



STRATEGIES TO INCREASE COVID-19 VACCINATION RATES IN MEDICAID ENROLLEES

CONSIDERATIONS FOR STATE LEADERS

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Executive Summary

State-level data [indicate](#) that COVID-19 vaccination rates are lower among people covered by Medicaid than the general population. With the emergence of additional variants of concern, such as Omicron, there is an urgent need to build vaccine confidence amongst those who remain unvaccinated. State Medicaid programs are developing innovative approaches to encourage beneficiaries to get vaccinated. Based on interviews with state officials, Medicaid Managed Care Organizations (MCOs), and providers serving Medicaid populations, this report explores how states are tackling the challenge of identifying gaps in vaccine access among their Medicaid populations and provides examples of promising strategies to improve COVID-19 vaccination rates among Medicaid beneficiaries. Key considerations for state leaders include:

- 1 Use data to monitor progress, identify disparities, and facilitate outreach;
- 2 Incentivize and support provider vaccination efforts;
- 3 Incentivize Medicaid plans to reach vaccination targets;
- 4 Identify opportunities to reduce barriers to vaccination; and
- 5 Provide technical assistance and communications resources to providers.

Background

As of May 2021, over 82 million people were **enrolled** in Medicaid and the Children's Health Insurance Program (CHIP), including over 39 million (47.2 percent) children. According to the Centers for Medicare and Medicaid Services (CMS), enrollment in Medicaid and CHIP increased by 17.1 percent between February 2020 and May 2021, likely driven by the COVID-19 pandemic and the continuous enrollment requirement in the Families First Coronavirus Response Act (FFCRA).¹

As with most vaccines, COVID-19 immunization rates are **lower** among uninsured individuals and Medicaid enrollees compared to those who have commercial insurance. Current COVID-19 vaccination rates average 15 to 20 percent lower for Medicaid enrollees than for those with other types of health insurance. **California** and **Utah** have released reports that illustrate these disparities, and similar disparities have been described across a number of other states. As the **majority** (61.1 percent in 2019) of Medicaid enrollees identify as Black, Hispanic, Asian American, or another non-white race or ethnicity, disparities in COVID-19 vaccinations disproportionately impact these populations, who have also experienced **disproportionate** rates of infection, hospitalization, and death due to COVID-19.

The Biden Administration and CMS released **guidance** that encourages states to use American Rescue Plan Act (ARPA) funding to promote COVID-19 vaccination for eligible Medicaid enrollees. While Medicaid programs and managed care plans have historically worked with state immunization programs to improve routine vaccination rates, the pandemic creates unique challenges and opportunities to develop or leverage effective strategies to increase COVID-19 vaccine access and uptake among Medicaid beneficiaries. Addressing disparities in vaccination rates will be especially important as states continue to vaccinate newly eligible children under 12 years of age and provide recommended "booster" vaccine doses to adults 18 years of age and older.

Barriers to Vaccination for Medicaid Enrollees

Understanding the attitudes held and barriers to vaccination faced by populations served by the Medicaid program is critical to designing effective interventions to reach these populations. For example, low vaccine confidence among low-income populations, a **large proportion** of whom are Medicaid eligible, exists on a spectrum ranging from unwavering refusal to consider vaccination to having questions about vaccination, primarily around vaccine safety. In May and June of 2021, the African American Research Collaborative, in partnership with The Commonwealth Fund, surveyed more than 12,000 Americans to better understand their access to and opinions about COVID-19 vaccines, which are published in the **American COVID-19 Vaccine Poll**. According to the poll, individuals with an annual income of less than \$50,000 are more likely to be hesitant to receive a COVID-19 vaccine than individuals who earn higher annual incomes. This population is also more likely to face barriers to successful vaccination, such as lack of transportation to vaccination sites and site hours that do not meet their needs. Low-income whites who were surveyed reported lower vaccine hesitancy (46.5 percent) and fewer barriers to vaccination (49.4 percent with one or more barriers) than low-income Blacks, where 48.9 percent reported hesitancy and 56.8 percent reported one or more barriers. Low-income Latinos reported

¹ The continuous enrollment requirement **mandated** that states receiving the temporary increase in federal Medicaid matching funds provided during the pandemic continue to cover certain Medicaid enrollees who may otherwise have been terminated from the program.

the lowest vaccine hesitancy (41.3 percent) but the greatest barriers to vaccination (59.3 percent). All low-income groups surveyed indicated that they preferred to receive a COVID-19 vaccine in their doctor's office, making the successful recruitment of medical providers who serve Medicaid populations, and who will counsel for and provide COVID-19 vaccines, paramount to success.

