SUPPORTING STATEMENT

PART A

Evaluation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Demonstration Grant Program: Survey Data Collection

Version: July 26, 2013

Agency for Healthcare Research and Quality (AHRQ)

CONTENTS

SURVEY DATA COLLECTION

A. Justification

1. Circumstances That Make the Collection of Information Necessary

The mission of the Agency for Healthcare Research and Quality (AHRQ), set forth in its authorizing legislation, The Healthcare Research and Quality Act of 1999 (http://www.ahrq.gov/hrqa99.pdf), is to enhance the quality, appropriateness, and effectiveness of health services and access to such services through the establishment of a broad base of scientific research and the promotion of improvements in clinical and health systems practices, including the prevention of diseases and other health conditions. AHRQ shall promote health care quality improvement by conducting and supporting the following:

1. Research that develops and presents scientific evidence regarding all aspects of health care
2. The synthesis and dissemination of available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policymakers, and educators
3. Initiatives to advance private and public efforts to improve health care quality

Also, AHRQ shall conduct and support research and evaluations, and support demonstration projects, with respect to the delivery of health care in inner-city areas and rural areas (including frontier areas) and health care for priority populations, which shall include (1) low-income groups, (2) minority groups, (3) women, (4) children, (5) the elderly, and (6) individuals with special health care needs, including individuals with disabilities and individuals who need chronic care or end-of-life health care.

Section 401(a) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Pub. L. 111-3, amended the Social Security Act (the Act) to enact section 1139A (42 U.S.C. 1320b-9a). AHRQ is requesting approval from the Office of Management and Budget (OMB) for the collection of quantitative data through a survey of pediatricians and family medicine physicians to support a comprehensive, mixed-methods evaluation of the quality demonstration grants authorized under section 1139A(d) of the Act (Attachment A). AHRQ's mission of improving the quality and effectiveness of health care in the United States aligns with evaluating whether, and through what mechanism, projects funded by the CHIPRA demonstration grants improve the quality of care received by children in Medicaid and the Children's Health Insurance Program (CHIP).

CHIPRA included funding for five-year grants so that States can experiment with and evaluate several promising ideas related to improving the quality of children's health care in Medicaid and CHIP.[1] In February 2010, the U.S. Department of Health and Human Services announced the award of 10 demonstration grants to States that convincingly articulated an achievable vision of what they could accomplish by the end of the five-year grant period, described strategies they would use to achieve the objectives, and explained how the strategies would achieve the objectives. Applicants were encouraged by CMS to address multiple grant categories (described below) and to partner with other States in designing and implementing their projects.

Of the 10 grantee States selected, six are partnering with other States, for a total of 18 demonstration States. The demonstration States are: Colorado (partnering with New Mexico); Florida (with Illinois); Maine (with Vermont); Maryland (with Wyoming and Georgia); Massachusetts; North Carolina; Oregon (with Alaska and West Virginia); Pennsylvania; South Carolina; and Utah (with Idaho).

These demonstration States are implementing 51 distinct projects in at least one of five possible grant categories, A to E. Category A grantees are experimenting with and/or evaluating the use of pediatric quality measures, including those in the initial core set of children's health care quality measures (a group of measures developed for state Medicaid and CHIP agencies to report in a standardized fashion to CMS). Category B grantees are promoting health information technologies for improved care delivery and patient outcomes. Category C grantees are implementing person-centered medical homes or other provider-based levels of service delivery. Category D grantees will evaluate the impact of a model pediatric electronic health record. Category E grantees are testing other State-designed approaches to quality improvement in Medicaid and CHIP.

AHRQ's goal in supporting an evaluation of the CHIPRA Quality Demonstration Grant Program is to provide insight into how best to implement quality improvement programs as well as information on how successful programs can be replicated to improve children's health care quality in Medicaid and CHIP.[2] The specific goals of this project are as follows:

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[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Programs: Children's Health Insurance Program Reauthorization Act of 2009: Section 401(D). Invitation to Apply for FY2010 CHIPRA Quality Demonstration Grants. September 30, 2009, CFDA 93.767.

[2] Ibid.

1. Identify CHIPRA State activities that measurably improve the nation's health care, especially as it pertains to children.
2. Develop a deep, systematic understanding of how CHIPRA demonstration States carried out their grant-funded projects.
3. Understand why the CHIPRA demonstration States pursued certain strategies.
4. Understand whether and how the CHIPRA demonstration States' efforts affected outcomes related to knowledge and behavior change in targeted providers and/or consumers of health care.

