

**Children's Health Insurance  
Program Reauthorization Act  
(CHIPRA) Express Lane Eligibility  
(ELE)**

**Supporting Statement Part B:  
Data Collection Procedures  
and Statistical Methods**

Final

April 6, 2012

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## **BACKGROUND**

As part of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Congress authorized a new policy known as Express Lane Eligibility (ELE). With ELE, a state's Medicaid and Children's Health Insurance Program (CHIP) can use another agency's eligibility findings to help children qualify for Medicaid or CHIP health coverage, despite these programs' different methods of determining eligibility. As part of the Reauthorization Act, Congress also mandated an extensive, rigorous evaluation of ELE, creating an exceptional opportunity to document ELE implementation across states and to assess the changes to coverage or administrative costs that may have resulted. The evaluation also provides an opportunity to examine other methods of simplified enrollment that states have been pursuing and to assess the benefits and potential costs of these methods compared to those of ELE. These other methods are referred to as "non-ELE" in this submission. The Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (HHS), will conduct this evaluation and report its findings to Congress.

Attachment M is the Final Design Report submitted to ASPE by the contractors on January 13, 2012.

### **B. Supporting Statement**

#### **1. Respondent Universe and Sampling Methods**

Congress specified that statistically valid samples should be obtained for the portion of the ELE evaluation that is *excluded* from this study: determining the percentage of children erroneously enrolled in Medicaid or CHIP as a result of reliance on findings of an Express Lane partner agency. Based on our understanding of CMS' instructions to States about the use of Express Lane Eligibility (which can be found here [http://www.insurekidsnow.gov/professionals/federal/express\\_lane.pdf](http://www.insurekidsnow.gov/professionals/federal/express_lane.pdf)), instructions on how states are to calculate these rates will be forthcoming through regulations, but to our knowledge have not been issued yet.

ASPE will not use statistical methods to establish respondent universes or to sample any informants from whom information will be collected for this ELE evaluation. As described below, the cost and enrollment studies and the 51-state survey are not based on samples but will focus on the entire program universe; thus there is no concern in these data collections about obtaining a statistically valid sample. The case studies (including site visits and focus groups) will gather in-depth information and insights from a variety of stakeholders at both state and local level organizations in a range of sizes, and will include focus groups with parents either enrolled/renewed through ELE method or in non-ELE states, through the simplification of interest in the state. The 30 state quarterly calls will gather information on

enrollment and retention simplifications in 30 states from key informants, and will be collected five times over the course of the study.

The qualitative findings from the quarterly calls, site visits, and focus groups will provide a critical complement to the quantitative components of this evaluation, allowing for a more nuanced understanding of state experiences as well as the opportunity to explore the strengths, weaknesses, and effects of varied state contexts and alternative approaches to ensuring children's coverage. Qualitative methods of data collection provide textured and nuanced findings that other research methods are unable to capture, however, certain challenges are inherent to this method of inquiry. Most notably, sample size is a limitation that will impact the generalizability of the evidence gathered through interviews and focus groups. By their nature, key informant interviews and focus groups obtain information from a relatively small number of individuals and thus cannot be presumed to represent the entire population of interest. *For key informant interviews*, we will work closely with well-known contacts at the state and local level to identify persons and organizations that hold the greatest promise for providing us with exposure to a broad and representative range of stakeholders, but we acknowledge that we may inadvertently miss important individuals and/or perspectives. *With regards to focus groups*, we will ask participating states to provide two randomly generated lists of families whose child was enrolled or retained through the ELE/non-ELE path in the past six months. Each list shall pertain to a zip code (either near the capital or near the secondary site the team will visit). Recruiters will invite potential participants to take part by phone using a focus group script that has been approved by an Institutional Review Board. Because we are focusing on parents living near certain localities that we are visiting, the participants in the focus groups may not be representative of all experiences of enrolling or renewing through the ELE/non-ELE path in the state, thus they may not be representative of families as a whole. Still, our qualitative approach will allow us to obtain a broad picture of the ELE/non-ELE path of interest and its impacts on families across each state and in selected localities which can be used to supplement and help interpret the quantitative findings (which are representative of the entire population).

