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# Improving Medicaid renewal outreach: Evidence from rapid-cycle testing in New Jersey

## *Report*

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### **Introduction**

During the COVID-19 pandemic, the federal government’s declaration of a Public Health Emergency (PHE) led to policy changes requiring states to keep Medicaid beneficiaries continually enrolled in their insurance plans. When the PHE ended in March 2023, states resumed eligibility redeterminations for individuals previously under continuous Medicaid enrollment. There was significant concern that such a large-scale unwinding of this policy would result in substantial coverage loss, both due to changes in individual eligibility and procedural issues, such as incomplete paperwork, outdated personal information, or lack of awareness of renewal status. In fact, these procedural disenrollments accounted for 77% of New Jersey’s Medicaid terminations in 2023.<sup>1</sup>

In anticipation of these policy terminations, the New Jersey Division of Medical Assistance and Health Services (DMAHS) tasked the state’s Regional Health Hubs (RHHs) with conducting outreach to households at risk of losing Medicaid coverage, with the goal of increasing awareness of coverage status and preventing unnecessary terminations. The four RHHs—the Trenton Health Team, the Health Coalition of Passaic, the Greater Newark Healthcare Coalition, and the Camden Coalition—serve as intermediaries between the state government, regional Medicaid recipients, and local providers and community organizations. Together, they connect and coordinate efforts across multiple sectors to address health needs throughout the state.

In addition to conducting outreach, DMAHS charged the RHHs with systematically testing and refining their Medicaid renewal protocols to identify strategies that could reduce procedural disenrollment at scale. As part of this directive, all four RHHs implemented A/B testing within their outreach pipelines to evaluate

alternative contact methods and sequencing. The Camden Coalition, drawing on its analytic and health information exchange infrastructure, also provided technical guidance to the other RHHs to support consistent implementation and cross-site learning.

## Background

New Jersey's Regional Health Hubs were formally established in state statute in 2020, positioning the state among early adopters of a "backbone organization" model within Medicaid. Rather than operating as direct service providers, the RHHs are designed to strengthen local care ecosystems by serving as trusted intermediaries between the state Medicaid agency, community-based providers, and NJ FamilyCare beneficiaries. Across their respective regions, the four hubs coordinate multi-sector partnerships, align local strategies with state priorities, and support the testing and scaling of innovations aimed at improving care delivery and equity.

A defining feature of the RHH model is its reliance on shared data infrastructure. Each hub operates a regional health information exchange that securely integrates health and related data to support population-level insights, targeted outreach, and system learning. This infrastructure enables the RHHs to move beyond ad-hoc collaboration toward more systematic, data-informed coordination across clinical, social service, and community partners.

In addition to convening providers and community organizations across seven counties, Camden Coalition works closely with the state Medicaid program and managed care organizations to support the implementation of major statewide initiatives, including benefits introduced through New Jersey's 1115 waiver. These activities position Camden Coalition at the intersection of policy, operations, and analytics, with a particular emphasis on using data to strengthen Medicaid access and continuity of coverage.

## Operational workflow and data infrastructure

The operational workflows used by the RHHs reflect their function as system integrators rather than service silos. In the context of Medicaid redetermination and renewal, this includes the ability to identify households at risk of coverage loss, coordinate outreach across multiple organizations, and monitor engagement in near real time. The [Camden Health Information Exchange](#) (HIE) has been a central enabling asset in this work, incorporating features such as Medicaid renewal indicators, standardized outreach documentation, and reporting tools that allow staff and partners to prioritize outreach and assess follow-up.

