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Multiyear Continuous Eligibility in Medicaid and CHIP: Five Keys to Maximizing Positive Benefits for Children and Their Families

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As of October 2024, three states (New Mexico, Oregon, and Washington) were implementing a new policy that retains children in Medicaid and the Children's Health Insurance Program (CHIP) up until age 6, regardless of changes in family income, without the need to undergo annual eligibility redeterminations. Several other states[1] have similar proposals under development. These policies, enacted under Section 1115 demonstrations, hold promise for reducing churn, which in turn could offer more peace of mind to parents, increase families' financial stability, promote receipt of medical care during a critical developmental period of children's lives, and improve kindergarten readiness, all of which could lead to better health and well-being in the long term (Boudreaux, Golberstein, and McAlpine 2016; Brantley and Ku 2022; Grossman, Tello-Trillo, and Willage 2022; Jackson, Agbai, and Rauscher 2021; MACPAC 2021; McMorrow et al. 2017; Pittard et al. 2012; Sommers and Oellerich 2013).

In July and August 2024, we conducted interviews focusing on multiyear continuous Medicaid/CHIP coverage for young children with 29 experts, including child advocates, Medicaid policy experts, federal and state policymakers, health care providers, health plan representatives, and Medicaid researchers (Box 1). We asked these key informants about their perspectives on the most important actions state Medicaid programs, managed care plans, and providers should consider to maximize the potential positive impacts of continuous eligibility until age 6 (CE6) on children and their families. From these interviews and available research evidence, we identified actions in five key areas, described in more detail below:

1. Ensure that eligibility systems are updated and functioning correctly and that staff are trained in the new policies.
2. Inform and educate families about CE6 and maintain regular contact.
3. Engage managed care organizations (MCOs), providers, community-based organizations (CBOs), and other state agencies in outreach, education, and assistance to families.
4. Leverage managed care contracting and oversight to support access to high-quality care and prioritize opportunities to improve health outcomes.
5. Monitor implementation in real-time and use the information to course correct.

BOX 1

Research Methods

In July and August 2024, Urban Institute researchers interviewed 29 experts, including child advocates, Medicaid policy experts, federal and state policymakers, health care providers, health plan representatives, and Medicaid researchers. Interview topics included the most important changes Medicaid programs and other organizations could take to maximize the benefits of CE6 policies, the most feasible short-term impacts of policies, expected impacts for different subgroups of children, and effects of CE6 policies on Medicaid programs and states. The research team took detailed notes on each interview and recorded and transcribed interviews when study participants granted permission. Team members analyzed interview notes to determine common themes and supplemented or corroborated interview findings with relevant evidence from published literature. The Urban Institute's Institutional Review Board reviewed and approved the research study protocols.

1. Ensure that eligibility systems are updated and functioning correctly and that staff are trained in the new policies.

Why It Matters

For the CE6 policy to maintain Medicaid/CHIP coverage and reduce churn and gaps in coverage,[2] eligibility and enrollment systems will need to work correctly to keep eligible children continuously enrolled, support coverage of other family members, and promote retention in the program or seamless transitions of children to other coverage when they reach age 6. Enrollee notices will also need to clearly reflect children's multiyear coverage.

Current Context

In 2018, an estimated 8 to 11 percent of children nationally churned in and out of Medicaid and CHIP (i.e., reenrolled within months of disenrolling), suggesting that some children were losing coverage while still eligible or that their families had experienced a temporary fluctuation in income (MACPAC 2021). Other research has found that around half a million newborns whom Medicaid should have automatically covered for their first year of life were losing coverage annually during the 2010–18 period, indicating that the eligibility system and enrollment processes were not always working as intended for newborns (Johnson Group Consulting 2021). The unwinding of the pandemic-related Medicaid continuous coverage policy following the end of the public health emergency revealed additional policy and systems issues that states needed to address concerning Medicaid redeterminations (GAO 2024b). In the coming years, Medicaid programs will also be required to make other changes to comply with new federal eligibility, enrollment, and renewal rules designed to reduce unnecessary churn but which could introduce additional risks for systems glitches.[3] In addition, states often rely on vendors and contractors to conduct or support key functions, including eligibility, enrollment, and renewal, which can introduce additional complexity and risk of errors into daily operations.[4]

