Promoting Preventive Care in Early Childhood Well-Child Visits

Recorded January 6, 2025

Derek Mitchell:

Now I'd like to turn it over to Laura Armistead from Mathematica.

Laura, you now have the floor.

Laura Armistead:

Thank you, Derek.

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I want to welcome you all to our first webinar of the Improving Early Childhood Preventive Care webinar series. My name is Laura Armistead, and I'm a researcher with Mathematica.

For today's agenda, we'll begin with an introduction from Andy Snyder with the Centers for Medicare and Medicaid Services. We'll discuss the importance of well-child visits and highlight some of CMS's existing quality improvement resources. Then my colleague at Mathematica, Joe Zickafoose, will provide an overview of preventive care in early childhood and review related CMS Core Set data. We'll also highlight opportunities and approaches for state Medicaid and CHIP programs that can support improvement in early childhood preventive care. We'll have time at the end for a Q&A, and then close out by sharing information about upcoming webinars in the series and other quality improvement opportunities.

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With that, I'll turn things over to Andy Snyder with CMS.

Andrew Snyder:

Great, thanks so much, Laura.

I want to welcome everyone and thank you all for joining us on this snowy Monday across much of the country. As we get started with work on our new affinity group on promoting preventive care in early childhood well-child visits.

Let's go to the next slide, please.

Just to say a word about the importance of well-child visits, well-child visits, which are referred to in statute as "screening services," are the foundation of EPSDT coverage. That's the Early and Periodic Screening, Diagnostic, and Treatment benefit under Medicaid for Children. There are crucial entry points for identifying concerns and conditions that require follow-up care. These visits are intended to be comprehensive and include age-appropriate screenings; referral to diagnostic and specialty services; and referral to establish ongoing dental, vision, and hearing care.

Under EPSDT requirements, all states are required to develop or adopt a schedule of recommended screenings. Most states use the Bright Futures Periodicity Schedule developed by the AAP, the American Academy of Pediatrics, or use a modified version of Bright Futures. States must provide coverage for

appropriate immunizations to EPSDT-eligible children according to the pediatric vaccine schedule that's established by the CDC, the Centers for Disease Control and Prevention.

States must also develop or adopt a dental periodicity schedule in addition to the medical periodicity schedule in consultation with recognized dental organizations involved in child health, such as the periodicity schedule that's been developed by the American Academy for Pediatric Dentistry.

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We have been working on quality improvement resources related to well-child care for the past several years; and we would invite you, if you haven't already, to look at the QI TA resources on improvement well-child care that are available on Medicaid.gov. You can navigate to that by going on the Medicaid.gov main page to Medicaid Quality of Care and Improvement Initiatives, or just follow the link that is under the graphic on the right-hand side of the screen. Resources that you'll find there include webinar recordings; state highlights from the 2023 Improving Infant Well-Child Visits Affinity Group; a video on how to get started with a quality improvement project; and an example driver diagram and measurement strategy.

Basically, we know that folks working in state Medicaid agencies may not be super familiar with quality improvement tools and strategies, and we wanted to provide you some easy way then to think about how to implement QI projects related to infant well-care.

Notably, CMS has also recently summarized the best practices for adhering to EPSDT requirements in a State Health Official Letter, numbered 24-005, that is available at the link on this slide. That is a lengthy State Health Official Letter, a piece of subregulatory guidance that goes into great detail about policies, strategies, and best practices for states to deliver a variety of important services under EPSDT to EPSDT-eligible children in your program.

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So those resources that I just mentioned were developed as part of – well, the QI resources were developed as part of the Improving Infant Well-Child Visits Affinity Group that ran from 2021 to 2023, where six states participated in the affinity group and focused on improving infant well-child visits from ages 0 to 15 months of age. The states that participated in the affinity group included the six that are highlighted in the map on the right-hand side of the screen: California, South Dakota, Missouri, Texas, Virginia, and North Carolina.

That affinity group was preceded by a webinar series that also described approaches that states can use to improve attendance and quality of infant well-child visits. More information is located on that same webpage, and that includes recordings of that entire webinar series.

