

**Children's Health Insurance  
Program Reauthorization Act  
(CHIPRA) 10—State Evaluation**

**Supporting Statement Part A:  
Justification for the Study**

Final

August 22, 2011

**CONTENTS**

BACKGROUND..... 1

    A. Justification..... 2

        1. Need and Legal Basis..... 2

        2. Information Users..... 5

        3. Improved Information Technology..... 13

        4. Duplication of Similar Information..... 13

        5. Small Businesses..... 14

        6. Less Frequent Collection..... 15

        7. Special Circumstances..... 15

        8. *Federal Register* Notice/Outside Consultation..... 15

        9. Payment/Gift to Respondents..... 16

        10. Confidentiality..... 17

        12. Burden Estimate (Total Hours & Wages)..... 17

        13. Capital Costs (Maintenance of Capital Costs)..... 19

        14. Cost to Federal Government..... 19

        15. Program or Burden Changes..... 19

        16. Publication and Tabulation Dates..... 19

        17. Expiration Date..... 21

        18. Certification Statement..... 21

REFERENCES..... 22

ATTACHMENT A1: CHIPRA AUTHORIZING LEGISLATION

ATTACHMENT A2: CHIPRA AUTHORIZING LEGISLATION

ATTACHMENT B1: CHIP SURVEY OF ENROLLEES AND DISENROLLEES

ATTACHMENT B2: CHIP DATA ELEMENTS AND SOURCE TABLE

ATTACHMENT C: CASE STUDIES OF CHIP 10—STATE EVALUATION PROTOCOLS

C1: CASE STUDIES OF CHIP 10—STATE EVALUATION CORE  
PROTOCOL: STATE OFFICIALS

C2: CASE STUDIES FOR CHIP 10—STATE EVALUATION PROTOCOL:  
COMMUNITY-LEVEL ENROLLMENT AGENCIES

C3: CASE STUDIES FOR CHIP 10—STATE EVALUATION PROTOCOL:  
HEALTH CARE PROVIDERS

C4: CASE STUDIES OF CHIP 10—STATE EVALUATION PROTOCOL:  
MANAGED CARE PLANS/HEALTH PLAN ASSOCIATIONSS

## *Contents*

### ATTACHMENT D: FOCUS GROUP MODERATOR GUIDE

D1: CHIP 10—STATE EVALUATION FOCUS GROUP MODERATOR'S GUIDE: PARENT OF CHILDREN COVERED BY EMPLOYER'S SPONSORED HEALTH INSURANCE

D2: CHIP 10—STATE EVALUATION FOCUS GROUP MODERATOR'S GUIDE: PARENT F CHILDREN ENROLLED IN CHIP

D3: CHIP 10—STATE EVALUATION FOCUS GROUP MODERATOR'S GUIDE: PARENTS OF CHIP DISENROLLEES

D4: CHIP 10—STATE EVALUATION FOCUS GROUP MODERATOR'S GUIDE: PARENTS OF CHILEREN ELIGIBLE FOR CHIP BUT UNENROLLED

### ATTACHMENT E: 60—DAY FEDERAL REGISTER NOTICE

### ATTACHMENT F: 30—DAY PUBLIC COMMENT PLACEHOLDER

### ATTACHMENT G: CHIP WORK GROUP MEMBERS

### ATTACHMENT H: RESPONDENT MATERIALS (CONSENT FORM, LETTERS, FAQ)

### ATTACHMENT I: FOCUS GROUP CONSENT/CONFIDENTIALITY FORM

### ATTACHMENT J: CONTRACTOR CONFIDENTIALITY PLEDGE

### ATTACHMENT K: SITE VISIT PARTICIPATION CONSENT PROCEDURE

**TABLES**

1	Key Evaluation Questions and Data Sources.....	7
2	Estimated Annualized Burden Hours.....	18
3	Estimated annualized cost to Respondents for the Hours Burden.....	18

*Figures*

**FIGURE**

1	Conceptual Framework for the Evaluation of CHIP.....6
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## BACKGROUND

The Children's Health Insurance Program Reauthorization Act (CHIPRA) 10—State Evaluation will provide the federal government with new and detailed insights into how the Children's Health Insurance Program (CHIP) has evolved since its early years, what impacts on children's coverage and access to care have occurred, and what new issues have arisen as a result of policy changes related to CHIPRA and the Patient Protection and Affordable Care Act (PPACA) of 2010 (PL 111-148). The evaluation will address numerous key questions regarding the structure and impact of CHIP and Medicaid programs for children, including (1) to what extent CHIP has reduced uninsurance among children, and how this has been impacted by expansions to the program to cover more children with family incomes above 200 percent of the federal poverty level; (2) how enrollment and disenrollment trends have changed over time in CHIP, and what economic and policy factors appear to be driving those trends (such as reductions in access to employer coverage as a result of the economic downturn); and (3) what outreach, enrollment, and retention policies are most successful at increasing enrollment and retention in Medicaid and CHIP, particularly for children of racial and ethnic minorities and children with special health care needs. To answer these and other questions, the Assistant Secretary for Planning and Evaluation (ASPE) will draw on three new primary data collection efforts, including a survey of selected CHIP enrollees and disenrollees in 10 states (and Medicaid enrollees and disenrollees in 3 of these states), qualitative case studies in the 10 states, and a survey of State Program Administrators in all 50 States and the District of Columbia. ASPE seeks a three-year clearance for the first two information collections at this time. Each collection will take place once.

**Survey of enrollees and disenrollees.** The parent or primary caregiver of CHIP/Medicaid eligible children will be interviewed for this study. They will be selected from all eligible children in the 10 states' CHIP and Medicaid administrative files. Three groups of children will be eligible for the study: new CHIP/Medicaid enrollees (child enrolled in CHIP/Medicaid at least two months and less than three months at time of sample selection), established CHIP/Medicaid enrollees (child enrolled in CHIP/Medicaid five or more months at the time of sample selection), and recent CHIP/Medicaid disenrollees (child disenrolled from CHIP at least two months but less than three months at the time of sample selection). The sample will be divided into two domains: a multi-stage, clustered sample that will be interviewed by telephone (using computer-assisted telephone interviewing, or CATI) with a face-to-face follow-up of non-telephone households; and a stratified, unclustered random sample that will be interviewed by telephone only. While the clustered design is more costly than the unclustered design, it results in high response rates and improved population coverage. Without this design, children in non-telephone households (often subgroups such as Hispanics, Native Americans, and African Americans) would not be represented in the

study. The survey will collect data on application and enrollment; access, use, content of care, and satisfaction; program retention, renewal, and disenrollment; health insurance coverage; and child and family characteristics, including child health.

**Case studies.** The qualitative case studies in the 10 states will include site visit interviews with CHIP and Medicaid administrators and other public and child health stakeholders. In addition, researchers will conduct focus groups in the 10 states; participants will include parents of (1) CHIP enrollees, (2) CHIP disenrollees; (3) CHIP eligible but uninsured, and (4) parents of children covered by employer-sponsored insurance. The case studies will characterize the program implementation and impacts, implications of the Affordable Care Act, and enrollment retention, access, and utilization trends.

