ ID (ICF/IID)  
Measure Type EX  
Measure No. 12  
Average Monthly Number of ICF/IID Medicaid Beds, 14+  

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 539 084-R-S70-1 01-07-01 EX 13  
Key Measure: N  
New Measure: N  
Percentage Measure: N  

BL 2018 Definition  
This explanatory measure is the average number of certified beds in community ICFs/IID that have eight beds or less.

BL 2018 Data Limitations  
None.

BL 2018 Data Source  
The Health and Human Services Commission (HHSC) maintains a database within the Client Assignment and Registration (CARE) system of all ICF/IID providers that contains information about location and size of each facility. The agency certifies beds for the purpose of Medicaid reimbursement. The number of certified beds determines the size of the facility.

BL 2018 Methodology  
The number of Medicaid certified beds in ICFs/IID with eight beds or less each month is determined for the last day of the month. The measure is the average number of beds each month as calculated for the reporting quarter and year-to-date. The numerator is the sum of the monthly bed count for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2018 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.

BL 2019 Definition  

BL 2019 Data Limitations  

BL 2019 Data Source  

BL 2019 Methodology  


### Strategy-Related Measures Definitions
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Automated Budget and Evaluation System of Texas (ABEST)

#### BL 2018 Definition
This output measure is the average number of Medicaid-funded individuals who reside in all Community ICFs/IID.

#### BL 2018 Data Limitations
Because it takes several months to close out 100% of the claims for a month of service, the number of days of service ultimately incurred must be estimated for months that have not yet closed out, by using "completion factors" applied to the number of days of service on claims 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 days of service on approved-to-pay claims to-date divided by the appropriate completion factor, divided by the number of calendar days in the month equals the estimated number of persons ultimately served.

#### BL 2018 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 TMHP (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-ID services by facility size are obtained from the commission's Service Authorization System (SAS).

#### BL 2018 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 the number of calendar days in that month. In addition, the data is reported and analyzed by bed size groupings; small (6 beds or less), medium (7 to 14 beds), and large (15 beds or more). For the most part, the number of individuals ultimately served is estimated by the "completion factor" method explained above. 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.)

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 SAS).

#### BL 2018 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.
Strategy-Related Measures Definitions
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 1 Medicaid
Objective No. 2 Community Services and Supports - Entitlement
Strategy No. 7 Intermediate Care Facilities - for Individuals w/ ID (ICF/IID)
Measure Type OP
Measure No. 2 Average Number of ICF/IID Medicaid Beds Per Month

Calculation Method: N
Target Attainment: Priority: Cross Reference: Agy 539 084-R-S70-1 01-07-01 OP 02
Key Measure: N New Measure: N Percentage Measure: N

BL 2018 Definition
This output measure is the average number of certified beds in all Community ICFs/IID.

BL 2018 Data Limitations
None

BL 2018 Data Source
The total number of Medicaid certified beds in all ICFs/IID each month is determined for the last day of the month. The measure is the average number of beds each month as calculated for the reporting quarter and year-to-date. The numerator is the sum of the monthly bed count for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2018 Methodology
The total number of Medicaid certified beds in all ICFs/IID each month is determined for the last day of the month. The measure is the average number of beds each month as calculated for the reporting quarter and year-to-date. The numerator is the sum of the monthly bed count for each month of the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator.

BL 2018 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.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
### BL 2018 Definition
This measure captures the average cost per month for serving Medicaid Home and Community-Based Services waiver (HCS) individuals.

### BL 2018 Data Limitations
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.

### BL 2018 Data Source
Est. are derived by first dividing the exp. to-date for a given month of service by the number of ind. for whom claims have been approved-to-pay to-date for the same month of service to yield an average monthly cost per ind. served to date for a given month of service. The average monthly cost per ind. to-date for each service month is then adj. by adding the average amount of change in cost expected to occur over the remaining payment months, using moving averages to calculate historical average amounts of change for each additional payment period. However, because of the normal amount of variation which occurs in processing billings from month-to-month, an alt. method is used for service months in which fewer than 3 payment periods of data is available. For these service months, the values are est. by using the average of the value generated by the methodology explained above, and the est. from the preceding month, plus the average monthly change for the 2 prior years.

### BL 2018 Methodology
The average value for each report period is calculated by taking the sum of the product of the adj.monthly cost per ind. for each month in the rept. period, times the est. “average number of ind. receiving HCS per month” for each month of the reporting period times the number of months in the reporting period, and dividing that sum by the sum of the est. “average number of individuals receiving HCS per month” for each month of the reporting period times the number of months in the reporting period. For exp., if payment data were available through Aug 13, the monthly cost for June 13 would be est. as follows: the average of: 1) the adj. value for June 13 and 2) the “adj. value for May 13 plus the average of the change in cost per month experienced from May 11 to June 11 and from May 12 to June 12. Please note that using an alt. method of est. for periods with relatively few payment periods is consistent with actuarial standards of practice.

### BL 2018 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.
Strategy-Related Measures Definitions
85th Regular Session, Agency Submission, Version 1
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 1 Medicaid
Objective No. 3 Long-term Care - Non-entitlement
Strategy No. 1 Home and Community-based Services (HCS)
Measure Type EF
Measure No. 2 Avg Mthly Cost Indiv Served: Home and Community-Based Svcs Residential

Calculation Method: N  Target Attainment:  Priority:  Cross Reference: Agy 539 084-R-S70-1 01-03-02 EF 02
Key Measure: N  New Measure: N  Percentage Measure: N

**BL 2018 Definition**
This measure captures the average cost per month for serving Medicaid Non-Residential Home and Community-Based Services waiver (HCS) individuals.

**BL 2018 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 actual enrollments for the current quarter.

**BL 2018 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 Client Assignment and Registration (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.

**BL 2018 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. The aggregated monthly expenditure amount for each of the three months in the reporting quarter is summed. The aggregated number of individuals for each of the three months in the reporting quarter is also summed. The quarterly aggregated expenditure amount is divided by the quarterly aggregated number of individuals enrolled for an average monthly cost per individual for the reporting quarter. Once the billing data for previously reported quarters is complete, the values reported in ABEST will be updated using only the aggregated average monthly billing rate for all waivers.

**BL 2018 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.

**BL 2019 Definition**
BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**

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**BL 2018 Definition**
This measure captures the average cost per month for serving Medicaid Non-Residential Home and Community-Based Services waiver (HCS) individuals.

**BL 2018 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 actual enrollments for the current quarter.

**BL 2018 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 Client Assignment and Registration (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.

**BL 2018 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. The aggregated monthly expenditure amount for each of the three months in the reporting quarter is summed. The aggregated number of individuals for each of the three months in the reporting quarter is also summed. The quarterly aggregated expenditure amount is divided by the quarterly aggregated number of individuals enrolled for an average monthly cost per individual for the reporting quarter. Once the billing data for previously reported quarters is complete, the values reported in ABEST will be updated using only the aggregated average monthly billing rate for all waivers.

**BL 2018 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.

**BL 2019 Definition**
BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**

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Automated Budget and Evaluation System of Texas (ABEST)

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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

**Goal No.** 1  
**Objective No.** 3  
**Strategy No.** 1  
**Measure Type** EX  
**Measure No.** 1  
**Calculation Method:** N  
**Target Attainment:** L  
**Priority:** M  
**Cross Reference:**

**Key Measure:** Y  
**New Measure:** Y  
**Percentage Measure:** N

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**BL 2018 Definition**

This measure provides an unduplicated workload count of priority population eligible individuals receiving intellectual disability Medicaid Home and Community-Based Services waiver (HCS) funded services at the end of the fiscal year.

**BL 2018 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.

**BL 2018 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.

**BL 2018 Methodology**

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

**BL 2018 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.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
**BL 2018 Definition**

This measure provides a simple count of individuals who express an interest in Home and Community-Based Waiver services (HCS). For purposes of this measure, interest is defined as placing one’s name on the interest list with the local authority for HCS waiver services. The count only includes those individuals on the list who are in “open” status (i.e., it excludes those individuals who are being processed for eligibility to begin receiving the service.)

**BL 2018 Data Limitations**

The accuracy of the HCS interest list is dependent upon the submission of accurate data by the Local Authorities (LAs). There may be duplication of names between interest lists for ID services.

**BL 2018 Data Source**

An individual seeking ID services or an individual seeking ID services on behalf of another individual with intellectual or developmental disabilities begins the review of service options with the local authority staff. If the individual, legal representative or family member decides they are interested in HCS waiver services, the name of the individual is entered onto the interest list for HCS waiver services in the CARE system.

**BL 2018 Methodology**

This is a simple count on the last day of the month of individuals whose names have been entered into the Client Assignment and Registration (CARE) system as interested in HCS waiver services. When calculating the average monthly number of individuals on the interest for a given fiscal year, the average of the months in the fiscal year is calculated. When necessary, future and past periods are estimated based on the counts of the available months.

**BL 2018 Purpose**

This measure is an indicator of the unmet need for services provided under the HCS waiver as currently funded by this strategy and is a tool for projecting future funding needs.

**BL 2019 Definition**

BL 2019 Data Limitations

BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
### Strategy-Related Measures Definitions

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#### Goal No. 1 Medicaid

#### Objective No. 3 Long-term Care - Non-entitlement

#### Strategy No. 1 Home and Community-based Services (HCS)

#### Measure Type EX

#### Measure No. 3 Tot # Declined Svcs or Found to be Ineligible for Svcs FY HCS Waiver

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<th>Target Attainment:</th>
<th>Priority:</th>
<th>Cross Reference: Agy 539 084-R-S70-1 01-03-03 EX 03</th>
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**BL 2018 Definition**

This measure reports the number of clients who were waiting on interest lists and either then declined services when they became available or were deemed to be ineligible for those particular waiver services. As clients come to the top of the interest list, they are either deemed ineligible, or there is no affirmative response to enroll.

**BL 2018 Data Limitations**

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information. Payment lag or using sample data may also be a limitation.

**BL 2018 Data Source**

Regional Staff enters data into a reporting database known as Community Services Interest List (CSIL) that is maintained by State Office Program.

**BL 2018 Methodology**

The measure is calculated by subtracting the number of clients enrolled on Interest Lists in various waiver programs from the total number of clients enrolled and denied to get total number of clients declined or ineligible for services.

**BL 2018 Purpose**

This measure is a mechanism for tracking those clients waiting on an interest list and then for multiple reasons had to come off of them.

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#### Goal No. 1 Medicaid

#### Objective No. 3 Long-term Care - Non-entitlement

#### Strategy No. 1 Home and Community-based Services (HCS)

#### Measure Type EX

#### Measure No. 3 Tot # Declined Svcs or Found to be Ineligible for Svcs FY HCS Waiver

<table>
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<th>Priority:</th>
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**BL 2019 Definition**

This measure reports the number of clients who were waiting on interest lists and either then declined services when they became available or were deemed to be ineligible for those particular waiver services. As clients come to the top of the interest list, they are either deemed ineligible, or there is no affirmative response to enroll.

**BL 2019 Data Limitations**

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information. Payment lag or using sample data may also be a limitation.

**BL 2019 Data Source**

Regional Staff enters data into a reporting database known as Community Services Interest List (CSIL) that is maintained by State Office Program.

**BL 2019 Methodology**

The measure is calculated by subtracting the number of clients enrolled on Interest Lists in various waiver programs from the total number of clients enrolled and denied to get total number of clients declined or ineligible for services.

**BL 2019 Purpose**

This measure is a mechanism for tracking those clients waiting on an interest list and then for multiple reasons had to come off of them.
BL 2018 Definition
This measure reports the average number of clients per month, who were receiving other HHSC Services, while on the Interest List.

BL 2018 Data Limitations
Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information.

BL 2018 Data Source
Regional Staff enters data into a reporting database known as Community Services Interest List (CSIL) that is maintained by State Office Program, but matching up with SAS data to include people receiving other services.

BL 2018 Methodology
This Measure is calculated by taking the Number of clients receiving other HHSC services while on the interest list divided by the number of months.

BL 2018 Purpose
This measure is a mechanism for tracking those clients on the interest list who receive other HHSC services while waiting.
BL 2018 Definition
This measure reports the annual number of individuals whose name was released from the HCS interest list, resulting in a non-enrollment closure expressed as a percentage of all individuals whose name was released from a HCS interest list. As individuals come to the top of the interest list, they are either deemed ineligible, or there is no affirmative response to enroll.

BL 2018 Data Limitations
Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information. Payment lag or using sample data may also be a limitation.

BL 2018 Data Source
Community Services Interest List (CSIL) that is maintained by Agency Staff. Each month, reports are generated from this system that provide the number of individuals released from the interest list, the number of individuals enrolled, the number of non-enrollment enclosures, and the number of individuals in release status for whom the final disposition is still pending.

BL 2018 Methodology
The measure is calculated by dividing the number of individuals whose names were released from the HCS interest list and where the HCS interest list record for those individuals were closed during the fiscal year without the individuals being enrolled for HCS, by the total number of individuals whose names were released from the HCS interest list and where the HCS interest list record for those individuals were closed during the fiscal year.

BL 2018 Purpose
This measure is a mechanism for tracking the percentage of those individuals that come to the top of the interest list, that are either deemed ineligible, or from whom there is no affirmative response to enroll.
BL 2019 Methodology

BL 2019 Purpose
**Agency Code:** 529  
**Agency:** Health and Human Services Commission  
**Goal No.** 1  
**Objective No.** 3  
**Strategy No.** 1  
**Measure Type** EX  
**Measure No.** 6

**Calculation Method:** N  
**Target Attainment:** H  
**Priority:** H  
**Cross Reference:**

**Key Measure:** Y  
**New Measure:** Y  
**Percentage Measure:** Y

**BL 2018 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.

**BL 2018 Data Limitations**

Because it takes several months to close out 100% 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 individuals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

**BL 2018 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.

**BL 2018 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.

**BL 2018 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.
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 1  
Objective No. 3  
Strategy No. 1  
Measure Type OP  
Measure No. 1

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 539 084-R-S70-1 01-03-02 OP 01

Key Measure: Y  
New Measure: N  
Percentage Measure: N

BL 2018 Definition
This measure captures the unduplicated count of priority population eligible individuals who receive Home and Community-Based Services waiver (HCS) funded services on a monthly basis.

BL 2018 Data Limitations
Because it takes several months to close out 100% 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 individuals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

BL 2018 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 Client Assignment and Registration (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.

BL 2018 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. 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 CARE).

BL 2018 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.
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**Agency Code:**  529  **Agency:**  Health and Human Services Commission

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**Agency: Health and Human Services Commission**

**Goal No. 1 Medicaid**

**Objective No. 3 Long-term Care - Non-entitlement**

**Strategy No. 2 Community Living Assistance and Support Services (CLASS)**

**Measure Type EF**

**Measure No. 1 Average Monthly Cost Per Individual: CLASS Waiver**

**Calculation Method:** N  **Target Attainment:**  

**Priority:**  

**Cross Reference:** Agy 539 084-R-S70-1 01-03-03 EF 01

**Key Measure:** Y  **New Measure:** N  **Percentage Measure:** N

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**BL 2018 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 measure 1 of this strategy.

**BL 2018 Data Limitations**

Because it takes several months to close out 100% 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.

**BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software.

**BL 2018 Methodology**

Estimates are derived by first dividing the exp. to-date for a given month of service by the number of ind. for who claims have been approved-to-pay to-date for the same month of service to yield an average monthly cost per ind. served to date for a given month of service. The average monthly cost per ind. to-date for each service month is then adjusted by adding the average amount of change in cost expected to occur over the remaining payment months, using moving averages to calculate hist. average amounts of change for each add. payment period. However, because of the normal amount of variation which occurs in processing billings from month-to-month, an alt. method is used for service months in which fewer than three payment periods of data is available. For these service months, the values are est. by using the average of the value generated by the methodology explained above, and the est. from the preceding month, plus the average monthly change for the two prior years.

**BL 2018 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.

**BL 2019 Definition**
BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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<td>Community Living Assistance and Support Services (CLASS)</td>
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<td>Measure Type</td>
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<td>Average Number on Interest List: Community Living Assistance &amp; Support</td>
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**BL 2018 Definition**
This measure reports the average monthly unduplicated number of individuals who have requested CLASS waiver services, but are placed on an interest list for CLASS due to funding constraints. Individuals are placed on an interest list by means of a telephone call to the State Office Interest List Hotline or by completion of Form 3620, Intake Summary of Individual’s Need for Services. The count only includes those individuals on the list who are in “open” status (i.e., it excludes those individuals who are being processed for eligibility to begin receiving the service.) The count may include individuals who are waiting for CLASS while receiving other Community Services and Supports.

**BL 2018 Data Limitations**
Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information.

**BL 2018 Data Source**
Data are captured by means of a reporting database maintained by State Office program staff.

**BL 2018 Methodology**
Counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly counts of individuals on the interest list for CLASS (as described above) for all months of the reporting period, by the number of months in the reporting period.

**BL 2018 Purpose**
This measure is an indicator of the unmet need for services provided under the Medicaid CLASS waiver as currently funded by this strategy and is a tool for projecting future funding needs.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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Agency Code: **529**  
Agency: Health and Human Services Commission

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**Goal No. 1 Medicaid**  
**Objective No. 3 Long-term Care - Non-entitlement**  
**Strategy No. 2 Community Living Assistance and Support Services (CLASS)**

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**BL 2018 Definition**
This measure reports the number of individuals who, based upon approved-to-pay claims, received one or more services under the Community Living Assistance & Support Services (CLASS) waiver during the last month of the fiscal year being reported.

**BL 2018 Data Limitations**
Because it takes several months to close out 100% 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 individuals on approved-to-pay claims to date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

**BL 2018 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 (SAS) 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 (CMS) by means of ad hoc query.

**BL 2018 Methodology**
This is a simple unduplicated count of individuals who received CLASS waiver services during the last month of the fiscal year being reported.

**BL 2018 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.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
BL 2018 Definition

This measure reports the number of clients who were waiting on interest lists and either then declined services when they became available or were deemed to be ineligible for those particular waiver services. As clients come to the top of the interest list, they are either deemed ineligible, or there is no affirmative response to enroll.

BL 2018 Data Limitations

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information. Payment lag or using sample data may also be a limitation.

BL 2018 Data Source

Regional Staff enters data into a reporting database known as Community Services Interest List (CSIL) that is maintained by State Office Program

BL 2018 Methodology

The measure is calculated by subtracting the number of clients enrolled on Interest Lists in various waiver programs from the total number of clients enrolled and denied to get total number of clients declined or ineligible for services.

BL 2018 Purpose

This measure is a mechanism for tracking those clients waiting on an interest list and then for multiple reasons had to come off of them.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

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BL 2019 Purpose
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<tr>
<td>Strategy No.</td>
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<td>Measure Type</td>
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<td>Measure No.</td>
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Calculation Method: N  Target Attainment:  Priority:  Cross Reference: Agy 539 084-R-S70-1 01-03-03 EX 04
Key Measure: Y  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measure reports the average number of clients per month, who were receiving other HHSC Services, while on the Interest List.

BL 2018 Data Limitations
Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information.

BL 2018 Data Source
Regional Staff enters data into a reporting database known as Community Services Interest List (CSIL) that is maintained by State Office Program, but matching up with SAS data to include people receiving other services.

BL 2018 Methodology
This Measure is calculated by taking the Number of clients receiving other HHSC services while on the interest list divided by the number of months.

BL 2018 Purpose
This measure is a mechanism for tracking those clients on the interest list who receive other HHSC services while waiting.
### BL 2018 Definition

This measure reports the annual number of individuals whose name was released from the CLASS interest list, resulting in a non-enrollment closure expressed as a percentage of all individuals whose name was released from a CLASS interest list. As individuals come to the top of the interest list, they are either deemed ineligible, or there is no affirmative response to enroll.

### BL 2018 Data Limitations

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information. Payment lag or using sample data may also be a limitation.

### BL 2018 Data Source

Community Services Interest List (CSIL) that is maintained by Agency Staff. Each month, reports are generated from this system that provide the number of individuals released from the interest list, the number of individuals enrolled, the number of non-enrollment enclosures, and the number of individuals in release status for whom the final disposition is still pending.

### BL 2018 Methodology

The measure is calculated by dividing the number of individuals whose names were released from the CLASS interest list and where the CLASS interest list record for those individuals were closed during the fiscal year without the individuals being enrolled for CLASS, by the total number of individuals whose names were released from the CLASS interest list and where the CLASS interest list record for those individuals were closed during the fiscal year.

### BL 2018 Purpose

This measure is a mechanism for tracking the percentage of those individuals that come to the top of the interest list, that are either deemed ineligible, or from whom there is no affirmative response to enroll.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

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**Agency Code:** 529  
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**Goal No.** 1  
**Objective No.** 3  
**Strategy No.** 2  
**Measure Type** EX  
**Measure No.** 5  
**Calculation Method:** N  
**Target Attainment:** Priority:  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** Y  
**Cross Reference:** Agy 539 084-R-S70-1 01-03-03 EX 05
BL 2019 Methodology

BL 2019 Purpose
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Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 1 Medicaid  
Objective No. 3 Long-term Care - Non-entitlement  
Strategy No. 2 Community Living Assistance and Support Services (CLASS)  
Measure Type OP  
Measure No. 1 Average Number of Individuals Served Per Month: CLASS Waiver

BL 2018 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 Medicaid Related Conditions waiver (CLASS). 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.

BL 2018 Data Limitations
Because it takes several months to close out 100% 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 individuals on approved-to-pay claims to date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

BL 2018 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 (SAS) 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software.

BL 2018 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. 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 SAS).
BL 2018 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.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

**Goal No. 1** Medicaid  
**Objective No. 3** Long-term Care - Non-entitlement  
**Strategy No. 3** Deaf-Blind Multiple Disabilities (DBMD)

**Measure Type** EF  
**Measure No. 1** Average Monthly Cost Per Individual: Deaf-Blind Waiver

---

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 01-03-04 EF 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

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**BL 2018 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 Deaf-blind with Multiple Disabilities Waiver individuals is defined under output measure 1 of this strategy.

**BL 2018 Data Limitations**

Because it takes several months to close out 100% 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.

**BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software.

**BL 2018 Methodology**

First divide expenditures for a given month by the number of ind. to yield an avg monthly cost. This is then adj. by adding the avg change in cost expected over the remaining payment months, using moving avgs to calculate hist. average amounts of change for each additional payment period. When fewer than 3 payment periods of data is avail, the values are est. by using the avg of the value generated by the methodology above, and the est. from the preceding month, plus the avg monthly change for the 2 prior years. The avg value for each report period is calculated by taking the sum of the product of the adj.monthly cost per ind. for each month in the rept. period, times the est. “average number of ind. receiving DBMD per month” for each month of the reporting period times the number of months in the reporting period, and dividing that sum by the sum of the est.”average number of individuals receiving DBMD per month” for each month times the number of months in the reporting period.

**BL 2018 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 Deaf-blind with Multiple Disabilities 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.
Goal No. 1 Medicaid
Objective No. 3 Long-term Care - Non-entitlement
Strategy No. 3 Deaf-Blind Multiple Disabilities (DBMD)
Measure Type EX
Measure No. 1 Average Number on Interest List: Deaf-Blind Mult Disabilities Waiver

BL 2018 Definition
This measure reports the average monthly unduplicated number of individuals who have requested Deaf-blind with Multiple Disabilities Waiver services, but are placed on an interest list for Deaf-blind with Multiple Disabilities Waiver services due to funding constraints. Individuals are placed on an interest list by means of a telephone call to the State Office Interest List Hotline or by completion and submittal of Form 6501 Deaf-Blind Medicaid Waiver Interest List Form. The count only includes those individuals on the list who are in “open” status (i.e., it excludes those individuals who are being processed for eligibility to begin receiving the service.) The count may include individuals who are waiting for Deaf-blind with Multiple Disabilities Waiver services while receiving other Community Services and Supports.

BL 2018 Data Limitations
Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information.

BL 2018 Data Source
Data are reported by means of a reporting database maintained by State Office program staff.

BL 2018 Methodology
Counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly counts of individuals on the interest list for Deaf-blind with Multiple Disabilities Waiver (as described above) for all months of the reporting period, by the number of months in the reporting period.

BL 2018 Purpose
This measure is an indicator of the unmet need for services provided under the Deaf-blind with Multiple Disabilities Waiver as currently funded by this strategy and is a tool for projecting future funding needs.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
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Agency Code: 529  Agency: Health and Human Services Commission

Goal No. 1  Medicaid
Objective No. 3  Long-term Care - Non-entitlement
Strategy No. 3  Deaf-Blind Multiple Disabilities (DBMD)
Measure Type EX
Measure No. 2  # of Persons Receiving Services at the End of the Fiscal Year: DBMD

Calculation Method: N  Target Attainment: N  Priority: N  Cross Reference: Agy 539 084-R-S70-1 01-03-04 EX 02

Key Measure: Y  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measure reports the number of individuals who, based upon approved-to-pay claims, received one or more services under the Medicaid Deaf-blind with Multiple Disabilities waiver during the last month of the fiscal year being reported.

BL 2018 Data Limitations
Because it takes several months to close out 100% 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. 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.

BL 2018 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 (SAS) 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 (CMS) by means of ad hoc query.

BL 2018 Methodology
This is a simple unduplicated count of individuals who received Medicaid Deaf-blind with Multiple Disabilities waiver services during the last month of the fiscal year being reported.

BL 2018 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.

BL 2019 Definition

BL 2019 Data Limitations
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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#### Calculation Method: N  Target Attainment:  Priority: Cross Reference: Agy 539 084-R-S70-1 01-03-04 EX 03

#### Key Measure: Y  New Measure: N  Percentage Measure: N

---

#### BL 2018 Definition

This measure reports the number of clients who were waiting on interest lists and either then declined services when they became available or were deemed to be ineligible for those particular waiver services. As clients come to the top of the interest list, they are either deemed ineligible, or there is no affirmative response to enroll.

#### BL 2018 Data Limitations

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information. Payment lag or using sample data may also be a limitation.

#### BL 2018 Data Source

Regional Staff enters data into a reporting database known as Community Services Interest List (CSIL) that is maintained by State Office Program.

#### BL 2018 Methodology

The measure is calculated by subtracting the number of clients enrolled on Interest Lists in various waiver programs from the total number of clients enrolled and denied to get total number of clients declined or ineligible for services.

#### BL 2018 Purpose

This measure is a mechanism for tracking those clients waiting on an interest list and then for multiple reasons had to come off of them.

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#### BL 2019 Definition

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#### BL 2019 Data Limitations

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#### BL 2019 Data Source

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#### BL 2019 Methodology

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**Goal No.:** Medicaid  
**Objective No.:** Long-term Care - Non-entitlement  
**Strategy No.:** Deaf-Blind Multiple Disabilities (DBMD)  
**Measure Type:** EX  
**Measure No.:** Avg # DBMD Interest List Receiving Other Svcs Per Mth

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-03-04 EX 04

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure reports the average number of clients per month, who were receiving other HHSC Services, while on the Interest List.

**BL 2018 Data Limitations**
Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information.

**BL 2018 Data Source**
Regional Staff enters data into a reporting database known as Community Services Interest List (CSIL) that is maintained by State Office Program, but matching up with SAS data to include people receiving other services.

**BL 2018 Methodology**
This Measure is calculated by taking the Number of clients receiving other HHSC services while on the interest list divided by the number of months.

**BL 2018 Purpose**
This measure is a mechanism for tracking those clients on the interest list who receive other HHSC services while waiting.
### Agency Code: 529

**Agency:** Health and Human Services Commission

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#### Goal No. 1 Medicaid

#### Objective No. 3 Long-term Care - Non-entitlement

#### Strategy No. 3 Deaf-Blind Multiple Disabilities (DBMD)

#### Measure Type EX

#### Measure No. 5 % Declined Svcs or Found to be Ineligible Svcs at the EOY DBMD Waiver

### Calculation Method: N

### Target Attainment: 

### Priority: 

### Cross Reference: Agy 539 084-R-S70-1 01-03-04 EX 05

### Key Measure: N

### New Measure: N

### Percentage Measure: Y

#### BL 2018 Definition

This measure reports the number of clients who were waiting on interest lists and either then declined services when they became available or were deemed to be ineligible for those particular waiver services. As clients come to the top of the interest list, they are either deemed ineligible, or there is no affirmative response to enroll.

#### BL 2018 Data Limitations

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information. Payment lag or using sample data may also be a limitation.

#### BL 2018 Data Source

Regional Staff enters data into a reporting database known as Community Services Interest List (CSIL) that is maintained by State Office Program.

#### BL 2018 Methodology

The measure is calculated by subtracting the number of clients enrolled on Interest Lists in various waiver programs from the total number of clients enrolled and denied to get total number of clients declined or ineligible for services.

#### BL 2018 Purpose

This measure is a mechanism for tracking those clients waiting on an interest list and then for multiple reasons had to come off of them.

#### BL 2019 Definition

#### BL 2019 Data Limitations

#### BL 2019 Data Source

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<td>Average Number of Individuals Served Per Month: Deaf-Blind Waiver</td>
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**Calculation Method:** N  **Target Attainment:**  **Priority:** Cross Reference: Agy 539 084-R-S70-1 01-03-04 OP 01

**Key Measure:** Y  **New Measure:** N  **Percentage Measure:** N

**BL 2018 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 Deaf-blind with Multiple Disabilities Waiver. This waiver provides an array of services to people who are deaf-blind with multiple disabilities as an alternative to institutional care. The major focus of the program is to increase the individual's opportunity to communicate and to lead active lives. Services include: case management, assisted living, habilitation, respite, nursing, specialized medical equipment, environmental modification, behavior communication specialist, intervener, and therapies.

**BL 2018 Data Limitations**
Because it takes several months to close out 100% 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. 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.

**BL 2018 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 (SAS) 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software.

**BL 2018 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. 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 SAS).
BL 2018 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 Deaf-blind with Multiple Disabilities 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.
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<td>Measure No.</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-03-06 EF 01  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

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

**BL 2018 Data Limitations**

Because it takes several months to close out 100% of the services 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.

**BL 2018 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.

**BL 2018 Methodology**

First divide expenditures for a given month by the number of ind. to yield an avg monthly cost. This is then adj. by adding the avg change in cost expected over the remaining payment months, using moving avgs to calculate hist. average amounts of change for each additional payment period. When fewer than 3 payment periods of data is avail, the values are est. by using the avg of the value generated by the methodology above, and the est. from the preceding month, plus the avg monthly change for the 2 prior years.

The average value for each report period is calculated by taking the sum of the product of the adj. monthly cost per ind. for each month in the rept. period, times the est. “average number of ind. receiving HCS per month” for each month of the reporting period times the number of months in the reporting period, and dividing that sum by the sum of the est. “average number of individuals receiving HCS per month” for each month times the number of months in the reporting period.

**BL 2018 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.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 1: Medicaid  
Objective No. 3: Long-term Care - Non-entitlement  
Strategy No. 4: Texas Home Living Waiver  
Measure Type: EX  
Measure No. 1: # of Individuals Receiving Svcs at the End of the Fiscal Year: Tx HML

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 539 084-R-S70-1 01-03-06 EX 01

Key Measure: Y  
New Measure: N  
Percentage Measure: N

**BL 2018 Definition**
This measure provides an unduplicated workload count of priority population eligible individuals receiving ID Texas Home Living (TxHmL) waiver funded services at the end of the fiscal year.

**BL 2018 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 the Automated Budget and Evaluation System of Texas (ABEST) will be available when the appropriation year closes.

**BL 2018 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.

**BL 2018 Methodology**
This is a simple unduplicated count of individuals that received TxHmL waiver services at the end of the fiscal year.

**BL 2018 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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**Calculation Method:** N  
**Target Attainment:** L  
**Priority:** M  
**Cross Reference:**

**Key Measure:** N  
**New Measure:** Y  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure provides a simple count of individuals who express an interest in Texas Home Living Waiver services (TxHmL). For purposes of this measure, interest is defined as placing one’s name on the interest list with the local authority for TxHmL waiver services. The count only includes those individuals on the list who are in “open” status (i.e., it excludes those individuals who are being processed for eligibility to begin receiving the service.)

**BL 2018 Data Limitations**

The accuracy of the TxHmL interest list is dependent upon the submission of accurate data by the Local Authorities (LAs). There may be duplication of names between interest lists for ID services.

**BL 2018 Data Source**

An individual seeking ID services or an individual seeking ID services on behalf of another individual with intellectual or developmental disabilities begins the review of service options with the local authority staff. If the individual, legal representative or family member decides they are interested in TxHmL waiver services, the name of the individual is entered onto the interest list for TxHmL waiver services in the CARE system.

**BL 2018 Methodology**

This is a simple count on the last day of the month of individuals whose names have been entered into the Client Assignment and Registration (CARE) system as interested in TxHmL waiver services. When calculating the average monthly number of individuals on the interest list for a given fiscal year, the average of the months in the fiscal year is calculated. When necessary, future and past periods are estimated based on the counts of the available months.

**BL 2018 Purpose**

This measure is an indicator of the unmet need for services provided under the TxHmL waiver as currently funded by this strategy and is a tool for projecting future funding needs.
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**Agency:** Health and Human Services Commission

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**Goal No.** 1  
Medicaid

**Objective No.** 3  
Long-term Care - Non-entitlement

**Strategy No.** 4  
Texas Home Living Waiver

**Measure Type:** EX

**Measure No.** 3  
Tot # Declined Svc Or Found To Be Ineligible For Svs Fy TXHMLV Waiver

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**Calculation Method:** N  
**Target Attainment:** L  
**Priority:** M  
**Cross Reference:**

**Key Measure:** N  
**New Measure:** Y  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the annual number of individuals whose names were released from the TxHmL interest list and for whom a final disposition has been reached, resulting in a non-enrollment closure. As individuals come to the top of the interest list, they are either enrolled, deemed ineligible, determined there is no affirmative response to enroll, or still in process. This measure excludes from the calculation those individuals who are still in process.

**BL 2018 Data Limitations**

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information. Payment lag or using sample data may also be a limitation.

**BL 2018 Data Source**

Local Authority Staff enter "reason for closure" data into the CARE Interest List database.

**BL 2018 Methodology**

The measure is calculated by subtracting the number of clients enrolled on Interest Lists in various waiver programs from the total number of clients enrolled and denied to get total number of clients declined or ineligible for services.

**BL 2018 Purpose**

This measure is a mechanism for tracking those clients waiting on an interest list and then for multiple reasons had to come off of them.
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Agency: Health and Human Services Commission

Goal No. 1 Medicaid  
Objective No. 3 Long-term Care - Non-entitlement  
Strategy No. 4 Texas Home Living Waiver  
Measure Type EX  
Measure No. 4 Avg # On TXHL Waiver Interest List Receiving Other Services Per Month

**BL 2018 Definition**

This measure reports the average number of clients per month, who were receiving other LTSS Services, while on the Interest List.

**BL 2018 Data Limitations**

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information.

**BL 2018 Data Source**

Local Authority Staff enters individuals names into the CARE interest list. These names are then matched against service authorization data from the Service Authorization System to determine whether individuals on the Texas Home Living Interest list are receiving other services.

**BL 2018 Methodology**

This Measure is calculated by taking the annual number of clients receiving other HHSC services while on the interest list divided by the number of months.

**BL 2018 Purpose**

This measure is a mechanism for tracking those clients on the interest list who receive other HHSC services while waiting.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
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<td>% Declined Svcs Or Found To Be Ineligible Svcs At The Eoy TXHL Waiver</td>
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**Calculation Method:** N  
**Target Attainment:** L  
**Priority:** M  
**Cross Reference:**

**Key Measure:** N  
**New Measure:** Y  
**Percentage Measure:** N

---

**BL. 2018 Definition**

This measure reports the number of individuals whose name was released from the TxHmL interest list, resulting in a non-enrollment closure, expressed as a percentage of all individuals whose name was released from a TxHmL interest list and for whom a final disposition has been reached. As individuals come to the top of the interest list, they are either enrolled, deemed ineligible, determined there is no affirmative response to enroll, or still in process. This measure excludes from the calculation those individuals who are still in process.

**BL. 2018 Data Limitations**

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information. Payment lag or using sample data may also be a limitation.

**BL. 2018 Data Source**

Local Authority Staff enters data into the CARE Interest List system. Each month, reports are generated from this system that provide the number of individuals released from the interest list, the number of individuals enrolled, the number of non-enrollment enclosures, and the number of individuals in release status for whom the final disposition is still pending.

**BL. 2018 Methodology**

The measure is calculated by dividing the number of individuals whose names were released from the TxHmL interest list and where the TxHmL interest list record for those individuals were closed during the fiscal year without the individuals being enrolled for TxHmL, by the total number of individuals whose names were released from the TxHmL interest list and where the TxHmL interest list record for those individuals were closed during the fiscal year.

**BL. 2018 Purpose**

This measure is a mechanism for tracking the percentage of those individuals that come to the top of the interest list, that are either deemed ineligible, or from whom there is no affirmative response to enroll.

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**BL. 2019 Definition**

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**BL. 2019 Data Limitations**
BL 2019 Data Source

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BL 2019 Purpose
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<td>Avg Number of Individuals Served Per Month: Texas Home Living Waiver</td>
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**Calculation Method:** N  **Target Attainment:**  **Priority:**  **Cross Reference:** Agy 539 084-R-S70-1 01-03-06 OP 01

**Key Measure:** Y  **New Measure:** N  **Percentage Measure:** N

---

**BL 2018 Definition**

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

**BL 2018 Data Limitations**

Because it takes several months to close out 100% 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 individuals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

**BL 2018 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 Client Assignment and Registration (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.

**BL 2018 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 CARE).

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

**BL 2018 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.
**Strategy-Related Measures Definitions**
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**Goal No. 1 Medicaid**

**Objective No. 3 Long-term Care - Non-entitlement**

**Strategy No. 5 Program of All-inclusive Care for the Elderly (PACE)**

**Measure Type EF**

**Measure No. 1 Avg Monthly Cost Per Recipient: Program for All Inclusive Care (PACE)**

**Calculation Method:** N  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 01-05-01 EF 01  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 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.

**BL 2018 Data Limitations**
Because it takes several months to close out 100% 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.

**BL 2018 Data Source**
Two types of data are used to report this measure. The number of individuals authorized to receive MDCP services are obtained from the commission’s Service Authorization System (SAS) 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software.

**BL 2018 Methodology**
First, the expenditures to-date for a given month of service are divided by the number of individuals for whom claims have been approved-to-pay to-date for the same month of service to yield an average monthly cost per individual served to date for a given month of service. The average value for each reporting period is then calculated by taking the sum of the product of the adjusted monthly cost per individual for each month in the reporting period (as calculated above), times the estimated “average number of individuals receiving PACE per month” (as calculated in XX.XX Output measure 1) for each month of the reporting period times the number of months in the reporting period, and dividing that sum by the sum of the estimated “average number of individuals receiving PACE per month” for each month of the reporting period.

**BL 2018 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.
BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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**Goal No. 1 Medicaid**

**Objective No. 3 Long-term Care - Non-entitlement**

**Strategy No. 5 Program of All-inclusive Care for the Elderly (PACE)**

**Measure Type EX**

**Measure No. 1 Number of Persons Receiving Svcs End of Fiscal Year: PACE**

**Calculation Method: N**

**Target Attainment:**

**Priority:**

Cross Reference: Agy 539 084-R-S70-1 01-05-01 EX 01

**Key Measure: Y**

**New Measure: N**

**Percentage Measure: N**

---

**BL 2018 Definition**

This measure reports the number of individuals who, based upon approved-to-pay claims, received one or more services under the Program of All-Inclusive Care for the Elderly (PACE) during the last month of the fiscal year being reported.

**BL 2018 Data Limitations**

Because it takes several months to close out 100% 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.

**BL 2018 Data Source**

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

**BL 2018 Methodology**

This is a simple unduplicated count of individuals who received Program of All-inclusive Care for the Elderly (PACE) services during the last month of the fiscal year being reported.

**BL 2018 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.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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**Goal No. 1 Medicaid**

**Objective No. 3 Long-term Care - Non-entitlement**

**Strategy No. 5 Program of All-inclusive Care for the Elderly (PACE)**

**Measure Type OP**

**Measure No. 1 Avg # of Recipients Per Month: Program for All Inclusive Care (PACE)**

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  

**Cross Reference:** Agy 539 084-R-S70-1 01-05-01 OP 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure reports the monthly average number of individuals who are enrolled in a Program for All Inclusive Care For the Elderly (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.

**BL 2018 Data Limitations**

Because it takes several months to close out 100% 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.

**BL 2018 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 (SAS) 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software.

**BL 2018 Methodology**

The sum of the monthly number of PACE recipients for all months of the reporting period is divided by the number of months in the reporting period. 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.) 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 SAS).

Using an alternate method of estimation for periods with relatively few payment periods is consistent with actuarial standards of practice.
BL 2018 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.
**Strategy-Related Measures Definitions**

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<td>Goal No.</td>
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<td>Objective No.</td>
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<tr>
<td>Strategy No.</td>
<td>6</td>
<td>Medically Dependent Children Program (MDCP)</td>
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<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
<td>1</td>
<td>Average Monthly Cost Per Individual: MDCP Waiver</td>
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**Calculation Method:** N  **Target Attainment:**  **Priority:**
Cross Reference: Agy 539 084-R-S70-1 01-03-05 EF 01

**Key Measure:** Y  **New Measure:** N  **Percentage Measure:** N

**BL 2018 Definition**

This measure reports the average cost of Medically Dependent Children Program (MDCP) 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 children served is defined under output measure 1 of this strategy.

**BL 2018 Data Limitations**

Because it takes several months to close out 100% 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.

**BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software.

**BL 2018 Methodology**

First divide expenditures for a given month by the number of individuals to yield an average monthly cost. This is then adjusted by adding the average change in cost expected over the remaining payment months, using moving averages to calculate historical averages of change for each additional payment period. When fewer than 3 payment periods of data are available, the values are estimated by using the average of the value generated by the methodology above, and the estimated from the preceding month, plus the average monthly change for the 2 prior years.

The average value for each report period is calculated by taking the sum of the product of the adjusted monthly cost per individual for each month in the reporting period, times the estimated “average number of individuals receiving MDCP per month” for each month of the reporting period times the number of months in the reporting period, and dividing that sum by the number of the estimated “average number of individuals receiving MDCP per month” for each month times the number of months in the reporting period.

**BL 2018 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 MDCP-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.
### Strategy-Related Measures Definitions

#### 85th Regular Session, Agency Submission, Version 1

#### Automated Budget and Evaluation System of Texas (ABEST)

#### Goal No. 1 Medicaid

#### Objective No. 3 Long-term Care - Non-entitlement

#### Strategy No. 6 Medically Dependent Children Program (MDCP)

#### Measure Type EX

#### Measure No. 1 Average Number on Interest List Per Month: MDCP Waiver

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<td>Strategy No.</td>
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<td>Measure No.</td>
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<td>Average Number on Interest List Per Month: MDCP Waiver</td>
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**Calculation Method:** N

**Target Attainment:**

**Priority:**

Cross Reference: Agy 539 084-R-S70-1 01-03-05 EX 01

**Key Measure:** Y

**New Measure:** N

**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the average monthly unduplicated number of individuals who have requested Medically Dependent Children Program (MDCP) services, but are placed on an interest list for these services due to funding constraints. Individuals are placed on an interest list by means of a telephone call to the State Office Interest List Hotline or through completion of a Form 3620, Intake/Summary of Individuals Need for Services. The count only includes those individuals on the list who are in “open” status (i.e., it excludes those individuals who are being processed for eligibility to begin receiving the service.)

**BL 2018 Data Limitations**

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information.

**BL 2018 Data Source**

Counts are collected on a monthly basis. Data are reported by means of a reporting database maintained by State Office program staff.

**BL 2018 Methodology**

The monthly average for the reporting period is calculated by dividing the sum of the monthly counts of individuals on the interest list for MDCP (as described above) for all months of the reporting period, by the number of months in the reporting period.

**BL 2018 Purpose**

This measure is an indicator of the unmet need for services provided under the MDCP as currently funded by this strategy and is a tool for projecting future funding needs.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
**Strategy-Related Measures Definitions**

85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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<td>Objective No. 3</td>
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<td>Medically Dependent Children Program (MDCP)</td>
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<tr>
<td>Measure Type EX</td>
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<tr>
<td>Measure No. 2</td>
<td># Persons Receiving Svcs at the End of the Fiscal Year: MDCP</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  

Cross Reference: Agy 539 084-R-S70-1 01-03-05 EX 02

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the number of individuals who, based upon approved-to-pay claims, received one or more services under the Medically Dependent Children Program (MDCP) during the last month of the fiscal year being reported.

**BL 2018 Data Limitations**

Because it takes several months to close out 100% 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 individuals on approved-to-pay claims to date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

**BL 2018 Data Source**

Two types of data are used to report this measure. The number of individuals authorized to receive MDCP services are obtained from the commission's Service Authorization System (SAS) 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 (CMS) by means of ad hoc query.

**BL 2018 Methodology**

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

**BL 2018 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.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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<td>Measure No.</td>
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<td>Tot # Declined Svcs or Found to be Ineligible for Svcs FY MDCP Waiver</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 01-03-05 EX 03  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure reports the number of clients who were waiting on interest lists and either then declined services when they became available or were deemed to be ineligible for those particular waiver services. As clients come to the top of the interest list, they are either deemed ineligible, or there is no affirmative response to enroll.

**BL 2018 Data Limitations**

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information. Payment lag or using sample data may also be a limitation.

**BL 2018 Data Source**

Regional Staff enters data into a reporting database known as Community Services Interest List (CSIL) that is maintained by State Office Program

**BL 2018 Methodology**

Regional Staff enters data into a reporting database known as Community Services Interest List (CSIL) that is maintained by State Office Program

**BL 2018 Purpose**

This measure is a mechanism for tracking those clients waiting on an interest list and then for multiple reasons had to come off of them.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
Strategy-Related Measures Definitions
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 1: Medicaid
Objective No. 3: Long-term Care - Non-entitlement
Strategy No. 6: Medically Dependent Children Program (MDCP)
Measure Type: EX
Measure No. 4: Avg # on MDCP Interest List Receiving Other DADS Svcs Per Mth

Calculation Method: N
Target Attainment: Cross Reference: Agy 539 084-R-S70-1 01-03-05 EX 04
Priority: 
Key Measure: Y
New Measure: N
Percentage Measure: N

BL 2018 Definition
ADDITIONAL EDITS NEEDED FROM AGENCY NOVEMBER 2016. This measure reports the average number of clients per month, who were receiving other HHSC Services, while on the Interest List.

BL 2018 Data Limitations
Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information.

BL 2018 Data Source
Regional Staff enters data into a reporting database known as Community Services Interest List (CSIL) that is maintained by State Office Program, but matching up with SAS data to include people receiving other services.

BL 2018 Methodology
This Measure is calculated by taking the Number of clients receiving other HHSC services while on the interest list divided by the number of months.

BL 2018 Purpose
This measure is a mechanism for tracking those clients on the interest list who receive other HHSC services while waiting.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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<td>Measure No.</td>
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**Calculation Method:** N  **Target Attainment:**  **Priority:**  
Cross Reference: Agy 539 084-R-S70-1 01-03-05 EX 05

**Key Measure:** N  **New Measure:** N  **Percentage Measure:** Y

### BL 2018 Definition

The measure is calculated by counting the number of individuals whose name was released from the MDCP interest list and where the MDCP interest list record for that individual was closed during the fiscal year without the individual being enrolled for MDCP expressed as a percentage of all individuals whose name was released from a MDCP interest list.

### BL 2018 Data Limitations

Individuals on the list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information. Payment lag or using sample data may also be a limitation.

### BL 2018 Data Source

Community Services Interest List (CSIL) that is maintained by Agency Staff. Each month, reports are generated from this system that provide the number of individuals released from the interest list, the number of individuals enrolled, the number of non-enrollment enclosures, and the number of individuals in release status for whom the final disposition is still pending.

### BL 2018 Methodology

The measure is calculated by dividing the number of individuals whose names were released from the MDCP interest list and where the MDCP interest list record for those individuals were closed during the fiscal year without the individuals being enrolled for MDCP, by the total number of individuals whose names were released from the MDCP interest list and where the MDCP interest list record for those individuals were closed during the fiscal year.

### BL 2018 Purpose

This measure is a mechanism for tracking those individuals that come to the top of the interest list, they are either deemed ineligible, or there is no affirmative response to enroll expressed as a percentage of all individuals whose name was released from a MDCP interest list.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**

85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

**Goal No.** 1  
**Objective No.** 3  
**Strategy No.** 6  
**Measure Type** OP  
**Measure No.** 1  
**Measure Definition:** Average Number of Individuals Served Per Month: MDCP Waiver

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-03-05 OP 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the monthly average unduplicated number of individuals who received one or more services under the Medically Dependent Children Program (MDCP) Waiver.

**BL 2018 Data Limitations**

Because it takes several months to close out 100% 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 individuals on approved-to-pay claims to date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

**BL 2018 Data Source**

Two types of data are used to report this measure. The number of individuals authorized to receive MDCP services are obtained from the commission's Service Authorization System (SAS) 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software.

**BL 2018 Methodology**

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. For the most part, the number of individuals ultimately receiving services are estimated by the “completion factor” method, 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.) 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 SAS).

**BL 2018 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 MDCP-funded services with related costs and outcomes.
**BL 2018 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. TP 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 (LPR). This measure involves Type 30 (TP 30) program recipient months and expenditures.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

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

**BL 2018 Methodology**

The total TP 30 expenditures incurred are divided by the total number of TP 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.

**BL 2018 Purpose**

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

**BL 2019 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. TP 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 (LPR). This measure involves Type 30 (TP 30) program recipient months and expenditures.

**BL 2019 Data Limitations**

None.

**BL 2019 Data Source**

The Premiums Payable System and the STMR 647A provided by the state Medicaid Contractor.
BL 2019 Methodology
The total TP 30 expenditures incurred are divided by the total number of TP 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.

BL 2019 Purpose
Captures the average monthly cost of providing Medicaid to TP 30 non-citizens residing in the U.S., who are in need of medical services due to an emergency condition.
**Strategy-Related Measures Definitions**

85th Regular Session, Agency Submission, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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<td>Measure No.</td>
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**Calculation Method:** N  
**Target Attainment:** H  
**Priority:** H  
**Cross Reference:** Agy 529 084-R-S70-1 02-02-01 OP 01

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

Federally Qualified Health Centers (FQHC) look-alikes meet all the requirements to receive one of the grants under the Public Health Service Act but does not actually receive any of these grants, according to FQHC status qualification guidelines.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

The data source is Vision 21 from the Ad Hoc Query Platform, which is managed by HHSC. The Medicaid Contractor's Provider Enrollment Agreement provides information to the database. The Medicaid contractor currently generates reports in the form of an Access database from a query that gathers monthly information on the active FQHC providers. Data is provided to HHSC in an Excel Spreadsheet.

**BL 2018 Methodology**

The quarterly average for number of enrolled FQHCs is the sum of the number of actively participating FQHCs and FQHC look-alikes for each month in the three month period divided by three. The year-to-date average for number of enrolled FQHCs is the sum of the number of actively participating FQHCs and FQHC look-alikes for each month in the given period divided by the total number of months in that period.

**BL 2018 Purpose**

Captures the average monthly number of FQHCs and FQHC look-alikes.

---

**BL 2019 Definition**

Federally Qualified Health Centers (FQHC) look-alikes meet all the requirements to receive one of the grants under the Public Health Service Act but does not actually receive any of these grants, according to FQHC status qualification guidelines.

**BL 2019 Data Limitations**

None.

**BL 2019 Data Source**


The data source is Vision 21 from the Ad Hoc Query Platform, which is managed by HHSC. The Medicaid Contractor's Provider Enrollment Agreement provides information to the database. The Medicaid contractor currently generates reports in the form of an Access database from a query that gathers monthly information on the active FQHC providers. Data is provided to HHSC in an Excel Spreadsheet.

**BL 2019 Methodology**

The quarterly average for number of enrolled FQHCs is the sum of the number of actively participating FQHCs and FQHC look-alikes for each month in the three month period divided by three. The year-to-date average for number of enrolled FQHCs is the sum of the number of actively participating FQHCs and FQHC look-alikes for each month in the given period divided by the total number of months in that period.

**BL 2019 Purpose**

Captures the average monthly number of FQHCs and FQHC look-alikes.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 1  
Objective No. 4  
Strategy No. 1  
Measure Type OP  
Measure No. 2

**Goal No. 1 Medicaid**

**Objective No. 4 Other Medicaid Services**

**Strategy No. 1 Non-Full Benefit Payments**

**Measure Type OP**

**Measure No. 2 Average Monthly Number of Non-citizens Receiving Emergency Services**

**Calculation Method: N**  
**Target Attainment: L**  
**Priority: H**

Cross Reference: Agy 529 084-R-S70-1 02-02-01 OP 02

**Key Measure: Y**  
**New Measure: N**  
**Percentage Measure: N**

**BL 2018 Definition**

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

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

The Premium Payable System.

**BL 2018 Methodology**

The Average Number of Undocumented Persons Recipient Months Per Month is the average number of TP 30 recipient months per month. It is the sum of the monthly TP 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.

**BL 2018 Purpose**

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

**BL 2019 Definition**

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

**BL 2019 Data Limitations**

None.
**BL 2019 Data Source**
The Premium Payable System.

**BL 2019 Methodology**
The Average Number of Undocumented Persons Recipient Months Per Month is the average number of TP 30 recipient months per month. It is the sum of the monthly TP 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.

**BL 2019 Purpose**
This measure reflects the average monthly number of TP 30 aliens residing in the U.S. who have an emergency medical condition covered by Medicaid.
**Strategy-Related Measures Definitions**

85th Regular Session, Agency Submission, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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**Goal No. 1 Medicaid**

**Objective No. 4 Other Medicaid Services**

**Strategy No. 2 For Clients Dually Eligible for Medicare and Medicaid**

**Measure Type EF**

**Measure No. 1 Average Part B Premium Per Month**

---

**Calculation Method:** N  
**Target Attainment:** L  
**Priority:** H  
**Cross Reference:** Agy 529 084-R-S70-1 02-02-05 EF 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

The average monthly premium paid for Supplemental Medical Insurance Benefits (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.

**BL 2018 Data Limitations**

This measure includes Qualified Medicare Beneficiary Qualifying Individuals (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.

**BL 2018 Data Source**

Social Security Act and report MF 232-01

**BL 2018 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.

**BL 2018 Purpose**

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

---

**BL 2019 Definition**

The average monthly premium paid for Supplemental Medical Insurance Benefits (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.

**BL 2019 Data Limitations**

This measure includes Qualified Medicare Beneficiary Qualifying Individuals (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.
BL 2019 Data Source
Social Security Act and report MF 232-01

BL 2019 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.

BL 2019 Purpose
HHSC pays the Social Security Administration a premium for coverage of physician and other related services.
**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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<td>Other Medicaid Services</td>
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<td>Strategy No.</td>
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<td>Measure Type</td>
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<td></td>
</tr>
<tr>
<td>Measure No.</td>
<td>2</td>
<td>Average Part A Premium Per Month</td>
</tr>
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</table>

**Calculation Method:** N  
**Target Attainment:** L  
**Priority:** L

**Cross Reference:** Agy 529 084-R-S70-1 02-02-05 EF 02

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
The average monthly premium paid for Medicare Part A coverage for Medicare eligible Medicaid clients. The Medicare Part A premium is set by the Social Security Administration and is effective for each calendar year. Medicare Part A is hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
Social Security Act and report MF832 01.

**BL 2018 Methodology**
The average is calculated by taking the total estimated dollar value of claims projected to be incurred by clients and dividing this total by the number of projected recipient months to be incurred. The numerator will be the sum of full and reduced rate Part A dollars; the denominator will be the sum of full and reduced rate Part A recipient months. The Medicare Part A premium is set by the Social Security Administration and is effective for each calendar year.

**BL 2018 Purpose**
HHSC pays the Social Security Administration a premium for coverage of inpatient hospital stays and other related services.

**BL 2019 Definition**
The average monthly premium paid for Medicare Part A coverage for Medicare eligible Medicaid clients. The Medicare Part A premium is set by the Social Security Administration and is effective for each calendar year. Medicare Part A is hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

**BL 2019 Data Limitations**
None.

**BL 2019 Data Source**
Social Security Act and report MF832 01.
BL 2019 Methodology
The average is calculated by taking the total estimated dollar value of claims projected to be incurred by clients and dividing this total by the number of projected recipient months to be incurred. The numerator will be the sum of full and reduced rate Part A dollars; the denominator will be the sum of full and reduced rate Part A recipient months. The Medicare Part A premium is set by the Social Security Administration and is effective for each calendar year.

BL 2019 Purpose
HHSC pays the Social Security Administration a premium for coverage of inpatient hospital stays and other related services.
Strategy-Related Measures Definitions
85th Regular Session, Agency Submission, Version 1
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<tr>
<td>Measure Type EF</td>
<td>Measure No. 3 Avg Qualified Medicare Beneficiaries (QMBs) Cost Per Recipient Month</td>
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**Calculation Method:** N
**Target Attainment:** L
**Priority:** H

Cross Reference: Agy 529 084-R-S70-1 02-02-05 EF 03

**Key Measure:** N
**New Measure:** N
**Percentage Measure:** N

**BL 2018 Definition**
This measure is the average monthly cost for the payment of Medicare deductible and coinsurance benefits for eligible Medicaid clients, Qualified Medicare Beneficiaries (QMBs).

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
The Premiums Payable System and monthly STMR650 provided by the Medicaid contractor.

**BL 2018 Methodology**
The calculation is made by taking the total yearly deductible and coinsurance payments paid and dividing this by the total monthly number of QMB recipient months for the year. Data is 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.

**BL 2018 Purpose**
This measure is the average monthly cost for the payment of deductible and coinsurance benefits for Medicare eligible Medicaid clients.

**BL 2019 Definition**
This measure is the average monthly cost for the payment of Medicare deductible and coinsurance benefits for eligible Medicaid clients, Qualified Medicare Beneficiaries (QMBs).

**BL 2019 Data Limitations**
None.

**BL 2019 Data Source**
The Premiums Payable System and monthly STMR650 provided by the Medicaid contractor.
BL 2019 Methodology
The calculation is made by taking the total yearly deductible and coinsurance payments paid and dividing this by the total monthly number of QMB recipient months for the year. Data is 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.

BL 2019 Purpose
This measure is the average monthly cost for the payment of deductible and coinsurance benefits for Medicare eligible Medicaid clients.
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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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<td>4</td>
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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

**Goal No. 1** Medicaid  
**Objective No. 4** Other Medicaid Services  
**Strategy No. 2** For Clients Dually Eligible for Medicare and Medicaid

**Measure Type:** OP  
**Measure No. 1** Average Part B Recipient Months Per Month

**Calculation Method:** N  
**Target Attainment:** H  
**Priority:** H  
Cross Reference: Agy 529 084-R-S70-1 02-02-05 OP 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

The average monthly number of recipient months of eligibility for which a premium payment is made for supplemental medical insurance benefits (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.

**BL 2018 Data Limitations**

This measure includes Qualified Medicare Beneficiary Qualifying Individuals (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.

**BL 2018 Data Source**

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

**BL 2018 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.

**BL 2018 Purpose**

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

**BL 2019 Definition**

The average monthly number of recipient months of eligibility for which a premium payment is made for supplemental medical insurance benefits (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.

**BL 2019 Data Limitations**
This measure includes Qualified Medicare Beneficiary Qualifying Individuals (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.

**BL 2019 Data Source**
Monthly MF 232-01 report, which provides the number of premiums for each month on an incurred basis.

**BL 2019 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.

**BL 2019 Purpose**
HHSC pays the Social Security Administration a premium for Medicare Part B coverage for Qualified Medicare Beneficiaries (QMB), which covers physician and other related services.
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Goal No. 1: Medicaid  
Objective No. 4: Other Medicaid Services  
Strategy No. 2: For Clients Dually Eligible for Medicare and Medicaid  
Measure Type: OP  
Measure No. 2: Average Part A Recipient Months Per Month

Calculation Method: N  
Target Attainment: H  
Priority: H  
Cross Reference: Agy 529 084-R-S70-1 02-02-05 OP 02

Key Measure: N  
New Measure: N  
Percentage Measure: N

**BL 2018 Definition**

The average monthly number of Medicare eligible recipients for which a Medicare Part A premium is paid. HHSC pays the Social Security Administration a premium for Part A coverage for Qualified Medicare Beneficiaries (QMB) and Medicaid Qualified Medicare Beneficiaries (MQMB). The premium covers hospitalizations and other related services.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

Monthly MF 832-01 report, which provides the number of premiums for each month on an incurred basis.

**BL 2018 Methodology**

The average is the sum of the monthly recipient months in the reporting period divided by the number of months summed. Part A full rate and reduced rate recipient months are included. Data are 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.

