State Medicaid and CHIP Experiences Promoting Preventive Care in Early Childhood

Recorded May 5, 2025

Andy Snyder:

I want to welcome everybody and thank you all for joining us for this second webinar in our series. Today's webinar about, "State Medicaid and CHIP Experiences Promoting Preventive Care through Well-Child Visits in Early Childhood."

Our objectives for the call today are to review the importance of early childhood preventive care and well-child visits for children ages 0 to 3, share some resources that CMS has prepared on well-child quality improvement, or QI, and hear directly from some states to explore state strategies and lessons learned for improving childhood immunization and lead screening rates and other preventive care. We think it will be a good hour of content, and we look forward to the discussion.

Now I am going to turn things over to Laura Armistead with our QI Support Team at Mathematica. Laura?

Laura Armistead:

Next slide, please.

My name is Laura Armistead, and I'm a researcher with Mathematica. We have a great webinar planned for you today, and here's our agenda.

To kick things off, I'm going to provide an overview of some of the key details we covered in our first webinar on recommendations for preventive care in early childhood. Then we'll have presentations from two state Medicaid programs. First, Richard Holaday with Delaware will discuss their efforts to improve lead screening, followed by a presentation from Dr. Elsie Verbick and Dr. Julie Fedderson in Nebraska to describe their work to improve childhood immunizations. After both states have presented, then we'll open up the floor for questions. Finally, I'll close out by sharing some information about the other webinars in this series.

I briefly wanted to mention that the materials from today's webinar – including slides, a recording, and a transcript – will be posted on Medicaid.gov after this webinar.

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In the next few slides, we'll briefly revisit some of the content we covered in Webinar 1 and provide an overview of early childhood well-child and preventive care.

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This is probably well-known to many on this call; but it's important to remind about our "why" for focusing on early childhood, and that's really because the first few years in a child's life are a pivotal period of development. Research increasingly shows that experiences and exposures in early childhood can have substantial effects on a child's long-term physical, behavioral, cognitive, and social and emotional health. Medicaid plays a critical role in supporting children in accessing early childhood preventive care, and this is in large part because Medicaid covers a significant portion of children in the United States.

In 2022, Medicaid and the Children's Health Insurance Program, or CHIP, covered 42% of children under age 6 and three-fourths of children in families with lower incomes. Through the EPSDT benefit, Medicaid-eligible children under the age of 21 are assured coverage for comprehensive health services and preventive care including well-child visits, immunizations, diagnostic and screening services, and other services necessary to correct or improve health conditions.

Furthermore, a growing body of research shows strong links between Medicaid coverage of children and long-term benefits in adulthood including improved health, reduced disability, and greater educational attainment.

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Well-child visits, referred to in statute as "screening services," are covered through the EPSDT benefit and serve as the foundation for delivering preventive care for children. However, as illustrated in the chart on the slide, for children ages 15 to 30 months eligible for Medicaid and CHIP, well-child visit attendance is more than 20% lower than children of this age with private insurance. This demonstrates a real opportunity for a quality improvement focus in this area, which may also help support improvement in delivery of key preventive services.

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The American Academy of Pediatrics, or AAP, has developed a comprehensive set of recommendations for preventive pediatric health care which includes a recommendation that children receive 11 well-child visits through the first 30 months of a child's life and annually starting at age 3. On this slide is an excerpt of the AAP and Bright Futures recommendations for children ages 12 months to 3 years of age. The important thing to note here is that every well-child 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 carries.

Additionally, at certain ages children are also recommended to receive general developmental screening, autism-specific screenings, and lead screening.

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There are many benefits associated with children receiving the recommended number of well-child visits. For one, these visits provide a vehicle for delivery of recommended preventive health services and serve as an opportunity to catch up on care that might have been missed earlier in life. Well-child visits are also important for monitoring a child's growth and development, addressing parental concerns, providing education to caregivers, and enabling connections to diagnostic and specialty services and dental care.

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Given the many benefits we just covered, monitoring adherence to recommendations for early childhood preventive care is critical. This slide highlights some of the key early childhood preventive care measures that are part of the CMS Child Core Set which includes those measuring well-child visits, immunizations, developmental screening, lead screening, and fluoride varnish application.

We will not be reviewing state performance on these measures today, but that data is available on Medicaid.gov and was covered in Webinar 1 for those that are interested.

