USER'S GUIDE

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) DATABASE

I. INTRODUCTION AND OVERVIEW

The State Children's Health Insurance Program (SCHIP) Database contains extensive, program-specific information about each of the programs implemented in the 50 states, five territories, and the District of Columbia. The database was commissioned by the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, in cooperation with the Centers for Medicare and Medicaid Services (CMS), and was constructed by Mathematica Policy Research (MPR) with assistance from the Congressional Research Service (CRS). The database is maintained by ASPE. State plan amendments approved after May 31, 2001, were coded and entered by staff of the Division of State Children's Health Insurance Programs at CMS.

The database was designed to capture a wide array of program characteristics--primarily as Ayes@ or Ano@ indicators--in a form that would facilitate cross-program comparisons. For each component program the database contains 186 variables that describe eligibility provisions, outreach and enrollment, benefits, quality assurance, cost sharing, and performance measures. The database will be useful to state and federal officials, policymakers, researchers, and the general public--anyone who has a need for or interest in obtaining information on the comparative features of the programs developed by the states and territories under the SCHIP legislation.

To construct the database, MPR staff abstracted information from all state plans and amendments approved by the date specified on the main menu of the web user interface, as well as any written responses to questions posed by CMS regarding the programs= structure or operations. Information about each SCHIP component program (Medicaid expansion or separate state program) and each amendment is contained in a separate record in the database. The database also contains a record for each Section 1115 demonstration approved by the date on the main menu.

One special feature of the database allows users to view only those program characteristics that applied as of a date specified by the user, making it easier to match these characteristics to survey or administrative data on eligibility or enrollment or to track the development of program features over time. Another feature allows users to aggregate all programs and amendments within a state, in order to see a general overview of the state or territory's SCHIP as of the date on the main menu.

The following sections discuss the structure of the SCHIP Database, describe the approach used to aggregate individual program and amendment records to the state level, explain how to view tables, and describe the sources of information used to construct the database.

II. STRUCTURE OF THE DATABASE

The SCHIP Database was created with Microsoft Access, which provides a table-generating capability for organizing and viewing information stored in the database. In its current form, a web-based interface enables users to view on-screen and print a set of pre-defined tables that collectively display all of the information contained in the database.

Each record in the Microsoft Access database refers to a SCHIP component program, a program amendment, or Section 1115 demonstration in an individual state or territory. Each record contains 186 variables. The following three sections discuss how descriptions of the state programs are organized into records, what information is contained in each record, and what coding conventions were used in entering the data.

A. DATABASE RECORDS

Many states have implemented multiple programs or components that can be distinguished from one another by their eligibility criteria (e.g., different income thresholds, or disability requirements), service coverage (comprehensive vs. enhanced or supplemental services), and program structure (direct coverage vs. premium assistance). Types of component programs include:

- Medicaid expansion programs
- Separate state programs that provide *comprehensive direct coverage*
- Separate state programs that provide *enhanced services*
- Separate state programs that provide *premium assistance*

Data are entered and stored in the database at the program level--that is, each program is assigned its own record. Amendments to programs are entered and stored as separate records as well. This allows the database to be updated without changing previously-recorded information, which makes quality control easier and allows the database to document what provisions were in effect at what time. This record structure is described more fully--with illustrations--below.

(1) Information about each SCHIP component program and each amendment is stored in a separate record within the database. For example, if a state has a Medicaid expansion program, a comprehensive separate state program, and an enhanced services program for children with disabilities, and two of the programs have been amended, there will be a total of 5 records (3 program records and 2 amendment records) in the database.

(2) Only programs and amendments approved on or before the date specified on the main menu of the web user interface are currently included in the database.

(3) Each program record presents the information contained in the state=s original submission (or, if the program was created through an amendment, in that amendment) and the official correspondence related to it. Each program record therefore presents a snapshot of a program at its inception, rather than as it may have been modified more recently.

(4) If the information in the state=s original submission or an amendment was later revised in the state=s written responses to questions posed by CMS, the record will contain the information communicated in the correspondence rather than the information presented in the original submission or amendment.

(5) Each program is identified by name and by a number that reflects the order in which it was approved, while each amendment is identified by the name and/or number of the program it modified and by number. For example, if a state has a Medicaid expansion program, a separate state program referred to by the state as "Phase II," and an amendment that affects the separate state program, the Medicaid expansion program is identified as program 1, and the separate state program is identified as program 2 (or Phase II). The amendment is identified as amendment 1, program 2 (or amendment 1, Phase II). If the amendment created a new program called "Phase III" instead of changing an existing one, it would be called amendment 1, program 3 (or amendment 1, Phase III).

(6) Amendment records differ from program records in that an amendment record captures only the information that has changed as a result of the amendment. For example, if a state submitted an amendment to raise the income threshold for coverage in the separate state program from 185 to 200 percent of the FPL, all of the items in the amendment record following an overview section will be blank except for the income threshold item, which will show the new 200 percent threshold. In cases where an amendment created a new program, however, the amendment record will contain all of the information about the new program.

(7) If an amendment contains provisions that affect more than one program, the changes to each program are captured in separate amendment records. (In this case, a state that implemented a Medicaid expansion program and a comprehensive separate state program and then submitted an amendment to modify both programs would have four records in the database, not three.)

(8) Unnumbered amendment records are used to record program changes that are slated for implementation at a different time than the state plan or amendment in which they are described. There were two instances in which an original state program (in Indiana and Connecticut) included a scheduled change in the income eligibility threshold, which was to go into effect on a specified date. We represented this change by creating a pseudo-amendment record, numbered A0", which replaced the old threshold with the new threshold on the date specified in the original state plan.

(9) Unnumbered amendment records are also used to account for the phase-out of SCHIP Medicaid expansions in some states. Under the OBRA Medicaid expansions, states are required to provide Title XIX Medicaid coverage to children born after September 30, 1983, whose family incomes are below the poverty level. The upper age limit for Title XIX Medicaid coverage for poverty-level children accordingly rises each year. Some states used Title XXI funds to accelerate this phase-in of Medicaid coverage, but as of October 1, 2002, all of the children covered under these Title XXI Medicaid expansions will be covered under Title XIX,

and states whose Title XXI Medicaid expansions covered only poverty-level children born on or before September 30, 1983 will no longer have combination SCHIP programs.

To assure that the SCHIP database reflects this change for such states, an unnumbered amendment record was created to change the program type from "combination" to "separate program only" on October 1, 2002. In addition, since the lower bound of the age group covered changes continuously, the "age group covered" variable displays only the upper age limit so that the information is valid at any point in time selected by the user.

