

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 1 of 38

| | |
|------------------|---|
| Agency Code: 529 | Agency: Health and Human Services Commission |
| Goal No. 1 | HHS Enterprise Oversight and Policy |
| Objective No. 1 | Enterprise Oversight and Policy |
| Outcome No. 1 | % Persons Receiving Long-term Care Served in Community-based Settings |

Calculation Method: N **Target Attainment: H** **Priority: M** **Cross Reference: Agy 529 082-R-S70-1 01-01 OC 01**
Key Measure: N **New Measure: N** **Percent Measure: Y**

BL 2014 Definition

This is a measure of the percentage of persons receiving long-term care services in community-based settings.

BL 2014 Data Limitations

The number of persons served will be based on the program data that best represents the number of persons served in the program, usually based on performance measure data. The 'total' number of persons served will not always be the most representative data in programs such as CIDC, which provides a variety of inexpensive ancillary services to large numbers of clients. A small percentage of children in the Medically Dependent Children's program continue to receive services in nursing facilities; however, the percentage is so small that the program should be classified as community-based.

BL 2014 Data Source

The source of data will be reports on the number of persons served from the operating agencies providing long-term care services. Institutional services are provided by the Department of Aging and Disability Services and Department of State Health Services and are defined as services provided in state schools, state mental hospitals, nursing facilities/hospice and ICF-MR facilities. Community services are defined as the services in the Department of Aging and Disability Services' community care objectives: Community Care - Entitlement, Community Care - Waivers, Community Care - State, and Program of All-inclusive Care for the Elderly (PACE) and HHSC's STAR+PLUS program. The Health and Human Services Commission will report the number of persons receiving long-term care services in STAR+PLUS (those formally receiving services in PHC, DAHS and CBA at DADS).

BL 2014 Methodology

1) Determine the number of the persons served in the programs classified as community-based services. 2) Determine the number of the persons served in institutional programs. 3) Divide the number of persons served in programs classified as community-based services (Step 1) by the sum of the persons served in community-based setting (Step 1) and the number of persons served in institutional programs (Step 2) 4) Multiply by 100.

BL 2014 Purpose

Historically, the State of Texas through actions by the Legislature has increased the resources devoted to serving persons with disabilities in community-based settings. In Executive Order GWB 99-2, the Governor of Texas affirmed the value of community-based supports for persons with disabilities as did the U.S. Supreme Court in the Olmstead v. Zimring case. HHSC is implementing a Promoting Independence Initiative to assure that the state moves deliberately and decisively toward a system of services and supports that fosters independence and provides meaningful opportunities for people with disabilities to live productive lives in their home communities, for those who choose to do so.

BL 2015 Definition

This is a measure of the percentage of persons receiving long-term care services in community-based settings.

BL 2015 Data Limitations

The number of persons served will be based on the program data that best represents the number of persons served in the program, usually based on performance measure data. The 'total' number of persons served will not always be the most representative data in programs such as CIDC, which provides a variety of inexpensive ancillary services to large numbers of clients. A small percentage of children in the Medically Dependent Children's program continue to receive services in nursing facilities; however, the percentage is so small that the program should be classified as community-based.

BL 2015 Data Source

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012

Time: 7:58:26PM

Page: 2 of 38

The source of data will be reports on the number of persons served from the operating agencies providing long-term care services. Institutional services are provided by the Department of Aging and Disability Services and Department of State Health Services and are defined as services provided in state schools, state mental hospitals, nursing facilities/hospice and ICF-MR facilities. Community services are defined as the services in the Department of Aging and Disability Services' community care objectives: Community Care - Entitlement, Community Care - Waivers, Community Care - State, and Program of All-inclusive Care for the Elderly (PACE) and HHSC's STAR+PLUS program. The Health and Human Services Commission will report the number of persons receiving long-term care services in STAR+PLUS (those formally receiving services in PHC, DAHS and CBA at DADS).

BL 2015 Methodology

1) Determine the number of the persons served in the programs classified as community-based services. 2) Determine the number of the persons served in institutional programs. 3) Divide the number of persons served in programs classified as community-based services (Step 1) by the sum of the persons served in community-based setting (Step 1) and the number of persons served in institutional programs (Step 2) 4) Multiply by 100.

BL 2015 Purpose

Historically, the State of Texas through actions by the Legislature has increased the resources devoted to serving persons with disabilities in community-based settings. In Executive Order GWB 99-2, the Governor of Texas affirmed the value of community-based supports for persons with disabilities as did the U.S. Supreme Court in the Olmstead v. Zimring case. HHSC is implementing a Promoting Independence Initiative to assure that the state moves deliberately and decisively toward a system of services and supports that fosters independence and provides meaningful opportunities for people with disabilities to live productive lives in their home communities, for those who choose to do so.

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 3 of 38

| | |
|------------------|---|
| Agency Code: 529 | Agency: Health and Human Services Commission |
| Goal No. 1 | HHS Enterprise Oversight and Policy |
| Objective No. 1 | Enterprise Oversight and Policy |
| Outcome No. 2 | Average Medicaid and CHIP Children Recipient Months Per Month |

Calculation Method: C **Target Attainment: H** **Priority: H** **Cross Reference: Agy 529 082-R-S70-1 01-01 OC 02**
Key Measure: Y **New Measure: N** **Percent Measure: N**

BL 2014 Definition

This is a measure of the monthly average number of poverty-related children served in Medicaid and CHIP

BL 2014 Data Limitations

None.

BL 2014 Data Source

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

BL 2014 Methodology

Sum the total number of children and newborn perinatal clients from the CHIP enrollment report with the total number of poverty-related 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 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 2014 Purpose

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

BL 2015 Definition

This is a measure of the monthly average number of poverty-related children served in Medicaid and CHIP

BL 2015 Data Limitations

None.

BL 2015 Data Source

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

BL 2015 Methodology

Sum the total number of children and newborn perinatal clients from the CHIP enrollment report with the total number of poverty-related 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 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 2015 Purpose

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

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 4 of 38

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

Goal No. 2 Medicaid

Objective No. 1 Medicaid Health Services

Outcome No. 1 Average Medicaid Acute Care Recipient Months Per Month

Calculation Method: N **Target Attainment:** H **Priority:** H **Cross Reference:** Agy 529 082-R-S70-1 02-01 OC 02

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

BL 2014 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 2014 Data Limitations

None

BL 2014 Data Source

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

BL 2014 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 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 2014 Purpose

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

BL 2015 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 2015 Data Limitations

None

BL 2015 Data Source

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

BL 2015 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 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 2015 Purpose

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 5 of 38

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

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 6 of 38

Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 2 Medicaid
Objective No. 1 Medicaid Health Services
Outcome No. 2 Average Medicaid Acute Care Cost Per Recipient Month

Calculation Method: N **Target Attainment:** L **Priority:** H **Cross Reference:** Agy 529 082-R-S70-1 02-01 OC 02
Key Measure: N **New Measure:** N **Percent Measure:** N

BL 2014 Definition

Average Medicaid Acute Care Cost per Recipient Month (for managed care and non-managed care combined) is the average amount paid for acute care for each recipient month incurred in the Aged and Medicare Related, Disability, Pregnant Women, Other Adults, and Children strategies.

BL 2014 Data Limitations

None

BL 2014 Data Source

Data sources for this measure are the monthly STMR/STRR 650/750 statistical reports compiled by the state Medicaid contractor, the Premium Payable System, and HMO rates. Dollars exclude costs for Texas Health Steps Dental, Prescription Drug, Medical Transportation Program, and Star+Plus Long-Term Support and Services.

BL 2014 Methodology

For a quarterly or annual weighted cost per recipient month, sum the Medicaid acute care dollars for given time period. Sum acute care recipient months for same time period. Quarterly or annual weighted cost per recipient month is therefore equal to total statewide dollar amounts for time period divided by total statewide recipient months for time period. Recipient months are derived from Premium Payable System. For more recent months of data, appropriate completion factors shall be applied in order to generate total incurables. Cost estimates shall be based on statistical reports that depict claim cost and/or encounter information (the STMR/STRR 650/750 reports furnished by the state Medicaid contractor) and HMO rates. Dollars come from Star HMO, PCCM (prior to March 2012), Star+Plus, STAR Health, and Fee-For-Service programs. Data is on an incurred basis. Forecasting models and trends are used to project future expenditures & recipient months.

BL 2014 Purpose

This measure determines the average cost per recipient month.

BL 2015 Definition

Average Medicaid Acute Care Cost per Recipient Month (for managed care and non-managed care combined) is the average amount paid for acute care for each recipient month incurred in the Aged and Medicare Related, Disability, Pregnant Women, Other Adults, and Children strategies.

BL 2015 Data Limitations

None

BL 2015 Data Source

Data sources for this measure are the monthly STMR/STRR 650/750 statistical reports compiled by the state Medicaid contractor, the Premium Payable System, and HMO rates. Dollars exclude costs for Texas Health Steps Dental, Prescription Drug, Medical Transportation Program, and Star+Plus Long-Term Support and Services.

BL 2015 Methodology

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012

Time: 7:58:26PM

Page: 7 of 38

For a quarterly or annual weighted cost per recipient month, sum the Medicaid acute care dollars for given time period. Sum acute care recipient months for same time period. Quarterly or annual weighted cost per recipient month is therefore equal to total statewide dollar amounts for time period divided by total statewide recipient months for time period. Recipient months are derived from Premium Payable System. For more recent months of data, appropriate completion factors shall be applied in order to generate total incurables. Cost estimates shall be based on statistical reports that depict claim cost and/or encounter information (the STMR/STRR 650/750 reports furnished by the state Medicaid contractor) and HMO rates. Dollars come from Star HMO, PCCM (prior to March 2012), Star+Plus, STAR Health, and Fee-For-Service programs. Data is on an incurred basis. Forecasting models and trends are used to project future expenditures & recipient months.

BL 2015 Purpose

This measure determines the average cost per recipient month.

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 8 of 38

Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 2 Medicaid
Objective No. 1 Medicaid Health Services
Outcome No. 3 Percent of Eligible Clients Receiving Acute Care Services

Calculation Method: N **Target Attainment:** H **Priority:** H **Cross Reference:** Agy 529 082-R-S70-1 01-01 OC 02
Key Measure: N **New Measure:** N **Percent Measure:** Y

BL 2014 Definition

Percent of eligible clients receiving acute care services.

BL 2014 Data Limitations

None.

BL 2014 Data Source

Premium Payable System for caseload and the MSIS report for population. (In January of each year, the MSIS data is complete for the previous federal fiscal year.)

BL 2014 Methodology

This measure is the percentage of the eligibles who actually receive acute care services, also referred to as the utilization rate. It indicates the annual unduplicated number of eligibles who actually received services divided by the annual unduplicated number of eligibles.

BL 2014 Purpose

Measures the percent of eligible clients receiving acute care services.

BL 2015 Definition

Percent of eligible clients receiving acute care services.

BL 2015 Data Limitations

None.

BL 2015 Data Source

Premium Payable System for caseload and the MSIS report for population. (In January of each year, the MSIS data is complete for the previous federal fiscal year.)

BL 2015 Methodology

This measure is the percentage of the eligibles who actually receive acute care services, also referred to as the utilization rate. It indicates the annual unduplicated number of eligibles who actually received services divided by the annual unduplicated number of eligibles.

BL 2015 Purpose

Measures the percent of eligible clients receiving acute care services.

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 9 of 38

Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 2 Medicaid
Objective No. 1 Medicaid Health Services
Outcome No. 4 Percent of 100% Poverty Population Covered by Acute Care Services

Calculation Method: N **Target Attainment: H** **Priority: H** **Cross Reference: Agy 529 082-R-S70-1 01-01 OC 02**
Key Measure: N **New Measure: N** **Percent Measure: Y**

BL 2014 Definition

This measure is the percentage of people in Texas at or below 100% of the Federal Poverty Income Level (FPIL) that are covered by acute care services.

BL 2014 Data Limitations

None.

BL 2014 Data Source

The Premium Payable System for recipient months. Poverty figures are derived from census survey data.

BL 2014 Methodology

The percentage is derived from the average number of recipient months for individuals eligible for acute care services divided by the estimated number of persons at or below 100% of the FPIL. When calculating the end of year figure, the average number of months is the sum of the monthly recipient month counts divided by the number of months summed.

BL 2014 Purpose

This measure is the percentage of people in Texas at or below 100% of the Federal Poverty Income Level (FPIL) that are covered by acute care services.

BL 2015 Definition

This measure is the percentage of people in Texas at or below 100% of the Federal Poverty Income Level (FPIL) that are covered by acute care services.

BL 2015 Data Limitations

None.

BL 2015 Data Source

The Premiums Payable System for recipient months. Poverty figures are derived from census survey data.

BL 2015 Methodology

The percentage is derived from the average number of recipient months for individuals eligible for acute care services divided by the estimated number of persons at or below 100% of the FPIL. When calculating the end of year figure, the average number of months is the sum of the monthly recipient month counts divided by the number of months summed.

BL 2015 Purpose

This measure is the percentage of people in Texas at or below 100% of the Federal Poverty Income Level (FPIL) that are covered by acute care services.

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 10 of 38

| | |
|------------------|---|
| Agency Code: 529 | Agency: Health and Human Services Commission |
| Goal No. 2 | Medicaid |
| Objective No. 1 | Medicaid Health Services |
| Outcome No. 5 | Average Medicaid Acute Care Child Under 21 Recipient Months Per Month |

Calculation Method: C **Target Attainment: L** **Priority: H** **Cross Reference: Agy 529 082-R-S70-1 01-01 OC 02**

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

BL 2014 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 SSI children and STAR Health.

BL 2014 Data Limitations

None

BL 2014 Data Source

The Premium Payable System.

BL 2014 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 2014 Purpose

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

BL 2015 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 SSI children and STAR Health.

BL 2015 Data Limitations

None

BL 2015 Data Source

The Premium Payable System.

BL 2015 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 2015 Purpose

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 11 of 38

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

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 12 of 38

| | |
|-------------------------|---|
| Agency Code: 529 | Agency: Health and Human Services Commission |
| Goal No. 2 | Medicaid |
| Objective No. 1 | Medicaid Health Services |
| Outcome No. 6 | Average Medicaid Acute Care (including Drug) Cost Per Recipient Month |

Calculation Method: N **Target Attainment: L** **Priority: H** **Cross Reference: Agy 529 082-R-S70-1 02-01 OC 02**

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

BL 2014 Definition

Average Medicaid Acute Care Cost per Recipient Month (for managed care and non-managed care combined) is the average amount paid for acute care for each recipient month incurred in the Aged and Medicare Related, Disability Related, Pregnant Women, Other Adults, or Children strategies.

BL 2014 Data Limitations

This measure involves the recipient months and costs for acute care services. It includes STAR+PLUS Acute Care, but not STAR+PLUS Long Term Care. Data is on an incurred basis. If data is incomplete, estimates will be made based on completion ratios and other forecasting techniques.

BL 2014 Data Source

Data source for this measure are the monthly STMR/STRR 650/750 statistical reports and the MH-series drug reports compiled by the state Medicaid contractor, the Premium Payable System, and HMO rates. Dollars exclude costs for Texas Health Steps Dental, Medical Transportation Program and STAR+PLUS Long Term Care and Support Services.

BL 2014 Methodology

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

BL 2014 Purpose

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

BL 2015 Definition

Average Medicaid Acute Care Cost per Recipient Month (for managed care and non-managed care combined) is the average amount paid for acute care for each recipient month incurred in the Aged and Medicare Related, Disability Related, Pregnant Women, Other Adults, or Children strategies.

BL 2015 Data Limitations

This measure involves the recipient months and costs for acute care services. It includes STAR+PLUS Acute Care, but not STAR+PLUS Long Term Care. Data is on an incurred basis. If data is incomplete, estimates will be made based on completion ratios and other forecasting techniques.

BL 2015 Data Source

Data source for this measure are the monthly STMR/STRR 650/750 statistical reports and the MH-series drug reports compiled by the state Medicaid contractor, the Premium Payable System, and HMO rates. Dollars exclude costs for Texas Health Steps Dental, Medical Transportation Program and STAR+PLUS Long Term Care and Support Services.

BL 2015 Methodology

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

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 13 of 38

BL 2015 Purpose

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

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 14 of 38

Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 2 Medicaid
Objective No. 1 Medicaid Health Services
Outcome No. 7 Medicaid Acute Care Rec Months: Proportion in Managed Care

Calculation Method: N **Target Attainment: L** **Priority: H** **Cross Reference: Agy 529 082-R-S70-1 01-01 OC 02**
Key Measure: Y **New Measure: N** **Percent Measure: Y**

BL 2014 Definition

The measure gives the proportion of recipient months for Medicaid clients enrolled in Managed Care plans compared to the total Medicaid Acute Care population during the reporting period. Total Medicaid Acute Care 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 or PCCM (prior to March 2012) programs for the reporting period.

BL 2014 Data Limitations

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

BL 2014 Data Source

The Premium Payable System.

BL 2014 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 2014 Purpose

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

BL 2015 Definition

The measure gives the proportion of recipient months for Medicaid clients enrolled in Managed Care plans compared to the total Medicaid Acute Care population during the reporting period. Total Medicaid Acute Care 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 or PCCM (prior to March 2012) programs for the reporting period.

BL 2015 Data Limitations

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

BL 2015 Data Source

The Premium Payable System.

BL 2015 Methodology

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012

Time: 7:58:26PM

Page: 15 of 38

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 2015 Purpose

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

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 16 of 38

Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 2 Medicaid
Objective No. 1 Medicaid Health Services
Outcome No. 8 Percent of THSTEPS (EPSDT) Eligible Pop. Screened Medicaid - Medical

Calculation Method: N **Target Attainment:** H **Priority:** H **Cross Reference:** Agy 529 082-R-S70-1 01-01 OC 02
Key Measure: N **New Measure:** N **Percent Measure:** Y

BL 2014 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 2014 Data Limitations

There are several limitations. The data reported only reflects the percentage of medical check-ups reported and completed 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 2014 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 2014 Methodology

The calculation is the result of dividing the number of THSteps eligible children who received at least one initial or periodic medical check-up by the number of children who should have received at least one medical check-up. To calculate the denominator, the average period of eligibility (in decimal years) for each age group (<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20) is multiplied by the recommended number of check-ups for the age group and then by the number of THSteps eligible children in the age group. The resulting numbers of children by age group who should have received a check-up are summed. The numerator is an unduplicated count of THSteps eligible children who received one or more documented check-ups.

BL 2014 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 eligibles 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 eligible.

BL 2015 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 2015 Data Limitations

There are several limitations. The data reported only reflects the percentage of medical check-ups reported and completed 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 2015 Data Source

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012

Time: 7:58:26PM

Page: 17 of 38

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 2015 Methodology

The calculation is the result of dividing the number of THSteps eligible children who received at least one initial or periodic medical check-up by the number of children who should have received at least one medical check-up. To calculate the denominator, the average period of eligibility (in decimal years) for each age group (<1, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20) is multiplied by the recommended number of check-ups for the age group and then by the number of THSteps eligible children in the age group. The resulting numbers of children by age group who should have received a check up are summed. The numerator is an unduplicated count of THSteps eligible children who received one or more documented check-ups.

BL 2015 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 eligibles 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 eligible.