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To support states in making improvements in performance on the previously-listed measures, CMS has made available a range of resources on the Well-Child Care page on Medicaid.gov. This includes materials from the webinars in this series, as well as resources developed as part of the Improving Infant Well-Child Visits affinity group that ran from 2021 to 2023. Resources available from that work include webinar recordings, state highlights, a video on how to get started with a quality improvement project, and an example driver diagram and measurement strategy. There is also a link to a State Health Official letter that was published in 2024 summarizing best practices for adhering to EPSDT requirements.

Next slide, please.

Now we're going to hear from our two states that are doing some really important work to improve early childhood preventive care. Richard Holaday is the Quality Director for Delaware's Division of Medicaid and Medical Assistance. He is going to kick us off by sharing more about Delaware's work to improve lead screening in children.

As a reminder, if you have any questions for our state presenters, please drop them in the Q&A panel throughout the presentation; and we'll try to get to as many of them as we can at the end of this webinar.

With that, I will turn things over to Richard in Delaware.

Richard Holaday.

Thank you, Laura, I appreciate it.

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Just a little introduction – again my name is Richard Holaday, and I've served as the Quality Director since April 2020 for the Delaware Division of Medicaid and Medical Assistance, or DMMA.

Delaware Medicaid provides coverage to approximately 270,000 members of whom 44.4% are children ages 0 to 20. The State operates under a full-risk managed care model with three contracted managed care organizations. That's AmeriHealth Caritas of Delaware, as we refer to them, ACDE; Delaware First Health, or DFH; and Highmark Health Options, or HHO. All three MCOs are required to deliver EPSDT services consistent with the AAP Bright Futures Periodicity Schedule, and that's also through our MCO contracts.

The DMMA Quality Unit monitors performance through HEDIS reporting; CMS Core Set measure reporting; and ongoing engagement with the MCOs which take place via Quarterly Quality meetings, which are being changed actually during the next quarter, that's going to be quality and clinical meetings; our monthly Q2Q meetings; and then also the quarterly quality improvement initiatives (QII) Task Force. Delaware's Medicaid quality strategy prioritizes health equity and early childhood screening to support long-term health outcomes.

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DMMA holds monthly, as I mentioned, and quarterly quality meetings with each individual contracted MCO. Those meetings will focus on general QI topics to include a review of HEDIS and CMS Core Set measures, specifically those that are laid out in the Quality Strategy; critical incident data that might require follow-up; and any compliance items with contractually-required quality activities.

EPSDT and preventive care may come out in these meetings, but it depends if something has been brought to our attention. So, the EPSDT screening performance – including measures like lead screening,

as I mentioned – may be discussed when data indicates a performance gap or when specific interventions are underway – changes, et cetera.

Coordination across all three MCOs – DMMA identifies common themes across individual MCO meetings and reinforces systemwide lessons and best practices during cross-MCO forums, such as the quarterly QII Task Force.

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Just a little bit of history – Delaware law mandates blood lead screenings at 12 and 24 months of age. This requirement was established during the Childhood Lead Poisoning Prevention Act in 1994. Proof of screening is required for childcare, preschool, and kindergarten enrollment.

House Bill 222, which was signed on June 30, 2021, strengthened screening mandates and clarified provider responsibilities; and that is specifically that blood lead screenings were to be at 12 and 24 months of age. Screening mandates align with EPSDT and AAP Bright Futures guidelines, and this legislative framework also supports early detection and public health equity.

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The Childhood Lead Poisoning Prevention Advisory Committee, or the CLPPAC, increased pressure on the Division of Public Health, or DPH, and state leadership to improve screening policy and oversight. In 2021, DMMA began sharing Medicaid lead screening data with DPH and the CLPPAC to augment public health reporting. DMMA then encouraged its MCOs to participate in CLPPAC meetings to foster accountability and coordination.

Advocacy gained traction as Medicaid outperformed private insurance rates on lead screening, which helped drive HB 222 in 2021 which mandated, as I mentioned before, screenings at 12 and 24 months of age and strengthened provider reporting requirements.

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DMMA shares Medicaid lead screening data annually with both DPH and the CLPPAC to support public health reporting. DMMA participants in the monthly CLPPAC meetings alongside DPH and its Medicaid MCOs and other community stakeholders. Collaborative discussions identify screening gaps, inform outreach initiatives, and support coordinated efforts to improve lead screening rates.