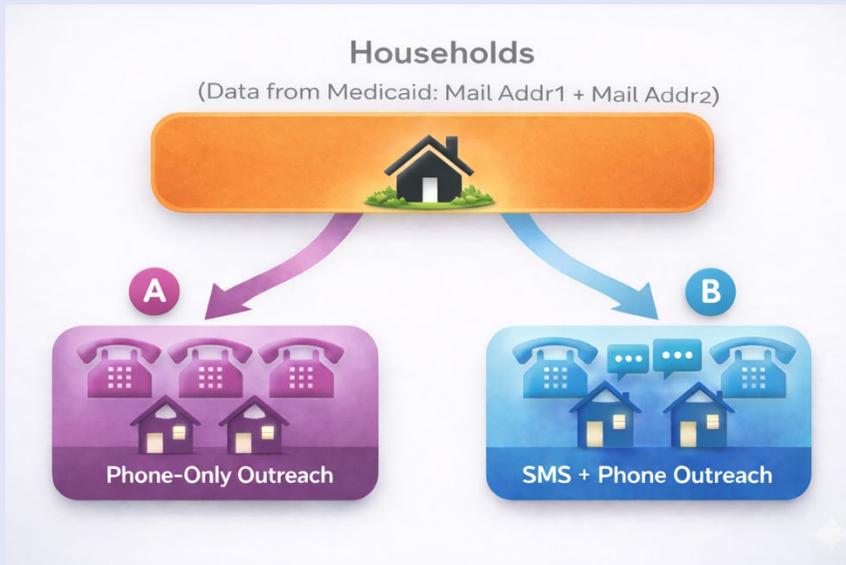
Importantly, Camden Coalition has extended these capabilities beyond its own region by developing tools and analytic approaches that can be shared across the RHH network. Recent enhancements to the HIE have outreach strategies and refine operational practices based on empirical performance rather than anecdote alone.

Specifically, all RHHs utilized the platform CareEvolution to facilitate their outreach to households at risk of losing their Medicaid coverage. During the initial phase of outreach, when the only method of contact was phone calls, the Camden Coalition built out the HIE-based infrastructure to monitor the workflow and the outreach outcomes. These included a form to capture all necessary workflow data, reports to identify the

monthly target population and surface all relevant data for the outreach staff as they made their calls, and analytic tools to track key performance indicators.

The New Jersey DMAHS provided critical population files to the RHHs each month, making real-time identification of at-risk populations possible. Their green list files included the information of all Medicaid policyholders in the state; the red list files highlighted the households halfway through the renewal process and at risk of losing their coverage; the purple list files indicated the households whose coverage had been terminated. Throughout the outreach process, the red list files drove the workflow by specifying the target households to call, while the green and purple lists allowed for critical evaluation of outreach success. Here, the RHHs' HIE provided essential supplementary data, particularly through its ability to link Medicaid's contact information for households with recent contact information from clinical providers to those households. This allowed the outreach staff to access additional, potentially more recent phone numbers of policyholders, and even use them in cases where Medicaid did not have any reported contact information.

**FIGURE 1**



**Figure 1.** Using household-level Medicaid information which aggregated both the name and address of the Medicaid policyholder, 50% of households were assigned randomly to receive Treatment A, the standard phone-only outreach, and the remaining 50% received Treatment B, the SMS + Phone outreach.

## Rationale and hypothesis

Although the initial Medicaid unwinding phase has passed, termination rates in New Jersey remain elevated. Looking ahead, the passage of the One Big Beautiful Bill Act in 2025 further heightens the importance of effective outreach by introducing stricter work requirements and requiring states to conduct eligibility redeterminations twice annually, rather than once. As a result, improving contact with at-risk households remains a critical and ongoing policy challenge.

The traditional phone call outreach approach has been found to increase health insurance enrollment rates before, especially when facilitating a live conversation with an organizational representative. Evidence

suggests that the personalized aspect of a phone call exceeds the impact of emails and other automated messaging.<sup>2, 3</sup> These results were replicated in an early evaluation of the Camden Coalition's telephonic outreach attempts in 2023 and 2024. However, the primary limitation of the phone-only approach has been low pick-up rates. Typically, of the Camden Coalition phone calls made to viable numbers, team members only made contact with the individual in 20-25% of the cases. One reason for this might be that individuals were avoiding calls from unknown numbers; another reason could be that the calls, which typically occurred between 9 am and 5 pm, conflicted with individuals' work hours and daily routines. As such, it became necessary for the RHHs' to consider and evaluate alternative or supplemental outreach methods to improve engagement and reduce coverage losses due to non-response.