Below, we discuss in detail all five methods of qualitative data collection.

**a. Administrative Cost Data Collection in Non-ELE States**

As part of the case studies in the six non-ELE states, ASPE will work with Medicaid and CHIP program directors to identify key informants to participate in a discussion of their state's best financial estimates of the costs incurred to establish non-ELE enrollment mechanisms and the savings that have occurred by abbreviating or omitting steps in the traditional enrollment process. Because we want to calculate the savings and not have the states estimate the savings, we are asking questions that permit us to make these calculations. For example, in Supporting Statement A, Attachment B, Item

C.3, we ask states to report both the days to process a new application through the ELE or other simplified route [for the non-ELE states] and days to process an application through the state’s “standard” application route; this permits us to do the cost/savings calculation. Given we later ask them for wages for involved staff, we can put a dollar amount on savings or costs for implementing ELE or non-ELE simplifications.

Studying the program costs for alternate approaches to simplifying enrollment will enable us to examine administrative costs per child. The value added of this approach is to compare the findings for each of the non-ELE states with those documented in ELE states, providing a point of comparison regarding the relative costs and benefits of ELE versus alternate, non-ELE, approaches to simplifying enrollment a state might consider. This portion of the study will specifically answer the research questions, what other approaches or processes do states have in place to identify potentially eligible children, and streamline eligibility and enrollment for Medicaid, CHIP, and other publicly subsidized health insurance programs? How do they compare to ELE? We will seek administrative cost data parallel to those acquired for ELE states during the first year of the evaluation.

#### **b. Enrollment Data Collection in Non-ELE States**

ASPE will work with Medicaid and CHIP program directors to identify state-level computer programmers to extract data required to populate aggregate table shells provided by the study team. Requested data will include aggregate monthly non-ELE enrollments and traditional enrollments for children who primarily qualify for Medicaid or CHIP on the basis of income (rather than disability, foster care status, and so on), demographic characteristics including the child’s age, race/ethnicity, primary language, citizenship status, household income, and urban/rural status), past enrollment records for a period of prior public coverage in Medicaid or CHIP, to help address whether non--ELE enrollees are truly new to the system and how recently they might have had contact and information on disenrollments and reenrollments. This portion of the study will specifically address the research questions, what other approaches or processes do states have in place to identify potentially eligible children, and streamline eligibility and enrollment for Medicaid, CHIP, and other publicly subsidized health insurance programs? How do they compare to ELE?

#### **c. Case Studies in ELE or Non-ELE States**

The case studies are designed to help answer three key research questions:

- What ELE practices proved most effective in enrolling and retaining children in Medicaid and CHIP? What barriers to enrollment and retention remain in these states?

- What other approaches or processes do states have in place to identify potentially eligible children, and streamline eligibility and enrollment for Medicaid, CHIP, and other publicly subsidized health insurance programs? How do they compare to ELE?
- What are best practices for implementing outreach and streamlined enrollment programs and activities to facilitate identification and enrollment of eligible children into Medicaid and CHIP?

**In ELE states:** The case studies in the ELE states will be conducted over three days to examine and report on each state's eligibility and enrollment processes for Medicaid and CHIP; the factors that influence state policy choices in this area; and the ways in which ELE fits into overall strategies for identifying, enrolling, and retaining eligible but uninsured children in coverage. By examining states' experiences in implementing diverse ELE programs and exploring whether and how ELE processes improve states' ability to reach uninsured children, ASPE will generate unique findings that add richness and context to the evaluation's quantitative findings. The sample for the case studies and focus groups will consist of eight states with federally approved state plan amendments as of June 2011: Alabama, Georgia, Iowa, Louisiana, Maryland, New Jersey, Oregon, and South Carolina. These states were selected because at the time this contract was awarded, they were the only states with approved ELE programs in place. Colorado has subsequently been approved (in Spring 2012) for ELE by CMS. At this time, we are reluctant to replace one of the non-ELE states with Colorado, although this is a possibility. We are in discussions with CMS about the value of this approach; there are considerations, such as "losing" a non-ELE simplification for study, as well as the fact that Colorado's program while promising, has currently been limited in its implementation because of data and participation issues (they are partnering with the National School Lunch Program, and only 24 or 176 school districts are participating).

