

OBJECTIVE OUTCOME DEFINITIONS REPORT

84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 1 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 529 083-R-S70-1 01-01 OC 01

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

BL 2016 Definition

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

BL 2016 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 Disabled Children's Services Program, 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 2016 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 (DADS), the Department of State Health Services, and HHSC are defined as services provided in state schools, state mental hospitals, nursing facilities/hospice and Intermediate Care Facilities for Individuals with an Intellectual Disability. Community services are defined as the services in the community care objectives: Community Care - Entitlement, Community Care - Waivers, Community Care - State, and Program of All-inclusive Care for the Elderly 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 Primary Home Care, Daily Activity and Health Services and Community-Based Alternatives at DADS).

BL 2016 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 2016 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 2017 Definition

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

BL 2017 Data Limitations

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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 Disabled Children's Services Program, 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 2017 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 (DADS), the Department of State Health Services, and HHSC are defined as services provided in state schools, state mental hospitals, nursing facilities/hospice and Intermediate Care Facilities for Individuals with an Intellectual Disability. Community services are defined as the services in the community care objectives: Community Care - Entitlement, Community Care - Waivers, Community Care - State, and Program of All-inclusive Care for the Elderly 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 Primary Home Care, Daily Activity and Health Services and Community-Based Alternatives at DADS).

BL 2017 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 2017 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.

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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: N Target Attainment: H Priority: H Cross Reference: Agy 529 083-R-S70-1 01-01 OC 02
Key Measure: Y New Measure: N Percent Measure: N

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 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 Supplemental Security Income (SSI) clients are not included in this count. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

BL 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

None.

BL 2017 Data Source

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

BL 2017 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 Supplemental Security Income (SSI) clients are not included in this count. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

BL 2017 Purpose

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

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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 529 083-R-S70-1 02-01 OC 01

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

BL 2016 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 2016 Data Limitations

None

BL 2016 Data Source

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

BL 2016 Methodology

A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. If data are incomplete, estimates will be made based on completion ratios and other forecasting techniques. The quarterly average is the sum of the recipient months (managed care and non-managed care combined) for the three months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months (managed care and non-managed care combined) divided by the number of months summed.

BL 2016 Purpose

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

BL 2017 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 2017 Data Limitations

None

BL 2017 Data Source

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

BL 2017 Methodology

A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. If data are incomplete, estimates will be made based on completion ratios and other forecasting techniques. The quarterly average is the sum of the recipient months (managed care and non-managed care combined) for the three months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months (managed care and non-managed care combined) divided by the number of months summed.

BL 2017 Purpose

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

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

Calculation Method: N Target Attainment: H Priority: H Cross Reference: Agy 529 083-R-S70-1 02-01 OC 03

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

BL 2016 Definition

Percent of enrolled clients receiving acute care services.

BL 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 Methodology

This measure is the percentage of the enrolled 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 2016 Purpose

Measures the percent of enrolled clients receiving acute care services.

BL 2017 Definition

Percent of enrolled clients receiving acute care services.

BL 2017 Data Limitations

None.

BL 2017 Data Source

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

BL 2017 Methodology

This measure is the percentage of the enrolled 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 2017 Purpose

Measures the percent of enrolled clients receiving acute care services.

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Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 2 Medicaid
Objective No. 1 Medicaid Health Services
Outcome No. 3 Percent of 100% Poverty Population Covered by Acute Care Services

Calculation Method: N **Target Attainment:** H **Priority:** H **Cross Reference:** Agy 529 083-R-S70-1 02-01 OC 04

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

BL 2016 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 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

This measure is the percentage of people in Texas at or below 100% of the FPIL that are covered by acute care services.

BL 2017 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 2017 Data Limitations

None.

BL 2017 Data Source

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

BL 2017 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 2017 Purpose

This measure is the percentage of people in Texas at or below 100% of the FPIL that are covered by acute care services.

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Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 2 Medicaid
Objective No. 1 Medicaid Health Services
Outcome No. 4 Average Medicaid Acute Care Child Under 21 Recipient Months Per Month

Calculation Method: N Target Attainment: L Priority: H Cross Reference: Agy 529 083-R-S70-1 02-01 OC 05

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

BL 2016 Definition

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

BL 2016 Data Limitations

None

BL 2016 Data Source

The Premium Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

None

BL 2017 Data Source

The Premium Payable System.

BL 2017 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 2017 Purpose

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

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Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 2 Medicaid
Objective No. 1 Medicaid Health Services
Outcome No. 5 Average HHSC Medicaid Client Svcs(including Drug) Cost/Recipient Month

Calculation Method: N **Target Attainment: L** **Priority: H** **Cross Reference: Agy 529 083-R-S70-1 02-01 OC 06**

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

BL 2016 Definition

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

BL 2016 Data Limitations

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

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

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

BL 2017 Data Source

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

BL 2017 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.

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BL 2017 Purpose

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

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Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 2 Medicaid
Objective No. 1 Medicaid Health Services
Outcome No. 6 Medicaid Rec Months: Proportion in Managed Care

Calculation Method: N **Target Attainment: H** **Priority: H** **Cross Reference: Agy 529 083-R-S70-1 02-01 OC 07**

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

BL 2016 Definition

The measure gives the proportion of recipient months for Medicaid clients enrolled in Managed Care plans compared to the total Medicaid full benefit population during the reporting period. Total Medicaid Recipients Months is the number of recipient months (managed care and non-managed care combined) for Medicaid recipients in the Aged and Medicare Related, Disability-Related, Pregnant Women, Other Adults, and Children strategies. Managed Care recipient months are the total number of recipient months for the above named strategies in the STAR, STAR+PLUS, STAR Health, Dual Demonstration or STAR Kids (beginning in FY2017) programs for the reporting period.

BL 2016 Data Limitations

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

BL 2016 Data Source

The Premium Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 Definition

The measure gives the proportion of recipient months for Medicaid clients enrolled in Managed Care plans compared to the total Medicaid full benefit population during the reporting period. Total Medicaid Recipients Months is the number of recipient months (managed care and non-managed care combined) for Medicaid recipients in the Aged and Medicare Related, Disability-Related, Pregnant Women, Other Adults, and Children strategies. Managed Care recipient months are the total number of recipient months for the above named strategies in the STAR, STAR+PLUS, STAR Health, Dual Demonstration or STAR Kids (beginning in FY2017) programs for the reporting period.

BL 2017 Data Limitations

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

BL 2017 Data Source

The Premium Payable System.

BL 2017 Methodology

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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 2017 Purpose

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

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Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 2 Medicaid
Objective No. 1 Medicaid Health Services
Outcome No. 7 Percent of THSTEPS (EPSDT) Enrolled Pop. Screened Medicaid - Medical

Calculation Method: N **Target Attainment:** H **Priority:** H **Cross Reference:** Agy 529 083-R-S70-1 02-01 OC 08

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

BL 2016 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 2016 Data Limitations

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

BL 2016 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 2016 Methodology

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

BL 2016 Purpose

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

BL 2017 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 2017 Data Limitations

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

BL 2017 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 2017 Methodology

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

BL 2017 Purpose

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

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Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 2 Medicaid
Objective No. 1 Medicaid Health Services
Outcome No. 8 Avg # of Members Receiving Waiver Services through STAR+PLUS

Calculation Method: N **Target Attainment: H** **Priority: H** **Cross Reference: Agy 529 083-R-S70-1 02-01 OC 09**

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

BL 2016 Definition

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

BL 2016 Data Limitations

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

BL 2016 Data Source

The Premiums Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

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

BL 2017 Data Source

The Premiums Payable System.

BL 2017 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 2017 Purpose

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

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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 Nonwaiver Community Care through STAR+PLUS

Calculation Method: N Target Attainment: H Priority: H Cross Reference: Agy 529 083-R-S70-1 02-01 OC 10

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

BL 2016 Definition

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

BL 2016 Data Limitations

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

BL 2016 Data Source

The Premiums Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

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

BL 2017 Data Source

The Premiums Payable System.

BL 2017 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 2017 Purpose

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

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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 529 083-R-S70-1 02-03 OC 01

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

BL 2016 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 2016 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 2016 Data Source

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

BL 2016 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 2016 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 2017 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 2017 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 2017 Data Source

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

BL 2017 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 2017 Purpose

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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.

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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 529 083-R-S70-1 02-03 OC 02**

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

BL 2016 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 2016 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 2016 Data Source

Health Maintenance Organization encounter Universe, Medicaid administration contractor; 8-months Eligibility Files, HHSC.

BL 2016 Methodology

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

Member Months: All member months for the measurement year.

Emergency Department (ED) Visits*: Institutional encounters with Current Procedural Terminology (CPT) codes 99281-99285, or Unexpended Balance (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 2016 Purpose

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

BL 2017 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 2017 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 2017 Data Source

Health Maintenance Organization encounter Universe, Medicaid administration contractor; 8-months Eligibility Files, HHSC.

BL 2017 Methodology

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

Member Months: All member months for the measurement year.

Emergency Department (ED) Visits*: Institutional encounters with Current Procedural Terminology (CPT) codes 99281-99285, or Unexpended Balance (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 2017 Purpose

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

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

Calculation Method: N **Target Attainment:** H **Priority:** H **Cross Reference:** Agy 529 083-R-S70-1 03-01 OC 01

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

BL 2016 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 2016 Data Limitations

None.

BL 2016 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 2016 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 2016 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 2017 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 2017 Data Limitations

None.

BL 2017 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 2017 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 2017 Purpose

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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.

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Agency Code: **529** Agency: **Health and Human Services Commission**
Goal No. 3 Children's Health Insurance Program Services
Objective No. 1 CHIP Services
Outcome No. 2 Average CHIP Programs Recipient Months Per Month

Calculation Method: N **Target Attainment: H** **Priority: H** **Cross Reference: Agy 529 083-R-S70-1 03-01 OC 02**

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

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 Methodology

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

BL 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

NONE.

BL 2017 Data Source

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

BL 2017 Methodology

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

BL 2017 Purpose

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

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

Calculation Method: N Target Attainment: L Priority: H Cross Reference: Agy 529 083-R-S70-1 03-01 OC 03

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

BL 2016 Definition

The measure provides the average monthly benefit cost paid to Children's Health Insurance Program (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 costs include amounts paid to health plans, the dental contractor, and Department of State Health Services (DSHS) to cover vaccines.

BL 2016 Data Limitations

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

BL 2016 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 Department of State Health Services (DSHS) (or successor agency), which shows the amount used for vaccinating CHIP-enrolled children.

BL 2016 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 Perinatal) are totaled for the reporting period. This total is divided by the total number of CHIP-enrolled children (CHIP II and 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 2016 Purpose

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

BL 2017 Definition

The measure provides the average monthly benefit cost paid to Children's Health Insurance Program (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 costs include amounts paid to health plans, the dental contractor, and Department of State Health Services (DSHS) to cover vaccines.

BL 2017 Data Limitations

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

BL 2017 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 Department of State Health Services (DSHS) (or successor agency), which shows the amount used for vaccinating CHIP-enrolled children.

BL 2017 Methodology

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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 Perinatal) are totaled for the reporting period. This total is divided by the total number of CHIP-enrolled children (CHIP II and 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 2017 Purpose

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

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

Calculation Method: N **Target Attainment: L** **Priority: H** **Cross Reference: Agy 529 083-R-S70-1 03-01 OC 04**

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

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

None.

