DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES
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State Demonstrations Group

December 18, 2025

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

Dear Assistant Commissioner Woods:

The Centers for Medicare & Medicaid Services (CMS) completed its review of New Jersey's Final Report for the COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled "New Jersey FamilyCare Comprehensive Demonstration" (Project Numbers: 11-W-00279/2 and 21-W-00068/2, approved on September 13, 2023. This report covers the demonstration period from March 1, 2020, through June 30, 2024. CMS determined that the Final Report, submitted on August 29, 2025 is in alignment with the CMS-approved Evaluation Design, and therefore approves the state's Final Report.

The approved Final Report may now be posted on the state's Medicaid website. CMS will also post the approved Final Report on Medicaid.gov.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE amendment. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S
Digitally signed by DANIELLE DALY -S
Date: 2025.12.18 05:02:52 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

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

RUTGERS
Center for State Health Policy
A Unit of the Institute for Health, Health Care Policy and Aging Research

Analysis of the Children's Health Insurance Program (CHIP) Continuous Coverage Provision to Examine Enrollment and Access to Care and Quality

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August 2025

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Acknowledgements

Prepared for the New Jersey Department of Human Services. Any opinions expressed in this report are those of the authors and do not necessarily represent the view of the New Jersey Department of Human Services.

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Introduction

On September 13, 2023, the Centers for Medicare and Medicaid Services (CMS) approved an amendment to New Jersey's §1115 Demonstration authorizing 12-month continuous eligibility for children in its separate Children's Health Insurance Program (CHIP), effective for the period retroactively from March 1, 2020 and ending when all redeterminations for Medicaid and CHIP were conducted during the unwinding period (beginning in April 2023). New Jersey finished their redeterminations at the end of June 2024. There are exceptions to extended eligibility for enrollees who are not eligible for coverage because, for example, they voluntarily withdrew or no longer live in New Jersey. The CHIP program in New Jersey is available for children ages 0-1 who are within 194%-350% of the Federal Poverty Line (FPL) and children ages 1 to 18 who are between 142%-350% of the FPL (in both cases, including a 5% disregard of income). Children with income levels lower than the CHIP guidelines qualify for Medicaid.

Before the amendment, fluctuations in family income or administrative issues could result in coverage "churn", leading to gaps in coverage and discontinuity of care. The state aimed to reduce these disruptions during the COVID-19 pandemic, when healthcare access and stability were particularly critical for vulnerable populations. The central challenge for this policy was ensuring effective implementation and addressing barriers to continuity and access within the evolving landscape of the pandemic and post-pandemic Medicaid redeterminations.

The effects of this policy change are evaluated by examining changes in selected enrollment and access to care and quality metrics from the pre- to the post-implementation period of the CHIP continuous eligibility. In this chapter we present results from a mixed-methods analysis that include qualitative interviews with stakeholders and estimates from interrupted time series analyses (see Methods section for details) that account for individual characteristics (i.e., age) while assessing the impacts of the continuous eligibility under the Demonstration.

Methods

This evaluation used a mixed-methods approach, integrating quantitative analyses of NJ Medicaid claims data with qualitative analysis of interviews conducted with key informants including advocates and state agency representatives involved in the implementation of the CHIP extension. Quantitative analyses assessed the effectiveness of the program by examining outcomes on selected metrics over the demonstration period while they remain continuously enrolled under this policy change. Qualitative interviews provided context for the quantitative results and highlight policy successes and challenges that could not be captured through quantitative measures. Quantitative and qualitative data sources, measures, and analytic methods are detailed below.

Quantitative Methods

Data Sources

The quantitative analyses in this chapter were generated using Medicaid enrollment, fee-for-service (FFS) claims, and managed care encounter data for January 1, 2017 through December 31, 2023. We used recipient and claims-level information to allow for stratification of access and quality metrics to relevant subpopulations (i.e., race/ethnicity).

Claims-based Measures

The measures in this chapter are calculated for 2017-2023 and are intended to assess enrollment and access to care and the quality of care for NJ FamilyCare beneficiaries affected by the CHIP continuous coverage provision. The research questions guided our selection of measures which were subsequently reviewed by CMS. Several types of outcomes are examined: enrollment, overall hospital use, and avoidable hospital use reflecting inadequate quality of ambulatory care. Table A lists the measures calculated using the Medicaid FFS claims and managed care encounter data.

Table A: Inventory of Measures

	Annual Measures	**Type**	**Period**
	Enrollment		
1	CHIP enrollment	Population-based	2017-2023
	Utilization of Care		
2	Inpatient hospitalizations (per 1000 children)	Population-based	2017-2023
	Quality		
3	Avoidable hospitalizations (per 1000 children)	Population-based	2017-2023

Population Definitions

The above measures are calculated for one relevant population of beneficiaries identified in our Medicaid claims database as follows:

NJ FamilyCare Eligibility: Children with any period of active CHIP enrollment in a particular year, as indicated by the effective dates of their Program Status Codes, made up the beneficiary cohort for that year. Assignment to eligibility categories was based on the protocol used for Medicaid's monthly public reporting. The resulting study population was made up of children age 0-1 with

family incomes between 194%-350% FPL and children 1-18 with family incomes between 142%-350% FPL.

