Providing Multi-Year Continuous Enrollment (CE) to Medicaid/CHIP Populations: *State Toolkit*

Prepared by Manatt Health

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Driving Innovation Across States

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Learning Objectives

This toolkit is intended to support decision-making in states interested in, actively pursuing, or implementing section 1115 demonstrations to provide CE to Medicaid and Children's Health Insurance Program (CHIP) populations, with a focus on multi-year CE for young children.

States may use this toolkit to inform:

Understanding how other states are leveraging section 1115 demonstration waivers to pursue multi-year CE coverage for their Medicaid and CHIP populations.

Cost estimates of providing multi-year CE.

Planning for federal CE-specific evaluation and monitoring requirements.

Understanding how new federal regulations will impact CE policy.

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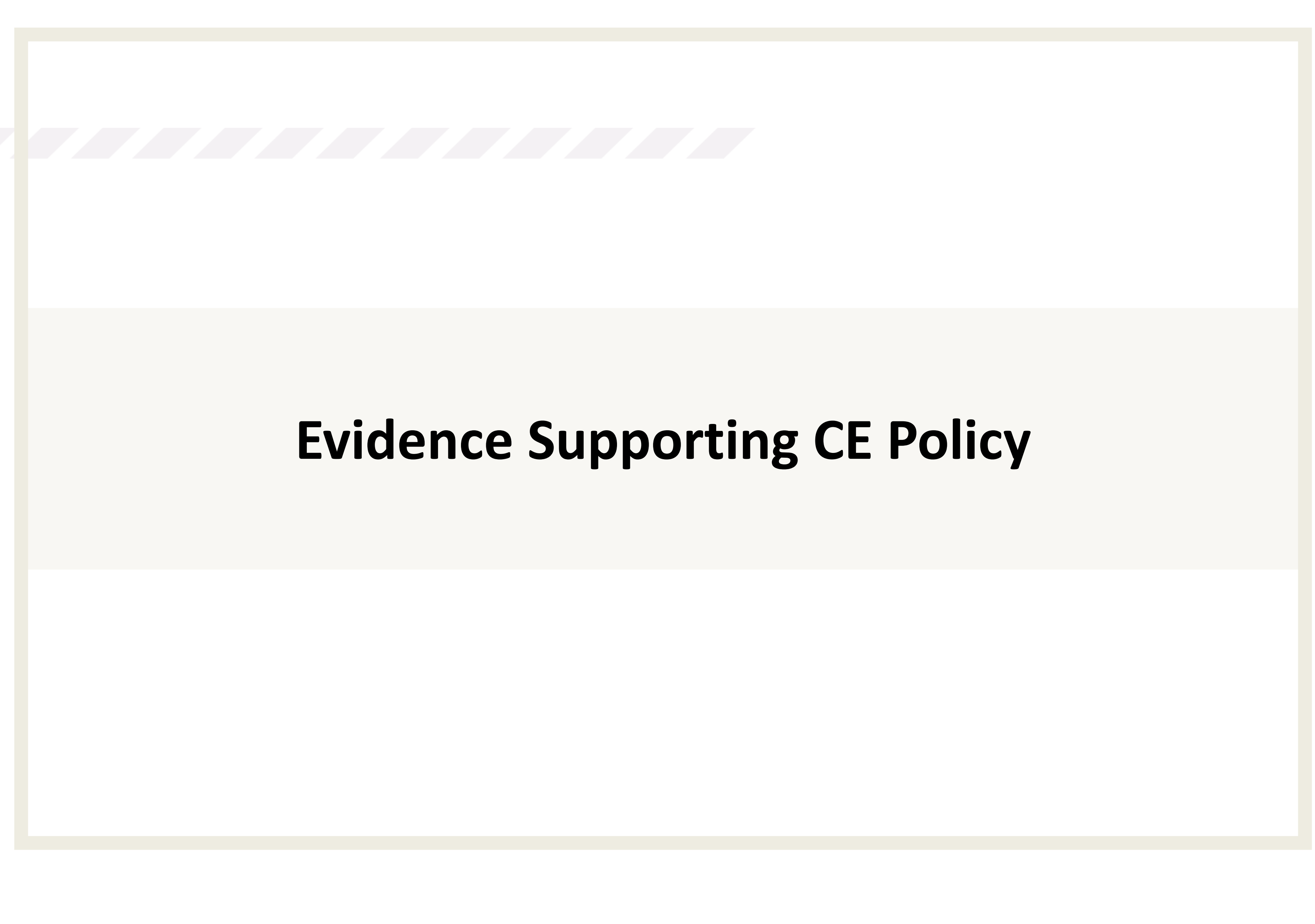

Evidence Supporting CE Policy

CE Policies: A Solution to Churn

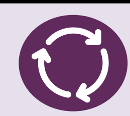
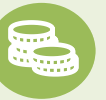
CE policies offer a solution to churn* by ensuring stable coverage for a prescribed period, without requiring additional paperwork and regardless of fluctuations in family circumstances.

- Medicaid/CHIP members experience churn largely as a result of **administrative issues, such as paperwork requirements, lost mail, state information technology issues, and short-term income changes.**
- In 2018, nationwide an estimated **11.2% of full-benefit Medicaid/CHIP children** and **12.1% of adults on Medicaid were disenrolled,** and then subsequently re-enrolled within one year.
- Similar rates of churn among children and adults, despite children's higher eligibility levels, underscore the **impact that administrative burdens have in particular for children's coverage**.
- **Medicaid unwinding has further highlighted the problem of coverage loss due to procedural, not eligibility, reasons.**
  - To date, 69% of all disenrollments nationwide are procedural.
  - From March 2023 through the end of the year, over 4 million children lost Medicaid/CHIP coverage. The majority of children losing Medicaid coverage are likely still eligible.