## **A. Justification**

### **1. Need and Legal Basis**

CHIP was enacted in 1997 to help close coverage gaps for low-income children whose families could not afford private coverage for them but had incomes too high to qualify for Medicaid. Since that time, CHIP has grown to cover more than 5 million children—the largest expansion of public health insurance coverage for children since Medicaid. CHIP is funded as a block grant to states, with federal matching rates higher than those typically received under Medicaid. States have some control over the design of their CHIP programs, including program type (Medicaid expansion, separate program, or a combination of the two); eligibility thresholds; outreach strategies; and enrollment and retention policies. States also have flexibility, within parameters set by the statute, to design CHIP benefit packages and cost-sharing rules. Because of this flexibility, the characteristics of CHIP programs vary across states (Rosenbach et al. 2007). By 2005, 29 states had adopted eligibility thresholds under CHIP of 200 percent of the federal poverty level (FPL); 13 set thresholds below 200 percent of the FPL; and 8 expanded eligibility to children in families with incomes above 200 percent of the FPL (First Focus 2009). Furthermore, about two-thirds of states chose to implement their CHIP expansions through a separate program, either alone or in combination with a Medicaid expansion, which introduced variations in benefits and cost-sharing. The coverage offered by separate CHIP programs more closely resembles the very broad coverage available under Medicaid than that typically available under private health insurance, and most are operated under capitated managed care arrangements (Kenney and Dorn 2009; Wooldridge et al. 2005).

Research evidence from CHIP's early years indicates the program has made great progress in several areas. With expansions in the program, new investments in outreach, and enrollment simplifications introduced beginning in the late 1990s, uninsured rates declined among children, both for those

made newly eligible for public coverage under CHIP and those already eligible for Medicaid (Hudson and Selden 2007; Davidoff et al. 2005; Kenney and Yee 2007; Kenney and Chang 2004; Dubay et al. 2007; Kenney et al. 2005; Rosenbach et al. 2007). The early research also indicates improvements in access to care and increases in receipt of preventive care among the children who gained public coverage (Rosenbach et al. 2007; Kenney and Chang 2004). At the same time, however, millions of children remained uninsured despite being eligible for Medicaid or CHIP, and many enrolled in public coverage did not receive recommended levels of care (DeNavas et al. 2009). Moreover, uninsured rates among low-income children vary widely from state to state and across subgroups (Lynch et al. 2010).

**The Children's Health Insurance Program Reauthorization Act.**

Uncertainty surrounding ongoing funding ended in February 2009 when CHIP was reauthorized for an additional four and a half years through CHIPRA (Georgetown Center for Children and Families 2009). CHIPRA provided states with new tools to address shortfalls both in enrollment and in access to and quality of care. A number of provisions were designed to expand eligibility for public coverage among children and increase takeup of public coverage among uninsured children already eligible for



Medicaid and CHIP (Georgetown Center for Children and Families 2009).<sup>1</sup> CHIPRA authorized new outreach and enrollment grants, as well as bonus payments to states that both adopted five of eight enrollment/retention strategies and exceeded target enrollment numbers. States also received new options to use Express Lane Eligibility strategies to facilitate eligibility determination, enrollment, and retention, and for meeting citizen documentation requirements. CHIPRA allowed states to use federal dollars to cover legal immigrant children who had been in the United States less than five years (previously, coverage for such children had to be financed exclusively with state funds), provided higher federal matching rates for translation and interpreter services and additional federal allotments to states to cover the costs of expanding eligibility and enrolling more eligible children. Other provisions were designed to improve access to and quality of care for the children served by Medicaid and CHIP (HHS 2010).

**The CHIP program today.** Since the enactment of CHIPRA in early 2009, a number of states have introduced policy changes to their Medicaid and CHIP programs: 15 have expanded eligibility to higher-income children; 17 have sought approval to introduce improvements in their enrollment and retention processes; as of April 2011, 7 states have received approval to take advantage of the new Express Lane option for Medicaid (Alabama, Georgia, Iowa, Louisiana, Maryland, New Jersey, and Oregon), and four states (Georgia, Iowa, New Jersey and Oregon) also received approval to do this for CHIP; and 19 states have begun using federal funds to cover legal immigrant children and/or pregnant women who had been in the country less than five years (HHS 2010; Families USA 2010). An initial \$40 million in outreach grants was awarded to 42 states and the District of Columbia, and an additional \$10 million was awarded for targeting Native American children.

In addition, as required under CHIPRA, a core set of quality measures has been developed by the Agency for Healthcare Research and Quality (AHRQ), and Quality Demonstration Grants have been awarded that include both single-state projects and multistate collaborations involving 18 states overall; an evaluation of the Quality Demonstration Grants has been funded; and a contract to develop a model electronic health record format for children in Medicaid and CHIP has been awarded. Also, the Government Accountability Office (GAO) has initiated three mandated studies on, respectively, Medicaid/CHIP dental services for children, parent and caretaker coverage, and Medicaid/CHIP primary and specialty services for

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<sup>1</sup> These provisions include (1) adopting 12-month continuous eligibility for all children, (2) eliminating the asset test for children, (3) eliminating in-person interview requirements at application and renewal, (4) using joint applications and supplemental forms and the same application and renewal verification process for the two programs, (5) allowing for administrative or paperless verification at renewal through the use of prepopulated forms or ex parte determinations, (6) exercising the option to use presumptive eligibility when evaluating children's eligibility for coverage, (7) exercising the new option in the law to use Express Lane Eligibility procedures; and (8) exercising the new options in the law regarding premium assistance.

children; and the Institute of Medicine has formed a committee to study Pediatric Health and Pediatric Health Care Quality.

CHIP covered 5 million children in June 2009 and 7.7 million children over the course of federal fiscal year 2009 (Cohen Ross 2009). As of December 2009, all but 4 states (Alaska, Idaho, North Dakota, and Oklahoma) had eligibility thresholds for children at or above 200 percent of the FPL, with almost half (24 states) having thresholds at or above 250 percent of the FPL and 18 with thresholds of 300 percent or higher (HHS 2010; Cohen Ross et al. 2009). Most states have chosen to expand coverage of children through separate programs, either alone or in combination with smaller Medicaid expansions, while 12 states have relied exclusively on Medicaid expansions for child populations covered by CHIP. Still, most states have not taken full advantage of the flexibility in CHIP to streamline eligibility policies and thus maximize their potential for enrollment. For example, while most have dropped the asset test as part of the eligibility determination process and no longer require an in-person interview at enrollment or renewal, fewer than half have 12-month continuous eligibility for children, and just 14 states have presumptive eligibility (Cohen Ross 2009). Most states charge premiums and/or copayments in their CHIP programs, but the amount charged varies across income groups and states (Cohen Ross 2009).

**CHIP in the future.** CHIP's evolution is occurring within a rapidly changing health care environment. PPACA introduces comprehensive health reforms, including an expansion of Medicaid to adults and children up to 133 percent of the FPL; a maintenance of effort (MOE) requirement through 2019 on state Medicaid and CHIP coverage for children; new subsidies for coverage for families with incomes up to 400 percent of the FPL; the creation of state health insurance exchanges and reforms to health insurance markets; the development of streamlined enrollment systems; and the introduction of coverage mandates for both individuals (including children) and employers. PPACA also provides two additional years of federal funding for CHIP (extending it through 2015) and increases federal CHIP matching rates by as much as 23 percentage points in 2015 and beyond. Starting in January 2014, more parents below 133 percent of the FPL will become eligible for Medicaid, and children in that income group who are enrolled in CHIP will be transitioned to Medicaid. The MOE requirements under PPACA limit the ability of states to change eligibility and enrollment procedures for Medicaid and CHIP but may lead to cuts in provider payment rates for the next few years. Also, despite the MOE requirement on CHIP and Medicaid coverage for children through 2019, it is not clear how long states will be able to continue their CHIP programs beyond 2015 unless additional federal allotments are provided. With no additional federal funding for CHIP after 2015, many children enrolled in separate CHIP programs will likely be shifted into health insurance exchanges or employer-sponsored insurance (ESI) plans.