Analytic Approach

In this evaluation report using data from January 2017 through December 2023, employed interrupted time series (also known as segmented regression) analysis to examine the effect of the CHIP continuous coverage on beneficiaries ever enrolled under the provision for the demonstration period (i.e., repeated cross sections) given there was no available comparison group. The repeated cross-sectional rates examined outcomes for all individuals gaining eligibility under the expansion, controlling for changes in composition of each year's enrolled population. Interrupted time series analysis assumes that the policy effect may lead to a change in the level, and/or time trend of the outcome metrics, in this case quality (i.e., avoidable hospitalizations), enrollment, and inpatient hospitalizations. The analysis tests whether this changes occurred in level or trend. Potential confounding may arise from factors that determine the outcomes of interest and change at the same time as the policy implementation. Our models adjusted for age in an effort to mitigate such effects. Our estimation procedures were conducted using SAS Enterprise Guide 7.15 and STATA MP 19.5 software.

Limitations

There are some limitations in our modeling approach which we noted in our evaluation plan. First, detailed analysis of individual recommended chronic condition management services, for example, was not feasible because there are insufficient numbers of children available to measure condition-specific outcomes. However, use of the AHRQ PDI metric reflects the adequacy of ambulatory care services for a group of conditions. Some individuals may have been misclassified in their CHIP eligibility, but we expect that number to be negligible to this analysis overall. In addition, analyses were collapsed at the annual level, using the average of outcomes and any covariates thus, our control variables were limited. However, we would not necessarily expect meaningful differences with the inclusion of more covariates like gender. Lastly, the post-policy implementation period is limited, but it is unlikely that adding a longer period would substantially change the results. Moreover, the CHIP continuous coverage provision overlapped with the implementation of the Medicaid unwinding (e.g., the process of states carrying out redetermination after COVID-19 continuous enrollment provisions), which could dilute the impacts of the CHIP policy. We would expect the Medicaid unwinding to decrease our enrollment outcome and increase hospitalizations (including avoidable), which would strengthen conclusions about policy impact that we can draw from any significant findings related to the CHIP provision.

Qualitative Methods

For the qualitative analysis, we interviewed 6 participants representing 4 organizations. Interviews captured the internal and external factors influencing the implementation of the CHIP continuous eligibility. Participants also discussed various barriers and facilitators to access continuous eligibility, including external and personal factors. The research team convened to discuss key themes throughout the interviews, then used qualitative coding techniques through NVivo to pull quotes that were relevant to each of the themes.

Key Informant Interviews. We conducted semi-structured key informant interviews to capture the internal and external factors influencing the CHIP continuous eligibility policy's progress. The interview guide included questions that explored the program's implementation process and recommendations to ensure the State meets its goals of supporting insurance coverage for children in New Jersey. During the interview, participants were first read a description of the CHIP amendment policy change to ground the conversation. See Appendix A for the interview guide.

We recruited key informant interview participants who could share insights on the progress of the policy across two groups: consumer advocacy groups and the state (e.g., NJ Division of Medical Assistance and Health Services [DMAHS/Medicaid] and the NJ Division of Mental Health & Addiction Services [DMHAS]). We targeted 10 key informants to ensure thematic saturation (i.e., the point at which salient new themes no longer emerge) and a range of roles and perspectives.

Recruitment was informed by state recommendations and existing internal knowledge of advocates and related key informants. We emailed an invitation to an initial selection of key informants (i.e., purposeful sampling), and during interviews, we asked participants to recommend additional key informants (i.e., snowball sampling). We sent email invitations to a total of 16 key informants who represented 9 organizations. We recruited a total of six individuals (37.5% participation rate): two providers, two advocates, and two state representatives. Six individuals were non-responsive, and four declined for reasons including: recommended another stakeholder within their organization and recommended another organization.

Interviews were conducted from April to May 2025 virtually using Zoom. Each interview employed two trained interviewers, with one serving as lead and the other taking notes and asking clarifying questions. Interviews were conducted with one participant at a time, lasted about 60 minutes, were confidential, and audio-recorded with consent.

<u>Analytic Methods</u>

For the qualitative data analysis, we used thematic analysis techniques (Braun & Clarke, 2006), in which team members immersed themselves in the data using interview transcripts to generate

relevant themes. Concurrently, we employed both inductive and deductive approaches, which enhanced the robustness of findings (Miles et al. 2013). The research team identified the key themes of facilitators and barriers to the CHIP extension implementation (i.e., inductive analytical approach). The facilitators and barriers were then mapped to the original hypothesis (i.e., deductive approach). To enhance the results, representative quotes were identified that augment and help contextualize the findings.

Limitations

Our qualitative analysis was limited for several reasons. First, due to the timing of the CHIP amendment, it is possible that participants confused the CHIP continuous coverage provision with similar policies like New Jersey's Cover All Kids or COVID-19 pandemic continuous coverage provisions. This would result in opinions shared about policies beyond the scope of the CHIP continuous coverage provision. We took steps to minimize confusion by using a semi-structured interview guide with frequent redirection by the interviewers to remain grounded in the policy at hand. Second, our interviews only reflect the views of 6 participants, which was below our target of 10 key informants. The literature indicates saturation is typically reached in qualitative research with between 9 and 17 participants when there is a homogenous sample (Hennink & Kaiser 2021). Though we were unable to recruit more than 6 participants, we believe they offer a range of expertise and perspectives that may not have been meaningfully improved by 4 additional participants. Relatedly, while interviews were voluntary and confidential, given the small number of interviewees it may be possible for readers of the final report to infer their identity. Participants were informed of this possibility, and thus it may have affected what was shared in the interviews. Lastly, the interviews were focused on indirect reporters and not Medicaid beneficiaries themselves, which limits our ability to interpret the impact of the policy on beneficiaries.

