FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

The framework is designed to:

- **A.** Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- B. Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- C. Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- D. Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **TX**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Signature:

Chris Traylor

SCHIP Program Name(s): **All, Texas**

SCHIP Program Type:

- ☐ SCHIP Medicaid Expansion Only
- ☒ Separate Child Health Program Only
- ☐ Combination of the above

Reporting Period: **2006** *Note: Federal Fiscal Year 2006 starts 10/1/05 and ends 9/30/06.*

Contact Person/Title: **Olga Rodriguez, Deputy Director, Medicaid/CHIP**

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Health and Human Services Commission

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Submission Date: **2/9/2007**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

~~1)~~ To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. You are encouraged to complete this table for the different SCHIP programs within your state, e.g., if you have two types of separate child health programs within your state with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility						**From**	0	% of FPL conception to birth	0	% of FPL
	From		% of FPL for **infants**		% of FPL	**From**	185	% of FPL for **infants**	200	% of FPL
	From		% of FPL for children ages **1 through 5**		% of FPL	**From**	133	% of FPL for 1 **through 5**	200	% of FPL
	From		% of FPL for children ages **6 through 16**		% of FPL	**From**	100	% of FPL for children ages **6 through 16**	200	% of FPL
	From		% of FPL for children ages **17 and 18**		% of FPL	**From**	100	% of FPL for children ages **17 and 18**	200	% of FPL

Is presumptive eligibility provided for children?	☐	No	☒	No
	☐	Yes, for whom and how long?	☐	Yes, for whom and how long?
	☐	N/A	☐	N/A

Is retroactive eligibility available?	☐	No	☒	No
	☐	Yes, for whom and how long?	☐	Yes, for whom and how long?
	☐	N/A	☐	N/A

Does your State Plan contain authority to implement a waiting list?	Not applicable	☒	No
		☐	Yes
		☐	N/A

Does your program have a mail-in application?	☐	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program over the phone?	☐	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Does your program have an application on your website that can be printed, completed and mailed in?	☐	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Can an applicant apply for your program on-line?	☐	No	☐	No
	☐	Yes – please check all that apply	☒	Yes – please check all that apply
	☐	Signature page must be printed and mailed in	☒	Signature page must be printed and mailed in
	☐	Family documentation must be mailed (i.e., income documentation)	☒	Family documentation must be mailed (i.e., income documentation)
	☐	Electronic signature is required	☐	Electronic signature is required
			☐	No Signature is required
	☐	N/A	☐	N/A

Does your program require a face-to-face interview during initial application	☐	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	☐	No	☐	No
	☐	Yes	☒	Yes
	Specify number of months		Specify number of months	3
	☐	N/A	☐	N/A

Does your program provide period of continuous coverage <u>regardless of income changes?</u>	☐	No	☐	No
	☐	Yes	☒	Yes
	Specify number of months		Specify number of months	6
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
			Death, move out of state, acquisition of other insurance coverage, or turns age 19.	

	☐	N/A	☐	N/A

Does your program require premiums or an enrollment fee?	☐	No	☐	No
	☐	Yes	☒	Yes
	Enrollment fee amount		Enrollment fee amount	35
	Premium amount		Premium amount	
	Yearly cap		Yearly cap	
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)	
			Please see the narrative text below.	
	☐	N/A	☐	N/A

Does your program impose copayments or coinsurance?	☐	No	☐	No
	☐	Yes	☒	Yes
	☐	N/A	☐	N/A

Does your program impose deductibles?	☐	No	☒	No
	☐	Yes	☐	Yes
	☐	N/A	☐	N/A

Does your program require an assets test?	☐	No	☐	No
	☐	Yes	☒	Yes
	If Yes, please describe below		If Yes, please describe below	
			Families with incomes above 150% FPL may not have assets that exceed specified limits after certain allowances are made. Liquid assets, such as cash and bank accounts, and certain vehicle values are considered. Real property, such as a home, is not counted as an asset.	
	☐	N/A	☐	N/A

Does your program require income disregards?	☐	No	☒	No
	☐	Yes	☐	Yes
	If Yes, please describe below		If Yes, please describe below	
	☐	N/A	☐	N/A

Is a preprinted renewal form sent prior to eligibility expiring?	☐	No	☐	No
	☐	Yes	☒	Yes
		☐ We send out form to family with their information pre-completed and ask for confirmation		☒ We send out form to family with their information pre-completed and ask for confirmation
		☐ We send out form but do not require a response unless income or other circumstances have changed		☐ We send out form but do not require a response unless income or other circumstances have changed
	☐	N/A	☐	N/A

Enter any Narrative text below.

Children with family incomes at or below 133% are not charged an enrollment fee. Children with family incomes above 133% and up to and including 150% FPL the fee is $25 per family per six month enrollment period. Children with family incomes above 150% and up to and including 185% FPL the fee is $35 per family per six month enrollment period. Children with family incomes above 185% FPL are charged $50 per family per six month enrollment period. The enrollment fee is capped yearly. For children with family incomes at or below 100% to 150% FPL, the cap is 1.25% of family income. For children with family incomes at or below 151% to 200% FPL, the cap is 2.5% of family income.

~~2.~~ Is there an assets test for children in your Medicaid program?	☒ Yes	☐ No	☐ N/A
~~3.~~ Is it different from the assets test in your separate child health program?	☒ Yes	☐ No	☐ N/A
~~4.~~ Are there income disregards for your Medicaid program?	☒ Yes	☐ No	☐ N/A
~~5.~~ Are they different from the income disregards in your separate child health program?	☒ Yes	☐ No	☐ N/A
~~6.~~ Is a joint application used for your Medicaid and separate child health program?	☒ Yes	☐ No	☐ N/A

7. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate “yes” or “no change” by marking appropriate column.

	Medicaid Expansion SCHIP Program			Separate Child Health Program		
	Yes	No Change	N/A	Yes	No Change	N/A
~~a)~~ Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☐	☐	☐	☒	☐
~~b)~~ Application	☐	☐	☐	☒	☐	☐
~~c)~~ Application documentation requirements	☐	☐	☐	☒	☐	☐
~~d)~~ Benefit structure	☐	☐	☐	☒	☐	☐
~~e)~~ Cost sharing (including amounts, populations, & collection process)	☐	☐	☐	☒	☐	☐
~~f)~~ Crowd out policies	☐	☐	☐	☐	☒	☐
~~g)~~ Delivery system	☐	☐	☐	☐	☒	☐
~~h)~~ Eligibility determination process (including implementing a waiting lists or open enrollment periods)	☐	☐	☐	☐	☒	☐
~~i)~~ Eligibility levels / target population	☐	☐	☐	☐	☒	☐
~~j)~~ Assets test in Medicaid and/or SCHIP	☐	☐	☐	☐	☒	☐
~~k)~~ Income disregards in Medicaid and/or SCHIP	☐	☐	☐	☐	☒	☐
~~l)~~ Eligibility redetermination process	☐	☐	☐	☐	☒	☐
~~m)~~ Enrollment process for health plan selection	☐	☐	☐	☐	☒	☐
~~n)~~ Family coverage	☐	☐	☐	☐	☒	☐
~~o)~~ Outreach (e.g., decrease funds, target outreach)	☐	☐	☐	☒	☐	☐
~~p)~~ Premium assistance	☐	☐	☐	☐	☒	☐
~~q)~~ Prenatal Eligibility expansion	☐	☐	☐	☐	☒	☐
~~r)~~ Waiver populations (funded under title XXI)						
Parents	☐	☐	☐	☐	☐	☒
Pregnant women	☐	☐	☐	☐	☐	☒
Childless adults	☐	☐	☐	☐	☐	☒

~~s)~~ Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	☐	☐	☐	☐	☐	☐
~~t)~~ Other – please specify					
~~a.~~ _____	☐	☐	☐	☐	☐	☒
~~b.~~ _____	☐	☐	☐	☐	☐	☒
~~c.~~ _____	☐	☐	☐	☐	☐	☒

8. For each topic you responded yes to above, please explain the change and why the change was made, below:

~~a)~~ Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
~~b)~~ Application	Some of the questions and instructions on the application regarding the required documentation were re-worded to clarify what information clients need to provide.
~~c)~~ Application documentation requirements	At the time of renewal, Texas Children's Health Insurance Program (CHIP) applicants must prove their family income level by providing one document that verifies the source and amount of income.
~~d)~~ Benefit structure	Effective January 2006, dental benefits were restored. Benefits include routine check-ups, routine cleanings, x-rays, fillings, and sealants.
~~e)~~ Cost sharing (including amounts, populations, & collection process)	Children with family incomes at or below 133% are not charged an enrollment fee. Children with family incomes above 133% and up to and including 150% FPL the fee is $25 per family per six month enrollment period. Children with family incomes above 150% and up to and including 185% FPL the fee is $35 per family per six month enrollment period. Children with family incomes above 185% FPL are charged $50 per family per six month enrollment period.
~~f)~~ Crowd out policies	
~~g)~~ Delivery system	

~~h)~~ Eligibility determination process (including implementing a waiting lists or open enrollment periods)	
~~i)~~ Eligibility levels / target population	
~~j)~~ Assets test in Medicaid and/or SCHIP	
~~k)~~ Income disregards in Medicaid and/or SCHIP	
~~l)~~ Eligibility redetermination process	
~~m)~~ Enrollment process for health plan selection	
~~n)~~ Family coverage	
~~o)~~ Outreach	In May 2006, HHSC began a one-year, $2.3 million outreach campaign promoting CHIP and Children's Medicaid. The outreach effort uses a three-prong strategy: community-based activism, mass media, and Internet marketing.
~~p)~~ Premium assistance	
~~q)~~ Prenatal Eligibility Expansion	
~~r)~~ Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
~~s)~~ Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	
~~t)~~ Other – please specify	
a.	
b.	
c.	

Enter any Narrative text below.

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three subsections that gather information on the core performance measures for the SCHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data are available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001. To address this SCHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of 19 measures, the group recommended seven core measures, including four core child health measures:

- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Children's access to primary care practitioners

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is not required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

This section contains templates for reporting performance measurement data for each of the core child health measures. Please report performance measurement data for the three most recent years (to the extent that data are available). In the first and second column, report data from the previous two years' annual reports (FFY 2004 and FFY 2005). If you previously reported no data for either of those years, but you now have recent data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2006). Additional instructions for completing each row of the table are provided below.

If Data Not Reported, Please Explain Why:
If you cannot provide a specific measure, please check the box that applies to your State for each performance measure as follows:

- Population not covered: Check this box if your program does not cover the population included in the measure.
- Data not available: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
- Small sample size: Check this box if the sample size (i.e., denominator) for a particular measure is less than 30. If the sample size is less than 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
- Other: Please specify if there is another reason why your state cannot report the measure.

Status of Data Reported:
Please indicate the status of the data you are reporting, as follows:

- Provisional: Check this box if you are reporting data for a measure, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2006.
- Final: Check this box if the data you are reporting are considered final for FFY 2006.

– Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:
For each performance measure, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2006). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

Data Source:
For each performance measure, please indicate the source of data – administrative data (claims), hybrid data (claims and medical records), survey data, or other source. If another data source was used, please explain the source.

Definition of Population included in the Measure:
Please indicate the definition of the population included in the denominator for each measure (such as age, continuous enrollment, type of delivery system). Check one box to indicate whether the data are for the SCHIP population only, or include both SCHIP and Medicaid (Title XIX) children combined. Also provide a definition of the numerator (such as the number of visits required for inclusion).

Note: You do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

Year of Data:
Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to utilization of services.

Performance Measurement Data (HEDIS® or Other):
In this section, please report the numerators, denominators, and rates for each measure (or component). The template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for each measure. If the form fields do not give you enough space to fully report on your measure, please use the "additional notes" section.