**Mandate for the current evaluation.** It is within this context of the gap in children's health care needs that Congress mandated a new CHIPRA evaluation to be conducted by ASPE. The CHIPRA legislation directed that the evaluation of the program be patterned after the previous evaluation. Congress stipulated that the evaluation include surveys of enrollees and disenrollees in 10 states and specified several criteria to be used in selecting these states. A report on the evaluation is to be submitted to Congress by December 31, 2011. In September 2010, ASPE awarded the second congressionally mandated contract for the evaluation of CHIP to Mathematica Policy Research, Inc., and its subcontractor, the Urban Institute. The evaluation will be conducted over a three-year period.

Coming five years after completion of the first evaluation, the current evaluation will provide new and detailed insights into how the program has evolved since its early years, what impacts on children's coverage and access to care have occurred, and what new issues have arisen as a result of policy changes related to CHIPRA and PPACA. Building on prior evaluations focused on the early years of CHIP, it will explore how states have grappled with important implementation challenges as the program matured and their experiences in enrolling, retaining, and delivering care to children in low-income families. It will place particular emphasis on understanding enrollee experiences in getting care and the types of services received, as well as how CHIP compares with other public and private coverage. Using a mixture of quantitative and qualitative research methods, the evaluation will document how CHIP programs have developed, where they stand today, and where they may be headed in the future. It will draw on new primary data collection efforts modeled after the previous evaluation, including surveys of enrollees and disenrollees in CHIP (10 states) and Medicaid (3 states), site visits and focus groups in the 10 survey states, and a survey of program administrators in every state. To analyze states' progress in enrolling and retaining children and to document effective policies and practices, the evaluation will also make use of various secondary data sources, including annual reports, other program data states submit to the Centers for Medicare & Medicaid Services (CMS), and administrative data files from state eligibility and enrollment systems. It also will tap data from other national surveys to understand how CHIP and Medicaid are perceived by low-income families with uninsured children who may be eligible and to gauge the extent to which CHIP is reducing the share of low-income children who are uninsured.

**Authorizing legislation.** See Attachment A: Authorizing Legislation, for the text of the 1997 and 2009 authorizing legislation.

## **2. Information Users**

ASPE will use the data collected and analyzed in the CHIPRA 10-State Evaluation to evaluate the CHIP program and its contributions to closing the health care coverage gap for low-income children whose families do not

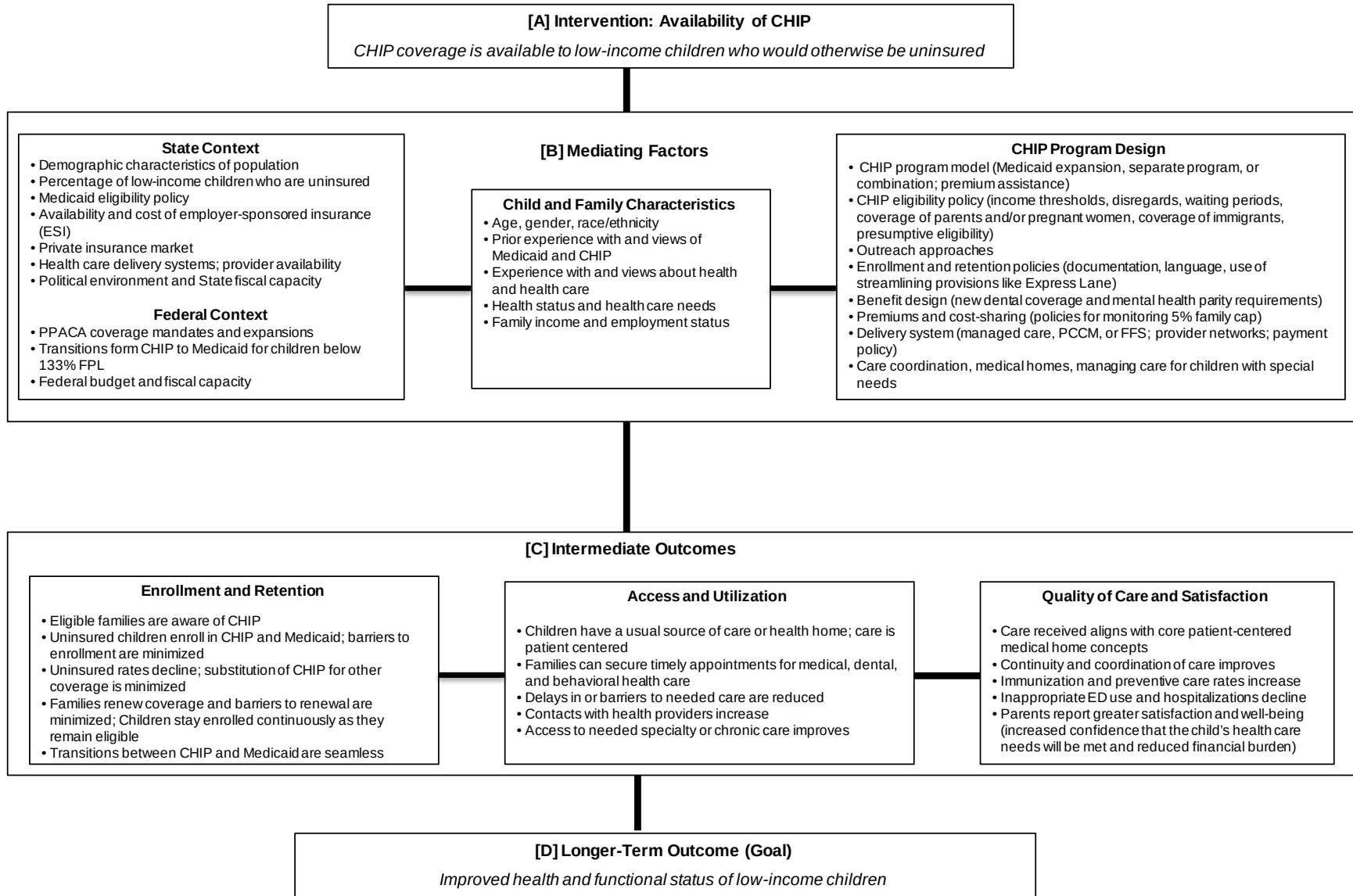
qualify for Medicaid, but cannot afford private coverage for them. Data from the survey, case studies (site visits and focus groups), and other national datasets will be integrated into the analysis.

**Conceptual framework.** The conceptual framework guiding decisions on the design and execution of the major CHIP evaluation components is shown in Figure 1. The framework illustrates the process by which CHIP contributes to the health and well-being of eligible low-income children. Several important factors may mediate the effects of CHIP (Box B), including the state and federal program contexts (left side) and the design of the program in a given state (right side)—all of which must be considered carefully in the evaluation. Examples of contextual factors at the state level include the demographic characteristics of the target population, the baseline rate of uninsured children, Medicaid eligibility policies, and the structures of private insurance markets and health care delivery systems. At the federal level, contextual factors include the implementation of significant health care reform provisions, such as the individual mandate and the movement of many low-income citizens into Medicaid. Changes such as the individual mandate could result in a large influx of first-time applicants to CHIP as parents pursue coverage for their children.