B. CONTENTS OF A RECORD

Each record contains 186 data fields or variables, organized in a way that parallels the structure of the state plan template that states followed in preparing their submissions. The record contains these sections:

Identifiers and Overview (10 fields)

Program Description (7 fields)

Standards of Eligibility (23 fields)

Provisions to Ensure Medicaid Eligibles are Enrolled in Medicaid (5 fields)

Provisions to Prevent Substitution of Private Coverage (6 fields)

Provision of Assistance to Indians (4 fields)

Coordination with Other Programs (6 fields)

Outreach and Enrollment (14 fields)

Type of Benchmark (8 fields)

Service Delivery Model and Benefit Maximums (7 fields)

Benefits (42 fields)

Demonstrations/Waivers (3 fields)

Quality Assurance (13 fields)

Cost Sharing (11 fields)

Performance Measures (15 fields)

Amendment Information, Footnotes, and Additional Information Provided by State Officials (12 fields)

This grouping of fields or a variation thereof is used in each of the tables described in Chapter IV.

Depending on the table, footnotes may be displayed in the notes section at the end of the table or in pop-up boxes that can be accessed by clicking on the asterisk that appears beside the footnoted item. When footnotes appear at the end of a table, there are two fields allotted to each footnote: one identifying the field to which the note applies and the second containing the note itself. When viewing tables, the user is advised to always check the footnote section to see if any pertinent information is present.

The notes section includes two additional text fields. The first provides room for an extended description of any changes made by an amendment that cannot be adequately conveyed within the other fields. The second contains any additional information provided by the state officials who reviewed tables displaying data on their respective state programs. State officials did not review data on programs or amendments that were approved past September 30, 1999. This information is not contained in the state plan or any other official correspondence between CMS and the state. Because the database was intended to reflect what is on record with CMS, we have not revised the state plan or amendments to show this information but have elected to present it separately.

C. CODING CONVENTIONS

Most of the fields in the database are coded Ayes@ or Ano@ to indicate that a specified feature *is* or *is not* present. Most of the yes/no fields were coded directly from check boxes in the state plan template, and no interpretation was required of the coders. For other items, however, the assignment of codes was based on a reading of text in the state plan template or amendment. We coded these items conservatively, meaning that we did not identify a particular feature as present unless there was explicit language to that effect.[1]

Most of the remaining fields contain text descriptions. These text descriptions range from just a few words to a paragraph. Fields that are used to specify Aother@ information contingent on the presence of a "yes" in the preceding field are blank when they are not required, however. The remaining fields contain numeric information, such as an income eligibility threshold or age group.

On an amendment record, as noted previously, only those fields that were actually changed by the amendment contain values or text. Also, on an 1115 demonstration program record, only a description of the waiver is presented; most of the variables are blank. On a program record, however, all but a few fields must always be filled. When a field could not be completed from the information reported in the source documents, one of three different codes was used to explain why the data are missing. The codes ANA,@ ANR,@ or A--@ were used to convey the following:

[1] Sections for which the coding was based primarily on a reading of text in the state plan template include those pertaining to procedural assurances (Section 4.4), outreach and enrollment (Section 5), service delivery model (Section 3), quality assurance (Section 7) and cost sharing (Section 8).

Items are coded as *ANA@ (not applicable)* when they are not relevant to the program in question. For example, if the state has only a Medicaid expansion program, the item ASame state agency determines eligibility for Medicaid and the separate state program@ would not be applicable and would therefore be coded as ANA.@

Items are coded as *ANR@ (not reported)* when the information is not available in the materials the state submitted to CMS. For example, if the state did not mention in its discussion of outreach and enrollment strategies whether or not it planned to use an outreach broker, this item would be coded as ANR.@ (This item would be coded as a Ano@ only if the state explicitly stated that it did not use an outreach broker.)

Items are coded as A--@ if the state was *not required to complete the section of the state plan template in which the item appears and did not volunteer the information elsewhere.* States with Medicaid expansion programs were permitted to skip many sections of the template; the dash indicates that the state was not required to provide the information in question and did not do so. If a state voluntarily reported the information in another section of the template, the database includes what the state reported.

The "NA" and "—" codes rarely appear on amendment records, where fields are used to indicate only what features have been changed. An exception occurs if an amendment makes a conditional field no longer applicable--for example, by replacing income thresholds that vary by age group with a single threshold for all age groups. In this case, NA would appear in place of the age-specific thresholds reported in the original plan record.

Most of the items in the database are self-explanatory to users who have a detailed familiarity with SCHIP. For those who do not, we have provided (on the first screen) a link to the CMS website location containing a downloadable copy of the SCHIP state plan template and instructions for completing the state plan template. Even with this documentation, however, three items may require further explanation:

Enhanced Services Program	These are programs that provide a limited set of services to enhance those provided by a more comprehensive program. Generally, enrollment in an enhanced services program is limited to children with special needs.
Residency Requirement	This item is coded as a Ayes@ only if the state requires more than that the applicant be a current resident of the state--for example, if the state requires that the applicant have resided in the state for a certain length of time.
Notes	In some tables, additional information about an item is provided in the ANotes@ section at the end of the table. AItem@ contains the variable name, and ANote@ displays the additional information.

III. APPROACH TO STATE- AND NATIONAL-LEVEL AGGREGATIONS

A. STATE-LEVEL AGGREGATION

The state-level aggregation creates a single record for each state or territory. To provide the user with the most current possible overview of each state's SCHIP, all programs within a state are aggregated as they existed on paper at CMS on the date that appears on the main menu. Over a dozen different approaches were used to aggregate variables to the state level. This section provides a general overview of these approaches and describes the specific strategies used for selected variables. Appendix A contains tables that describe each approach in detail and identify which was applied to each variable.

The key decision to be made in specifying the aggregation approach for each variable was whether to disregard or highlight differences among the component programs in a state. For example, if one of the state's component programs offers continuous eligibility while another does not, the aggregation could simply show that continuous eligibility is offered in at least one program, indicate that the programs vary in this regard, or specify which program offers continuous eligibility and which does not. Which of these approaches was used depends upon the variable.

For most variables of the "yes/no" type, the state-level aggregation shows if any of the state's component programs has the feature in question. That is, if there is a "yes" for the variable in any program record, the state-level table displays a "yes" for that variable. (In keeping with the conservative coding approach described earlier, a "no" appears in the state-level aggregation only if the variable is coded "no" in *all* of the state's component program records.) Examples of variables handled in this way include most of those related to procedural assurances (e.g., provisions to ensure Medicaid eligibles are enrolled in Medicaid), service delivery model, quality assurance, and performance measures.

For variables that contain descriptive text about a program feature, the aggregation generally displays either the text from each component program record (with the descriptions separated by slashes or program numbers in parentheses) or the number of each program record in which descriptive text appears. For example, if any of a state's component programs have a disability requirement, the state-level table identifies by number (under "Programs with Disability Requirement") the programs that have such a requirement. The user can see the name of each component program by placing the on-screen arrow over the program number using the mouse (a "mouse-over") and can view the actual description from each program record by clicking on the program number to call up a pop-up window.

For the variables that describe program benefits, the state-level aggregation focuses exclusively on the benefits offered by the comprehensive separate state program (if any). Because states were not required to complete the benefits section of the state plan template for Medicaid expansion programs, the information provided by the states in this section of the template generally refers only to their separate state programs. The aggregation strategy for these variables reflects the fact that, in records for Medicaid expansion programs, these variables are simply coded with a dash ("--").