In particular, the RHHs began investigating the effect of incorporating SMS messages into their outreach workflow. SMS messaging was an attractive option for priming individuals for the future call from the organization based on its low cost and ability to be easily scaled. While there is limited research done on the specific effect of SMS messages on improving phone contact rates, these types of automated messages have previously been shown to improve enrollment rates in health insurance. In Oklahoma, SMS messages were utilized to boost Medicaid enrollment after the end of the PHE in 2023. During that enrollment period, the Oklahoma Health Care Authority sent multiple text messages to individuals without coverage, which ultimately helped double the state's plan selection rate from 10% to 20%.<sup>4</sup> In California, researchers tested the comparative differences of sending a phone call, an email, or sending both a call and email regarding Medicaid and marketplace insurance enrollment. In their sample population of over 2,000 households, the combination of both the automated email and the personal phone call resulted in the greatest increase in enrollment rates.<sup>5</sup> As such, the Camden Coalition and the other NJ RHHs hypothesized that sending an automated SMS as a complement to the established phone call approach would improve both household contact and Medicaid renewal rates.

## Outreach protocols and study design

To test the hypothesis that SMS messages can complement phone calls to improve overall contact rates, the Camden Coalition conducted rapid-cycle, randomized A/B testing. A/B testing is an approach that compares two different treatments by randomly assigning individuals in the sample population to either Treatment A or Treatment B and then evaluating the treatments' relative success. In healthcare, it has been used to test a variety of patient engagement and clinical workflow interventions, such as appointment reminders, patient education materials, and preventative care outreach.<sup>6, 7, 8</sup> Because the RHHs conducted high-volume outreach to households every month, this allowed for rapid-cycle testing, a faster form of A/B testing that allows for small changes to be made, tested, and improved upon without disrupting the overall workflow. In this study, the Camden Coalition evaluated two outreach strategies for households at risk for Medicaid termination: Treatment A (control), which consisted of a phone call alone, and Treatment B (intervention), which paired an SMS message with a follow-up phone call. Households were randomly assigned to one of the two groups.

At-risk households were defined as those on the Medicaid red lists, which are published monthly to identify individuals whose policies are subject to termination in the following month. The Camden Coalition's target population consisted of households in the southern NJ counties of Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem. The study duration was from February 2025 to October 2025.

Month-to-month, outreach protocols evolved with modest adjustments to SMS timing and content. In February, the SMS and phone call were delivered within the same week. In subsequent months, the protocol was revised so that the SMS was sent during the first week of the month to signal an upcoming call later in the renewal cycle. SMS content also changed over time. In February and March, messages simply informed individuals that they were undergoing Medicaid renewal and should expect a call from the Camden Coalition. Beginning in April, the SMS language was enhanced with custom logic to include a specific hotline number based on the type of coverage and the case location assignment, which households could call for more direct application support.

Households in Burlington, Camden, Cumberland, Gloucester, and Salem were contacted monthly between February and October 2025 and were included in the primary A/B testing framework. In these households, SMS messages were sent in the months of February, March, April, May, June, September, and October; July and August were excluded from A/B testing due to disruptions in SMS delivery.

In Atlantic and Cape May counties, outreach capacity was more limited. Phone calls were conducted when the overall volume of the other counties was low enough (February, July, and October), and A/B testing with SMS was implemented in February and October.

Across all participating counties and months, the primary A/B testing sample comprised 22,907 households. In addition, in June, 1,040 households in Atlantic and Cape May received SMS messages without a corresponding phone call. These households were therefore included in a secondary analysis comparing no outreach to SMS-only outreach.

We analyzed the results in three complementary ways to ensure the findings were robust. First, we examined outcomes for all households based on the outreach strategy they were originally assigned, regardless of whether the text message was successfully delivered (Intent-to-Treat). This approach reflects how the protocol operates in practice.