Actions to Consider

- ***Ensure that eligibility system and enrollment process changes have been correctly implemented***. Glitches in systems that determine eligibility, process enrollments, and generate enrollee notices could result in children eligible for CE6 erroneously losing coverage or their families being misinformed about their coverage status. Interviewees suggested states conduct robust testing to monitor systems performance, investigate problems, and address issues proactively, both for children overall and for a variety of scenarios/subgroups of children (e.g., newborns, families with children of multiple ages, and children in different eligibility groups such as those eligible based on a disability or family income).
- ***Adequately train agency staff and vendors***. Key informants stressed the importance of ensuring that staff, vendors, and contractors who support or operate eligibility and enrollment systems understand the continuous eligibility policy, the "why" behind it, and what it means for enrollees. This was seen as critical to ensuring that staff and vendors are alert to problems, effectively communicate policy details, and correctly apply the CE6 policy in automated eligibility and enrollment systems and manual processes.
- ***Improve ex parte rates.*** Interviewees noted that ex parte, or automatic, renewal conducted at the individual level would be particularly important under CE6 policies to maintain coverage of other eligible family members, including older siblings and parents, and safeguard eligible kids dropping off Medicaid once the CE6 period ends.[5] States could continue to work on improving their ex parte processes and use strategies from unwinding (and potentially implement or keep 1902(e)(14)(A) waivers if they become permanent)(Kane and Thornton 2023).
- ***Integrate different public coverage programs***. Ensuring integration between Medicaid and separate CHIP programs and between these programs and Marketplaces would help support coverage for other family members and potential coverage transitions for children turning six (MACPAC 2022).

2. Inform and educate families about CE6 and maintain regular contact.

Why It Matters

For CE6 policies to achieve maximum positive impacts, key informants emphasized that it is essential that families with young children are aware of the policy and understand how it affects eligibility and renewal requirements for their young children as well as for older kids and parents who are not directly impacted by the policy. For example, families may ask what happens if they get a higher-paying job, move out of state and back, their immigration status changes, their young child becomes newly eligible for employer-sponsored insurance or uses Medicaid as wraparound coverage, or their child ages out of the policy. Families may have mistrust or concerns, such as the possibility of surprise medical bills if they are not confident their children will retain coverage, and these concerns could discourage them from seeking needed care. Families may also not have high levels of health/health insurance literacy and be unaware of the range of health benefits and support services their children are entitled to in Medicaid or how to access them. This suggests that to maximize the potential value of CE6 policies, state agencies, MCOs, providers, and families would need to remain in active communication.

Current Context

Despite efforts to streamline and simplify Medicaid communications (MAC Learning Collaboratives 2017), notices about coverage decisions and renewals, open enrollment, and plan selection processes have notoriously been complex and confusing (sometimes even discouraging) for many enrollees to understand and act on (e.g. if action is required to keep their coverage or select a health plan).[6] Analysis of survey data suggests that while the public health emergency's continuous coverage requirement was in effect, some enrollees were unaware that they were covered by Medicaid (Ding, Sommers, and Glied, 2024). Furthermore, the public health emergency showed that, in the absence of conducting regular eligibility checks and sending renewal requests to enrollees, Medicaid agencies lost contact with some families (e.g., because they lacked updated addresses for those who moved) (CMS 2022a), and many enrollees lost familiarity with (or, for new enrollees, never had exposure to) the renewal process,[7] which likely contributed to unnecessary disenrollments among eligible enrollees during the unwinding.[8] A similar scenario could happen to children covered under CE6 if Medicaid agencies lose touch with enrolled families during the CE6 period. Even when agencies continue to send regular notices and insurance cards to children covered under the CE6 policy, that may not be frequent enough. But unwinding experiences also offer tools and strategies that states can draw on.[9]

