OMB No. 0930-xxxx
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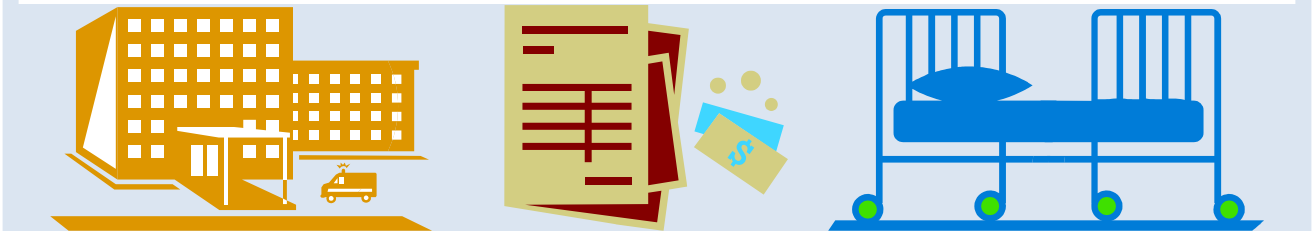
SAMHSA Survey of Revenues and Expenses

October 27, 2009



Label with Facility Name and Address

Substance Abuse & Mental Health Services Administration

MATHEMATICA
Policy Research, Inc.

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-xxxx. Public reporting burden for this collection of information is estimated to average 2.5 hours per client per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland, 20857.

PLEASE READ THIS ENTIRE PAGE BEFORE COMPLETING THE QUESTIONNAIRE

A representative from SAMHSA's contractor (Mathematica Policy Research, Inc., - Mathematica) will be calling to touch base with you to answer any questions you might have about this questionnaire.

You may choose to complete the questionnaire on paper or Online. If you would rather complete Online, the orange flyer in your questionnaire packet contains the internet address and your unique user ID and password. If you need immediate advice or information before the Mathematica representative calls you, call the SSR&E helpline at 1-866-xxxxxxx.

INSTRUCTIONS

All the questions ask about this facility, that is, the facility whose name and location are printed on the front cover. If you have any questions about how the phrase this facility applies to your facility, please call the SSR&E helpline at 1-866-xxxxxxx. Answer ONLY for the specific facility whose name and location are printed on the front cover. If this is a separate psychiatric unit of a general hospital, consider the psychiatric unit as the relevant "facility" for the purpose of this survey.

We are asking about the following topics:

A. Facility Characteristics
B. Facility Services Provided
C. Facility Net Revenue
D. Facility Expenses
E. Facility Client Counts and Characteristics

Sections F and G request contact information in case we have questions.

Who should respond? One or more staff members may need to respond. You may need to contact a parent organization located elsewhere. Our goal is to help you obtain complete and accurate information and we are committed to help you in any way we can.

We appreciate answers to all questions in this questionnaire. Where it is not possible for you to provide detailed information, please provide totals.

Please pay close attention to the definitions in Appendix A. It is important that all facilities provide uniform information.

The symbol and number, for example (1), indicates you can find definition 1 in Appendix A.

Medicaid and S-CHIP names vary by state. Please check Appendix B for the names of Medicaid and S-CHIP in your state. Some Medicaid and S-CHIP names are the same within the state.

SECTION A: FACILITY CHARACTERISTICS

The reporting unit for this form is the facility (1) or establishment identified on the cover.

A1. Is the facility at this address a jail, prison, or other organization that provides treatment exclusively for incarcerated persons or juvenile detainees?

1 Yes ➔ **GO TO G1 (page 10)**

0 No

A2. Is the facility at this address a solo practice, meaning an office with a single practitioner or therapist?

1 Yes ➔ **GO TO G1 (page 10)**

0 No

A3. Is the facility at this address operated by or part of a larger organization, such as a hospital, a local health or mental health department, or a company, or nonprofit with more than one location for service delivery?