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EPSDT screening requirements are actually embedded in MCO contracts. They require the MCOs to ensure that their providers are following the AAP Bright Futures Periodicity Schedule. In August 2022, DMMA led an internal review of MCO data capture and compliance related to EPSDT screening. The MCOs conducted a barrier analysis and provided targeted education to address provider needs such as equipment, billing practices, and screening timelines. The MCOs distributed point-of-care lead screening devices to priority sites.

Back at that time, just as a caveat, we only had two MCOs at that point. AmeriHealth prioritized high-volume pediatric practices and schools in older housing areas, and then Highmark Health Options prioritized providers in ZIP codes with the greatest screening gaps.

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AmeriHealth Caritas of Delaware, Highmark Health Options, and Delaware First Health, which I mentioned entered the market in January 2023, implemented member incentives to promote well-child visits and lead screenings.

The MCOs conducted targeted outreach to members through calls, text messages, and Community Health Navigators, or CHNs. The MCOs used EPSDT dashboards to identify care gaps and monitor screening performance. Outreach efforts aligned with care gap closure strategies and equity-focused initiatives.

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So here you'll be able to see one of the dashboards that our MCOs used. This was actually provided by Highmark Health Options. This dashboard was created using Tableau and claims data. Just digging into this screenshot, they can narrow down to a specific screening type. They'll be able to see the completion rate by the provider. They'll also be able to see by age group, there on the lower right, of their members and compliance, and then also on the lower left by age group.

Next slide.

So the MCO strategies also included provider education on billing, coding, and lead screening tests for best practices. Provider site visits and quarterly provider report cards were used to support engagement. Collaborations with DPH, Head Start, and community advisory groups. Community wellness efforts, including the mobile lead screening events with the Division of Public Health and parent education sessions, where they addressed general challenges, such as provider training needs when distributing point-of-care lead screening devices.

Next slide.

All right, so we'll go on to see our results and outcomes.

Next slide, please.

Here you'll see, starting with the federal fiscal year 2021, we were actually, for the most part, performing above the national rate. But as we began to educate our – work with our providers, work with community engagement, we were able to bring Delaware's statewide rate above the national rate. We're looking at the rate increasing in our 2025 submission, so we're really excited about the work that we're doing and we're continuing to do.

Next slide, please.

All right, lessons learned – next slide, please.

So, the biggest thing is that sustainable change starts with community engagement, including the collaboration with the CLPPAC. Involvement from state leadership, including legislators and the governor, increased visibility and accountability. Breaking down silos within state government, particularly between DMMA and DPH, specifically related to data sharing, also enabled coordinated action, shared goals and, as I mentioned, improved data sharing. Multistakeholder collaboration strengthened long-term infrastructure and trust.

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All right, ongoing efforts – so we continue to build on progress with a focus on sustainability and strategic alignment. We are continuing to monitor calendar year 2024 data for NCQA reporting, which is next month, and then the CMS Core Sets reporting, which is in December. Ongoing collaboration with the Division of Public Health and the CLPPAC, the sharing of annual Medicaid lead screening data with

stakeholders including the CLPPAC, and ongoing community collaborations between the Division of Public Health, Medicaid MCOs, and community organizations.

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Future directions – so we're improving access to preventive services, including well-child visits and lead screening, is a continued focus for DMMA. Member incentives supporting completion of all well-child visits and lead screenings. EPSDT dashboards are being used to monitor care gaps and target outreach across all three MCOs. Collaborative quality improvement initiatives to address barriers to early childhood preventive care.

Here's a link, which will be shared after the webinar, of Delaware's 2023 Quality Strategy, which goes into more depth.

I believe that is the last slide. The next slide is my contact information. Thank you so much.

Laura Armistead:

Okay, thank you, Richard, for a great presentation. We really appreciate you sharing today.

As a reminder, we're going to hold our questions until after both states have presented. So, we're going to roll right into our presentation from Nebraska describing their efforts to improve childhood immunization. Dr. Elsie Verbick is the Medical Services Director with the Nebraska Division of Medicaid and Long-Term Care. She'll be presenting with Dr. Julie Fedderson, the Chief Medical Officer with UnitedHealthcare Community and State Plan of Nebraska. With that, I'll turn things over.

Dr. Verbik, take it away.

Dr. Verbik, we're having some trouble hearing your audio.

Dr. Julie Fedderson:

I know Dr. Verbik is traveling. This is Julie Fedderson. I'm going to jump in for her until she gets her audio up and running.