**In non-ELE states:** ASPE will visit case study sites in six states that do not use ELE but that have implemented other simplified policies or practices to enroll or renew children's enrollment in public coverage. These states will be selected based on the criteria outlined below (next paragraph). Site visits will entail an interview with state and local key informants as well as two focus groups in four of the states, with respondents drawn from families of children who have enrolled through the non-ELE pathway. In selecting non-ELE states, we will seek examples of Medicaid or CHIP program simplifications that offer easier enrollment or renewal for children. We have already identified many examples worthy of study, including presumptive eligibility, online renewal, ex parte renewal, the use of electronic signature and/or no paperwork requirements for online applications.

Because ASPE is seeking viable alternatives to ELE that help states enroll children and keep them enrolled, we will select states with a particular intervention for study. However, we will also balance the sample across other

relevant dimensions. These will include outcome variables such as enrollment rates in public coverage; rates of low-income, uninsured children; census region; the quality of state data systems; the state's receipt of a 2011 CHIPRA bonus payment; and the state's participation in another major study (to avoid over studying states and to reduce the burden on state officials). Using these variables, garnered from the Census as well as other publicly available data, we will prioritize the interventions of greatest interest based on which simplifications make it easiest for families to enroll their children and keep them enrolled. We will then identify which non-ELE states, of the 43 states without an approved ELE program as of July 2011, have one or more of these interventions in place. We will recommend states for this study based on these interventions as well as the other criteria of interest (for example, rather than selecting 6 states within one or two census regions, we will seek to ensure that all census regions are represented; likewise, we will attempt to select states with variation in the number of uninsured but eligible children). Because these states will be in the administrative cost and enrollment study (see Section B.1.a and B.1.b above), we also need states with strong data systems. At the same time, we will recommend back-up states should the initially selected non-ELE states decline participation. We have developed a shortlist of recommended states that vary along the dimensions of interest, and we are in discussions with key CMS staff as to the advantages and disadvantages of given states; for example, as discussed above, we are consulting with CMS about replacing one of the non-ELE states with Colorado, a newer ELE implementation states.

**i. Key Informant Interviews in ELE and Non-ELE Case Study States**

During the three-day site visits, we will conduct key informant interviews with an average of 15 people in each ELE and non-ELE state (210 interviews total). As noted in the introduction, we will work closely with well known state officials to identify the right respondents in each state. First, the teams will interview state officials who are knowledgeable about CHIP and Medicaid program design, implementation, and monitoring, including program directors, policymakers, and child health advocates. Next, the team will interview local key informants such as 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 in outreach. In our response to Question B2, we describe how key informants will be selected and recruited.

During the interviews, ASPE will inquire about Medicaid and CHIP program features, the ELE/non-ELE policy development and implementation process, outcomes of ELE/non-ELE policies, views on ELE, the potential of ELE to improve adult enrollment into Medicaid under health reform, lessons learned, and best practices.



## **ii. Focus Groups in ELE and Non-ELE States**

**Participant selection.** We will hold two focus groups in each ELE state, one in the capital and one at the local site. We will ask participating states to provide two randomly generated lists of families whose child was enrolled or retained through ELE in the past 6 to 10 months. Both focus groups will be held with parents of children who were enrolled or whose eligibility was renewed via ELE programs. The parents will be asked about how they learned of their child's eligibility, how they consented to enrollment, what benefits they thought coverage would offer, whether they were able to access services, and how they renewed their children's eligibility.

In four of the six non-ELE states, we will hold two focus groups with families of children who have recently enrolled in public insurance through a non-ELE pathway (eight focus groups total). Similar to the ELE states, the non-ELE focus groups will include families whose children have enrolled or renewed through the non-ELE pathway of interest within the past 6 to 10 months, and participants will be recruited in the same manner (discussed below). After the six non-ELE states are selected, we will recommend four states that, based on the state-selection evidence, employ outreach or enrollment interventions that might be easily replicated or could be used to easily enroll large numbers of children (or adults beginning in 2014). We will only select states for which families can be identified in state records. Participants will be identified in the same manner as the ELE states (from state provided administrative records).