Note: SARTS will calculate the rate if you enter the numerator and denominator. Otherwise, if you only have the rate, enter it in the rate box.

If you typically calculate separate rates for each health plan, report the aggregate state-level rate for each measure (or component). The preferred method is to calculate a "weighted rate" by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator. Alternatively, if numerators and denominators are not available, you may calculate an "unweighted average" by taking the mean rate across health plans.

Explanation of Progress:
The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2007, 2008, and 2009. Based on your recent performance on the measure (from FFY 2004 through 2006), use a combination of expert opinion and "best guesses" to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small

increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years.

In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:
Please use this section to provide any other comments on the measure, such as data limitations or plans to report on a measure in the future.

NOTE: Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

MEASURE: Well Child Visits in the First 15 Months of Life

FFY 2004	FFY 2005	FFY 2006
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: N/A	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: N/A	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Two data sources were used to calculate the quality of care indicators: encounter-level enrollment information and encounter-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, the Managed Care Organization (MCO) in which the person was enrolled, and the number of months the person was enrolled in the program. The encounter-level claims/encounter data contained CPT and ICD 9-CM codes.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Two data sources were used to calculate the quality of care indicators: encounter-level enrollment information and encounter-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, the MCO in which the person was enrolled, and the number of months the person was enrolled in the program. The encounter-level claims/encounter data contained CPT and ICD 9-CM codes.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Two data sources were used to calculate the quality of care indicators: person-level enrollment information and person-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, the MCO in which the person is enrolled, and the number of months the person was enrolled in the program. The person-level claims/encounter data contained CPT, ICD 9-CM, and POS codes, and other information necessary to calculate the quality of care indicators.
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population.
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:** 2005

Well Child Visits in the First 15 Months of Life (continued)

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 77 Denominator: 652 Rate: 11.8 4 visits Numerator: 130 Denominator: 652 Rate: 19.9 1 visit Numerator: 75 Denominator: 652 Rate: 11.5 5 visits Numerator: 153 Denominator: 652 Rate: 23.5 2 visits Numerator: 60 Denominator: 652 Rate: 9.2 6+ visits Numerator: 79 Denominator: 652 Rate: 12.1 3 visits Numerator: 78 Denominator: 652 Rate: 12 Additional notes on measure: Baseline/ Year information reported in 2004: Year 1 - January 1, 2002 to December 31, 2002 No Visits: 187/1,526 (12.25%) One Visit: 165/1,526 (10.81%) Two Visits: 98/1,526 (12.98%) Three Visits: 245/1,526 (16.06%) Four Visits: 317/1,526 (20.77%) Five Visits: 272/1,526 (17.82%) Six or More Visits: 138/1,126 (9.04%)	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 17 Denominator: 303 Rate: 5.6 4 visits Numerator: 51 Denominator: 303 Rate: 16.8 1 visit Numerator: 22 Denominator: 303 Rate: 7.3 5 visits Numerator: 93 Denominator: 303 Rate: 30.7 2 visits Numerator: 18 Denominator: 303 Rate: 5.9 6+ visits Numerator: 76 Denominator: 303 Rate: 25.1 3 visits Numerator: 26 Denominator: 303 Rate: 8.6 Additional notes on measure: Please see attachment entitled Well Child Visits in the First 15 Months of Life.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with specified number of visits 0 visits Numerator: 7 Denominator: 112 Rate: 6.3 4 visits Numerator: 15 Denominator: 112 Rate: 13.4 1 visit Numerator: 8 Denominator: 112 Rate: 7.1 5 visits Numerator: 37 Denominator: 112 Rate: 33 2 visits Numerator: 5 Denominator: 112 Rate: 4.5 6+ visits Numerator: 29 Denominator: 112 Rate: 25.9 3 visits Numerator: 11 Denominator: 112 Rate: 9.8 Additional notes on measure: N/A
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A

Explanation of Progress:

Annual Performance Objective for FFY 2007: The annual performance objective for FFY 2007 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, the Texas Health and Human Services Commission (HHSC) has set overarching performance improvement goals for the MCOs to achieve in state fiscal year (SFY) 2007. One of these goals is to improve access to primary care services.

Annual Performance Objective for FFY 2008: The annual performance objective for FFY 2008 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2008. HHSC will determine those goals for SFY 2008 in May 2007.

Annual Performance Objective for FFY 2009: The annual performance objective for FFY 2009 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2009. HHSC will determine those goals for SFY 2009 in May 2008.

Explain how these objectives were set: HHSC writes the overarching performance improvement goals for the MCOs into the annual contract with the health plans.

Other Comments on Measure: N/A

MEASURE: Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life

FFY 2004	FFY 2005	FFY 2006
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30) *Specify sample size*: ☐ Other. *Explain*: N/A	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: N/A	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Two data sources were used to calculate the quality of care indicators: encounter-level enrollment information and encounter-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, the MCO in which the person was enrolled, and the number of months the person was enrolled in the program. The encounter-level claims/encounter data contained CPT and ICD 9-CM codes.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Two data sources were used to calculate the quality of care indicators: encounter-level enrollment information and encounter-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, the MCO in which the person was enrolled, and the number of months the person was enrolled in the program. The encounter-level claims/encounter data contained CPT and ICD 9-CM codes.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Two data sources were used to calculate the quality of care indicators: person-level enrollment information and person-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, the MCO in which the person is enrolled, and the number of months the person was enrolled in the program. The person-level claims/encounter data contained CPT, ICD 9-CM, and POS codes, and other information necessary to calculate the quality of care indicators.
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population.
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:** 2005

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 29150 Denominator: 60742 Rate: 48 Additional notes on measure: Baseline/ Year information reported in 2004: Year 1 – January 1, 2002 to December 31, 2002 One or More Visits: 29,215/ 113,988 (25.63%)	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 13024 Denominator: 24267 Rate: 53.7 Additional notes on measure: Additional notes on measure: Baseline / Year information reported in 2005: Year 1 – January 1, 2002 to December 31, 2002 One or More Visits: 29,215/ 113,988 (25.63%) Enrollee numbers may be smaller for Year 3 due to changes implemented following the 2003 Legislative Session. Those changes include a premium increase for families above 100 percent of the FPL and a 90-day waiting period for coverage.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 14318 Denominator: 27036 Rate: 53 Additional notes on measure: N/A

Well-Child Visits in Children the 3rd, 4th, 5th, and 6th Years of Life (continued)

FFY 2004	FFY 2005	FFY 2006
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A

Explanation of Progress:

Annual Performance Objective for FFY 2007: The annual performance objective for FFY 2007 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC has set overarching performance improvement goals for the MCOs to achieve in state fiscal year (SFY) 2007. One of these goals is to improve access to primary care services.

Annual Performance Objective for FFY 2008: The annual performance objective for FFY 2008 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2008. HHSC will determine those goals for SFY 2008 in May 2007.

Annual Performance Objective for FFY 2009: The annual performance objective for FFY 2009 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2009. HHSC will determine those goals for SFY 2009 in May 2008.

Explain how these objectives were set: HHSC writes the overarching performance improvement goals for the MCOs into the annual contract with the health plans.

Other Comments on Measure: N/A

MEASURE: Use of Appropriate Medications for Children with Asthma

FFY 2004	FFY 2005	FFY 2006
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: N/A	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: N/A	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Three data sources were used to calculate the quality of care indicators: encounter-level enrollment information, encounter-level health care claims/encounter data, and pharmacy data. The encounter-level claims/encounter data contained CPT and ICD 9-CM codes.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Three data sources were used: encounter-level enrollment, health care claims/encounter data, and pharmacy data. The enrollment files contained data about the person's age, gender, the MCO in which the person was enrolled, and the number of months the person was enrolled in the program. The claims/encounter data contained CPT and ICD 9-CM codes. The pharmacy data contains data about filled prescriptions including the drug name, dose, date filled, and refill information.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Please see attachment entitled Use of Appropriate Medication for Children with Asthma.

FFY 2004	FFY 2005	FFY 2006
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population. CHIP in Texas claims encounter data were compiled for the time period of December 1, 2001 to November 30, 2003. Per HEDIS specifications, 2 years of data was utilized.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population. Per HEDIS specifications, 2 years of data was utilized.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population. Per HEDIS specifications, 2 years of data was utilized.
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:** 2005

Use of Appropriate Medications for Children with Asthma (continued)

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 2313 Denominator: 3203 Rate: 72.2 10-17 years Numerator: 2893 Denominator: 4037 Rate: 71.7 Combined rate (5-17 years) Numerator: Denominator: Rate: Additional notes on measure: Numerators, denominators, and rates specified above were for Year 1 (December 1, 2002 to November 30, 2003), the baseline calculations. Performance Progress was not applicable. The combined rate (5-17 years) is N/A because HEDIS breaks down this measure for more appropriate tracking and reporting by age cohort. The EQRO updated this measure to comply with HEDIS, which currently measures ages 5-9 and 10-17.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 1558 Denominator: 2193 Rate: 71 10-17 years Numerator: 2255 Denominator: 3289 Rate: 68.6 Combined rate (5-17 years) Numerator: Denominator: Rate: Additional notes on measure: Please see attachment entitled Use of Appropriate Medication for Children with Asthma.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent receiving appropriate medications 5-9 years Numerator: 1425 Denominator: 2058 Rate: 69.2 10-17 years Numerator: 2289 Denominator: 3435 Rate: 66.6 Combined rate (5-17 years) Numerator: Denominator: Rate: Additional notes on measure: Rate reported for 18-19 years: 131/215 (60.93%) The combined rate (5-17 years) is N/A because HEDIS breaks down this measure for more appropriate tracking and reporting by age cohort. The EQRO updated this measure to comply with HEDIS, which currently measures ages 5-9 and 10-17.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A

Explanation of Progress:

Annual Performance Objective for FFY 2007: The annual performance objective for FFY 2007 is for the MCOs to meet or exceed the HEDIS established national benchmarks.

Annual Performance Objective for FFY 2008: The annual performance objective for FFY 2008 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2008. HHSC will determine those goals for SFY 2008 in May 2007.

Annual Performance Objective for FFY 2009: The annual performance objective for FFY 2009 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2009. HHSC will determine those goals for SFY 2009 in May 2008.

Explain how these objectives were set: HHSC writes the overarching performance improvement goals for the MCOs into the annual contract with the health plans.

Other Comments on Measure: N/A

MEASURE: Children's Access to Primary Care Practitioners

FFY 2004	FFY 2005	FFY 2006
If Data Not Reported, Please Explain Why: ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: N/A	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: N/A	**If Data Not Reported, Please Explain Why:** ☐ Population not covered. ☐ Data not available. *Explain*: ☐ Small sample size (less than 30). *Specify sample size*: ☐ Other. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☒Other. *Explain*: N/A
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Two data sources were used to calculate the quality of care indicators: the encounter-level enrollment information, encounter-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, the MCO in which the person was enrolled, and the number of months the person was enrolled in the program. The encounter-level claims/encounter data contained CPT and ICD 9-CM codes.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Two data sources were used to calculate the quality of care indicators: encounter-level enrollment information and encounter-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, the MCO in which the person was enrolled, and the number of months the person was enrolled in the program. The encounter-level claims/encounter data contained CPT and ICD 9-CM codes.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: Please see attachment entitled Children's Access to Primary Care Practitioners.