Considerations and Promising Practices for State Leaders

Throughout the COVID-19 vaccination effort, state leaders have collaborated with leaders from the public health field, health care systems, Medicaid MCOs, community organizations, and other partners to promote access to COVID-19 vaccines, engage communities at higher risk of harms from COVID-19, and improve population vaccination rates. Close coordination and communication with healthcare providers, MCOs, and community organizations serving low-income populations can help ensure that critical voices are part of planning efforts, resources and efforts are aligned, and stakeholders are guided by a common mission. In addition to these core coordination efforts, key considerations and promising practices for improving vaccination rates in the Medicaid population include:

1 USE DATA TO MONITOR PROGRESS, IDENTIFY DISPARITIES, AND FACILITATE OUTREACH



State Medicaid programs, MCOs, and providers have aligned resources to vaccinate their patient populations against COVID-19. However, many health systems, vaccine providers, and health plans have access to limited vaccination data for their enrollees through claims or electronic health records (EHRs), which hinders their ability to know who is already vaccinated and to efficiently identify and engage unvaccinated members.

By improving information and data exchange between state Immunization Information Systems (IISs), health plans, and health systems partners, states can improve their own data and use that data to identify disparities, efficiently target resources, and support providers and plans in effectively engaging Medicaid enrollees to increase vaccination rates. Key considerations and promising practices include:

Facilitating data sharing: Timely and complete access to vaccination data from state, territorial, and jurisdictional IISs is critical to vaccination efforts but often requires states to address regulatory and technology barriers. In states where sharing immunization registry data with healthcare partners is permissible under legislation or privacy regulations, states have taken steps to facilitate information-sharing by developing Data Use Agreements (DUAs) that enable Medicaid partners to access immunization registry information. During the COVID-19 pandemic, states have made progress towards sharing IIS data with key health care partners through a variety of mechanisms:

- **Michigan's** CareConnect360 web portal tool allows Medicaid health plans to view information on their members. Michigan's Medicaid program worked with the state IIS to ensure that plans receive daily feeds of their members' immunization status.
- In **Ohio**, a cloud platform called **InnovateOhio** allows state agencies to share data with one another. Data from the state IIS is matched with Medicaid claims data to provide MCOs with lists of their members and their vaccination status.
- In **Illinois**, local health departments and health plans share immunization data through the Illinois Comprehensive Automated Immunization Registry Exchange (**I-CARE**), a web-based application that pulls data from Medicaid claims, care coordination claims, and monthly updates from the state IIS.

Using data to identify disparities: States need to first understand where vaccination gaps exist among their Medicaid-enrolled populations. To enable real-time access to vaccination records for Medicaid beneficiaries, many state immunization programs strengthened IIS functionality to allow plans to receive regular updates on unvaccinated members. Some programs have established application programming interfaces (APIs) that can support real-time queries to help partners identify “hot spots” with low vaccine uptake.² **California** has published reports that compare COVID-19 vaccination rates among Medicaid enrollees versus the general population, which have raised awareness of disparities and have helped to generate support, including financial resources, to address them. **Michigan** created a dashboard that illustrates differences in Medicaid health plan members’ vaccination rates by geographic region, county, age group, and race and ethnicity. Nationwide, gaps in available data on race, ethnicity, and other important demographic characteristics make it difficult to track improvements in vaccination rates across different segments of the population.

Using data to facilitate outreach and communications: Medicaid programs and health plans can use immunization data to proactively reach out to their members to encourage vaccination, address barriers, and recruit providers to become COVID-19 vaccine providers.

- MCOs in **Ohio** use immunization data and the [Ohio Opportunity Index](#) to identify counties and ZIP codes in the state with the lowest vaccination rates. MCOs “microtarget” members in these areas, sending text messages to unvaccinated members who live near vaccination sites like pharmacies.
- **Kentucky** uses data on COVID-19 vaccinations and social determinants of health to inform where additional opportunities for vaccination are needed for Medicaid fee-for-service members. The state targets vaccine outreach to areas with low vaccine uptake and high social vulnerability, and local vaccine champions in these communities provide the outreach to members.
- **Oregon** has shared information with its coordinated care organizations (CCOs - Oregon’s version of regional managed care) that shows which providers in their networks are enrolled as COVID-19 vaccine providers. This process allowed CCOs to conduct targeted outreach to recruit providers who are not enrolled in the COVID-19 vaccination program. Oregon also obtained information about where CCO members are enrolled for primary care, allowing outreach and preferential allocation of vaccine to those providers.