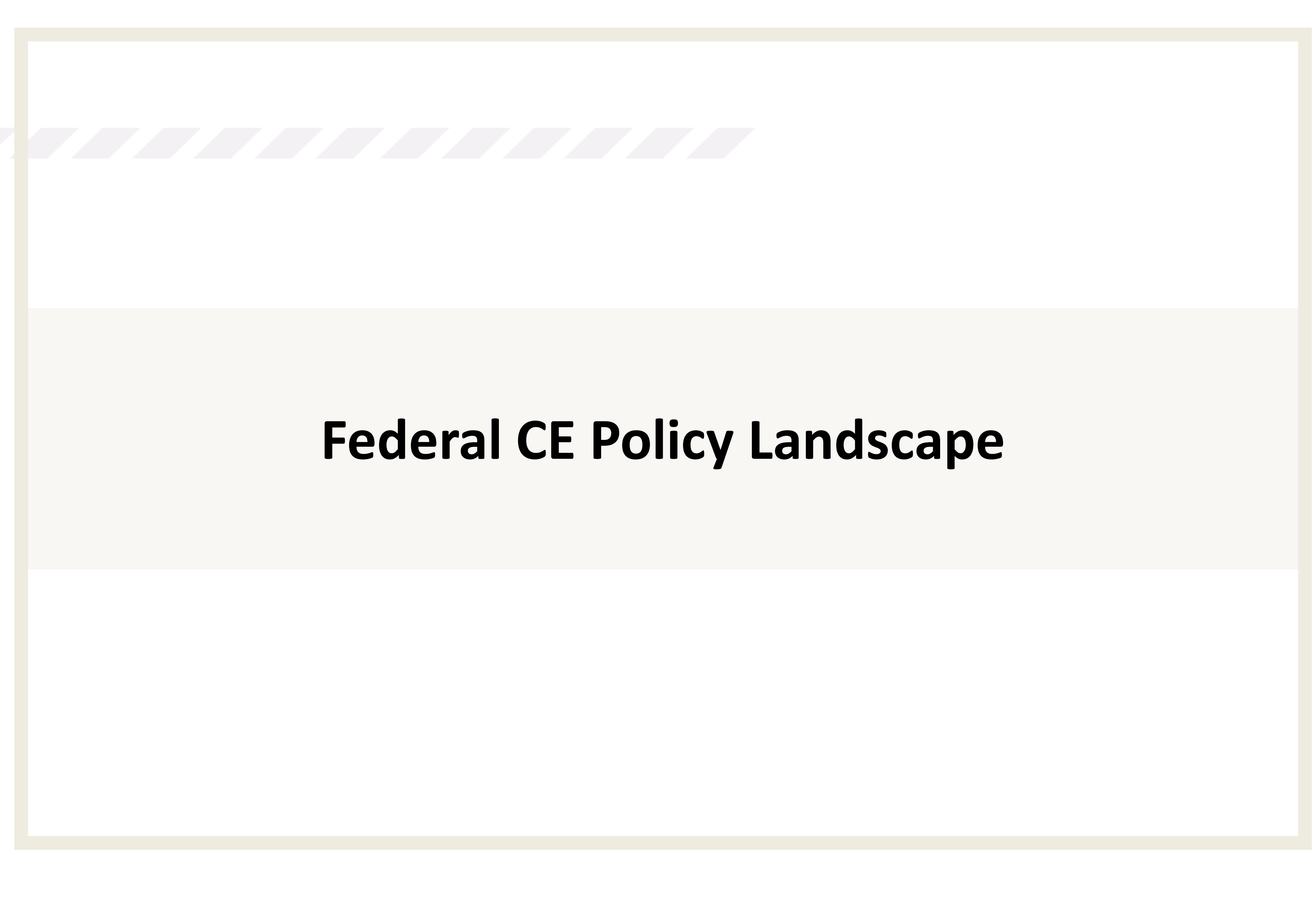
The temporary loss of Medicaid coverage, in which enrollees are disenrolled and then re-enroll within a short period of time, is referred to as "churn."

Source: KFF, Medicaid Enrollment Churn and Implications for Continuous Coverage Policies; Medicaid Enrollment and Unwinding Tracker – Overview; CMS, Child and Youth Data Snapshot (December 2023); Georgetown Center for Children and Families, Child Medicaid Disenrollment Data Shows Wide Variation in State Performance as Continuous Coverage Pandemic Protections Lifted.

Benefits of CE Policies

 Continuity of Care	Health Outcomes	 Costs
▪ **Individuals are more likely to access medically appropriate preventive care,** rather than seeking emergency care, and have fewer missed prescriptions. ▪ Improves connection to treatment for **chronic conditions**. ▪ **Supports recovery from disruptions in care.** ▪ **Promotes health equity** by reducing churn rates in groups disproportionately impacted by procedural disenrollment [i.e., Black and Latino(a) individuals] and health inequities.	**Adults** ▪ Contributes to **earlier cancer identification** and **improved outcomes**, specifically among women with breast and cervical cancer. **Children** ▪ Associated with **better health**, **reduced school absenteeism**, and **higher academic achievement for children.** ▪ Ensures coverage for **early detection of developmental delays** and access to needed treatments to improve lifelong outcomes.	▪ Longer coverage periods are associated with **lower monthly Medicaid expenditures** among both adults and children. ▪ **Creates administrative efficiencies** and lessens associated costs and burdens (e.g., application reprocessing, resubmitting claims, rescheduling missed appointments and treatments).

Source: Georgetown University, CCF (2022). Medicaid and Chip Continuous Coverage for Children. Ku et al, Improving Medicaid's Continuity of Coverage and Quality of Care, Association of Community Health Plans; CBO, Exploring the Effects of Medicaid During Childhood on the Economy and the Budget; KFF, Medicaid Postpartum Coverage Extension Tracker.


Federal CE Policy Landscape

Federal CE Requirements and Options for States

Effective January 1, 2024, federal law requires 12-months CE for children up to age 19.

Since 1997. Optional for states to provide 12 months of CE for children in Medicaid and CHIP.

March 2020. The Families First Coronavirus Response Act required CE for Medicaid enrollees through the public health emergency (PHE).

March 2023. The Consolidated Appropriations Act (CAA) requires 12 months of CE for children up to age 19 effective January 2024.

Fall 2023. CMS released guidance on the CAA requirement.
****SHVS' summary of the SHO letter is available here.***

January 2024. Implementation of the CAA CE requirement.

March 2024. The Biden administration proposed new options for states to provide CE for youth in the President's Fiscal Year 2025 Budget.

States may seek section 1115 waiver authority to expand upon these provisions for children and adults.

Source: CMS, State Health Official Letter. CMS, CE FAQs. Fiscal Year 2025 Budget in Brief.

President Biden's Fiscal Year 2025 Budget

On March 11, the Biden Administration released the Fiscal Year 2025 Budget, which proposes new state options to provide CE to children and adolescents.

CE-Related Provisions	Description	Costs Over 10 Years
Allows States to Provide CE up to Age 6	Builds on the CAA's CE requirement by establishing a state option to provide CE from birth until the child turns 6.	Medicaid Costs: $4.2 billion
		Net Costs: $4.2 billion
Allows States to Provide 36 Months of CE for All Children	Establishes a state option to provide 36 months of CE for children under the age of 19.	Medicaid Costs: $5.2 billion
		Net Costs: $5.4 billion

Note: The budget would also prohibit enrollment fees and premiums in CHIP.

States selecting to implement both state options would provide CE to children until they turn 6, then CE periods of 36 months until they turn 19.