Special aggregation strategies were adopted for certain variables, including "Age Group Covered," "Upper Income Threshold," "Duration of Eligibility" and several of the variables related to cost sharing.

- ***Age Group Covered.*** For this variable, the aggregation strategy depends on the program type (Medicaid expansion, separate state program, or combination program) and whether the state has more than one comprehensive separate state program. For states with Medicaid expansion programs only, the state-level aggregation displays the age group covered by the expansion. For states with separate state programs or combination programs, the state-level aggregation displays the age group covered by the comprehensive separate state program. (A separate state program is defined as comprehensive if it is neither an enhanced services program nor a premium assistance program.) If there is more than one such program, the aggregation displays the age group covered by each. For example, California has two comprehensive separate state programs: Healthy Families/Health Insurance Plan (MRMIB), which covers children under age 19, and Healthy Families/Access for Infants and Mothers (AIM), which covers children under age 1 whose mothers are enrolled in AIM. For "Age -level record for California therefore displays the following: "<19(Prg.2)/<1(Prg.3)." The name of each program can be viewed by placing the on-screen arrow over the number.

- ***Upper Income Threshold.*** The strategy used for this variable also depends on the program type. For states that have only Medicaid expansion programs, the state-level aggregation displays the upper income threshold for that program. For states that have only separate state programs, the aggregation displays the threshold for the comprehensive separate state program (defined as above). If there is more than one such program, the aggregation displays the highest value for this variable. For states with combination programs, the aggregation displays the thresholds for both the Medicaid expansion and the comprehensive separate state program. For example, California has a Medicaid expansion program that covers children up to 100 percent of the Federal poverty level (FPL), and two comprehensive separate state programs that both cover children up to 250 percent of the FPL. For "Upper Income Threshold," the state-level record for California therefore displays the following: "100 (ME)/250 (SSP)."

- ***Duration of Eligibility.*** The aggregation strategy for this variable also takes note of differences among component programs. If different eligibility periods are specified for different programs, the state-level table displays the word, "Varies."

- ***Cost-Sharing Variables.*** Differences among programs are highlighted in the aggregation for certain cost-sharing variables ("Maximum per Child," "Maximum per Family," "Annual Amount," and "Amount per Visit"). For states in which premium, deductible and copayment amounts were specified for a single program (or the amounts for each program were the same), the state-level table displays those amounts. For states where amounts vary across component programs, the state-level table displays all of the amounts, with each separated from the next by a slash.

B. NATIONAL-LEVEL AGGREGATION

The national-level aggregation summarizes the information in the state-level tables. The national-level summary statistics appear in the tables that present state-level data for all 50 states, the District of Columbia and the five U.S. territories that receive Title XXI funds.

For the "yes/no" variables, the national-level aggregation simply displays the number of states and/or territories that have a "yes" entry for a particular variable--for example, the number of states that impose some type of cost sharing. Given the conservative coding approach used in creating the program-level records, the counts for some variables should be viewed as lower bounds. As noted, when we assigned codes based on a reading of the text in the state plan template or amendment, we identified a feature as present (or not) only if there was explicit language to that effect. When the state or territory did not specifically indicate the presence or absence of a feature, we coded the item as "missing/not specified." Hence, the upper bound for the national counts for these variables would be the sum of the "yes" and the "missing/not [2]

For most of the numeric variables, the aggregation displays both the mean and the range of values that appear in the state-level table. In almost all cases, negative and zero values were excluded in calculating the means and ranges. (Zero values were included in calculating the mean and range for the number of state plan amendments approved by CMS.)

Text variables, such as the descriptions of disability requirements are not aggregated to the national level.

[2] Sections for which the coding was based primarily on a reading of text in the state plan template include those pertaining to procedural assurances (Section 4.4), outreach and enrollment (Section 5), service delivery model (Section 3), quality assurance (Section 7) and cost sharing (Section 8).

IV. HOW TO VIEW TABLES

The user interface for the SCHIP Database provides four modes for viewing tables that display selected contents of the database:

- View a single component program or amendment (for a particular state)
- View a state-level summary (for a particular state)
- View all component programs and amendments (for all states)
- View state-level summaries (for all states)

The Aview a single component program or amendment@ option allows the user to display a pre-specified set of fields for either a single program or amendment as originally proposed or a programat a specified point in. The "view a state-level summary" and "view state-level summaries" options both compile the information in individual program and amendment records into a single state record per state. The Aview all component programs and amendments@ option allows the user to display all fields for all records in the database.

A. VIEW A SINGLE COMPONENT PROGRAM OR AMENDMENT

Clicking this option brings up a screen that allows the user to select a state (or territory) from a list box (Exhibit IV.1).

Clicking on a state and then the box labeled Aselect plan@ brings up the next screen, which gives the user two options for viewing a single program from the selected state (Exhibit IV.2). The first option is to select both a program and a date. With this option, program changes created by any amendments that were implemented as of the date selected by the user will be incorporated into the program, yielding a description of the program as it existed on that date. Literally, non-blank amendment fields will replace the original program fields. If two amendments produce alterations to the same field, the later of the two amendments will prevail.

The second option is to select an individual record--either an original program or an amendment. Using this option to view an amendment record is the easiest way to determine what program features were changed by the amendment. Apart from the overview section, only those fields that refer to program characteristics changed by the amendment will be filled; the rest of the fields will be blank.

1. Select a Program to View as of a Particular Date

To use the first option, select a program from the names displayed in the list box at the top of the screen. After selecting a program, select a month, day, and year from the list boxes

EXHIBIT IV.1

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) DATABASE

View a Component Program or Amendment

Select a State: CT Select Program or Amendment

EXHIBIT IV.2

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) DATABASE

View a Component Program or Amendment

Select a Program to View:

HUSKY Program | Part A

As of:

Select a Month: 3 **Day:** 15 **Year:** 2002 View Program

NOTE: This database reflects programs and amendments approved through May 31, 2001.

OR

Select a Program or Amendment to View as Approved:

HUSKY Program | Part A -- Program

View

displayed across the center of the screen. All amendments implemented as of the selected date will be applied to the program. When the table appears, a legend above the upper right corner will indicate how many amendments have been applied. If a program was created by an amendment, that amendment will not be included in the count. Exhibit IV.3 displays part of a single-program table, with the variable names displayed down the left-hand column and their values displayed in the right hand column.

Note that because implementation dates usually follow approval dates, there may be amendments with implementation dates after the date that appears on the main menu. While it is necessary to enter a later date to see the effects of amendments that were approved by the specified date but implemented later, the user is cautioned that the database may not include *all* amendments that were implemented by this later date, for some of these amendments may not have been approved until after the specified date. Furthermore, given that states sometimes implement amendments before receiving formal approval, the database may not even include all amendments that were implemented by the date that appears on the main menu.