Program design features (right side of Box B) long have been recognized as a major potential influence on CHIP enrollment and service delivery. Examples of these features include program model, outreach approaches, eligibility determination and redetermination processes, benefit design, delivery system, and premiums and other cost-sharing. The flexibility afforded by CHIPRA only adds to this list of potential design features (such as coverage of recent immigrants) and the variation in features across states.

Child and family characteristics are also important mediating factors. Prior experiences with Medicaid and CHIP and with health care more broadly, health status, age, race/ethnicity and cultural background, and socioeconomic status are among the characteristics that may influence enrollment and service use experiences and outcomes.

**Figure 1. Conceptual Framework for the Evaluation of CHIP**



To understand the role that these mediators may have in CHIP’s success, the evaluation will focus considerable attention on their linkages to important intermediate outcomes (Box C), including participation and uninsurance rates, patterns of program enrollment and retention, access to health care, and quality of and satisfaction with care. For example, various outcomes pertaining to health care access—such as the likelihood of having a usual source of care, the use of health care services, and levels of unmet need—all may be affected by the backgrounds and experiences of CHIP enrollees and/or the features of their state programs. Understanding these and other linkages in turn forms the basis for assessing not merely whether CHIP is effective but also how and for whom it is most effective, thereby greatly advancing our understanding of how well the program is achieving its ultimate goal: the improved health of low-income children (Box D).

**Analytic approach: Key questions and methods.** ASPE’s approach will combine a vast amount of data to address a broad range of research questions (see Table 1). As shown in the table, these research questions cluster into seven often interrelated topic areas: (1) program context and design features; (2) outreach and enrollment; (3) retention and disenrollment; (4) access, utilization, content of care, and satisfaction; (5) the relationship between CHIP and other coverage; (6) effects on the uninsured; and (7) implications for health reform. As further shown in the table, our investigation of these questions often will feature a mix of qualitative and quantitative data sources, yielding a “mixed-methods” approach to addressing many questions that will improve the depth, rigor, and generalizability of our findings. For some questions, we will rely primarily on qualitative information and analysis, while for others the primary approach will incorporate quantitative data and methods. Most often, the two types of data and analyses will complement one another so that the final results will benefit from the specificity and rigor associated with quantitative methods and the explanatory richness and contextual value of the qualitative work.

**Table 1. Key Evaluation Questions and Data Source**

Key Evaluation Questions	Qualitative Data/Analyses	Quantitative Data/Analyses
<b>Program Context and Design Features</b>		
How do key design features vary across states? What design changes have states made, and why?	CARTS, SEDS, other program data Site visits Survey of program administrators	
How do CHIP benefit packages and delivery system features compare with Medicaid and private coverage?	CARTS, SEDS, other program data National data sources on Medicaid and private insurance Site visits Survey of program administrators	

CHIP OMB Supporting Statement Part A

Key Evaluation Questions	Qualitative Data/Analyses	Quantitative Data/Analyses
What effect do program design features have on key program outcomes (enrollment, retention, access, use, and satisfaction)? Do states with specific program features experience increased enrollment and/or lower rates of uninsurance?	CARTS, SEDS, other program data Site visits Survey of program administrators	CHIP survey SLAITS CPS/ACS
How has the economic downturn affected states? What is the current state budget picture? How has the passage of CHIPRA changed the funding debates in each state? In what ways are states preparing for implementation of national health care reform? How has the enactment of PPACA affected state CHIP programs?	Site visits Survey of program administrators National data sources on state economic indicators	
<b>Outreach and Enrollment</b>		
How do families learn about CHIP and Medicaid? What information is most helpful in their decisions about applying/enrolling? What aspects of the program are most appealing, and what factors influence enrollment decisions?	Site visits Focus groups	CHIP survey Medicaid survey SLAITS
What are effective and ineffective outreach strategies for Medicaid and CHIP? How do different outreach strategies affect families' knowledge of public programs and motivation to enroll?	Site visits Focus groups Survey of program administrators	CHIP survey Medicaid survey Enrollment/ admin data SLAITS
What are the principal barriers to enrollment for Medicaid and CHIP? What role do waiting lists and waiting periods play?	Site visits Focus groups CARTS, SEDS, other program data Survey of program administrators	CHIP survey Medicaid survey Enrollment/ admin data SLAITS
What policies and practices are states employing to improve enrollment outcomes? What strategies are used for specific populations, such as children with special needs, racial/ethnic minorities, and children in immigrant families?	Site visits CARTS, SEDS, other program data Survey of program administrators	
What are the trends in CHIP enrollment, Medicaid enrollment, and enrollment in public coverage overall for the study states? How do trends differ across states? To what extent are trends driven by changes in new enrollment versus changes in disenrollment/retention?	CARTS, SEDS, other program data	Enrollment/ admin data
What are the trends in program churning and transitions between Medicaid and CHIP? How do these vary across states? What effect do these have on enrollment in public coverage?	CARTS, SEDS, other program data	Enrollment/ admin data
In states that are more successful in enrolling eligible children in Medicaid and CHIP, what practices make them more successful? If other states adopt these practices, are they likely to get the same results?	Site visits Focus groups CARTS, SEDS, other program data Survey of program administrators	CHIP survey Medicaid survey Enrollment/ admin data

CHIP OMB Supporting Statement Part A

Key Evaluation Questions	Qualitative Data/Analyses	Quantitative Data/Analyses
How do premiums, cost-sharing, and other program design features influence enrollment outcomes?	Site visits Focus groups CARTS, SEDS, other program data	Enrollment/ admin data
How does coordination (or lack of coordination) between Medicaid and CHIP affect the enrollment of children in both programs?	Site visits CARTS, SEDS, other program data Survey of program administrators	CHIP survey Medicaid survey Enrollment/ admin data SLAITS
What are the impacts of state budget constraints and maintenance-of-effort requirements on the level of state outreach and enrollment efforts?	Site visits Survey of program administrators	Enrollment/ admin data
<b>Retention and Disenrollment</b>		
How do families learn about program renewal requirements and procedures? What are their experiences with the renewal process?	Site visits Focus groups	CHIP survey Medicaid survey SLAITS
How long do children remain enrolled? How does this vary across states? What policies and practices seem to influence enrollment duration?	Site visits Focus groups CARTS, SEDS, other program data	CHIP survey Medicaid survey Enrollment/ admin data
Why do children exit the program? To what extent are exits intended/voluntary versus unintended?	Focus groups	CHIP survey Enrollment/ admin data SLAITS
What portion of children exiting to uninsured status may still be eligible for CHIP or Medicaid? What portion returns to the program after a spell of disenrollment?	Site visits CARTS, SEDS, other program data	CHIP survey Medicaid survey Enrollment/ admin data
How do premiums, cost-sharing, and other program design features influence retention outcomes?	Site visits Focus groups CARTS, SEDS, other program data	Enrollment/ admin data
What are more and less effective retention practices for Medicaid and CHIP?	Site visits Focus groups CARTS, SEDS, other program data Survey of program administrators	CHIP survey Medicaid survey Enrollment/ admin data
<b>Access, Utilization, Content of Care, and Satisfaction</b>		
What experiences do enrollees have in seeking and obtaining health care? Have they had difficulties in finding a doctor or dentist? Have they been able to get timely appointments? How do these experiences compare with their experiences before enrollment?	Focus groups	CHIP survey Medicaid survey
Where do enrollees usually access care? Do they have a usual source of care?	Focus groups	CHIP survey Medicaid survey
How adequate are provider networks in meeting the needs of enrollees?	Site visits Survey of program administrators	CHIP survey Medicaid survey



