1999 CENTER for STATE HEALTH POLICY 2024

CSHP Reflections

25 years informing, supporting, and stimulating sound and creative state health policy in New Jersey and around the nation

November 2024

RUTGERS UNIVERSITY

Table of Contents

Foreword

Dear Friends,

Congratulations to the Rutgers Center for State Health Policy (CSHP) team on 25 years of providing rigorous research, evaluating health policy and programs, and educating current and future health policymakers to drive health equity solutions in New Jersey.

We all have dreams for ourselves and our families that depend on living our healthiest lives possible. New Jersey is a leader when it comes to health and wellbeing, and ranks eleventh in an annual state-by-state assessment of the nation's health. But not every New Jersey resident has the same opportunity for health based on where they live, how much money they make or their race and ethnicity.

Policies, practices and structural racism have created more barriers for some than others. While low infant mortality is one of New Jersey's strengths, there are still unacceptable disparities by race and at the county level – Black infants throughout the state are twice as likely to die before their first birthdays as White infants. But the good news is that because these disparities are a result of policies that were intentionally built over time, together, with intentionality, we can dismantle them.

The work of the CSHP, combined with changing narratives around who is deserving of good health, is essential to shaping a more equitable future in New Jersey and throughout America. That's why the Robert Wood Johnson Foundation (RWJF) has invested $52 million in the CSHP since it was established in 1999.

Over time, RWJF's longstanding partnership with the CSHP has evolved from filling existing data and research gaps to promote health equity across New Jersey to examining the root causes of barriers to health such as structural racism in efforts to lift those barriers.

Through building the Center's capacity to provide timely and relevant information to policymakers and state agencies, RWJF funding has helped make CSHP a core part of New Jersey's policy infrastructure. The center provides consultation to the state on a variety of issues; for example, CSHP provided a rapid analysis of Census data to support the development of the "Cover All Kids" law in New Jersey, which enables all children, regardless of immigration status, to receive comprehensive coverage.

To build community power and move the policy agenda forward, the Center regularly works with community stakeholder groups such as the Camden Coalition, Citizen Action and others, and partners on research projects with organizations on the ground like Monarch Housing Associates.

CSHP's core research focus areas – health system performance improvement, population health, health care and access coverage and health and long-term care workforce – align with RWJF's goals to transform health in our lifetime.

Our partnership with CSHP has contributed to these goals and yielded so many important results over the last 25 years, including:

- **Preventing Childhood Obesity in New Jersey:** In 2008, CSHP initiated the NJ Child Obesity Study examining the connection between food and community conditions for physical activity to the prevention of childhood obesity in racially and ethnically diverse cities of Newark, Camden, Trenton and New Brunswick. CSHP provided comprehensive data produced for each of the four cities to community coalitions to develop prevention initiatives based on these data.
- **Advancing big data capacity through an Integrated Population Health Data (iPHD) Project:** Enacted through legislation in 2016, the iPHD enables and promotes population health research by integrating healthcare and social services data. RWJF has supported the Center in the development and operations of the iPHD since then. To date, the iPHD governing board – which includes representatives from New Jersey state agencies and experts on data security, research, consumer interests – has approved 12 projects addressing birth equity, the opioid crisis, and social determinants of health led by investigators from Montclair State University, Hackensack Meridian School of Medicine, the Central Jersey Family Health Consortium, Rutgers and other institutions.
- **Developing a policy roadmap to help all New Jerseyans live their healthiest lives** and to inform statewide activities.
- **Launching the RWJF-funded New Jersey Population Health Cohort Study (NJHealth Study)** in 2022 to collect data about the historically understudied effects of structural racism and discrimination on the health and wellbeing of 8,000 New Jerseyans from communities of color, multigenerational families, low-income communities and immigrant populations. The NJHealth Study also has a very active Community Advisory Committee, chaired by Victor Murray of the Camden Coalition with members from diverse backgrounds, some of whom work for advocacy organizations. The committee helps guide study implementation and recruitment, including subgroups with representatives from immigrant communities that are part of the study, who assist with language translations of questionnaires and recruitment materials.
- **Addressing health equity through housing** as part of the Rutgers Housing and Health Equity Cluster, using collaborative research and community-engaged work. CSHP has an extensive body of work addressing homelessness and housing instability in New Jersey and other states. Using Medicaid and homeless services data, interviews with people with lived experience, and interviews with teams developing innovative programs to promote cross-sector collaboration between housing and health services organizations, the Center builds on its National Institutes of Health-funded study of housing and health outcomes among Medicaid beneficiaries. CSHP is also working closely with the New Jersey Medicaid program to support the implementation of new Medicaid benefits to promote housing stability among beneficiaries, with hopes of evaluating and disseminating findings from those innovations once those strategies are in place.

We know the public policies that are needed to help everyone and every family in New Jersey to live their healthiest lives possible. But while we have made some progress on health equity, we have much more to do to address some of the greatest health disparities in the nation. That means understanding how our public health and healthcare systems – along with other institutions and organizations – uphold and perpetuate racial inequities, so that we can work toward a future where these barriers are not only lifted but eliminated.

BEST,

Richard E. Besser, MD
President and CEO, RWJF

INTRODUCTION

CSHP Reflections

Rutgers Institute for Health - New Brunswick

In the 1932 *New State Ice Co. v. Liebmann* decision, U.S. Supreme Court Justice Louis D. Brandeis referred to states as "laboratories of democracy" where creative ideas can emerge and be tested. This is no truer than in health and social spheres where federal law provides for formal authorities for states to test new ideas. Achieving the promise of state innovation requires the impartiality and rigor that academic institutions can bring.

In the late 1990s a triumvirate of leaders including David Mechanic, founding director of Rutgers Institute for Health, Health Care Policy and Aging Research, James Knickman, former vice president of research & evaluation at the Robert Wood Johnson Foundation, and Len Fishman, commissioner of the then New Jersey Department of Health and Senior Services, collectively identified the need for an academic center with a mission to inform state health policy in New Jersey. That idea sparked the creation and development of Rutgers Center for State Health Policy (CSHP/Center). Now in its 25th year, it is time to reflect on the Center's work toward its mission of informing, supporting, and stimulating sound and creative state health policy. This celebratory report – *CSHP Reflections* – shows the arc of the Center's progress and achievements in informing and supporting New Jersey's work to innovate in key health policy areas.

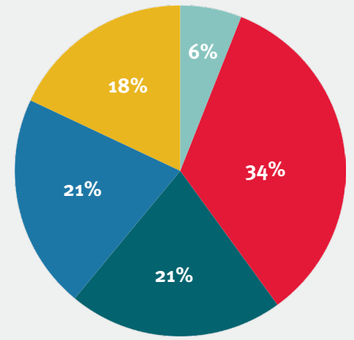
Central to the achievement of its aims was, and continues to be, the unwavering support of the Robert Wood Johnson Foundation. In 1999, the Foundation committed $11 million to establish the Center and has since provided five core support renewal grants totaling $24 million with an additional $2 million renewal award pending. This investment and display of trust provided the Center vital core resources to build a team of skilled faculty and staff to rapidly respond to emerging policy questions, develop important data resources, and translate research to policy and practice. In the two-plus decades since its founding, CSHP has leveraged its expertise to develop a rich portfolio of research from diverse governmental and philanthropic funders, building upon RWJF's investments to extend the Center's impact and reach in New Jersey and beyond.

Rutgers Center for State Health Policy informs, supports, and stimulates sound and creative state health policy in New Jersey and around the nation.

CSHP Reflections celebrates the 25th anniversary of the Center with a sampling of CSHP's work and impacts. While not possible to capture all the Center's accomplishments inside this document,

Grants & Contracts Awarded

1999-2024



Grant Funds to Date: $134,091,103

A BRIEF HISTORY *of* CSHP

A look back at the last *25 years* of informing and supporting sound health policy in New Jersey

1999

The Center is founded with generous support from the Robert Wood Johnson Foundation (RWJF). Joel C. Cantor is tapped to be the inaugural director of the Center.

the chapters that follow explore six major themes woven through CSHP's work and evolution since its founding. Selected CSHP research products are listed at the end of each chapter for those interested in more detailed findings. For those interested in further exploration, CSHP's website (cshp.rutgers.edu) features the full corpus of accomplishments of its faculty and staff, including easily searchable databases of projects and publications.

The chapters that follow, in general chronological order, focus on major throughlines of CSHP's work. The first chapter provides an overview of CSHP's work to inform policies promoting accessible, affordable, comprehensive private health insurance. The Center's work in this area began in its earliest days, first by informing policies to address failures in the individually purchased coverage market and examining strategies for advancing equitable access to health insurance coverage in New Jersey and nationally. The chapter highlights how many New Jersey policies portended components of the Affordable Care Act (ACA).

The second chapter describes work developed and led by then CSHP Co-Director Dr. Susan Reinhard, recently retired senior vice president and director of the AARP Public Policy Institute and chief strategist of the Center to Champion Nursing in America, focusing on **long-term care services and supports, especially home- and community-based services** programs. Having overseen program reforms related to family caregiving, consumer choice, and community-based care in her former role as deputy commissioner of the NJ Department of Health & Senior Services, Dr. Reinhard was ideally suited to spearhead technical assistance efforts and help states navigate the changing policy landscape after the 1999 U.S. Supreme Court decision in *Olmstead v. L.C.*, which compelled states to provide care and support in the most integrated community setting appropriate. While these issues were of central importance to New Jersey, this work had extensive implications for innovations among states across the country.

While **health equity** is a value infused throughout the Center's portfolio of work, the third chapter highlights projects that demonstrate the Center's policy-solutions-oriented approach to equity, describing work specifically addressing closing gaps in care for a leading cause of morbidity and mortality – heart disease. Drawing lessons from New Jersey's innovations in the regulation of cardiac services, this chapter illustrates how the Center's work helps advance the practical science of health equity.

The fourth chapter discusses a key area of focus for the Center's current work – studying **Medicaid policy** innovations. Building upon its work on New Jersey's Medicaid accountable care organization (ACO) demonstration program (also featured in Chapter 5), CSHP was tapped to lead evaluations of the state's Medicaid comprehensive §1115 demonstrations, currently launching its third, five-year renewal. Under federal and state authorities, CSHP serves as the independent evaluator of major policy innovations in New Jersey's Medicaid program. These innovations are aimed at addressing pressing health needs for populations facing some of the most complex health and social challenges, including providing humane and effective long-term care services for enrollees with disabilities and promoting housing stability for Medicaid members at-risk of homelessness.

The fifth chapter describes CSHP's role in addressing one of the greatest challenges in the US health care system – financing, organizing, and providing high quality care for **people with complex conditions**, including those facing challenges related to social determinants of health. Along with providing analytic support for the creation of the state's innovative Medicaid ACO demonstration in partnership with the Camden Coalition, state officials, and others, CSHP led a major national initiative to change the paradigm of care for high-need, high-cost populations. This commitment continues today with a renewed focus on research about strategies to reduce expensive, avoidable hospital emergency department and inpatient care and increase access to essential community-based health and social care services.