2 INCENTIVIZE AND SUPPORT PROVIDER VACCINATION EFFORTS



Medicaid agencies and MCOs play an important role in encouraging medical providers to enroll in the COVID-19 vaccination program and in assisting providers in overcoming barriers to vaccinating their Medicaid-enrolled patients. Critical to the success of the vaccination program is recognition of the additional costs incurred by medical practices that elect to provide COVID-19 vaccinations to their patients. Vaccine storage and handling equipment, additional staffing to schedule vaccination appointments and return patient messages, efforts to contact and recall patients, and expanded clinic hours all result in increased expense to medical offices. Burnout, opportunities for higher pay, and the recent federal [employer vaccine mandate](#) have contributed to a national [shortage](#) of nurses and medical assistants, leaving medical offices overwhelmed and understaffed. Pediatricians experienced [surges](#) in demand during

² For more information on strategies for improving information exchange between immunization registries and healthcare partners, see [Improving Immunization Information Sharing to Support Targeted COVID-19 Vaccination Outreach](#).

the fall back-to-school period, and supporting pediatric offices is particularly [important](#) in light of the new emergency use authorization of the Pfizer-BioNTech vaccine for children ages 5 to 11 years old. To help overcome these challenges and increase provider willingness to provide COVID-19 vaccinations, Medicaid agencies and plans are implementing strategies to incentivize providers to enroll as vaccine providers, conduct outreach and provide counseling to unvaccinated patients, and increase vaccination coverage across the populations they serve.

Federal and state leaders recognize that examining provider incentives and reimbursement policies is critical to supporting vaccination efforts. Medicaid agencies and health plans are financially incentivizing providers to close the vaccination gap among individuals covered under Medicaid. Most states are at least matching Medicare [rates](#) for COVID-19 vaccine reimbursement. [Illinois](#), [Massachusetts](#), and [Ohio](#) Medicaid programs are examples of states reimbursing vaccine administration fees above average Medicare rates, recognizing the increased effort medical professionals must make to administer COVID-19 vaccinations. However, providers who counsel patients are typically only paid if the patient elects to receive the COVID-19 vaccine during that office visit. To encourage providers to spend time counseling patients on the benefits of the COVID-19 vaccine, regardless of the immediate outcome, several states modified their reimbursement policies for patient counseling. For example, [North Carolina's](#) Medicaid program began paying for preventive medicine counseling and/or risk factor reduction intervention(s) provided to beneficiaries of all ages ([CPT code 99401](#)). Providers are reimbursed for up to 15 minutes of counseling to Medicaid beneficiaries on the benefits of receiving a COVID-19 vaccine, whether or not the patient chooses to be vaccinated. This counseling reimbursement also allows for multiple conversations between a provider and beneficiary to take place, as charges may be attached to multiple office visits. The Biden Administration also [announced](#) that all Medicaid programs will be required to reimburse health care providers for counseling visits for eligible youth up to age 21 with 100 percent federal funding through the public health emergency and the following year.

State Medicaid programs are also incentivizing MCOs to award funding to providers who are increasing vaccination rates among members, including waiving contract language to allow plans to invest additional funding in vaccination outreach efforts. For example:

- As part of its COVID-19 Vaccine Incentive Program, the [California](#) Department of Health Care Services (DHCS) required Medicaid health plans to outline a vaccine response plan that would close vaccination gaps among Medicaid-enrolled individuals. The various approaches health plans are taking to incentivize providers are summarized in a COVID-19 Vaccine [Promising Practices](#) resource published by DHCS. Some health plans are [providing](#) financial incentives for physicians to enroll in California's COVID-19 vaccination [program](#) and offsetting costs associated with providing COVID-19 vaccines at primary care practices. Many health plans in the state are giving incentive payments for primary care provider (PCP) or pharmacy visits that include a COVID-19 vaccine. Additionally, some plans are using pay-for-performance programs and taking a tiered incentive approach with PCPs based on the percentage of patients they vaccinate.
- The [Michigan](#) Medicaid program established a temporary bonus pool to support vaccine providers and rewards the health plans that reach certain benchmarks of COVID-19 vaccinations (See Section 3). Michigan's MeridianHealth MCO [COVID-19 Vaccination Provider Incentive Program](#) pays providers for each member vaccinated. Incentive rates per member are tiered such that providers are paid more when a higher percentage of members are vaccinated. For instance, the provider incentive amount is \$10 per member when fewer than 55 percent of the member

population is vaccinated, \$50 per member when 55 to 70 percent of members are vaccinated, and \$100 per member when over 70 percent of members are vaccinated.