2. Select a Specific Program or Amendment to View

To view a single record with the second option, click on the arrow in the right corner of the list box that appears near the bottom of the screen. This will open up a list of all of the program records and amendments for that state. In contrast to the list box at the top of the screen, this list box displays amendments as well as programs. The list shows the overall program name and the phase or component name and then identifies the type of record. "Program" indicates a record for a program that was created by the state's original submission. "Amendment" indicates either a record for a program that was created by an amendment or a record for an amendment that modified an existing program. Most amendment records are also identified by number, indicating the order in which they were approved by CMS. Amendments that do not have a number capture program changes slated to be implemented at a different time than the state plan or amendment in which they were described. (See Chapter II, Section A, items 8 and 9 for more information about unnumbered amendments.)

B. VIEW A STATE-LEVEL SUMMARY

Clicking this option will bring up a screen similar to the opening screen for "view a component program or amendment" option, which allows the user to select a state or territory from a list box.

Once the user has selected a state, a table similar to the single-program table appears. The user does not have the option of selecting a point in time at which to view the state's program. All amendments approved by the date specified on the main menu are applied before information in the program records is compiled into a single record for each state.

For some variables, the aggregation displays the number of each program that has a particular feature, such as a disability requirement (Exhibit IV.4). These numbers appear in either a black or white box. In either case, the user can ordinarily see the name of the program by placing the on-screen pointer over the number in the box, using the mouse. The program name will not appear, however, if the state has only one component program.

EXHIBIT IV.3

State Children's Health Insurance Program

NR = not reported
NA = not applicable
-- = the state was not required to complete this section of the state plan template and did not volunteer the information.

Number of Amendments: 3

State Name	CT
Program #	1
Program Name	HUSKY Program
Phase or Component	Part A
Amendment #	0
Amendment Creates a New Program	NA
Waiver/ Demonstration #	NA
SCHIP Type	Combination program
Approved	4/27/98
Implemented	1/1/98

Program Description	
Medicaid Expansion	Yes
Separate State Program	No
Enhanced Services Program	No
Employer-Sponsored Coverage	No
Statewide	Yes
Area Served, if Not Statewide	NA
Section 1115 Demonstration	No

Eligibility Provisions	
Age Group Covered (Children)	<19
Upper Income Threshold (% FPL)	185
Upper Income Threshold Varies by Age Group	No
… Threshold for Infants (% FPL)	NA

EXHIBIT IV.4

Eligibility Provisions	
Age Group Covered	<19
Upper Income Threshold	185(ME) 300(SSP)
Programs with Varying Thresholds	
Programs That Use Income Disregards	2 3 4
Programs That Use Assets Tests	
Residency Requirement in Any SSP	No
Description of Residency Requirement	
Any Programs with Disability Requirement	Yes
Programs with Disability Requirement	3 4
Coverage-Related Standards in Any Program	Yes

EXHIBIT IV.5

State: CT
Program Name: HUSKY Program/HUSKY Plus Behavioral Health Plan
Description of Disability Requirement: Clinical determination of eligibility based on severe psychiatric and/or substance abuse symptoms, substantial evidence of marked impairment in functioning across multiple areas, and treatment needs that cannot be reasonably met within the standard HUSKY benefit package.

When the program number appears in a white box, clicking on the number will activate a pop-up window, showing the name of the state, the name of the component program, the variable name, and the text from the relevant record. For example, if the user clicks on the "4" under "Programs with Disability Requirement" in the table for Connecticut, the information in Exhibit IV.5 appears. The user can print the information in the pop-up box by clicking on "File" in the toolbar at the top of the box and then clicking "Print." The box can be closed by clicking on "File," then "Close," or by clicking on the "X" in the upper right corner of the box.

C. VIEW ALL COMPONENT PROGRAMS AND AMENDMENTS

Selecting this option will bring up an outline that lists all of the sections of the database (Exhibit IV.6). Clicking on one of the sections listed in the outline will bring up a tabular display containing that set of variables for all component programs and amendments. For example, clicking on "Overview" will bring up the table shown in Exhibit IV.7.

The variables in the section are listed horizontally across the top of the table, and the programs and amendments are listed vertically along the left side. In the first four columns of each tabular display appear four variables described collectively as "identifiers": the name of the state, the name of the state's SCHIP, the name of the phase or component, and, if applicable, the amendment number. (States and territories are identified by their two-character postal abbreviations, which are reproduced in a document that can be accessed from the initial screen.)

The number of variables included in each table has been limited so that the columns can be printed in portrait format at the default font size. To view all of the records, however, the user must scroll down, and a print of a table in the default font size will require at least two pages.

To select another section of the database to view, the user must click the "Back" button on the browser to return to the outline listing the sections.

D. VIEW STATE-LEVEL SUMMARIES

Selecting this option will bring up an outline almost identical to the outline that appears when the user selects the "view all component programs and amendments" option. As with that option, clicking on one of the sections listed in the outline will bring up a tabular display containing that set of variables for all states. For example, if the user clicks on "Type of Benchmark for Benefits Package," the screen in Exhibit IV.8 appears.

In these tables, the variables are listed horizontally across the top of the table, and the states are listed vertically along the left side. In the first four columns of each tabular display appear four "identifier" variables: the name of the state, the number of component programs in the state's SCHIP, the name of the state's program, and the number of program amendments approved as of the date that appears on the main menu. The national-level aggregations appear at the bottom of each table.

EXHIBIT IV.6

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) DATABASE

Overview (section 1)
Program Description (section 1)

Eligibility Provisions: Standards of Eligibility (section 4.1)
- **Part I (Income Thresholds, Disregards, Asset Tests, Residency Requirements)**
- **Part II (Disability Requirements, Standards Related to Other Coverage)**
- **Part III (Duration of Eligibility, Presumptive Eligibility, Continuous Eligibility)**

Eligibility Provisions: Procedural Assurances (section 4.4)
- **Provisions to Ensure Medicaid Eligibles Are Enrolled in Medicaid**
- **Provisions to Prevent Substitution of Private Coverage**
- **Provision of Assistance to Indians**
- **Coordination with Other Programs**

Eligibility Provisions: Outreach and Enrollment (section 5)
- **Part I**
- **Part II**

Type of Benchmark for Benefits Package (section 6.1)
Service Delivery Model (section 3) and Benefit Maximums

Benefits (section 6.2)
- **Part I**
- **Part II**
- **Part III**
- **Part IV**
- **Part V**

Demonstrations and Waivers (section 6.5)
Quality Assurance (section 7)
Measurement of Health Plan Quality (section 7)

Cost Sharing (section 8)
- **Deductibles and Copayments**
- **Premiums**

Performance Measures (section 9)
- **Part I**
- **Part II**

Amendment Information Not Captured Elsewhere and Footnotes 1-2
Footnotes 3-5
Other Information Provided by State Officials

EXHIBIT IV.7

SCHIP Characteristics

NR = not reported
NA = not applicable
-- = the state was not required to complete this section of the state plan template and did not volunteer the information.