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So today we're going to be talking about our new affinity group offering that will be coming – rolling out in the next couple of months on Improving Preventive Care in Early Childhood. AAP and the Bright Futures schedule recommend 11 well-child visits through the first 30 months of a child's life and annually starting at age 3. Well-child visit attendance among children 0 to 30 months eligible for Medicaid and CHIP is more than 20 percentage points lower compared to children with private insurance. So there definitely is that kind of quality performance gap that we think is amenable to QI approaches.

Also the Child Core Set, which is administered by CMS, includes several measures that may be impacted by attendance at well-child visits including the W30 measure, Well-Child Visits in the First 30 Months of Life; the CIS measure, Childhood Immunization Status; the DEV measure, Developmental Screening in

the First Three Years of Life; LSC, the Lead Screening in Children measure; and the TFL measure, Topical Fluoride for Children.

So, we think that sort of building on our experience with the Infant Well-Child Group that thinking about improving preventive care via a well-child visit but that touches on all of these areas of state performance is a valuable next offering for states. So, to tell you a little bit more about the data on all of these measures and the rationale, I would like to turn things over now to Joe Zickafoose with Mathematica.

Joe?

Joe Zickafoose:

Thanks so much, Andy.

We can go to the next slide.

As Andy mentioned, I'll spend the next 10 minutes or so reviewing key aspects of preventive care in early childhood and how they connect to well-child visits as the primary mechanism for getting that care. Then we'll also take a look at some of the data across states that really illustrate what we think are prime opportunities for improvement.

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This is probably well-known to many folks on this call, but it's important to remind ourselves about why these well-child visits are so important. Every visit represents an opportunity to do two main things; one, to deliver recommended preventive care and also to catch up on care that might have been missed earlier in life. So, throughout the first several years of life, there's these opportunities to both stay on time and to catch up, which is why it is so important to attempt to meet the goals for these visits.

As Andy touched on earlier, key aspects of preventive care that are delivered during these visits include the immunizations, lead screening, developmental screenings, and oral health care. Additionally, growth and development are key indicators of child health; and well-child visits are important for tracking these to assess management of known conditions, detect emerging conditions, and identify any barriers to the child thriving, such as health-related social needs.

Also during visits, a key aspect is providing caregiver education and support, often referred to as "anticipatory guidance." These visits are also key opportunities that connect children and their caregivers to any additional diagnostic and treatment services that the child might need based on known conditions or conditions that are identified during the visit.

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So as an example, this table shows core preventive services recommended by the American Academy of Pediatrics and Bright Futures Guidelines for children ages 12 months through 3 years. As Andy mentioned, many states base their EPSDT preventive care guidelines based on these. As you look through this table, you can see that every visit includes an opportunity for a complete physical exam; screening for behavioral, social, and emotional challenges; immunizations; and application of fluoride varnish to decrease risk for [dental] caries.

Additionally, there are key ages within this time frame for general developmental screening; autism-specific screening; and lead screening.

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But despite their importance, we continue to struggle to meet goals for well-child visits for children enrolled in Medicaid and CHIP. On this slide, you can see a graph of the percentage of children who met goals for at least six well-child visits for ages 0 to 15 months. In the lower line, you can see performance for children in Medicaid, which has shown a slight uptick from 53% to 57% between 2020 and 2022. But you still see a significant lag behind children with commercial insurance who are generally closer to the 80% range.

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For children ages 15 to 30 months, the measure is [the percentage] of at least two well-child visits in this time frame as recommended. We see about 70% of children in Medicaid meet that goal, which has stayed relatively steady over the 2020 to 2022 time frame; but this is compared to 87% to 88% of children in commercial insurance, and we see no signs of closing that gap over recent years.

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When we look across state Medicaid programs, we can see lots of opportunity for improvement. So on this slide, we're looking at the measure of receiving six or more well-child visits during the first 15 months of life. The median state level for meeting this goal was 59%. This means that at least half of states were below that 59% by definition; and as you look to the left of the slide, you can see that only a couple of states surpassed 70%.

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We see a very similar pattern for well-child visits between 15 and 30 months of age, where the measure is of receiving at least two of these visits. The state median was 65%, again showing about half the states below that and very few states exceeding 70%.

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When we look at measures of specific preventive services for these age groups, you'll start to see very similar patterns for immunizations, development screenings, lead screening, and fluoride varnish – all pointing us towards these opportunities for improvement.