Results

Findings are summarized below for the hypothesis, which was based on the research questions guiding the evaluation.

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

Research Question 1a: Did providing continuous coverage to CHIP children increase the duration of enrollment?

Research Question 1b: Did providing continuous coverage to CHIP children impact overall and avoidable hospitalizations?

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

Quantitative Results

We present findings for our three primary outcomes: enrollment, inpatient hospitalizations, and avoidable hospitalizations using interrupted time series analyses. For these outcomes, we report results overall followed by a subgroup analysis conducted by race and ethnicity.

The sample included 405,190 New Jersey children under the age of 19 with at least one month of CHIP coverage. In unadjusted comparisons relative to the mean number of months enrolled based on pre-CHIP continuous coverage trends, we found evidence of positive but marginally significant changes in the mean months enrolled in CHIP (1.80, $p<0.1$; 95% CI: -0.06, 3.65). In interrupted time series models, we found no evidence of statistically significant changes in inpatient hospitalizations per 1000 children (-1.53; 95% CI: -16.09, 13.02) or avoidable hospitalizations per 1000 children (-0.02; 95% CI: -0.48, 0.44) at the start of the policy (Table 1). In 2023, the year the CHIP continuous coverage provision ended, and the Medicaid unwinding began, we observe a statistically significant decrease of 0.12 in avoidable hospitalizations per 1000 children ($p<0.05$; 95% CI: -0.21, -0.02) and a marginally significant decrease of 2.19 in hospitalizations per 1000 children ($p<0.1$; 95% CI: -5.24, 0.87). In 2023, we find no evidence of significant changes in children's enrollment (-0.76, 95% CI: -3.56, 2.04).

Figure 1 provides a visual representation of results for the primary outcome, enrollment. Prior to the CHIP amendment, we find the number of months children were enrolled in CHIP in a year was steadily decreasing. In 2020, with the implementation of the CHIP continuous coverage provision, we begin to see an upward trend in enrollment, peaking in 2021. These findings translate to children being enrolled in CHIP, on average, over three-quarters of a year or nearly

10.5 months at peak policy implementation in 2021. In 2023, the end of CHIP continuous coverage and the start of the Medicaid unwinding, we observe a 0.76 decrease in the mean number of months enrolled in CHIP (95% CI: -3.56, 2.04), but this is not statistically significant.

Results for the subgroup analysis by race and ethnicity can be found in Appendix C. Relative to expected means based on pre-CHIP continuous coverage trends, we found evidence of marginally significant increases ($p<0.1$) in the mean number of months enrolled in CHIP for Hispanic or Latine children (0.9, 95% CI: 0.0, 1.8), Asian children (1.2, 95% CI: -0.3, 2.7), and children whose race was identified as other (2.5, 95% CI: -0.2, 5.3). Among non-Hispanic white children, we observe a statistically significant decrease of 0.7 mean number of months enrolled in CHIP at the end of the continuous coverage provision and start of Medicaid unwinding in 2023 ($p<0.05$; 95% CI: -1.1, -0.3) and a small but statistically significant increase of 0.1 in avoidable hospitalizations per 1000 children ($p<0.05$; 95% CI: 0.0, 0.1). We observe a similar albeit slightly larger statistically significant decrease of 1.0 mean number of months enrolled in CHIP among Hispanic or Latine children for the same period ($p<0.05$; 95% CI: -1.8, -0.2) and a small but statistically significant increase of 0.2 in avoidable hospitalizations per 1000 children ($p<0.05$; 95% CI: 0.0, 0.4).

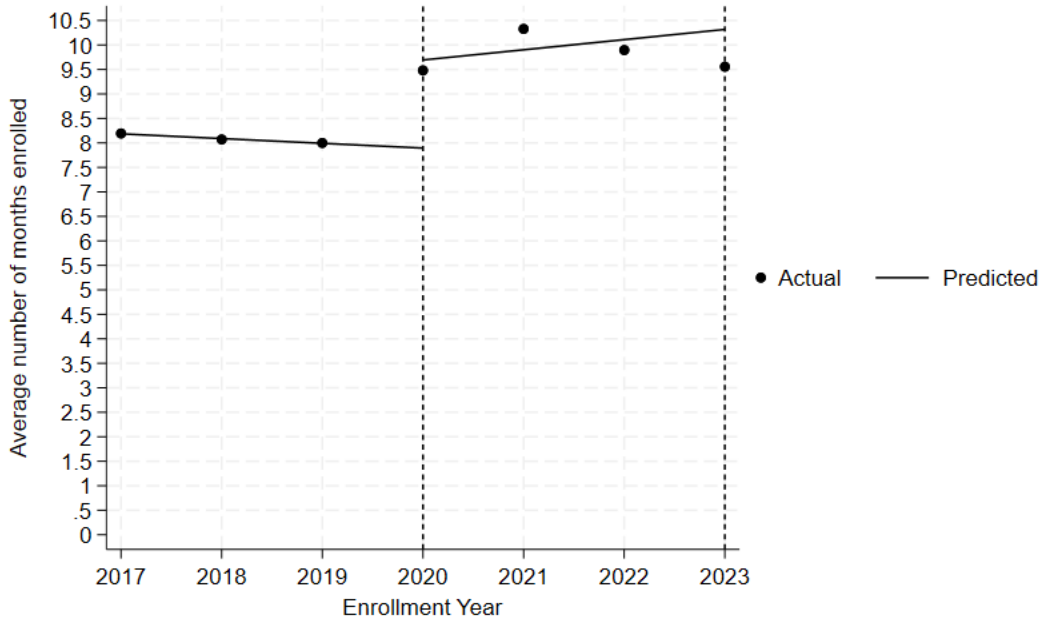
Table 1. Adjusted changes in enrollment, utilization, and quality of care while the Children's Health Insurance Program (CHIP) continuous coverage provision was in place and during Medicaid unwinding among children under 19, 2017-2023