1 Yes

0 No

A4. Did this facility deliver any substance abuse or mental health services at or from this location at any time during its 2008 fiscal year?

1 Yes

0 No ➔ **GO TO G1 (page 10)**

A5. Will staff at this facility be able to provide information about net revenue (4), staffing, client counts, and expenses?

1 Yes, can provide information

0 No, will need to obtain information from larger organization ➔ **GO TO G2 (page 10)**

SECTION B: FACILITY SERVICES PROVIDED

B1. Please record the start and end dates of this facility's 2009 fiscal reporting year (2). *Examples of common fiscal reporting years include July 1, 2008 through June 30, 2009, October 1, 2008 through September 30, 2009, and January 1, 2009 through December 30, 2009.*

FROM: _____ / _____ / _____
Month Day Year

THROUGH: _____ / _____ / _____
Month Day Year

B2. During the Question B1 fiscal year, did this facility provide <u>direct substance abuse treatment services</u> at or from this location?

1 Yes

0 No ➔ **GO TO B4 (page 2)**

B3. During the Question B1 fiscal year, did this facility provide substance abuse treatment in any of the settings of care (3) listed below? **Please mark Yes or No for each setting of care.**

Substance Abuse Treatment Setting of Care	MARK "YES" OR "NO" ON EACH LINE: Yes	No
a. Hospital <u>Inpatient</u> *(24-Hour Care)*.....	1	0
b. Residential *(24-Hour Care)*	1	0
c. Outpatient Care.....	1	0

B4. During the Question B1 fiscal year, did this facility provide direct mental health treatment services at or from this location?

1 ☐ Yes

0 ☐ No ➔ **GO TO B6 (below)**

B5. During the Question B1 fiscal year, did this facility provide mental health treatment in any of the settings of care (☐3) listed below.

Mental Health Treatment Setting of Care	MARK "YES" OR "NO" ON EACH LINE: Yes	No
a. Hospital Inpatient (24-Hour Care)	1 ☐	0 ☐
b. Residential (24-Hour Care).	1 ☐	0 ☐
c. Outpatient Care	1 ☐	0 ☐

B6. What is the main focus of this facility at this location?

MARK ONE ONLY

1 ☐ Substance abuse treatment services

2 ☐ Mental health treatment services

3 ☐ Mix of mental health and substance abuse treatment services (*neither is primary*)

4 ☐ General health care (e.g., community or public health center, or a community hospital)

5 ☐ Other *(Specify):*

_____

B7. Who operates this facility at this location?

MARK ONE ONLY

1 ☐ Private for-profit organization

2 ☐ Private non-profit organization

3 ☐ State government

4 ☐ Local/county government/ special authority

5 ☐ Tribal government

6 ☐ Federal Government

7 ☐ Other *(Specify):*_____

➔GO TO B8 (next column)

B7a. Which Federal Government agency operates the facility?

MARK ONE ONLY

1 ☐ Department of Veterans Affairs

2 ☐ Department of Defense

3 ☐ Indian Health Service

4 ☐ Other *(Specify):*

_____

B8. Is this facility located in, or operated by, a hospital?

1 ☐ Yes

0 ☐ No

B9. Please mark the categories that describe your facility.

MARK ALL THAT APPLY

1 ☐ General Hospital (including VA hospital)

2 ☐ Psychiatric Hospital

3 ☐ Substance Abuse Specialty Hospital

4 ☐ Other Specialty Hospital

(Specify):

_____

5 ☐ Outpatient Facility Specializing in Substance Abuse

6 ☐ Halfway House Specializing in Substance Abuse

7 ☐ Residential Substance Abuse Treatment Facility

8 ☐ Multi-setting (non-hospital) Substance Abuse Treatment Facility

9 ☐ Residential Treatment Center for Children with Serious Emotional Disturbances

10 ☐ Residential Mental Health Treatment Center for Adults

11 ☐ Outpatient/Partial Care Mental Health Organization

12 ☐ Multi-setting (non-hospital) Mental Health Facility

Other:

13 ☐ Other *(Specify):*

_____

B9a. Please record the number (1 – 13) of the category that best describes your facility: __

SECTION C: FACILITY NET REVENUE

C1. During the Question B1 fiscal year, what was the total net revenue or total funding (4) by source (5) at this facility? Please break out the *total net revenue or total funding* into substance abuse treatment or mental health treatment based on primary diagnoses for the treatment.