## CHIP OMB Supporting Statement Part A

Key Evaluation Questions	Qualitative Data/Analyses	Quantitative Data/Analyses
What types of services do enrollees receive? To what extent does the care received include recommended preventive care screenings, guidance, immunizations, and other services?		CHIP survey Medicaid survey
How well does the process of care align with the core principles of a patient-centered medical home?	Focus groups	CHIP survey Medicaid survey
How well are providers communicating with families?	Focus groups	CHIP survey Medicaid survey
How do cost-sharing and other benefit design features affect access and use?	Site visits Focus groups	CHIP survey Medicaid survey
How do the costs incurred by families compare with other coverage the child may have had before, or to which they currently have access?	Focus groups	
What unmet health care needs do children have while enrolled? Are costs a factor?	Focus groups	CHIP survey Medicaid survey
How has the program affected family well-being (financial burden and confidence that their child's health care needs will be met)?	Focus groups	CHIP survey Medicaid survey
How satisfied are families with the health services received and with the program overall?	Focus groups	CHIP survey Medicaid survey
What impact does CHIP have on access, use, content of care, and satisfaction?		CHIP survey
<b>Relationship Between CHIP and Other Coverage</b>		
What type of coverage do children have prior to enrollment and after disenrolling? How long do they have that coverage and why do they lose it?	Focus groups	CHIP survey Medicaid survey Enrollment/ admin data
What share of CHIP enrollees has private coverage prior to enrolling? What share has access to private coverage while enrolled? How does that vary with program design/crowd-out policies?	Focus groups	CHIP survey Medicaid survey Enrollment/ admin data
For those uninsured prior to enrolling, how long were they uninsured? Was this influenced by CHIP waiting period policies?	Focus groups	CHIP survey Medicaid survey Enrollment/ admin data
How does the coverage children have before enrolling and after they exit compare with coverage under CHIP? What are the major differences in covered services and costs?	Site visits Focus groups	CHIP survey Medicaid survey
To what extent is CHIP substituting for (crowding out) private coverage? What share of new enrollees was uninsured prior to enrolling?	Site visits Focus groups	CHIP survey Medicaid survey
How has CHIP affected the Medicaid program (e.g., structure, scope, enrollee perceptions, relationship with other coverage)?	Site visits Focus groups Survey of program administrators	CHIP survey Medicaid survey

## CHIP OMB Supporting Statement Part A

Key Evaluation Questions	Qualitative Data/Analyses	Quantitative Data/Analyses
How has CHIP altered or factored into the movement of low-income children between public coverage, private coverage, and uninsurance?	Site visits Survey of program administrators	CHIP survey Medicaid survey Enrollment/ admin data
Does CHIP serve as a short- or long-term coverage approach for low-income children?	Site visits CARTS, SEDS, other program data	CHIP survey Enrollment/ admin data
Are children making seamless transitions from CHIP to Medicaid and vice versa? What policies are in place to promote these transitions? What improvements could be made?	Site visits	CHIP survey Medicaid survey Enrollment/ admin data
How does the role of public coverage for low-income children vary from state to state? How has CHIP affected this dynamic?	Site visits	CHIP survey Medicaid survey Enrollment/ admin data
<b>Effects on the Uninsured</b>		
What effect has CHIP had on the rate of health insurance among low-income children?		Enrollment/ admin data CPS, ACS
How well are states covering children in specified target groups?	Site visits	Enrollment/ admin data CPS, ACS
<b>Implications for Health Reform</b>		
What lessons from CHIP are most applicable to health reform?	Site visits Survey of program administrators	
How has PPACA affected state programs, and what future changes are expected?	Site visits Survey of program administrators	
How are families of CHIP enrollees likely to respond to coverage options introduced through health reform? Do parents value having everyone in the family under the same coverage (CHIP or ESI)?	Focus groups	CHIP survey Medicaid survey
How knowledgeable are parents about options for purchasing coverage in the private market and through exchanges?	Focus groups	CHIP survey Medicaid survey

NOTE: The CHIP Survey and Medicaid Survey utilize a common survey instrument, with only a few questions unique to one program or the other.

CARTS = CHIP Annual Report Template System

SEDS = Statistical Enrollment Data System

CPS = Current Population Survey

ACS = American Communities Survey

SLAITS = State and Local Integrated Telephone Survey

*Program context and design features.* A thorough understanding of the design features of state CHIP programs, and the context within which they operate, is vital for assessing their influence as mediating factors in several analyses, encompassing the experiences of both CHIP enrollees and children eligible for CHIP but not enrolled. The primary data sources we will tap for

information on design features of state programs will include CHIP annual reports submitted to CMS and other national data, site visits, and the survey of state program administrators. Questions explored in this area will include the following: What are the key design features of state programs (program model; eligibility policies; waiting periods and other policies to deter crowd-out of other coverage; enrollment and renewal policies and practices; benefit packages and cost sharing; delivery systems, managed care arrangements, provider networks, and payment policies)? How and why have these features changed over time? How do program design features influence key program outcomes (enrollment, retention, access, service use, and satisfaction)? What is the current budget picture for states, and how has the passage of CHIPRA changed the funding debates in each state?

*Outreach and enrollment.* CHIPRA provides new funding for state and local agencies to engage in outreach activities for difficult-to-reach populations, such as minorities and immigrants. In addition, the law encourages adoption of new processes to streamline enrollment. To understand which strategies are most effective at promoting enrollment, we will combine findings from analyses of several data sources, including (1) the focus groups and key informant interviews conducted through the case studies, (2) the survey of program administrators, (3) data on application/enrollment experiences from the CHIP survey, (4) enrollment and other administrative data that may highlight promising activities, and (5) data from SLAITS on the eligible-but-uninsured population. The analysis will address such questions as: What are effective and ineffective outreach strategies for CHIP and Medicaid? How have combined CHIP/Medicaid enrollment practices affected enrollment in both programs? What are the trends in program churning and transitions between Medicaid and CHIP?

*Retention and disenrollment.* ASPE is interested in understanding enrollment and retention trends and dynamics and why these trends may have changed over time. Of particular concern is whether there are barriers that prevent low-income children from remaining enrolled in the program and to what extent CHIP acts as a long-term source of insurance coverage. We will address these issues by using CHIP (and when available, Medicaid) enrollment/administrative data to measure the flow of low-income children into and out of the program, combining these measures with qualitative data from the case studies and the survey of program administrators to understand patterns. Data from SLAITS will provide insights into why some uninsured children disenroll despite still being eligible. The analyses will address such questions as: Why do children disenroll from CHIP? How effective are streamlining practices, such as paperless verification or the elimination of in-person interviews, at improving the retention rate in CHIP? How long do children typically remain enrolled in CHIP?