Moreover, for over 50 years, all Medicaid-eligible children and youth have been entitled to Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which requires states to provide comprehensive health and developmental screenings (including hearing, vision, and dental) and provide treatment for identified conditions (Rosenbaum 2016). These protections also apply to children and youth in 16 states with separate CHIP programs that provide EPSDT benefits for some or all CHIP enrollees.[10] However, states have not been fully compliant with EPSDT requirements, and EPSDT services have been chronically underused (Perkins and Avery 2023); reportedly, only about half of children and youth eligible for EPSDT benefits received at least one initial or periodic screening in 2019, and 1 in 10 children ages 3 to 5 were not screened (Young et al. 2021). New Centers for Medicare & Medicaid Services (CMS) guidance released in September 2024 aims to increase states' adherence to their obligation "to ensure that individual eligible children get the health care they need, when they need it, in the most appropriate setting" by reiterating state requirements and identifying strategies to promote accessibility of EPSDT benefits, including by expanding the provider workforce, with a particular focus on ensuring access to EPSDT benefits for children with special health needs (CMS 2024). Although EPSDT requirements are independent of CE6 policies, full compliance with these long-established obligations is likely key to the ultimate success of multiyear continuous eligibility in ensuring access to needed care and promoting positive health outcomes.

Actions to Consider

- ***Improve clarity of notices***. Key informants suggested improvements, including using plain language, eliminating unnecessary details, accurately translating notices into multiple languages, testing notices with enrollees, and incorporating feedback to improve notices before release. They suggested specific information could be added to notices, including health care

services that are available and recommended for each enrolled child, contacts for any questions, and available coverage options for other family members.

- ***Create robust communications and information about CE6***. Recommended actions include (1) updating state websites and developing downloadable materials in multiple languages with accurate information about the CE6 policy; (2) providing straightforward explanations of the concept of multiyear continuous eligibility (e.g., "coverage from birth to kindergarten without interruption"); (3) laying out concrete examples of how the policy translates into real-life benefits for families in different circumstances; and (4) developing explainers that can ease common concerns, including around changes in family income or immigration status, and highlight the policy's benefits for young children to help them grow and thrive.
- ***Educate and train call center staff and enrollment caseworkers.*** Key informants emphasized that call center staff and enrollment caseworkers will need to be trained so they can educate families about the policy change, provide correct information in response to families' questions, and incorporate the new policy into call scripts and protocols—with special attention to clarifying details like precise age cutoffs, exemptions, and implications for family members not affected by CE6. Relatedly, multiple key informants emphasized that states would need to provide sufficient translation/interpretation supports in call centers.
- ***Stay in regular contact with and maintain updated contact information for families throughout the CE6 period.*** Interviewees argued for the importance of states explicitly planning for how often and in what format to touch base with enrollees to remind them about continuous eligibility and available services and how to ensure accurate contact information is maintained for enrollees under CE6 policy (such as using the National Change of Address database as allowed by CMS).
- ***Ensure that families with children covered by CE6 policies are informed about EPSDT benefits.*** Maximizing the potential benefits of CE6 policies depends on identifying and treating problems early and children obtaining the care they need to support their healthy development. Recent CMS guidance emphasizes states' responsibilities to ensure families' awareness of the breadth of EPSDT benefits using a variety of modes and in understandable language (CMS 2024). Several key informants suggested that all communications about CE6 should reiterate the range of services children covered by the policy are entitled to and how to access them.

3. Engage MCOs, providers, CBOs, and other state agencies in outreach, education, and assistance to families.

Why It Matters

Key informants consistently highlighted the importance of on-the-ground support and direct face-to-face interactions in helping enrollees navigate Medicaid coverage and health care. Although some interviewees argued that communications about CE6 should be state-driven, many recognized that enrollees often have more direct contact with and trust in health care providers, MCOs, or CBOs than with state agencies. Engaging these entities and other trusted messengers in ongoing outreach and communications about health insurance coverage, the importance of ongoing preventive care, how to access care, and the CE6 policy could be essential to increasing awareness of the policy and helping

families take full advantage of the available coverage, thus supporting their kids' healthy development (Flores et al. 2016).

Informants also emphasized the importance of engaging with other state agencies to ensure that CE6 does not inadvertently lead families to lose access to other benefits, such as the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families, for example, if families assume they no longer need to renew coverage for those benefits either. CE6 policies on their own will not be enough to ensure the health and well-being of children if families encounter other barriers to thriving, such as food insecurity and unstable or unhealthy housing.