BL 2017 Data Source

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

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BL 2017 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 2017 Purpose

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

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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 529 083-R-S70-1 04-01 OC 01

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

BL 2016 Definition

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

BL 2016 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 2016 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 2016 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 2016 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 2017 Definition

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

BL 2017 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 2017 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 2017 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 2017 Purpose

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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).

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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: N Target Attainment: L Priority: H Cross Reference: Agy 529 083-R-S70-1 04-01 OC 02

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

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

Ad hoc computer runs using benefit and client eligibility files.

BL 2016 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 2016 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 2017 Definition

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

BL 2017 Data Limitations

None.

BL 2017 Data Source

Ad hoc computer runs using benefit and client eligibility files.

BL 2017 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 2017 Purpose

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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.

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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 529 083-R-S70-1 04-01 OC 03

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

BL 2016 Definition

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

BL 2016 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 2016 Data Source

Data is obtained from reports in the eligibility determination system.

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 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 2017 Data Source

Data is obtained from reports in the eligibility determination system.

BL 2017 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 2017 Purpose

OBJECTIVE OUTCOME DEFINITIONS REPORT

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

OBJECTIVE OUTCOME DEFINITIONS REPORT

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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 529 083-R-S70-1 04-02 OC 01**

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

BL 2016 Definition

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

BL 2016 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 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 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 2017 Data Source

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

BL 2017 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 2017 Purpose

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

OBJECTIVE OUTCOME DEFINITIONS REPORT

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

Calculation Method: C **Target Attainment: H** **Priority: M** **Cross Reference:** Agy 529 083-R-S70-1 07-01 OC 01

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

BL 2016 Definition

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

BL 2016 Data Limitations

No limitations.

BL 2016 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 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

No Limitation.

BL 2017 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 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 529 083-R-S70-1 01-01-01 OP 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

HHSC, financial services and rate analysis. Rates are based on data collected from service vendors.

BL 2016 Methodology

Methodologies specific to various programs.

BL 2016 Purpose

Rates are used to reimburse vendors for services provided.

BL 2017 Definition

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

BL 2017 Data Limitations

None.

BL 2017 Data Source

HHSC, financial services and rate analysis. Rates are based on data collected from service vendors.

BL 2017 Methodology

Methodologies specific to various programs.

BL 2017 Purpose

Rates are used to reimburse vendors for services provided.

Strategy-Related Measures Definitions
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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: H** **Priority: H** Cross Reference:
Key Measure: Y **New Measure: Y** **Percentage Measure: N**

BL 2016 Definition

This measure reports the average cost of determining eligibility for Temporary Assistance for Needy Families and State Two-parent cash assistance, Supplemental Nutrition Assistance Program, Medicaid for Elderly and People with Disability, Medicaid, and Children's Health Insurance Program. Determining eligibility refers to actions taken to determine the eligibility status of applicants or ongoing cases: approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2016 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 2016 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 2016 Methodology

The data is computed as follows: the numerator consists of the sum of the eligibility determination sub-strategy departments expenditures divided by the number of months in the reporting period. The sum of the eligibility determination sub-strategy departments expenditures reflect actual costs for each reporting period plus accrued expenditures for the 4th quarter of the reporting period based on appropriation year (year in which funds were appropriated for use regardless of fiscal year/accounting period expenditure is paid). The denominator is the data reported for 1-1-2-1 OP-1 for the reporting period. Dividing the numerator by the denominator yields the average cost for the period.

BL 2016 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 2017 Definition

This measure reports the average cost of determining eligibility for Temporary Assistance for Needy Families and State Two-parent cash assistance, Supplemental Nutrition Assistance Program, Medicaid for Elderly and People with Disability, Medicaid, and Children's Health Insurance Program. Determining eligibility refers to actions taken to determine the eligibility status of applicants or ongoing cases: approved, denied, or open/closed applications, and sustained or denied complete reviews.

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BL 2017 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 2017 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 2017 Methodology

The data is computed as follows: the numerator consists of the sum of the eligibility determination sub-strategy departments expenditures divided by the number of months in the reporting period. The sum of the eligibility determination sub-strategy departments expenditures reflect actual costs for each reporting period plus accrued expenditures for the 4th quarter of the reporting period based on appropriation year (year in which funds were appropriated for use regardless of fiscal year/accounting period expenditure is paid). The denominator is the data reported for 1-1-2-1 OP-1 for the reporting period. Dividing the numerator by the denominator yields the average cost for the period.

BL 2017 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
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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 529 083-R-S70-1 01-01-02 EF 02
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This measure reports the percentage of Temporary Assistance for Needy Families (TANF) benefits delivered correctly, as determined by the most recent TANF quality control (QC) results for the fiscal year. "Issued in error" is the difference between the dollar amount of benefits actually issued and the dollar amount of benefits that would have been issued had all relevant client information been reported in an accurate and timely fashion by the client and had all relevant client information been processed in accordance with applicable state and/or federal guidelines. (This definition includes over issuances greater than the error tolerance threshold only, and encompasses such things as a client reporting inaccurate information, a client not reporting changes on a timely basis, agency failure to correctly apply policy, and so on.)

BL 2016 Data Limitations

Does not apply.

BL 2016 Data Source

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

BL 2016 Methodology

The reported data are computed as follows: The numerator consists of the number of benefit dollars in the QC sample for the period, minus the number of dollars issued in error for the period, as determined through the QC review process. Only over issuances greater than the error tolerance threshold are included. The denominator consists of the number of benefit dollars in the QC sample for the period. Dividing the numerator by the denominator yields the accuracy rate for the period.

BL 2016 Purpose

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

BL 2017 Definition

This measure reports the percentage of Temporary Assistance for Needy Families (TANF) benefits delivered correctly, as determined by the most recent TANF quality control (QC) results for the fiscal year. "Issued in error" is the difference between the dollar amount of benefits actually issued and the dollar amount of benefits that would have been issued had all relevant client information been reported in an accurate and timely fashion by the client and had all relevant client information been processed in accordance with applicable state and/or federal guidelines. (This definition includes over issuances greater than the error tolerance threshold only, and encompasses such things as a client reporting inaccurate information, a client not reporting changes on a timely basis, agency failure to correctly apply policy, and so on.)

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BL 2017 Data Limitations

Does not apply.

BL 2017 Data Source

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

BL 2017 Methodology

The reported data are computed as follows: The numerator consists of the number of benefit dollars in the QC sample for the period, minus the number of dollars issued in error for the period, as determined through the QC review process. Only over issuances greater than the error tolerance threshold are included. The denominator consists of the number of benefit dollars in the QC sample for the period. Dividing the numerator by the denominator yields the accuracy rate for the period.

BL 2017 Purpose

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

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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 529 083-R-S70-1 01-01-02 EF 03
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This measure reports the percentage of Supplemental Nutrition Assistance Program (SNAP) benefits delivered correctly, as determined by the most recent SNAP quality control results for the fiscal year, adjusted for the federal review regression percentage. "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, greater than the error tolerance threshold, 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 2016 Data Limitations

For the federal review process, Food and Nutrition Service (FNS) randomly selects approximately one third of each state's annual sample and subjects each of the selected cases to an independent review to determine the accuracy of benefits issued. FNS uses its findings on this subset of cases to adjust the state's error rate through regression a term describing the statistical process of FNS projecting its findings from the subset of 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.

BL 2016 Data Source

Data are based on the quality control (QC) eligibility review and the Federal re-review process, which uses a statewide random sample of SNAP benefits. This sample complies with federally mandated precision tests. Annually, FNS calculates and publishes the official error rate by the end of June for the prior federal review year.

BL 2016 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, greater than the error tolerance threshold and it is the absolute value of the magnitude of the error that contributes to the numerator for example, two cases, one with a \$50 over issuance and one with a \$50 under issuances, do not cancel each other out but instead contribute a total of \$100 to the numerator. The numerator also includes ineligible cases, with the contribution to the numerator being equal to the amount of the benefit issued.

BL 2016 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

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BL 2017 Definition

This measure reports the percentage of Supplemental Nutrition Assistance Program (SNAP) benefits delivered correctly, as determined by the most recent SNAP quality control results for the fiscal year, adjusted for the federal review regression percentage. "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, greater than the error tolerance threshold, 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 2017 Data Limitations

For the federal review process, Food and Nutrition Service (FNS) randomly selects approximately one third of each state's annual sample and subjects each of the selected cases to an independent review to determine the accuracy of benefits issued. FNS uses its findings on this subset of cases to adjust the state's error rate through regression a term describing the statistical process of FNS projecting its findings from the subset of 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.

BL 2017 Data Source

Data are based on the quality control (QC) eligibility review and the Federal re-review process, which uses a statewide random sample of SNAP benefits. This sample complies with federally mandated precision tests. Annually, FNS calculates and publishes the official error rate by the end of June for the prior federal review year.

BL 2017 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, greater than the error tolerance threshold and it is the absolute value of the magnitude of the error that contributes to the numerator for example, two cases, one with a \$50 over issuance and one with a \$50 under issuances, do not cancel each other out but instead contribute a total of \$100 to the numerator. The numerator also includes ineligible cases, with the contribution to the numerator being equal to the amount of the benefit issued.

BL 2017 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
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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 529 083-R-S70-1 01-01-02 EF 04
Key Measure: N **New Measure: N** **Percentage Measure: Y**

BL 2016 Definition

This measure is the number of eligibility case decisions that were completed within established timeframes for CHIP, Medicaid for the Elderly and People with Disabilities (MEPD), Texas Works (TW) programs for TANF and State Two Parent Cash Assistance, SNAP, and Medicaid for Families and Children, expressed as a percentage of all eligibility decisions completed in the same period. Case decisions are defined as applications approved, denied, or applications open/closed. TW programs include Title 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, Medical Assistance Only, Qualified Medicare Beneficiary, Specified Low-income Medicare Beneficiaries, other long term care Medicaid eligible qualified individuals, and Medicaid Waiver programs. CHIP includes traditional and Perinate programs.

BL 2016 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 2016 Data Source

Data is obtained from Datamart, the interface for the eligibility determination system reporting.

BL 2016 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 2016 Purpose

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

BL 2017 Definition

This measure is the number of eligibility case decisions that were completed within established timeframes for CHIP, Medicaid for the Elderly and People with Disabilities (MEPD), Texas Works (TW) programs for TANF and State Two Parent Cash Assistance, SNAP, and Medicaid for Families and Children, expressed as a percentage of all eligibility decisions completed in the same period. Case decisions are defined as applications approved, denied, or applications open/closed. TW programs include Title 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, Medical Assistance Only, Qualified Medicare Beneficiary, Specified Low-income Medicare Beneficiaries, other long term care Medicaid eligible qualified individuals, and Medicaid Waiver programs. CHIP includes traditional and Perinate programs.

Strategy-Related Measures Definitions

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BL 2017 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 2017 Data Source

Data is obtained from Datamart, the interface for the eligibility determination system reporting.

BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 529 083-R-S70-1 01-01-02 EX 01
Key Measure: Y **New Measure: N** **Percentage Measure: Y**

BL 2016 Definition

This measure reports the value of Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (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 2016 Data Limitations

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

BL 2016 Data Source

The TANF payment standard is as published in the Texas Works Handbook; the United States Department of Agriculture 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 2016 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 2016 Purpose

This measure quantifies the benefit levels provided through the TANF financial assistance, SNAP and Medicaid programs as compared to federally established poverty levels.

BL 2017 Definition

This measure reports the value of Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (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 2017 Data Limitations

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

BL 2017 Data Source

Strategy-Related Measures Definitions

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Automated Budget and Evaluation System of Texas (ABEST)

The TANF payment standard is as published in the Texas Works Handbook; the United States Department of Agriculture 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 2017 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 2017 Purpose

This measure quantifies the benefit levels provided through the TANF financial assistance, SNAP and Medicaid programs as compared to federally established poverty levels.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	1	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 529 083-R-S70-1 01-01-02 EX 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

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

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

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

BL 2017 Data Source

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

BL 2017 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
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BL 2017 Purpose

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

Strategy-Related Measures Definitions
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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 529 083-R-S70-1 01-01-02 EX 03

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

BL 2016 Definition

This measure reports the number of persons receiving Supplemental Nutrition Assistance Program (SNAP) expressed as a percent of the state's population potentially eligible to receive SNAP. The number of persons potentially eligible for SNAP is defined as persons living in households with income at or below 130 percent of the poverty level.

BL 2016 Data Limitations

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

BL 2016 Data Source

Recipient data are from the month-end SNAP Case extract from the eligibility determination system. The population of potential eligibles is estimated using baseline information obtained from the last two March Current Population Surveys administered by the U.S. Census Bureau. The baseline information is extrapolated using standard demographic and other statistical techniques that rely on data provided by the population estimates and projections program of the Texas State Data Center.

BL 2016 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 2016 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 2017 Definition

This measure reports the number of persons receiving Supplemental Nutrition Assistance Program (SNAP) expressed as a percent of the state's population potentially eligible to receive SNAP. The number of persons potentially eligible for SNAP is defined as persons living in households with income at or below 130 percent of the poverty level.

BL 2017 Data Limitations

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

BL 2017 Data Source

Strategy-Related Measures Definitions

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Recipient data are from the month-end SNAP Case extract from the eligibility determination system. The population of potential eligibles is estimated using baseline information obtained from the last two March Current Population Surveys administered by the U.S. Census Bureau. The baseline information is extrapolated using standard demographic and other statistical techniques that rely on data provided by the population estimates and projections program of the Texas State Data Center.

BL 2017 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 2017 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
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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 of Direct Delivery Staff with Less than One Year	

Calculation Method: C **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 01-01-02 EX 05

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

BL 2016 Definition

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

BL 2016 Data Limitations

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

BL 2016 Data Source

Data are obtained from payroll/personnel system queries.

BL 2016 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 2016 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 2017 Definition

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

BL 2017 Data Limitations

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

BL 2017 Data Source

Data are obtained from payroll/personnel system queries.

BL 2017 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
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BL 2017 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
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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 529 083-R-S70-1 01-01-02 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This measure reports the average monthly number of eligibility determinations for Temporary Assistance for Needy Families and State Two Parent Cash Assistance, Supplemental Nutrition Assistance Program, Medicaid for the Elderly and People with Disabilities, Medicaid and Children's Health Insurance Program. Determining eligibility refers to actions taken to determine the eligibility status of applicants or ongoing cases: approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2016 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 2016 Data Source

Data are obtained from Datamart.

BL 2016 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 2016 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 2017 Definition

This measure reports the average monthly number of eligibility determinations for Temporary Assistance for Needy Families and State Two Parent Cash Assistance, Supplemental Nutrition Assistance Program, Medicaid for the Elderly and People with Disabilities, Medicaid and Children's Health Insurance Program. Determining eligibility refers to actions taken to determine the eligibility status of applicants or ongoing cases: approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2017 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 2017 Data Source

Data are obtained from Datamart.

Strategy-Related Measures Definitions

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BL 2017 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 2017 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
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	1	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: L** Cross Reference: Agy 529 083-R-S70-1 01-01-02 OP 02

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

BL 2016 Definition

This measure reports the average monthly number of eligibility determinations for Temporary Assistance for Needy Families and State Two Parent Cash Assistance, Supplemental Nutrition Assistance Program, Medicaid for the Elderly and People with Disabilities, Medicaid and Children's Health Insurance Program per staff person. Determining eligibility refers to approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2016 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 2016 Data Source

The numerator is the data for 1-1-2-OP-1. The number of staff is from a monthly query from the payroll/personnel system.

BL 2016 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 2016 Purpose

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

BL 2017 Definition

This measure reports the average monthly number of eligibility determinations for Temporary Assistance for Needy Families and State Two Parent Cash Assistance, Supplemental Nutrition Assistance Program, Medicaid for the Elderly and People with Disabilities, Medicaid and Children's Health Insurance Program per staff person. Determining eligibility refers to approved, denied, or open/closed applications, and sustained or denied complete reviews.

BL 2017 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.

Strategy-Related Measures Definitions
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BL 2017 Data Source

The numerator is the data for 1-1-2-OP-1. The number of staff is from a monthly query from the payroll/personnel system.

BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
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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 529 083-R-S70-1 01-01-02 OP 03

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

BL 2016 Definition

This measure reports the average monthly number of Supplemental Nutrition Assistance Program (SNAP) recipients. Data include public assistance and non-public assistance recipients. Public assistance recipients are members of households in which all members receive Temporary Assistance for Needy Families (TANF) or State Two-Parent Cash Assistance or Supplemental Security Income and TANF. Non-public assistance recipients are members of households in which no one or only some of the members receive TANF or State Two-Parent Cash Assistance.

BL 2016 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 2016 Data Source

Data are obtained from automated monthly reports, SNAP benefit system Issuance Household Profile and the SNAP Case extract from an eligibility determination system.

BL 2016 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 2016 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 2017 Definition

This measure reports the average monthly number of Supplemental Nutrition Assistance Program (SNAP) recipients. Data include public assistance and non-public assistance recipients. Public assistance recipients are members of households in which all members receive Temporary Assistance for Needy Families (TANF) or State Two-Parent Cash Assistance or Supplemental Security Income and TANF. Non-public assistance recipients are members of households in which no one or only some of the members receive TANF or State Two-Parent Cash Assistance.

BL 2017 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.

Strategy-Related Measures Definitions
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BL 2017 Data Source

Data are obtained from automated monthly reports, SNAP benefit system Issuance Household Profile and the SNAP Case extract from an eligibility determination system.

BL 2017 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 2017 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
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code: 529	Agency: Health and Human Services Commission
Goal No.	1 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 30 Days

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 01-02-01 EF 01
Key Measure: N **New Measure: N** **Percentage Measure: Y**

BL 2016 Definition

This is a measure of the percentage of Informal Dispute Resolution reviews (IDRs) for nursing facilities and intermediate care facilities for individuals with an intellectual disability or related condition (ICF/IID) completed by HHSC that are completed within the required timeline of 30 calendar days from receipt of the IDR request to the date the final recommendation and rationale is submitted to the provider. The IDR process provides adjudication by an appropriate disinterested person of disputes relating to deficiencies and/or violations cited against a nursing facility, or ICF/IID by the state survey agency.

BL 2016 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 2016 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 2016 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 2016 Purpose

The IDR process, for nursing facilities and ICF/IIDs 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 2017 Definition

This is a measure of the percentage of Informal Dispute Resolution reviews (IDRs) for nursing facilities and intermediate care facilities for individuals with an intellectual disability or related condition (ICF/IID) completed by HHSC that are completed within the required timeline of 30 calendar days from receipt of the IDR request to the date the final recommendation and rationale is submitted to the provider. The IDR process provides adjudication by an appropriate disinterested person of disputes relating to deficiencies and/or violations cited against a nursing facility, or ICF/IID by the state survey agency.

BL 2017 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
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BL 2017 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 2017 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 2017 Purpose

The IDR process, for nursing facilities and ICF/IIDs 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
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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.	2	Percent of Dispute Resolutions Completed Within 90 Day Timeframe	

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

BL 2016 Definition

This is a measure of the percentage of Informal Dispute Resolution reviews (IDRs) for assisted living facilities completed by HHSC that are completed within the required timeline of 90 calendar days from receipt of the IDR request to the date the final recommendation and rationale is submitted to the provider. The IDR process provides adjudication by an appropriate disinterested person of disputes relating to violations cited against an assisted living facility by the state survey agency.

BL 2016 Data Limitations

Extenuating circumstances that result in delays in IDR completion may need to be identified and such circumstances excluded from the 90 calendar day timeline.

BL 2016 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 2016 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 2016 Purpose

The IDR process for assisted living facilities, by legislation, should be completed within 90 calendar days of the IDR request. Texas Government Code, §531.058 establishes the 90 calendar day timeframe. Per the Texas Government Code, §311.014, if the due date falls on a Saturday, Sunday or legal holiday, the due date becomes the following business day. IDR due dates that meet this criteria will be recognized the next business day.

BL 2017 Definition

This is a measure of the percentage of Informal Dispute Resolution reviews (IDRs) for assisted living facilities completed by HHSC that are completed within the required timeline of 90 calendar days from receipt of the IDR request to the date the final recommendation and rationale is submitted to the provider. The IDR process provides adjudication by an appropriate disinterested person of disputes relating to violations cited against an assisted living facility by the state survey agency.

BL 2017 Data Limitations

Extenuating circumstances that result in delays in IDR completion may need to be identified and such circumstances excluded from the 90 calendar day timeline.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2017 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 2017 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 2017 Purpose

The IDR process for assisted living facilities, by legislation, should be completed within 90 calendar days of the IDR request. Texas Government Code, §531.058 establishes the 90 calendar day timeframe. Per the Texas Government Code, §311.014, if the due date falls on a Saturday, Sunday or legal holiday, the due date becomes the following business day. IDR due dates that meet this criteria will be recognized the next business day.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	1	HHS Enterprise Oversight and Policy	
Objective No.	2	HHS Consolidated System Support Services	
Strategy No.	1	Consolidated System Support	
Measure Type	OP		
Measure No.	1	Initiatives to Address Disproportionality and Disparities	

Calculation Method: C **Target Attainment:** **Priority:** Cross Reference: Agy 529 083-R-S70-1 01-02-01 OP 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This measure calculates the number of initiatives of the HHSC Center for the Elimination of Disproportionality and Disparities (CEDD) central office staff and regional equity specialists. Initiatives include, but are not limited to, providing technical assistance and training; and collaborating across systems and in communities to address disproportionality and disparities within human services, education, juvenile justice, health, mental health and other systems

BL 2016 Data Limitations

None.

BL 2016 Data Source

Monthly reports prepared by CEDD

BL 2016 Methodology

This measure is calculated using the monthly reports capturing all initiatives implemented during the reporting period. The number of initiatives implemented each month is summed to yield the reporting period result. An initiative may begin in one reporting period but is only reported for the reporting period when implemented.

BL 2016 Purpose

This measure provides the count of initiatives implemented by the Center for the Elimination of Disproportionality and Disparities.