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012

Time: 7:58:26PM

Page: 18 of 38

| | |
|------------------|--|
| Agency Code: 529 | Agency: Health and Human Services Commission |
| Goal No. 2 | Medicaid |
| Objective No. 1 | Medicaid Health Services |
| Outcome No. 9 | Avg # of Members Receiving Waiver Services through STAR+PLUS |

Calculation Method: N **Target Attainment:** H **Priority:** H **Cross Reference:** Agy 529 082-R-S70-1 01-01 OC 02

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

BL 2014 Definition

This measure reports the monthly average number of STAR+PLUS members, enrolled in the 1915(c) component of STAR+PLUS, 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 2014 Data Limitations

This measure only includes STAR+PLUS members who are enrolled in the 1915(c) waiver component of STAR+PLUS. This measure does not describe the level, type or amount of community care received by members.

BL 2014 Data Source

The Premiums Payable System.

BL 2014 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 2014 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. This data is a useful tool for projecting future funding needs.

BL 2015 Definition

This measure reports the monthly average number of STAR+PLUS members, enrolled in the 1915(c) component of STAR+PLUS, 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 2015 Data Limitations

This measure only includes STAR+PLUS members who are enrolled in the 1915(c) waiver component of STAR+PLUS. This measure does not describe the level, type or amount of community care received by members.

BL 2015 Data Source

The Premiums Payable System.

BL 2015 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 2015 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. This data is a useful tool for projecting future funding needs.

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012

Time: 7:58:26PM

Page: 19 of 38

Agency Code: 529 Agency: Health and Human Services Commission

Goal No. 2 Medicaid

Objective No. 1 Medicaid Health Services

Outcome No. 10 Avg # of Members Receiving Nonwaiver Community Care through STAR+PLUS

Calculation Method: N Target Attainment: H Priority: H Cross Reference: Agy 529 082-R-S70-1 02-01 OC 02

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

BL 2014 Definition

This measure reports the monthly average number of STAR+PLUS members, not enrolled in the 1915(c) component of STAR+PLUS, 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 2014 Data Limitations

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

BL 2014 Data Source

The Premiums Payable System.

BL 2014 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 2014 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. This data is a useful tool for projecting future funding needs.

BL 2015 Definition

This measure reports the monthly average number of STAR+PLUS members, not enrolled in the 1915(c) component of STAR+PLUS, 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 2015 Data Limitations

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

BL 2015 Data Source

The Premiums Payable System.

BL 2015 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 2015 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. This data is a useful tool for projecting future funding needs.

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 20 of 38

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

Goal No. 2 Medicaid

Objective No. 3 Medicaid Support

Outcome No. 1 Percent of Medicaid Eligible Population Served

Calculation Method: N **Target Attainment: H** **Priority: H** **Cross Reference: Agy 529 082-R-S70-1 02-04 OC 01**

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

BL 2014 Definition

This is a measure of the percentage of the population estimated to be eligible for Medicaid that enrolls in the program. Both acute care and long-term care Medicaid programs are included.

BL 2014 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 2014 Data Source

Measure is estimated using demographic (population) surveys such as the Current Population Survey (CPS), the Survey of Income and Program Participation (SIPP), the American Community Survey (ACS) 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 2014 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.

BL 2014 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 2015 Definition

This is a measure of the percentage of the population estimated to be eligible for Medicaid that enrolls in the program. Both acute care and long-term care Medicaid programs are included.

BL 2015 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 2015 Data Source

Measure is estimated using demographic (population) surveys such as the Current Population Survey (CPS), the Survey of Income and Program Participation (SIPP), the American Community Survey (ACS) 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 2015 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.

BL 2015 Purpose

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012

Time: 7:58:26PM

Page: 21 of 38

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.

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012

Time: 7:58:26PM

Page: 22 of 38

Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 2 Medicaid
Objective No. 3 Medicaid Support
Outcome No. 2 Emergency Room Visits Per 1,000 Avg Member Months/Year

Calculation Method: N **Target Attainment:** L **Priority:** H **Cross Reference:** Agy 529 082-R-S70-1 02-04 OC 02

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

BL 2014 Definition

This is to measure Emergency Room Visits per 1,000 Average Member Months/Year in Medicaid Managed Care programs during the reporting period.

BL 2014 Data Limitations

The ER visits are captured using the codes defined here. Other ER visits that are not codes as such are not captured in this measure.

BL 2014 Data Source

HMO encounter Universe, TMHP; 8-months Eligibility Files, HHSC.

BL 2014 Methodology

Population: Medicaid clients enrolled in STAR, STAR HEALTH and STAR+PLUS programs.

Member Months: All member months for the measurement year.

Emergency Department Visits*: Institutional encounters with CPT codes 99281-99285, or UB revenue code 045x, or UB revenue code 0981, or CPT codes 10040-69979 with Place of Service 23. Count multiple ED visits on the same date of service as one visit. An unduplicated visit is identified using the client number and date of service.

Calculation: (Emergency Department Visits*12*1,000) / (member months)

BL 2014 Purpose

Measures emergency room visits per 1000 average member months per year for clients enrolled in Medicaid Managed Care programs.

BL 2015 Definition

This is to measure Emergency Room Visits per 1,000 Average Member Months/Year in Medicaid Managed Care programs during the reporting period.

BL 2015 Data Limitations

The ER visits are captured using the codes defined here. Other ER visits that are not codes as such are not captured in this measure.

BL 2015 Data Source

HMO encounter Universe, TMHP; 8-months Eligibility Files, HHSC.

BL 2015 Methodology

Population: Medicaid clients enrolled in STAR, STAR HEALTH and STAR+PLUS programs.

Member Months: All member months for the measurement year.

Emergency Department Visits*: Institutional encounters with CPT codes 99281-99285, or UB revenue code 045x, or UB revenue code 0981, or CPT codes 10040-69979 with Place of Service 23. Count multiple ED visits on the same date of service as one visit. An unduplicated visit is identified using the client number and date of service.

Calculation: (Emergency Department Visits*12*1,000) / (member months)

BL 2015 Purpose

Measures emergency room visits per 1000 average member months per year for clients enrolled in Medicaid Managed Care programs.

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 23 of 38

| | |
|------------------|---|
| Agency Code: 529 | Agency: Health and Human Services Commission |
| Goal No. 3 | Children's Health Insurance Program Services |
| Objective No. 1 | CHIP Services |
| Outcome No. 1 | Percent of CHIP-eligible Children Enrolled |

Calculation Method: N **Target Attainment: H** **Priority: H** **Cross Reference: Agy 529 082-R-S70-1 03-01 OC 01**

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

BL 2014 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 2014 Data Limitations

None.

BL 2014 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 2014 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 2014 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 2015 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 2015 Data Limitations

None.

BL 2015 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 2015 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 2015 Purpose

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 24 of 38

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.

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version I
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 25 of 38

| | |
|-------------------------|---|
| Agency Code: 529 | Agency: Health and Human Services Commission |
| 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 529 082-R-S70-1 03-01 OC 02**
Key Measure: Y **New Measure: N** **Percent Measure: N**

BL 2014 Definition

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

BL 2014 Data Limitations

None.

BL 2014 Data Source

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

BL 2014 Methodology

Divide the cumulative number of CHIP recipient months (CHIP II and Perinates) 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 2014 Purpose

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

BL 2015 Definition

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

BL 2015 Data Limitations

NONE.

BL 2015 Data Source

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

BL 2015 Methodology

Divide the cumulative number of CHIP recipient months (CHIP II and Perinates) 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 2015 Purpose

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

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 26 of 38

| | |
|------------------|---|
| Agency Code: 529 | Agency: Health and Human Services Commission |
| Goal No. 3 | Children's Health Insurance Program Services |
| Objective No. 1 | CHIP Services |
| Outcome No. 3 | Average CHIP Programs Benefit Cost without Prescription Benefit |

Calculation Method: N **Target Attainment: L** **Priority: H** **Cross Reference: Agy 529 082-R-S70-1 03-01 OC 02**
Key Measure: N **New Measure: N** **Percent Measure: N**

BL 2014 Definition

The measure provides the average monthly benefit cost paid to CHIP enrolled medical (including immunizations and excluding prescription drugs) and dental providers on behalf of all CHIP-enrolled children (which includes CHIP Phase II and CHIP Perinatal). Benefit include amounts paid to health plans, the dental contractor, and HHSC to cover contractor administration.

BL 2014 Data Limitations

Prescription Drug Benefits are excluded from this monthly benefit calculation as they are reported separately.

BL 2014 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 minus the drug capitation portion of the premiums as of 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.

BL 2014 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 Perinates) are totaled for the reporting period. This total is divided by the total number of CHIP-enrolled children (CHIP II and Perinates) 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 2014 Purpose

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

BL 2015 Definition

The measure provides the average monthly benefit cost paid to CHIP enrolled medical (including immunizations and excluding prescription drugs) and dental providers on behalf of all CHIP-enrolled children (which includes CHIP Phase II and CHIP Perinatal). Benefit include amounts paid to health plans, the dental contractor, and HHSC to cover contractor administration.

BL 2015 Data Limitations

Prescription Drug Benefits are excluded from this monthly benefit calculation as they are reported separately.

BL 2015 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 minus the drug capitation portion of the premiums as of 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.

BL 2015 Methodology

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012

Time: 7:58:26PM

Page: 27 of 38

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 Perinates) are totaled for the reporting period. This total is divided by the total number of CHIP-enrolled children (CHIP II and Perinates) 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 2015 Purpose

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

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012

Time: 7:58:26PM

Page: 28 of 38

| | |
|------------------|--|
| Agency Code: 529 | Agency: Health and Human Services Commission |
| Goal No. 3 | Children's Health Insurance Program Services |
| Objective No. 1 | CHIP Services |
| Outcome No. 4 | Average CHIP Programs Benefit Cost with Prescription Benefit |

Calculation Method: N **Target Attainment:** L **Priority:** H **Cross Reference:** Agy 529 082-R-S70-1 03-01 OC 04

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

BL 2014 Definition

The measure provides the average monthly benefit cost paid to 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 DSHS (or successor agency) to cover contractor administration.

BL 2014 Data Limitations

None.

BL 2014 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 FFS is the monthly MH 494 report, provided by the state Medicaid contractor.

BL 2014 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 2014 Purpose

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

BL 2015 Definition

The measure provides the average monthly benefit cost paid to 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 DSHS (or successor agency) to cover contractor administration.

BL 2015 Data Limitations

None.

BL 2015 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 FFS is the monthly MH 494 report, provided by the state Medicaid contractor.

BL 2015 Methodology

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012

Time: 7:58:26PM

Page: 29 of 38

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 2015 Purpose

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

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012

Time: 7:58:26PM

Page: 30 of 38

| | |
|------------------|--|
| Agency Code: 529 | Agency: Health and Human Services Commission |
| Goal No. 4 | Encourage Self Sufficiency |
| Objective No. 1 | Assistance Services |
| Outcome No. 1 | Percent of Total Children in Poverty Receiving TANF & State Assistance |

Calculation Method: N **Target Attainment:** H **Priority:** H **Cross Reference:** Agy 529 082-R-S70-1 04-01 OC 01

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

BL 2014 Definition

This measure reports the number of children receiving TANF and the State Two-Parent Cash Assistance program benefits expressed as a percent of all children in Texas living in poverty.

BL 2014 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 2014 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 2014 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 2014 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 2015 Definition

This measure reports the number of children receiving TANF and the State Two-Parent Cash Assistance program benefits expressed as a percent of all children in Texas living in poverty.

BL 2015 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 2015 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 2015 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 2015 Purpose

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 31 of 38

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).

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 32 of 38

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

Goal No. 4 Encourage Self Sufficiency

Objective No. 1 Assistance Services

Outcome No. 2 Number of Adults Exhausting TANF & State Assistance Benefits

Calculation Method: C **Target Attainment: L** **Priority: H** **Cross Reference: Agy 529 082-R-S70-1 04-01 OC 02**

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

BL 2014 Definition

This measure reports the unduplicated number of adult 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 2014 Data Limitations

None.

BL 2014 Data Source

Ad hoc computer runs using benefit and client eligibility.

BL 2014 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 2014 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 2015 Definition

This measure reports the unduplicated number of adult 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 2015 Data Limitations

None.

BL 2015 Data Source

Ad hoc computer runs using benefit and client eligibility.

BL 2015 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 2015 Purpose

OBJECTIVE OUTCOME DEFINITIONS REPORT

83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 33 of 38

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 OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 34 of 38

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

Goal No. 4 Encourage Self Sufficiency

Objective No. 1 Assistance Services

Outcome No. 3 % TANF Caretakers Leaving Due to Increased Employment Earnings

Calculation Method: N **Target Attainment: H** **Priority: H** **Cross Reference: Agy 529 082-R-S70-1 04-01 OC 03**

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

BL 2014 Definition

This measure reports the number of 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 2014 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 2014 Data Source

Data is obtained from TP400214CTIERSf file.

BL 2014 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 2014 Purpose

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

BL 2015 Definition

This measure reports the number of 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 2015 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 2015 Data Source

Data is obtained from TP400214CTIERSf file.

BL 2015 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 2015 Purpose

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 35 of 38

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

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 36 of 38

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

Goal No. 4 Encourage Self Sufficiency

Objective No. 2 Other Family Support Services

Outcome No. 1 Percent Adult Victims Requesting Shelter Denied Due to Lack of Space

Calculation Method: N **Target Attainment:** L **Priority:** H **Cross Reference:** Agy 529 082-R-S70-1 04-02 OC 01

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

BL 2014 Definition

This measure reports the number of adult victims of family violence who were denied shelter at the time of their request due to lack of space in the shelter they contacted, expressed as a percent of all adult victims of domestic violence who requested shelter. 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 2014 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 2014 Data Source

Data are obtained from the automated Integrated Tracking 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 2014 Methodology

The number of adult victims denied shelter due to lack of space (numerator) is divided by the sum of the number of adult victims denied shelter due to lack of space and the total number of adults receiving residential services (denominator), multiplied by 100.

BL 2014 Purpose

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

BL 2015 Definition

This measure reports the number of adult victims of family violence who were denied shelter at the time of their request due to lack of space in the shelter they contacted, expressed as a percent of all adult victims of domestic violence who requested shelter. 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 2015 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 2015 Data Source

Data are obtained from the automated Integrated Tracking 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 2015 Methodology

The number of adult victims denied shelter due to lack of space (numerator) is divided by the sum of the number of adult victims denied shelter due to lack of space and the total number of adults receiving residential services (denominator), multiplied by 100.

BL 2015 Purpose

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 37 of 38

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

OBJECTIVE OUTCOME DEFINITIONS REPORT
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Date: 7/29/2012
Time: 7:58:26PM
Page: 38 of 38

Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 7 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: C **Target Attainment:** H **Priority:** M **Cross Reference:** Agy 529 082-R-S70-1 07-01 OC 03

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

BL 2014 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 are handled by various programs in OIG.

BL 2014 Data Limitations

No limitations.

BL 2014 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 2014 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 2014 Purpose

This is a measure of the effectiveness of OIG's efforts to maximize recoveries to HHSC programs.

BL 2015 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 are handled by various programs in OIG.

BL 2015 Data Limitations

No Limitation.

BL 2015 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 2015 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 2015 Purpose

This is a measure of the effectiveness of OIG's efforts to maximize recoveries to HHSC programs.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | | 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 | | Average Cost Per Minority Health Initiative Developed |

Calculation Method: C **Target Attainment: L** **Priority: M** Cross Reference: Agy 529 082-R-S70-1 01-01-01 EF 01

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

BL 2014 Definition

This measure is defined as the total Minority Health budget divided by the number of initiatives developed. An initiative is defined as efforts by HHSC central and regional staff that affect minority and disadvantaged populations, improve health status, or preserve the public health throughout the state.

BL 2014 Data Limitations

None

BL 2014 Data Source

HHSC Operating Budget

BL 2014 Methodology

This measure is defined as the total Minority Health budget divided by the number of initiatives developed.

BL 2014 Purpose

Measures the average cost per minority health initiative.

BL 2015 Definition

This measure is defined as the total Minority Health budget divided by the number of initiatives developed. An initiative is defined as efforts by HHSC central and regional staff that affect minority and disadvantaged populations, improve health status, or preserve the public health throughout the state.

BL 2015 Data Limitations

None.

BL 2015 Data Source

HHSC Operating Budget

BL 2015 Methodology

This measure is defined as the total Minority Health budget divided by the number of initiatives developed.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Purpose

Measures the average cost per minority health initiative.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|-------------------------------------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | HHS Enterprise Oversight and Policy | |
| Objective No. | 1 | Enterprise Oversight and Policy | |
| Strategy No. | 1 | Enterprise Oversight and Policy | |
| Measure Type | OP | | |
| Measure No. | 1 | Number of Rates Determined Annually | |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-01 OP 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

The number of rates determined annually for Medicaid and non-Medicaid programs for both acute and long-term care services.

BL 2014 Data Limitations

None.

BL 2014 Data Source

HHSC, Financial Services Division; Rate Analysis Department. Rates are based on data collected from service vendors.

BL 2014 Methodology

Methodologies specific to various programs.

BL 2014 Purpose

Rates are used to reimburse vendors for services provided.

BL 2015 Definition

The number of rates determined annually for Medicaid and non-Medicaid programs for both acute and long-term care services.

BL 2015 Data Limitations

None.

BL 2015 Data Source

HHSC, Financial Services Division; Rate Analysis Department. Rates are based on data collected from service vendors.

BL 2015 Methodology

Methodologies specific to various programs.

BL 2015 Purpose

Rates are used to reimburse vendors for services provided.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---------------------------------------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | HHS Enterprise Oversight and Policy | |
| Objective No. | 1 | Enterprise Oversight and Policy | |
| Strategy No. | 1 | Enterprise Oversight and Policy | |
| Measure Type | OP | | |
| Measure No. | 2 | Number of Guardianship and MMP Grants | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-01 OP 02

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

BL 2014 Definition

This is a measure of the number of local guardianship or money management programs that receive Assistance grants from HHSC.

BL 2014 Data Limitations

No limitations.

BL 2014 Data Source

The data source is monthly and yearly reports from local program grantees. Reports are desk-audited by HHSC.

BL 2014 Methodology

The measure is calculated as a count of programs for which HHSC provides funding during the quarter. A grant made earlier in the fiscal year is assumed to be in effect during any reporting quarter that fiscal year.

BL 2014 Purpose

HHSC is statutorily charged with providing administrative support to the HHSC Guardianship Advisory Board and financial assistance through grants to local guardianship and money management programs. These programs provide essential services to protect the safety and rights of incapacitated individuals in Texas without family funds.

BL 2015 Definition

This is a measure of the number of local guardianship or money management programs that receive Assistance grants from HHSC.

BL 2015 Data Limitations

No Limitations.

BL 2015 Data Source

The data source is monthly and yearly reports from local program grantees. Reports are desk-audited by HHSC.