- *If substance abuse and/or mental health treatment revenue are combined with other revenue (e.g., prevention, education), provide your best estimate of the substance abuse and/or mental health treatment portions for the Total Net Revenue row. Where it is not possible for you to provide detailed information, please provide totals.*
- *If federal, state, or local government funding is passed through other levels of government or other organizations before it is received by you, please identify funds with the original source if you are aware of this source. For example, if you receive federal block grant funds from a local SA/MH agency, please report that funding as federal block grant funds.*
- *If you have no revenue from a source or treatment type, enter "0" in the field.*
- *Do not report revenues related to affiliated companies that provide no MH/SA services.*

Revenue Source	Column A Total Facility Net Revenue	Column B Primary SA Treatment Net Revenue	Column C Primary MH Treatment Net Revenue
Total Net Revenue.....	**$** _____	**$** _____	**$** _____
a. Medicaid/S-CHIP (claims or direct program payment).....	$ _____	**$** _____	**$** _____
b. Medicare (claims).....	$ _____	**$** _____	**$** _____
c. Federal block grant funding	$ _____	**$** _____	**$** _____
d. Other Federal funding (including HUD, criminal and juvenile justice, Dept. of VA, TRICARE, Access to Recovery).....	$ _____	**$** _____	**$** _____
e. State SA/MH agencies	$ _____	**$** _____	**$** _____
f. Other State funding (including criminal and juvenile justice, state welfare, child and family services).....	$ _____	**$** _____	**$** _____
g. Local government funding (including criminal and juvenile justice system).....	$ _____	**$** _____	**$** _____
h. Private insurance.....	$ _____	**$** _____	**$** _____
i. Self-pay (e.g., out-of-pocket).....	$ _____	**$** _____	**$** _____
j. Other (e.g., philanthropy, investments, etc.) Please specify: _____	$ _____	**$** _____	**$** _____

C2. In Question C1 column A, you reported that your total revenue or funding is $xxx, which is different from the sum of revenue or funding reported in columns B plus C for SA and MH treatment. Please describe the services or other items represented by this difference.

C3. Does this facility receive funding from the criminal and juvenile justice system for provision of SA and/or MH treatment services?

1 ☐ Yes

0 ☐ No ➔ **GO TO C5 (below)**

C4. During the Question B1 fiscal year, what was the total funding for provision of MH and/or SA services that this facility received from the criminal and juvenile justice system by level of government?

- *If you have no revenue from a source or treatment type, enter "0" in the field.*

Funding Source	Column A Total Facility Funding	Column B Primary SA Treatment Funding	Column C Primary MH Treatment Funding
Total Criminal and Juvenile Justice Funding..	**$** _____	**$** _____	**$** _____
a. Federal funding.....	**$** _____	**$** _____	**$** _____
b. State funding	**$** _____	**$** _____	**$** _____
c. Local government funding.....	**$** _____	**$** _____	**$** _____

C5. Did you answer "YES" to <u>direct substance abuse treatment services</u> in Question B2 (page 1)?

1 ☐ Yes

0 ☐ No ➔ **GO TO C8 (page 5)**

PRIMARY SUBSTANCE ABUSE TREATMENT REVENUE

C6. Please divide the Total Primary SA Treatment Revenue you indicated in Question C1, Column B by settings of care (3). Record the revenue breakdown in the actual dollar amounts. Enter "0" if the facility does not offer a setting of care.