	Pre-CHIP continuous coverage	First year continuous coverage began		Continuous coverage		Medicaid unwinding	
	Baseline mean	Change[a]	95% CI	Change[a]	95% CI	Change[a]	95% CI
Enrollment	8.09	1.80*	-0.06, 3.65	0.30	-0.91, 1.52	-0.76	-3.56, 2.04
Hospitalizations (per 1,000 children)	8.58	-1.53	-16.09, 13.02	1.07	-6.24, 8.37	-2.19*	-5.24, 0.87
Avoidable hospitalizations (per 1,000 children)	0.46	-0.02	-0.48, 0.44	0.22*	-0.01, 0.45	-0.12**	-0.21, -0.02

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2017-2023; Analysis by Rutgers Center for State Health Policy

Notes: The pre-CHIP continuous coverage provision baseline period was 2017-2019. The CHIP continuous coverage was retroactive to 2020. Medicaid unwinding began with the end of the COVID-19 public health emergency in March 2023 and the New Jersey disenrollment period ended in mid-2024. Enrollment is measured as the average number of months enrolled in CHIP per year. Hospitalizations and avoidable hospitalizations are measured per 1,000 children. Avoidable hospitalizations are calculated according to the AHRQ pediatric quality overall (PDI) composite that include: the Asthma Admission Rate, Diabetes Short-Term Complications Admission Rate, Gastroenteritis Admission Rate, and Urinary Tract Infection Admission Rate. These are measures of potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions and reflect on access to and the quality of ambulatory care. Models adjusted for age. [a]Percentage points. *** p<0.01, ** p<0.05, *p<0.1

Figure 1. Trends in children's enrollment in the Children's Health Insurance Program (CHIP) while the continuous coverage provision was in place and during Medicaid and CHIP unwinding, 2017-2023



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2017-2023; Analysis by Rutgers Center for State Health Policy

Notes: The pre-CHIP continuous coverage provision baseline period was 2017-2019. The CHIP continuous coverage was retroactive to 2020. Medicaid unwinding began with the end of the COVID-19 public health emergency in March 2023, and the New Jersey disenrollment period ended in mid-2024. Enrollment is measured as the average number of months enrolled in CHIP per year. Models adjusted for age.

Qualitative Results

Overall, key informants perceived that the CHIP continuous coverage provision led to increased health care coverage and meaningful improvements in quality and access to care for CHIP beneficiaries in NJ. Informants also highlighted several areas that need continued development and shared an overarching concern about the future of children's health insurance coverage given federal cuts to Medicaid that began with the unwinding at the end of the COVID-19 public health emergency. Still, key informants expressed optimism about New Jersey's efforts to expand children's insurance coverage, and the following quote reflects a widely shared perception that New Jersey is moving in the right direction.

> *"But I also think the New Jersey legislature has always been supportive of FamilyCare. Compared to other states, we have one of the most generous programs in the country. I think only New York has a more generous – I've heard they go up to 400% of federal poverty. I've been to meetings nationally where … I can get to say New Jersey FamilyCare covers people up to 350% of poverty kids. And other states are struggling to keep it at 185."*

Focusing on the amendment regarding continuous CHIP eligibility (2017-2023), seven factors were cited as influential to the policy's implementation, either positively or negatively:

- Support from advocacy and community groups
- Strong partnership with Medicaid managed care organizations (MCOs)
- Insurance churn
- Insurance stability across Medicaid households
- Low reimbursement rates for providers
- Provider network (in)adequacy
- Administrative hurdles to Medicaid applications (e.g., changing addresses, literacy, language)
- Institutional knowledge improved
- Public awareness and perception

Below, we describe participants' perceptions of these factors in the context of facilitators and barriers to the implementation of the CHIP continuous coverage provision.

Facilitator: Support from community and/or advocacy organizations and strong partnerships with MCOs improved enrollment in CHIP

Stakeholders overwhelmingly reported that the success of the CHIP amendment implementation was in large part thanks to relationships with advocacy and community organizations with deep ties to the communities the CHIP policy targeted. They described relying on the organizations to

reach potential CHIP beneficiaries, provide education on the policy changes, and assist with enrollment in the program.

> *"They really turned it out and I think deserve so much of the credit for the success of the expansion population, connecting them to coverage, because they are the trusted messengers in the communities. They were able to hear from these folks that they know this program is safe. It's true, you can enroll, all of those things."* (Advocacy representative)

Community and advocacy organizations were not the only ones to support the implementation of CHIP continuous coverage; several stakeholders shared about the critical role MCOs played in the implementation.