BL 2015 Methodology

The measure is calculated as a count of programs for which HHSC provides funding during the quarter. A grant made earlier in the fiscal year is assumed to be in effect during any reporting quarter that fiscal year.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Purpose

HHSC is statutorily charged with providing administrative support to the HHSC Guardianship Advisory Board and financial assistance through grants to local guardianship and money management programs. These programs provide essential services to protect the safety and rights of incapacitated individuals in Texas without family funds.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | HHS Enterprise Oversight and Policy | |
| Objective No. | 1 | Enterprise Oversight and Policy | |
| Strategy No. | 1 | Enterprise Oversight and Policy | |
| Measure Type | OP | | |
| Measure No. | 3 | #Minority Health Initiatives Implemented to Address Dispro&Disparities | |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-01 OP 03
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

Efforts by HHSC central and regional staff that impact vulnerable populations, using the Texas Model to increase the number of internal and external stakeholders throughout the state, will be considered as initiatives. Vulnerable populations are defined as "any group of people whose health care needs exceed the average or who are "at greater risk [than the average person] for poor health status and health care access." Internal and external stakeholders include leaders and staff within HHSC and other systems and Institutions serving vulnerable populations, community and faith based organizations, and other members of the community including persons who are recipients of government services.

BL 2014 Data Limitations

None.

BL 2014 Data Source

These initiatives will be identified in periodic reports submitted by the Center for Elimination of Disproportionality and Disparities. Periodic reports are issued monthly to CEDD and quarterly to HHSC and federal funder.

BL 2014 Methodology

The count of initiatives is cumulative for the year.

BL 2014 Purpose

Measures the number of Initiatives implemented.

BL 2015 Definition

Efforts by HHSC central and regional staff that impact vulnerable populations, using the Texas Model to increase the number of internal and external stakeholders throughout the state, will be considered as initiatives. Vulnerable populations are defined as "any group of people whose health care needs exceed the average or who are "at greater risk [than the average person] for poor health status and health care access." Internal and external stakeholders include leaders and staff within HHSC and other systems and Institutions serving vulnerable populations, community and faith based organizations, and other members of the community including persons who are recipients of government services.

BL 2015 Data Limitations

None.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

These initiatives will be identified in periodic reports submitted by the Center for Elimination of Disproportionality and Disparities. Periodic reports are issued monthly to CEDD and quarterly to HHSC and federal funder.

BL 2015 Methodology

The count of initiatives is cumulative for the year.

BL 2015 Purpose

Measures the number of Initiatives implemented.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | | HHS Enterprise Oversight and Policy |
| Objective No. | 1 | | Enterprise Oversight and Policy |
| Strategy No. | 2 | | Integrated Eligibility and Enrollment (IEE) |
| Measure Type | EF | | |
| Measure No. | 1 | | Average Cost Per Eligibility Determination |

Calculation Method: N **Target Attainment: L** **Priority: L** Cross Reference: Agy 529 082-R-S70-1 01-01-02 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the average cost of determining eligibility for TANF and State Two-parent cash assistance, food stamps (SNAP), MEPD, Medicaid, and CHIP. Determining eligibility refers to actions taken to determine the eligibility status of applicants or ongoing cases: approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2014 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 2014 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 2014 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 1-1-2-1OP-1 for the reporting period. Dividing the numerator by the denominator yields the average cost for the period.

BL 2014 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 2015 Definition

This measure reports the average cost of determining eligibility for TANF and State Two-parent cash assistance, food stamps (SNAP), MEPD, Medicaid, and CHIP. Determining eligibility refers to actions taken to determine the eligibility status of applicants or ongoing cases: approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2015 Data Limitations

There may be more than one eligibility determination for a case during the reporting period. Data may be collected from different systems.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 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-IOP-1 for the reporting period. Dividing the numerator by the denominator yields the average cost for the period.

BL 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | HHS Enterprise Oversight and Policy | |
| Objective No. | 1 | Enterprise Oversight and Policy | |
| Strategy No. | 2 | Integrated Eligibility and Enrollment (IEE) | |
| Measure Type | EF | | |
| Measure No. | 2 | Accuracy Rate of Benefits Issued: TANF | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-02 EF 02

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

BL 2014 Definition

This measure reports the percentage of 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 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 2014 Data Limitations

Does not apply.

BL 2014 Data Source

Data are based on the quality control eligibility review, which uses a statewide random sample of TANF benefits.

BL 2014 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 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 2014 Purpose

This measure is an indicator of accountability and efficiency of agency operations as it pertains to the issuance of TANF benefits.

BL 2015 Definition

This measure reports the percentage of 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 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 2015 Data Limitations

Does not apply.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

Data are based on the quality control eligibility review, which uses a statewide random sample of TANF benefits.

BL 2015 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 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 2015 Purpose

This measure is an indicator of accountability and efficiency of agency operations as it pertains to the issuance of TANF benefits.

Strategy-Related Measures Definitions
 83rd Regular Session, SBR, Version 1
 Automated Budget and Evaluation System of Texas (ABEST)

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

| | | |
|---------------|----|---|
| Goal No. | 1 | HHS Enterprise Oversight and Policy |
| Objective No. | 1 | Enterprise Oversight and Policy |
| Strategy No. | 2 | Integrated Eligibility and Enrollment (IEE) |
| Measure Type | EF | |
| Measure No. | 3 | Accuracy Rate of Benefits Issued: SNAP |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-02 EF 03

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

BL 2014 Definition

This measure reports the percentage of SNAP benefits delivered correctly, as determined by the most recent SNAP quality control results for the fiscal year, adjusted for the federal re review regression percentage. "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 both over issuances and under issuances, 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 2014 Data Limitations

For the federal re review process, 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 re reviewed cases to estimate what would have been found had a federal re 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; in Texas, FNS' regression for federal fiscal year 2006 added 0.1%.

BL 2014 Data Source

Data are based on the quality control 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.

BL 2014 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. 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, 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 2014 Purpose

This measure is an indicator of accountability and efficiency of agency operations as it pertains to the issuance of SNAP benefits.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Definition

This measure reports the percentage of SNAP benefits delivered correctly, as determined by the most recent SNAP quality control results for the fiscal year, adjusted for the federal re review regression percentage. "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 both over issuances and under issuances, 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 2015 Data Limitations

For the federal re review process, 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 re reviewed cases to estimate what would have been found had a federal re 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; in Texas, FNS' regression for federal fiscal year 2006 added 0.1%.

BL 2015 Data Source

Data are based on the quality control 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.

BL 2015 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. 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, 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 2015 Purpose

This measure is an indicator of accountability and efficiency of agency operations as it pertains to the issuance of SNAP benefits.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | HHS Enterprise Oversight and Policy | |
| Objective No. | 1 | Enterprise Oversight and Policy | |
| Strategy No. | 2 | Integrated Eligibility and Enrollment (IEE) | |
| Measure Type | EF | | |
| Measure No. | 4 | Percent of Eligibility Decisions Completed on Time | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-02 EF 04
Key Measure: N **New Measure: N** **Percentage Measure: Y**

BL 2014 Definition

This measure is the number of eligibility case decisions that were completed within established timeframes for 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 XIX 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 (SSI), Medical Assistance Only (MAO), Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiaries (SLMB), other LTC ME qualified individuals, and Medicaid Waiver programs.

BL 2014 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 2014 Data Source

Data is obtained from Datamart, the interface for TIERS reporting.

BL 2014 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 2014 Purpose

This measure quantifies timeliness and is an indicator of productivity as it pertains to determining eligibility for Texas Works and MEPD benefits.

BL 2015 Definition

This measure is the number of eligibility case decisions that were completed within established timeframes for 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 XIX 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 (SSI), Medical Assistance Only (MAO), Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiaries (SLMB), other LTC ME qualified individuals, and Medicaid Waiver programs.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Data Source

Data is obtained from Datamart, the interface for TIERS reporting.

BL 2015 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 2015 Purpose

This measure quantifies timeliness and is an indicator of productivity as it pertains to determining eligibility for Texas Works and MEPD benefits.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | HHS Enterprise Oversight and Policy | |
| Objective No. | 1 | Enterprise Oversight and Policy | |
| Strategy No. | 2 | Integrated Eligibility and Enrollment (IEE) | |
| Measure Type | EF | | |
| Measure No. | 5 | Average Cost Per Healthy Marriage Grant | |

Calculation Method: C **Target Attainment: L** **Priority: L** Cross Reference: Agy 529 082-R-S70-1 01-01-02 EF 05
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

The average amount awarded through grant contracts and subcontracts to local and community based organizations for capacity building and pre-marital and healthy marriage services to couples.

BL 2014 Data Limitations

None

BL 2014 Data Source

Program contract database, web portol and copies of contracts and subcontracts.

BL 2014 Methodology

The sum of the amount of all funds awarded by HHSC divided by the number of healthy marriage grant contracts and subcontracts awarded during the reporting period. The data will be obtained using standard data collection procedures, which include but not limited to public outreach, research, and the web portol. The annual amount of all existing awards will be counted in the first quarter and new ones will be added to the cumulative total in subsequent quarters. The denominator is the data in measure 1-1-2-OP-4.

BL 2014 Purpose

To provide information on the dispersal of program funds for capacity building and program services.

BL 2015 Definition

The average amount awarded through grant contracts and subcontracts to local and community based organizations for capacity building and pre-marital and healthy marriage services to couples.

BL 2015 Data Limitations

None

BL 2015 Data Source

Program contract database, web portol and copies of contracts and subcontracts.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Methodology

The sum of the amount of all funds awarded by HHSC divided by the number of healthy marriage grant contracts and subcontracts awarded during the reporting period. The data will be obtained using standard data collection procedures, which include but not limited to public outreach, research, and the web portol. The annual amount of all existing awards will be counted in the first quarter and new ones will be added to the cumulative total in subsequent quarters. The denominator is the data in measure 1-1-2-OP-4.

BL 2015 Purpose

To provide information on the dispersal of program funds for capacity building and program services.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | HHS Enterprise Oversight and Policy | |
| Objective No. | 1 | Enterprise Oversight and Policy | |
| Strategy No. | 2 | Integrated Eligibility and Enrollment (IEE) | |
| Measure Type | EX | | |
| Measure No. | 1 | % Poverty Met by TANF, SNAP, and Medicaid Benefits | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-02 EX 01
Key Measure: N **New Measure: N** **Percentage Measure: Y**

BL 2014 Definition

This measure reports the value of TANF, SNAP and Medicaid benefits that a family of three receives expressed as a percent of the poverty income guideline amount for a three person family.

BL 2014 Data Limitations

Projected poverty income guidelines are subject to change due to changes in the projected Consumer Price Index (CPI).

BL 2014 Data Source

The TANF payment standard is as published in the Texas Works Handbook; the USDA publishes regulations on SNAP allotments; the value of medical benefits is estimated using cost per member per month and the current Federal Poverty Income Guidelines are issued annually by the U.S. Department of Health and Human Services and published in the Federal Register under Rules and Regulations.

BL 2014 Methodology

Data are computed by adding together the maximum monthly TANF grant amount for a family of three, the monthly SNAP allotment for a family of three with no countable income, and the monthly value of Medicaid benefits for a TANF family of three; dividing this total by the federal poverty income guideline amount for a family of three, and then multiplying by 100.

BL 2014 Purpose

This measure quantifies the benefit levels provided through the TANF financial assistance, SNAP and Medicaid programs as compared to federally established poverty levels. Because the receipt of these benefits does not move clients out of poverty, the data reflected by this measure are an indication of unmet need.

BL 2015 Definition

This measure reports the value of TANF, SNAP and Medicaid benefits that a family of three receives expressed as a percent of the poverty income guideline amount for a three person family.

BL 2015 Data Limitations

Projected poverty income guidelines are subject to change due to changes in the projected Consumer Price Index (CPI).

BL 2015 Data Source

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

The TANF payment standard is as published in the Texas Works Handbook; the USDA publishes regulations on SNAP allotments; the value of medical benefits is estimated using cost per member per month and the current Federal Poverty Income Guidelines are issued annually by the U.S. Department of Health and Human Services and published in the Federal Register under Rules and Regulations.

BL 2015 Methodology

Data are computed by adding together the maximum monthly TANF grant amount for a family of three, the monthly SNAP allotment for a family of three with no countable income, and the monthly value of Medicaid benefits for a TANF family of three; dividing this total by the federal poverty income guideline amount for a family of three, and then multiplying by 100.

BL 2015 Purpose

This measure quantifies the benefit levels provided through the TANF financial assistance, SNAP and Medicaid programs as compared to federally established poverty levels. Because the receipt of these benefits does not move clients out of poverty, the data reflected by this measure are an indication of unmet need.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | HHS Enterprise Oversight and Policy | |
| Objective No. | 1 | Enterprise Oversight and Policy | |
| Strategy No. | 2 | Integrated Eligibility and Enrollment (IEE) | |
| Measure Type | EX | | |
| Measure No. | 2 | Total Value of SNAP Benefits Distributed | |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-02 EX 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the total amount (dollar value) of SNAP issued to households that have been determined eligible for benefits.

BL 2014 Data Limitations

This measure does not include costs for administration of the program.

BL 2014 Data Source

Data is obtained from the monthly report, net SNAP Issuances by month prepared by EBT staff.

BL 2014 Methodology

The value of SNAP distributed during the months of the reporting period is totaled. The value of net monthly issuances is calculated by adding authorizations and subtracting cancelled and expunged deposits, and client paybacks.

BL 2014 Purpose

This measure conveys the total amount of SNAP benefits distributed. These benefits are 100 percent federally funded.

BL 2015 Definition

This measure reports the total amount (dollar value) of SNAP issued to households that have been determined eligible for benefits.

BL 2015 Data Limitations

This measure does not include costs for administration of the program.

BL 2015 Data Source

Data is obtained from the monthly report, net SNAP Issuances by month prepared by EBT staff.

BL 2015 Methodology

The value of SNAP distributed during the months of the reporting period is totaled. The value of net monthly issuances is calculated by adding authorizations and subtracting cancelled and expunged deposits, and client paybacks.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Purpose

This measure conveys the total amount of SNAP benefits distributed. These benefits are 100 percent federally funded.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | HHS Enterprise Oversight and Policy | |
| Objective No. | 1 | Enterprise Oversight and Policy | |
| Strategy No. | 2 | Integrated Eligibility and Enrollment (IEE) | |
| Measure Type | EX | | |
| Measure No. | 3 | Percent of Potential Eligible Population Receiving SNAP Benefits | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-02 EX 03
Key Measure: N **New Measure: N** **Percentage Measure: Y**

BL 2014 Definition

This measure reports the number of persons receiving 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 2014 Data Limitations

The population potentially eligible for SNAP is subject to change as updates/revisions to the population estimates and projections become available.

BL 2014 Data Source

Recipient data are from the month-end SNAP Case extract from TIERS. 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 2014 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 2014 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 2015 Definition

This measure reports the number of persons receiving 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 2015 Data Limitations

The population potentially eligible for SNAP is subject to change as updates/revisions to the population estimates and projections become available.

BL 2015 Data Source

Recipient data are from the month-end SNAP Case extract from TIERS. 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | HHS Enterprise Oversight and Policy | |
| Objective No. | 1 | Enterprise Oversight and Policy | |
| Strategy No. | 2 | Integrated Eligibility and Enrollment (IEE) | |
| Measure Type | EX | | |
| Measure No. | 4 | Percent Potential Eligible Population Receiving CPW Medicaid | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-02 EX 04
Key Measure: N **New Measure: N** **Percentage Measure: Y**

BL 2014 Definition

Number of persons receiving services provided by the Children, Pregnant Women and Medically Needy (CPW Medicaid) programs expressed as % of state's population potentially eligible to receive these services. Potential eligibles include: NonTANF elig pregnant women >= age 19 with income at/below 158% of poverty. NonTANF elig pregnant women < age 19 with income at/below 185% of poverty. NonTANF elig infants < age 1 with family income at/below 185% of pov. NonTANF elig children 1 to 6 years are elig if family inc. is at/below 133% of pov. NonTANF elig children age 6 thru 18 are elig if family's income is at/below 100% of pov. Persons in the Medically Needy (MN) group are considered elig if medical bills reduce their family income < the MN income limit so that children < age 19 or pregnant women become Medicaid elig. Persons who would otherwise qualify for TANF but chose not to get TANF or have timed out of TANF may qualify for TANF level Medicaid coverage.

BL 2014 Data Limitations

The population potentially eligible for CPW Medicaid programs is subject to change as updates/revisions to the population estimates and projections become available. Legislation enacted by the Texas Legislature may result in significant changes in the number of individuals receiving Medicaid.

BL 2014 Data Source

Recipient data is pulled from the monthly MED ID FILE FULL. 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 2014 Methodology

Data are computed by totaling the number of children, pregnant women and medically needy persons receiving medical care through CPW Medicaid programs 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 CPW Medicaid recipients. This result is divided by the population potentially eligible for the CPW Medicaid programs, and then multiplied by 100.

BL 2014 Purpose

This measure is an expression of the impact the agency is having on serving the population potentially eligible for services available under the Children, Pregnant Women and Medically Needy (CPW Medicaid) programs. It is an indicator of the percent of need being met.

BL 2015 Definition

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Number of persons receiving services provided by the Children, Pregnant Women and Medically Needy (CPW Medicaid) programs expressed as % of state's population potentially eligible to receive these services. Potential eligibles include: NonTANF elig pregnant women \geq age 19 with income at/below 158% of poverty. NonTANF elig pregnant women $<$ age 19 with income at/below 185% of poverty. NonTANF elig infants $<$ age 1 with family income at/below 185% of pov. NonTANF elig children 1 to 6 years are elig if family inc. is at/below 133% of pov. NonTANF elig children age 6 thru 18 are elig if family's income is at/below 100% of pov. Persons in the Medically Needy (MN) group are considered elig if medical bills reduce their family income $<$ the MN income limit so that children $<$ age 19 or pregnant women become Medicaid elig. Persons who would otherwise qualify for TANF but chose not to get TANF or have timed out of TANF may qualify for TANF level Medicaid coverage.

BL 2015 Data Limitations

The population potentially eligible for CPW Medicaid programs is subject to change as updates/revisions to the population estimates and projections become available. Legislation enacted by the Texas Legislature may result in significant changes in the number of individuals receiving Medicaid.

BL 2015 Data Source

Recipient data is pulled from the monthly MED ID FILE FULL. 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 2015 Methodology

Data are computed by totaling the number of children, pregnant women and medically needy persons receiving medical care through CPW Medicaid programs 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 CPW Medicaid recipients. This result is divided by the population potentially eligible for the CPW Medicaid programs, and then multiplied by 100.

BL 2015 Purpose

This measure is an expression of the impact the agency is having on serving the population potentially eligible for services available under the Children, Pregnant Women and Medically Needy (CPW Medicaid) programs. It is an indicator of the percent of need being met.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | HHS Enterprise Oversight and Policy | |
| Objective No. | 1 | Enterprise Oversight and Policy | |
| Strategy No. | 2 | Integrated Eligibility and Enrollment (IEE) | |
| Measure Type | EX | | |
| Measure No. | 5 | Percent of Direct Delivery Staff with Less than One Year | |

Calculation Method: C **Target Attainment: L** **Priority:** Cross Reference: Agy 529 082-R-S70-1 01-01-02 EX 05
Key Measure: N **New Measure: N** **Percentage Measure: Y**

BL 2014 Definition

This measure reports the percentage of supervisors, workers and clerks with less than one year tenure.

BL 2014 Data Limitations

Only tenure in the current position is counted. The count of eligibility determination staff may differ from actual full-time equivalents.

BL 2014 Data Source

Data are obtained from HRMS database queries.

