DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop S2-25-26 Baltimore, Maryland 21244-1850



State Demonstrations Group

January 17, 2025

Greg Woods Assistant Commissioner Division of Medical Assistance and Health Services State of New Jersey Department of Human Services P.O. Box 712 Trenton, NJ 08625-0712

Dear Assistant Commissioner Woods:

The Centers for Medicare & Medicaid Services (CMS) approved New Jersey's Evaluation Design for the CHIP Continuous Eligibility COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "New Jersey FamilyCare Comprehensive Demonstration" (Project Nos: 11-W-00279/2 and 21-W-00068/2). We sincerely appreciate the state's commitment to efficiently meeting the requirement for an Evaluation Design as was stipulated in the approval letter for this amendment dated September 13, 2023, especially under these extraordinary circumstances.

In accordance with 42 CFR 431.424(c), the approved Evaluation Design may now be posted to the state's Medicaid website within 30 days. CMS will also post the approved Evaluation Design on Medicaid.gov.

Consistent with the approved Evaluation Design, the draft Final Report will be due to CMS one year after the end of the amendment approval period (June 2025).

We sincerely appreciate the state's commitment to evaluating the CHIP Continuous Eligibility COVID-19 PHE amendment under these extraordinary circumstances. We look forward to our continued partnership on the New Jersey FamilyCare Comprehensive Demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S

Danielle Daly

Digitally signed by Danielle Daly -S Date: 2025.01.17 05:01:01 -05'00'

Director Division of Demonstration Monitoring and Evaluation

cc: Terri Fraser, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Evaluation Design for CHIP Amendment, Version8.29.24

A. General Background Information

On September 13, 2023, CMS approved an amendment to New Jersey's 1115 Demonstration regarding continuous eligibility for children in its separate Children's Health Insurance Program (CHIP), effective for the period retroactively from March 1, 2020 and ending when all redeterminations for Medicaid and CHIP are conducted during the unwinding period. New Jersey Medicaid plans to be finished with the bulk of the unwinding by the end of June 2024.¹ There are exceptions for enrollees who are not eligible for coverage because, for example, they voluntarily withdrew or no longer live in New Jersey. The CHIP program in New Jersey is available for children ages 0-1 who are within 194%-350% of the Federal Poverty Line (FPL) and children ages 1 to 18 who are between 142%-350% of the FPL (in both cases, including a 5% disregard of income). Children with income levels lower than the CHIP guidelines qualify for Medicaid.

B. Evaluation Hypotheses and Questions

We posit that continuous eligibility from March 2020 through June 2024 will minimize coverage gaps and improve continuity of access to program benefits and care, thereby improving health outcomes during the study period of January 2020 through December 2023.

Below we present the *driver diagram* (Figure CHIP.1: Separate CHIP Children Continuous Coverage Driver Diagram) that delineates the pathway from the policy change to improved outcomes. Here the secondary drivers represent the various services available to separate CHIP children.

Aim	Primary Drivers	Secondary Drivers
1.A. Ensures that eligible separate CHIP program beneficiaries have access to all necessary services (both physical and behavioral) to	Full CHIP State plan services for eligible children in separate CHIP program	• Consistent coverage for CHIP benefits for 12 months, regardless of income fluctuations or other
improve health and well-being 1.B. Improve enrollment, utilization, and quality of health		changes that would otherwise affect eligibility for children age 0-1 with family incomes between
care -Increase enrollment -Reduce avoidable hospitalizations		194%-350% FPL and children 1-18 with family incomes between 142%-350% FPL
	Causality ←	·,

Figure CHIP.1. Separate CHIP Children Continuous Coverage Driver Diagram

We next detail the hypotheses and corresponding research questions that help assess the impact of ensuring continuous coverage to eligible children in the separate CHIP program. These are also summarized in table CHIP.2.

¹ See <u>https://www.nj.gov/humanservices/dmahs/boards/maac/MAAC_Meeting_Presentation_7-19-23.pdf</u>, slide 15.

<u>Hypothesis 1</u>: Extending continuous coverage for CHIP children from March 2020 through June 2024 will result in greater coverage and higher quality of care among eligible beneficiaries during the study period of January 2020 through December 2023.

<u>Research Question 1a</u>: Did providing continuous coverage to CHIP children **increase the duration of enrollment**?