Current Context

As part of emergency responses to the COVID-19 pandemic, states have increasingly leveraged broad stakeholder coalitions and community partnerships to reach historically marginalized communities. These relationships proved important during the unwinding of Medicaid's pandemic-related continuous coverage requirement.[11] Advocates and community organizations mobilized to support outreach and assistance to Medicaid enrollees and hold state agencies accountable for unwinding outcomes out of concern for mass coverage losses (Heard 2023).[12] These partnerships could be activated to promote CE6. Some key informants also noted that many federal and state agencies and programs are focused on young children and their families, but often these agencies do not coordinate or collaborate effectively, which can reduce the potential positive impacts on beneficiaries (Lou et al. 2023). For example, only some states have fully integrated eligibility systems for multiple health and social programs, posing administrative barriers for state agencies and enrollees in ensuring all eligible people receive the benefits to which they are entitled (CMS 2022b).

Actions to Consider

- ***Engage a wide range of community-based partners***. Informants mentioned CBOs, community health workers, Head Start providers, child care providers, faith leaders, and other trusted on-the-ground entities that serve families with young children that could be tapped to help spread awareness of CE6 as well as how to leverage coverage to support access to care and address children's developmental needs.
- ***Leverage insurance navigator networks***. Interviewees noted the role of community-based insurance navigators (e.g., Affordable Care Act navigator entities and Connecting Kids to Coverage grantees)[13] in spreading awareness about CE6, answering families' questions, providing assistance with obtaining coverage for other family members, and helping families renew or transition to other coverage once a child's CE6 period expires. One interviewee emphasized the critical need for contact information for navigators to be included in state notices and letters to enrollees.
- ***Empower providers to support outreach to families***. Key informants emphasized the important role of providers and suggested that states could provide them with talking points, flyers, and other communication materials to support outreach and education to the families they serve. Moreover, they suggested that states and MCOs share information on children's eligibility status, coverage period, and renewal dates with providers (e.g., through provider portals) so

they can easily verify eligibility and enrollment when families seek care and relay important information regarding coverage and renewals.

- ***Improve provider education***. Furthermore, informants argued that states should ensure providers are knowledgeable about EPSDT requirements and benefits and have access to available screening tools and reimbursement codes. For instance, interviewees said states could promote the Bright Futures framework[14] for supporting healthy childhood development and implement evidence-based models that support the healthy development of young children, such as the Healthy Steps, Reach Out and Read, and DULCE programs.[15]
- ***Coordinate with SNAP, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Title V Maternal and Child Health Services Block Grant, home visiting, Head Start/Early Head Start, child care, prekindergarten, and other relevant programs and organizations***. Other state agencies and programs that serve families with young children could help ensure there is a good understanding of the CE6 policy and what it means for families' renewals, and communicate to families that they still need to renew other benefits just as before the CE6 policy. Exchanging enrollee data between Medicaid and other public agencies could also ensure alignment in outreach and maximum uptake of benefits among eligible families while minimizing burden on families. Furthermore, effective collaboration between Medicaid and entities such as early intervention services providers, home visiting programs such as Maternal Infant and Early Childhood Home Visiting, and early childhood education programs would ensure smooth referrals and receipt of the services that young children need to thrive.
- ***Use MCOs and state-based foundations to support communication efforts.*** We also heard about the need to leverage the important role of health plans and philanthropy in funding ongoing public outreach and education efforts, such as advertising and education campaigns focusing on what services are available and recommended for young children, how to select a health plan and find which providers are in-network, how to access needed health care and what to do when access problems are encountered, what families should expect of their child's primary care provider and other health care providers, and what type of developmental supports young children should be receiving.

4. Leverage managed care contracting and oversight to support access to high-quality care and prioritize opportunities to improve health outcomes.