**Recruitment of focus group respondents.** We will enlist the help of Medicaid and CHIP agencies to recruit potential participants. We will work with the state and its partners, as appropriate, to identify families to recruit. For all groups, we will target families whose children were newly enrolled or had renewed through the ELE/non-ELE pathway of interest within the prior 6 to 10 months. This will provide relevant information about how families were identified for enrollment, why they enrolled, what benefits of coverage they perceived, whether they had accessed services, and if and how they renewed their children's eligibility. We will ask participating states to provide two randomly generated lists of families whose child was enrolled or retained through the ELE/non-ELE path in the past six months. Each list shall pertain to a zip code (either near the capital or near the secondary site the team will visit). Recruiters will invite potential participants to take part by phone using a focus group script that has been approved by an Institutional Review Board.

## **d. 51-State Survey**

We will conduct a survey of Medicaid and CHIP program directors in all 50 states and the District of Columbia. The purpose of the 51-state survey is to conduct a census survey of CHIP and Medicaid program administrators in all 50 states and the District of Columbia about specific state policies related to

enrolling and retaining low-income children in the Medicaid or CHIP programs. It will provide the first comprehensive catalogue of all states' (1) outreach methods (for example, by mass media, direct marketing, use of community partners, use of participating health plans to do outreach, among others), (2) use of third party data to identify potentially eligible children (and if so, which third party data is used, challenges using that data, etc.), (3) outreach strategies likely to be employed in Medicaid in 2014 for the adult expansion population and collect data on reasons why those outreach strategies have been selected, (4) simplification strategies used for enrollment and (separately) for retention, separately in Medicaid and in CHIP, as well as document each state's use of simplifications in processing steps at application and renewal, and will ask about the impact of those simplifications on increasing enrollment and improving administrative efficiency of cost savings, if those aspects have been assessed by the state, and (5) status of Express Lane plan amendments (approved, implemented, under review, etc.) and documenting reasons why states have or have not applied for approval to undertake ELE.

**51-state survey data collection.** We will conduct the survey electronically, using an online instrument running on a Dataweb platform. The survey will include questions with multiple-choice response options; branched questions (for example, depending on his or her answers, the respondent will be directed to particular follow-up questions); and an opportunity for the respondent to provide additional information, including statistics, in a comment box for each question. The breadth of information gathered might necessitate completing the survey in multiple sessions or by multiple respondents within a state agency; we will therefore structure the survey so that it can be saved and completed at a later time.

#### **e. 30-State Quarterly Monitoring Calls**

The purpose of the quarterly monitoring task is (1) to provide policymakers with up-to-date information on the state policy context in 30 states regarding CHIP and Medicaid existing and planned enrollment and retention simplifications, (2) to understand state reported implications of those policies on enrollment and costs (if known), and (3) to understand challenges and successes related to states' policy decisions about enrollment and/or retention simplifications. This information will be gathered through ongoing document review of published information as well as through quarterly interviews with a key policy official in 30 states (the 30 states will exclude the 14 case study states, to minimize burden for the states participating). The data collected through this task will enable the evaluation team (1) to understand and assess ongoing policy developments, (2) to fill in knowledge gaps about simplification approaches, challenges, and successes, (3) to identify state trends in enrollment and retention policies, and (4) to inform the recommendations for legislative or administrative changes that would improve the effectiveness of enrolling children through

the reliance on findings of ELE partner agencies that Congress identified in the CHIPRA legislation that authorized ELE (P.L. 111-3 Page 123 STAT. 47].

**State selection.** ASPE will identify 30 states for monitoring and tracking key activities related to enrolling children in publicly subsidized health insurance programs. Members of the Technical Assistance Group (TAG) made several recommendations for selecting a diverse group of states. The design is to:

- Select a mix of states that are highly and minimally active in pursuing simplifications
- Select a mix of states with high and low numbers of uninsured children
- Select states already participating in other studies, which could facilitate low-cost access to data
- Selected states will not be among the 14 states participating in the case studies. We will thus select the 30 states from among the 37 states not in the case studies.