- *If substance abuse treatment revenue is combined with other revenue, provide your best estimate of the substance abuse treatment portions for the Total Net Revenue row.*

Setting of Care	Total Net Primary SA Treatment Revenue by Setting of Care
Total Primary SA Treatment Net Revenue.....	**$** _____
a. Hospital Inpatient (24-Hour Care)	$ _____
b. Residential (24-Hour Care).....	$ _____
c. Outpatient Care	$ _____

C7. Did you answer "YES" to direct mental health treatment services in Question B4 (page 2)?

1 ☐ Yes

0 ☐ No ➔ **GO TO SECTION D (page 6)**

PRIMARY MENTAL HEALTH TREATMENT REVENUE

C8. Please divide the total Primary MH Treatment Revenue you indicated in Question C1, Column C by settings of care (3). Record the revenue breakdown in the actual dollar amounts. Enter "0" if the facility does not offer a setting of care.

- *If mental health treatment revenue is combined with other revenue, provide your best estimate of the mental health treatment portions for the Total Net Revenue row.*

Setting of Care	Total Net Primary MH Treatment Revenue by Setting of Care
Total Net Primary MH Treatment Revenue.....	**$** _____
a. Hospital Inpatient (24-Hour Care)	$ _____
b. Residential (24-Hour Care).....	$ _____
c. Outpatient Care.....	$ _____

SECTION D: FACILITY EXPENSES

TOTAL COSTS / EXPENSES

D1. For the Question B1 fiscal year, please enter the total expenses (costs) (6) for both substance abuse and mental health treatment for this facility in Column A. Break out the substance abuse treatment expenses (costs) in Column B and the mental health treatment expenses (costs) in Column C.

- *If these data are obtained from a financial report in thousands of dollars, add three zeros to convert to dollars.*
- *If data specific to primary substance abuse or primary mental health care treatment are not available from the facility's financial reports, please provide your best estimate.*
- *Please enter "0" if there were no expenses for Column B or C.*
- *Do not report expenses related to affiliated companies that provide no MH/SA services.*

	Column A Total Expenses	Column B Primary Substance Abuse Treatment Expenses	Column C Primary Mental Health Treatment Expenses
Total Facility Expenses (Costs).....	$ _____	$ _____	$ _____

D2. Of the total expenses (costs) reported in Question F1, Column A, what amounts were for the following expenses:

Expenses (Costs)	Expenses
a. Annual payroll.....	$ _____
b. Employer costs for fringe benefits (7).....	$ _____
c. Contract labor costs (including temporary help).....	$ _____
d. All other operating expenses.....	$ _____

SECTION E: CLIENT COUNTS AND CHARACTERISTICS

E1. On March 31, 2008, how many clients were actively enrolled in treatment at this facility?

- *Count each client one time even if the client received multiple services on that day.*
- *Do not count family members, friends, or other non-treatment clients.*
- *Mark "0" if no clients received services in the setting of care.*
- ***In counting active outpatient clients.*** *Count if they were enrolled to receive treatment on March 31, 2008. An enrolled outpatient client must have received at least one service during March 2008 and still be enrolled on March 31, 2008.*

Setting of Care	Total Number of Clients on March 31, 2008	Primary SA Clients on March 31, 2008	Primary MH Clients on March 31, 2008
a. Hospital Inpatient *(24-Hour Care)*.....			
b. Residential *(24-Hour Care)*.....			
c. Active Outpatient Care			
Total Client Count.....		Box A	Box B

E2. Of the clients actively enrolled in substance abuse treatment on March 31, 2008 (Box A at Question E1), how many had the following characteristics?

Age of active SA clients on March 31, 2008	Number
a. Age less than 18 years	
b. Age 18 years or older	

E3. Of the clients actively enrolled in substance abuse treatment on March 31, 2008 (Box A at Question E1), how many were being treated for both substance abuse disorders and mental health disorders?

Number SA clients being treated for both SA and MH disorders: _____

E4. Of the total clients actively enrolled in substance abuse treatment on March 31, 2008 (Box A at Question E1), how many were treated for….