BL 2014 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 2014 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 2015 Definition

This measure reports the percentage of supervisors, workers and clerks with less than one year tenure.

BL 2015 Data Limitations

Only tenure in the current position is counted. The count of eligibility determination staff may differ from actual full-time equivalents.

BL 2015 Data Source

Data are obtained from HRMS database queries.

BL 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | HHS Enterprise Oversight and Policy | |
| Objective No. | 1 | Enterprise Oversight and Policy | |
| Strategy No. | 2 | Integrated Eligibility and Enrollment (IEE) | |
| Measure Type | OP | | |
| Measure No. | 1 | Average Monthly Number of Eligibility Determinations | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-02 OP 01

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

BL 2014 Definition

This measure reports the average monthly number of eligibility determinations for TANF and State Two Parent Cash Assistance, SNAP, MEPS, Medicaid and CHIP. Determining eligibility refers to actions taken to determine the eligibility status of applicants or ongoing cases: approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2014 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 2014 Data Source

Data are obtained from Datamart.

BL 2014 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 2014 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 2015 Definition

This measure reports the average monthly number of eligibility determinations for TANF and State Two Parent Cash Assistance, SNAP, MEPS, Medicaid and CHIP. Determining eligibility refers to actions taken to determine the eligibility status of applicants or ongoing cases: approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2015 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 2015 Data Source

Data are obtained from Datamart.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | | HHS Enterprise Oversight and Policy |
| Objective No. | 1 | | Enterprise Oversight and Policy |
| Strategy No. | 2 | | Integrated Eligibility and Enrollment (IEE) |
| Measure Type | OP | | |
| Measure No. | 2 | | Avg Number of Eligibility Determinations Per Staff Person Per Month |

Calculation Method: C **Target Attainment: H** **Priority:** Cross Reference: Agy 529 082-R-S70-1 01-01-02 OP 02
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the average monthly number of eligibility determinations for TANF and State Two Parent Cash Assistance, SNAP, MEPD, Medicaid, and CHIP per staff person. Determining eligibility refers to approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2014 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 2014 Data Source

The numerator is the data for 1-1-2-OP-1. The number of staff is from a monthly query of HRMS.

BL 2014 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 2014 Purpose

This measure is useful for comparing eligibility staff workload over time.

BL 2015 Definition

This measure reports the average monthly number of eligibility determinations for TANF and State Two Parent Cash Assistance, SNAP, MEPD, Medicaid, and CHIP per staff person. Determining eligibility refers to approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2015 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 2015 Data Source

The numerator is the data for 1-1-2-OP-1. The number of staff is from a monthly query of HRMS.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

This measure is useful for comparing eligibility staff workload over time.

Strategy-Related Measures Definitions
 83rd Regular Session, SBR, Version 1
 Automated Budget and Evaluation System of Texas (ABEST)

| | |
|-------------------------|---|
| Agency Code: 529 | Agency: Health and Human Services Commission |
| Goal No. | 1 HHS Enterprise Oversight and Policy |
| Objective No. | 1 Enterprise Oversight and Policy |
| Strategy No. | 2 Integrated Eligibility and Enrollment (IEE) |
| Measure Type | OP |
| Measure No. | 3 Average Number of Recipients Per Month: SNAP |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-02 OP 03
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the average monthly number of SNAP recipients. Data include public assistance (PA) and non-public assistance (NPA) recipients. Public assistance recipients are members of households in which all members receive TANF or State Two-Parent Cash Assistance or SSI 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 2014 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 2014 Data Source

Data are obtained from automated monthly reports, SNAP EBT Issuance Household Profile and the SNAP Case extract from TIERS.

BL 2014 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 2014 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 2015 Definition

This measure reports the average monthly number of SNAP recipients. Data include public assistance (PA) and non-public assistance (NPA) recipients. Public assistance recipients are members of households in which all members receive TANF or State Two-Parent Cash Assistance or SSI 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 2015 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 2015 Data Source

Data are obtained from automated monthly reports, SNAP EBT Issuance Household Profile and the SNAP Case extract from TIERS.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | HHS Enterprise Oversight and Policy | |
| Objective No. | 1 | Enterprise Oversight and Policy | |
| Strategy No. | 2 | Integrated Eligibility and Enrollment (IEE) | |
| Measure Type | OP | | |
| Measure No. | 4 | Average Number of Healthy Marriage Grants Awarded | |

Calculation Method: C **Target Attainment: H** **Priority: L** Cross Reference: Agy 529 082-R-S70-1 01-01-02 OP 04
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

The number of grant contracts awarded to community-based and faith-based organizations for capacity building and pre-marital and healthy marriage services.

BL 2014 Data Limitations

None

BL 2014 Data Source

Program contract database, web portol and copies of contracts and subcontracts.

BL 2014 Methodology

The number of healthy marriage grant contracts and subcontracts awarded during the year will be obtained using standard data collection procedures. All existing awards will be counted in the first quarter and new ones will be added to the cumulative total in subsequent quarters.

BL 2014 Purpose

To provide information on the dispersal of program operations for capacity building and services to couples throughout the state.

BL 2015 Definition

The number of grant contracts awarded to community-based and faith-based organizations for capacity building and pre-marital and healthy marriage services.

BL 2015 Data Limitations

None

BL 2015 Data Source

Program contract database, web portol and copies of contracts and subcontracts.

BL 2015 Methodology

The number of healthy marriage grant contracts and subcontracts awarded during the year will be obtained using standard data collection procedures. All existing awards will be counted in the first quarter and new ones will be added to the cumulative total in subsequent quarters.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Purpose

To provide information on the dispersal of program operations for capacity building and services to couples throughout the state.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 1 | | HHS Enterprise Oversight and Policy |
| Objective No. | 2 | | HHS Consolidated System Support Services |
| Strategy No. | 1 | | Consolidated System Support |
| Measure Type | EF | | |
| Measure No. | 1 | | Percent of Informal Dispute Resolutions Completed Within Timeframes |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-02-01 EF 01
Key Measure: N **New Measure: N** **Percentage Measure: Y**

BL 2014 Definition

This is a measure of the percentage of Informal Dispute Resolution reviews (IDRs) 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 decision 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, assisted living facility or intermediate care facility for persons with mental retardation by the state survey agency.

BL 2014 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 2014 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 2014 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 2014 Purpose

The IDR process, by legislation, should be completed within 30 calendar days of the IDR request. Texas Government Code, §531.058 establishes the 30 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 2015 Definition

This is a measure of the percentage of Informal Dispute Resolution reviews (IDRs) 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 decision 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, assisted living facility or intermediate care facility for persons with mental retardation by the state survey agency.

BL 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 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 2015 Purpose

The IDR process, by legislation, should be completed within 30 calendar days of the IDR request. Texas Government Code, §531.058 establishes the 30 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 1 | Aged and Medicare-related Eligibility Group | |
| Measure Type | EF | | |
| Measure No. | 1 | Average Aged and Medicare-Related Acute Cost Per Recipient Month | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-01-01 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

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

BL 2014 Data Limitations

None.

BL 2014 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 HMO capitation rates. Dollars exclude costs for Texas Health Steps dental, prescription drugs, Medical Transportation Program, and STAR+PLUS long term services and supports.

BL 2014 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 2014 Purpose

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

BL 2015 Definition

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

BL 2015 Data Limitations

None.

BL 2015 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 HMO capitation rates. Dollars exclude costs for Texas Health Steps dental, prescription drugs, Medical Transportation Program, and STAR+PLUS long term services and supports.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 1 | Aged and Medicare-related Eligibility Group | |
| Measure Type | EF | | |
| Measure No. | 2 | Avg Cost Per Aged & Medicare-Related Recipient Month: STAR+PLUS LTC | |

Calculation Method: C **Target Attainment:** **Priority:** Cross Reference: Agy 529 082-R-S70-1 02-01-01 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

The average monthly long term care cost per Medicare eligible recipient month in STAR+PLUS managed care. Recipient month is defined as one month's membership (member month) 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.

BL 2014 Data Limitations

Cost data does not include acute care costs.

BL 2014 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 2014 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 2014 Purpose

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

BL 2015 Definition

The average monthly long term care cost per Medicare eligible recipient month in STAR+PLUS managed care. Recipient month is defined as one month's membership (member month) 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.

BL 2015 Data Limitations

Cost data does not include acute care costs.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 1 | Aged and Medicare-related Eligibility Group | |
| Measure Type | OP | | |
| Measure No. | 1 | Average Aged and Medicare-Related Recipient Months Per Month | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-01-01 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

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

BL 2014 Data Limitations

None.

BL 2014 Data Source

The Premiums Payable System.

BL 2014 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 2014 Purpose

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

BL 2015 Definition

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

BL 2015 Data Limitations

None.

BL 2015 Data Source

The Premiums Payable System.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| 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 529 082-R-S70-1 02-01-01 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

The average monthly number of Medicare client recipient months in STAR+PLUS. A recipient month is defined as one month's membership (member month) 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 Health Maintenance Organization (HMO) managed care model.

BL 2014 Data Limitations

None.

BL 2014 Data Source

The Premiums Payable System.

BL 2014 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 2014 Purpose

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

BL 2015 Definition

The average monthly number of Medicare client recipient months in STAR+PLUS. A recipient month is defined as one month's membership (member month) 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 Health Maintenance Organization (HMO) managed care model.

BL 2015 Data Limitations

None.

BL 2015 Data Source

The Premiums Payable System.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 2 | Disability-Related Eligibility Group | |
| Measure Type | EF | | |
| Measure No. | 1 | Average Disability-Related Acute Cost Per Recipient Month | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-01 EF 01

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

BL 2014 Definition

The average monthly expenditure per Disability-Related recipient month.

BL 2014 Data Limitations

None.

BL 2014 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 HMO capitation rates. Dollars exclude costs for Texas Health Steps dental, prescription drugs, Medical Transportation Program, and STAR+PLUS long term support and services.

BL 2014 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 2014 Purpose

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

BL 2015 Definition

The average monthly expenditure per Disability-Related recipient month.

BL 2015 Data Limitations

None.

BL 2015 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 HMO capitation rates. Dollars exclude costs for Texas Health Steps dental, prescription drugs, Medical Transportation Program, and STAR+PLUS long term support and services.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 2 | Disability-Related Eligibility Group | |
| Measure Type | EF | | |
| Measure No. | 2 | Avg Cost/Disability-Related Recipient Month:STAR+PLUS Long Term Care | |

Calculation Method: C **Target Attainment: L** **Priority: L** Cross Reference: Agy 529 082-R-S70-1 02-01-01 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

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 2014 Data Limitations

The allocation of premium to long term care vs. acute care is estimated. The Premium Payment System is based on premium payments and not actual costs.

BL 2014 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 2014 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 2014 Purpose

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

BL 2015 Definition

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 2015 Data Limitations

The allocation of premium to long term care vs. acute care is estimated. The Premium Payment System is based on premium payments and not actual costs.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 2 | Disability-Related Eligibility Group | |
| Measure Type | OP | | |
| Measure No. | 1 | Average Disability-Related Recipient Months Per Month | |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-01-01 OP 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

The average monthly number of Disability-Related recipient months including STAR+PLUS. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

BL 2014 Data Limitations

None.

BL 2014 Data Source

The Premiums Payable System.

BL 2014 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 2014 Purpose

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

BL 2015 Definition

The average monthly number of Disability-Related recipient months including STAR+PLUS. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services.

BL 2015 Data Limitations

None.

BL 2015 Data Source

The Premiums Payable System.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 2 | Disability-Related Eligibility Group | |
| Measure Type | OP | | |
| Measure No. | 2 | Average Disability-Related Recipient Months Per Month: STAR+PLUS | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-01-01 OP 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

The average monthly number of non-Medicare client recipient months in STAR+PLUS. A recipient month is defined as one month's membership (member month) in STAR+PLUS for an individual who is in the non-Medicare category. 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 Health Maintenance Organization (HMO) managed care model.

BL 2014 Data Limitations

None.

BL 2014 Data Source

The Premium's Payable System.

BL 2014 Methodology

Average recipient months per month is calculated by summing the non Medicare STAR+PLUS 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, and retroactive decisions. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

BL 2014 Purpose

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

BL 2015 Definition

The average monthly number of non-Medicare client recipient months in STAR+PLUS. A recipient month is defined as one month's membership (member month) in STAR+PLUS for an individual who is in the non-Medicare category. 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 Health Maintenance Organization (HMO) managed care model.

BL 2015 Data Limitations

None.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

The Premium's Payable System.

BL 2015 Methodology

Average recipient months per month is calculated by summing the non Medicare STAR+PLUS 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, and retroactive decisions. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

BL 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| 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** Cross Reference: Agy 529 082-R-S70-1 02-01-03 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

The average monthly expenditure per Pregnant Women recipient month.

BL 2014 Data Limitations

None.

BL 2014 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 HMO capitation rates. Dollars exclude costs in Texas Health Steps Dental, Medical Transportation Program, and prescription drug.

BL 2014 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 2014 Purpose

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

BL 2015 Definition

The average monthly expenditure per Pregnant Women recipient month.

BL 2015 Data Limitations

None.

BL 2015 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 HMO capitation rates. Dollars exclude costs in Texas Health Steps Dental, Medical Transportation Program, and prescription drug.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 3 | Pregnant Women Eligibility Group | |
| Measure Type | OP | | |
| Measure No. | 1 | Average Pregnant Women Recipient Months Per Month | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-01-03 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 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 2014 Data Limitations

None.

BL 2014 Data Source

The Premiums Payable System.

BL 2014 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 2014 Purpose

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

BL 2015 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 2015 Data Limitations

None.

BL 2015 Data Source

The Premiums Payable System.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 4 | Other Adults Eligibility Group | |
| Measure Type | EF | | |
| Measure No. | 1 | Average TANF-Level Adult Cost Per Recipient Month | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-01-04 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

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

BL 2014 Data Limitations

None.

BL 2014 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 HMO capitation rates. Dollars exclude Texas Health Steps Dental, Medical Transportation Program, and prescription drug.

BL 2014 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 2014 Purpose

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

BL 2015 Definition

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

BL 2015 Data Limitations

None.

BL 2015 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 HMO capitation rates. Dollars exclude Texas Health Steps Dental, Medical Transportation Program, and prescription drug.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 4 | Other Adults Eligibility Group | |
| Measure Type | EF | | |
| Measure No. | 2 | Average Expansion Adult Cost Per Recipient Month | |

Calculation Method: N **Target Attainment:** **Priority:** Cross Reference: Agy 529 082-R-S70-1 02-01-04 EF 02
Key Measure: N **New Measure:** N **Percentage Measure:** N

BL 2014 Definition

The average monthly expenditure per Expansion Adult recipient month. The Expansion Adult group is there population of adults defined in the Affordable Care Act who will become Medicaid eligible as of January 2014.

BL 2014 Data Limitations

None.

BL 2014 Data Source

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

BL 2014 Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates by the number of projected recipient months to be incurred. The measure will include Managed Care & Non Managed Care for the named group. 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 2014 Purpose

This measure reflects the average cost per recipient month for the named group. It will show information expected to be of interest to legislators and the public.

BL 2015 Definition

The average monthly expenditure per Expansion Adult recipient month. The Expansion Adult group is there population of adults defined in the Affordable Care Act who will become Medicaid eligible as of January 2014.

BL 2015 Data Limitations

None.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

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

BL 2015 Methodology

The average monthly expenditure for the named group is calculated by dividing the total estimated dollars from claims and HMO capitation rates by the number of projected recipient months to be incurred. The measure will include Managed Care & Non Managed Care for the named group. 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 2015 Purpose

This measure reflects the average cost per recipient month for the named group. It will show information expected to be of interest to legislators and the public.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| 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 529 082-R-S70-1 02-01-02 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

The average monthly number of 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 2014 Data Limitations

None.

BL 2014 Data Source

The Premium Payable System.

BL 2014 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 2014 Purpose

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

BL 2015 Definition

The average monthly number of 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 2015 Data Limitations

None.

BL 2015 Data Source

The Premium Payable System.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 4 | Other Adults Eligibility Group | |
| Measure Type | OP | | |
| Measure No. | 2 | Average Expansion Adult Recipient Months Per Month | |

Calculation Method: N **Target Attainment:** **Priority:** Cross Reference: Agy 529 082-R-S70-1 02-01-02 OP 02

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

BL 2014 Definition

The average monthly number of Expansion Adult recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. The Expansion Adult group is the population of adults as defined in the Affordable Care Act who will become Medicaid eligible as of January 2014.

BL 2014 Data Limitations

None.

BL 2014 Data Source

Data is obtained from the Premiums Payable System.

BL 2014 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 2014 Purpose

This measure reflects the average cost per recipient month for the named group. It will show information expected to be of interest to legislators and the public.

BL 2015 Definition

The average monthly number of Expansion Adult recipient months. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. The Expansion Adult group is the population of adults as defined in the Affordable Care Act who will become Medicaid eligible as of January 2014.

BL 2015 Data Limitations

None.

BL 2015 Data Source

Data is obtained from the Premiums Payable System.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

This measure reflects the average cost per recipient month for the named group. It will show information expected to be of interest to legislators and the public.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | | Medicaid |
| Objective No. | 1 | | Medicaid Health Services |
| Strategy No. | 5 | | Children Eligibility Group |
| Measure Type | EF | | |
| Measure No. | 1 | | Average Poverty-Related Children Cost Per Recipient Month |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-01-05 EF 03
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 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 2014 Data Limitations

None.

BL 2014 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 HMO capitation rates. Dollars exclude costs for Texas Health Steps Dental, Medical Transportation and prescription drug.

BL 2014 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 SSI kids and STAR Health.). Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

BL 2014 Purpose

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

BL 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Limitations

None.

BL 2015 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 HMO capitation rates. Dollars exclude costs for Texas Health Steps Dental, Medical Transportation and prescription drug.

BL 2015 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 SSI kids and STAR Health.). Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

BL 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 5 | Children Eligibility Group | |
| Measure Type | EF | | |
| Measure No. | 2 | Average STAR Health Foster Care Children Cost Per Recipient Month | |

Calculation Method: C **Target Attainment: L** **Priority: L** Cross Reference: Agy 529 082-R-S70-1 02-01-05 EF 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

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

BL 2014 Data Limitations

None.

BL 2014 Data Source

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

BL 2014 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 2014 Purpose

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

BL 2015 Definition

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

BL 2015 Data Limitations

None.

BL 2015 Data Source

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 5 | Children Eligibility Group | |
| Measure Type | OP | | |
| Measure No. | 1 | Average Poverty-Related Children Recipient Months Per Month | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-01-05 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

The average monthly number of recipient months for clients in the Children strategy, excluding STAR Health children. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. The Children group includes all age-group related children. It does not include SSI children, medically needy children, children in the STAR Health program or members under 19 in the Pregnant Women risk group.

BL 2014 Data Limitations

None.

BL 2014 Data Source

The Premiums Payable System.

BL 2014 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 2014 Purpose

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

BL 2015 Definition

The average monthly number of recipient months for clients in the Children strategy, excluding STAR Health children. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. The Children group includes all age-group related children. It does not include SSI children, medically needy children, children in the STAR Health program or members under 19 in the Pregnant Women risk group.

BL 2015 Data Limitations

None.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

The Premiums Payable System.