To meet these goals AHRQ has designed a comprehensive evaluation that will make the best use of qualitative and quantitative research methods, including the following activities and data collections:

1. Medicaid and CHIP Enrollment and Claims Data – We are requesting statewide Medicaid and CHIP enrollment and claims data on all publicly-covered children and youth, ages 0-21, in select CHIPRA demonstration states. Claims from outpatient, inpatient, long term care, and pharmacy services will be used to create outcome measures of access, quality, and Medicaid expenditures. Claims will also be used for claims-based attribution of children to intervention and comparison practices. The enrollment files will provide a limited amount of basic information on child-level demographics as well as define the enrollment periods. The primary goal of the cross-state quantitative evaluation is to determine the impact of CHIPRA demonstration funding on the adoption or improvement of a medical home model of care or new health IT, and subsequently, on the access to care, quality of care, and health care expenditures among publicly-insured children. This activity does not impose a burden on the public, does not require OMB clearance and is not included in the burden estimates in Section 12.

2. Pediatrician and Family Physician Survey – This survey will include a random sample of physicians in Massachusetts, North Carolina, Ohio, and Pennsylvania. The questionnaire includes questions that support an analysis of (1) physician attitudes towards specific strategies and resources aimed at improving the quality of care provided to pediatric patients; (2) the extent to which physicians' practices have attempted to implement changes in order to improve the quality of care provided to pediatric patients; (3) physician attitudes towards the utility of receiving performance feedback on nine of measures in the core quality measure set

that are most relevant to primary care; (4) perceived usefulness of quality-of-care reports received by physician practices; (5) current practices and attitudes towards pay-for-performance financial incentive systems based on quality measure outcomes; (6) physicians' uses of and attitudes towards electronic health records (EHR) in quality measurement and improvement; (7) current and expected medical home accreditation processes; and (8) physician and practice demographic information. These data will be analyzed in conjunction with the CMS claims data described in #1 above to gain insight on physician perspectives on quality measures and quality reporting and foster understanding of the strategies and resources that seemed to contribute most (or least) to those outcomes. The questionnaire is included as Attachment B.

3. Key Staff Interviews –Key staff members are staff directly involved in the design and oversight of grant-funded activities. The purpose of these interviews is to gain insight into the implementation of demonstration projects, to understand contextual factors, and to identify lessons and implications for the broad application and sustainability of projects. We are conducting two rounds of semi-structured interviews with up to 4 key staff members per state. The first round was completed in 2012, and the second round will occur in 2014, pending OMB approval.

4. Implementation Staff Interviews – Other implementation staff are staff involved in the day-to-day implementation of grant-funded projects. These staff members include state agency employees, provider trainers or coaches, health IT vendors, and/or project consultants. The purpose of these interviews is to gain insight into the opportunities and challenges related to key technical aspects of project implementation. We are conducting two rounds of semi-structured interviews with up to 16 other implementation staff members per state. The first round was completed in 2012, and the second round will occur in 2014, pending OMB approval.

5. Stakeholder Interviews – External stakeholders have a direct interest in children's care quality in Medicaid and CHIP. Stakeholders include representatives of managed care organizations, state chapters of the American Academy of Pediatrics, advocacy organizations for children and families, and social service agencies. These stakeholders will be familiar with the CHIPRA projects and may serve on advisory panels or workgroups related to one or more projects. The interviews will gather insight into the opportunities and challenges related to project implementation, stakeholder satisfaction with their project involvement,

and contextual factors. We are conducting two rounds of semi-structured interviews with up to 8 external stakeholders per state. The first round was completed in 2012, and the second round will occur in 2014, pending OMB approval.

6. Health Care Provider Interviews –Depending on the projects a state is implementing, providers participating in demonstration activities can include clinicians from private practices, public clinics, federally qualified health centers, care management entities, or school based health centers. Interviews will capture information about project-related activities, providers' perceptions of the likelihood of achieving intended outcomes, and providers' involvement in other quality-improvement initiatives. We are conducting two rounds of semi-structured interviews with up to 12 providers per state. The first round was completed in 2012, and the second round will occur in 2014, pending OMB approval.

7. Parent Focus Groups – We will hold in-person focus groups with parents, guardians, or other caregivers of children who are enrolled in Medicaid or CHIP and are served by the physician practices involved in the CHIPRA demonstration. We will hold four focus groups in four states implementing patient centered medical home demonstrations. The number of participants per focus group will range from 8 to 10, resulting in a maximum of 160 adults participating. These focus groups will occur in 2014, pending OMB approval.