Identifiers				Overview				
State	**Program**	**Phase or Component**	**Amend.#**	**Amendment creates a new program**	**Waiver/ Demo #**	**SCHIP Type**	**Approved**	**Implemented**
AK	AK Denali KidCare		NA	NA	NA	Medicaid expansion	12/11/98	3/1/99
AL	AL SCHIP	Phase 1		NA	NA	Separate state program		10/1/01
AL	AL SCHIP	Phase 1	NA	NA	NA	Medicaid expansion	1/30/98	2/1/98
AL	AL SCHIP	All Kids (Phase 2)		NA	NA	Separate state program		10/1/01
AL	AL SCHIP	All Kids (Phase 2)	1	Yes	NA	Combination program	8/18/98	9/1/98
AL	AL SCHIP	All Kids (Phase 2)	2	No	NA	Combination program	9/24/99	4/1/00
AL	AL SCHIP	Plus (Phase 3)		NA	NA	Separate state program		10/1/01
AL	AL SCHIP	Plus (Phase 3)	2	Yes	NA	Combination program	9/24/99	4/1/00

EXHIBIT IV.8

SCHIP Characteristics

NR = not reported
NA = not applicable
-- = the state was not required to complete this section of the state plan template and did not volunteer the information.
ME = Medicaid expansion
SSP = Separate state program

Identifiers				Type of Benchmark							
				Benchmark for Comprehensive Separate State Program							
State	# of Programs	Name	# of Amendments	Medicaid	FEHBP	State Employee Plan	HMO w/Largest Enrollment	Benchmark Equivalent	Specify Benchmark Plan	Secretary-Approved Coverage	Existing State-Based Coverage
AK	1	AK Denali KidCare	NA	NA	NA	NA	NA	NA		NA	NA
AL	3	AL SCHIP	2	No	No	No	Yes	No		No	No
AR	2	AR CHIP	1	No	No	No	No	No		Yes	No
AS	1	AS SCHIP	NA	NA	NA	NA	NA	NA		NA	NA
AZ	1	KidsCare	4	No	No	No	No	No		Yes	No

For some variables, the multi-state tables, like the single-state tables, display the number of each component program that has the feature in question. The user can see the name of the program by placing the on-screen pointer over the number in the black or white box. Clicking on the program number in a white box will activate a pop-up window.

To select another section of the database to view, the user must click the "Back" button on the browser to return to the outline listing the sections.

V. SOURCES OF INFORMATION

Official CMS documents provide the source of most of the information contained in the database. These documents include:

- Original state plan submissions and amendments approved by CMS on or before the date that appears on the main menu of the web user interface
- The states= written responses to CMS questions seeking clarification of plan provisions
- CMS tracking documents and CMS fact sheets, which provided program and amendment implementation dates
- CMS descriptions of approved Section 1115 demonstrations, from the CMS website

In addition, during the coding process, telephone calls were made to a few states to clarify key information.

There was no explicit cut-off date for the states= written responses to CMS questions, but because the responses will almost certainly precede the approval dates for the plans or amendments to which they apply, we would assert that all correspondence relevant to plans or amendments approved by the date on the main menu, is included.

MPR completed two rounds of updates to the database. In the first update, all documents approved by September 30, 1999, were included in the database. In the second update, all documents approved by May 31, 2001, were included. During the first update, all of the states and territories were given an opportunity to review tables containing information on their own plans and amendments. The administering agency in each state or territory was sent a letter accompanied by one or more tables displaying information about each component program approved by CMS through September 30, 1999. Detailed instructions for reviewing the tables were included. A review period of three weeks was specified, but ultimately all corrections submitted by the agencies were incorporated into the database.

In reviewing the tables, states were instructed to identify the source of each correction with a reference to where the information could be found in the official documents maintained by CMS. Examples included: Aoriginal submission, section 4.1,@ Aamendment approved 9/9/99, p. 5,@ and Aletter dated 5/5/98, p. 2.@ Several states provided corrections that could not be documented in their correspondence with CMS. Rather than edit the state plan or amendment records to reflect these unofficial corrections, we opted to capture this information in a separate field identified as AOther Information Provided by State Officials." States were not given the opportunity to review changes to the database during the second update. Consequently there are no entries in the "Other Information Provided by State Officials" field for programs or amendments approved between 9/31/99 and 5/31/01.

ASPE and CMS assumed responsibility for the database in May 2002. Information from amendments and Section 1115 demonstrations approved after May 31, 2001 was coded and entered by CMS staff.

APPENDIX A

STATE-LEVEL AGGREGATION STRATEGIES

TABLE A. 1

APPROACHES FOR AGGREGATING SCHIP
COMPONENT PROGRAM RECORDS TO THE STATE LEVEL

Approach	Description
A	Display the value from the most recent record. (That is, the record with the latest implementation date.)
B	Display the highest value.
C	Drop this variable. (There should be no line for it on the state-level tables.)
D	Set to "yes" (1) if any of the state's records contain a "yes" (1) for this variable. Set to "no" (0) if all of the state's records contain a "no" (0) for this variable. Set to "NR" if neither of the above conditions is met.
D2	Set to "yes" (1) if any of the state's records contain a "yes" (1) for this variable. Set to "no" (0) if any of the state's records contain a "no" (0) for this variable and none contains a "yes" (1) or "NR" (-1) Set to "NA" (-2) if all of the state's records contain an "NA" (-2) for this variable. Set to " No or NR" if none of the above conditions is met.
E	Set to "yes" (1) if any of the state's records contain a "yes" (1) for this variable. Set to "no" (0) if all of the state's records contain a "no" (0) for this variable. Set to "—" (-3) if all of the state's records contain a " -3) for this variable. Set to "No or NR" if none of the above conditions is met.
F	Sum any values $ that meet the specified condition.
G	Set to highest value if any of the state's records contain a value >0 for this variable. Set to "NA" (-2) if all of the state's records contain "NA -2) for this variable. Set to "—" (-3) if all of the state's records contain a " -3) for this variable Set to "NA/NR" (indicating the information was either not available or not reported) if none of the above conditions is met.
H	If field is blank for all program records, leave blank. Otherwise, display the program number for each component program that has a non-blank response. (Program numbers should be separated by at least a couple of spaces.) For example, say the state has 3 component programs and programs 1 and 2 have some kind of response for this variable (e.g., a disability requirement). On the state level table, the variable name would be "Programs That Have a Disability Requirement" and the response that would be 1 2." The user would then be able to see the names of programs 1 and 2 by placing the on-screen arrow over each number, using the mouse (a "mouse-over").
H2	If field is blank or set to "NA" (-2) for all program records, leave blank. Otherwise, display the program number for each component program that has a non-blank response, as in H.