Source:. Fiscal Year 2025 Budget in Brief

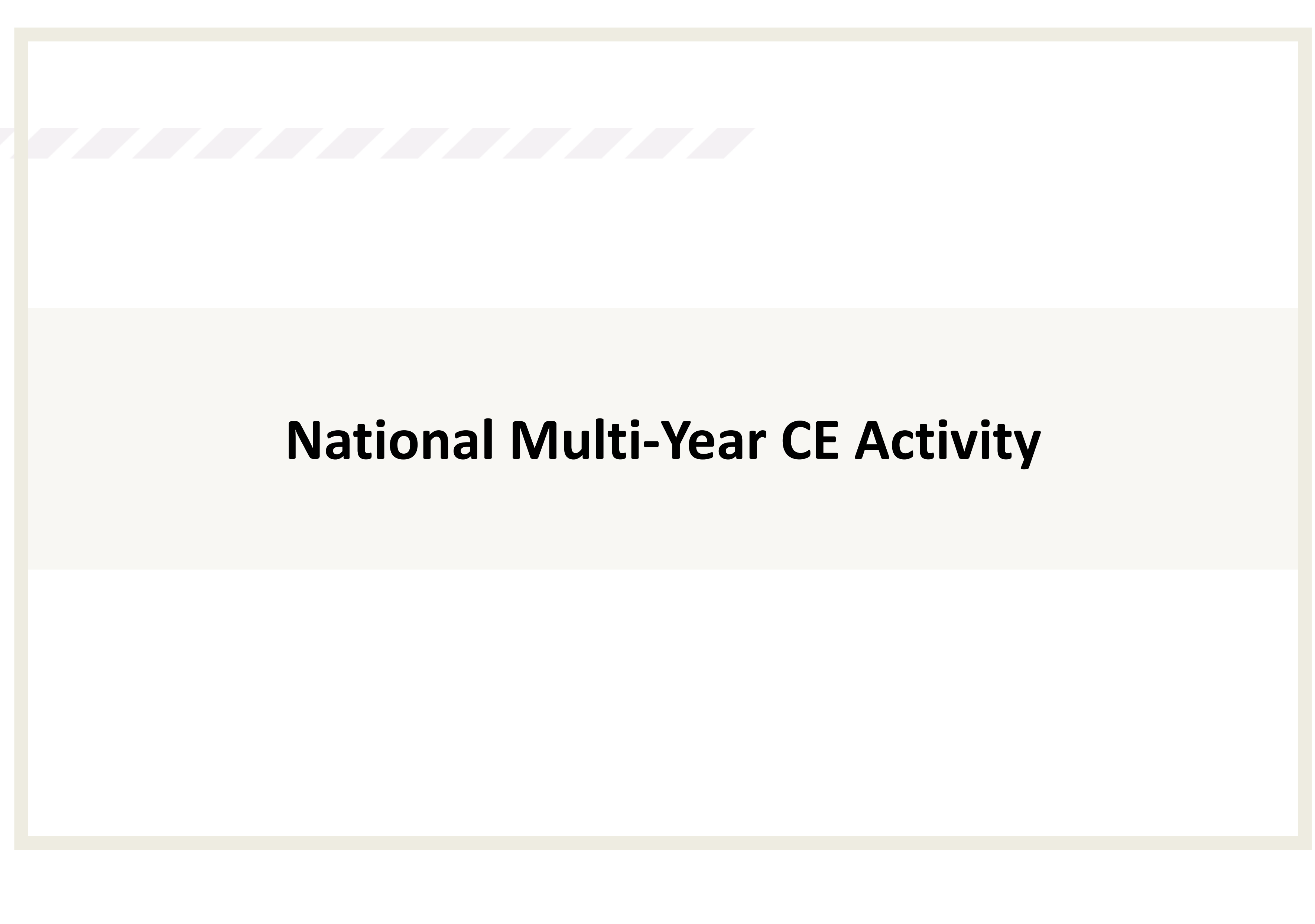
The Impact of the E&E Final Rule on CE

On March 27, the Centers for Medicare & Medicaid Services (CMS) released a final rule, "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program (BHP) Application, Eligibility Determination, Enrollment and Renewal Processes" that seeks to ensure continuity of coverage for CHIP and BHP-enrolled individuals.

- **Currently, under the new CAA CE requirement, CHIP-enrolled children must stay continuously enrolled in coverage for 12 months, regardless of non-payment of premiums*; however, they could be disenrolled at the end of 12 months and prevented from re-enrolling due to unpaid premiums.**
- **Under the new E&E regulations, a state cannot require payment of past due premiums as a condition of re-enrollment.** Effective June 2025, existing policies and past-due premiums must not be a condition of re-enrollment in states.
- **States are encouraged to consider other mechanisms for addressing timely payment of premiums**, including frequent reminders, multiple payment options, and pursuit of past due premiums.

*CMS released a proposed rule on July 11, that would **codify the requirements of the CAA** to require 12-months of CE for children under the age of 19 enrolled in Medicaid and CHIP. CMS also proposes to **remove the previous options of applying CE to a subgroup of enrollees or limiting CE to a time period of less than 12 months**. For CHIP, CMS also proposes to **remove failure to pay premiums as an optional exception to CE.**

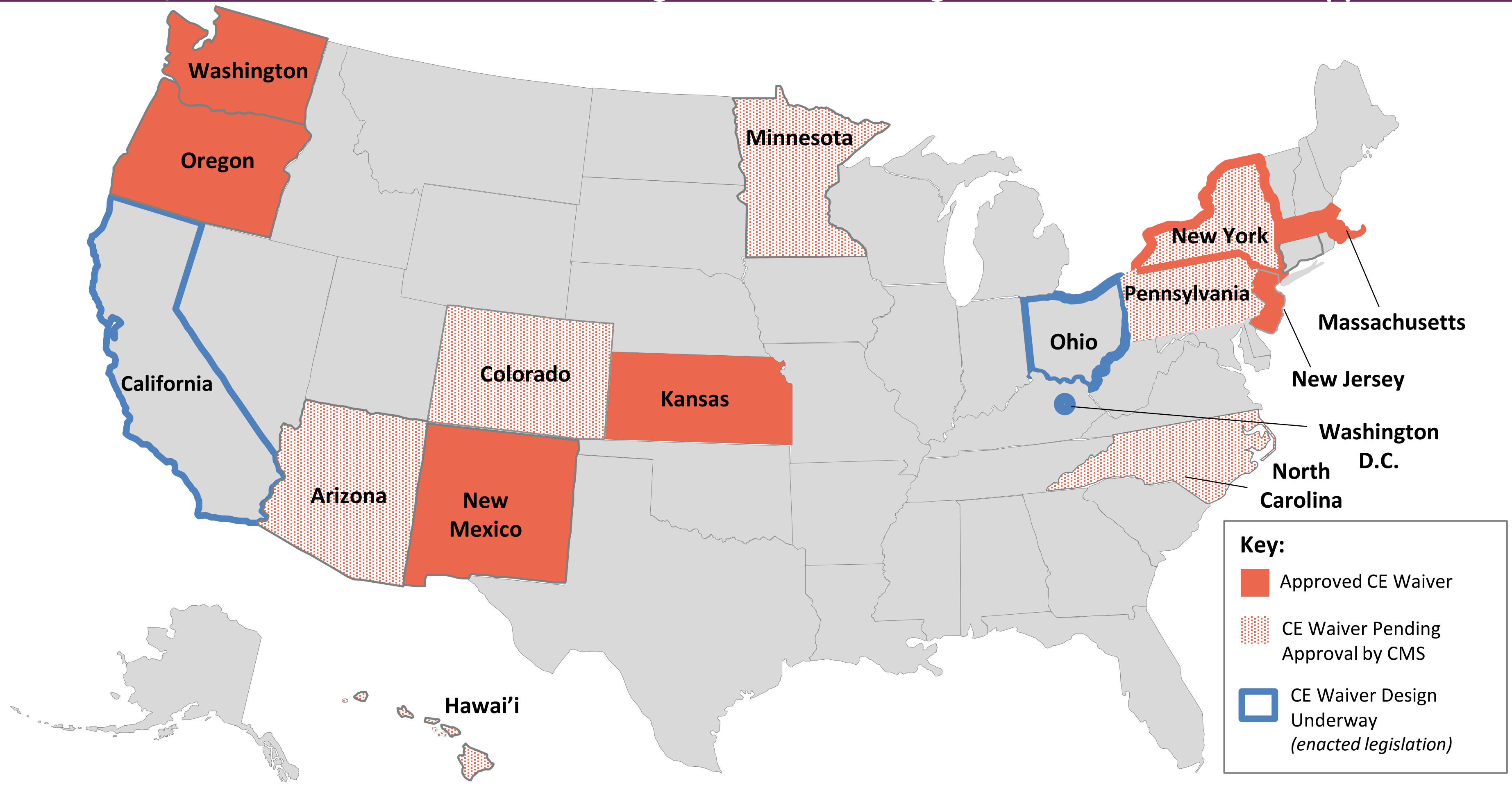
Source: 42 C.F.R. §§ 457.570 and 600.525, 457.65, 457.340, 457.350, 457.805, and 457.810, and 457.480.