The sixth and final chapter discusses CSHP's growing **population health** research and data development portfolio. This includes groundbreaking work exploring the role of community food and physical activity environments in childhood weight status and informing strategies and evidence-based interventions. The Center continues its leadership in this area with the development of two significant population health research initiatives – the New Jersey Integrated Population Health Data (iPHD) Project and the New Jersey Population Health Cohort Study (referred to as the NJHealth Study). Both promote interdisciplinary research spanning universities and other research institutions within and beyond New Jersey, creating wide-reaching opportunities to improve the health and wellbeing of residents and advance health equity for all.

Under the leadership of CSHP Director Joel Cantor and Executive Director Margaret Koller, with the commitment and contributions of the Center's faculty and staff, present and past, and the support of philanthropic partners and state government colleagues, CSHP has developed a wide-ranging research portfolio spanning multiple health policy domains. While substantial progress has been made in the more than two decades since its founding, CSHP's work is by no means complete. Challenging health policy issues at the state and national levels remain, including stubbornly wide health inequities, high and rising health care costs, and continued under-utilization of essential health services and over-utilization of low-value care. Looking toward the future with anticipation, the Center has rich and challenging work ahead to advance its mission to *inform, support, and stimulate sound and creative health policy in New Jersey and around the nation*.

2001

Susan Reinhard, CSHP's then co-director, spearheaded technical assistance efforts to help states navigate the shift toward promoting community living for those requiring longer duration support.

2002

CSHP initiated a major study of the troubled Individual Health Coverage Market in New Jersey, co-funded by RWJF and the Commonwealth Fund.

CHAPTER 1

Making Health Insurance More Affordable in New Jersey

Trenton, New Jersey

States are often the most successful laboratories of policy innovation in insurance coverage, an important factor in accessing health care and improving health outcomes. This has certainly been the case in New Jersey, which has a long history of pursuing efforts to make health insurance coverage more affordable and accessible for its residents. Many of the policy initiatives that were implemented in New Jersey over the better part of the last three decades reflected core affordability and equity strategies that were advanced in the 2010 Affordable Care Act (ACA). CSHP has been an engaged partner and has had a seat at the policy table over the last 25 years, working shoulder-to-shoulder with state policymakers, legislative leaders, and diverse stakeholders to maximize access to affordable health insurance in New Jersey. Below is a historical snapshot of selected reforms and how CSHP's work has influenced these efforts.

Embracing ACA principles long before its enactment

In the early 1990s, New Jersey's bi-partisan legislature sought to develop a system of affordable and accessible health insurance, especially for children and people without access to employer-sponsored health plans. Nearly two decades before the Affordable Care Act became the law of the land, New Jersey's 1992 Health Care Reform Act created insurance programs for individuals and small employers that ensured coverage could not be denied due to medical risk or pre-existing conditions.

The 1992 reforms created a subsidy program encouraging enrollment in individual health insurance plans. It was an important step, but ultimately fell short -- at its peak, only assisting 20,000 people. The effort was ultimately repealed, with funds redirected to focus on expanding coverage for children through the then newly enacted federal Children's Health Insurance Program (CHIP).

Fast Facts on Coverage Inside New Jersey (2022)

- Over 96% of children had health coverage.
- Over 92% of eligible children participated in Medicaid/CHIP.
- 92% of non-elderly residents had insurance coverage.

Source: NJ State Health Assessment Data (NJSHAD): Health Indicator Report

2006

The Center hosted a New Jersey Health Policy Conference, *Striving for Excellence in NJ Health Care*, with the support of RWJF.

2006

Center Director Joel Cantor received the Rutgers University President's Award for Research in Service to New Jersey.

Highlighting problems and identifying a path toward sustainable individual market reforms

As subsidies ended and regulations intended to make coverage more affordable were implemented, individual health insurance program enrollment plunged from about 180,000 in 1995 to 85,000 in 2001. To assess underlying issues and identify solutions, CSHP – with support from the Commonwealth Fund and the Robert Wood Johnson Foundation – analyzed the individual market reforms. Published in 2004, this impact analysis pointed to why – after a brief period of rising enrollment and stable premiums – the individual insurance market rapidly became unsustainable. "Pure" community rating (with no differential premiums by age, sex, or health status), along with rules preventing insurance companies from excluding people with pre-existing conditions and the end of subsidies led to rising costs and enrollment declines, particularly among young (and often healthy) adults. With those remaining in the individual market having substantial health care needs, premiums soared. Not surprisingly, enrollment among low-income participants also dropped significantly with the end of state subsidies. The study concluded that the program spiraled because it was impossible in a voluntary, unsubsidized health insurance market to guarantee coverage access and ban health-related or demographic premium variations. CSHP's work not only pointed to the unsustainability of those dynamics but also laid the groundwork for future action. CSHP conducted simulation modeling of health insurance market regulatory options for New Jersey, which were foundational to reforms ultimately enacted to help stabilize the market. This experience in New Jersey also proved to be instructive years later in the constitutional defense of provisions of the ACA.

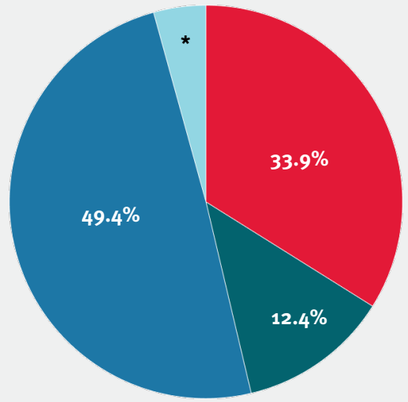
Taking the pulse on priorities and appetites for change among New Jerseyans

Fast forward to May 2008 when CSHP Director Joel Cantor testified before New Jersey's Senate Health, Human Services, and Senior Citizens Committee, which was then considering a bill to expand health insurance coverage.

Public Views on Need for Reform from CSHP's New Jersey Health Care Opinion Poll (2007)

Which of the following three statements come closest to expressing your overall view of the health care system in New Jersey?

- 49.4% There is some good things about our healthcare system, but fundamental changes are needed.
- 33.9% Our healthcare system has so much wrong with it that we need to completely rebuild it.
- 12.4% On the whole. The healthcare system works pretty well and only minor changes are necessary to make it work better.



*** "Don't Know" and refused responses**

Source: Rutgers Center for State Health Policy, New Jersey Health Care Opinion Poll, 2007

2008

Led by Research Professor Michael Yedidia, CSHP initiated the NJ Childhood Obesity Study, examining the contribution of the food and physical activity environment to the prevalence and prevention of childhood obesity in four low-income New Jersey cities.

2008

Joel Cantor, Director of the Center, testifies before the State Senate's Health, Human Services, and Senior Citizens Committee, which was considering a bill to expand health care coverage in New Jersey.

Based on CSHP's 2007 New Jersey Health Care Opinion Poll, Cantor reported that New Jerseyans were "deeply dissatisfied with the status quo in health care," and that "the public [had] a deep desire for state government to address the dual problems of health care cost and coverage."

At the time of the poll, about 92% of residents believed it was important for "New Jersey's government leaders to address the cost of health care and health insurance this year." Similarly, nearly as many (85%) also wanted the state to expand health care to those without insurance.

The NJ Senate enacted legislation in 2008 to address what Cantor identified as "the greatest [health care] challenge" of that decade – improving affordability of coverage for everyone. This health care reform bill, pre-dating the ACA by two years, reflected statewide support for expanded health care access. Passed by the legislature and signed by then Governor Jon Corzine, the law prioritized children, mandating health insurance coverage through private or employer-sponsored insurance or public programs such as NJ FamilyCare, the state's Medicaid program. The law also expanded NJ FamilyCare for low-income parents.

Equally important, the law reformed New Jersey's existing commercial market to make coverage more affordable for uninsured populations needing individual policies, those not yet eligible for Medicare, and people with pre-existing health conditions who are most vulnerable to coverage gaps.

The ACA was signed into law by President Obama two years later in 2010. While many of its provisions were not effective right away, an important provision enabling young adults to remain on their parents' health insurance until the age of 26 went into effect immediately.

Informing the Field on Effectiveness of Young Adult Dependent Coverage Policies

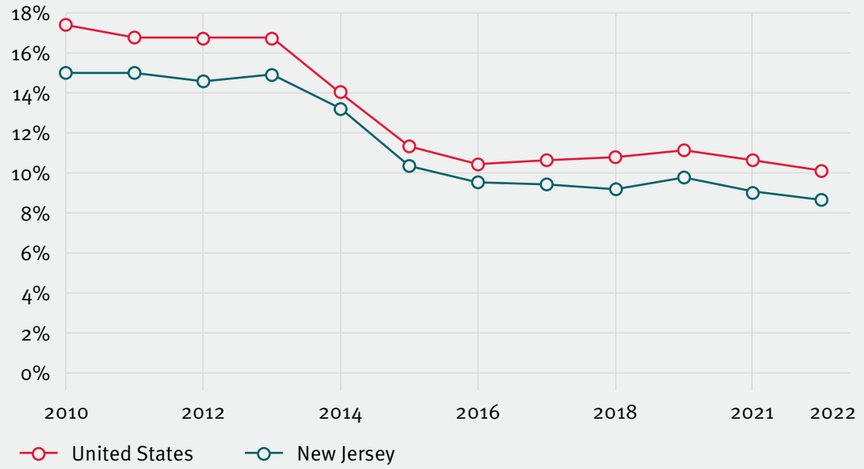
- CSHP researchers conducted a series of studies about the **effectiveness of policies allowing young adults to stay on their parents' private health insurance** plans.
- An early CSHP study found that state-based young adult-dependent laws enacted before the ACA were largely ineffective, but that the **ACA-based rule requiring plans to cover dependents up to age 26 effectively increased coverage** among this group.

Significantly, New Jersey was already at the forefront of this policy wave, passing a state Dependent Under 31 (DU31) law in 2006 permitting dependents to remain on their parents' private insurance plans until their 31st birthday if they met certain other eligibility criteria.

With full implementation of the ACA provisions in 2014, New Jersey swiftly expanded the number of residents with health coverage, building on a foundation of insurance reforms that had previously been adopted at the state level, a commitment to coverage that continues today.

The road to ACA implementation in New Jersey, while challenging, was certainly less steep than in other states because the seeds had already been planted with previous policy innovations decades earlier that continue growing today. Since the ACA's passage, New Jersey's uninsured rate dropped from 15% in 2010 to 6.8% in 2022.

Uninsured Persons Under Age 65 by Year, New Jersey and the United States, 2010 to 2022



Source's: KFF State Health Facts.