**BL 2018 Purpose**

HHSC pays the Social Security Administration a premium for Part A coverage for Qualified Medicare Beneficiaries (QMB) and Medicaid Qualified Medicare Beneficiaries (MQMB). The premium covers hospitalizations and other related services.

**BL 2019 Definition**

The average monthly number of Medicare eligible recipients for which a Medicare Part A premium is paid. HHSC pays the Social Security Administration a premium for Part A coverage for Qualified Medicare Beneficiaries (QMB) and Medicaid Qualified Medicare Beneficiaries (MQMB). The premium covers hospitalizations and other related services.

**BL 2019 Data Limitations**

None.

**BL 2019 Data Source**

Monthly MF 832-01 report, which provides the number of premiums for each month on an incurred basis.
BL 2019 Methodology
The average is the sum of the monthly recipient months in the reporting period divided by the number of months summed. Part A full rate and reduced rate recipient months are included. Data are 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.

BL 2019 Purpose
HHSC pays the Social Security Administration a premium for Part A coverage for Qualified Medicare Beneficiaries (QMB) and Medicaid Qualified Medicare Beneficiaries (MQMB). The premium covers hospitalizations and other related services.
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**Goal No. 1 Medicaid**  
**Objective No. 4 Other Medicaid Services**  
**Strategy No. 2 For Clients Dually Eligible for Medicare and Medicaid**  
**Measure Type OP**  
**Measure No. 3 Average QMBs Recipient Months Per Month**

**Calculation Method:** N  
**Target Attainment:** H  
**Priority:** H  
**Cross Reference:** Agy 529 084-R-S70-1 02-02-05 OP 03

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure is the average monthly number of Medicare eligible Medicaid clients who meet the criteria established by federal legislation.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

The Premiums Payable System.

**BL 2018 Methodology**

The quarterly average is the sum of the recipient months for the 3 months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months 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 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.

**BL 2018 Purpose**

HHSC is required to pay Medicare premiums, deductibles, and coinsurance liabilities for Qualified Medicare Beneficiaries whose income is at or below certain eligibility criteria. These clients are not eligible for other Title XIX services.

**BL 2018 Definition**

This measure is the average monthly number of Medicare eligible Medicaid clients who meet the criteria established by federal legislation.

**BL 2019 Data Limitations**

None.

**BL 2019 Data Source**

The Premiums Payable System.

**BL 2019 Methodology**
Strategy-Related Measures Definitions
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The quarterly average is the sum of the recipient months for the 3 months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months 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 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.

BL 2019 Purpose

HHSC is required to pay Medicare premiums, deductibles, and coinsurance liabilities for Qualified Medicare Beneficiaries whose income is at or below certain eligibility criteria. These clients are not eligible for other Title XIX services.
**Strategy-Related Measures Definitions**
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**Goal No. 3 Children's Health Insurance Program Services**

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<th>CHIP Services</th>
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<td>Measure Type</td>
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<td>Measure No.</td>
<td>1</td>
<td>Average CHIP Children Benefit Cost Per Recipient Month</td>
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**Calculation Method:** N  
**Target Attainment:** L  
**Priority:** H  
**Cross Reference:** Agy 529 084-R-S70-1 03-01-01 EF 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure is the average monthly cost per recipient month of health and dental premiums plus newborn screening and vaccine costs (excluding prescription drugs) for the Children’s Health Insurance Program (CHIP) II program for a reporting period.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
The Administrative Services Contractor furnishes a monthly report to HHSC containing the costs each health and dental plan have incurred during the month. For vaccine and newborn screening costs, HHSC receives a quarterly invoice from Department of State Health Services.

**BL 2018 Methodology**
The amounts owed to the health and dental 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 CHIP Perinatal costs or recipient months.

**BL 2018 Purpose**
The measure provides the average monthly benefit cost paid to CHIP enrolled medical (including immunizations and excluding prescription drugs) and dental plan providers on behalf of CHIP federally funded clients.

**BL 2019 Definition**

This measure is the average monthly cost per recipient month of health and dental premiums plus newborn screening and vaccine costs (excluding prescription drugs) for the Children’s Health Insurance Program (CHIP) II program for a reporting period.

**BL 2019 Data Limitations**
None.

**BL 2019 Data Source**
The Administrative Services Contractor furnishes a monthly report to HHSC containing the costs each health and dental plan have incurred during the month. For vaccine and newborn screening costs, HHSC receives a quarterly invoice from Department of State Health Services.
**BL 2019 Methodology**

The amounts owed to the health and dental 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 CHIP Perinatal costs or recipient months.

**BL 2019 Purpose**

The measure provides the average monthly benefit cost paid to CHIP enrolled medical (including immunizations and excluding prescription drugs) and dental plan providers on behalf of CHIP federally funded clients.
### BL 2018 Definition

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

### BL 2018 Data Limitations

None.

### BL 2018 Data Source

Data are obtained from the Administrative Services Contractor. The contractor produces monthly enrollment reports showing cumulative enrollment.

### BL 2018 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.

### BL 2018 Purpose

Measures the average number of Traditional CHIP recipient months.

### BL 2019 Definition

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

### BL 2019 Data Limitations

None.

### BL 2019 Data Source

Data are obtained from the Administrative Services Contractor. The contractor produces monthly enrollment reports showing cumulative enrollment.

### BL 2019 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.
BL 2019 Purpose

Measures the average number of Traditional CHIP recipient months.
Strategy-Related Measures Definitions
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 3 Children's Health Insurance Program Services
Objective No. 1 CHIP Services
Strategy No. 2 CHIP Perinatal Services
Measure Type EF
Measure No. 1 Average Perinatal Benefit Cost Per Recipient Month

Calculation Method: N  Target Attainment: L  Priority: L
Cross Reference: Agy 529 084-R-S70-1 03-01-02 EF 01

BL 2018 Definition
This measure is the average monthly cost of health premiums (excluding prescription drugs) for the Children’s Health Insurance Program (CHIP) Perinatal program for a reporting period.

BL 2018 Data Limitations
Data is on an incurred basis. If data is incomplete, estimates will be made based on completion ratios and other forecasting techniques.

BL 2018 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 Department of State Health Services.

BL 2018 Methodology
The amounts owed to the health carriers are totaled for the reporting period. 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, re determinations, 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.

BL 2018 Purpose
Captures the average cost of CHIP Perinatal recipients per month, excluding drug costs.

BL 2019 Definition
This measure is the average monthly cost of health premiums (excluding prescription drugs) for the Children’s Health Insurance Program (CHIP) Perinatal program for a reporting period.

BL 2019 Data Limitations
Data is on an incurred basis. If data is incomplete, estimates will be made based on completion ratios and other forecasting techniques.

BL 2019 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 Department of State Health Services.
BL 2019 Methodology
The amounts owed to the health carriers are totaled for the reporting period. 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, re determinations, 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.

BL 2019 Purpose
Captures the average cost of CHIP Perinatal recipients per month, excluding drug costs.
### BL 2018 Definition

This measure is the average monthly number of children enrolled in coverage under the Children’s Health Insurance Program (CHIP) Perinatal program for a reporting period.

### BL 2018 Data Limitations

None.

### BL 2018 Data Source

Data are obtained through the enrollment vendor who provides monthly enrollment reports showing cumulative enrollment.

### BL 2018 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, re determinations, 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.

### BL 2018 Purpose

Captures the average number of CHIP Perinatal recipients month.

### BL 2019 Definition

This measure is the average monthly number of children enrolled in coverage under the Children’s Health Insurance Program (CHIP) Perinatal program for a reporting period.

### BL 2019 Data Limitations

None.

### BL 2019 Data Source

Data are obtained through the enrollment vendor who provides monthly enrollment reports showing cumulative enrollment.
BL 2019 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, re determinations, 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.

BL 2019 Purpose
Captures the average number of CHIP Perinatal recipients month.
Strategy-Related Measures Definitions
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 3 Children's Health Insurance Program Services
Objective No. 1 CHIP Services
Strategy No. 3 CHIP PRESCRIPTION DRUGS
Measure Type EF
Measure No. 1 Average Cost/CHIP Recipient Month: Pharmacy Benefit

Calculation Method: N Target Attainment: L Priority: H
Key Measure: Y New Measure: N Percentage Measure: N
Cross Reference: Agy 529 084-R-S70-1 03-01-03 EF 01

**BL 2018 Definition**
This measure is the total Children’s Health Insurance Program (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.

**BL 2018 Data Limitations**
The CHIP prescription dollars do not include any rebates.

**BL 2018 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.

**BL 2018 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, re determinations, 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.

**BL 2018 Purpose**
The measure captures the total CHIP prescription cost incurred divided by the total number of CHIP recipient months.

**BL 2019 Definition**
This measure is the total Children’s Health Insurance Program (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.

**BL 2019 Data Limitations**
The CHIP prescription dollars do not include any rebates.

**BL 2019 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.
BL 2019 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, re determinations, 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.

BL 2019 Purpose
The measure captures the total CHIP prescription cost incurred divided by the total number of CHIP recipient months.
BL 2018 Definition
This measure is the average monthly cost per recipient month of dental premiums for the Children’s Health Insurance Program (CHIP) II program for a reporting period.

BL 2018 Data Limitations
None.

BL 2018 Data Source
The Administrative Services Contractor furnishes a monthly report to HHSC containing the costs each dental plan has incurred during the month.

BL 2018 Methodology
The amounts owed to the dental 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 CHIP Perinatal costs or recipient months.

BL 2018 Purpose
The measure provides the average monthly benefit cost paid to CHIP enrolled dental plan providers on behalf of CHIP federally funded clients.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 4  
Objective No. 1  
Strategy No. 1  
Measure Type EF  
Measure No. 1  

**Low Monthly Cost Per Healthy Texas Women Client**

**Calculation Method:** N  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 529 084-R-S70-1 04-02-03 EF 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure reports the average monthly number of recipient months for recipients who receive services in the Healthy Texas Women Program as of November 1, 2012, when the state-based program took effect.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

The Premium Payable System.

**BL 2018 Methodology**

A recipient month is defined as one month's coverage for an individual who has been determined as eligible for HTW. 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, and 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. The quarterly average is the sum of the recipient months for the three months in the specified quarter by 3. The year to date average is the sum of the monthly recipient months to date divided by the number of months summed.

**BL 2018 Purpose**

This measure reflects the average number of recipient months per month for which a claim or premium is paid for clients in the HTW.
### Strategy-Related Measures Definitions

**Automated Budget and Evaluation System of Texas (ABEST)**

#### 85th Regular Session, Agency Submission, Version 1

**Health and Human Services Commission**

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#### Calculation Method: N

#### Target Attainment: L

#### Priority: L

#### Cross Reference:

#### Key Measure: Y

#### New Measure: Y

#### Percentage Measure: N

### BL 2018 Definition

This measure reports the average monthly cost of providing family planning services to eligible clients with HHSC family planning funds.

### BL 2018 Data Limitations

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

### BL 2018 Data Source

Client data are from the TMHP Vision 21 Data Warehouse Ad Hoc Query Platform (AHQP) Claims Universe. Expenditures data are from the Health and Human Services Contract Administration and Tracking System.

### BL 2018 Methodology

The average annual cost is total funds expended for family planning contracts divided by the unduplicated number of clients receiving family planning services from contracting and/or enrolled entities.

### BL 2018 Purpose

This measure reports the average monthly cost of providing family planning services for eligible clients with HHSC family planning funds.
**Strategy-Related Measures Definitions**
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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### Agency Code: 529
**Agency:** Health and Human Services Commission

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**Goal No. 4 Provide Additional Health-related Services**

**Objective No. 1 Provide Primary Health and Specialty Care**

**Strategy No. 1 Women's Health Program**

---

**Measure Type:** EX

**Measure No.:** # of Certified Clinical Providers Enrolled in Healthy Texas Women Pgm

---

**Calculation Method:** N

**Target Attainment:** L

**Priority:** M

**Cross Reference:**

**Key Measure:** Y

**New Measure:** Y

**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the number of certified clinical providers enrolled and eligible to provide Healthy Texas Woman (HTW) services to HTW clients.

**BL 2018 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.

**BL 2018 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).

**BL 2018 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.

**BL 2018 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.
### BL 2018 Definition

This measure reports the number of certified providers enrolled and eligible to provide Family Planning (FP) services to FP clients.

### BL 2018 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.

### BL 2018 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).

### BL 2018 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.

### BL 2018 Purpose

This measure can be used to determine the number of certified clinical providers who can treat FP clients and to determine multi-year trends in provider enrollment.
Strategy-Related Measures Definitions
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agenda Code: 529  Agency: Health and Human Services Commission

Goal No. 4  Provide Additional Health-related Services
Objective No. 1  Provide Primary Health and Specialty Care
Strategy No. 1  Women's Health Program
Measure Type EX
Measure No. 3  Percent of Women Receiving Contraceptive Services Who Receive a LARC

Calculation Method: N  Target Attainment: L  Priority: L  Cross Reference:
Key Measure: Y  New Measure: Y  Percentage Measure: Y

BL 2018 Definition
This measure reports the number of clients in the HTW program that received a new or replacement long acting removable contraceptive method in the given timeframe.

BL 2018 Data Limitations
Data only reports on clients with certified HTW providers that provide an annual women's health examination and prescribe family planning drugs and/or devices.

BL 2018 Data Source
Client data is derived from a combination of service dates, related procedure (CPT) codes for the device and insertion/reinsertion procedures, and the associated National Drug Code (NDC).

BL 2018 Methodology
This is the unduplicated number of clients receiving services as reported by certified HTW providers.

BL 2018 Purpose
This measure is a mechanism for tracking the number of HTW clients that received either a new or replacement LARC. It also highlights recent trends in prescriptions, and would be sensitive to providers' efforts to recommend LARCs to new clients or existing clients seeking to switch methods.
**Agency Code:**  529  
**Agency:**  Health and Human Services Commission

**Goal No.**  4  
Provide Additional Health-related Services

**Objective No.**  1  
Provide Primary Health and Specialty Care

**Strategy No.**  1  
Women's Health Program

**Measure Type**  OP

**Measure No.**  1  
Avg Monthly # Women Receiving Services through Healthy Texas Women

**Calculation Method:**  C  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 529 084-R-S70-1 04-02-03 OP 01

**Key Measure:**  Y  
**New Measure:**  N  
**Percentage Measure:**  N

**BL 2018 Definition**
This measure reports the average monthly number of recipient months for recipients who receive services in the Healthy Texas Women Program as of November 1, 2012, when the state-based program took effect.

**BL 2018 Data Limitations**
None

**BL 2018 Data Source**
The Premium Payable System.

**BL 2018 Methodology**
A recipient month is defined as one month's coverage for an individual who has been determined as eligible for HTW. 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. The quarterly average is the sum of the recipient months for the three months in the specified quarter by 3. The year to date average is the sum of the monthly recipient months to date divided by the number of months summed.

**BL 2018 Purpose**
This measure reflects the average monthly number of recipient months per month for which a claim or premium is paid for clients in the HTW.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 4  Provide Additional Health-related Services
Objective No. 1  Provide Primary Health and Specialty Care
Strategy No. 1  Women's Health Program
Measure Type: OP
Measure No. 2  Avg Mo # of Adults Receiving Services through Family Planning

**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 529 084-R-S70-1 04-02-03 OP 02

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 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.

**BL 2018 Data Limitations**
Complete data may not be available for the reporting period at the time the report is due.

**BL 2018 Data Source**
Client data is from the Texas Medicaid Health Partnership Vision 21 Data Warehouse Ad Hoc Query Platform (AHQP) Claims Universe.

**BL 2018 Methodology**
The total number of persons receiving family planning services is the unduplicated count of individuals whose claims were paid for with HHSC Family Planning funds.

**BL 2018 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.
Goal No. 4 Provide Additional Health-related Services
Objective No. 1 Provide Primary Health and Specialty Care
Strategy No. 1 Women's Health Program
Measure Type OP
Measure No. 3 Number of Infants <1 and Children Age 1-21 Years Provided Services

Calculation Method: C  Target Attainment:  Priority:  Cross Reference: Agy 537 084-R-S70-1 02-01-02 OP 02
Key Measure: Y  New Measure: N  Percentage Measure: N

**BL 2018 Definition**
This measure reports the unduplicated number of infants <1 and children (ages 1 through 21) receiving dental and child health services, such as prenatal, dysplasia, genetics, newborn hearing and metabolic screenings, vision and hearing screening, spinal screening through contracting agencies, and the HHSC Oral Health Program funded with Title V and/or related general revenue.

**BL 2018 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.

**BL 2018 Data Source**
System report 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.

**BL 2018 Methodology**
Reported data is calculated by adding the number of clients reported for the contracting agencies and the HHSC Oral Health Program.

**BL 2018 Purpose**
This measure reports the unduplicated number of infants <1 and children (ages 1 through 21) receiving dental and child health services, such as prenatal, dysplasia, genetics, newborn hearing and metabolic screenings, vision and hearing screening, and spinal screening through contracting agencies and the HHSC Oral Health Program funded with Title V and/or related general revenue.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
### BL 2018 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.

### BL 2018 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.

### BL 2018 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.

### BL 2018 Methodology

Reported data is calculated by adding the number of clients from reports for the contracting agencies.

### BL 2018 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.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology

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<td>Measure No.</td>
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- **Calculation Method:** C
- **Target Attainment:**
- **Priority:**
- **Cross Reference:** Agy 537 084-R-S70-1 02-01-02 OP 03
- **Key Measure:** Y
- **New Measure:** N
- **Percentage Measure:** N
BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 4  
Objective No. 1  
Strategy No. 2  
Measure Type OP  
Measure No. 1

Goal: Provide Additional Health-related Services  
Objective: Provide Primary Health and Specialty Care  
Measure Type: OP  
Measure No.: Number of Persons Receiving Services as Alternative to Abortion

Calculation Method: C  
Target Attainment:  
Priority:  
Cross Reference: Agy 529 084-R-S70-1 04-02-02 OP 01

Key Measure: Y  
New Measure: N  
Percentage Measure: N

BL 2018 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.).

BL 2018 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 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.

BL 2018 Data Source
The data source is the Alternatives to Abortion contractor's data collection system.

BL 2018 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.

BL 2018 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.).

BL 2019 Definition

BL 2019 Data Limitations
Strategy-Related Measures Definitions
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
### Strategy-Related Measures Definitions

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<td>Priority:</td>
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**BL 2018 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.).

**BL 2018 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.

**BL 2018 Data Source**

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

**BL 2018 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.

**BL 2018 Purpose**

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

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
**Strategy-Related Measures Definitions**
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

**Agency Code:** 529  
**Agency:** Health and Human Services Commission

**Goal No.** 4  
Provide Additional Health-related Services

**Objective No.** 1  
Provide Primary Health and Specialty Care

**Strategy No.** 3  
Early Childhood Intervention Services

**Measure Type** EF

**Measure No.** 1  
Average Monthly Cost Per Child: Comprehensive Services/State & Federal

---

**BL 2018 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.

**BL 2018 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.

**BL 2018 Data Source**
The Health and Human Services Accounting System (HHSAS), which is reconciled to Uniform Statewide Accounting System (USAS). Quarterly and annual financial reports, financial report items: State and Federal funds, expended by quarter for ECI services. TKIDS: number served in comprehensive services.

**BL 2018 Methodology**
HHSC appropriation authority includes all general revenue and federal funds allocated to the HHSC ECI services strategy. 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 ECI services. The denominator is the average monthly number of comprehensive children served in ECI services. The formula is numerator/denominator.

**BL 2018 Purpose**
This measure provides information regarding the HHSC ECI appropriated expenditures for providing comprehensive services to eligible children. This data can be used for projecting future expenditures and evaluating performance.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**
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**Agency:** Health and Human Services Commission

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**Goal No. 4 Provide Additional Health-related Services**

**Objective No. 1 Provide Primary Health and Specialty Care**

**Strategy No. 3 Early Childhood Intervention Services**

**Measure Type EF**

**Measure No. 2 Average Monthly Cost Per Child: Comprehensive Services/Local**

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 538 084-R-S70-1 01-01-01 EF 02

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

A monthly average of local funds collected and expended for comprehensive services divided by the monthly average of children receiving comprehensive services in the reporting period. Local funds include all revenue expended by ECI providers for comprehensive services other than the State and Federal funds described in the efficiency measure for Comprehensive Services/State and Federal funds. Local funds include the Medicaid Therapy funds (state and federal) residing at HHSC.

**BL 2018 Data Limitations**

The accuracy of local funds expended for ECI services is periodically verified through monitoring and reviews of annual audits. Local funds expenditure data may not be complete as provider quarterly and annual reports are not submitted until 30 days after the end of each quarter.

**BL 2018 Data Source**

Quarterly and annual financial reports, financial report items: funding sources that comprise local funds expended for ECI services. TKIDS: number served in comprehensive services.

**BL 2018 Methodology**

HHSC appropriation authority includes all local funds allocated to the ECI Services. 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 local funds utilized to fund the ECI Services program. The denominator is the average monthly number of comprehensive children served in ECI services. The formula is numerator/denominator.

**BL 2018 Purpose**

This measure is important because it provides the agency with information regarding the cost of providing comprehensive services to eligible children from sources other than ECI. This data can be used for projecting future expenditures and comparing local costs and performance.

---

**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 4  Provide Additional Health-related Services
Objective No. 1  Provide Primary Health and Specialty Care
Strategy No. 3  Early Childhood Intervention Services
Measure Type EX
Measure No. 1  Average Monthly Number of Hrs of Service Delivered Per Child Per Month

Calculation Method: N  Target Attainment:  
Priority:  
Cross Reference: Agy 538 084-R-S70-1 01-01-01 EX 01

Key Measure: Y  New Measure: N  Percentage Measure: N

**BL 2018 Definition**

The number of hours of service delivered per child per month for children in ECI comprehensive services.

**BL 2018 Data Limitations**

The accuracy of the data is dependent on accurate and timely information being entered into the Texas Kids Intervention Data System (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.

**BL 2018 Data Source**

Local providers enter data into the Texas Kids Intervention Data System (TKIDS). Delivered services are those provided to the child/family according to each child's Individualized Family Service Plan (IFSP). The number of children receiving comprehensive services is determined by the cases in the enrolled disposition at any time in the reporting period.

**BL 2018 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.

**BL 2018 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Goal No. 4 Provide Additional Health-related Services
Objective No. 1 Provide Primary Health and Specialty Care
Strategy No. 3 Early Childhood Intervention Services
Measure Type OP
Measure No. 1 Average Monthly Number of Referrals to Local Programs

BL 2018 Definition
The number of children who received comprehensive intervention services through ECI service providers expressed as a percentage of the total number of Texas children under three years of age.

BL 2018 Data Limitations
The accuracy of the data is dependent on accurate and timely information being entered into the Texas Kids Intervention Data System (TKIDS) by local contractors. The accuracy of local reporting is periodically verified through monitoring.

BL 2018 Data Source
Local contract providers enter data into the Texas Kids Intervention Data System (TKIDS). Determine the total number of unduplicated monthly referrals, as identified by cases that entered the referral disposition in the reporting period.

BL 2018 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.

BL 2018 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.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
Strategy-Related Measures Definitions
85th Regular Session, Agency Submission, Version 1
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Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 4 Provide Additional Health-related Services
Objective No. 1 Provide Primary Health and Specialty Care
Strategy No. 3 Early Childhood Intervention Services
Measure Type OP
Measure No. 2 Percent Of Children Determined Eligible For ECI Services

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference:

Key Measure: Y  
New Measure: Y  
Percentage Measure: Y

BL 2018 Definition
A monthly average of children who receive eligibility determination services (unduplicated by month) in ECI programs.

BL 2018 Data Limitations
The accuracy of the data is dependent on accurate and timely information being entered into the Texas Kids Intervention Data System (TKIDS) by local contractors. The accuracy of local reporting is periodically verified through monitoring.

BL 2018 Data Source
Local contract providers enter data into the Texas Kids Intervention Data System (TKIDS). Determine the total number of unduplicated children receiving eligibility determination services monthly, as indicated by cases that entered the eligibility determination disposition in the reporting period or received a screening prior to the start of the eligibility determination disposition.

BL 2018 Methodology
The unduplicated number of children receiving eligibility determination services is summed for each month of the reporting period, and the total is divided by the number of months in the reporting period.

BL 2018 Purpose
This measure is important because it informs the agency of the level of effort directed toward identifying children, determining eligibility and establishing a plan for services.
### Strategy-Related Measures Definitions

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Automated Budget and Evaluation System of Texas (ABEST)

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<td>Measure No.</td>
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<td>Number of Monitoring Visits Conducted</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 538 084-R-S70-1 01-01-01 OP 04

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

The number of on-site monitoring trips conducted to determine fiscal and/or program compliance.

**BL 2018 Data Limitations**

This measure does not include in-house monitoring activities.

**BL 2018 Data Source**

Entries are recorded in the ECI Monitoring Trip Log, which is a log of fiscal and/or programmatic monitoring visits conducted by agency staff.

**BL 2018 Methodology**

Sum the log entries for fiscal and/or programmatic monitoring trips completed during the reporting period.

**BL 2018 Purpose**

This measure is important because it describes the level of agency activity directed toward maintaining quality services and compliance with Federal and State laws, rules, and policies as measured by the number of on-site monitoring trips.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
BL 2018 Definition
A monthly average of children who receive comprehensive intervention services (unduplicated by month) in ECI programs.

BL 2018 Data Limitations
The accuracy of the data is dependent on accurate and timely information being entered into the Texas Kids Intervention Data System (TKIDS) by local contractors. The accuracy of local reporting is periodically verified through monitoring.

BL 2018 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.

BL 2018 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.

BL 2018 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.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
### Agency Code: 529  |  Agency: Health and Human Services Commission

| Goal No. | 4 | Provide Additional Health-related Services |
| Objective No. | 1 | Provide Primary Health and Specialty Care |
| Strategy No. | 4 | Ensure ECI Respite Services & Quality ECI Services |
| Measure Type | EF | |
| Measure No. | 1 | Average Time for Complaint Resolution |

**Calculation Method:** N  |  **Target Attainment:** |  **Priority:**  |  **Cross Reference:** Agy 538 084-R-S70-1 01-01-03 EF 01

| Key Measure: N | New Measure: N | Percentage Measure: N |

**BL 2018 Definition**

The number of calendar days per complaint resolved, summed for all complaints resolved, that elapsed from receipt of a request for agency investigation to the date upon which final action on the complaint was taken by the agency, divided by the number of complaints resolved. The calculation excludes complaints determined to be not under the jurisdiction of the agency's statutory authority.

**BL 2018 Data Limitations**

This measure applies only to jurisdictional complaints.

**BL 2018 Data Source**

Entries are made in the ECI Complaint Log. The ECI Complaint Log is a list, by fiscal year, of complaints filed against the agency or its local providers, and the date of final disposition. Issuance of a letter of findings or documentation of complaint withdrawal is considered final disposition and resolution.

**BL 2018 Methodology**

The number of days required for the final disposition of a complaint is determined by the number of calendar days from the date the written complaint was received by the ECI state office staff to the date of the complaint's final disposition. Final disposition is determined by the date of the findings letter or letter verifying complaint withdrawal.

**BL 2018 Purpose**

This measure is important because it provides the agency with information regarding the time state staff spend investigating formal complaints in order to evaluate the efficiency of the process and the agency's compliance with federal statute.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Strategy-Related Measures Definitions
85th Regular Session, Agency Submission, Version 1
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<tr>
<td>Measure No.</td>
<td>1</td>
<td>Average Monthly Number of Children Receiving Respite Services</td>
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BL 2018 Definition
A monthly average of children (and their families) who receive respite services in ECI programs.

BL 2018 Data Limitations
The accuracy of the data is dependent upon the accurate and timely submission of respite reports by local contractors. Counts cannot be unduplicated across contractors because the State does not collect this data at the client-level.

BL 2018 Data Source
Local contract providers submit Respite Reports at the end of each quarter. These reports include an item that identifies the number of children receiving respite each month in the quarter.

BL 2018 Methodology
The number of children receiving respite is summed for each month of the reporting period, and the total is divided by the number of months in the reporting period.

BL 2018 Purpose
Some families of children with developmental delays and disabilities need respite. Monitoring the level of respite services provided to ECI families is important to project future service needs and fiscal needs.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

Cross Reference: Agy 538 084-R-S70-1 01-01-02 OP 01
BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 4  Provide Additional Health-related Services
Objective No. 1  Provide Primary Health and Specialty Care
Strategy No. 5  Children's Blindness Services
Measure Type EF
Measure No. 1  Average Monthly Cost Per Child: Children's Blindness Services

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 538 084-R-S70-1 01-02-01 EF 01

Key Measure: Y  
New Measure: N  
Percentage Measure: N

BL 2018 Definition
Measures the average monthly cost per consumer served in the Blind Children's Vocational Discovery and Development Program (BCVDDP).

BL 2018 Data Limitations
None.

BL 2018 Data Source
The data sources are the program related expenditures and encumbrances during the reporting period from the HHSC Accounting System (HHSAS and the DBS 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”).

BL 2018 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”).

BL 2018 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.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
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<td>Key Measure:</td>
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#### BL 2018 Definition

Measures the unduplicated number of consumers served for the fiscal year in the DBS 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.

#### BL 2018 Data Limitations

The number of consumers served in a given reporting period is affected by consumers that are carried over from the previous fiscal year as well as the uneven flow of consumers entering and exiting the program during the reporting period.

#### BL 2018 Data Source

Data is from the DBS automated consumer statistical system. Field staff who work with consumers collect, input, and update consumer data in this system.

#### BL 2018 Methodology

Data is from the DBS automated consumer statistical system. Field staff who work with consumers collect, input, and update consumer data in this system.

#### BL 2018 Purpose

DBS establishes a projection for the population in need of services that can reasonably be served within available resources. This measure tracks and demonstrates progress toward meeting that projected target.

#### BL 2019 Definition

#### BL 2019 Data Limitations

#### BL 2019 Data Source

#### BL 2019 Methodology
### Strategy-Related Measures Definitions

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<td>Measure No.</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**

*Cross Reference: Agy 538 084-R-S70-1 01-02-01 OP 01*

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

### BL 2018 Definition

Measures the average number of consumer cases in the DBS 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.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

Data is from the DBS automated consumer statistical system. Field staff who work with consumers collect, input, and update consumer data in this system.

**BL 2018 Methodology**

The DBS 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 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.

**BL 2018 Purpose**

The DBS 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 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
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**Goal No. 4 Provide Additional Health-related Services**  
**Objective No. 1 Provide Primary Health and Specialty Care**  
**Strategy No. 6 Autism Program**  
**Measure Type EF**  
**Measure No. 1 Average Monthly Cost Per Child Receiving Focused Autism Services**

**Calculation Method:** N  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 538 084-R-S70-1 01-03-01 EF 02

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

A monthly average of state funds expended for services divided by the average monthly number of children receiving focused autism services in the reporting period.

**BL 2018 Data Limitations**

Data reliability is dependent on the accuracy of information submitted to HHSC by the autism grantees.

**BL 2018 Data Source**

Data sources for this measure are 1) HHSAS Financial data and invoices, and 2) Consumer Data Report.

**BL 2018 Methodology**

HHSC appropriation authority includes all general revenue funds allocated to the Autism Program strategy. 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 focused autism services in the autism program for the reporting period. The denominator is the unduplicated number of children receiving focused autism services for the reporting period. The formula is numerator/denominator/number of months in the reporting period.

**BL 2018 Purpose**

This measure allows HHSC to monitor grant funds expended and to ensure costs are in line with monthly projections.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
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<td>Measure No.</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 538 084-R-S70-1 01-03-01 EX 02

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**  
Measures the unduplicated number of children served with focused services for the fiscal year by the HHSC Autism Program.

**BL 2018 Data Limitations**  
Data reliability is dependent on the accuracy of information submitted to HHSC by autism grantees.

**BL 2018 Data Source**  
Data source for this measure is: Consumer Data Report.

**BL 2018 Methodology**  
Sum of unduplicated children served with focused autism services for the fiscal year.

**BL 2018 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.

**BL 2019 Definition**  

**BL 2019 Data Limitations**  

**BL 2019 Data Source**  

**BL 2019 Methodology**  

**BL 2019 Purpose**
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#### Calculation Method: N

**Target Attainment:** Cross Reference: Agy 538 084-R-S70-1 01-03-01 OP 02

**Key Measure:** Y

**New Measure:** N

**Percentage Measure:** N

#### BL 2018 Definition

A monthly average of unduplicated children who are receiving or who have received focused autism services in the HHSC Autism Program.

#### BL 2018 Data Limitations

Data reliability is dependent on the accuracy of information submitted to HHSC by autism grantees.

#### BL 2018 Data Source

Data source for this measure is the Consumer Data Report.

#### BL 2018 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.

#### BL 2018 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.

#### BL 2019 Definition

#### BL 2019 Data Limitations

#### BL 2019 Data Source

#### BL 2019 Methodology

#### BL 2019 Purpose
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<td>Strategy No.</td>
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<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  

**Cross Reference:** Agy 537 084-R-S70-1 01-03-05 EF 02  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**  
This measure reports the average paid for eligible Children with Special Health Care Needs (CSHCN) Services Program clients receiving health care benefits. For purposes of this measure, health care benefits as defined in rule include medical services, enabling services (excluding transportation), and family support services.

**BL 2018 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.

**BL 2018 Data Source**  
The average monthly cost per client receiving health care benefits is obtained from the program’s automated data system.

**BL 2018 Methodology**  
The average monthly cost per CSHCN Services Program client is calculated by dividing the amount paid for receiving health care benefits by the number of CSHCN Services Program clients who received health care benefits and averaging across the reporting period. Estimates may be included based on the data available.

**BL 2018 Purpose**  
This measure is used to monitor trends in the cost of care for the clients receiving health care benefits reimbursed by the CSHCN Services Program and reflects the program's ability to meet some of the needs of clients.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Goal No. 4 Provide Additional Health-related Services
Objective No. 1 Provide Primary Health and Specialty Care
Strategy No. 7 Children with Special Health Care Needs
Measure Type EX
Measure No. 1 # of Clients Removed from Waiting List & Provided Health Care Benefits

**BL 2018 Definition**
This measure captures the unduplicated workload count of clients (adults and children) removed from the Children with Special Health Care Needs (CSHCN) Services Program waiting list and made eligible to receive health care benefits in accordance with CSHCN Services Program Rules §38.16 AND who had health care benefits claims for a paid dollar amount for dates of service during the fiscal year being reported. For purposes of this measure, health care benefits as defined in rule include medical services, enabling services (excluding transportation), and family supports services.

**BL 2018 Data Limitations**
The paid claims data is reported based on 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. 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.

**BL 2018 Data Source**
The unduplicated workload count of clients (adults and children) removed from the waiting list who receive health care benefits services is obtained from the program’s automated system.

**BL 2018 Methodology**
The measure is calculated by identifying the unduplicated workload count of clients (adults and children) who have been removed from the waiting list, based on the definition above, and by summing the number of those who have paid claims for health care benefits.

**BL 2018 Purpose**
This measure is used to monitor the number of unduplicated workload count of clients (adults and children) removed from the waiting list who receive health care benefits reimbursed by the CSHCN Services Program.
BL 2019 Methodology

BL 2019 Purpose
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#### BL 2018 Definition

This measure reports the average monthly caseload of clients in the Children with Special Health Care Needs (CSHCN) Services Program who receive health care benefits paid by the program. For purposes of this measure, health care benefits, as defined in rule, include medical services, enabling services, (excluding transportation), and family support services.

#### BL 2018 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.

#### BL 2018 Data Source

The average monthly caseload of clients receiving health care benefits is obtained from the program’s automated data system.

#### BL 2018 Methodology

This measure is calculated by summing the number of clients with paid claims for health care benefits in a month and averaging such across the reporting period. Estimates may be used for quarters in which claims data is incomplete.

#### BL 2018 Purpose

This measure is used to monitor trends in the cost of care for clients receiving health care benefits reimbursed by the CSHCN Services Program and reflects the program's ability to meet some of the needs of clients.

#### BL 2019 Definition

#### BL 2019 Data Limitations

#### BL 2019 Data Source

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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 537 084-R-S70-1 01-03-05 OP 02  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N
BL 2019 Methodology

BL 2019 Purpose
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Agency Code: 529  
Agency: Health and Human Services Commission

Goal No.  4  Provide Additional Health-related Services
Objective No.  1  Provide Primary Health and Specialty Care
Strategy No.  9  Kidney Health Care
Measure Type  EF
Measure No.  1  Average Cost Per Chronic Disease Service - Kidney Health Care

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 537 084-R-S70-1 01-03-04 EF 01

Key Measure: N  
New Measure: N  
Percentage Measure: N

BL 2018 Definition
This measure includes Kidney Health Care (KHC) 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 KHC client per fiscal year.

BL 2018 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.

BL 2018 Data Source
Data are derived from the KHC claims processing and budget reporting systems.

BL 2018 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.

BL 2018 Purpose
To measure the average amount paid per KHC client per fiscal year.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
### Agency Code: 529

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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 537 084-R-S70-1 01-03-04 OP 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

### BL 2018 Definition

The measure is the total number of unduplicated clients for whom Kidney Health Care (KHC) made payment or reimbursed for chronic disease services received during the fiscal year. This includes medical, drugs and transportation services and payment of Medicare Part D premiums.

### BL 2018 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.

### BL 2018 Data Source

Data are derived from KHC claims processing and budget reporting systems.

### BL 2018 Methodology

The measure is the total number of unduplicated clients for whom KHC made payment or reimbursed for chronic disease services received during the fiscal year. Data are non-cumulative, and the reported values will be updated on a quarterly basis.

### BL 2018 Purpose

The measure is the total number of unduplicated clients for whom KHC made payment or reimbursed for services received during the fiscal year.
BL 2019 Purpose
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<td>Number of Epilepsy Program Clients Provided Services</td>
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</table>

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 537 084-R-S70-1 01-03-06 EX 01

**BL 2018 Definition**
Number of epilepsy program clients provided outreach activities, case management, and (direct) medical services by HHSC funded contractors.

**BL 2018 Data Limitations**
None

**BL 2018 Data Source**
Information is obtained from the Epilepsy Contractor Quarterly Reports.

**BL 2018 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.

**BL 2018 Purpose**
Measures the number of epilepsy program clients provided services which include outreach activities, case management, and (direct) medical services.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529  
Agency: Health and Human Services Commission  

Goal No. 4  Provide Additional Health-related Services  
Objective No. 1  Provide Primary Health and Specialty Care  
Strategy No. 10  Additional Specialty Care  
Measure Type EX  
Measure No. 2  Number of Hemophilia Assistance Program Clients  

Calculation Method: N  
Target Attainment: N  
Priority: N  

Cross Reference: Agy 537 084-R-S70-1 01-03-07 EX 01  

BL 2018 Definition  
Number of Hemophilia Assistance Program (HAP) clients that receive financial assistance for blood factor products through HHSC approved providers.  

BL 2018 Data Limitations  
None.  

BL 2018 Data Source  
HAP history files.  

BL 2018 Methodology  
The measure is the total number of unduplicated clients for whom the HAP made payment for services received during the fiscal year.  

BL 2018 Purpose  
Measures the number of HAP clients that receive financial assistance for blood factor products through HHSC approved providers.  

BL 2019 Definition  

BL 2019 Data Limitations  

BL 2019 Data Source  

BL 2019 Methodology  

BL 2019 Purpose
Strategy-Related Measures Definitions
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Agency Code: 529  Agency: Health and Human Services Commission

Goal No. 4 Provide Additional Health-related Services
Objective No. 1 Provide Primary Health and Specialty Care
Strategy No. 11 Community Primary Care Services
Measure Type EF
Measure No. 1 Average Cost Per Primary Health Care Eligible Patient

Calculation Method: N  Target Attainment: N  Priority: N  Cross Reference: Agy 537 084-R-S70-1 02-01-04 EF 01
Key Measure: N  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measure reports the average cost per Primary Health Care eligible patient provided access to primary care services. The cost includes service and administrative dollars spent by contractors.

BL 2018 Data Limitations
Complete data may not be available for the reporting period at the time the report is due.

BL 2018 Data Source
The sources for this measure are the contractor monthly and annual reports. Fee-for-service client data are from the TMHP Vision 21 Data Warehouse Ad Hoc Query Platform (AHQP) Claims Universe. Expenditure data is from the Health and Human Services Contract Administration and Tracking System.

BL 2018 Methodology
Average cost per Primary Health Care eligible patient provided access to primary care services per year is calculated by dividing the unduplicated number of patients who are screened and found eligible for services into the available contract funding for the fiscal year.

BL 2018 Purpose
Measures average cost per Primary Health Care eligible patients provided access to primary care services per year.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
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<td>Provide Additional Health-related Services</td>
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<tr>
<td>Objective No.</td>
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<td>Provide Primary Health and Specialty Care</td>
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<tr>
<td>Strategy No.</td>
<td>11</td>
<td>Community Primary Care Services</td>
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<tr>
<td>Measure Type</td>
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<td># of Primary Hlth Care Eligible Patients Provided Primary Care Svcs</td>
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**Calculation Method:** C  **Target Attainment:**  **Priority:**

Cross Reference: Agy 537 084-R-S70-1 02-01-04 OP 01

**Key Measure:** Y  **New Measure:** N  **Percentage Measure:** N

**BL 2018 Definition**

This measure is the unduplicated number of Primary Health Care clients provided primary care services.

**BL 2018 Data Limitations**

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

**BL 2018 Data Source**

The sources for this measure are the contractor monthly and annual reports. Fee-for-service client data are from the Texas Medicaid Health Partnership Vision 21 Data Warehouse Ad Hoc Query Platform (AHQP) Claims Universe.

**BL 2018 Methodology**

This is the unduplicated number of Primary Health Care clients receiving services as reported by contractors.

**BL 2018 Purpose**

Measures the number of Primary Health Care Program clients provided primary health care services.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529
Agency: Health and Human Services Commission

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</table>

Provide Additional Health-related Services
Provide Primary Health and Specialty Care
Abstinence Education
Number of Persons Served in Abstinence Education Programs

Calculation Method: C
Target Attainment: Priority:
Cross Reference: Agy 537 084-R-S70-1 01-03-03 OP 01
Key Measure: Y
New Measure: N
Percentage Measure: N

**BL 2018 Definition**
Number of Persons receiving services delivered by the Abstinence Education Program.

**BL 2018 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.

**BL 2018 Data Source**
Summary report derived from bi-annual activity reports. Numbers served will be totaled from the data reports from the Abstinence Education program.

**BL 2018 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.

**BL 2018 Purpose**
Measures the number of persons receiving services.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
### Agency Code: 529
### Agency: Health and Human Services Commission

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<td>Objective No.</td>
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<td>Provide Community Behavioral Health Services</td>
</tr>
<tr>
<td>Strategy No.</td>
<td>1</td>
<td>Community Mental Health Services (MHS) for Adults</td>
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<tr>
<td>Measure Type</td>
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<td></td>
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<tr>
<td>Measure No.</td>
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<td>Average Monthly Cost Per Adult: Community Mental Health Services</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 537 084-R-S70-1 02-02-01 EF 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**
It measures the HHSC appropriation authority cost per consumer per level of care as defined by the companion output measure.

**BL 2018 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.

**BL 2018 Data Source**
At the end of each quarter, staff of the local authorities input expenditure information into the data warehouse. 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.

**BL 2018 Methodology**
The number of months in the reporting period is 3 for each quarter.

The numerator is the total HHSC appropriation authority funds utilized to fund adult Mental Health community services as reported in the data warehouse / 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.

**BL 2018 Purpose**
This measure captures HHSC appropriation authority cost per person for adult community mental health services provided through the Texas Resilience and Recovery levels of care 1M-4.
### Agency Code: 529

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<th>Goal No.</th>
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<tr>
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<tr>
<td>2</td>
<td>Provide Community Behavioral Health Services</td>
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<tr>
<td>1</td>
<td>Community Mental Health Services (MHS) for Adults</td>
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<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Measure No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EX</td>
<td>1</td>
<td>Number of Adults Receiving Community Mental Health Services Per Year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calculation Method: N</th>
<th>Target Attainment:</th>
<th>Priority:</th>
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<tr>
<td>Cross Reference: Agy 537 084-R-S70-1 02-02-01 EX 01</td>
<td>Key Measure: N</td>
<td>New Measure: N</td>
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</table>

**BL 2018 Definition**

This measure provides an unduplicated workload count of priority population eligible adults who receive mental health community services through one of the five levels of care 1M-4 in Texas Resilience & Recovery during one fiscal year. Mental health community services include a wide range of activities that are provided in the communities where the consumers live. The specific services include, but are not limited to, assessment and/or service coordination, psychiatric rehabilitation services (assertive community treatment, supported housing, supported employment), counseling services and medication services.

**BL 2018 Data Limitations**

Data collection will depend on the completion of the Uniform Assessment as prescribed.

**BL 2018 Data Source**

Every adult mental health consumer receives a Uniform Assessment for Texas Resilience and Recovery upon admission to the local authority and two to four times per year thereafter. The assessment includes the Adult Needs and Strengths Assessment level of care and the authorized level of care. Local authority staff enters this information into the Clinical Management of Behavioral Health Services system. Consumers are only counted once for this measure.

**BL 2018 Methodology**

The total unduplicated number of adults that receive a level of care under Texas Resilience and Recovery for mental health community services during the fiscal year regardless of how the services for the individuals were funded is tallied for each local authority and system-wide.

**BL 2018 Purpose**

This measure provides the actual number of adults who receive community services through Texas Resilience and Recovery levels of care 1M-4 during one fiscal year. It is a number used to compare system activity over a period of two or more fiscal years.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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<td>Provide Additional Health-related Services</td>
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<tr>
<td>Objective No. 2</td>
<td>Provide Community Behavioral Health Services</td>
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<tr>
<td>Strategy No. 1</td>
<td>Community Mental Health Services (MHS) for Adults</td>
</tr>
<tr>
<td>Measure Type OP</td>
<td>Average Monthly Number of Adults Receiving Community MH Services</td>
</tr>
<tr>
<td>Measure No. 1</td>
<td>Calculation Method: N Target Attainment:</td>
</tr>
<tr>
<td>Key Measure: Y</td>
<td>New Measure: N Percentage Measure: N</td>
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</table>

**BL 2018 Definition**
This measure captures the unduplicated count of priority population 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. These services may be provided on a monthly or quarterly basis depending upon the service. The service packages include a wide range of activities that are provided in the communities where the consumers live. The specific services include, but are not limited to, assessment and/or service coordination, psychiatric rehabilitation services (assertive community treatment, supported housing, supported employment), counseling services and medication services. Quarterly and year-to-date performance is stated as the average of the months in the reporting period.

**BL 2018 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.

**BL 2018 Data Source**
There are four levels of care a mental health consumer may be assigned. Each level of care has a designated service package that the Mental Health consumer may receive. Persons receiving community mental health services achieve optimal benefit from those services appropriately addressing their identified needs. There may be persons whose authorized level of care does not match the recommended level of care as determined by the Uniform Assessment. These exceptions are usually due to clinical judgment, resource limitations, continuity of care per Utilization Management guidelines and/or consumer choice.

The total unduplicated number of persons assigned to receive these Mental Health community services each month is calculated. For each quarter of the fiscal year, the unduplicated number of persons served in each month of the quarter is averaged. The production report lists total number of adults assigned to a particular service each month regardless of funding source.

**BL 2018 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 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.

BL 2018 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.
**BL 2018 Definition**
This measure captures information regarding what it costs the state each month, on average, to provide community services to children and adolescents who are assigned to any of the Texas Resilience and Recovery (levels of care 1,2,3,4, or YC). It measures the HHSC appropriation authority cost per consumer per level of care as defined by the companion output measure.

**BL 2018 Data Limitations**
The accuracy of the commission's data warehouse system is dependent upon accurate and timely information being entered into the database by the local mental health authorities. If the local authority does not provide accurate data for the quarter, this measure will not be accurate.

**BL 2018 Data Source**
At the end of each quarter, staff of the local authorities input expenditure information into 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.

**BL 2018 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 and Medicaid Rehabilitation funds that the local authorities receive based on the submission of claims. The number of months in the reporting period are 3 for each quarter and either 3, 6, 9, or 12 for year to date.

**Calculation**
Numerator = The total HHSC appropriation authority funds utilized to fund community MH children's community services as reported in the data warehouse/ the number of months in the reporting period.

Denominator = 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.

**BL 2018 Purpose**
This measure captures HHSC appropriation authority cost per child receiving mental health services in the community provided through the Texas Resilience and Recovery levels of care 1,2,3,4, or YC.
Agency Code: 529
Agency: Health and Human Services Commission

Goal No.  4  Provide Additional Health-related Services
Objective No.  2  Provide Community Behavioral Health Services
Strategy No.  2  Community Mental Health Services (MHS) for Children
Measure Type  EX
Measure No.  1  Number of Children Receiving Community MH Services Per Year

Calculation Method: N  Target Attainment:  Priority:  Cross Reference: Agy 537 084-R-S70-1 02-02-02 EX 01
Key Measure: N  New Measure: N  Percentage Measure: N

**BL 2018 Definition**
This measure provides an unduplicated workload count of priority population eligible children and adolescents receiving mental health community services through Texas Resiliency and Recovery levels of care 1,2,3,4, or Young Child. Community services available to children include, but are not limited to, assessment and/or service coordination, counseling, medication services, day treatment services, and family support services. Year-to-date performance is stated as the average of the months in the reporting period.

**BL 2018 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.

**BL 2018 Data Source**
There are five levels of care a mental health consumer may be assigned. Each level of care has a flexible array of services that the mental health consumer may receive. Persons achieve optimal benefit from those services appropriately addressing their identified needs. There may be children whose authorized level of care does not match the recommended level of care as determined by the Child and Adolescent Needs and Strengths assessment, however these exceptions are usually due to clinical judgment, resource limitations, continuity of care per UM guidelines and/or consumer choice. As persons enter community programs, registration information and assignment to a specific level of care is entered into the commission's data warehouse by local mental health authority staff. Production reports of consumers served are issued quarterly based on the information in the data warehouse system. If a child receives more than one community service during the year, the child is counted only once.

**BL 2018 Methodology**
The total unduplicated number of children and adolescents that receive a mental health community level of care 1,2,3,4, or Young Child (through Texas Resilience and Recovery) during the fiscal year is tallied for each local authority and system-wide. The production report lists total number of different children served each month and unduplicated number served year-to-date.

**BL 2018 Purpose**
This measure provides the actual number of children and adolescents who receive services through Texas Resilience and Recovery (levels of care 1,2, 3,4, or YC) and provides information about the total system activity during one fiscal year. It is a frequently requested number used to compare system activity over a period of two or more fiscal years.

**BL 2019 Definition**
BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**

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**Agency:** Health and Human Services Commission

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**Goal No. 4 Provide Additional Health-related Services**

**Objective No. 2 Provide Community Behavioral Health Services**

**Strategy No. 2 Community Mental Health Services (MHS) for Children**

**Measure Type OP**

**Measure No. 1 Average Monthly Number of Children Receiving Community MH Services**

---

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**

Cross Reference: Agy 537 084-R-S70-1 02-02-02 OP 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure captures the unduplicated count of priority population eligible children (under age 18) whose services are funded with HHSC appropriation authority funds and who receive mental health community services through 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. Community services available to children include, but are not limited to, assessment and/or service coordination, counseling, medication services, day treatment services, and family support services. Quarterly performance is stated as the average of the months in the reporting period.

**BL 2018 Data Limitations**

The accuracy of the commission's data is dependent upon accurate and timely information being entered into the data warehouse system by the local mental health authorities. The Data Verification Criteria Manual provides general guidance regarding timelines for closure of assignments to specific services.

**BL 2018 Data Source**

When a child is assigned to a specific level of care, this information is entered into the data warehouse. Production reports of children served regardless of funding are issued quarterly based on the information in the data warehouse. The total unduplicated number of children assigned to receive any Mental Health community service each month is calculated. To obtain an unduplicated number of children, each child 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 children served in each month of the quarter is averaged.

**BL 2018 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 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 Texas Resilience and Recovery levels of care 1,2,3,4, or Young Child each month of the reporting period * state funded percentage. The state funded percent is expenditures financed through the HHSC appropriation authority for children's community Mental Health services / Total expenditures for children's community MH services *100.

The denominator is the number of months in the period. The formula is numerator/denominator.
BL 2018 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.
**Strategy-Related Measures Definitions**
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<td>Strategy No.</td>
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<td>Community Mental Health Crisis Services (CMHCS)</td>
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<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
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<td>Avg GR Spent Per Person for Crisis Residential Services</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 537 084-R-S70-1 02-02-03 EF 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure captures the average amount of General Revenue (GR) spent per person for a crisis residential service (i.e., respite, crisis residential, crisis stabilization unit, extended observation, or inpatient psychiatric room and board) and including competitive funding for crisis residential options from Community Mental Health Centers including NorthSTAR during the fiscal year.

**BL 2018 Data Limitations**
The accuracy of the Commission's client databases is dependent upon accurate and timely information being entered into the data warehouses by Community Mental Health Centers and ValueOptions (NorthSTAR). For NorthSTAR, while the majority of paid records are available within 30 days of service, some information lags up to 90 days. Values in ABEST will be updated the quarter following the initial entry to ensure the most accurate data are available. Computation of this measure is also dependent upon accurate and timely submission of Report III to HHSC by Community Mental Health Centers.

**BL 2018 Data Source**
Crisis service data are from encounter records in the HHSC Mental Retardation and Behavioral Health Outpatient Warehouse and NorthSTAR data warehouse.

**BL 2018 Methodology**
The numerator is the total GR expenditures for crisis residential services as in Report III submitted to HHSC by Community Mental Health Centers and Value Options.

The denominator is the unduplicated year-to-date number of persons who receive a crisis residential service funded by GR.

**BL 2018 Purpose**
None.
### BL 2018 Definition

This measure captures the average amount of General Revenue (GR) spent per person for a crisis outpatient service (i.e., mobile crisis outreach team, walk-in crisis, or crisis follow-up) from Community Mental Health Centers including NorthSTAR during the fiscal year.

### BL 2018 Data Limitations

The accuracy of the Commission's client databases is dependent upon accurate and timely information being entered into the data warehouses by Community Mental Health Centers and ValueOptions (NorthSTAR). For NorthSTAR, while the majority of paid records are available within 30 days of service, some information lags up to 90 days. Values in ABEST will be updated the quarter following the initial entry to ensure the most accurate data are available. Computation of this measure is also dependent upon accurate and timely submission of Report III to HHSC by Community Mental Health Centers.

### BL 2018 Data Source

Crisis service data are from encounter records in the HHSC Mental Retardation and Behavioral Health Outpatient Warehouse and NorthSTAR data warehouse.

### BL 2018 Methodology

The numerator is the total GR expenditures for crisis outpatient services as in Report III submitted to HHSC by Community Mental Health Centers and Value Options.

The denominator is the unduplicated year-to-date number of persons who receive a crisis outpatient service funded by GR.

The formula is numerator/denominator

### BL 2018 Purpose

None.
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**Agency:** Health and Human Services Commission

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<th>Measure Type</th>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 537 084-R-S70-1 02-02-03 OP 01  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure captures the unduplicated year-to-date number of persons (regardless of age) who receive a crisis residential service (i.e., respite, crisis residential, crisis stabilization unit, extended observation, or inpatient psychiatric room and board) from Community Mental Health Centers including NorthSTAR during the fiscal year, and whose services are funded by General Revenue.

**BL 2018 Data Limitations**

The accuracy of the Commission's client databases is dependent upon accurate and timely information being entered into the data warehouses by Community Mental Health Centers and ValueOptions (NorthSTAR). For NorthSTAR, while the majority of paid records are available within 30 days of service, some information lags up to 90 days. Values in ABEST will be updated the quarter following the initial entry to ensure the most accurate data are available. Computation of this measure is also dependent upon accurate and timely submission of the Crisis Redesign Budget Category Survey to HHSC by Community Mental Health Centers and Value Options.

**BL 2018 Data Source**

Crisis service data are from encounter records in the HHSC Mental Retardation and Behavioral Health Outpatient Warehouse and NorthSTAR data warehouse.

**BL 2018 Methodology**

The unduplicated number of persons who receive a residential crisis service from Community Mental Health Centers including NorthSTAR, where the source of funding was General Revenue, is summed for the fiscal year.

**BL 2018 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 of Crisis Redesign. 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This measure captures the unduplicated year-to-date number of persons (regardless of age) who receive a crisis outpatient service (i.e., mobile crisis outreach team, walk-in crisis, or crisis follow-up) from Community Mental Health Centers including NorthSTAR during the fiscal year, and whose services are funded by General Revenue.

### BL 2018 Data Limitations

The accuracy of the Commission's client databases is dependent upon accurate and timely information being entered into the data warehouses by Community Mental Health Centers and ValueOptions (NorthSTAR). For NorthSTAR, while the majority of paid records are available within 30 days of service, some information lags up to 90 days. Values in ABEST will be updated the quarter following the initial entry to ensure the most accurate data are available. Computation of this measure is also dependent upon accurate and timely submission of Crisis Redesign Budget Category Survey to HHSC by Community Mental Health Centers and Value Options.

### BL 2018 Data Source

Crisis service data are from encounter records in the HHSC Mental Retardation and Behavioral Health Outpatient Warehouse and NorthSTAR data warehouse.

### BL 2018 Methodology

The unduplicated number of persons who receive an outpatient crisis service from Community Mental Health Centers including NorthSTAR, where the source of funding was General Revenue, is summed for the fiscal year.

### BL 2018 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 of Crisis Redesign. 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.

### BL 2019 Definition

This measure captures the unduplicated year-to-date number of persons (regardless of age) who receive a crisis outpatient service (i.e., mobile crisis outreach team, walk-in crisis, or crisis follow-up) from Community Mental Health Centers including NorthSTAR during the fiscal year, and whose services are funded by General Revenue.

### BL 2019 Data Limitations

The accuracy of the Commission's client databases is dependent upon accurate and timely information being entered into the data warehouses by Community Mental Health Centers and ValueOptions (NorthSTAR). For NorthSTAR, while the majority of paid records are available within 30 days of service, some information lags up to 90 days. Values in ABEST will be updated the quarter following the initial entry to ensure the most accurate data are available. Computation of this measure is also dependent upon accurate and timely submission of Crisis Redesign Budget Category Survey to HHSC by Community Mental Health Centers and Value Options.

### BL 2019 Data Source

Crisis service data are from encounter records in the HHSC Mental Retardation and Behavioral Health Outpatient Warehouse and NorthSTAR data warehouse.
BL 2019 Methodology

BL 2019 Purpose
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<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
<td>1</td>
<td>Average Mo Cost Per Youth for Substance Abuse Prevention Services</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 537 084-R-S70-1 02-02-05 EF 02

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measures the average cost per youth, aged 17 or below, receiving authorized substance abuse prevention services.

**BL 2018 Data Limitations**
The average cost of services is affected by the nature of the prevention activity and intensity of the prevention services. This measure only reflects HHSC funded cost. Program measures are aggregate reports and are not based on individual level services for each strategy. For individuals who receive more than one service, there will be duplication in the total count of numbers served.

**BL 2018 Data Source**
Contractually-required prevention activities/services (Key Performance Measures) are submitted by the providers via the Performance Measures reports, which are entered directly into the HHSC Clinical Management for Behavioral Health Services (CMBHS). Expenditures for services are maintained in the Uniform Statewide Accounting System.

**BL 2018 Methodology**
The numerator is 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 youth, age 17 or below, receiving prevention services, as reported by providers in the CMBHS Measures Reports. This includes all key performance measures related to information dissemination, education, alternative activities, problem identification and referral, community-based processes, and environmental strategies.

**BL 2018 Purpose**
Intended to measure average cost per youth participant. This data is also useful in determining efficiency and cost effectiveness of the programs over time.
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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

| Goal No. | 4 | Provide Additional Health-related Services |
|------------------------------------------------|
| Objective No. | 2 | Provide Community Behavioral Health Services |
| Strategy No. | 4 | Substance Abuse Prevention, Intervention and Treatment |
| Measure Type | EF | |
| Measure No. | 2 | Average Mo Cost Per Adult for Substance Abuse Intervention Services |

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 537 084-R-S70-1 02-02-05 EF 03

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**  
This measures the average cost per adult, age 18 or above, receiving intervention services for substance abuse.

**BL 2018 Data Limitations**  
Average cost of services is affected by quality and intensity of service. This measure only reflects HHSC-funded cost. Program measures are aggregate reports and not based on individual level. For individuals who receive more than one service, there is a chance of duplication in the total count of numbers served.

**BL 2018 Data Source**  
Contractually-required intervention activities/services (key performance measures) are submitted by the providers via the Performance Activity Measure reports, which are entered directly into the HHSC Clinical Management for Behavioral Health Services system. Expenditures for direct services from providers, along with HHSC non-service expenditures are maintained in the Uniform Statewide Accounting System.