<u>Research Question 1b</u>: Did providing continuous coverage to CHIP children **impact overall and avoidable hospitalizations**?

<u>Research Question 1c</u>: What challenges and facilitators of success did the State encounter when implementing the continuous coverage to CHIP children?

C. Methodology

Table CHIP.1. Inventory of Measures

Measure		Brief Description		
Enrollı	ment	•		
1.	CHIP and Medicaid enrollment	Total number of months enrolled during study period.		
		Enrollment gaps: the number of days between two enrollment periods for an enrollee. ²		
Utiliza	tion of Care			
2.	Inpatient hospitalizations	Individuals receive inpatient hospital treatment for surgery or for nonsurgical medical treatment.		
Quality				
3.	Avoidable hospitalizations: pediatric quality indicators (AHRQ)	The AHRQ Pediatric Quality Overall (PDI) Composite is composed of the Asthma Admission Rate, Diabetes Short-Term Complications Admission Rate, Gastroenteritis Admission Rate, and Urinary Tract Infection Admission Rate. ³ These are measures of potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions and reflect on access to and the quality of ambulatory care.		

² Bradley Corallo et al., "Medicaid Enrollment Churn and Implications for Continuous Coverage Policies" (Kaiser Family Foundation, December 14, 2021), https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churnand-implications-for-continuous-coverage-policies/; Jamie R. Daw et al., "Women In The United States Experience High Rates Of Coverage 'Churn' In Months Before And After Childbirth," *Health Affairs* 36, no. 4 (April 1, 2017): 598–606, https://doi.org/10.1377/hlthaff.2016.1241.

³ See <u>https://qualityindicators.ahrq.gov/Downloads/Modules/PDI/V2023/PDI_Composite_Measures.pdf</u>

Note: Because of the claims runout period, claims will only be available through December 2023.

For hypothesis 1 and research questions 1a-1b

<u>Study population</u>: For examining the overall effect of the continuous coverage provision for CHIP children, the study population will be comprised of children age 0-1 with family incomes between 194%-350% FPL and children 1-18 with family incomes between 142%-350% FPL.

<u>Analytic strategy</u>: This analysis will use a cohort of CHIP children eligible for the separate CHIP program and examine their outcomes on selected metrics over the demonstration period while they remain continuously enrolled under this policy change. Trends among CHIP children will be compared between the baseline period (2017-2019) and the public health emergency (PHE) period plus the unwinding period (2020-2023). We may use longer or shorter baseline period, if required by our model specifications.

We will calculate monthly and yearly enrollment-adjusted rates of outcomes for all beneficiaries ever enrolled under the continuous coverage provision for the demonstration period (i.e., repeated cross sections). The cohort approach compares the same people over time to ensure that observed changes in utilization are not due to differences in characteristics of beneficiaries newly enrolling or disenrolling during this period. Small sample sizes may limit the monthly analysis, in which case we will rely on pooled cross-sections at the quarterly or annual level. The repeated cross-sectional rates examine outcomes for all individuals gaining eligibility under the expansion controlling for changes in composition of each year's enrolled population.

We will conduct both descriptive analysis and a regression-based approach. We will first create bar charts or line diagrams to examine trends over time on a monthly, quarterly, and/or yearly basis depending on available sample sizes. Next, we will use interrupted time series (segmented regression analysis) to examine the effect on policy groups given there is no available comparison group. Interrupted time series analysis assumes that the policy effect may lead to a change in level, and a change in the existing time trend of the metric measuring quality or any other outcomes of interest. The regression analysis can measure this change in trend or level. Potential confounding may arise from factors that determine our outcomes of interest and change at the same time as the policy implementation. However, our multivariate analysis adjusts for demographic and geographic factors to mitigate such effects. Interrupted time series analysis will be an additional strategy to examine the impact of continuous eligibility policies overall on a cohort of CHIP children in the absence of a robust comparison group. Standard errors will be cluster-corrected by zip codes to adjust for non-independence of observations. The models for outcomes will be run using two time periods: baseline (2017-2019) and the public health emergency plus the unwinding (2020-2023).