2008

The Center was designated RWJF's national program office for awarding research grants to Evaluate Innovations in Nursing Education (EIN).

2009

The Center evaluated New Jersey regulations of coronary angiography, a critically important diagnostic test, showing that the State's reforms eliminated a large disparity in utilization by Black compared to white patients.

Informing the debate within and beyond New Jersey

In June 2012, as the ACA was being litigated in the court of public opinion as well as in judicial halls, the Supreme Court in the *National Federation of Independent Business v. Sebelius* case upheld the constitutionality of the ACA's minimum essential coverage provision, known as the individual mandate. The mandate required most people to maintain a minimum level of health insurance coverage. In oral arguments, then Solicitor General Donald B. Verrilli Jr. drew from CSHP research to make the federal government's case for the imperative of an individual coverage mandate. Informed by learnings from New Jersey's experience with adverse selection described above (when a market is disproportionately driven by people with substantial health care needs, propelling costs and prompting healthier, "lower risk" individuals to seek other alternatives, including dropping insurance altogether), Verrilli argued that the absence of an individual mandate to mitigate risk would toll the death knell for the ACA.

Over the past 25 years, New Jersey policymakers, legislators, and other stakeholders have relied on CSHP's analysis to inform health coverage policy decisions and assess and improve existing programs. CSHP's research on the public attitudes and perceptions of health insurance coverage, effects of insurance and insurance practices, and the extent to which New Jersey residents have (or have been denied) access to quality care have helped inform decision making and progress in expanding coverage.

No doubt, challenges remain in ensuring affordable access to health insurance in New Jersey and across the country. As federal health insurance coverage policies and available subsidies change and private insurance markets continue to evolve, the need for evidence-informed decision making has never been greater. As we move forward to the next decade of post-ACA policy that now includes the presence of a robust state-based marketplace, *Get Covered NJ*, to purchase non-group insurance, CSHP stands ready to continue its work in providing analytic expertise and serving as a neutral convener and trusted stakeholder to help advance policies to improve access and affordability.

CHAPTER 2

Building and Strengthening Home- and Community-Based Service Capacity for People with Long-Term Care Needs

Gloucester, New Jersey

2009

The Center hosts its second New Jersey Health Policy Conference, *More is Not Better: Improving Value in NJ Health Care*, launching collaborations with the Camden Coalition to address care for complex patients with high avoidable healthcare utilization.

2010

The Patient Protection and Affordable Care Act (known as the ACA or "Obamacare") is signed into law.

Within and beyond New Jersey, there is inadequate capacity to effectively provide home- and community-based services (HCBS) for all those individuals needing them. In its early years, CSHP led a series of efforts to help build and strengthen state capacity to provide HCBS for individuals with long-term illnesses and disabilities, many of whom would otherwise be forced to get care and support in institutional settings. The body of work stemming from these efforts, which continues to inform policymaking today, helped pave the way for widespread adoption of strategies and programs enabling more individuals to have their needs met in their homes and communities.

Most seniors and individuals with disabilities prefer to remain in their homes and communities. A 2021 AARP *Home and Community Preferences* survey found that more than 75% of older Americans, a majority of whom will need long-term services and supports (LTSS) after age 65, prefer to age in place. Despite these preferences, Medicaid – the primary funder of LTSS for older individuals and those with disabilities – traditionally focused on reimbursing institutional-based care. For years, policies favoring institutional-based care settings prevailed, despite evidence suggesting this care is generally more costly than home- and community-based alternatives.

Understanding and capitalizing on the tides of change

While selected states had explored alternative models for providing care and supports to individuals in their homes and communities, a series of trends prompted what some termed "formidable" forces for a "balancing" of care — shifting from institutional-based care toward home and community alternatives.

> ***"So … people want to stay at home. There is no question about it … We really have to shift the funding to more home and community-based services."***
>
> Reflections on HCBS from former CSHP Co-Director Dr. Susan Reinhard

These included:

- An increased number of aging Americans;
- Mounting preferences expressed by older adults and people with disabilities to get needed care and help outside institutional settings;
- Accompanying policy shifts, like the Americans with Disabilities Act (ADA), mandating integration, rather than isolation, of individuals with disabilities; and
- Pressures to curb Medicaid costs, which were consuming a sizeable share of state budgets.

As these trends unfolded, a tipping point for change came from the 1999 Supreme Court decision in *Olmstead v. L.C.*, finding Georgia's inability to provide adequate and timely community-based care to two women with disabilities, who were repeatedly re-institutionalized due to a lack of services and supports, violated their ADA rights. The decision forced states to provide care and support in the most integrated setting appropriate.

Maximizing impacts through helping states navigate shifts to HCBS

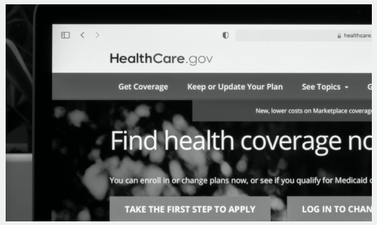
Recognizing a lack of state capacity to respond to the *Olmstead* ruling and growing demand for HCBS, private and public funders launched programs to help build and strengthen these alternatives. One such effort included some $280 million in Real Choice Systems Change (RCSC) grants from the Centers for Medicare & Medicaid Services (CMS) to promote community living through grants to all states, territories, and the District of Columbia. Technical assistance to help guide and leverage these funds was included in the programming.

In 2001, CSHP's then co-director, Dr. Susan Reinhard, was well-suited to spearhead these technical assistance efforts, helping New Jersey and other states navigate these program and policy shifts. In her former role as deputy commissioner of the then NJ Department of Health and Senior Services, Dr. Reinhard had overseen program reforms related to family caregiving, consumer choice, and community-based care. CSHP's burgeoning technical assistance portfolio was supported through a range of initiatives, including the Robert Wood Johnson Foundation's State Solutions and federal Real Choice Systems Change and Community Living Exchange programs. Under Reinhard's leadership, CSHP assembled a skilled and experienced team of former state officials and policy experts to provide a range of expertise and specialized offerings tailored to meet state-specific needs. The team provided an array of technical assistance, including:

- **Developing individualized state assessments and plans:** Reflecting on the technical assistance efforts, the team noted success in proactively outreaching to states, conducting "continuous" assessment of state needs, and creating customized plans to meet them. Plans evolved as state progress did, moving from early implementation to operationalizing and sustaining change.
- **Creating conversations within and across states:** A cornerstone of CSHP's technical assistance was linking states with others further along the continuum of HCBS program development, providing opportunities for states to learn from the experiences of other states. Through ongoing regional and national meetings, states collectively strategized on

2011

Governor Chris Christie signed legislation that authorized a demonstration testing the use of Accountable Care Organizations (ACOs) in Medicaid, with CSHP providing analytic support.



2011

CSHP is tapped by the State to conduct a series of analyses supporting New Jersey's response to opportunities under the ACA.

challenges and solutions. Regular state surveys drove agendas for discussions. Topic-driven conference calls and "issue summits" were convened on pressing priorities, with relevant technical experts brought in as needed. A strategic move was to regularly include CMS on cross-state policy calls to facilitate bi-directional learning. States appreciated hearing clarifications on policies directly from CMS; CMS appreciated the chance to provide input into the real-time implementation decision points of these policies in the field. *Connecting the Dots* meetings were also launched to promote discussions among decision makers inside individual states — each holding levers for systems change — to prepare and align for action.

- **Creating practical products to navigate specific issues:** The technical assistance team developed a variety of practical products for states, including customer-driven issue briefs, topical papers, best practice reports, sample policies (complete with approaches, strengths, and weaknesses), monitoring tools and indicators, and toolboxes on areas such as *Money Follows the Person* and nursing home transition initiatives. Websites were launched to provide forums for states to exchange information, including opportunities to ask and respond to questions.

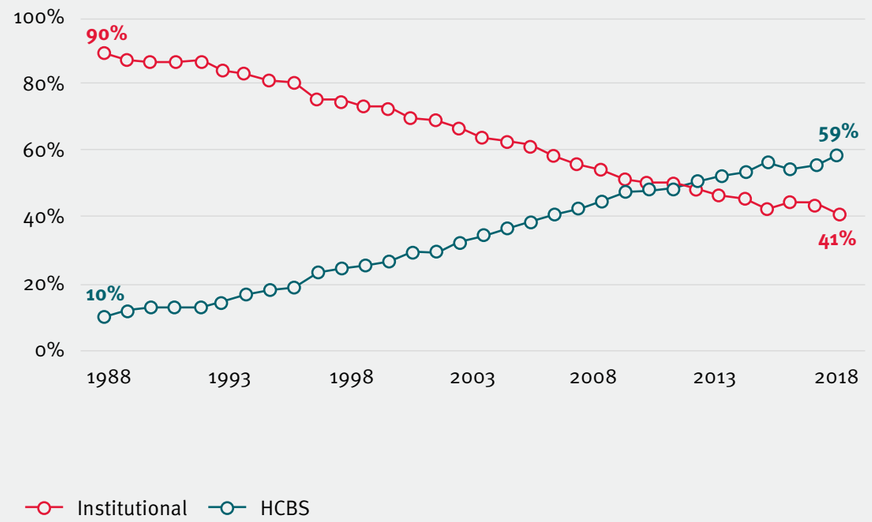
Collective impacts from these efforts were widespread. Over 1,100 informational documents were created and posted on HCBS.org, some having tens of thousands of downloads. Papers developed by the Technical Assistance team were referenced by CMS on its website and throughout its correspondence to states, extending the reach of these efforts. The *Connecting the Dots* approach to facilitate in-state connections and collaborations on systems reform was adopted by several states, including Massachusetts, Indiana, Ohio, and Pennsylvania. This concept was also ultimately incorporated into CMS's request for proposals. In New Jersey, along with helping facilitate *Money Follows the Person* strategies, information from program pilots was used in policy debates around nurse delegation reforms.

What was the impact of all these efforts?
Over time, Medicaid LTSS funding shifted, aided in part by the work of CSHP. In 2013, the scales of "balancing" finally tipped with more LTSS funding spent on HCBS than institutional care (as shown to the right).

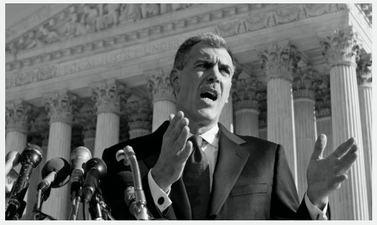
With a significant share of states still spending less than half of LTSS funding on HCBS, these shifts continue to unfold. Several program grantees cited the foundational work and technical assistance provided by CSHP years ago as critical to their success in implementing change. Papers supported through these efforts, including those on community choice counseling, are still used by policymakers today.