**BL 2018 Methodology**  
The sum of direct service expenditures and HHSC non-service expenditures for the intervention programs reporting services by age category and serving adults, age 18 or above, divided by the total number of adults served. The HHSC non-service expenditures are pro-rated based on the percent of total direct service expenditures attributed to youth and adults. Number served is the total number of adults, age 18 or above, receiving intervention services, as reported by providers in Performance Activity Reports.

**BL 2018 Purpose**  
Useful in determining efficiency over time.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**

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**Agency Code:** 529  
**Agency:** Health and Human Services Commission  
**Goal No.** 4  
**Objective No.** 2  
**Strategy No.** 4  
**Measure Type** EF  
**Measure No.** 3

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 537 084-R-S70-1 02-02-05 EF 04

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measures the average cost per youth, age 17 or below, receiving intervention services for substance abuse.

**BL 2018 Data Limitations**

Average cost of services is affected by quality and intensity of service. This measure only reflects HHSC funded cost. Program measures are aggregate reports and not based on individual level. For individuals who receive more than one service, there is a chance of duplication in the total count of numbers served.

**BL 2018 Data Source**

Contractually-required intervention activities/services (key performance measures) and age categories are submitted by the providers via the Performance Activity Measure reports, which are entered directly into the HHSC Clinical Management for Behavioral Health Services system. Expenditures for direct services from providers, along with HHSC non-service expenditures are maintained in the Uniform Statewide Accounting System.

**BL 2018 Methodology**

The sum of direct service expenditures and HHSC non-service expenditures for the intervention programs reporting services by age category and serving youth, age 17 or below, divided by the total number of youth served. The HHSC non-service expenditures are pro-rated based on the percent of total direct service expenditures attributed to youth and adults. Number served is the total number of youth, age 17 or below, receiving intervention services, as reported by providers in Performance Activity Reports.

**BL 2018 Purpose**

Useful in determining efficiency over time.

---

**BL 2019 Definition**

---

**BL 2019 Data Limitations**

---

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
### Strategy-Related Measures Definitions

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<td>Measure No.</td>
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<td>Average Mo Cost Per Adult Served in Treatment Programs for SA</td>
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#### BL 2018 Definition
This measures the average cost per adult, age 18 or above, who is discharged from a treatment service for substance abuse.

#### BL 2018 Data Limitations
Cost of treatment may cross fiscal years. Discharge from treatment in this measure refers only to the ending of a level of care (service) at a single service provider for the HHSC substance abuse program. Data does not necessarily reflect discharge from a continuum of care, which usually includes multiple programs and levels of service (episode).

#### BL 2018 Data Source
Discharge and end-services information and client billings are submitted by providers via the HHSC Clinical Management for Behavioral Health Services system. Direct client expenditures, along with HHSC substance abuse program non-service expenditures, are maintained in the Uniform Statewide Accounting System.

#### BL 2018 Methodology
The sum of substance abuse treatment claims associated with adult clients, age 18 or above, who are discharged from a level of service during the reporting period divided by the number of adult clients who are discharged from a level of service during the reporting period.

#### BL 2018 Purpose
Useful in evaluating program efficiency over time.

#### BL 2019 Definition

#### BL 2019 Data Limitations

#### BL 2019 Data Source

#### BL 2019 Methodology
BL 2019 Purpose
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Agency Code: 529
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Goal No. 4
Provide Additional Health-related Services

Objective No. 2
Provide Community Behavioral Health Services

Strategy No. 4
Substance Abuse Prevention, Intervention and Treatment

Measure Type EF

Measure No. 5
Average Mo Cost Per Youth Served in Treatment Programs for SA

Calculation Method: N
Target Attainment: N
Priority: N

Cross Reference: Agy 537 084-R-S70-1 02-02-05 EF 06

Key Measure: N
New Measure: N
Percentage Measure: N

BL 2018 Definition
This measures the average cost per youth, age 17 or below, who is discharged from a treatment service for substance abuse.

BL 2018 Data Limitations
Cost of completion may cross fiscal years. Discharge from treatment in this measure refers only to the ending of a level of care (service) at a single service provider for the HHSC substance abuse program. Data does not necessarily reflect discharge from a continuum of care, which usually includes multiple programs and levels of service (episode).

BL 2018 Data Source
Discharge and end-service information and client billings are submitted by providers via the HHSC Clinical Management for Behavioral Health Services system.

BL 2018 Methodology
The sum of substance abuse treatment claims associated with youth clients, age 17 or below, who are discharged from a level of service during the reporting period divided by the number of youth clients who are discharged from a level of service during the reporting period.

BL 2018 Purpose
Useful in evaluating program efficiency over time.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
Agency Code: 529  
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Goal No. 4  
Provide Additional Health-related Services

Objective No. 2  
Provide Community Behavioral Health Services

Strategy No. 4  
Substance Abuse Prevention, Intervention and Treatment

Measure Type EX

Measure No. 1  
% of Adults Completing Treatment Programs for Substance Abuse

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 537 084-R-S70-1 02-02-05 EX 01

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**Bl. 2018 Definition**

This measures the percent of adults, age 18 or above, completing treatment service monthly for substance abuse as reported by providers.

**Bl. 2018 Data Limitations**

This only reflects clients in HHSC substance abuse funded programs. 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).

**Bl. 2018 Data Source**

Discharge and completion information reported by providers via the HHSC Clinical Management and Behavioral Health Services system.

**Bl. 2018 Methodology**

The total adults, age 18 or above, who completed a treatment service for substance abuse during the reporting period divided by the total number of adult clients discharged or ending the service during the reporting period. Excluded from the calculation are adults who did not successfully complete a treatment service.

**Bl. 2018 Purpose**

Intended to identify adults who completed treatment.

**Bl. 2019 Definition**

**Bl. 2019 Data Limitations**

**Bl. 2019 Data Source**

**Bl. 2019 Methodology**
BL 2019 Purpose
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<td>Measure No.</td>
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<td>% of Youth Completing Treatment Programs for SA</td>
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**Calculation Method:** N

**Target Attainment:** N

**Priority:** Cross Reference: Agy 537 084-R-S70-1 02-02-05 EX 02

**Key Measure:** N

**New Measure:** N

**Percentage Measure:** N

---

**BL 2018 Definition**

This measures the percent of youth, age 17 or below, completing treatment service quarterly for substance abuse as reported by providers.

**BL 2018 Data Limitations**

This only reflects clients in HHSC substance abuse funded programs. Completion of treatment in this measure refers only to the completion of a level of care (service) at a single service provider. Data does not necessarily reflect completion of a continuum of care, which usually includes multiple programs and levels of service (episode).

**BL 2018 Data Source**

Discharge and completion information reported by providers via the HHSC Clinical Management and Behavioral Health Services system.

**BL 2018 Methodology**

The total youth, age 17 or below, who completed a treatment program for substance abuse during the reporting period divided by the total number of youth clients discharged during the reporting period. Excluded from the calculation are youth who did not successfully complete treatment services.

**BL 2018 Purpose**

Intended to identify youth who completed treatment.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
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**Goal No.** 4
**Provide Additional Health-related Services**

**Objective No.** 2
**Provide Community Behavioral Health Services**

**Strategy No.** 4
**Substance Abuse Prevention, Intervention and Treatment**

**Measure Type** OP
**Measure No.** 1
**Avg Mo Number of Youth Served in Substance Abuse Prevention Programs**

**Calculation Method:** N
**Target Attainment:** Cross Reference: Agy 537 084-R-S70-1 02-02-05 OP 02
**Priority:** Y
**New Measure:** N
**Percentage Measure:** N

**BL 2018 Definition**
This measures the total average monthly number of youth, age 17 and below, served through HHSC-funded direct and in-direct substance abuse prevention program service types as reported by providers.

**BL 2018 Data Limitations**
Program measures are aggregate reports and not based on individual level services for each strategy. For individuals who receive more than one service, there will be duplication in the total count. HHSC requires prevention providers to provide comprehensive prevention services which may result in participants receiving one or more prevention services. Comprehensive services are designed to include multiple prevention activities within the required Center for Substance Abuse Prevention strategies to ensure the programs meet the needs of the participants and reinforce the skills learned in the prevention program. Due to the nature of the prevention activities within each of the strategies, there is no way to capture an unduplicated count of the services provided.

**BL 2018 Data Source**
Contractually-required prevention activities/services (Key Performance Measures) and age categories are submitted by the providers via the Performance Activity Measure reports, which are entered directly into the HHSC Clinical Management for Behavioral Health Services system. The Key Performance Measures are directly aligned under one of the six Centers for Substance Abuse Prevention Strategies which include: information dissemination, prevention education, alternative activities, problem identification and referral, community-based processes, and environmental/social policy.

**BL 2018 Methodology**
For each quarter, the total number of youth served with HHSC prevention funds in each month of the quarter is averaged. The total numbers served include youth served within each of the required key performance measures for all prevention service types.

The numerator is the sum of the monthly number of youth receiving substance abuse prevention services with HHSC appropriation authority funds during each month of the period. The denominator is the number of months in the period. The formula is numerator/denominator.

**BL 2018 Purpose**
To determine the number of youth receiving substance abuse prevention services and to monitor HHSC-funded prevention providers’ program performance.
**Strategy-Related Measures Definitions**
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### BL 2018 Definition
This measures the number of youth served quarterly, ages 17 or below, in treatment programs for substance abuse as reported by providers.

### BL 2018 Data Limitations
This shows only clients treated in HHSC substance abuse funded programs.

### BL 2018 Data Source
Billing information is reported by providers via the Clinical Management for Behavioral Health Services system.

### BL 2018 Methodology
For each quarter of the fiscal year, the number of youths served in HHSC Substance Abuse treatment programs in each month of the quarter is averaged. The numerator is the sum of the monthly unduplicated number of youth in Substance Abuse treatment programs with HHSC appropriation authority funds during each month of the period. The denominator is the number of months in the period. The formula is numerator/denominator.

### BL 2018 Purpose
This information is used in the strategic planning and budget allocation processes.

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### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology
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<td>Avg Mo Number of Adults Served in SA Intervention Programs</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 537 084-R-S70-1 02-02-05 OP 03

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measures the number of adults, age 18 or above, served in intervention services for substance abuse as reported by providers.

**BL 2018 Data Limitations**
For individuals who receive more than one service, there is a chance of duplication in the total count.

**BL 2018 Data Source**
Contractually-required intervention activities/services (key performance measures) and age categories are submitted by the providers in the monthly Performance Activity Measure reports, which are entered directly into the HHSC Clinical Management for Behavioral Health Services System (CMBHS).

**BL 2018 Methodology**
For each quarter of the fiscal year, the number of adults served with HHSC substance abuse intervention services in each month of the quarter is averaged. The numerator is the sum of the monthly unduplicated number of adults receiving substance abuse intervention services with HHSC appropriation authority funds during each month of the period. The denominator is the number of months in the period. The formula is numerator/denominator.

**BL 2018 Purpose**
Useful in determining relative proportion of adults receiving intervention services for substance abuse.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**


BL 2019 Purpose
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**Calculation Method:** N
**Target Attainment:** N
**Priority:** N

**Cross Reference:** Agy 537 084-R-S70-1 02-02-05 OP 04

**Key Measure:** Y
**New Measure:** N
**Percentage Measure:** N

**BL 2018 Definition**
This measures the number of youth, age 17 or below, served in intervention services for substance abuse as reported by providers.

**BL 2018 Data Limitations**
For individuals who receive more than one service, there is a chance of duplication in the total count.

**BL 2018 Data Source**
Contractually-required intervention activities/services (key performance measures) and age categories are submitted by the providers via the Performance Activity Measure reports, which are entered directly into the HHSC Clinical Management for Behavioral Health Services System (CMBHS).

**BL 2018 Methodology**
For each quarter of the fiscal year, the number of youths served with HHSC substance abuse intervention services in each month of the quarter is averaged. The numerator is the sum of the monthly unduplicated number of youth receiving substance abuse intervention services with HHSC appropriation authority funds during each month of the period. The denominator is the number of months in the period. The formula is numerator/denominator.

**BL 2018 Purpose**
Useful in determining relative proportion of youth receiving intervention services.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
### BL 2018 Definition

This measures the number of adults, ages 18 or above, served in treatment programs for substance abuse as reported by providers.

### BL 2018 Data Limitations

This shows only clients treated in HHSC funded programs.

### BL 2018 Data Source

Billing information is reported by providers via the HHSC Clinical Management for Behavioral Health Services System (CMBHS).

### BL 2018 Methodology

For each quarter of the fiscal year, the number of adults in HHSC substance abuse treatment programs in each month of the quarter is averaged. The numerator is the sum of the monthly unduplicated number of adults receiving substance abuse treatment services with HHSC appropriation authority funds during each month of the period. The denominator is the number of months in the period. The formula is numerator/denominator.

### BL 2018 Purpose

This information is used in the strategic planning and budget allocation processes.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology

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Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 4: Provide Additional Health-related Services
Objective No. 3: Build Community Capacity
Strategy No. 1: Indigent Health Care Reimbursement (UTMB)
Measure Type: OP
Measure No. 1: Counties Receiving State Assistance Funds from CIHCP

Calculation Method: C  
Target Attainment:  
Priority:  
Cross Reference: Agy 537 084-R-S70-1 02-03-03 OP 01

Key Measure: N  
New Measure: N  
Percentage Measure: N

BL 2018 Definition
This measure reports the actual number of participating eligible counties spending over eight percent (8%) of the county's general revenue tax levy and receiving reimbursement from the County Indigent Health Care Program (CIHCP) state assistance fund.

BL 2018 Data Limitations
CIHCP relies on data received from participating eligible counties.

BL 2018 Data Source
Data are derived from reports (CIHCP Form 105) submitted by CIHCP participating eligible counties.

BL 2018 Methodology
This measure is the number of unduplicated counties, which CIHCP reimbursed for services paid during the fiscal year. Data is cumulative.

BL 2018 Purpose
This measure reports the actual number of unduplicated eligible counties spending over eight percent (8%) of the county's general revenue tax levy and receiving reimbursement from the CIHCP state assistance fund.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
<table>
<thead>
<tr>
<th>Agency Code: 529</th>
<th>Agency: Health and Human Services Commission</th>
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</thead>
<tbody>
<tr>
<td>Goal No.</td>
<td>4 Provide Additional Health-related Services</td>
</tr>
<tr>
<td>Objective No.</td>
<td>3 Build Community Capacity</td>
</tr>
<tr>
<td>Strategy No.</td>
<td>2 County Indigent Health Care Services</td>
</tr>
<tr>
<td>Measure Type</td>
<td>EX</td>
</tr>
<tr>
<td>Measure No.</td>
<td>1 Average Monthly # of Indigents Receiving Health Care Services</td>
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**Calculation Method:** N  **Target Attainment:** N  **Priority:** N  **Cross Reference:** Agy 537 084-R-S70-1 02-03-02 EX 01
**Key Measure:** N  **New Measure:** N  **Percentage Measure:** N

**BL 2018 Definition**
This measure reflects the average monthly number of indigent patients receiving health care services through the University of Texas Medical Branch (UTMB), which pays for services with funds from the State-Owned Multi-Categorical Teaching Hospital Account.

**BL 2018 Data Limitations**
The Texas Department of State Health Services depends on UTMB to provide the documentation of voucher billing.

**BL 2018 Data Source**
Data are submitted to HHSC as documentation of voucher billing from UTMB.

**BL 2018 Methodology**
Sum the number of indigent patients per month and divide by the number of months summed. NOTE: House Bill 1799 (76th Legislature), 1999, established the State-Owned Multi-Categorical Teaching Hospital Account and requires the deposit into this account of unclaimed lottery prize monies. When the appropriations limit has been reached, no further reimbursements are made to UTMB. When computing the measure for fiscal years that have exceeded the limit before the end of the year, include only those months that have sufficient funds to pay for all of the patients. Exclude any months from the calculation process that involve partially paid or non-paid months.

**BL 2018 Purpose**
Measures the average monthly number of indigent patients receiving health care services through UTMB. These services are funded through the State-Owned Multi-Categorical Teaching Hospital Account.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
### Strategy-Related Measures Definitions

**Automated Budget and Evaluation System of Texas (ABEST)**

#### 85th Regular Session, Agency Submission, Version 1

**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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<th>Measure No.</th>
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<td>2</td>
<td>EX</td>
<td>2</td>
<td>Avg Monthly Cost Per Indigent Patient Receiving Health Care Services</td>
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- **Agency Code:** 529  
- **Agency:** Health and Human Services Commission

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<tr>
<th>Calculation Method:</th>
<th>Target Attainment:</th>
<th>Priority:</th>
<th>Cross Reference: Agy 537 084-R-S70-1 02-03-02 EX 02</th>
</tr>
</thead>
</table>

- **Key Measure:** N  
- **New Measure:** N  
- **Percentage Measure:** N

---

**BL 2018 Definition**

This measure reflects the average cost per indigent patient receiving services from the University of Texas Medical Branch (UTMB).

**BL 2018 Data Limitations**

HHSC depends on UTMB to provide the documentation of voucher billing.

**BL 2018 Data Source**

Data are submitted to the Texas Department of State Health Services as documentation of voucher billing from UTMB.

**BL 2018 Methodology**

The average monthly cost equals the sum of dollars spent by UTMB from the State-Owned Multi-Categorical Teaching Hospital Account for indigent health care services divided by the sum of indigent patients receiving health care services.

**BL 2018 Purpose**

Measures the average cost per indigent patient receiving services from UTMB. These services are funded through the State-Owned Multi-Categorical Teaching Hospital Account.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**

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**BL 2019 Methodology**

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**BL 2019 Purpose**

---
**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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<tr>
<th>Goal No.</th>
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<tr>
<td>Objective No.</td>
<td>1</td>
<td>Financial and Other Assistance</td>
</tr>
<tr>
<td>Strategy No.</td>
<td>1</td>
<td>Temporary Assistance for Needy Families Grants</td>
</tr>
<tr>
<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
<td>1</td>
<td>Average Monthly Grant: TANF Basic Cash Assistance</td>
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</table>

**Calculation Method:** N  
**Target Attainment:** L  
**Priority:** H  
Cross Reference: Agy 529 084-R-S70-1 04-01-01 EF 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**
This measure reports the dollar amount of the average monthly Temporary Assistance for Needy Families (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.

**BL 2018 Data Limitations**
Data are incomplete at initial reporting due to cancellations and supplemental payments.

**BL 2018 Data Source**
Data is obtained from the "TANF Warrant History" file, based on eligibility determination system.

**BL 2018 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.

**BL 2018 Purpose**
This measure provides the unit cost of one of the service components funded under this strategy.

---

**BL 2019 Definition**
This measure reports the dollar amount of the average monthly Temporary Assistance for Needy Families (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.

**BL 2019 Data Limitations**
Data are incomplete at initial reporting due to cancellations and supplemental payments.

**BL 2019 Data Source**
Data is obtained from the "TANF Warrant History" file, based on eligibility determination system.
BL 2019 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.

BL 2019 Purpose
This measure provides the unit cost of one of the service components funded under this strategy.
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<thead>
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<th>Agency:</th>
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<tr>
<td>Objective No.</td>
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<td>Financial and Other Assistance</td>
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<tr>
<td>Strategy No.</td>
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<td>Temporary Assistance for Needy Families Grants</td>
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<tr>
<td>Measure No.</td>
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<td>Average Monthly Grant: State Two-Parent Cash Assistance Program</td>
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**Calculation Method:** N  
**Target Attainment:** L  
**Priority:** L  
Cross Reference: Agy 529 084-R-S70-1 04-01-01 EF 02

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 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.

**BL 2018 Data Limitations**  
Data are incomplete at initial reporting due to cancellations and supplemental payments.

**BL 2018 Data Source**  
Data is obtained from the 'TANF Warrant History' file, based on eligibility determination system.

**BL 2018 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.

**BL 2018 Purpose**  
This measure provides the unit cost of one of the service components funded under this strategy.

**BL 2019 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.

**BL 2019 Data Limitations**  
Data are incomplete at initial reporting due to cancellations and supplemental payments.

**BL 2019 Data Source**  
Data is obtained from the 'TANF Warrant History' file, based on eligibility determination system.

**BL 2019 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.

BL 2019 Purpose

This measure provides the unit cost of one of the service components funded under this strategy.
### BL 2018 Definition

This measure is the total number of initial applications for TANF Basic, TANF State Two-Parent, One-Time TANF Basic and One-Time TANF Two-Parent programs approved for benefits, expressed as a percentage of all initial TANF applications disposed within the reporting quarter. A disposed application is one that has been worked to a decision as either approved or denied for eligibility for the program.

### BL 2018 Data Limitations

There may be more than one disposition for a TANF application during the reporting quarter.

### BL 2018 Data Source

Data are obtained from DataMart, the interface for TIERS reporting.

### BL 2018 Methodology

Determine the total number of initial applications disposed for TANF each month of the reporting quarter. Of these, identify the total number that were approved. Calculate the percentage by dividing the total number of approvals by the total number of dispositions for each quarter and for the cumulative quarters as the year progresses.

### BL 2018 Purpose

Determine the total number of initial applications disposed for TANF each month of the reporting quarter.
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85th Regular Session, Agency Submission, Version 1  
Automated Budget and Evaluation System of Texas (ABEST)

**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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<th>Strategy No.</th>
<th>Measure Type</th>
<th>Measure No.</th>
<th>Description</th>
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<tr>
<td>5</td>
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<td>1</td>
<td>OP</td>
<td>1</td>
<td>Average Number of TANF Basic Cash Assistance Recipients Per Month</td>
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</tbody>
</table>

**Calculation Method:** N  
**Target Attainment:** H  
**Priority:** H  
**Cross Reference:** Agy 529 084-R-S70-1 04-01-01 OP 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure reports the monthly average number of persons who received a Temporary Assistance for Needy Families (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.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

Data is obtained from the "TANF Warrant History" file based on an eligibility determination system.

**BL 2018 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.

**BL 2018 Purpose**

This measure provides an average monthly count of persons receiving federally funded TANF cash assistance.

**BL 2019 Definition**

This measure reports the monthly average number of persons who received a Temporary Assistance for Needy Families (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.

**BL 2019 Data Limitations**

None.

**BL 2019 Data Source**

Data is obtained from the "TANF Warrant History" file based on an eligibility determination system.
BL 2019 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.

BL 2019 Purpose
This measure provides an average monthly count of persons receiving federally funded TANF cash assistance.
Goal No. 5 Encourage Self Sufficiency
Objective No. 1 Financial and Other Assistance
Strategy No. 1 Temporary Assistance for Needy Families Grants
Measure Type OP
Measure No. 2 Avg Number of State Two-Parent Cash Assist Recipients Per Month

Calculation Method: N  Target Attainment: H  Priority: H
Cross Reference: Agy 529 084-R-S70-1 04-01-01 OP 02

Key Measure: Y  New Measure: N  Percentage Measure: N

BL 2018 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.

BL 2018 Data Limitations
None.

BL 2018 Data Source
Data is obtained from the 'TANF Warrant History' file based on an eligibility determination system.

BL 2018 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.

BL 2018 Purpose
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.

BL 2019 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.

BL 2019 Data Limitations
None.

BL 2019 Data Source
Data is obtained from the 'TANF Warrant History' file based on an eligibility determination system.

BL 2019 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.

**BL 2019 Purpose**

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.
**Strategy-Related Measures Definitions**

85th Regular Session, Agency Submission, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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<th>Objective No.</th>
<th>Strategy No.</th>
<th>Measure Type</th>
<th>Measure No.</th>
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<tbody>
<tr>
<td>5</td>
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<tr>
<td>Encourage Self Sufficiency</td>
<td>Financial and Other Assistance</td>
<td>Temporary Assistance for Needy Families Grants</td>
<td>Average Number of TANF One-time Payments Per Month</td>
<td></td>
</tr>
</tbody>
</table>

**Calculation Method:** N  
**Target Attainment:** H  
**Priority:** H  
**Cross Reference:** Agy 529 084-R-S70-1 04-01-01 OP 03

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the number of One Time (OT) payments issued. Temporary Assistance for Needy Families (TANF) One Time payments provides a $1000 emergency cash payment to families not receiving monthly TANF/two parent benefits and who meet all TANF eligibility requirements. In order to receive a one-time payment, families must meet all TANF requirements and at least one of the crisis criteria as outlined in the Texas Works Handbook.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

Data is obtained from the 'TANF Warrant History' file based on an eligibility determination system.

**BL 2018 Methodology**

The number of average payments per month is computed by summing the number of TANF One time payments in all months of the reporting period and dividing by the number of months in the reporting period. Because data is reported on an incurred basis, the most recent data are completed using completion ratios. Forecasting models and trends are used to project future estimates.

**BL 2018 Purpose**

This measure provides an average monthly count of persons receiving a TANF one-time payment.

---

**BL 2019 Definition**

This measure reports the number of One Time (OT) payments issued. Temporary Assistance for Needy Families (TANF) One Time payments provides a $1000 emergency cash payment to families not receiving monthly TANF/two parent benefits and who meet all TANF eligibility requirements. In order to receive a one-time payment, families must meet all TANF requirements and at least one of the crisis criteria as outlined in the Texas Works Handbook.

**BL 2019 Data Limitations**

None.

**BL 2019 Data Source**

Data is obtained from the 'TANF Warrant History' file based on an eligibility determination system.
BL 2019 Methodology
The number of average payments per month is computed by summing the number of TANF One time payments in all months of the reporting period and dividing by the number of months in the reporting period. Because data is reported on an incurred basis, the most recent data are completed using completion ratios. Forecasting models and trends are used to project future estimates.

BL 2019 Purpose
This measure provides an average monthly count of persons receiving a TANF one-time payment.
Strategy-Related Measures Definitions
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<td>Objective No.</td>
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<td>Financial and Other Assistance</td>
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<tr>
<td>Measure No.</td>
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<td>Number of Children Receiving $30 Once a Year Grant</td>
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Calculation Method: C  Target Attainment: L  Priority: H  Cross Reference: Agy 529 084-R-S70-1 04-01-01 OP 04

Key Measure: N  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measure reports the number of children who received the once a year grant of $30 per child. Children are eligible to receive this grant if they were eligible to receive TANF or State Two Parent Cash Assistance benefits for the month of August.

BL 2018 Data Limitations
None.

BL 2018 Data Source
Data is obtained from the "TANF Warrant History" file based on an eligibility determination system

BL 2018 Methodology
An ad hoc report will provide a count of children who received the once a year grant.

BL 2018 Purpose
This measure shows the number of children in Texas impacted by the funds appropriated in this strategy for a once a year grant that is to be provided each August to assist TANF and two parent families purchase school clothes and supplies.

BL 2019 Definition
This measure reports the number of children who received the once a year grant of $30 per child. Children are eligible to receive this grant if they were eligible to receive TANF or State Two Parent Cash Assistance benefits for the month of August.

BL 2019 Data Limitations
None.

BL 2019 Data Source
Data is obtained from the "TANF Warrant History" file based on an eligibility determination system

BL 2019 Methodology
An ad hoc report will provide a count of children who received the once a year grant.
BL 2019 Purpose

This measure shows the number of children in Texas impacted by the funds appropriated in this strategy for a once a year grant that is to be provided each August to assist TANF and two parent families purchase school clothes and supplies.
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 5  
Objective No. 1  
Strategy No. 1  
Measure Type OP  
Measure No. 5

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Calculation Method: N  
Target Attainment: L  
Priority: H  
Cross Reference: Agy 529 084-R-S70-1 04-01-01 OP 05

Key Measure: N  
New Measure: N  
Percentage Measure: N

**BL 2018 Definition**
This measure reports the monthly average number of TANF One time Grandparent payments made during the reporting period. The 76th session of the Texas Legislature authorized the department to provide assistance payments to qualified grandparents on behalf of dependent children. The eligible grandparent population was expanded by SB297 of the 77th Legislature to include grandparents age 45 and older with an income of 200% of poverty or under.

**BL 2018 Data Limitations**
Only one TANF One time Grandparent payment is counted per TANF Grandparent case.

**BL 2018 Data Source**
TANF One time Grandparent payment data are from the agency's Client Server Support System Grandparent Payment System database.

**BL 2018 Methodology**
The number of monthly TANF Grandparent payments is summed for all months in the reporting period, then divided by the number of months in the reporting period to determine the average per month.

**BL 2018 Purpose**
This measure provides information on the utilization of TANF One time Grandparent payments.

**BL 2019 Definition**
This measure reports the monthly average number of TANF One time Grandparent payments made during the reporting period. The 76th session of the Texas Legislature authorized the department to provide assistance payments to qualified grandparents on behalf of dependent children. The eligible grandparent population was expanded by SB297 of the 77th Legislature to include grandparents age 45 and older with an income of 200% of poverty or under.

**BL 2019 Data Limitations**
Only one TANF One time Grandparent payment is counted per TANF Grandparent case.

**BL 2019 Data Source**
TANF One time Grandparent payment data are from the agency's Client Server Support System Grandparent Payment System database.
**BL 2019 Methodology**

The number of monthly TANF Grandparent payments is summed for all months in the reporting period, then divided by the number of months in the reporting period to determine the average per month.

**BL 2019 Purpose**

This measure provides information on the utilization of TANF One time Grandparent payments.
Strategy-Related Measures Definitions
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<td>5 Encourage Self Sufficiency</td>
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<tr>
<td>Objective No.</td>
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<tr>
<td>Strategy No.</td>
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<tr>
<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
<td>6 Avg # TANF/State Cash Adults Per Month w/ State Time-limited Benefits</td>
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**Calculation Method:** N  
**Target Attainment:** H  
**Priority:** H  
**Cross Reference:** Agy 529 084-R-S70-1 04-01-01 OP 06

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

### BL 2018 Definition

This measure reports the average number of adults receiving Temporary Assistance for Needy Families (TANF) or State Two Parent Cash Assistance in the month who have used one or more state time limited months. The term "time limited" refers to the maximum length of time that a client is eligible to receive benefits. State time limits are determined based on education, functional literacy and work history, and are for 12, 24 or 36 months.

### BL 2018 Data Limitations

Mandatory clients (those w/o employment services exemptions or good cause for not participating) begin using their state time limited benefits 1 month after they are contacted by TX Workforce Commission (TWC) or a local entity directly or indirectly under contract with TWC for participation in the Choices program if they have a 12 or 24 month limit. Clients with a 36 month limit are given 12 months before their state time limited benefits begin, to correct basic educational deficiencies. All of these clients continue to use state time limited benefits unless they are given good cause not to participate, move outside the area served by the Choices program, their Choices case is closed, or they cease receiving TANF or State Two Parent Cash Asst. Exempt clients who participate in the Choices program use their state time limited benefits only in the months in which they participate in Choices.

### BL 2018 Data Source

Data are obtained from computer runs using monthly eligibility files. These files are used to establish the number of months that are counted toward a person's state time limit.

### BL 2018 Methodology

Data is calculated by adding the monthly number of TANF and State Two Parent Cash Assistance adults who have used one or more state time limited months, and dividing by the number of months in the reporting period. Data are unduplicated within the month.

### BL 2018 Purpose

This measure quantifies the population at risk of losing TANF funded financial assistance or State Two Parent Cash Assistance due to the state time limited eligibility criteria stipulated in recent state welfare reform laws.

### BL 2019 Definition

This measure reports the average number of adults receiving Temporary Assistance for Needy Families (TANF) or State Two Parent Cash Assistance in the month who have used one or more state time limited months. The term "time limited" refers to the maximum length of time that a client is eligible to receive benefits. State time limits are determined based on education, functional literacy and work history, and are for 12, 24 or 36 months.
BL 2019 Data Limitations
Mandatory clients (those w/o employment services exemptions or good cause for not participating) begin using their state time limited benefits 1 month after they are contacted by TX Workforce Commission (TWC) or a local entity directly or indirectly under contract with TWC for participation in the Choices program if they have a 12 or 24 month limit. Clients with a 36 month limit are given 12 months before their state time limited benefits begin, to correct basic educational deficiencies. All of these clients continue to use state time limited benefits unless they are given good cause not to participate, move outside the area served by the Choices program, their Choices case is closed, or they cease receiving TANF or State Two Parent Cash Asst. Exempt clients who participate in the Choices program use their state time limited benefits only in the months in which they participate in Choices.

BL 2019 Data Source
Data are obtained from computer runs using monthly eligibility files. These files are used to establish the number of months that are counted toward a person's state time limit.

BL 2019 Methodology
Data is calculated by adding the monthly number of TANF and State Two Parent Cash Assistance adults who have used one or more state time limited months, and dividing by the number of months in the reporting period. Data are unduplicated within the month.

BL 2019 Purpose
This measure quantifies the population at risk of losing TANF funded financial assistance or State Two Parent Cash Assistance due to the state time limited eligibility criteria stipulated in recent state welfare reform laws.
### BL 2018 Definition

This measure reports the average number of adults receiving Temporary Assistance for Needy Families (TANF) or State Two Parent Cash Assistance in the month who have used one or more time limited months. The term "time limited" refers to the maximum length of time that a client is eligible to receive benefits. TANF and State Two-Parent Cash Assistance programs allow a maximum of 60 months of benefits.

### BL 2018 Data Limitations

All adult clients begin using their time limited benefits effective October 1999 or their first month on TANF or State Two-Parent Cash Assistance, if later. Months counted toward the state time limit from November 1996 through September 1999 also count towards the 60 month time limit.

### BL 2018 Data Source

Data are obtained from computer runs using monthly eligibility files. These files are used to establish the number of months that are counted toward a person’s Federal time limit.

### BL 2018 Methodology

Data is calculated by summing for all months of the reporting period, the monthly number of TANF and State Two-Parent Cash Assistance adults who have used one or more 60 month time limited months, and dividing by the number of months in the reporting period. Data are unduplicated within the month.

### BL 2018 Purpose

This measure quantifies the population at risk of losing TANF funded financial assistance or State Two Parent Cash Assistance due to the 60 month time limited eligibility criteria stipulated in recent federal welfare reform laws.

### BL 2019 Definition

This measure reports the average number of adults receiving Temporary Assistance for Needy Families (TANF) or State Two Parent Cash Assistance in the month who have used one or more time limited months. The term "time limited" refers to the maximum length of time that a client is eligible to receive benefits. TANF and State Two-Parent Cash Assistance programs allow a maximum of 60 months of benefits.

### BL 2019 Data Limitations

All adult clients begin using their time limited benefits effective October 1999 or their first month on TANF or State Two-Parent Cash Assistance, if later. Months counted toward the state time limit from November 1996 through September 1999 also count towards the 60 month time limit.

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**Goal No. 5** Encourage Self Sufficiency

**Objective No. 1** Financial and Other Assistance

**Strategy No. 1** Temporary Assistance for Needy Families Grants

**Measure Type** OP

**Measure No. 7** Avg # TANF/State Cash Adults/Month with Federal Time-limited Benefits

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BL 2019 Data Source
Data are obtained from computer runs using monthly eligibility files. These files are used to establish the number of months that are counted toward a person’s Federal time limit.

BL 2019 Methodology
Data is calculated by summing for all months of the reporting period, the monthly number of TANF and State Two-Parent Cash Assistance adults who have used one or more 60 month time limited months, and dividing by the number of months in the reporting period. Data are unduplicated within the month.

BL 2019 Purpose
This measure quantifies the population at risk of losing TANF funded financial assistance or State Two Parent Cash Assistance due to the 60 month time limited eligibility criteria stipulated in recent federal welfare reform laws.
### BL 2018 Definition

The average food cost per person is the average cost of supplemental allowable foods purchased as part of the services to eligible WIC program participants.

### BL 2018 Data Limitations

The most recent data available is used at reporting deadline.

### BL 2018 Data Source

Actual food costs are obtained from the HHSC automated accounting records, which aggregate payments made to vendors with food funds. Rebates are calculated within the WIC automated system using the effective contract rebate rates as specified in the respective contracts.

### BL 2018 Methodology

To calculate the post-rebate average cost per participant, the total food cost for the reporting period less the total rebate dollars received during the reporting period is divided by the total number of participants served during the reporting period. This calculation is based on a federal fiscal year.

### BL 2018 Purpose

Measures the average food costs per person receiving services.

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<td>2</td>
<td>Provide WIC Services: Benefits, Nutrition Education &amp; Counseling</td>
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<td>Measure Type</td>
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<td>Average Food Costs Per Person Receiving Services</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 537 084-R-S70-1 02-01-01 EF 01  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N
BL 2019 Purpose
**Strategy-Related Measures Definitions**
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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<td>Measure Type EX</td>
<td>Measure No. 1 WIC Breastfeeding Initiation Rate</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 537 084-R-S70-1 02-01-01 EX 01  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure represents the percent of infants whose mothers were participants in the program during pregnancy and initiated breastfeeding at or before the time of the infant’s certification of eligibility.

**BL 2018 Data Limitations**
If a WIC mother does not certify her infant prior to seven months of age, the data is not available.

**BL 2018 Data Source**
This performance measure is derived from the WIC Automated Benefits Delivery System that records: • the number of infants, who were born to WIC mothers, • whether or not the infant is currently being breastfed, and • if the infant is not currently breastfed, the date breastfeeding ended. These fields are required fields in the clinics.

**BL 2018 Methodology**
The percent is calculated by dividing the most recently completed month’s unduplicated number of infants, whose mothers were participants in the program during pregnancy, breastfed at or before the time of their certification of eligibility by the total unduplicated number of infants whose mothers were participants in the program during pregnancy.

**BL 2018 Purpose**
This measure is intended to show the effectiveness of the program’s efforts to encourage pregnant women to initiate breastfeeding. It is not intended to measure duration of breastfeeding.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
Strategy-Related Measures Definitions
85th Regular Session, Agency Submission, Version 1
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 5 Encourage Self Sufficiency
Objective No. 1 Financial and Other Assistance
Strategy No. 2 Provide WIC Services: Benefits, Nutrition Education & Counseling
Measure Type OP
Measure No. 1 Number of WIC Families Provided Nutrition Education & Counseling

Calculation Method: C
Target Attainment: Priority: Cross Reference: Agy 537 084-R-S70-1 02-01-01 OP 01
Key Measure: N New Measure: N Percentage Measure: N

BL 2018 Definition
The total number of times WIC families receive either group nutrition education or individual nutrition counseling during the reporting period. WIC participants are typically seen at the WIC clinic every 3 months and are offered group education or individual counseling during each of these visits. This is a duplicative count because participants may receive 4 or more educational contacts per year.

BL 2018 Data Limitations
Estimates may be used at reporting deadlines.

BL 2018 Data Source
The WIC automated data system is the data source. Local WIC agencies document nutrition education and counseling contacts on the system at the clinic level and transmit this data to the central WIC office at HHSC.

BL 2018 Methodology
The WIN system is queried at the central WIC office to derive this total for the reporting period. This calculation is based on a federal fiscal year.

BL 2018 Purpose
Measures the total number of times WIC families receive either group nutrition education or individual nutrition counseling during the reporting period.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

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<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This output measures actual state-wide monthly participation determined by the number of WIC clients provided with supplemental foods for a particular month. 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 or food instruments during the reporting period.

**BL 2018 Data Limitations**
Most recent data available is used at reporting deadlines.

**BL 2018 Data Source**
Participation counts are collected through the WIC automated system.

**BL 2018 Methodology**
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.

**BL 2018 Purpose**
This output measures actual state-wide monthly participation determined by the number of WIC clients provided with supplemental food for a particular month.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
Strategy-Related Measures Definitions
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Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 5  
Objective No. 1  
Strategy No. 3  
Measure Type OP  
Measure No. 1  

Goal: Encourage Self Sufficiency  
Objective: Financial and Other Assistance  
Strategy: Refugee Assistance  
Measure: Number of Refugees Receiving Services

Calculation Method: C  
Target Attainment: H  
Priority: L  

Cross Reference: Agy 529 084-R-S70-1 04-01-02 OP 01

Key Measure: N  
New Measure: N  
Percentage Measure: N

BL 2018 Definition
The number provided is an unduplicated count of refugee clients who receive refugee services which include medical and financial services.

BL 2018 Data Limitations
Social and financial services are dependent on each contractor timely and accurately entering information into the data collection system maintained by program. Data on medical services are dependent on HHSC Eligibility Staff timely and accurately entering information in the eligibility determination system. Program relies on agency programs to provide information (e.g., extracts and compiles applicable information, provides the file, cross-references available information, eliminates duplication and makes any necessary corrections to data).

BL 2018 Data Source
Information on social and financial services is obtained from the data collection system maintained by Office of Immigration and Refugee Affairs (OIRA) which is an on-line automated system that records the number of refugees receiving these services. Medical information is obtained from a report from the eligibility determination system.

BL 2018 Methodology
Program area extracts and compiles data on medical services from the eligibility determination system to identify TP02 clients. TP02 is a designator for clients who receive refugee medical services. IT queries the OIRA data collection system to obtain a list of refugee clients that receive social and financial services and cross references this list with the list of clients receiving medical services. Program area identifies any duplication and develops a comprehensive, unduplicated count of clients who received refugee services which would include social, medical and financial services.

BL 2018 Purpose
This measure provides a count of unduplicated persons receiving refugee services funded by HHSC which include medical and financial services.

BL 2019 Definition
The number provided is an unduplicated count of refugee clients who receive refugee services which include medical and financial services.

BL 2019 Data Limitations
Social and financial services are dependent on each contractor timely and accurately entering information into the data collection system maintained by program. Data on medical services are dependent on HHSC Eligibility Staff timely and accurately entering information in the eligibility determination system. Program relies on agency programs to provide information (e.g., extracts and compiles applicable information, provides the file, cross-references available information, eliminates duplication and makes any necessary corrections to data).

BL 2019 Data Source
Information on social and financial services is obtained from the data collection system maintained by Office of Immigration and Refugee Affairs (OIRA) which is an on-line automated system that records the number of refugees receiving these services. Medical information is obtained from a report from the eligibility determination system.

BL 2019 Methodology
Program area extracts and compiles data on medical services from the eligibility determination system to identify TP02 clients. TP02 is a designator for clients who receive refugee medical services. IT queries the OIRA data collection system to obtain a list of refugee clients that receive social and financial services and cross references this list with the list of clients receiving medical services. Program area identifies any duplication and develops a comprehensive, unduplicated count of clients who received refugee services which would include social, medical and financial services.

BL 2019 Purpose
This measure provides a count of unduplicated persons receiving refugee services funded by HHSC which include medical and financial services.
BL 2018 Definition
Reports unduplicated number of Federal Emergency Management Agency (FEMA) referrals for Other Needs Assistance (ONA) under the Individual and Households Program (IHP) approved for a grant during a presidentially declared disaster. The maximum grant is $31,400 for each individual/household, and is adjusted annually. Grants are provided for disaster-related serious needs and necessary expenses not met by the victim's insurance, voluntary organizations or other relief organizations. For property losses, the victim must be denied loan assistance by the Small Business Administration. IHP grants may consist of Housing Assistance provided directly by FEMA and ONA (for repair or replacement of personal property and vehicles or for medical or funeral assistance) provided by HHSC. Victims must apply for assistance within 60 days after the President declares a major disaster.

BL 2018 Data Limitations
The measurement is limited in determining operational success in that each incident is an individual incident that cannot be benchmarked. The target is to measure the impact of the incident. In that we have to acknowledge the scope, type(s), impact area(s), and number of disasters will limit the agency in measuring success in dollars awarded. Knowing this amount is important to measuring the agency response or impact on public recovery from disaster.

BL 2018 Data Source
Data is obtained from reports on applications approved from the Disaster Assistance Reporting Information System, which interfaces with the federal National Emergency Management Information System.

BL 2018 Methodology
Reported data are computed as follows: The number of applications approved is summed for each state fiscal year based either on the month of payment or the date the disaster is declared as determined for each disaster by HHSC executive leadership.

BL 2018 Purpose
This measure is a mechanism for assessing in the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the services delivered.
Reports unduplicated number of Federal Emergency Management Agency (FEMA) referrals for Other Needs Assistance (ONA) under the Individual and Households Program (IHP) approved for a grant during a presidentially declared disaster. The maximum grant is $31,400 for each individual/household, and is adjusted annually. Grants are provided for disaster-related serious needs and necessary expenses not met by the victim's insurance, voluntary organizations or other relief organizations. For property losses, the victim must be denied loan assistance by the Small Business Administration. IHP grants may consist of Housing Assistance provided directly by FEMA and ONA (for repair or replacement of personal property and vehicles or for medical or funeral assistance) provided by HHSC. Victims must apply for assistance within 60 days after the President declares a major disaster.

BL 2019 Data Limitations
The measurement is limited in determining operational success in that each incident is an individual incident that cannot be benchmarked. The target is to measure the impact of the incident. In that we have to acknowledge the scope, type(s), impact area(s), and number of disasters will limit the agency in measuring success in dollars awarded. Knowing this amount is important to measuring the agency response or impact on public recovery from disaster.

BL 2019 Data Source
Data is obtained from reports on applications approved from the Disaster Assistance Reporting Information System, which interfaces with the federal National Emergency Management Information System.

BL 2019 Methodology
Reported data are computed as follows: The number of applications approved is summed for each state fiscal year based either on the month of payment or the date the disaster is declared as determined for each disaster by HHSC executive leadership.

BL 2019 Purpose
This measure is a mechanism for assessing in the agency's performance as it pertains to implementing the provisions of this strategy. It quantifies the services delivered.
BL 2018 Definition

This measure reports the average monthly cost of providing direct delivery guardianship services by the Health and Human Services Commission (HHSC) staff.

BL 2018 Data Limitations

As a comparative measure with the cost of guardianships provided by HHSC contractors, this is limited by the fact that all of the assessments for capacity and identification of less restrictive alternatives for both direct delivery and contracted guardianships are performed by HHSC staff, not contractors.

BL 2018 Data Source

Actual expenditures are from the Health and Human Services Administrative System – Financials System (HHSAS-FS) for Program Activity Code (PAC) 580 (Guardianship Staff Services). The number of wards receiving HHSC guardianship services is currently from the Guardianship Online Database (GOLD) system; where the guardianship letter was issued on or before the end of the reporting month. This measure includes both new and on-going guardianship services provided directly by HHSC staff. GOLD has replaced the Information Management Protecting Adults and Children in Texas (IMPACT) data source for the number of guardianships.

BL 2018 Methodology

Annual expenditure projections for PAC 580 are made using an internal budget document that includes actual expenditures reported on HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. These amounts are totaled and the total is divided by the number of months in the reporting period to arrive at the average monthly cost. The average monthly cost per HHSC direct delivery guardianship ward served is calculated by dividing the average monthly cost by the average monthly number of HHSC direct delivery wards served.

BL 2018 Purpose

This measure is useful as a benchmark and to monitor changes in HHSC staff costs for serving direct delivery Guardianship wards.

BL 2019 Definition

BL 2019 Data Limitations
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
**BL 2018 Definition**

This measure reports the average monthly cost of providing contracted guardianship services by private guardianship programs.

**BL 2018 Data Limitations**

As a comparative measure with the cost of guardianships provided by Health and Human Services Commission (HHSC) staff, this is limited by the fact that all of the assessments for capacity and identification of less restrictive alternatives for both direct delivery and contracted guardianships are performed by HHSC staff, not contractors.

**BL 2018 Data Source**

Actual expenditures are from the Health and Human Services Administrative System – Financials System (HHSAS-FS) for Program Activity Code (PAC) 580 (Guardianship Staff Services). The actual cost of the contracts plus a representative share of the state office contract monitoring staff is used. The number of wards receiving HHSC guardianship services through contractors is currently from the Guardianship Online Database (GOLD) system the guardianship letter was issued on or before the end of the reporting month. This measure includes both new and on-going guardianship services provided by HHSC contractors. Gold has replaced IMPACT as a data source for the number of guardianships.

**BL 2018 Methodology**

Annual expenditure projections for PAC 580 are made using an internal budget document that includes actual expenditures reported on HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. These amounts are totaled and the total is divided by the number of months in the reporting period to arrive at the average monthly cost. The average monthly cost per HHSC contracted guardianship ward served is calculated by dividing the average monthly cost by the average monthly number of HHSC contracted wards served.

**BL 2018 Purpose**

This measure is useful as a benchmark and to monitor changes in HHSC costs for serving contracted Guardianship wards.

**BL 2019 Definition**

**BL 2019 Data Limitations**
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Goal No. 6 Community & Independent Living Services & Coordination
Objective No. 1 Long-term Care Services & Coordination
Strategy No. 1 Guardianship
Measure Type EX
Measure No. 1 Average Monthly Cost Per Adult Guardianship Ward

Cross Reference: Agy 539 084-R-S70-1 01-01-02 EX 01

BL 2018 Definition
This measure reports the average monthly cost of providing guardianship services.

BL 2018 Data Limitations
None.

BL 2018 Data Source
Actual expenditures are from the Health and Human Services Administrative System – Financials System (HHSAS-FS) for Program Activity Code (PAC) 580 (Guardianship Staff Services). The number of wards receiving the Health and Human Services Commission (HHSC) guardianship services is from the Information Management Protecting Adults and Children in Texas (IMPACT) system; located in the guardianship detail table where the guardianship letter was issued on or before the end of the reporting month and the event activity type is coded as 'GUA'. This measure includes both new and on-going guardianship services. Due to possible modifications in the HHSC 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.

BL 2018 Methodology
Annual expenditure projections for PAC 580 are made using an internal budget document that includes actual expenditures reported on HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. These amounts are totaled and the total is divided by the number of months in the reporting period to arrive at the average monthly cost. The average monthly cost per HHSC guardianship ward served is calculated by dividing the average monthly cost by the average monthly number of ward served.

BL 2018 Purpose
This measure is useful as a benchmark and to monitor changes in costs attributed to serving HHSC Guardianship wards.

BL 2019 Definition

BL 2019 Data Limitations
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

**Agency Code:** 529

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**BL 2018 Definition**
The measure shows the count of individuals for whom the Department of Family and Protective (DFPS) has validated abuse, neglect or exploitation and made a referral to the Health and Human Services Commission (HHSC), and for whom HHSC guardianship staff must perform an assessment to determine whether or not to apply for guardianship.

**BL 2018 Data Limitations**
The measure does not reflect the outcome of the assessment process; however, in combination with the measure showing the average number of guardianships, it provides a more complete picture of staff workloads.

**BL 2018 Data Source**
Data are currently captured electronically in the Guardianship Online Database (GOLD). The guardianship data system produces a standard monthly report of the number of referrals received. The numerator is the total number of referrals received for the year to date. The denominator is the number of months in the year to date.

**BL 2018 Methodology**
Divide the numerator by the denominator. When calculating the second quarter, third quarter, and fourth quarter, the year-to-date total is recalculated.

**BL 2018 Purpose**
The purpose of this measure is to show the average number of new cases that HHSC guardianship staff must review each month and conduct a capacity assessment for.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
Agency Code: 529

Agency: Health and Human Services Commission

Goal No. 6 Community & Independent Living Services & Coordination

Objective No. 1 Long-term Care Services & Coordination

Strategy No. 1 Guardianship

Measure Type OP

Measure No. 1 Avg Number of Wards Receiving Guardianship Services from HHSC Staff

Calculation Method: N  
Target Attainment: Priority: Cross Reference: Agy 539 084-R-S70-1 01-01-02 OP 01

Key Measure: N  
New Measure: N  
Percentage Measure: N

**BL 2018 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 Health and Human Services Commission (HHSC) staff. The latter on-going guardianships refer to guardianships initiated in previous months and without closure dates.

**BL 2018 Data Limitations**

The usefulness of the data as a workload indicator is limited by the fact that the measure does not include the number of cases being assessed for the appropriateness of guardianship or cases for which less restrictive alternatives are found. This makes comparison with the number of guardianships served by contractors difficult because HHSC staff performs the assessments on wards referred to contractors for guardianship. Documentation can be delayed by the volume of work, which is impacted by vacancies, sick leave, vacation leave, turnover, Guardianship Online Database (GOLD) system downtime, etc.

**BL 2018 Data Source**

Using GOLD, the data are gathered by counting HHSC’s 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 only direct-delivery guardianships. The denominator is the sum of months in the reporting period. The IMPACT detail table was replaced with a report from GOLD system.

**BL 2018 Methodology**

Divide the numerator by the denominator. When calculating the second quarter, third quarter, and fourth quarter, the year-to-date total is recalculated.

**BL 2018 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 HHSC guardianship program.

**BL 2019 Definition**

**BL 2019 Data Limitations**
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Goal No. 6  Community & Independent Living Services & Coordination
Objective No. 1          Long-term Care Services & Coordination
Strategy No. 1   Guardianship
Measure Type OP
Measure No. 2      Avg # Wards Rec Guardianship Svcs: Private Guardianship Programs

BL 2018 Definition
The measure shows the count of wards for whom guardianship has been established through court order. The count includes both new and on-going guardianships for which HHSC pays a contracted private guardianship program to provide services. The latter on-going guardianships refers to guardianships initiated in previous months and without closure dates.

BL 2018 Data Limitations
The usefulness of the data as a comparative workload indicator of wards served by HHSC staff is limited by the fact that the measure does not include the number of cases being assessed for the appropriateness of guardianship or cases for which less restrictive alternatives are found, functions performed by HHSC staff. Documentation can be delayed by the volume of work, which is impacted by vacancies, sick leave, vacation leave, turnover, Guardianship Online Database (GOLD) system downtime, etc.

BL 2018 Data Source
Using GOLD, the data are gathered by counting HHSC contracted 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 only contracted guardianships. The denominator is the sum of months in the reporting period. IMPACT was replaced as a data source by a new GOLD guardianship data system developed by HHSC.

BL 2018 Methodology
Divide the numerator by the denominator. When calculating the second quarter, third quarter, and fourth quarter, the year-to-date total is recalculated.

BL 2018 Purpose
The purpose of this measure is to show the average number of adults for whom HHSC purchased guardianship services during the reporting period. It indicates part of the workload volume in HHSC guardianship program. If HHSC did not contract for these services, they would have to be performed by HHSC staff.

BL 2019 Definition

BL 2019 Data Limitations
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition
This measure reports the average cost of non-Medicaid Title XX-funded Community Services and Supports 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 non-Medicaid Title XX-funded Community Services and Supports individuals is defined under output measure 1 of this strategy.

### BL 2018 Data Limitations
Because it takes several months to close out 100% 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-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.

### BL 2018 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 (CMS) by means of ad hoc query.

### BL 2018 Methodology
The sum of monthly expenditures for non-Medicaid Title XX-funded Community Services and Supports by month-of-service for all months in the reporting period is divided by the average monthly number of non-Medicaid Title XX-funded Community Services and Supports individuals for the months of the reporting period; this is then divided by the number of months in the reporting period.

### BL 2018 Purpose
This measure quantifies the unit cost for providing eligible individuals with services funded under this strategy. This unit cost is a tool for projecting future funding needs.

### BL 2019 Definition

### BL 2019 Data Limitations
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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BL 2018 Definition
This measure reports the average cost of a home-delivered meal funded by the Social Services Block Grant (SSBG). 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 meals served is defined under output measure 2 of this strategy.

BL 2018 Data Limitations
Because it takes several months to close out 100% of the claims for a month of service, the number of individuals must be estimated for months that have not yet closed out, by using "completion factors" specific to each service applied to the number of clients 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.

BL 2018 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 (CMS) by means of ad hoc query.

BL 2018 Methodology
The sum of monthly expenditures for meals services by month-of-service for all months in the reporting period is divided by the average monthly number of meals served during the months of the reporting period; this is then divided by the number of months in the reporting period.

BL 2018 Purpose
This measure quantifies the average unit cost for one of the services (home-delivered meals) provided under this strategy. This unit cost is a tool for projecting future funding needs.

BL 2019 Definition

BL 2019 Data Limitations

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<tr>
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<td>Community &amp; Independent Living Services &amp; Coordination</td>
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<td>Average Cost Per Home-delivered Meal (SSBG)</td>
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BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
The statewide average State Unit on Aging (HHSC) cost per congregate meal is a measure of the statewide average per meal cost to provide congregate meals to individual's age 60 and older and other eligible individuals. Congregate meals are hot or other appropriate meals served in a setting, which promotes social interaction as well as improved nutrition. Congregate meals provide one-third (1/3) of the recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences - National Research Council and are served in a congregate setting. These meals include standard meals, which are regular meals that are served to the majority of participants. Additionally, therapeutic meals or liquid supplements, which are special meals or liquid supplements that have been prescribed by a physician (i.e., diabetic diets, renal diets, pureed diets, tube feeding) may be served in the congregate setting.

Only State Unit on Aging HHSC funded units are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging HHSC, they are not included in this measure's calculation.

The number of meals is based on data reported to the Commission by area agencies on aging (AAAs). Expenditures are reported by the AAAs and include accrued expenses.

The statewide average State Unit on Aging HHSC cost per meal is calculated by dividing State Unit on Aging HHSC appropriated expenditures reported by the AAAs used to provide congregate meals to individuals age 60 or older and other eligible individuals by the number of congregate meals funded by the State Unit on Aging HHSC during the fiscal year.

This measure identifies the statewide average cost per congregate meal.
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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<td>Measure No.</td>
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<td>Statewide Average Cost Per Home-delivered Meal (AAA)</td>
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**Calculation Method:** N  **Target Attainment:**  **Priority:**
Cross Reference: Agy 539 084-R-S70-1 01-04-01 EF 04

**Key Measure:** N  **New Measure:** N  **Percentage Measure:** N

**BL 2018 Definition**
The statewide average State Unit on Aging HHSC cost per home delivered meal is a measure of the statewide average per meal cost to provide home delivered meals to individuals age 60 and older and other eligible individuals. Home delivered meals are hot, cold, frozen, dried, canned or supplemental food (with a satisfactory storage life), which provide one-third (1/3) of the recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences - National Research Council and are delivered to an eligible individual in his/her place of residence.

**BL 2018 Data Limitations**
Only State Unit on Aging HHSC funded units are considered for this measure. While some units funded by other sources may be reported to the State Unit on Aging HHSC, they are not included in this measure's calculation.

**BL 2018 Data Source**
The number of home delivered meals is based on data reported to the Commission by area agencies on aging (AAAs). Data is reported only for those individuals for whom an intake form is completed. Expenditures are reported by the AAAs and include accrued expenses.

**BL 2018 Methodology**
The statewide average State Unit on Aging HHSC cost per meal is calculated by dividing State Unit on Aging HHSC appropriated expenditures reported by the AAAs used to provide home delivered meals to individuals age 60 or older and other eligible individuals by the number of home delivered meals funded by State Unit on Aging HHSC during the fiscal year.

**BL 2018 Purpose**
This measure identifies the statewide average cost per home delivered meal.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Agencies:

Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 6
Objective No. 1
Strategy No. 2
Measure Type EF
Measure No. 5

Statewide Average Cost Per Person Receiving Homemaker Services (AAA)

Calculation Method: N
Target Attainment: Priority:
Cross Reference: Agy 539 084-R-S70-1 01-04-01 EF 05
Key Measure: N
New Measure: N
Percentage Measure: N

BL 2018 Definition
This is a measure of the statewide average program cost per individual to provide homemaker services to individual age 60 and older funded by the State Unit on Aging HHSC. Homemakers provide services that involve the performance of housekeeping/home management, meal preparation and/or escort tasks and shopping assistance for individuals who need assistance with these activities in their place of residence.

BL 2018 Data Limitations
Only State Unit on Aging HHSC funded individuals are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging HHSC, they are not included in the measure calculation.

BL 2018 Data Source
The number of individuals receiving homemaker services is based on data reported to the Commission by area agencies on aging (AAAs). Data is reported only for those individuals for whom an intake form is completed. Expenditures are reported by the AAAs and include accrued expenses.

BL 2018 Methodology
The statewide average cost per person receiving homemaker services is calculated by dividing expenditures reported by the AAAs used to provide homemaker services to individuals age 60 or older by the unduplicated number of individuals receiving homemaker services funded by the State Unit on Aging HHSC.

BL 2018 Purpose
This measure identifies the State Unit on Aging HHSC average cost per individual receiving homemaker services.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
**Strategy-Related Measures Definitions**
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<td>Measure No.</td>
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<td>Statewide Avg Cost Per Person Rec Personal Assistance Services (AAA)</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 539 084-R-S70-1 01-04-01 EF 06

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
The statewide average cost per individual receiving personal assistance services is a measure of the statewide average program cost per individual used to provide personal assistance services to people age 60 and older. Personal assistance is the act of assisting another person with tasks that the individual would typically do if he were able. This covers hands-on assistance in all activities of daily living. Personal assistance staff are trained and supervised.

**BL 2018 Data Limitations**
Only State Unit on Aging HHSC funded individuals are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging HHSC, they are not included in the measure calculation.

**BL 2018 Data Source**
The number of individuals receiving personal assistance services is based on data reported to the Commission by the area agencies on aging (AAAs). Data is reported only for those individuals for whom an intake form is completed. Expenditures are reported by the AAAs and include accrued expenses.