National Multi-Year CE Activity

State CE Activity

As of July 2024, seven states have received CMS approval to implement CE, seven states have pending waivers, and three states have enacted legislation authorizing the state to seek waiver approval.



Source: KFF, Section 1115 Waiver Watch: Continuous Eligibility Waivers; See Appendix for detail.

Summary of States' CE Waiver Demonstration Features

Most state waivers are for multi-year CE for children, but states are also pursuing CE for adults and special populations.

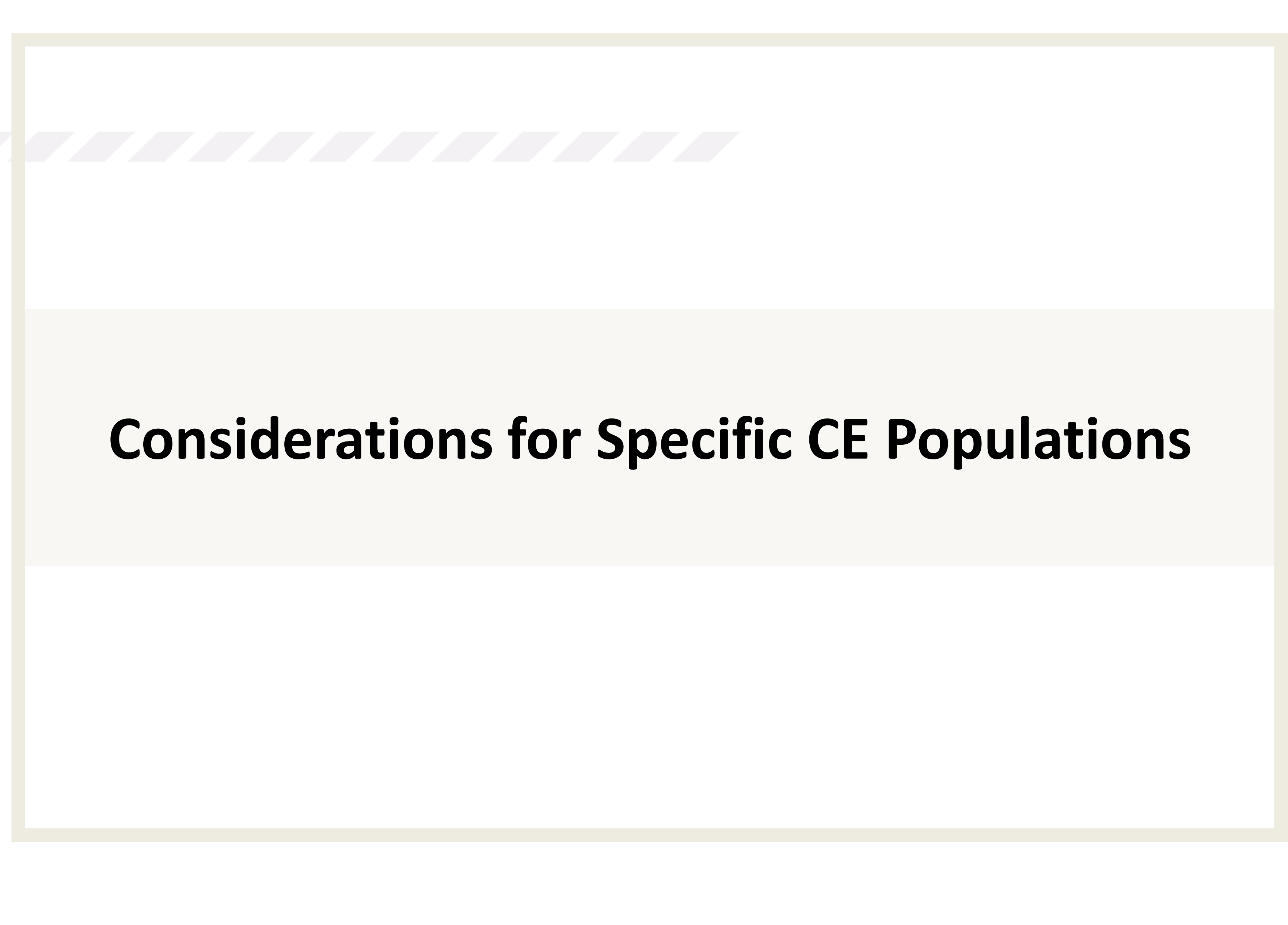
- **12 states are focusing on providing multi-year CE to young children, typically under age six.**
- Seven states are or plan to **provide CE for adolescents and adults.**
- Some states are or plan to **extend 12 months or more CE to targeted, special populations:**
  - Individuals experiencing homelessness.
  - Youth with Special Health Care Needs (YSHCN).
  - Former foster youth.
  - Justice-involved individuals.
- **State waiver exceptions to CE** typically align with the exceptions that apply to the mandatory one-year CE coverage for children in place through the CAA:
  - Individual requests voluntary termination.
  - Individual dies or moves out of state.
  - The agency determines that eligibility was erroneously granted.

Approved CE Demonstrations

State	Multi-Year CE for Young Children	CE for Adolescents/Adults	CE for Special Populations
Kansas		12 Months CE for Parents and Other Caretaker Relatives	
Massachusetts		12 Months CE for Adults 19+ *[based on Modified Adjusted Gross Income (MAGI) or non-MAGI]*	• 12 Months CE for Individuals Released From Correctional Facilities • 24 Months CE for Individuals Experiencing Homelessness
New Jersey		12 Months CE for Adults *(based on Modified Adjusted Gross Income)*	
New Mexico	Ages 0-6		
New York		12 Months CE for Adults *(based on MAGI)*	
Oregon	Ages 0-6	Age 6+ for 24 months	24 Months CE for YSHCN Ages 19-26
Washington	Ages 0-6		

Pending CE Demonstrations

State	Waiver Status	Multi-Year CE for Young Children	CE for Adolescents/Adults	CE for Special Populations
Arizona	*Submitted and Pending Approval by CMS*			**Multi-Year CE for Former Foster Youth Ages 18-26**
Colorado		Ages 0-3		12 Months for Individuals Released From Correctional Facilities
Hawai'i		Ages 0-6	Ages 6-19 for 24 Months	
Pennsylvania		Ages 0-6		12 Months for Individuals Released From Correctional Facilities
Minnesota		Ages 0-6	Ages 19-20 for 12 Months	
New York		Ages 0-6		
North Carolina		Ages 0-6	Ages 6-18 for 24 Months	**Multi-Year CE for Former Foster Youth Ages 18-26** (aged out prior to 1/1/23)
California	*State Designing Waiver (Enacted Legislation)*	Ages 0-5 (2026)		
DC		Ages 0-6		
Ohio		Ages 0-4		


Considerations for Specific CE Populations

Calculating Federal Medical Assistance Percentage (FMAP) for CE Populations

Approved CE demonstration waiver Special Terms and Conditions (STCs) include specific FMAP rates for different CE populations.