Why It Matters

With robust and stable enrollment and greater awareness and understanding of CE6 policies and Medicaid benefits among families and providers, continuous eligibility could lead to more utilization of primary and preventive services, improved rates of early identification and treatment of developmental delays, and improved management of chronic diseases and complex medical or behavioral health issues. Ultimately, these health care improvements in early childhood could promote better health and well-being of children, setting them up for greater success in school, with lasting positive impacts on their health and socioeconomic outcomes long into adulthood (Farr, Lou, and Daly, 2024). But to realize this potential, young Medicaid enrollees will need access to comprehensive, high-quality, developmentally

appropriate primary and specialty care and supportive services that are culturally appropriate. Under federal EPSDT requirements, children enrolled in Medicaid are entitled to a higher standard of care than adults regarding access to health care to diagnose and treat medical and developmental conditions. Key informants consistently emphasized the important role that MCOs have in promoting awareness about CE6 and supporting enrollees in receiving preventive care and necessary specialty care and other services that they need, as required under EPSDT obligations (CMS 2024).

Current Context

Most Medicaid/CHIP-covered children nationwide, and over 90 percent in states with CE6 policies as of 2024, were enrolled in capitated managed care plans in 2022 (Hinton and Raphael 2024; Williams et al. 2022). Under managed care arrangements, MCOs have incentives to control costs through narrow provider networks and utilization management practices, which can negatively affect timely access to care.[16] Furthermore, variation across contracted MCOs in provider networks and covered benefits can lead to complexity and confusion among families in the health plan selection process and further disrupt care (Allen, Verdeflor, and Caraveo 2022). State Medicaid agencies have increasingly been using MCO contracts to support the objectives of the Medicaid program and advance program goals. For example, MCO contracts often include requirements and financial rewards to improve the delivery of and experiences with care, address enrollees' health-related social needs, or reduce racial and ethnic disparities in outcomes (Bailit Health 2024; Hinton and Diana 2024). Some key informants noted that many, if not most, managed care quality improvement initiatives and performance metrics pertain to adult populations and often focus on high-needs and high-cost enrollees, such as those experiencing homelessness or multiple chronic diseases.[17]

Additionally, some key informants thought that the steady funding MCOs would be able to count on through per-member per-month payments for CE6 enrollees over multiple years should be accompanied by new expectations or requirements. For instance, some referred to requiring health plans to address barriers, such as narrow provider networks, cumbersome prior authorization processes, and high rates of claim denials that can delay and deter care (GAO 2024; MACPAC 2024). Informants also argued that Medicaid programs have paid too little attention to the needs of children, including in terms of quality improvement initiatives, incentive metrics, or alternative payment models. Many informants argued that new federal requirements and stronger oversight of managed care would help ensure that CE6 policies reduce unmet health and developmental needs among young children, improve quality metrics for young children in the state, and fulfill the promise of EPSDT.[18]

State Medicaid agencies are responsible for ensuring access to high-quality care for all covered services, including those states that use fee-for-service models for all Medicaid enrollees or select enrollees, such as those with special health care needs, or for certain types of services (Hinton et al. 2022).[19] It will be important for Medicaid/CHIP programs to work with primary care providers to ensure that they and the families of the young children enrolled in fee-for-service programs are also aware of the continuous eligibility policy and services recommended for young children and required under the EPSDT benefit.