	Number
a. Primarily alcohol abuse treatment	
b. Primarily drug abuse treatment	
c. Both alcohol and drug abuse treatment	

E5. Of the total clients actively enrolled in mental health treatment (Box B in Question E1) on March 31, 2008, how many had the following characteristics?

Age of active MH clients on March 31, 2008	Number	Nu
a. Age less than 18 years		
b. Age 18 years or older		

E6. Of the clients actively enrolled in mental health treatment on March 31, 2008 (Box B at Question E1), how many were being treated for both mental health and substance abuse disorders?

Number MH clients being treated for both MH and SA disorders: _____

SECTION F: WHO COMPLETED THE QUESTIONNAIRE

F1. Please provide your EIN (employer identification number) below.

_____

F2. Who was primarily responsible for completing different sections of the questionnaire? This information will only be used if we need to contact you to clarify your responses. It will not be published.

Name:

_____

Title:

_____

Section or Sections Completed:

_____

Phone Number: (_____) – _____ – _____

Fax Number: (_____) – _____ – _____

Email Address: _____

Name:

_____

Title:

_____

Section or Sections Completed:

_____

Phone Number: (_____) – _____ – _____

Fax Number: (_____) – _____ – _____

Email Address: _____

Name:

_____

Title:

_____

Section or Sections Completed:

_____

Phone Number: (_____) – _____ – _____

Fax Number: (_____) – _____ – _____

Email Address: _____

F3. If your responses reflect revenue or costs of a facility other than the treatment facility named on the label, or if some responses require clarification, please explain below.

If you are completing this form on paper, please place it in the pre-addressed and pre-stamped envelope provided and mail it to Mathematica Policy Research, Inc.

If you are completing this form on the web, press this button to submit it.

SECTION G: FOLLOW-UP QUESTIONS

G1. Thank you for your time. Your facility does not need to complete the remainder of the form. However, it is important that we receive the answers you have given so far. Please complete the information below and then return the form in the envelope supplied to the address below.

Princeton Survey Operations Center

Your Name:

_____

Your Facility or Larger Organization:

_____

Address:

_____

City/State/Zip:

_____

Phone Number: (_____) – _____ – _____

Email: _____

G2. Who at the larger organization should we contact?

Name:

_____

Larger Organization Name:

_____

Address:

_____

City/State/Zip:

_____

Phone Number: (_____) – _____ – _____

Email: _____

If you are recording this information on paper, please put form in the pre-addressed and pre-stamped envelope provided and mail it to Mathematica Policy Research, Inc.

If you are completing this information on the web, press this button to submit it.

APPENDIX A: DEFINITIONS OF IMPORTANT TERMS

(1) **Facility:** All the questions ask about this facility, that is, the facility whose name and location are printed on the front cover. If you have any questions about how the phrase this facility applies to your facility, please call Ellen Bouchery of The Lewin Group at 703-580-1751. Answer ONLY for the specific facility whose name and location are printed on the front cover, unless otherwise specified in the questionnaire. If this is a separate psychiatric unit of a general hospital, consider the psychiatric unit as the relevant "facility" for the purpose of this survey.

A facility is a single physical location where services are delivered or that is the base of operations for delivering services off-site in a community. A facility will usually be located at the address on the label. For **general hospitals**, however, the "facility" is the specialty mental health and/or substance abuse treatment delivery unit within a single physical hospital location. For **other general health care providers** (such as community health centers) the "facility" encompasses only the services related to the delivery of mental health and substance abuse treatment and the related expenses, revenues, client counts and staffing.

(2) **Fiscal reporting year:** The most recent complete fiscal year for which you can report revenues, expenses, and client counts. Record the start and end dates for the fiscal year in Question B1.

(3) **Setting of care:** The main types of setting where treatment is delivered are:

Inpatient (24-hour care in a hospital).