8. Adolescent Focus Groups – We will hold in-person focus groups with adolescents who are enrolled in Medicaid or CHIP and are served by school based health centers involved in the CHIPRA demonstration. We will hold four focus groups in one state implementing school based health center projects. The number of participants per focus group will range from 8 to 10, resulting in a maximum of 40 adolescents participating. These focus groups will occur in 2014, pending OMB approval.

The qualitative component of the evaluation is designed to develop a rich understanding of States' implementation activities (goal 2), document the rationale for the selection of particular strategies (goal 3), and support judicious interpretations about project implementation and how projects may or may not contribute to observed outcomes (if any). The first round of qualitative data collection for the project was previously approved by OMB (OMB Control No. 0935-0190).

The quantitative component of the evaluation is designed to measure any improvements in children's health care quality (goal 1) and outcomes related to knowledge and behavior change in targeted providers (goal 4) that grant-funded projects intend to affect. To do this, the evaluation will conduct secondary analyses of existing data from States' Medicaid and CHIP administrative and claims files and conduct a survey of physicians in selected demonstration States.

This information collection request seeks approval to conduct the pediatrician and family physician survey only. The remainder of this Supporting Statement, as well as the Supporting Statement Part B, pertains only to the pediatrician and family physician survey. A separate information collection request will be submitted for the interviews and focus groups. Administrative and survey data will be analyzed with descriptive and inferential techniques appropriate to answering questions about outcomes and impacts.

This study is being conducted by AHRQ through its contractor, Mathematica Policy Research Inc., and their subcontractors, the Urban Institute and AcademyHealth, pursuant to AHRQ's statutory authority to conduct and support research on health care and on systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness and value of healthcare services and with respect to quality measurement and improvement. 42 U.S.C. 299a(a)(1) and (2).

2. Purpose and Use of Information

The information collected through the pediatrician and family physician survey will be a key source of evidence for the cross-State evaluation of the demonstration. The CMS claims data and survey data will be analyzed with descriptive and inferential techniques appropriate to answering questions about outcomes and impacts. The survey will provide important information on attitudes about and experiences with pediatric health care quality measurement and improvement. These attitudes and experiences will provide important context for State efforts to improve children's health care through primary care providers and identify important potential barriers to wider implementation of proposed models. The findings from the survey will likely be included in issue briefs, case studies, and peer-reviewed journal articles.

3. Use of Improved Information Technology

The survey instrument will be administered primarily by mail. Physicians are busy professionals with many competing priorities. Mail survey administration offers the respondent the ability to complete the survey in parts at his or her convenience. In order to maximize response rates with a population that can be especially challenging to reach, physicians will be offered two alternative modes for survey completion—fax and telephone.

During follow-up efforts to reach nonresponders, the contractor will provide faxed copies of the questionnaire upon request. The faxed questionnaire will be a copy of the mail survey, which the respondent can fill out and return by fax, email (via scanning), or mail—whichever mode is least burdensome.

The contents of the survey instrument will be identical across each mode of survey administration. Survey items were mapped to the research questions forming the project's goals. This comparison enables identification of the survey items required to adequately address the research questions of interest and identifies any unnecessary items that can be deleted from the instruments. This procedure ensures the thoroughness of each instrument while collecting only the minimum information necessary for the project's purposes.

4. Efforts to Identify Duplication

The proposed survey is specifically designed as part of the evaluation of CHIPRA quality demonstration grant program. The evaluation of the CHIPRA quality demonstration grants and this survey do not duplicate any prior or concurrent evaluation efforts at the national level. CMS does allow grantees to engage contractors to conduct independent evaluations of the grant-funded projects in their States. Seven grantees (Colorado, Florida, Maine, Maryland, Massachusetts, South Carolina, and Utah) have allocated funds for independent, State-level evaluations. AHRQ's contractor is working closely with these State-based evaluators to coordinate data collection activities, avoid duplication, and ensure that the combined cross-State and State evaluations are more comprehensive than either would be alone. For example, South Carolina was removed from the physician survey sample to avoid duplication because there is an existing State-based survey of providers.

The survey instrument will be used to collect only evaluation information that is related to the demonstration activities and that cannot be obtained from other sources. Where possible, AHRQ will use all-payer databases and existing administrative data and secondary data sources, such as States' written progress reports to CMS and Medicaid and CHIP enrollment, claims, and encounter data, to address its research questions. For States with independent evaluation teams, sharing of data by the State-based evaluators with AHRQ's evaluation contractor will reduce duplication of efforts to access and prepare data sets.