> *"So then the MCOs started helping, and they would call their clients. The people who enrolled through them -- their members. Not their clients -- their members, and they would say, get your information out there. Or they were also sharing the updated contact information with FamilyCare. There were greater efforts for people to make sure that stuff was getting mailed to the most current address and there was follow-up."* (Advocacy representative)

> *"So we probably meet maybe once a quarter, physical meeting just to review patients, the demographics, the utilization, any issues and or problems. I like the fact that they are very responsive to any issues and challenges which may become a barrier, but we get to it before it becomes a huge barrier and allow our patients to receive services that they need."* (Provider representative)

Stakeholders acknowledged historical challenges reaching members who may frequently move or change phone numbers. They leaned on their partnership with MCOs who benefit from more regular contact with members and maintain updated addresses, phone numbers, and eligibility information. With this, MCOs act as an intermediary, providing members with policy updates on the CHIP amendment and reporting enrollment and access barriers back to providers and the state.

Facilitator: Continuous coverage without frequent redeterminations reduces insurance churn

Key informants cited frequent churn or gaps in insurance coverage among children as a primary goal of the CHIP continuous coverage provision. A few stakeholders reported less frequent disruptions to children's health insurance coverage where fluctuations in family income or administrative issues were no longer an issue.

> *"I think that just having it alone, the fact that no one could be termed from coverage was the main event, the biggest help and success there. To help avoid all the churn and be able*

to connect more kids to and have access to their care, preventative care and otherwise, having that guaranteed coverage for 12 months is so helpful, having that efficiency administratively. I think that from the state perspective, but also for folks having to go through that application process." (Advocacy representative)

"I think that once a year is generally the right schedule for renewals. And even at that, we have families that don't report timely for their renewal. And that ends up being another point of churn, unfortunately, where people have to get back on the program and reestablish their coverage. When if they had just sent in their renewal on time, they could have remained covered under the program." (State representative)

It was difficult for stakeholders to reflect on continuous coverage outside of the context of Medicaid unwinding where children have lost coverage en masse. Many shared their views on redetermination and its impacts on churn.

Facilitator: Insurance stability across a household is critical to maintaining insurance for children

State stakeholders overwhelmingly reported the importance of health insurance for an entire household as one way to improve children's coverage. They credited the CHIP amendment as contributing to this goal through a reduction in administrative burden felt by both members and administrators. Reducing administrative burden can support consistent coverage (e.g., reduce churn) for an entire household.

"The one thing, a big thing that came up as a theme was that if your parent is uninsured, then you're less likely to be insured as a child, even with all of these, even with the CHIP amendment continuous coverage provision, and even with Cover All Kids." (State representative)

"We try to make sure that if a family has different renewal dates, that within a year, we line them up. If somebody, a child, has continuous coverage, but let's say, a newborn turns one earlier in that year, we'll renew that newborn on their first birthday, but we'll renew the whole family. So instead of renewing that kid with the continuous coverage six months from that time, we'll take them out another six months. So everyone next year has the same date." (State representative)

"I think the move to continuous eligibility is a good move. One of the things that we are really focused on, not just here but federally, and it's been for a long time, is to minimize the burden for the families, minimize the burden for them, barriers to access the coverage. That's been the focus for as long as I can remember." (State representative)

Key informants that participated reported improvement in children's coverage when previously uninsured or underinsured parents also gain coverage.

Barrier: Low reimbursement rates and insufficient provider networks

While stakeholders were generally optimistic about seeing increased health care utilization in relation to the CHIP continuous coverage provision, one advocacy representative emphasized, "*kids have a FamilyCare card, but that doesn't mean they actually have access to a doctor"*, noting insurance coverage does not universally equal access to health care. Many informants highlighted low reimbursement rates for providers that makes it challenging for Medicaid and CHIP populations to access care in a timely and geographically convenient way.

> *"The reimbursement rate is already low."* (Advocacy representative)

> *"And a big, big parts of that is A, the reimbursement rates are extremely low, because although Medicaid by the state, the Medicaid fee for service schedule that the state publishes is almost adequate-ish. As a Medicaid provider, it would be okay, but the MCOs pay us a fraction of those rates, that does not allow a practice to not only to thrive, but to even sustain*" (Provider representative)

Stakeholders remarked about the relationship between low reimbursement rates and provider networks, stating that low reimbursement rates can lead to an inadequate provider network where members might have trouble accessing specialists.

> *"I think the current issue is really adding an adequate network. Which gets to the 'What are you paying for rates?'"* (Advocacy representative)

> *"It's the rate and how to make sure the state has enough of different specialties."* (Advocacy representative)

Stakeholders suggested increased provider reimbursement rates would improve access to care for those who gained coverage under the continuous eligibility.

Barrier: Burdensome applications, convoluted renewal processes, and outdated administrative procedures combine to create administrative hurdles to enrollment

New Jersey has existing application and renewal requirements as well as burdensome administrative procedures that stakeholders identified as barriers to the continuous coverage implementation. Additionally, key informants underscored the difficulty of reaching the CHIP population given external factors like housing instability and language or literacy issues.

> *"I think probably we somehow have to figure out a better way to inform parents that their children are going to be covered for 12 months without any break in their coverage, because we've always educated families. If something changes in your household, report*

it within 10 days, and people understand that they need to do that. So, if they have a change in income, and their income limit has risen beyond the limit for CHIP eligibility, that no longer is going to affect their children until it's time for renewal. But they still are going to report that change." (State representative)

"Sometimes, folks receive things and they don't necessarily open them right away. I know that I am an offender of that myself. I think just even getting the word out about it, we tried our best to get to as many communities as possible and get the word out to as many communities as possible." (Advocacy representative)

"Because, again, there's language issues, literacy problems, and just people's lives being maybe a little bit more hectic. And, also, the fact that sometimes people are moving. They might not be able to pay the rent for a couple months, so they move in with a family member." (Advocacy representative)

Key informants made suggestions to improve the application process in ways that would support increased enrollment for eligible members and reduce burden for state administrators. See *key informant recommendations* below for more details.