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Here we see levels of children who have met immunization goals by age 2; specifically the Combination 3 measure among the Core Set. The median state level is 62%, again with only a couple states exceeding 70%.

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For developmental screening during ages 0 to 3 years, the median state performance in 2023 was 36%. You can see the wide range of variation pointing to opportunities for improvement.

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Similarly, for lead screening for which the measure is having received one or more blood lead tests, we see a median state performance of 57%.

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For fluoride varnish during this age, the median state level was 19%. So, we clearly have lots of opportunities to improve preventive care through well-child visits for children in early childhood.

Now I'll hand off to my colleague, Laura Armistead, to discuss approaches that states have used and could use to start making improvements towards these goals.

Laura Armistead:

Thank you, Joe.

Next slide, please.

There are a wide range of approaches that state Medicaid and CHIP programs can implement to improve preventive care in early childhood. In the next few slides, we'll highlight strategies that state Medicaid and CHIP programs have used to support attendance at well-child visits and improve the delivery of preventive care for young children.

The state examples we'll discuss are related to the following areas: managed care contracting; Medicaid and CHIP payment policies; processes for Medicaid and CHIP eligibility and enrollment; strategic alignment across programs and policies; family and caregiver engagement; and, partnerships with other state agencies, managed care plans, and providers.

Now we'll review each in more detail.

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First, we'll discuss well-child specific approaches to managed care contracting. States that enroll Medicaid-eligible children in managed care can incorporate QI activities into its managed care contracts. For example, some states have included measures and specific benchmarks into its quality assurance and performance improvement programs for its managed care plans, including measures related to well-child visit attendance and delivery of preventive care, such as those in the CMS Child Core Set.

Other states have included requirements for its managed care plans to support families in overcoming barriers to attending well-child visits, such as conducting proactive outreach with members. As one example, Texas Medicaid managed care plans are encouraged to proactively engage with its members to educate them about well-child visits and offer support to families in scheduling upcoming well-child visits.

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The next approach we'll discuss is Medicaid and CHIP payment policies. state Medicaid and CHIP programs use a range of financial efforts to support the delivery of coverage services, implement new benefits, and encourage quality improvement efforts. Some states are implementing value-based payment approaches based on the utilization of specific services, like well-child visits or other quality indicators. Other states have implemented same-day billing policies, which allow providers to bill for sick visits and well-child visits on the same day. This enables providers to leverage sick visits as an opportunity to get caught up on any missed well-child visits.

Other states are implementing CHIP Health Services Initiatives, or HSIs, which allow states to use CHIP funding to implement efforts aimed at improving attendance at well-child visits and receipt of preventive care for eligible children. For example, Oklahoma Medicaid established an HSI to expand the number of providers participating in the Reach Out and Read program. As part of the program, participating providers received screening tools and training to improve the quality of well-child visits and encourage developmental screenings during those visits.

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Ensuring Medicaid-eligible children have timely and appropriate access to well-child visits and preventive care requires that they first obtain appropriate coverage. As such, states have also pursued improvement approaches aimed at streamlining eligibility and enrollment processes. Some states have developed and implemented resources and tools to ensure families have culturally-appropriate support and information needed to navigate Medicaid and CHIP enrollment.

For example, New Mexico leverages community health workers to support families in receiving culturally-appropriate system navigation support, which includes facilitating enrollment in Medicaid. Other states have implemented processes or policies that simplify or automate Medicaid and CHIP enrollment, which can support continuous coverage and further support children in accessing timely well-child visits.

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Ensuring alignment across programs and policies, such as managed care oversight activities, is another key area where states have implemented approaches to improve delivery of preventive care. Some states have included specific quality improvement objectives related to well-child visits in its managed care quality strategy. Other states have required managed care plans to implement performance improvement projects, or PIPs, to improve attendance at well-child visits and the delivery of preventive care in early childhood.

Utah used a similar approach by implementing PIPs for several of its Medicaid-accountable care organizations aimed at improving performance on the measure, "Well-Child Visits in the First 30 Months of Life." As part of its PIPs, ACOs were required to conduct reminder phone calls with members and provide education on the importance of timely well-child visits.