Most importantly, these early technical assistance efforts established CSHP as a trusted policy partner, providing practical help and timely, objective information to leverage "open windows" of opportunity to help create sound and informed change in and beyond New Jersey.

Shares of Medicaid LTSS Expenditures 1988-2018



Source: Mathematica LTSS Expenditure Reports FY 2017-2018, 2019.



2012

In his oral argument before the US Supreme Court making the case for the Affordable Care Act, the Solicitor General, Donald Verrilli, drew directly from research published by CSHP to make the federal government's case for the individual mandate.

2013

The New Jersey Medical and Health Sciences Education Restructuring Act went into effect, integrating the University of Medicine and Dentistry of New Jersey (UMDNJ) with Rutgers.

CHAPTER 3

Advancing Health Equity and Closing Disparities in New Jersey

Newark, New Jersey

Spotlighting health disparities and informing strategies to eliminate them has been a cornerstone of CSHP's work since its founding. Despite being a high-income state often at the forefront of progressive health policy, New Jersey has surprisingly deep health inequities. New Jersey's equity gap was strikingly evident in the first Commonwealth Fund State Health Scorecard, co-authored by researchers at CSHP, which ranked the Garden State 33rd in health system equity.

CSHP has worked to understand where, how, and why health inequities exist. Its evaluation of New Jersey cardiac services regulatory reforms in the late 1990s exemplifies the Center's work to find policy levers to close health disparities. This study, funded by the US Agency for Healthcare Research and Quality (AHRQ), assessed impacts of legislative changes to expand access to cardiac angiography, an important procedure in diagnosing serious, treatable heart disease.

Motivating the New Jersey reforms at the time, Black Americans were less likely to receive this important diagnostic test despite being 30% more likely than whites to die from heart disease and having a higher prevalence of cardiac risk factors, such as high blood pressure. CSHP investigators studied the impact of regulatory changes on this long-standing access gap, finding a rapid increase in the rate at which New Jerseyans who are Black received the procedure. These changes were not mirrored in nearby states that did not implement similar reforms. Before these changes were implemented, Black patients were about 20% less likely to undergo an angiography procedure than their white counterparts. **After these reforms, Black patients received the diagnostic procedure at about the same rate as white patients.**

New Jersey Cardiac Angiography Hospital Licensure Reforms

- **1996**
  Established a pilot program doubling the number of hospitals licensed to perform cardiac angiography for low-risk patients only.
- **1998**
  Allowed some originally licensed cardiac angiography hospitals to add cardiac surgery, contingent, in part, on demonstrating a record of addressing access disparities.
- **2001**
  Created a process for hospitals licensed to serve low-risk patients to "graduate" to full-service licensure (including high-risk patients).

2014

Governor Christie acknowledges CSHP's federally funded work testing strategies to improve care for patients with complex conditions, tasking Rutgers "to expand the scope" of its research to help "innovate and improve" care for Medicaid high-utilizers inside New Jersey.

2014

The Center is selected to serve as New Jersey's program evaluator for the first NJ FamilyCare Medicaid comprehensive §1115 demonstration.

Digging into the data for a deeper understanding of policy consequences

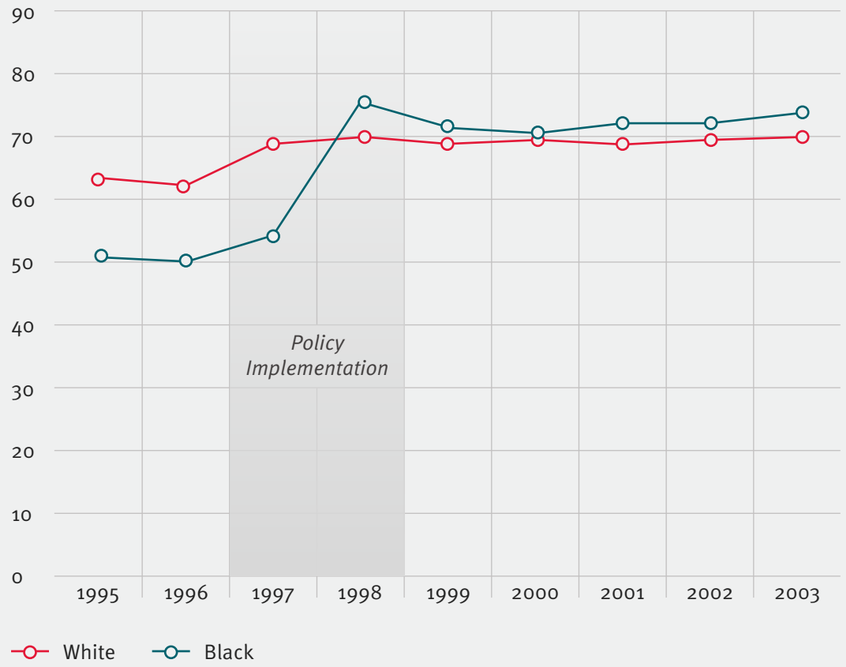
Interestingly, CSHP researchers observed that the share of angiography patients who were Black increased most in hospitals licensed to provide this service *before* the New Jersey reforms, not those newly licensed to perform the test on low-risk patients. From their analyses, they concluded that pre-reform restrictions on hospital capacity to deliver these important services were, in effect, allowing hospitals to skew services to higher income, well-insured populations which were disproportionately white. In interviews at one of the hospitals licensed to perform angiography before the reforms, a hospital executive overseeing cardiac services attributed the closing of the Black-white gap to a change in their major referring cardiology practice after the reforms to one that was "…seeing more [local] area patients, which may explain the increase in [service to Black patients]." Seeing the hospital's angiography data arrayed by race, the official reflected "…we've never looked at this, so this is new to us."

Restrictions on the number of hospitals permitted to perform cardiac angiography were at one time common across states. Evidence at the time suggested that concentrating the service in a limited number of centers of excellence would ensure high quality. Pre-reform licenses would typically be awarded to major urban teaching centers which disproportionately served local patients who were low-income and often people of color. However, **CSHP's study revealed that these well-intended regulations led to a form of structural discrimination, in this case, leading to a persistent access gap to this important procedure for Black patients.**

New Jersey Black-White Gap in NJ Cardiac Angiography

Age/Sex adjusted, inpatient and same-day procedures

Rate per 10,000 adults



Source: Cantor,DeLia, Tiedmann, Stanley, and Konebusch, Health Affairs, 2009

2015

CSHP launched the federally funded State Innovation Model (SIM) Design award, coordinating a suite of activities focused on advancing systems changes, particularly related to improving care and service delivery for the state's Medicaid population.

iPHD NEW JERSEY

2016

New Jersey Governor Chris Christie signs legislation authorizing the NJ Integrated Population Health Data (iPHD) Project.

Understanding linkages between diffusion of new medical technology and racial disparities

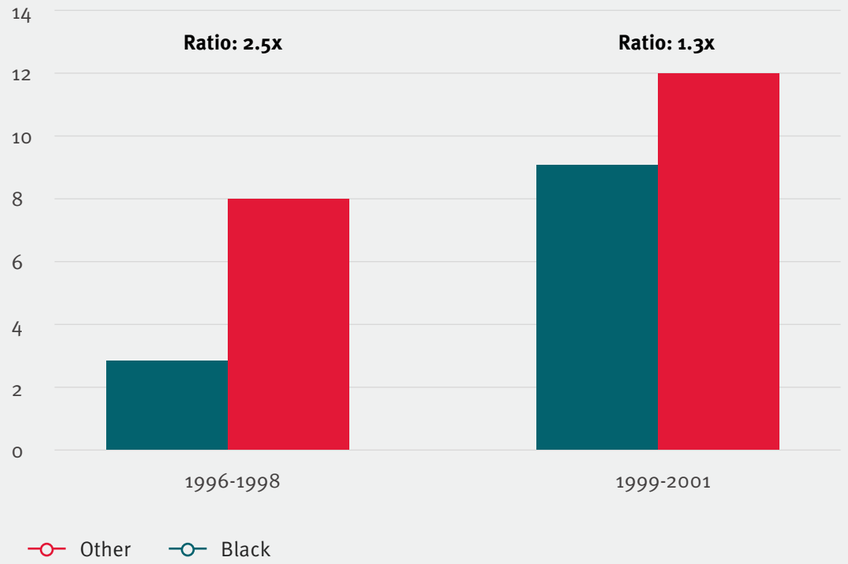
The Center's in-depth evaluation of New Jersey cardiac service regulatory reforms revealed that limiting service availability, even when intended to promote high-quality care, can lead to structural access barriers for minoritized populations. But even without regulatory actions, supply constraints can lead to similar outcomes, especially for new medical technologies, when these services are offered first by research and teaching hospitals before being diffused more broadly. CSHP studied one such technology, implantable cardioverter defibrillators (ICDs), for patients at risk of sudden cardiac death.

A small pacemaker-like device, ICDs detect abnormal heart beats and deliver often life-saving electric shocks to restore normal heart rhythms. First licensed by the US Food and Drug Administration in 1985 and recommended for wide adoption in a 1996 scientific "consensus statement," ICDs became widely known when former Vice President Dick Cheney received one in 2001.

CSHP's study examined disparities in ICD treatment across the country and found that even after consensus for widespread adoption, Black-white disparities remained. Yet the study also documented that **as more facilities added ICD implantation capacity, the disparity declined by about half**. Like CSHP's New Jersey cardiac angiography study, the Center's ICD study concluded that when service supply is constrained, racial disparities are exacerbated.

Black-White Gap in Implantable Cardioverter Defibrillators (ICDs) Therapy Among Patients At Risk of Sudden Cardiac Death, US*

Rate per 100 At-Risk Patients



*Hospital diagnosis of sustained ventricular tachycardia or ventricular fibrillation.
Source: Stanley, DeLia, Cantor, J Nat Med Assn. 2007

2017

The Center convened a panel discussion, titled *Health Care Reform After the Affordable Care Act,* exploring the implications of "repealing and replacing" the ACA.

Get Covered NJ

2020

CSHP's data snapshot of health insurance coverage in the state helped to inform the implementation of NJ's state-based health insurance marketplace, "Get Covered NJ."

Identifying policy levers to break the scourge of disparities

Although Black-white gaps and other disparities in medical treatment have been documented for years, fewer studies have illuminated pathways through which these gaps arise and can be addressed -- work essential for informing solutions to structural disparities.

Understanding disparity-driving mechanisms is a necessary first step, but the challenge of formulating and implementing policy solutions to eliminate those disparities remains. One initial step is ensuring that patients enrolled in studies of new treatments are diverse, a strategy embraced by Rutgers Health through its National Institutes of Health-funded New Jersey Alliance for Clinical and Translational Sciences and related initiatives.