Actions to Consider

- ***Require MCOs to engage with CE6 beneficiaries in a meaningful way***. Key informants argued that MCOs should make efforts to raise awareness about the policy and educate families about the benefits and supports available, the providers in their network, and the preventive and follow-up care children should be receiving under Medicaid's comprehensive pediatric benefit, EPSDT, when developmental or other issues are identified. Ideally, they thought that the content of this engagement between MCOs and members should be informed by direct input from their members (e.g., advising on the messaging that would be most helpful). The Ensuring Access to Medicaid Services Final Rule promotes the engagement of beneficiaries and other key stakeholders in new Medicaid Advisory Committees and Beneficiary Advisory Councils, which could be one source of community input.[20]
- ***Provide greater oversight of MCO performance***. Oversight strategies mentioned by key informants could include requiring MCOs to document outreach and engagement rates and report address and contact information changes to the Medicaid agency. New managed care rules strengthen states' monitoring and enforcement standards, but states could go even further and amend managed care contracts to include requirements and incentives to promote greater access and utilization of pediatric services, including well-child visits, immunizations, screenings, and referrals to treatment.[21] Given long-standing disparities within Medicaid and disparities in children's health outcomes (Flores and The Committee on Pediatric Research 2010),[22] states could publicly report MCO-level performance data stratified by race/ethnicity and other key characteristics for each of the Core Set/Healthcare Effectiveness Data and Information Set (HEDIS) measures.[23] States could also require that MCOs ensure access to evidence-based pediatric-specific interventions and implement quality improvement strategies specific to pediatric populations.[24] Value-added care models (e.g., team-based pediatric primary care to support whole families) could be designed to reward greater health plan investments in young children (Perrin et al. 2023). Informants also called for states to establish minimum medical loss ratios for pediatric services and to monitor plans' spending on services for children.
- ***Require and monitor the adequacy of provider networks***. Informants emphasized the necessity of ensuring MCOs have adequate pediatric primary and specialty care networks and suggested that states also require and monitor the accuracy of provider directories (Kissam et al. 2024). For example, the Managed Care Rule establishes maximum wait time standards for pediatric primary care, behavioral health, and specialty services and requires that states monitor MCO compliance (through secret shopper surveys) with wait times and the accuracy of provider directories.[25] Some informants suggested this information will help states identify and address access issues, and broader provider networks could also minimize the need for families to switch health plans during the CE6 period and further strengthen continuity of care. States could support provider participation in Medicaid (including for high-priority services like behavioral health care, other specialty care, and therapies like speech therapy and occupational therapy), such as through MCO incentive metrics,[26] increasing provider payment rates, and updating/streamlining administrative requirements (e.g., licensing, billing systems, and addressing delays in reimbursement).[27] Other considerations to ensure children are connected

to the services they need could include partnering with neighboring Medicaid programs to allow cross-state access to services and expanding the use of telehealth and specialty provider consultation models (e.g., Project ECHO).[28]

- ***Provide oversight related to claims denials and prior authorization***. Key informants mentioned that denials and prior authorization requirements could create barriers to access and argued that stronger oversight over MCO prior authorization and claims review processes were needed, including requiring reporting by health plans.[29] CMS guidance emphasizes that the EPSDT obligation "creates a higher standard of coverage for eligible children than for adults," and states are responsible for ensuring these higher standards are reflected in medical necessity criteria, utilization management tools, and fair hearings processes for children and youth under age 21 (CMS 2024). In other words, states are required to ensure that MCOs comply with child-focused definitions of medical necessity in prior authorization policies when delivering services required under EPSDT.
- ***Support MCOs' development of patient-centered pediatric medical home models and multidisciplinary team-based care models that include care coordination functions***. With longer-term stable coverage, CE6 offers providers an opportunity to develop relationships with families, ensure continuity of care, and provide more hands-on assistance to families in accessing needed specialty care and other services. This could include encouraging practices to offer extended and weekend hours that specifically include well-child visits and immunizations to combat the problem of practices offering extended hours for sick visits only.
- ***Improve accountability***. Multiple informants suggested that more transparency around Medicaid MCOs' responsibilities could improve accountability. Strategies for accountability could include publicizing contracting details, providing more mechanisms for enrollees and providers to report violations and barriers they are experiencing, and ensuring MCOs are accountable for following through on recommendations from newly created Medicaid Advisory Committees and Beneficiary Advisory Councils.[30]

5. Monitor implementation in real-time and use the information to course correct.

Why It Matters

Tracking the implementation of new policies is important to assess whether the policies are being implemented as intended, use learnings to modify implementation approaches, and provide context for understanding impact findings for states. Implementation analyses can also yield important insights to inform federal policy guidance and the design and implementation of CE6 policies in other states.

Current Context

As part of Section 1115 waiver demonstrations, states will be required to report on the CE6 policy through a monitoring protocol, but CMS has not yet issued guidance on the contents of that reporting about the CE6 policy. At this point, very little information is available on how the CE6 rollout is unfolding in the early implementation states.