Facilitator: Lessons learned from the implementation of the CHIP amendment as well as other related policies like Cover All Kids has provided robust institutional knowledge and improved administrative procedures overall

Stakeholders were overwhelmingly in agreement that over the last several years, New Jersey's efforts to improve children's health insurance coverage through the CHIP continuous coverage provision and Cover All Kids campaign has improved administrative processes overall and inspired changes to longstanding systems.

"It just, it helps people not have to go through that application process, because as we know, sometimes you get things that happen that are unforeseen and people get disconnected to coverage that shouldn't be. So, they are helpful in streamlining and eliminating really the need to submit renewal forms, because instead, the Medicaid staff can use these various administrative data on income and other circumstances to determine eligibility and keep the people from having to manually do it themselves, do the applications themselves." (Advocacy representative)

"We are working on -- we're trying to create a better ex parte process. The ex parte process is when we try to renew someone without having to outreach them using current data. So we look at the information from last year, and then we run a data check. And if we can get a match, then we do not have to send out a renewal form. So I think that the work

we're already doing in that space is going to reduce the amount of churn." (State representative)

"Because of the pandemic and unwinding, CMS gave us permission to just allow us to use those addresses. I think that's helped a lot because they are more in touch with the members. They have more demographic information. They have better phone numbers, better email addresses, everything." (State representative)

"Or they were also sharing the updated contact information with FamilyCare. There were greater efforts for people to make sure that stuff was getting mailed to the most current address and there was follow-up." (Provider representative)

Barrier: Public perception and awareness

A few stakeholders, primarily those serving as providers in the community, shared that the public may not be aware of policy changes or are fearful of interacting with the health care system whether accessing health services or enrolling in health insurance like CHIP. This may be for a variety of reasons summarized by key informants below.

"And a lot of them don't know when they drop it, a lot of them move a lot of times. So whatever recertification papers they did receive go to the wrong places, and they're not aware." (Provider representative)

"We already see that there's more uninsured patients that are not signing up and we know that there's a lot of fear in the community that we serve to either give their information or to sign up or even to come either to us or to schools" (Provider representative)

"We see a lot of kids who we, who used to have Medicaid or used to have NJ Family Care and no longer do and are not aware that they no longer do. And that's where a lot of the problems come in. So they'll come in and either give us a card that they think is valid and we have to check eligibility on every patient. We see everyone no matter what anyway, but we do check eligibility and we do submit to NJ fam, whatever their plan is, if they do have it. And a lot of them don't know when they drop it, a lot of them move a lot of times." (Provider representative)

Summary of Key Informant Recommendations

Key informants provided the following overall recommendations that they believed may help enrollment and access to care beyond the years of continuous eligibility covered by the CHIP amendment in this Demonstration. These recommendations aim to help the State of New Jersey improve children's health insurance coverage.

1. Expand Medicaid buy-in program to fill insurance gaps for children and individuals just above income eligibility limits.
2. Improve the auto reenrollment process by taking advantage of auto renewal waivers (E14) and taking away the procedural part as much as possible to relieve the burden of having to reenroll.
3. Consider reevaluating the compensation for Medicaid providers "a lot more providers might consider taking Medicaid patients if they were compensated for it or compensated at least somewhat fairly."
4. Encourage preventative care for children to improve long-term health outcomes and reduce the need for specialized visits, decrease focus on utilization numbers.
5. Increase provider reimbursement rates keeping in mind training and credential costs to incentivize practitioners working with the Medicaid and CHIP population.
6. Improve access to health services by providing supports that relieve stress due to social determinants of health, such as transportation, housing, health literacy, etc.
7. Increase and promote conversation about the CHIP program to boost awareness in the community.
8. Encourage leadership and policy makers to spend more time in the community, interacting with people with lived experience to understand their needs.
9. Simplify the application process by using other state benefits programs (i.e., TANF, SNAP) to determine eligibility and automatically enroll eligible people.
10. Improve availability of "one-stop-shop" sites that include clinics and enrollment offices to maintain patient engagement and support busy, time-constrained members.
11. Increase FPL cut off to retain more eligible parents and their children.
12. Implement a client portal (or mobile app) where members have access to all benefit and health information, receive electronic notices, and electronically submit updates for renewal.
13. Implement universal case numbers so a case can seamlessly transfer between agencies to decrease gaps in coverage.
14. Build an integrated eligibility system for the state that contains all CHIP eligibility and enrollment rules.

Discussion

The following summarizes the findings from our analyses of quantitative and qualitative data. We further discuss general conclusions based on the findings.

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

Findings from our models marginally support the Hypothesis, although they are not consistently statistically significant. In the first year of continuous coverage, we found marginally statistically significant evidence of a nearly 2-month increase in enrollment. Our results suggest small decreases in hospitalizations and avoidable hospitalizations in the first year of continuous coverage, but neither were statistically significant. We do observe statistically significant decreases in hospitalizations and avoidable hospitalizations, concentrated during the unwinding period, which may reflect children losing coverage and thus access to care rather than an improvement in preventative care.