FFY 2004	FFY 2005	FFY 2006
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2003 Technical Specifications were used to determine the eligible population. Per HEDIS specifications, 2 years of data was utilized to determine the eligible population.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: For the baseline measure, HEDIS 2004 Technical Specifications were used to determine the eligible population.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: A stratified random sample of families was selected to participate in the Established Enrollee Survey. To be eligible for inclusion in the sample, the child had to be enrolled in CHIP in Texas for 12 continuous months in the past year. The sample was stratified to include representation from the 13 CHIP MCOs. A target was set of 3,900 completed telephone surveys.
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:** 2006

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 3001 Denominator: 3172 Rate: 94.6 7-11 years Numerator: 62639 Denominator: 67710 Rate: 92.5 25 months-6 years Numerator: 64378 Denominator: 71105 Rate: 90.5 12-19 years Numerator: Denominator: Rate: Additional notes on measure: Baseline/ Year information reported in 2004: Year 1 – January 1, 2002 to December 31, 2002 Children Ages 12 to 24 months: 17,937/ 19,009 (94.26%) Children Ages 25 months to 6 years: 55,673/ 63,258 (88.01%) Children Ages 7 to 11 years: 38,329/ 41,894 (91.49%)	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 18406 Denominator: 19009 Rate: 96.8 7-11 years Numerator: 37978 Denominator: 40978 Rate: 92.7 25 months-6 years Numerator: 24584 Denominator: 27306 Rate: 90 12-19 years Numerator: 48420 Denominator: 54252 Rate: 89.3 Additional notes on measure: Please see attachment entitled Children's Access to Primary Care Practitioners.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: Denominator: Rate: 7-11 years Numerator: Denominator: Rate: 25 months-6 years Numerator: Denominator: Rate: 12-19 years Numerator: Denominator: Rate: Additional notes on measure: 2004 and 2005 data used HEDIS. For 2006, HHSC reported the data using the CAHPS survey.
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: 3358 Denominator: 3904 Rate: 86 Additional notes on measure: The HEDIS measure was not run to obtain this data. Instead, presence of a usual source of care was determined by an affirmative response to the CAHPS survey question, “Do you have one person you think of as your child’s personal doctor or nurse?”

FFY 2004	FFY 2005	FFY 2006
Explanation of Progress: **Annual Performance Objective for FFY 2007:** The annual performance objective for FFY 2007 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC has set overarching performance improvement goals for the MCOs to achieve in state fiscal year (SFY) 2007. One of these goals is to improve access to primary care services. **Annual Performance Objective for FFY 2008:** The annual performance objective for FFY 2008 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2008. HHSC will determine those goals for SFY 2008 in May 2007. **Annual Performance Objective for FFY 2009:** The annual performance objective for FFY 2009 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2009. HHSC will determine those goals for SFY 2009 in May 2008. *Explain how these objectives were set:* HHSC writes the overarching performance improvement goals for the MCOs into the annual contract with the health plans.		
Other Comments on Measure: N/A		

SECTION IIB: ENROLLMENT AND UNINSURED DATA

~~1.~~ The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by SARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2005	FFY 2006	Percent change FFY 2005-2006
SCHIP Medicaid Expansion Program	0	0	
Separate Child Health Program	526406	585461	11.22

~~A.~~ Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent.

Please see attachment entitled Enrollment and Uninsured Data.

~~2.~~ The table below shows trends in the three-year averages for the number and rate of uninsured children in your State based on the Current Population Survey (CPS), along with the percent change between 1996-1998 and 2003-2005. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FFY 2006 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996 - 1998	1,084	74.1	18.1	1.2
1998 - 2000	973	70.2	16.3	1.1
2000 - 2002	1,013	65.2	15.9	.9
2002 - 2004	967	63.4	14.9	.9
2003 - 2005	927	58.3	14.0	.8
Percent change 1996-1998 vs. 2003-2005	-14.5*%*	NA	-22.7**%**	NA

* Significant at the .10 level, 2-tailed test

** Significantly different from zero at the .01 level, 2-tailed test

~~A.~~ Please explain any activities or factors that may account for increases or decreases in your number and/or rate of uninsured children.

Please see answer to 2.B.

~~B.~~

~~C.~~ Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates.

Historically, the CPS estimates have under-estimated the number of children ever enrolled in Medicaid/CHIP during an entire one-year period. The annual rate of uninsured children could be over-stated by the CPS due to the under-estimation of the Medicaid/CHIP population.

~~3.~~ Please indicate by checking the box below whether your State has an alternate data source and/or methodology for measuring the change in the number and/or rate of uninsured children.

☐ Yes (please report your data in the table below)

☒ No (skip to Question #4)

Please report your alternate data in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	
Reporting period (2 or more points in time)	
Methodology	
Population (Please include ages and income levels)	
Sample sizes	
Number and/or rate for two or more points in time	
Statistical significance of results	

~~A.~~ Please explain why your State chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.

~~B.~~ What is your State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

~~D.~~ What are the limitations of the data or estimation methodology?

~~4.~~ How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information

Telephone surveys conducted by the state's EQRO, the Institute for Child Health Policy, the University of Florida, indicate that children were enrolled in Medicaid as a result of CHIP outreach activities and enrollment simplification. The State does not have an estimate of the number of children

who have been enrolled in Medicaid as a result of CHIP outreach activities and enrollment simplification. However, because the same application is used for Children's Medicaid and CHIP, all children are screened for both programs when they apply.

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

This subsection gathers information on your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. The format of this section has been revised for FFY 2006 to provide your State with an opportunity to track progress over time. This section contains templates for reporting performance measurement data for each of five categories of strategic objectives, related to:

- Reducing the number of uninsured children
- SCHIP enrollment
- Medicaid enrollment
- Increasing access to care
- Use of preventative care (immunizations, well child care)

Please report performance measurement data for the three most recent years for which data are available (to the extent that data are available). In the first two columns, please enter the data you reported for each objective in the previous two years' annual reports (FFY 2004 and FFY 2005). In the third column, please report the most recent data available at the time you are submitting the annual report.

Note that the term *performance measure* is used differently in Section IIA versus IIC. In Section IIA, the term refers to the four core child health measures. In this section, the term is used more broadly, to refer to any data your State provides as evidence towards a particular goal within a strategic objective. For the purpose of this section, "objectives" refer to the five broad categories listed above, while "goals" are State-specific, and should be listed in the appropriate subsections within the space provided for each objective.

NOTES: Please do not reference attachments in this section. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

In addition, please do not report the same data that were reported in Sections IIA or IIB. The intent of this section is to capture goals and measures that your State did not_report elsewhere in Section II.

Additional instructions for completing each row of the table are provided below.

Goal:

For each objective, space has been provided to report up to three goals. Use this section to provide a brief description of each goal you are reporting within a given strategic objective.

Type of Goal:

For each goal you are reporting within a given strategic objective, please indicate the type of goal, as follows:

- New/revised: Check this box if you have revised or added a goal. Please explain how and why the goal was revised.
- Continuing: Check this box if the goal you are reporting is the same one you have reported in previous annual reports.
- Discontinued: Check this box if you have met your goal and/or are discontinuing a goal. Please explain why the goal was discontinued.

Status of Data Reported:
Please indicate the status of the data you are reporting for each goal, as follows:

- Provisional: Check this box if you are reporting performance measure data for a goal, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2006.

- Final: Check this box if the data you are reporting are considered final for FFY 2006.

- Same data as reported in a previous year's annual report: Check this box if the data you are reporting are the same data that your State reported for the goal in another annual report. Indicate in which year's annual report you previously reported the data.

Measurement Specification:
This section is included for only two of the objectives— objectives related to increasing access to care, and objectives related to use of preventative care—because these are the two objectives for which States may report using the HEDIS® measurement specification. In this section, for each goal, please indicate the measurement specification used to calculate your performance measure data (i.e., were the measures calculated using the HEDIS® specifications, HEDIS®-like specifications, or some other method unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2006). If using HEDIS®-like specifications, please explain how HEDIS® was modified.

Data Source:
For each performance measure, please indicate the source of data. The categories provided in this section vary by objective. For the objectives related to reducing the number of uninsured children and SCHIP or Medicaid enrollment, please indicate whether you have used eligibility/enrollment data, survey data (specify the survey used), or other source. For the objectives related to access to care and use of preventative care, please indicate whether you used administrative data (claims), hybrid data (claims and medical records), survey data (specify the survey used), or other source. In all cases, if another data source was used, please explain the source.

Definition of Population Included in Measure:
Please indicate the definition of the population included in the denominator for each measure (such as age, continuous enrollment, type of delivery system). Also provide a definition of the numerator (such as the number of visits required for inclusion, e.g., one or more visits in the past year).

For measures related to increasing access to care and use of preventative care , please also check one box to indicate whether the data are for the SCHIP population only, or include both SCHIP and Medicaid (Title XIX) children combined.

Year of Data:
Please report the year of data for each performance measure. The year (or months) should correspond to the *period in which enrollment or utilization took place*. Do *not* report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to enrollment or utilization of services.

Performance Measurement Data:
Describe what is being measured: Please provide a brief explanation of the information you intend to capture through the performance measure.

Numerator, Denominator, and Rate: Please report the numerators, denominators, and rates for each measure (or component). For the objectives related to increasing access to care and use of preventative care, the template provides two sections for entering the performance measurement data, depending on whether you are reporting using HEDIS® or HEDIS®-like methodology or a methodology other than HEDIS®. The form fields have been set up to facilitate entering numerators, denominators, and rates for

each measure. If the form fields do not give you enough space to fully report on your measure, please use the “additional notes” section.

If you typically calculate separate rates for each health plan, report the aggregate state-level rate for each measure (or component). The preferred method is to calculate a “weighted rate” by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator. Alternatively, if numerators and denominators are not available, you may calculate an “unweighted average” by taking the mean rate across health plans.

Explanation of Progress:

The intent of this section is to allow your State to highlight progress and describe any quality improvement activities that may have contributed to your progress. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality improvement plans. In this section, your State is also asked to set annual performance objectives for FFY 2007, 2008, and 2009. Based on your recent performance on the measure (from FFY 2004 through 2006), use a combination of expert opinion and “best guesses” to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years. In future annual reports, you will be asked to comment on how your actual performance compares to the objective your State set for the year, as well as any quality improvement activities that have helped or could help your State meet future objectives.

Other Comments on Measure:

Please use this section to provide any other comments on the measure, such as data limitations or plans to report on a measure in the future.