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 5 | Children Eligibility Group | |
| Measure Type | OP | | |
| Measure No. | 2 | Average Number of Qualified Alien Recipient Months per Month | |

Calculation Method: N **Target Attainment: H** **Priority: L** Cross Reference: Agy 529 082-R-S70-1 02-01-05 OP 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the average monthly number of recipient months (managed care and non managed care combined) for Medicaid recipients who are Qualified Aliens. Until the passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA), children who legally entered the United States on or after August 22, 1996, were not eligible for CHIP or Medicaid, with certain exceptions, for five years from their date of entry. Prior to May 2010, Texas covered certain qualified alien children under CHIP with 100 percent state funds, if they met all other Medicaid or CHIP eligibility requirements. In May 2010, Texas began drawing federal match for these children and covering children meeting Medicaid eligibility requirements through Medicaid rather than CHIP.

BL 2014 Data Limitations

None.

BL 2014 Data Source

The Premium Payable System.

BL 2014 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 for the three months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months to date 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 2014 Purpose

This measure identifies the average number of recipient months per month for the named group.

BL 2015 Definition

This measure reports the average monthly number of recipient months (managed care and non managed care combined) for Medicaid recipients who are Qualified Aliens. Until the passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA), children who legally entered the United States on or after August 22, 1996, were not eligible for CHIP or Medicaid, with certain exceptions, for five years from their date of entry. Prior to May 2010, Texas covered certain qualified alien children under CHIP with 100 percent state funds, if they met all other Medicaid or CHIP eligibility requirements. In May 2010, Texas began drawing federal match for these children and covering children meeting Medicaid eligibility requirements through Medicaid rather than CHIP.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Limitations

None.

BL 2015 Data Source

The Premium Payable System.

BL 2015 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 for the three months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months to date 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 2015 Purpose

This measure identifies the average number of recipient months per month for the named group.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 1 | Medicaid Health Services | |
| Strategy No. | 5 | Children Eligibility Group | |
| Measure Type | OP | | |
| Measure No. | 3 | Average STAR Health Foster Care Children Recipient Months Per Month | |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-01-05 OP 03
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 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 2014 Data Limitations

None.

BL 2014 Data Source

The Premiums Payable System.

BL 2014 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 2014 Purpose

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

BL 2015 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 2015 Data Limitations

None.

BL 2015 Data Source

The Premiums Payable System.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 1 | Non-Full Benefit Payments | |
| Measure Type | EF | | |
| Measure No. | 1 | Average Emergency Services for Non-citizens Cost Per Recipient Month | |

Calculation Method: C **Target Attainment: L** **Priority: L** Cross Reference: Agy 529 082-R-S70-1 02-02-01 EF 01

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

BL 2014 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 2014 Data Limitations

None.

BL 2014 Data Source

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

BL 2014 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 2014 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 2015 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 2015 Data Limitations

None.

BL 2015 Data Source

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 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
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 1 | Non-Full Benefit Payments | |
| Measure Type | EF | | |
| Measure No. | 2 | Average Women's Health Services Cost Per Recipient Month | |

Calculation Method: C **Target Attainment:** **Priority:** Cross Reference: Agy 529 082-R-S70-1 02-02-01 EF 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the average monthly expenditure per Women's Health Services recipient month as of November 1, 2012, when the state-based program took effect. Prior to this date, this measure reflects the average monthly expenditure per Women's Health Waiver recipient month.

BL 2014 Data Limitations

None.

BL 2014 Data Source

Cost is compiled from the monthly STMR650 statistical report provided by the Medicaid contractor (TMHP). Caseload data comes from the Premium Payable System.

BL 2014 Methodology

The average monthly cost for the named group is calculated by dividing the total estimated dollars from claims by the number of projected incurred recipient months. 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 2014 Purpose

This measure reflects the average amount paid for Women's Health Waiver/Women's Health Service Program for each recipient month.

BL 2015 Definition

This measure reports the average monthly expenditure per Women's Health Services recipient month as of November 1, 2012, when the state-based program took effect. Prior to this date, this measure reflects the average monthly expenditure per Women's Health Waiver recipient month.

BL 2015 Data Limitations

None.

BL 2015 Data Source

Cost is compiled from the monthly STMR650 statistical report provided by the Medicaid contractor (TMHP). Caseload data comes from the Premium Payable System.

BL 2015 Methodology

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

The average monthly cost for the named group is calculated by dividing the total estimated dollars from claims by the number of projected incurred recipient months. 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 2015 Purpose

This measure reflects the average amount paid for Women's Health Waiver/Women's Health Service Program for each recipient month.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 1 | Non-Full Benefit Payments | |
| Measure Type | OP | | |
| Measure No. | 1 | Average Monthly Number of Enrolled Federally Qualified Health Centers | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-02-01 OP 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

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 2014 Data Limitations

None.

BL 2014 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 2014 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 2014 Purpose

Captures the average monthly number of FQHCs and FQHC look-alikes.

BL 2015 Definition

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 2015 Data Limitations

None.

BL 2015 Data Source

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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 2015 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 2015 Purpose

Captures the average monthly number of FQHCs and FQHC look-alikes.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 1 | Non-Full Benefit Payments | |
| Measure Type | OP | | |
| Measure No. | 2 | Average Number of Non-citizens Recipient Months Per Month | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-02-01 OP 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 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 TANF or other medical programs. These persons are undocumented aliens and certain legal permanent resident (LPR) aliens. This measure includes all TP 30 program recipient months.

BL 2014 Data Limitations

None.

BL 2014 Data Source

The Premium Payable System.

BL 2014 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 2014 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 2015 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 TANF or other medical programs. These persons are undocumented aliens and certain legal permanent resident (LPR) aliens. This measure includes all TP 30 program recipient months.

BL 2015 Data Limitations

None.

BL 2015 Data Source

The Premium Payable System.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 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
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 1 | Non-Full Benefit Payments | |
| Measure Type | OP | | |
| Measure No. | 3 | Average Number of Women's Health Services Recipient Months Per Month | |

Calculation Method: C **Target Attainment: H** **Priority: L** Cross Reference: Agy 529 082-R-S70-1 02-02-01 OP 02
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the average monthly number of recipient months for recipients who receive services in the Women's Health Services program as of November 1, 2012, when the state-based program took effect. Prior to this date, this measure reflects the average monthly expenditure per Women's Health Waiver recipient month.

BL 2014 Data Limitations

None.

BL 2014 Data Source

The Premium Payable System.

BL 2014 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. 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 2014 Purpose

This measure reflects the average number of recipient months per month for which a claim or premium is paid for clients in the Women's Health Waiver/Women's Health Services program.

BL 2015 Definition

This measure reports the average monthly number of recipient months for recipients who receive services in the Women's Health Services program as of November 1, 2012, when the state-based program took effect. Prior to this date, this measure reflects the average monthly expenditure per Women's Health Waiver recipient month.

BL 2015 Data Limitations

None.

BL 2015 Data Source

The Premium Payable System.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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. 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 2015 Purpose

This measure reflects the average number of recipient months per month for which a claim or premium is paid for clients in the Women's Health Waiver/Women's Health Services program.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | | Medicaid |
| Objective No. | 2 | | Other Medicaid Services |
| Strategy No. | 2 | | Medicaid Prescription Drugs |
| Measure Type | EF | | |
| Measure No. | 1 | | Average Cost Per Medicaid Prescription |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-02-02 EF 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure is the total Medicaid prescription cost incurred divided by the total number of prescriptions incurred in the reporting period for a given state fiscal year. For historical purposes, CHIP Phase I and Spillover are included.

BL 2014 Data Limitations

The Prescription Drug strategy includes self administered outpatient Medicaid prescriptions paid through pharmacies and administered in the patient's home or nursing home, as well as IV therapies. Prescriptions administered in physician's offices, hospitals, or clinics are not included in this measure. These prescriptions are paid in Medicaid acute care claims. The Vendor Drug dollars do not include any rebates or Clawback expenses.

BL 2014 Data Source

Drug costs and number of prescription claims for drugs paid FFS comes from monthly MH 492 reports provided by the Medicaid contractor. Costs for HMO clients are based on caseload from the Premiums Payable System and capitation rates set by the HHSC Actuarial Analysis Division. Number of prescriptions for HMO clients are pulled from Encounter data.

BL 2014 Methodology

This measure is the total Medicaid prescription cost (for FFS and managed care clients) incurred divided by the total number of prescriptions incurred in the reporting period for a given state fiscal year. 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.

BL 2014 Purpose

Captures the total prescription cost incurred divided by the total number of prescriptions incurred in the reporting period for a given state fiscal year.

BL 2015 Definition

This measure is the total Medicaid prescription cost incurred divided by the total number of prescriptions incurred in the reporting period for a given state fiscal year. For historical purposes, CHIP Phase I and Spillover are included.

BL 2015 Data Limitations

The Prescription Drug strategy includes self administered outpatient Medicaid prescriptions paid through pharmacies and administered in the patient's home or nursing home, as well as IV therapies. Prescriptions administered in physician's offices, hospitals, or clinics are not included in this measure. These prescriptions are paid in Medicaid acute care claims. The Vendor Drug dollars do not include any rebates or Clawback expenses.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

Drug costs and number of prescription claims for drugs paid FFS comes from monthly MH 492 reports provided by the Medicaid contractor. Costs for HMO clients are based on caseload from the Premiums Payable System and capitation rates set by the HHSC Actuarial Analysis Division. Number of prescriptions for HMO clients are pulled from Encounter data.

BL 2015 Methodology

This measure is the total Medicaid prescription cost (for FFS and managed care clients) incurred divided by the total number of prescriptions incurred in the reporting period for a given state fiscal year. 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.

BL 2015 Purpose

Captures the total prescription cost incurred divided by the total number of prescriptions incurred in the reporting period for a given state fiscal year.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---------------------------------------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 2 | Medicaid Prescription Drugs | |
| Measure Type | OP | | |
| Measure No. | 1 | Total Medicaid Prescriptions Incurred | |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-02-02 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the number of Medicaid prescription drugs incurred in the reporting period. For historical purposes, CHIP Phase I and Spillover are included.

BL 2014 Data Limitations

The Prescription Drug strategy includes self administered outpatient Medicaid prescriptions paid through pharmacies and administered in the patient's home or nursing home, as well as IV therapies. Prescriptions administered in physician's offices, hospitals, or clinics are not included in this measure. These prescriptions are paid in Medicaid acute care claims.

BL 2014 Data Source

The number of prescription claims for drugs paid FFS comes from monthly MH-series prescription drug reports provided by the Medicaid contractor. Drug claims for HMO clients is pulled from Encounter data.

BL 2014 Methodology

Total Number of Medicaid Prescriptions equals the number of prescriptions incurred for payment in the reporting period for a given state fiscal year for both FFS and managed care 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 claim counts.

BL 2014 Purpose

This measure reports the number of prescriptions incurred for payment in the reporting period for a given state fiscal year.

BL 2015 Definition

This measure reports the number of Medicaid prescription drugs incurred in the reporting period. For historical purposes, CHIP Phase I and Spillover are included.

BL 2015 Data Limitations

The Prescription Drug strategy includes self administered outpatient Medicaid prescriptions paid through pharmacies and administered in the patient's home or nursing home, as well as IV therapies. Prescriptions administered in physician's offices, hospitals, or clinics are not included in this measure. These prescriptions are paid in Medicaid acute care claims.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

The number of prescription claims for drugs paid FFS comes from monthly MH-series prescription drug reports provided by the Medicaid contractor. Drug claims for HMO clients is pulled from Encounter data.

BL 2015 Methodology

Total Number of Medicaid Prescriptions equals the number of prescriptions incurred for payment in the reporting period for a given state fiscal year for both FFS and managed care 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 claim counts.

BL 2015 Purpose

This measure reports the number of prescriptions incurred for payment in the reporting period for a given state fiscal year.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 3 | Medical Transportation | |
| Measure Type | EF | | |
| Measure No. | 1 | Average Cost Per One-Way Medical Transportation Trip | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-02-03 EF 01

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

BL 2014 Definition

This measure provides an efficiency indication of the cost of providing client transportation services through the Medical Transportation Program.

BL 2014 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 2014 Data Source

The data source is the Medicaid Management Information System (MMIS) Certified Claims Processing System .

BL 2014 Methodology

The average cost is derived by dividing the total cost of services by the number of paid one-way trips.

BL 2014 Purpose

The purpose of this measure is to report the average cost of client transportation trips.

BL 2015 Definition

This measure provides an efficiency indication of the cost of providing client transportation services through the Medical Transportation Program.

BL 2015 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 2015 Data Source

The data source is the Medicaid Management Information System (MMIS) Certified Claims Processing System .

BL 2015 Methodology

The average cost is derived by dividing the total cost of services by the number of paid one-way trips.

BL 2015 Purpose

The purpose of this measure is to report the average cost of client transportation trips.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 3 | Medical Transportation | |
| Measure Type | EF | | |
| Measure No. | 2 | Average Nonemergency Transportation (NEMT) Cost Per Recipient Month | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-02-03 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 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.

BL 2014 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 2014 Data Source

Medicaid data are obtained from the Premiums Payable System (PPS) and the Health and Human Services Administrative System (HHSAS).

BL 2014 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 FRB dollar amounts for the time period divided by the total recipient months for the time period. 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 2014 Purpose

This measure determines the average cost per recipient month.

BL 2015 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.

BL 2015 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 2015 Data Source

Medicaid data are obtained from the Premiums Payable System (PPS) and the Health and Human Services Administrative System (HHSAS).

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 FRB dollar amounts for the time period divided by the total recipient months for the time period. 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 2015 Purpose

This measure determines the average cost per recipient month.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 3 | Medical Transportation | |
| Measure Type | OP | | |
| Measure No. | 1 | Number of Recipient One-way Trips Provided by Medical Transportation | |

Calculation Method: C **Target Attainment: H** **Priority:** Cross Reference: Agy 529 082-R-S70-1 02-02-03 OP 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the number of one way trips provided (paid) by the Medical Transportation Program as reported in the Medicaid Management Information System (MMIS) Certified Claims Processing System.

BL 2014 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 2014 Data Source

The data source is the MMIS Certified Claims Processing System.

BL 2014 Methodology

The number of one-way trips provided (paid) by the Medical Transportation Program as reported in the MMIS Certified Claims Processing System.

BL 2014 Purpose

The purpose of this measure is to report the number of one-way trips provided (paid) by the Medical Transportation Program.

BL 2015 Definition

This measure reports the number of one way trips provided (paid) by the Medical Transportation Program as reported in the Medicaid Management Information System (MMIS) Certified Claims Processing System.

BL 2015 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 2015 Data Source

The data source is the MMIS Certified Claims Processing System.

BL 2015 Methodology

The number of one-way trips provided (paid) by the Medical Transportation Program as reported in the MMIS Certified Claims Processing System.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Purpose

The purpose of this measure is to report the number of one-way trips provided (paid) by the Medical Transportation Program.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 3 | Medical Transportation | |
| Measure Type | OP | | |
| Measure No. | 2 | Average Nonemergency Transportation (NEMT) Recipient Months Per Month | |

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

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

BL 2014 Definition

NEMT Recipient Months per Month is the average monthly number of recipient months for categorically eligible Medicaid recipients (clients through 20 years of age and clients 21 years and older) in the Full Risk Broker's Service Delivery Area.

BL 2014 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 2014 Data Source

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

BL 2014 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 four months retrospective 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 quarterly average is the sum of the recipient months for the three months in the specified quarter divided by three. The year to date average is the sum of the monthly recipient months divided by the number of months summed.

BL 2014 Purpose

The purpose of this measure is to report efficiency indication of the cost of providing nonemergency medical transportation (NEMT) services through a Full Risk Broker (FRB) model.

BL 2015 Definition

NEMT Recipient Months per Month is the average monthly number of recipient months for categorically eligible Medicaid recipients (clients through 20 years of age and clients 21 years and older) in the Full Risk Broker's Service Delivery Area.

BL 2015 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 2015 Data Source

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 four months retrospective 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 quarterly average is the sum of the recipient months for the three months in the specified quarter divided by three. The year to date average is the sum of the monthly recipient months divided by the number of months summed.

BL 2015 Purpose

The purpose of this measure is to report efficiency indication of the cost of providing nonemergency medical transportation (NEMT) services through a Full Risk Broker (FRB) model.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 4 | Health Steps (EPSDT) Dental | |
| Measure Type | EF | | |
| Measure No. | 1 | Avg Cost Per THSteps (EPSDT) Dental Recipient Months Per Month | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-02-04 EF 01

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

BL 2014 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 2014 Data Limitations

None.

BL 2014 Data Source

The STM650 report compiled monthly by the state Medicaid contractor is used for FFS dental costs, and the Premium Payable System and rates set by the HHSC Actuarial Analysis Division is used for DMO dental costs (starting March 2012).

BL 2014 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 2014 Purpose

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

BL 2015 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 2015 Data Limitations

None.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

The STM650 report compiled monthly by the state Medicaid contractor is used for FFS dental costs, and the Premium Payable System and rates set by the HHSC Actuarial Analysis Division is used for DMO dental costs (starting March 2012).

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
 83rd Regular Session, SBR, Version 1
 Automated Budget and Evaluation System of Texas (ABEST)

| | |
|-------------------------|---|
| Agency Code: 529 | Agency: Health and Human Services Commission |
| Goal No. | 2 Medicaid |
| Objective No. | 2 Other Medicaid Services |
| Strategy No. | 4 Health Steps (EPSDT) Dental |
| Measure Type | EX |
| Measure No. | 1 Number of THSteps (EPSDT) Dental Clients Served |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-02 EX 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This is an unduplicated count of the number of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental clients who received at least one THSteps (EPSDT) paid dental or orthodontic service during the reporting period.

BL 2014 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. A limitation is that providers have 90 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.

BL 2014 Data Source

The data source is 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 2014 Methodology

This is an unduplicated count of the number of THSteps(EPSDT) clients who received at least one THSteps (EPSDT) paid dental or orthodontic service during the reporting period.

BL 2014 Purpose

Measures the number of THSteps (EPSDT) dental and orthodontic clients served.

BL 2015 Definition

This is an unduplicated count of the number of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental clients who received at least one THSteps (EPSDT) paid dental or orthodontic service during the reporting period.

BL 2015 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. A limitation is that providers have 90 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

The data source is 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 2015 Methodology

This is an unduplicated count of the number of THSteps (EPSDT) clients who received at least one THSteps (EPSDT) paid dental or orthodontic service during the reporting period.

BL 2015 Purpose

Measures the number of THSteps (EPSDT) dental and orthodontic clients served.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 4 | Health Steps (EPSDT) Dental | |
| Measure Type | OP | | |
| Measure No. | 1 | Average THSteps (EPSDT) Dental Recipient Months Per Month | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-02-04 OP 01

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

BL 2014 Definition

This is the average recipient months per month of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental and/or orthodontic recipient months eligible for at least one THSteps (EPSDT) paid dental or orthodontic service during the reporting period.

BL 2014 Data Limitations

None.

BL 2014 Data Source

The Premium Payable System.

BL 2014 Methodology

Average recipient months per month is calculated by summing the number of THSteps Dental eligible recipient months and dividing by the number of months summed. 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 2014 Purpose

Measures the average number of THSteps (EPSDT) dental or orthodontic recipient months.