My name is Juie Fedderson. I am the Chief Medical Officer for UnitedHealthcare Community and State. I represent one of the Medicaid managed care entities here in the state of Nebraska. Dr. Verbik – I am incredibly fortunate to work with. She is our Medical Services Director here for Nebraska DHHS.

I might just – Dr. Verbik, if you are not with us, I might just go ahead and go through the slides if that's okay.

Dr. Elsie Verbik:

Can you hear me, Dr. Fedderson?

Dr. Julie Fedderson:

I can hear you now.

Dr. Elsie Verbik:

Okay, lovely, I'm so sorry.

Good afternoon, everybody.

I am the Medical Services Director for the Division of Medicaid and Long-Term Care at Nebraska DHHS, Elsie Verbik. (inaudible) this afternoon for this opportunity to share with you what we are doing for childhood immunizations.

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You will see that we serve around 330,000 Nebraskans, which is approximately 17% of the state's population; and close to 50% of the Medicaid population is under the age of 17, and the majority are White.

Next slide.

This slide shows our performance on Combo 3 [rate] in yellow, with a HEDIS Medicaid average in blue. You will see improvement in performance start to show in the year 2020.

Next slide.

On this slide, you will see our performance on Combo 10 [rate].

Next slide.

In 2017, Nebraska moved to an integrated managed care model for health care delivery with three MCOs. Right at inception, the State prioritized these childhood immunization quality measures by selecting them to be on the MCOs' Quality Performance Program. This program allows the MCOs to own back their revenue when their quality performance meets target threshold values that the State sets as goals.

Dr. Fedderson, I'm going to hand the microphone back to you.

Dr. Julie Fedderson:

Excellent.

Next slide, please.

So, in Nebraska, the Medicaid population is divided fairly equally into three different managed care organizations that consist of Nebraska Total Care, UnitedHealthcare, and Molina. I'm going to be representing some of the strategies of the managed care organizations to support the Medicaid members with immunizations and other things.

Next slide, please.

All right, so for the payers, there's sort of these traditional strategies to impact quality and outcomes. I'm going to go into more detail about this in the presentation, but I want to start with the importance of leveraging data and then processes.

We have utilized various data reports to show overall performance, gaps in care, and specific opportunities in cohorts of members. I'm going to share some examples of what those look like here in a bit. We are very fortunate in the state of Nebraska to have a State Immunization Registry, and we have worked directly with them to obtain data that may have not ordinarily been available or maybe it lags behind claims-based systems. It has also allowed us to focus on areas that might be using alternate routes for immunizations or barriers that providers are having with getting their claims through. Our providers also have access to their data through a portal system for each of the MCOs.

A second critical piece for the managed care organizations is making sure that our internal processes evolve in order to capture and integrate the priorities for Nebraska Medicaid. This is really where that great collaborative work with our Medicaid and Long-Term Care Division has really exceeded, and I think has really helped to impact our outcomes. We have taken the goals that are set as part of that Medicaid program; and we try to keep them consistent for a period of time to allow for process adjustment within the managed care organizations. The managed care organizations have been cognizant to ensure that not only do our traditional sort of incentives align with those immunization goals but to also build those into our contracts and into our incentive programs.

Our member-facing outreach integrates immunization education and assistance when needed to fulfill well-child visits and includes screening processes that focus on the whole person to ensure that they are aware of things they need and how to achieve them. Oftentimes, we provide real-time connections. Finally, provider advocates and quality staff working with our providers help to identify immunization challenges whether claims, coding, or access issues.

Next slide, please.

This is an example of a generated UnitedHealthcare Care Opportunity Report. This is used in our payer contracts for the incentive and quality programs and for our accountable care organizations. There are multiple tabs, hard to capture on one single slide, but depending on how a practice wants to see its data, they can look and see not only higher-level reports – which is what's captured in this example – of overall compliance of a measure within a specific cohort, but then they can also crosstab to see the specific members' data for direct outreach.

We utilize these types of reports not only to share data with our providers, but also when we have individualized meetings with our providers to understand the difficulties that they may be having with individualized member outreach or even with cohorts of members.

Next slide.

The next two slides show heat-map style data from the managed care organizations. We really started to augment our kind of traditional reports with this type of data back during the pandemic. When we started working with health departments and the State Immunization Registry and some of the more community-based organizations, we found that utilizing this type of representation for different geographic views was really a great way to communicate data and to get people thinking about what might be the problems or opportunities in those specific areas.