**BL 2018 Methodology**
The statewide average cost per individual receiving personal assistance services is calculated by dividing State Unit on Aging HHSC expenditures reported by the AAAs used to provide personal assistance services to individuals age 60 or older by the unduplicated number of individuals receiving personal assistance services funded by the State Unit on Aging HHSC.

**BL 2018 Purpose**
This measure identifies the statewide average cost per individual receiving personal assistance services.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
**BL 2018 Definition**

This is a measure of the statewide average program cost per home to provide home repair or modification for the dwellings of individual age 60 and older. Residential repair services consist of repairs or modifications of client-occupied dwellings essential for the health and safety of the occupants. This service can also include limited housing, counseling, and moving expenses where repairs of modifications will not attain reasonable standards of health and safety.

**BL 2018 Data Limitations**

Only State Unit on Aging HHSC funded units are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging HHSC, they are not included in the measure calculation.

**BL 2018 Data Source**

The number of homes is based on data reported to the Commission by area agencies on aging (AAAs). Expenditures are reported by the AAAs and include accrued expenses.

**BL 2018 Methodology**

The statewide average cost per modified home is calculated by dividing State Unit on Aging HHSC expenditures reported by the AAAs used to provide these services to individuals age 60 or older by the unduplicated number of homes receiving home repair/modification funded by the State Unit on Aging HHSC.

**BL 2018 Purpose**

This measure identifies the statewide average State Unit on Aging HHSC cost per modified home.
Automated Budget and Evaluation System of Texas (ABEST)

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<td>Average Monthly Cost of In-home Family Support Per Individual</td>
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Calculation Method: N  Target Attainment:  Priority:  Cross Reference: Agy 539  084-R-S70-1  01-04-04  EF 01
Key Measure: Y  New Measure: N  Percentage Measure: N

**BL 2018 Definition**
This measure reports the average in-home/family support cash assistance per individual per month. Individuals are provided assistance for the purchase of supportive services that will enable them to remain independent. Individuals are eligible for assistance up to $1,200 a year.

**BL 2018 Data Limitations**
Does not apply.

**BL 2018 Data Source**
Data are obtained from the commission’s Health and Human Services Administrative System (HHSAS) Financials.

**BL 2018 Methodology**
Data are computed by taking the projected in-home funding expended monthly, and dividing by the total number of individuals per month. The computation is based on a rolling 12-month average individual count and rolling 12-months of expenditure data, with a one-month lag.

**BL 2018 Purpose**
This measure is important because it quantifies the average cost per unit of service. This unit cost is a tool for projecting future funding needs.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
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**Goal No.** 6  Community & Independent Living Services & Coordination

**Objective No.** 1  Long-term Care Services & Coordination

**Strategy No.** 2  Non-Medicaid Services

**Measure Type** EX

**Measure No.** 1  Avg # of Persons on Interest List Per Month: Non-Medicaid CSS (XX)

**Calculation Method:** N  **Target Attainment:**  **Priority:**  
Cross Reference: Agy 539 084-R-S70-1 01-04-01 EX 01

**Key Measure:** N  **New Measure:** N  **Percentage Measure:** N

**BL 2018 Definition**

This measure reports the average monthly duplicated number of individuals who have requested one or more Title XX-funded non-Medicaid Community Services and Supports through completion of a Community Services and Supports Intake Form 2110, but are placed on an interest list for requested service(s) due to funding constraints. The count only includes those individuals on the list who are in “open” status (i.e., it excludes those individuals who are being processed for eligibility to begin receiving the service.) The count includes individuals who are waiting for one or more Title XX-funded non-Medicaid Community Services and Supports while receiving other Community Services and Supports.

**BL 2018 Data Limitations**

Individuals on the interest list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information.

**BL 2018 Data Source**

Regional staff enters the data into a reporting database maintained by State Office program staff.

**BL 2018 Methodology**

Counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly counts of individuals on the interest list for (one or more) non-Medicaid Community Services and Supports (as described above) for all months of the reporting period, by the number of months in the reporting period.

**BL 2018 Purpose**

This measure is important because it is an indicator of the unmet need for services provided under non-Medicaid Community Services and Supports as currently funded by this strategy.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition
This measure reports the monthly average unduplicated number of individuals who, based upon approved-to-pay claims, received one or more non-Medicaid Title XX-funded Community Services and Supports and did not receive either entitlement or waiver services. Services included under this category are: Family Care, Home-delivered Meals, Emergency Response Services, Adult Foster Care, Day Activities and Health Services (funded through Social Services Block Grant), Consumer Managed Personal Attendant Services, Residential Care, and Special Services for Individuals with Disabilities.

### BL 2018 Data Limitations
Because it takes several months to close out 100% 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. 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.

### BL 2018 Data Source
Two types of data are used to report this measure. 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 (SAS) 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, the number of units of service approved-to-pay, and the amounts approved-to-pay are obtained from claims payment data provided by TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software.

### BL 2018 Methodology
Since a high percentage of individuals who receive Meals and/or Emergency Response Services also receive other services, an unduplicated monthly count of individuals receiving one or more non-Medicaid Title XX-funded community care services must be estimated. This is accomplished by multiplying counts for these two services by the percentage of individuals who are authorized to receive these services only, as opposed to these services in addition to other services, according to information obtained from SAS authorization data. 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.

### BL 2018 Purpose
This measure provides a count of individuals who received Non-Medicaid Title XX funded community services and supports, who did not receive other community services and supports (Medicaid entitlement or Medicaid Waiver services). This measure is important because when it is combined with the measure reporting the total number of individuals receiving Medicaid entitlement services and the measure reporting the total number of individuals receiving Medicaid waiver services, it yields the total number of individuals receiving community supports and services through programs administered by the Health and Human Services Commission (HHSC).

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
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<td>2 Non-Medicaid Services</td>
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<td>Measure No.</td>
<td>3 Avg # of Individuals Receiving Svc at the End of the Fiscal Yr: XX/GR</td>
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Calculation Method: N  Target Attainment:  Priority:  Cross Reference: Agy 539 084-R-S70-1 01-04-01 EX 03
Key Measure: Y  New Measure: N  Percentage Measure: N

**BL 2018 Definition**
This measure provides an unduplicated workload count of priority population eligible adults and children who receive ID community services at the end of the fiscal year. ID community services include non-residential services including: vocational services, training services, respite services, and specialized therapies.

**BL 2018 Data Limitations**
This measure provides the actual number of individuals who receive community services and provides information about the total system activity during one fiscal year. It is a frequently requested number used to compare system activity over a period of two or more fiscal years. 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.

**BL 2018 Data Source**
As individuals enter the community programs, registration information is entered into the commission's Client Assignment and Registration (CARE) system 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. Individuals who receive more than one community service during the year are counted only once for the year.

**BL 2018 Methodology**
The total unduplicated number of individuals that receive a ID community service during the fiscal year regardless of how the services for the individuals were funded is tallied for each local authority and system-wide.

**BL 2018 Purpose**
This measure provides the actual unduplicated number of persons who receive ID community services and provides information about the total system activity during one fiscal year.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**
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<td>Measure No.</td>
<td>4</td>
<td>Average Number on Interest List Per Month: IHFS Individuals</td>
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**BL 2018 Definition**
This measure reports the count of individuals who have requested In-Home Family Support (IHFS) services through completion of the Community Care intake Form 2110 but, due to funding limitations, have not been able to obtain services. The count only includes those individuals on the list who are in “open” status (i.e., it excludes those individuals who are being processed for eligibility to begin receiving the service.)

**BL 2018 Data Limitations**
Individuals on the interest list are contacted at least annually to determine whether they are still interested in remaining on the list and to verify contact information.

**BL 2018 Data Source**
Counts are collected on a monthly basis. Data are reported by means of a reporting database maintained by State Office program.

**BL 2018 Methodology**
Counts are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the monthly counts of individuals on the interest list for In Home and Family Support (as described above) for all months of the reporting period, by the number of months in the reporting period.

**BL 2018 Purpose**
This measure is an indicator of the unmet need for services currently funded under this strategy.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
### BL 2018 Definition
This measure reports the number of individual who received in-home/family support assistance in the month of August of each fiscal year. Individuals are provided assistance for the purchase of supportive services that will enable them to remain independent. Individuals are eligible for assistance up to $1200 per year in cash subsidy for the purpose of ongoing services and/or the purchase of equipment or architectural modifications.

### BL 2018 Data Limitations
Does not apply.

### BL 2018 Data Source
Data are obtained from the commission's Health and Human Services Administrative System (HHSAS) Financials.

### BL 2018 Methodology
Data for this measure are the sum of one month of data from 1 August to 31 August in each reporting fiscal year to report the number of in-home individuals who receive assistance. Reported data reflects data capture due to one-month lag during normal reporting.

### BL 2018 Purpose
This measure provides a means to establish baseline funding levels from biennium to biennium

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### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology
BL 2019 Purpose
This measure reports the monthly average unduplicated number of individuals who, based upon approved-to-pay claims, received a home-delivered meal funded through the Social Services Block Grant (SSBG). Individuals are provided with hot, nutritious meals delivered directly to their home.

Because it takes several months to close out 100% 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 individuals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of individuals ultimately served.

Two types of data are used to report this measure. The number of individuals authorized to receive home delivered meals, as well as the number of meals authorized, are obtained from the commission's Service Authorization System (SAS) 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, the number of meals approved-to-pay, and the amounts approved-to-pay are obtained from the commission's Claims Management System (CMS) by means of ad hoc query.

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.

This measure provides a count of eligible individuals who are receiving home-delivered meals, a service that contributes to enabling them to remain in their own home as opposed to being placed in another more restrictive setting.
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Goal No. 6 Community & Independent Living Services & Coordination
Objective No. 1 Long-term Care Services & Coordination
Strategy No. 2 Non-Medicaid Services
Measure Type OP
Measure No. 2 Average Number of Home-delivered Meals Provided Per Month (SSBG)

Calculation Method: N
Target Attainment: 
Priority: 
Cross Reference: Agy 539 084-R-S70-1 01-04-01 OP 02

Key Measure: N
New Measure: N
Percentage Measure: N

BL 2018 Definition
This measure reports the monthly average number of home-delivered meals on approved-to-pay claims submitted by Meals providers and funded through the Social Services Block Grant (SSBG).

BL 2018 Data Limitations
Because it takes several months to close out 100% of the claims for a month of service, the number of meals ultimately provided must be estimated for months that have not yet closed out, by using "completion factors" applied to the number of meals approved-to-pay to-date and/or the number of meals authorized. 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 meals on approved-to-pay claims to-date divided by the appropriate completion factor equals the estimated number of meals ultimately provided.

BL 2018 Data Source
Two types of data are used to report this measure. The number of individuals authorized to receive home delivered meals, as well as the number of meals authorized, are obtained from the commission's Service Authorization System (SAS) 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, the number of meals approved-to-pay, and the amounts approved-to-pay, are obtained from the commission's Claims Management System (CMS) by means of ad hoc query.

BL 2018 Methodology
Data are collected on a monthly basis. The monthly average for the reporting period is calculated by dividing the sum of the number of home-delivered meals provided (as described above) for all months of the reporting period, by the number of months in the reporting period.

BL 2018 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 volume of services delivered (meals).

BL 2019 Definition

BL 2019 Data Limitations
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**

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**Goal No. 6 Community & Independent Living Services & Coordination**

**Objective No. 1 Long-term Care Services & Coordination**

**Strategy No. 2 Non-Medicaid Services**

**Measure No. 3 Number of Individuals Receiving Congregate Meals (AAA)**

---

**BL 2018 Definition**

The measure is the unduplicated number of individuals age 60 and older and other eligible individuals reported to the Department by area agencies on aging (AAAs) as receiving congregate meals funded by the State Unit on Aging (HHSC). Congregate meals are hot or other appropriate meals served to eligible individuals which meets one-third (1/3) of the recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences B National Research Council and which is served in a congregate setting. There are two types of congregate meals. These are standard meals which are regular meals from the standard menu that are served to the majority of all of the participants and therapeutic meals or liquid supplements that have been prescribed by a physician and are planned specifically for an individual participant by a dietician (i.e., diabetic diets, renal diets, pureed diets, tube feeding) may be served in the congregate setting.

**BL 2018 Data Limitations**

Only State Unit on Aging (HHSC) funded individuals are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging (HHSC), they are not included in the measure calculation.

**BL 2018 Data Source**

The number of individuals is based on data reported to the Commission by the AAAs.

**BL 2018 Methodology**

The measure is the total unduplicated count by AAA, of individuals receiving a congregate meal funded by the State Unit on Aging (HHSC).

**BL 2018 Purpose**

This is an output measure that identifies an unduplicated count of individuals receiving a congregate meal funded by the State Unit on Aging (HHSC).

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

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### Agency Code: 529

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#### Agency: Health and Human Services Commission

**Goal No. 6 Community & Independent Living Services & Coordination**

**Objective No. 1 Long-term Care Services & Coordination**

**Strategy No. 2 Non-Medicaid Services**

**Measure Type OP**

**Measure No. 4 Number of Congregate Meals Served (AAA)**

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**Key Measure: N**

**New Measure: N**

**Percentage Measure: N**

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**BL 2018 Definition**

The measure is the number of congregate meals provided to individuals age 60 and older and other elig. individuals reported to the Department by area agencies on aging (AAAs) as rec’g congregate meals funded by the State Unit on Aging (HHSC). Congregate meals are hot or other appro. meals served to elig. indvs that meet 1/3 of the recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences B National Research Council and which is served in a congregate setting. There are two types of congregate meals. These are standard meals which are regular meals from the standard menu that are served to the majority or all of the participants and therapeutic meals or liquid supplements which are special meals or liquid supplements that have been prescribed by a physician and are planned specifically for an individual participant by a dietician (i.e., diabetic diets, renal diets, pureed diets, tube feeding) may be served in the congregate setting.

**BL 2018 Data Limitations**

Only State Unit on Aging (HHSC) funded units are considered for this measure. While some units funded by other sources may be reported to the State Unit on Aging (HHSC), they are not included in this measure's calculation.

**BL 2018 Data Source**

The number of congregate meals is based solely on data reported to the Department by the AAAs.

**BL 2018 Methodology**

The measure is the total congregate meals served to individuals age 60 and older and other eligible individuals.

**BL 2018 Purpose**

This is an output measure that identifies the total congregate meals served to individuals age 60 and older and other eligible individuals.

---

**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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**Goal No. 6 Community & Independent Living Services & Coordination**

**Objective No. 1 Long-term Care Services & Coordination**

**Strategy No. 2 Non-Medicaid Services**

**Measure No. 5 Number of Individuals Receiving Home-delivered Meals (AAA)**

**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-04-01 OP 05

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

The measure is the unduplicated number of individuals age 60 and older and other eligible individuals reported to the Department by area agencies on aging (AAAs) as receiving home delivered meals funded by the State Unit on Aging (HHSC). Home delivered meals are hot, cold, frozen, dried, canned or supplemental food (with a satisfactory storage life) which provide a minimum of one-third (1/3) of the recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences B National Research Council, and are delivered to an eligible individual in his/her place of residence.

**BL 2018 Data Limitations**

Only State Unit on Aging (HHSC) funded individuals are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging (HHSC), they are not included in the measure calculation.

**BL 2018 Data Source**

The number of individuals receiving home delivered meals is based on data reported to the Commission by the AAAs.

**BL 2018 Methodology**

The measure is the total unduplicated number, by AAA, of individuals age 60 and older and other eligible individuals receiving a home delivered meal.

**BL 2018 Purpose**

This measure identifies the unduplicated number of individuals receiving home delivered meals.
BL 2019 Purpose
**Strategy-Related Measures Definitions**  
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### Agency Code: 529  
**Agency:** Health and Human Services Commission

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**Goal No. 6 Community & Independent Living Services & Coordination**  
**Objective No. 1 Long-term Care Services & Coordination**  
**Strategy No. 2 Non-Medicaid Services**

**Measure Type OP**  
**Measure No. 6 Number of Home-delivered Meals Served (AAA)**

**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 539 084-R-S70-1 01-04-01 OP 06

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

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**BL 2018 Definition**

The measure is the number of home delivered meals served to individuals age 60 and older and other eligible individuals reported to the Department by area agencies on aging (AAAs) as receiving home delivered meals funded by the State Unit on Aging (HHSC). Home delivered meals are hot, cold, frozen, dried, canned or supplemental food (with a satisfactory storage life) which provide a minimum of one-third (1/3) of the recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences B National Research Council, and are delivered to an eligible individual in his/her place of residence.

**BL 2018 Data Limitations**

Only State Unit on Aging (HHSC) funded units are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging (HHSC), they are not included in the measure calculation.

**BL 2018 Data Source**

The number of home delivered meals served to individuals age 60 and older is based on data reported to the Commission by the AAAs. Data is reported only for those individuals for whom an intake form is completed.

**BL 2018 Methodology**

The measure is the total number of meals served to individuals age 60 and older and other eligible individuals.

**BL 2018 Purpose**

This measure identifies the number of home delivered meals served.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
**Agency Code:** 529  
**Agency:** Health and Human Services Commission

**Goal No.** 6  
**Objective No.** 1  
**Strategy No.** 2  
**Measure Type** OP  
**Measure No.** 7

**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-04-01 OP 07

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

The measure is the unduplicated number of individuals age 60 and older, who are receiving homemaker services funded by the State Unit on Aging HHSC, as reported to the Commission by area agencies on aging (AAAs). Trained and supervised homemakers provide services that involve the performance of housekeeping/home management, meal preparation and/or escort tasks and shopping assistance for individuals who need assistance with these activities in their place of residence.

**BL 2018 Data Limitations**

Only State Unit on Aging HHSC funded individuals are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging HHSC, they are not included in the measure calculation.

**BL 2018 Data Source**

The number of unduplicated individuals receiving homemaker services is based on data reported to the Commission by AAAs. Data is reported only for those individuals for whom an intake form is completed.

**BL 2018 Methodology**

The number of individuals 60 and older receiving homemaker services is the unduplicated total reported to the Commission by the AAAs.

**BL 2018 Purpose**

This measure identifies the total unduplicated number of individuals 60 and over who have received homemaker services funded by the State Unit on Aging HHSC.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
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Agency: Health and Human Services Commission

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Goal No. 6 Community & Independent Living Services & Coordination
Objective No. 1 Long-term Care Services & Coordination
Strategy No. 2 Non-Medicaid Services
Measure Type: OP
Measure No. 8 Number of Individuals Receiving Personal Assistance (AAA)

Calculation Method: C  
Target Attainment:  
Priority:  
Cross Reference: Agy 539 084-R-S70-1 01-04-01 OP 08

Key Measure: N  
New Measure: N  
Percentage Measure: N

**BL 2018 Definition**
The measure is the unduplicated number of individuals age 60 and older who have received personal assistance services funded by the State Unit on Aging HHSC, as reported to the Commission by area agencies on aging (AAAs). Personal assistance is the act of assisting another person with tasks that that individual would typically do if he were able. This covers hands-on assistance in all activities of daily living. Trained and supervised home health staffs provide the services for individuals who need assistance with these activities in their place of residence.

**BL 2018 Data Limitations**
Only State Unit on Aging HHSC funded individuals are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging HHSC, they are not included in the measure calculation.

**BL 2018 Data Source**
The number of unduplicated individuals receiving personal assistance services is based on data reported to the Commission by the AAAs. Data is reported only for those individuals for whom an intake form is completed.

**BL 2018 Methodology**
The number of persons 60 and older receiving personal assistance services is the unduplicated total reported to the Commission by the AAAs.

**BL 2018 Purpose**
This measure identifies the total unduplicated number of individuals 60 and over who have received personal assistance services funded by the State Unit on Aging HHSC.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

The measure is the unduplicated number of homes reported to the Commission by area agencies on aging (AAAs) as receiving repair or modification services funded by the State Unit on Aging HHSC. Residential repair services consist of repairs or modifications of an individual-occupied dwelling that are essential for the health and safety of the occupants.

### BL 2018 Data Limitations

None.

### BL 2018 Data Source

The unduplicated number of homes receiving repair/modification is based on data reported to the Commission by the AAAs. Data is reported only for those individuals for whom an intake form is completed.

### BL 2018 Methodology

The number of homes receiving repair/modification is the unduplicated total reported to the Commission by the AAAs.

### BL 2018 Purpose

This measure identifies the number of homes receiving repair/modification services funded by the State Unit on Aging HHSC.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology
### Strategy-Related Measures Definitions

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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-04-01 OP 10

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

The measure is the number of one-way trips provided to individuals age 60 and older and other eligible individuals reported to the Commission by area agencies on aging (AAAs) as receiving demand-response transportation services. Transportation services consist of taking an elderly individual from one location to another. Demand-response transportation carries elderly individuals from a specific origin to a specific destination upon advance request (usually 24 hours).

**BL 2018 Data Limitations**

Only State Unit on Aging HHSC funded units are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging HHSC, they are not included in the measure calculation. In addition, AAAs determine the level and the types of transportation services that they will provide.

**BL 2018 Data Source**

The number of one-way demand-response trips is based on data reported to the Commission by the AAAs. Data is reported only for those individuals for whom an intake form is completed.

**BL 2018 Methodology**

The number of one-way demand-response trips is the total reported to the State Unit on Aging HHSC by the AAAs.

**BL 2018 Purpose**

This measure identifies the total number of one-way trips that are funded by the State Unit on Aging HHSC.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
### Agency Code: 529  
Agency: Health and Human Services Commission

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**Calculation Method:** N  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 01-04-01 OP 11  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure is the total number of senior volunteers (age 55 or older) who have provided at least one hour of community volunteer service through the federally funded Retired and Senior Volunteer Programs (RSVP) during the year.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
The data source is a report titled, State Unit on Aging HHSC RSVP Performance Report, completed by the Corporation for National Service. The data is verified by monitoring activities conducted by the Corporation for National Service which contracts with the Commission to administer the state RSVP program as part of the federal RSVP program.

**BL 2018 Methodology**
The total number of senior volunteers (age 55 or older) who have provided at least one hour of community volunteer services through the RSVP program is reported quarterly on a report entitled the State Unit on Aging HHSC RSVP Performance Report, completed by the Corporation for National Service.

**BL 2018 Purpose**
This measure accounts for the number of senior volunteers (age 55 or older) who have provided at least one hour of community service through the federally funded RSVP program during the year.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
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Agency: Health and Human Services Commission

Goal No. 6 Community & Independent Living Services & Coordination
Objective No. 1 Long-term Care Services & Coordination
Strategy No. 2 Non-Medicaid Services
Measure Type OP
Measure No. 12 Avg # of Individuals Served Per Month: Non Medicaid Comm Care (XX/GR)

Calculation Method: N
Target Attainment: Priority:
Cross Reference: Agy 539 084-R-S70-1 01-04-01 OP 12
Key Measure: Y New Measure: N Percentage Measure: N

BL 2018 Definition
This measure reports the monthly average unduplicated number of individuals who received one or more of the following Non Medicaid Community Care (XX / GR) services: adult foster care, client managed personal assistance services (CMPAS), day activity and health services (DAHS), emergency response services, home-delivered meals, personal assistance services (Family Care), residential care, and special services for persons with disabilities.

BL 2018 Data Limitations
Because it takes several months to close out 100% 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-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.

BL 2018 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 TMHP (the Medicaid claims adjudicator) that is accessed and reported through an agency-developed application that utilizes COGNOS software

BL 2018 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 SAS).

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

BL 2018 Purpose
This measure provides a count of eligible persons who are receiving Non Medicaid Community Care (XX / GR) services that contribute to enabling them to remain in their own home as opposed to being placed in another more restrictive setting.
### BL 2018 Definition

This measure reports the monthly average number of individuals who received in-home/family support assistance at the end of the fiscal year. Individuals are provided assistance for the purchase of supportive services that will enable them to remain independent. Individuals are eligible for assistance up to $3,600 a year.

### BL 2018 Data Limitations

Does not apply.

### BL 2018 Data Source

Data are obtained from the commission's Health and Human Services Administrative System (HHSAS) Financials.

### BL 2018 Methodology

Data for this measure are the sum of one month of data from 1 August to 31 August in each reporting fiscal year to report the number of in-home Individuals who receive assistance. Reported data reflects data capture due to one-month lag during normal reporting.

### BL 2018 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 services for which funding has been appropriated.

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### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology
BL 2019 Purpose
**BL 2018 Definition**

This measure captures information regarding what it costs the state each month, on average, to provide community ID services to each individual who is assigned to these services regardless of age. It measures the Health and Human Services Commission (HHSC) appropriation authority cost per individual as defined by the companion output measure.

**BL 2018 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 Client Assignment and Registration (CARE) system up to 4 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 Legislative Budget Board (LBB) determines whether to reopen ABEST to allow for these updates.)

**BL 2018 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.

**BL 2018 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 ID 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

**BL 2018 Purpose**

This measure captures HHSC appropriation authority cost per person for adult and child community ID services.
BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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**Measure No. 2 Average Monthly Cost Per Individual Receiving Employment Services**

**Calculation Method:** N

**Target Attainment:** N

**Priority:** N

**Cross Reference:** Agy 539 084-R-S70-1 01-04-02 EF 02

**Key Measure:** N

**New Measure:** N

**Percentage Measure:** N

**BL 2018 Definition**

This measure captures information regarding what it costs the state each month, on average, to provide employment services to each individual who is assigned to this service regardless of age. It measures the Health and Human Services Commission HHSC appropriation authority cost per individual as defined by the companion output measure.

**BL 2018 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 authority. 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 Client Assignment and Registration (CARE) system up to 4 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 Legislative Budget Board (LBB) determines whether to reopen ABEST to allow for these updates.)

**BL 2018 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.

**BL 2018 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 employment services as reported in CARE / the number of months in the reporting period. The denominator is the average monthly number of individuals with intellectual disabilities receiving employment services that are served with HHSC appropriation authority funds. The formula is numerator/denominator.

**BL 2018 Purpose**

This measure captures HHSC appropriation authority cost per individuals for adult and child in employment services.

**BL 2019 Definition**
BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This measure captures information regarding what it costs the state each month, on average, to provide day training services to each individual who is assigned to this service regardless of age. It measures the Health and Human Services Commission (HHSC) appropriation authority cost per individual as defined by the companion output measure.

### BL 2018 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 authority. 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 Client Assignment and Registration (CARE) system up to 4 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 Legislative Budget Board (LBB) determines whether to reopen ABEST to allow for these updates.)

### BL 2018 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.

### BL 2018 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 employment services as reported in CARE / the number of months in the reporting period. The denominator is the average monthly number of individuals with intellectual disabilities receiving day training services that are served with HHSC appropriation authority funds. The formula is numerator/denominator.

### BL 2018 Purpose

This measure captures HHSC appropriation authority cost per individuals for adult and child in day training services.
BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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**Agency:** Health and Human Services Commission

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**Goal No. 6:** Community & Independent Living Services & Coordination  
**Objective No. 1:** Long-term Care Services & Coordination  
**Strategy No. 3:** Non-Medicaid Developmental Disability Community Services  
**Measure Type:** EF  
**Measure No.:** Average Monthly Cost Per Individual Receiving Therapies

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 01-04-02 EF 04

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

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**BL 2018 Definition**

This measure captures information regarding what it costs the state each month, on average, to provide therapy to each individual who is assigned to this service regardless of age. It measures the Health and Human Services Commission (HHSC) appropriation authority cost per individual as defined by the companion output measure.

**BL 2018 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 authority. 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 Client Assignment and Registration (CARE) system up to 4 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 Legislative Budget Board (LBB) determines whether to reopen ABEST to allow for these updates.)

**BL 2018 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.

**BL 2018 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 employment services as reported in CARE / the number of months in the reporting period. The denominator is the average monthly number of individuals with intellectual disabilities receiving therapies that are served with HHSC appropriation authority funds. The formula is numerator/denominator.

**BL 2018 Purpose**

This measure captures HHSC appropriation authority cost per individuals for adult and child in therapy.

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**BL 2019 Definition**
BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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<td>N</td>
<td>N</td>
<td>Agy 539 084-R-S70-1 01-04-02 EF 05</td>
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**BL 2018 Definition**
This measure captures information regarding what it costs the state each month, on average, to provide respite to each individual who is assigned to this service regardless of age. It measures the Health and Human Services Commission (HHSC) appropriation authority cost per individual as defined by the companion output measure.

**BL 2018 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 authority. 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 Client Assignment and Registration (CARE) system up to 4 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 Legislative Budget Board (LBB) determines whether to reopen ABEST to allow for these updates.)

**BL 2018 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.

**BL 2018 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 respite as reported in CARE / the number of months in the reporting period. The denominator is the average monthly number of individuals with intellectual disabilities receiving respite that are served with HHSC appropriation authority funds. The formula is numerator/denominator.

**BL 2018 Purpose**
This measure captures HHSC appropriation authority cost per individuals for adult and child in respite.

**BL 2019 Definition**
BL 2019 Data Limitations

BL 2019 Data Source

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<tr>
<td>Measure No.</td>
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<td>Average Monthly Cost Per Individual Receiving Independent Living</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-04-02 EF 06

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure captures information regarding what it costs the state each month, on average, to provide independent living services to each individual who is assigned to this service regardless of age. It measures the Health and Human Services Commission (HHSC) appropriation authority cost per individual as defined by the companion output measure.

**BL 2018 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 authority. 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 Client Assignment and Registration (CARE) system up to 4 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 Legislative Budget Board (LBB) determines whether to reopen ABEST to allow for these updates.)

**BL 2018 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.

**BL 2018 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 employment services as reported in CARE / the number of months in the reporting period. The denominator is the average monthly number of individuals with intellectual disabilities receiving independent living services that are served with HHSC appropriation authority funds. The formula is numerator/denominator.

**BL 2018 Purpose**
This measure captures HHSC appropriation authority cost per individuals for adult and child in independent living.

**BL 2019 Definition**
BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Measure No. 1 Number Individuals With ID Receiving Community Svcs End of Fiscal Year

Calculation Method: N Target Attainment: Priority: Cross Reference: Agy 539 084-R-S70-1 01-04-02 EX 01
Key Measure: Y New Measure: N Percentage Measure: N

**BL 2018 Definition**
This measure provides an unduplicated workload count of priority population eligible adults and children who receive ID community services at the end of the fiscal year. ID community services include non-residential services including: vocational services, training services, respite services, and specialized therapies.

**BL 2018 Data Limitations**
This measure provides the actual number of individuals who receive community services and provides information about the total system activity during one fiscal year. It is a frequently requested number used to compare system activity over a period of two or more fiscal years. The accuracy of the department's CARE system is dependent upon accurate and timely information being entered into the data warehouse system by the local authorities.

**BL 2018 Data Source**
As individuals enter the community programs, registration information is entered into the department's Client Assignment and Registration (CARE) system 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. Individuals who receive more than one community service during the year are counted only once for the year.

**BL 2018 Methodology**
The total unduplicated number of individuals that receive a ID community service during the fiscal year regardless of how the services for the individuals were funded is tallied for each local authority and system-wide.

**BL 2018 Purpose**
This measure provides the actual unduplicated number of persons who receive ID community services and provides information about the total system activity during one fiscal year.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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### Agency Code: 529

**Agency:** Health and Human Services Commission

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<td>Avg # Individuals on Interest List Per Month: ID Community Services</td>
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**Calculation Method:** N

**Target Attainment:**

**Priority:**

Cross Reference: Agy 539 084-R-S70-1 01-04-02 EX 02

**Key Measure:** N

**New Measure:** N

**Percentage Measure:** N

---

**BL 2018 Definition**

This measure provides a simple count of individuals who express an interest in general revenue (GR) funded ID community services. For purposes of this measure, interest is defined as placing one’s name on the interest list with the local authority for GR funded ID community services. The count only includes those individuals on the list who are in “open” status (i.e., it excludes those persons who are being processed for eligibility to begin receiving the service.)

**BL 2018 Data Limitations**

The accuracy of the GR funded ID community services interest list is dependent upon the submission of accurate data by the Local Authorities (LAs). There may be duplication of names between interest lists for ID services.

**BL 2018 Data Source**

A person seeking ID services or an individual seeking ID services on behalf of another person with intellectual or developmental disabilities begins the review of service options with the local authority staff. If the individual, legal representative or family member decides they are interested in GR funded ID community services, the name of the individual is entered onto the interest list for GR funded ID community services in the Department of Aging and Disability Services’ (DADS) database system.

**BL 2018 Methodology**

This is a simple count on the last day of each month of individuals whose names have been entered into the DADS database system as interested in GR funded ID community services.

**BL 2018 Purpose**

Pursuing GR funded ID community services is initiated by individuals, family members, and legally authorized representatives following discussions of service options with staff of the local authorities.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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<td>Measure Type</td>
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<td>Measure No.</td>
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<td>Average Monthly # of Individuals with ID Receiving Community Services</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-04-02 OP 01  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure captures the unduplicated count of priority population eligible adults and children whose services are funded with the Health and Human Services Commission (HHSC) appropriation authority funds and who receive ID community services. ID 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.

**BL 2018 Data Limitations**
The accuracy of the commission's Client Assignment and Registration (CARE) system is dependent upon accurate and timely information being entered into the data warehouse system by the local mental health authorities. The Data Verification Criteria Manual provides general guidance regarding timelines for closure of assignments to specific services.

**BL 2018 Data Source**
As individuals enter the comm. progs, 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 ID 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.

**BL 2018 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 (GR) funds and required local match. The numerator is the sum of the number of individuals receiving ID community service each month of the reporting period. The denominator is the number of months in the period. The formula is numerator/denominator.

**BL 2018 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.

**BL 2019 Definition**
BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
BL 2018 Definition

This measure captures the unduplicated count of priority population eligible adults and children whose services are funded with the Health and Human Services Commission (HHSC) appropriation authority funds and who receive employment services.

BL 2018 Data Limitations

The accuracy of the commission's Client Assignment and Registration (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.

BL 2018 Data Source

As individuals enter the community programs, registration information 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 number of individuals assigned to receive any intellectual disabilities employment service each month is calculated. For each quarter of the fiscal year, individuals served in each month of the quarter is averaged.

BL 2018 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 (GR) funds and required local match. The numerator is the sum of the number of individuals receiving employment services each month of the reporting period. The denominator is the number of months in the period. The formula is numerator/denominator.

BL 2018 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.

BL 2019 Definition
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
**Measure Type**: OP

**Measure No.**: 3  
Avg Mthly # Indiv w Intellectual Disability (ID) Recv Day Train Svcs

**Cross Reference**: Agy 539 084-R-S70-1 01-04-02 OP 03

**BL 2018 Definition**

This measure captures the unduplicated count of priority population eligible adults and children whose services are funded with the Health and Human Services Commission (HHSC) appropriation authority funds and who receive day training services.

**BL 2018 Data Limitations**

The accuracy of the commission's Client Assignment and Registration (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.

**BL 2018 Data Source**

As individuals enter the community programs, registration information 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 number of individuals assigned to receive any intellectual disabilities day training service each month is calculated. For each quarter of the fiscal year, individuals served in each month of the quarter is averaged.

**BL 2018 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 (GR) funds and required local match. The numerator is the sum of the number of individuals receiving day training services each month of the reporting period. The denominator is the number of months in the period. The formula is numerator/denominator.

**BL 2018 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**
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**Goal No. 6 Community & Independent Living Services & Coordination**

**Objective No. 1 Long-term Care Services & Coordination**

**Strategy No. 3 Non-Medicaid Developmental Disability Community Services**

**Measure Type OP**

**Measure No. 4 Avg Mthly # Indiv w Intellectual Disability (ID) Rec Therapies**

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**Calculation Method:** N  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 01-04-02 OP 04

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure captures the unduplicated count of priority population eligible adults and children whose services are funded with the Health and Human Services Commission (HHSC) appropriation authority funds and who receive therapies.

**BL 2018 Data Limitations**

The accuracy of the commission's Client Assignment and Registration (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.

**BL 2018 Data Source**

As individuals enter the community programs, registration information 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 number of individuals assigned to receive any intellectual disabilities therapy each month is calculated. For each quarter of the fiscal year, individuals served in each month of the quarter is averaged.

**BL 2018 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 (GR) funds and required local match. The numerator is the sum of the number of individuals receiving therapies each month of the reporting period. The denominator is the number of months in the period. The formula is numerator/denominator.

**BL 2018 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.

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**BL 2019 Definition**

**BL 2019 Data Limitations**
BL 2019 Data Source

BL 2019 Methodology

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**Objective No. 1 Long-term Care Services & Coordination**

**Strategy No. 3 Non-Medicaid Developmental Disability Community Services**

**Measure No. 5 Avg Mthly # Indiv w Intellectual Disability (ID) Rec Respite**

**Calculation Method:** N  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 01-04-02 OP 05

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure captures the unduplicated count of priority population eligible adults and children whose services are funded with the Health and Human Services Commission (HHSC) appropriation authority funds and who receive respite.

**BL 2018 Data Limitations**
The accuracy of the commission's Client Assignment and Registration (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.

**BL 2018 Data Source**
As individuals enter the community programs, registration information 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 number of individuals assigned to receive any intellectual disabilities respite each month is calculated. For each quarter of the fiscal year, individuals served in each month of the quarter is averaged.

**BL 2018 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 (GR) funds and required local match. The numerator is the sum of the number of individuals receiving respite each month of the reporting period. The denominator is the number of months in the period. The formula is numerator/denominator.

**BL 2018 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
BL 2018 Definition

This measure captures the unduplicated count of priority population eligible adults and children whose services are funded with the Health and Human Services Commission (HHSC) appropriation authority funds and who receive independent living services.

BL 2018 Data Limitations

The accuracy of the commission's Client Assignment and Registration (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.

BL 2018 Data Source

As individuals enter the community programs, registration information 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 number of individuals assigned to receive any intellectual disabilities independent living services each month is calculated. For each quarter of the fiscal year, individuals served in each month of the quarter is averaged.

BL 2018 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 (GR) funds and required local match. The numerator is the sum of the number of individuals receiving therapies each month of the reporting period. The denominator is the number of months in the period. The formula is numerator/denominator.

BL 2018 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.

BL 2019 Definition
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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<td>Objective No.</td>
<td>1</td>
<td>Long-term Care Services &amp; Coordination</td>
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<td>Strategy No.</td>
<td>3</td>
<td>Non-Medicaid Developmental Disability Community Services</td>
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<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
<td>7</td>
<td>Avg Mthly # of Ind Intellectual Disability (ID) Receiv Crisis Services</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-04-02 OP 07

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure captures the unduplicated count of priority eligible adults and children whose services are funded with the Health and Human Services Commission (HHSC) appropriation authority and who receive crisis services.

**BL 2018 Data Limitations**
The accuracy of the commission's Client Assignment and Registration (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.

**BL 2018 Data Source**
As individuals enter the community programs, registration information 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 number of individuals assigned to receive any intellectual disabilities crisis services each month is calculated. For each quarter of the fiscal year, individuals served in each month of the quarter is averaged.

**BL 2018 Methodology**
To obtain the number of individuals served with HHSC appropriation authority of funds, HHSC uses a production report which reflects the numbers of priority population individuals served each month with general revenue (GR) funds and required local match. The numerator is the sum of the number of individuals receiving therapies each month of the reporting period. The denominator is the number of months in the period. The formula is numerator/denominator.

**BL 2018 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**
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<td>Objective No.</td>
<td>2</td>
<td>Provide Rehabilitation Services to Persons with General Disabilities</td>
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<tr>
<td>Strategy No.</td>
<td>1</td>
<td>Independent Living Services (General, Blind, and CILs)</td>
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<tr>
<td>Measure Type</td>
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<td>Cost Per Person Served by Centers for Independent Living</td>
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**Calculation Method: N**

**Target Attainment:**

**Priority:**

Cross Reference: Agy 538 084-R-S70-1 02-03-02 EF 01

**Key Measure: N**

**New Measure: N**

**Percentage Measure: N**

---

**BL 2018 Definition**

Estimated Independent Living contract amounts expended by DRS supported Centers for Independent Living divided by the number of persons served in DRS supported Centers for Independent Living.

**BL 2018 Data Limitations**

The number of consumers served by IL Centers is provided by the centers. DRS does not control the data that is submitted.

**BL 2018 Data Source**

Consumer information is provided by monthly reports from DRS supported Centers for Independent Living, and estimated expenditures are based upon data from DRS financial information system.

**BL 2018 Methodology**

Estimated IL contract amounts expended by DRS supported Centers for Independent Living divided by the number of persons served in DRS supported Centers for Independent Living. Non-cumulative

**BL 2018 Purpose**

The purpose of this measure is to calculate the financial resources (costs) needed to serve each consumer.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
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**Goal No. 6 Community & Independent Living Services & Coordination**  
**Objective No. 2 Provide Rehabilitation Services to Persons with General Disabilities**  
**Strategy No. 1 Independent Living Services (General, Blind, and CILs)**  
**Measure Type EF**  
**Measure No. 2 Average Monthly Cost/Person Rec'g Contracted Independent Living Svc**

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:**

**Key Measure:** Y  
**New Measure:** Y  
**Percentage Measure:** N

---

**BL 2018 Definition**  
Measures the average monthly cost per person receiving HHSC contracted Independent Living Services.

**BL 2018 Data Limitations**  
Contractors have their own case management systems and are required to enter/upload specified data elements into the HHSC IL Data Reporting System. Timeliness of data uploads may be an issue; the reported measure will be based on data available at time of reporting.

**BL 2018 Data Source**  
Contractors have their own case management systems and are required to enter/upload specified data elements into the HHSC IL Data Reporting System; the uploaded data will be used to identify consumers served and amounts invoiced.

**BL 2018 Methodology**  
HHSC appropriation authority includes all general revenue and federal funds allocated to the Independent Living Services strategy. The number of months in the reporting period is 3 for each quarter and either 3, 6, 9 or 12 for year to date. Total amount expended and encumbered divided by the total amount of consumers served (as defined in 05-02-01-OP-03).

**BL 2018 Purpose**  
This measure tracks the average monthly cost per person served through the Independent Living contractors. It provides one indication of the efficiency of the program.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
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<td>Provide Rehabilitation Services to Persons with General Disabilities</td>
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<tr>
<td>Strategy No.</td>
<td>Independent Living Services (General, Blind, and CILs)</td>
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<tr>
<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
<td># of Consumers Rec'g Contracted Independent Living Services Per Year</td>
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<tr>
<td>N</td>
<td>Y</td>
<td>N</td>
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</table>

**BL 2018 Definition**

Unduplicated count of people receiving Independent Living Services as reported by HHSC IL contractors through the Independent Living Data Reporting System for the fiscal year.

**BL 2018 Data Limitations**

Contractors have their own case management systems and are required to enter/upload specified data elements into the HHSC IL Data Reporting System. Timeliness of data uploads may be an issue; the reported measure will be based on data available at time of reporting.

**BL 2018 Data Source**

Contractors have their own case management systems and are required to enter/upload specified data elements into the HHSC IL Data Reporting System; the uploaded data will be used to identify consumers served.

**BL 2018 Methodology**

At the end of the fiscal year, the sum of unduplicated people served. The served count, in accordance with the Rehabilitation Services Administration (RSA) 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. The served count will include individuals who have a signed or waived plan but are waiting for one or more purchased services.

**BL 2018 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. It is important because the agency seeks to serve the maximum number of people with limited resources, and the volume served tracks progress toward the goal the agency set.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**

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BL 2019 Methodology

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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 538 084-R-S70-1 02-03-02 OP 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
Number of people receiving services from DRS supported Centers for Independent Living as reported in monthly reports received from DRS supported Centers for Independent Living.

**BL 2018 Data Limitations**
The Division for Rehabilitation Services has no control over the timing of receiving the report data from the centers. Reports on measures submitted contain the available data at the time of report compilation, which is typically reporting the information for the previous month.

**BL 2018 Data Source**
Data collected by the Centers is sent to DRS monthly.

**BL 2018 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.

**BL 2018 Purpose**
DRS 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
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<tr>
<td>Key Measure: Y</td>
<td>New Measure: Y</td>
<td>Percentage Measure: N</td>
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</table>

**BL 2018 Definition**

Measures the number of consumers who exited the Independent Living program during the reporting period who achieved an Independent Living goal(s).

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

Data is from the DBS automated consumer statistical system. Field staff who work with consumers indicate in this system whether a consumer has achieved an employment outcome.

**BL 2018 Methodology**

All consumers identified as having successfully achieved an independent living goal(s) in the DBS automated consumer statistical system during the reporting period are included in the count.

**BL 2018 Purpose**

Achieving an independent living goal(s) is the desired result of the Independent Living program. DBS establishes a projection for the number of consumers who will achieve an independent living goal(s). This measure tracks and demonstrates progress toward meeting that projection.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
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<td>6</td>
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<td>OP</td>
<td>3</td>
<td>Avg Monthly # of People Rec'g HHSC Contracted Independent Living Svcs</td>
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<th>Target Attainment:</th>
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<tr>
<td>Key Measure: Y</td>
<td>New Measure: Y</td>
<td>Percentage Measure: N</td>
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**BL 2018 Definition**

A monthly average number of people receiving HHSC contracted Independent Living Services. Average is based on unduplicated count of people receiving Independent Living Services during each month of the reporting period.

**BL 2018 Data Limitations**

Contractors have their own case management systems and are required to enter/upload specified data elements into the HHSC IL Data Reporting System. Timeliness of data uploads may be an issue; the reported measure will be based on data available at time of reporting.

**BL 2018 Data Source**

Contractors have their own case management systems and are required to enter/upload specified data elements into the HHSC IL Data Reporting System; data in that system will be used to calculate the average monthly served.

**BL 2018 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 HHSC contracted Independent Living services each month in the reporting period. The denominator is the number of months in the reporting period. The formula is numerator/denominator. The served count, in accordance with the Rehabilitation Services Administration (RSA) 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.

**BL 2018 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 average monthly number of consumers provided services. It is important because the agency seeks to serve the maximum number of people with limited resources, and the volume served tracks progress toward the goal the agency set.

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**BL 2019 Definition**

**BL 2019 Data Limitations**
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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<th>Measure No.</th>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:**

**Key Measure:** N  
**New Measure:** Y  
**Percentage Measure:** N

**BL 2018 Definition**

Measures the number of consumers who exited the Independent Living program during the reporting period who achieved an Independent Living goal(s).

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

Data is from the DBS automated consumer statistical system. Field staff who work with consumers indicate in this system whether a consumer has achieved an employment outcome.

**BL 2018 Methodology**

All consumers identified as having successfully achieved an independent living goal(s) in the DBS automated consumer statistical system during the reporting period are included in the count.

**BL 2018 Purpose**

Achieving an independent living goal(s) is the desired result of the Independent Living program. DBS establishes a projection for the number of consumers who will achieve an independent living goal(s). This measure tracks and demonstrates progress toward meeting that projection.

**BL 2019 Definition**
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 6
Objective No. 2
Strategy No. 2
Measure Type EF
Measure No. 1

Goal: Community & Independent Living Services & Coordination
Objective: Provide Rehabilitation Services to Persons with General Disabilities
Strategy: Blindness Education, Screening and Treatment (BEST) Program
Measure Type: EF
Measure: Average Cost Per Individual Treated in BEST Program

Calculation Method: N
Target Attainment: N
Priority: N
Cross Reference: N
Key Measure: N
New Measure: Y
Percentage Measure: N

BL 2018 Definition
Measures the average cost per individual receiving treatment services through the Blindness Education, Screening and Treatment (BEST) program.

BL 2018 Data Limitations
Ensuring field staff make timely entry of successful completed closures during the reporting period

BL 2018 Data Source
The data sources are the program related expenditures and encumbrances during the reporting period from HHSC’s Accounting System (HHSAS); and the number of consumers treated (Performance Measure 05-02-02-OP-01: “Number of Individuals Receiving Treatment Services in BEST Program”).

BL 2018 Methodology
The formula is numerator/denominator. The numerator is the total HHSC expenditures and encumbrances utilized during the reporting period to fund treatment services for the BEST program. The denominator is the number of individuals receiving treatment services during the reporting period (Performance Measure 05-02-02-OP-01: “Number of Individuals Receiving Treatment Services in BEST Program”).

BL 2018 Purpose
This measure tracks the average cost per individual treated in BEST program. It provides one indication of the efficiency of the program.

BL 2019 Definition
BL 2019 Data Limitations
BL 2019 Data Source
BL 2019 Methodology
BL 2019 Purpose
### BL 2018 Definition

Measures the average cost per individual receiving screening or treatment services through the Blindness Education, Screening and Treatment (BEST) program.

### BL 2018 Data Limitations

Data reliability for the screening component is dependent upon the accuracy of information entered by contractor staff and submitted to DBS on a quarterly basis. Also, the contractor’s report is not due until thirty days after the end of the quarter. The end-of-year report is not affected since the contractor completes screening services well in advance of the end of the fiscal year.

### BL 2018 Data Source

The data sources are the program related expenditures and encumbrances during the reporting period from HHSC’s Accounting System and the number of consumers screened (Performance Measure 05-02-02-OP-02: “Number of Individuals Receiving Screening Svcs in BEST Program”).

### BL 2018 Methodology

The formula is numerator/denominator. The numerator is the total HHSC expenditures and encumbrances utilized during the reporting period to fund screening services for the BEST Program. The denominator is the number of individuals receiving screening services during the reporting period (Performance Measure 05-02-02-OP-02: “Number of Individuals Receiving Screening Svcs in BEST Program”).

### BL 2018 Purpose

This measure tracks the average cost per individual screened by the BEST Program. It provides one indication of the efficiency of the program.
BL 2019 Purpose
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 6 Community & Independent Living Services & Coordination
Objective No. 2 Provide Rehabilitation Services to Persons with General Disabilities
Strategy No. 2 Blindness Education, Screening and Treatment (BEST) Program
Measure Type OP
Measure No. 1 Number of Individuals Receiving Treatment Services in BEST Program

Calculation Method: C  Target Attainment:  Priority:  Cross Reference:
Key Measure: Y  New Measure: Y  Percentage Measure: N

BL 2018 Definition
Measures the number of individuals receiving treatment services during the reporting period through the Blindness Education, Screening and Treatment (BEST) program.

BL 2018 Data Limitations
Ensuring field staff makes timely entry of successful completed closures during the reporting period.

BL 2018 Data Source
Data for the treatment services comes from HHSC’s automated consumer statistical system.

BL 2018 Methodology
This is a count of the number of individuals receiving eye treatment services during the reporting period.

BL 2018 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.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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<tr>
<td>Strategy No.</td>
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<td>Measure No.</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:**

**Key Measure:** Y  
**New Measure:** Y  
**Percentage Measure:** N

**BL 2018 Definition**
Measures the number of individuals receiving screening services during the reporting period through the Blindness Education, Screening and Treatment (BEST) program.

**BL 2018 Data Limitations**
Quarterly reporting for the screening component is impacted by the fact that the contractor’s report is not due until thirty days after the end of the quarter. For this reason, services provided during a previous reporting period may not be reported until the following reporting period. The end-of-year report is not affected since the contractor completes screening services well in advance of the end of the fiscal year.

**BL 2018 Data Source**
Data for the screening services comes from quarterly reports submitted by a contractor.

**BL 2018 Methodology**
This is a count of the number of individuals receiving eye screenings as reported by the contractor during the reporting period.

**BL 2018 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
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<td>Measure No.</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 538 084-R-S70-1 02-03-04 EF 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

#### BL 2018 Definition
Measures the average monthly cost per person receiving Comprehensive Rehabilitation Services.

#### BL 2018 Data Limitations
The agency cannot control rising costs of service. This affects the average number of consumers served. Reimbursements from comparable benefits can be difficult to predict. This affects the actual dollars spent and the average cost per consumer.

#### BL 2018 Data Source
Consumer data is provided by HHSC's consumer statistical system. Expenditure data is provided through the agency financial system (HHSAS).

#### BL 2018 Methodology
HHSC appropriation authority includes all general revenue funds allocated to the Comprehensive Rehabilitation Services (CRS) strategy. 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 total amount expended and encumbered, and the denominator is defined in 02-03-04-OP-01.

#### BL 2018 Purpose
This measure provides information that shows the efficiency of how funds are used. It is important because it provides information on changes in the cost of services. As costs per CRS consumer increases, the number of consumers served decreases.

#### BL 2019 Definition

#### BL 2019 Data Limitations

#### BL 2019 Data Source

#### BL 2019 Methodology
### BL 2018 Definition

Unduplicated number of people receiving Comprehensive Rehabilitative Services as reported by DRS’ consumer statistical system for the fiscal year.

### BL 2018 Data Limitations

None.

### BL 2018 Data Source

As funds are allocated to consumers, HHSC's consumer statistical system collects and updates information. This information is monitored for accuracy. The data from this system is the source for calculations of this measure.

### BL 2018 Methodology

For the fiscal year, the sum of unduplicated people served. 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.

### BL 2018 Purpose

The measure demonstrates provision of critical rehabilitation services to eligible Texans. It is important because an estimated 80% 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.
### Agency Code: 529
### Agency: Health and Human Services Commission
### Goal No. 6 Community & Independent Living Services & Coordination
### Objective No. 2 Provide Rehabilitation Services to Persons with General Disabilities
### Strategy No. 3 Provide Services to People with Spinal Cord/Traumatic Brain Injuries
### Measure Type OP
### Measure No. 1 Avg Monthly # of People Receiving Comprehensive Rehabilitation Svcs

<table>
<thead>
<tr>
<th>Calculation Method: N</th>
<th>Target Attainment:</th>
<th>Priority:</th>
<th>Cross Reference: Agy 538 084-R-S70-1 02-03-04 OP 01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Measure: Y</td>
<td>New Measure: N</td>
<td>Percentage Measure: N</td>
<td></td>
</tr>
</tbody>
</table>

**BL 2018 Definition**

A monthly average of people receiving Comprehensive Rehabilitation Services as reported by DRS’ consumer statistical system.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

As funds are allocated to consumers, DRS’ consumer statistical system collects and updates information. This information is monitored for accuracy. The data from this system is the source for calculations of this measure.

**BL 2018 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.

**BL 2018 Purpose**

The measure demonstrates provision of critical rehabilitation services to eligible Texans. It is important because an estimated 80% of the consumers age 16 and above who suffer and survive a traumatic spinal cord or traumatic brain injuries 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.
### BL 2018 Definition

The number of eligible consumers who achieved CRS goals on their rehabilitation plans, thereby increasing their level of independence.

### BL 2018 Data Limitations

None.

### BL 2018 Data Source

Data is from the HHSC consumer reporting system. Staff will input and update consumer data on achievement of CRS plan goals.

### BL 2018 Methodology

Count of the total number of individuals with CRS cases closed “successful” in the reporting period.

### BL 2018 Purpose

This measure establishes a standard of accountability that HHSC can monitor in support of the CRS program for persons receiving services.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology

### BL 2019 Purpose
Goal No. 6  Community & Independent Living Services & Coordination
Objective No. 2  Provide Rehabilitation Services to Persons with General Disabilities
Strategy No. 4  Provide Services to Persons Who Are Deaf or Hard of Hearing
Measure Type EF
Measure No. 1  Average Cost Per Individual Served, Educated, and Trained

Calculation Method: N  Target Attainment:  Priority:  Cross Reference:
Key Measure: N  New Measure: Y  Percentage Measure: N

BL 2018 Definition
This measures the average cost per individual served.

BL 2018 Data Limitations
This measure is limited by the type of project proposed by contractors for the various services provided.

BL 2018 Data Source
Reports submitted by contractors on the number of individuals receiving some type of communication access and agency records of program costs are the sources of data.

BL 2018 Methodology
The total strategy expenditures and encumbrances divided by the number of individuals served.

BL 2018 Purpose
To determine the cost of communication access services based on the number of individuals served.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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<th>Health and Human Services Commission</th>
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<tr>
<td>Goal No.</td>
<td>6</td>
<td>Community &amp; Independent Living Services &amp; Coordination</td>
<td></td>
</tr>
<tr>
<td>Objective No.</td>
<td>2</td>
<td>Provide Rehabilitation Services to Persons with General Disabilities</td>
<td></td>
</tr>
<tr>
<td>Strategy No.</td>
<td>4</td>
<td>Provide Services to Persons Who Are Deaf or Hard of Hearing</td>
<td></td>
</tr>
<tr>
<td>Measure Type</td>
<td>EF</td>
<td>Average Cost Per Interpreter Certificate Issued</td>
<td></td>
</tr>
<tr>
<td>Measure No.</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 538 084-R-S70-1 02-02-02 EF 02

BL 2018 Definition  
This measures the average cost per interpreter certificate issued.

BL 2018 Data Limitations  
There are no data limitations anticipated.

BL 2018 Data Source  
Agency records of program costs and a personal computer database showing number of certificates issued are the data sources.

BL 2018 Methodology  
The total amount of funds expended for the program divided by the number of certificates issued.

BL 2018 Purpose  
To assist the agency in assessing actual costs to administer the program and to set fee levels to recover costs.

BL 2019 Definition  

BL 2019 Data Limitations  

BL 2019 Data Source  

BL 2019 Methodology  

BL 2019 Purpose
### Agency Code: 529

#### Agency: Health and Human Services Commission

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<th>Strategy No.</th>
<th>Measure Type</th>
<th>Measure No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>2</td>
<td>4</td>
<td>EF</td>
<td>3</td>
<td>Average Time for Ethics Complaint Resolution</td>
</tr>
</tbody>
</table>

**Goal No. 6 Community & Independent Living Services & Coordination**

**Objective No. 2 Provide Rehabilitation Services to Persons with General Disabilities**

**Strategy No. 4 Provide Services to Persons Who Are Deaf or Hard of Hearing**

**Measure Type EF**

**Measure No. 3 Average Time for Ethics Complaint Resolution**

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 538 084-R-S70-1 02-02-02 EF 03

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measures the average number of days to resolve a certified interpreter ethics complaint. This measure is related to attaining customer satisfaction.

**BL 2018 Data Limitations**

This measure is limited by the complexity of the issue to be resolved and the number of individuals involved.

**BL 2018 Data Source**

Agency records of the dates complaints are received and the dates complaints are resolved is the data source

**BL 2018 Methodology**

Count the number of days between the dates complaints are received and the dates complaints are resolved; divide this sum of days by the number of complaints resolved during a fiscal year.

**BL 2018 Purpose**

To ensure interpreter compliance with rules and standards of ethical behavior to eliminate communication barriers and to guarantee equal access for people who are deaf or hard of hearing.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
**Strategy-Related Measures Definitions**
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<th>Health and Human Services Commission</th>
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<td>6</td>
<td>Community &amp; Independent Living Services &amp; Coordination</td>
<td></td>
</tr>
<tr>
<td>Objective No.</td>
<td>2</td>
<td>Provide Rehabilitation Services to Persons with General Disabilities</td>
<td></td>
</tr>
<tr>
<td>Strategy No.</td>
<td>4</td>
<td>Provide Services to Persons Who Are Deaf or Hard of Hearing</td>
<td></td>
</tr>
<tr>
<td>Measure Type</td>
<td>EF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure No.</td>
<td>4</td>
<td>Average Cost Per Equipment/Service Application Processed</td>
<td></td>
</tr>
</tbody>
</table>

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** Cross Reference: Agy 538 084-R-S70-1 02-02-03 EF 01  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measures the average cost for the agency to process each application for specialized telecommunications equipment or services.

**BL 2018 Data Limitations**
There are no data limitations.

**BL 2018 Data Source**
The total amount of funds expended to administer the equipment/service voucher program divided by the number of equipment/service applications processed will give an average cost for the agency to process each application. Reimbursement to vendors for equipment or services is not part of this measure.

**BL 2018 Methodology**
The total amount of funds expended to administer the equipment/service voucher program divided by the number of equipment/service applications processed will give an average cost for the agency to process each application. Reimbursement to vendors for equipment or services is not part of this measure.

**BL 2018 Purpose**
To determine the cost of the program based on the number of applications received.
BL 2019 Purpose
Strategy-Related Measures Definitions
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<td>Community &amp; Independent Living Services &amp; Coordination</td>
</tr>
<tr>
<td>Objective No. 2</td>
<td>Provide Rehabilitation Services to Persons with General Disabilities</td>
</tr>
<tr>
<td>Strategy No. 4</td>
<td>Provide Services to Persons Who Are Deaf or Hard of Hearing</td>
</tr>
<tr>
<td>Measure Type EF</td>
<td>Average Time to Process an Equipment/Service Application Received</td>
</tr>
<tr>
<td>Measure No. 5</td>
<td></td>
</tr>
</tbody>
</table>

Calculation Method: N  Target Attainment:  Priority:  Cross Reference: Agy 538 084-R-S70-1 02-02-03 EF 02
Key Measure: N  New Measure: N  Percentage Measure: N

**BL 2018 Definition**
This calculates the average time to process an application into the database from the date the application was received.