BL 2015 Definition

This is the average recipient months per month of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental and/or orthodontic recipient months eligible for at least one THSteps (EPSDT) paid dental or orthodontic service during the reporting period.

BL 2015 Data Limitations

None.

BL 2015 Data Source

The Premium Payable System.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Methodology

Average recipient months per month is calculated by summing the number of THSteps Dental eligible recipient months and dividing by the number of months summed. 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 2015 Purpose

Measures the average number of THSteps (EPSDT) dental or orthodontic recipient months.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 4 | Health Steps (EPSDT) Dental | |
| Measure Type | OP | | |
| Measure No. | 2 | # of THSteps (EPSDT) Active Dent Providers Providing Medicaid Services | |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-03-03 OP 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This is an unduplicated count of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental providers who have provided paid dental services to at least one THSteps (EPSDT) Medicaid eligible client during the state fiscal year.

BL 2014 Data Limitations

The data reported only reflects that number of dental providers who have provided paid dental services. This does not measure access to dental services across the state. Dentists have 90 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, estimations or projections may be included based on available data.

BL 2014 Data Source

The data source HISR301A is generated by the Medicaid Claims Administrator. Other automated systems may replace the current system. The data from this system 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 2014 Methodology

The calculation methodology includes a cumulative unduplicated count of THSteps (EPSDT) dental providers who have provided paid dental services to at least one THSteps (EPSDT) Medicaid eligible client during the state fiscal year.

BL 2014 Purpose

The purpose of the measure is to monitor the unique number of active THSteps (EPSDT) dental providers providing Medicaid services.

BL 2015 Definition

This is an unduplicated count of Texas Health Steps (THSteps) Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental providers who have provided paid dental services to at least one THSteps (EPSDT) Medicaid eligible client during the state fiscal year.

BL 2015 Data Limitations

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

The data reported only reflects that number of dental providers who have provided paid dental services. This does not measure access to dental services across the state. Dentists have 90 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, estimations or projections may be included based on available data.

BL 2015 Data Source

The data source HISR301A is generated by the Medicaid Claims Administrator. Other automated systems may replace the current system. The data from this system 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 2015 Methodology

The calculation methodology includes a cumulative unduplicated count of THSteps (EPSDT) dental providers who have provided paid dental services to at least one THSteps (EPSDT) Medicaid eligible client during the state fiscal year.

BL 2015 Purpose

The purpose of the measure is to monitor the unique number of active THSteps (EPSDT) dental providers providing Medicaid services.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | | Medicaid |
| Objective No. | 2 | | Other Medicaid Services |
| Strategy No. | 5 | | For Clients Dually Eligible for Medicare and Medicaid |
| Measure Type | EF | | |
| Measure No. | 1 | | Average SMIB Premium Per Month |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-01-05 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 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 2014 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 2014 Data Source

Social Security Act and report MF 232-01.

BL 2014 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 2014 Purpose

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

BL 2015 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 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

Social Security Act and report MF 232-01.

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
 83rd Regular Session, SBR, Version 1
 Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | | Medicaid |
| Objective No. | 2 | | Other Medicaid Services |
| Strategy No. | 5 | | For Clients Dually Eligible for Medicare and Medicaid |
| Measure Type | EF | | |
| Measure No. | 2 | | Average Part A Premium Per Month |

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

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

[BL 2014 Definition](#)

[BL 2014 Data Limitations](#)

[BL 2014 Data Source](#)

[BL 2014 Methodology](#)

[BL 2014 Purpose](#)

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 5 | For Clients Dually Eligible for Medicare and Medicaid | |
| Measure Type | EF | | |
| Measure No. | 3 | Avg Qualified Medicare Beneficiaries (QMBs) Cost Per Recipient Month | |

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

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

BL 2014 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 2014 Data Limitations

None.

BL 2014 Data Source

The Premiums Payable System and monthly STMR650 provided by the Medicaid contractor.

BL 2014 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 2014 Purpose

This measure is the average monthly cost for the payment of deductible and coinsurance benefits for Medicare eligible Medicaid clients.

BL 2015 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 2015 Data Limitations

None.

BL 2015 Data Source

The Premiums Payable System and monthly STMR650 provided by the Medicaid contractor.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

This measure is the average monthly cost for the payment of deductible and coinsurance benefits for Medicare eligible Medicaid clients.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 5 | For Clients Dually Eligible for Medicare and Medicaid | |
| Measure Type | OP | | |
| Measure No. | 1 | Average SMIB Recipient Months Per Month | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 02-01-01 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 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 2014 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 2014 Data Source

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

BL 2014 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 2014 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 2015 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 2015 Data Limitations

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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 2015 Data Source

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

BL 2015 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 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 5 | 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 529 082-R-S70-1 01-01-01 OP 01

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

BL 2014 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 2014 Data Limitations

None.

BL 2014 Data Source

Monthly MF 832-01 report, which provides the number of premiums for each month on an incurred basis.

BL 2014 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 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 2014 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 2015 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 2015 Data Limitations

None.

BL 2015 Data Source

Monthly MF 832-01 report, which provides the number of premiums for each month on an incurred basis.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 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 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 2 | Medicaid | |
| Objective No. | 2 | Other Medicaid Services | |
| Strategy No. | 5 | 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: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 01-01-01 OP 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure is the average monthly number of Medicare eligible Medicaid clients who meet the criteria established by federal legislation.

BL 2014 Data Limitations

None.

BL 2014 Data Source

The Premiums Payable System.

BL 2014 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 2014 Purpose

HHSC is required to pay Medicare premiums, deductibles, and coinsurance liabilities for QMBs whose income is at or below certain eligibility criteria. These clients are not eligible for other Title XIX services.

BL 2015 Definition

This measure is the average monthly number of Medicare eligible Medicaid clients who meet the criteria established by federal legislation.

BL 2015 Data Limitations

None.

BL 2015 Data Source

The Premiums Payable System.

BL 2015 Methodology

Strategy-Related Measures Definitions

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

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 2015 Purpose

HHSC is required to pay Medicare premiums, deductibles, and coinsurance liabilities for QMBs whose income is at or below certain eligibility criteria. These clients are not eligible for other Title XIX services.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| 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. | 1 | Children's Health Insurance Program (CHIP) | |
| Measure Type | EF | | |
| Measure No. | 1 | Average CHIP Children Benefit Cost Per Recipient Month | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 03-01-01 EF 01

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

BL 2014 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 CHIP II program for a reporting period.

BL 2014 Data Limitations

None.

BL 2014 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 2014 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 2014 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 2015 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 CHIP II program for a reporting period.

BL 2015 Data Limitations

None.

BL 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| 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. | 1 | Children's Health Insurance Program (CHIP) | |
| Measure Type | OP | | |
| Measure No. | 1 | Average CHIP Children Recipient Months Per Month | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 03-01-01 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

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

BL 2014 Data Limitations

None.

BL 2014 Data Source

Data are obtained from the Administrative Services Contractor. The contractor produces monthly enrollment reports showing cumulative enrollment.

BL 2014 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 2014 Purpose

Measures the average number of Traditional CHIP recipient months.

BL 2015 Definition

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

BL 2015 Data Limitations

None.

BL 2015 Data Source

Data are obtained from the Administrative Services Contractor. The contractor produces monthly enrollment reports showing cumulative enrollment.

BL 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Purpose

Measures the average number of Traditional CHIP recipient months.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| 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: C **Target Attainment: H** **Priority: L** Cross Reference: Agy 529 082-R-S70-1 03-01-04 EF 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

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

BL 2014 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 2014 Data Source

Medicaid/CHIP and Decision Support Database Management 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 2014 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 2014 Purpose

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

BL 2015 Definition

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

BL 2015 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 2015 Data Source

Medicaid/CHIP and Decision Support Database Management 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| 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 | OP | | |
| Measure No. | 1 | Average Perinatal Recipient Months Per Month | |

Calculation Method: N **Target Attainment: H** **Priority:** Cross Reference: Agy 529 082-R-S70-1 03-01-04 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

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

BL 2014 Data Limitations

None.

BL 2014 Data Source

Data are obtained from HHSC Decision Support-Database Management through the enrollment vendor who provides monthly enrollment reports showing cumulative enrollment.

BL 2014 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 2014 Purpose

Captures the average number of CHIP Perinatal recipients month.

BL 2015 Definition

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

BL 2015 Data Limitations

None.

BL 2015 Data Source

Data are obtained from HHSC Decision Support-Database Management through the enrollment vendor who provides monthly enrollment reports showing cumulative enrollment.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

Captures the average number of CHIP Perinatal recipients month.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| 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 Per CHIP Prescription | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 03-01-05 EF 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure is the total CHIP prescription costs (which includes CHIP, Immigrant children, School Employee children, and Perinates) incurred during the reporting period divided by the total number of prescriptions incurred during the reporting period.

BL 2014 Data Limitations

Prescriptions administered in physicians's offices, hospitals, or clinics are not included in this measure but would be included in the capitated rate paid to the CHIP provider.

BL 2014 Data Source

HHSC computer reports 342 and 346.

BL 2014 Methodology

Divide the total CHIP prescription costs incurred during the reporting period by the total number of CHIP prescriptions incurred during the reporting period. The CHIP prescription dollars do not include any rebates.

BL 2014 Purpose

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

BL 2015 Definition

This measure is the total CHIP prescription costs (which includes CHIP, Immigrant children, School Employee children, and Perinates) incurred during the reporting period divided by the total number of prescriptions incurred during the reporting period.

BL 2015 Data Limitations

Prescriptions administered in physicians's offices, hospitals, or clinics are not included in this measure but would be included in the capitated rate paid to the CHIP provider.

BL 2015 Data Source

HHSC computer reports 342 and 346.

BL 2015 Methodology

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Divide the total CHIP prescription costs incurred during the reporting period by the total number of CHIP prescriptions incurred during the reporting period. The CHIP prescription dollars do not include any rebates.

BL 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| 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 | OP | | |
| Measure No. | 1 | Total Number of CHIP Prescriptions | |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 03-01-05 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the number of CHIP prescriptions incurred for CHIP enrolled children (which includes CHIP Phase II and Perinatal clients) for the reporting period.

BL 2014 Data Limitations

Prescriptions administered in physicians' offices, hospitals, or clinics are not included in this measure but would be included in the capitated rate paid to the CHIP provider.

BL 2014 Data Source

Prior to March 2012, the source is the monthly MH 494 statistical report provided by ACS (or subsequent contractor) on a monthly basis. As of the drug carve-in effective March 2012, the prescription count for HMO administered drugs is acquired from Encounter data. Because data are reported on an incurred basis, the most recent prescription counts are completed using completion ratios. Forecasting models and trends are used to project future counts.

BL 2014 Methodology

Number of CHIP Prescriptions is the total number of prescriptions incurred for payment during the reporting period for children enrolled in CHIP (which includes CHIP Phase II and CHIP Perinatal program).

BL 2014 Purpose

This measure reports the number of CHIP prescriptions incurred for payment for the reporting period.

BL 2015 Definition

This measure reports the number of CHIP prescriptions incurred for CHIP enrolled children (which includes CHIP Phase II and Perinatal clients) for the reporting period.

BL 2015 Data Limitations

Prescriptions administered in physicians' offices, hospitals, or clinics are not included in this measure but would be included in the capitated rate paid to the CHIP provider.

BL 2015 Data Source

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Prior to March 2012, the source is the monthly MH 494 statistical report provided by ACS (or subsequent contractor) on a monthly basis. As of the drug carve-in effective March 2012, the prescription count for HMO administered drugs is acquired from Encounter data. Because data are reported on an incurred basis, the most recent prescription counts are completed using completion ratios. Forecasting models and trends are used to project future counts.

BL 2015 Methodology

Number of CHIP Prescriptions is the total number of prescriptions incurred for payment during the reporting period for children enrolled in CHIP (which includes CHIP Phase II and CHIP Perinatal program).

BL 2015 Purpose

This measure reports the number of CHIP prescriptions incurred for payment for the reporting period.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 1 | Assistance Services | |
| Strategy No. | 1 | Temporary Assistance for Needy Families Grants | |
| Measure Type | EF | | |
| Measure No. | 1 | Average Monthly Grant: TANF Basic Cash Assistance | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-01-01 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the dollar amount of the average monthly TANF grant per recipient for the federally funded TANF program. The TANF program provides a monthly financial assistance payment to eligible families with children and with no or one certified adult.

BL 2014 Data Limitations

Data are incomplete at initial reporting due to cancellations and supplemental payments.

BL 2014 Data Source

Data is obtained from the "TANF Warrant History" file.

BL 2014 Methodology

This measure is calculated by dividing the total dollar amount of grants to TANF recipients in reporting period by total number of TANF 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 2014 Purpose

This measure provides the unit cost of one of the service components funded under this strategy.

BL 2015 Definition

This measure reports the dollar amount of the average monthly TANF grant per recipient for the federally funded TANF program. The TANF program provides a monthly financial assistance payment to eligible families with children and with no or one certified adult.

BL 2015 Data Limitations

Data are incomplete at initial reporting due to cancellations and supplemental payments.

BL 2015 Data Source

Data is obtained from the "TANF Warrant History" file.

BL 2015 Methodology

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

This measure is calculated by dividing the total dollar amount of grants to TANF recipients in reporting period by total number of TANF 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 2015 Purpose

This measure provides the unit cost of one of the service components funded under this strategy.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 1 | Assistance Services | |
| Strategy No. | 1 | Temporary Assistance for Needy Families Grants | |
| Measure Type | EF | | |
| Measure No. | 2 | Average Monthly Grant: State Two-Parent Cash Assistance Program | |

Calculation Method: N **Target Attainment: L** **Priority:** Cross Reference: Agy 529 082-R-S70-1 04-01-01 EF 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 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 2014 Data Limitations

Data are incomplete at initial reporting due to cancellations and supplemental payments.

BL 2014 Data Source

Data is obtained from the 'TANF Warrant History' file.

BL 2014 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 2014 Purpose

This measure provides the unit cost of one of the service components funded under this strategy.

BL 2015 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 2015 Data Limitations

Data are incomplete at initial reporting due to cancellations and supplemental payments.

BL 2015 Data Source

Data is obtained from the 'TANF Warrant History' file.

BL 2015 Methodology

Strategy-Related Measures Definitions

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

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 2015 Purpose

This measure provides the unit cost of one of the service components funded under this strategy.

Strategy-Related Measures Definitions
 83rd Regular Session, SBR, Version 1
 Automated Budget and Evaluation System of Texas (ABEST)

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

| | | |
|---------------|----|---|
| Goal No. | 4 | Encourage Self Sufficiency |
| Objective No. | 1 | Assistance Services |
| Strategy No. | 1 | Temporary Assistance for Needy Families Grants |
| Measure Type | EX | |
| Measure No. | 1 | % of Potential Eligible Population Receiving TANF/State Cash Assist |

| | | | |
|------------------------------|-----------------------------|------------------------------|---|
| Calculation Method: N | Target Attainment: H | Priority: H | Cross Reference: Agy 529 082-R-S70-1 04-01-01 EX 01 |
| Key Measure: N | New Measure: N | Percentage Measure: Y | |

BL 2014 Definition

This measure reports the monthly average number of TANF recipients expressed as a percent of the state's population potentially eligible to receive TANF and State Two Parent Cash Assistance benefits. The population potentially eligible for TANF is comprised of persons at or below 100% of poverty in families with children under age 18 who are deprived of parental support due to the absence and/or disability of the parent(s). The population potentially eligible for State Two Parent Cash Assistance is defined as persons at or below 100% of poverty in families with children under age 18 who are deprived of parental support due to the unemployment of the parent(s).

BL 2014 Data Limitations

The estimated potential eligible population is subject to change as a result of updates/revisions to the population estimates and projections.

BL 2014 Data Source

Recipient data are from ad hoc runs against the TANF Warrant history file. The population potentially eligible for TANF and State Two Parent Cash Assistance 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 2014 Methodology

This measure is computed by totaling the number of TANF and State Two Parent Cash Assistance recipient months in the reporting period and dividing by the number of months in the reporting period. This result is divided by the number of persons potentially eligible for TANF, and then multiplied by 100 to obtain the percent of potentially eligible population receiving TANF and State Two Parent Cash Assistance.

BL 2014 Purpose

This measure is an expression of the impact the agency is having on reaching and serving the population potentially eligible to receive TANF and State Two-Parent Cash Assistance grant services. It is an indicator of the percent of need being met.

BL 2015 Definition

This measure reports the monthly average number of TANF recipients expressed as a percent of the state's population potentially eligible to receive TANF and State Two Parent Cash Assistance benefits. The population potentially eligible for TANF is comprised of persons at or below 100% of poverty in families with children under age 18 who are deprived of parental support due to the absence and/or disability of the parent(s). The population potentially eligible for State Two Parent Cash Assistance is defined as persons at or below 100% of poverty in families with children under age 18 who are deprived of parental support due to the unemployment of the parent(s).

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Limitations

The estimated potential eligible population is subject to change as a result of updates/revisions to the population estimates and projections.

BL 2015 Data Source

Recipient data are from ad hoc runs against the TANF Warrant history file. The population potentially eligible for TANF and State Two Parent Cash Assistance 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 2015 Methodology

This measure is computed by totaling the number of TANF and State Two Parent Cash Assistance recipient months in the reporting period and dividing by the number of months in the reporting period. This result is divided by the number of persons potentially eligible for TANF, and then multiplied by 100 to obtain the percent of potentially eligible population receiving TANF and State Two Parent Cash Assistance.

BL 2015 Purpose

This measure is an expression of the impact the agency is having on reaching and serving the population potentially eligible to receive TANF and State Two-Parent Cash Assistance grant services. It is an indicator of the percent of need being met.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 1 | Assistance Services | |
| Strategy No. | 1 | Temporary Assistance for Needy Families Grants | |
| Measure Type | OP | | |
| Measure No. | 1 | Average Number of TANF Basic Cash Assistance Recipients Per Month | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-01-01 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the monthly average number of persons who received a TANF grant from the federally funded TANF program during the reporting period. The TANF program provides a monthly financial assistance payment to low income families with children and with no or one certified parent.

BL 2014 Data Limitations

None.

BL 2014 Data Source

Data is obtained from the "TANF Warrant History" file.

BL 2014 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 2014 Purpose

This measure provides an average monthly count of persons receiving federally funded TANF cash assistance.

BL 2015 Definition

This measure reports the monthly average number of persons who received a TANF grant from the federally funded TANF program during the reporting period. The TANF program provides a monthly financial assistance payment to low income families with children and with no or one certified parent.

BL 2015 Data Limitations

None.

BL 2015 Data Source

Data is obtained from the "TANF Warrant History" file.

BL 2015 Methodology

Strategy-Related Measures Definitions

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

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 2015 Purpose

This measure provides an average monthly count of persons receiving federally funded TANF cash assistance.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 1 | Assistance Services | |
| 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: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-01-01 OP 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 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 2014 Data Limitations

None.

BL 2014 Data Source

Data is obtained from the 'TANF Warrant History' file

BL 2014 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 2014 Purpose

This measure provides an average monthly count of persons receiving State-paid two parent TANF cash assistance.

BL 2015 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 2015 Data Limitations

None.

BL 2015 Data Source

Data is obtained from the 'TANF Warrant History' file.