Approach	Description
I	If field is blank for all program records, leave blank. Otherwise, display text from any non-blank fields. Separate text from individual program records with a slash (/).
I2	If field is blank or set to "NR" (-1) or "NA" (-2) for all program records, leave blank. Otherwise, display text from any non-blank fields. Separate text from individual program records with a slash (/).
J	Display the program number for each component program that has a "yes" (1) response for the *previous* variable. For example, for variable M1A, look at the values for variable M1 in the component program records, and then show the numbers of the programs for which M1=1. As with approach H, program numbers should be separated by at least a couple of spaces, and the mouse-over should show the names of the programs indicated.
K	Subset to records for comprehensive separate state programs. These are records in which A2= "yes" (1) and both A3 and A4 = "no" (0). Then follow the strategy described in E. If there is no comprehensive separate state program, set to "NA" (-2).
L2	If field is blank or <0 for all program records, leave blank. Otherwise, display the program number for each component program that has a non-blank response. (Program numbers should be separated by at least a couple of spaces.)
M	If field is blank for all program records, leave blank. Otherwise, display the program number for each component program that has a "yes" (1) response. (Program numbers should be separated by at least a couple of spaces.) For example, say the state has 3 component programs and programs 1 and 2 have a "yes" for this variable (e.g., they have income disregards). On the state level table, the variable name would be "Programs That Use Disregards" and the response displayed would be "1 2." The user would then be able to see the names of programs 1 and 2 with the "mouse over." Note: this approach is very similar to approach H--the only difference is that with H, we are looking for a non-blank response, while with M, we are looking for a "yes" response.
N	If field is blank for all programs, leave blank. If field is not blank and the value is the same for all programs, display that value. If field is not blank and the value differs across programs and all of the values are <0 enter "NA/NR." If the field is not blank and the value differs across programs, and there is only one positive value, display that value. Otherwise, enter "Varies."

Notes: NA=not applicable; NR=not reported; -- (dash) = state was not required to complete this section of the state plan template and did not volunteer the information.

TABLE A.2

SPECIFICATIONS FOR CREATING A STATE-LEVEL RECORD

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
Overview (State-Level Information)					
	i.a	State Name	State Name		State name will be the same for all records that are to be combined.
	i.b	SCHIP Type	SCHIP Type	Medicaid expansion only (1) Separate program only (2) Combination (3)	A
Program or Amendment Identifiers					
	ii.a	Program #	***# of Programs***		B
	ii.b	Program Name	Program Name		Program name will be the same for all records that are to be combined.
	ii.bb	Program or phase name			C
	ii.c	Amendment #	***# of Amendments***		B
	ii.cc	Waiver/Demonstration #	***# of Waivers/Demonstrations***	Set to –2 (display "NA" on the tables) unless coder enters a positive integer to indicate the number of the waiver/demonstration	B
	ii.d	Amendment creates a new program			C
	ii.e	Approved	***First/Last Program or Amendment Approved***		Display earliest and latest date, separated by a dash.
	ii.f	Implemented	***First/Last program or Amendment Implemented***		Display earliest and latest date, separated by a dash.

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
Program Description (Section 1)					
Program Type	A1	Medicaid expansion	***Includes Medicaid Expansion***	yes (1) no (0) missing/not specified (-1)	D
	A2	Separate state program	***# of Separate State Programs***	yes (1) no (0) missing/not specified (-1)	F
	A3	Enhanced Services Program	***# of Enhanced Services Programs***	yes (1) no (0) missing/not specified (-1)	F
	A4	Employer Sponsored Coverage	***Includes Employer- Sponsored Coverage***	yes (1) no (0) missing/not specified (-1)	D
	A8	Statewide	Statewide	yes (1) no (0) missing/not specified (-1) not applicable (-2) not required to provide (-3) ***Note: these constitute the Astandard options@***	Set to "no" (0) if any of the state's records contain a "no" (0) for this variable. Set to "yes" (1) if all of the state's records contain a "yes" (1) for this variable. Set to "NA/NR" if neither condition is met.
	A9	Area served if not statewide	***Programs That Serve Selected Regions***		H2
	K2A	Section 1115 Demonstration	Section 1115 Demonstration	Yes (1) No (0)	E

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
Eligibility Provisions: Standards of Eligibility (Section 4.1)					
	B1	Age Group Covered (Children)	Age Group Covered		If the state has only a Medicaid expansion program (A1=1 and A2=0 for all state program records), display the value of B1 for the program where A1=1. If the state has separate state program(s) (A2=1 for any state program records), display the value of B1 for the comprehensive separate state program, where A2=1 and both A3 and A4=0. If the state has more than one such program, display the value of B1 for the first such program, followed by the program number in parentheses (with Prg. Before the number), a slash, the value of B1 for the second such program, and the number in parentheses (again, with "Prg." Before the number).

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
	B2	Upper Income Threshold	***Upper Income Threshold***		If the state has only a Medicaid expansion program (A1=1 and A2=0 for all state program records), display the value of B2 for the record where A1=1. If the state has only separate state program(s) (A1=0 and A2=1 for all state program records), display the value of B2 in the record for the comprehensive separate state program (where A2=1 and both A3 and A4=0). If there is more than one such program, display the highest value. If the state ha a combination program (A1=1 for at least one program record and A2=1 for at least one program record), display the value of B2 for the record where A1=1, followed by "(ME)/", followed by the highest value for any records where A2=1 and both A3 and A4=0, followed by ("SSP)."
	B2A	Income Threshold Varies by Age Group	***Programs With Varying Thresholds***	Standard options	M
Income Threshold by Age Group	B3	Threshold for Infants (% FPL)			C
	B4	Other Age Group			C
	B5	Threshold for Other Age Group (% FPL)			C
	B12	Income Disregards	***Programs That Use Income Disregards***	Standard options.	M

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
	B13	Assets Test	***Programs That Use Assets Test***s	Standard options	M
	B13 A	Residency Requirement	***Residency Requirement in SSP***	Standard options	K
	B14	Description of Residency Requirement	Description of Residency Requirement		Subset to records for comprehensive separate state programs (programs in which A2=1 and both A3 and A4=0. Display the text for this variable that appears in that record. If there are no separate state programs, leave blank.
	B14 A	Disability Requirement	***Any Programs With Disability Requirement***	Standard options	E
	B15	Description of Disability Requirement	***Programs with Disability Requirement***		H
Standards related to other health insurance coverage	B16	Any Standards Related to Health Insurance Coverage	***Any Coverage Standards***	Standard options	E
	B17	Mandatory Period of No Coverage	Mandatory Period of No Coverage	Standard options	E
	B18	Mandatory Period of No Coverage (Months)	Mandatory Period of No Coverage (Months)		N
	B19	Other Standards	Other Coverage Standards	Standard options	E
	B20	Specify other health insurance-related criteria	***Programs That Specify Other Standards***		H
	B21	Duration of Eligibility Specified	Duration of Eligibility Specified	Standard options	E