<table>
<tr><th>CE Population</th><th>States</th><th>STC</th></tr>
<tr><td>Medicaid Expansion Adults [defined at 42 CFR 433.204(a)(1]</td><td>MA, NJ, NY, OR</td><td rowspan="2">Given that some of the "newly eligible" individuals in the ACA Medicaid Expansion Adult group will be retained in coverage under CE even if they are no longer eligible due to income changes, CMS will provide regular FMAP and not enhanced FMAP for 2.6% of Expansion Adults covered by CE.</td></tr>
<tr><td>Individuals Released From a Correctional Facility</td><td>MA</td></tr>
<tr><td>Individuals Experiencing Homelessness</td><td>MA</td><td>No downward adjustment of the enhanced Medicaid Expansion FMAP Rate (90%) is required.</td></tr>
<tr><td>Medicaid/CHIP Children</td><td>NM, OR, WA</td><td>No STCs addressing match rate.</td></tr>
</table>

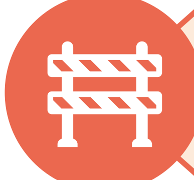
Source: See Appendix.

Considerations for Former Foster Youth

In recognition of the higher health needs and impact of churn on former foster youth, Arizona and North Carolina are seeking to provide multi-year CE to this population up to age 26.

Former foster youth have **increased prevalence of physical and behavioral health needs compared to other youth**, including higher rates of adverse childhood experiences.

Youths aging out of foster care are at **high risk for becoming homeless, creating instability that can disrupt health coverage** (i.e., returned mail, challenges adhering the procedural requirements).



Former foster youth show a **higher reliance on public insurance coverage** than the general population and have been **under-resourced**. This can be compounded by state systems/operations that do not ensure continuity of coverage for youth leaving foster care or facilitate streamlined re-enrollment.

CE for former foster youth aligns with the intention of both the ACA and Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities ("SUPPORT") Act to promote Medicaid enrollment until age 26.

Source: Arizona Former Foster Youth Annual Automatic Renewal Amendment Request ; Former Foster Care Children Medicaid Policy Update

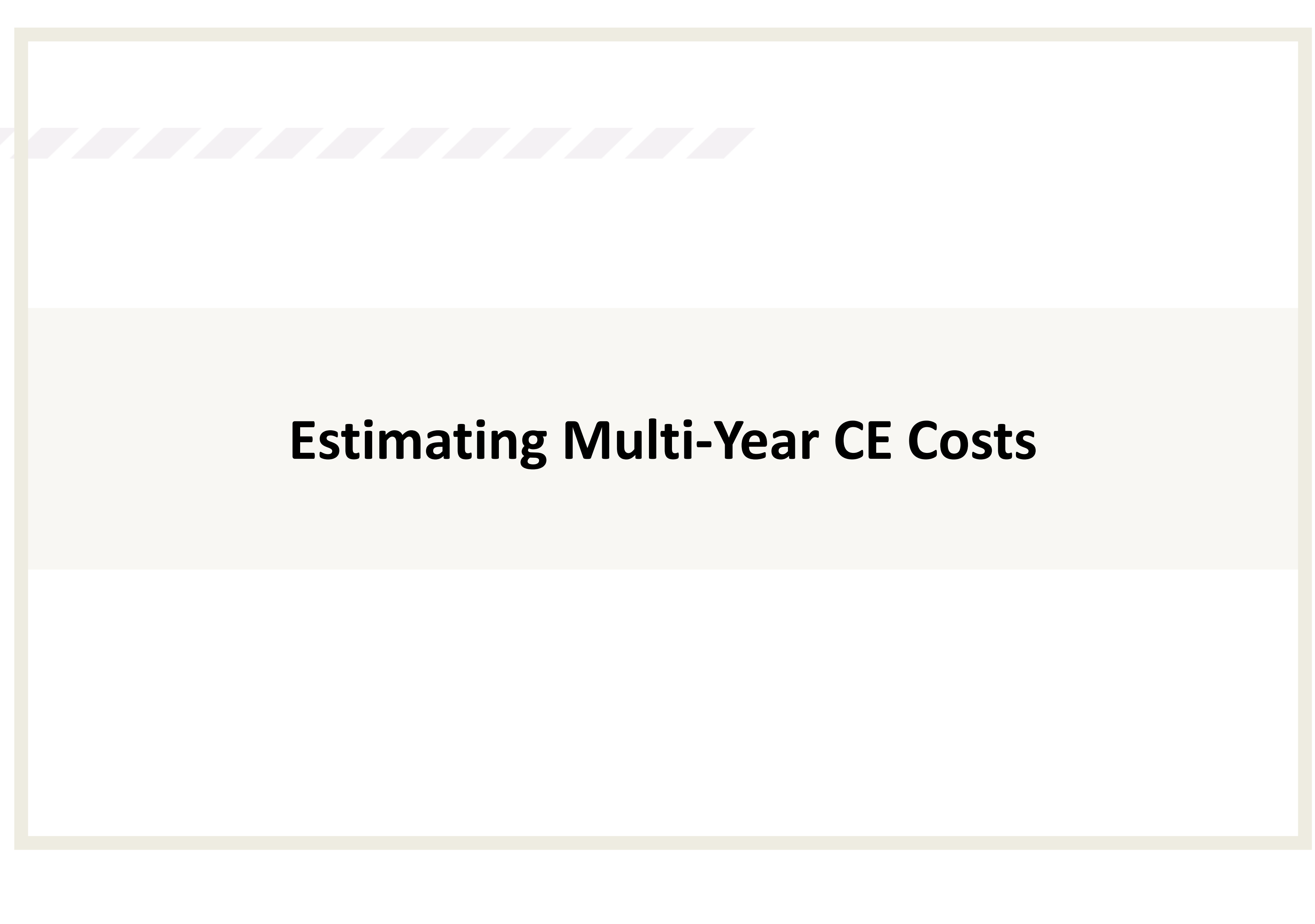
Considerations for Individuals Experiencing Homelessness or Justice Involvement

Massachusetts is leveraging existing processes and systems as part of its implementation plan to identify and provide CE to individuals experiencing homelessness and/or who are justice-involved.

MA CE Waiver Populations	CE Duration	Identification Strategy	Operational Considerations
Experiencing Homelessness: Individuals under 65 with a confirmed status of homelessness for at least six months.	24 months	Member or applicant is identified as homeless through the statewide Homeless Management Information System or from Department of Housing and Community Development Emergency Assistance Program. Once identified, a flag is placed in the person's MassHealth record.	Implemented in December 2023 through an automatic process (i.e., verification, systems communications, and upgrades).
Justice-Involved: Individuals under 65 released from a correctional institution.*	12 months	Correctional facilities notify MassHealth when a member is in custody, or a member or new applicant is being released. Notification occurs through direct communication procedures or electronic data matching. Once identified, a flag is placed in the person's MassHealth record.	Implemented in April 2023 through a manual process: a designated team at MassHealth initiates contact with correctional facilities. MassHealth expects to finish automating systematic enrollment processing of justice-involved individuals in July 2024.