The second item (numbers of uninsured children) comes from the Census, but the rest of these items derive from a variety of other sources, such as the Kaiser Family Foundation, Center on Budget and Policy Priorities, and information internal to our contractors, Mathematica, Urban Institute, and HMA about which states are participating in other large studies. Table B1 below shows the expected sample sizes each of the respondent groups in this evaluation.

**Table B1. Universe of Sample Members**

Universe of Sample Members	Respondent	Sample Numbers
<b>Administrative Data in Non-ELE States</b>	Key informants	18
<b>Enrollment Data in Non-ELE States</b>	State-level computer programmers	6
<b>Case Studies</b>		<b>210</b>
ELE states	State and local key informants	120
Non-ELE states		90
<b>Focus Groups</b>		<b>240</b>
ELE states (2 groups x 8 states x 10 respondents)	ELE states: parents of children who enrolled or renewed coverage through ELE	160
Non-ELE states (2 groups x 4 states x 10 respondents)	Non-ELE states: the non-ELE pathway of interest	80
<b>51-State Survey</b>	Medicaid and CHIP program directors	<b>68<sup>a</sup></b>
<b>30-State Quarterly Monitoring Calls</b>	Key informants	<b>30</b>

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Note: All states will participate in the 51-state survey, but the other categories (case studies, 30-state quarterly monitoring calls) will be mutually exclusive.

<sup>a</sup>The 68 respondents include 2 respondents in 17 states where there is a separate Medicaid and separate CHIP program director to interview (for a total of 34 respondents) and another 34 respondents in states with a single (combined) Medicaid and CHIP director.

**2. Procedures for the Collection of Information**

Table B2 displays how the data will be collected.

**Table B2. Data Collection Methods**

	Statistical Method for Stratification and Sample Selection	Estimation Procedures	Degree of Accuracy Needed for the Purpose Described in the Justification	Unusual Problems Requiring Specialized Sampling Procedures	Less Frequent Than Annual Data Collection	Data Collection Method
Administrative Cost Data Collection in 6 Non-ELE States	n.a. (State will provide data on entire population, no sample needed)	n.a.	Accuracy required to understand what the administrative cost differences of simplifications are within the state as well as to compare them to ELE state costs	n.a.	Only collected once	Telephone interview or on site interview as part of case study to understand administrative costs using administrative cost discussion guide.
Enrollment Data Collection in 6 Non-ELE States	n.a. (State will provide data on entire population, no sample needed)	n.a.	Accuracy required to understand what the enrollment differences of simplifications are within the state as well as to compare them to ELE enrollment	n.a.	Only collected once	Excel spreadsheets will be provided to state officials to be completed by state programmer.
<b>Case Studies</b>						
ELE states Non-ELE states	n.a.	n.a.	n.a.	n.a.	Only collected once	Key informants will be identified by speaking with Medicaid and CHIP officials and soliciting their recommendations on key informants in various categories (who are the most well-informed state officials, advocates, state legislators, etc.)
<b>Focus Groups</b>						
ELE states (2 groups x 8 states x 10 respondents)	Sample members from a random state-	n.a.	Accuracy of state data files on who entered through the ELE/non-ELE	None	Only collected once	We will ask participating states to provide two randomly