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
	B22	Duration of Eligibility (Months)	Duration of Eligibility (Months)		If the value of B22 is the same for all programs in the state, display that value. If the values differ, but only one is positive, display that value. If the values differ and more than one is positive, enter "Varies." Otherwise, enter "NA/NR"
	B23	Presumptive Eligibility	Presumptive Eligibility	Standard options	E
	B24	Continuous Eligibility	Continuous Eligibility	Standard options	E
	B25	Other Standards (Not Federally Mandated)	Other Standards (Not Federally Mandated)	Standard options	E
	B26	Specify other standards	***Programs That Specify Other Standards***		H
Eligibility Provisions: Procedural Assurances (Section 4.4)					
Provisions to ensure Medicaid eligibles are enrolled in Medicaid	E1	Joint SCHIP/Medicaid Application	Joint Application	Standard options	E
	E2	Same Eligibility Staff for SCHIP/Medicaid	Same Eligibility Staff for SCHIP/Medicaid	Standard options	E
	E3	Applications Screened and Forwarded to Medicaid	Applications Screened and Forwarded to Medicaid	Standard options	E
	E4	Other Provisions	Other Provisions	Standard options	E
	E5	Specify Other	***Programs That Specify Other Provisions***		H

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
Provisions to prevent substitution of private coverage	E6	Mandatory Period of No Coverage	Mandatory Period of No Coverage	Standard options	E
	E7	Mandatory Period of No Coverage (Months)	Mandatory Period of No Coverage (Months)		N
	E8	State Has Other Insurance Subsidy Programs	Other Insurance Subsidy Programs	Standard options	E
	E9	Check Against Database of Insurance Holders	Check Against Database of Insurance Holders	Standard options	E
	E10	Other	Other Provisions	Standard options	E
	E11	Specify other	***Programs That Specify Other Provisions***		H
Provision of assistance to Indians	E12	**Drop this variable from all tables.**	**Drop this variable from all tables.**		
	E13	Targeted Outreach	Targeted Outreach	Standard options	E
	E14	Special Providers (e.g., IHS)	Special Providers (e.g., IHS)	Standard options	E
	E15	Other	Other Provisions	Standard options	E
	E16	Specify other	***Programs That Specify Other Provisions***		H
Coordination with other insurance programs	E17	State Has No Other Insurance Programs	State Has No Other Insurance Programs	yes, not applicable (1) no, applicable (0) missing/unspecified (-1) not applicable (-2) not required to provide (-3)	E
	E18	Joint Outreach	Joint Outreach	Standard options	E

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
	E19	Joint Application	Joint Application	Standard options	E
	E20	Joint Eligibility Determination	Joint Eligibility Determination	Standard options	E
	E21	Referrals	Referrals	Standard options	E
	E22	Other	Other Provisions	Standard options	E
	E23	Specify Other	***Programs That Specify Other Provisions***		H
Outreach and Enrollment (Section 5)					
	F1	Radio, TV, and Print Media	Radio, TV, and Print Media	Standard options	E
	F7	Toll-Free Info Number	Toll-Free Info Number	Standard options	E
	F8	In-Person Outreach	In-Person Outreach	Standard options	E
	F2	Outreach Broker	Outreach Broker	Standard options	E
	F3	Enrollment Broker	Enrollment Broker	Standard options	E
	F4	Same Broker for Outreach/Enrollment	Same Broker for Outreach/Enrollment	Standard options	E
Joint Application Forms	F9	Joint Medicaid/SCHIP Application	Medicaid/SCHIP	Standard options	E
	F10	Medicaid and/or SCHIP Application Includes Other Programs	Medicaid and/or SCHIP Form Includes Other Programs	Standard options	E
	F11	Specify other programs	***Programs That Specify Other Programs Use Form***		H
	F6	Applicants May Mail/Fax Application	Mail/Fax Application	Standard options	E
	D2	Enrollment Counseling	Enrollment Counseling	Standard options	E
		PCP and/or HMO Selection at	PCP and/or HMO Selection at		

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
	D4	Application	Application	Standard options	E
	F12	Other Methods of Outreach and Enrollment	Other Methods	Standard Options	E
	F13	Specify other methods	***Programs That Specify Other Methods***		H
Benchmark for Comprehensive Separate State Program (Section 6.1)					
Note: We are proposing to display the benchmark only for comprehensive separate state programs.					
	H1	Medicaid	Medicaid	Standard options	K
	H2	FEHBP	FEHBP	Standard options	K
	H3	State employee Plan	State employee Plan	Standard options	K
	H4	HMO with Largest Enrollment	HMO with Largest Enrollment	Standard options	K
	H5	Benchmark Equivalent	Benchmark Equivalent	Standard options	K
	H6	Specify Benchmark Plan	Specify Benchmark Plan		I
	H7	Secretary-Approved Coverage	Secretary-Approved Coverage	Standard options	K
	H8	Existing State-Based Coverage	Existing State-Based Coverage	Standard options	K
Service Delivery Model (Section 3)					
	G2	FFS	FFS	Standard options	E
	G3	PCCM	PCCM	Standard options	E
	G4	HMO/Prepaid Health Plan	HMO/Prepaid Health Plan	Standard options	E
	G1	Medicaid Providers Approved for SCHIP	Medicaid Providers Approved for SCHIP	Standard options	E

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
	H9	Annual/Lifetime Benefit Maximum	***Any Programs With Annual/Lifetime Benefit Maximum***	Standard options	E
	H10	Annual Maximum	***Programs With Annual Maximum***		L2
	H11	Lifetime Maximum	***Programs With Lifetime Maximum***		L2
Benefits in Comprehensive Separate State Program (Section 6.2)					
	J2	Inpatient services	Inpatient	Standard options	K
	J3	Outpatient services	Outpatient	Standard options	K
	J4	Physician services	Physician	Standard options	K
	J5	Surgical services	Surgical	Standard options	K
	J6	Clinic services and other ambulatory	Clinic/other ambulatory	Standard options	K
	J7	Prescription drugs	Prescription drugs	Standard options	K
	J8	Over-the-counter drugs	Over-the-counter drugs	Standard options	K
	J9	Laboratory and radiological services	Lab/radiology	Standard options	K
	J10	Prenatal care ***OR*** prepregnancy family planning services and supplies	Prenatal ***OR*** family planning	Standard options	K
	J11	Prenatal care	Prenatal	Standard options	K
	J12	Prepregnancy family planning services and supplies	Family planning	Standard options	K
	J13	Inpatient mental health	Inpatient mental health (IMH)	Standard options	K
	J14	Limits on amount, duration, scope of inpatient mental health	Limits on IMH	Standard options	K