**BL 2018 Data Limitations**
There are no data limitations.

**BL 2018 Data Source**
Agency database of applications which documents the date the application was received and the date the application was entered into the database.

**BL 2018 Methodology**
For applications received during a reporting period, sum the number of days from the date the application was received to the date the application was entered. Divide this sum of days by the number of applications entered during the reporting period.

**BL 2018 Purpose**
To provide an indication of the responsiveness of agency staff to process an application and generate a voucher or follow-up letter.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
**Strategy-Related Measures Definitions**

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<tr>
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<td>6</td>
<td>Community &amp; Independent Living Services &amp; Coordination</td>
</tr>
<tr>
<td>Objective No.</td>
<td>2</td>
<td>Provide Rehabilitation Services to Persons with General Disabilities</td>
</tr>
<tr>
<td>Strategy No.</td>
<td>4</td>
<td>Provide Services to Persons Who Are Deaf or Hard of Hearing</td>
</tr>
<tr>
<td>Measure Type</td>
<td>OP</td>
<td></td>
</tr>
<tr>
<td>Measure No.</td>
<td>1</td>
<td>Number Receiving Communication Access Services</td>
</tr>
</tbody>
</table>

**Calculation Method:** C  **Target Attainment:**  **Priority:**  
Cross Reference: Agy 538 084-R-S70-1 02-02-01 OP 01

**Key Measure:** N  **New Measure:** N  **Percentage Measure:** N

---

**BL 2018 Definition**
This measures the total number of individuals who are deaf or hard of hearing who received communication access services. Communication access includes services such as interpreting, Communications Access Real-time Translation (CART), information and referral, services to senior citizens and case coordination.

**BL 2018 Data Limitations**
This measure is limited to measuring only persons who are deaf or hard of hearing. This measure does not include those individuals with whom persons who are deaf or hard or hearing are trying to communicate. This measure is limited by the type of project proposed by contractors for the various services provided.

**BL 2018 Data Source**
Reports submitted by contractors on the number of individuals receiving some type of communication access service and agency records are the sources of data. Data does not include services provided under the interagency contracts.

**BL 2018 Methodology**
Sum the total number of individuals receiving some type of communication access service.

**BL 2018 Purpose**
To promote an effective system of services to individuals who are deaf or hard of hearing.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
Agency Code: 529

<table>
<thead>
<tr>
<th>Objective No.</th>
<th>Goal No.</th>
<th>Strategy No.</th>
<th>Measure Type</th>
<th>Measure No.</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>6</td>
<td>4</td>
<td>OP</td>
<td>2</td>
<td>Number of Reviews of Contracted Entities. These reviews are used to determine contractors' performances in compliance with contracts and is a systematic inspection of the contractor's financial records, personnel records, service records, and service delivery records. These reviews consist of on-site and desks reviews.</td>
</tr>
</tbody>
</table>

**BL 2018 Data Limitations**
This measure is limited by the number of contracts awarded.

**BL 2018 Methodology**
Sum the number of reviews of contractor's records conducted by agency staff.

**BL 2018 Purpose**
To ensure contractors' compliance with contracts to promote an effective system of services to individuals who are deaf or hard of hearing.
BL 2019 Purpose
## Agency: Health and Human Services Commission

<table>
<thead>
<tr>
<th>Agency Code</th>
<th>Agency</th>
<th>Goal No.</th>
<th>Objective No.</th>
<th>Strategy No.</th>
<th>Measure Type</th>
<th>Measure No.</th>
<th>BL 2018 Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>529</td>
<td></td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>OP</td>
<td>3</td>
<td>This measures the total number of consumers educated and interpreters trained.</td>
</tr>
</tbody>
</table>

**BL 2018 Data Limitations**
This measure is limited by the amount of donations/grants the agency may receive, the amount of administrative fees generated from interagency contracts and the types of projects proposed and contracted.

**BL 2018 Data Source**
Agency records of participant sign-in sheets from each education and training event is the data source.

**BL 2018 Methodology**
Sum the total number of individuals who were provided education and training.

**BL 2018 Purpose**
To eliminate communication barriers and to guarantee equal access for people who are deaf or hard of hearing.

<table>
<thead>
<tr>
<th>Calculation Method:</th>
<th>Target Attainment:</th>
<th>Priority:</th>
<th>Cross Reference: Agy 538 084-R-S70-1 02-02-02 OP 01</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Strategy-Related Measures Definitions
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 6 Community & Independent Living Services & Coordination
Objective No. 2 Provide Rehabilitation Services to Persons with General Disabilities
Strategy No. 4 Provide Services to Persons Who Are Deaf or Hard of Hearing
Measure Type OP
Measure No. 4 Number of Interpreter Certificates Issued

Calculation Method: C  Target Attainment:  Priority:  Cross Reference: Agy 538 084-R-S70-1 02-02-02 OP 02
Key Measure: Y  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measures the number of interpreter certificates issued during a fiscal year.

BL 2018 Data Limitations
None

BL 2018 Data Source
Agency database documenting the effective date and the expiration date of a certificate.

BL 2018 Methodology
Sum the number of certificates issued.

BL 2018 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.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Goal No.  6   Community & Independent Living Services & Coordination
Objective No.  2   Provide Rehabilitation Services to Persons with General Disabilities
Strategy No.  4   Provide Services to Persons Who Are Deaf or Hard of Hearing
Measure Type  OP
Measure No.  5   Number of Interpreter Tests Given

**Calculation Method: C**

**Target Attainment:**

**Priority:**

Cross Reference: Agy 538  084-R-S70-1  02-02-02  OP 04

**Key Measure:** N

**New Measure:** N

**Percentage Measure:** N

---

**BL 2018 Definition**

This measures the number of interpreter tests given during a fiscal year. This is a measure of productivity.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

Agency records of the number of interpreter tests given during a fiscal year.

**BL 2018 Methodology**

Sum the number of interpreter tests given.

**BL 2018 Purpose**

To increase the availability of interpreters to eliminate communication barriers and to guarantee equal access for people who are deaf or hard of hearing.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
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#### Health and Human Services Commission

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<th>Strategy No.</th>
<th>Measure Type</th>
<th>Measure No.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>529</td>
<td>Health and Human Services Commission</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>OP</td>
<td>6</td>
<td>Number of Equipment/Service Vouchers Issued</td>
</tr>
</tbody>
</table>

**Calculation Method:** C  
**Target Attainment:** Priority:  
**Cross Reference:** Agy 538 084-R-S70-1 02-02-03 OP 01  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 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.

**BL 2018 Data Limitations**  
This measure does not provide an accurate account of the number of multiple vouchers issued for replacement of lost or expired vouchers.

**BL 2018 Data Source**  
Agency database documenting voucher print date is the data source.

**BL 2018 Methodology**  
Agency database generates a count of vouchers issued for financial assistance.

**BL 2018 Purpose**  
To ensure equal access to the telephone system for persons with a disability.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
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<tr>
<td>Objective No.</td>
<td>3</td>
<td>Other Community Support Services</td>
</tr>
<tr>
<td>Strategy No.</td>
<td>1</td>
<td>Family Violence Services</td>
</tr>
<tr>
<td>Measure Type</td>
<td>EF</td>
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<tr>
<td>Measure No.</td>
<td>1</td>
<td>HHSC Avg Cost Per Person Receiving Family Violence Services</td>
</tr>
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</table>

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 529 084-R-S70-1 04-02-01 EF 01  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure reports the HHSC average cost per person receiving shelter services, non-residential services or both and the average cost per client receiving both services. A "Shelter" provides residential and nonresidential services to victims of family violence including a secure 24-hour-a-day temporary emergency residence, emergency medical care, emergency transportation, intervention services, legal assistance (civil and criminal), information on educational arrangements for children, information about training for and seeking employment and referral to community resources. "Non-resident services" refers to the delivery of the following in a non-live-in environment: Counseling, assistance in obtaining medical care, transportation, legal assistance, employment services, law enforcement liaison, and information and referral to other resources.

**BL 2018 Data Limitations**

Data is dependent on each contractor timely and accurately entering information into the Family Violence Program data collection system.

**BL 2018 Data Source**

Data is obtained from the automated data collection system maintained by the Family Violence Program.

**BL 2018 Methodology**

The program area receives data from the automated system maintained by the Family Violence Program and queries data according to program requirements for all quarters, the annual funding for Family Violence providers is divided by four to get the estimated expenditures attributable to the quarter being reported to determine the average cost for the reporting period. The average cost is the numerator for this measure. The denominator for this measure is the sum of the number of clients specific to the quarter being reported. Divide the numerator by the denominator to calculate the average cost per person receiving family violence services. When calculating the second quarter, third quarter, and fourth quarter, the year to date total is recalculated.

**BL 2018 Purpose**

This measure quantifies the average cost to the agency for each person receiving Family Violence services. This data is a useful tool for projecting future funding needs.

**BL 2019 Definition**

**BL 2019 Data Limitations**
Strategy-Related Measures Definitions
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BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
This measure reports the average percent of the cost of centers providing family violence services which is funded by HHSC.

**BL 2018 Data Limitations**
None

**BL 2018 Data Source**
The HHSC allocation amount and the projected total resources to the centers for providing family violence services as recorded on the approved budget submitted by the family violence center.

**BL 2018 Methodology**
Data are computed by taking the total amount of HHSC funding to centers (numerator), and dividing by the sum of the total amount of HHSC funding to centers and the total amount of other resources the centers apply to the shelter/program (denominator).

**BL 2018 Purpose**
This measure is important because it indicates the impact of funding appropriated to the agency on the operating budget of domestic violence centers that contract with the agency.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
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<td>Community &amp; Independent Living Services &amp; Coordination</td>
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</tr>
<tr>
<td>Objective No.</td>
<td>3</td>
<td>Other Community Support Services</td>
<td></td>
</tr>
<tr>
<td>Strategy No.</td>
<td>1</td>
<td>Family Violence Services</td>
<td></td>
</tr>
<tr>
<td>Measure Type</td>
<td>OP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure No.</td>
<td>1</td>
<td>Number of Persons Served by Family Violence Programs/Shelters</td>
<td></td>
</tr>
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</table>

**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  

Cross Reference: Agy 529 084-R-S70-1 04-02-01 OP 01  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
Reports number of victims of family violence and their children who receive either shelter, or non-residential services, and clients who receive a combination of both services from family violence programs that contract with the state. Shelter services include 24-hour a day shelter emergency medical care, emergency transportation, intervention services, legal assistance (civil and criminal), information on educational arrangements for children, information about training for and seeking employment, and referral to community resources. Non-residential services are the delivery of all of the above services in a non-live-in environment.

**BL 2018 Data Limitations**
Data is dependent on each contractor timely and accurately entering information into the Family Violence Program data collection system. Duplication may occur when a client re-enters the program within the reporting period.

**BL 2018 Data Source**
Data is obtained from the automated data collection system maintained by the Family Violence Program.

**BL 2018 Methodology**
Staff receives data from the automated system maintained by the Family Violence Program and queries data according to program requirements to obtain the unduplicated number of persons served.

**BL 2018 Purpose**
This measure provides caseload information for this strategy. It provides a count of the total number of persons receiving services from family violence programs and shelters.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
### Measure Type OP

#### Measure No. 2: Number of Participating Family Violence Programs/Shelters

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N  

**Cross Reference:** Agy 529  084-R-S70-1  04-02-01  OP 02

**BL 2018 Definition**

This measure reports the total number of Residential and Non-Residential programs contracting with the state to provide family violence services. Residential and Non-Residential programs are community based, non-profit agencies that contract with HHSC to provide services to clients of the family violence programs.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

This data is obtained from a count of current residential and non-residential contractors who participate in the program during this reporting period.

**BL 2018 Methodology**

The number of residential and non-residential programs are counted at the end of the reporting period.

**BL 2018 Purpose**

This measure is an indicator of the availability of domestic violence services funded by HHSC.

---

**Agency Code:** 529  
**Agency:** Health and Human Services Commission  
**Goal No.:** 6  
**Objective No.:** 3  
**Strategy No.:** 1  
**Measure Type:** OP  
**Measure No.:** 2  

**BL 2019 Definition**

BL 2019 Data Limitations

None

**BL 2019 Data Source**

This data is obtained from a count of current residential and non-residential contractors who participate in the program during this reporting period.

**BL 2019 Methodology**

The number of residential and non-residential programs are counted at the end of the reporting period.

**BL 2019 Purpose**

This measure is an indicator of the availability of domestic violence services funded by HHSC.
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<td>Measure No.</td>
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**Calculation Method:** C  **Target Attainment:**  **Priority:**  
Cross Reference: Agy 529 084-R-S70-1 04-02-01 OP 03

**Key Measure:** N  **New Measure:** N  **Percentage Measure:** N

**BL 2018 Definition**
This measure reports the number of hotline calls from or about victims of family violence received by family violence programs/shelters that contract with HHSC. Hotline calls are calls made to a telephone number that is answered by trained shelter center volunteer(s), staff, or HHSC-approved service contractors in which immediate intervention through safety planning (assessing for danger); understanding and support; information, education, and referrals to victims of family violence is provided twenty-four hours a day, every day of the year.

**BL 2018 Data Limitations**
Data is dependent on each contractor timely and accurately entering information into the Family Violence Program data collection system.

**BL 2018 Data Source**
Data are obtained from the automated data collection system maintained by the Family Violence Program.

**BL 2018 Methodology**
Staff receives data from the automated system maintained by the Family Violence Program and queries data according to program requirements to obtain the number of hotline calls.

**BL 2018 Purpose**
This measure demonstrates the level of hotline services needed.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
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Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 6  
Objective No. 3  
Strategy No. 2  
Measure Type EX  
Measure No. 1  
Total Number of Court-appointed Volunteers Advocating for Children

Calculation Method: N  
Target Attainment: H  
Priority: M  
Cross Reference: Agy 529 084-R-S70-1 04-02-04 EX 01

Key Measure: N  
New Measure: N  
Percentage Measure: N

BL 2018 Definition
The number of volunteers currently advocating for a child

BL 2018 Data Limitations
Community individuals to advocate the best interests of abused or neglected children are limited resources, and depend upon ongoing recruitment.

BL 2018 Data Source
An active CASA volunteer is defined as any volunteer active in the reporting period. The source document is the Texas CASA statistical report compiled from CASA standard reporting forms submitted by local CASA programs.

BL 2018 Methodology
The annual calculation is the total number of active volunteers on the first day of the fiscal year plus the number of additional volunteers that became active during each quarter. The quarterly calculation is the total number of active volunteers on the first day of the fiscal year, plus the number of additional volunteers that became active during each quarter.

BL 2018 Purpose
A child in conservatorship of the Child Protective Services Division of the Texas Department of Family and Protective Services who receives services of a court-appointed volunteer spends less time in the judicial system.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 6 Community & Independent Living Services & Coordination
Objective No. 3 Other Community Support Services
Strategy No. 2 Child Advocacy Programs
Measure Type EX
Measure No. 2 Total Number of Counties Served by CASA Programs

Calculation Method: N  Target Attainment: H  Priority: M
Cross Reference: Agy 529 084-R-S70-1 04-02-04 EX 02
Key Measure: N  New Measure: N  Percentage Measure: N

BL 2018 Definition
The total number of counties where the services of volunteers from Court Appointed Special Advocate (CASA) programs are available to provide advocacy services on behalf of children in the court system. The measure reflects the total number of counties in which a member of the judiciary has shown intent by signed written agreement to swear in CASA volunteers and assign cases to the CASA program. Only those counties with CASA volunteers available to accept cases will be counted.

BL 2018 Data Limitations
The number of counties served is dependent upon the need in certain counties for advocacy, number of programs in existence, available funding for expansion, and judicial approval.

BL 2018 Data Source
Texas CASA statistical report compiled from CASA standard reporting forms submitted by local CASA programs.

BL 2018 Methodology
The calculation for this measure is a cumulative count of the total number of counties served by CASA programs.

BL 2018 Purpose
The more counties set-up with available CASA volunteers, the more available advocacy there is for children.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
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**Goal No. 6 Community & Independent Living Services & Coordination**

**Objective No. 3 Other Community Support Services**

**Strategy No. 2 Child Advocacy Programs**

**Measure Type EX**

**Measure No. 3 # of Children Receiving Services from the Court-Appointed Volunteers**

---

**Calculation Method:** N  
**Target Attainment:** H  
**Priority:** M

Cross Reference: Agy 529 084-R-S70-1 04-02-04 EX 03

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

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**BL 2018 Definition**

The total number of children involved in cases in which CASA has been assigned. The child is either the subject of a suit affecting the parent-child relationship brought by a governmental entity, or is under the control or supervision of the Child Protective Services Division of the Texas Department of Family and Protective Services.

**BL 2018 Data Limitations**

The number of children served is dependent upon the number of children in need of advocacy, volunteers available, and programs in existence.

**BL 2018 Data Source**

Texas CASA statistical report compiled from CASA standard reporting forms submitted by local CASA programs.

**BL 2018 Methodology**

The annual calculation is the total number of children served on the first day of the fiscal year plus the number of additional children served throughout the fiscal year.

**BL 2018 Purpose**

It is important that a CASA volunteer be appointed to a case as early as possible once there has been removal of the child from the home. This advocacy will provide the child with a better opportunity for a safe, permanent, family home that will reduce the amount of time the child spends under court jurisdiction.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**

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**BL 2019 Methodology**

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**BL 2018 Definition**

This measure captures information regarding what it costs the Health and Human Services Commission (HHSC) each month, on average, to provide State Supported Living Centers and State Center services.

**BL 2018 Data Limitations**

Data must be current and accurate in the commission's Client Assignment and Registration (CARE) system as of the date the reports are produced.

**BL 2018 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.

**BL 2018 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.

**BL 2018 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 state supported living center residents.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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<td>Measure Type EF</td>
<td>Measure No. 2 Avg #Days Ind w/IDD Wait for Admission SSLC-Civil Com</td>
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BL 2018 Definition
This measure provides the number of days that individuals with an intellectual or developmental disability wait for admission to a state supported living center (SSLC), when the individual would accept admission to any center in the state. This measure is for civil admissions only.

BL 2018 Data Limitations
If an individual submits an application packet for a specific SSLC and subsequently decides to accept admission to any center with an appropriate vacancy, the individual is moved from the database for a specific SSLC to the database for any SSLC effective on the first day of the month of the change. When the individual is subsequently admitted to a SSLC, the number of days the individual waited for admission will be calculated from the date of initial referral for a specific SSLC. The effect of this methodology will be an increase in the average days individuals wait for admission to any SSLC. However, there does not seem to be a more precise method of calculating days that an individual waits for admission.

BL 2018 Data Source
The source of the data is the completed application packet. Once the packet is received at the local SSLC, center staff will review the packet for completeness. If all required information is included in the application packet, center staff will input the referral information into a desktop database that is electronically submitted to the State SSLC division at the Health and Human Services Commission (HHSC) by the local center. (Maintaining this information in the Client Assignment and Registration (CARE) system is being studied and may be implemented at some future time.)

BL 2018 Methodology
This is an average of days that all individuals wait for admission to a SSLC when any center would be acceptable. The numerator is the total of all days that individuals waited for admission to any SSLC for those individuals admitted to a SSLC during the quarter. The denominator is the number of individuals admitted to a facility during the reporting period from the waiting list for any SSLC. The formula is numerator/denominator. For year-to-date each quarter: The numerator is the sum of days all individuals admitted during the months from the beginning of the fiscal year to the end of the current quarter waited for admission to any facility. The denominator is the number of individuals admitted from the waiting list for any SSLC since the beginning of the fiscal year. The formula is numerator/denominator. This measure is for civil admissions only.

BL 2018 Purpose
Admissions to SSLCs are based on specific criteria as defined in Texas Administrative Code (TAC), Title 40, Part 1, Chapter 2, Subchapter F. Individuals are considered to be waiting for admission to a SSLC upon receipt of a completed application packet by the SSLC. Responsibility for completion of the application packet to a SSLC rests with the local authority (LA), as provided in TAC, Title 40, Part 1, Rule §2.265. Number of days that an individual waits for admission reflects the availability of services and efficiency of the system in accommodating individual choice. This measure is for civil admissions only.
**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
### Strategy-Related Measures Definitions

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**Goal No. 7 Mental Health State Hospitals, SSLCs and Other Facilities**

**Objective No. 1 State Supported Living Centers**

**Strategy No. 1 State Supported Living Centers**

**Measure Type EF**

**Measure No. 3 Avg # Days Indiv IDD Wait Admission any SSLC - Civil Commitment**

**Calculation Method: N**

**Target Attainment:**

**Priority:**

Cross Reference: Agy 539 084-R-S70-1 01-08-01 EF 03

**Key Measure: N**

**New Measure: N**

**Percentage Measure: N**

**BL 2018 Definition**

This measure provides the number of days that individuals with an intellectual or developmental disability, under a criminal court commitment, wait for admission to a state supported living center (SSLC), when the individual would accept admission to any center in the state.

**BL 2018 Data Limitations**

This measure provides the number of days that individuals with an intellectual or developmental disability wait for admission to a state supported living center (SSLC), under a criminal commitment, when the individual would accept admission to any center in the state. For individuals seeking admission under a criminal court commitment, the date the facility receives notice of the pending admission will be counted as the first date of the individual’s wait for admission.

**BL 2018 Data Source**

The source of the data is the completed application packet or notice of a pending criminal court commitment. Once the packet is received at the local SSLC, center staff will review the packet for completeness. If all required information is included in the application packet, center staff will input the referral information into a desktop database that is electronically submitted to the State SSLC division at the Health and Human Services Commission (HHSC) by the local center. For individuals seeking admission under a criminal court commitment, the receiving SSLC will be responsible for working with either the committing court or State Hospital for receipt of all needed documents for admission.

**BL 2018 Methodology**

This is an average of days that all individuals, under a criminal court commitment, wait for admission to a SSLC when any center would be acceptable. The numerator is the total of all days that individuals under a criminal court commitment waited for admission to any SSLC for those individuals admitted to a SSLC during the quarter. The denominator is the number of such individuals admitted to a facility during the reporting period from the waiting list for any SSLC. The formula is numerator/denominator. For year-to-date each quarter: The numerator is the sum of days all such individuals admitted during the months from the beginning of the fiscal year to the end of the current quarter waited for admission to any facility. The denominator is the number of such individuals admitted from the waiting list for any SSLC since the beginning of the fiscal year. The formula is numerator/denominator.

**BL 2018 Purpose**

Admissions to SSLCs are based on specific criteria as defined in Texas Administrative Code (TAC), Title 40, Part 1, Chapter 2, Subchapter F. Individuals are considered to be waiting for admission to a SSLC upon receipt of a completed application packet by the SSLC. Responsibility for completion of the application packet to a SSLC rests with the local authority (LA), as provided in TAC, Title 40, Part 1, Rule §2.265. For individuals seeking admission under a criminal court commitment, the date the facility receives notice of the pending admission will be counted as the first date of the individual’s wait for admission. Number of days that an individual waits for admission reflects the availability of services and efficiency of the system in accommodating individual choice.
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**Goal No. 7 Mental Health State Hospitals, SSLCs and Other Facilities**

**Objective No. 1 State Supported Living Centers**

**Strategy No. 1 State Supported Living Centers**

**Measure Type EF**

**Measure No. 4 Avg # Days Individuals w/ID Wait Admission Specific Living Ctr Campus**

**Calculation Method:** N  
**Target Attainment:**  
**Priority:**

Cross Reference: Agy 539 084-R-S70-1 01-08-01 EF 04

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure provides the number of days that individuals with intellectual and developmental disabilities wait for admission to a state supported living center (SSLC), when the individual would only accept admission to a specific center.

**BL 2018 Data Limitations**

If an individual submits an application packet for a specific SSLC and subsequently decides to accept admission to any center with an appropriate vacancy, the individual is moved from the database for a specific SSLC to the database for any SSLC effective on the first day of the month of the change. When the individual is subsequently admitted to a SSLC, the number of days the individual waited for admission will be calculated from the date of initial referral for a specific SSLC. This methodology should not affect the average days persons wait for admission to a specific SSLC.

**BL 2018 Data Source**

The source of the data is the completed application packet. Once the packet is received at the local SSLC, center staff will review the packet for completeness. If all required information is included in the application packet, center staff will input the referral information into a desktop database that is electronically submitted to the State SSLC division at the Health and Human Services Commission (HHSC) by the local facility. (Maintaining this information in the Client Assignment and Registration (CARE) system is being studied and may be implemented at some future time.)

**BL 2018 Methodology**

This is an average of days that all individuals wait for admission to a specified SSLC. The numerator is the total of all days that individuals waited for admission to a specific SSLC for those individuals admitted to a SSLC during the quarter. The denominator is the number of individuals admitted to a center during the reporting period from the waiting list for a specific SSLC. The formula is numerator/denominator. For year-to-date each quarter: The numerator is the sum of days all individuals admitted during the months from the beginning of the fiscal year to the end of the current quarter waited for admission to a specific facility. The denominator is the number of individuals admitted from the waiting list for a specific SSLC since the beginning of the fiscal year. The formula is numerator/denominator.

**BL 2018 Purpose**

Admissions to SSLCs are based on specific criteria as defined in Texas Administrative Code (TAC), Title 40, Part 1, Chapter 2, Subchapter F. Individuals are considered to be waiting for admission to a SSLC upon receipt of a completed application packet by the designated SSLC. Responsibility for completion of the application packet to a SSLC rests with the local authority (LA) as provided in TAC, Title 40, Part 1, Rule §2.265. Number of days that an individual waits for admission reflects the availability of services and efficiency of the system in accommodating individual choice.
BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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- **Measure No. 1:** Number of LC Campus Residents Who Are under 18 Years of Age Per Year

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 01-08-01 EX 01

**BL 2018 Definition**

This measure provides a snapshot look at the age of residents in state supported living centers (SSLC). Of concern in this measure are those residents who are children and adolescents and require compliance with federal and state regulations pertaining to education.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

Individuals employed by the SSLC enter the date of birth at the time of admission into the commission's system. A standard production report provides the number of customers served less than 18 years of age.

**BL 2018 Methodology**

This measure is a simple unduplicated count of SSLC residents between the ages of 0 and 17 (inclusive). It is a point in time measure obtained on the last day of the state fiscal year (8/31).

**BL 2018 Purpose**

This measure allows the agency to track the proportion of children and adolescents residing in SSLCs for planning purposes. Individuals with intellectual and developmental disabilities who are in residence at SSLCs include school aged youth whose educational needs are largely met by the school system.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 7 Mental Health State Hospitals, SSLCs and Other Facilities
Objective No. 1 State Supported Living Centers
Strategy No. 1 State Supported Living Centers
Measure Type EX
Measure No. 2 Avg # Day Individls Interested SSLC Placement Wait Admission

Calculation Method: N
Target Attainment: 
Priority: 
Cross Reference: Agy 539 084-R-S70-1 01-08-01 EX 02

BL 2018 Definition
This measure provides the number of days that individuals with an intellectual or developmental disability, under a criminal court commitment, wait for admission to a state supported living center (SSLC), when the individual would accept admission to any center in the state.

BL 2018 Data Limitations
This measure provides the number of days that individuals with an intellectual or developmental disability wait for admission to a state supported living center (SSLC), under a criminal commitment, when the individual would accept admission to any center in the state. For individuals seeking admission under a criminal court commitment, the date the facility receives notice of the pending admission will be counted as the first date of the individual’s wait for admission.

BL 2018 Data Source
The source of the data is the completed application packet or notice of a pending criminal court commitment. Once the packet is received at the local SSLC, center staff will review the packet for completeness. If all required information is included in the application packet, center staff will input the referral information into a desktop database that is electronically submitted to the State SSLC division at the Health and Human Services Commission (HHSC) by the local center. For individuals seeking admission under a criminal court commitment, the receiving SSLC will be responsible for working with either the committing court or State Hospital for receipt of all needed documents for admission.

BL 2018 Methodology
This is an average of days that all individuals, under a criminal court commitment, wait for admission to a SSLC when any center would be acceptable. The numerator is the total of all days that individuals under a criminal court commitment waited for admission to any SSLC for those individuals admitted to a SSLC during the quarter. The denominator is the number of such individuals admitted to a facility during the reporting period from the waiting list for any SSLC. The formula is numerator/denominator. For year-to-date each quarter: The numerator is the sum of days all such individuals admitted during the months from the beginning of the fiscal year to the end of the current quarter waited for admission to any facility. The denominator is the number of such individuals admitted from the waiting list for any SSLC since the beginning of the fiscal year. The formula is numerator/denominator.

BL 2018 Purpose
Admissions to SSLCs are based on specific criteria as defined in Texas Administrative Code (TAC), Title 40, Part 1, Chapter 2, Subchapter F. Individuals are considered to be waiting for admission to a SSLC upon receipt of a completed application packet by the SSLC. Responsibility for completion of the application packet to a SSLC rests with the local authority (LA), as provided in TAC, Title 40, Part 1, Rule §2.265. For individuals seeking admission under a criminal court commitment, the date the facility receives notice of the pending admission will be counted as the first date of the individual’s wait for admission. Number of days that an individual waits for admission reflects the availability of services and efficiency of the system in accommodating individual choice.
BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This measure provides a simple count of individuals who express an interest in pursuing State Supported Living Center (SSLC) admission by initiating an application for such admission. For purposes of this measure, interest is defined as beginning the application process for SSLCs. This measure reflects only civil admissions.

### BL 2018 Data Limitations

The accuracy of the SSLC interest list is dependent upon the submission of written information to the facility by the Local Authority (LA). This measure captures an unduplicated count of individuals throughout the year regardless of on-going or continued interest and does not provide data regarding number of individuals interested in SSLC admission on any given day.

### BL 2018 Data Source

When an individual seeking SSLC admission on behalf of an individual with intellectual and developmental disabilities begins the application process, the name of the individual is entered into the Health and Human Services Commission (HHSC) Client Assignment and Registration (CARE) system database as an "inquiry" for SSLC services. Staff of the SSLC input this data into the database.

### BL 2018 Methodology

This is a continuous simple count of individuals from point of interest to admission. The count includes the number of individuals on the interest list on the first day of the fiscal year and all additions and subtractions to the list during the fiscal year. This measure reflects only civil admissions.

### BL 2018 Purpose

SSLC admissions (other than placements pursuant to the Family Code) are initiated by family members and legally authorized representatives following discussions of residential options with staff of the Local Authorities (LAs). This measure reflects only civil admissions.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source
BL 2019 Methodology

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**Strategy-Related Measures Definitions**

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<td>Number of SSLC Residents Per Year</td>
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**BL 2018 Definition**
This measure provides an unduplicated workload count of individuals receiving State Supported Living Center (SSLC) services during one fiscal year.

**BL 2018 Data Limitations**
Data must be current and accurate in the commission's Client Assignment and Registration (CARE) system as of the date the reports are produced.

**BL 2018 Data Source**
Enrollment data are obtained from the commission's CARE system. Standard production reports from the CARE system provide the unduplicated number of individuals served during the year by the SSLCs.

**BL 2018 Methodology**
This measure is a simple count of individuals with one day or longer in residence at a SSLC at any time during the state fiscal year.

**BL 2018 Purpose**
This measure provides the actual number of individuals who reside at a SSLC campus at any time during the year.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
**Strategy-Related Measures Definitions**

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Automated Budget and Evaluation System of Texas (ABEST)

**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 01-08-01 OP 01  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure provides the number of individuals enrolled in State Supported Living Center 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 state supported living centers.

**BL 2018 Data Limitations**

None.

**BL 2018 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 Client Assignment and Registration (CARE) system. All individuals enrolled in SSLC facilities have an assignment code in the CARE system that indicates whether the person is on campus or absent from the campus with reason for absence. A standard production report (HC021950) from the CARE system provides the information.

**BL 2018 Methodology**

The numerator is the total number of individuals absent or present in all state suported living center facilities for each month in the reporting period (as shown in report HC021950). The denominator is the number of months in the reporting period, quarter or year to date. The formula is numerator/denominator.

**BL 2018 Purpose**

This measure reflects the system-wide level of activity occurring over time and allows the agency to associate the utilization of state supported living center campus services with related costs and outcomes.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
**BL 2018 Definition**

This measure provides the number of individuals with intellectual or developmental disabilities requesting residential services in a state supported living center facility (SSLC) anywhere in the state, on average any given month. This measure applies only to civil admissions.

**BL 2018 Data Limitations**

The count includes only those individuals for whom a completed application has been received and admission to any facility in the state is acceptable to the individual or legally authorized representative.

**BL 2018 Data Source**

When an individual with an intellectual or developmental disability or the individual's legally authorized representative requests residential services in a SSLC, and the local authority (LA) determines that the individual meets the criteria for admission or commitment, the LA will compile all information required to complete an application packet. The complete application packet is forwarded to the SSLC serving the area in which the applicant lives. The source of the data is the completed application packet. Once the packet is received at the designated SSLC, facility staff will review the packet for completeness. If all required information is included in the application packet, facility staff will input the referral information into a desktop database that is electronically submitted to the SSLC division at the Health and Human Services Commission (HHSC) by the local facility.

**BL 2018 Methodology**

This information includes name of individual, Client Assignment and Registration (CARE) system identification number, date of referral, designated facility, and the LA. The State Office for SSLC retains responsibility for management of the waiting list. The average monthly number of individuals waiting for admission to any SSLC is calculated as follows: The numerator is the total number of individuals waiting in month one of the quarter, plus the total number of individuals waiting in month two of the quarter, plus the total number of individuals waiting in month three of the quarter. The denominator is the number of months in the reporting period. For year-to-date, the number waiting in 3, 6, 9 or 12 months is summed and divided by the number of months year-to-date. The formula is numerator/denominator. This measure applies only to civil admissions.

**BL 2018 Purpose**

Admissions to SSLCs are based on specific criteria as defined in Texas Administrative Code (TAC), Title 40, Part 1, Chapter 2, Subchapter F. Individuals are considered to be waiting for admission to a SSLC upon receipt of a completed application packet by the designated SSLC. Responsibility for completion of the application packet to a SSLC facility rests with the LA as provided in TAC, Title 40, Part 1, Rule §2.265. At times, a completed application packet is received on the same day as admission. These individuals are not counted as waiting for purposes of this measure, although the LA may have been working on getting the application completed for several months. This measure applies only to civil admissions.
BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**
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Goal No. 7 Mental Health State Hospitals, SSLCs and Other Facilities
Objective No. 1 State Supported Living Centers
Strategy No. 1 State Supported Living Centers
Measure Type OP
Measure No. 3 Avg Mthly # Indiv IDD Pend Admission any SSLC Criminal Commitment

**Calculation Method:** N
**Target Attainment:** N
**Priority:** N

**Cross Reference:** Agy 539 084-R-S70-1 01-08-01 OP 03

**Key Measure:** N
**New Measure:** N
**Percentage Measure:** N

---

**BL 2018 Definition**
This measure provides the number of individuals with intellectual or developmental disabilities requesting residential services, through a criminal commitment, in a state supported living center facility (SSLC), on average any given month.

**BL 2018 Data Limitations**
The count includes only those individuals for whom a completed application has been received, under a criminal court commitment, and admission to any facility in the state is acceptable to the individual or legally authorized representative. While a criminal court commitment may not specify the SSLC to which an individual is committed, Mexia SSLC is the only facility available for male forensic admissions and San Angelo SSLC is the only facility available for females.

**BL 2018 Data Source**
For individuals being admitted to a SSLC under a criminal court commitment, a request for admission is received by either the committing court or a request for admission is received by a State Hospital. The purpose of the admission is for fitness to proceed or competency restoration. The complete application packet is forwarded to the appropriate SSLC depending on the individual’s gender. The source of the data is the completed application packet. Once the packet is received at the designated SSLC, facility staff will review the packet for completeness. If all required information is included in the application packet, facility staff will input the referral information into a desktop database that is electronically submitted to the SSLC division at the Health and Human Services Commission (HHSC) by the local facility.

**BL 2018 Methodology**
This information includes name of individual, Client Assignment and Registration (CARE) system ID number, date of referral, designated facility, and the LA. State Office SSLC div. will maintain a pending admission list for individuals seeking admission under a criminal court commitment. The average monthly number of individuals waiting for admission under criminal court commitment is calculated as follows: The numerator is the total number of individuals under criminal court commitment waiting in month one of the quarter, plus the total number of such individuals waiting in month two of the quarter, plus the total number of such individuals waiting in month three of the quarter. The denominator is the number of months in the reporting period. For year-to-date, the number waiting in 3, 6, 9 or 12 months is summed and divided by the number of months year-to-date. The formula is numerator/denominator.

---

**BL 2018 Purpose**
Admissions to SSLCs are based on specific criteria as defined in Texas Administrative Code (TAC), Title 40, Part 1, Chapter 2, Subchapter F. Individuals are considered to be waiting for admission to a SSLC upon receipt of a completed application packet by the designated SSLC or notification of a criminal court order. Responsibility for completion of the application packet to a SSLC facility rests with the LA as provided in TAC, Title 40, Part 1, Rule §2.265. At times, a completed application packet is received on the same day as admission. These individuals are not counted as waiting for purposes of this measure, although the LA may have been working on getting the application completed for several months. Requests for admissions are received from committing criminal courts and State Hospitals. Only these requests will be included in this measure.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Strategy-Related Measures Definitions
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Goal No. 7 Mental Health State Hospitals, SSLCs and Other Facilities
Objective No. 1 State Supported Living Centers
Strategy No. 1 State Supported Living Centers
Measure Type OP
Measure No. 4 Avg Mthly # Individls w/IDD Waiting Admission Specific LC Campus

BL 2018 Definition
This measure provides the number of individuals with intellectual or developmental disabilities requesting residential services in a specified SSLC, on average for any given month. This measure applies only to civil admissions.

BL 2018 Data Limitations
The count includes only those individuals for whom a completed application has been received and admission is restricted to one facility.

BL 2018 Data Source
When an individual with an intellectual or developmental disability, or the individual's legally authorized representative requests residential services in a SSLC, and the local authority (LA) determines that the individual meets the criteria for admission or commitment, the LA compiles all info required to complete an application. The complete application is forwarded to the SSLC serving the area in which the applicant lives. This local state supported living center ensures the application packet is forwarded to the specified state supported living center. The source of the data is the completed application packet. Once the packet is received at the local state supported living center facility, facility staff will review the packet for completeness. If all required information is included in the application packet, facility staff will input the referral information into a desktop database that is electronically submitted to the SSLC division at HHSC by the local facility.

BL 2018 Methodology
This information includes name of individual, Client Assignment and Registration (CARE) identification number, date of referral, designated facility, the desired facility, and the LA. (Maintaining this information in the CARE system is being studied and may be implemented at some future time.) The average monthly number of individuals waiting for admission to a specific SSLC is calculated as follows: The numerator is the total number of individuals waiting in month one of the quarter, plus the total number of individuals waiting in month two of the quarter, plus the total number of individuals waiting in month three of the quarter. The denominator is the number of months in the reporting period. For year-to-date the number waiting in 3, 6, 9 and 12 months is summed and divided by the number of months year-to-date. The formula is numerator/denominator. This measure applies only to civil admissions.

BL 2018 Purpose
Admissions to SSLCs are based on specific criteria as defined in Texas Administrative Code (TAC), Title 40, Part 1, Chapter 2, Subchapter F. Individuals are considered to be waiting for admission to a state supported living center facility upon receipt of a complete application packet by the designated state supported living center. Responsibility for completion of the application packet to a state supported living center rests with the LA as provided in TAC, Title 40, Part 1, Rule §2.265. At times, a completed application packet is received on the same day as admission. These individuals are not counted as waiting for purposes of this measure, although the LA may have been working on getting the application completed for several months. This measure applies only to civil admissions.
Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 7  Mental Health State Hospitals, SSLCs and Other Facilities
Objective No. 1  State Supported Living Centers
Strategy No. 1  State Supported Living Centers
Measure Type OP
Measure No. 5  Number of Referrals to the Ombudsman

Calculation Method: C  Target Attainment:  Priority:  Cross Reference: Agy 539  084-R-S70-1  01-08-01  OP 05
Key Measure: N  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measure reports the number of reviews/ investigations performed by the Independent Ombudsman.

BL 2018 Data Limitations
Data for this measure is available and updated on the 15th of each month.

BL 2018 Data Source
The numbers of referrals reviewed /investigated are tracked on the Assistant Ombudsman report.

BL 2018 Methodology
Total number of reviews /investigations on a monthly basis; and compiling them to determine a total for the fiscal year.

BL 2018 Purpose
This measure provides a means to establish the baseline for funding levels from biennium to biennium.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**

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**Agency:** Health and Human Services Commission

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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-08-01 OP 06

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**B 2018 Definition**

This measure reports the number of reviews/ investigations performed by the Independent Ombudsman.

**B 2018 Data Limitations**

Data for this measure is available and updated on the 15th of each month.

**B 2018 Data Source**

The numbers of referrals reviewed /investigated are tracked on the Assistant Ombudsman report.

**B 2018 Methodology**

Total number of reviews /investigations on a monthly basis; and compiling them to determine a total for the fiscal year.

**B 2018 Purpose**

This measure provides a means to establish the baseline for funding levels from biennium to biennium.

**B 2019 Definition**

**B 2019 Data Limitations**

**B 2019 Data Source**

**B 2019 Methodology**

**B 2019 Purpose**
**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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**Goal:** Mental Health State Hospitals, SSLCs and Other Facilities  
**Objective:** State Supported Living Centers  
**Strategy:** State Supported Living Centers  
**Measure Type:** OP  
**Measure:** # Unfounded Abuse/Neglect/Exploitation Allegations Against SSLC Staff

**Calculation Method:** C  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 07  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (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).

**BL 2018 Data Limitations**

The source data for this measure is supplied by the Department of Family and Protective Services (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.

**BL 2018 Data Source**

Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

**BL 2018 Methodology**

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at all state supported living centers by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**

This measure is a mechanism for tracking unfounded allegations against SSLC staff.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 7  
Mental Health State Hospitals, SSLCs and Other Facilities

Objective No. 1  
State Supported Living Centers

Strategy No. 1  
State Supported Living Centers

Measure Type OP

Measure No. 8  
# Confirmed Abuse/Neglect/Exploitation Incidents at SSLC

Calculation Method: C  
Target Attainment:  
Priority:  
Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 08

Key Measure: Y  
New Measure: N  
Percentage Measure: N

**BL 2018 Definition**
This measure reports confirmed allegations against State Supported Living Center (SSLC) staff. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

**BL 2018 Data Limitations**
This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

**BL 2018 Data Source**
Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

**BL 2018 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.

**BL 2018 Purpose**
This measure is a mechanism for assessing confirmed allegations of A/N/E at all State Supported Living Centers.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
**BL 2018 Definition**

This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (SSLC) staff at the Abilene SSLC. 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).

**BL 2018 Data Limitations**

The source data for this measure is supplied by the Department of Family and Protective Services (DFPS). To ensure confidentiality, DFPS can provide data quarterly in aggregate for the Abilene SSLC. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

**BL 2018 Data Source**

Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

**BL 2018 Methodology**

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Abilene SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Abilene SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2019 Definition**

**BL 2019 Data Limitations**

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**Calculation Method:** C
**Target Attainment:**
**Priority:**
Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 10

**Key Measure:** N
**New Measure:** N
**Percentage Measure:** N

**BL 2018 Definition**
This measure reports confirmed allegations against State Supported Living Center (SSLC) staff at the Abilene SSLC. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

**BL 2018 Data Limitations**
This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

**BL 2018 Data Source**
Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

**BL 2018 Methodology**
The measure is calculated by totaling the number of confirmed allegations of A/N/E at the Abilene SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**
This measure is a mechanism for assessing confirmed allegations of A/N/E at the Abilene SSLC.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
Agency Code: 529  Agency: Health and Human Services Commission

Goal No. 7  Mental Health State Hospitals, SSLCs and Other Facilities
Objective No. 1  State Supported Living Centers
Strategy No. 1  State Supported Living Centers
Measure Type OP
Measure No. 11  Number of Unfounded A/N/E Allegations Against SSLC Staff - Austin

Calculation Method: C  Target Attainment:  Priority:  Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 11
Key Measure: N  New Measure: N  Percentage Measure: N

**BL 2018 Definition**

This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (SSLC) staff at the Austin SSLC. 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).

**BL 2018 Data Limitations**

The source data for this measure is supplied by the Department of Family and Protective Services (DFPS). To ensure confidentiality, DFPS can provide data quarterly in aggregate for the Austin SSLC. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

**BL 2018 Data Source**

Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

**BL 2018 Methodology**

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Austin SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Austin SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
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Calculation Method: C  Target Attainment:  Priority: Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 12
Key Measure: N  New Measure: N  Percentage Measure: N

**BL 2018 Definition**
This measure reports confirmed allegations against State Supported Living Center (SSLC) staff at the Austin SSLC. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

**BL 2018 Data Limitations**
This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

**BL 2018 Data Source**
Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

**BL 2018 Methodology**
The measure is calculated by totaling the number of confirmed allegations of A/N/E at the Austin SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**
This measure is a mechanism for assessing confirmed allegations of A/N/E at the Austin SSLC.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
Strategy-Related Measures Definitions
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Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 7  
Objective No. 1  
Strategy No. 1  
Measure Type OP  
Measure No. 13  

Calculation Method: C  
Target Attainment:  
Priority:  
Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 13

Key Measure: N  
New Measure: N  
Percentage Measure: N

BL 2018 Definition
This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (SSLC) staff at the Brenham SSLC. 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).

BL 2018 Data Limitations
The source data for this measure is supplied by the Department of Family and Protective Services (DFPS). To ensure confidentiality, DFPS can provide data quarterly in aggregate for the Brenham SSLC. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

BL 2018 Data Source
Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

BL 2018 Methodology
The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Brenham SSLC by Department of Family and Protective Services investigators during a fiscal year.

BL 2018 Purpose
The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Brenham SSLC by Department of Family and Protective Services investigators during a fiscal year.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
BL 2018 Definition
This measure reports confirmed allegations against State Supported Living Center (SSLC) staff at the Brenham SSLC. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

BL 2018 Data Limitations
This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

BL 2018 Data Source
Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

BL 2018 Methodology
The measure is calculated by totaling the number of confirmed allegations of A/N/E at the Brenham SSLC by Department of Family and Protective Services investigators during a fiscal year.

BL 2018 Purpose
This measure is a mechanism for assessing confirmed allegations of A/N/E at the Brenham SSLC.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
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<tr>
<td>Objective No.</td>
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<tr>
<td>Measure No.</td>
<td>15</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 15

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (SSLC) staff at the Corpus Christi SSLC.

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).

**BL 2018 Data Limitations**
The source data for this measure is supplied by the Department of Family and Protective Services (DFPS). To ensure confidentiality, DFPS can provide data quarterly in aggregate for the Corpus Christi SSLC. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

**BL 2018 Data Source**
Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

**BL 2018 Methodology**
The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Corpus Christi SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**
The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Corpus Christi SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
**BL 2018 Definition**

This measure reports confirmed allegations against State Supported Living Center (SSLC) staff at the Corpus Christi SSLC. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

**BL 2018 Data Limitations**

This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

**BL 2018 Data Source**

Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

**BL 2018 Methodology**

Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

**BL 2018 Purpose**

This measure is a mechanism for assessing confirmed allegations of A/N/E at the Corpus Christi SSLC.
BL 2019 Purpose
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<td>Measure No.</td>
<td>17  Number of Unfounded A/N/E Allegations Against SSLC Staff - Denton</td>
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Calculation Method: C  Target Attainment:  Priority: Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 17
Key Measure: N  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (SSLC) staff at the Denton SSLC. 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).

BL 2018 Data Limitations
The source data for this measure is supplied by the Department of Family and Protective Services (DFPS). To ensure confidentiality, DFPS can provide data quarterly in aggregate for the Denton SSLC. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

BL 2018 Data Source
Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

BL 2018 Methodology
The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Denton SSLC by Department of Family and Protective Services investigators during a fiscal year.

BL 2018 Purpose
The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Denton SSLC by Department of Family and Protective Services investigators during a fiscal year.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
**BL 2018 Definition**
This measure reports confirmed allegations against State Supported Living Center (SSLC) staff at the Denton SSLC. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

**BL 2018 Data Limitations**
This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

**BL 2018 Data Source**
Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

**BL 2018 Methodology**
The measure is calculated by totaling the number of confirmed allegations of A/N/E at the Denton SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**
This measure is a mechanism for assessing confirmed allegations of A/N/E at the Denton SSLC.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
**Strategy-Related Measures Definitions**

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**Goal No. 7 Mental Health State Hospitals, SSLCs and Other Facilities**

**Objective No. 1 State Supported Living Centers**

**Strategy No. 1 State Supported Living Centers**

**Measure No. 19 Number of Unfounded A/N/E Allegations Against SSLC Staff - El Paso**

**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-08-01 OP 19

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (SSLC) staff at the El Paso SSLC. 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).

**BL 2018 Data Limitations**

The source data for this measure is supplied by the Department of Family and Protective Services (DFPS). To ensure confidentiality, DFPS can provide data quarterly in aggregate for the El Paso SSLC. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

**BL 2018 Data Source**

Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

**BL 2018 Methodology**

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the El Paso SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the El Paso SSLC by Department of Family and Protective Services investigators during a fiscal year.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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<tr>
<td>Objective No.</td>
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<td>State Supported Living Centers</td>
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<td>Measure No.</td>
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Calculation Method: C  
Target Attainment:  
Priority:  
Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 20

Key Measure: N  
New Measure: N  
Percentage Measure: N

**BL 2018 Definition**

This measure reports confirmed allegations against State Supported Living Center (SSLC) staff at the El Paso SSLC. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

**BL 2018 Data Limitations**

This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

**BL 2018 Data Source**

Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

**BL 2018 Methodology**

The measure is calculated by totaling the number of confirmed allegations of A/N/E at the El Paso SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**

This measure is a mechanism for assessing confirmed allegations of A/N/E at El Paso SSLC.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
**BL 2018 Definition**

This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (SSLC) staff at the Lubbock SSLC. 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).

**BL 2018 Data Limitations**

The source data for this measure is supplied by the Department of Family and Protective Services (DFPS). To ensure confidentiality, DFPS can provide data quarterly in aggregate for the Lubbock SSLC. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

**BL 2018 Data Source**

Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

**BL 2018 Methodology**

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Lubbock SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Lubbock SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Goal No. 7 Mental Health State Hospitals, SSLCs and Other Facilities
Objective No. 1 State Supported Living Centers
Strategy No. 1 State Supported Living Centers
Measure Type OP
Measure No. 22 Number Confirmed Abuse/Neglect/Exploitation Allegations SSLC - Lubbock

**BL 2018 Definition**
This measure reports confirmed allegations against State Supported Living Center (SSLC) staff at the Lubbock SSLC. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

**BL 2018 Data Limitations**
This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

**BL 2018 Data Source**
Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

**BL 2018 Methodology**
The measure is calculated by totaling the number of confirmed allegations of A/N/E at the Lubbock SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**
This measure is a mechanism for assessing confirmed allegations of A/N/E at the Lubbock SSLC.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
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<td>Measure No.</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 23

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (SSLC) staff at the Lufkin SSLC. 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).

**BL 2018 Data Limitations**

The source data for this measure is supplied by the Department of Family and Protective Services (DFPS). To ensure confidentiality, DFPS can provide data quarterly in aggregate for the Lufkin SSLC. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

**BL 2018 Data Source**

Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

**BL 2018 Methodology**

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Lufkin SSLC by Department of Family and Protective Services investigators during a fiscal year.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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Goal No. 7  Mental Health State Hospitals, SSCLCs and Other Facilities
Objective No. 1  State Supported Living Centers
Strategy No. 1  State Supported Living Centers
Measure Type  OP
Measure No. 24  Number Confirmed Abuse/Neglect/Exploitation Allegations SSLC - Lufkin

Calculation Method: C  Target Attainment:  Priority:  Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 24
Key Measure: N  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measure reports confirmed allegations against State Supported Living Center (SSLC) staff at the Lufkin SSLC. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

BL 2018 Data Limitations
This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

BL 2018 Data Source
Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

BL 2018 Methodology
The measure is calculated by totaling the number of confirmed allegations of A/N/E at the Lufkin SSLC by Department of Family and Protective Services investigators during a fiscal year.

BL 2018 Purpose
This measure is a mechanism for assessing confirmed allegations of A/N/E at the Lufkin SSLC.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
### BL 2018 Definition

This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (SSLC) staff at the Mexia SSLC. 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).

### BL 2018 Data Limitations

The source data for this measure is supplied by the Department of Family and Protective Services (DFPS). To ensure confidentiality, DFPS can provide data quarterly in aggregate for the Mexia SSLC. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

### BL 2018 Data Source

Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

### BL 2018 Methodology

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Mexia SSLC by Department of Family and Protective Services investigators during a fiscal year.

### BL 2018 Purpose

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Mexia SSLC by Department of Family and Protective Services investigators during a fiscal year.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source
BL 2019 Methodology

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**Calculation Method:** C  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 01-08-01 OP 26

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure reports confirmed allegations against State Supported Living Center (SSLC) staff at the Mexia SSLC. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

**BL 2018 Data Limitations**
This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

**BL 2018 Data Source**
Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

**BL 2018 Methodology**
The measure is calculated by totaling the number of confirmed allegations of A/N/E at the Mexia SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**
This measure is a mechanism for assessing confirmed allegations of A/N/E at the Mexia SSLC.
BL 2019 Purpose
### Strategy-Related Measures Definitions

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**BL 2018 Definition**

This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (SSLC) staff at the Richmond SSLC. 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).

**BL 2018 Data Limitations**

The source data for this measure is supplied by the Department of Family and Protective Services (DFPS). To ensure confidentiality, DFPS can provide data quarterly in aggregate for the Richmond SSLC. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

**BL 2018 Data Source**

Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

**BL 2018 Methodology**

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Richmond SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**

The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Richmond SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 7  
Mental Health State Hospitals, SSLCs and Other Facilities

Objective No. 1  
State Supported Living Centers

Strategy No. 1  
State Supported Living Centers

Measure Type: OP

Measure No. 28  
Number Confirmed Abuse/Neglect/Exploitation Allegations SSLC-Richmond

Calculation Method: C  
Target Attainment:  
Priority:  
Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 28

Key Measure: N  
New Measure: N  
Percentage Measure: N

**BL 2018 Definition**
This measure reports confirmed allegations against State Supported Living Center (SSLC) staff at the Richmond SSLC. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

**BL 2018 Data Limitations**
This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

**BL 2018 Data Source**
Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

**BL 2018 Methodology**
The measure is calculated by totaling the number of confirmed allegations of A/N/E at the Richmond SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**
This measure is a mechanism for assessing confirmed allegations of A/N/E at the Richmond SSLC.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
Strategy-Related Measures Definitions
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Automated Budget and Evaluation System of Texas (ABEST)

Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 7 Mental Health State Hospitals, SSLCs and Other Facilities
Objective No. 1 State Supported Living Centers
Strategy No. 1 State Supported Living Centers
Measure Type OP
Measure No. 29 Number of Unfounded A/N/E Allegations Against SSLC Staff - San Angelo

Calculation Method: C
Target Attainment: N
Priority: "n"
Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 29

Key Measure: N
New Measure: N
Percentage Measure: N

BL 2018 Definition
This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (SSLC) staff at the San Angelo SSLC. 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).

BL 2018 Data Limitations
The source data for this measure is supplied by the Department of Family and Protective Services (DFPS). To ensure confidentiality, DFPS can provide data quarterly in aggregate for the San Angelo SSLC. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

BL 2018 Data Source
Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

BL 2018 Methodology
The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the San Angelo SSLC by Department of Family and Protective Services investigators during a fiscal year.

BL 2018 Purpose
This measure is a mechanism for assessing the relationship between San Angelo SSLC staff and residents.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
**BL 2018 Definition**

This measure reports confirmed allegations against State Supported Living Center (SSLC) staff at the San Angelo SSLC. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

**BL 2018 Data Limitations**

This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

**BL 2018 Data Source**

Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

**BL 2018 Methodology**

The measure is calculated by totaling the number of confirmed allegations of A/N/E at the San Angelo SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**

This measure is a mechanism for assessing confirmed allegations of A/N/E at the San Angelo SSLC.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**

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**BL 2019 Methodology**
BL 2019 Purpose
Strategy-Related Measures Definitions
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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

**Goal No.** 7  
**Objective No.** 1  
**Strategy No.** 1  
**Measure Type** OP  
**Measure No.** 31

**Calculation Method:** C  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 31

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (SSLC) staff at the San Antonio SSLC. 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).

**BL 2018 Data Limitations**
The source data for this measure is supplied by the Department of Family and Protective Services (DFPS). To ensure confidentiality, DFPS can provide data quarterly in aggregate for the San Antonio SSLC. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

**BL 2018 Data Source**
Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

**BL 2018 Methodology**
The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the San Antonio SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**
This measure is a mechanism for assessing the relationship between San Antonio SSLC staff and residents.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 7  
Objective No. 1  
Strategy No. 1  
Measure Type OP  
Measure No. 32  

**Goal No. 7 Mental Health State Hospitals, SSLCs and Other Facilities**

**Objective No. 1 State Supported Living Centers**

**Strategy No. 1 State Supported Living Centers**

**Measure Type OP**

**Measure No. 32 Number Confirmed Abuse/Neglect/Exploitation Allegations SSLC San Antonio**

**Calculation Method: C**  
**Target Attainment:**  
**Priority:**

Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 32

**Key Measure: N**  
**New Measure: N**  
**Percentage Measure: N**

---

**BL 2018 Definition**

This measure reports confirmed allegations against State Supported Living Center (SSLC) staff at the San Antonio SSLC. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

**BL 2018 Data Limitations**

This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

**BL 2018 Data Source**

Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

**BL 2018 Methodology**

The measure is calculated by totaling the number of confirmed allegations of A/N/E at the San Antonio SSLC by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**

This measure is a mechanism for assessing confirmed allegations of A/N/E at the San Antonio SSLC.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

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BL 2019 Purpose
Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 7 Mental Health State Hospitals, SSLCs and Other Facilities
Objective No. 1 State Supported Living Centers
Strategy No. 1 State Supported Living Centers
Measure Type OP
Measure No. 33 # Unfounded A/N/E Allegations Against SSLC Staff Rio Grande State Ctr

Calculation Method: C  Target Attainment:  Priority: Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 33
Key Measure: N  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measure reports the number of unfounded allegations as reported by victims against State Supported Living Center (SSLC) staff at the Rio Grande State Center. 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).

BL 2018 Data Limitations
The source data for this measure is supplied by the Department of Family and Protective Services (DFPS). To ensure confidentiality, DFPS can provide data quarterly in aggregate for the Rio Grande State Center. The allegations are reported by intake date. The investigation may take some time to complete. Monthly totals may change until all investigations are complete.

BL 2018 Data Source
Information Management Protecting Adults and Children in Texas (IMPACT) at DFPS.

BL 2018 Methodology
The measure is calculated by totaling the number of A/N/E allegations as reported by victims deemed unfounded at the Rio Grande State Center by Department of Family and Protective Services investigators during a fiscal year.

BL 2018 Purpose
This measure is a mechanism for assessing the relationship between Rio Grande State Center SSLC staff and residents.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
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<td># Confirmed Abuse/Neglect/Exploitation Allegati SSLC Rio Grande S Ctr</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 539 084-R-S70-1 01-08-01 OP 34

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure reports confirmed allegations against Rio Grande State Center SSLC staff. Confirmed is defined as an allegation which is determined to be supported by the preponderance of the evidence.

**BL 2018 Data Limitations**
This data is supplied by the Department of Family and Protective Services (DFPS) and the Health and Human Services Commission (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.

**BL 2018 Data Source**
Information Management Protecting Adults and Children in Texas (IMPACT) at the Department of Family and Protective Services (DFPS).

**BL 2018 Methodology**
The measure is calculated by totaling the number of confirmed allegations of A/N/E at the Rio Grande State Center by Department of Family and Protective Services investigators during a fiscal year.

**BL 2018 Purpose**
This measure is a mechanism for assessing confirmed allegations of A/N/E at the Rio Grande State Center.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
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Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 7  
Objective No. 2  
Strategy No. 1  
Measure Type EF  
Measure No. 1  

**Measure Type**: EF

**Measure No.**: 1  
**Goal No.**: 7  
**Objective No.**: 2  
**Strategy No.**: 1  
**Measure No.**: 1  
**Agency Code**: 529  
**Agency**: Health and Human Services Commission

**Calculation Method**: N  
**Target Attainment**: N  
**Priority**: N  
**Cross Reference**: Agy 537 084-R-S70-1 03-01-03 EF 01

**Key Measure**: Y  
**New Measure**: N  
**Percentage Measure**: N

**BL 2018 Definition**
This measure captures information regarding what it costs HHSC, on average, per occupied state mental health facility bed.

**BL 2018 Data Limitations**
Data must be current and accurate in the commission's accounting system as of the date reports are produced.

**BL 2018 Data Source**
The expenditures for facility operations are entered into the commission's accounting system for each mental health facility.