*Access, utilization, content of care, and satisfaction.* CHIP aims to reduce barriers to care and unmet needs and improve access to needed services and receipt of appropriate preventive and acute care services. Achieving good quality of care for children requires coordination across multiple providers and systems, especially for children with special health care needs. Another key issue is understanding how cost-sharing affects the use of services. To address questions in these areas, we plan to focus primarily on data from the CHIP surveys, supplemented with findings from the case studies and the survey of program administrators to help explain the basis for any positive effects and how any variation in outcomes across states may be linked to program design. Questions addressed in this analysis include: What experiences do CHIP enrollees have in seeking or obtaining health care, and how does this compare with their experiences prior to enrollment? How satisfied are enrollees with CHIP and the health services they receive? What impact does CHIP have on the type of health care received, the content of care, and family well-being (i.e., financial concerns and confidence in the ability to obtain needed care)?

*Relationship between CHIP and other coverage.* The CHIP program is positioned as an important bridge between Medicaid and private health insurance. To explore the dynamic between these types of coverage, we will rely on three main data sources/analyses—the CHIP survey, the Medicaid survey, and the SLAITS data. In addition, data from our case studies will supplement the findings by providing insights into how CHIP affects family coverage decisions and the basis for any notable variation in findings across states. The analysis will address such questions as: How has CHIP altered or factored into the movement of low-income children between public coverage, private coverage, and uninsurance? Do families view the CHIP program as a long-term or short-term coverage option?

*Impact on uninsured children.* A central objective of CHIP is to provide insurance coverage to low-income children who are not eligible for Medicaid

and do not have other insurance. ASPE is particularly interested in assessing what impact the CHIP program is having on the uninsured rate for low-income children, how this varies from state to state, and how well states are reaching their targeted populations. To inform ASPE about this issue, we will draw on analyses of the CPS and ACS, along with national sources of program enrollment data, to estimate participation rates among eligible low-income children. We will supplement these data with enrollment data from states and CHIP survey data to examine this issue more closely in the 10 targeted states. As with several other analyses, qualitative data from the case studies and CHIP program administrator survey will help us interpret findings and provide a qualitative assessment of this vital matter. The analysis will inform such questions as: What are the implications of setting eligibility at higher levels to target (uninsured) children?

*Implications for health reform.* The passage of health reform legislation in early 2010 substantially changed the context for this evaluation. ASPE now must gather information to help inform the role CHIP will play in an environment with broader Medicaid enrollment and a mandate for coverage supported by state-based exchanges for purchasing private insurance and facilitating enrollment in public coverage. Discovering all we can about family coverage preferences and parents' ability to navigate the insurance market are important first steps for predicting future CHIP enrollment and easing the transition from one program to another. We mainly will use a combination of the CHIP survey and focus group data to address such questions as: Do parents prefer to have everyone in the family under the same coverage (CHIP or ESI)? What do parents know about purchasing coverage in the health insurance market and through such mechanisms as exchanges?

➤ Attachment B1 contains the survey instrument.

**Limitations of the Study.** The ten states selected for the evaluation include a majority of all CHIP enrollees nationwide, ensuring that the evaluation findings cover a large fraction of those with recent or current CHIP coverage. Although it is not possible to generalize these findings outside the study states we anticipate that many important findings from the ten study states may be applicable to the population covered in other States, for two related reasons. First, as detailed in our state selection memo, we believe that the ten study states capture much of the important variation in CHIP features and CHIP populations nationwide -- a belief that we can further validate during the evaluation by drawing on our 50-state survey of CHIP administrators and from the CARTS data. Second, despite this wide variation, we expect (based on the prior evaluation) that many key study findings will persist across the ten states, suggesting that they generalize to CHIP elsewhere.

With just three states the focus of the companion Medicaid household survey, we will naturally be less able to make generalized statements about

the Medicaid program no matter the findings. Having purposefully chosen the three largest states for this study, however, findings will cover a large fraction of the children enrolled in Medicaid nationwide. In addition, even with just three states, findings from the evaluation can still provide meaningful insight into the Medicaid population -- particularly in how the children enrolled in Medicaid and program experiences compare with those of children covered by CHIP. Indeed, to the extent that these comparative findings persist across the three Medicaid states, they will offer easily the most robust and detailed understanding to date of the similarities and differences that exist between children and families on the two programs.

### **3. Improved Information Technology**

The CHIPRA 10-State Evaluation will comply fully with the Government Paperwork Elimination Act (GPEA), Public Law 105-277, Title xvii by employing technology efficiently in an effort to reduce burden on respondents. ASPE will use a Computer-Assisted Telephone Interview (CATI) methodology to survey all respondents. Respondents in the clustered sample will be followed in-person by field staff carrying cellular telephones for the respondents to telephone the contractor's Call Center and be interviewed using CATI technology. ASPE will administer a single questionnaire in CATI with three major paths through it, depending on the sample types: recent enrollees, established enrollees, and recent disenrollees.

CATI surveys optimize resources and typically guarantee high quality data because the technology incorporates automated range checks and branching and enforces consistency among critical questions. CATI programming will allow interviewers to collect information that is specific to each respondent, thereby eliminating undue time burden on respondents. The questionnaire solicits only information that corresponds to the specific research items discussed in question A2, above. No superfluous or unnecessary information is being requested of respondents. Finally, interviewers can toggle between English and Spanish versions of the instrument in order to minimize respondent language burden.

### **4. Duplication of Similar Information**

ASPE recognizes that certain questions asked on the prior CHIP survey remain relevant, valid, and reliable for this study's primary purpose and has taken a majority of questions from the prior questionnaire. However, a number of questions in the previous survey focused on the newly authorized CHIP program and are no longer relevant to a more mature CHIP program in 2011. ASPE reviewed existing questions from numerous other surveys, and has incorporated those questions into the current CHIP 10-State instrument. To avoid duplication we have drawn questions from the following surveys:

- CHIP Survey (2002 - 2003)
- Healthy Kids - San Mateo County: Baseline Survey

- Healthy Kids – Los Angeles County: Baseline Survey
  - National Survey of Children’s Health (NSCH)
  - CMS Medicaid/CHIP Survey
  - Children with Special Health Care Needs (CSHCN) Screener – widely used in MEPS, CAHPS, and NSCSHCN
  - National Survey of Children with Special Health Care Needs 2005 - 2006 (NSCSHCN)
  - Medical Expenditure Panel Survey – PE 2009 (MEPS 2009-PE)
  - MEPS-Child Preventive Health Survey
  - Kaiser Family Foundation 2005 Low-Income Survey
  - Maine Child Health Survey
  - National Health Insurance Survey-Child (2009)
  - Consumer Assessment of Health Care Providers and Systems (CAHPS) Clinician and Group Survey
- Attachment B2 contains sources of all questions.

**Case studies: site visits and focus groups.** ASPE used the case study protocols from the previous evaluation as a starting point for developing the protocols for the current evaluation. It was necessary to significantly modify the protocols to address current CHIPRA issues, such as additional coverage options (coverage of legally resident immigrant children/pregnant women without imposing a 5-year waiting period) and new enrollment simplification strategies (such as citizenship documentation via Social Security Administration data match, and Express Lane Eligibility), among others. ASPE also reviewed Focus Group moderator guides developed for the Health Kids Study (Los Angeles County) and Covering Kids and Families for the Robert Wood Johnson Foundation.

## 5. Small Businesses

The **Survey of Enrollees and Disenrollees** will interview the parents or primary caretakers of children enrolled in CHIP or Medicaid. No small businesses or entities will be impacted.

**Case studies: focus groups** will be conducted with families touched by CHIP and Medicaid programs. No small businesses or entities will be impacted.