We can provide this data a variety of different ways depending on what organization we're working with. Generally, the geographic views are either by local health departments, region or county, or even ZIP code which we have found particularly helpful in urban settings.

Next slide.

Using the gap closure reports in combination with a heat-map style of a report really helps us to understand the areas of need and then allows for more discussion about what could be ways to improve the outcomes in that population.

Next slide.

Education – a lot of folks talk about education; but for the Medicaid population, it's really one of the most integral parts of that managed care organization's duties. We take the opportunity anytime that we can speak about immunization and to really build it into our educational platforms.

From a provider-focused area, we have monthly meetings on both routine and emerging topics. Actually, upcoming is measles obviously; but we also have some of our top providers that join us on a monthly basis for joint operational committees and clinical meetings, where not only do we look at a high-level overview of their particular data but we also talk to them individually about things that they are experiencing in their communities or with UnitedHealthcare patients or with managed care patients in general and how we can help support them and advocate for any needed changes to barriers that they may be experiencing.

From a member perspective, we have a handbook. We have newsletters. We also have a direct portal where members can get in and take a look at these items for education. A couple of unique areas that we look through is collaboration with public health partners as well as community-based organizations. Back during the pandemic, this was a very valuable outreach that started with the managed care organizations really trying to understand what our public health partners were experiencing.

What we found was that Medicaid goals really are public health goals. We have used the public health departments to be able to identify their community needs, and then those have also addressed vaccine hesitancy or misinformation and really produce sort of a bidirectional ability to talk about some of the issues that they're facing with immunization on the on-the-ground front.

One of the most valuable pieces of education really is establishing that feedback loop. We really wanted to understand what our providers in our communities are facing, so that input from the providers and community is incredibly important. We want to make sure our messages are community- and culturally-appropriate. When we engage on any sort of project, whether it be immunization or another Medicaid priority, we reach out for subject matter expert input. So, we use our provider and member advisory committees; we use our community approaches at health fairs. We also use our schools, our churches, and even our powwows to give us some input as to what is going on in the community and what would be useful things for us to present.

When we do get engagement and do actual focus projects, we do some hot-wash type processes post those programs in order to identify areas of improvement and some lessons learned with each and every project that we do. We've utilized work with our academic partners through the two large medical schools here to identify and create education and messaging using trusted advisors within communities. These were folks who were not technically and generally were not even health care associated at all. These were folks that were either families or women or community leaders that were recognized as trusted sources of information.

One of the places that this was incredibly successful was utilizing members of the faith community to leverage faith-based education of their parishioners when we were working with immunizations to get the word out and also to address any fears or alleviate any issues that folks may have been going through to try to access immunization. We also utilize our schools heavily and community wellness events to get our messages out and to make sure that our communities know how to access not only their Medicaid benefits but also the supports that are available to them through the managed care organizations.

Finally, we've been working with some national programs in order to utilize their information – particularly, thanks to the American Cancer Association – and participating in pilots. Most recently, that is focusing on IMA, HEDIS measures, and HPV.

Next slide, please.

This slide represents an example of an educational repository that was created and built with the help of one of our academic partners that was used to provide access locations for vaccinations. It also provided media kits that anyone could use, including health departments or community-based organizations, to

provide to their individuals that they were working with. There were also some partner resources about immunization – again about the value of that, some immunization charts, when you should be immunized, et cetera.

This was during a period of time when the community was really expressing a lot of fatigue and mistrust around immunizations in general. So, our focus with this particular campaign was to really bring back the normalcy of preventive health care and for people to just live their lives uninterrupted by illness and preventive care and how it can get you there.

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I'm going to highlight a few of our member-focused strategies as well. In the Medicaid population, direct outreach is really critical. This allows us not only to connect with our members where they are, but it ensures that they are screened for all components of their health care and their social care needs. It also takes the opportunity to real-time assist with appointments problems or transportation issues, which often represent the barriers to care that our members are coming into contact with.

We also do various other types of programs that utilize things like live call-in programs or even auto callers or vendors that provide additional touchpoints for immunization reminders to our members and then can also connect them with a care coordinator who can then also help them make sure that they get that well-child visit.