- For the last several months, **Kentucky** Medicaid has waived the encounter penalties built into MCO contracts, which are based on timeliness, accuracy and completeness of encounter submission. MCOs are able to use the money saved from the waived penalties towards any of their COVID-19 vaccination programming. One Kentucky MCO is reimbursing all participating PCPs on a tiered basis depending on the percentage of Medicaid members vaccinated. The initial incentive payment, using member vaccination rates as of September 2021, provides a payout of over \$400,000 to 554 providers. Another Kentucky MCO is giving providers \$25 for each patient they vaccinate.

There are also specific considerations for incentivizing pediatricians to vaccinate children, many of whom are enrolled in Medicaid. For additional considerations for pediatricians, see [COVID-19 Vaccines and Children: State Strategies to Increase Access and Uptake through Pediatric Providers](#).

3 INCENTIVIZE MEDICAID PLANS TO REACH VACCINATION TARGETS



With over 69 percent of Medicaid beneficiaries [enrolled](#) in managed care, Medicaid MCOs play a critical role in engaging their member populations. States have leveraged a variety of strategies to encourage MCOs to reach vaccination targets for the communities they serve, including creating performance measures and incentive pools, and encouraging collaboration among MCOs. Promising practices include:

- In April 2021, **Oregon** [developed](#) an incentive measure for its CCOs to encourage substantial progress towards the vaccination of eligible members by December 31, 2021. The state designed the incentive measure with equity at the center; bonus funds are only available to CCOs if they increase vaccination rates in members ages 16 and older across race and ethnicity groups. For members ages 16 and older, CCOs can qualify to receive up to 90 percent of total bonus funds by reaching a 70 percent benchmark overall or a CCO-specific improvement target *and* at least a 42 percent vaccination rate for all race/ethnicity groups. Improvement targets are specific to each CCO to account for regional differences in vaccination rates to date.
- **Michigan** [established](#) a temporary bonus pool for Medicaid health plans that set benchmarks for COVID-19 vaccinations in members ages 16 and older. Benchmarks were set based on milestones in the Governor's "[MI Vacc to Normal](#)" plan, which aims to vaccinate 70 percent of state residents ages 16 and older. Medicaid health plans that vaccinate 55 percent of their members ages 16 and older are eligible to receive a 30 percent share of bonus pool funding, and plans that vaccinate 70 percent of that population are eligible to receive a 100 percent share of funding. If a plan does not meet either benchmark, its share of funding is returned to the pool for distribution to plans that met benchmarks. The state plans to continue this initiative in the next fiscal year.
- **Ohio's** MCOs are working together to meet shared vaccination goals. MCOs can earn back their quality withhold if they all meet certain benchmarks. The Medicaid program also established a sub-goal for plans to increase vaccination rates in areas with the lowest opportunity indices, which accounts for economic, educational, health, and community-related factors. Plans can earn additional funds on top of the withhold based on progress toward vaccinating additional Medicaid managed care members.

- **California's** Department of Health Care Services [Vaccine Incentive Program](#) for MCOs uses seven outcome measures to assess progress towards narrowing gaps in vaccination rates between Medicaid members and the general population. Data for the incentive program is collected over six months and is evaluated every two months. MCOs will be paid based on performance on these measures and three additional intermediate outcome measures. Any leftover funds from the program will be used to create a high-performance pool and distributed to MCOs based on performance on a measure set and achievement criteria. Preliminary data examined in the two months since the program began found increases in the percentage of Medi-Cal beneficiaries ages 12 years and older who received at least one dose of a COVID-19 vaccine across targeted age, racial, and ethnic groups. This signals progress towards the state's goals of closing one-third of the gap between the Medi-Cal population and the statewide population for 12-25 year olds, and closing one-third of the gap between the African American and Native American Medi-Cal and overall Medi-Cal populations.