**Case studies: site visits**, however, will gather in-depth information and insights from a variety of stakeholders at both state and local level organizations in a range of sizes. At the state level, interviews will likely include officials responsible for CHIP and Medicaid administration, public health and maternal and child health officials, governors’ health policy staff,

state legislators and their staffs, family and child advocates, vendors under contract with the state (such as those responsible for eligibility review and plan enrollment), and providers representing such groups as the American Academy of Pediatrics and the state Primary Care Association. At the local level interviews will likely include county social services administrators, front-line eligibility workers, local public health officials, managed care organizations, health insurance plans, representatives of the business and employer communities, local clinic- and office-based pediatric providers, and community-based organizations involved with outreach.



In order to minimize the burden on small organizations within our site visit sample, ASPE plans to keep the site visit interviews short (no more than one hour for a given informant), to interview only the relevant stakeholders at any given organization, and to ask only questions that contribute to the analytic purposes of the site visits. See Attachments C1-C4 and D1-D4 for a draft of the site visit and focus moderator protocols.

## **6. Less Frequent Collection**

CHIPRA 10-state evaluation information collections—Survey of Enrollees and Disenrollees and the Case Studies—will take place one time only. Each respondent will be interviewed or attend a focus group one time only.

ASPE collected data for the initial CHIP evaluation in 2002 - 2003 and has not collected data about the program since that time. If the CHIPRA 10-state data collection does not take place, ASPE will not be able to meet its obligation to Congress to provide new and detailed insights into how the CHIP program has evolved since its early years, what impacts on children's coverage and access to care have occurred, and what new issues have arisen as a result of policy changes related to CHIPRA and PPACA. Building on prior evaluations focused on the early years of CHIP, ASPE will use be able to explore how states have grappled with important implementation challenges as the program matured and understand their experiences in enrolling, retaining, and delivering care to children in low-income families. Without the CHIPRA 10-state survey, ASPE will not be able to understand enrollee experiences in getting care and the types of services received, nor how CHIP compares with other public and private coverage.

There are no technical or legal obstacles to reducing respondent burden.

## **7. Special Circumstances**

This request fully complies with the general information collection guidelines of 5 CFR 1320.5(d)(2). No special circumstances apply.

## **8. Federal Register Notice/Outside Consultation**

The 60-day Federal Register Notice was published in the Federal Register on March 28, 2011, volume 76, number 59, pp. 17128 - 17129. See Attachment E.

**Public comments.** There were no public comments to the 60-day Federal Register Notice. We have reserved Attachment F as a placeholder for any comments based on the 30-day Federal Register Notice.

**Consultation Outside the Agency.** ASPE convened a Work Group on October 20, 2010 to discuss the study design. Meetings with the Work Group will continue as additional critical topics arise, notably the Work Group consulted on the survey instrument content in January and February, 2011.

In addition to ASPE staff (Elizabeth Pham, Kenneth Finegold, Erica Berry, Lisa Dubai, and Susan Todd), the Work Group consists of the following members:

- AHRQ
  - Cindy Brach, Senior Health Policy Researcher
- CMS
  - Stacey Green, Technical Director for the Arizona Title XXI Program
  - Renee Mentnech, Director of Research and Evaluations Group in the Office of Research, Development and Information
  - Tonya Moore, Title XXI Project Office
  - Linda Nablo, Director, Division of Children's Health Insurance Programs
  - Jennifer Ryan, Deputy Director, Children and Adults Health Programs Group
  - Victoria Wachino, Director, Children and Families Health Programs Group, Center for Medicaid, CHIP, and Survey and Certification
- NCHS
  - Linda Bilheimer, Associate Director for Analysis and Epidemiology
  - Stephen Blumberg, Senior Statistician, Division of Health Interview Statistics
- Other Federal Workgroup Members
  - Suzanne Auerbach, HHS / ASFR, Senior Policy Analyst
  - Rebecca Hirshorn, HHS/ASL, Legislative Analyst
  - Jennifer Snow, HHS/IOS, Policy Advisor

➤ Attachment G contains Work Group members' contact information.

## **9. Payment/Gift to Respondents**

ASPE recognizes the time burden placed on respondents to the survey and the focus groups. Incentive payments to respondents have been shown to encourage participation and thereby increase response rates, which in turn improves the validity and reliability of the data. "While there is no gold standard on how much incentive to offer a survey respondent, the OMB has approved use of monetary incentives in the range of \$20 to \$30 with specific target populations similar to those of interest here."<sup>2</sup> The referenced study

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<sup>2</sup> Jason Markesich and Martha D. Kovac, *The Effects of Differential Incentives on Completion Rates: A Telephone Survey Experiment with Low-Income Respondents*.

population were recipients of Temporary Assistance for Needy Families—low-income population similar to the Medicaid and CHIP population of this study. ASPE will provide a post-paid gift card worth \$20.00 upon completion of the survey—whether by CATI or by in-field telephone follow-up. If any respondent agrees to participate using their own cell phone, ASPE will provide an additional \$5 to cover expenses associated with use of private cell phones. Respondents will be assured that the \$20 will not affect their benefits in Medicaid, CHIP, or any other program. The \$20 incentive will be made in the form of a gift card, because those benefits are easier and more convenient to redeem than checks, especially for participants who may not have bank accounts.

Focus group participants will be given an incentive of \$50 gift-card when they attend the focus group. The burden on focus group participants is much greater than on CATI respondents: in addition to each focus group taking two hours, participants must leave their homes, travel to another site, perhaps employ child-minders. In addition, the focus group setting consists of intense interactions that may be burdensome.

## **10. Confidentiality**

ASPE has embedded protections for privacy and confidentiality in the study design. The information collection will fully comply with all respects of the Privacy Act. Individuals and agencies will be assured of the privacy of their replies under Section 934(c) of the Public Health Service Act, 42 USC 299c-3(c). All participants, survey or qualitative focus groups, will be told in the advance letter and again during the interview that data they provide will be treated in a confidential manner, unless otherwise compelled by law. They also will be informed that participation is voluntary, that they may refuse to answer any question, and can stop the interview at any time without any risk to their participation in the CHIP or Medicaid programs.

The preferred method for obtaining **survey consent** is to read the specific ‘your rights as a participant’ text as part of the CATI survey’s gaining cooperation for participation. The interviewer will read the rights and record the sample member’s response to each in the CATI survey. The four elements of consent are: the sample member understands the nature of the survey (subject matter, duration), the privacy of the information he or she provides as well as his/her identity, the voluntary nature of participation, and any benefits, risks, or discomfort involved. Consent procedures are included in Attachment H Respondent Materials.

As part of focus group recruiting, potential participants will be sent information about the focus group. The elements of consent will be explained in this document. When participants arrive at the focus group location, they will be given a paper consent form to be read, signed, and returned to the

moderator. The focus group moderator will answer any questions posed by the participants about consent or privacy. See Attachment I for the focus group consent form.

Additional confidentiality assurances to survey sample members or focus group participants can be added as needed, such as identifying information and will be kept separate from data; data will be reported only in aggregate form; only authorized users will have access to the data; and information gathered for this study will be made available only to researchers authorized to work on the study. Finally, respondents will be informed that all contractor employees sign a pledge to protect the confidentiality of data and respondent identity, and breaking that pledge is grounds for immediate dismissal and possible legal action. Attachment J contains a copy of the contractor's confidentiality pledge. Attachment K contains a copy of the consent text to be added to the email invitation to potential site visit participants.