CSHP remains a leader in adding to the knowledge base for under-studied populations and informing strategies to eliminate health inequities through its major research initiatives, including evaluating innovations in the NJ FamilyCare (Medicaid) program and through the NJHealth Study, both discussed in the chapters that follow.

Trenton, New Jersey

CHAPTER 4

Informing Innovations in Medicaid Policy and Delivery Systems

2020

New Jersey and the country face the COVID-19 pandemic, leading to massive social and economic displacement.

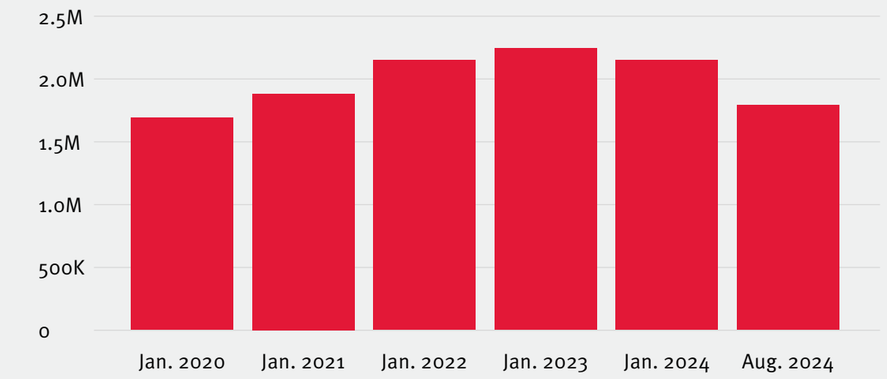
2021

Joel Cantor leads the NJ Population Health Cohort (NJHealth) Study, launched with an $8 million grant from the Robert Wood Johnson Foundation.

No program has shaped CSHP's analytic priorities more than Medicaid. This program has been a lifeline for many individuals with low-incomes and disabilities, improving access and a range of health outcomes, including among infants and children. Created in 1965, Medicaid provides state matching grants to subsidize health insurance coverage for low-income individuals. Along with Medicare and employer-sponsored coverage, Medicaid is one of three major pillars in the American health insurance system.

Medicaid programs vary, each state having considerable discretion when it comes to who is covered, what services are offered to enrollees, and how services are delivered. The saying goes that, when you see one state Medicaid program, you see one state Medicaid program. **New Jersey has one of the more expansive Medicaid programs, called NJ FamilyCare, with more than 1.8 million state residents enrolled as of August 2024, or nearly one in five residents.** Enrollment has grown over the years, peaking at more than 2 million residents during the COVID-19 public health emergency.

Number of Individuals Enrolled in NJ FamilyCare, 2020-2024



Source: NJ Department of Human Services, Division of Medical Assistance and Health Services

From its inception, CSHP has focused on Medicaid policy, and its partnership with the state became particularly robust starting in 2011, when New Jersey policymakers established the Medicaid Accountable Care Organization (ACO) demonstration project and assigned CSHP a key analytic role. During this period, state Medicaid officials also contracted with CSHP to evaluate its Medicaid comprehensive §1115 demonstration program which launched a major transformation of long-term services and supports (LTSS) provided to enrollees who are aging or have disabilities. Most recently, CSHP has collaborated with the state to examine Medicaid challenges in serving people experiencing homelessness.

Answering the call to evaluate the impact of Medicaid ACOs

State legislation in 2011 (P.L. 2011, Chapter 114) created a pilot project to assess the efficacy of ACOs in enhancing Medicaid's cost-effectiveness through reducing utilization of expensive, but avoidable hospital care while enhancing the quality of community-based services.

To incentivize providers to participate in the ACO demonstration, the state offered opportunities to share in savings generated by the ACOs if they achieved quality care targets. The law sought to promote policy learning by understanding ACOs' effectiveness in achieving quality and savings goals. Subsequently, state Medicaid officials approved three ACOs in Camden, Newark, and Trenton, and tapped CSHP for analytic expertise, given the methodological complexity involved in assessing the ACO pilot.

The ACO law required state agencies to provide "all data necessary" to CSHP "for analysis in support of" the state's "review of gainsharing plans" and "to perform the annual evaluation of the demonstration project." CSHP promptly responded to the legislative mandate, undertaking the complex task of developing methods to estimate any savings achieved by the three ACOs.

In 2012, CSHP recommended an approach to calculate ACO savings, with extensive consultation with state Medicaid officials. Analyses concluded that the three ACOs did not produce appreciable cost savings over the limited period of the demonstration, yet suggested that ACOs yielded benefits in meeting the health care needs of underserved populations. Among other things, ACOs served as conveners and connectors among diverse health and social service providers in their communities. To preserve these benefits, the state enacted new legislation transitioning the three ACO pilots into formal Regional Health Hub (RHH) partnerships, adding a fourth RHH in Passaic County.

CSHP's work contributed important new findings about the design of Medicaid ACO initiatives in other states. New Jersey's decision to provide CSHP with Medicaid data as well as CSHP's ability to produce rigorous findings established important

2021

CSHP awarded a grant from the National Institutes of Health to study homelessness as a social determinant of health among Medicaid beneficiaries and how permanent supportive housing may improve Medicaid utilization among people experiencing homelessness.

NJ FAMILY CARE
Affordable health coverage. Quality care.

2021

CSHP provided a policy memo to Medicaid leadership estimating the remaining uninsured children in NJ. The memo informed Governor Phil Murphy's "Cover All Kids" initiative.

precedents that served as the bedrock for future work. This initial analytic collaboration required navigating inherently complex legal, data security, and privacy concerns, which often impede such analytic arrangements between state Medicaid agencies and external research organizations. CSHP's access to New Jersey Medicaid data fortified an analytic partnership that has deepened since this first collaboration.

Evaluating the impacts of innovations in NJ's Medicaid Program

The §1115 demonstrations have been central to the evolution of New Jersey's Medicaid program. CSHP's evaluations of these waivers have bolstered its analytic capacity and partnership with the state.

In 2012, state Medicaid officials received federal approval of a demonstration waiver that, among other things, sought to transform LTSS delivery by moving it into managed care. LTSS involves assistance with daily living activities such as bathing and eating. Federal Medicaid law requires all states to provide LTSS to eligible seniors and younger individuals with disabilities who reside in nursing homes. States have more options regarding whether and how to cover LTSS in beneficiaries' homes and community settings. In the 1980s, federal Medicaid policy began exploring shifts for

"There are other researchers. But they are the ones. They're kind of it. Or they're at least first, second, and third on the list of academic-style researchers who have the necessary expertise, who focus on Medicaid, who have the technical knowledge. It's really critical that they exist, because if you want to do the kinds of evidence-based policymaking that you should do, you need that resource."

Policymaker on CSHP's work, from RWJF 2021 Assessment

providing LTSS in homes and communities (i.e., home- and community-based services [HCBS]) rather than nursing homes or other long-term care facilities.

In the early 2000s, under then Center Co-Director and Research Professor Dr. Susan Reinhard, CSHP offered technical assistance to states that helped rebalance LTSS toward homes and communities (described in Chapter 2). With the waiver demonstration, New Jersey policymakers launched a significant initiative to improve the state's performance on this front. As of 2010, New Jersey ranked well below most states in the proportion of LTSS enrollees served through HCBS, but more than doubled the share of LTSS enrollees receiving care at home over the span of four years, a trend that has continued.

The 2012 waiver demonstration aimed to advance the shift by assigning managed care organizations (MCOs) a key role in delivering LTSS. New Jersey turned to CSHP to meet the federal requirement that §1115 demonstrations undergo a formal, independent evaluation. CSHP issued several progress reports about the 2012-2017 demonstration and an overall assessment of the waiver's impact. While these reports identified certain challenges, they also pointed to positive developments. Encouraged by these findings, the state obtained federal approval to renew the §1115 demonstration for two subsequent five-year periods, with CSHP again serving as program evaluator.

Key Features of Medicaid Waivers

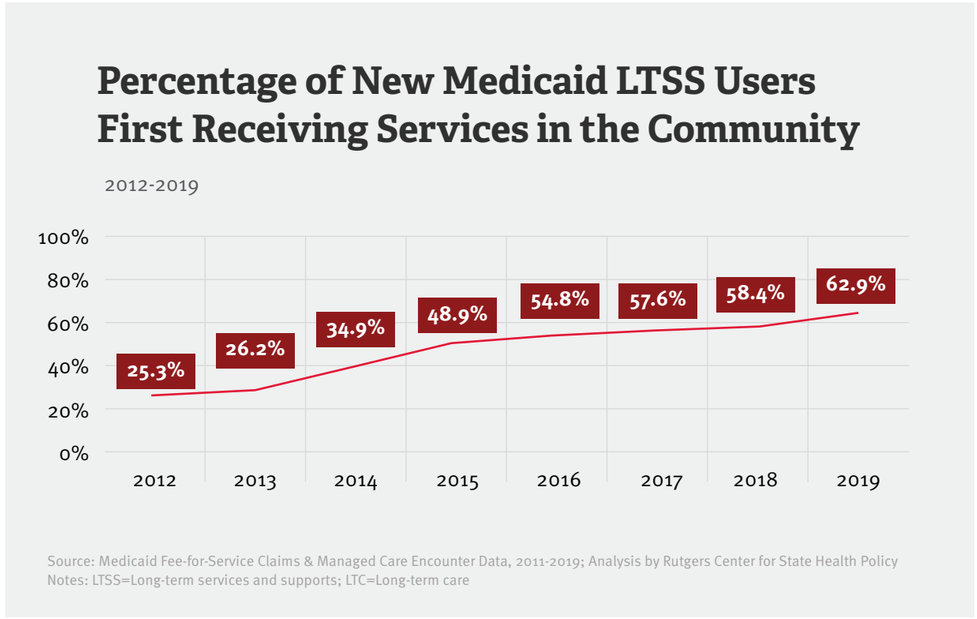
- States may apply for different types of waivers; among the most common of these are §1115 demonstrations.
- When the federal government approves waivers, they permit states to test innovations, even if they depart from standard Medicaid rules.
- Waiver authority only permits initiatives that advance the purpose of Medicaid - to provide coverage and promote the health of beneficiaries. Waivers typically also require budget neutrality.

2021

Gov. Murphy signs EO 277, launching the NJ HART program with the Center providing analytic and strategic guidance.

2022

The Center convened the first Research Consortium for the NJ Integrated Population Health Data (iPHD) Project.



Tracking results from the transition to Managed LTSS

The number and proportion of LTSS recipients receiving care in homes and communities grew dramatically over the decade of the two demonstrations. Importantly, by 2019, over half of the state's Medicaid LTSS beneficiaries received assistance in homes and communities rather than in nursing homes or other institutions.