4 IDENTIFY OPPORTUNITIES TO REDUCE BARRIERS TO VACCINATION



Low-income populations served by state Medicaid programs may report barriers to vaccine access related to transportation, the ability to have time off from work to get vaccinated, language and accessibility challenges, limited clinic hours, limited access to health care providers, or geographic distance to vaccination sites. Reaching people in their communities and allowing them to “[stumble into](#)” vaccine sites is critical. States continue to work with health plans and health care providers to ensure that their Medicaid populations, including those who are homebound, are able to access vaccines. Promising practices include:

- **Massachusetts**-based health plans have partnered with local health and cultural organizations for outreach and education to help register people for vaccination. The state also provides mobile vaccine clinics for Medicaid patients in medically underserved areas of the state, including rural areas, and among populations with limited English proficiency. Massachusetts also has an [In-Home Vaccination Central Intake Line](#) that assists homebound individuals in scheduling and receiving in-home vaccinations. Representatives who speak English and Spanish are available, and the line has translators who cover over 100 different languages.
- **Arizona**, along with other state Medicaid programs such as in **Connecticut** and **Florida**, will reimburse non-emergency medical transportation (NEMT) providers for driving eligible Medicaid members to and from their COVID-19 vaccination appointments, including reimbursement for time spent waiting during the vaccination appointment.
- Individuals aged 12 and older in **Ohio** are [encouraged](#) to get vaccinated at CVS, Walgreens, Rite Aid, and other community pharmacies without an appointment. Ohio MCOs are also providing [transportation](#) for their members to increase access and ease of vaccination. Ohio Medicaid plans are supporting local public health and other community organizations' (schools, churches, county fairs, etc.) vaccination events. Medicaid plans are also deploying mobile vaccine units and community health workers to areas of the state to meet people where they are. Ohio CareSource leveraged the preexisting relationship between Ohio's Housing and Urban Development (HUD) program and individuals in affordable and subsidized housing to provide vaccinations to residents, and community events were held in housing developments and included food trucks. These events were found to be successful and replicable.

- **Kentucky**'s fee-for-service Medicaid program reached approximately 90 percent of its members, including homebound individuals, by going door-to-door and offering vaccinations to everyone in the household through their "[Shot of Hope](#)" at-home program. They are reviving this process for booster shots. [Wellcare of Kentucky](#) is also offering voluntary, in-home COVID-19 vaccines and \$100 gift cards to incentivize their Medicaid members ages 12 and older to get vaccinated.

5 PROVIDE TECHNICAL ASSISTANCE AND COMMUNICATIONS RESOURCES TO PROVIDERS



As new age groups become eligible for vaccination and vaccine messaging and billing guidance are constantly updated, it is critical that states continuously share updated resources with providers to match the needs of the time. Many physicians are still experiencing challenges with providing patients with accurate vaccine information and are reporting a need for additional resources for communicating with patients and training staff on topics like vaccine administration and billing procedures. Some agencies provide updated information on COVID-19 vaccination coverage, reimbursement, and billing on their webpages. Several agencies and health plans aim to address challenges in counseling unvaccinated patients by equipping providers with responses to objections to vaccination or other communications resources. For example:

- **Illinois** Medicaid health plans are supporting providers with educational tools and scripts to help improve vaccine confidence, such as the [Recharge Immunization Toolkit](#).
- The **Texas** Medicaid program hosts biweekly provider webinars to communicate new information on COVID-19 vaccines, with up to 1,000 providers in attendance. Additionally, the Texas Department of Health and Human Services' [COVID-19 Vaccine Communication Tools](#) page includes communication and social media materials in English and Spanish, provider talking points for sharing vaccine information with patients, and FAQ posters targeting misinformation about COVID-19 vaccines. Texas also started an outreach campaign to help enroll COVID-19 vaccine providers who serve vulnerable children, informed by evidence that [providers](#) can be the most effective messenger to help people decide to get vaccinated.
- Blue Cross Blue Shield of **Arizona**'s Medicaid plan recently launched a provider training series focused on building clinical capacity for motivational interviewing with patients who are vaccine hesitant.
- **Oregon**'s state Medicaid officials set up a learning collaborative where they regularly provide COVID-19 updates to their CCOs. Leadership discusses community vaccine uptake and strategies to increase vaccination rates, with local strategies tailored by the local public health authorities. As an agency, they discussed support for vaccinating children through another series of learning collaboratives, webinars for pediatricians, and meetings that brought together providers and local health departments to collaborate around these efforts. State officials highlighted one practice that developed a COVID-19 coloring book and a game to help combat misinformation.



Conclusion

State Medicaid programs, health plans, and providers have mutual interests in ensuring the health of Medicaid members. These stakeholders can work together to leverage their significant expertise and resources to ensure that Medicaid members are adequately protected from COVID-19. As states continue to innovate and explore approaches for improving vaccination rates among targeted populations, evaluating the impact of these strategies on vaccination coverage rates can help refine and support additional efforts to vaccinate children as well as booster vaccination efforts.

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