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3)

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) To compare annual data on the number and percent enrolled in CHIP to the estimated number of potentially eligible children in the state.	**Goal #1 (Describe)** To compare annual data on the number and percent enrolled in CHIP to the estimated number of otherwise uninsured income-eligible children in the state.	**Goal #1 (Describe)** To compare annual data on the number and percent enrolled in CHIP to the estimated number of otherwise uninsured income-eligible children in the state.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: 1) U.S. Census Bureau. March 2004 Current Population Survey (CPS); 2) Texas CHIP program enrollment files; and 3) Population projections data by age group from the Texas State Data Center (TXSDC).	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: 1) U.S. Census Bureau. March 2004 and 2005 CPS; 2) Texas CHIP program enrollment files; and 3) Population projections data by age group from the TXSDC.	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: 1) U.S. Census Bureau. March 2005 and 2006 CPS; 2) Texas CHIP program enrollment files; and 3) Population projections data by age group from the TXSDC.
Definition of Population Included in the Measure: Definition of denominator: Estimated number of CHIP-income potential eligibles. Definition of numerator: Number of CHIP-income enrollees as of September 2004. Note: Number of otherwise uninsured children under age 19, who are not Medicaid income eligible, with incomes at/below 200% of poverty.	**Definition of Population Included in the Measure:** Definition of denominator: This is the estimated number of otherwise uninsured children under age 19 meeting the income eligibility criteria for the CHIP program as of September 2005. Definition of numerator: Please see attachment entitled Objectives Related to Reducing the Number of Uninsured Children.	**Definition of Population Included in the Measure:** Definition of denominator: This is the estimated number of otherwise uninsured children under age 19 meeting the income eligibility criteria for the CHIP program as of September 2006. Definition of numerator: Please see attachment entitled Objectives Related to Reducing the Number of Uninsured Children.
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006

FFY 2004	FFY 2005	FFY 2006
Performance Measurement Data: Described what is being measured: To estimate potentially eligible population: Direct application/extrapolation of unadjusted historical March 2004 CPS information on percent of uninsured children under 19, by age group and program-related percent of poverty income level, to population projections for children under 19, by age group. Numerator: 310000 Denominator: 377000 Rate: 82.2 Additional notes on measure: Baseline/Year information reported in 2004: FFY 2003 (proxy is CHIP enrollment as of September 2003) Numerator = 369,000 (number of CHIP-income enrollees as of September 2003) Denominator = 425,000 (estimated number of CHIP-income potential eligibles) Estimated Participation Rate = 87%	**Performance Measurement Data:** Described what is being measured: To estimate the potential population of otherwise uninsured CHIP income-eligible children: Direct application/extrapolation of unadjusted historical data on uninsured derived from the March CPS. These data were applied to the projected population of children under age 19, by age group and CHIP-specific percent of poverty income levels, to obtain projections of the population of otherwise uninsured children meeting the CHIP income eligibility criteria. Numerator: 299000 Denominator: 537000 Rate: 55.7 Additional notes on measure: Please see attachment entitled Objectives Related to Reducing the Number of Uninsured Children.	**Performance Measurement Data:** Described what is being measured: To estimate the potential population of otherwise uninsured CHIP income-eligible children: Direct application/extrapolation of unadjusted historical data on uninsured derived from the March CPS. These data were applied to the projected population of children under age 19, by age group and CHIP-specific percent of poverty income levels, to obtain projections of the population of otherwise uninsured children meeting the CHIP income eligibility criteria. Numerator: 268000 Denominator: 517000 Rate: 51.8 Additional notes on measure: Please see attachment entitled Objectives Related to Reducing the Number of Uninsured Children.

Explanation of Progress:

Annual Performance Objective for FFY 2007: Starting Jan. 1, 2007, a CHIP Perinatal program will provide prenatal care benefits to the unborn children of low-income women who do not qualify for Medicaid. Once born, the infants will continue to receive CHIP medical benefits for the remainder of their 12-month eligibility period. Due to this program expansion, the monthly average enrollment in CHIP is projected to grow to about 370,000 in FFY 2007 -- compared to the monthly average enrollment of 309,000 during FFY 2006.

Annual Performance Objective for FFY 2008: Starting Jan. 1, 2007, a CHIP Perinatal program will provide prenatal care benefits to the unborn children of low-income women who do not qualify for Medicaid. Once born, the infants will continue to receive CHIP medical benefits for the remainder of their 12-month eligibility period. Due to this program expansion, the monthly average enrollment in CHIP is projected to grow to about 430,000 -- compared to the monthly average enrollment of 309,000 during FFY 2006.

Annual Performance Objective for FFY 2009: Starting Jan. 1, 2007, a CHIP Perinatal program will provide prenatal care benefits to the unborn children of low-income women who do not qualify for Medicaid. Once born, the infants will continue to receive CHIP medical benefits for the remainder of their 12-month eligibility period. Due to this program expansion, the monthly average enrollment in CHIP is projected to grow to about 440,000 -- compared to the monthly average enrollment of 309,000 during FFY 2006.

Explain how these objectives were set: The objectives assume growth in enrollment due to the extension of CHIP benefits to: 1) The unborn children of pregnant women at or below 200% of poverty that do not qualify for Medicaid, and; 2) The infants born to non-U.S. citizens mothers at or below 200% of poverty. In addition, U.S. Citizen and qualified U.S. resident children under age 19 at/or below 200% of poverty, who do not qualify for Medicaid, and who would otherwise be uninsured, will continue to qualify for CHIP benefits.

Other Comments on Measure: N/A

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3) (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe) N/A	**Goal #2 (Describe)** N/A	**Goal #2 (Describe)** N/A
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*: N/A	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*: N/A	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*: N/A
Definition of Population Included in the Measure: Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A	**Performance Measurement Data:** Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A	**Performance Measurement Data:** Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A
Explanation of Progress: **Annual Performance Objective for FFY 2007:** N/A **Annual Performance Objective for FFY 2008:** N/A **Annual Performance Objective for FFY 2009:** N/A *Explain how these objectives were set:* N/A		
Other Comments on Measure: N/A		

Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIB, Questions 2 and 3) (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe) N/A	**Goal #3 (Describe)** N/A	**Goal #3 (Describe)** N/A
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*: N/A	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*: N/A	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☐ Other. *Specify*: N/A
Definition of Population Included in the Measure: Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A	**Performance Measurement Data:** Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A	**Performance Measurement Data:** Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A
Explanation of Progress: **Annual Performance Objective for FFY 2007:** N/A **Annual Performance Objective for FFY 2008:** N/A **Annual Performance Objective for FFY 2009:** N/A *Explain how these objectives were set:* N/A		
Other Comments on Measure: N/A		

Objectives Related to SCHIP Enrollment

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) Document the rate of disenrollment from CHIP over the last two State fiscal years and the trends and changes in the rate across time. Assess families' reasons for disenrolling their children.	**Goal #1 (Describe)** Document the rate of disenrollment from CHIP over the last two State fiscal years and the trends and changes in the rate across time.	**Goal #1 (Describe)** Document the rate of disenrollment from CHIP over the last two State fiscal years and the trends and changes in the rate across time.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: Two data sources were used in these analyses. First, the enrollment broker for CHIP in Texas provided enrollment files. These files were used to identify the children who met the sample selection criteria and to obtain contact information for the families. Second, telephone survey data was obtained from families whose children disenrolled from CHIP in Texas.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: Two data sources were used in these analyses. First, the enrollment broker for CHIP provided enrollment files. These files were used to identify the children who met the sample selection criteria and to obtain contact information for the families. Second, telephone survey data was obtained from families whose children disenrolled from CHIP. The survey instrument was designed to identify the sociodemographic characteristics and health status of those who disenroll from CHIP and identify why.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: Please see attachment entitled Objectives Related to SCHIP Enrollment.
Definition of Population Included in the Measure: Definition of denominator: Number of completed telephone surveys. Definition of numerator: Please see the attachment entitled Objectives Related to SCHIP Enrollment.	**Definition of Population Included in the Measure:** Definition of denominator: Number of completed telephone surveys. Definition of numerator: Please see attachment entitled Objectives Related to SCHIP Enrollment.	**Definition of Population Included in the Measure:** Definition of denominator: Number of completed telephone surveys. Definition of numerator: Most frequently cited reasons for disenrollment. A random sample of families was selected to participate in the disenrollee survey using the following criteria: 1) the child had to have been enrolled in CHIP in Texas for six months or longer and 2) disenrolled for two months or longer between the period of December 2005 through April 2006. A target was set of 400 completed telephone surveys with families of disenrollees.

FFY 2004	FFY 2005	FFY 2006
Year of Data: 2004	**Year of Data:**	**Year of Data:** 2006
Performance Measurement Data: Described what is being measured: Please see attachment entitle Objectives Related to SCHIP Enrollment. Numerator: Denominator: Rate: Additional notes on measure: Numerators, denominators, and rates specified above were for Year 1 baseline calculations. Performance Progress was not applicable.	**Performance Measurement Data:** Described what is being measured: Please see Definition of Population Included in Measure. Numerator: Denominator: Rate: Additional notes on measure: Numerator: N/A Denominator: N/A Rate: N/A Baseline/Year information reported in 2005 - Most frequently cited reasons for disenrollment: Child was switched to Medicaid (189/500=37.80%) Could not or did not complete the renewal process (144/500=28.80%) Obtained other insurance policy (134/500=26.80%) Child no longer eligible for this program because family income was too high (199/500=23.80%)	**Performance Measurement Data:** Described what is being measured: Please see Definition of Population Included in Measure. Most frequently cited reasons for disenrollment: Child switched from CHIP to Medicaid (141/400 = 35.25%) Child no longer eligible for this program because income was too high (120/400 = 30.00%) Could not or did not complete the renewal process (110/400 = 27.50%) Obtained other insurance policy (107/400 = 26.75%) Numerator: Denominator: Rate: Additional notes on measure: Numerator: See above Denominator: See above Rate: See above

Explanation of Progress:

Annual Performance Objective for FFY 2007: HHSC has set overarching performance improvement goals for the MCOs to achieve in state fiscal year (SFY) 2007. One of these goals is to improve current member understanding about the CHIP benefit renewal process.

Annual Performance Objective for FFY 2008: HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2008. HHSC will determine those goals for SFY 2008 in May 2007.

Annual Performance Objective for FFY 2009: HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2009. HHSC will determine those goals for SFY 2009 in May 2008.

Explain how these objectives were set: HHSC writes the overarching performance improvement goals for the MCOs into the annual contract with the health plans.

Other Comments on Measure: N/A

Objectives Related to SCHIP Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe) Identify the sociodemographic and health characteristics of the disenrollees relative to those who remain enrolled.	**Goal #2 (Describe)** Identify the sociodemographic and health characteristics of the disenrollees relative to those who remain enrolled.	**Goal #2 (Describe)** Identify the sociodemographic and health characteristics of the disenrollees relative to those who remain enrolled.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: Please see attachment entitled Objectives Related to SCHIP Enrollment.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: Please see attachment entitled Objectives Related to SCHIP Enrollment.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: Please see attachment entitled Objectives Related to SCHIP Enrollment.
Definition of Population Included in the Measure: Definition of denominator: Please see attachment entitled Objectives Related to SCHIP Enrollment. Definition of numerator: Please see attachment entitled Objectives Related to SCHIP Enrollment.	**Definition of Population Included in the Measure:** Definition of denominator: Please see attachment entitled Objectives Related to SCHIP Enrollment. Definition of numerator: Please see attachment entitled Objectives Related to SCHIP Enrollment.	**Definition of Population Included in the Measure:** Definition of denominator: Please see attachment entitled Objectives Related to SCHIP Enrollment. Definition of numerator: Please see attachment entitled Objectives Related to SCHIP Enrollment.
Year of Data: 2004	**Year of Data:**	**Year of Data:** 2006

FFY 2004	FFY 2005	FFY 2006
Performance Measurement Data: Described what is being measured: Please see Definition of Population Included in Measure. Children who disenrolled were older (about 11 years old compared to 10 years old among enrollees). There was no disproportionate disenrollment of any particular racial or ethnic group. Eleven percent of disenrollees has special health care needs compared to 16 percent of those remaining in the program. (6,077/56,529=10.75% Disenrollees; 58,490/374,215=15.63% Remaining enrollees) Numerator: Denominator: Rate: Additional notes on measure: Numerator: See above Denominator: See above Rate: See above Additional notes on measure: Numerators, denominators, and rates specified above were for Year 1 baseline calculations. Performance Progress was not applicable.	**Performance Measurement Data:** Described what is being measured: Please see Definition of Population Included in Measure. Numerator: Denominator: Rate: Additional notes on measure: Please see the attachment entitled Objectives Related to SCHIP Enrollment.	**Performance Measurement Data:** Described what is being measured: Please see attachment entitled Objectives Related to SCHIP Enrollment. Numerator: Denominator: Rate: Additional notes on measure: Numerator: See above Denominator: See above Rate: See above

Explanation of Progress:

Annual Performance Objective for FFY 2007: One of the overarching performance improvement goals that HHSC has set for the MCOs to achieve in state fiscal year (SFY) 2007 is to improve current member understanding about the CHIP benefit renewal process to help current members retain their enrollment status.

