



## **HEALTH CARE FINANCING ADMINISTRATION**

### **State Children's Health Insurance Program (SCHIP) Statistical Data System**

#### **Additional Instructions for Data Entry**

***September 2000***

## I. INTRODUCTION

The State Children's Health Insurance Program (SCHIP) Statistical Enrollment Data System (SEDS) is a web-based application maintained by the Health Care Financing Administration (HCFA) to collect enrollment data from the States. The three statistical reporting forms posted on the web (Forms HCFA-21E, HCFA-64.21E, and HCFA-64EC) gather basic information about participation of SCHIP and non-SCHIP beneficiaries in federally funded children's health insurance programs.

The Forms Training Guide provides detailed instructions for accessing the system, entering and submitting data, and creating reports. This manual provides additional information to guide States through the data-entry process.

## II. SUBMISSION OF DATA

States should submit quarterly enrollment data within thirty (30) days after the end of the quarter and aggregate annual data within thirty (30) days after the end of the fourth quarter.

For States that allow *retroactive eligibility*, these initial enrollment reports will be deemed preliminary. These States should also submit *final* reports thirty (30) days after the end of the *next* quarter. The final reports should include information about children whose eligibility was retroactive to the earlier quarter. So, for example, a State with retroactive eligibility would submit a preliminary report for the second quarter of the federal fiscal year (January 1 through March 31) by April 30 and a final report for that quarter by July 31. The final report for the second quarter would include information about children who applied in the third quarter (April 1 through June 30) whose eligibility was retroactive to some time in the second quarter.<sup>1</sup>

## III. REPORTING FORMS

The three (3) reporting forms posted on the web collect information about children with three (3) different types of federally funded health care coverage.

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<sup>1</sup>As explained later in this document, children whose eligibility is retroactive to an earlier quarter should be counted as "ever enrolled" in *both quarters* (the quarter in which they applied and the quarter to which their eligibility was retroactive) but as "new enrollees" only in the *earlier quarter*. In many cases, these children will be counted as new enrollees only on the *final* report for the earlier quarter.

Ⓒ **Form HCFA-21E.** This form collects data on children enrolled in separate child health programs.

Use one (1) copy of this form to report data for each separate child health program and/or operational entity. If, for example, a State operates one separate child health program that serves children with disabilities and a second separate child health program that serves other children, the State should submit two (2) Form HCFA-21Es. The system will combine data from the two forms to create an aggregate report. In the case of special programs that provide additional services to certain children who are enrolled in the State’s comprehensive separate child health program, the State should use the narrative function in the system to note on the form for the non-comprehensive program that the children counted on the form are also counted on the form for the comprehensive program. Say, for example, that the State operates a program that provides only behavioral health services to children with special needs who are enrolled in the State’s comprehensive child health program. The State should submit one Form HCFA-21E for each of these two programs. On the form for the behavioral health program, the State should note that children enrolled in this program are also enrolled in comprehensive program.

Ⓒ **Form HCFA-64.21E.** This form collects data on children enrolled in Medicaid expansion SCHIPs. Use one (1) copy of this form to provide data on all children covered by the State’s Medicaid expansion.

Ⓒ **Form HCFA-64EC.** This form collects data on children enrolled in the Medical Assistance Program—that is, Title XIX-funded Medicaid coverage, which we will refer to throughout this manual as “traditional Medicaid.” Use one (1) copy of this form to provide data on all children covered by traditional Medicaid.

All three (3) forms collect enrollment data by age category, State-defined income levels, and type of service delivery system. Each report consists of four (4) screens (pages), one for each of four (4) specified age groups. Separate columns are designated for each income group, and separate rows for each type of delivery system in which enrollees may be served.

The quarterly report for each program should present unduplicated *within-program* counts of enrollees, disenrollees, and enrollment months for *each program*. Enrollment in other programs before, during, or after the quarter should not affect the statistics for any program. A child who was enrolled in two different programs (e.g., traditional Medicaid and a SCHIP Medicaid expansion) during the quarter should be counted twice (once on each quarterly report).

***Example***

A child was enrolled in a State’s SCHIP Medicaid expansion at the beginning of the quarter, disenrolled, and then enrolled in the

***Reporting Instructions***

Information about this child should be reported on Form HCFA-64.21E (the SCHIP Medicaid expansion form) and

**Example**

State's separate child health program later in the quarter.

A child was enrolled in traditional Medicaid at the beginning of the quarter and transferred to the State's Medicaid expansion later in the quarter.