BL 2017 Definition

This measure calculates the number of initiatives of the HHSC Center for the Elimination of Disproportionality and Disparities (CEDD) central office staff and regional equity specialists. Initiatives include, but are not limited to, providing technical assistance and training; and collaborating across systems and in communities to address disproportionality and disparities within human services, education, juvenile justice, health, mental health and other systems

BL 2017 Data Limitations

None.

BL 2017 Data Source

Monthly reports prepared by CEDD

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
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BL 2017 Methodology

This measure is calculated using the monthly reports capturing all initiatives implemented during the reporting period. The number of initiatives implemented each month is summed to yield the reporting period result. An initiative may begin in one reporting period but is only reported for the reporting period when implemented.

BL 2017 Purpose

This measure provides the count of initiatives implemented by the Center for the Elimination of Disproportionality and Disparities.

Strategy-Related Measures Definitions
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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 Cost Per Recipient Month	

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-01-01 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

None.

BL 2017 Data Source

Strategy-Related Measures Definitions

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

BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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	

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-01-01 EF 02

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

BL 2016 Definition

The average monthly capitated cost per Medicare eligible recipient month in STAR+PLUS managed care. Recipient month is defined as one month's membership (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. This measure does not include premiums paid for drug benefits.

BL 2016 Data Limitations

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

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 Definition

The average monthly capitated cost per Medicare eligible recipient month in STAR+PLUS managed care. Recipient month is defined as one month's membership (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. This measure does not include premiums paid for drug benefits.

BL 2017 Data Limitations

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

Strategy-Related Measures Definitions

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BL 2017 Data Source

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

BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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Agency Code:	529	Agency:	Health and Human Services Commission
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: Total	

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-01-01 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

The Premiums Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

None.

BL 2017 Data Source

The Premiums Payable System.

Strategy-Related Measures Definitions

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BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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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 529 083-R-S70-1 02-01-01 OP 02
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

The Premiums Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

None.

BL 2017 Data Source

The Premiums Payable System.

Strategy-Related Measures Definitions

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BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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Agency Code:	529	Agency:	Health and Human Services Commission
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 Cost Per Recipient Month	

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-01-02 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

The average monthly expenditure per Disability-Related recipient month.

BL 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 Definition

The average monthly expenditure per Disability-Related recipient month.

BL 2017 Data Limitations

None.

BL 2017 Data Source

Strategy-Related Measures Definitions

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

BL 2017 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 2017 Purpose

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

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

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-01-02 EF 02

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

BL 2016 Definition

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

BL 2016 Data Limitations

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

BL 2016 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 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

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

Strategy-Related Measures Definitions

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BL 2017 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 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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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.	3	Average Cost/Disability-related Recipient Month: STAR Kids	

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

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 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 2016 Methodology

The average monthly premium per non Medicare recipient month is calculated by dividing the total premiums paid to the STAR Kids Health Maintenance Organization (HMOs) including administrative fees on behalf of members for the months in the reporting period by the total number of recipient months projected to be incurred in the reporting period. Data is accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

BL 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

None.

Strategy-Related Measures Definitions

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BL 2017 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 2017 Methodology

The average monthly premium per non Medicare recipient month is calculated by dividing the total premiums paid to the STAR Kids Health Maintenance Organization (HMOs) including administrative fees on behalf of members for the months in the reporting period by the total number of recipient months projected to be incurred in the reporting period. Data is accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

BL 2017 Purpose

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

Strategy-Related Measures Definitions
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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: Total	

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-01-02 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

The Premiums Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

None.

BL 2017 Data Source

The Premiums Payable System.

Strategy-Related Measures Definitions

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BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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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 529 083-R-S70-1 02-01-02 OP 02

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

BL 2016 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 2016 Data Limitations

None.

BL 2016 Data Source

The Premium's Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 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 2017 Data Limitations

None.

Strategy-Related Measures Definitions

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BL 2017 Data Source

The Premium's Payable System.

BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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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.	3	Average Disability-related Recipient Months Per Month: STAR Kids	

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

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

BL 2016 Definition

The average monthly number of Disability-Related children in the STAR Kids program. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. The STAR Kids program will begin in September 2016.

BL 2016 Data Limitations

None.

BL 2016 Data Source

The Premiums Payable System.

BL 2016 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. This measure reflects only managed care clients in the STAR Kids program. 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 2016 Purpose

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

BL 2017 Definition

The average monthly number of Disability-Related children in the STAR Kids program. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services. The STAR Kids program will begin in September 2016.

BL 2017 Data Limitations

None.

BL 2017 Data Source

The Premiums Payable System.

Strategy-Related Measures Definitions

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BL 2017 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. This measure reflects only managed care clients in the STAR Kids program. 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 2017 Purpose

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

Strategy-Related Measures Definitions
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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 529 083-R-S70-1 02-01-03 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

The average monthly expenditure per Pregnant Women recipient month.

BL 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 Definition

The average monthly expenditure per Pregnant Women recipient month.

BL 2017 Data Limitations

None.

BL 2017 Data Source

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

Strategy-Related Measures Definitions

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BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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Agency Code:	529	Agency:	Health and Human Services Commission
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 529 083-R-S70-1 02-01-03 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 Data Limitations

None.

BL 2016 Data Source

The Premiums Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 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 2017 Data Limitations

None.

BL 2017 Data Source

The Premiums Payable System.

Strategy-Related Measures Definitions

84th Regular Session, Agency Submission, Version 1
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BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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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 529 083-R-S70-1 02-01-04 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

None.

BL 2017 Data Source

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

Strategy-Related Measures Definitions

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BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 529 083-R-S70-1 02-01-04 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

The Premium Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

None.

BL 2017 Data Source

The Premium Payable System.

Strategy-Related Measures Definitions

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Automated Budget and Evaluation System of Texas (ABEST)

BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 529 083-R-S70-1 02-01-05 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 Methodology

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

BL 2016 Purpose

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

BL 2017 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

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BL 2017 Data Limitations

None.

BL 2017 Data Source

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

BL 2017 Methodology

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

BL 2017 Purpose

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

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-01-05 EF 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

None.

BL 2017 Data Source

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

Strategy-Related Measures Definitions

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Automated Budget and Evaluation System of Texas (ABEST)

BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 529 083-R-S70-1 02-01-05 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

The Premiums Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

None.

Strategy-Related Measures Definitions

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Automated Budget and Evaluation System of Texas (ABEST)

BL 2017 Data Source

The Premiums Payable System.

BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 529 083-R-S70-1 02-01-05 OP 02

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

BL 2016 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, children who legally entered the United States on or after August 22, 1996, were not eligible for Children's Health Insurance Program (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 2016 Data Limitations

None.

BL 2016 Data Source

The Premium Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 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, children who legally entered the United States on or after August 22, 1996, were not eligible for Children's Health Insurance Program (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
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BL 2017 Data Limitations

None.

BL 2017 Data Source

The Premium Payable System.

BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-01-05 OP 03
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 Data Limitations

None.

BL 2016 Data Source

The Premiums Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 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 2017 Data Limitations

None.

BL 2017 Data Source

The Premiums Payable System.

Strategy-Related Measures Definitions

84th Regular Session, Agency Submission, Version 1
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BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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: N **Target Attainment: L** **Priority: L** Cross Reference: Agy 529 083-R-S70-1 02-02-01 EF 01

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

BL 2016 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 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 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 2016 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 2017 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 2017 Data Limitations

None.

BL 2017 Data Source

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

Strategy-Related Measures Definitions

84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2017 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 2017 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
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 529 083-R-S70-1 02-02-01 OP 01

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

BL 2016 Definition

Federally Qualified Health Centers (FQHC) look-alikes meet all the requirements to receive one of the grants under the Public Health Service Act but does not actually receive any of these grants, according to FQHC status qualification guidelines.

BL 2016 Data Limitations

None.

BL 2016 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 2016 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 2016 Purpose

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

BL 2017 Definition

Federally Qualified Health Centers (FQHC) look-alikes meet all the requirements to receive one of the grants under the Public Health Service Act but does not actually receive any of these grants, according to FQHC status qualification guidelines.

BL 2017 Data Limitations

None.

BL 2017 Data Source

Strategy-Related Measures Definitions

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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 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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-citizen Recipient Months Per Month	

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-02-01 OP 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

The Premium Payable System.

BL 2016 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 2016 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 2017 Definition

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

BL 2017 Data Limitations

None.

Strategy-Related Measures Definitions

84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2017 Data Source

The Premium Payable System.

BL 2017 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 2017 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
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-02-02 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

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

BL 2016 Data Source

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

BL 2016 Methodology

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

BL 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

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

BL 2017 Data Source

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

Strategy-Related Measures Definitions

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BL 2017 Methodology

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

BL 2017 Purpose

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

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	2	Medicaid	
Objective No.	2	Other Medicaid Services	
Strategy No.	3	Medical Transportation	
Measure Type	EF		
Measure No.	1	Average Nonemergency Transportation (NEMT) Cost Per Recipient Month	

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-02-03 EF 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 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 2016 Data Source

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

BL 2016 Methodology

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

BL 2016 Purpose

This measure determines the average cost per recipient month.

BL 2017 Definition

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

BL 2017 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 2017 Data Source

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

Strategy-Related Measures Definitions

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Automated Budget and Evaluation System of Texas (ABEST)

BL 2017 Methodology

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

BL 2017 Purpose

This measure determines the average cost per recipient month.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 529 083-R-S70-1 02-02-04 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 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 2017 Data Limitations

None.

Strategy-Related Measures Definitions

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BL 2017 Data Source

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

BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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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 529 083-R-S70-1 02-02-04 EX 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 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 2016 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 2016 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 2016 Purpose

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

BL 2017 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 2017 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.

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BL 2017 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 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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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 529 083-R-S70-1 02-02-04 OP 01

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

BL 2016 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 2016 Data Limitations

None.

BL 2016 Data Source

The Premium Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 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 2017 Data Limitations

None.

BL 2017 Data Source

The Premium Payable System.

Strategy-Related Measures Definitions

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BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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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 529 083-R-S70-1 02-02-04 OP 02
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 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 2016 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 2016 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 2016 Purpose

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

BL 2017 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 2017 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.

Strategy-Related Measures Definitions

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BL 2017 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 2017 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 2017 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
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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 Part B Premium Per Month	

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-02-05 EF 01

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

BL 2016 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 2016 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 2016 Data Source

Social Security Act and report MF 232-01

BL 2016 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 2016 Purpose

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

BL 2017 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 2017 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

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BL 2017 Data Source

Social Security Act and report MF 232-01

BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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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: L** **Priority: L** Cross Reference: Agy 529 083-R-S70-1 02-02-05 EF 02

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

BL 2016 Definition

The average monthly premium paid for Medicare Part A coverage for Medicare eligible Medicaid clients. The Medicare Part A premium is set by the Social Security Administration and is effective for each calendar year. Medicare Part A is hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

BL 2016 Data Limitations

None.

BL 2016 Data Source

Social Security Act and report MF832 01.

BL 2016 Methodology

The average is calculated by taking the total estimated dollar value of claims projected to be incurred by clients and dividing this total by the number of projected recipient months to be incurred. The numerator will be the sum of full and reduced rate Part A dollars; the denominator will be the sum of full and reduced rate Part A recipient months. The Medicare Part A premium is set by the Social Security Administration and is effective for each calendar year.