Annual Performance Objective for FFY 2008: HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2008. HHSC will determine those goals for SFY 2008 in May 2007.

Annual Performance Objective for FFY 2009: HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2009. HHSC will determine those goals for SFY 2009 in May 2008.

Explain how these objectives were set: HHSC writes the overarching performance improvement goals for the MCOs into the annual contract with the health plans.

Other Comments on Measure: N/A

Objectives Related to SCHIP Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe) Document trends in the case-mix and per member per month (PMPM) health care expenditures in conjunction with the disenrollment trends. Document children's insurance status and their access to employer-based coverage upon leaving the program.	**Goal #3 (Describe)** Document trends in the case-mix and per member per month (PMPM) health care expenditures in conjunction with the disenrollment trends. Document children's insurance status and their access to employer-based coverage upon leaving the program.	**Goal #3 (Describe)** Document children's insurance status and their access to employer-based coverage upon leaving the program. Document trends in the case-mix and per member per month (PMPM) health care expenditures in conjunction with the disenrollment trends.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: PMPM Expenditures: Claims and encounter data were used to classify the children with special health care needs. Insurance status: Two data sources were used in these analyses. First, the enrollment broker for CHIP in Texas provided enrollment files. Second, information obtained from survey data from families whose children disenrolled from CHIP in Texas.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: PMPM Expenditures: Claims and encounter data were used to classify the children with special health care needs.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: Please see attachment entitled Objectives Related to SCHIP Enrollment.
Definition of Population Included in the Measure: Definition of denominator: Please see attachment entitled Objectives Related to SCHIP Enrollment. Definition of numerator: Please see attachment entitled Objectives Related to SCHIP Enrollment.	**Definition of Population Included in the Measure:** Definition of denominator: Please see attachment entitled Objectives Related to SCHIP Enrollment. Definition of numerator: Please see attachment entitled Objectives Related to SCHIP Enrollment.	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: Definition of numerator: N/A Disenrollee Survey: A random sample of families was selected to participate in the disenrollee survey using the following criteria: 1) the child had to have been enrolled in CHIP in Texas for six months or longer and 2) disenrolled for two months or longer between the period of December 2005 through April 2006. A target was set of 400 completed telephone surveys with families of disenrollees.

FFY 2004	FFY 2005	FFY 2006
Year of Data: 2003	**Year of Data:**	**Year of Data:** 2006
Performance Measurement Data: Described what is being measured: Please see Definition of Population Included in the Measure. Overall: $53.82 Healthy: $26.98 Significant Acute: $118.32 Single Minor Chronic: $137.42 Multiple Minor Chronic: $280.94 Single Dominant or Moderate Chronic: $195.92 Pair Dominant or moderate Chronic: $795.41 Triplet Dominant or Moderate Chronic: $11,218.88 Malignancies: $2,955.50 Catastrophic: $1,548.36 Insurance Status: N/A Numerator: Denominator: Rate: Additional notes on measure: Please see attachment entitled Objectives Related to SCHIP Enrollment.	**Performance Measurement Data:** Described what is being measured: Please see Definition of Population Included in the Measure. Numerator: Denominator: Rate: Additional notes on measure: Please see attachment entitled Objectives Related to SCHIP Enrollment.	**Performance Measurement Data:** Described what is being measured: Please see attachment entitled Objectives Related to SCHIP Enrollment. Numerator: Denominator: Rate: Additional notes on measure: Numerator: See above Denominator: See above Rate: See above Additional notes on measure: N/A

Explanation of Progress:

Annual Performance Objective for FFY 2007: One of the overarching performance improvement goals that HHSC has set for the MCOs to achieve in state fiscal year (SFY) 2007 is to improve current member understanding about the CHIP benefit renewal process to help current members retain their enrollment status.

Annual Performance Objective for FFY 2008: HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2008. HHSC will determine those goals for SFY 2008 in May 2007.

Annual Performance Objective for FFY 2009: HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2009. HHSC will determine those goals for SFY 2009 in May 2008.

Explain how these objectives were set: HHSC writes the overarching performance improvement goals for the MCOs into the annual contract with the health plans.

Other Comments on Measure: N/A

Objectives Related to Medicaid Enrollment

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) N/A	**Goal #1 (Describe)** N/A	**Goal #1 (Describe)** N/A
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: N/A	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: N/A	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: N/A
Definition of Population Included in the Measure: Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A	**Performance Measurement Data:** Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A	**Performance Measurement Data:** Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A
Explanation of Progress: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		

FFY 2004	FFY 2005	FFY 2006
Other Comments on Measure: N/A		

Objectives Related to Medicaid Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe) N/A	**Goal #2 (Describe)** N/A	**Goal #2 (Describe)** N/A
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: N/A	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: N/A	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: N/A
Definition of Population Included in the Measure: Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A	**Performance Measurement Data:** Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A	**Performance Measurement Data:** Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A
Explanation of Progress: **Annual Performance Objective for FFY 2007:** N/A **Annual Performance Objective for FFY 2008:** N/A **Annual Performance Objective for FFY 2009:** N/A *Explain how these objectives were set:* N/A		

FFY 2004	FFY 2005	FFY 2006
Other Comments on Measure: N/A		

Objectives Related to Medicaid Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe) N/A	**Goal #3 (Describe)** N/A	**Goal #3 (Describe)** N/A
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: N/A	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: N/A	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: N/A
Definition of Population Included in the Measure: Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: N/A Definition of numerator: N/A
Year of Data:	**Year of Data:**	**Year of Data:**
Performance Measurement Data: Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A	**Performance Measurement Data:** Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A	**Performance Measurement Data:** Described what is being measured: N/A Numerator: Denominator: Rate: Additional notes on measure: N/A
Explanation of Progress: **Annual Performance Objective for FFY 2007:** N/A **Annual Performance Objective for FFY 2008:** N/A **Annual Performance Objective for FFY 2009:** N/A *Explain how these objectives were set:* N/A		
Other Comments on Measure: N/A		

Objectives Increasing Access to Care (Usual Source of Care, Unmet Need)

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) Document trends in number and percent of CHIP in Texas enrollees who have access to primary care practitioners.	**Goal #1 (Describe)** Document trends in number and percent of CHIP in Texas enrollees who have access to primary care practitioners.	**Goal #1 (Describe)** Document trends in number and percent of CHIP in Texas enrollees who have access to primary care practitioners.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☒ Discontinued. *Explain*: The Institute for Child Health Policy, the organization that the Texas HHSC contracts with to evaluate its CHIP program did not run this measure this year. The HHSC Strategic Decision Support unit intends to run the measure for FFY 2007.
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: N/A
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Two data sources were used to calculate the quality of care indicators: encounter–level enrollment information and encounter-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, the MCO in which the person was enrolled, and the number of months the person was enrolled in the program. The encounter-level claims/encounter data contained Physician's CPT and ICD 9-CM codes.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Two data sources were used to calculate the quality of care indicators: encounter-level enrollment information and encounter-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, the MCO in which the person was enrolled, and the number of months the person was enrolled in the program. The encounter-level claims/encounter data contained CPT and ICD 9-CM codes.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: N/A
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: For the baseline measure, HEDIS 2003 Technical Specifications were used to determine the eligible population.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: For the baseline measure, HEDIS 2003 Technical Specifications were used to determine the eligible population.	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: N/A
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:**

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: Please see attachment entitled Objectives Related to Increasing Access to Care.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: Please see attachment entitled Objectives Related to Increasing Access to Care.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A
Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A

Explanation of Progress:

Annual Performance Objective for FFY 2007: The annual performance objective for FFY 2007 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC has set overarching performance improvement goals for the MCOs to achieve in state fiscal year (SFY) 2007. One of these goals is to improve access to primary care services.

Annual Performance Objective for FFY 2008: The annual performance objective for FFY 2008 is for the MCOs to meet orexceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2008. HHSC will determine those goals for SFY 2008 in May 2007.

Annual Performance Objective for FFY 2009: The annual performance objective for FFY 2009 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2009. HHSC will determine those goals for SFY 2009 in May 2008.

Explain how these objectives were set: HHSC writes the overarching performance improvement goals for the MCOs into the annual contract with the health plans.

Other Comments on Measure: N/A

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe) N/A	**Goal #2 (Describe)** N/A	**Goal #2 (Describe)** N/A
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: N/A	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: N/A	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: N/A
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: N/A	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: N/A	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: N/A
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: N/A
Year of Data:	**Year of Data:**	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A

FFY 2004	FFY 2005	FFY 2006
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A
Explanation of Progress: **Annual Performance Objective for FFY 2007:** N/A **Annual Performance Objective for FFY 2008:** N/A **Annual Performance Objective for FFY 2009:** N/A *Explain how these objectives were set:* N/A		
Other Comments on Measure: N/A		

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe) N/A	**Goal #3 (Describe)** N/A	**Goal #3 (Describe)** N/A
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: N/A	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: N/A	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: N/A
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: N/A	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: N/A	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: N/A
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: N/A
Year of Data:	**Year of Data:**	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A

FFY 2004	FFY 2005	FFY 2006
Performance Measurement Data: Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A
Explanation of Progress: **Annual Performance Objective for FFY 2007:** N/A **Annual Performance Objective for FFY 2008:** N/A **Annual Performance Objective for FFY 2009:** N/A *Explain how these objectives were set:* N/A		
Other Comments on Measure: N/A		

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) Document trends in number and percent of CHIP in Texas enrollees receiving well child care in the first 15 months of life.	**Goal #1 (Describe)** Document trends in number and percent of CHIP in Texas enrollees receiving well child care in the first 15 months of life.	**Goal #1 (Describe)** Document trends in number and percent of CHIP in Texas enrollees receiving well child care in the first 15 months of life.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Two data sources were used to calculate the quality of care indicators: encounter-level enrollment information and encounter-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, the MCO in which the person was enrolled, and the number of months the person was enrolled in the program. The encounter-level claims/encounter data contained Physician's CPT and ICD 9-CM codes.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Two data sources were used: encounter-level enrollment information and encounter-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, the MCO in which the person was enrolled, and the number of months the person was enrolled in the program. The encounter-level claims/encounter data contained CPT codes and ICD 9-CM codes.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Please see attachment entitled Objectives Related to Use of Preventative Care.
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population.
Year of Data: 2003	**Year of Data:** 2004	**Year of Data:** 2005

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: No Visits: 77/652 (11.81%) One Visit: 75/652 (11.50%) Two Visits: 60/652 (9.20%) Three Visits: 78/652 (11.96%) Four Visits: 130/652 (19.94%) Five Visits: 153/652 (23.47%) Six or More Visits: 70/652 (12.12%) Numerator: See above Denominator: See above Rate: See above Additional notes on measure: N/A	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: Please see attachment entitled Objectives Related to Use of Preventative Care.	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: No Visits: 7/ 112 (6.25%) One Visit: 8/ 112 (7.14%) Two Visits: 5/ 112 (4.46%) Three Visits: 11/ 112 (9.82%) Four Visits: 15/ 112 (13.39%) Five Visits: 37/ 112 (33.04%) Six or More Visits: 29/ 112 (25.89%) Numerator: See above Denominator: See above Rate: See above Additional notes on measure: N/A
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A

Explanation of Progress:

Annual Performance Objective for FFY 2007: The annual performance objective for FFY 2007 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC has set overarching performance improvement goals for the MCOs to achieve in state fiscal year(SFY) 2007. One of these goals is to improve access to primary care services.

Annual Performance Objective for FFY 2008: The annual performance objective for FFY 2008 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2008. HHSC will determine those goals for SFY 2008 in May 2007.