We then conducted two additional analyses focused only on households that actually received the intended outreach, excluding cases where the text failed to deliver (Per-Protocol). In one version, we compared these households directly; in the other, we further adjusted the comparison so that the groups were as similar as possible using propensity score matching, a statistical method that pairs households based on similar characteristics across groups and excludes the unpaired households. This helps to isolate the effect of the outreach strategy itself.

The primary outcome variable was a successful phone contact, defined by a completed conversation with a member of the household. This was measured from February 2025 to October 2025. The secondary outcome variable was Medicaid renewal status, defined by the presence or absence of the household on the monthly Medicaid purple list, which tracks policy terminations and lags behind the Medicaid red lists. As such, this was measured from February 2025 through June 2025.

## Study population

The study population consisted of households at risk of losing Medicaid coverage during the months of February, March, April, May, June, September, and October of 2025. Households from Burlington, Camden, Cumberland, Gloucester, and Salem counties were included across all study months, while households from Atlantic and Cape May were only included in February and October due to operational constraints.

Cape May, the county with the fewest households, had 242 in the sample population, while Camden had 7,536 households, the greatest among the counties (Table 1). Across all months, the analytic sample comprised 22,907 households, with monthly sample sizes ranging from approximately 2,200 to over 4,200 households (Table 1).

Overall, the study population reflects a predominately family-based and working-age Medicaid population. Just over half of the households included children. About half of the heads of household were between the ages of 18 and 40, and the average household size was under two members, with most households containing a single Medicaid policyholder (either the child or the adult). These statistics, along with the diverse racial and ethnic composition of the sample, are summarized in Table 2.

Category	Subcategory	Number of households
<b>Month</b>	February	2,244
	March	3,341
	April	3,206
	May	4,015
	June	4,228
	September	2,774
	October	3,099
	<b>County</b>	Atlantic
Burlington		4,650
Camden		7,536
Cape May		262
Cumberland		4,840
Gloucester		3,219
Salem		1,389
<b>TOTAL</b>		<b>All households</b>

Characteristics	Value
Households with children	52.1%
Female head of household	58.2%
Head of household aged 18-40	50.5%
Mean household size	1.86%
One Medicaid policyholder only	55.9%
Caucasian	32.6%
African-American	23.7%
Hispanic	16.9%
Multiracial	13.4%
Asian/Pacific Islander	1.4%