Actions to Consider

- ***Conduct real-time enrollment monitoring***. There was uniform agreement that now is the time to track and report on the performance of enrollment and eligibility systems in states that have begun implementing CE6 policies. Examples of metrics to track included verifying that no newborns and other children under age 6 are becoming disenrolled from Medicaid (except in cases of voluntary disenrollment, moving out of state, or death), variation in retention of coverage across key subgroups, and how actual enrollment compares to projected enrollment. Additional monitoring could assess how families' incomes fluctuated during the CE6 period to understand how children's eligibility would have shifted in the absence of CE6 and how much churn was avoided.
- ***Monitor timely receipt of preventive services and treatment***. Key informants argued that states should use claims data to monitor changes in utilization metrics like receipt of well-child visits, immunizations, and developmental screenings and referrals, as well as whether treatment services are being delivered following the identification of health or developmental problems. One key informant noted it would be important to track the extent to which improvements in service use are reaching historically marginalized groups, such as by monitoring utilization by race/ethnicity, health status, and other key characteristics.
- ***Use quality metrics and other tools***. Informants maintained states should assess child health and well-being data (e.g., the National Survey of Children's Health and other survey data), develop appropriate child-centric quality metrics, and use HEDIS data to monitor access to and quality of care.[31]
- ***Monitor provider-level impacts***. According to key informants, tracking provider-level data would also be important. Although some informants thought that primary care providers and community health centers could absorb higher volumes of children seeking care, others raised concerns about longer wait times for appointments and higher rates of unmet need, particularly for specialty care and early intervention services. They also suggested that states could assess changes in payer mixes (e.g., ensuring providers and hospitals are not suffering as a result of lower payment because children who otherwise might have employer-sponsored insurance are remaining in Medicaid), paying particular attention to small practices, sole practitioners, and safety net providers who may be at greater risk of experiencing adverse financial repercussions because of changes in payer mix.
- ***Monitor impacts on other public benefits***. Informants further suggested that states and sister agencies jointly assess changes in the uptake and maintenance of other benefits in families with young children, like SNAP, parental Marketplace coverage, WIC, and school/preschool meals, to ensure that families maintain or even increase access to other benefits for which they are eligible.
- ***Engage with communities.*** Interviewees also emphasized the need to capture feedback not available from other data sources like enrollment and claims data. Examples included listening sessions and regular meetings with providers, CBOs, and the broader community where the agency would provide updates and answer questions on the CE6 policy, as well as other

methods for creating feedback loops from providers and CBOs on how implementation is unfolding.

- ***Conduct qualitative data collection and reporting.*** Some key informants noted the power of storytelling. States could encourage providers, case managers, CBOs, and evaluators to document and share real-life examples and stories of families affected by the CE6 policy or who had struggled when the policy was not in effect. If possible, this would also include collecting information directly from families through surveys on parental satisfaction, family stress, and out-of-pocket medical costs.

Conclusion

CE6 policies hold promise for improving health care coverage and continuity of care for young children, reducing family stress and medical debt, increasing school readiness, improving families' and children's overall health and well-being, and improving the efficiency of state Medicaid programs by lessening administrative burdens and costs (Hu et al. 2016; Swartz et al. 2015; Wagnerman, Chester, and Alker 2017).[32] Along with these short- and medium-term benefits, continuous eligibility in Medicaid during critical early years could foster children's healthy growth and development, yielding long-term benefits to their overall health and well-being (Boudreaux, Golberstein, and McAlpine 2016; Center on the Developing Child 2010; Park, Alker, and Corcoran 2020). According to interviews with key informants, realizing the full potential benefits will require concerted efforts to ensure eligibility systems are updated properly, families are educated on the policy, providers and other stakeholders are engaged in outreach efforts, MCOs are held accountable, and implementation is closely monitored to finetune approaches. Putting in efforts to ensure the success of CE6 in the pioneering states is important for laying the groundwork for other states and/or age groups. Finally, while important for the success of CE6 policies, these efforts may also apply more broadly to maximize the benefits of Medicaid coverage for older children and children in states without CE6 policies to ensure that *all* Medicaid-eligible children retain uninterrupted coverage and have access to services and benefits to which they are entitled in Medicaid that meet their health needs and support their healthy development.

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Notes

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