**BL 2018 Methodology**
This is the 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 administrative and residential operations. Excluded costs include depreciation and employee benefits paid by the Employee Retirement System. The numerator is the total expenditures (less exclusion as above) paid by HHSC for state mental health facilities in the reporting period / Number of 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.

**BL 2018 Purpose**
This measure allows the department to estimate the funding necessary to provide the number of state mental health facilities beds needed by its consumers.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
**Goal No. 7 Mental Health State Hospitals, SSLCs and Other Facilities**

**Objective No. 2 Mental Health State Hospital Facilities and Services**

**Strategy No. 1 Mental Health State Hospitals**

**Measure Type EX**

**Measure No. 1 Number of Consumers Served by State Mental Health Facilities Per Year**

**Calculation Method: N**

**Target Attainment:**

**Priority: Cross Reference: Agy 537 084-R-S70-1 03-01-03 EX 01**

**Key Measure: N New Measure: N Percentage Measure: N**

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**BL 2018 Definition**
This measure provides an unduplicated count of all adults and children receiving services through the state mental health facilities during one fiscal year.

**BL 2018 Data Limitations**
None.

**BL 2018 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 reports.

**BL 2018 Methodology**
This measure is an unduplicated count of individuals with one day or longer in residence at a state mental health facility during the state fiscal year.

**BL 2018 Purpose**
This measure provides the actual number of persons admitted to all state mental health facilities each year plus the number of persons in residence in all state mental health facilities at the beginning of the year.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
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<td>OP</td>
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<td>Average Daily Census of State Mental Health Facilities</td>
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**BL 2018 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.

**BL 2018 Data Limitations**

Data is accurate to the extent that it is correctly entered into the data warehouse system.

**BL 2018 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.

**BL 2018 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 residing on campus during the reporting period by the number of days each person is on campus. 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.

**BL 2018 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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### Agency Code: 529
Agency: Health and Human Services Commission

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**Goal No. 7 Mental Health State Hospitals, SSILCs and Other Facilities**

**Objective No. 2 Mental Health State Hospital Facilities and Services**

**Strategy No. 1 Mental Health State Hospitals**

**Measure Type OP**

**Measure No. 2 Number of Admissions to State Mental Health Facilities**

**Calculation Method:** C

**Target Attainment:**

**Priority:**

**Cross Reference:** Agy 537 084-R-S70-1 03-01-03 OP 03

**Key Measure:** N

**New Measure:** N

**Percentage Measure:** N

**BL 2018 Definition**

This measure captures the number of admissions to all State Mental Hospitals.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

The electronic medical record. Whenever a person is admitted to a State Mental Hospital (by a physician’s order) a new episode is created in the electronic medical record.

**BL 2018 Methodology**

The total number of new episodes created for all State Mental Hospitals each month is calculated then summed by quarter and year-to-date. An “episode of treatment” begins at the date/time when a doctor’s order is signed admitting a patient to a hospital and ends at the date/time a doctor’s order is signed discharging that patient from that hospital.

**BL 2018 Purpose**

Admissions are one of the basic measures of service provided to the community and workload to the hospitals. Admissions represent the beginning of a new episode of treatment and there are specific tasks and costs associated with each new admission independent of the average bed day cost for an episode.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 537 084-R-S70-1 03-02-01 EF 01  
**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure captures information regarding what it costs the state each day, on average, to provide inpatient services in the Community Hospitals to each mental health consumer assigned to this service regardless of age. It measures the HHSC appropriation authority cost per consumer as defined by the companion output measure.

**BL 2018 Data Limitations**
This measure captures information regarding what it costs the state each day, on average, to provide inpatient services in the Community Hospitals to each mental health consumer assigned to this service regardless of age. It measures the HHSC appropriation authority cost per consumer as defined by the companion output measure.

**BL 2018 Data Source**
At the end of each quarter, staff of the local authorities input expenditure information into the data warehouse. 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. For this strategy, only those dollars appropriated for Community Hospitals that are used for inpatient services at the hospitals are included in the cost calculation.

**BL 2018 Methodology**
The numerator is the total HHSC appropriation authority funds for Community Hospitals utilized to fund Community Hospital inpatient services as reported in the data warehouse / 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.

**BL 2018 Purpose**
This measure captures HHSC appropriation authority cost of Community Hospital inpatient services.

**BL 2019 Definition**

**BL 2019 Data Limitations**
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This measure provides an unduplicated workload count of eligible adults and children who receive Community Hospital Inpatient services during one fiscal year. Community Hospital services are provided in inpatient psychiatric facilities (identified under the community hospital strategy). This does not include any facility not licensed as a hospital. (i.e. Kerrville, Crisis Stabilization Unit).

### BL 2018 Data Limitations

The accuracy of the commission's data warehouse is dependent upon accurate and timely information being entered by the local mental health authorities. For purposes of measurement, an open assignment to a service is calculated as receiving the service. The expectation is for assignments to be ended when persons are discharged from the Community Hospital.

### BL 2018 Data Source

As persons enter the community programs, registration information is entered into the commission's data warehouse by staff of the local mental health authority. When an individual is assigned to a specific program, this information is also entered into the data warehouse. Production reports of consumers served are issued quarterly based on the information in the data warehouse.

### BL 2018 Methodology

The total unduplicated number of adults and children that receive Community Hospital Inpatient service during the fiscal year regardless of how the services for the individuals were funded is tallied for each local authority and system-wide.

### BL 2018 Purpose

This measure provides the actual number of adults and children who receive Community Hospital Inpatient services and provides information about the total system activity during one fiscal year. It is a frequently requested number used to compare system activity over a period of two or more fiscal years.
BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No.  7  Mental Health State Hospitals, SSLCs and Other Facilities
Objective No.  2  Mental Health State Hospital Facilities and Services
Strategy No.  2  Mental Health Community Hospitals
Measure Type OP
Measure No.  1  Average Daily Number of Occupied MH Community Hospital Beds

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 537 084-R-S70-1 03-02-01 OP 02

Key Measure: Y  
New Measure: N  
Percentage Measure: N

BL 2018 Definition

Community Hospital services are provided in inpatient psychiatric facilities (identified under the community hospital strategy). This does not include any facility not licensed as a hospital (i.e. Kerrville, Crisis Stabilization Unit). This measure captures the unduplicated count of priority population eligible adults and children whose services are funded with HHSC appropriation authority funds and who occupy a Community Hospital bed on a daily basis. Quarterly performance is stated as the average of the days in the reporting period.

BL 2018 Data Limitations

The accuracy of the commission’s data warehouse is dependent upon accurate and timely information being entered into the database by the local mental health authorities. For purposes of measurement, an open assignment to a service is calculated as receiving the service. The expectation is for assignments to be ended when persons are discharged from the Community Hospital.

BL 2018 Data Source

As persons enter the community programs, registration information is entered into the commission's data warehouse by staff of the local mental health authority. When an individual is assigned to a specific program, this information is also entered into the data warehouse. Production reports of consumers served are issued quarterly based on the information in the data warehouse. The total number of bed days utilized by adults and children in Community Hospitals each quarter is calculated. The production report lists total bed days each quarter regardless of how the services for the individuals were funded.

BL 2018 Methodology

This is an average daily count by quarter of the total number of persons who occupy a Mental Health Community Hospital bed on any given day (as financed through HHSC appropriation authority for Inpatient Community Hospital Service). The numerator is the total number of bed days utilized in Mental Health Community Hospitals for the reporting period. The denominator is the number of days in the reporting period. The formula is numerator/denominator.

BL 2018 Purpose

Community Hospital services are provided to adults and children in acute crisis situations where inpatient care is necessary. The service is usually of short duration and is used as an alternative to hospitalization in a state mental health facility.

BL 2019 Definition

BL 2019 Data Limitations
### BL 2018 Definition

Calculated monthly, this measure reflects the total operating cost per day of inpatient care provided.

### BL 2018 Data Limitations

None

### BL 2018 Data Source

Monthly accounting reports, medical records system, and billing system.

### BL 2018 Methodology

It is calculated by dividing the total expenses for inpatient services for a given period by the total number of patient days for the same period.

### BL 2018 Purpose

Measures the average cost per patient day at the Texas Center for Infectious Disease.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology

### BL 2019 Purpose
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**BL 2018 Definition**
Calculated monthly, this measure reflects the total direct operating cost per patient visit.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
Monthly accounting reports and medical records.

**BL 2018 Methodology**
It is calculated by dividing the total expenses for outpatient services by the total number of outpatient visits.

**BL 2018 Purpose**
Measures the average cost per outpatient visit at the South Texas Health Care system.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 7 Mental Health State Hospitals, SS LCS and Other Facilities
Objective No. 3 Other Facilities
Strategy No. 1 Other State Medical Facilities
Measure Type EX
Measure No. 1 Number of Visits Per Year, Rio Grande State Center Outpatient Clinic

Measurement Details:

**BL 2018 Definition**
An outpatient clinic visit is one in which a scheduled or unscheduled individual who is not an inpatient of the hospital is registered to receive non-emergency services. Each registration at the outpatient clinic is considered one outpatient visit. Services can include: 1) those provided by a member of the active medical staff or by a consultant who is paid from hospital funds, or 2) those which do not require a physician but which involve diagnosis and treatment, necessitating use of the administrative services of the outpatient clinic.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
Daily log.

**BL 2018 Methodology**
Total number of outpatient visits.

**BL 2018 Purpose**
Measures the number of outpatient visits to the South Texas Health Care system.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

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Agency Code:  529  
Agency:  Health and Human Services Commission

Goal No. 7  Mental Health State Hospitals, SSICs and Other Facilities
Objective No. 3  Other Facilities
Strategy No. 1  Other State Medical Facilities
Measure Type OP
Measure No. 1  Number of Inpatient Days, Texas Center for Infectious Disease

Calculation Method: C  
Target Attainment:  
Priority:  
Cross Reference: Agy 537 084-R-S70-1 03-01-01 OP 01

Key Measure: Y  
New Measure: N  
Percentage Measure: N

BL 2018 Definition
The total number of days of care charged for occupied inpatient beds.

BL 2018 Data Limitations
Patients may have left the Texas Center for Infectious Disease (TCID) grounds without medical advice or with an authorized pass, will not have returned at midnight, and when the patient returns, the daily census must be updated. So, adjusted daily census reports are common and monthly reporting can be delayed.

BL 2018 Data Source
Total daily census is aggregated in the Hospital Information System at midnight.

BL 2018 Methodology
The measure is computed by summing the data for the reporting, period, daily, weekly, monthly, quarterly, and year-to-date.

BL 2018 Purpose
TCID is budgeted to operate two inpatient patient care units. The standard of treatment for Tuberculosis is outpatient directly observed therapy. While admission to Texas Center for Infectious Disease is based on clinical conditions of patients requiring hospitalization, monitoring of total patient days regularly is a public health indicator both of acuity of patient conditions and complications in communities.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
Goal No. 7 Mental Health State Hospitals, SSCLs and Other Facilities
Objective No. 3 Other Facilities
Strategy No. 1 Other State Medical Facilities
Measure Type OP
Measure No. 2 Number of Admissions: Total Number Patients Admitted to TCID

Calculation Method: C
Target Attainment: N
Priority: N
Cross Reference: Agy 537 084-R-S70-1 03-01-01 OP 02

Key Measure: N
New Measure: N
Percentage Measure: N

**BL 2018 Definition**

Number of admissions for the reporting period.

**BL 2018 Data Limitations**

Data collection is dependent upon completion of admission documentation when a patient is admitted to Texas Center for Infectious Disease (TCID) for inpatient treatment.

**BL 2018 Data Source**

Admission summary for each patient admitted to TCID is logged into patient accounting systems and data is compiled monthly, quarterly and annually.

**BL 2018 Methodology**

Whole number cumulated for the reporting period.

**BL 2018 Purpose**

Measures activity and utilization of more expensive Tuberculosis inpatient treatment.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 7: Mental Health State Hospitals, SSLSs and Other Facilities
Objective No. 3: Other Facilities
Strategy No. 1: Other State Medical Facilities
Measure Type: OP
Measure No. 3: Avg # Outpatient Visits/Day, Rio Grande State Center Outpatient Clinic

Calculation Method: C  
Target Attainment: N/A  
Priority: N/A  
Cross Reference: Agy 537 084-R-S70-1 03-01-02 OP 01

Key Measure: Y  
New Measure: N  
Percentage Measure: N

**BL 2018 Definition**

An outpatient clinic visit is one in which a scheduled or unscheduled individual who is not an inpatient of the hospital is registered to receive non-emergency services. Each registration at the outpatient clinic is considered one outpatient visit. Services can include: 1) those provided by a member of the active medical staff or by a consultant who is paid from hospital funds, or 2) those which do not require a physician but which involve diagnosis and treatment, necessitating use of the administrative services of the outpatient clinic.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

Daily log.

**BL 2018 Methodology**

Total number of outpatient visits.

**BL 2018 Purpose**

Measures the number of outpatient visits to the South Texas Health Care system.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
### Agency Code: 529
### Agency: Health and Human Services Commission

#### Goal No. 8
Regulatory, Licensing and Consumer Protection Services

#### Objective No. 1
Regulation of Facilities and Consumer Products

#### Strategy No. 1
Health Care Facilities & Community-based Regulation

#### Measure No. 1: Average Cost Per Facility Visit

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 02-01-01 EF 01

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

### BL 2018 Definition
This measure reports the average cost of a facility visit. A facility visit is defined as an on-site visit by one or more surveyors for the purpose of conducting a licensing inspection, a standard or a re-certification survey, a complaint investigation, monitoring visit, or a follow-up visit.

### BL 2018 Data Limitations
A visit that has multiple purposes is counted only once. (i.e. A standard survey during which a complaint investigation and follow-up are conducted is counted as one visit.)

### BL 2018 Data Source
The average cost is based on direct costs attributed to the Health and Human Services Commission (HHSC) program activity codes 430 (Survey & Certification Title XVIII Services), 433 (Nursing Facility Survey and Certification), 434 (ICF/IID Survey and Certification), 436 (Survey and Certification Generic Staff), and 436 (PPECC Survey and Certification) as recorded in the commission's Health and Human Services Administrative System. Included are salary, travel, and overhead (operating costs) expenses. Data for the number of on-site visits is obtained from the Compliance, Assessment, Registration, Enforcement System (CARES) using the ad hoc query system. This report will be titled “Facility On-Site Visits” in the future.

### BL 2018 Methodology
Data are computed by totaling the cost amounts for the appropriate reporting periods (numerator) and then dividing by the number of on-site visits for the same time period (denominator) to yield the average cost.

### BL 2018 Purpose
This measure provides the unit cost for a facility visit. It is an indicator of the efficiency of agency operations and is a tool for projecting future funding needs.

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Page 577 of 804
BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This measure reports the average cost of issuing a Medicaid contract to a nursing facility, ICF/IID or hospice service provider. Issuance of a Medicaid provider contract results after the nursing facility, ICF/IID, or hospice provider has met all of the criteria discussed under output measure 10 of this strategy.

### BL 2018 Data Limitations

Does not apply.

### BL 2018 Data Source

The average cost is based on a percentage of the salary costs for the employees (Full-time Equivalents (FTEs) in the Facility Enrollment Section, Regulatory Services, who perform the nursing facility, ICF/IID, and hospice service Medicaid provider enrollment work. These FTE salary costs are accounted for in the commission's automated Health and Human Services Administrative System. The affected FTEs expend from 5% to 90% of their time on this effort. The percentage of time each FTE spends on this activity is determined by the Unit manager's administrative experience. Data are obtained from the Health and Human Services Commission (HHSC) Provider Central Data Repository (CDR). At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report will be titled “Medicaid Facility Service Contracts Issued” in the future.

### BL 2018 Methodology

Cost data are computed by totaling the associated percentage of salary costs for all FTEs for the appropriate reporting period (numerator). This result is then divided by the number of nursing facility, ICF/IID and hospice service Medicaid contracts issued for the same reporting period (denominator) to yield the average cost.

### BL 2018 Purpose

This measure provides the unit cost for issuing a Medicaid contract to eligible participating nursing facilities, ICFs/IID and hospice service providers. It is an indicator of the efficiency of agency operations and is a tool for projecting future funding needs.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 02-01-01 EF 02  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N
BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This measure reports the average monthly cost attributable to investigations that remain open and that are closed during the reporting period, and includes investigations conducted in mental health or intellectual disability settings, which may include state supported living centers, state hospitals, state centers, private ICF/IID facilities, community centers, and Medicaid waiver programs.

### BL 2018 Data Limitations

None

### BL 2018 Data Source

Total program cost is from HHSAS-FS and an internal budget document (OOELEDGER.xls) for APS Facility Investigations Strategy PACs 445 (APS Facility Investigations), 452 (APS Facility Investigations Program Support), 498 (APS Facility Investigations - Cost Pool Staff) and 499 (APS Facility Investigations Training Cost Pool Staff). Number of investigations is from IMPACT. Open investigations have no investigation completion or closure dates. Closed investigations are indicated by a completion or stage closure date during the reporting period.

Due to possible modifications in the FPS 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.

### BL 2018 Methodology

Annual expenditure projections Facility investigation PACs are made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported on HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. Each quarter, annual expenditure projections are multiplied by the percent of the year elapsed and reduced by previous quarter(s) dollars to get estimated expenditures attributable to the report quarter. Quarterly amounts are totaled and divided by the number of reporting period months to yield the average monthly cost (numerator). The average monthly number of investigations is calculated by dividing the cumulative count of cases investigated during the reporting period by the number of reporting period months (denominator).

Divide the numerator by the denominator to calculate the average monthly cost per investigation. When calculating 2nd, 3rd, & 4th quarters the year-to-date total is recalculated.

### BL 2018 Purpose

This measure is useful as a benchmark and to monitor changes in agency costs attributable to the investigation function.
**Strategy-Related Measures Definitions**
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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<td>Measure No.</td>
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<td>APS Daily Caseload per Worker (Facility Investigations)</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 530 084-R-S70-1 04-01-01 EF 05

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure provides the average daily caseload for Facility investigators. Facility investigations require formal written witness statements and often involve multiple alleged victims and perpetrators. Facility investigations must be initiated within 1 hour of intake. With limited exceptions, investigations must be completed within 14 days of intake.

**BL 2018 Data Limitations**

Data from HHSAS-HR is point-in-time at the end of the month, so only the last record for the month is captured.

**BL 2018 Data Source**

For each day during the reporting period count stages from IMPACT that were open at any time during the day and for which the primary assignment is to a Facility Investigator with the appropriate job class and paid out of PAC 445 (APS Facility Investigations) in HHSAS-HR. The following stages are included: Investigation (INV).

For numerator, count stages assigned to caseworkers that were open during the day for each day during the reporting period if the primary assignment is to a Facility investigator with the appropriate job class and paid out of PAC 445 (APS Facility Investigations) in HHSAS-HR.

For the denominator, calculate the total number of caseworkers with primary assignments for each day during the report period, excluding trainees with less than 57 days of service. Trainees with 57 to 152 days of service are counted as half (.5) of a caseworker.

**BL 2018 Methodology**

Divide the numerator (sum of all daily case counts) for the reporting period by the denominator (sum of all daily caseworker counts) during 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.

**BL 2018 Purpose**

This measure is an indicator of an average amount of work handled each day by investigators in MH and ID settings. The intent is to approximate what a caseworker would state if asked about the workload being managed.
### BL 2018 Definition

This measure reports the number of facilities that are terminated from the Medicare (Title XVIII) and/or the Medicaid (Title XIX) program, the number of facilities that have had their license revoked, and the number of facilities that were denied license renewal during the reporting period. Reasons for denial of a license are described in the rules for nursing facilities (Section 19.214), for ICF/IID (Section 90.17), for assisted living facilities (Section 92.17), for adult day care facilities (Section 98.19), and PPECC (Section 40.15).

### BL 2018 Data Limitations

Does not apply.

### BL 2018 Data Source

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) and CARES Central Data Repository (CDR) and the Automated Survey Processing Environment (ASPEN) system. A report for certification termination will be run from ASPEN and report for licensure terminations will be run from CARES.

### BL 2018 Methodology

The number of facilities terminated from licensure and/or certification programs during the months of the reporting period is totaled.

### BL 2018 Purpose

This measure is a reflection of the agency's performance as it pertains to initiating corrective actions/enforcement of facilities out of compliance.
### Strategy-Related Measures Definitions

85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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<tr>
<td>Measure No.</td>
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<td>Number of Medicaid Facility Contracts Terminated</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 02-01-01 EX 02  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

### BL 2018 Definition

This measure reports the number of nursing facilities, ICFs/IID, Hospice facilities, and PPECCs that have had their Medicaid provider contract terminated for failure to meet the Medicaid contracting requirements, for revocation or denial of their license, or for termination of their Medicaid certification.

### BL 2018 Data Limitations

Does not apply.

### BL 2018 Data Source

Data are obtained from the Texas Health and Human Services Commission (HHSC) Provider Central Data Repository (CDR). At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report does not have a name or number.

### BL 2018 Methodology

The number of Medicaid facility contracts terminated during the months of the reporting period is summed.

### BL 2018 Purpose

This measure is a reflection of the agency's performance as it pertains to initiating corrective actions/enforcement of facilities out of compliance.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology

### BL 2019 Purpose
### Strategy-Related Measures Definitions

85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

#### Agency Code: 529
Agency: Health and Human Services Commission

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**Goal No. 8 Regulatory, Licensing and Consumer Protection Services**

**Objective No. 1 Regulation of Facilities and Consumer Products**

**Strategy No. 1 Health Care Facilities & Community-based Regulation**

**Measure Type EX**

**Measure No. 3 Number of Deaths from Abuse/Neglect/Exploitation: Facility Settings**

**Calculation Method: N**

**Target Attainment:**

**Priority:**

Cross Reference: Agy 530 084-R-S70-1 04-01-01 EX 03

**Key Measure: N**

**New Measure: N**

**Percentage Measure: N**

---

**BL 2018 Definition**

This measure reports the number of deaths due to abuse or neglect of APS clients receiving mental health or intellectual disability services, which include state supported living centers, state hospitals, state centers, private ICF-IID facilities, community centers, and Medicaid waiver programs.

**BL 2018 Data Limitations**

The data is limited due to self-reporting by mental health or intellectual disability facilities.

**BL 2018 Data Source**

The data are gathered from IMPACT using allegation disposition and serious injury codes.

**BL 2018 Methodology**

The measure equals the count of the number of cases with investigation completion dates within the reporting period in which at least one allegation disposition is coded as 'CON' (confirmed), there is a DOD (date of death) indicated, the reason for death is abuse or neglect and resulting fatality is indicated by the code of 'Fatal' in the seriousness of the injury field.

**BL 2018 Purpose**

This measure captures the number of deaths from maltreatment in mental health and intellectual disability programs. The number of deaths from maltreatment in mental health or intellectual disability programs is an important indicator of problems in the service delivery system, i.e., that care and treatment are substandard.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**

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**BL 2019 Methodology**

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BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 8  Regulatory, Licensing and Consumer Protection Services
Objective No. 1  Regulation of Facilities and Consumer Products
Strategy No. 1  Health Care Facilities & Community-based Regulation
Measure Type EX
Measure No. 4  Number of APS Caseworkers who Completed Basic Skills Development

Calculation Method: N  
Target Attainment: N  
Priority: N  
Cross Reference: Agy 530 084-R-S70-1 04-01-02 EX 01

Key Measure: N  
New Measure: N  
Percentage Measure: N

**BL 2018 Definition**

This measure counts the number of APS Caseworkers who completed Basic Skills Development (BSD) training during the reporting period.

**BL 2018 Data Limitations**

Fluctuations in this measure can be attributable to additional FTEs appropriated by the legislature and ongoing APS employee retention efforts.

**BL 2018 Data Source**

HHSAS-HRMS Administrator Training Database

**BL 2018 Methodology**

The calculation is a count of the number of caseworkers for whom the session end date in the HHSAS-HRMS Administrator Training Database is during 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.

**BL 2018 Purpose**

This measure monitors the volume of APS caseworkers completing BSD.
**BL 2018 Definition**

The number of complaint investigations 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 acute health facilities, free standing emergency medical care facilities, chemical dependency treatment facilities, narcotic treatment programs, massage therapy schools, massage establishments, orthotic/prosthetic facilities, medical radiologic technologist training schools, midwifery training programs, and offender education programs which are documented by an appropriate investigative report. The professional licensing and certification unit’s and emergency management program’s investigations are initiated upon notification of possible violations of state laws or rules.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

The data are computed manually & fr computerized db infor fr survey & investing docs. submitted by staff, the acute hlth facil, the free standing emrgy medical care facil, chemical depn nmt trnt facil, massage therapy schs, massage estabs, orthotic/prosthetic facil, medical radiologic technologist trng schs, midwifery trng progs, & offender edu progs. The prof licensing & cert unit (PLCU), health facil compliance prog (HFCP), & the emrgy mgmt prg (EMP) activities are tracked by using a computerized trackg sys for complaints. They also collect complaint data on the entities regulated. The HFCP also collects data on the acute hlth facil, free standing emrgy medical care facil, & chemical depn nmt trnt facil self-investig & on the follow-up of these invests. PLCU collects data for massage therapy schs, massage estabs, orthotic/prosthetic facil, medical radiologic technologist trng schs, midwifery trng progs, & offender edu progs. Doc identifies the automated db stored in PLCU, HFCP & EMP.

**BL 2018 Methodology**

The complaint investigations are totaled quarterly and are cumulative for the fiscal year.

**BL 2018 Purpose**

A complaint investigation is based on allegations of potential violations of state & fed. Regs. The investigative rpt, completed by the surveyor or the acute health facility, free standing emergency medical care facilities, chemical dependency treatment facilities, massage therapy schools, massage establishments, orthotic/prosthetic facilities, medical Rad technologist training schools, midwifery training pgms & offender edu. pgms, who performs the investigation, shows the allegation(s) considered; the investigative process; the area(s) found to be deficient in meeting any relevant regulations; & the surveyor’s or acute health facility’s, free standing emerg medical care facil’s massage therapy school’s, massage establishment’s, orthotic/prosthetic facility’s medical Rad technologist training school’s, midwifery training pgm’s, and offender edu. pgm’s, chemical dependency treatment facility’s, narcotic treatment program’s finding(s) relating to the validity of the allegation(s).
BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
### Strategy-Related Measures Definitions

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**Goal No. 8 Regulatory, Licensing and Consumer Protection Services**

**Objective No. 1 Regulation of Facilities and Consumer Products**

**Strategy No. 1 Health Care Facilities & Community-based Regulation**

**Measure Type OP**

**Measure No. 2 Number of Health Care Delivery Entity Surveys Conducted**

**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  

Cross Reference: Agy 537 084-R-S70-1 04-01-05 OP 02

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure is defined as the number of surveys pertaining to the quality of health care delivery and health-related educational programs under state and federal regulations conducted by staff, excluding complaint investigations. Health care delivery entities include: orthotic and prosthetic facilities, acute care facilities, free standing emergency medical care facilities, chemical dependency treatment facilities, narcotic treatment programs, emergency medical services providers, and massage establishments. Health-related educational program entities include massage therapist, medical radiologic technologist, midwife, and emergency management courses.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

This measure is the total number of surveys pertaining to the quality of health care delivery and health-related educational programs conducted by staff for each quarter, excluding complaint investigations, and is cumulative for the fiscal year.

**BL 2018 Methodology**

This measure is the total number of surveys pertaining to the quality of health care delivery and health-related educational programs conducted by staff for each quarter, excluding complaint investigations, and is cumulative for the fiscal year.

**BL 2018 Purpose**

This measure is the total number of surveys pertaining to the quality of health care delivery and health-related educational programs under state and federal regulations conducted by staff, excluding complaint investigations.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Strategy-Related Measures Definitions
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 8 Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Strategy No. 1 Health Care Facilities & Community-based Regulation
Measure Type OP
Measure No. 3 Number of Licenses Issued for Health Care Entities

Calculation Method: C
Target Attainment: Priority:
Cross Reference: Agy 537 084-R-S70-1 04-01-05 OP 03
Key Measure: N
New Measure: N
Percentage Measure: N

BL 2018 Definition
The number of licenses issued reflects the number of newly licensed entities, entities renewing licenses, changing ownership (i.e., entities bought and sold), changing address, name, and number of beds. Entities include: general, special, and private mental hospitals; crisis stabilization units; ambulatory surgical and birthing centers; special care, end stage, abortion, and orthotic/prosthetic facilities, free standing emergency medical care facilities, chemical dependency treatment facilities, narcotic treatment programs, massage therapy schools, massage establishments, offender education programs, midwife training programs, medical radiologic training schools, and emergency medical services providers.

BL 2018 Data Limitations
This measure may be less than the actual workload due to applications received and reviewed where no license is issued (for various reasons). This measure does not reflect the number of licensed entities at any given time (i.e., a count of licensed entities) due to the fact that while initial licenses are being issued to new entities, a number of entities are closing or undergoing a change of ownership.

BL 2018 Data Source
After the receipt of a complete application and licensing fee and upon completion of the application review, a license is issued to the entity. All license data is entered into the regulatory databases.

BL 2018 Methodology
The licenses issued are totaled each quarter and are cumulative for the fiscal year.

BL 2018 Purpose
These counts can be used for analyzing trends in the 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.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This is the total number of facility certifications issued for nursing facilities (NF) and ICFs/IID. This includes Medicare only nursing facilities, dually certified (Medicare/Medicaid) nursing facilities, Medicaid only nursing facilities, and ICFs/IID.

### BL 2018 Data Limitations

Does not apply.

### BL 2018 Data Source

Data are obtained from the federal Automated Survey Processing Environment (ASPEN) system and compiled by Data Management and Analysis Sub-Unit. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed to make the necessary calculations. The report will be titled “Number of Long-term Care Facility Certifications Issued” in the future.

### BL 2018 Methodology

The number of Long Term Care facility certifications issued for each of the components during the months of the reporting period are totaled. The components are then summed.

### BL 2018 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 workload expended by the agency in response to its charge of certifying residential care facilities for participation in the Medicare/Medicaid programs. This data is useful in projecting future funding needs.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**

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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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<tbody>
<tr>
<td>8</td>
<td>1</td>
<td>1</td>
<td>OP</td>
<td>5</td>
<td>Number of Long-term Care Facility Licenses Issued</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 02-01-01 OP 02  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the total number of facility licenses issued for all types of facilities (nursing facilities, ICFs/IID, assisted living facilities, adult day care facilities, and PPECCs). Data includes new and renewed licenses. A license is considered as issued once it has been printed. Each license has a new expiration date printed on it. (This date may differ from the date on which the license is actually printed.) Nursing facilities are licensed for a three-year period and assisted living facilities, adult day care facilities, and ICFs/IID are licensed for a two year period.

**BL 2018 Data Limitations**

This measure excludes change of ownership during a licensure period, change of facility name during a licensure period, bed decrease and increase changes, change of facility administrator for nursing facilities and ICFs/IID, and change in ownership of facility stock.

**BL 2018 Data Source**

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) and CARES Central Data Repository (CDR). At the end of the reporting period, an ad hoc report will be done containing the required data elements needed to make the necessary calculations. The report will be titled “Number of Long-term Care Facility Licenses Issued” in the future.

**BL 2018 Methodology**

The number of Long-term Care facility licenses issued during the months of the reporting period is summed.

**BL 2018 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 workload expended by the agency in response to its charge to license the various types of residential care facilities. This data is a useful tool for projecting future funding needs.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**

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BL 2019 Methodology

BL 2019 Purpose
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<td>Objective No.</td>
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<td>Regulation of Facilities and Consumer Products</td>
<td></td>
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<tr>
<td>Strategy No.</td>
<td>1</td>
<td>Health Care Facilities &amp; Community-based Regulation</td>
<td></td>
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<tr>
<td>Measure Type</td>
<td>OP</td>
<td># of On-site Nursing Facility/ICF/IID Monitoring Visits Completed</td>
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<td>Measure No.</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 539 084-R-S70-1 02-01-01 OP 03  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure reports the number of monitoring visits to nursing facilities and Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IDD) during the reporting period. A monitoring visit is an on-site visit in addition to the annual inspection/survey to determine financially unstable facilities' compliance with state and federal standards. However, if during a monitoring visit, more than one type of activity is performed (a survey, follow-up to investigation and a new investigation) each type of activity is counted separately for reporting purposes.

**BL 2018 Data Limitations**
Does not apply.

**BL 2018 Data Source**
Data are obtained from the Central Data Repository (CDR) that pulls data from the Compliance, Assessment, Regulation, Enforcement System (CARES) and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed to make the necessary calculations. The report will be titled “# of on-site Nursing Facility/ICF/IID Monitoring Visits Completed” in the future.

**BL 2018 Methodology**
The total number of completed monitoring visits is calculated by summing the number of monitoring visits to nursing facilities with visits to ICFs/IID during the months of the reporting period.

**BL 2018 Purpose**
This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy and indicates how many regulatory visits nursing facilities/ICFs/IID average per month to determine compliance with state and federal regulations.

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**
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**Agency Code:** 529
**Agency:** Health and Human Services Commission

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<th>Measure No.</th>
<th>Description</th>
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<tr>
<td>8</td>
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<td>1</td>
<td>OP</td>
<td>7</td>
<td>Number of Inspections Completed Per Year</td>
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**Calculation Method:** C  **Target Attainment:**  **Priority:**

**Cross Reference:** Agy 539 084-R-S70-1 02-01-01 OP 04

**Key Measure:** N  **New Measure:** N  **Percentage Measure:** N

**BL 2018 Definition**
This measure reports the number of inspections conducted by the Health and Human Services Commission (HHSC), Regulatory Services. An inspection is defined as one of the following: a re-certification survey (ICFs/IID), a standard survey (certified nursing facilities), an initial survey (ICFs/IID or certified nursing facilities), an initial or annual licensing inspection (licensed only nursing facilities, assisted living facilities, adult day care facilities, or PPECCs), or change of ownership. A licensing inspection done in conjunction with a survey of a certified facility is not counted as a separate inspection.

**BL 2018 Data Limitations**
Does not apply.

**BL 2018 Data Source**
Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) and CARES Central Data Repository (CDR). At the end of the reporting period, an ad hoc report will be done containing the required data elements needed to make the necessary calculations. The report will be titled “Number of Inspections Completed Per Year” in the future.

**BL 2018 Methodology**
The numbers of inspections completed in long-term care facilities (nursing facilities, ICFs/IID, assisted living facilities, adult day care facilities, and PPECCs) during the months of the reporting period are totaled.

**BL 2018 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 agency’s workload of inspecting facilities to ensure their compliance with state and federal standards. This data is a useful tool for projecting future funding needs.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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<tbody>
<tr>
<td>8</td>
<td>1</td>
<td>1</td>
<td>OP</td>
<td>8</td>
<td>Number of First Follow-up Visits Completed Per Year</td>
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</table>

**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 02-01-01 OP 05  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the number of first follow-up visits completed during the fiscal year for all types of facilities (nursing facilities, ICFs/IID, assisted living facilities, adult day care facilities, and PPECCs). The number of visits resulting in adverse actions and the number of visits not resulting in adverse actions are both included in the count.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the required calculations. The report will be titled “Number of First Follow-up Visits Completed Per Year” in the future.

**BL 2018 Methodology**

The number of first follow-up visits completed during the months covered by the reporting period is summed.

**BL 2018 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 agency's workload of conducting first follow-up visits to those long-term care facilities not in compliance with state and federal standards at the time of the initial survey, most recent re-certification survey, most recent licensing inspection or complaint/incident investigation, bed change visits, or facility status verification visit to determine if the facility (usually unlicensed) is in compliance with licensure standards. This data is useful in determining future funding needs.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
**BL 2018 Definition**

This measure reports the number of complaint investigations and the number of incident investigations completed in nursing facilities, ICFs/IID, assisted living facilities, adult day care facilities, PPECCs, and unlicensed facilities. For purposes of this measure, a complaint investigation is defined as the on-site investigation of all allegations associated with an individual complaint intake (assigned an identification number upon intake). An incident investigation is defined as the on-site investigation of all areas of facility compliance associated with an incident as reported by the facility. Facility staff are required to self-report incidents that have resulted in or has the potential of resulting in injury or harm to a resident.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data is obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR), which pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report will be titled “Number of Investigations Completed” in the future.

**BL 2018 Methodology**

The number of complaint and incident investigations completed during the months of the reporting period is summed.

**BL 2018 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 agency's workload in pursuing the validity of inappropriate treatment of residents and/or the existence of other sub-standard conditions. This data is useful in determining future funding needs.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This measure reports the total dollar amount of administrative penalties imposed for all types of facilities during the state fiscal year. It also includes the total amount of civil monetary penalties (CMP) imposed by the commission for nursing facilities participating in the Medicaid program, and the total dollar amount of CMPs imposed by the federal Centers for Medicare and Medicaid Services (CMS) on facilities participating in the Medicare/Medicaid (dually certified) or Medicare programs. An administrative penalty is imposed after the state-licensing agency, HHSC Regulatory Services Licensing, has reviewed the staff recommendation of penalty based upon the findings of the facility's deficient practice(s) and decided on a final penalty. For CMPs, a penalty is imposed after the State Medicaid agency and/or CMS have reviewed the state survey/investigative team's recommendation of a penalty based on the facility's deficient practice(s) and decided on a final penalty.

### BL 2018 Data Limitations

Does not apply.

### BL 2018 Data Source

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR), which pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report will be titled “Total Dollar Amount Imposed from Fines” in the future.

### BL 2018 Methodology

The total dollar amounts imposed for fines during the months of the reporting period are summed.

### BL 2018 Purpose

This measure quantifies one of the primary administrative tools available to the agency to ensure that residential care facilities implement the necessary actions to correct deficient conditions and practices.

### BL 2019 Definition

This measure reports the total dollar amount of administrative penalties imposed for all types of facilities during the state fiscal year. It also includes the total amount of civil monetary penalties (CMP) imposed by the commission for nursing facilities participating in the Medicaid program, and the total dollar amount of CMPs imposed by the federal Centers for Medicare and Medicaid Services (CMS) on facilities participating in the Medicare/Medicaid (dually certified) or Medicare programs. An administrative penalty is imposed after the state-licensing agency, HHSC Regulatory Services Licensing, has reviewed the staff recommendation of penalty based upon the findings of the facility's deficient practice(s) and decided on a final penalty. For CMPs, a penalty is imposed after the State Medicaid agency and/or CMS have reviewed the state survey/investigative team's recommendation of a penalty based on the facility's deficient practice(s) and decided on a final penalty.
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Goal No. 8 Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Strategy No. 1 Health Care Facilities & Community-based Regulation
Measure Type OP
Measure No. 11 Total Dollar Amount Assessed from Fines

**BL 2018 Definition**

This measure reports the total dollar amount of administrative penalties assessed for all types of facilities during the reporting period. It also includes the total amount of civil monetary penalties (CMP) assessed by the department for nursing facilities participating in the Medicaid program, and the total dollar amount of CMPs assessed by the federal Centers for Medicare and Medicaid Services (CMS) for facilities participating in Medicare/Medicaid (dually certified) or Medicare programs. A penalty is assessed after the appeal/review process is completed and waiver, negotiated settlement, or hearing proceedings are finalized, and an assessment amount is agreed upon or set.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data is obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR), which pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report will be titled “Total Dollar Amount Assessed from Fines” in the future.

**BL 2018 Methodology**

The total dollar amounts assessed from fines during each month of the reporting period are totaled. Monthly totals are summed to obtain the year-to-date amount.

**BL 2018 Purpose**

This measure quantifies one of the primary administrative tools available to the agency to ensure that residential care facilities implement the necessary actions to correct deficient conditions and practices.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 8 Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Strategy No. 1 Health Care Facilities & Community-based Regulation
Measure Type OP
Measure No. 12 Total Dollar Amount Collected from Fines

Calculation Method: C  Target Attainment: Priority:  Cross Reference: Agy 539 084-R-S70-1 02-01-01 OP 09
Key Measure: Y  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measure reports the total dollar amount of administrative penalties collected for all types of facilities during the reporting period. It also includes the total amount of civil monetary penalties (CMP) collected by the department for nursing facilities participating in the Medicaid program, and the total dollar amount of CMPs collected by the federal Centers for Medicare and Medicaid Services (CMS) for facilities participating in Medicare/Medicaid (dually certified) or Medicare programs. A penalty amount collected is the amount that facilities have actually paid to the State Medicaid agency and/or the CMS for penalties assessed.

BL 2018 Data Limitations
Does not apply.

BL 2018 Data Source
Data are obtained monthly from the Accounting Division reports of accounts received for the payment of administrative penalties and civil monetary penalties. They are derived from a combination of the class (appropriation budget) and the cash account (0004500). The reports are named Administrative Penalties, and Civil Monetary Penalties.

BL 2018 Methodology
The total dollar amounts collected from fines during the months of the reporting period are summed. Monthly data are totaled over the reporting period.

BL 2018 Purpose
This measure quantifies one of the primary administrative tools available to the agency to ensure that residential care facilities implement the necessary actions to correct deficient conditions and practices.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
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Agency: Health and Human Services Commission

Goal No. 8 Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Strategy No. 1 Health Care Facilities & Community-based Regulation
Measure Type OP
Measure No. 13 Number of Medicaid Facility and Hospice Service Contracts Issued

Calculation Method: C  Target Attainment:  Priority:  
Cross Reference: Agy 539 084-R-S70-1 02-01-01 OP 10
Key Measure: N  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measure reports the number of Medicaid provider contracts issued to nursing facilities, ICFs/IID, hospice service providers, and PPECCs. Contracts issued include new facilities or services contracted, ownership changes resulting in a contract issuance, and re-applications after a facility or service's contract is terminated. Enrollment into the Medicaid program involves the facility/service meeting all Medicaid contracting criteria including acceptable completion of the enrollment/application process, compliance with the pertinent state licensing regulations and compliance with the applicable federal and state Medicaid certification regulations. A Medicaid contract is issued after the facility/service is licensed and/or certified. Based on this contract, the facility or service is eligible for vendor payments for the Medicaid individuals residing in the facility or Medicaid individuals receiving hospice services.

BL 2018 Data Limitations
Does not apply.

BL 2018 Data Source
Data are obtained from the Health and Human Services Commission (HHSC) Provider Central Data Repository (CDR). At the end of the reporting period, an ad hoc report will be done containing the data elements needed to make the necessary calculations. The report will be titled “Number of Medicaid Facility Service Contracts Issued” in the future.

BL 2018 Methodology
The number of Medicaid nursing facility contracts issued during the months of the reporting period is summed; the number of ICF/IID contracts issued during the months of the reporting period is summed; the number of hospice service contracts issued during the months of the reporting period is summed; and the number of PPECC contracts issued during the months of the reporting period is summed. These four sums are totaled to obtain the reported data.

BL 2018 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 workload expended by the agency in response to its charge of issuing contracts to Medicaid certified nursing facility, ICF/IID, hospice service providers and PPECC. This data is a tool for projecting future funding needs.

BL 2019 Definition

BL 2019 Data Limitations
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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**Agency:** Health and Human Services Commission

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**Goal No. 8 Regulatory, Licensing and Consumer Protection Services**

**Objective No. 1 Regulation of Facilities and Consumer Products**

**Strategy No. 1 Health Care Facilities & Community-based Regulation**

**Measure Type OP**

**Measure No. 14 Number of Home and Community Support Services Agency Licenses Issued**

---

**Calculation Method:** C  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 02-01-01 OP 11  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the total number of licenses issued by the Health and Human Services Commission (HHSC) Regulatory Services Home and Community Support Services Agency (HCSSA) staff. For reporting purposes, a license is considered as issued once it has been printed. Each license has a new expiration date printed on it. (This date may differ from the date on which the license is actually printed.) HCSSAs are licensed for one year.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data are obtained from the HCSSA Integrated System Central Data Repository (CDR). Data will be contained in an ad hoc report from the CDR done at the end of the reporting period. This report will be titled “Number of Home and Community Support Services Agency Licenses Issued” in the future.

**BL 2018 Methodology**

Data for the appropriate number of months in the reporting period is summed.

**BL 2018 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 agency's workload of inspecting agencies to ensure their compliance with state and federal requirements. This data is a useful tool for projecting future funding needs.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**

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**BL 2019 Methodology**

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BL 2019 Purpose
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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

**Goal No.:** 8  
**Objective No.:** 1  
**Strategy No.:** 1  
**Measure Type:** OP  
**Measure No.:** 15

**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 02-01-01 OP 12

---

**BL 2018 Definition**

This measure reports the total number of inspections conducted during the reporting period by the Health and Human Services Commission (HHSC) Regulatory Services Home and Community Support Services Agency (HCSSA). For reporting purposes, an inspection is defined as one of the following: an initial licensing survey; an initial certification survey (Medicare certified agencies), a re-survey (licensed only). A licensing inspection done in conjunction with a survey of a Medicare certified agency is not counted as a separate inspection.

---

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data are obtained from the regional HCSSA workload report (Excel worksheet) submitted monthly and compiled by the Data Management and Analysis Sub-Unit. Data will be contained in an ad hoc report done at the end of the reporting period. This report will be titled “Number of Home & Community Support Services Agency Inspections Conducted” in the future.

---

**BL 2018 Methodology**

Monthly data, covering the appropriate months of the reporting period, are totaled.

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**BL 2018 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 agency's workload of inspecting agencies to ensure their compliance with state and federal requirements. This data is a useful tool for projecting future funding needs.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**

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<td>Objective No.</td>
<td>Regulatory, Licensing and Consumer Protection Services</td>
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<td>Objective No.</td>
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<td>Strategy No.</td>
<td>Regulation of Facilities and Consumer Products</td>
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<td>Measure No.</td>
<td>16</td>
<td>Measure Type</td>
<td>Number of Complaint Investigations Conducted: HCSSA</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 02-01-01 OP 13

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the number of complaint investigations conducted in Home and Community Support Services Agencies (HCSSA). A complaint investigation is defined as an on-site visit conducted for the purpose of determining compliance with federal and state requirements when a complaint has been filed with the department.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data are obtained from the regional HCSSA workload report (Excel worksheet) submitted monthly and compiled by Data Management and Analysis Sub-unit. Data will be contained in an ad hoc report done at the end of the reporting period. This report will be titled “Number of Complaint Investigations Conducted: HCSSA” in the future.

**BL 2018 Methodology**

For reporting purposes, monthly data covering the appropriate months in the reporting period are totaled.

**BL 2018 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 agency's workload of inspecting agencies to ensure their compliance with state and federal requirements. This data is a useful tool for projecting future funding needs.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**

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**BL 2019 Methodology**
**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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<td>1</td>
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**Goal:** Regulatory, Licensing and Consumer Protection Services  
**Objective:** Regulation of Facilities and Consumer Products  
**Strategy:** Health Care Facilities & Community-based Regulation  
**Measure Type:** OP  
**Measure No.:** # Substantiated Complaint Allegation Abuse/Neglect: Nursing Facilities

**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 02-01-01 OP 14  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure reports the number of substantiated complaint allegations of resident abuse and/or neglect in nursing facilities during the state fiscal year. A substantiated complaint allegation is defined as an allegation received as a complaint from a resident, family member, or the public that is determined to be a violation of standards. Regional Regulatory Services survey/investigation staff determine whether allegations are substantiated after a thorough investigation. Abuse and neglect are defined by state and federal regulations. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Abuse and neglect of children residing in nursing facilities is defined by Texas Family Code, Section 261.001.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled “# Substantiated Complaint Allegation Abuse/Neglect: Nursing Facilities” in the future.

**BL 2018 Methodology**

This measure is computed by summing the number of substantiated complaint allegations of abuse/neglect in nursing facilities during the months of the reporting period.

**BL 2018 Purpose**

This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in nursing facilities. It is a tool for evaluating the program's effectiveness and assessing the accountability of facilities.

**BL 2019 Definition**

**BL 2019 Data Limitations**
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Goal No. 8  Regulatory, Licensing and Consumer Protection Services
Objective No. 1  Regulation of Facilities and Consumer Products
Strategy No. 1  Health Care Facilities & Community-based Regulation
Measure Type OP
Measure No. 18  # Substantiated Complaint Allegations of Abuse/Neglect: ALF

**BL 2018 Definition**

This measure reports the unduplicated number of substantiated complaint allegations of abuse and/or neglect in assisted living (AL) facilities during the state fiscal year. Abuse and neglect are defined by state and federal regulations. {See outcome measure 4 for the definitions of abuse and neglect.}

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled “# Substantiated Complaint Allegations of Abuse/Neglect: ALF” in the future.

**BL 2018 Methodology**

The numbers of substantiated complaint allegations of abuse/neglect in assisted living facilities during the months of the reporting period are totaled.

**BL 2018 Purpose**

This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in assisted living facilities. It is a tool for evaluating the program's effectiveness and assessing the accountability of facilities.
BL 2019 Purpose
**Measure Type OP**

**Measure No. 19** # Substantiated Complaint Allegations of Abuse/Neglect: Adult Day Care

**Agency Code: 529**

**Agency:** Health and Human Services Commission

**Goal No.** 8 Regulatory, Licensing and Consumer Protection Services

**Objective No.** 1 Regulation of Facilities and Consumer Products

**Strategy No.** 1 Health Care Facilities & Community-based Regulation

**Calculation Method:** C  

**Target Attainment:**  

**Priority:**  

Cross Reference: Agy 539 084-R-S70-1 02-01-01 OP 16

**Key Measure:** N  

**New Measure:** N  

**Percentage Measure:** N

**BL 2018 Definition**

This measure reports the unduplicated number of substantiated complaint allegations of abuse and/or neglect in adult day care facilities during the state fiscal year. Abuse and neglect are defined by state and federal regulations. {See outcome measure 4 for the definitions of abuse and neglect.}

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled “# Substantiated Complaint Allegations of Abuse/Neglect: Adult Day Care” in the future.

**BL 2018 Methodology**

The numbers of substantiated complaint allegations of abuse/neglect in adult day care facilities during the months of the reporting period are totaled.

**BL 2018 Purpose**

This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in adult day care facilities. It is a tool for evaluating the program's effectiveness and assessing the accountability of facilities.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
Strategy-Related Measures Definitions
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<td>Measure No.</td>
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<td>Number of Substantiated Complaint Allegations of Abuse/Neglect: ICF/IID</td>
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Calculation Method: C  Target Attainment:  Priority:  Cross Reference: Agy 539 084-R-S70-1 02-01-01 OP 17
Key Measure: N  New Measure: N  Percentage Measure: N

**BL 2018 Definition**

This measure reports the number of substantiated complaint allegations of abuse and/or neglect in ICFs/IID during the state fiscal year. A substantiated complaint allegation is defined as an allegation received as a complaint from a resident, family member, or the public that is determined to be a violation of standards. Abuse and neglect are defined by state and federal regulations. See outcome measure 4 for definition of abuse and neglect.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled “Number of Substantiated Complaint Allegations of Abuse/Neglect: ICF/IID” in the future.

**BL 2018 Methodology**

This measure is computed by summing the number of substantiated complaint allegations of abuse/neglect in ICFs/IID during the months of the reporting period.

**BL 2018 Purpose**

This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in ICFs/IID. It is a tool for evaluating the program's effectiveness and assessing the accountability of facilities.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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**Agency:** Health and Human Services Commission

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**Goal No. 8 Regulatory, Licensing and Consumer Protection Services**

**Objective No. 1 Regulation of Facilities and Consumer Products**

**Strategy No. 1 Health Care Facilities & Community-based Regulation**

**Measure Type OP**

**Measure No. 21 # Substantiated Complaint Allegations Physical Plant: NF**

**Calculation Method:** C

**Target Attainment:**

**Priority:**

Cross Reference: Agy 539 084-R-S70-1 02-01-01 OP 18

**Key Measure:** N

**New Measure:** N

**Percentage Measure:** N

**BL 2018 Definition**

This measure reports the unduplicated number of substantiated allegations of unsafe physical plant and/or environmental conditions in nursing facilities (NF) during the state fiscal year. "Unsafe physical plant" is defined as any deficient practice cited under the Life Safety Code and Construction Standards. "Unsafe environmental conditions" is defined as requirements related to the operation of the heating and air conditioning system, water temperatures in areas used by residents and pest control problems that may impact resident health and safety, or related findings.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled "# Substantiated Complaint Allegations Physical Plant: NF" in the future.

**BL 2018 Methodology**

The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

**BL 2018 Purpose**

This measure is important because it provides the actual number of known unsafe conditions occurring in nursing facilities. It is a tool for evaluating the program's effectiveness and assessing the accountability of facilities.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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**Agency Code:** 529
**Agency:** Health and Human Services Commission

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<td>22</td>
<td># Substantiated Complaint Allegations Unsafe Physical Plant: ALF</td>
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**Calculation Method:** C
**Target Attainment:**
**Priority:**
**Cross Reference:** Agy 539 084-R-S70-1 02-01-01 OP 19

**Key Measure:** N
**New Measure:** N
**Percentage Measure:** N

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**BL 2018 Definition**

This measure reports the unduplicated number of substantiated allegations of unsafe physical plant and/or environmental conditions in assisted living facilities (ALF) during the state fiscal year. "Unsafe physical plant" is defined as any deficient practice cited under the Life Safety Code and Construction Standards. "Unsafe environmental conditions" is defined as requirements related to the operation of the heating and air conditioning system, water temperatures in areas used by residents and pest control problems that may impact resident health and safety, or related findings.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled “# Substantiated Complaint Allegations Unsafe Physical Plant: ALF” in the future.

**BL 2018 Methodology**

The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

**BL 2018 Purpose**

The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

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BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This measure reports the unduplicated number of substantiated allegations of unsafe physical plant and/or environmental conditions in adult day care (ADC) facilities during the state fiscal year. "Unsafe physical plant" is defined as any deficient practice cited under the Life Safety Code and Construction Standards. "Unsafe environmental conditions" is defined as requirements related to the operation of the heating and air conditioning system, water temperatures in areas used by residents and pest control problems that may impact resident health and safety, or related findings.

### BL 2018 Data Limitations

Does not apply.

### BL 2018 Data Source

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled “# Substantiated Complaint Allegations Unsafe Physical Plant: ADC” in the future.

### BL 2018 Methodology

The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

### BL 2018 Purpose

This measure is important because it provides the actual number of known unsafe conditions occurring in adult day care facilities. It is a tool for evaluating the program's effectiveness and assessing the accountability of facilities.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

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| Goal No. | 8 | Regulatory, Licensing and Consumer Protection Services |
| Objective No. | 1 | Regulation of Facilities and Consumer Products |
| Strategy No. | 1 | Health Care Facilities & Community-based Regulation |
| Measure Type | OP |
| Measure No. | 23 | # Substantiated Complaint Allegations Unsafe Physical Plant: ADC |

**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 02-01-01 OP 20  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N
BL 2019 Methodology

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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 8
Objective No. 1
Strategy No. 1
Measure Type OP
Measure No. 24

Goal No. 8 Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Strategy No. 1 Health Care Facilities & Community-based Regulation
Measure Type OP
Measure No. 24 # Substantiated Complaint Allegations of Unsafe Physical: ICF/IID

Calculation Method: C
Target Attainment: Priority: Cross Reference: Agy 539 084-R-S70-1 02-01-01 OP 21
Key Measure: N New Measure: N Percentage Measure: N

**BL 2018 Definition**
This measure reports the unduplicated number of substantiated allegations of unsafe physical plant and/or environmental conditions in ICFs/IID during the state fiscal year. "Unsafe physical plant" is defined as any deficient practice cited under the Life Safety Code and Construction Standards. "Unsafe environmental conditions" is defined as requirements related to the operation of the heating and air conditioning system, water temperatures in areas used by residents and pest control problems that may impact resident health and safety, or related findings.

**BL 2018 Data Limitations**
Does not apply.

**BL 2018 Data Source**
Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled "# Substantiated Complaint Allegations of Unsafe Physical Plant: ICF/IID" in the future.

**BL 2018 Methodology**
The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

**BL 2018 Purpose**
This measure is important because it provides the actual number of known unsafe conditions occurring in ICFs/IID. It is a tool for evaluating the program's effectiveness and assessing the accountability of facilities.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 02-01-01 OP 22  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**  
This measure reports the number of initial reviews completed on Home and Community Services (HCS) and Texas Home Living (TxHmL) contracts. An initial review is defined as an on-site visit conducted for the purpose of determining compliance with state requirements for certification with the department.

**BL 2018 Data Limitations**  
Does not apply.

**BL 2018 Data Source**  
Data are obtained from an Access database which records all reviews completed. The Access database is maintained by Waiver Survey and Certification staff. Data is entered into the database as review reports are submitted. Data will be contained in an ad hoc report done at the end of the reporting period. This report has no official name or report number.

**BL 2018 Methodology**  
For reporting purposes, monthly data covering the appropriate months in the reporting period are totaled.

**BL 2018 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 agency's workload of certifying HCS and TxHmL contracts to ensure their compliance with state requirements. This data is a useful tool for projecting future funding needs.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
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### Agency Code: 529
Agency: Health and Human Services Commission

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<td>Strategy No.</td>
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<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
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<td># of Annual HCS &amp; TxHmL Recertification Reviews Completed</td>
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### Calculation Method: C
### Target Attainment: N
### Priority: N

### Cross Reference: Agy 539 084-R-S70-1 02-01-01 OP 23

### BL 2018 Definition

This measure reports the number of annual recertification reviews completed on Home and Community Services (HCS) and Texas Home Living (TxHmL) contracts. An annual recertification review is defined as an on-site visit conducted for the purpose of determining compliance with state requirements for recertification with the department.

### BL 2018 Data Limitations

Does not apply.

### BL 2018 Data Source

Data are obtained from an Access database which records all reviews completed. The Access database is maintained by Waiver Survey and Certification staff. Data is entered into the database as review reports are submitted. Data will be contained in an ad hoc report done at the end of the reporting period. This report has no official name or report number.

### BL 2018 Methodology

For reporting purposes, monthly data covering the appropriate months in the reporting period are totaled.

### BL 2018 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 agency's workload of recertifying HCS and TxHmL contracts to ensure their compliance with state requirements. This data is a useful tool for projecting future funding needs.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology
### BL 2018 Definition
This measure reports the unduplicated number of final reports received from the Texas Department of Family and Protective Services (DFPS) related to allegations of abuse, neglect or exploitation of persons served in the Home and Community-Based Services (HCS), Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), or Texas Home Living (TxHmL) programs.

### BL 2018 Data Limitations
Does not apply.

### BL 2018 Data Source
Data are obtained from an Access database. Data will be contained in an ad hoc report done at the end of the reporting period. This report has no official name or report number.

### BL 2018 Methodology
The numbers of final reports related to allegations of abuse, neglect or exploitation of persons served in the HCS, ICF/IID, or TxHmL programs during the months of the reporting period are totaled.

### BL 2018 Purpose
This measure is important because it shows the actual number of reports received related to abuse, neglect or exploitation of persons who receive HCS, ICF/IID, or TxHmL services. It is a tool for assessing the frequency and outcomes of the DFPS investigations related to the HCS, ICF/IID and TxHmL programs.
BL 2019 Purpose
### Agency Code: 529  
**Agency:** Health and Human Services Commission

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<td>8</td>
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<td>Number of Abuse/Neglect Reports Reviewed: HCS, ICF/IID &amp; TxHmL Providers</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 02-01-01 OP 25

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure reports the unduplicated number of reviews conducted by Waiver Survey and Certification staff of final reports received from the Texas Department of Family and Protective Services (DFPS) related to allegations of abuse, neglect or exploitation of persons who receive services through the Home and Community-Based Services (HCS), Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), and Texas Home Living (TxHmL) programs.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data are obtained from data entry in an Access database. Data will be contained in an ad hoc report done at the end of the reporting period. This report has no official name or report number.

**BL 2018 Methodology**

The numbers of reviews conducted by Waiver Survey and Certification staff related to final reports received from DFPS related to exploitation of persons served in the HCS, ICF/IID, andTxHmL programs.

**BL 2018 Purpose**

This measure is important because it represents the workload for staff related to follow up on allegations of abuse, neglect or exploitation. It is a tool for assessing the care consumers receive and compliance of HCS, ICF/IID, and TxHmL contractors to state requirements. It is also useful as a tool for forecasting future staff resources.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This measure reports the number of monitoring visits to Prescribed Pediatric Extended Care Centers (PPECC) during the reporting period. A monitoring visit is an on-site visit in addition to the annual inspection/survey to determine financially unstable facilities' compliance with state and federal standards. However, if during a monitoring visit, more than one type of activity is performed (a survey, follow-up to investigation and a new investigation) each type of activity is counted separately for reporting purposes.

### BL 2018 Data Limitations

Does not apply.

### BL 2018 Data Source

Data are obtained from the Central Data Repository (CDR) that pulls data from the Compliance, Assessment, Regulation, Enforcement System (CARES) and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed to make the necessary calculations. The report will be titled “# of on-site PPECC Monitoring Visits Completed” in the future.