## Results

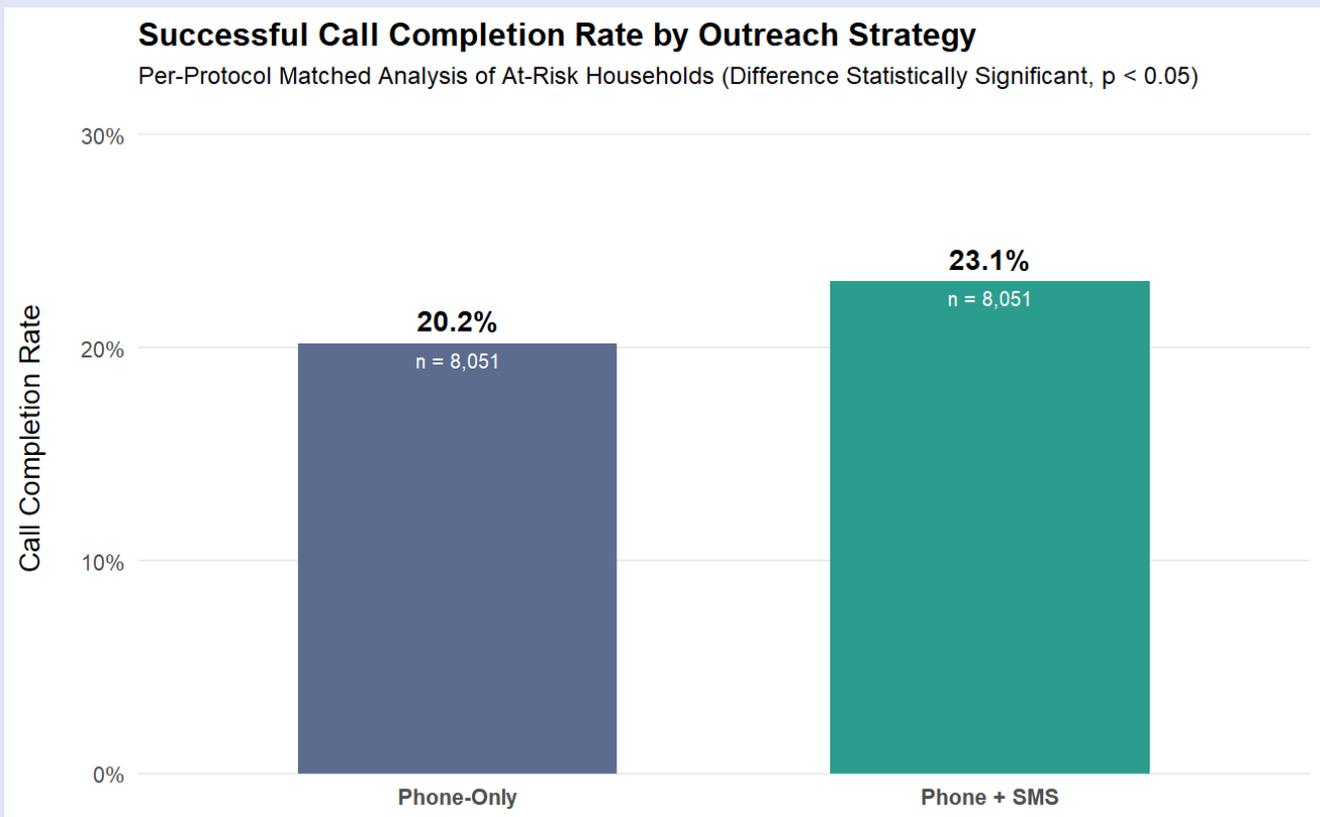
Before performing the analyses, the slight month-to-month variations in protocol were tested to determine whether samples needed to be analyzed separately. We observed no significant differences in successful outreach or renewal rates across protocols. As a result, the samples were pooled and treated as a single analytic population.

When examining the effect of including an SMS message before a call in the Intent-to-Treat (ITT) analysis, the treatment group showed a modest increase in successful phone contact of 0.6 percentage points (21.0% vs. 20.4%), though this difference was not statistically significant ( $n = 22,909$ ;  $p = 0.254$ ). A similarly small increase was observed in renewal rates, rising from 45.6% in the control group to 46.2% in

the treatment group, which was also not statistically significant ( $n = 17,091$ ;  $p = 0.737$ ). When stratifying the sample by county, results were comparable, with minor and statistically insignificant differences in both contact and renewal rates.

Overall, approximately 23% of households assigned to receive an SMS experienced a failed delivery. These households were then removed from the sample population for the per-protocol analyses. In the per-protocol unmatched analysis, 23.3% of households receiving an SMS completed a successful phone call, representing a statistically significant increase over the 20.4% successful contact rate among call-only households ( $n = 20,244$ ;  $p < 0.05$ ). A similar difference was observed in the per-protocol matched analysis (23.1% vs 20.2%), which was also statistically significant ( $n = 16,102$ ;  $p < 0.05$ ).