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State Medicaid and CHIP programs are also implementing approaches to engage parents and caregivers to support improvement efforts. For some states, this looks like partnering with managed care plans to offer incentives, such as gift cards, to managed care enrollees for attending well-child visits. Other states have directly engaged families in quality improvement activities to ensure lived experience is incorporated.

For example, Washington Medicaid managed care plans conducted focus groups with caregivers to learn more about the barriers and challenges families face in getting their children to well-child visits. These focus groups provided important learnings related to caregiver communication preferences and challenges with attending appointments during standard business hours, which led to clinics offering evening and weekend appointment times.

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Finally, state Medicaid and CHIP programs are also forging new connections and leveraging existing partnerships with providers, managed care plans, and other state agencies to foster synergies on the sharing of well-child information and resources. Some states have developed partnerships with primary care practices to promote and improve developmental screening during well-child visits. Other states are disseminating data and best practices to providers and managed care plans to support improvement efforts, such as the state's external quality review report.

Other states have implemented processes to share data more regularly with partners. For example, Connecticut maintains practice-level dashboards for providers via an online portal. These dashboards include information on children with missed or late well-child visits to support practices in conducting targeted outreach to families to reschedule missed visits.

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So, we are going to now transition into a question-and-answer time. So, I'm going to turn things back over to Joe so we can talk through any questions that we may have from our attendees today.

Joe?

Joe Zickafoose:

Thanks so much, Laura.

So I want to encourage everybody who's attending if you have a question, please share it in the Q&A pod in Web-Ex. If it's not showing up for you for any reason, go to the lower right-hand corner where those three dots, and you should find it under there as well.

Also, as a reminder, the slides from the presentation today and the recording will be posted on Medicaid.gov. It usually takes us about a week or so to get those posted. If you registered for the webinar today, you will automatically get a notification when those are available.

All right, so I will start with one of the first questions that we got, which is a multipart question here; so, I'll break it up here a little bit and try to address several of the pieces.

To begin with, the question asks: *"What are the hypotheses about these performance numbers?"*

So I assume we're referring to the variation in state performance on preventive care delivery, including well-child visits for children in Medicaid. Really, the goal of the webinar today is really to kick off a webinar series about preventive care in early childhood for children in Medicaid and to lead into an opportunity for states to participate in a specific affinity group related to the topic. These numbers really were the driving force in putting together the [Improving Early Childhood Preventive Care] Affinity Group, and the hypotheses behind that are really the idea that there are different types of barriers to getting children to preventive care.

Some of those barriers are perhaps universal to all children and families, regardless of their insurance type. As we saw, even in commercial insurance the performance levels were in the 80s percent, so certainly not in the 90s or above. But there are additional barriers for children and families in Medicaid. Even beyond those more universal [barriers] that within each state there can be unique barriers specific to a state. So the goal eventually for the affinity group is to help states address those specific barriers using a quality improvement approach to try to work through and identify approaches that might work well for them.

The second half of this question asks: *"Whether the panelists are collaborating with a national AAP or any of the state branches?"*

The affinity groups are set up specifically to work with state Medicaid programs, but we do encourage states to reach out to professional organizations that might be helpful for their work and vice versa for any professional organizations that are interested in and working on this to reach out to their state Medicaid agency to discuss the possibility of participating in the affinity group.

Okay, all right, so I am going to take a look at additional questions here.

So next question, which I think I will probably hand off to Andy as a leading expert on this: *"For the topical fluoride varnish median data, is this specific to topical fluoride applied in a medical office; or does it include topical fluoride applied in the dental office?"*

Andrew Snyder:

Thanks, Joe.

So this is data that we can publicly report for 2023 in order to be able to publicly report the data, it did need to be aggregated to the level of all places where topical fluoride was applied. So it's the version of this measure that includes fluorides that are applied in primary care medical settings as well as dental settings. So it is a consideration when you look at that particular measure.

The other consideration is of course that it looks at the entire age range of, I believe, 1 to 20 [years]. So if you're thinking about what is the intervention that's connected with a well-child visit, that is more like the U.S. Preventive Services Task Force recommendation to look at application in primary care medical offices for kids under 6 [years]. So what we're providing in these slides is sort of the national overview for what we're able to publicly able to report in 2023. When we get to the point of providing some technical assistance to states that decide to participate in this affinity group, we would try to help them sort of understand what their data looks like for that more kind of targeted population.