Finally, ASPE is seeking Institutional Review Board (IRB) clearance from Public/Private Ventures (P/PV) in Philadelphia, PA. Conditional approval was received in September 2011, and final approval is expected by the end of October 2011.

## **12. Burden Estimate (Total Hours & Wages)**

ASPE estimates the following burden hours based on budgeted length of interview, site visit interview, or focus group. ASPE conducted a pretest of the survey instrument and made revisions based on the results (the pretest report is attached to Supporting Statement Part B as Attachment J). The final instrument averaged 35 minutes per complete. Note that there is only one survey instrument that covers both the parents/guardians of CHIP sample members and the parents/guardians of Medicaid sample members. The questionnaire wording reflects the sample members' statuses relative to CHIP or Medicaid; there are fewer than a handful of questions specific to only CHIP or Medicaid.

CHIP OMB Supporting Statement Part A

**Table 2. Estimated Annualized Burden Hours**

Type of Respondent	Forms	Number of Respondents	Number of Responses per Respondent	Average Burden Per Response (in hours)	Total Burden Hours
CHIP Enrollees and Disenrollees	Survey of CHIP Enrollees and Disenrollees (Attachment B)	19,500	1	30/60	9,750
CHIP and Medicaid Personnel	Site Visits (Attachments C1 - C4)	300	1	1	300
Parents and Other Family Members of Children ( 3 focus groups per state = 30 focus groups total)	Focus Groups (Attachments D1 - D4)	240	1	2	480
<b>Total Burden</b>					<b>10,530</b>

ASPE used the Department of Labor website to determine the annualized cost to respondents and displays these figures in the Table 3 below.

**Table 3. Estimated annualized cost to Respondents for the Hours Burden**

Type of Respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
CHIP/ Medicaid Enrollees and Disenrollees	9,750	\$11.76	\$114,660
CHIP and Medicaid Personnel	300	\$43.96	\$13,188
Parents and Other Family Members of Children	480	\$16.27	\$78,096
<b>Total</b>	<b>10,530</b>	<b>--</b>	<b>\$205,944</b>

We calculated the average wage for CHIP enrollees as \$16.27, the published Bureau of Labor Statistics (BLS)'s<sup>3</sup> median hourly rate over all occupations. We calculated the average wage for Medicaid enrollees as \$7.25, BLS's minimum wage. We took the average of the two wages to come up with an estimate for the hourly wage for this respondent group (\$11.76). We calculated the CHIP and Medicaid personnel as \$43.96, BLS's median hourly wage for management occupations. Focus groups will be conducted with CHIP enrollees/disenrollees at an average wage rate of \$15.95.

### **13. Capital Costs (Maintenance of Capital Costs)**

There is no capital and start up cost to respondents associated with this data collection.

### **14. Cost to Federal Government**

The evaluation will take place over a three year period. The total cost of the evaluation to the government is \$9,076,450. ASPE determined the annualized cost to be \$3,025,483 per year by dividing the total funded amount by three years. The total evaluation cost was based on the contractor's budget that calculated wages and hours for all staff, all mailing costs, telephone charges, and overhead costs per contract year.

In addition to the evaluation costs, there are personnel costs of several Federal employees involved in the oversight and analysis of information collection that amount to an annualized cost of \$36,600 for Federal labor. The total annualized cost for the evaluation is therefore the sum of the annual contracted evaluation cost (\$3,025,483) and the annual Federal labor cost (\$36,600), or a total of \$3,062,083 per year.

### **15. Program or Burden Changes**

This is a new data collection.

### **16. Publication and Tabulation Dates**

While the evaluation consists of more than a dozen tasks, it is more easily thought of as a set of five coordinated components with findings that will be integrated to address a large number of overlapping research questions:

1. The most ambitious component involves the design, administration, and analysis of data from a major **survey of CHIP enrollees and disenrollees** to be conducted in 10 carefully chosen states. Administered to the parents or guardians of children with current or

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<sup>3</sup> May 2010 National Occupational Employment and Wage Estimates, United States. Electronically published by the Department of Labor, Bureau of Labor Statistics, as Occupational Employment Statistics.

recent CHIP coverage, the study will address questions that cannot be examined satisfactorily from existing data. The survey will provide a critical source of information on the demographic and socioeconomic characteristics of CHIP children and their families; perceptions of and experiences with application and renewal processes; the health status and health care needs of CHIP enrollees; enrollee experiences with accessing health care; and satisfaction with the program. A complementary **survey of Medicaid enrollees**, administered in 3 of the 10 CHIP survey states, will extend findings on these and other questions to the children and families enrolled in Medicaid.

2. A second major component involves the design, execution, and analysis of qualitative data from **CHIP case studies** in the same 10 states selected for the survey. Featuring **site visits** to various state and local stakeholders (such as program administrators, providers, and child advocates) and **focus groups** with families of CHIP-enrolled children, these studies likewise will address many questions that cannot be explored well through existing data. Examples include understanding perceptions of CHIP in the selected states, the barriers eligible families may experience when enrolling in the program or accessing health care, the extent to which CHIPRA has changed the programs' design or administration, and the likely ramifications of health care reform.
3. The last component to feature primary data is a **survey of CHIP program administrators** conducted in all 50 states and the District of Columbia; this component also involves the design, execution, and analysis of data. Reprising a similar survey conducted as part of the original CHIP evaluation, the survey of program administrators will focus on providing context for many of the questions examined through the case studies, helping us to interpret findings in a national perspective.
4. The fourth component will make use of **state program data**—CHIP annual reports and related data submitted by states, as well as administrative data from state eligibility and enrollment systems—to analyze enrollment and retention trends and dynamics and identify program features and other factors influencing these outcomes. We will explore enrollment and retention trends, including transitions between CHIP and other coverage and trends in churning out of and into the program. Using information from the case studies and other program documents, we will investigate how state-specific factors, such as innovative outreach practices and enrollment and retention policies, affect the rates and patterns observed in these data.
5. Drawing on data from several **national surveys** (the NSCH module of the State and Local Area Integrated Telephone Survey [SLAITS], CPS, and ACS), we will estimate program participation rates, explore

how low-income families with uninsured children perceive CHIP and Medicaid, and determine the implications of health reform provisions for the larger population of families with uninsured children.

Each of these components will yield findings that will be captured in **source-specific reports** released over the course of the evaluation. Despite their seeming independence, however, the design and execution of the different components will be closely coordinated. For example, we will coordinate instrument development for the stakeholder interviews conducted as part of the case studies with the discussion guide for the CHIP survey of program administrators to ensure that we address common research questions as completely and consistently as possible. Likewise, we will coordinate the instrument development for the CHIP survey with the moderator guides for the focus groups. Moreover, the findings from the source-specific reports will be synthesized into two major reports. The first will be a **2011 evaluation report** that will include findings from the analysis of state program reports and other secondary data. This report will be submitted to Congress in December 2011. The more comprehensive **2013 evaluation report** will integrate findings and lessons from all of the study components to address the full range of research questions effectively. Submission of this report to Congress is schedule for June 2013. Details regarding the contents of these reports (and any alternatives to the source-specific reports we may want to consider) will be discussed and refined during the first year of the evaluation.

### **17.Expiration Date**

The OMB number and expiration date will be displayed on every document seen by a sample member. Interviewers will be able to access the OMB number and expiration date at any point in the survey.

### **18.Certification Statement**

No exceptions are being sought.



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