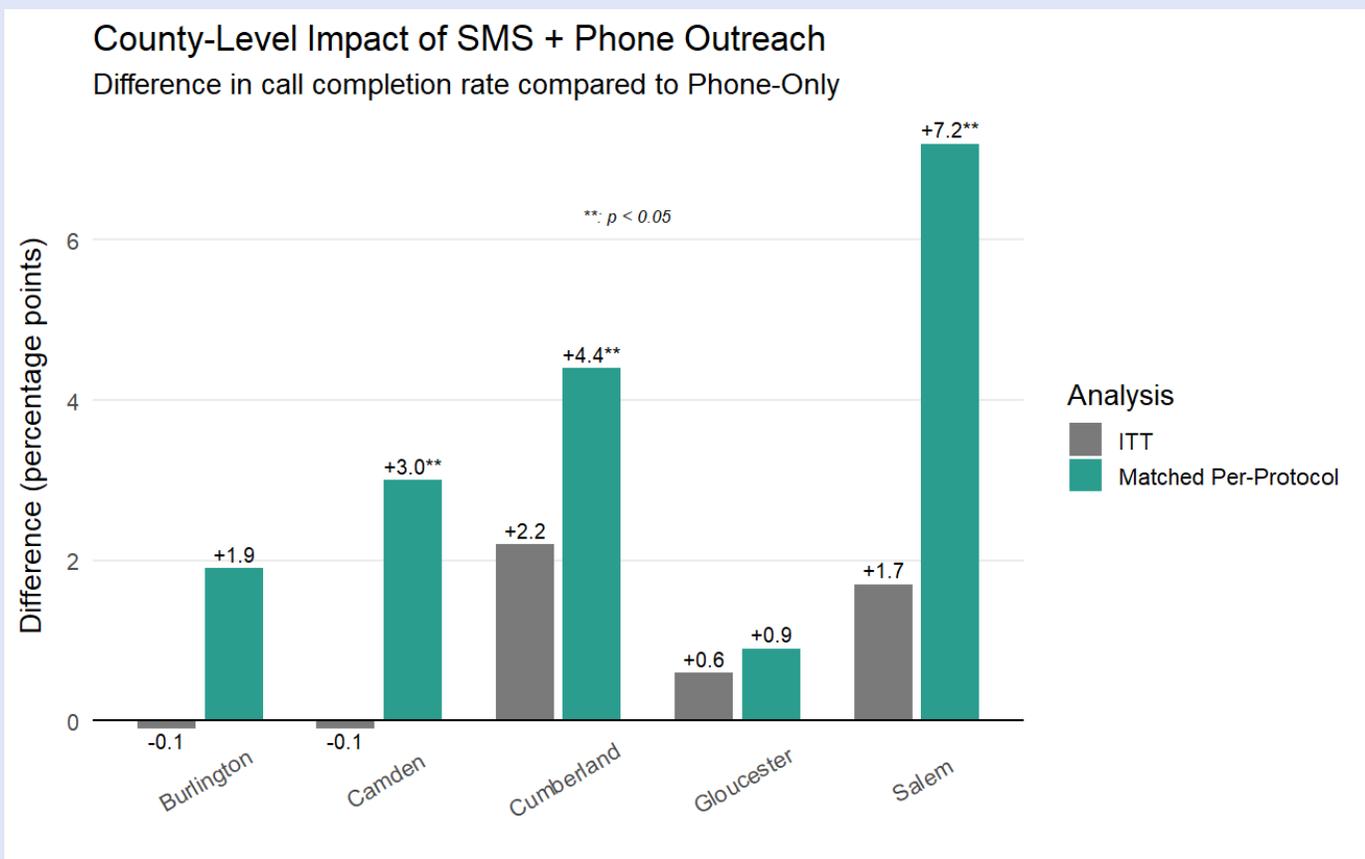
**FIGURE 2**



**Figure 2.** Including SMS outreach was associated with an increase in successful call completion rates by 2.9 percentage points. This analysis was performed on households that successfully received SMS and corresponding Phone-Only households matched by similar characteristics.

Minor improvements in renewal rates were observed in each approach—+0.5 percentage points (pp) for the per-protocol unmatched, and +0.2 pp for the per-protocol matched—but neither was statistically significant. County-level differences were also evident, with the SMS treatment producing the largest increase in successful phone contact in Camden, Cumberland, and Salem (+3.0 pp, +4.4 pp, and +7.2 pp, respectively). Each of these increases was statistically significant in the per-protocol analysis ( $p < 0.05$ ).