### BL 2018 Methodology

The total number of completed monitoring visits is calculated by summing the number of monitoring visits to PPECCs during the months of the reporting period.

### BL 2018 Purpose

This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy and indicates how many regulatory visits PPECCs average per month to determine compliance with state and federal regulations.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
**Calculate Method: C**
**Target Attainment: C**
**Priority: C**

**Key Measure: N**
**New Measure: N**
**Percentage Measure: N**

**BL 2018 Definition**
This measure reports the number of substantiated complaint allegations of resident abuse and/or neglect in Prescribed Pediatric Extended Care Centers (PPECC) during the state fiscal year. A substantiated complaint allegation is defined as an allegation received as a complaint from a resident, family member, or the public that is determined to be a violation of standards. Regional Regulatory Services survey/investigation staff determine whether allegations are substantiated after a thorough investigation. Abuse and neglect are defined by state and federal regulations. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Abuse and neglect of children residing in nursing facilities is defined by Texas Family Code, Section 261.001.

**BL 2018 Data Limitations**
Does not apply.

**BL 2018 Data Source**
Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled “# Substantiated Complaint Allegation Abuse/Neglect: PPECCs” in the future.

**BL 2018 Methodology**
This measure is computed by summing the number of substantiated complaint allegations of abuse/neglect in PPECCs during the months of the reporting period.

**BL 2018 Purpose**
This measure is important because it shows the actual known incidence rate of abuse and neglect occurring in PPECCs. It is a tool for evaluating the program's effectiveness and assessing the accountability of facilities.

**BL 2019 Definition**

**BL 2019 Data Limitations**
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
**BL 2018 Definition**

This measure reports the unduplicated number of substantiated allegations of unsafe physical plant and/or environmental conditions in Prescribed Pediatric Extended Care Centers (PPECC) during the state fiscal year. "Unsafe physical plant" is defined as any deficient practice cited under the Life Safety Code and Construction Standards. "Unsafe environmental conditions" is defined as requirements related to the operation of the heating and air conditioning system, water temperatures in areas used by residents and pest control problems that may impact resident health and safety, or related findings.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Data are obtained from the Compliance, Assessment, Regulation, Enforcement System (CARES) Central Data Repository (CDR) that pulls data from the CARES and other systems. At the end of the reporting period, an ad hoc report will be done containing the required data elements needed, including a list of allegation codes pre-defined by Regulatory Services Survey Operations staff, to make the necessary calculations. The report will be titled “# Substantiated Complaint Allegations Physical Plant: PPECC” in the future.

**BL 2018 Methodology**

The number of substantiated complaint allegations will be totaled to cover the appropriate months of the reporting period.

**BL 2018 Purpose**

This measure is important because it provides the actual number of known unsafe conditions occurring in PPECCs. It is a tool for evaluating the program's effectiveness and assessing the accountability of facilities.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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### Agency Code: 529  
### Agency: Health and Human Services Commission

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<td>8</td>
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<td>1</td>
<td>OP</td>
<td>32</td>
<td>Number of Completed Investigations in Facility Settings</td>
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#### Calculation Method: C  
#### Target Attainment:  
#### Priority: Cross Reference: Agy 530 084-R-S70-1 04-01-01 OP 04

**Key Measure: Y**  
**New Measure: N**  
**Percentage Measure: N**

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**BL 2018 Definition**

This measure reports the number of completed investigations of maltreatment of persons served in mental health or intellectual disability settings, which may include state supported living centers, state hospitals, state centers, private ICF-IID facilities, community centers, and Medicaid waiver programs.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

An investigation completion is indicated by a closure or completion date during the reporting period. Investigation closures must be counted in order to capture all completed investigations. Due to an IMPACT design problem, the investigation completion date for rapid closures is left blank and a closed date is entered. In Facility investigations, rapid closures are used when investigations determine that situations reported to FPS are not within the purview of FPS to continue to investigate. Examples of such cases include client rights issues, administrative issues, and clinical practice issues appropriate for peer review.

**BL 2018 Methodology**

The measure is calculated by counting the number of Facility investigations for which an investigation completion date or investigation closure date is entered in IMPACT. The quarterly and annual counts are equal to the sum of the completed and closed investigations in 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.

**BL 2018 Purpose**

The purpose of this measure is to track the number of investigations of abuse/neglect/exploitation of persons who are 65 or older or who have disabilities in Facility settings completed during the reporting period. This measure provides useful information for management purposes. The number of completed investigations and the promptness with which they are completed are important indicators of workload and performance in mental health and intellectual disability investigations.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission  

Goal No. 8  
Objective No. 1  
Strategy No. 1  
Measure Type OP  
Measure No. 33  

Calculation Method: C  
Target Attainment:  
Priority: Cross Reference: Agy 530 084-R-S70-1 04-01-01 OP 05  
Key Measure: N  
New Measure: N  
Percentage Measure: N

BL 2018 Definition  
This measure reports the number of completed investigations in mental health or intellectual disability settings, which may include state supported living centers, state hospitals, state centers, private ICF/IID facilities, community centers, and Medicaid waiver programs in which maltreatment of an individual or group of individuals was confirmed.

BL 2018 Data Limitations  
None

BL 2018 Data Source  
Confirmed reports refer to those investigations in Output Measure “Number of Completed Investigations in Facility Settings” in which the overall disposition is confirmed at the end of the investigation. Confirmed investigations are coded as ‘CON’ at the completion of the investigation stage in IMPACT.

BL 2018 Methodology  
The measure is calculated by totaling the sum of confirmed Facility investigations each month of the reporting period.

BL 2018 Purpose  
The purpose of this measure is to track the number of completed investigations of abuse/neglect/exploitation of persons who are 65 or older or who have disabilities in Facility settings for which the allegations of abuse/neglect/exploitation have been substantiated. The measure is useful for internal management purposes. The number of confirmed reports is an indicator of the quality of care being provided to persons served by or through mental health or intellectual disability programs.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
This measure is an unduplicated count of victims in confirmed incidents of maltreatment occurring in mental health or intellectual disability settings, which may include state supported living centers, state hospitals, state centers, private ICF-IID facilities, community centers, and Medicaid waiver programs.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
Count the number of confirmed victims when the investigation completion date is during the reporting period and the overall disposition is confirmed. Confirmed victims are unduplicated by reporting period.

**BL 2018 Methodology**
The calculation consists of the sum of confirmed victims during the reporting period.

**BL 2018 Purpose**
The purpose of this measure is to track the number of persons who are 65 or older or who have disabilities identified as confirmed victims in completed investigations. This information is useful for internal management purposes.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
Goal No. 8 Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Strategy No. 2 Credentialing/Certification of Health Care Professionals & Others
Measure Type EF
Measure No. 1 Average Cost Per License Issued: Nursing Facility Administrators

Calculation Method: N  Target Attainment:  Priority:  Cross Reference: Agy 539 084-R-S70-1 02-01-02 EF 01
Key Measure: N  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measure reports the average cost per license issued to nursing facility administrators. The issuance of licenses establishes the minimal competency of practitioners.

BL 2018 Data Limitations
Does not apply.

BL 2018 Data Source
The number of nursing facility administrator licenses is currently entered in a FoxPro system maintained by the Texas Health and Human Services Commission (HHSC). The cost of nursing facility administrator licensing staff will be obtained from the Health and Human Services Administrative System.

BL 2018 Methodology
The average cost is calculated by dividing the total cost of the direct charge for nursing facility administrator licensing staff by the total number of licenses issued. The total cost of nursing facility administrator licensing staff includes salary, travel, and overhead of direct staff identified by budgeted-job-number plus a portion of the cost of salary, travel, and overhead of the Licensing Unit supervisor and the Credentialing general administration staff allocated to this function based on full-time equivalents (FTEs). The program activity code overhead costs will be allocated to this function based on FTE. The Credentialing staff will report the total number of licenses issued each reporting period.

BL 2018 Purpose
This measure quantifies the unit cost associated with issuing licenses to nursing facility administrators. This unit cost indicates the efficiency of agency operations and is a useful tool for projecting future funding needs.
BL 2019 Methodology

BL 2019 Purpose
### Strategy-Related Measures Definitions

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<td>Average Cost Per Credential Issued: Nurse/Medication Aides</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** Cross Reference: Agy 539 084-R-S70-1 02-01-02 EF 02  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

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**BL 2018 Definition**

This measure reports the average cost per issuance of nurse aide certifications and medication aide permits. The issuance of certifications and permits establishes the minimal competency of practitioners.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Nurse Aide Competency Evaluation Service (NACES) reports the number of nurse aide tests given each month. The number of nurse aide certifications is entered in the Nurse Aide Registry. The number of medication aide permits is entered in the Automated Review Management System (ARMS) maintained by Pearson VUE, which the Health and Human Services (HHSC) Credentialing staff has access to. The cost of nurse aide registry staff and medication aide staff are obtained from the Health and Human Services Administrative System.

**BL 2018 Methodology**

Divide tot cost of reimbursable nurse aide(NA)tests+tot $ of direct charge NA registry staff who process certs in the Credentialing Sec. & 95% of medication aide(MA)staff by tot # of certs & permits issued. Tot $ of reimbursable NA tests is obtained by multiplying the set fee/test X the tot # of tests given. Fee/test is set by contract w Pearson VUE. The $ of NA registry staff who process certs (ID by BJN) includes $ of salary, travel & overhead + portion of $ of salary, travel & overhead of NA Unit supervisor & Credentialing general admin staff allocated to this function based on FTE. $ of MA staff issuing permits (ID by BJN) includes $ of salary, travel & overhead X 95% + portion of salary, travel & overhead $ of Licensing Unit supervisor & Credentialing general admin staff allocated to this function based on FTE. PAC overhead $ will be allocated to this function based on FTE. Credentialing staff will report the tot # certifications; and permits issued each reporting period.

**BL 2018 Purpose**

This measure quantifies the unit cost associated with issuing credentials to nurse aides and medication aides. This unit cost indicates the efficiency of agency operations and is a useful tool for projecting future funding needs.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 8 Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Strategy No. 2 Credentialing/Certification of Health Care Professionals & Others
Measure Type EF
Measure No. 3 Average Cost Per Complaint Resolved: Nursing Facility Administrators

Calculation Method: N
Target Attainment: N
Priority: N
Cross Reference: Agy 539 084-R-S70-1 02-01-02 EF 03

Key Measure: N
New Measure: N
Percentage Measure: N

BL 2018 Definition
This measure reports the average cost per referral or complaint on nursing facility administrators. The resolution of the referrals and complaints maintains the function of establishing the minimal competency of practitioners.

BL 2018 Data Limitations
Does not apply.

BL 2018 Data Source
Referrals are received from the Regulatory Services staff and complaints are received from the public. The number of referrals and complaints received is captured by the CARTS (Complaints and Referral Tracking Systems) database maintained by the Professional and Credentialing Enforcement unit of Regulatory Services. The cost of the Complaints and Investigations unit will be obtained from the Health and Human Services Administrative System.

BL 2018 Methodology
The average is calculated by dividing the total cost of direct charge staff in the Investigations branch plus the reimbursements made to the Nursing Facilities Administrators Advisory Committee members for travel expenses by the total number of referrals and complaints received. The calculation of this average will be exclusive of the costs for legal support. The cost of staff in the Investigations branch (excluding one BJN) includes the cost of salary, travel, and overhead plus a portion of the cost of salary, travel, and overhead of the Professional Credentialing Enforcement general administration staff allocated to this function based on full-time equivalents (FTE). The program activity code overhead costs will be allocated to this function based on FTE. The staff in the Investigations branch will report the number of referrals and complaints received for the reporting period.

BL 2018 Purpose
This measure quantifies the unit cost associated with pursuing the validity of complaints and referrals of nursing facility administrators. This unit cost indicates the efficiency of agency operations and is a useful tool for projecting funding needs.

BL 2019 Definition

BL 2019 Data Limitations
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 8  
Objective No. 1  
Strategy No. 2  
Measure Type EF  
Measure No. 4

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 539 084-R-S70-1 02-01-02 EF 04

Key Measure: N  
New Measure: N  
Percentage Measure: N

**BL 2018 Definition**

This measure reports the average cost per referral on nurse aides, medication aides, and uncredentialed direct care personnel. The resolution of the referrals maintains the function of establishing the minimal competency of practitioners.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

Referrals are received from Regulatory Services staff. The number of referrals received is tracked in the Employee Misconduct Registry (EMR) and Nurse Aide and Medication Aide tracking databases. The cost of the staff handling referrals on nurse aides, medication aides, and uncredentialed staff is obtained from the Health and Human Services Administrative System.

**BL 2018 Methodology**

Divide total cost($) of a staff in the Nurse Aide Registry (NAR) unit, 5% of a medication aide (MA), 100% of Employee Misconduct Registry (EMR) staff & 5% of a progr spec ingen admin supervising EMR staff by total # of referrals & complaints received. Calculation excludes $ for legal support & intake of complaints/investigations for NAs. Staff $ of NAR unit handling NA complaints (ID by BJN) include salary, travel & overhead (STO) + part $ of STO of NAR unit supervisor & Credentialing gen admin staff alloc to this function based on FTE. MA staff $ (ID by BJN) include STO X 5% + part of STO of Licensng supervisor & Credentialing gen admin staff alloc to this function based on FTE. EMR staff $ (ID by BJN) include STO + 5% of STO of a prog spec in gen admin directly supervsing EMR staff & part STO of Credentialing gen admin staff alloc to this function based on FTE. PAC OH $ are alloc based on FTE. Complaints/Investigations Unit reports # of referrals/complaints received in the reporting period.

**BL 2018 Purpose**

This measure quantifies the unit cost associated with pursuing the validity of complaints and referrals of nurse aides, medication aides, and uncredentialed direct care personnel. This unit cost indicates the efficiency of agency operations and is a useful tool for projecting funding needs.

**BL 2019 Definition**

**BL 2019 Data Limitations**
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**Goal No. 8:** Regulatory, Licensing and Consumer Protection Services  
**Objective No. 1:** Regulation of Facilities and Consumer Products  
**Strategy No. 2:** Credentialing/Certification of Health Care Professionals & Others

**Measure Type:** OP  
**Measure No. 1:** # Health Care Professionals & LCDCs Licensed, Permit, Cert, Registrd

**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 537 084-R-S70-1 04-01-04 OP 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This output measure reflects the cumulative total (both initial and renewals) of individuals licensed, permitted, certified, registered, documented, or placed on a registry.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

The data is obtained manually and from automated databases.

**BL 2018 Methodology**

This output measure reflects the cumulative total (both initial and renewals) of individuals licensed, permitted, certified, registered, documented, or placed on a registry.

**BL 2018 Purpose**

This output measure reflects the cumulative total (both initial and renewals) of individuals licensed, permitted, certified, registered, documented, or placed on a registry.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
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<td>Measure No.</td>
<td>2</td>
<td>Number of Licenses Issued Per Year: Nursing Facility Administrators</td>
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**BL 2018 Definition**
This measure reports the total number of licenses issued or renewed for nursing facility administrators during all months of the reporting period.

**BL 2018 Data Limitations**
Does not apply.

**BL 2018 Data Source**
Data are obtained from the automated nursing facility administrator database.

**BL 2018 Methodology**
Data are calculated by totaling the number of licenses issued and renewed during the months of the reporting period.

**BL 2018 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529  Agency: Health and Human Services Commission

Goal No. 8  Objective No. 1  Strategy No. 2
Measure Type OP  Measure No. 3

Calculation Method: C  Target Attainment:  Priority:  
Key Measure: N  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measure reports the total number of credentials issued or renewed for nurse aides and medication aides during all months of the reporting period.

BL 2018 Data Limitations
Does not apply.

BL 2018 Data Source
Data are obtained from the Automated Review Management System (ARMS).

BL 2018 Methodology
Data are computed by totaling the number of permits and certifications issued or renewed during the months of the reporting period.

BL 2018 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.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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<td>Credentialing/Certification of Health Care Professionals &amp; Others</td>
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<td>Measure Type</td>
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<td>Measure No.</td>
<td>4</td>
<td>Number of Complaints Resolved/Year: Nursing Facility Administrators</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 539 084-R-S70-1 02-01-02 OP 03

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure reports the total number of complaints and referrals against nursing facility administrators that were resolved during all months of the reporting period. Complaints and referrals are resolved by the Health and Human Services Commission (HHSC), either administratively by the Professional Credentialing Enforcement branch or through formal Hearings conducted by the commission's Legal Division.

**BL 2018 Data Limitations**
Does not apply.

**BL 2018 Data Source**
This information is manually collected. Manual collections of data are pen and paper tabulations of information manually pulled from computer based records. There are no report titles or identifying numbers associated with this process.

**BL 2018 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.

**BL 2018 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
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<td>Measure Type</td>
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<td>Measure No.</td>
<td>5 Number of Complaints Resolved/Year: Nurse/Medication Aides/Direct Care</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 539 084-R-S70-1 02-01-02 OP 04

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure reports the number of referrals against medication aides, nurse aides, and uncredentialed staff that have been resolved. The uncredentialed staff is all direct care personnel not licensed by another state agency in long-term care facilities licensed by the Health and Human Services Commission (HHSC). Referrals are resolved by HHSC either administratively by the Professional Credentialing Enforcement branch or through formal hearings conducted by the commission's Legal Division.

**BL 2018 Data Limitations**

Does not apply.

**BL 2018 Data Source**

This information is collected manually. Manual collections of data are pen and paper tabulations of information manually pulled from Employee Misconduct Registry, Nurse Aide and Mediation Aide tracking database. There are no report titles or identifying numbers associated with this process.

**BL 2018 Methodology**

Data are computed by tabulating the number of referrals with final action of dismissal or imposition of sanctions for each month of the reporting period. These monthly numbers for each of the months in the reporting period are summed.

**BL 2018 Purpose**

This measure quantifies the agency's workload as it pertains to implementing the provisions funded under this strategy. This data is useful in projecting future funding needs.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

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<td>Measure No.</td>
<td>6     Number of Professional Complaint Investigations Conducted</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 537 084-R-S70-1 04-01-04 OP 02

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**  
The number of health care professional complaint investigations conducted is defined as the total number of investigations performed by staff which are documented by an appropriate investigative report. The investigations are initiated upon notification of possible violations of state laws or rules.

**BL 2018 Data Limitations**  
None.

**BL 2018 Data Source**  
The data are extracted from an automated regulatory system which has an enforcement module for tracking complaint investigations

**BL 2018 Methodology**  
The complaint investigations are totaled quarterly and are cumulative for the fiscal year

**BL 2018 Purpose**  
Investigating complaints against health care professionals is an element of regulation and public health protection.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
**Agency Code:** 529  
**Agency:** Health and Human Services Commission

**Goal No.** 8  
**Objective No.** 1  
**Strategy No.** 3  
**Measure Type** EF  
**Measure No.** 1  
**Measure Name:** Average Monthly Cost per Primary Day Care Licensing Activity

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 530 084-R-S70-1 05-01-01 EF 01

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure gives an average monthly cost for DFPS to perform primary Day Care Licensing activities. Primary Day Care Licensing activities included are Inspections, Non-Abuse/Neglect Investigations and Abuse/Neglect Investigations.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

Data is from the Child-care Licensing Automation Support System (CLASS), where a record is kept by operation of the number and dates of all activities conducted. Total program cost is from HHSAS-FS and an internal budget document (OEOLEDGER.xls) for PAC 610 (Day Care Licensing). Due to modifications in the FPS fiscal system, PACs may change. Should this occur, the current equivalent codes will be substituted and documented in the performance folder.

**BL 2018 Methodology**

Annual expenditure projections for PAC 610 are made using an internal budget document (OEOLEDGER.xls) that includes actual expenditures reported in HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. For all quarters, the annual expenditure projections are multiplied by the percent of the year elapsed for the reporting period and then are reduced by the previous quarter(s) dollars to get the estimated expenditures attributable to the quarter being reported, the numerator. The denominator is the number of Inspections, Non-Abuse/Neglect Investigations and Abuse/Neglect Investigations completed in Day Care facilities during the reporting period. Inspections conducted as part of non-abuse/neglect investigations or abuse/neglect investigations, attempted inspections, and assessments are not included. Divide the numerator by the denominator to calculate the average cost per primary day care licensing activity.

**BL 2018 Purpose**

This measure is useful as a benchmark, and may be used along with other data to evaluate the value of day care licensing activities.
**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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**Goal No. 8 Regulatory, Licensing and Consumer Protection Services**  
**Objective No. 1 Regulation of Facilities and Consumer Products**  
**Strategy No. 3 Child Care Regulation**  
**Measure Type EF**  
**Measure No. 2 Average Monthly Cost per Primary Residential Licensing Activity**

**Calculation Method:** N  
**Target Attainment:**  
**Priority:** Cross Reference: Agy 530 084-R-S70-1 05-01-01 EF 02  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**  
This measure gives an average monthly cost for DFPS to perform primary Residential Licensing activities. Primary Residential Licensing activities included are Inspections, Non-Abuse/Neglect Investigations and Abuse/Neglect Investigations.

**BL 2018 Data Limitations**  
None.

**BL 2018 Data Source**  
Data is from the Child-care Licensing Automation Support System (CLASS), where a record is kept by operation of the number and date of all activities conducted. Total program cost is from HHSAS-FS and an internal budget document (OOELEDGER.xls). Due to modifications in the FPS fiscal system, PACs may change. Should this occur, the current equivalent codes will be substituted and documented in the performance folder.

**BL 2018 Methodology**  
Annual expenditure projections are made using an internal budget document (OOELEDGER.xls) that includes actual expenditures reported in HHSAS-FS for the reporting period, annualizing those expenditures and adding estimates for accruals and encumbrances. For all quarters, the annual expenditure projections are multiplied by the percent of the year elapsed for the reporting period and then are reduced by the previous quarter(s) dollars to get the estimated expenditures attributable to the quarter being reported, the numerator. The denominator is the number of Inspections, Non-Abuse/Neglect Investigations, and Abuse/Neglect Investigations completed in residential facilities during the reporting period. Inspections conducted as part of non-abuse/neglect investigations or abuse/neglect investigations are not included. Divide the numerator by the denominator to calculate the average cost per primary residential licensing activity.

**BL 2018 Purpose**  
This measure is useful as a benchmark, and may be used along with other data to evaluate the value of residential licensing activities.
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**Goal No. 8 Regulatory, Licensing and Consumer Protection Services**

**Objective No. 1 Regulation of Facilities and Consumer Products**

**Strategy No. 3 Child Care Regulation**

**Measure Type EF**

**Measure No. 3 Average Monthly Day Care Caseload per Monitoring Worker**

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 530 084-R-S70-1 05-01-01 EF 03  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 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.

**BL 2018 Data Limitations**
None.

**BL 2018 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 HHSAS-HR to PAC 610 (Day Care Licensing) identified as CCL Inspector III-V (1322A, 1323A, 1324A). 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 service are counted as full time. Due to possible modifications in the FPS 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.

**BL 2018 Methodology**
Count the number of facility and investigation assignments associated with day care monitoring workers in PAC 610 during the reporting period (numerator) and divide by the number of day care monitoring workers in PAC 610 with active assignments during the reporting period (denominator). When calculating 2nd, 3rd, & 4th quarters the year-to-date total is recalculated. 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.

**BL 2018 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.
Strategy-Related Measures Definitions
85th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code: 529  
Agency: Health and Human Services Commission

Goal No.  8  Regulatory, Licensing and Consumer Protection Services
Objective No.  1  Regulation of Facilities and Consumer Products
Strategy No.  3  Child Care Regulation
Measure Type EF
Measure No.  4  Average Monthly Residential Caseload per Monitoring Worker

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 530 084-R-S70-1 05-01-01 EF 04

Key Measure: N  
New Measure: N  
Percentage Measure: N

BL 2018 Definition
This measure provides the average monthly caseload for a residential child care licensing monitoring worker.

BL 2018 Data Limitations
None.

BL 2018 Data Source
Facility and investigation assignments 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 HHSAS-HR identified as RCCL Inspector IV-VI (1323D, 1324D, 1325D). 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 service are counted as full time.

Due to possible modifications in the FPS 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.

BL 2018 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).

When calculating 2nd, 3rd, & 4th quarters the year-to-date total is recalculated. 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.

BL 2018 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.
**Automated Budget and Evaluation System of Texas (ABEST)**

**85th Regular Session, Agency Submission, Version 1**

**Strategy-Related Measures Definitions**

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**Goal No. 8: Regulatory, Licensing and Consumer Protection Services**

**Objective No. 1: Regulation of Facilities and Consumer Products**

**Strategy No. 3: Child Care Regulation**

**Measure No. 5: Average Monthly Day Care Caseload per Investigator**

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 530 084-R-S70-1 05-01-01 EF 05  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This measure provides the average monthly caseload for a day care licensing investigators.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

Facility and Investigation assignments are captured in the Child-care Licensing Automation Support System (CLASS). The CCL day care licensing investigators are identified as CCL Specialist I-III and CCL Generalist Investigator (5024V, 5025V, 5026V, 5023U). Investigator trainees with less than 61 days of service are not counted. Investigators with 61-120 days of service are counted as half a worker. Investigators with 121 or more days of service are counted as full time.

**BL 2018 Methodology**

Count the number of facility and investigation assignments associated with day care licensing investigators in PAC 610 during the reporting period (numerator) and divide by the number of day care licensing investigators in PAC 610 with facility or investigation assignments during the reporting period (denominator).

Divide the numerator by the denominator to get the average monthly caseload per investigator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. 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.

**BL 2018 Purpose**

This measure is an indicator of an average amount of work handled by day care licensing investigators, and is useful for determining and comparing staffing levels based on workload.
### BL 2018 Definition

This measure provides the average monthly caseload for a residential child care investigator.

### BL 2018 Data Limitations

None.

### BL 2018 Data Source

Facility and investigation assignments are captured in data and entered into the Child-care Licensing Automation Support System (CLASS). The residential child care investigators are identified as RCC Investigator I-III (5026D, 5027D, 5026E, 5027E). Investigator trainees with less than 61 days of service are not counted. Investigators with 61-120 days of service are counted as half a worker. Investigators with 121 or more days of service are counted as full time.

### BL 2018 Methodology

Count the number of facility and investigation assignments associated with residential child care licensing investigators during the reporting period (numerator) and divide by the number of residential child care licensing investigators in PAC 620 with facility and investigation assignments during the reporting period (denominator).

Divide the numerator by the denominator to get the average monthly caseload per investigator. When calculating 2nd, 3rd, & 4th quarters, the year-to-date total is recalculated. 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.

### BL 2018 Purpose

This measure is an indicator of an average amount of work handled by RCCL Investigators, and is useful for determining and comparing staffing levels based on workload.
**Strategy-Related Measures Definitions**
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<td>Measure No.</td>
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**Calculation Method:** N
**Target Attainment:** N
**Priority:** N
**Cross Reference:** Agy 530 084-R-S70-1 05-01-01 EX 01

**Key Measure:** N
**New Measure:** N
**Percentage Measure:** N

**BL 2018 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 is a count of all permitted operations and administrators on the last day of the reporting period.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
When an operation or administrator is licensed or registered permitted, licensing staff enter this information into the Child-care Licensing Automation Support System (CLASS).

**BL 2018 Methodology**
Add together the totals from Explanatory Measures “Number of Licensed Child Care Centers,” "Number of Licensed Child Care Homes”, “Number of Licensed Residential Child Care Facilities”, “Number of Registered Child Care Homes,” “Number of Listed Family Homes,” “Number of Child Placing Agencies,” “Number of Child Care Administrators,” and “Number of Child-Placing Agency Administrators,” and the number of operations with a certificate of compliance.

**BL 2018 Purpose**
The purpose of this measure is to state the total number of operations, family homes and administrators that are regulated by the agency. This is important data in planning for adequate resources within the program.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**
85th Regular Session, Agency Submission, Version 1
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<td>Measure Type EX</td>
<td>Number of Licensed Child Care Centers</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 530 084-R-S70-1 05-01-01 EX 02

**BL 2018 Definition**
A Licensed Child Care Center is a child day-care operation that is licensed to provide care for seven or more children birth through 13 years of age for less than 24 hours a day, at a location other than the permit holder’s home.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
When child care centers are licensed, licensing staff enter the issuance into the Child-care Licensing Automation Support System (CLASS).

**BL 2018 Methodology**
From CLASS calculate the number of child care centers that are licensed and are in an active status on the last day of the reporting period.

**BL 2018 Purpose**
The purpose of this measure is to state the total number of Child Care Centers that are regulated by the agency. It is a subset of the Explanatory Measure “Number of Licenses, Certifications, Registrations and Listings.” This is important data in planning for adequate resources in staffing for this activity.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 8  Regulatory, Licensing and Consumer Protection Services
Objective No. 1  Regulation of Facilities and Consumer Products
Strategy No. 3  Child Care Regulation
Measure Type EX
Measure No. 3  Number of Licensed Child Care Homes

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 530 084-R-S70-1 05-01-01 EX 03

Key Measure: N  
New Measure: N  
Percentage Measure: N

BL 2018 Definition
A Licensed Child Care Home is a child day-care operation that is licensed to provide care for children from birth through 13 years of age for less than 24 hours a day in the caregivers own residence. The total number of children in care, including children related to the caregiver must not exceed 12, including the children related to the caregiver.

BL 2018 Data Limitations
None.

BL 2018 Data Source
When child care centers are licensed, licensing staff enter the issuance into the Child-care Licensing Automation Support System (CLASS).

BL 2018 Methodology
On the last day of the reporting period, from CLASS calculate the number of child care centers that are licensed and are operations with an initial license or a non-expiring license in an active status on the last day of the reporting period, as of the end of the month.

BL 2018 Purpose
The purpose of this measure is to state the total number of Child Care Centers that are regulated by the agency. It is a subset of the Explanatory Measure “Number of Licenses, Certifications, Registrations and Listings.” This is important data in planning for adequate resources in staffing for this activity.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
Residential operations are licensed to provide 24-hour care for children. The operation types are: General Residential Operations, Independent Foster Family Homes and Independent Foster Group Homes. General Residential Operations are licensed to provide child care for 13 or more children under the age of 18 and may provide various treatment services or programmatic services. Residential treatment centers, a subset of general residential operations, are licensed to provide care exclusively for children requiring treatment services for emotional disorders. Additional programmatic services provided are Child Care Services Only, Emergency Services Only, and Multiple Services.

Data Limitations

None.

Data Source

When a residential operation is licensed, residential licensing staff enters the date of issuance into the Child-care Licensing Automation Support System (CLASS).

Methodology

From CLASS calculate the number of child care homes that are licensed and are in an active status on the last day of the reporting period.

Purpose

The purpose of this measure is to state the total number of residential child care operations that are regulated or reviewed by the agency. It is a subset of the Explanatory Measure “Number of Licenses, Certifications, Registrations and Listings.” This is important data in planning for adequate resources in staffing this activity.
BL 2019 Methodology

BL 2019 Purpose
Strategy-Related Measures Definitions
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<td>Measure No.</td>
<td>5 Number of Registered Child Care Homes</td>
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Calculation Method: N  Target Attainment: N  Priority: Cross Reference: Agy 530 084-R-S70-1 05-01-01 EX 05

Key Measure: N  New Measure: N  Percentage Measure: N

**BL 2018 Definition**
A registered child-care home is a child day-care operation that is permitted to in which the primary caregiver provides care for not more than six children from birth through 13 years, and may provide care after-school for not more than six additional elementary school children in the caregiver's own residence. The total number of children in care at any given time, including the children related to the caregiver, must not exceed 12.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
When an operation is registered, licensing staff enters the date of issuance into the Child-care Licensing Automation Support System (CLASS).

**BL 2018 Methodology**
From CLASS calculate the number of registered child care homes that are permitted and are in an active status on the last day of the reporting period.

**BL 2018 Purpose**
The purpose of this measure is to state the total number of registered child-care homes that are regulated by the agency. It is a subset of the Explanatory Measure “Number of Licenses, Certifications, Registrations and Listings.” This is important data in planning for adequate resources in staffing this activity.
BL 2019 Purpose
Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 8 Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Strategy No. 3 Child Care Regulation
Measure Type EX
Measure No. 6 Number of Agency Homes and CPS Foster Homes

Calculation Method: N  Target Attainment:  Priority:  Cross Reference: Agy 530 084-R-S70-1 05-01-01 EX 06
Key Measure: N  New Measure: N  Percentage Measure: N

**BL 2018 Definition**
Agency Foster Family Homes are facilities that have been verified by a Child Placing Agency (CPA) provide care for not more than six children for 24 hours a day, are used only by a licensed child-placing agency and meets department standards. Agency and Foster Group Homes that have been verified by a CPA may provide are facilities that provides care for seven to twelve children for 24 hours a day. Foster homes are verified by a CPA once they meet applicable minimum standards.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
Agency Home information is entered into the Child-care Licensing Automation Support System (CLASS). Data for CPS Foster Family and Foster Group homes is captured in the Information Management Protecting Adults and Children in Texas (IMPACT) system.

**BL 2018 Methodology**
From CLASS calculate the number of child care homes that are licensed and are in an active status on the last day of the reporting period. Add the number of Agency Foster Homes and Agency Group Homes from CLASS and the number of CPS Foster Family Homes and CPS Foster Group Homes from IMPACT to get the total Number of Foster Homes.

**BL 2018 Purpose**
The purpose of this measure is to state the total number of foster homes that are regulated by a private Child Placing Agency or CPS. This is important data in planning for adequate staffing for this activity and for identifying growth trends.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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Goal No. 8
Objective No. 1
Strategy No. 3
Measure Type EX
Measure No. 7

Number of Listed Family Homes

**Calculation Method:** N
**Target Attainment:**
**Priority:**

Cross Reference: Agy 530 084-R-S70-1 05-01-01 EX 07
Key Measure: N
New Measure: N
Percentage Measure: N

**Bl 2018 Definition**
A listed family home is a child day-care operation that is permitted to provide cares for no more than three unrelated children in the caregiver's own residence. There are no minimum standards for this type of care. Licensing does not conduct routine inspections at listed family homes. Inspections are only conducted when there is a report of abuse or neglect of a child, immediate risk to the health and safety of a child, that the home administered a medication to a child in violation of Human Resources Code §42.065, or that the home is receiving compensation for four or more unrelated children.

**Bl 2018 Data Limitations**
None.

**Bl 2018 Data Source**
When a home is listed, this information is entered into the Child-care Licensing Automation Support System (CLASS) by regional licensing staff.

**Bl 2018 Methodology**
From CLASS calculate the number of permitted listed family homes in full an active status on the last day of the reporting period.

**Bl 2018 Purpose**
The purpose of this measure is to count the number of listed family homes. It is a subset of the Explanatory Measure "Number of Licenses, Certifications, Registrations and Listings." This data is important in determining what resources should be allocated to this function.

**Bl 2019 Definition**

**Bl 2019 Data Limitations**

**Bl 2019 Data Source**

**Bl 2019 Methodology**
BL 2019 Purpose
BL 2018 Definition
A child-placing agency is licensed by DFPS and may then verify foster and adoptive homes by assuring that they meet applicable minimum standards. A branch office is both the location of a child’s record and a foster home’s record and the place from which both are overseen. A branch office functions in the same capacity as a main CPA office, but just under the oversight of a main CPA office. FPS regulates a branch office in the same way it regulates a main office, by assigning a licensing representative and by conducting unannounced, annual monitoring inspections.

BL 2018 Data Limitations
None.

BL 2018 Data Source
When a Child Placing Agency is licensed, residential licensing staff enter the date of issuance into the Child-care Licensing Automation Support System (CLASS).

BL 2018 Methodology
From CLASS calculate the number of child placing agencies including branch offices in active status on the last day of the reporting period.

BL 2018 Purpose
The purpose of this measure is to state the total number of child-placing agencies and branch offices that are regulated by the agency. It is a subset of the Explanatory Measure "Number of Licenses, Certifications, Registrations and Listings." This is important data in planning for adequate resources in staffing this activity.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
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Agency: Health and Human Services Commission  
Goal No. 8  
Objective No. 1  
Strategy No. 3  
Measure Type EX  
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**BL 2018 Definition**
Licensed child care administrators administer residential child care operations. They must meet certain qualifications, pass a written examination and pay an annual fee.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
A list of licensed administrators is maintained in CLASS.

**BL 2018 Methodology**
From CLASS, count the number of active and inactive child care administrators' licenses on the last day of the reporting period.

**BL 2018 Purpose**
The purpose of this measure is to state the total number of child care administrators that are regulated by the agency. It is a subset of the Explanatory Measure "Number of Licenses, Certifications, Registrations and Listings." This is important data in planning for adequate resources in staffing this activity. Include both active and inactive licenses.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

BL 2019 Purpose
**Strategy-Related Measures Definitions**

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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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**Goal No. 8 Regulatory, Licensing and Consumer Protection Services**

**Objective No. 1 Regulation of Facilities and Consumer Products**

**Strategy No. 3 Child Care Regulation**

**Measure Type EX**

**Measure No. 10 Number of Criminal Record Checks**

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 530 084-R-S70-1 05-01-01 EX 10

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

Criminal record checks are conducted on residential and child day care directors, owners, operators, administrators, employees (including those the operation intends to hire), persons applying to adopt or foster children through any licensed child placing agency, persons under contract with operations who have unsupervised contact with children in care on a regular or frequent basis, applicants for child care administrator’s licenses and other persons age 14 years or older who reside at the facility or home or who will regularly or frequently be at the facility or home while children are in care, including volunteers. Persons are checked upon being hired or when they apply for a license, certification, registration or listing and every 24 months thereafter.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

Data for both types of criminal records checks are entered into the Child-care Licensing Automation Support System (CLASS) by licensing staff. Checks against the Department of Public Safety (DPS) database are sent and received via a batch process. FBI checks are submitted electronically through the DPS selected vendor.

**BL 2018 Methodology**

Count the number of criminal history checks processed during the reporting period.

**BL 2018 Purpose**

The purpose of this measure is to determine the workload associated with the Legislative mandate to conduct criminal history checks on persons working in child care. It measures compliance with the statute and provides valuable information on the resources required for this function. The checks themselves help determine whether or not a person's presence at a facility is a violation of minimum standards, the licensing statute, licensing rules and/or would present a risk to the health and safety of children in care.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**

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BL 2019 Methodology

BL 2019 Purpose
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**BL 2018 Definition**
Licensed child-placing agency administrators administer residential child care operations. They must meet certain qualifications, pass a written examination and pay an annual fee.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
A list of licensed child-placing agency administrators is maintained in the Child-care Licensing Automation Support System (CLASS).

**BL 2018 Methodology**
From CLASS count the number of active and inactive child-placing agency administrators' licenses on the last day of the reporting period.

**BL 2018 Purpose**
The purpose of this measure is to count the total number of child-placing agency administrators that are regulated by the agency. It is a subset of the Explanatory Measure "Number of Licenses, Certifications, Registrations and Listings." This is important data in planning for adequate resources in staffing this activity.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 8  
Objective No. 1  
Strategy No. 3  
Measure Type EX  
Measure No. 12  

Percent of Child Care Licensing Workers: Two or More Years of Service

Calculation Method: N  
Target Attainment:  
Priority:  
Cross Reference: Agy 530 084-R-S70-1 05-01-01 EX 12

Key Measure: N  
New Measure: N  
Percentage Measure: Y

**BL 2018 Definition**

CCL direct delivery caseworkers are identified as:
- CCL Inspector III-V (1322A, 1323A, 1324 A, 5040C),
- CCI Specialist I-III (5024V, 5025V, 5026V),
- RCC Investigator I-II (5026D, 5027D) and;
- RCCL Inspector IV-VI (1323D, 1324 D, 1325 D).
- Res Child Care Spc I- Invest 5026E
- Res Child Care Spc II-Invest 5027E
- CCL Generalist Investigator (5023U)

Staff tenure is calculated from date of hire. All applicable caseworker types will be included, if additional job codes or caseworker categories are created.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

The total number of CCL direct delivery caseworkers with two or more years of service is the numerator. The total number of CCL direct delivery caseworkers is the denominator. Information for this measure is taken from HHSAS-HR.

Due to possible modifications in the FPS fiscal system, PACs or worker job classification codes are subject to change. Should this occur, the current equivalent codes will be substituted and documented in the performance measure folder.

**BL 2018 Methodology**

Divide the numerator by the denominator and multiply by 100 to achieve a percentage.

**BL 2018 Purpose**

This measure is a useful indicator of staff competencies and a general reflection of staff satisfaction.
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 530 084-R-S70-1 05-01-01 EX 13

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

### BL 2018 Definition
Central registry checks are required for certain individuals in day care and residential operations. This measure provides the number of central registry checks that were requested during the reporting period.

### BL 2018 Data Limitations
None.

### BL 2018 Data Source
Data for Central Registry checks are obtained from the Child-care Licensing Automation Support System (CLASS).

### BL 2018 Methodology
Count the number of Central Registry checks that were requested during the reporting period.

### BL 2018 Purpose
The purpose of this measure is to count the Central Registry checks conducted by licensing staff.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology

### BL 2019 Purpose
Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 8: Regulatory, Licensing and Consumer Protection Services
Objective No. 1: Regulation of Facilities and Consumer Products
Strategy No. 3: Child Care Regulation
Measure Type: OP
Measure No. 1: Number of New Permits

Calculation Method: C
Target Attainment: Priority:
Key Measure: N
New Measure: N
Percentage Measure: N

**BL 2018 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 new permits that were issued during the reporting period. A new permit is issued when all of the requirements for issuance are met.

**BL 2018 Data Limitations**
The number of facilities and persons that apply is market-driven and is outside the agency's control.

**BL 2018 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 Child-care Licensing Automation Support System (CLASS).

**BL 2018 Methodology**
For the reporting period, sum the number of new permits that were issued to operations and administrators.

**BL 2018 Purpose**
The purpose of this measure is to track the entrance of operations and administrators into the child care system as a predictor of workload. It is important in projecting the need for regulatory resources.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
**Strategy-Related Measures Definitions**
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**Goal No. 8 Regulatory, Licensing and Consumer Protection Services**

**Objective No. 1 Regulation of Facilities and Consumer Products**

**Strategy No. 3 Child Care Regulation**

**Measure Type OP**

**Measure No. 2 Number of Child Care Facility Inspections**

**Calculation Method:** C

**Target Attainment:**

**Priority:**

**Key Measure:** Y

**New Measure:** N

**Percentage Measure:** N

---

**BL 2018 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.

---

**BL 2018 Data Limitations**

None.

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**BL 2018 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 is 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.

---

**BL 2018 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. 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.

---

**BL 2018 Purpose**

To achieve quality services.

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**BL 2019 Definition**

The purpose of this measure is to assess the involvement of licensing staff in monitoring regulated facilities. It is an indicator of workload. Regulated facilities would include facilities subject to regulation, licensed or certified for day care and residential care, registered and listed family homes, foster and adoptive homes verified by Child Placing Agencies.
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 8 Regulatory, Licensing and Consumer Protection Services
Objective No. 1 Regulation of Facilities and Consumer Products
Strategy No. 3 Child Care Regulation
Measure Type OP
Measure No. 3 Number of Completed Non-Abuse/Neglect Investigations

Calculation Method: C  Target Attainment: Cross Reference: Agy 530 084-R-S70-1 05-01-01 OP 03
Priority: 03

Key Measure: N  New Measure: N  Percentage Measure: N

BL 2018 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 may be 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.

BL 2018 Data Limitations
None.

BL 2018 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 Child-care Licensing Automation Support System (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.

BL 2018 Methodology
Sum the total number of non-abuse/neglect investigations completed within 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.

BL 2018 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.

BL 2019 Definition

BL 2019 Data Limitations
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**
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<td>Measure Type</td>
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<td></td>
<td></td>
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<tr>
<td>Measure No.</td>
<td>4</td>
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<td>Number of Completed Child Abuse/Neglect Investigations</td>
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</table>

**BL 2018 Definition**
An abuse/neglect investigation occurs when a report is made to Licensing that alleges that a child in an operation's care was or may be harmed because of an act or omission by a person working under the auspices of a child care operation. Such harm must meet the definitions of abuse or neglect, as described in the Texas Family Code and Texas Administrative Code. Other statutes, administrative rules, or minimum standards may also be in violation. This includes the following types of operations: those that may be subject to regulation, those that are permitted and foster and adoptive homes verified by Child Placing Agencies. This is a count of all abuse/neglect investigations completed during the reporting period.

**BL 2018 Data Limitations**
None.

**BL 2018 Data Source**
The Information Management Protecting Adults and Children in Texas (IMPACT) application is the official source of record for abuse/neglect information at DFPS. The investigation stage closure date in IMPACT identifies when an abuse/neglect investigation was completed.

**BL 2018 Methodology**
Count the number of abuse/neglect investigations in IMPACT that have an investigation stage closure date that falls within 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.

**BL 2018 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.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

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<td></td>
<td></td>
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<td>Measure No.</td>
<td>5</td>
<td>Number of Validated Child Abuse/Neglect Reports</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 530 084-R-S70-1 05-01-01 OP 05

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure counts the number of child abuse/neglect investigations in which the disposition of at least one allegation was validated. These investigations are done by licensing staff using a preponderance of evidence rule.

**BL 2018 Data Limitations**

None.

**BL 2018 Data Source**

The Information Management Protecting Adults and Children in Texas (IMPACT) application is the official source of record for abuse/neglect information at DFPS. The investigation stage closure date in IMPACT identifies when an abuse/neglect investigation was completed. The overall disposition in IMPACT indicates whether any of the allegations were validated.

**BL 2018 Methodology**

Count the number of licensing child abuse/neglect investigations in IMPACT with an investigation stage closure date that falls within the reporting period and the overall disposition is Reason to Believe (RTB).

**BL 2018 Purpose**

Count the number of licensing child abuse/neglect investigations in IMPACT with an investigation stage closure date that falls within the reporting period and the overall disposition is Reason to Believe (RTB). "RTB" completed by licensing investigators within the reporting period.

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**BL 2019 Definition**

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**BL 2019 Data Limitations**

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**BL 2019 Data Source**

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**BL 2019 Methodology**

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BL 2019 Purpose
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<td>Measure Type</td>
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<td>Average Cost Per Quality Monitoring Program Visit</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 02-01-03 EF 01

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure reports the number of Medicaid certified nursing homes which have increased or fully implemented the use of evidence-based best practices expressed as a percent of all such nursing homes reviewed each year.

**BL 2018 Data Limitations**
This measure reports nursing home practice not resident level data. Any improvements made in resident outcomes cannot be attributed solely to the technical assistance regarding evidence-based best practices provided during Quality Monitoring Program reviews. A convenience sample of residents in each nursing home serves as the basis for this performance measure.

**BL 2018 Data Source**
Assessments are performed on a convenience sample of approximately five people per Quality Monitoring Program review in Texas Medicaid certified nursing homes as established in Health & Safety Code, Chapter 255. Quality Assurance Early Warning System for Long-Term Care Facilities; Rapid Response Teams. Assessments are conducted based on information gathered by interview, observation and record review.

**BL 2018 Methodology**
Evidence-based best practices (EBBPs) in nursing homes (NFs) are organized into three clinical groupings. Nursing: Diabetes, Fall Risk Management, Influenza Vaccinations, Pneumococcal Vaccinations, Mechanical Restraint Reduction, Pain Management, and Pressure Ulcer Prevention. Dietitian: Advance Care Planning, Artificial Nutrition & Hydration, Healthy Hydration, and Weight Management. Pharmacist: Anti-Psychotic Medication Use, Anxiolytic Medication Use, Medication Simplification, Pain Medication Management, and Sedative/Hypnotic Medication Use. Data on the use of EBBPs by NFs is gathered by HHSC's quality monitors during QMP reviews. This data, placed in HHSC's QMMT database, tracks the practices that NFs have implemented. For this measure, the HHSC's QMMT database will be queried to determine the % of NFs, from all those receiving QMP reviews, showing an increase in EBBPs. NFs that have already implemented all elements will be shown as having improved.

**BL 2018 Purpose**
To promote the improvement in quality of care in focus areas the Health and Human Services Commission have identified as statewide priorities.

**BL 2019 Definition**
Strategy-Related Measures Definitions
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BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 8
Objective No. 1
Strategy No. 4
Measure Type EX
Measure No. 1

% Nurs Homes Have Increased/Fully Implemented Evidence-Based Practices

Calculation Method: N
target attainment: N
Priority: N
Cross Reference: Agy 539 084-R-S70-1 02-01-03 EX 01

Key Measure: N
New Measure: N
Percentage Measure: Y

BL 2018 Definition

This measure reports the average cost of a unit of work of the Quality Monitoring Program during the reporting period. In the case of Quality Monitoring Visits, each visit represents a number of units of work equal to the number of days required to conduct the visit. Rapid Response Team visits, requiring two or more monitors, will represent two or more units of work. Work units for Provider Technical Assistance Meetings that require the participation of quality monitor program staff is equal to the number of facilities that attend the educational meeting.

BL 2018 Data Limitations

Does not apply.

BL 2018 Data Source

Units of work are obtained from a visit database that records actual units of work and checked against monthly activity reports collected by the Quality Monitoring Program managers. The average cost per unit of work is calculated from the program budget and the units of work. There is no specific report name or number.

BL 2018 Methodology

The total number of completed work units is determined from the quality monitoring visits, rapid response team visits and facility participation in provider technical assistance meetings occurring during the reporting period. The quarterly program budget is one-fourth of the annual total distributed to the regions for this activity.

BL 2018 Purpose

This measure is a mechanism for assessing the unit cost of implementing the provisions of this strategy.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
Agency Code: 529  Agency: Health and Human Services Commission

Goal No. 8  Regulatory, Licensing and Consumer Protection Services
Objective No. 1  Regulation of Facilities and Consumer Products
Strategy No. 4  Long-Term Care Quality Outreach
Measure Type OP
Measure No. 1  Number of Quality Monitoring Visits to Nursing Facilities

Calculation Method: C  Target Attainment:  Priority:  Cross Reference: Agy 539 084-R-S70-1 02-01-03 OP 01
Key Measure: N  New Measure: N  Percentage Measure: N

**BL 2018 Definition**
This measure reports the number of Quality Monitoring Program Work Units that are comprised of Quality Monitoring Visits (QMV), Rapid Response Team (RRT) visits, and Provider Technical Assistance Meetings for nursing facilities during the reporting period. QMV are usually performed by a single quality monitor; RRT visits require two or more quality monitors. Both visit types involve individual facilities. Provider Technical Assistance Meetings, like RRT visits, are multidisciplinary; in addition, they provide technical assistance to multiple providers at once. In this measure, a "visit" is defined as the deployment of an individual monitor to a facility; more precisely this is the program's unit of work, and RRT visits may represent 2 or more units of work (because they may require 2 or more monitors).

**BL 2018 Data Limitations**
Does Not apply.

**BL 2018 Data Source**
Units of work are obtained from a visit database that records actual units of work and checked against monthly activity reports collected by the Quality Monitoring Program managers. There is no specific report name or number.

**BL 2018 Methodology**
The total number of completed monitoring visits is determined by counting the number of visits identified as Quality Monitoring visits (including Rapid Response visits) occurring during the reporting period. Similarly, Provider Education Meetings are counted from records of the events.

**BL 2018 Purpose**
This measure is a mechanism for assessing the agency's performance as it pertains to implementing the provisions of this strategy and indicates how many Quality Monitoring visits and technical assistance events are occurring in accordance with the requirements of Senate Bill 1839, 77th Legislature, Regular Session, 2001.
**Strategy-Related Measures Definitions**

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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 529 084-R-S70-1 01-01-02 EF 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**  
This measure reports the average cost of determining for Temporary Assistance for Needy Families and State Two-parent cash assistance, Supplemental Nutrition Assistance Program, Medicaid for Elderly and People with Disability, Medicaid, and Children's Health Insurance Program. 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.

**BL 2018 Data Limitations**  
There may be more than one eligibility determination for a case during the reporting period. Data may be collected from different systems.

**BL 2018 Data Source**  
Costs are obtained from expense queries for the eligibility determination sub-strategy using standard internal data collection protocols and internal procedures. The average monthly number of eligibility determinations is reported as 1-1-2-OP-1.

**BL 2018 Methodology**  
The data is computed as follows: the numerator consists of the sum of the eligibility determination sub-strategy departments expenditures divided by the number of months in the reporting period. The sum of the eligibility determination sub-strategy departments expenditures reflect actual costs for each reporting period plus accrued expenditures for the 4th quarter of the reporting period based on appropriation year (year in which funds were appropriated for use regardless of fiscal year/accounting period expenditure is paid). The denominator is the data reported for 1-1-2-1-OP-1 for the reporting period. Dividing the numerator by the denominator yields the average cost for the period.

**BL 2018 Purpose**  
This measure is useful for comparing costs, over time, of the principal workload drivers for Eligibility Determination, the largest sub-strategy within the Integrated Eligibility and Enrollment Strategy.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Goal No. 9 Program Eligibility Determination & Enrollment
Objective No. 1 Program Eligibility Determination & Enrollment
Strategy No. 1 Integrated Financial Eligibility and Enrollment (IEE)
Measure Type EF
Measure No. 2 Accuracy Rate of Benefits Issued: TANF

Calculation Method: N  Target Attainment:  Priority:  Cross Reference: Agy 529  084-R-S70-1  01-01-02  EF 02
Key Measure: N  New Measure: N  Percentage Measure: N

BL 2018 Definition
This measure reports the percentage of Temporary Assistance for Needy Families (TANF) benefits delivered correctly, as determined by the most recent TANF quality control (QC) results for the fiscal year. "Issued in error" is the difference between the dollar amount of benefits actually issued and the dollar amount of benefits that would have been issued had all relevant client information been reported in an accurate and timely fashion by the client and had all relevant client information been processed in accordance with applicable state and/or federal guidelines. (This definition includes over issuances greater than the error tolerance threshold only, and encompasses such things as a client reporting inaccurate information, a client not reporting changes on a timely basis, agency failure to correctly apply policy, and so on.)

BL 2018 Data Limitations
Does not apply.

BL 2018 Data Source
Data are based on the quality control (QC) eligibility review, which uses a statewide random sample of TANF benefits.

BL 2018 Methodology
The reported data are computed as follows: The numerator consists of the number of benefit dollars in the QC sample for the period, minus the number of dollars issued in error for the period, as determined through the QC review process. Only over issuances greater than the error tolerance threshold are included. The denominator consists of the number of benefit dollars in the QC sample for the period. Dividing the numerator by the denominator yields the accuracy rate for the period.

BL 2018 Purpose
This measure is an indicator of accountability and efficiency of agency operations as it pertains to the issuance of TANF benefits.

BL 2019 Definition

BL 2019 Data Limitations
**Strategy-Related Measures Definitions**
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<tr>
<td>Measure No.</td>
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<td>Accuracy Rate of Benefits Issued: SNAP</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
Cross Reference: Agy 529 084-R-S70-1 01-01-02 EF 03

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure reports the percentage of Supplemental Nutrition Assistance Program (SNAP) benefits delivered correctly, as determined by the most recent SNAP quality control results for the fiscal year, adjusted for the federal review regression percentage. "Issues in error" is the difference between the dollar amount of benefits actually issued and the dollar amount of benefits that would have been issued had all relevant client information been reported in an accurate and timely fashion by the client and had all relevant client information been.

**BL 2018 Data Limitations**
For the federal review process, Food and Nutrition Service (FNS) randomly selects approximately one third of each state's annual sample and subjects each of the selected cases to an independent review to determine the accuracy of benefits issued. FNS uses its findings on this subset of cases to adjust the state's error rate through regression a term describing the statistical process of FNS projecting its findings from the subset of reviewed cases to estimate what would have been found had a federal review been conducted on all cases in the state's sample. For most states and in most years, the regression adjustment increases the state's error rate.

**BL 2018 Data Source**
Data are based on the quality control (QC) eligibility review and the Federal re-review process, which uses a statewide random sample of SNAP benefits. This sample complies with federally mandated precision tests. Annually, FNS calculates and publishes the official error rate by the end of June for the prior federal review year.

**BL 2018 Methodology**
The data are computed as follows: The numerator consists of the number of benefit dollars in the QC sample for the period, minus the number of dollars issued in error for the period, as determined through the QC review process. The denominator consists of the number of benefit dollars in the QC sample for the period. Dividing the numerator by the denominator yields the accuracy rate for the period. The numerator includes both over issuances and under issuances, greater than the error tolerance threshold and it is the absolute value of the magnitude of the error that contributes to the numerator. For example, two cases, one with a $50 over issuance and one with a $50 under issuances, do not cancel each other out but instead contribute a total of $100 to the numerator. The numerator also includes ineligible cases, with the contribution to the numerator being equal to the amount of the benefit issued.

**BL 2018 Purpose**
This measure is an indicator of accountability and efficiency of agency operations as it pertains to the issuance of SNAP benefits.
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 9 Program Eligibility Determination & Enrollment
Objective No. 1 Program Eligibility Determination & Enrollment
Strategy No. 1 Integrated Financial Eligibility and Enrollment (IEE)
Measure Type EF
Measure No. 4 Percent of Eligibility Decisions Completed on Time

Calculation Method: N
Target Attainment: Priority: Cross Reference: Agy 529 084-R-S70-1 01-01-02 EF 04
Key Measure: N New Measure: N Percentage Measure: Y

BL 2018 Definition
This measure is the number of eligibility case decisions that were completed within established timeframes for CHIP, Medicaid for the Elderly and People with Disabilities (MEPD), Texas Works (TW) programs for TANF and State Two Parent Cash Assistance, SNAP, and Medicaid for Families and Children, expressed as a percentage of all eligibility decisions completed in the same period. Case decisions are defined as applications approved, denied, or applications open/closed. TW programs include Title XIS Medical Programs for Families and Children, TANF and State Two Parent Cash Assistance, and SNAP. MEPD includes all Title XIX Medicaid services provided to aged or disabled people residing in Texas including Supplemental Security Income, Medical Assistance Only, Qualified Medicare Beneficiary, Specified Low-income Medicare Beneficiaries, other long term care Medicaid eligible qualified individuals, and Medicaid Waiver programs. CHIP includes traditional and Perinate programs.

BL 2018 Data Limitations
The definition of “application” as applied to the case decisions may evolve as policy changes are implemented, which may impact the resulting counts.

BL 2018 Data Source
Data is obtained from Datamart, the interface for the eligibility determination system reporting.

BL 2018 Methodology
The total number of applications processed on time (not delinquent) in the reporting period divided by the total number of applications processed in the same reporting period, multiplied by 100, determines the percent of eligibility decisions completed on time.

BL 2018 Purpose
This measure quantifies timeliness and is an indicator of productivity as it pertains to determining eligibility for Texas Works, CHIP, and MEPD benefits.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**
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**Agency Code:** 529  
**Agency:** Health and Human Services Commission

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<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
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<td>Total Value of SNAP Benefits Distributed</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 529 084-R-S70-1 01-01-02 EX 02

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the total amount (dollar value) of Supplemental Nutrition Assistance Program (SNAP) issued to households that have been determined eligible for benefits.

**BL 2018 Data Limitations**

This measure does not include costs for administration of the program.

**BL 2018 Data Source**

Data is obtained from the monthly report, net SNAP Issuances by month prepared by benefit system staff.

**BL 2018 Methodology**

This measure reports the total amount (dollar value) of Supplemental Nutrition Assistance Program (SNAP) issued to households that have been determined eligible for benefits.

**BL 2018 Purpose**

This measure conveys the total amount of SNAP benefits distributed. These benefits are 100 percent federally funded.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
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<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
<td>2</td>
<td>Percent of Potential Eligible Population Receiving SNAP Benefits</td>
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</tbody>
</table>

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** Y

**BL 2018 Definition**
This measure reports the number of persons receiving Supplemental Nutrition Assistance Program (SNAP) expressed as a percent of the state's population potentially eligible to receive SNAP. The number of persons potentially eligible for SNAP is defined as persons living in households with income at or below 130 percent of the poverty level.

**BL 2018 Data Limitations**
The population potentially eligible for SNAP is subject to change as updates/revisions to the population estimates and projections become available.

**BL 2018 Data Source**
Recipient data are from the month-end SNAP Case extract from the eligibility determination system. The population of potential eligibles is estimated using baseline information obtained from the last two March Current Population Surveys administered by the U.S. Census Bureau. The baseline information is extrapolated using standard demographic and other statistical techniques that rely on data provided by the population estimates and projections program of the Texas State Data Center.

**BL 2018 Methodology**
Data are computed by totaling the number of SNAP recipients over all months in the reporting period, and dividing by the number of months in the reporting period to determine the average monthly number of SNAP recipients. This result is divided by the number of persons potentially eligible for SNAP, and then multiplied by 100.