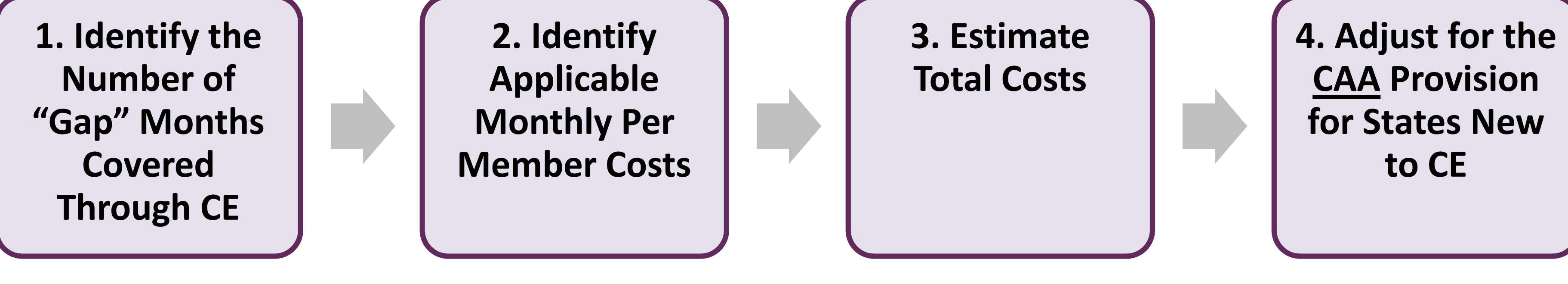
*Correctional institution is defined as County Correctional Facilities, state Department of Corrections Facilities, and Department of Youth Services juvenile justice facilities.

Source: Massachusetts Attachment O: Continuous Eligibility Implementation Plan


Estimating Multi-Year CE Costs

Overview: An Approach for States to Assess the Cost of Multi-Year CE for Children

The following is one approach for estimating the cost of implementing a multi-year CE policy for children up to age six (or a different age depending on the policy).*



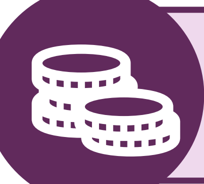
This toolkit offers one way of reaching a reasonable estimate of cost and impact; states may need to modify it depending on available data and resources.

*Steps 1-3 of this analysis may be used to assess the cost of CE for adults and other populations.

Data Needed for Analysis

To conduct a cost analysis of multi-year CE, states may utilize the following data:

Person-level Medicaid/CHIP data [e.g., three years of data for children if available (it may be feasible with one to two years of data)] prior to the PHE.* If possible, this data would be provided for the target age group, by age, and without consideration of retroactive coverage.



Per-member, per-month (PMPM) costs for populations covered by the proposed policy.

Trend rate to project enrollment and costs forward across multiple years.

*Due to the Medicaid continuous coverage requirement in place during the PHE, the current unwinding of this requirement, and changes in economic conditions, three years of data prior to the PHE will reflect a different baseline than the post-PHE enrollment reality. However, using pre-PHE data still represents the best possible baseline for estimating gap months to avoid confounders related to the PHE.

Identify the Number of Members Gap Months Covered Through CE, Year One

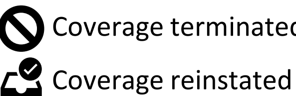
The following is one approach for estimating the number of additional member months that would be covered each year due to the new multi-year CE policy for children.

- If possible, this analysis recommends categorizing each child by **age**, **Medicaid vs. CHIP**, and **whether each child was or was not enrolled in Medicaid for any amount of time during the previous year** (this will support estimating gap months in later years).
- **For each child, states would identify the number of months equal to the sum of the following:**
  - When the child lost and regained coverage.
  - When the child lost coverage and turned six.
  - When the child lost coverage and the end of the year.
- The sum of these months will be the number of **gap months** that would be covered under CE (see next slide).

Note: This toolkit refers to a CE policy for ages zero to six; states considering a different age group will want to adjust accordingly.

Note: If possible, this analysis would be completed for each of the three years prior to the PHE. Gap months would then be added across the three years and divided by three to arrive at estimated year one gap months.

Illustrative Example: Sum of Gap Months

Key: Coverage active  Coverage terminated, Coverage reinstated

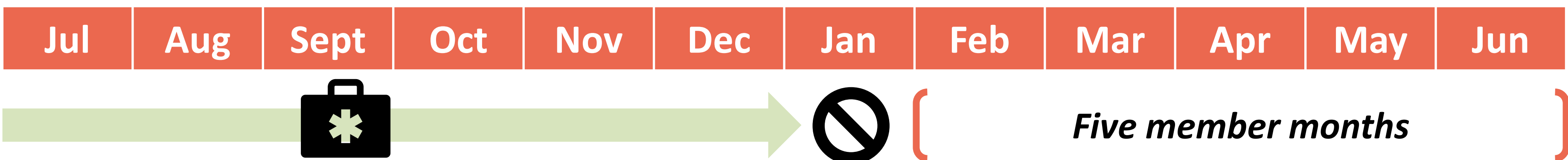
Ex 1. Tommy, age 5, loses coverage at the end of March and has his coverage reinstated in June.

State Fiscal Year

Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun

Two member months

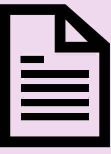
Ex 2. Maria, age 2, lost coverage at the end of January but did not regain coverage within the state fiscal year.



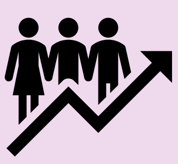
Gap months should include months in which a child received retroactive coverage upon returning to Medicaid. The costs associated with retroactive coverage may offset some CE costs for those months.

Adjustments for Multi-Year CE

States will need to make two major adjustments to appropriately account for costs of multi-year CE:



Children with coverage initially protected under CE who subsequently "age out" of policy.



Children newly enrolled in Medicaid who were not previously enrolled the prior year (i.e., would not have had coverage protected through CE the prior year).

Identify Member Gap Months Covered Through Multi-Year CE, Year Two and Beyond

Overview	Illustrative Example
Children with CE from Year One: Estimate the number of children (and associated member months) with coverage protected in the prior year that would "age out" of the program in year two.	**6,000** member months receiving CE in year one − **1,000** member months for children aging out in year two = **5,000 member months protected in year two**
Enrollees with Coverage Newly Protected in Year Two: Identify the number of gap months tied to individuals who were not enrolled in Medicaid for any time during the prior year and adjust for enrollment growth.	+ *Among 1,000 gap months for children aged one to two, 600 are tied to individuals enrolled in Medicaid that were not enrolled at any time during the prior year.* **600** gap months for children aged one to two newly eligible for Medicaid in year two (not previously eligible for CE) × Projected enrollment trend of **5%** = **630 member months newly protected in year two**

Subsequent Years: Each year, a cohort of children new to Medicaid will enter the program and have coverage protected through CE. In addition, children with coverage protected from prior years will retain coverage (except for those that "age out").

Identify Applicable Monthly Per Member Costs

States may identify the monthly costs of the multi-year CE policy by determining the average PMPM for each year of the financial projection (e.g., five-year waiver period).

Year One

- **Identify the PMPM costs for children.** The PMPM may vary by age and, if so, the different costs could be applied to the different age cohorts. Alternatively, states can use an average child PMPM cost for the broader Medicaid program.

If the policy will cover Medicaid and CHIP, this analysis should be conducted separately for Medicaid and CHIP-enrolled children to account for differential per member costs and federal matching rates.

Subsequent Years

- **Trend PMPMs from year one** based on projections in per-enrollee costs (e.g., through state budget projections or rate-setting assumptions).