In addition to increasing access to HCBS, the MCO transition lowered per-person costs. By 2019, per person, inflation-adjusted spending on HCBS by MCOs declined by about 20% compared to prior costs. The evaluation did not find that waiver demonstrations impacted HCBS quality; rather, an examination of multiple indicators suggested that quality remained consistent.

While the transition of LTSS to MCOs was a major focus of CSHP's waiver evaluation, the Center also assessed other waiver components. Notably, CSHP evaluated the Delivery System Reform Incentive Program (DSRIP) embedded in the initial waiver. **DSRIP aimed to reward hospital-based networks that enhanced care access and improved quality and population health while lowering Medicaid costs.** Evaluation found that DSRIP improved outcomes related to certain chronic health conditions, including hospitalization reductions and emergency department (ED) visits among those with asthma.

Dissemination of CSHP evaluation findings about New Jersey's DSRIP experience helped inform a national movement to implement hospital pay-for-performance initiatives to advance population health and health equity. They found, for example, that while NJ DSRIP largely achieved its health improvement goals, in surveys and interviews, stakeholders identified the need to cover short-term costs to maintain financial viability of DSRIP initiatives, particularly in safety net hospitals.

Long-term evaluation and learning through waiver demonstrations helped support New Jersey's continuous aims of enhancing the accessibility, quality, and cost-effectiveness of care under its Medicaid program. In turn, this work has made CSHP appreciate the challenges in achieving these improvements and seek analyses to help identify paths toward progress. These evaluations also enhanced CSHP's experience and capacity in drawing on large Medicaid data files to help contribute to the knowledge base on Medicaid innovation across the nation. Over the last decade, this has become a signature area of policy expertise for CSHP and a foundation of the Center's effort to expand its data capacity to inform strategies to improve population health and address challenges related to health equity (see related iPHD efforts in Chapter 6).

Focusing on Medicaid enrollees experiencing homelessness

Initially outside the context of a waiver demonstration, CSHP has also analyzed Medicaid policies focused on people experiencing homelessness – which includes about 650,000 Americans on a given day, including over 10,000 in New Jersey. Being unhoused is associated with poor health, including a greater likelihood of experiencing mental health and substance use challenges and facing disproportionate risks of morbidity and mortality. Individuals who are unhoused also often incur higher health care costs primarily through higher rates of ED use and hospitalization.

New Jersey Medicaid and housing officials authorized CSHP, with funding from Medicaid and The Nicholson Foundation, to study related policy implications and options. The study found that individuals with behavioral or physical disabilities who had experienced only limited time without a suitable place to live still had greater ED and

2022

CSHP receives the fifth renewal of its core infrastructure grant from RWJF.

2023

Acenda Integrated Health recognizes the Center with its Research Pioneer Award for its research and partnerships.

inpatient hospital utilization. Assessing these findings, CSHP concluded that the adoption of Medicaid tenancy support services could help individuals achieve more long-term, stable housing, possibly contributing to better health outcomes while reducing spending on avoidable health care interventions.

Impact on Health Care Spending

Health care costs of New Jersey Medicaid enrollees who used homelessness services, such as emergency shelters, **were as much as 27% greater than those of a comparison group** of demographically and clinically matched beneficiaries who had not used homeless services.

Informed by this research, **New Jersey Medicaid officials included tenancy-support and sustaining provisions and other services in their request for a §1115 demonstration renewal starting in 2023.** Federal officials approved the new demonstration, authorizing a comprehensive initiative providing intensive outreach, care management, and housing transition and tenancy support to an array of individuals covered through Medicaid who were at risk of becoming unhoused.

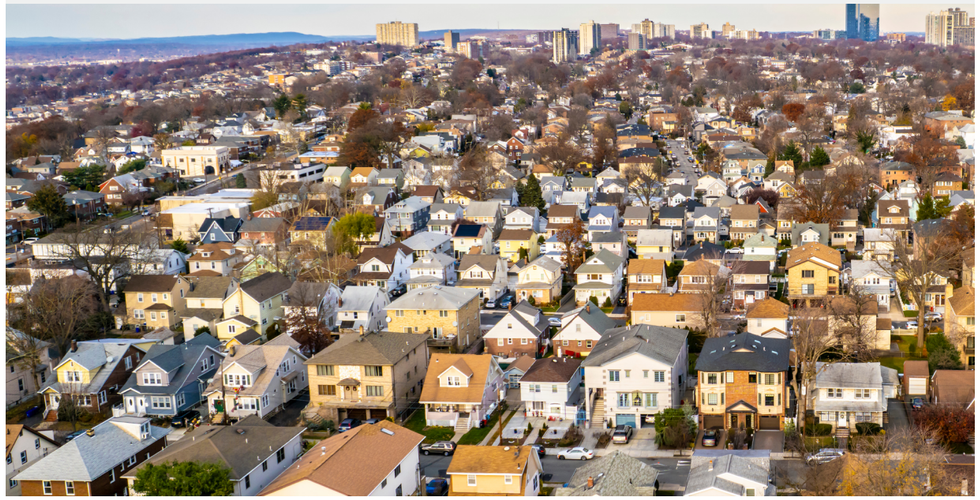
Building on its growing expertise in intersectional health and homelessness issues, CSHP received a National Institute on Minority Health and Health Disparities (NIMHD) grant from the National Institutes of Health in 2021 for a new study. This research, conducted in collaboration with investigators from the Rutgers School of Social Work and the University of Pittsburgh School of Public Health, examines linked 2011-2022 homelessness services and Medicaid administrative data from New Jersey and Pennsylvania.

Under the NIMHD grant and with additional support from the Robert Wood Johnson Foundation and the National Alliance to End Homelessness, CSHP and its collaborators are examining how homelessness shapes suboptimal health care utilization, how permanent supportive housing can help reduce avoidable hospital utilization and improve utilization of essential community-based health services, and how service and health care delivery organizations can collaborate to improve the health and wellbeing of people experiencing homelessness.

As CSHP celebrates its 25th anniversary, its partnership with New Jersey Medicaid is entering a new phase aimed at addressing some of the critical social determinants of health, with CSHP evolving its Medicaid analytic work as New Jersey's programming continues to advance. CSHP is designing a rigorous evaluation of an expanded set of demonstration projects, including examining housing supports, enhanced LTSS, community health worker pilot projects, and other initiatives—all innovations that hold the promise of improving the care and outcomes of Medicaid beneficiaries in New Jersey for decades to come.

Impact on Health Care Access

- Medicaid-funded **utilization of hospital inpatient and emergency services declined sharply after beneficiaries were placed in permanent supportive housing** following homeless bouts.
- **Supportive housing users increased their use of prescription drugs**, likely to help manage chronic conditions, which may have contributed to reductions in acute care utilization.



2023

The federal government approved the second renewal of the NJ FamilyCare Medicaid comprehensive §1115 demonstration, designating CSHP as the independent evaluator. The demonstration supports community health worker pilot and homelessness projects.

2023

CSHP Executive Director Margaret Koller wins the 2023 Rutgers Health Chancellor's Award for distinguished service in furthering the mission of Rutgers Health.

CHAPTER 5

Improving Care for Patients with Complex Health and Social Needs

Newark, New Jersey

For nearly two decades, CSHP has brought analytic horsepower and policy expertise to deepen understanding of issues and challenges in improving health and wellbeing for those patients with complex needs and high utilization of preventable hospital services.

Individuals with complex health and social challenges sometimes rely on intensive and expensive health care services — including hospital emergency department (ED) and inpatient care — to help meet needs that are often more effectively addressed elsewhere. These patients, sometimes referred to as "super-utilizers" of health care, often account for a disproportionate share of costs, without realizing proportionate gains in health and wellbeing.

Through analyzing a range of data to systematically study these patients, and testing and evaluating potential strategies for helping them, CSHP has provided a more complete picture of this population and improved collective understanding of solutions for addressing their needs.

Spotlighting the problem for decision makers

We know today that social factors, such as economic security, stable and safe housing, and strong social supports have a considerable impact on health and wellbeing. This was not, however, conventional wisdom in 2009, when CSHP convened 180 leaders for its *"More is Not Better"* policy conference, focusing on New Jersey achieving higher value for its considerable health care spending. Featured at the conference were findings from the Commonwealth Fund/CSHP co-authored State Scorecard on Health System Performance, which ranked New Jersey 48th among states in avoidable hospital use and cost — what one presenter called "a black eye" on NJ's report.

These findings were reinforced in a presentation by Dr. Jeffrey Brenner, a primary care physician who then led the Camden Coalition of Health Care Providers (now the Camden Coalition). Dr. Brenner described work to find "hot spots" inside the city with concentrations of patients who were repeatedly cycling through hospitals for care more effectively provided in other settings. He estimated that roughly 90% of costs were concentrated in 20% of Camden's patients. One patient had 113 hospital visits in a single year. Head colds, ear infections, and sore throats were among top ED diagnoses — amounting to what Brenner called "a lot of money to buy bad care." He also emphasized the complex social needs faced by many of these patients. Brenner made the case for shifting resources to more localized coordinated care, driven by multidisciplinary care teams, like his Camden Coalition — an idea that would eventually draw both state and national attention.

Leading the evaluation of alternatives to address the problem

As noted in Chapter 4, in 2011, then Governor Chris Christie signed into law P.L. 2011, c.114 to test the

2024

Rutgers School of Public Health Assistant Professor Slawa Rokicki published "Perinatal Depression Associated With Increased Pediatric Emergency Department Use And Charges In The First Year Of Life", in *Health Affairs*, the first publication using iPHD data.

Rutgers CSHP remains committed to advancing health equity and fostering innovative policy solutions that address the evolving needs of New Jersey's residents.

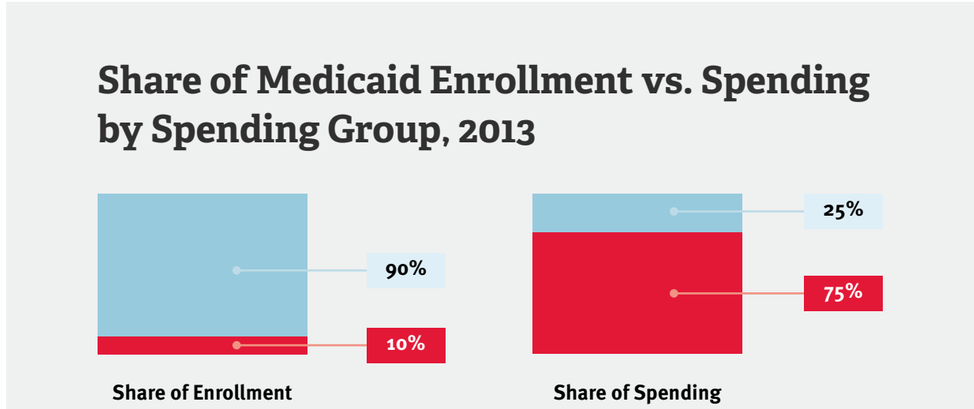
use of Accountable Care Organizations (ACOs) in Medicaid. New Jersey's ACO demonstration included focusing on care coordination for "high risk, high-cost utilizers" and "stretching" Medicaid "to integrate social services." The law called on CSHP for its analytic capacity to assess the demonstration, specifying the Center get "all data necessary" to do so—data that proved invaluable to better understanding the state's high-need patients.