Residential Mental Health Treatment (24-hour residential program, usually with a physician in attendance or on call, in which treatment is provided as part of the stay).

Residential Substance Abuse Treatment (24-hour residential program, usually with a psychologist and/or social worker in attendance or on call, in which treatment is provided as part of the stay).

Outpatient (Less than 24-hour care, where the client visits the facility or the facility may send staff to the client's location).

(4) **Net Revenue:** Revenues actually received. **"**Net revenue" is defined as "gross revenue" (billed charges) minus (negotiated discounts + bad debt). It also includes grants of payments from state and local governments as well as philanthropic giving. See "Net Revenue Sources" below.

(5) **Net Revenue Sources:** We need to know the facility's net revenue by revenue source, that is, "insurer or other organization that signed the check." Sources we ask about are:

Medicaid/S-CHIP - Names may vary by state, such as MediCAL for California. Hospitals should include any disproportionate share (DSH) payments received and exclude any DSH payments transferred to another government agency or facility.

Medicare - Federal health insurance program that covers people over 65 years of age and sometimes covers people with disabling conditions. Include all forms of Medicare (i.e., Medicare, Medicare Advantage, Medicare Advantage Plus).

Criminal Justice System (Federal, State, or local prisons/jails and court-ordered treatment for adults or juveniles, when distinct from other programs). Include revenue that comes directly from the courts or justice system to your facility, rather than through the State mental health or substance abuse authority.

Other Federal Funding - For example, payments from the Indian Health Service or Housing and Urban Development (HUD).

Other State and Local Government Payments - For example, state grants or subsidies to hospitals; school funds; State Health Department funds; and city, county or special district funding.

Private Insurance (The client's private insurance payments).

Client Out-of-Pocket Payments (Direct cash or credit card payments from the client).

(6) **Expenses:** Operating expenses include total annual payroll, total employer costs for fringe benefits, contract labor costs (including temporary help), and other operating costs such as purchased services, utilities, depreciation, amortization, rent, taxes, interest expense, fund-raising expense, and any other expense associated with direct operating costs for this facility. For **facilities**, include all operating expenses of the facility; for **general hospitals**, include operating expenses of the mental health or substance abuse specialty unit; for **other general health providers**, include only operating expenses associated with mental health and substance abuse treatment. Do not include non-operating expenses that are not related to the primary operations of this facility (such as the cost of maintaining space that is rented to others outside of this business).

(7) **Fringe Benefits:** Include all **employer** costs associated with the following benefits for employees: Social Security and Medicare Payroll Taxes (FICA), State and Federal unemployment insurance taxes, group health insurance premiums, group life insurance premiums, pension and retirement contributions, workers' compensation premiums, union health and welfare plan contributions, educational benefits, and other payroll-related benefits.