Qualitative interviews suggested that efforts led by the State to provide continuous coverage to children enrolled in CHIP were perceived as improving enrollment and health care access, supporting our hypothesis despite the absence of a clear effect in our quantitative analysis. Notably, qualitative interviewees highlighted ways in which administrative systems improved as a result of policies like the CHIP amendment and Cover All Kids, indicating long-term investments in children's health insurance coverage by the State. Access to care remains a key concern of interviewees regardless of supportive policies, especially considering low provider reimbursement rates and few specialty providers.

To conclude, during the three years of the CHIP continuous coverage provision, our analysis suggests that the State made meaningful progress toward improving enrollment and decreasing churn for NJ children. In 2023, the effect was offset by the Medicaid unwinding when children began losing coverage.

Conclusions

The NJ FamilyCare CHIP amendment was implemented retroactively on March 1, 2020, ending when all redeterminations for Medicaid and CHIP were conducted during the unwinding period with New Jersey completing their unwinding in June 2024. The goals of this amendment were to reduce churn for children under 19 by increasing enrollment and improving utilization and quality of care. To achieve this goal, NJ FamilyCare established a continuous coverage provision for CHIP-eligible children wherein children would not lose health insurance coverage, regardless of income fluctuations, through the end of the COVID-19 public health emergency in March 2023.

Findings from this evaluation indicate that the State made meaningful progress toward its objectives. Most measures improved in a direction consistent with the Demonstration's goals, albeit findings overall were not statistically significant, they may have been influenced by external factors (e.g., COVID-19, additional state and federal initiatives). Qualitative interviews with providers, state agency representatives, and other stakeholders enriched the quantitative findings by highlighting contextual factors impacting the success of the CHIP continuous coverage provision. Strong leadership from Medicaid and MCOs in addition to critical support from advocates and community organizations played a pivotal role in driving enrollment. Challenges such as provider reimbursement rates, network adequacy, and the application itself remain barriers to coverage.

While there remain several areas for continued development, a widely shared perception among involved stakeholders is that New Jersey is moving in the right direction with its children's health insurance coverage goals, and key informants shared recommendations they believed could facilitate ongoing improvement. Stakeholders suggested broader financial eligibility (e.g., increased FPL), auto enrollment, and an integrated eligibility system as necessary next steps to continue expanding children's access to coverage.

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Appendix A: Interview Guide

Question Bank

1. First, tell me a little bit about your specific role or relationship to the implementation of the CHIP continuous coverage provision and how long you've been in that role?

2. Thinking about the implementation of the continuous coverage provision, what are some facilitators of success and barriers that you have observed?

3. What are 1-2 recommendations you would make to ensure the State meets its goals of supporting insurance coverage for children in New Jersey?
   Probe: *What strategies would you use to overcome barriers? What components of the continuous coverage provision worked well? What should be changed?*

4. Before we close, is there something else about the implementation of the CHIP continuous coverage provision that you would like to share that hasn't been covered?

5. Finally, if we want to clarify anything you have said during the interview, is it all right to contact you? We will not list your name or other specific identifying information about you or in our report. Are there additional steps you would like us to take in our reporting to protect your identity?

Appendix B: AHRQ Prevention Quality Indicators and Pediatric Quality Indicators – Composites and Constituents

Overall Composite (PQI #90)	
PQI #01 Diabetes Short-Term Complications Admission Rate	PQI #11 Bacterial Pneumonia Admission Rate
PQI #03 Diabetes Long-Term Complications Admission Rate	PQI #12 Urinary Tract Infection Admission Rate
PQI #05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	PQI #13 Angina without Procedure Admission Rate[1]
PQI #07 Hypertension Admission Rate	PQI #14 Uncontrolled Diabetes Admission Rate
PQI #08 Congestive Heart Failure (CHF) Admission Rate	PQI #15 Asthma in Younger Adults Admission Rate
PQI #10 Dehydration Admission Rate	PQI #16 Rate of Lower-Extremity Amputation Among Patients With Diabetes
Acute Composite (PQI #91)	
PQI #10 Dehydration Admission Rate	PQI #12 Urinary Tract Infection Admission Rate
PQI #11 Bacterial Pneumonia Admission Rate	
Chronic Composite (PQI #92)	
PQI #01 Diabetes Short-Term Complications Admission Rate	PQI #13 Angina without Procedure Admission Rate[13]
PQI #03 Diabetes Long-Term Complications Admission Rate	PQI #14 Uncontrolled Diabetes Admission Rate
PQI #05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	PQI #15 Asthma in Younger Adults Admission Rate

[1] This component was retired in Version 6.0 of the PQI software which accommodated ICD-10 coding. This software version was used for generating the overall composite indicator beginning in October 2015.

PQI #07 Hypertension Admission Rate

PQI #08 Congestive Heart Failure (CHF) Admission Rate

PQI #16 Rate of Lower-Extremity Amputation Among Patients With Diabetes

Source: Prevention Quality Indicators Technical Specifications - Version 6.0, September 2016; http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx.

Overall Composite (PDI #90)

PDI #14 Asthma Admission Rate

PDI #15 Diabetes Short-Term Complications Admission Rate

PDI #16 Gastroenteritis Admission Rate

PDI #18 Urinary Tract Infection Admission Rate

Source: Pediatric Quality Indicators Technical Specifications - Version 6.0, September 2016; https://www.qualityindicators.ahrq.gov/Archive/PQI_TechSpec_ICD10_v60.aspx.