**BL 2018 Purpose**
This measure is an expression of the impact the agency is having on serving the population potentially eligible to receive SNAP. It is an indicator of the percent of need being met.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 9  Program Eligibility Determination & Enrollment
Objective No. 1  Program Eligibility Determination & Enrollment
Strategy No. 1  Integrated Financial Eligibility and Enrollment (IEE)
Measure Type EX
Measure No. 3  Percent of Direct Delivery Staff with Less than One Year

Calculation Method: N  Target Attainment: N  Priority: N  Cross Reference: Agy 529 084-R-S70-1 01-01-02 EX 04
Key Measure: N  New Measure: N  Percentage Measure: Y

**BL 2018 Definition**
This measure reports the percentage of supervisors, workers and clerks with less than one year tenure.

**BL 2018 Data Limitations**
Only tenure in the current position is counted. The count of eligibility determination staff may differ from actual full-time equivalents.

**BL 2018 Data Source**
Data are obtained from payroll/personnel system queries.

**BL 2018 Methodology**
The number of supervisors, workers and clerks with less than one year of tenure at the end of the reporting period is divided by the total number of supervisors, workers, and clerks at the end of the reporting period. The result is expressed as a percentage.

**BL 2018 Purpose**
At least one year is required for staff to become proficient in eligibility determination tasks. The measure may explain timeliness, performance, staffing and cost anomalies.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
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<tr>
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<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
<td>1</td>
<td>Average Monthly Number of Eligibility Determinations</td>
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</table>

**Calculation Method:** N

**Target Attainment:**

**Priority:**

*Cross Reference: Agy 529 084-R-S70-1 01-01-02 OP 01*

**Key Measure:** Y

**New Measure:** N

**Percentage Measure:** N

**BL 2018 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 Children’s Health Insurance Program. 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.

**BL 2018 Data Limitations**

There may be more than one eligibility determination for a case during the reporting period. Data may be collected from different systems.

**BL 2018 Data Source**

Data are obtained from Datamart.

**BL 2018 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.

**BL 2018 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.
### BL 2018 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 Children’s Health Insurance Program per staff person. Determining eligibility refers to approved, denied, or open/closed applications, and sustained or denied complete reviews.

### BL 2018 Data Limitations
There may be more than one eligibility determination for a case during the reporting period. Data may be collected from different systems. The count of eligibility determination staff may differ from actual full-time equivalents.

### BL 2018 Data Source
The numerator is the data for 9-I-1-OP-2. The number of staff is from a monthly query from the payroll/personnel system.

### BL 2018 Methodology
Data for the numerator 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 for the denominator are computed by totaling, over all months in the reporting period, the number of eligibility determination staff and dividing by the number of months in the reporting period.

### BL 2018 Purpose
This measure is useful for comparing eligibility staff workload over time.

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<th>Priority:</th>
<th>Key Measure: N</th>
<th>New Measure: N</th>
<th>Percentage Measure: N</th>
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<tr>
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<td></td>
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Cross Reference: Agy 529 084-R-S70-1 01-01-02 OP 02
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<td>Measure Type</td>
<td>OP</td>
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<tr>
<td>Measure No.</td>
<td>3 Average Number of Recipients Per Month: SNAP</td>
</tr>
</tbody>
</table>

**BL 2018 Definition**

This measure reports the average monthly number of Supplemental Nutrition Assistance Program (SNAP) recipients. Data include public assistance and non-public assistance recipients. Public assistance recipients are members of households in which all members receive Temporary Assistance for Needy Families (TANF) or State Two-Parent Cash Assistance or Supplemental Security Income and TANF. Non-public assistance recipients are members of households in which no one or only some of the members receive TANF or State Two-Parent Cash Assistance.

**BL 2018 Data Limitations**

Recipients are counted in each month they receive a SNAP benefit, so this measure does not report an unduplicated count of recipients over time.

**BL 2018 Data Source**

Data are obtained from automated monthly reports, SNAP benefit system Issuance Household Profile and the SNAP Case extract from an eligibility determination system.

**BL 2018 Methodology**

Data are computed by totaling, over all months in the reporting period, the monthly number of SNAP recipients and dividing this total by the number of months in the reporting period.

**BL 2018 Purpose**

This measure shows the number of Texans impacted by the agency's performance in implementing the provisions of this strategy. It is an indicator of the agency's workload as it pertains to providing services to persons receiving SNAP benefits. It is useful for projecting caseloads and future funding needs. It is also information that legislators and the public frequently request.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
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Agency Code: 529  
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Goal No. 9  
Objective No. 2  
Strategy No. 1  
Measure Type EF  
Measure No. 1  

Cross Reference: Agy 539 084-R-S70-1 01-01-01 EF 01

**BL 2018 Definition**

This is a measure of the statewide average cost per individual provided care coordination, exclusive of the cost of services brokered or procured for the individual.

**BL 2018 Data Limitations**

Only State Unit on Aging (HHSC) funded individuals are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging HHSC, they are not included in the measure calculation.

**BL 2018 Data Source**

The number of individuals is based on data reported to the Commission by area agencies on aging. Data is reported only for those individuals for whom an intake form is completed. Expenditures are reported by area agencies on aging and include accrued expenses.

**BL 2018 Methodology**

The statewide average cost per care coordination individual is calculated by dividing area agencies on aging expenditures used to provide care coordination to individuals age 60 or older by the unduplicated number of individuals year-to-date receiving care coordination services funded by the State Unit on Aging (HHSC) during the fiscal year.

**BL 2018 Purpose**

This measure identifies the statewide average State Unit on Aging (HHSC) cost per care coordination individual.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This measure identifies the statewide average cost per individual receiving legal assistance services.

### BL 2018 Data Limitations

Only State Unit on Aging (HHSC) individuals are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging (HHSC), they are not included in the measure calculation.

### BL 2018 Data Source

Data for those individuals for whom an intake form is completed are reported to the Commission by area agencies on aging. The reported number of individuals is the sum of individuals reported from the area agencies on aging. Expenditures are reported by area agencies on aging and include accrued expenses.

### BL 2018 Methodology

The average cost per legal assistance individual is calculated by dividing area agencies on aging expenditures used to provide legal assistance to persons age 60 or older by the unduplicated number of individuals receiving legal assistance services as reported to the Department by the area agencies on aging as funded by the State Unit on Aging (HHSC).

### BL 2018 Purpose

At the state level, this measure provides a means for decision-makers to project service levels based on a given level of funding. For the state agency, this is a comparative efficiency measure between different programs, and is useful for monitoring and evaluating providers.

### BL 2019 Definition


### BL 2019 Data Limitations


### BL 2019 Data Source


### BL 2019 Methodology


**BL 2018 Definition**

This measure captures information regarding what it costs the state each month, on average, to provide community service coordination ID services to each individual regardless of age. It measures the Health and Human Services Commission’s (HHSC’s) appropriation authority cost per individual as defined by the companion output measure.

**BL 2018 Data Limitations**

Because it takes 365 days to close out 100% of the claims for a month of service, the number of individuals ultimately served as well as cost per individual per month 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.

**BL 2018 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 the commission’s Claims Management System (CMS) by means of ad hoc query.

**BL 2018 Methodology**

The sum of monthly expenditures for service coordination - Medicaid Funding, by month-of-service, for all months in the reporting period is divided by the monthly average number of individuals receiving service coordination – Medicaid Funding for all months of the reporting period; this result is then divided by the number of months in the reporting period.

**BL 2018 Purpose**

This measure captures HHSC appropriation authority cost of assessment and service coordination ID services in the community, regardless of age.
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<th>BL 2019 Data Source</th>
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<td>BL 2019 Methodology</td>
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</tr>
</tbody>
</table>
### BL 2018 Definition

This measure reports the average monthly cost per community services and supports case. Costs include those associated with the functional eligibility and case coordination process.

### BL 2018 Data Limitations

N/A

### BL 2018 Data Source

Two types of data are used to report this measure. The number of individuals to receive Community Services and Supports is obtained from the Health and Human Services Commission’s (HHSC’s) Service Authorization System (SAS) by means of ad hoc query. These raw individual counts by type of service are then multiplied by service specific weights to get a product or caseload equivalent. Data for direct costs are obtained from the commission’s Health and Human Services Administrative System (HHSAS) Financials. Primary Home Care is included in the costs. Other sources used in the computation of this measure are identified under output measure 6.

### BL 2018 Methodology

The sum of the Community Services and Supports functional eligibility and case coordination budget expended and cost pool data from Program Activity Code (PAC) 372 (CCAD Eligibility Determination), for each of the months of the reporting period are divided by the sum of the number of individuals determined eligible for Community Services and Supports in the months of the reporting period, and this is divided by the number of months in the reporting period to obtain the monthly cost per case.

### BL 2018 Purpose

This measure is important because it is an indicator of the unit cost associated with implementing the provisions of this strategy as it pertains to providing HHSC funded Community Services and Supports. This unit cost indicates the efficiency of HHSC’s operations and is a useful tool for projecting future funding needs.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
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Agency: Health and Human Services Commission

Goal No. 9  
Program Eligibility Determination & Enrollment

Objective No. 2  
Long-term Care Eligibility Determination & Enrollment

Strategy No. 1  
Intake, Access, and Eligibility to Services and Supports

Measure Type EF  
Avg Mthly Cost Indiv ID Recvg Assessment & Svc Coordination Non-Med

Measure No. 5  
Calculation Method: N  
Target Attainment:  
Priority: Cross Reference: Agy 539 084-R-S70-1 01-01-01 EF 05

Key Measure: N  
New Measure: N  
Percentage Measure: N

BL 2018 Definition
This measure captures information regarding what it costs the state each month, on average, to provide community assessment and service coordination ID services to each individual regardless of age. It measures the Health and Human Services Commission’s (HHSC’s) appropriation authority cost per individual as defined by the companion output measure.

BL 2018 Data Limitations
The accuracy of the commission’s individual database is dependent upon accurate and timely information being entered into the data warehouse system by the local MRALA. 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 that is used for reporting in the Automated Budget and Evaluation System of Texas (ABEST). Final expenditure information may be entered into the data warehouse up to 4 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.)

BL 2018 Data Source
At the end of each quarter, staff of the local authorities input expenditure information into 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.

BL 2018 Methodology
The sum of monthly expenditures for assessment and service coordination - Non-Medicaid Funding, by month-of-service, for all months in the reporting period is divided by the monthly average number of individuals receiving assessment and service coordination – Non-Medicaid Funding for all months of the reporting period; this result is then divided by the number of months in the reporting period.

BL 2018 Purpose
This measure captures HHSC appropriation authority cost of assessment and service coordination ID services in the community, regardless of age.

BL 2019 Definition

BL 2019 Data Limitations
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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<td>Measure No.</td>
<td>6 Cost Per Call to the ADRC Toll-free Line</td>
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</tbody>
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**BL 2018 Definition**

The measure of the average cost per call made to the 1-855-YES-ADRC toll free line.

**BL 2018 Data Limitations**

Only individuals calling the aging and disability resource centers via the 1-855-YES-ADRC toll-free line are considered for this measure. The aging and disability resource centers may also provide service to walk-in clients, clients contacted through an outreach event, or clients who use an alternate phone number to reach the aging and disability resource centers. The aging and disability resource center may receive funding that is not reported to the Commission, but is used to provide aging and disability resource center services. Expenditures include funds spent to provide services to individuals regardless of how the individual contacted the aging and disability resource center. Expenditures also include operational costs associated with operating and staffing the aging and disability resource centers.

**BL 2018 Data Source**

The total number of calls is based on the Health and Human Services Commission (HHSC) report provided through Century link Communication Cooperation or the current toll-free line vendor. Expenditures are reported by the aging and disability resource centers and include accrued expenses for toll-free line administration, staffing, and service delivery. The aging and disability resource centers will submit expenditure reports for the reporting period monthly by the 15th of the following month. Expenditure information will be collected for funding streams tied to related activities and staffing such as the contractually required dedicated aging and disability resource center phone line, staffing plan, and aging and disability resource centers intake and referral. The Commission sums the reported totals from the aging and disability resource centers to create a state total.

**BL 2018 Methodology**

The statewide average cost per call is calculated by dividing total expenditures for toll-free line administration, staffing, and service delivery by the total number of calls to the toll-free line for the reporting period.

**BL 2018 Purpose**

This measure identifies the statewide average Commission cost per call via the toll-free line to the aging and disability resource centers.
BL 2018 Definition
This is a measure of the statewide average cost per individual receiving aging and disability resource center services that are veterans age or older or are veterans that have a disability.

BL 2018 Data Limitations
Veteran status is recorded based on the individual’s self-reported status in most instances. Some individuals may choose not to indicate veteran’s status. This is a contractor reported measure and may be subject to the limitations of the contractor’s data systems. Veteran-related expenditures include only funds expended for the provision of services to veterans, including veteran specialized staff positions, veteran-specific outreach, and veteran-specific training and education. The aging and disability resource center may receive funding that is not reported to the Commission, but is used to provide veteran-related aging and disability resource center services.

BL 2018 Data Source
The number of veterans served is reported by the aging and disability resource center contractors. The aging and disability resource center intake process will require identification of veteran status and a record of all related activities. In addition, client tracking tools, staffing plans, and requests for reimbursement will identify staff and units delivered in service to veterans. Expenditures are reported by the aging and disability resource centers monthly by the 15th of the following month and include accrued expenses. The Commission sums the reported totals from the aging and disability resource centers to create a state total.

BL 2018 Methodology
The statewide average cost per veteran is calculated by dividing total veteran-related expenditures by the total unduplicated number of individuals that are veterans age 60 or older or are veterans that have a disability based on data reported to the Commission by aging and disability resource centers.

BL 2018 Purpose
This measure identifies the statewide average Commission cost per veteran receiving services through the aging and disability resource centers.

BL 2019 Definition

BL 2019 Data Limitations
BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
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Agency: Health and Human Services Commission

Goal No. 9 Program Eligibility Determination & Enrollment
Objective No. 2 Long-term Care Eligibility Determination & Enrollment
Strategy No. 1 Intake, Access, and Eligibility to Services and Supports
Measure Type EX
Measure No. 1 Total Expenditures for the Ombudsman Program

Calculation Method: N
Target Attainment: N
Priority: N
Cross Reference: Agy 539 084-R-S70-1 01-01-01 EX 01

Key Measure: N
New Measure: N
Percentage Measure: N

BL 2018 Definition
This measure identifies the reported total of all funds expended for the Ombudsman Program, which includes Federal Older Americans Act Title III and Title VII, other federal, State General Revenue and local cash.

BL 2018 Data Limitations
Only expenditures reported by the area agencies on aging to the Health and Human Services Commission (HHSC - the State Unit on Aging) on the quarterly report are included for this measure.

BL 2018 Data Source
Ombudsman expenditures are reported to the State Unit on Aging (HHSC) quarterly by area agencies on aging.

BL 2018 Methodology
Total expenditures are calculated by compiling the reported expenditures of each area agency on aging.

BL 2018 Purpose
At the state level, this measure provides a means to assess the level of activity and support for the Ombudsman program and is used as a monitoring tool for program oversight.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
### BL 2018 Definition

This measure identifies the cumulative, unduplicated number of licensed assisted living facilities visited by certified ombudsmen in the Long-Term Care (LTC) Ombudsman Program.

### BL 2018 Data Limitations

All unduplicated visits to licensed assisted living facilities by certified ombudsmen during the fiscal year will be included in this count, as reported by local LTC Ombudsman Programs. This measure will only count one visit per assisted living facility.

### BL 2018 Data Source

The number of visits to assisted living facilities is reported on a monthly basis by the local LTC Ombudsman Programs in the format specified by the Health and Human Services Commission (HHSC).

### BL 2018 Methodology

The calculation is the cumulative number of unduplicated visits to licensed assisted living facilities by certified ombudsmen.

### BL 2018 Purpose

This measure is an explanation of the LTC Ombudsman Program coverage and advocacy efforts in licensed assisted living facilities. The measure provides information to decision-makers and state agency staff to recognize the scope of services provided by the program. State agency staff may also identify opportunities for training and technical assistance to the local LTC Ombudsman Programs.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology
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Objective No. 2  
Strategy No. 1  
Measure Type OP  
Measure No. 1  

Program Eligibility Determination & Enrollment  
Long-term Care Eligibility Determination & Enrollment  
Intake, Access, and Eligibility to Services and Supports

Cross Reference: Agy 539 084-R-S70-1 01-01-01 OP 01

**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

The total number of active Ombudsmen is defined as volunteers and staff who have completed appropriate instruction/prescribed training, and received recognition by the State Ombudsman as being a qualified Ombudsman and identified as having an active status in the program.

**BL 2018 Data Limitations**

All certified Ombudsmen who were active during the fiscal year will be included in the unduplicated count of active certified Ombudsmen for this measure.

**BL 2018 Data Source**

The unduplicated number of active certified Ombudsmen is reported quarterly by area agencies on aging in the format specified by the Department. The area agencies on aging report both the unduplicated number of active Ombudsmen for the quarter and for the fiscal year. To be active in a state quarter, an Ombudsman visits long-term care facilities within the state quarter, or investigates/resolves complaints when identified, or provides other Ombudsman services such as in-services for long-term care facilities/community groups.

**BL 2018 Methodology**

The calculation is the total certified Ombudsmen listed on the quarterly active ombudsman list. The area agencies on aging report both the unduplicated number of active Ombudsmen for the quarter and for the fiscal year.

**BL 2018 Purpose**

This measure is an explanation and identification of the total number of active certified Ombudsmen. The output allows decision-makers and state agency staff to identify trends of the program.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Strategy-Related Measures Definitions  
85th Regular Session, Agency Submission, Version 1  
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<td>Measure No.</td>
<td>2</td>
<td>Number of Persons Receiving Care Coordination</td>
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**Calculation Method:** C  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-01-01 OP 02

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**  
The measure is the unduplicated number of individuals age 60 and older receiving care coordination services during the fiscal year. Care coordination may include assessment, service plan development, arranging of comprehensive and unified services, follow-up, monitoring of an individual's or family's status and services delivered, and periodic review, with any necessary revision of the service plan. The State Unit on Aging’s HHSC care coordination services is intended to give preference to short-term intervention. Short-term intervention is considered three months or less; however, this does not preclude individuals from receiving longer-term services when deemed appropriate by their care coordinator.

**BL 2018 Data Limitations**  
Only State Unit on Aging (HHSC) funded individuals are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging, they are not included in the measure calculation.

**BL 2018 Data Source**  
The number of individuals is based on data reported to the Commission by area agencies on aging. Data is reported only for those individuals for whom an intake form is completed.

**BL 2018 Methodology**  
This calculation is based on the total unduplicated individuals age 60 and older that receive care coordination services based on data reported to the Commission by area agencies on aging.

**BL 2018 Purpose**  
This measure indicates the number of unduplicated individuals age 60 or older receiving care coordination services during the fiscal year.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**
BL 2019 Methodology

BL 2019 Purpose
Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 9 Program Eligibility Determination & Enrollment
Objective No. 2 Long-term Care Eligibility Determination & Enrollment
Strategy No. 1 Intake, Access, and Eligibility to Services and Supports
Measure Type OP
Measure No. 3 Number of Persons Receiving Legal Assistance

Calculation Method: C
Target Attainment:
Priority:
Cross Reference: Agy 539 084-R-S70-1 01-01-01 OP 03

Key Measure: N
New Measure: N
Percentage Measure: N

BL 2018 Definition
The measure is the total number of individuals age 60 and older receiving legal assistance services during the fiscal year. Legal assistance service is advice and representation by an attorney (including assistance by a paralegal or law student under the supervision of an attorney), or counseling or representation by a non-lawyer where permitted by law.

BL 2018 Data Limitations
Only State Unit on Aging (HHSC) funded individuals are considered for this measure. While some individuals funded by other sources may be reported to the State Unit on Aging (HHSC), they are not included in the measure calculation.

BL 2018 Data Source
Data for those individuals for whom an intake form is completed are reported to the Commission by area agencies on aging. The reported number of individuals is the sum of individuals reported from the area agencies on aging.

BL 2018 Methodology
The reported number of individuals is the sum of persons reported from the area agencies on aging.

BL 2018 Purpose
This measure indicates the amount of legal assistance services provided statewide by area agencies on aging.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology
BL 2019 Purpose
### BL 2018 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 Health and Human Services Commission (HHSC) appropriation authority funds and who receive ID 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.

### BL 2018 Data Limitations

Because it takes 365 days to close out 100% 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.

### BL 2018 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 (CMS) by means of ad hoc query.

### BL 2018 Methodology

To obtain the number of individuals served with HHSC appropriation authority funds, the numerator is the sum of the number of individuals receiving ID 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.

### BL 2018 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.

### BL 2019 Definition

### BL 2019 Data Limitations

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### BL 2018 Definition
This measure reports the unduplicated monthly average number of individuals authorized by Community Services and Supports workers to receive one or more Community Services and Supports. These individuals (Income Eligible, Supplemental Security Income (SSI)) are eligible to receive the following services: Family Care, Primary Home Care, Meals Only, Day Activity and Health Services (DAHS) Only, Foster Care, Special Services to individuals with Disabilities, Residential Care, Emergency Response Services (ERS) Only, Medically Dependent Children Program, In-Home and Family Support, and Community-based Alternatives.

### BL 2018 Data Limitations
Since a high percentage of individuals who receive meals, DAHS and/or ERS also receive other services, for Meals, DAHS and ERS, the monthly unduplicated average count of community services and supports individuals includes only those Meals, DAHS or ERS individuals who are not authorized to receive any other service. For services other than Meals, DAHS, or ERS, individuals are counted without regard to duplication.

### BL 2018 Data Source
The number of individuals receiving the above services is obtained from the commission's Service Authorization System (SAS) by means of ad hoc query. These files are used to isolate the Community Services and Supports caseload by type of service, by region and then summed to a statewide total on a monthly basis. The individuals, (Income Eligibles, SSI) receiving community services and supports only are reported.

### BL 2018 Methodology
The data reported for this measure are calculated by dividing the sum of the monthly number of Community Services and Supports individuals for all months of the reporting period by the number of months in the reporting period.

### BL 2018 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 agency's workload as it pertains to determining the eligibility of persons receiving the Health and Human Services Commission (HHSC) -funded community services and supports. This information is useful as a tool for assessing future funding needs.

### BL 2019 Definition

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**Goal No. 9 Program Eligibility Determination & Enrollment**

**Objective No. 2 Long-term Care Eligibility Determination & Enrollment**

**Strategy No. 1 Intake, Access, and Eligibility to Services and Supports**

**Measure Type OP**

**Measure No. 6 Average Case Equivalents Per Community Services and Supports Worker**

**Calculation Method: N**
**Target Attainment: Priority:**

**Cross Reference: Agy 539 084-R-S70-1 01-01-01 OP 06**

**Key Measure: N**
**New Measure: N**
**Percentage Measure: N**

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**BL 2018 Definition**

This measure reports the average case equivalents/Community Services and Supports (CS&S) worker. It is developed by using the unduplicated monthly avg # of individuals authorized by CS&S workers to receive 1 or more CS&S. Individuals (Income Eligibles, Supplemental Security Income (SSI) eligibles) are eligible to receive: Family Care, Primary Home Care, Meals Only, Day Activity and Health Services (DAHS) Only, Foster Care, Special Services to Indvs with Disabilities, Residential Care, Emergency Response Services Only, Medically Dependent Children Program, In-home & Family Support, & Community-based Alternatives. An elig worker is defined as a filled position with a budgeted job # that includes an alpha character identifier unique to elig workers. CS&S workers determine financial elig only for those individuals with income above the SSI level. They also determine functional elig for all CS&S individuals, they plan and authorize services for all individuals, as well as monitor services delivered by providers.

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**BL 2018 Data Limitations**

Since a high percentage of individuals who receive Meals, Day Activity and Health Services (DAHS) and/or Emergency Response Services (ERS) also receive other services, for Meals, DAHS and ERS, the monthly unduplicated average count of Community Services and Supports individuals includes only those Meals, DAHS or ERS individuals who are not authorized to receive any other service. For services other than Meals, DAHS, or ERS, individuals are counted without regard to duplication.

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**BL 2018 Data Source**

The number of individuals authorized to receive the above services is obtained from the commission's Service Authorization System (SAS) by means of ad hoc query. These files are used to isolate the Community Services and Supports caseload by type of service, by region and then summed to a statewide total on a monthly basis. The individuals (Income Eligibles, SSI eligibles) receiving Community Services and Supports only are reported.

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**BL 2018 Methodology**

The amount of time needed to perform the functions associated with this measure varies significantly depending upon the type of case. Therefore, the department periodically conducts workload studies in order to develop "relative case weights" by type of case so that "standardized" case equivalents can be used to more effectively manage workloads. A "standardized" case equivalent is defined as a Community Attendant Service (CAS) case, since these cases make up the largest proportion of total cases. Case data are multiplied by relative case weights from the most recent Community Services and Supports workload study to obtain the number of CAS equivalents. The number of caseload equivalents is divided by the number of filled eligibility workers in Program Activity Code (PAC) 372 (CCAD Eligibility Determination) and 377 (Nursing Facility Waiver Eligibility Determination) to obtain the reported data.
BL 2018 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 level of effort (workload) expended by staff and indicates the efficiency of the agency's operations. It is also a useful tool for assessing future funding needs.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

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**Goal No.** 9  Program Eligibility Determination & Enrollment
**Objective No.** 2  Long-term Care Eligibility Determination & Enrollment
**Strategy No.** 1  Intake, Access, and Eligibility to Services and Supports
**Measure Type** OP
**Measure No.** 7  Avg Number of Standardized Community Serv Case Equivalents Per Month

**Calculation Method:** N  **Target Attainment:** N  **Priority:** N  **Cross Reference:** Agy 539 084-R-S70-1 01-01-01 OP 07

**Key Measure:** N  **New Measure:** N  **Percentage Measure:** N

**BL 2018 Definition**
This measure reports the average number of standardized Community Services and Supports case equivalents per month. A "standardized" Community Services and Supports case equivalent is defined as the amount of monthly work effort associated with a Community Attendant Service (CAS) case. Community Services and Supports workers determine initial and on-going financial eligibility for those individuals with income above the SSI level. They also determine initial and on-going functional eligibility for all Community Services and Supports individuals. In addition, they plan and authorize services for all Community Services and Supports individuals, update service plans as needed, provide case management, and monitor the services delivered by providers.

**BL 2018 Data Limitations**
The amount of time needed to perform the above functions varies significantly depending upon the type of case. Therefore, the commission periodically conducts workload studies in order to develop "relative case weights" based upon the amount of worker time needed per cases, by type of case, so that "standardized" case equivalents can be used to more effectively manage workloads. The information used to develop the case weights for Community Services and Supports was collected September 2000 – June 2001.

**BL 2018 Data Source**
The individual counts (see method of calculation for list of individual populations) are obtained from the commission’s Service Authorization System (SAS) by means of ad hoc query.

**BL 2018 Methodology**
The measure is calculated by using the monthly average number of individuals authorized by Community Services and Supports workers to receive one or more of the following services: Family Care, Primary Home Care, Meals Only, Day Activity and Health Services (DAHS) Only, Foster Care, Special Services to Individuals with Disabilities, Residential Care, Emergency Response Services (ERS) Only, Meals as a second service, ERS as a second service, DAHS as a second service, and Community-based Alternatives. The above individual counts by type of service are then multiplied by the appropriate relative case weights derived from the most recent Community Services and Supports workload study to obtain the number of CAS case equivalents.

**BL 2018 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 workload that must be handled by Community Services and Supports workers.

**BL 2019 Definition**
BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
Strategy-Related Measures Definitions
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<tr>
<td>Measure No.</td>
<td>8</td>
<td>Avg Mthly # of Individ W/ ID Recv Assess, Serv Coord - Non-Medicaid FD</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 01-01-01 OP 08

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure captures the non-Medicaid unduplicated count of priority population, as defined by Local Authority Contract, eligible individuals whose services are funded with the Health and Human Services Commission’s (HHSC’s) appropriation authority funds and who receive ID community assessment and/or service coordination 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 by HHSC appropriations authority.

**BL 2018 Data Limitations**
The accuracy of the Client Assignment and Registration (CARE) system is dependent upon accurate and timely information being entered into the data warehouse system by the local mental health authorities. For purposes of measurement, an open assignment to a service is calculated as receiving the service.

**BL 2018 Data Source**
As individuals enter the comm. programs, registration info.is entered into the CARE 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. To be counted as served in assessment or service coordination, the individual must have an open assignment to assessment or service coordination for the month(s) being reported. Production reports of individuals served are issued quarterly based on the information in the data warehouse system. The total unduplicated number of individuals with open assignments to ID community assessment and/or service coordination service each month is calculated. 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 individuals assigned to a particular service each month regardless of how the services for the individuals were funded.

**BL 2018 Methodology**
To obtain the number of individuals served with HHSC appropriation authority funds, the numerator is the sum of the number of individuals receiving ID 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.

**BL 2018 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.

**BL 2019 Definition**
BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
### Strategy-Related Measures Definitions

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<td>OP</td>
<td>9</td>
<td># Events of Persons Recv Community Contacts Concerning ID Serv/Year</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:**  
**Cross Reference:** Agy 539 084-R-S70-1 01-01-01 OP 09

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**
This measure provides a count of events in which persons either are screened for community services or receive other benefits not counted as “services” during one fiscal year. These benefits include screening for potential eligibility for services, updating interest list status and contact data and assistance with obtaining eligibility for Medicaid and other benefit programs.

**BL 2018 Data Limitations**
This measure provides the actual number of events in which persons receive the type of contacts in the definition. Anonymous inquiries are permitted so an unduplicated count of individuals is not feasible.

**BL 2018 Data Source**
Local ID authorities are required to provide this function in their local service areas in their Performance Contract and these functions are funded only through general revenue. Each contact of this type is recorded as an encounter in the encounter data system and submitted to the state agency by the local authorities.

**BL 2018 Methodology**
The total number of contacts during the fiscal year is counted for each local authority and system-wide.

**BL 2018 Purpose**
The purpose of this measure is to quantify a portion of the activities for which GR funds are required to be expended by the local authorities.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
Goal No.  9  Program Eligibility Determination & Enrollment
Objective No. 2  Long-term Care Eligibility Determination & Enrollment
Strategy No. 1  Intake, Access, and Eligibility to Services and Supports
Measure Type  OP
Measure No. 10  Number of Calls to the ADRC Toll-free Line

**BL 2018 Definition**

The measure is the total calls made to the 1-855-YES-ADRC toll free line.

**BL 2018 Data Limitations**

Only individuals calling the aging and disability resource centers via the 1-855-YES-ADRC toll-free line are considered for this measure. The aging and disability resource centers may also provide service to walk-in clients, clients contacted through an outreach event, or clients who use an alternate phone number to reach the aging and disability resource centers.

**BL 2018 Data Source**

The total number of calls is based on the Century link Communication Cooperation or the current toll-free line vendor report provided through the Health and Human Services Commission (HHSC).

**BL 2018 Methodology**

This calculation is the total number of calls to the toll-free line for the reporting period.

**BL 2018 Purpose**

This measure indicates the number of individuals contacting the aging and disability resource centers via the toll-free line for the ADRC toll-free line.
BL 2019 Purpose
**Strategy-Related Measures Definitions**

**Automated Budget and Evaluation System of Texas (ABEST)**

**85th Regular Session, Agency Submission, Version 1**

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**Strategy-Related Measures Definitions**

**Agency Code:** 529

**Agency:** Health and Human Services Commission

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**Goal No. 9 Program Eligibility Determination & Enrollment**

**Objective No. 2 Long-term Care Eligibility Determination & Enrollment**

**Strategy No. 1 Intake, Access, and Eligibility to Services and Supports**

**Measure Type OP**

**Measure No. 11 Number of Veterans Served by the ADRCS**

**Calculation Method:** C

**Target Attainment:**

**Priority:**

Cross Reference: Agy 539 084-R-S70-1 01-01-01 OP 11

**Key Measure:** N

**New Measure:** N

**Percentage Measure:** N

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**BL 2018 Definition**

The measure is the unduplicated number of individuals receiving aging and disability resource center services that are veterans age 60 or older or are veterans that have a disability.

**BL 2018 Data Limitations**

The aging and disability resource center intake process will require identification of veteran status and a record of all related activities. Veteran status is recorded based on the individual’s self-reported status in most instances. Some individuals may choose not to indicate veteran’s status. This is a contractor reported measure and may be subject to the limitations of the contractor’s data systems.

**BL 2018 Data Source**

The number of veterans served is reported by the aging and disability resource center contractors monthly by the 15th of the following month. The Commission sums the reported totals from the aging and disability resource centers to create a state total.

**BL 2018 Methodology**

The calculation is based on the total unduplicated number of individuals that are veterans age 60 or older or are veterans that have a disability based on data reported to the Commission by the aging and disability resource centers monthly.

**BL 2018 Purpose**

This measure identifies the number of veterans receiving services through the aging and disability resource centers.

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**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
### Agency Code: 529  
**Agency:** Health and Human Services Commission

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<td>Measure Type</td>
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<td>Measure No.</td>
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**Calculation Method:** N  
**Target Attainment:**  
**Priority:** 
**Cross Reference:** Agy 539 084-R-S70-1 01-01-01 OP 12

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**

This measure reports the avg case equivalents/Comm. Services and Supports (CS&S) worker. It is developed by using the unduplicated monthly avg # of individuals authorized by CS&S workers to receive 1 or more CS&S. Individuals (Income Eligibles, Supp. Security Income (SSI) eligible) are eligible to receive: Family Care, Primary Home Care, Meals Only, Day Activity and Health Services (DAHS) Only, Foster Care, Special Services to Indivs with Disabilities, Residential Care, Emergency Response Services Only, Medically Dependent Children Program, and In-home & Family Support. An eligible worker is defined as a filled position with a budgeted job # that includes an alpha character identifier unique to elig workers. CS&S workers determine financial elig only for those individuals with income above the SSI level. They also determine functional elig for all CS&S individuals, they plan and authorize services for all individuals, as well as monitor services delivered by providers.

**BL 2018 Data Limitations**

Since a high percentage of individuals who receive Meals, Day Activity and Health Services (DAHS) and/or Emergency Response Services (ERS) also receive other services, for Meals, DAHS and ERS, the monthly unduplicated average count of Community Services and Supports individuals includes only those Meals, DAHS or ERS individuals who are not authorized to receive any other service. For services other than Meals, DAHS, or ERS, individuals are counted without regard to duplication.

**BL 2018 Data Source**

The number of individuals authorized to receive the above services is obtained from the commission’s Service Authorization System (SAS) by means of ad hoc query. These files are used to isolate the Community Services and Supports caseload by type of service, by region and then summed to a statewide total on a monthly basis. The individuals, (Income Eligible, SSI eligible) receiving Community Services and Supports only are reported.

**BL 2018 Methodology**

The amount of time needed to perform the functions associated with this measure varies significantly depending upon the type of case. Therefore, the commission periodically conducts workload studies in order to develop "relative case weights" by type of case so that "standardized" case equivalents can be used to more effectively manage workloads. A "standardized" case equivalent is defined as a Community Attendant Service (CAS) case, since these cases make up the largest proportion of total cases. Case data are multiplied by relative case weights from the most recent Community Services and Supports workload study to obtain the number of CAS case equivalents. The number of caseload equivalents is divided by the number of filled eligibility workers in Program Activity Code (PAC) 372 (CCAD Eligibility Determination) and 377 (Nursing Facility Waiver Eligibility Determination) to obtain the reported data.
BL 2018 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 level of effort (workload) expended by staff and indicates the efficiency of the agency's operations. It is also a useful tool for assessing future funding needs.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
**Strategy-Related Measures Definitions**

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<td>Avg Number of Standardized Community Serv Case Equivs Per Month (CAS)</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  
**Cross Reference:** Agy 539 084-R-S70-1 01-01-01 OP 13

**BL 2018 Definition**

This measure reports the average number of standardized Community Services and Supports case equivalents per month. A "standardized" Community Services and Supports case equivalent is defined as the amount of monthly work effort associated with a Community Attendant Service (CAS) case. Community Services and Supports workers determine initial and on-going financial eligibility for those individuals with income above the SSI level. They also determine initial and on-going functional eligibility for all Community Services and Supports individuals. In addition, they plan and authorize services for all Community Services and Supports individuals, update service plans as needed, provide case management, and monitor the services delivered by providers.

**BL 2018 Data Limitations**

The amount of time needed to perform the above functions varies significantly depending upon the type of case. Therefore, the commission periodically conducts workload studies in order to develop "relative case weights" based upon the amount of worker time needed per cases, by type of case, so that "standardized" case equivalents can be used to more effectively manage workloads. The information used to develop the case weights for Community Services and Supports was collected September 2000 – June 2001.

**BL 2018 Data Source**

The individual counts (see method of calculation for list of individual populations) are obtained from the commission’s Service Authorization System (SAS) by means of ad hoc query.

**BL 2018 Methodology**

The measure is calculated by using the monthly average number of individuals authorized by Community Services and Supports workers to receive one or more of the following services: Family Care, Primary Home Care, Meals Only, Day Activity and Health Services (DAHS) Only, Foster Care, Special Services to Individuals with Disabilities, Residential Care, Emergency Response Services (ERS) Only, Meals as a second service, ERS as a second service, and DAHS as a second service. The above individual counts by type of service are then multiplied by the appropriate relative case weights derived from the most recent Community Services and Supports workload study to obtain the number of CAS case equivalents.

**BL 2018 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 workload that must be handled by Community Services and Supports workers.

**BL 2019 Definition**
Goal No. 10  Provide Disability Determination Services within SSA Guidelines
Objective No. 1  Increase Decisional Accuracy and Timeliness of Determinations
Strategy No. 1  Determine Federal SSI and SSDI Eligibility
Measure Type  EF
Measure No. 1  Cost Per Disability Case Determination

Calculation Method: N  Target Attainment: N  Priority: N  Cross Reference: Agy 538 084-R-S70-1 03-01-01 EF 01
Key Measure: Y  New Measure: N  Percentage Measure: N

**BL 2018 Definition**
Total DDS expenditures per the financial information system divided by the total number of cases determined as reported by the National Disability Determination Services System.

**BL 2018 Data Limitations**
None

**BL 2018 Data Source**
The National Disability Determination Services System. The NDDSS is the Social Security Administration (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).

**BL 2018 Methodology**
Total DDS expenditures divided by the total number of cases determined. Figures are non-cumulative.

**BL 2018 Purpose**
This measure is intended to calculate the cost per case of determining whether an individual is eligible for benefits when they apply to the Social Security Administration for disability benefits.

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
BL 2019 Purpose
Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 10  
Objective No. 1  
Strategy No. 1  
Measure Type OP  
Measure No. 1  

Provide Disability Determination Services within SSA Guidelines  
Increase Decisional Accuracy and Timeliness of Determinations  
Determine Federal SSI and SSDI Eligibility  
Number of Disability Cases Determined

Calculation Method: C  
Target Attainment:  
Priority:  
Cross Reference: Agy 538 084-R-S70-1 03-01-01 OP 01

Key Measure: Y  
New Measure: N  
Percentage Measure: N

BL 2018 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.

BL 2018 Data Limitations
Data is collected through National Disability Determination Services System.

BL 2018 Data Source
The National Disability Determination Services System. The NDDSS is the Social Security Administration (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).

BL 2018 Methodology
Total number of cases determined and cleared as reported by the National Disability Determination Services System. Figures are cumulative.

BL 2018 Purpose
The purpose of this measure is to determine whether persons who apply to the Social Security Administration for disability benefits are eligible for benefits.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
### Strategy-Related Measures Definitions

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#### Measure No. 1: Number of Completed Provider and Recipient Investigations

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<td>Measure No.</td>
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<td>Number of Completed Provider and Recipient Investigations</td>
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**Calculation Method:** C  
**Target Attainment:** H  
**Priority:** H  

Cross Reference: Agy 529 084-R-S70-1 07-01-01 OP 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

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**BL 2018 Definition**

This is a measure of the Medicaid Program Integrity and the General Investigations sections of Office of Inspector General (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.

**BL 2018 Data Limitations**

No limitations.

**BL 2018 Data Source**

OIG case management systems.

**BL 2018 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.

**BL 2018 Purpose**

This measures the effectiveness of a major activity of OIG. House Bill 2292, 78th Legislature, charged HHSC (OIG) with the investigation and enforcement of fraud, abuse, or waste in health and human services programs.

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**BL 2019 Definition**

This is a measure of the Medicaid Program Integrity and the General Investigations sections of Office of Inspector General (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.

**BL 2019 Data Limitations**

No limitations.

**BL 2019 Data Source**

OIG case management systems.

**BL 2019 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.

**BL 2019 Purpose**

This measures the effectiveness of a major activity of OIG. House Bill 2292, 78th Legislature, charged HHSC (OIG) with the investigation and enforcement of fraud, abuse, or waste in health and human services programs.
Strategy-Related Measures Definitions
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 11 Office of Inspector General
Objective No. 1 Client and Provider Accountability
Strategy No. 1 Office of Inspector General
Measure Type OP
Measure No. 2 Number of Audits and Reviews Performed

Calculation Method: C Target Attainment: H Priority: L
Cross Reference: Agy 529 084-R-S70-1 07-01-01 OP 02
Key Measure: Y New Measure: N Percentage Measure: N

BL 2018 Definition
This measures the total number of programmatic and financial audits and reviews of HHS programs conducted by the Office of Inspector General (OIG). An audit is a programmatic or financial engagement conducted and reported in accordance with Governmental Auditing Standards. A review is an engagement classified as a non-audit service in accordance with Governmental Auditing Standards. Internal audits conducted by Internal Audit departments and in accordance with the Institute of Internal Auditors Standards are not included.

BL 2018 Data Limitations
None.

BL 2018 Data Source
OIG case management systems.

BL 2018 Methodology
Total sum of audits and non-audit engagements conducted.

BL 2018 Purpose
To measure audits and non-audits engagements represents a positive approach to review funded HHS programs.

BL 2019 Definition
This measures the total number of programmatic and financial audits and reviews of HHS programs conducted by the Office of Inspector General (OIG). An audit is a programmatic or financial engagement conducted and reported in accordance with Governmental Auditing Standards. A review is an engagement classified as a non-audit service in accordance with Governmental Auditing Standards. Internal audits conducted by Internal Audit departments and in accordance with the Institute of Internal Auditors Standards are not included.

BL 2019 Data Limitations
None.

BL 2019 Data Source
OIG case management systems.
BL 2019 Methodology
Total sum of audits and non-audit engagements conducted.

BL 2019 Purpose
To measure audits and non-audits engagements represents a positive approach to review funded HHS programs.
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<td>Measure No. 3</td>
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**Calculation Method:** C  
**Target Attainment:** H  
**Priority:** L  
**Cross Reference:** Agy 529 084-R-S70-1 07-01-01 OP 03

**Key Measure:** N  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**  
This is a measure of the number of case mix reviews which are either on-site or desk reviews to assure nursing facilities submit accurate data which reflects actual resident conditions.

**BL 2018 Data Limitations**  
No limitations.

**BL 2018 Data Source**  
Nurse reviewers and/or administrative technicians in the field enter into the agency's database information collected during the on-site reviews. State office staff collects and accumulates information from all regions in a centralized tracking system.

**BL 2018 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.

**BL 2018 Purpose**  
Case mix 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. Case mix reviews also determine the need for corrective action procedures and/or referral to Medicaid Program Integrity.

**BL 2019 Definition**  
This is a measure of the number of case mix reviews which are either on-site or desk reviews to assure nursing facilities submit accurate data which reflects actual resident conditions.

**BL 2019 Data Limitations**  
No limitations.

**BL 2019 Data Source**  
Nurse reviewers and/or administrative technicians in the field enter into the agency's database information collected during the on-site reviews. State office staff collects and accumulates information from all regions in a centralized tracking system.

**BL 2019 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.
BL 2019 Purpose

Case mix 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. Case mix reviews also determine the need for corrective action procedures and/or referral to Medicaid Program Integrity.
**Strategy-Related Measures Definitions**

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### BL 2018 Definition

This is a measure of utilization reviews, which are on site or desk 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. The purpose of utilization review is to detect and correct improper Medicaid billing practices by hospitals.

### BL 2018 Data Limitations

No limitations.

### BL 2018 Data Source

Nurse reviewers and/or administrative assistants in the field enter into the agency's database information collected during the on-site and desk reviews of charts. State office staff collects and accumulates information from all regions in a centralized tracking system.

### BL 2018 Methodology

Nurse reviewers enter data in the field of the application indicating the number of reviews performed, and this data is summed up for the state for the reporting period.

### BL 2018 Purpose

This measure is intended to determine the medical necessity for care, the appropriateness of the DRG assignments, the quality of patient care, and recover inappropriate Medicaid payments. Inpatient utilization reviews are required by public Law 92-603 to be conducted in all Title XIX participating hospitals.

---

### BL 2019 Definition

This is a measure of utilization reviews, which are on site or desk 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. The purpose of utilization review is to detect and correct improper Medicaid billing practices by hospitals.

### BL 2019 Data Limitations

No limitations.

### BL 2019 Data Source

Nurse reviewers and/or administrative assistants in the field enter into the agency's database information collected during the on-site and desk reviews of charts. State office staff collects and accumulates information from all regions in a centralized tracking system.
BL 2019 Methodology
Nurse reviewers enter data in the field of the application indicating the number of reviews performed, and this data is summed up for the state for the reporting period.

BL 2019 Purpose
This measure is intended to determine the medical necessity for care, the appropriateness of the DRG assignments, the quality of patient care, and recover inappropriate Medicaid payments. Inpatient utilization reviews are required by public Law 92-603 to be conducted in all Title XIX participating hospitals.
**Strategy-Related Measures Definitions**
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Agency: **Health and Human Services Commission**

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**Agency: Health and Human Services Commission**

**Goal No. 11 Office of Inspector General**

**Objective No. 1 Client and Provider Accountability**

**Strategy No. 1 Office of Inspector General**

**Measure Type: OP**

**Measure No. 5 Total Dollars Recovered (Millions)**

**Calculation Method:** C  
**Target Attainment:** H  
**Priority:** H  
Cross Reference: Agy 529 084-R-S70-1 07-01-01 OP 05

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

**BL 2018 Definition**

This is a measure of the total monetary recoveries resulting from activities of the Office of Inspector General (OIG) at the end of each quarter and fiscal year. Recoveries include the following departments within OIG: Quality Review, Technology Analysis, Development & Support, Audit, Medicaid Program Integrity, and General Investigations. These recoveries include Dollars actually recovered.

**BL 2018 Data Limitations**

OIG is dependent upon other agencies and vendors for the recovery of some of the funds involved in the measure.

**BL 2018 Data Source**

The sources of data are the OIG case management systems and the claims administrator system and databases. OIG staff collects data on recoveries on a monthly basis, entering the information in the appropriate system and/or database.

**BL 2018 Methodology**

The sum of dollars recovered (Dollars actually recovered) by each section of OIG for the reporting period.

**BL 2018 Purpose**

This measure addresses the efforts of OIG to maximize recoveries in all HHS program. HB 2292, requires that the Commission, through OIG, coordinate investigative efforts to aggressively recover money.

**BL 2019 Definition**

This is a measure of the total monetary recoveries resulting from activities of the Office of Inspector General (OIG) at the end of each quarter and fiscal year. Recoveries include the following departments within OIG: Quality Review, Technology Analysis, Development & Support, Audit, Medicaid Program Integrity, and General Investigations. These recoveries include Dollars actually recovered.

**BL 2019 Data Limitations**

OIG is dependent upon other agencies and vendors for the recovery of some of the funds involved in the measure.

**BL 2019 Data Source**

The sources of data are the OIG case management systems and the claims administrator system and databases. OIG staff collects data on recoveries on a monthly basis, entering the information in the appropriate system and/or database.
BL 2019 Methodology
The sum of dollars recovered (Dollars actually recovered) by each section of OIG for the reporting period.

BL 2019 Purpose
This measure addresses the efforts of OIG to maximize recoveries in all HHS program. HB 2292, requires that the Commission, through OIG, coordinate investigative efforts to aggressively recover money.
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Goal No. 11 Office of Inspector General
Objective No. 1 Client and Provider Accountability
Strategy No. 1 Office of Inspector General
Measure Type OP
Measure No. 6 Total Dollars Saved (Millions)

Calculation Method: C  Target Attainment: H  Priority: H
Cross Reference: Agy 529 084-R-S70-1 07-01-01 OP 06

Key Measure: N  New Measure: N  Percentage Measure: N

**BL 2018 Definition**
This is a measure of the total dollars saved (cost savings) resulting from activities of the Office of Inspector General (OIG) at the end of each quarter and fiscal year. Cost savings, or dollars saved, are defined as documented savings to the state programs. Cost savings may arise from administrative actions/sanctions against a provider or recipient, policy changes initiated at the behest of OIG, and/or education efforts to providers, recipients, consultants, contractors, and vendors.

**BL 2018 Data Limitations**
OIG is dependent upon other agencies and vendors for the implementation of its recommendations, with the exception of training activities.

**BL 2018 Data Source**
Staff within OIG tracks cost savings arising from activities of OIG. The sources of data include: the HHSC Medicaid contracting system; OIG's policy development tracking systems; OIG's training and education databases; and the Medicaid claims administrator. Data is collected on an ongoing basis by staff within OIG and is summarized on a monthly basis.

**BL 2018 Methodology**
The effect of actions taken by OIG is measured against claims payments by the claims administrator and/or other sources during the reporting period. Actions taken can include payment holds put in place due to billing errors or fraud. Subsequently, providers billing patterns are seized or greatly reduced. Actions taken can also be excluding a provider from the Medicaid program for billing errors or fraud and the provider is no longer billing the Medicaid program. The sum of unduplicated cost savings is then calculated for the reporting period.

**BL 2018 Purpose**
This measure addresses the effectiveness of the OIG. It addresses the efforts of OIG in the area of administrative actions and sanctions, policy recommendations and development, and effective education of providers.

**BL 2019 Definition**
This is a measure of the total dollars saved (cost savings) resulting from activities of the Office of Inspector General (OIG) at the end of each quarter and fiscal year. Cost savings, or dollars saved, are defined as documented savings to the state programs. Cost savings may arise from administrative actions/sanctions against a provider or recipient, policy changes initiated at the behest of OIG, and/or education efforts to providers, recipients, consultants, contractors, and vendors.

**BL 2019 Data Limitations**
OIG is dependent upon other agencies and vendors for the implementation of its recommendations, with the exception of training activities.
**BL 2019 Data Source**

Staff within OIG tracks cost savings arising from activities of OIG. The sources of data include: the HHSC Medicaid contracting system; OIG's policy development tracking systems; OIG's training and education databases; and the Medicaid claims administrator. Data is collected on an ongoing basis by staff within OIG and is summarized on a monthly basis.

**BL 2019 Methodology**

The effect of actions taken by OIG is measured against claims payments by the claims administrator and/or other sources during the reporting period. Actions taken can include payment holds put in place due to billing errors or fraud. Subsequently, providers billing patterns are seized or greatly reduced. Actions taken can also be excluding a provider from the Medicaid program for billing errors or fraud and the provider is no longer billing the Medicaid program. The sum of unduplicated cost savings is then calculated for the reporting period.

**BL 2019 Purpose**

This measure addresses the effectiveness of the OIG. It addresses the efforts of OIG in the area of administrative actions and sanctions, policy recommendations and development, and effective education of providers.
Strategy-Related Measures Definitions
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Agency Code: 529  
Agency: Health and Human Services Commission

Goal No. 11 Office of Inspector General
Objective No. 1 Client and Provider Accountability
Strategy No. 1 Office of Inspector General
Measure Type OP
Measure No. 7 Referrals to OAG Fraud Control Unit

Calculation Method: C  
Target Attainment: H  
Priority: H  
Cross Reference: Agy 529 084-R-S70-1 07-01-01 OP 07

Key Measure: N  
New Measure: N  
Percentage Measure: N

BL 2018 Definition
This is a measure of the number of cases of credible allegations of fraud that are referred to the Office of the Attorney General (OAG) for investigation and potential presentation for prosecution.

BL 2018 Data Limitations
No limitations.

BL 2018 Data Source
OIG case management system. All referrals made to the Office of the Attorney General are entered into the case management system and monitored on a monthly basis. Upon acceptance of a referral for investigation, the Office of the Attorney General notifies OIG through a letter of acceptance. OIG staff enters and maintains the status of the referral into the case management system.

BL 2018 Methodology
Sum of cases of credible allegations of fraud referred to the Office of the Attorney General during the reporting period.

BL 2018 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.

BL 2019 Definition
This is a measure of the number of cases of credible allegations of fraud that are referred to the Office of the Attorney General (OAG) for investigation and potential presentation for prosecution.

BL 2019 Data Limitations
No limitations.

BL 2019 Data Source
OIG case management system. All referrals made to the Office of the Attorney General are entered into the case management system and monitored on a monthly basis. Upon acceptance of a referral for investigation, the Office of the Attorney General notifies OIG through a letter of acceptance. OIG staff enters and maintains the status of the referral into the case management system.
BL 2019 Methodology
Sum of cases of credible allegations of fraud referred to the Office of the Attorney General during the reporting period.

BL 2019 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.
Strategy-Related Measures Definitions
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Agency Code: 529
Agency: Health and Human Services Commission

Goal No. 12  HHS Enterprise Oversight and Policy
Objective No. 1  Enterprise Oversight and Policy
Strategy No. 1  Enterprise Oversight and Policy
Measure Type EF
Measure No. 1  Percent of Informal Dispute Resolutions Completed Within 30 Days

Calculation Method: N  Target Attainment:  Priority:  Cross Reference: Agy 529 084-R-S70-1 01-02-01 EF 01
Key Measure: N  New Measure: N  Percentage Measure: Y

BL 2018 Definition
This is a measure of the percentage of Informal Dispute Resolution reviews (IDRs) for nursing facilities and intermediate care facilities for individuals with an intellectual disability or related condition (ICF/IID) completed by HHSC that are completed within the required timeline of 30 calendar days from receipt of the IDR request to the date the final recommendation and rationale is submitted to the provider. The IDR process provides adjudication by an appropriate disinterested person of disputes relating to deficiencies and/or violations cited against a nursing facility, or ICF/IID by the state survey agency.

BL 2018 Data Limitations
Extenuating circumstances that result in delays in IDR completion may need to be identified and such circumstances excluded from the 30 calendar day timeline.

BL 2018 Data Source
The percentage of IDR reviews conducted within the required timeline is determined via an HHSC maintained database, in coordination with state survey agency long-term care regulatory automated system.

BL 2018 Methodology
To calculate the measure, divide the number of IDRs completed within the required timeline by the total number of IDRs completed during the reporting period of the fiscal year.

BL 2018 Purpose
This is a measure of the percentage of Informal Dispute Resolution reviews (IDRs) for nursing facilities and intermediate care facilities for individuals with an intellectual disability or related condition (ICF/IID) completed by HHSC that are completed within the required timeline of 30 calendar days from receipt of the IDR request to the date the final recommendation and rationale is submitted to the provider. The IDR process provides adjudication by an appropriate disinterested person of disputes relating to deficiencies and/or violations cited against a nursing facility, or ICF/IID by the state survey agency.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source
BL 2019 Methodology

BL 2019 Purpose
This is a measure of the percentage of Informal Dispute Resolution reviews (IDRs) for assisted living facilities completed by HHSC that are completed within the required timeline of 90 calendar days from receipt of the IDR request to the date the final recommendation and rationale is submitted to the provider. The IDR process provides adjudication by an appropriate disinterested person of disputes relating to violations cited against an assisted living facility by the state survey agency.

**BL 2018 Data Limitations**

Extenuating circumstances that result in delays in IDR completion may need to be identified and such circumstances excluded from the 90 calendar day timeline.

**BL 2018 Data Source**

The percentage of IDR reviews conducted within the required timeline is determined via an HHSC maintained database, in coordination with state survey agency long-term care regulatory automated system.

**BL 2018 Methodology**

To calculate the measure, divide the number of IDRs completed within the required timeline by the total number of IDRs completed during the reporting period of the fiscal year.

**BL 2018 Purpose**

The IDR process for assisted living facilities, by legislation, should be completed within 90 calendar days of the IDR request. Texas Government Code, §531.058 establishes the 90 calendar day timeframe. Per the Texas Government Code, §311.014, if the due date falls on a Saturday, Sunday or legal holiday, the due date becomes the following business day. IDR due dates that meet this criteria will be recognized the next business day.
BL 2019 Methodology

BL 2019 Purpose
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<th>529</th>
<th>Agency: Health and Human Services Commission</th>
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<tr>
<td>Goal No.</td>
<td>12</td>
<td>HHS Enterprise Oversight and Policy</td>
</tr>
<tr>
<td>Objective No.</td>
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<td>Measure Type</td>
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<tr>
<td>Measure No.</td>
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<td>Number of Rates Determined Annually</td>
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Calculation Method: C  Target Attainment:  Priority: Cross Reference: Agy 529 084-R-S70-1 01-01-01 OP 01
Key Measure: N  New Measure: N  Percentage Measure: N

BL 2018 Definition
The number of rates determined annually for Medicaid and non-Medicaid programs for both acute and long-term care services.

BL 2018 Data Limitations
None.

BL 2018 Data Source
HHSC, financial services and rate analysis. Rates are based on data collected from service vendors.

BL 2018 Methodology
Methodologies specific to various programs.

BL 2018 Purpose
Rates are used to reimburse vendors for services provided.

BL 2019 Definition

BL 2019 Data Limitations

BL 2019 Data Source

BL 2019 Methodology

BL 2019 Purpose
### BL 2018 Definition

This measure calculates the number of initiatives of the HHSC Center for the Elimination of Disproportionality and Disparities (CEDD) central office staff and regional equity specialists. Initiatives include, but are not limited to, providing technical assistance and training; and collaborating across systems and in communities to address disproportionality and disparities within human services, education, juvenile justice, health, mental health and other systems.

### BL 2018 Data Limitations

None.

### BL 2018 Data Source

Monthly reports prepared by CEDD.

### BL 2018 Methodology

This measure is calculated using the monthly reports capturing all initiatives implemented during the reporting period. The number of initiatives implemented each month is summed to yield the reporting period result. An initiative may begin in one reporting period but is only reported for the reporting period when implemented.

### BL 2018 Purpose

This measure provides the count of initiatives implemented by the Center for the Elimination of Disproportionality and Disparities.

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### Agency Code: 529  
Agency: Health and Human Services Commission

<table>
<thead>
<tr>
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BL 2019 Purpose
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<td>Measure Type</td>
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<td>Average Cost Per Sex Offender for Treatment and Supervision</td>
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**Calculation Method:** N  
**Target Attainment:** N  
**Priority:** N  

Cross Reference: Agy 537 084-R-S70-1 07-01-01 EF 01

**Key Measure:** Y  
**New Measure:** N  
**Percentage Measure:** N

---

**BL 2018 Definition**  
The average cost per civilly committed sex offender for treatment and supervision per reporting period, annualized, for all current, civilly committed sex offenders.

**BL 2018 Data Limitations**  
The database provides point-in-time data only; it does not provide the actual amount of time during a reporting period that a civilly committed sex offender received service. Data does not discern that a sex offender was served for only part of a reporting period, rather than the entire reporting period.

**BL 2018 Data Source**  
Civilly Committed Sex Offender database, HHSC financial system. Data is non-cumulative.

**BL 2018 Methodology**  
The average cost per civilly committed sex offender is calculated by taking the expenditures from the HHSC financial system related to the civilly committed sex offenders program for the reporting period and annualizing them, and then dividing them by the number of current, civilly committed sex offenders (excluding those who were in prison for the entire reporting period) as of the last date of the reporting period.

**BL 2018 Purpose**  
Provide the average annual cost of treatment and supervision provided per current, civilly committed sex offender not residing in prison, per reporting period.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**
### Measure No. 1 Number of New Civil Commitments

#### Calculation Method: N

Target Attainment: N  
Priority: N  
Cross Reference: Agy 537 084-R-S70-1 07-01-01 EX 01

Key Measure: Y  
New Measure: N  
Percentage Measure: N

**BL 2018 Definition**

The number of sex offenders who were civilly committed during the reporting period.

**BL 2018 Data Limitations**

None

**BL 2018 Data Source**

Civilly Committed Sex Offender database

**BL 2018 Methodology**

Program will run a report on Corrections Software Solutions that identifies the number of sex offenders that were civilly committed during the reporting period.

**BL 2018 Purpose**

To determine the number of new civil commitment cases for the reporting period.

---

**BL 2019 Definition**

**BL 2019 Data Limitations**

**BL 2019 Data Source**

**BL 2019 Methodology**

**BL 2019 Purpose**
### BL 2018 Definition

The number of current sex offenders who have been civilly committed, receiving treatment and supervision, which have not been in prison for the entire reporting period.

### BL 2018 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).

### BL 2018 Data Source

Civilly Committed Sex Offender database

### BL 2018 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.

### BL 2018 Purpose

To determine the number of current sex offenders who have been civilly committed and are receiving treatment and supervision.

### BL 2019 Definition

### BL 2019 Data Limitations

### BL 2019 Data Source

### BL 2019 Methodology
BL 2019 Purpose