Estimate Total Costs

Once a baseline cost is established, states can determine the estimated total cost of the multi-year CE policy, inclusive of federal and non-federal shares, through the following calculations:

Step	Calculation
1	**Multiply estimated member months** in each year by the applicable PMPM to identify total costs.
2	**Multiply total costs by the state's Medicaid FMAP** for the applicable year to identify the federal share of Medicaid costs. *If CE also applies to CHIP, calculate total costs associated with Medicaid and CHIP separately, and apply the appropriate FMAP to each set of costs (regular vs. CHIP-enhanced FMAP).*
3	**Subtract the federal share** from total computable costs to identify the non-federal share (i.e., the share of the total cost borne by the state).

Adjust for the CAA Provision for States New to CE

States that will have 12 months of CE for all children for the first time in January 2024, because of the 2023 CAA, may overstate the number of gap months associated with a multi-year CE policy using historical data. States have options to discount their multi-year CE cost to recognize the impact of 12-month CE:

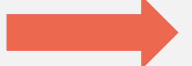
Option 1:

Discount the cost by limiting the count of gap months to instances where a child lost coverage at renewals **or**, if the state has already identified the cost of one-year CE in anticipation of the new law, that cost can be subtracted from the multi-year CE cost.

Option 2:

Apply the findings from a recent study that calculated the enrollment impact of one-year CE.

See Next Slide



Source: 2023 CAA; Health Affairs, Continuous Eligibility and Coverage Policies Expanded Children's Medicaid Enrollment.

Adjust for the CAA Provision for States New to CE, Example Approach

Step	Example
1. For each year, divide new costs associated with multi-year CE by projected child Medicaid expenditures for the target group (e.g., aged zero to six) absent multi-year CE ("baseline expenditures").	For year three of a CE program for children aged zero to six, assume: ▪ Total estimated costs associated with protected gap months are \$10,000,000. ▪ Baseline Medicaid child expenditures in year three (without CE) are estimated to be \$100,000,000. ▪ Multi-year CE costs are 10% of baseline expenditures.
2. Take the percentage in Step 1 and add the number one (e.g., 10% becomes 1.10) Then, divide by 1.0462. Finally, subtract the number one from the result and convert to a percentage.	1.10 ÷ 1.0462* = 1.0514 1.0514 − 1 = .0514 × 100 = 5.14%
3. Multiply the result from Step 2 by baseline expenditures (from Step 1) to arrive at an adjusted cost for multi-year CE, after removing costs that would be attributable to the new federal 12-month CE requirement.	\$100,000,000 *Baseline expenditures* × 5.14% *Adjusted percentage increase attributable to multi-year CE* = \$5,140,000 *Costs attributable to multi-year CE*

*4.62% represents the relative difference in child Medicaid enrollment resulting from the continuous coverage requirement.

The same calculation should be completed for each year of estimates until full ramp (i.e., when the cohort originally eligible for CE in the program's first year has fully aged out of the program), and discount percentages should be applied to the total, federal and state costs.

Source: Health Affairs, Continuous Eligibility and Coverage Policies Expanded Children's Medicaid Enrollment.

Offsetting Savings

There may be offsetting savings for states to consider as part of this analysis:

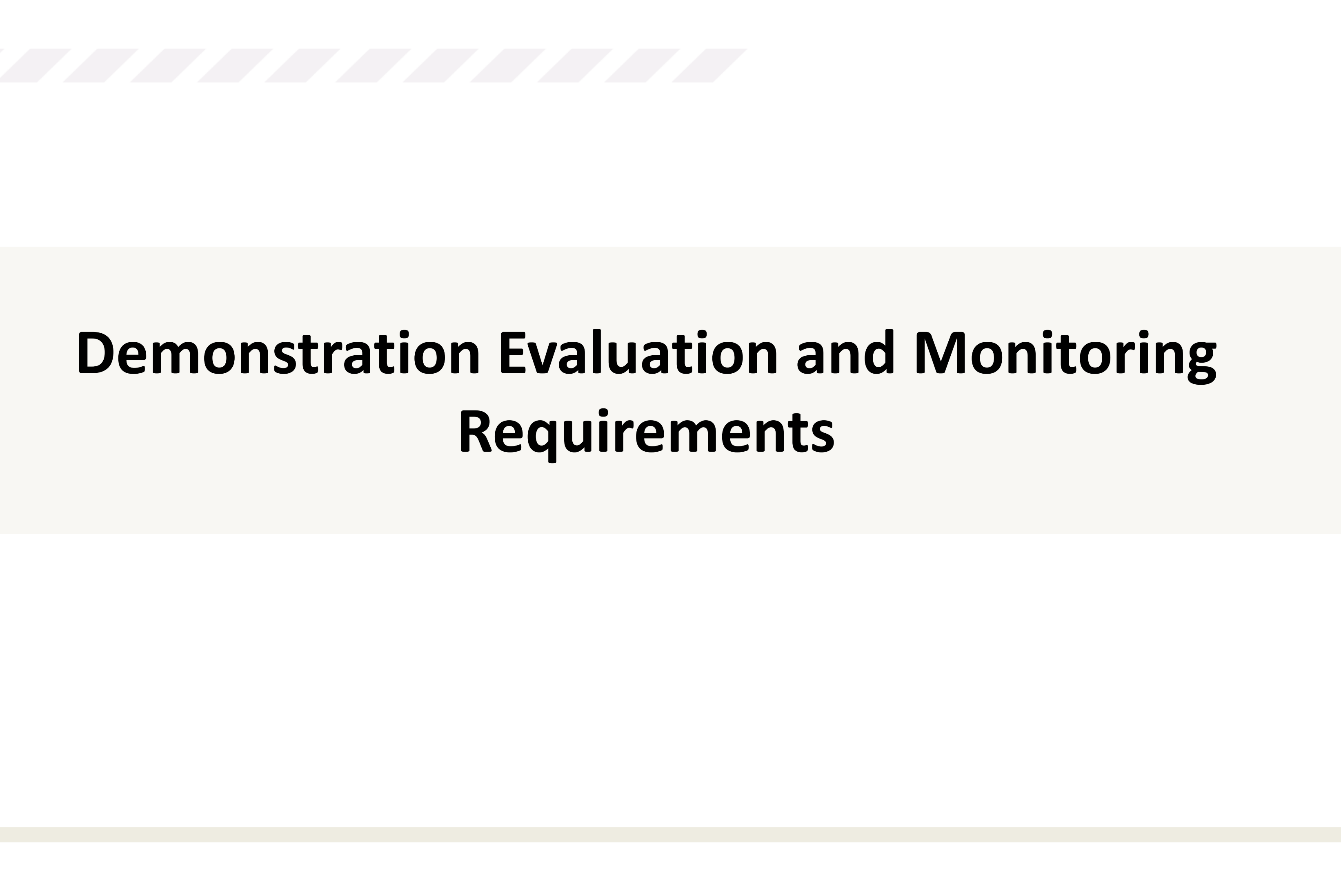
Retroactive Coverage

- If possible, the analysis of gap months should **exclude any retroactive coverage** to account for all the gaps in coverage that occurred.
- However, if there are costs attributable to retroactive coverage, **those can be used to reduce the cost of multi-year CE** (assuming they are not already counted in the state's estimate of the cost of implementing the 2023 CAA's one-year CE requirement).

Other Cost Savings

- Ending churn for a large group of children should result in **administrative savings for states** (fewer eligibility and enrollment actions) and **potential savings related to any similar costs built into the state's capitation rate paid to health plans**.

Source: Health Affairs, Continuous Eligibility and Coverage Policies Expanded Children's Medicaid.