5. Involvement of Small Entities

The evaluation may collect data from physicians in small private practices. Every effort will be made to administer the survey at the convenience of these respondents by offering multiple modes of survey completion. Based on pre-testing, surveys are estimated to take 15 minutes or less to complete. Furthermore, to gain a broad picture of participating physicians' perspectives, physicians will be distributed across multiple practices. In the large State-based sample of physicians, the likelihood of multiple physicians within a practice being selected to participate is small; thus, the overall burden on any one practice will be small. The information being requested will be held to the minimum required for the intended use.

6. Consequences if Information Is Collected Less Frequently

The survey will be administered at one point in time only—during the spring of 2014. If the survey data described in this document are not collected, AHRQ will not be able to gain physician perspectives on the value and utility of quality measurement, reporting, and health information technologies for improving quality care of children. Without these data, AHRQ will not have access to the data necessary to identify critical factors related to the value and utility of quality measures and quality-improvement initiatives. Further, without these data, AHRQ will not be able to provide feedback to demonstration States about effective strategies to work with the pediatric care providers.

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. Register Notice and Outside Consultations

a. Federal Register Notice

As required by 5 CFR 1320.8(d), notice was published in the Federal Register on May 31st, 2013 for 60 days, and again on August 14th, 2013 for 30 days. No comments were received. The Notice is included as Attachment F.

b. Outside Consultations

AHRQ consulted individuals outside the agency about the research and data collection activities for this evaluation. These individuals include the CMS personnel who oversee and monitor grant planning and implementation in the demonstration States: Barbara Dailey and Karen Llanos (CMS/CMCS). AHRQ also consults a 14-member technical expert panel on design, measurement, and analytical challenges. The full panel meets annually, and a subgroup of panel members has reviewed and commented on this sampling and data collection plan and earlier versions of the survey instrument.[3] There are no unresolved issues stemming from these consultations.

9. Payments/Gifts to Respondents

Physicians are a particularly challenging population to survey. Physicians have busy work schedules with many competing priorities. Office staff are often tasked with limiting access to the physician so that his or her time is available for patient-related needs. A 1997 meta-analysis of mail survey response rates found that response rates amongst physicians are 14 percent lower on average than mail surveys conducted with the general population.[4]

In order to encourage response and maximize response rates, the initial mailing to physicians will include a $5 bill as a token of thanks, in advance, for survey participation. Prepaid incentives are consistently found to increase survey response rates relative to offering no incentive or incentives promised upon completion, especially among physicians.[5] Monetary incentives are typically associated with higher rates of response relative to nonmonetary incentives.[6] A meta-analysis of 66 published surveys of physicians found that small monetary incentives are associated with increased response among physicians.[7] Using a $5 prepaid incentive will help improve the response rate, as the literature suggests, while working within budgetary constraints.

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[3] Technical expert panel sub-group for physician survey: Bruce Bagley, American Academy of Family Physicians; Steve Blumberg, Centers for Disease Control and Prevention; David Kelly, Pennsylvania Department of Public Welfare; Jonathan Klein, American Academy of Pediatrics; Cynthia Minkovitz, Johns Hopkins School of Public Health; Lynn Olson, American Academy of Pediatrics; Mark Weissman, Children's National Medical Center

[4] Asch DA, Jedrziewski MK, Christakis NA. Response rates to mail surveys published in medical journals. *Journal of Clinical Epidemiology*. 1997;50(10): 1129-136.

[5] Singer E, Ye C. The use and effects of incentives in surveys. *The Annals of the American Academy of Political and Social Science*. 2013; 645: 112-141.

Donaldson GW. Physician participation in research surveys: A randomized study of inducements to return mailed research questionnaires. *Evaluation and the Health Professions.* 1999;22(4): 3427-441.

[6] Church AH.. Estimating the effect of incentives of mail survey responses rates: A meta-analysis. *Public Opinion Quarterly*. 1993;57(1): 62-79.

[7] VanGeest JB, Johnson TP, Welch V. Methodologies for improving response rates in survey of physicians: A systematic review. *Evaluation and the Health Professions*. 2007;30(303): 303-321.