**Reporting Instructions**

Form HCFA-21E (the separate child health program form).<sup>2</sup>

Information about this child should be reported Form HCFA-64EC (the traditional Medicaid form) and on Form HCFA-64.21E (the Medicaid expansion form).<sup>3</sup>

**IV. DEFINITIONS AND RULES**

This section defines the various reporting categories specified on the forms and provides detailed reporting rules.

**A. HEADER ITEMS**

The following items appear in the header of all three (3) forms, unless otherwise specified.

**Quarter and Year.** Enter the quarter (1-4) and the Federal Fiscal Year (FFY) to which the data pertain. The FFY runs from October 1 through September 30. For example, the first quarter of FFY 2000 is October 1 through December 31, 1999; the second quarter is January 1 through March 31, 2000; the third quarter is April 1 through June 30, 2000; and the fourth quarter is July 1 through September 30, 2000.

**Program Code.** (This item appears only on Form HCFA-21E, the separate child health program form.) States should report enrollment data for each separate child health program and/or operational entity on a separate copy of Form HCFA-21E. The program code uniquely identifies the separate child health program to which the report pertains. To create a program code, enter the two-letter State abbreviation followed by a number from 1 to 9999. For example, the State of Florida would enter *FL1*, for its first separate child health program, *FL2* for its second separate child health program, and so forth.

**Type of Eligible.** (This item appears only on Form HCFA-64.21E, the Medicaid expansion form). This two-character code identifies the Medicaid expansion group or groups to which the data pertain.

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<sup>2</sup>As explained in Section IV.C, this child should be reported as a “disenrollee” in the Medicaid expansion, a “new enrollee” in the separate child health program, and as “ever enrolled” in both programs.

<sup>3</sup>As explained in Section IV.C, this child should be reported as a “disenrollee” in traditional Medicaid, a “new enrollee” in the Medicaid expansion, and as “ever enrolled” in both programs.

Ⓒ **U2.** Select “U2” if the State’s Medicaid expansion covers only the 1905(U)(2) expansion group, optional targeted low income children. These are uninsured children under age 19 who meet Title XXI eligibility requirements who would not be eligible for traditional Medicaid under the State plan in effect on 3/31/97.

Ⓒ **U3.** Select “U3” if the State’s Medicaid expansion covers only the 1905(U)(3) expansion group. These are children under age 19 born before 10/1/83 who would not be eligible for traditional Medicaid under the State plan in effect on 3/31/97 only because of their age. (Had they been born on or after 10/1/83, these children *would* qualify for traditional Medicaid under the State’s poverty-related eligibility provisions.)

Ⓒ **BO.** Select “BO” if the State’s Medicaid expansion covers both groups.

**Age of Children.** Each reporting form has four (4) screens (pages), one for each of four (4) specified age groups: “Under 1,” “1-5,” “6-12,” and “13-18” (inclusive). Age is defined as the child’s age on the last day of his or her enrollment during the quarter.

***Example***

An infant was enrolled in a State’s Medicaid expansion through March 1. He turned one year old on March 3.

***Reporting Instructions***

This child should be counted in the “Under 1” age group for the second quarter, because he was under one year of age on his last day of enrollment during the quarter.

**Family Income.** States should report data separately for at least two (2) income groups. Each income group should be specified in relation to the Federal poverty level (FPL). States may define countable income and the family unit as they choose.

The specific income groups for which a State reports data will depend on the cost-sharing requirements in its SCHIP. States that do not impose cost-sharing or that use a sliding scale to apply cost-sharing should report data for each program by two income categories: (1) up to and including 150% of the FPL and (2) over 150% of the FPL. States that impose cost-sharing at State-specified income levels (e.g., above 185% of the FPL) should report data by income categories that match their cost-sharing categories.

Each form provides five (5) columns, to allow States to report data for up to five (5) income groups. For each income group, the State should enter a column heading specifying the income range covered. The forms are partially automated. The system automatically sets to zero (0) the lower end of the income range in the heading for the first column. After the State specifies the upper end of the income range in the first

column, the system will automatically set the lower end of the income range in the *next* column to one more than the value entered in the preceding column. So, for example, if the state enters “150” as the upper end of the income range in the first column, the system will set the lower end of the income range in the next column to “151.”

***Example***

A State does not impose cost-sharing and covers children with family income up to 200% of the FPL.

A State imposes one level of cost sharing on families with incomes up to 144% of the FPL and another on families with incomes above that level. The State covers children with family income up to 200% of the FPL.