APPENDIX B: STATE NAMES FOR MEDICAID AND S-CHIP

STATE	2009 MEDICAID PROGRAM NAME	2009 S-CHIP PROGRAM NAME
Alabama	Patient 1st, MLIF, or SOBRA	AL-Kids, AL-Kids Plus, ALL KIDS, or SOBRA
Alaska	Alaska Division of Health Care Services, CAMA or Pro-West (Qualis Health)	Denali KidCare
Arizona	AHCCCS, Arizona Health Care Cost Containment System	KidsCare
Arkansas	ConnectCare	ARKids First, Child Health Insurance Program, AR Kids First
California	Medi-Cal	Healthy Families
Colorado	Primary Care Physician Program (PCPP); BabyCare/KidsCare; Health Colorado	Child Health Plan Plus, or CHP+
Connecticut	Connecticut Medical Assistance Program	The HUSKY Plan, HUSKY PLUS, Husky Part A, or Husky Part B
Delaware	The Delaware Medical Assistance Program, Diamond State Health Plan	The Delaware Healthy Children Program, DHCP
District of Columbia	DC Healthcare Alliance	DC Healthy Families, DC Healthy Kids
Florida	MediPass	Florida KidCare
Georgia	Georgia Better Health Care, Georgia Healthy Families	Georgia Families, PeachCare for Kids
Hawaii	Med-QUEST, Hawaii QUEST, QUEST	Hawaii QUEST, Hawaii SCHIP, MedQuest
Idaho	NONE	Medicaid Basic Plan, Idaho SCHIP
Illinois	All Kids, FamilyCare, Moms & Babies as well as AABD (Aged, Blind & Disabled)	AllKids, Kidcare
Indiana	Hoosier Healthwise	Hoosier Healthwise Package “C”
Iowa	MediPass	Healthy and Well Kids in Iowa, HAWK - I
Kansas	NONE	HealthWave
Kentucky	KyHealth Choices, The Kentucky Patient Access and Care System, KenPAC, Kentucky Medicaid, Passport Health Plan	KCHIP, Kentucky Children’s Health Insurance Program
Louisiana	NONE	LACHIP, Louisiana Children’s Health Insurance Program
Maine	MaineCare	MaineCare, CubCare
Maryland	Maryland Medical Assistance, HealthChoice	HealthChoice, Maryland Children’s Health Program
Massachusetts	MassHealth	MassHealth, Children’s Medical Security Plan
Michigan	NONE	MIChild, Healthy Kids, Michigan SCHIP
Minnesota	The Medical Assistance Program, MinnesotaCare, General Assistance Medical Care	Minnesota Care, Minnesota Medical Assistance Program
Mississippi	NONE	Mississippi Children’s Health Insurance Program, CHIP

STATE	2009 MEDICAID PROGRAM NAME	2009 S-CHIP PROGRAM NAME
Missouri	MC+	MC+ for Kids, HealthNet for Kids
Montana	Passport to Health	Montana CHIP
Nebraska	Nebraska Health Connection, NHC	Kids Connection
Nevada	NONE	Nevada Check Up, Nevada SCHIP
New Hampshire	NONE	NH Healthy Kids Gold , NH Healthy Kids Silver
New Jersey	NONE	NJ Family Care, Family Care
New Mexico	The SALUD! Program, New Mexico Medicaid	New MexiKids, New Mexico SCHIP
New York	NONE	Child Health Plus, New York SCHIP
North Carolina	Carolina Access, Baby Love, Health Check	NC Health Choice for Children, North Carolina SCHIP, NCHC
North Dakota	Primary Care Provider Program	North Dakota Healthy Steps, SCHIP
Ohio	Ohio Medicaid, Healthy Families	Healthy Start, SCHIP
Oklahoma	SoonerCare	SoonerCare
Oregon	The Oregon Medical Assistance Program, OMAP, Oregon Health Plan, OHP	State Child Health Insurance Program, SCHIP, Oregon Health Plan
Pennsylvania	Health Choices	CHIP, Children's Health Insurance Program
Rhode Island	RIteCare	Medicaid RIte Care Program Expansion
South Carolina	Partner for Health	Partners for Healthy Children, Healthy Connections Kids
South Dakota	NONE	Children's Health Insurance Program, South Dakota SCHIP
Tennessee	TennCare	TennCare, CoverKids, Tennessee CHIP
Texas	State of Texas Access Reform, STAR, Star Plus	Children's Health Insurance Program, CHIP, Texas Healthy Steps
Utah	NONE	Utah Children's Health Insurance Program, Utah SCHIP
Vermont	NONE	Dr. Dynasaur, Vermont SCHIP
Virginia	NONE	The Family Access to Medical Insurance Security Plan or FAMIS, Virginia SCHIP
Washington	Healthy Options	Healthy Kids Now!, Washington SCHIP
West Virginia	Physician Assured Access System, PAAS, Mountain Health Trust	Children's Health Insurance Program, WV CHIP
Wisconsin	BadgerCare, Healthy Start	Wisconsin BadgerCare, Badger Care Plus
Wyoming	EqualityCare	Wyoming Kid Care,