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	Statistical Method for Stratification and Sample Selection	Estimation Procedures	Degree of Accuracy Needed for the Purpose Described in the Justification	Unusual Problems Requiring Specialized Sampling Procedures	Less Frequent Than Annual Data Collection	Data Collection Method
	provided sample of those who enrolled or renewed in the past six months through the ELE/non-ELE pathway		pathway critical for identifying appropriate participants			generated lists of families whose child was enrolled or retained through the ELE/non-ELE path in the past six months. Each list shall pertain to a zip code (either near the capital or near the secondary site the team will visit). Recruiters will invite potential participants to take part. In the focus groups, trained focus group leaders will lead a discussion based on the guide.
<b>51-State Survey</b>	All Medicaid and CHIP directors in all 50 states and the District of Columbia	n.a.	Accuracy needed so that most correct state data collected	None	Only collected once	Online survey; participants will be identified through existing databases Health Management Associates (HMA) maintains on Medicaid and CHIP directors. These key informants will be invited to participate through email and will complete the interview either online or via a Word document that they can email or fax back.
<b>30-State Quarterly Monitoring Calls</b>	Respondents will be key state officials identified by Medicaid and CHIP officials as informed about states' outreach, enrollment, and retention issues	n.a.	Accuracy is needed to collect the most reliable state data	None	No; collected five times over 13 months	Via telephone interviews, for up to five quarters. The first call will last about one hour; subsequent calls will last about 15 minutes.

**Data collection and quality assurance.** Most of the data collected through this study will be qualitative, obtained through site visits and focus groups in 14 states. Qualitative studies tend to focus on complex topics that are not adequately addressed by existing data and metrics. As discussed above, we are aware that qualitative methods of data collection provide textured and nuanced findings that other research methods are unable to capture, however, certain challenges are inherent to this method of inquiry; most notably, sample size is a limitation that will impact the generalizability of the evidence gathered through interviews and focus groups. By their nature, key informant interviews and focus groups obtain information from a relatively small number of individuals and thus cannot be presumed to represent the entire population of interest. However, they are critical to provide the contextual information needed to interpret the quantitative findings.

The study team will use a number of procedures to ensure that data collection methods are consistent and that the data are secure and of high quality, yielding convincing, credible, and actionable results that will be widely accepted. This begins with a data collection plan for each instrument to be used. Quality assurance reviewers will ensure that the data collection plans and attendant instruments (1) cover the range of pertinent data; (2) include all relevant perspectives; (3) are operational given project resources and time constraints; (4) are appropriate tools to enhance the completeness, consistency, and reliability of data; (5) include sufficient detail on how data collection techniques will be implemented and what form of training will be provided to interviewers; (6) include a plan to process the data (for example, developing consistent write-ups of interviews across site visitors, sites, and interviewees); and (7) address any unique cultural or linguistic requirements, particularly for interviews or focus groups.

### **3. Methods of Maximizing Response Rates and Handling Nonresponse**

#### **a. Administrative Cost and Enrollment Data Collections**

Payments to states are included in our design and were intended to give states some incentive to participate, but mostly to make states “whole” for participating in this project: that is, the payments are intended to reimburse states fairly for costs incurred to participate in the costs and enrollment portion of the study, including participating in interviews, collecting data, spending programmer time to complete required enrollment tabulations, etc. ASPE initially budgeted \$100,000 per state for participation in the enrollment and administrative costs data collection aspects of the study. Upon further consideration, we realized that this level of compensation might be excessive, based on our review of prior similar data collection efforts. Therefore, we worked to estimate the number of hours for various staff levels that would be required to complete each data collection effort, and to

translate those hours into dollar amounts based on our experience working with states on similar data collection efforts.

We therefore propose to reimburse states as follows:

- \$5,000 for participating once in the program costs data study. This reimbursement covers the following tasks: describing standard enrollment processes and associated costs in detail; describing non-ELE path of interest enrollment processes and costs in detail; start-up costs associated with non-ELE path of interest; and the differences in time and direct expenditures associated with a non-ELE path of interest application compared with standard application processes. The State also will review the Research Team's summary of enrollment process changes and associated costs and savings, based on the above consultations, and to provide any comments and data that are otherwise missing from the summary. Staff whose input might be requested include those working in policy, eligibility, information technology, and human resources.
- \$30,000 for participating once in the enrollment study. This reimbursement covers the following tasks: providing aggregate monthly non-ELE enrollments and traditional enrollments for children who primarily qualify for Medicaid or CHIP on the basis of income (rather than disability, foster care status, and so on), demographic characteristics including the child's age, race/ethnicity, primary language, citizenship status, household income, and urban/rural status), past enrollment records for a period of prior public coverage in Medicaid or CHIP, all in Microsoft Excel file formats (table shells are in Attachment C of Supporting Statement A).
- In the event the state can document additional costs beyond the total of \$35,000, ASPE can make additional funds available to reimburse for the time and resources expended on the cost and enrollment studies.