BL 2015 Methodology

Strategy-Related Measures Definitions

83rd Regular Session, SBR, Version 1

Automated Budget and Evaluation System of Texas (ABEST)

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 2015 Purpose

This measure provides an average monthly count of persons receiving State-paid two parent TANF cash assistance.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 1 | Assistance Services | |
| Strategy No. | 1 | Temporary Assistance for Needy Families Grants | |
| Measure Type | OP | | |
| Measure No. | 3 | Average Number of TANF One-time Payments Per Month | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-01-01 OP 03
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the number of One Time (OT) payments issued. 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 2014 Data Limitations

None.

BL 2014 Data Source

Data is obtained from the 'TANF Warrant History' file

BL 2014 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.

BL 2014 Purpose

This measure provides an average monthly count of persons receiving a TANF one-time payment.

BL 2015 Definition

This measure reports the number of One Time (OT) payments issued. 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 2015 Data Limitations

None.

BL 2015 Data Source

Data is obtained from the 'TANF Warrant History' file

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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.

BL 2015 Purpose

This measure provides an average monthly count of persons receiving a TANF one-time payment.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 1 | Assistance Services | |
| Strategy No. | 1 | Temporary Assistance for Needy Families Grants | |
| Measure Type | OP | | |
| Measure No. | 4 | Number of Children Receiving \$30 Once a Year Grant | |

Calculation Method: C **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-01-01 OP 04
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 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 2014 Data Limitations

None.

BL 2014 Data Source

Data is obtained from the "TANF Warrant History" file.

BL 2014 Methodology

An ad hoc report will provide a count of children who received the once a year grant.

BL 2014 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 2015 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 2015 Data Limitations

None.

BL 2015 Data Source

Data is obtained from the "TANF Warrant History" file.

BL 2015 Methodology

An ad hoc report will provide a count of children who received the once-a-year grant.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 1 | Assistance Services | |
| Strategy No. | 1 | Temporary Assistance for Needy Families Grants | |
| Measure Type | OP | | |
| Measure No. | 5 | Average Monthly Number of TANF Grandparent Payments | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-01-01 OP 05

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

BL 2014 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 2014 Data Limitations

Only one TANF One time Grandparent payment is counted per TANF Grandparent case.

BL 2014 Data Source

TANF One time Grandparent payment data are from the agency's Client Server Support System Grandparent Payment System database.

BL 2014 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 2014 Purpose

This measure provides information on the utilization of TANF One time Grandparent payments.

BL 2015 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 2015 Data Limitations

Only one TANF One time Grandparent payment is counted per TANF Grandparent case.

BL 2015 Data Source

TANF One time Grandparent payment data are from the agency's Client Server Support System Grandparent Payment System database.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

This measure provides information on the utilization of TANF One time Grandparent payments.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 1 | Assistance Services | |
| Strategy No. | 1 | Temporary Assistance for Needy Families Grants | |
| Measure Type | OP | | |
| Measure No. | 6 | Avg # TANF/State Cash Adults Per Month w/ State Time-limited Benefits | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-01-01 OP 06
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the average number of adults receiving 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 2014 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 2014 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 2014 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 2014 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 2015 Definition

This measure reports the average number of adults receiving 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 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 2015 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 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 1 | Assistance Services | |
| 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 | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-01-01 OP 07

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

BL 2014 Definition

This measure reports the average number of adults receiving 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 2014 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 2014 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 2014 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 2014 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 2015 Definition

This measure reports the average number of adults receiving 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 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 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 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 1 | Assistance Services | |
| Strategy No. | 2 | Refugee Assistance | |
| Measure Type | OP | | |
| Measure No. | 1 | Number of Refugees Receiving Financial Services | |

Calculation Method: C **Target Attainment: H** **Priority: L** Cross Reference:
Key Measure: N **New Measure: Y** **Percentage Measure: N**

BL 2014 Definition

The number provided is an unduplicated count of refugee clients who receive financial services.

BL 2014 Data Limitations

This measure is calculated using the information entered into the Refugee Data Center (RDC) database by contracted providers. HHSC Information Technology staff queries and reports the number of refugee clients who receive financial services monthly, quarterly, and annually. The limitation of the data is that the providers must first enter the services information before IT is able to run the reports.

BL 2014 Data Source

The RDC system is an on-line automated system which records the number of refugees who receive social, medical, and financial services.

BL 2014 Methodology

Data from the RDC system identifies the number of refugees who receive financial services funded by HHSC during this reporting period.

BL 2014 Purpose

This measure provides a count of unduplicated persons receiving financial services funded by HHSC.

BL 2015 Definition

The number provided is an unduplicated count of refugee clients who receive financial services.

BL 2015 Data Limitations

This measure is calculated using the information entered into the Refugee Data Center (RDC) database by contracted providers. HHSC Information Technology staff queries and reports the number of refugee clients who receive financial services monthly, quarterly, and annually. The limitation of the data is that the providers must first enter the services information before IT is able to run the reports.

BL 2015 Data Source

The RDC system is an on-line automated system which records the number of refugees who receive social, medical, and financial services.

BL 2015 Methodology

Data from the RDC system identifies the number of refugees who receive financial services funded by HHSC during this reporting period.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Purpose

This measure provides a count of unduplicated persons receiving financial services funded by HHSC.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 1 | Assistance Services | |
| Strategy No. | 2 | Refugee Assistance | |
| Measure Type | OP | | |
| Measure No. | 2 | Number of Refugees Receiving Social Services | |

Calculation Method: C **Target Attainment: H** **Priority: L** Cross Reference:
Key Measure: Y **New Measure: Y** **Percentage Measure: N**

BL 2014 Definition

The number provided is an unduplicated count of refugee clients who receive contracted social services, such as job placement, case management, citizenship services, and vocational training.

BL 2014 Data Limitations

This measure is calculated using the information entered into the Refugee Data Center (RDC) database by contracted providers. HHSC Information Technology staff queries and reports the number of refugee clients who receive social services monthly, quarterly, and annually. The limitation of the data is that the providers must first enter the services information before IT is able to run the reports.

BL 2014 Data Source

The RDC system is an on-line automated system which records the number of refugees who receive social, medical, and financial services.

BL 2014 Methodology

Data from the RDC system identifies the number of refugees who receive social services funded by HHSC in the reporting period.

BL 2014 Purpose

This measure provides a count of unduplicated persons receiving social services funded by HHSC

BL 2015 Definition

The number provided is an unduplicated count of refugee clients who receive contracted social services, such as job placement, case management, citizenship services, and vocational training.

BL 2015 Data Limitations

This measure is calculated using the information entered into the Refugee Data Center (RDC) database by contracted providers. HHSC Information Technology staff queries and reports the number of refugee clients who receive social services monthly, quarterly, and annually. The limitation of the data is that the providers must first enter the services information before IT is able to run the reports.

BL 2015 Data Source

The RDC system is an on-line automated system which records the number of refugees who receive social, medical, and financial services.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Methodology

Data from the RDC system identifies the number of refugees who receive social services funded by HHSC in the reporting period.

BL 2015 Purpose

This measure provides a count of unduplicated persons receiving social services funded by HHSC

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 1 | Assistance Services | |
| Strategy No. | 2 | Refugee Assistance | |
| Measure Type | OP | | |
| Measure No. | 3 | Number of Refugees Receiving Medical Services | |

Calculation Method: C **Target Attainment: H** **Priority: L** Cross Reference:
Key Measure: N **New Measure: Y** **Percentage Measure: N**

BL 2014 Definition

The number provided is an unduplicated count of refugee clients who receive medical services.

BL 2014 Data Limitations

This measure is calculated using the information entered into the Refugee Data Center (RDC) database by contracted providers. HHSC Information Technology staff queries and reports the number of refugee clients who receive medical services monthly, quarterly, and annually. The limitation of the data is that the providers must first enter the services information before IT is able to run the reports.

BL 2014 Data Source

The RDC system is an on-line automated system which records the number of refugees who receive social, medical, and financial services.

BL 2014 Methodology

Data from the RDC system identifies the number of refugees who receive medical services funded by HHSC in the reporting period.

BL 2014 Purpose

This measure provides a count of unduplicated persons receiving medical services funded by HHSC.

BL 2015 Definition

The number provided is an unduplicated count of refugee clients who receive medical services.

BL 2015 Data Limitations

This measure is calculated using the information entered into the Refugee Data Center (RDC) database by contracted providers. HHSC Information Technology staff queries and reports the number of refugee clients who receive medical services monthly, quarterly, and annually. The limitation of the data is that the providers must first enter the services information before IT is able to run the reports.

BL 2015 Data Source

The RDC system is an on-line automated system which records the number of refugees who receive social, medical, and financial services.

BL 2015 Methodology

Data from the RDC system identifies the number of refugees who receive medical services funded by HHSC in the reporting period.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Purpose

This measure provides a count of unduplicated persons receiving medical services funded by HHSC.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|------------------------------|---|---------------------------------|---|
| Agency Code: 529 | Agency: Health and Human Services Commission | | |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 1 | Assistance Services | |
| Strategy No. | 3 | Disaster Assistance | |
| Measure Type | OP | | |
| Measure No. | 1 | Number of Applications Approved | |
| Calculation Method: C | Target Attainment: H | Priority: H | Cross Reference: Agy 529 082-R-S70-1 04-01-03 OP 01 |
| Key Measure: N | New Measure: N | Percentage Measure: N | |

BL 2014 Definition

Reports unduplicated number of FEMA referrals for Other Needs Assistance (ONA) under the Individual and Households Program (IHP) approved for a grant 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 Other Needs Assistance (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 2014 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 2014 Data Source

Data is obtained from reports on applications approved from the Disaster Assistance Reporting Information System (DARIS), which interfaces with the federal National Emergency Management Information System (NEMIS).

BL 2014 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 2014 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 2015 Definition

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Reports unduplicated number of FEMA referrals for Other Needs Assistance (ONA) under the Individual and Households Program (IHP) approved for a grant 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 Other Needs Assistance (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 2015 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 2015 Data Source

Data is obtained from reports on applications approved from the Disaster Assistance Reporting Information System (DARIS), which interfaces with the federal National Emergency Management Information System (NEMIS).

BL 2015 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 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | | Encourage Self Sufficiency |
| Objective No. | 2 | | Other Family Support Services |
| Strategy No. | 1 | | Family Violence Services |
| Measure Type | EF | | |
| Measure No. | 1 | | HHSC Avg Cost Per Person Receiving Family Violence Shelter Services |

Calculation Method: C **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-02-01 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the HHSC average cost per person receiving services at a Family Violence Shelter Center. A "Shelter" is a secure 24-hour-a-day temporary emergency residence providing direct delivery of services to adult victims of family violence. These services includes: access to emergency medical care, intervention services, access to emergency transportation, legal assistance (civil and criminal), educational arrangements for children, employment assistance, and referral to community resources.

BL 2014 Data Limitations

This information is helpful in that it will provide data regarding the costs of operating a Shelter Center (which by statute provides both shelter and nonresidential services) versus the costs of operating a Non-residential Center; however, it will not provide information on the average cost per client for strictly residential services versus the average cost per client for strictly nonresidential services.

BL 2014 Data Source

The total available dollar amount is the HHSC Family Violence allocation amount to client services per grant awards to family violence providers. Client services is defined as Residential services. The number of victims of family violence receiving services is obtained from the automated Integrated Tracking System, maintained by the Family Violence Program.

BL 2014 Methodology

Data are computed by taking the total available dollar amount (numerator), and dividing by the number of clients served in Residential Services(denominator).

BL 2014 Purpose

This measure quantifies the average cost to the agency for each person receiving a service under the provisions funded by this strategy. This data is a useful tool for projecting future funding needs.

BL 2015 Definition

This measure reports the HHSC average cost per person receiving services at a Family Violence Shelter Center. A "Shelter" is a secure 24-hour-a-day temporary emergency residence providing direct delivery of services to adult victims of family violence. These services includes: access to emergency medical care, intervention services, access to emergency transportation, legal assistance (civil and criminal), educational arrangements for children, employment assistance, and referral to community resources.

BL 2015 Data Limitations

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

This information is helpful in that it will provide data regarding the costs of operating a Shelter Center (which by statute provides both shelter and nonresidential services) versus the costs of operating a Non-residential Center; however, it will not provide information on the average cost per client for strictly residential services versus the average cost per client for strictly nonresidential services.

BL 2015 Data Source

The total available dollar amount is the HHSC Family Violence allocation amount to client services per grant awards to family violence providers. Client services is defined as Residential services. The number of victims of family violence receiving services is obtained from the automated Integrated Tracking System, maintained by the Family Violence Program.

BL 2015 Methodology

Data are computed by taking the total available dollar amount (numerator), and dividing by the number of clients served in Residential Services(denominator).

BL 2015 Purpose

This measure quantifies the average cost to the agency for each person receiving a service under the provisions funded by this strategy. This data is a useful tool for projecting future funding needs.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 2 | Other Family Support Services | |
| Strategy No. | 1 | Family Violence Services | |
| Measure Type | EF | | |
| Measure No. | 2 | HHSC Average Cost/Person for Family Violence Non-Residential Services | |

Calculation Method: C **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-02-01 EF 02

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

BL 2014 Definition

This measure reports the HHSC average cost per client receiving services from Family Violence non-residential centers. A "Non-residential Center" provides direct delivery of services to adult victims of family violence. These services include: access to a 24-hour-a-day shelter, access to emergency medical care, intervention services, access to emergency transportation, legal assistance (civil and criminal), educational arrangements for children, employment assistance, and referral to community resources.

BL 2014 Data Limitations

This information is helpful in that it will provide data regarding the costs of operating a Non residential Center versus the costs of operating a Residential Shelter Center; however, the comparison is limited as Residential Shelter Centers also provide non-residential services.

BL 2014 Data Source

The total available dollar amount is the HHSC Family Violence allocation amount to client services per grant awards to family violence non-residential service providers. Client services is defined as non- residential services. The number of victims of family violence receiving services is obtained from the automated Integrated Tracking System, maintained by the Family Violence Program.

BL 2014 Methodology

Data are computed by taking the total available dollar amount (numerator), and dividing by the number of clients receiving non-residential services(denominator).

BL 2014 Purpose

This measure quantifies the average cost to the agency for each person receiving a service under the provisions funded by this strategy. This data is a useful tool for projecting future funding needs.

BL 2015 Definition

This measure reports the HHSC average cost per client receiving services from Family Violence non-residential centers. A "Non-residential Center" provides direct delivery of services to adult victims of family violence. These services include: access to a 24-hour-a-day shelter, access to emergency medical care, intervention services, access to emergency transportation, legal assistance (civil and criminal), educational arrangements for children, employment assistance, and referral to community resources.

BL 2015 Data Limitations

This information is helpful in that it will provide data regarding the costs of operating a Non residential Center versus the costs of operating a Residential Shelter Center; however, the comparison is limited as Residential Shelter Centers also provide non-residential services.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

The total available dollar amount is the HHSC Family Violence allocation amount to client services per grant awards to family violence non-residential service providers. Client services is defined as non- residential services. The number of victims of family violence receiving services is obtained from the automated Integrated Tracking System, maintained by the Family Violence Program.

BL 2015 Methodology

Data are computed by taking the total available dollar amount (numerator), and dividing by the number of clients receiving non-residential services(denominator).

BL 2015 Purpose

This measure quantifies the average cost to the agency for each person receiving a service under the provisions funded by this strategy. This data is a useful tool for projecting future funding needs.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 2 | Other Family Support Services | |
| Strategy No. | 1 | Family Violence Services | |
| Measure Type | EX | | |
| Measure No. | 1 | Number of Women Battered in the Last 12 Months | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-02-01 EX 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the estimated number of women battered during the last 12 months.

BL 2014 Data Limitations

The estimated number of women ages 18 or older is subject to change as a result of updates/revisions to the population data. Also, data source #1 noted below is based on a 1989 study.

BL 2014 Data Source

Data are based on the following two sources: 1) Domestic Violence in Texas: A Study of Statewide and Rural Spouse Abuse conducted by Grant, Preda, and Martin, 1989. This study estimates that the number of women over age 18 experiencing physical abuse as 8.8% and sexual abuse as 2.6%, combined for 11.4%. 2) The estimated number of women ages 18 and older is obtained from the population estimates and projections program of the Texas State Data Center.

BL 2014 Methodology

Data are calculated by applying the proportion of women over age 18 who are expected to experience abuse, 11.4%, to the current estimate of Texas females ages 18 and older.

BL 2014 Purpose

This measure demonstrates the level of need for domestic violence services in Texas.

BL 2015 Definition

This measure reports the estimated number of women battered during the last 12 months.

BL 2015 Data Limitations

The estimated number of women ages 18 or older is subject to change as a result of updates/revisions to the population data. Also, data source #1 noted below is based on a 1989 study.

BL 2015 Data Source

Data are based on the following two sources: 1) Domestic Violence in Texas: A Study of Statewide and Rural Spouse Abuse conducted by Grant, Preda, and Martin, 1989. This study estimates that the number of women over age 18 experiencing physical abuse as 8.8% and sexual abuse as 2.6%, combined for 11.4%. 2) The estimated number of women ages 18 and older is obtained from the population estimates and projections program of the Texas State Data Center.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Methodology

Data are calculated by applying the proportion of women over age 18 who are expected to experience abuse, 11.4%, to the current estimate of Texas females ages 18 and older.

BL 2015 Purpose

This measure demonstrates the level of need for domestic violence services in Texas.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 2 | Other Family Support Services | |
| Strategy No. | 1 | Family Violence Services | |
| Measure Type | EX | | |
| Measure No. | 2 | Percent of Family Violence Program Budgets Funded by HHSC | |

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-02-01 EX 02

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

BL 2014 Definition

This measure reports the average percent of the cost of centers providing family violence services which is funded by HHSC.

BL 2014 Data Limitations

The total amount of funding available is the entire HHSC Family Violence client services allocation.

BL 2014 Data Source

The allocation amount and the projected total resources to the centers for providing family violence services are recorded on the approved budget submitted by the family violence center.

BL 2014 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 2014 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 2015 Definition

This measure reports the average percent of the cost of centers providing family violence services which is funded by HHSC.

BL 2015 Data Limitations

The total amount of funding available is the entire HHSC Family Violence client services allocation.

BL 2015 Data Source

The allocation amount and the projected total resources to the centers for providing family violence services are recorded on the approved budget submitted by the family violence center.

BL 2015 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).

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | | Encourage Self Sufficiency |
| Objective No. | 2 | | Other Family Support Services |
| Strategy No. | 1 | | Family Violence Services |
| Measure Type | OP | | |
| Measure No. | 1 | | Number of Persons Served by Family Violence Programs/Shelters |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-02-01 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

Reports number of victims of family violence and their children who receive shelter, non-residential services, and clients who receive both services from family violence programs/shelters that contract with the state. "Shelter", as defined in the Texas Health and Human Services Dictionary of Services and Facilities, is 24-hour a day temporary emergency residence provided in a secure location. Shelter for victims of family violence includes the following services: emergency medical care, counseling services, emergency transportation, legal assistance (civil and criminal), educational arrangements for children, employment assistance, and referral to community resources. Non-residential services may include counseling, assistance in obtaining medical care, transportation, legal assistance, employment services, law enforcement liaison and information and referral to other resources. "Non-residential services" is the delivery of all of the above services in a non-live-in environment.

BL 2014 Data Limitations

None.