Member rewards are also utilized. The image that's on this slide shows one of the managed care organization's rewards programs for its members. This provides basically a gift card for childcare items or other nonclinical needs, like utilities, when a member completes a needed visit for getting their immunizations done or their well-child visits done.

Finally, I've already mentioned a little bit about education focus; but we really want to again hit on the fact that education needs to be available to members in their chosen language. So, we have really focused on when we are doing things on media or when we are distributing education that it is in multiple languages and that the members really get the information in front of them in a way that they are most comfortable with working with it.

Next slide, please.

For our provider-focused strategy, I've mentioned a little bit that we incorporate our Medicaid priorities into our contracting and incentives; and that's true. That includes our ACO quality measures. It includes value-based contracts that we have. It doesn't matter if we're working with an accountable care organization, an individual practitioner, or even pharmacies. All of those have the opportunity to if they are focusing on certain Medicaid priorities – and in this case, we have immunizations in those contracts – that they will get improved outcomes for themselves from incentives by addressing those Medicaid priorities.

We also offer some direct support of our providers in that gap closure work because we do think it's incredibly important that providers have a support system within the managed care organization. We utilize – we call them "clinical practice consultants." Essentially, these are nurses that are trained in quality and HEDIS metrics; and they are there to support providers not only with the data that they are receiving but also when they are working those gap lists and assisting with care management or case issues, if that is needed, or other nonclinical items like transportation support or claims and coding issues – anything that might come up.

Finally, we also try to really build a network beyond the primary care provider. We want to utilize our programs within local health departments with our academic partners and our community-based

organizations to make sure that they are all aware of what the other is doing when it comes to a Medicaid priority. We have used some of the things that are going on with our federally qualified health centers through their association to make sure that they are aware of what our priorities are as a Medicaid organization and how can they incorporate that into some of their priorities as well.

I have listed on there "Project Access." Project Access is actually a separate program that was started in 2023 to improve overall access to our primary care services through our FQHCs. Part of this is really optimization of their clinical operations, and we want to see them really developing clinical operations that support Medicaid priorities like immunization.

Finally, Pathways programs – this is where we veer off the sort of traditional payer model. These are really nontraditional partner collaborations in order to educate communities and public health on Medicaid priorities.

We started the Pathway programs again back when the pandemic was going on because we really saw an opportunity for Medicaid managed care to work more closely with public health. What we have found is that by utilizing our local health departments to share data, to promote education, to leverage community programs that are already perhaps in place, and to evolve our messages to be more culturally-appropriate or community-appropriate that we have actually been able to reach out to a much more extensive group of individuals and also make sure that individuals in the community who are providing support for their communities know where they can find access not only to Medicaid but also to the managed care organizations if they run into members that are having difficulty.

We also have cross-collaborative efforts with our nontraditional partners. We do encourage that our primary care services are working with schools and faith-based entities to really round out the community. Also it just provides us invaluable information about what communities are facing, what kinds of things are really, well frankly, on the gossip chain right now, what's being said about immunizations now, what are people talking about – so that we can adjust accordingly and then we can also put out, as quickly as possible, information to hopefully change things that might be misinformation.

Next slide.

This is just an example of one of the things that we have worked with together. We worked with our health department. This is out in Scotts Bluff County, which is one of our very, very rural centers. They had a Halloween event. Most of the time it's when the families would come to the zoo, they'd visit some public health exhibits. But we were able to actually bring in sort of some discussion and a conversation about vaccines from the MCOs.

Over two days, about 2,000 people were in attendance, which is big for this rural part of Nebraska; and it was almost entirely families. We got really a no-pressure environment where kids got to talk about vaccinations, got to talk about their fears, and they even got to give a stuffed animal a vaccination at the end. So, it was sort of this idea of how do we create a more community environment around preventive care?

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I'm going to summarize some of the best practices that we have found for our managed care entities in Nebraska. One of the first things is just building that immunization strategy into your daily processes. If you're calling screen members, that should be one of your questions. If you're working with contracts or those sorts of things, immunizations should be top-of-mind when working on those things to make sure that you can really leverage your providers and your daily processes to constantly take a look at those priorities.

The data exchange, focusing on gaps and opportunities – these days, resources can be thin for some of our providers. So, what they're really looking for is a way to focus their energy and their time. So, bringing them data that shows them here is the issue, here is the focus area where we feel that you would be most effective, is incredibly helpful.