Annual Performance Objective for FFY 2009: The annual performance objective for FFY 2009 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2009. HHSC will determine those goals for SFY 2009 in May 2008.

Explain how these objectives were set: HHSC writes the overarching performance improvement goals for the MCOs into the annual contract with the health plans.

FFY 2004	FFY 2005	FFY 2006
Other Comments on Measure: N/A		

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe) Document trends in number and percent of CHIP in Texas enrollees receiving well child care in the 3rd, 4th, 5th, and 6th years of life.	**Goal #2 (Describe)** Document trends in number and percent of CHIP in Texas enrollees receiving well child care in the 3rd, 4th, 5th, and 6th years of life.	**Goal #2 (Describe)** Document trends in number and percent of CHIP in Texas enrollees receiving well child care in the 3rd, 4th, 5th, and 6th years of life.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2004	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 2005	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications	**Measurement Specification:** ☒HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: HEDIS 2004 Technical Specifications
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: Please see attachment entitled Objectives Related to Use of Preventative Care.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Two data sources were used to calculate the quality of care indicators: encounter-level enrollment information and encounter-level health care claims/encounter data. The enrollment files contained information about the person's age, gender, the MCO in which the person was enrolled, and the number of months the person was enrolled in the program. The encounter-level claims/encounter data contained CPT codes and ICD 9-CM codes.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Please see attachment entitled Objectives Related to Use of Preventative Care.
Definition of Population Included in the Measure: Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population.	**Definition of Population Included in the Measure:** Definition of denominator: ☒ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: HEDIS 2004 Technical Specifications were used to determine the eligible population.
Year of Data: 2003	**Year of Data:**	**Year of Data:** 2005

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 29150 Denominator: 60742 Rate: 48 Additional notes on measure: Numerator, denominator, and rate for one or more visits. Baseline/ Year information reported in 2004: Year 1 (January 1, 2002 to December 31, 2002) One or More Visits: 29,215/ 113,988 (25.63%)	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 13024 Denominator: 24267 Rate: 53.7 Additional notes on measure: Numerator, denominator, and rate for one or more visits. Enrollee numbers may be smaller for Year 3 due to changes implemented following the 2003 Legislative Session. Those changes include a premium increase for families above 100 percent of the federal poverty level (FPL) and a 90-day waiting period for coverage. Baseline/Year information reported in 2005: Year 1 (January 1, 2002 to December 31, 2002) One or More Visits: 29,215/113,988 (25.63%)	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: 14318 Denominator: 27036 Rate: 53 Additional notes on measure: N/A
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A

Explanation of Progress:

Annual Performance Objective for FFY 2007: The annual performance objective for FFY 2007 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC has set overarching performance improvement goals for the MCOs to achieve in state fiscal year (SFY) 2007. One of these goals is to improve access to primary care services.

Annual Performance Objective for FFY 2008: The annual performance objective for FFY 2008 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2008. HHSC will determine those goals for SFY 2008 in May 2007.

Annual Performance Objective for FFY 2009: The annual performance objective for FFY 2009 is for the MCOs to meet or exceed the HEDIS established national benchmarks. In addition to this goal, HHSC will set overarching improvement goals for the MCOs to achieve in SFY 2009. HHSC will determine those goals for SFY 2009 in May 2008.

Explain how these objectives were set: HHSC writes the overarching performance improvement goals for the MCOs into the annual contract with the health plans.

Other Comments on Measure: N/A

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #3 (Describe) N/A	**Goal #3 (Describe)** N/A	**Goal #3 (Describe)** N/A
Type of Goal: ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A	**Type of Goal:** ☐ New/revised. *Explain*: ☐ Continuing. ☐ Discontinued. *Explain*: N/A
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Measurement Specification: ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: N/A	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: N/A	**Measurement Specification:** ☐HEDIS. *Specify version of HEDIS used*: ☐HEDIS-like. *Specify version of HEDIS used*: *Explain how HEDIS was modified*: ☐Other. *Explain*: N/A
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: N/A	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: N/A	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*: N/A
Definition of Population Included in the Measure: Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: N/A	**Definition of Population Included in the Measure:** Definition of denominator: ☐ Denominator includes SCHIP population only. ☐ Denominator includes SCHIP and Medicaid (Title XIX). Definition of numerator: N/A
Year of Data:	**Year of Data:**	**Year of Data:**
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A

FFY 2004	FFY 2005	FFY 2006
Other Performance Measurement Data: *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure: N/A
Explanation of Progress: **Annual Performance Objective for FFY 2007:** N/A **Annual Performance Objective for FFY 2008:** N/A **Annual Performance Objective for FFY 2009:** N/A *Explain how these objectives were set:* N/A		
Other Comments on Measure: N/A		

1. What other strategies does your State use to measure and report on access to, quality, or outcomes of care received by your SCHIP population? What have you found?

The State of Texas EQRO contractor, the Institute of Child Health Policy, University of Florida, produced Quality of Care and Financial Performance reports on an annual basis. These reports provided information regarding state and health plan-specific performance using selected HEDIS indicators and Clinical Risk Groups (CRGs). CRGs are used to estimate enrollee health risk profiles and are also used to contextually place health care expenditures and health care use patterns in the MCO.

The EQRO invokes other strategies including biennial CAHPS telephone surveys of families with children who are newly enrolled, recently disenrolled, and continuously enrolled in CHIP. These telephone surveys cover issues such as enrollee satisfaction, experiences with enrollment, and reasons for disenrollment. In addition, the EQRO conducts an annual evaluation of all MCOs' Quality Assurance Improvement Plans serving the CHIP population.

2. What strategies does your SCHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your SCHIP population? When will data be available?

The State of Texas will continue to contract with an external independent EQRO for the production of annual quality of care and financial performance reports, as well as patient satisfaction surveys. The CAHPS surveys are administered every other year. The next survey results will be reported in 2008. The chart books (quality of care) are reported annually. The next chart books should be reported May 2007

3. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

In State Fiscal Year (SFY) 2006, a special follow-up analysis to the CAHPS survey was conducted. The report was titled, Children with Special Health Care Needs: Quality of Care in the Medicaid and Children's Health Insurance Programs in Texas. The major finding indicated that Texas has a higher percentage of CSHCN in their public insurance programs than in the general population. For example, based on parent report using the CSHCN Screener, 22 percent of children in the Primary Care Case Management (PCCM) Program, 22 percent in CHIP, and 18 percent in the State of Texas Access Reform (STAR) MCO Programs have special health care needs. In comparison, an estimated 12 percent of children in Texas have special needs based on parent report with the CSHCN Screener.

4. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings.

Please see attachment entitled Section II Program's Strategic Objectives and Performance Goals.

Enter any Narrative text below.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

OUTREACH

~~1.~~ How have you redirected/changed your outreach strategies during the reporting period?

In May 2006, HHSC began a one-year, $2.3 million outreach campaign promoting CHIP and Children's Medicaid. The outreach effort uses a three-prong strategy: community-based activism, mass media, and Internet marketing.

The community-based activism involves work with social service-oriented community-based organizations that contract with HHSC and other organizations that do not. HHSC has produced print materials that can be ordered online for no cost (see http://www.chipmedicaid.com/cbo/order.htm). HHSC is working to make organizations aware of the availability of these materials and encouraging them to order the materials and distribute them to the families they serve. The materials give brief information about CHIP/Children's Medicaid and direct people to the toll-free hotline number and the website, www.CHIPmedicaid.org.

Another component of the community-based activism involves working with faith-based organizations in the Houston area. This is a pilot project that could expand to other areas of Texas. The faith-based work has resulted in establishment of a CHIP/Children's Medicaid Faith-based Coalition made up of 15 of Houston's largest churches. The coalition works to distribute CHIP/Children's Medicaid information through church activities and ministry work in the Houston area.

The third component of the community-based activism involves partnerships with for profit organizations like H-E-B grocery stores. H-E-B has given HHSC opportunities to distribute CHIP/Children's Medicaid information in H-E-B stores throughout the H-E-B service area and at community-wide events H-E-B sponsors during the November/December holiday season. HHSC is pursuing other such public/private partnerships to expand the distribution of information about CHIP/Children's Medicaid.

The mass media component of the outreach campaign is largely being carried out Sherry Matthews Advocacy Marketing, a private contractor. Mass media components include statewide radio ads, Spanish language TV ads (in markets with heavy concentration of Hispanic viewers), print ads in minority publications, bus and bus station ads, billboard ads, and radio public service programming. The mass media components were purchased for exposure in May/June 2006, August/September 2006, and will again be purchased to run in May/June 2007 or September/August 2007.

The Internet marketing component of the outreach campaign is development of the website, www.CHIPmedicaid.org, which has English and Spanish information for consumers as well as information and materials for organizations and individuals who work with families who may be eligible for these benefits.

~~2.~~ What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness?

Overall, the effectiveness of the outreach campaign is being measured by the number of new and renewal applications processed, hits to the website and, by extension, the number of children enrolled in CHIP and Children's Medicaid. None of our measures give us insight as to which of our outreach efforts are resulting in new or renewal applications.

~~3.~~ Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)? Have these efforts been successful, and how have you measured effectiveness?

Our outreach efforts generally target families that might be eligible for CHIP/Children's Medicaid. Our community-based efforts are effective in helping us reach our target. Our paid media efforts target women age 18 to 44 who are low income and ethnic minorities.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program above 200 through 250% of FPL must complete question 1. All other states with trigger mechanisms should also answer this question.

~~1.~~ Does your state cover children between 200 and 250 percent of the FPL or does it identify a trigger mechanism or point at which a substitution prevention policy is instituted?

- ☐ Yes
- ☒ No
- ☐ N/A

If yes, please identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

States with separate child health programs over 250% of FPL must complete question 2. All other states with substitution prevention provisions should also answer this question.

~~2.~~ Does your state cover children above 250 percent of the FPL or does it employ substitution prevention provisions?

- ☐ Yes
- ☒ No
- ☐ N/A

If yes, identify your substitution prevention provisions (waiting periods, etc.).

All States must complete the following 3 questions

~~3.~~ Describe how substitution of coverage is monitored and measured and the effectiveness of your policies.

Data from the CHIP administrative system contains information on a family's access to other insurance at the time of the CHIP application. This data indicates if insurance was or was not in effect. If insurance coverage had been in effect, this data indicates whether the family qualified for one of the good cause exceptions to the 90-day waiting period.

~~4.~~ At the time of application, what percent of applicants are found to have insurance?

At the time of reporting, this information is unavailable. HHSC expects the percent of applicants that are found to have health insurance to be similar to last year. When the information becomes available, HHSC will submit it as an addendum to the report. In FFY 2005, there was an average of 1,394 kids, or 7 percent, applying each month that had other coverage. Of those, 122 on average were denied CHIP eligibility and 1,272 dropped their other coverage.

~~5.~~ Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP?

At the time of reporting, this information is unavailable. HHSC expects the percent of applicants that are found to have health insurance to be similar to last year. When the information becomes available, HHSC will submit it as an addendum to the report. In FFY 2005, there was an average of 1272 kids coming in each month who had dropped other coverage. On average each month, 422 of them waited out the 90-day period for prior coverage, 56 had an exception because of the 10 percent cost rule and 795 had another good cause exception. The crowd out rate was 2.2 percent.

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

~~1.~~ Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

Texas has nearly identical processes in place for initial certification and re-determination in CHIP and Medicaid. In both, a child's family will receive a renewal packet approximately 90 days prior to the last day of coverage under the program. Since the period of eligibility for both programs is six months, the renewal process begins in the fourth month of coverage. Families in both programs may complete the renewal process entirely through the mailing of information. Neither program requires families to visit a physical location in order to renew their coverage. As long as the families complete the renewal process by the "cut-off" date for enrollment process in their last month of coverage, they can start another span of eligibility without a lapse in coverage.