Do you think that about covers it, Joe?

Joe Zickafoose:

Yeah, I think so. If not, whoever asked that question please feel free to share a follow-up.

All right, next up – oops, be sure and scroll here correctly.

There's a question about: *"What's the name of the portal for providers that Connecticut has implemented to identify missed or late EPSDT visits?"* I will hand it off to Laura to address that.

Laura Armistead:

Thanks, Joe.

So, I know we had a presentation from Connecticut in the Infant Well-Child States Spotlight webinar. So I assume that information comes from there, and we can drop a link to the slides and the recording to that in the Chat. So I don't know the name of the portal, but we can point you to the resource where we got the information.

Joe Zickafoose:

Thanks, Laura.

The next question I see here is: *"What role can preschools and childcare centers play in increasing access to preventive well-child visits and developmental screeners? Are there any states exploring partnerships in this area?"*

That's not a specific topic that we have information about today but is certainly an area that some organizations and states have explored. If there are any on the call today who want to share information about work that they have, you can feel free to drop that in the Chat for the overall group. If a state is interested in exploring that as an avenue for improving well-child visits, that certainly would be an opportunity for anyone who chooses to participate in the affinity group.

Okay, just looking through here....

Okay, so we have a question here about: *"Are there specific strategies for federally qualified health centers, Indian health service, and rural health centers?"* The person notes that, *"Since these providers are paid by encounter, we experience less-detailed coding; specifically, the well-child procedure codes from these providers since the detailed coding does not impact their payments."*

So I think this person is getting at the point for the specific preventive care services such as, for example, lead screening or developmental screening. They can sometimes be challenging to identify those specific services because they're included within kind of a bundle for the encounter. That's I don't think anything that we have specific information to address this afternoon unless, Andy or Laura, you have anything additional to add. But issues like that are things that we have had states work on within affinity groups, both one specific to preventive care for children but there's also an analogous example of prenatal care for women, which is often delivered under a bundle for states; and states have looked at opportunities at unbundling and other approaches to help them better understand their overall performance levels and seek to improve them.

Andy and Laura, anything to add to that?

Andrew Snyder:

Nothing else from me. I mean, we've had other occasions when we've worked with states on interventions where they wanted to try to – it was actually looking specifically at delivery of fluoride varnish in federally-qualified health centers – a state or two kind of encountered the same kinds of issues where they didn't get detailed information on encounter data, but the state via an 1115 demonstration offered an incentive payment for improved utilization rates. In order for the FQHCs to kind of participate in that incentive, needed to provide a little bit of additional information to accompany the less-detailed things that the state was getting through the encounter data. So there's a couple of ways to kind of approach those kinds of issues.

Joe Zickafoose:

Thanks, Andy.

Oh, okay, so an interesting question here, which I think we'll also need to punt a little bit on. Someone asked: *"Where are those same states on the EPSDT 416 reporting for well-child care, and how is that being looked at?"*

We specifically pulled Core Set data for the presentation today because those are the measures that we are focusing on typically within the affinity group. We did not look directly at the EPSDT 416 data for this presentation today; but again, that is something that could be explored for states that do participate in the affinity group.

Okay, next up there's a question here that says: *"Some of the slides did not include all states; specifically, the depression screening and fluoride varnish. How was the information collected?"*

So the data we presented today was for 2023, which was the last year before mandatory reporting for the Core Set kicked in. So prior to that, states could choose which Core Set measures they were submitting. So not all states were submitting data on those measures at that time. But going into the 2024 data, the states will be required to submit.

Andy, anything else you want to add related to the mandatory reporting?

Andrew Snyder:

No, I don't think there's anything more to add other than, yes, as of late 2024, reporting of the Child Core Set and certain Adult Core Set measures is now mandatory. So you will start to see versions of Core Set reporting that reflect mandatory reporting for all 50 states and the District of Columbia in the coming months – probably not for a while yet. But I think our most recent available products are things like the 2023 Child Chart Pack, which maybe we can put a link to that in the Chat or just the Child Core Set page so that folks can see that.