A State has set two cost-sharing breaks, one at 130% of the FPL and another at 145% of the FPL. The State covers children with family income up to 225% of the FPL

***Reporting Instructions***

This State should provide data in two (2) columns. The column headings should read “0 – 150” and “151 – 200.”

This State should provide data in two (2) columns. The column headings should read “0 – 144” and “145 – 200.”

This State should provide data in three (3) columns. The column headings should read “0 – 130,” “131 – 145,” and “146 – 225.”

**B. CATEGORIES OF SERVICE DELIVERY SYSTEM**

States must report each descriptive statistic (e.g., unduplicated number of new enrollees) by the type of delivery system in which the children were served: fee-for-service (FFS), a managed care arrangement, or primary care case management (PCCM). Each child should be grouped in one of these three categories based on the system in which he or she was *last* covered during the quarter. This categorization should reflect the basic plan in which a child was enrolled. For example, a child enrolled in a FFS plan who receives mental health services through a “carve-out” to a prepaid health plan should be counted in the FFS group. The three types of service delivery systems are defined as follows.

***Fee for service.*** FFS is defined in this context as a payment system in which providers submit claims to the State (or a claims processing firm that contracts with the State) and are paid a specific amount for each service performed. Enrollees are free to visit any State-certified provider. Count a child in the FFS category if FFS was the *last* system in which he or she was covered for basic services during the quarter.

***Managed care arrangements.*** Managed care is defined in this context as a system in which the State contracts with health maintenance organizations (HMOs) or health insuring organizations (HIOs) to

provide a comprehensive set of services on a prepaid capitated risk basis.<sup>4</sup> Enrollees choose a plan and a primary care provider (PCP), who will be responsible for managing their care. Count a child in the managed care category if managed care was the *last* system in which he or she was covered for basic services during the quarter.

***Primary care case management.*** PCCM is defined in this context as a system in which the State contracts directly with PCPs who are responsible for providing or coordinating medical services to the SCHIP or Medicaid enrollees under their care. Most State PCCM programs reimburse PCPs on a FFS basis for medical services and also pay them a monthly management fee; some programs operate on a partial capitation basis. Count a child in the PCCM category if PCCM was the *last* system in which he or she was covered for basic services during the quarter.

***Example***

A child applied to and was enrolled in a State’s separate child health program during the first month of the quarter. The State first provided her with FFS coverage and then enrolled her in an HMO later in the quarter.

A child was enrolled in a Medicaid expansion PCCM program and a prepaid behavioral health plan throughout the quarter.

A child was enrolled in an HMO in the State’s separate child health program for the first two weeks of the quarter. She was then transferred to the State’s Medicaid expansion, where she was covered under FFS for the next six weeks and then enrolled in an HMO for the rest of the quarter.

***Reporting Instructions***

This child should be counted in the managed care category, because managed care was the last system in which she was covered for basic services during the quarter.

This child should be counted in the PCCM category, because the PCCM program was the last system in which she was covered for basic services during the quarter.

This child should be counted in the managed care category on the report for the separate child health program (HCFA-21E) and in the managed care category on the Medicaid expansion report (HCFA-64.21E). Managed care was the only system in which the child was covered for basic services in the separate child health program and the last system in which she was covered for basic services in the Medicaid expansion.

## **C. ENROLLMENT MEASURES**

This section defines each enrollment measure and outlines rules for counting enrollees, new enrollees, disenrollees, and enrollment months. Some key rules are highlighted in Table 1.

***Unduplicated Number of Children Ever Enrolled During the Quarter.*** Report each child

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<sup>4</sup>Some prepaid health plans (PHPs) also provide a comprehensive set of services on a risk basis.

enrolled in the program for any length of time during the quarter. Count each child once on each quarterly report regardless of the number of times he or she was enrolled or re-enrolled in the program during the quarter. (However, if a child was enrolled in multiple programs--separate child health program, Medicaid expansion, or traditional Medicaid--during the quarter, count him or her on the quarterly report for each.) Note that any child reported as a new enrollee or disenrollee during the quarter must also be reported as ever enrolled. Report each child under the service delivery system in which he or she was *last* covered for basic services during the quarter.

Report children with retroactive eligibility as “ever enrolled” in the quarter in which they applied *and*, if their coverage became effective in an earlier quarter, as “ever enrolled” in that quarter as well (on the final report for that quarter, as described in Section II).