10. Assurance of Confidentiality

Individuals and organizations will be assured of the confidentiality of their replies under Section 944(c) of the Public Health Service Act. 42 U.S.C. 299c-3(c). That law requires that information collected for research conducted or supported by AHRQ that identifies individuals or establishments be used only for the purpose for which it was supplied.

Respondents will be given this assurance during initial contact by mail, as well as all subsequent contacts by email, fax, and telephone. Respondents will be informed that participation is voluntary, that they may refuse to answer any question, and that they may stop their participation at any time.

AHRQ will not request identifying information from respondents who complete the survey, and contact information used to generate the survey sample will only be linked to survey responses by a unique, nonidentifying numeric code in order to monitor survey completion and provide follow-up contacts as necessary with nonrespondents. Names will not be linked to comments or responses in data provided to AHRQ. Data will be reported in aggregate form in all reports. The contractor will safeguard all data, and only authorized users will have access to them. Information gathered for this study will be made available only to researchers authorized to work on the study.

Safeguarding Data. The contractor has established corporate data security plans for the handling of all sample information, returned questionnaires, and survey data. The data security plan meets the requirements of U.S. Federal Government agencies and is continually reviewed for compliance with new government requirements and data collection needs. Such security is based on (1) exacting company policy promulgated by the highest corporate officers in consultation with systems staff and outside consultants, (2) a secure systems infrastructure that is continually monitored and evaluated with respect to security risks, and (3) secure work practices of an informed staff that take all necessary precautions when dealing with confidential data.

All contractor staff members sign a pledge of confidentiality. A copy of this text is in Attachment G. Confidential data are kept in study-specific folders that only a minimum number of staff members may access. Returned mail surveys are stored in locked, secure facilities.

11. Questions of a Sensitive Nature

AHRQ is not collecting information of a sensitive nature from any respondent. Questions will elicit information and physician perspectives on quality measures and health information technologies designed to improve quality of care delivered to pediatric patients.

12. Estimates of Annualized Burden Hours and Cost

Exhibit 1 shows the estimated annualized burden hours for the respondent’s time to participate in this evaluation. The survey will be completed by 1,200 pediatricians and family physicians working in primary care settings in four States (300 per State) and takes 15 minutes to complete. The total burden is estimated to be 300 hours.

Exhibit 2 shows the estimated annualized cost burden associated with the respondent’s time to participate in this evaluation. The total cost burden is estimated to be $ 25,578.

Exhibit 1. Estimated Annualized Burden Hours

Form Name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Pediatrician and Family Physicians Survey	1,200	1	15/60	300
Total	1,200	n/a	n/a	300

Exhibit 2. Estimated Annualized Cost Burden

Form Name	Number of respondents	Total burden hours	Average hourly wage rate*	Total cost burden
Pediatrician and Family Physicians Survey	1,200	300	$85.26	$25,578
Total	1,200	300	n/a	$25,578

*Based upon the higher of the two means of the hourly wages for general and family practitioners and general pediatricians, National Compensation Survey: “May 2011 National Occupational Employment and Wage Estimates, United States.” U.S. Department of Labor, Bureau of Labor Statistics.

13. Estimates of Annualized Respondent Capital and Maintenance Costs

Capital and maintenance costs include the purchase of equipment, computers or computer software or services, or storage facilities for records as a result of complying with this data collection. There are no additional costs to the respondents.

14. Estimates of Annualized Cost to the Government

Exhibit 3 shows the total and annualized cost for the physician survey portion of this evaluation.

Exhibit 3. Estimated Total and Annual Cost

Cost Component	**Total Cost**	**Annualized Cost**[8]
Project Development	$58,284	$38,856
Data Collection Activities	$40,684	$27,123
Data Processing and Analysis	$65,200	$43,467
Publication of Results	$30,000	$20,000
Project Management	$19,297	$12,865
Overhead	$16,009	$10,673
Total	$229,474	$152,983

15. Changes in Hour Burden

This is a new data collection.

16. Time Schedule, Publication and Analysis Plans

AHRQ expects survey data collection to begin in spring 2014, pending OMB clearance. AHRQ's contractor will synthesize the survey data in the form of a final report for AHRQ's review by fall 2014. The contractor will go on to prepare communication materials for a range of audiences (State policymakers, State agency staff, Medicaid and CHIP providers, and academics), beginning in July 2014 until the contract ends in September 2015. The effort to publish may include preparing and submitting manuscripts to one or more peer-reviewed publications, beginning in mid-2014. Exhibit 4 presents the anticipated data collection and reporting schedule.