As Derek just put in the Chat, we know that a lot of the folks listening in from states just went through their first cycle of mandatory Child Core Set reporting. If there's any questions that folks from the state Medicaid agencies have or technical assistance that you need on Core Set reporting particularly, please do reach out to the email address there: MACQualityTA@cms.hhs.gov.

Joe Zickafoose:

Thanks, Andy.

So one of the participants asked a question: *"Can you give more details of the state-implemented VBP, value-based payment program, to improve these numbers?"*

We weren't exactly sure which program the question was submitted in relation to. So if the person who submitted the question could follow up with a more specific version, we'll see if we can address it. In preparing the presentation today, we had to sift through a lot of different types of information to try to identify examples. One of the important lessons from this is there's rarely a single go-to source for information on these. So if you could follow up about the – if there was something specific that you were asking about, that would be helpful.

Okay, so we have a question here that's more provider-oriented. The question is: *"What are some best practice recommendations you have for providers to stay up-to-date with the ever-change state Medicaid and CHIP policies?"*

So, a couple of recommendations – and I'll let other folks chime in as well. If you are a provider yourself trying to follow these policies, there's a couple ways to do this. I can't guarantee that you can always keep up because things can be moving quickly and can be very detailed, but a couple options. One is state Medicaid agencies release updates all the time through various forms of communication. So it's good to check whether you as a provider are already on the list for those updates. Generally, if you've been enrolled in Medicaid, you should be included on that list; but your contact information may or may not be up-to-date. So, you can look for information on your state Medicaid agency website specific to provider updates to make sure that you're signed up for those.

States often also just release general update announcements as well. So again, looking for the Listserv or other means of communication that the State provides are two good approaches. Then thinking about any professional organizations in your state, generally provider or professional organizations, such as local chapters of the AAP or the Academy of Family Physicians, provide policy updates as well.

Andy, any specific recommendations from the federal side?

Andrew Snyder:

I mean, as you know, Medicaid programs in states are administered by the states under broad federal guidelines. So getting in touch with your state Medicaid agency is always going to be the best way to know about changes and updates that are coming for your Medicaid or CHIP program. Everything that

you said about how to stay in touch is great and well-taken. There also, I'm sure, are opportunities to stay connected through Medicaid Advisory Committees that provider organizations or providers often have seats on.

But, yes, I think there's broad guidance that comes from us here at CMS. But in terms of the kind of day-to-day of how your state Medicaid agency is processing claims and handling beneficiary enrollment and things like that, the state Medicaid agency is always going to be your best point of contact.

Joe Zickafoose:

Okay, continuing down the list there's a question that asks: *"Will these affinity groups be similar or the same as the previous one?"*

So in referring to the previous one, there was a prior affinity group, as we've mentioned, that focused on well-child visits in the birth to 15 month age range. This follow-up affinity group will be very similar but will be focused on later age groups. Laura will be touching on that in a little bit as we get ready to wrap up.

Next up there's a question here that asks: *"Has the stratification of the well-child birth to 30-month measure identified disparities in care that could help with improving compliance with early childhood visits and associated screenings?"*

So at this time, the Core Set reporting does not include stratifications that would specifically identify disparities. But we do know that in the prior affinity group and then just other work that states have done, there definitely are examples of states that are looking at different types of different stratifications of data to look at opportunities for improvement.

For example, in looking at disparities based on geography or disparities based on sociodemographic groups, there definitely has been work on that and certainly would be an opportunity within the affinity group.

Another question here: *"For those states with higher rates shown on the charts, were the states in affinity groups typically in the higher percentages for outcomes reported?"*

In some cases, yes; but as you saw, there are only a handful of states that participated. Some of those states were ones that had recognized that they had been facing challenges and were already in a lower range. So that was their opportunity to work on improvements.

Some of those efforts were very focused on specific groups; some of them were more statewide. I don't think we can show specifically the inclusion in the affinity group has shown increases just yet, but we're hoping to see that for the future.

Okay, so another question here related to fluoride that I will pass off to Andy: *"Does the data for fluoride varnish application include DBM data as well from the dental insurance or only from the MCOs? Additionally, is this data inclusive of dental visits or only fluoride completed in a medical office?"*

So I think a little bit you've touched on already and a little bit of a new question.