***Unduplicated Number of New Enrollees in the Quarter.*** Report as a new enrollee any child enrolled in the program at any time during the quarter *who was not enrolled in the program as of the last day of the previous quarter.* Count each child once on each quarterly report regardless of the number of times he or she enrolled and re-enrolled in the program during the quarter. If, for example, a child was enrolled for the first time in a State’s separate child health program in the first month of a quarter, disenrolled in the second, and re-enrolled in the third, he or she should be counted as one new enrollee on the report for that quarter. (However, if a child became enrolled in multiple programs--separate child health program, Medicaid expansion, or traditional Medicaid--during the quarter, count him or her on the quarterly report for each.) Report each new enrollee under the service delivery system in which he or she was *last* covered for basic services during the quarter.

As illustrated in the following examples, a child’s status on the last day of the previous quarter determines whether he or she is categorized as a new enrollee in the current quarter.

***Example***

A child was enrolled in a State’s separate child health program through the last day of the quarter 1 but no longer enrolled as of the first day of quarter 2. She was subsequently re-enrolled later in quarter 2.

A child was enrolled in the separate child health program through the next-to-the-last day of quarter 1. He was subsequently re-enrolled later in quarter 2.

***Reporting Instructions***

This child should not be counted as a new enrollee on the quarter 2 report, because she was enrolled in the separate child health program on the last day of quarter 1.

This child should be counted as a new enrollee on the quarter 2 report, because he was not enrolled in the separate child health program on the last day of quarter 1.

A child’s prior enrollment in another program (traditional Medicaid, Medicaid expansion, or separate child health program) should not affect his or her categorization as a new enrollee in a given program. If,

for example, a child was enrolled in a State’s Medicaid expansion at the beginning of a quarter, and then moved to the State’s separate child health program later in the quarter, he or she should be reported as a new enrollee in the separate child health program on the report for the quarter (as well as a disenrollee from the Medicaid expansion, as explained in the next section).

***Example***

A child enrolls in traditional Medicaid at the beginning of the quarter. She is subsequently found eligible for the State’s separate child health program and transferred to that program at the end of the quarter.

***Reporting Instructions***

This child should be reported as a “new enrollee” and as “ever enrolled” on both the quarterly report for traditional Medicaid and the quarterly report for the separate child health program.

As noted, a child with retroactive eligibility should be reported as a new enrollee in the quarter in which his or her coverage became effective. If a child’s eligibility is retroactive to an earlier quarter, the State should report him or her as a “new enrollee” (as well as “ever enrolled”) in that *earlier* quarter when it submits its final (updated) report for that quarter. (See Section II.)

***Example***

A child applies for coverage in the middle of quarter 2 (after the State has submitted its preliminary report for quarter 1) and is found eligible for traditional Medicaid. Her eligibility is retroactive to the middle of quarter 1. She remains enrolled throughout quarter 2.

***Reporting Instructions***

This child should be reported as a “new enrollee” and as “ever enrolled” on the final report for quarter 1. (This is the updated quarterly report submitted by the State within 30 days of the end of the following quarter.) This child should also be reported as “ever enrolled” (but not as a “new enrollee”) on both the preliminary and final reports for quarter 2.

A child applies for coverage at the end of quarter 2 and is found eligible for the State’s Medicaid expansion. Her eligibility is retroactive to the beginning of quarter 2. She remains enrolled throughout the quarter.

This child should be reported as a “new enrollee” and as “ever enrolled” on both the preliminary and final reports for quarter 2.

***Unduplicated Number of Disenrollees in the Quarter.*** Report as a disenrollee any child who disenrolled from the program at any time during the quarter *who was not re-enrolled as of the last day of the quarter*. Count each child once on each quarterly report regardless of the number of times he or she enrolled and disenrolled from the program during the quarter. (However, if a child disenrolled from multiple programs--separate child health program, Medicaid expansion, or traditional Medicaid--during the quarter, count him or her on the quarterly report for each.) Report each disenrollee under the service delivery system in which he or she was *last* covered for basic services during the quarter.

Two circumstances—“aging out” and disenrollment at the end of a quarter--warrant particular attention. A child who “ages out” of a program during the quarter (for example, an SCHIP enrollee who turns 19) should be counted as a disenrollee during that quarter. A child who is disenrolled at the end of the quarter should be reported as a disenrollee in that quarter. That is, a child who is enrolled through the last day of the quarter for which the State is reporting data but who is no longer enrolled as of the first day of the *next* quarter should be counted as a disenrollee in the *earlier* quarter (the quarter being reported). This rule ensures that a child is reported as a disenrollee only in a quarter in which he or she is reported as ever enrolled.