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[8] Annualized over the expected 18-month data collection and management period in 2013-2014 during which the majority of the design, implementation, analysis, and dissemination of the results will occur.

Exhibit 4 Schedule of Proposed Data Collection, Reports and Publication

Survey Respondent Types	Start of Data Collection	Completion of Data Collection	Methodology Report to AHRQ	Analytic Reports and Communications to Other Audiences
Physicians	March 2014	July 2014	October 2014	November 2014 and later

Survey data described in this clearance package will be analyzed to address the following broad research goals for the evaluation that have been described in Section 1.

1. Identify CHIPRA State activities that measurably improve the nation's health care, especially as it pertains to children.
2. Understand whether and how the CHIPRA demonstration States' efforts affected outcomes related to knowledge and behavior change in targeted providers and/or consumers of health care.

Specific goals for the survey data collection include:

- Provide quantitative data related to demonstration projects focused on using quality measures at the practice level to improve quality of care for children.
- Help identify critical factors related to physician perceptions of the value and utility of quality measure and quality-improvement initiatives.
- Help other States identify strategies for working with the pediatric community to replicate models found to be effective.

Analysis Plan for Survey Data

Before the analysis begins, the contractor will produce a cleaned data file and data dictionary for the analysis, and will summarize response patterns for the survey overall and for individual questions. The analysis itself will include the following steps:

- Descriptive analyses: Tables will be generated showing univariate and bivariate distributions for key variables. For example, a table could show what percentage of respondents that indicate that they receive reports on quality measures for children and examine responses across provider characteristics and States.

- Hypothesis testing: A series of multivariate models will be generated to address the hypotheses. Logistic and linear regression models will be used for dichotomous and continuous variables constructed from the survey responses, respectively, adjusting for clustering by state when appropriate. Key hypotheses include:
    - Physicians in demonstration states will be more likely to report receiving reports on pediatric quality measures when compared to physicians in a non-demonstration state.
    - Physicians in demonstration states will be more likely to report that they find reports on pediatric quality measures useful in improving the care that they deliver to children when compared to physicians in a non-demonstration state.
- Exploratory analyses: Comparisons in attitudes and experiences with pediatric quality and measurement are also planned between pediatricians and family physicians. However, it will not be clear until the survey is completed whether there will be sufficient power for these comparisons given the different distributions of these specialties across states and the potential for differential response rates by specialty.

Limitations on the analysis: In presenting the results of our analyses, we will acknowledge limitations that may constraint the validity and generalizability of our conclusions. These limitations include the cross-sectional collection of data and other quality measurement, reporting, and improvement initiatives that are occurring at the same time as the CHIPRA Quality Demonstration Grant Program.

The quantitative data collected under this clearance package, when combined with evaluation data from other sources, will directly support an analysis of (1) demonstration projects focused on using quality measures and health information technologies at the practice level to improve quality of care for children, (2) critical factors related to physician perceptions of the value and utility of quality measures and quality-improvement initiatives, and (3) strategies for working with the pediatric community to replicate demonstration models found to be successful.

In the other quantitative analyses for the evaluation, patient-level claims, enrollment, encounter, and expenditure data for Medicaid and CHIP beneficiaries and descriptive data on participating practices will be used to address research questions related to service use. Claims from outpatient, inpatient, long term care, and pharmacy services will be used to create outcome measures of access, quality, and Medicaid expenditures. Claims also will be used for claims-based attribution of children to intervention and comparison practices. The enrollment files will provide a limited amount of basic information on child-level demographics, basis of Medicaid eligibility, and enrollment periods. The primary goal of the cross-state quantitative evaluation is to determine the impact of CHIPRA demonstration funding on the adoption or improvement of a medical home model of care or new health IT, and subsequently, on the access to care, quality of care, and health care expenditures among publicly-insured children. This activity does not impose a burden on the public, does not require OMB clearance, and is not included in the burden estimates in Section 12. The analyses of the physician survey and these other data analyses are separate, but the interpretation of our findings from both analyses will be integrated to the extent possible.

17. Exemption for Display of Expiration Date

AHRQ does not seek this exemption.

List of Attachments:

A. Children’s Health Insurance Program Reauthorization Act of 2009
B. Pediatrician and Family Physician Survey
C. CHIPRA Physician Survey Advance and Cover Letters
D. CHIPRA Physician Survey Reminder Postcard
E. CHIPRA Physician Survey Reminder Letter
F. Federal Register Notice
G. Confidentiality Pledge