Andrew Snyder:

Yeah, so DBM is Dental Benefits Manager. So that's entities that are either capitated or administrative services entities that are managing dental benefits for states. MCOs are comprehensive managed care organizations that include medical and dental.

So this is all coming from the Child Core Set reporting for 2023 as we talked about, and the reporting unit there is the state. So the information that the state should be sending us should be aggregated across health plans and delivery type. Like Joe said, 2023 data is one of our last years of voluntary reporting data. So what we were able to aggregate, report publicly for the 37 states that submitted on TFL, the TFL – topical fluoride measure – was the combined rate across dental and medical services and for that entire age range of 1 to 20 [years].

So there's some considerations when you look at that data, but the idea is it's intended to capture all of the service delivery. Again, as we're thinking about what's the applicability to well-child visits for young kids, we would work with states in the affinity group to look at just a part of that.

Also, I'll just take the opportunity to plug again that we have a page of resources – an entire page of resources on a QI project that we ran for the last few years specifically on improving access to oral health preventive services in primary care.

Joe Zickafoose:

Okay, so we have a question here. The person asks – they are curious to know: *"How some states are connecting with families who are often unable to make contact with, such as for example updated addresses and numbers?"*

I would just stay in response to that in general to stay tuned for upcoming webinars where we are going to be including states who have worked on these challenges who can speak to the specific approaches that they have taken. So please, I encourage folks to register for the upcoming webinars connected to this series.

Okay, and I think we, in the interest of time, will need to go ahead and move on to some of our wrap-up pieces.

Laura, I will hand it off to you.

Laura Armistead:

Great, thanks, Joe.

So we wanted to take just a few minutes to talk about what's coming up.

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So we'll briefly highlight some of the remaining webinars that we have planned in this series, which we've kind of alluded to throughout the webinar so far. Our next webinar we have coming up is on Monday, March 3rd, at 2:00 p.m. Eastern. It is "State Medicaid and CHIP Experiences Promoting Preventive Care Through Well-Child Visits in Early Childhood." This is really designed to build off of today's discussion and be kind of like a Part 2, where we will have some presentations from state Medicaid and CHIP programs that are actually implementing approaches to improve preventive care, such as developmental assessments, blood screenings, and immunizations – all the things we talked about that are key preventive care provided during early childhood well-child visits.

So this will hopefully expand on some of the approaches and strategies that states are using in more detail, and it will be a great opportunity to ask some of these more meaty questions that we've gotten in the Q&A today.

We have a third webinar that will be coming on Monday, April 14th, at 2:00 p.m. to 3:00 p.m. Eastern. That one is "Addressing Barriers to Well-Child Visits and Preventive Care: Promising Approaches to Transportation Challenges for Medicaid and CHIP." This webinar will discuss transportation-related barriers to well-child visits and preventive care because we know that's a common barrier that families face in getting their kids to well-child visits. So this webinar will really focus on transportation-related barriers, and it will also share some lessons learned from some other state Medicaid and CHIP programs that have implemented some innovative approaches to addressing transportation-related barriers.

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Then on Monday, March 31st, at 2:00 p.m. to 3:00 p.m. Eastern, we will host an informational webinar which will describe in more detail the upcoming affinity group that we have planned, which will focus on improving preventive care in early childhood. So, we'll talk a bit more about what's to come, the focus of the affinity group, the different technical assistance activities that will be provided to states that participate. Then we'll also talk through the expression interest repository for states that are interested in participating so you have more information on how to do that.

There's a link on this slide where you can register for all of the remaining webinars in the Early Childhood Preventive Care series. So that is available to you there.

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I'm going to – before we close out – just pause to see if we have any other audience questions before we close things out today.

[Pause]

I do not see any, so that will be it for today. We want to thank you all for being with us today and spending this hour. We hope it's been helpful and informative. As you leave the webinar, you will be prompted to complete a survey. So please do provide feedback on your experience and the content we covered in today's session; it's very helpful.

As a reminder, we will post the recording, slides, and a transcript of today's webinar on Medicaid.gov. If you have any questions at all, please email: MedicaidCHIPQI@cms.hhs.gov.

Thank you all again and have a great rest of your day.