Helping to spread and test models to improve care for these patients

In 2012, while the ACOs were developing, leveraging a Center for Medicare and Medicaid Innovation (CMMI) Health Care Innovation Award, CSHP partnered with the Camden Coalition and others to test using multi-disciplinary care teams throughout the country to connect high-need, complex patients to appropriate clinical care and social services to help manage their conditions and overcome obstacles to health. The four-site pilot was ambitious, seeking to decrease avoidable hospitalizations and ED visits, improve outcomes, and reduce costs for more than 1,100 patients, with over 70% having three or more chronic conditions. A learning network captured lessons across sites. According to an independent evaluation by Mathematica Policy Research, care teams felt "the program gave them the opportunity to build relationships with participants, help participants navigate the health care system, teach them to manage chronic conditions, and address social issues that otherwise presented recurring obstacles to health improvement or appropriate use of the health system." While findings were mixed, and evaluators called for more study, program participation was associated with a 37% reduction in unplanned hospital readmissions among Medicare fee-for-service patients, suggesting "adaptations of the Camden model hold promise for reducing short-term service use and spending for Medicare super-utilizers." Mixed findings highlighted the complexity and challenges of spreading innovative policy models, particularly for these patients.

Bringing new, evidenced-based recommendations to the policy debate

In a 2014 budget address, Governor Christie noted that, in the prior year, 5% of Medicaid recipients accounted for 50% of its costs, calling out impacts of those with "chronic emergency room visits," "complex medical conditions," and repeat inpatient stays on New Jersey's health care spending. The Governor nodded to CSHP's work on the above CMMI demonstration, tasking Rutgers "to expand the scope" of its research to help "innovate and improve" care for Medicaid patients with high utilization inside New Jersey. In response to this request, Rutgers convened a Working Group on Medicaid High Utilizers, which analyzed Medicaid data and convened stakeholders to develop recommendations for policymakers grappling with how to improve care for these patients. CSHP confirmed that small groups accounted for large shares Medicaid's $9.4 billion spending in 2013, with the top 1% of spenders having 20 times the rate of avoidable hospitalizations than the bottom 90%, and the top 10% of spenders accounting for 75% of all spending (see chart above). Moreover, looking over time, CSHP found "persistence" in high-spend among this population, with high rates of overall inpatient admissions, including avoidable hospitalizations and readmissions. Those within the top 1% were more likely to have a disability, be near the end of life, or receive Long-Term Services and Supports. A striking 85% of these patients had a mental health or substance abuse diagnosis. These findings set the table for additional CSHP work focused on improving care for New Jersey's at-risk populations (also highlighted in Chapter 4).



Source: Analysis and Recommendations for Medicaid High Utilizers in New Jersey, 2016

Leveraging integrated data to identify opportunities to improve health

By 2015, CSHP was leading its second large grant from CMMI, coordinating activities under the New Jersey State Innovation Model (SIM) Design Award to advance system changes, particularly to improve care and service delivery for the state's Medicaid population. Timing coincided with the launch of the Camden Coalition, Trenton Health Team, and Healthy Greater Newark ACOs —also focused on improving care for Medicaid patients. The state armed these ACOs with access to Medicaid claims and encounter data. This allowed the ACOs to track all Medicaid utilization for patients in their areas, providing a major resource to better understand and address health needs of their respective populations. The ACOs also linked this data with other data sets, like school attendance data, to better manage childhood asthma, demonstrating the value and power of integrating large datasets.

CSHP's evaluation of ACO experiences found they were well-positioned, especially with integrated

> ***"We learned that there's a whole lot more going on at home than patients bring to the clinic ..."***
>
> - Pilot team member

data, to become connectors of diverse health and social service providers and drive broader regional health efforts. Evolving into Regional Health Hubs under subsequent legislation, ACOs built health information exchanges to identify and organize community efforts to address social determinants of health. Their experience helped prompt creation of the CSHP-led Integrated Population Health Data Project (described in Chapter 6), which promotes research using linked data to better understand and improve factors underlying health.

Synthesizing accumulated evidence over time

Most recently, CSHP has helped the field understand and build on evidence stemming from evaluations of the Camden Coalition and other care models for complex patients, including addressing areas for future study. A recent CSHP collaboration with researchers at the Massachusetts Institute of Technology and Camden Coalition showed that the model led to significant and sustained improvements in utilization of community-based ambulatory care, largely driven by increases in primary care visits.

The significant body of work that CSHP has brought to this issue of patients with complex needs and high-utilization of high-cost care has helped shape understanding of this important area and moved New Jersey and the field forward in adopting strategies to connect these patients to health and other services critical to improving and sustaining their health and wellbeing.

As CSHP looks forward, it continues to focus on strategies to improve care while also reducing avoidable costs for underserved populations. A current project in CSHP's portfolio includes a detailed study to help identify ways to improve care and quality of life for Medicaid beneficiaries with sickle cell disease while working to stem persistently costly, avoidable ED and hospital care among these patients. Research findings hold the promise of informing future Medicaid program innovations to enhance quality of life for these individuals.

> ***"Notably, beyond serving its care management functions, the claims data are being merged with data from other sectors such as the prison system, schools, and housing to enhance ability to address social determinants of health and foster cross-sector initiatives to improve population health."***
>
> Evaluator reflections on the legacy of NJ's Medicaid ACO Demonstration

CHAPTER 6

Using Data and Research to Advance Population Health

Rutgers University - New Brunswick

Despite being one of the highest income states in the nation, New Jersey continues to grapple with persistent and deeply rooted health inequities – inequities laid bare during the COVID-19 pandemic. Sensing an opportunity to apply its analytic expertise and leverage the power of data, CSHP embarked on three robust population health projects to inform policy strategies to address vexing population health challenges and make New Jersey a healthier and more equitable state.

These three studies include: the New Jersey Childhood Obesity Study, the Integrated Population Health Data (iPHD) Project, and the New Jersey Population Health Cohort (NJHealth) Study.

Better understanding effective strategies to address childhood obesity in NJ cities: The NJ Childhood Obesity Study

Prompted by alarming rates of childhood obesity, especially in low-income, underserved communities, in 2008 CSHP initiated the NJ Childhood Obesity Study, examining connections between food and physical activity environments and childhood obesity in four low-income New Jersey cities.

Funders and policymakers have launched efforts to improve the availability of healthy food and physical activity environments in communities with high rates of obesity. However, evidence to inform which of these environmental changes are most effective has lagged. CSHP seized the opportunity to help inform policy solutions.

Initially funded by the Robert Wood Johnson Foundation (RWJF) and then with three grants from the National Institutes of Health, the Childhood Obesity Study tracked public school children in Newark, Camden, Trenton, and New Brunswick from 2011-2024.

CSHP's research agenda proceeded in three phases:

- Extensive data collection on individuals and schools to inform targeting and tailoring of RWJF-funded environmental interventions within these communities.
- Long-term follow-up with households and schools to assess the impact of local environmental changes on children's weight status and inform effective prevention efforts.
- Examination of the influence of emerging environmental developments and impacts on students' weight (for example, the COVID-19 pandemic, associated school closings and policies, and federal regulations on the nutritional content of school meals).

Effectively targeting interventions requires understanding who is most at-risk and why. Data collection included a survey of 1,500 households with children in the four cities. Researchers also explored healthy and unhealthy food outlets, opportunities for physical activity in nearby neighborhoods, and height and weight measurements of all students at the 120 public schools in these cities. To assess the effectiveness of policy interventions, data was collected six additional times over 10 years in the four cities by CSHP.

CSHP's childhood obesity research found that feasible and incremental interventions have an impact. For example, proximity to food outlets matters. Living near convenience stores selling high caloric and sugary food significantly contributes to unhealthy weight, and increased exposure to small grocery stores selling healthy food is associated with improved weight outcomes. These small grocery stores included those participating in "Healthy Corner Store" initiatives, which provided incentives to upgrade inventory. Notably, changes in supermarket access had no meaningful consequences for weight status.

In schools, federal regulations to upgrade nutritional standards for meal programs were successful in promoting healthier offerings. Changes over time contributed to significant improvements in students' weight status. These findings highlight the health value of more modest environmental changes that can be implemented by community groups, local governments, and federal and state policymakers.

Key Findings from CSHP Obesity Studies

- Changes in federal nutrition standards for school meals – implemented in 2012 as part of the ***Healthy Hunger-Free Kids Act*** – **contributed to healthier offerings** in the 120 public schools examined in this study.
- **More nutritious school meals** and greater **opportunities for physical activity at school** were **associated with heathier weight status.**
- In the community food environment, exposure to additional **convenience stores and more fast-food restaurants resulted in weight gain over time.**
- Greater **availability of small grocery stores selling healthier items led to healthier weight outcomes.**

Recognizing that for many children, schools are the best and sometimes only source of healthy meals, CSHP has examined the impact of the COVID-19 pandemic on availability of healthy food and physical activity opportunities through a project funded in 2020 by the National Institute of Child Health and Human Development. Prior to the pandemic, a startling **30 million children relied on school meal programs for up to half of their daily nutritional needs.** This study, which will conclude in 2024, analyzes the consequences of pandemic-related school closings for students' weight status and the mitigating effects of federal emergency meal programs. Findings are expected to yield critical evidence for policies to address future public health emergencies and improve food safety nets.

Leveraging the power of linked data: Launching the NJ Integrated Population Health Data (iPHD) Project

State administrative data are rich sources of information that is underutilized in population health research. A significant challenge, however, is that these data, capturing important information about social services, health care, births, deaths, and other public health statistics rest in silos, disconnected from each other -- their impact muted by their isolation.

Recognizing this gap and the opportunity to advance New Jersey's health through "Big Data", in 2016, New Jersey's legislature passed and then Gov. Chris Christie signed P.L. 2015, c. 193, authorizing the Integrated Population Health Data (iPHD) Project. The law designated CSHP

with the responsibility of implementing the iPHD, including supporting a Governing Board comprised of state officials and public appointees, developing policies and procedures, integrating state administrative data sources, and establishing processes for the Governing Board's approval of research applications.

iPHD Research Priorities

- Informing New Jersey's integrated approach to addressing the **opioid epidemic**
- Improving **maternal and infant health**
- Assuring access to physical and behavioral health services and **addressing social determinants of health**
- Conducting analyses to support New Jersey's response to **COVID-19 and other public health emergencies**
- Promoting equitable access to **high-value health services**

Anchored by five research priorities, the iPHD was launched with five NJ Department of Health (DOH) data sources dating as far back as 2000 and updated annually. Research projects focused on these data are key to unlocking advancements in population health and in the delivery of targeted state programming. As of September 2024, there are more than 79 million records linked – a powerful repository for researchers. In addition, the Governing Board has approved plans for iPHD expansion by adding 11 other data sets over the next several years, including not only data from the NJ DOH, but records from the New Jersey Department of Children and Families (DCF), the New Jersey Department of Corrections, and the New Jersey Department of Human Services (DHS).