***Example***

A child was enrolled in a State’s separate child health program through the last day of the quarter 1 but no longer enrolled as of the first day of quarter 2. She was subsequently re-enrolled in quarter 3.

A child was enrolled in a State’s separate child health program in the first month of the quarter, disenrolled in the second month, and re-enrolled in the third month.

***Reporting Instructions***

This child should be counted as a disenrollee on the quarter 1 report, not the quarter 2 report.

This child should not be counted as a disenrollee on the quarterly report, because she was re-enrolled in the same program by the end of the quarter.

***Number of Member-Months of Enrollment in the Quarter.*** Tally member-months for each child ever enrolled during the quarter. Count one month for each month in which the child was enrolled for at least one day. Count all of a child’s member-months for a quarter under the service delivery system in which he or she was *last* covered for basic services during the quarter.

***Example***

A child was enrolled for half the first month of the quarter, disenrolled, and then re-enrolled late in the third month of the quarter. In the first month, the child was in a FFS system, but in the third month, she was enrolled in a managed care plan.

A child was enrolled in an HMO in the State’s separate child health program for the first two weeks of the quarter. She was then transferred to the State’s Medicaid expansion, where she was covered under FFS for the

***Reporting Instructions***

The number of member-months of enrollment for this child would be two (2), one for each month in which she was enrolled at least one day. Both months would be counted under “managed care arrangements,” because this was the last system in which she was covered for basic services during the quarter.

The number of member-months of enrollment reported for this child on the separate child health program form (HCFA-21E) would be one (1), for the single month in which she was enrolled for two weeks.

***Example***

next six weeks and then enrolled in an HMO for the rest of the quarter.

***Reporting Instructions***

This month would be counted under “managed care arrangements.” The number of member-months reported for this child on the Medicaid expansion form (HCFA-64.21E) would be three (3), because she was enrolled in the Medicaid expansion for at least one day in all three months. These three months would be counted under “managed care arrangements,” because this was the last system in which she was covered for basic services during the quarter.

***Average Number of Months of Enrollment.*** The system automatically calculates the average number of months of enrollment by dividing the figures entered in section 4 (member-months of enrollment) by the corresponding figures in section 1 (number ever enrolled).

***Number of Children Enrolled At Quarter’s End.*** Report the number of children enrolled in the program on the last day of the quarter. Report each child under the service delivery system in which he or she was covered for basic services on that day. This point-in-time number will almost always be less than the number ever enrolled during the quarter.

***Unduplicated Number of Children Ever Enrolled in the Year.*** This item appears only on the report for the fourth quarter of the FFY. Report each child enrolled in the program at any time during the FFY (October 1 through September 30). Count each child once regardless of the number of times he or she was enrolled or re-enrolled in the program during the year. (However, if a child was enrolled in multiple programs--separate child health program, Medicaid expansion, or traditional Medicaid--during the year, count him or her on the annual report for each.) Report each child under the service delivery system in which he or she was *last* covered for basic services during the quarter.

## TABLE 1

### KEY RULES FOR REPORTING ENROLLMENT DATA

- C Each quarterly report (HCFA-21E, HCFA-64.21E, and HCFA-64EC) should present unduplicated *within-program* counts of enrollees, disenrollees, and enrollment months for *each program*. A child's enrollment in another children's health insurance program before, during, or after the quarter should not affect how he or she is reported or categorized on the report for any given program.
- C A child who was enrolled in two programs during the quarter should be counted twice (once on each quarterly report).
- C Any child reported as a new enrollee or disenrollee during a quarter must also be reported as ever enrolled during the quarter.
- C Children should be grouped into service delivery system categories based on the delivery system in which they were *last covered for basic services* during the quarter.
- C A "new enrollee" is a child who was enrolled in the program at any time during the quarter who was *not* enrolled on the last day of the *previous* quarter.
- C Children whose eligibility is retroactive to an earlier quarter should be reported as new enrollees in the quarter in which their coverage became effective, *not* in the quarter in which they applied. They should be reported as ever enrolled in both quarters.
- C A "disenrollee" is a child who was disenrolled from the program at any time during the quarter who was *not* re-enrolled as of the last day of the quarter.
- C A child who was enrolled only through the last day of a quarter (no longer enrolled as of the first day of the next quarter) should be counted as a disenrollee in the *earlier* quarter.
- C A child who "ages out" of a program during the quarter should be counted as a disenrollee in that quarter.
- C An "enrollment month" is any month in which a child was enrolled for at least one day.
- C All of a child's enrollment months for the quarter should be counted under the service delivery system in which he or she was *last* covered for basic services during the quarter.