*Note: There is one difference between Medicaid and CHIP renewal processes concerning children less than one year of age. Children under the age of one who qualify for Medicaid are covered through their first birthday. As such, their families may not receive the renewal packet until the tenth month of coverage.

~~2.~~ Please explain the process that occurs when a child's eligibility status changes from Medicaid to SCHIP and from SCHIP to Medicaid. Have you identified any challenges? If so, please explain.

Children determined by the Medicaid program to be CHIP-eligible are deemed to the CHIP program automatically. If a CHIP applicant appears to be Medicaid eligible, the child is referred to the Medicaid program.

If a child's eligibility status changes from Medicaid to CHIP, or vice versa, data regarding the child is electronically referred from one program to the other. Medicaid eligibility specialists will deem

children eligible for CHIP when they find children ineligible for Medicaid, but have family incomes below the CHIP-qualifying upper limit of 200 percent of the FPL. CHIP eligibility specialists do not perform any additional eligibility work for the child and immediately initiate the enrollment process for the transferring child. In turn, if CHIP eligibility workers determine that a child may be eligible for Medicaid, the child is referred to Medicaid. Medicaid eligibility staff must still conclusively determine the final eligibility for Medicaid.

Texas has faced new challenges due to working with a new contract that processes CHIP applications and administers the program. As issues are identified, Texas responds immediately and addresses those issues on an on-going basis. Implementation of the Integrated Eligibility System should resolve most, if not all, of these challenges.

~~3.~~ Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

No. The Medicaid system includes fee-for-service, health maintenance coverage in most metropolitan areas, and primary care case management coverage in most rural areas. The CHIP system has health maintenance coverage in the metropolitan areas and an exclusive provider organization in most rural areas. Some of the health maintenance organizations have contracts with Texas to provide services to both Medicaid and CHIP members.

ELIGIBILITY REDETERMINATION AND RETENTION

~~1.~~ What measures does your State employ to retain eligible children in SCHIP? Please check all that apply and provide descriptions as requested.

☒ Conducts follow-up with clients through caseworkers/outreach workers

☒ Sends renewal reminder notices to all families

- How many notices are sent to the family prior to disenrolling the child from the program?
  On average, 3.
- At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?)
  The initial packet is mailed at the beginning of the fourth month and followed by the reminder notice two weeks later. Non-responders will receive a second renewal packet in the fifth month.

☐ Sends targeted mailings to selected populations

- Please specify population(s) (e.g., lower income eligibility groups)

☐ Holds information campaigns

☐ Provides a simplified reenrollment process,

Please describe efforts (e.g., reducing the length of the application, creating combined Medicaid/SCHIP application)

☒ Conducts surveys or focus groups with disenrollees to learn more about reasons for disenrollment
please describe:

Texas contracts with an EQRO to conduct a disenrollment survey with the intent to identify the sociodemographic and health characteristics of those who disenroll, why disenrollees leave the program, if disenrollees obtained health insurance coverage after leaving the program, and disenrollees' opinions of premium affordability.

☐ Other, *please explain*:

~~2.~~ Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology.

In SFY 2006, the Texas STAR Program and CHIP in Texas Renewal/ Non-Renewal Survey Report was conducted. A random sample of families whose children did and did not renew coverage in STAR or CHIP was selected for the study. The EQRO used the monthly CHIP enrollment files for the CHIP samples. The CHIP samples were stratified to include representation from the 10 service delivery areas (SDAs).

The outcome of the surveys supported the following:

-Continuously review renewal packet notification processes for improvement.

-Consider different strategies to assist families in tracking the submission and status of their children's renewal packets.

-Continuously review processes for managing missing renewal packet information for improvement.

-Continuously review renewal materials and processes provided for Spanish-speaking enrollees for improvement.

For additional information on the survey report, see question 4 of Section IIC.

~~3.~~ Does your State generate monthly reports or conduct assessments that track the outcomes of individuals who disenroll, or do not reenroll, in SCHIP (e.g., how many obtain other public or private

coverage, how many remain uninsured, how many age-out, how many move to a new geographic area)

☒ Yes
☐ No
☐ N/A

When was the monthly report or assessment last conducted?

The most recent submission was on December 2006.

If you responded yes to the question above, please provide a summary of the most recent findings (in the table below) from these reports and/or assessments.

Findings from Report/Assessment on Individuals Who Disenroll, or Do Not Reenroll in SCHIP

Total Number of Dis-enrollees	**Obtain other public or private coverage**		**Remain uninsured**		**Age-out**		**Move to new geographic area**		**Other**	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
63,059	18,828	30	40,614	64	1,624	3	0	0	1,993	3

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information.

The Texas Access Alliance (TAA) CHIP A010 Enrollment Report, February/March 2006 -- Monthly enrollment report based on data from Texas CHIP enrollment data system. Includes monthly totals for individuals who are no longer enrolled in Texas CHIP, reported by disenrollment reason.

Survey of Non-Renewers in Texas CHIP, Fiscal Year 2006, prepared by the Institute for Child Health Policy, University of Florida -- Random telephone survey of families whose Texas CHIP coverage was not renewed. Non-renewing families were selected for the sample if they were disenrolled in February/March 2006 and the reason for disenrollment was either "failure to re-enroll" or "renewal complete, child no longer CHIP eligible."

COST SHARING

~~1.~~ Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

In 2004, Texas eliminated its annual enrollment fees and newly required CHIP premium payments for families between 101 and 150 percent of the FPL and increased premium payments for families above 150 percent FPL. The disenrollee survey conducted by the EQRO included questions to assess family opinions regarding premiums. Eighty-six percent of respondents perceived that the premium amount was just about right. This is slightly higher than the 81 percent of respondents who reported they thought the premiums were just about right in the 2004 disenrollee survey. In both 2004 and 2006, about 18 percent of respondents reported they experienced difficulty paying the premium either every month or every few months. Overall, respondents were largely in favor of contributing financially for their child's health care coverage. Ninety-four percent replied that they felt better paying part of the cost of their child's health care coverage, and 96 percent indicated that paying the premium was worth the peace of mind it provided. These results are similar to those expressed by respondents in the 2004 disenrollee survey.

Family member opinions about premiums were also analyzed to see if there were differences in

opinions among racial/ethnic groups. Overall, opinions among the racial/ethnic groups were similar. However, 54 percent of Hispanics agreed or strongly agreed that paying for premiums sometimes seemed to be a waste of money because their child was healthy. This can be compared to the 12 percent of White, non-Hispanic respondents, 43 percent of Black, non-Hispanic respondents, and 32 percent of those representing other racial/ethnic groups who perceived that paying for premiums sometimes was a waste of money.

~~2.~~ Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

Several factors were identified during the survey process that could account for changes in disenrollment from CHIP in Texas, for example, changes in incomes of families or satisfaction with CHIP in Texas while enrolled. In order to assess whether such changes between 2004 and 2006 have had an impact on disenrollment from CHIP in Texas, multivariate analyses were conducted controlling for child

health and sociodemographic characteristics.

The following outcome variables were analyzed: perceptions of quality of care received through CHIP in Texas, satisfaction with child's physician while enrolled in CHIP in Texas, switching from CHIP in Texas to Medicaid, and disenrolling due to ineligibility in CHIP in Texas because of high income. These outcome variables were constructed as binary variables with two possible outcomes:

(1) perceptions of quality of care received through CHIP in Texas (i.e., quality) = 1, if the respondent thought that the quality of care was 'excellent', 'very good' or 'good' and quality = 0 otherwise;

(2) satisfaction with child's physician while enrolled in CHIP in Texas (i.e., doctor) = 1, if the respondent was 'very satisfied' or 'somewhat satisfied' with the child's physician while enrolled in CHIP in Texas and doctor = 0 otherwise;

(3) switching from CHIP in Texas to Medicaid (i.e., Medicaid) = 1, if the response to the question "did your child stop participating in this program because he/she switched from CHIP to Medicaid" was 'yes' and Medicaid = 0 otherwise; and

(4) ineligibility in CHIP in Texas because of high income (i.e., income) = 1, if the response to the question "did your child stop participating in this program because your child was no longer eligible for this program because your income was too high" was 'yes' and income = 0 otherwise.

As a result, a logit model was used in the estimations.

For each outcome variable, two regressions models were estimated. In the first model, the following health and sociodemographic variables were used:

(1) whether the child had a special health care need as measured by the CSHCN Screener (the reference group is no special needs); and

(2) the child's race/ethnicity characterized as White, non-Hispanic; Black, non-Hispanic; Hispanic; or Other (the reference group is White, non-Hispanic).

The second model that was estimated expanded on the first model. Specifically, the second model used health and sociodemographic variables and added a temporal variable and interactions between the temporal variable and the health and sociodemographic variables. The temporal variable indicated whether the caregiver was interviewed in 2004 or 2006 (where the reference group was 2004). Likelihood-ratio tests were used to compare these two regression models. The primary interest in comparing these two models was to explore if time was a significant factor affecting the responses of caregivers.

For the two regression models analyzing whether caregivers reported satisfaction with quality of care received through CHIP in Texas, results from the likelihood-ratio test showed that there were no changes in perceptions of quality of care received in CHIP in Texas between 2004 and

2006 ($X2(5) = 2.20$, $p=0.821$).

For the two regression models analyzing whether caregivers reported satisfaction with child's physician while enrolled in CHIP in Texas, results from the likelihood-ratio test showed that there were no changes in satisfaction with child's physician while enrolled in CHIP in Texas between 2004 and 2006 ($X2(4) = 2.69$, $p=0.611$).

For the two regression models analyzing whether caregivers reported switching from CHIP in Texas to Medicaid as the reason for disenrolling from CHIP in Texas, results from the likelihood-ratio test showed that there were no changes between 2004 and 2006 ($X2(5) = 9.18$, $p=0.102$).

For the two regression models analyzing whether caregivers reported disenrolling due to ineligibility in CHIP in Texas because of high income, results from the likelihood-ratio test showed that the second model had more explanatory power ($X2(5) = 12.35$, $p=0.030$). Expected

probabilities from the second model after controlling for health and sociodemographic variables revealed that 30 percent of families reported disenrolling from CHIP in Texas due to ineligibility because of high income in 2006 compared to 23 percent of families reporting ineligibility due to income in 2004. This difference may partly result from policy changes that implemented asset testing for families with incomes at or above 150 percent of FPL.

~~3.~~ If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of health services in SCHIP. If so, what have you found?

CHIP in Texas has undergone substantial changes since its inception, including policy changes and changes in management of certain aspects of enrollment and renewal processes. A survey of families who disenrolled from the program in 2006 compared with those who disenrolled from the program in 2004 helps to illuminate the sociodemographic and health characteristics of those leaving the program, why families disenrolled their children, and if their children have health care coverage post-disenrollment.

There are some specific areas in which the results of the 2006 disenrollee survey are very similar to those of the 2004 survey. Areas in which fiscal year 2006 and 2004 results are similar include:

-Satisfaction levels of respondents were very similar for both years. In 2006, 94 percent of respondents indicated that they would have kept their children in CHIP if that were an option. In 2004, 92 percent of respondents would have kept their child in the program. In fiscal year 2006, 70 percent of respondents indicated that their experiences with CHIP were “very good” to “excellent.” In fiscal year 2004, 67 percent of respondents reported

that their experiences were “very good” to “excellent.”

-Overall, there were some similar opinions regarding the ease of renewal for both years. Seventy-nine percent of respondents thought the renewal process was “about as easy

as it could be” in 2006 compared to the 80 percent of respondents who were surveyed in 2004.