**FIGURE 3**



**Figure 3.** Shows county-level differences in call completion rates between households receiving SMS + phone outreach and those receiving phone-only outreach, presented for both ITT and matched per-protocol analyses. The matched per-protocol estimates are larger across most counties, reflecting analyses restricted to households that successfully received SMS messages. The largest observed differences appear in Salem (+7.2 percentage points), Cumberland (+4.4), and Camden (+3.0). When households that did not successfully receive an SMS are included, the estimated differences are smaller. When looking at the impacts of including SMS in household outreach within each county, it had the greatest impact on call completion rates in Camden (+3.0 percentage points), Cumberland (+4.4), and Salem (+7.2). This result is from the analysis that only included households that successfully received their SMS. When including households that did not successfully receive an SMS, the impact shrinks.

In June, the infrastructure to place phone calls to households in Atlantic and Cape May was not in place, so the treatment group received an SMS message, while the control group received no outreach. A small increase in renewal rates was observed (ITT: +1.8%, n = 1,040; per-protocol matched: +4%, n = 804), though neither was statistically significant.

Exploratory analyses were then performed to identify characteristics within the sample population that might be associated with SMS delivery failure. County-level differences were apparent: Burlington had only 14.4% of SMS messages fail to deliver, while Cumberland exhibited markedly higher failure rates at just under 40%. Having a child in the household was associated with lower failure rates (18.1% vs. 23.9% for households without children). Finally, households with a greater number of phone numbers on file were more likely to experience SMS failure, with a 29% failure rate among households with four or more phone numbers.

## Discussion and next steps

The results of our A/B testing indicate that when SMS delivery is successful, it is a useful method for increasing the rate of completed conversations among households outreach telephonically. In the | intent-to-treat analysis, which included all households regardless of protocol issues, no significant improvements were observed. However, when focusing on households with successful SMS delivery in the per-protocol analysis, increases of multiple percentage points were observed. These gains of 2-3% are operationally meaningful; when extrapolated over a full year, they could result in roughly 1,000 additional at-risk households being successfully contacted within the Camden Coalition's catchment. Given the relatively low-cost and efficiency of SMS delivery, our analysis supports the conclusion that SMS is a useful tool to integrate as an enhancement to existing Medicaid redetermination outreach methods. From a policy perspective, these findings suggest that relatively small, low-cost adjustments to outreach sequencing can yield meaningful gains when implemented across large populations.

Given that improvements in outreach were observed primarily among households with successful SMS delivery, this suggests that some difficulties in contacting households stem from issues with the phone numbers on file. Moreover, because having more phone numbers on file was correlated with higher SMS failure rates, this may serve as an indicator of instability and elevated risk for policy termination. As such, next steps should include identifying households with phone number issues earlier in the process to enable more targeted intervention.

One example could be sending an SMS to households on the Medicaid green list, which precedes the red list. For households that receive successful SMS delivery, the outreach protocol could proceed with the SMS plus phone call approach if they appear again on the red list. For those experiencing SMS delivery failure to the primary phone number on file, the subsequent text message (sent during the red list month) could be directed to the next most recent phone number on file, potentially increasing the likelihood of successful contact.

Beyond the specific findings related to SMS outreach, this work underscores the broader value of investing in infrastructure that enables rapid-cycle testing at scale. Such infrastructure allows organizations to

iteratively evaluate and refine engagement and outreach strategies in real time, supporting more responsive, adaptable, and evidence-driven policy implementation.

It is important to acknowledge that there are many steps to improving Medicaid renewal rates, and achieving successful contact does not guarantee the completion of the renewal application. Overall, though, for both Medicaid redetermination and other initiatives that rely on outreach methods, this analysis demonstrates the benefits of incorporating SMS into the outreach workflow, particularly as a means of preceding or pre-empting a later phone call.

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## About the Camden Coalition

The Camden Coalition works to improve care for people with complex health and social needs in Camden, NJ, and across the country. The organization implements person-centered programs and pilots new models that address chronic illness and social barriers to health and well-being. Supported by a robust data infrastructure, cross-sector convening, and shared learning, its community-based programs improve outcomes for some of society's most vulnerable individuals. The Camden Coalition's National Center for Complex Health and Social Needs (National Center) connects complex care practitioners with each other and with data, tools, and other resources.



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