Direct support to providers – this is something that has also been well-received in Nebraska, being able to have somebody that can work with them side by side when they're checking their portals, when they're checking their data, so they make sure that we're abreast of any issues that they may be experiencing; and we can also kind of help guide them to approaching immunizations the way they need to.

Leveraging community input – this is sharing priorities. Again, one of the most vital things that we've discovered is generally public health priorities overlap Medicaid priorities. So, we should really leverage what each other are using and doing in the community. There are oftentimes many ways for us to participate as managed care organizations; if not, just to be there as an entity but also to provide access or even just information and educational sessions.

Then finally, the integration – all areas of care, whether you're talking with dental providers or behavioral health providers, public health, et cetera – those are all opportunities, again, to talk about what are the priorities of Medicaid and how do they fit into maybe a provider's approach. This is one area that we're currently really trying to work in more, especially on our dental side. Our dental providers don't typically give immunizations in their clinic; but they are very interested in how do I recommend this, how do I make sure that my folks that see me have access, particularly for things like kiddos who are coming in and maybe should be getting vaccinated for HPV because that's going to reduce their episodes of oral cancer later.

So, this is a really wonderful opportunity to really think about education across the entire health care system and not just focus on the primary care provider.

I am going to send it back over to Elsie for some lessons learned.

Dr. Elsie Verbik:

Thank you, Dr. Fedderson.

Next slide.

The State certainly plays an important role in facilitating the MCO success, and we have learned that it is helpful to use the Quality Performance Program to promote the efforts of all three MCOs working concurrently on the same goal and to select quality measures, as you see on the slide, that align well and that could in fact augment the performance of the other quality measures. Then, it is wise to allow the MCOs time to design, implement, analyze, and improve on their initiatives and interventions, which then results in growth and the hardwiring of processes.

Certainly, it is essential to follow progress, and we have dedicated meetings with each MCO monthly.

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At the State, we foster a culture of oneness amongst our three MCOs; and we function essentially like a three-pronged fork. One Medicaid program with each MCO representing a prong in that fork. This close collaboration and sharing of best practices across the three MCOs results in a unified approach to the execution of Medicaid across the state. The clinical leadership of the three MCOs collaborates closely through these monthly meetings with each other and shares what has worked well and what has not worked so well.

The Division of Public Health, which is our immunization registry, which we call NESIIS, we collaborate closely with them, like Dr. Fedderson said. Nebraska Medicaid facilitates meetings with such stakeholders to ensure that any inefficiencies that the MCOs may be experiencing are alleviated as best possible.

I will close here and hand it back to Laura.

Laura Armistead:

Thank you, Dr. Verbik and Dr. Fedderson. We really appreciate all the detail you shared.

Next slide, please.

We're going to transition to our question and discussion time. We've already received several questions in the Chat. There's information on this slide as a reminder of how to submit a question. If you have one, please go ahead and drop that in the Chat box.

Only our presentation team can see the questions. We're reviewing, and we will read out the questions for our speakers to verbally respond. Just one more time, I wanted to remind you that all the materials from today will be made available on Medicaid.gov after the webinar. That includes slides and the recording and the transcript.

So, we have a couple of questions, and I think these can be answered by probably both of our state presenters.

Our first question is directed to our Nebraska team. They ask: "*Has your state been able to leverage community health workers, promotoras, or health navigators and, if so, what does that look like? How do you use them to support your child immunization work?"* Dr. Fedderson, I don't know if you want to tackle that one.

Dr. Julie Fedderson:

Actually, each of the MCOs have community health workers that are employed at the MCO. We utilize them for that outreach, particularly to our community-based organizations. They really are there not only as a liaison from the managed care entity, but they are also there to bring us back information about what's happening in the community. All three of the managed care organizations are involved that way. Some of us have community health workers embedded in certain centers that are opportunity areas for Medicaid, for access or for overall needs. So, yeah, we have leaned into the CHWs.

When you talk about health navigators, that's kind of what we would probably call our care and case management workers that we have. So, we do, at the managed care organizations, have specific folks that are connected with our members that can help them with certain components of navigation. As I've said before, a lot of times what we'll see is maybe the reason and there's a gap that is open is because that member does not have transport to get to an appointment; or perhaps there's an opportunity that we can fulfill to help them actually even get an appointment. That's really what our care and case managers do. So, in that fashion, they work like a health navigator.

Laura Armistead:

Great, thank you, Dr. Fedderson.