Appendix C: Subgroup Analyses

Table A1. Adjusted changes in enrollment, utilization, and quality of care while the Children's Health Insurance Program (CHIP) continuous coverage provision was in place and during Medicaid unwinding among children under 19 by race and ethnicity, 2017-2023

	Enrollment					Hospitalizations (per 1,000 children)				
	Pre-CHIP continuous coverage	First year that continuous coverage began		Medicaid unwinding		Pre-CHIP continuous coverage	First year that continuous coverage began		Medicaid unwinding	
	Baseline mean	Change[a]	95% CI	Change[a]	95% CI	Baseline mean	Change[a]	95% CI	Change[a]	95% CI
White, non-Hispanic	8.2	0.6	-0.3, 1.4	-0.7**	-1.1, -0.3	8.1	-1.9	-6.9, 3.0	-0.6	-5.1, 3.9
Black, non-Hispanic	7.5	0.7	-4.5, 6.0	-1.4	-6.4, 3.6	10.2	-2.1	-17.9, 13.7	-0.2	-12, 11.5
Hispanic or Latine	8.1	0.9*	0, 1.8	-1.0**	-1.8, -0.2	9.6	-1.2	-12, 9.5	-0.1	-6.6, 6.4
Asian	8.6	1.2*	-0.3, 2.7	0.2	-0.8, 1.08	4.6	-2.3	-8.9, 4.4	-0.8	-3.96, 2.4
Other	8.2	2.5*	-0.2, 5.3	0.5	-2.1, 3.03	7.3	-2.8	-11.3, 5.6	1.0	-3.87, 5.8

	Avoidable hospitalizations (per 1,000 children)				
	Pre-CHIP continuous coverage	First year that continuous coverage began		Medicaid unwinding	
	Baseline mean	Change[a]	95% CI	Change[a]	95% CI
White, non-Hispanic	0.4	-0.1	-0.2, 0.0	0.1**	0.0, 0.1
Black, non-Hispanic	0.7	0.6	-2.2, 3.3	0.7	-2, 3.3
Hispanic or Latine	0.5	-0.2*	-0.4, 0.1	0.2**	0, 0.4
Asian	0.5	-0.1	-1.7, 1.6	0.3	-0, 1
Other	0.5	0.1	-0.7, 0.9	0.1	-0.5, 0.7

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2017-2023; Analysis by Rutgers Center for State Health Policy

Notes: The pre-CHIP continuous coverage provision baseline period was 2017-2019. The CHIP continuous coverage was retroactive to 2020. Medicaid unwinding began with the end of the COVID-19 public health emergency in March 2023 and the New Jersey disenrollment period ended in mid-2024. Enrollment is measured as the average number of months enrolled in CHIP per year. Hospitalizations and avoidable hospitalizations are measured per 1,000 children. Avoidable hospitalizations are calculated according to the AHRQ pediatric quality overall (PDI) composite that include: the Asthma Admission Rate, Diabetes Short-Term Complications Admission Rate, Gastroenteritis Admission Rate, and Urinary Tract Infection Admission Rate. These are measures of potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions and reflect on access to and the quality of ambulatory care. Models adjusted for age. [a]Percentage points. *** p<0.01, ** p<0.05, *p<0.1

Appendix D: Approved Evaluation Plan, Children's Health Insurance Program (CHIP)

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

State Demonstrations Group

January 17, 2025

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

Dear Assistant Commissioner Woods:

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

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

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

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

Sincerely,

Danielle Daly -S

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

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

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

Evaluation Design for CHIP Amendment, Version8.29.24

A. General Background Information

On September 13, 2023, CMS approved an amendment to New Jersey's 1115 Demonstration regarding continuous eligibility for children in its separate Children's Health Insurance Program (CHIP), effective for the period retroactively from March 1, 2020 and ending when all redeterminations for Medicaid and CHIP are conducted during the unwinding period. New Jersey Medicaid plans to be finished with the bulk of the unwinding by the end of June 2024.[1] There are exceptions for enrollees who are not eligible for coverage because, for example, they voluntarily withdrew or no longer live in New Jersey. The CHIP program in New Jersey is available for children ages 0-1 who are within 194%-350% of the Federal Poverty Line (FPL) and children ages 1 to 18 who are between 142%-350% of the FPL (in both cases, including a 5% disregard of income). Children with income levels lower than the CHIP guidelines qualify for Medicaid.

B. Evaluation Hypotheses and Questions

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

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

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

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

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

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

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

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

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

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

C. Methodology

Table CHIP.1. Inventory of Measures

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

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

[3] See https://qualityindicators.ahrq.gov/Downloads/Modules/PDI/V2023/PDI_Composite_Measures.pdf

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

For hypothesis 1 and research questions 1a-1b

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

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

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

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

For hypothesis 1 and research question 1c

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

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

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

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

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

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

D. Limitations

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

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

Question Bank

1. First, tell me a little bit about your specific role or relationship to the implementation of the CHIP continuous coverage provision and how long you've been in that role?

2. Thinking about the implementation of the continuous coverage provision, what are some facilitators of success and barriers that you have observed?

3. What are 1-2 recommendations you would make to ensure the State meets its goals of supporting insurance coverage for children in New Jersey?
   Probe: *What strategies would you use to overcome barriers? What components of the continuous coverage provision worked well? What should be changed?*

4. Before we close, is there something else about the implementation of the CHIP continuous coverage provision that you would like to share that hasn't been covered?

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