BL 2016 Purpose

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

BL 2017 Definition

The average monthly premium paid for Medicare Part A coverage for Medicare eligible Medicaid clients. The Medicare Part A premium is set by the Social Security Administration and is effective for each calendar year. Medicare Part A is hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

BL 2017 Data Limitations

None.

BL 2017 Data Source

Social Security Act and report MF832 01.

Strategy-Related Measures Definitions

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BL 2017 Methodology

The average is calculated by taking the total estimated dollar value of claims projected to be incurred by clients and dividing this total by the number of projected recipient months to be incurred. The numerator will be the sum of full and reduced rate Part A dollars; the denominator will be the sum of full and reduced rate Part A recipient months. The Medicare Part A premium is set by the Social Security Administration and is effective for each calendar year.

BL 2017 Purpose

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

Strategy-Related Measures Definitions
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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: Agy 529 083-R-S70-1 02-02-05 EF 03

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

BL 2016 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 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 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 2017 Data Limitations

None.

BL 2017 Data Source

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

Strategy-Related Measures Definitions

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BL 2017 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 2017 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
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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 Part B Recipient Months Per Month	

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-02-05 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 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 2016 Data Source

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

BL 2016 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 2016 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 2017 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 2017 Data Limitations

Strategy-Related Measures Definitions

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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 2017 Data Source

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

BL 2017 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 2017 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
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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 529 083-R-S70-1 02-02-05 OP 02
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 Methodology

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

BL 2016 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 2017 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 2017 Data Limitations

None.

BL 2017 Data Source

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

Strategy-Related Measures Definitions

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BL 2017 Methodology

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

BL 2017 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
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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: H** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 02-02-05 OP 03

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

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

The Premiums Payable System.

BL 2016 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 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

None.

BL 2017 Data Source

The Premiums Payable System.

BL 2017 Methodology

Strategy-Related Measures Definitions

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The quarterly average is the sum of the recipient months for the 3 months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months divided by the number of months summed. Data is accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. Completion factors may be applied to incomplete data. Forecasting models and trends are used to project future expenditures and recipient months.

BL 2017 Purpose

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

Strategy-Related Measures Definitions
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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 529 083-R-S70-1 03-01-01 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This measure is the average monthly cost per recipient month of health and dental premiums plus newborn screening and vaccine costs (excluding prescription drugs) for the Children's Health Insurance Program (CHIP) II program for a reporting period.

BL 2016 Data Limitations

None.

BL 2016 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 2016 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 2016 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 2017 Definition

This measure is the average monthly cost per recipient month of health and dental premiums plus newborn screening and vaccine costs (excluding prescription drugs) for the Children's Health Insurance Program (CHIP) II program for a reporting period.

BL 2017 Data Limitations

None.

BL 2017 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

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BL 2017 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 2017 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
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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 529 083-R-S70-1 03-01-01 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

Measures the average number of Traditional CHIP recipient months.

BL 2017 Definition

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

BL 2017 Data Limitations

None.

BL 2017 Data Source

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

BL 2017 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
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BL 2017 Purpose

Measures the average number of Traditional CHIP recipient months.

Strategy-Related Measures Definitions
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Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	3	Children's Health Insurance Program Services	
Objective No.	1	CHIP Services	
Strategy No.	2	CHIP Perinatal Services	
Measure Type	EF		
Measure No.	1	Average Perinatal Benefit Cost Per Recipient Month	

Calculation Method: N **Target Attainment: L** **Priority: L** Cross Reference: Agy 529 083-R-S70-1 03-01-02 EF 01

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

BL 2016 Definition

This measure is the average monthly cost of health premiums (excluding prescription drugs) for the Children's Health Insurance Program (CHIP) Perinatal program for a reporting period.

BL 2016 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 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 Definition

This measure is the average monthly cost of health premiums (excluding prescription drugs) for the Children's Health Insurance Program (CHIP) Perinatal program for a reporting period.

BL 2017 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 2017 Data Source

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

Strategy-Related Measures Definitions

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BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
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Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	3	Children's Health Insurance Program Services	
Objective No.	1	CHIP Services	
Strategy No.	2	CHIP Perinatal Services	
Measure Type	OP		
Measure No.	1	Average Perinatal Recipient Months Per Month	

Calculation Method: N **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 03-01-02 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This measure is the average monthly number of children enrolled in coverage under the Children's Health Insurance Program (CHIP) Perinatal program for a reporting period.

BL 2016 Data Limitations

None.

BL 2016 Data Source

Data are obtained through the enrollment vendor who provides monthly enrollment reports showing cumulative enrollment.

BL 2016 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 2016 Purpose

Captures the average number of CHIP Perinatal recipients month.

BL 2017 Definition

This measure is the average monthly number of children enrolled in coverage under the Children's Health Insurance Program (CHIP) Perinatal program for a reporting period.

BL 2017 Data Limitations

None.

BL 2017 Data Source

Data are obtained through the enrollment vendor who provides monthly enrollment reports showing cumulative enrollment.

Strategy-Related Measures Definitions

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BL 2017 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 2017 Purpose

Captures the average number of CHIP Perinatal recipients month.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	3	Children's Health Insurance Program Services	
Objective No.	1	CHIP Services	
Strategy No.	3	CHIP PRESCRIPTION DRUGS	
Measure Type	EF		
Measure No.	1	Average Cost/CHIP Recipient Month: Prescription Drugs	

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 03-01-03 EF 01

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

BL 2016 Definition

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

BL 2016 Data Limitations

The CHIP prescription dollars do not include any rebates.

BL 2016 Data Source

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

BL 2016 Methodology

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

BL 2016 Purpose

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

BL 2017 Definition

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

BL 2017 Data Limitations

The CHIP prescription dollars do not include any rebates.

BL 2017 Data Source

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

Strategy-Related Measures Definitions

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BL 2017 Methodology

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

BL 2017 Purpose

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

Strategy-Related Measures Definitions
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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 529 083-R-S70-1 04-01-01 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This measure reports the dollar amount of the average monthly Temporary Assistance for Needy Families (TANF) Basic grant per recipient for the federally funded TANF program. The TANF Basic program provides a monthly financial assistance payment to eligible families with children and with no or one certified adult.

BL 2016 Data Limitations

Data are incomplete at initial reporting due to cancellations and supplemental payments.

BL 2016 Data Source

Data is obtained from the "TANF Warrant History" file, based on eligibility determination system.

BL 2016 Methodology

This measure is calculated by dividing the total dollar amount of grants to TANF Basic recipients in reporting period by total number of TANF Basic recipients per month for the same period. Because data are reported on an incurred basis, the most recent data are completed using completion ratios. Forecasting models and trends are used to project future estimates.

BL 2016 Purpose

This measure provides the unit cost of one of the service components funded under this strategy.

BL 2017 Definition

This measure reports the dollar amount of the average monthly Temporary Assistance for Needy Families (TANF) Basic grant per recipient for the federally funded TANF program. The TANF Basic program provides a monthly financial assistance payment to eligible families with children and with no or one certified adult.

BL 2017 Data Limitations

Data are incomplete at initial reporting due to cancellations and supplemental payments.

BL 2017 Data Source

Data is obtained from the "TANF Warrant History" file, based on eligibility determination system.

Strategy-Related Measures Definitions

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BL 2017 Methodology

This measure is calculated by dividing the total dollar amount of grants to TANF Basic recipients in reporting period by total number of TANF Basic recipients per month for the same period. Because data are reported on an incurred basis, the most recent data are completed using completion ratios. Forecasting models and trends are used to project future estimates.

BL 2017 Purpose

This measure provides the unit cost of one of the service components funded under this strategy.

Strategy-Related Measures Definitions
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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: L** Cross Reference: Agy 529 083-R-S70-1 04-01-01 EF 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 Data Limitations

Data are incomplete at initial reporting due to cancellations and supplemental payments.

BL 2016 Data Source

Data is obtained from the 'TANF Warrant History' file, based on eligibility determination system.

BL 2016 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 2016 Purpose

This measure provides the unit cost of one of the service components funded under this strategy.

BL 2017 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 2017 Data Limitations

Data are incomplete at initial reporting due to cancellations and supplemental payments.

BL 2017 Data Source

Data is obtained from the 'TANF Warrant History' file, based on eligibility determination system.

BL 2017 Methodology

Strategy-Related Measures Definitions

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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 2017 Purpose

This measure provides the unit cost of one of the service components funded under this strategy.

Strategy-Related Measures Definitions
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Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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: H** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 04-01-01 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This measure reports the monthly average number of persons who received a Temporary Assistance for Needy Families (TANF) grant from the federally funded TANF program during the reporting period. The TANF program provides a monthly financial assistance payment to low income families with children and with no or one certified parent.

BL 2016 Data Limitations

None.

BL 2016 Data Source

Data is obtained from the "TANF Warrant History" file based on an eligibility determination system.

BL 2016 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 2016 Purpose

This measure provides an average monthly count of persons receiving federally funded TANF cash assistance.

BL 2017 Definition

This measure reports the monthly average number of persons who received a Temporary Assistance for Needy Families (TANF) grant from the federally funded TANF program during the reporting period. The TANF program provides a monthly financial assistance payment to low income families with children and with no or one certified parent.

BL 2017 Data Limitations

None.

BL 2017 Data Source

Data is obtained from the "TANF Warrant History" file based on an eligibility determination system.

Strategy-Related Measures Definitions

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BL 2017 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 2017 Purpose

This measure provides an average monthly count of persons receiving federally funded TANF cash assistance.

Strategy-Related Measures Definitions
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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: H** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 04-01-01 OP 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 Data Limitations

None.

BL 2016 Data Source

Data is obtained from the 'TANF Warrant History' file based on an eligibility determination system.

BL 2016 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 2016 Purpose

This measure reports the monthly average number of persons who received a State Two-Parent Cash Assistance Program grant during the reporting period. The State Two-Parent Cash Assistance program provides a monthly financial assistance payment to eligible families with two certified adults.

BL 2017 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 2017 Data Limitations

None.

BL 2017 Data Source

Data is obtained from the 'TANF Warrant History' file based on an eligibility determination system..

BL 2017 Methodology

Strategy-Related Measures Definitions

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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 2017 Purpose

This measure reports the monthly average number of persons who received a State Two-Parent Cash Assistance Program grant during the reporting period. The State Two-Parent Cash Assistance program provides a monthly financial assistance payment to eligible families with two certified adults.

Strategy-Related Measures Definitions
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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 529 083-R-S70-1 04-01-01 OP 03

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

BL 2016 Definition

This measure reports the number of One Time (OT) payments issued. Temporary Assistance for Needy Families (TANF) One Time payments provides a \$1000 emergency cash payment to families not receiving monthly TANF/two parent benefits and who meet all TANF eligibility requirements. In order to receive a one-time payment, families must meet all TANF requirements and at least one of the crisis criteria as outlined in the Texas Works Handbook.

BL 2016 Data Limitations

None.

BL 2016 Data Source

Data is obtained from the 'TANF Warrant History' file based on an eligibility determination system.

BL 2016 Methodology

The number of average payments per month is computed by summing the number of TANF One time payments in all months of the reporting period and dividing by the number of months in the reporting period. Because data is reported on an incurred basis, the most recent data are completed using completion ratios. Forecasting models and trends are used to project future estimates.