For hypothesis 1 and research question 1c

<u>Data collection</u>: To understand the implementation of the continuous coverage provision in the CHIP program, researchers will conduct a series of interviews with key informants involved in the implementation of the policy, including DMAHS staff. Participant recruitment will be based on criteria established during protocol development and will primarily involve staff and key informants with existing relationships to the evaluators such as DMAHS staff and other state and local experts. Up to 10 interviews

of approximately 45-60 minutes will be completed. Interviews will be conducted on a voluntary and confidential basis and participants will be informed that due to the small number of interviews it may be possible for readers of the final report to infer their identity. Key informant interviewees participating in their professional roles (e.g., DMAHS staff) will not be offered participation incentives. In-depth individual interviews will use semi-structured, open-ended questions that invite input from appropriate individuals identified by DMAHS as having experience and subject matter expertise regarding the development and implementation of the CHIP continuous coverage provision. The interview guide can be found in the Appendix. Interviews will offer insights into policy implementation as well as identifying barriers and opportunities to improve. Interviews will be conducted virtually over Zoom and will be recorded and transcribed.

<u>Analytic strategy for interview data</u>: The information obtained from these interviews will be synthesized with the results from the other quantitative data analyses, providing an in-depth discussion of each of the domains/objectives to be considered. NVivo or similar software will be used to analyze for themes. A general inductive approach will be used to allow for themes to emerge. Where appropriate, themes will be categorized as a barrier or facilitator to provide a coherent analysis on the implementation of the CHIP continuous coverage provision.

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods			
Hypothesis 1: Extending continuous coverage for CHIP children will result in greater coverage and higher quality of care among eligible beneficiaries.							
RQ1a: Does providing continuous coverage to CHIP children increase the duration of enrollment?	-Medicaid enrollment	Outcomes among CHIP children will be compared between the baseline period (2017-2019) and the PHE plus unwinding period (2020-2023).	Medicaid Fee-for- Service and Encounter Claims Records	Examine trends in outcomes, descriptive, cross- sectional analysis			
RQ1b: Does providing continuous coverage to CHIP children impact overall and avoidable hospitalizations?	-Inpatient hospitalizations -Pediatric Quality Indicators (PDI) - avoidable hospitalizations	Pediatric Quality Indicators among CHIP children will be compared between the baseline period (2017-2019) and the PHE plus	As above	As above			

Table CHIP.2: Summary of Questions, Hypotheses and Methodology

		unwinding period (2020-2023).		
RQ1c: What challenges and facilitators of success did the State encounter when implementing the continuous coverage to CHIP children?	-Challenges and successes that DMAHS encountered when implementing the continuous coverage provision	Key state informants involved in the implementation of the continuous coverage provision.	Key informant interviews	Qualitative inductive theme identification

D. Limitations

This analysis has several limitations. First, detailed analysis of individual recommended chronic condition management services, for example, are not feasible. However, use of the AHRQ PDI metric will reflect the adequacy of ambulatory care services. Additionally, some individuals may be misclassified in their CHIP eligibility, but we expect that number to be negligible to this analysis overall. The post-policy implementation period is limited, but it is unlikely that adding a longer period would significantly change the results. To address potential implementation gaps and resulting evaluation biases, this analysis will conduct up to 10 interviews with DMAHS staff and other key informants to understand the implementation of this continuous coverage provision. While we expect these interviews to enhance our understanding of the pilot, the interviews are focused on indirect reporters and not the beneficiaries themselves, which will limit our ability to interpret the impact of the pilot for beneficiaries. While interviews will be voluntary and confidential, given the small number of interviews it may be possible for readers of the final report to infer their identity. Participants will be informed of this limitation, but it may affect what is shared in the interviews.

Appendix. In-depth key informant implementation interviews [goal: 45-60 minutes]

Question Bank

- 1. First, tell me a little bit about your specific role or relationship to the implementation of the CHIP continuous coverage provision and how long you've been in that role?
- 2. Thinking about the implementation of the continuous coverage provision, what are some facilitators of success and barriers that you have observed?
- 3. What are 1-2 recommendations you would make to ensure the State meets its goals of supporting insurance coverage for children in New Jersey?
 <u>Probe</u>: What strategies would you use to overcome barriers? What components of the continuous coverage provision worked well? What should be changed?
- 4. Before we close, is there something else about the implementation of the CHIP continuous coverage provision that you would like to share that hasn't been covered?