We will develop a list of back-up states that meet the key criteria in case a selected state declines to participate in the study.

#### **b. Case Studies: Site Visits, Key Informant Interviews, and Focus Groups**

Our methods of collecting data via case studies are entirely qualitative and do not involve calculation of response rates. The staff recruiting key informants for the site visits and participants for the focus groups will use carefully scripted recruiting methods, however, and work closely with local groups to recruit participants. Before visiting a site, we will ask CHIP and Medicaid directors to help identify key informants and to support ASPE's efforts to gain their cooperation for the interviews. For focus groups (see

Table B2), recruitment will be done by working with the state to identify in its administrative data new or renewing children who come in through an ELE or non-ELE route and recruiting participants from that administrative data. From these focus group lists, we will identify potential participants who meet the initial criteria enrolled or renewed through an ELE or non-ELE route. We will then conduct calls with them to ascertain their interest in participating. We expect roughly 15 of the eligible participants to agree to participate and 10 to actually attend the focus groups.

As an incentive to attend focus groups, we have allocated \$50 gift card as a respondent payment for each focus group participant. This amount was based on our recent experience recruiting for focus groups in both federally-sponsored and non-federal projects over the last two years with a similar population (parents with a child enrolled in Medicaid or CHIP), similar focus group length (90 to 120 minutes), and similar type of information collected (experiences with coverage, application, enrollment, retention, etc.). This experience indicates that (given the costs of travel and child care a participant must invest, as well as spending 90 to 120 minutes at the group, a \$50 payment level is needed to provide enough incentive to participants to attend.

If the expected 10 participants attend the focus group for which they were recruited, the project would incur \$12,000 in respondent payments (12 states x 10 participants per group x 2 groups x \$50). Given that Congress allocated \$5 million for the evaluation of ELE, and that this aspect of the study is the only one that will bring in family voices, we believe the cost is minimal compared to the contribution families' insights will bring to the study.

### **c. 51-State Survey of CHIP and Medicaid Directors**

To optimize state participation, we will send a personalized letter to each state Medicaid and CHIP director by email, explaining the purpose of the survey and the manner in which findings will be used. (We can send a hard copy as well if OMB requires, but our experience indicates that email is sufficient.) The email will include a web link to the instrument and our contact information in case the respondent has questions. We will monitor the response site regularly and will send at least two follow-up emails to nonrespondents during the field period. The survey instrument will remain live for four weeks after we send the second reminder email. It is possible, if we have to make reminder calls to respondents, that we will keep the site live for a slightly longer period to increase response rates. Our experience with similar surveys indicates that this will likely be the case, and we have planned for this contingency. HMA is conducting this work, and they administer several annual 51-state surveys of Medicaid and CHIP officials where they typically get 100 percent participation; based on their results and their state contacts, we are expecting 100 percent cooperation on this survey as well.



#### **d. 30-State Quarterly Monitoring**

We will recruit respondents who are well-informed and have the most accurate information about state policy, such as government officials who develop and implement enrollment and renewal policies. We also have a list of Medicaid and CHIP officials, which we will use as a starting point for identifying interviewees. Respondents will be informed at the outset that their participation will be required in up to five quarterly calls; if they cannot commit to that, we will find a back-up respondent in the state. Given that there may be some unavailability during each quarter, we expect a standard response rate of 80 percent across all quarters.

#### **4. Tests of Procedures or Methods to Be Undertaken**

Case study protocols and focus group protocols do not need to be pretested. They have been approved by an Institutional Review Board (see Attachment O). The 51-state survey has been pretested with three state Medicaid or CHIP program directors, and the 30-state quarterly interview guide was pretested with two closely matched respondents (these were also approved by the Institutional Review Board). These pretests occurred during the *Federal Register's* 60-day notice review period; results are found in Attachments N.1. and N.2.

#### **5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data**

##### **Individuals consulted on statistical aspects of the design:**

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