BL 2016 Purpose

This measure provides an average monthly count of persons receiving a TANF one-time payment.

BL 2017 Definition

This measure reports the number of One Time (OT) payments issued. Temporary Assistance for Needy Families (TANF) One Time payments provides a \$1000 emergency cash payment to families not receiving monthly TANF/two parent benefits and who meet all TANF eligibility requirements. In order to receive a one-time payment, families must meet all TANF requirements and at least one of the crisis criteria as outlined in the Texas Works Handbook.

BL 2017 Data Limitations

None.

BL 2017 Data Source

Data is obtained from the 'TANF Warrant History' file based on an eligibility determination system.

Strategy-Related Measures Definitions

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BL 2017 Methodology

The number of average payments per month is computed by summing the number of TANF One time payments in all months of the reporting period and dividing by the number of months in the reporting period. Because data is reported on an incurred basis, the most recent data are completed using completion ratios. Forecasting models and trends are used to project future estimates.

BL 2017 Purpose

This measure provides an average monthly count of persons receiving a TANF one-time payment.

Strategy-Related Measures Definitions
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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 529 083-R-S70-1 04-01-01 OP 04
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 Data Limitations

None.

BL 2016 Data Source

Data is obtained from the "TANF Warrant History" file based on an eligibility determination system

BL 2016 Methodology

An ad hoc report will provide a count of children who received the once a year grant.

BL 2016 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 2017 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 2017 Data Limitations

None.

BL 2017 Data Source

Data is obtained from the "TANF Warrant History" file based on an eligibility determination system

BL 2017 Methodology

An ad hoc report will provide a count of children who received the once a year grant.

Strategy-Related Measures Definitions
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BL 2017 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
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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 529 083-R-S70-1 04-01-01 OP 05

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

BL 2016 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 2016 Data Limitations

Only one TANF One time Grandparent payment is counted per TANF Grandparent case.

BL 2016 Data Source

TANF One time Grandparent payment data are from the agency's Client Server Support System Grandparent Payment System database.

BL 2016 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 2016 Purpose

This measure provides information on the utilization of TANF One time Grandparent payments.

BL 2017 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 2017 Data Limitations

Only one TANF One time Grandparent payment is counted per TANF Grandparent case.

BL 2017 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

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BL 2017 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 2017 Purpose

This measure provides information on the utilization of TANF One time Grandparent payments.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
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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 529 083-R-S70-1 04-01-01 OP 06

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

BL 2016 Definition

This measure reports the average number of adults receiving Temporary Assistance for Needy Families (TANF) or State Two Parent Cash Assistance in the month who have used one or more state time limited months. The term "time limited" refers to the maximum length of time that a client is eligible to receive benefits. State time limits are determined based on education, functional literacy and work history, and are for 12, 24 or 36 months.

BL 2016 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 2016 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 2016 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 2016 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 2017 Definition

This measure reports the average number of adults receiving Temporary Assistance for Needy Families (TANF) or State Two Parent Cash Assistance in the month who have used one or more state time limited months. The term "time limited" refers to the maximum length of time that a client is eligible to receive benefits. State time limits are determined based on education, functional literacy and work history, and are for 12, 24 or 36 months.

Strategy-Related Measures Definitions

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BL 2017 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 2017 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 2017 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 2017 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
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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: H** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 04-01-01 OP 07

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

BL 2016 Definition

This measure reports the average number of adults receiving Temporary Assistance for Needy Families (TANF) or State Two Parent Cash Assistance in the month who have used one or more time limited months. The term "time limited" refers to the maximum length of time that a client is eligible to receive benefits. TANF and State Two-Parent Cash Assistance programs allow a maximum of 60 months of benefits

BL 2016 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 2016 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 2016 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 2016 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 2017 Definition

This measure reports the average number of adults receiving Temporary Assistance for Needy Families (TANF) or State Two Parent Cash Assistance in the month who have used one or more time limited months. The term "time limited" refers to the maximum length of time that a client is eligible to receive benefits. TANF and State Two-Parent Cash Assistance programs allow a maximum of 60 months of benefits

BL 2017 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
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BL 2017 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 2017 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 2017 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
84th Regular Session, Agency Submission, Version 1
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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 Services	

Calculation Method: C **Target Attainment: H** **Priority: L** Cross Reference: Agy 529 083-R-S70-1 04-01-02 OP 02
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

The number provided is an unduplicated count of refugee clients who receive refugee services which include medical and financial services.

BL 2016 Data Limitations

Social and financial services are dependent on each contractor timely and accurately entering information into the data collection system maintained by program. Data on medical services are dependent on HHSC Eligibility Staff timely and accurately entering information in the eligibility determination system. Program relies on agency programs to provide information (e.g., extracts and compiles applicable information, provides the file, cross-references available information, eliminates duplication and makes any necessary corrections to data).

BL 2016 Data Source

Information on social and financial services is obtained from the data collection system maintained by Office of Immigration and Refugee Affairs (OIRA) which is an on-line automated system that records the number of refugees receiving these services. Medical information is obtained from a report from the eligibility determination system.

BL 2016 Methodology

Program area extracts and compiles data on medical services from the eligibility determination system to identify TP02 clients. TP02 is a designator for clients who receive refugee medical services. IT queries the OIRA data collection system to obtain a list of refugee clients that receive social and financial services and cross references this list with the list of clients receiving medical services. Program area identifies any duplication and develops a comprehensive, unduplicated count of clients who received refugee services which would include social, medical and financial services.

BL 2016 Purpose

This measure provides a count of unduplicated persons receiving refugee services funded by HHSC which include medical and financial services.

BL 2017 Definition

The number provided is an unduplicated count of refugee clients who receive refugee services which include medical and financial services.

BL 2017 Data Limitations

Strategy-Related Measures Definitions

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Social and financial services are dependent on each contractor timely and accurately entering information into the data collection system maintained by program. Data on medical services are dependent on HHSC Eligibility Staff timely and accurately entering information in the eligibility determination system. Program relies on agency programs to provide information (e.g., extracts and compiles applicable information, provides the file, cross-references available information, eliminates duplication and makes any necessary corrections to data).

BL 2017 Data Source

Information on social and financial services is obtained from the data collection system maintained by Office of Immigration and Refugee Affairs (OIRA) which is an on-line automated system that records the number of refugees receiving these services. Medical information is obtained from a report from the eligibility determination system.

BL 2017 Methodology

Program area extracts and compiles data on medical services from the eligibility determination system to identify TP02 clients. TP02 is a designator for clients who receive refugee medical services. IT queries the OIRA data collection system to obtain a list of refugee clients that receive social and financial services and cross references this list with the list of clients receiving medical services. Program area identifies any duplication and develops a comprehensive, unduplicated count of clients who received refugee services which would include social, medical and financial services.

BL 2017 Purpose

This measure provides a count of unduplicated persons receiving refugee services funded by HHSC which include medical and financial services.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
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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 529 083-R-S70-1 04-01-03 OP 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

Reports unduplicated number of Federal Emergency Management Agency (FEMA) referrals for Other Needs Assistance (ONA) under the Individual and Households Program (IHP) approved for a grant during a presidentially declared disaster. The maximum grant is \$31,400 for each individual/household, and is adjusted annually. Grants are provided for disaster-related serious needs and necessary expenses not met by the victim's insurance, voluntary organizations or other relief organizations. For property losses, the victim must be denied loan assistance by the Small Business Administration. IHP grants may consist of Housing Assistance provided directly by FEMA and ONA (for repair or replacement of personal property and vehicles or for medical or funeral assistance) provided by HHSC. Victims must apply for assistance within 60 days after the President declares a major disaster.

BL 2016 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 2016 Data Source

Data is obtained from reports on applications approved from the Disaster Assistance Reporting Information System, which interfaces with the federal National Emergency Management Information System.

BL 2016 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 2016 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 2017 Definition

Strategy-Related Measures Definitions

84th Regular Session, Agency Submission, Version 1
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Reports unduplicated number of Federal Emergency Management Agency (FEMA) referrals for Other Needs Assistance (ONA) under the Individual and Households Program (IHP) approved for a grant during a presidentially declared disaster. The maximum grant is \$31,400 for each individual/household, and is adjusted annually. Grants are provided for disaster-related serious needs and necessary expenses not met by the victim's insurance, voluntary organizations or other relief organizations. For property losses, the victim must be denied loan assistance by the Small Business Administration. IHP grants may consist of Housing Assistance provided directly by FEMA and ONA (for repair or replacement of personal property and vehicles or for medical or funeral assistance) provided by HHSC. Victims must apply for assistance within 60 days after the President declares a major disaster.

BL 2017 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 2017 Data Source

Data is obtained from reports on applications approved from the Disaster Assistance Reporting Information System, which interfaces with the federal National Emergency Management Information System.

BL 2017 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 2017 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
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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 Services	

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 04-02-01 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This measure reports the HHSC average cost per person receiving shelter services, non-residential services or both and the average cost per client receiving both services. A "Shelter" provides residential and nonresidential services to victims of family violence including a secure 24-hour-a-day temporary emergency residence, emergency medical care, emergency transportation, intervention services, legal assistance (civil and criminal), information on educational arrangements for children, information about training for and seeking employment and referral to community resources. "Non-resident services" refers to the delivery of the following in a non-live-in environment: Counseling, assistance in obtaining medical care, transportation, legal assistance, employment services, law enforcement liaison, and information and referral to other resources.

BL 2016 Data Limitations

Data is dependent on each contractor timely and accurately entering information into the Family Violence Program data collection system.

BL 2016 Data Source

Data is obtained from the automated data collection system maintained by the Family Violence Program.

BL 2016 Methodology

The program area receives data from the automated system maintained by the Family Violence Program and queries data according to program requirements for all quarters, the annual funding for Family Violence providers is divided by four to get the estimated expenditures attributable to the quarter being reported to determine the average cost for the reporting period. The average cost is the numerator for this measure. The denominator for this measure is the sum of the number of clients specific to the quarter being reported. Divide the numerator by the denominator to calculate the average cost per person receiving family violence services. When calculating the second quarter, third quarter, and fourth quarter, the year to date total is recalculated.

BL 2016 Purpose

This measure quantifies the average cost to the agency for each person receiving Family Violence services. This data is a useful tool for projecting future funding needs.

BL 2017 Definition

Strategy-Related Measures Definitions

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This measure reports the HHSC average cost per person receiving shelter services, non-residential services or both and the average cost per client receiving both services. A "Shelter" provides residential and nonresidential services to victims of family violence including a secure 24-hour-a-day temporary emergency residence, emergency medical care, emergency transportation, intervention services, legal assistance (civil and criminal), information on educational arrangements for children, information about training for and seeking employment and referral to community resources. "Non-resident services" refers to the delivery of the following in a non-live-in environment: Counseling, assistance in obtaining medical care, transportation, legal assistance, employment services, law enforcement liaison, and information and referral to other resources.

BL 2017 Data Limitations

Data is dependent on each contractor timely and accurately entering information into the Family Violence Program data collection system.

BL 2017 Data Source

Data is obtained from the automated data collection system maintained by the Family Violence Program.