Trenton, New Jersey

Datasets Available in iPHD (as of September 2024)

- **NJ Birth:** Births in NJ, including location, date, and time of delivery, as well as other attributes of newborn and mother/birthing person
- **NJ Mortality:** Deaths of NJ residents, regardless of location, including causes of death, location, and demographic information
- **NJ Hospital Discharge:** Hospital claims data from inpatient and outpatient departments, including admission and discharge dates, diagnoses, and charges
- **NJ Communicable Disease Reporting and Surveillance System:** COVID-19 related data, including dates of onset, lab results, and other relevant information
- **NJ Emergency Medical Services (EMS):** Details of EMS responses in NJ, including location, dates, times, and transport type

Additional Datasets Approved by Governing Board

- **Pregnancy Risk Assessment Monitoring System:** Risk factor information collected from birthing people in NJ, including access to pre/postnatal care and stressful life events
- **COVID-19 Vaccine:** Information about COVID-19 vaccine uptake in NJ, including the number of doses administered, dates of vaccination, and vaccine type
- **Cancer Registry:** Information about all cancer cases diagnosed and/or treated in NJ, including disease stage, treatments, and individual vital status
- **Cardiac Catheterization Data:** Information about cardiac catheterization procedures in NJ, including the location and number of procedures as well as patient and facility characteristics
- **Cardiac Surgery Data:** Information about cardiac surgical procedures in NJ, including the location and type of procedure, patient characteristics, and insurance coverage status
- **Trauma Registry Data:** Information about patients treated at trauma centers in NJ, including patient demographics, injury scene, and admissions and discharge/outcome data

Additional Datasets Approved by Governing Board Cont'd

- **The Children's System of Care (CSOC) CYBER Data:** Information about CSOC service utilization in NJ, including population characteristics, socioeconomic status, and service type
- **Child Protection and Permanency Data:** Information about at-risk youth in NJ, including the prevalence of abuse and neglect, referrals to state agencies, and placement rates
- **NJ Medicaid:** Claims and encounter data for NJ Medicaid enrollees, including eligibility information, health care performance measures, and enrollment in long-term care services
- **NJ Substance Abuse Monitoring System:** Information about Substance Use Disorder in NJ, including patient demographics, substance type, and types and locations of care
- **Incarceration Data:** Information about the incarcerated population in NJ, including types of offenses, individual demographics, and location and duration of incarceration

To date, the iPHD has completed three cycles of applications, and the Governing Board has approved data release for 12 projects, covering all five research priorities, proposed by investigators from institutions around New Jersey and beyond. The potential impact of the iPHD is enormous, with initial promising project findings continuing to be disseminated throughout the coming year.

iPHD Project Title	Institution
Trends in Adverse Birth Outcomes: Variations by Race and COVID-19 Exposure	Central Jersey Family Health Consortium
Perinatal Depression and Emergency Department Visits in the Postpartum Period: A Quasi-experimental Analysis	Rutgers School of Public Health
Social Vulnerability, Disparities, and the Health Impacts of the Intersecting COVID-19 and Opioid Epidemics on NJ Communities	Rutgers Center for Health Services Research
Ensuring Programmatic Exposure and Efficacy in Areas of Greatest Need: A Geographical Study of Mental Health Outcomes and Provision of Behavioral Health Services by the NJ Pediatric Psychiatry Collaborative	Hackensack Meridian School of Medicine
Prophylactic Salpingectomy Use at the Time of Postpartum Sterilization	Columbia University
The Impact of Severe Maternal Morbidity (SMM) on Mother and Children's Hospitalization/ED Use One Year After Birth	Montclair State University
Opioid-related Overdose and Mortality among Pregnant and Postpartum Individuals in NJ	Rutgers Center for Pharmacoepidemiology and Treatment Science
Linked Administrative Data as Surveillance of Overdose Crisis and Drug-related Adverse Health Events in NJ	Rutgers School of Social Work
Impact of "Opt for Help and Hope" on Drug Overdose Deaths among NJ Criminal Defendants, 2020-2025	NJ Office of the Attorney General and Johns Hopkins University
Integrating EMS Data with Hospital, Mortality, and Geographic Data to Identify Opioid Overdose Patterns Across Settings in NJ Communities	Rutgers Center for Health Services Research
Trends in Fatal and Nonfatal Opioid-Related Overdoses among Pregnant and Postpartum Women Living in NJ*	Icahn School of Medicine at Mount Sinai
Impacts of Obstetric Unit Closures on Maternal and Infant Health in NJ*	University of Illinois Chicago School of Public Health

*These approved projects were funded through the Robert Wood Johnson Foundation's Health Data for Action (HD4A) proposal mechanism.

Understanding drivers of health across diverse populations within the state: NJ Population Health Cohort (NJHealth) Study

Launched in 2022, the NJHealth Study is supported through generous funding from RWJF, Rutgers Health, and the State of New Jersey. This study examines health through a wide lens—seeking to generate new understanding of how life events and stress shape health, especially among groups from historically disadvantaged and minoritized populations, low-income households, multigenerational families, and New Jersey's growing immigrant population.

We know that New Jersey's richness comes from the mosaic of its ethnic and racial diversity, but it is also within these populations where some of the state's inequities are most deeply rooted. Anchored by strong partnerships with diverse communities across New Jersey to capture a full picture of state health and wellbeing, the study aims to enroll approximately 8,000 participants.

NJHealth considers a broader range of stressors than any prior study. At the societal level, the study targets seldom examined stressors, such as social media, public discord rooted in partisan polarization, shifts in public policy such as immigration enforcement, climate events, local crime, and manifestations of structural racism. It also examines individual stressors from common life events like unemployment or retirement and extraordinary events such as childhood trauma or criminal justice involvement. It explores how factors such as education, religious practices, and civic engagement can buffer or amplify the impact of stressors on health and wellbeing.

What makes this study unique? Unlike other research undertaken to learn more about the health of New Jerseyans, this study has multiple features including psychosocial and physiological measurement components. The study calls for interviewing residents aged 14 and older using innovative strategies to broadly represent New Jersey's diversity. In partnership with immigrant advocacy groups, faith-based organizations, and other community groups, the NJHealth team is building trust among groups who have not historically been well-served by research and now may have justifiable skepticism about participating in a study of this nature.

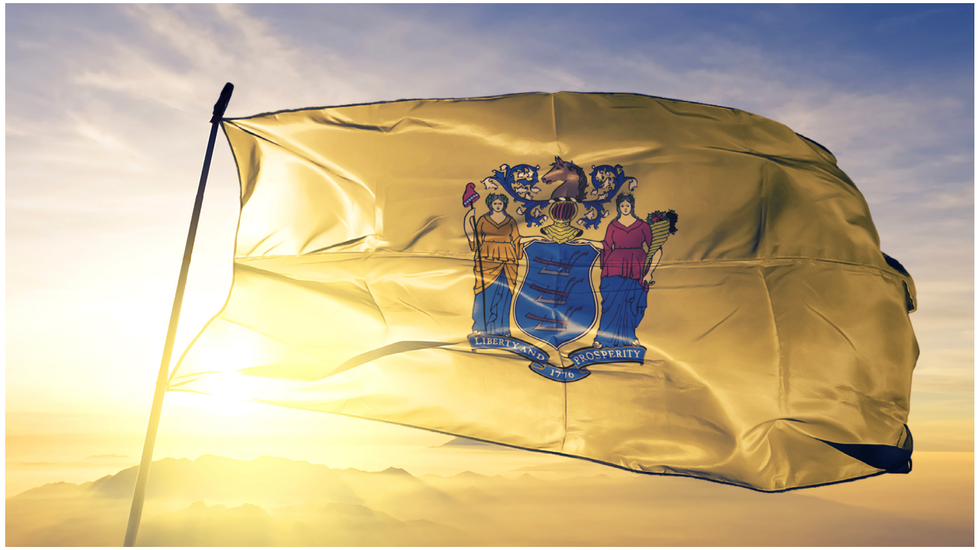
Another unique feature of this study design is the collection of participants' biomarkers, including DNA and fasting plasma to test for physical markers of stress, cognitive testing for older adults, and activity and movement data recorded by monitoring devices. Importantly for the Center's strategic goal of galvanizing the power of data, researchers will be able to link pertinent administrative records to each consenting NJHealth respondent, including health insurance coverage and health service use, results of routine medical tests, receipt of social service benefits, employment status, and mortality.

In the coming years, as the iPHD adds new data sources and the NJHealth Study continues to expand its reach, New Jersey will be on the forefront of states developing innovative data resources for studying and improving population health and addressing inequities in health and wellbeing. These resources will be used by researchers across disciplines and a range of learning institutions to bring diverse perspectives to the challenges of promoting optimal health for all New Jerseyans.

NJHealth Focuses on Recent Groups of New Jersey Immigrants

- Asian Indian
- Chinese
- Dominican
- Filipino
- Haitian
- Jamaican
- Korean
- Mexican
- Nigerian
- Those arriving as asylum seekers, refugees, and under other authorities

Trenton, New Jersey



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CSHP has been fortunate to be guided over the years by a loyal and engaged External Advisory Committee (EAC) that has shared their strategic insights at every juncture of CSHP's development. We are grateful to our current EAC members, including long-standing Chair Bruce Vladeck and our other current members including Len Fishman, Melissa Fox, Allison Hamblin, James Knickman, Christopher Koller, Ramesh Raghavan, Terry Shlimbaum, Deborah Spitalnik, and Jennifer Velez. We also thank all the other previous EAC members who contributed their strategic guidance and helped us navigate in the early days of the Center.

CSHP was launched in 1999 as a shared vision of David Mechanic, James Knickman, then vice president of research and evaluation at the Robert Wood Johnson Foundation (RWJF), and Len Fishman, then commissioner of the New Jersey Department of Health and Senior Services, who inspired RWJF to make its initial large investment to establish CSHP. Our work could only continue and have impact because of the sustained support and investment from our major funders, starting with RWJF and built upon by New Jersey state agencies, the state Legislature, and philanthropies committed to excellence in state health policy, especially the Nicholson Foundation and the Commonwealth Fund.

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WARMLY,

Joel Cantor | Distinguished Professor & Director

Margaret Koller | Executive Director

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