Demonstration Evaluation and Monitoring Requirements

Overview of CMS' Evaluation Requirements

CMS requires states to hire an independent vendor to support them in development and submission of the following reports as part of the evaluation of their waiver demonstrations:

Evaluation Design and Budget: A draft design and budget must be submitted for CMS approval no later than 180 calendar days after the demonstration's approval.

The evaluation design must include:

General Background Information + **Evaluation Questions and Hypotheses** **Methodology** **Methodological Limitations**

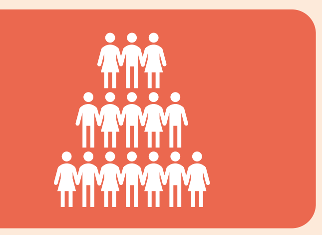
Interim Evaluation Report: Provides an update on the progress of the evaluation and presents findings to date; due to CMS one year prior to the end of the demonstration or at the time an application for demonstration extension is submitted.

Summative Evaluation Report: States submit this report, inclusive of an analysis of all years of the demonstration period, within 18 months of the end of the approval period. Once approved, the state must post the final report to the state's Medicaid website within 30 calendar days.

Source: CMS, 1115 Demonstration State Monitoring & Evaluation Resources.

CMS' CE-Specific Evaluation Requirements

For the CE component(s) of the state's demonstration, the evaluation design must include:



The impact of the CE policy program on all relevant populations, appropriately tailored for the specific time span of eligibility.

Example: How the CE policy affects coverage, enrollment and churn (i.e., temporary loss of coverage in which enrollees are disenrolled but then re-enroll within 12 months), as well as population-specific appropriate measures of service utilization and health outcomes.

An assessment of the effectiveness of the CE authority.

Example: For the state's populations of focus under the demonstration's CE policy, to the extent feasible, the state may collect and analyze data such as changes in enrollee income at 12-month intervals to inform how a longer period of eligibility can potentially help streamline the state's administrative processes around enrollment and eligibility determinations.

The state <u>may</u> conduct a comprehensive qualitative assessment involving enrollee focus groups and interviews with key stakeholders.

Source: Manatt analysis of approved section 1115 waivers, see Appendix.

States' Evaluation Design Trends

States with approved or pending waivers intend to evaluate the following hypotheses as part of their CE demonstrations:

Reductions in churn, lapses in coverage, and uninsured rates; maintenance or increased Medicaid enrollment.

Improved member satisfaction, health status, and quality of life.

Increased utilization of preventive services (including vaccinations, primary care and dental visits, and childhood screenings); and reduced utilization of acute care services.

Reduced expenditure growth (e.g., PMPM expenses) and administrative burden for the state.

States are stratifying these evaluation results to assess the impact of CE on promoting health equity (e.g., reducing inequities in churn rates by race/ethnicity)

Source: Manatt analysis of approved and pending section 1115 waivers, see Appendix.

Linking Evaluation Hypotheses to Data Sources

States have identified a range of data sources – including Medicaid enrollment, administrative claims data, and qualitative interviews – to evaluate the impact of CE policies on their target populations.

Evaluation Hypothesis	Example Data Sources
Reductions in churn, lapses in coverage, and uninsured rates; maintenance or increased Medicaid enrollment.	• Enrollment and eligibility data by age, race, and ethnicity • American Community Survey (ACS) • Data from Health Insurance Exchange
Improved member satisfaction, health status, and quality of life.	• Patient-reported outcomes measures/survey assessments [e.g., kindergarten readiness, self-reported measures of stability and security, time to first appointment, Consumer Assessment of Healthcare Providers and Systems survey, Behavioral Risk Factor Surveillance System] • Member interviews and focus groups
Increased utilization of preventive services; and reduced utilization of acute care services.	• Administrative claims data • Healthcare Effectiveness Data and Information Set quality measures (i.e., acute care utilization, well-child and adolescent visits, annual dental visits and oral evaluations, childhood/adolescent immunizations)
Reduced expenditure growth and administrative burden for the state.	• Operational data on agency staffing levels and case processing time • Program staff interviews/focus groups • Managed care capitation payments

Source: Manatt analysis of approved and pending waivers, see Appendix.

State Example: Washington

Washington's draft evaluation plan uses a mixed methods analysis to determine the impact of CE for young children zero through five relative to children in states without CE.

Hypothesis	Data Source	Analytic Methods
CE will be associated with **coverage gains**: • Lower uninsured rates for children	ACS 2017-2027	Difference-in-Differences (DID)
• Lower monthly disenrollment rates • Reduced churn/length of coverage gaps • Increased percentage of children with a long-term medical home	Integrated Client Database (ICDB) administrative data	Pre-post with controls
CE will **increase utilization** for the following quality measures: • Childhood immunization status • Well-Child Visits in the First 30 Months of Life • Child and Adolescent Well-Care Visits • Continuity of Primary Care for Children with Medical Complexity • Primary care visits • Visits with a non-primary care specialist physician • Developmental Screening in the First Three Years of Life		
CE will decrease **emergency department visits/hospitalizations**		
CE will be associated with **reduced PMPM** healthcare expenditures		
CE will be associated with **decreased poverty rates** and **increased preschool enrollment**	ACS 2017-2027	DID
Qualitative Questions: • How is the CE program implemented? What efforts facilitate knowledge of the program? What challenges emerge? • What is the experience of caregivers of children enrolled in this program?	Interviews with enrollees	Qualitative analysis

Source: Washington MTP 2.0 Evaluation Draft (available upon request).

CMS' CE-Specific Monitoring Requirements

In addition to general monitoring requirements states must adhere to as part of their demonstration*, such as submission of a Monitoring Protocol, conducting periodic calls with CMS, and submitting quarterly/annual reports, CMS has outlined several monitoring requirements specific to CE:

Monitoring Area	CE-Specific STCs
Enrollee-Reported Information and Periodic Data Checks	For individuals who qualify for a CE period that exceeds 12 months, **the state must continue to attempt to verify residency and whether the individual is deceased at least once every 12 months,** consistent with the data sources outlined in the state's verification plan(s) and/or confirmed by the household.
Annual Updates to Enrollee-Reported Information	**For all CE periods longer than 12 months, the state must have procedures and processes in place to accept and update enrollee contact information and must attempt to update enrollee contact information on an annual basis**, which may include annually checking data sources and partnering with health plans to encourage enrollees to update their contact information.
Performance Metrics	In addition to tracking enrollment and renewal metrics, systematic monitoring of the CE policy and enrollee churn must support—at a minimum—**understanding trends in preventive care services, including vaccination among populations of focus, and utilization of costlier and potentially avoidable services, such as inpatient hospitalizations and nonemergent use of emergency departments**.

*Analysis reflects only the following CE approvals during the Biden Administration: Massachusetts, New Mexico, Oregon and Washington.

Source: Massachusetts, New Mexico, Oregon, and Washington section 1115 waiver approvals.

Appendix

Sources

Approved CE Demonstrations	Pending CE Demonstrations	Enacted CE Legislation
Kansas *(Source)*	**Arizona** *(Source)*	**California** *(Source)*
Massachusetts *(Source)*	**Colorado** *(Source)*	**DC** *(Source)*
New Jersey *(Source)*	**Hawai'i** *(Source)*	**Ohio** *(Source)*
New Mexico *(Source)*	**Minnesota** *(Source)*	
New York *(Source)*	**New York** *(Source)*	
Oregon *(Source)*	**North Carolina** *(Source)*	
Washington *(Source)*	**Pennsylvania** *(Source)*	