BL 2017 Methodology

The program area receives data from the automated system maintained by the Family Violence Program and queries data according to program requirements for all quarters, the annual funding for Family Violence providers is divided by four to get the estimated expenditures attributable to the quarter being reported to determine the average cost for the reporting period. The average cost is the numerator for this measure. The denominator for this measure is the sum of the number of clients specific to the quarter being reported. Divide the numerator by the denominator to calculate the average cost per person receiving family violence services. When calculating the second quarter, third quarter, and fourth quarter, the year to date total is recalculated.

BL 2017 Purpose

This measure quantifies the average cost to the agency for each person receiving Family Violence services. This data is a useful tool for projecting future funding needs.

Strategy-Related Measures Definitions
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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		Percent of Family Violence Program Budgets Funded by HHSC

Calculation Method: N **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 04-02-01 EX 02

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

BL 2016 Definition

This measure reports the average percent of the cost of centers providing family violence services which is funded by HHSC.

BL 2016 Data Limitations

None.

BL 2016 Data Source

The HHSC allocation amount and the projected total resources to the centers for providing family violence services as recorded on the approved budget submitted by the family violence center.

BL 2016 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 2016 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 2017 Definition

This measure reports the average percent of the cost of centers providing family violence services which is funded by HHSC.

BL 2017 Data Limitations

None.

BL 2017 Data Source

The HHSC allocation amount and the projected total resources to the centers for providing family violence services as recorded on the approved budget submitted by the family violence center.

BL 2017 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
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BL 2017 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
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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: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 04-02-01 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

Reports number of victims of family violence and their children who receive either shelter, or non-residential services, and clients who receive a combination of both services from family violence programs that contract with the state. Shelter services include 24-hour a day shelter emergency medical care, emergency transportation, intervention services, legal assistance (civil and criminal), information on educational arrangements for children, information about training for and seeking employment, and referral to community resources. Non-residential services are the delivery of all of the above services in a non-live-in environment.

BL 2016 Data Limitations

Data is dependent on each contractor timely and accurately entering information into the Family Violence Program data collection system. Duplication may occur when a client re-enters the program within the reporting period.

BL 2016 Data Source

Data is obtained from the automated data collection system maintained by the Family Violence Program.

BL 2016 Methodology

Staff receives data from the automated system maintained by the Family Violence Program and queries data according to program requirements to obtain the unduplicated number of persons served.

BL 2016 Purpose

This measure provides caseload information for this strategy. It provides a count of the total number of persons receiving services from family violence programs and shelters.

BL 2017 Definition

Reports number of victims of family violence and their children who receive either shelter, or non-residential services, and clients who receive a combination of both services from family violence programs that contract with the state. Shelter services include 24-hour a day shelter emergency medical care, emergency transportation, intervention services, legal assistance (civil and criminal), information on educational arrangements for children, information about training for and seeking employment, and referral to community resources. Non-residential services are the delivery of all of the above services in a non-live-in environment.

BL 2017 Data Limitations

Data is dependent on each contractor timely and accurately entering information into the Family Violence Program data collection system. Duplication may occur when a client re-enters the program within the reporting period.

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BL 2017 Data Source

Data is obtained from the automated data collection system maintained by the Family Violence Program.

BL 2017 Methodology

Staff receives data from the automated system maintained by the Family Violence Program and queries data according to program requirements to obtain the unduplicated number of persons served.

BL 2017 Purpose

This measure provides caseload information for this strategy. It provides a count of the total number of persons receiving services from family violence programs and shelters.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	4	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 529 083-R-S70-1 04-02-01 OP 02

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

BL 2016 Definition

This measure reports the total number of Residential and Non-Residential programs contracting with the state to provide family violence services. Residential and Non-Residential programs are community based, non-profit agencies that contract with HHSC to provide services to clients of the family violence programs.

BL 2016 Data Limitations

None.

BL 2016 Data Source

This data is obtained from a count of current residential and non-residential contractors who participate in the program during this reporting period.

BL 2016 Methodology

The number of residential and non-residential programs are counted at the end of the reporting period.

BL 2016 Purpose

This measure is an indicator of the availability of domestic violence services funded by HHSC

BL 2017 Definition

This measure reports the total number of Residential and Non-Residential programs contracting with the state to provide family violence services. Residential and Non-Residential programs are community based, non-profit agencies that contract with HHSC to provide services to clients of the family violence programs.

BL 2017 Data Limitations

None.

BL 2017 Data Source

This data is obtained from a count of current residential and non-residential contractors who participate in the program during this reporting period.

BL 2017 Methodology

The number of residential and non-residential programs are counted at the end of the reporting period.

Strategy-Related Measures Definitions
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BL 2017 Purpose

This measure is an indicator of the availability of domestic violence services funded by HHSC

Strategy-Related Measures Definitions
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Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 529 083-R-S70-1 04-02-01 OP 03
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 Data Limitations

Data is dependent on each contractor timely and accurately entering information into the Family Violence Program data collection system.

BL 2016 Data Source

Data are obtained from the automated data collection system maintained by the Family Violence Program.

BL 2016 Methodology

Staff receives data from the automated system maintained by the Family Violence Program and queries data according to program requirements to obtain the number of hotline calls.

BL 2016 Purpose

This measure demonstrates the level of hotline services needed.

BL 2017 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 2017 Data Limitations

Data is dependent on each contractor timely and accurately entering information into the Family Violence Program data collection system.

BL 2017 Data Source

Data are obtained from the automated data collection system maintained by the Family Violence Program.

Strategy-Related Measures Definitions
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BL 2017 Methodology

Staff receives data from the automated system maintained by the Family Violence Program and queries data according to program requirements to obtain the number of hotline calls.

BL 2017 Purpose

This measure demonstrates the level of hotline services needed.

Strategy-Related Measures Definitions
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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: C **Target Attainment: H** **Priority: L** Cross Reference: Agy 529 083-R-S70-1 04-02-02 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

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

BL 2016 Data Limitations

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

BL 2016 Data Source

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

BL 2016 Methodology

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

BL 2016 Purpose

This measure is an indicator of the total number of clients who have received services as an alternative to abortions.

BL 2017 Definition

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

BL 2017 Data Limitations

Strategy-Related Measures Definitions

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

BL 2017 Data Source

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

BL 2017 Methodology

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

BL 2017 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
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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: Agy 529 083-R-S70-1 04-02-02 OP 02

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

BL 2016 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 2016 Data Limitations

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

BL 2016 Data Source

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

BL 2016 Methodology

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

BL 2016 Purpose

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

BL 2017 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 2017 Data Limitations

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

BL 2017 Data Source

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

Strategy-Related Measures Definitions

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BL 2017 Methodology

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

BL 2017 Purpose

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

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	4	Encourage Self Sufficiency	
Objective No.	2	Other Family Support Services	
Strategy No.	3	Texas Women's Health Program	
Measure Type	EF		
Measure No.	1	Average Women's Health Program Cost Per Recipient Month	

Calculation Method: N **Target Attainment: L** **Priority:** Cross Reference: Agy 529 083-R-S70-1 04-02-03 EF 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This measure reports the average monthly expenditure per Texas Women's Health Program recipient month as of November 1, 2012, when the state-based program took effect.

BL 2016 Data Limitations

None.

BL 2016 Data Source

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

BL 2016 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 2016 Purpose

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

BL 2017 Definition

This measure reports the average monthly expenditure per Texas Women's Health Program recipient month as of November 1, 2012, when the state-based program took effect.

BL 2017 Data Limitations

None.

BL 2017 Data Source

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

Strategy-Related Measures Definitions
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BL 2017 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 2017 Purpose

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

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	4	Encourage Self Sufficiency	
Objective No.	2	Other Family Support Services	
Strategy No.	3	Texas Women's Health Program	
Measure Type	EX		
Measure No.	1	Number of Providers Enrolled in Texas Women's Health Program	

Calculation Method: N **Target Attainment: H** **Priority: M** Cross Reference:
Key Measure: N **New Measure: Y** **Percentage Measure: N**

BL 2016 Definition

This measure reports the number of certified providers enrolled and eligible to provide Texas Women's Health Program (TWHP) services to TWHP clients.

BL 2016 Data Limitations

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

BL 2016 Data Source

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

BL 2016 Methodology

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

BL 2016 Purpose

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

BL 2017 Definition

This measure reports the number of certified providers enrolled and eligible to provide Texas Women's Health Program (TWHP) services to TWHP clients.

BL 2017 Data Limitations

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

BL 2017 Data Source

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

BL 2017 Methodology

Strategy-Related Measures Definitions

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

BL 2017 Purpose

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

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	4		Encourage Self Sufficiency
Objective No.	2		Other Family Support Services
Strategy No.	3		Texas Women's Health Program
Measure Type	OP		
Measure No.	1		Avg Number of Texas Women's Health Program Recipient Mo/Month

Calculation Method: C **Target Attainment: L** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 04-02-03 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This measure reports the average monthly number of recipient months for recipients who receive services in the Texas Women's Health Program as of November 1, 2012, when the state-based program took effect.

BL 2016 Data Limitations

None

BL 2016 Data Source

The Premium Payable System.

BL 2016 Methodology

A recipient month is defined as one month's coverage for an individual who has been determined as eligible for TWHP. 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 2016 Purpose

This measure reflects the average number of recipient months per month for which a claim or premium is paid for clients in the TWHP.

BL 2017 Definition

This measure reports the average monthly number of recipient months for recipients who receive services in the Texas Women's Health Program as of November 1, 2012, when the state-based program took effect.

BL 2017 Data Limitations

None

BL 2017 Data Source

The Premium Payable System.

Strategy-Related Measures Definitions

84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2017 Methodology

A recipient month is defined as one month's coverage for an individual who has been determined as eligible for TWHP. 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 2017 Purpose

This measure reflects the average number of recipient months per month for which a claim or premium is paid for clients in the TWHP.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 529 083-R-S70-1 07-01-01 EF 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This is the measure of the average dollars recovered (dollars actually recovered) and saved per completed provider and recipient investigations, completed hospital and nursing facility reviews, and completed audits.

BL 2016 Data Limitations

No limitations.

BL 2016 Data Source

Office of Inspector General (OIG) case management systems and activity summary sheets. Staff in OIG enters information on dollars recovered (dollars actually recovered and identified for recovery) and saved into data bases. Data is collected on a monthly basis and is maintained by OIG staff.

BL 2016 Methodology

This measure is calculated by adding the dollars recovered (dollars actually recovered) and dollars saved and dividing by the number of investigations, reviews, and audits completed during the same reporting period.

BL 2016 Purpose

This measure addresses how efficiently the OIG is completing investigations, reviews and audits.

BL 2017 Definition

This is the measure of the average dollars recovered (dollars actually recovered) and saved per completed provider and recipient investigations, completed hospital and nursing facility reviews, and completed audits.

BL 2017 Data Limitations

No limitations.

BL 2017 Data Source

Office of Inspector General (OIG) case management systems and activity summary sheets. Staff in OIG enters information on dollars recovered (dollars actually recovered and identified for recovery) and saved into data bases. Data is collected on a monthly basis and is maintained by OIG staff.

Strategy-Related Measures Definitions

84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2017 Methodology

This measure is calculated by adding the dollars recovered (dollars actually recovered) and dollars saved and dividing by the number of investigations, reviews, and audits completed during the same reporting period.