Richard, I know in your presentation you mentioned community health navigators. Is there anything more you can say about how those were leveraged to support your lead screening work?

Richard Holaday:

Yes, thank you, Laura.

So similarly to Nebraska, all three of our MCOs have community health workers or navigators directly employed by the MCOs. Some of the MCOs, similarly to Nebraska, actually have navigators with specific practice – larger-sized practice groups.

Laura Armistead:

Great, thank you, Richard.

The next question we have also is asked of the Nebraska team. They ask: *"Do you track your childhood immunization work in the form of a PIP using aims, goal, outcome measures, and intervention tracking measures to assess the effect of the intervention?"*

Dr. Elsie Verbik:

We in Nebraska haven't specifically put childhood immunizations into a PIP format; but we did through, like I said, the Quality Performance Program. The MCOs then in their quality teams, though it's not a formal PIP, they have their own strategies, as you've heard through Dr. Fedderson, where they then design, implement, get feedback, and then redesign their initiatives as needed – kind of a flexible method but not a formal document PIP like you and I know it for CMS.

Dr. Julie Fedderson:

I can add to that too. When we have done projects with, for instance, our health departments, we do create those projects like a process improvement project, where we pick a goal and then focus on achieving that goal – whether it's we're going to increase this by 2% this year or what have you and then utilize the sharing of data. We do meet with them when we have those projects underway on a frequent basis in order to see how their progress is going and to kind of keep track in a little bit more of a structured way.

It's not necessarily exactly like what all of the components of a PIP would be, but it does make them – especially the health departments and our community-based programs too, frankly – start thinking in a way that how do I effect and solution for this particular problem? What is the problem I'm trying to solve?

It keeps them kind of focused on a little bit of a smaller project because a lot of times if you talk about immunizations, you can get a lot of scope creep because there's a lot of immunizations. So, if we just focus on maybe one or two things that feels manageable or that they have identified that, hey, this is a problem in our community or in our county, we can provide some of that data. They can select that. They can pick some kind of metrics for themselves, and it really gives something tangible to go after even though it's not like a classic like black belt-driven style of project.

Laura Armistead:

Thank you for your responses.

We have just one more minute for a final question for the Nebraska team. If you could just quickly answer, *"How does your team work with MCOs to obtain immunization registry information on members, and how do you overcome data challenges due to mismatched data?"*

Dr. Elsie Verbik:

Dr. Fedderson?

Dr. Julie Fedderson:

Yeah, I can speak to this.

We have a couple of different ways that we work with the State Immunization Registry. We get a data feed from them and have been able to work with them directly on trying to make sure that the data coming through is accurate and good. But we do a little bit of manual work in terms of bumping it up internally to what we're showing from our side and with claims. The interesting thing is a lot of times we have found that our immunization registry data is – maybe has even a more robust set of immunizations than our claims data does, and this was particularly kind of highlighted when we have a lot of the smaller providers who maybe are just giving vaccinations and they're doing the state-mandated things but aren't dropping a claim for whatever reason.

But it is a little bit of – it's a bit a back and forth to make sure that that data has integrity and that what we're seeing coming over from the State registry is matching our own files.

We also do work quite significantly on our attribution model when we're working directly with providers because in the state of Nebraska, we use sort of an assignment for providers. There is an effort done by all the MCOs to update that assignment to make sure that those members are actually going to that provider. If we need to, we will adjust membership – especially if they're showing that maybe by their claims they're going to a completely different provider. So, we can keep our providers engaged and make sure that they feel that the data that is coming to them is accurate and data that they can work on and that they're not outreaching to members that actually aren't theirs.

Laura Armistead:

Thank you so much, Dr. Fedderson. I really appreciate you answering that.

I know we're about to end our time, so next slide, please – and one more.

We just wanted to quickly highlight the next webinar that we have coming up on June 16th, which will be talking about how states are addressing beneficiary transportation challenges. We'll have presentations from three of our states describing their lessons learned. Please join us for that, and there is a link on the slide for how to register for the remaining webinars. We really hope to see you there.

Next slide, please.

I know we didn't have time to answer all of our questions. So, the email on the screen is what you can use to direct any remaining questions if you have them.

When you exit the webinar, you will be prompted to complete a survey; so please do complete that. We look forward to seeing you at future webinars in this series. Thank you so much for your time today.

Thank you again to our presenters for the amazing and detailed information that they shared. Have a great rest of your day!