BL 2014 Data Source

Data are obtained from the automated Integrated Tracking System maintained by the Family Violence Program.

BL 2014 Methodology

The automated system computes an unduplicated count of the number of persons who received residential and non-residential services during the months of the reporting period.

BL 2014 Purpose

This measure provides caseload information for this strategy. It provides a count of the total number of persons receiving services.

BL 2015 Definition

Reports number of victims of family violence and their children who receive shelter, non-residential services, and clients who receive both services from family violence programs/shelters that contract with the state. "Shelter", as defined in the Texas Health and Human Services Dictionary of Services and Facilities, is 24-hour a day temporary emergency residence provided in a secure location. Shelter for victims of family violence includes the following services: emergency medical care, counseling services, emergency transportation, legal assistance (civil and criminal), educational arrangements for children, employment assistance, and referral to community resources. Non-residential services may include counseling, assistance in obtaining medical care, transportation, legal assistance, employment services, law enforcement liaison and information and referral to other resources. "Non-residential services" is the delivery of all of the above services in a non-live-in environment.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Limitations

none

BL 2015 Data Source

Data are obtained from the automated Integrated Tracking System maintained by the Family Violence Program.

BL 2015 Methodology

The automated system computes an unduplicated count of the number of persons who received residential and non-residential services during the months of the reporting period.

BL 2015 Purpose

This measure provides caseload information for this strategy. It provides a count of the total number of persons receiving services.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 2 | Other Family Support Services | |
| Strategy No. | 1 | Family Violence Services | |
| Measure Type | OP | | |
| Measure No. | 2 | Number of Participating Family Violence Programs/Shelters | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-02-01 OP 02

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

BL 2014 Definition

This measure reports the HHSC average cost per client receiving services from Family Violence non residential centers. A "Non residential Center" provides direct delivery of services to adult victims of family violence. These services include: access to a 24 hour a day shelter, access to emergency medical care, intervention services, access to emergency transportation, legal assistance (civil and criminal), educational arrangements for children, employment assistance, and referral to community resources.

BL 2014 Data Limitations

This information is helpful in that it will provide data regarding the costs of operating a Non residential Center versus the costs of operating a Residential Shelter Center; however, the comparison is limited as Residential Shelter Centers also provide non-residential services.

BL 2014 Data Source

The total available dollar amount is the HHSC Family Violence allocation amount to client services per grant awards to family violence non-residential service providers. Client services is defined as non- residential services. The number of victims of family violence receiving services is obtained from the automated Integrated Tracking System, maintained by the Family Violence Program.

BL 2014 Methodology

Data is computed by taking the total available dollar amount (numerator), and dividing by the number of clients receiving in non-residential services (denominator).

BL 2014 Purpose

This measure quantifies the average cost to the agency for each person receiving a service under the provisions funded by this strategy. This data is a useful tool for projecting future funding needs.

BL 2015 Definition

This measure reports the HHSC average cost per client receiving services from Family Violence non residential centers. A "Non residential Center" provides direct delivery of services to adult victims of family violence. These services include: access to a 24 hour a day shelter, access to emergency medical care, intervention services, access to emergency transportation, legal assistance (civil and criminal), educational arrangements for children, employment assistance, and referral to community resources.

BL 2015 Data Limitations

This information is helpful in that it will provide data regarding the costs of operating a Non residential Center versus the costs of operating a Residential Shelter Center; however, the comparison is limited as Residential Shelter Centers also provide non-residential services.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

The total available dollar amount is the HHSC Family Violence allocation amount to client services per grant awards to family violence non-residential service providers. Client services is defined as non- residential services. The number of victims of family violence receiving services is obtained from the automated Integrated Tracking System, maintained by the Family Violence Program.

BL 2015 Methodology

Data is computed by taking the total available dollar amount (numerator), and dividing by the number of clients receiving in non-residential services (denominator).

BL 2015 Purpose

This measure quantifies the average cost to the agency for each person receiving a service under the provisions funded by this strategy. This data is a useful tool for projecting future funding needs.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|-------------------------------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 2 | Other Family Support Services | |
| Strategy No. | 1 | Family Violence Services | |
| Measure Type | OP | | |
| Measure No. | 3 | Number of Hotline Calls | |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 04-02-01 OP 03
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 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 2014 Data Limitations

Does not apply.

BL 2014 Data Source

Data are obtained from the automated Integrated Tracking System maintained by the Family Violence Program.

BL 2014 Methodology

The automated system computes a count of the number of hotline calls received during the months of the reporting period by family violence programs/shelters that contract with HHSC.

BL 2014 Purpose

This measure demonstrates the level of hotline services needed.

BL 2015 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 2015 Data Limitations

Does Not Apply.

BL 2015 Data Source

Data are obtained from the automated Integrated Tracking System maintained by the Family Violence Program.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Methodology

The automated system computes a count of the number of hotline calls received during the months of the reporting period by family violence programs/shelters that contract with HHSC.

BL 2015 Purpose

This measure demonstrates the level of hotline services needed.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 2 | Other Family Support Services | |
| Strategy No. | 2 | Alternatives to Abortion. Nontransferable. | |
| Measure Type | OP | | |
| Measure No. | 1 | Number of Persons Receiving Services as Alternative to Abortion | |

Calculation Method: N **Target Attainment: L** **Priority:** Cross Reference: Agy 529 082-R-S70-1 04-02-02 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This measure reports the number of clients who receive services for 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 2014 Data Limitations

None.

BL 2014 Data Source

Numbers are based on data collected from service vendor. The service administrator is required to verify data under its contract. The service administrator verifies data monthly and ongoing.

BL 2014 Methodology

The reporting system calculates the number of unique clients who receive a variety of services each month, quarter, and annually.

BL 2014 Purpose

This measure is an indicator of the total number of clients who have received services as an alternative to abortions.

BL 2015 Definition

This measure reports the number of clients who receive services for 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 2015 Data Limitations

None.

BL 2015 Data Source

Numbers are based on data collected from service vendor. The service administrator is required to verify data under its contract. The service administrator verifies data monthly and ongoing.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Methodology

The reporting system calculates the number of unique clients who receive a variety of services each month, quarter, and annually.

BL 2015 Purpose

This measure is an indicator of the total number of clients who have received services as an alternative to abortions.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 4 | Encourage Self Sufficiency | |
| Objective No. | 2 | Other Family Support Services | |
| Strategy No. | 2 | Alternatives to Abortion. Nontransferable. | |
| Measure Type | OP | | |
| Measure No. | 2 | Number of Alternatives to Abortion Services Provided | |

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

BL 2014 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 2014 Data Limitations

Summary data is provided to HHSC to satisfy contractual performance reporting requirements. The Real Alternatives Program and Instructional Design (RAPID) database system is maintained by the provider. Data validation activities of the Alternatives to Abortion provider can result in adjustments to monthly and quarterly data sets.

BL 2014 Data Source

Source data for this measure is maintained and compiled by the Alternatives to Abortion provider from the RAPID database system. The service administrator is required to verify data under its contract. The service administrator verifies data monthly and ongoing.

BL 2014 Methodology

The RAPID reporting system calculates the number of unduplicated services provided on a monthly, quarterly, and annual basis.

BL 2014 Purpose

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

BL 2015 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 2015 Data Limitations

Summary data is provided to HHSC to satisfy contractual performance reporting requirements. The Real Alternatives Program and Instructional Design (RAPID) database system is maintained by the provider. Data validation activities of the Alternatives to Abortion provider can result in adjustments to monthly and quarterly data sets.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

Source data for this measure is maintained and compiled by the Alternatives to Abortion provider from the RAPID database system. The service administrator is required to verify data under its contract. The service administrator verifies data monthly and ongoing.

BL 2015 Methodology

The RAPID reporting system calculates the number of unduplicated services provided on a monthly, quarterly, and annual basis.

BL 2015 Purpose

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

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 7 | Office of Inspector General | |
| Objective No. | 1 | Client and Provider Accountability | |
| Strategy No. | 1 | Office of Inspector General | |
| Measure Type | EF | | |
| Measure No. | 1 | Average \$ Recovered & Saved/Completed Investigation, Review and Audit | |

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 07-01-01 EF 01

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

BL 2014 Definition

This is the measure of the average dollars recovered and saved per completed provider and recipient investigations, completed hospital and nursing facility reviews, and completed audits.

BL 2014 Data Limitations

No limitations.

BL 2014 Data Source

OIG case management systems and activity summary sheets. Staff in OIG enters information on dollars recovered and saved into data bases. Data is collected on a monthly basis and is maintained by OIG staff.

BL 2014 Methodology

This measure is calculated by adding the dollars recovered and dollars saved and dividing by the number of investigations, reviews, and audits completed during the same reporting period.

BL 2014 Purpose

This measure addresses how efficiently the Office of Inspector General is completing investigations, reviews and audits.

BL 2015 Definition

This is the measure of the average dollars recovered and saved per completed provider and recipient investigations, completed hospital and nursing facility reviews, and completed audits.

BL 2015 Data Limitations

No limitations.

BL 2015 Data Source

OIG case management systems and activity summary sheets. Staff in OIG enters information on dollars recovered and saved into data bases. Data is collected on a monthly basis and is maintained by OIG staff.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Methodology

This measure is calculated by adding the dollars recovered and dollars saved and dividing by the number of investigations, reviews, and audits completed during the same reporting period.

BL 2015 Purpose

This measure addresses how efficiently the Office of Inspector General is completing investigations, reviews and audits.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 7 | | Office of Inspector General |
| Objective No. | 1 | | Client and Provider Accountability |
| Strategy No. | 1 | | Office of Inspector General |
| Measure Type | EX | | |
| Measure No. | 1 | | Medicaid Providers Excluded |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 07-01-01 EX 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This is a measure of the total number of providers excluded from the Medicaid program as a result of activities of the Office of Inspector General (OIG), the U. S. Health and Human Services Department's Office of Inspector General, licensure board actions, and/or court actions/convictions.

BL 2014 Data Limitations

No limitations.

BL 2014 Data Source

Case management system maintained by OIG.

BL 2014 Methodology

A sum of exclusions imposed as the result of OIG activities, activities of the Office of Inspector General of USHHS, licensure board actions, and/or court actions/convictions.

BL 2014 Purpose

This measure addresses activities taken by OIG to protect the integrity of the Medicaid program and assure quality medical care to Medicaid recipients.

BL 2015 Definition

This is a measure of the total number of providers excluded from the Medicaid program as a result of activities of the Office of Inspector General (OIG), the U. S. Health and Human Services Department's Office of Inspector General, licensure board actions, and/or court actions/convictions.

BL 2015 Data Limitations

No limitations.

BL 2015 Data Source

Case management system maintained by OIG.

BL 2015 Methodology

A sum of exclusions imposed as the result of OIG activities, activities of the Office of Inspector General of USHHS, licensure board actions, and/or court actions/convictions.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Purpose

This measure addresses activities taken by OIG to protect the integrity of the Medicaid program and assure quality medical care to Medicaid recipients.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|---|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 7 | Office of Inspector General | |
| Objective No. | 1 | Client and Provider Accountability | |
| Strategy No. | 1 | Office of Inspector General | |
| Measure Type | OP | | |
| Measure No. | 1 | Number of Provider and Recipient Investigations | |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 07-01-01 OP 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This is a measure of the Medicaid Program Integrity (MPI) and the General Investigations sections of Office of Inspector General (OIG) that is responsible for investigating allegations, complaints, and referrals of Medicaid, TANF, and SNAP fraud, abuse, or waste.

BL 2014 Data Limitations

No limitations.

BL 2014 Data Source

OIG case management systems.

BL 2014 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 2014 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.

BL 2015 Definition

This is a measure of the Medicaid Program Integrity (MPI) and the General Investigations sections of Office of Inspector General (OIG) that is responsible for investigating allegations, complaints, and referrals of Medicaid, TANF, and SNAP fraud, abuse, or waste.

BL 2015 Data Limitations

No limitations.

BL 2015 Data Source

OIG case management systems.

BL 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|------------------------------------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 7 | 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 Performed | |

Calculation Method: C **Target Attainment: H** **Priority:** Cross Reference: Agy 529 082-R-S70-1 07-01-01 OP 02

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

BL 2014 Definition

This measures the total number of programmatic and financial audits and reviews of HHS programs conducted by the Office of Inspector General. 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 2014 Data Limitations

None.

BL 2014 Data Source

OIG case management systems.

BL 2014 Methodology

Total sum of audits and non-audit engagements conducted.

BL 2014 Purpose

To measure audits and non-audits engagements represents a positive approach to review funded HHS programs.

BL 2015 Definition

This measures the total number of programmatic and financial audits and reviews of HHS programs conducted by the Office of Inspector General. 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 2015 Data Limitations

None.

BL 2015 Data Source

OIG case management systems.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Methodology

Total sum of audits and non-audit engagements conducted.

BL 2015 Purpose

To measure audits and non-audits engagements represents a positive approach to review funded HHS programs.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|------------------------------------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 7 | Office of Inspector General | |
| Objective No. | 1 | Client and Provider Accountability | |
| Strategy No. | 1 | Office of Inspector General | |
| Measure Type | OP | | |
| Measure No. | 3 | Number of Nursing Facility Reviews | |

Calculation Method: C **Target Attainment: H** **Priority:** Cross Reference: Agy 529 082-R-S70-1 07-01-01 OP 03
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 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 2014 Data Limitations

No limitations.

BL 2014 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 2014 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 2014 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 2015 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 2015 Data Limitations

No limitations.

BL 2015 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 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|--|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 7 | Office of Inspector General | |
| Objective No. | 1 | Client and Provider Accountability | |
| Strategy No. | 1 | Office of Inspector General | |
| Measure Type | OP | | |
| Measure No. | 4 | Number of Hospital Utilization Reviews | |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 07-01-01 OP 04
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This is a measure of utilization reviews, which are on site 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 DRG, and quality of care. The purpose of utilization review is to detect and correct improper Medicaid billing practices by hospitals.

BL 2014 Data Limitations

No limitations.

BL 2014 Data Source

Nurse reviewers and/or administrative assistants in the field enter into the agency's database information collected during the on-site review of charts. State office staff collects and accumulates information from all regions in a centralized tracking system.

BL 2014 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 2014 Purpose

This measure is intended to determine the medical necessity for care, the appropriateness of the Diagnoses Related Groups (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 2015 Definition

This is a measure of utilization reviews, which are on site 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 DRG, and quality of care. The purpose of utilization review is to detect and correct improper Medicaid billing practices by hospitals.

BL 2015 Data Limitations

No limitations.

BL 2015 Data Source

Nurse reviewers and/or administrative assistants in the field enter into the agency's database information collected during the on-site review of charts. State office staff collects and accumulates information from all regions in a centralized tracking system.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 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 2015 Purpose

This measure is intended to determine the medical necessity for care, the appropriateness of the Diagnoses Related Groups (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
83rd Regular Session, SBR, 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. | 7 | 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 529 082-R-S70-1 07-01-01 OP 05
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 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, Information Technology, Audit, Medicaid Program Integrity, and General Investigations.

BL 2014 Data Limitations

OIG is dependent upon other agencies and vendors for the recovery of some of the funds involved in the measure.

BL 2014 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 2014 Methodology

The sum of dollars recovered by each section of OIG for the reporting period.

BL 2014 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 2015 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, Information Technology, Audit, Medicaid Program Integrity, and General Investigations.

BL 2015 Data Limitations

OIG is dependent upon other agencies and vendors for the recovery of some of the funds involved in the measure.

BL 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Methodology

The sum of dollars recovered by each section of OIG for the reporting period.

BL 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, 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. | 7 | 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:** Cross Reference: Agy 529 082-R-S70-1 07-01-01 OP 06

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

BL 2014 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 2014 Data Limitations

OIG is dependent upon other agencies and vendors for the implementation of its recommendations, with the exception of training activities.

BL 2014 Data Source

Staff within OIG tracks cost savings arising from activities of OIG. The sources of data include: the Office of Inspector General State Action Requests (SAR's) tracking system; OIG's policy development tracking systems; OIG's training and education databases; and the claims administrator, TMHP. Data is collected on an ongoing basis by staff within OIG and is summarized on a monthly basis.

BL 2014 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. The sum of cost savings is then calculated for the reporting period.

BL 2014 Purpose

This measure addresses the effectiveness of the Office of Inspector General (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 2015 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 2015 Data Limitations

OIG is dependent upon other agencies and vendors for the implementation of its recommendations, with the exception of training activities.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Data Source

Staff within OIG tracks cost savings arising from activities of OIG. The sources of data include: the Office of Inspector General State Action Requests (SAR's) tracking system; OIG's policy development tracking systems; OIG's training and education databases; and the claims administrator, TMHP. Data is collected on an ongoing basis by staff within OIG and is summarized on a monthly basis.

BL 2015 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. The sum of cost savings is then calculated for the reporting period.

BL 2015 Purpose

This measure addresses the effectiveness of the Office of Inspector General (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
83rd Regular Session, SBR, 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. | 7 | 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 529 082-R-S70-1 07-01-01 OP 07
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 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 2014 Data Limitations

No limitations.

BL 2014 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 2014 Methodology

Sum of cases of credible allegations of fraud referred to the Office of the Attorney General during the reporting period.

BL 2014 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 2015 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 2015 Data Limitations

No limitations.

BL 2015 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.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Methodology

Sum of cases of credible allegations of fraud referred to the Office of the Attorney General during the reporting period.

BL 2015 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
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

| | | | |
|---------------|------------|------------------------------------|---|
| Agency Code: | 529 | Agency: | Health and Human Services Commission |
| Goal No. | 7 | Office of Inspector General | |
| Objective No. | 1 | Client and Provider Accountability | |
| Strategy No. | 1 | Office of Inspector General | |
| Measure Type | OP | | |
| Measure No. | 8 | Cases: Fraud and Abuse System | |

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 082-R-S70-1 07-01-01 OP 08
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2014 Definition

This is a measure of the number of viable cases identified by MFADS through the use of neural and/or learning technology. The MFADS uses neural models and fraud detection algorithms to identify suspect cases of fraud, waste, or abuse for investigation by OIG. A case is an initiation of action against a Medicaid provider to include recoupment or referral of the case to the Office of the Attorney General.

BL 2014 Data Limitations

No limitations.

BL 2014 Data Source

The OIG case management system.

BL 2014 Methodology

The sum of cases identified by the MFADS during the reporting period.

BL 2014 Purpose

Senate Bill 30, 75th Legislature, mandates that the Commission use learning or neural network technology to identify suspect cases of fraud, waste, or abuse for investigation.

BL 2015 Definition

This is a measure of the number of viable cases identified by MFADS through the use of neural and/or learning technology. The MFADS uses neural models and fraud detection algorithms to identify suspect cases of fraud, waste, or abuse for investigation by OIG. A case is an initiation of action against a Medicaid provider to include recoupment or referral of the case to the Office of the Attorney General.

BL 2015 Data Limitations

No limitations.

BL 2015 Data Source

The OIG case management system.

Strategy-Related Measures Definitions
83rd Regular Session, SBR, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2015 Methodology

The sum of cases identified by the MFADS during the reporting period.

BL 2015 Purpose

Senate Bill 30, 75th Legislature, mandates that the Commission use learning or neural network technology to identify suspect cases of fraud, waste, or abuse for investigation.