BL 2017 Purpose

This measure addresses how efficiently the OIG is completing investigations, reviews and audits.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 529 083-R-S70-1 07-01-01 EX 01
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 Data Limitations

No limitations.

BL 2016 Data Source

Case management system maintained by OIG.

BL 2016 Methodology

A sum of exclusions imposed as the result of OIG activities, activities of the Office of Inspector General of the United States Department of Health and Human Services, licensure board actions, and/or court actions/convictions.

BL 2016 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 2017 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 2017 Data Limitations

No limitations.

BL 2017 Data Source

Case management system maintained by OIG.

BL 2017 Methodology

A sum of exclusions imposed as the result of OIG activities, activities of the Office of Inspector General of the United States Department of Health and Human Services, licensure board actions, and/or court actions/convictions.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
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BL 2017 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
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 Completed Provider and Recipient Investigations	

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 07-01-01 OP 01
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This is a measure of the Medicaid Program Integrity and the General Investigations sections of Office of Inspector General (OIG) that is responsible for investigating allegations, complaints, and referrals of Medicaid, Temporary Assistance for Needy Families, and Supplemental Nutrition Assistance Program fraud, abuse, or waste.

BL 2016 Data Limitations

No limitations.

BL 2016 Data Source

OIG case management systems.

BL 2016 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 2016 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 2017 Definition

This is a measure of the Medicaid Program Integrity and the General Investigations sections of Office of Inspector General (OIG) that is responsible for investigating allegations, complaints, and referrals of Medicaid, Temporary Assistance for Needy Families, and Supplemental Nutrition Assistance Program fraud, abuse, or waste.

BL 2017 Data Limitations

No limitations.

BL 2017 Data Source

OIG case management systems.

BL 2017 Methodology

Strategy-Related Measures Definitions

84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

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 2017 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
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 and Reviews Performed	

Calculation Method: C **Target Attainment: H** **Priority: L** Cross Reference: Agy 529 083-R-S70-1 07-01-01 OP 02
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This measures the total number of programmatic and financial audits and reviews of HHS programs conducted by the Office of Inspector General (OIG). An audit is a programmatic or financial engagement conducted and reported in accordance with Governmental Auditing Standards. A review is an engagement classified as a non-audit service in accordance with Governmental Auditing Standards. Internal audits conducted by Internal Audit departments and in accordance with the Institute of Internal Auditors Standards are not included.

BL 2016 Data Limitations

None.

BL 2016 Data Source

OIG case management systems.

BL 2016 Methodology

Total sum of audits and non-audit engagements conducted.

BL 2016 Purpose

To measure audits and non-audits engagements represents a positive approach to review funded HHS programs.

BL 2017 Definition

This measures the total number of programmatic and financial audits and reviews of HHS programs conducted by the Office of Inspector General (OIG). An audit is a programmatic or financial engagement conducted and reported in accordance with Governmental Auditing Standards. A review is an engagement classified as a non-audit service in accordance with Governmental Auditing Standards. Internal audits conducted by Internal Audit departments and in accordance with the Institute of Internal Auditors Standards are not included.

BL 2017 Data Limitations

None.

BL 2017 Data Source

OIG case management systems.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2017 Methodology

Total sum of audits and non-audit engagements conducted.

BL 2017 Purpose

To measure audits and non-audits engagements represents a positive approach to review funded HHS programs.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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: L** Cross Reference: Agy 529 083-R-S70-1 07-01-01 OP 03
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 Data Limitations

No limitations.

BL 2016 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 2016 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 2016 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 2017 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 2017 Data Limitations

No limitations.

BL 2017 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 2017 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
84th Regular Session, Agency Submission, Version 1
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BL 2017 Purpose

Case mix reviews determine the level of care provided by nursing facilities to Medicaid residents and the relationship of such care to the charges (billing) to the state. Case mix reviews also determine the need for corrective action procedures and/or referral to Medicaid Program Integrity.

Strategy-Related Measures Definitions
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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 529 083-R-S70-1 07-01-01 OP 04
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This is a measure of utilization reviews, which are on site or desk reviews which may be of a statistically valid, random, sample or a focused, case selection of hospital medical records for admissions, readmission, outliers, transfers, appropriate Diagnoses Related Groups (DRG), and quality of care. The purpose of utilization review is to detect and correct improper Medicaid billing practices by hospitals.

BL 2016 Data Limitations

No limitations.

BL 2016 Data Source

Nurse reviewers and/or administrative assistants in the field enter into the agency's database information collected during the on-site and desk reviews of charts. State office staff collects and accumulates information from all regions in a centralized tracking system.

BL 2016 Methodology

Nurse reviewers enter data in the field of the application indicating the number of reviews performed, and this data is summed up for the state for the reporting period.

BL 2016 Purpose

This measure is intended to determine the medical necessity for care, the appropriateness of the DRG assignments, the quality of patient care, and recover inappropriate Medicaid payments. Inpatient utilization reviews are required by public Law 92-603 to be conducted in all Title XIX participating hospitals.

BL 2017 Definition

This is a measure of utilization reviews, which are on site or desk reviews which may be of a statistically valid, random, sample or a focused, case selection of hospital medical records for admissions, readmission, outliers, transfers, appropriate Diagnoses Related Groups (DRG), and quality of care. The purpose of utilization review is to detect and correct improper Medicaid billing practices by hospitals.

BL 2017 Data Limitations

No limitations.

BL 2017 Data Source

Nurse reviewers and/or administrative assistants in the field enter into the agency's database information collected during the on-site and desk reviews of charts. State office staff collects and accumulates information from all regions in a centralized tracking system.

Strategy-Related Measures Definitions

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BL 2017 Methodology

Nurse reviewers enter data in the field of the application indicating the number of reviews performed, and this data is summed up for the state for the reporting period.

BL 2017 Purpose

This measure is intended to determine the medical necessity for care, the appropriateness of the DRG assignments, the quality of patient care, and recover inappropriate Medicaid payments. Inpatient utilization reviews are required by public Law 92-603 to be conducted in all Title XIX participating hospitals.

Strategy-Related Measures Definitions
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 529 083-R-S70-1 07-01-01 OP 05
Key Measure: Y **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This is a measure of the total monetary recoveries resulting from activities of the Office of Inspector General (OIG) at the end of each quarter and fiscal year. Recoveries include the following departments within OIG: Quality Review, Technology Analysis, Development & Support, Audit, Medicaid Program Integrity, and General Investigations. These recoveries include Dollars actually recovered.

BL 2016 Data Limitations

OIG is dependent upon other agencies and vendors for the recovery of some of the funds involved in the measure.

BL 2016 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 2016 Methodology

The sum of dollars recovered (Dollars actually recovered) by each section of OIG for the reporting period.

BL 2016 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 2017 Definition

This is a measure of the total monetary recoveries resulting from activities of the Office of Inspector General (OIG) at the end of each quarter and fiscal year. Recoveries include the following departments within OIG: Quality Review, Technology Analysis, Development & Support, Audit, Medicaid Program Integrity, and General Investigations. These recoveries include Dollars actually recovered.

BL 2017 Data Limitations

OIG is dependent upon other agencies and vendors for the recovery of some of the funds involved in the measure.

BL 2017 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
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BL 2017 Methodology

The sum of dollars recovered (Dollars actually recovered) by each section of OIG for the reporting period.

BL 2017 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
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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: H** Cross Reference: Agy 529 083-R-S70-1 07-01-01 OP 06
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 Data Limitations

OIG is dependent upon other agencies and vendors for the implementation of its recommendations, with the exception of training activities.

BL 2016 Data Source

Staff within OIG tracks cost savings arising from activities of OIG. The sources of data include: the HHSC Medicaid contracting system; OIG's policy development tracking systems; OIG's training and education databases; and the Medicaid claims administrator. Data is collected on an ongoing basis by staff within OIG and is summarized on a monthly basis.

BL 2016 Methodology

The effect of actions taken by OIG is measured against claims payments by the claims administrator and/or other sources during the reporting period. Actions taken can include payment holds put in place due to billing errors or fraud. Subsequently, providers billing patterns are seized or greatly reduced. Actions taken can also be excluding a provider from the Medicaid program for billing errors or fraud and the provider is no longer billing the Medicaid program. The sum of unduplicated cost savings is then calculated for the reporting period.

BL 2016 Purpose

This measure addresses the effectiveness of the OIG. It addresses the efforts of OIG in the area of administrative actions and sanctions, policy recommendations and development, and effective education of providers.

BL 2017 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 2017 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

84th Regular Session, Agency Submission, Version 1
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BL 2017 Data Source

Staff within OIG tracks cost savings arising from activities of OIG. The sources of data include: the HHSC Medicaid contracting system; OIG's policy development tracking systems; OIG's training and education databases; and the Medicaid claims administrator. Data is collected on an ongoing basis by staff within OIG and is summarized on a monthly basis.

BL 2017 Methodology

The effect of actions taken by OIG is measured against claims payments by the claims administrator and/or other sources during the reporting period. Actions taken can include payment holds put in place due to billing errors or fraud. Subsequently, providers billing patterns are seized or greatly reduced. Actions taken can also be excluding a provider from the Medicaid program for billing errors or fraud and the provider is no longer billing the Medicaid program. The sum of unduplicated cost savings is then calculated for the reporting period.

BL 2017 Purpose

This measure addresses the effectiveness of the OIG. It addresses the efforts of OIG in the area of administrative actions and sanctions, policy recommendations and development, and effective education of providers.

Strategy-Related Measures Definitions
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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.	7	Referrals to OAG Fraud Control Unit	

Calculation Method: C **Target Attainment: H** **Priority: H** Cross Reference: Agy 529 083-R-S70-1 07-01-01 OP 07
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 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 2016 Data Limitations

No limitations.

BL 2016 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 2016 Methodology

Sum of cases of credible allegations of fraud referred to the Office of the Attorney General during the reporting period.

BL 2016 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 2017 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 2017 Data Limitations

No limitations.

BL 2017 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

84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

BL 2017 Methodology

Sum of cases of credible allegations of fraud referred to the Office of the Attorney General during the reporting period.

BL 2017 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
84th Regular Session, Agency Submission, Version 1
Automated Budget and Evaluation System of Texas (ABEST)

Agency Code:	529	Agency:	Health and Human Services Commission
Goal No.	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 529 083-R-S70-1 07-01-01 OP 08
Key Measure: N **New Measure: N** **Percentage Measure: N**

BL 2016 Definition

This is a measure of the number of viable cases identified by MFADS (Medicaid Fraud and Abuse Detection System) 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 Office of Inspector General (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 2016 Data Limitations

No limitations.

BL 2016 Data Source

The case management component of MFADS and other OIG case management systems.

BL 2016 Methodology

The sum of cases identified by the MFADS during the reporting period.

BL 2016 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 2017 Definition

This is a measure of the number of viable cases identified by MFADS (Medicaid Fraud and Abuse Detection System) 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 Office of Inspector General (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 2017 Data Limitations

No limitations.

BL 2017 Data Source

The case management component of MFADS and other OIG case management systems.

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BL 2017 Methodology

The sum of cases identified by the MFADS during the reporting period.

BL 2017 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.