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
	J15	Outpatient mental health	Outpatient mental health (OMH)	Standard options	K
	J16	Limits on amount, duration, scope of outpatient mental health	Limits on OMH	Standard options	K
	J17	Durable medical equipment	Durable medical equipment	Standard options	K
	J18	Disposable medical supplies	Disposable medical supplies	Standard options	K
	J19	Home and community-based health care	Home/community-based health care	Standard options	K
	J20	Nursing care services	Nursing care	Standard options	K
	J21	Abortion	Abortion	Standard options	K
	J22	Dental - any services	Dental (Any)	Standard options	K
	J23	Routine dental services	Routine dental	Standard options	K
	J24	Emergency dental services	Emergency dental	Standard options	K
	J25	Inpatient substance abuse treatment	Inpatient substance abuse (ISA) treatment	Standard options	K
	J26	Limits on amount, duration, scope of inpatient substance abuse treatment	Limits on ISA treatment	Standard options	K
	J27	Outpatient substance abuse treatment	Outpatient substance abuse (OSA) treatment	Standard options	K
	J28	Limits on amount, duration, scope of outpatient substance abuse treatment	Limits on OSA treatment	Standard options	K
	J29	Case management	Case management	Standard options	K
	J30	Care coordination	Care coordination	Standard options	K

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
	J31	PT, OT, ***OR*** ST	PT, OT, or ST	Standard options	K
	J32	PT	PT	Standard options	K
	J33	OT	OT	Standard options	K
	J34	ST	ST	Standard options	K
	J35	Limits on amount, duration, scope of PT, OT, or ST	Limits on PT, OT, or ST	Standard options	K
	J36	Hospice care	Hospice	Standard options	K
	J37	Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services	Other Medical Services	Standard options	K
	J38	Specify other	Specify Other Medical Services		K
	J39	Premiums for private health care insurance coverage	Premiums for Private Coverage	Standard options	K
	J40	Medical Transportation	Medical Transportation	Standard options	K
	J41	Enabling Services	Enabling Services	Standard options	K
	J42	Other	Other Services	Standard options	K
	J43	Specify Other	Specify Other Services		K
Waivers (Section 6.3)					
	K1	Cost-Effective Alternatives	Cost-Effective Alternatives	1=box checked 0=box not checked	E
	K2	Purchase of Family Coverage	Purchase of Family Coverage	1=box checked 0=box not checked	E

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
	A9A	Description of Section 1115 Demonstration	Description of Section 1115 Demonstration	Text variable.	I
Quality Assurance (Section 7)					
	L1	External Audit/In-depth Review	External Audit/In-depth Review	Standard options	E
Credentialing and Certification	L2	Credentialing of Plans	Credentialing of Plans	Standard options	E
	L3	Credentialing of Providers	Credentialing of Providers	Standard options	E
State Reporting Requirements	L4	Plans Must Submit Claims/Encounter Data	Plans Must Submit Claims/Encounter Data	Standard options	E
	L5	Plans Must Report Summary Data	Plans Must Report Summary Data	Standard options	E
Enrollee Satisfaction	L6	Enrollee Survey	Enrollee Survey	Standard options	E
	L7	Enrollment Monitoring	Enrollment Monitoring	Standard options	E
	L8	Grievance/Complaint Process	Grievance/Complaint Process	Standard options	E
Measurement of Health Plan Quality	L9	QARI	QARI	Standard options	E
	L10	HEDIS	HEDIS	Standard options	E
	L11	FACCT	FACCT	Standard options	E
	L12	CAHPS	CAHPS	Standard options	E
	L13	State Specific System	State Specific System	Standard options	E
Cost Sharing (Section 8)					
	M1	Cost Sharing Required	Cost Sharing Required	Standard options	E
	M1A		***Programs With Cost-Sharing***		J
Deductibles	M8	Deductibles	Deductible	Standard options	E

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
	M9	Annual Deductible Amount	Annual Amount		I2
Copayments	M10	Copayments for Office Visits	Copays for Office Visits	Standard options	E
	M11	Copayment Amount Per Visit	Amount Per Visit		I2
Premiums	M2	Premiums Required	Premiums Required	Standard options	E
	M2A		***Programs With Premiums***		J
	M3	Income Threshold for Premiums (% FPL)	***Income Threshold for Premiums***		Display lowest value $0. If there are no values $0, leave blank.
	M3A		***Programs With an Income Threshold for Premiums (% FPL)***		If field for M3 is blank for all programs, display ANone.@ Otherwise, display the program number for each component program record that contains a value $0. (This approach is similar to approach J.)
	M4	Cap on Premium Amount per Child	Cap on Premium Amount per Child	Standard options	E
	M5	Maximum Premium per Child	Maximum per Child		I2
	M6	Cap on Premium per Family	Cap on Premium per Family	Standard options	E
	M7	Maximum Premium per Family	Maximum per Family		I2

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
Performance Measures (Section 9)					
	O1	% Eligible Children Enrolled in Medicaid	% Eligible Children Enrolled in Medicaid	yes (1) no (0) missing/unspecified (-1)	E
	O2	% Children Uninsured	% Children Uninsured	yes (1) no (0) missing/unspecified (-1)	E
	O3	% Children with a Usual Source of Care	% Children with a Usual Source of Care	yes (1) no (0) missing/unspecified (-1)	E
	O4	Progress on Health Problems	Progress on Health Problems	yes (1) no (0) missing/unspecified (-1)	E
	O5	All HEDIS Measures	All HEDIS Measures	yes (1) no (0) missing/unspecified (-1)	E
	O6	Other	Other	yes (1) no (0) missing/unspecified (-1)	E
	O7	Specify Other Measurement Set	***Programs That Specify Other Measurement Set***		H
HEDIS Measures Used, If Not Using Full Set	O8	Immunization Rates	Immunization Rates	yes (1) no (0) missing/unspecified (-1)	D2
	O9	Well Child Care Visits	Well Child Visits	yes (1) no (0) missing/unspecified (-1)	D2

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
	O10	Adolescent Well Care Visits	Adolescent Well Care Visits	yes (1) no (0) missing/unspecified (-1)	D2
	O11	Satisfaction	Satisfaction	yes (1) no (0) missing/unspecified (-1)	D2
	O12	Mental Health Care	Mental Health Care	yes (1) no (0) missing/unspecified (-1)	D2
	O13	Dental Care	Dental Care	yes (1) no (0) missing/unspecified (-1)	D2
	O14	Other	Other HEDIS	yes (1) no (0) missing/unspecified (-1)	D2
	O15	Specify Other	***Programs That Specify Other Measures***		H
Footnotes and Amendment Information Not Captured Elsewhere					
	P13	Other Changes Made by Amendment	Other Changes Made by Amendment		I
Notes	P1	Item (1)	Item (1)		I
	P2	Note (1)	Note (1)		H
	P3	Item (2)	Item (2)		I
	P4	Note (2)	Note (2)		H
	P5	Item (3)	Item (3)		I
	P6	Note (3)	Note (3)		H

Category	No.	Variable Name on Program-Level Tables	Variable Name on State-Level Tables	Response Options for Program-Level Tables	Instructions for Aggregating to the State level
	P7	Item (4)	Item (4)		I
	P8	Note (4)	Note (4)		H
	P9	Item (5)	Item (5)		I
	P10	Note (5)	Note (5)		H
	P11	Item (6)	Item (6)		I
	P12	Note (6)	Note (6)		H