-The percentage of children with special health care needs was similar for both surveys. Twenty-two percent of children disenrolled from CHIP in Texas in fiscal year 2004 and fiscal year 2006 surveys were identified as having a special health care need.

-The breakdown of the insurance coverage type that children had post-disenrollment by racial/ethnic group was similar for fiscal years 2004 and 2006. Of those who obtained insurance post-disenrollment for fiscal year 2006, a higher percentage of Hispanics were enrolled in Medicaid compared to White, non-Hispanics and Black, non-Hispanics (55 percent compared to 29 percent and 33 percent, respectively). Only 30 percent of Hispanics and 33 percent of those categorized as Other racial/ethnic groups obtained employer-sponsored insurance compared to 42 percent of White, non-Hispanics and Black, non-Hispanics.

-Overall, reasons provided for disenrollment in fiscal year 2006 are similar to those provided in fiscal year 2004. For fiscal year 2006, the most frequently cited reason for leaving the program was “child switched to Medicaid” (35 percent). This was followed by

30 percent of respondents who indicated that they were ineligible due to their income. Twenty-eight percent of respondents indicated they could not or did not complete the renewal process. Obtaining another insurance policy (27 percent) and ineligibility due to the child’s age (15 percent) also were frequently cited reasons for disenrollment.

There are some specific areas in which the results of the fiscal year 2006 disenrollee survey differ from those of the fiscal year 2004 survey. These areas include:

-A higher percentage of Hispanics are disenrolling from CHIP than in the past. Sixty-three percent of those children who disenrolled from CHIP during the time period studied were Hispanic. This can be compared to the 56 percent of disenrollees who were Hispanic who disenrolled during fiscal year 2004.

-The percent of disenrollees who obtained insurance post-disenrollment during fiscal year 2006 (31 percent) is six points lower than the percent of disenrollees who were covered by insurance post-disenrollment in fiscal year 2004 (37 percent). For fiscal year 2006, 45 percent enrolled in Medicaid, 36 percent enrolled in employer-sponsored insurance, and 9 percent enrolled in direct purchase insurance.

-Overall in fiscal year 2006, a higher percentage of Hispanics (74 percent) who disenrolled from CHIP in Texas did not obtain new coverage compared to White, non-

Hispanics or Black, non-Hispanics (61 and 57 percent, respectively). The percentage of Hispanics who did not obtain coverage post-disenrollment in 2006 (74 percent) is higher than the percentage of those who did not obtain insurance coverage in 2004 (68 percent).

-Recoding “other” responses for the 2006 survey responses for reason for disenrollment yielded a new category – “difficulties with the enrollment process” – that did not appear in the 2004 survey responses. Approximately five percent of respondents reported difficulties with the enrollment process in that their paperwork was lost, they had to file paperwork repeatedly, or they completed the enrollment paperwork but never received any follow-up confirmation from the Enrollment Broker.

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

~~1.~~ Does your State offer a premium assistance program for children and/or adults using Title XXI funds under any of the following authorities?

☐ Yes, please answer questions below.
☒ No, skip to Program Integrity subsection.

Children

☐ Yes, Check all that apply and complete each question for each authority.

☐ Premium Assistance under the State Plan
☐ Family Coverage Waiver under the State Plan
☐ SCHIP Section 1115 Demonstration
☐ Medicaid Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration
☐ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

Adults

☐ Yes, Check all that apply and complete each question for each authority.

☐ Premium Assistance under the State Plan (Incidentally)
☐ Family Coverage Waiver under the State Plan
☐ SCHIP Section 1115 Demonstration
☐ Medicaid Section 1115 Demonstration
☐ Health Insurance Flexibility & Accountability Demonstration
☐ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

~~2.~~ Please indicate which adults your State covers with premium assistance. (Check all that apply.)

☐ Parents and Caretaker Relatives
☐ Childless Adults

~~3.~~ Briefly describe your program (including current status, progress, difficulties, etc.)

~~4.~~ What benefit package does the program use?

~~5.~~ Does the program provide wrap-around coverage for benefits or cost sharing?

6. Identify the total number of children and adults enrolled in the premium assistance program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

_____ Number of adults ever-enrolled during the reporting period

_____ Number of children ever-enrolled during the reporting period

7. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your premium assistance program. How was this measured?

8. During the reporting period, what has been the greatest challenge your premium assistance program has experienced?

9. During the reporting period, what accomplishments have been achieved in your premium assistance program?

10. What changes have you made or are planning to make in your premium assistance program during the next fiscal year? Please comment on why the changes are planned.

11. Indicate the effect of your premium assistance program on access to coverage. How was this measured?

12. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured?

13. Identify the total state expenditures for family coverage during the reporting period. **(For states offering premium assistance under a family coverage waiver only.)**

PROGRAM INTEGRITY (COMPLETE ONLY WITH REGARD TO SEPARATE SCHIP PROGRAMS (I.E. THOSE THAT ARE NOT MEDICAID EXPANSIONS)

1. Does your state have a written plan that has safeguards and establishes methods and procedures for prevention, investigation and referral of cases of fraud and abuse? Please explain.
The Office of Inspector General (OIG) of the Texas HHSC is the agency tasked with investigation of waste, fraud and abuse in health and human service programs. These include, but are not limited to, food stamps, Medicaid and CHIP. Referral information is found on the internet at

http://www.hhs.state.tx.us/OIG/index.shtml and linked from Health and Human Services websites. The procedures used in the conduct of these investigations are included in the OIG Policies and Procedures Manual. Access to this manual is restricted to OIG employees and is password protected.

2. For the reporting period, please indicate the number of cases investigated, and cases referred, regarding fraud and abuse in the following areas:

~~a)~~ Provider credentialing

Number of cases investigated 0

Number of cases referred to appropriate law enforcement officials 0

~~b)~~ Provider billing

Number of cases investigated

Number of cases referred to appropriate law enforcement officials

~~c)~~ Beneficiary eligibility

Number of cases investigated 15

Number of cases referred to appropriate law enforcement officials 3

3. If your state relies on contractors to perform the above functions, how does your state provide oversight of those contractors?
Texas does not rely on contractors to perform the above functions. However, the HHSC OIG does receive referrals of cases of client fraud and abuse from the Texas Access Alliance, a vendor that screens CHIP applications.

Enter any Narrative text below.

Number of Provider Billing cases investigated:

The OIG investigates complaints regarding both CHIP and Medicaid providers reported by MCOs; however, the OIG does not track CHIP provider cases separately. A total of 760 Medicaid and CHIP cases were investigated and 201 cases were closed during the reporting period.

Number of Provider Billing cases referred to appropriate law enforcement officials:

A total 259 cases regarding Medicaid and CHIP providers were referred to the Attorney General's (OAG) Medicaid Fraud Control. The number of cases regarding CHIP providers that were referred to the OAG is unknown. Cases are only referred to Attorney General and not to law enforcement. The OAG, however, pursues criminal convictions.

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2005. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**2006**	**2007**	**2008**
Insurance payments	362,087,217	602,522,716	826,308,087
Managed Care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs	362,087,217	602,522,716	826,308,087
(Offsetting beneficiary cost sharing payments)	(5,405,503)	(4,576,380)	(4,576,380)
Net Benefit Costs	$ 356,681,714	$ 597,946,336	$ 821,731,707

Administration Costs			
Personnel	4,817,036	3,108,724	3,336,055
General Administration	1,605,679	1,036,241	1,112,018
Contractors/Brokers (e.g., enrollment contractors)	17,138,365	13,692,422	17,743,242
Claims Processing			
Outreach/Marketing costs	4,696,089	2,356,903	2,350,000
Other	926,102	952,069	852,412
Health Services Initiatives	49,686	315,004	
Total Administration Costs	29,232,957	21,461,363	25,393,727
10% Administrative Cap (net benefit costs ÷ 9)	39,631,302	66,438,482	91,303,523

Federal Title XXI Share	279,633,771	449,380,286	613,064,677
State Share	106,280,900	170,027,413	234,060,757

TOTAL COSTS OF APPROVED SCHIP PLAN	385,914,671	619,407,699	847,125,434

2. What were the sources of non-Federal funding used for State match during the reporting period?

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☒ Foundation grants
- ☐ Private donations
- ☒ Tobacco settlement

☒ Other (specify) Other sources of non-Federal funding used for the State match during the reporting period are prescription drug rebates and cost sharing.

Enter any Narrative text below.

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

Please reference and summarize attachments that are relevant to specific questions.

~~1.~~ If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled (an unduplicated enrollment count) in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

~~3.~~ What have you found about the impact of covering adults on enrollment, retention, and access to care of children?

~~4.~~ Please provide budget information in the following table for the years in which the demonstration is approved. *Note: This reporting period (Federal Fiscal Year 2005 starts 10/1/04 and ends 9/30/05).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**2006**	**2007**	**2008**	**2009**	**2010**
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #1					
Benefit Costs for Demonstration Population #2 (e.g., parents)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					

Fee for Service					
Total Benefit Costs for Waiver Population #2					

Benefit Costs for Demonstration Population #3
(e.g., pregnant women)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Benefit Costs for Demonstration Population #4
(e.g., childless adults)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Total Benefit Costs					
(Offsetting Beneficiary Cost Sharing Payments)					
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)					

Administration Costs

Personnel					
General Administration					
Contractors/Brokers *(e.g., enrollment contractors)*					
Claims Processing					
Outreach/Marketing costs					
Other *(specify)*					
Total Administration Costs					
10% Administrative Cap (net benefit costs ÷ 9)					

Federal Title XXI Share					
State Share					

TOTAL COSTS OF DEMONSTRATION					

When was your budget last updated (please include month, day and year)?

Please provide a description of any assumptions that are included in your calculations.

Other notes relevant to the budget:

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

~~1.~~ For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted SCHIP.

The fiscal and program policies for health care for low income, uninsured children and families are set by the Texas Legislature, which did not meet during the reporting period. However, the Texas Health and Human Services Commission did implement several initiatives during the reporting period as directed by the Texas Legislature who last met in the Spring of 2005:

• Effective January 1, 2006, CHIP cost-sharing switched from monthly premiums to a semi-annual enrollment fee; and

• On April 1, 2006, CHIP began to offer dental services to its members with the exception of those at or below 133%, Native Americans or Alaskan Natives.

~~2.~~ During the reporting period, what has been the greatest challenge your program has experienced?

One of the greatest challenges was the transitioning of the CHIP contract from the previous vendor Affiliated Computer Services (ACS) to the current vendor Texas ACCESS Alliance (TAA). There were some difficulties associated with the transition between the two vendors. For example, the current vendor has increased responsibilities compared with the previous vendor in terms of collecting applicants' information and processing the applications. In addition, there were some technical difficulties with the integration of data from the previous vendor to the current vendor.

~~3.~~ During the reporting period, what accomplishments have been achieved in your program?

Accomplishments achieved in Texas' CHIP program included reinstating dental benefits and switching from charging monthly premiums to charging one enrollment fee per six-month enrollment period.

~~4.~~ What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned.

a) Perinatal Program – The CHIP Perinatal program implemented January 2007.

b) System changes and training for the new vendor – The current business rules do not allow families determined eligible for CHIP to enroll in a health plan by telephone. A signed enrollment form sent to

the CHIP Administrative Contractor is required. Families will now be enrolled using a round robin approach in selecting health plans so that they are not disenrolled for not selecting a health plan. In the future, families will be able to call and select a health plan without requiring a signed enrollment form.

c) Eligibility determination – The agency continues to streamline the eligibility policy between the Children's Medicaid Program and CHIP for continuity and efficiency in determining eligibility and to better serve our clients.

Enter any Narrative text below.