Vaccine Financing: Impact on Access for Families and Physicians

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Disclaimer…

The opinions expressed in this presentation are solely those of the presenter and do not necessarily represent the official position of the American Medical Association or the National Influenza Vaccine Summit.

Vaccine Financing in the United States

- Vaccines For Children (VFC, ~43% of children)
  - Entitlement for children up to age 19 served by:
    - Medicaid
    - Without health insurance
    - American Indians and Alaska Natives
  - Underinsured children can receive VFC vaccines at Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs)
- Section 317 (~7% of children)
  - Used by states to cover non-VFC eligible children and adolescents (some states also use state funds)
  - Also has objective to improve adult IZ
  - Stagnant funding – 317 Coalition working to improve funding levels

Vaccine Financing in the United States

- Medicare
  - Covers vaccines for those 65 years and older
  - Influenza, Pneumococcal and Hepatitis B – Part B (by legislation)
  - All other vaccines – Part D (eg, shingles)
- Medicaid
  - Only public sector payer that provides for administration fee
  - Admin fee set by states with huge state-to-state variance; states have to contribute enough funds to draw the maximum federal matching contribution allowable
  - No state is close to the caps are set by CMS in 1994 for admin fees
- Private Sector (~47% of children)
  - Price of vaccine negotiated with distributors/manufacturers
  - Payment negotiated with payers
  - Providers responsible for administering vaccine then seeking payment (compare with pharmaceuticals where patient fills prescription)

In Need of a Booster Shot; Rising Costs Make Doctors Balk at Giving Vaccines

By ANDREW POLLACK
New York Times

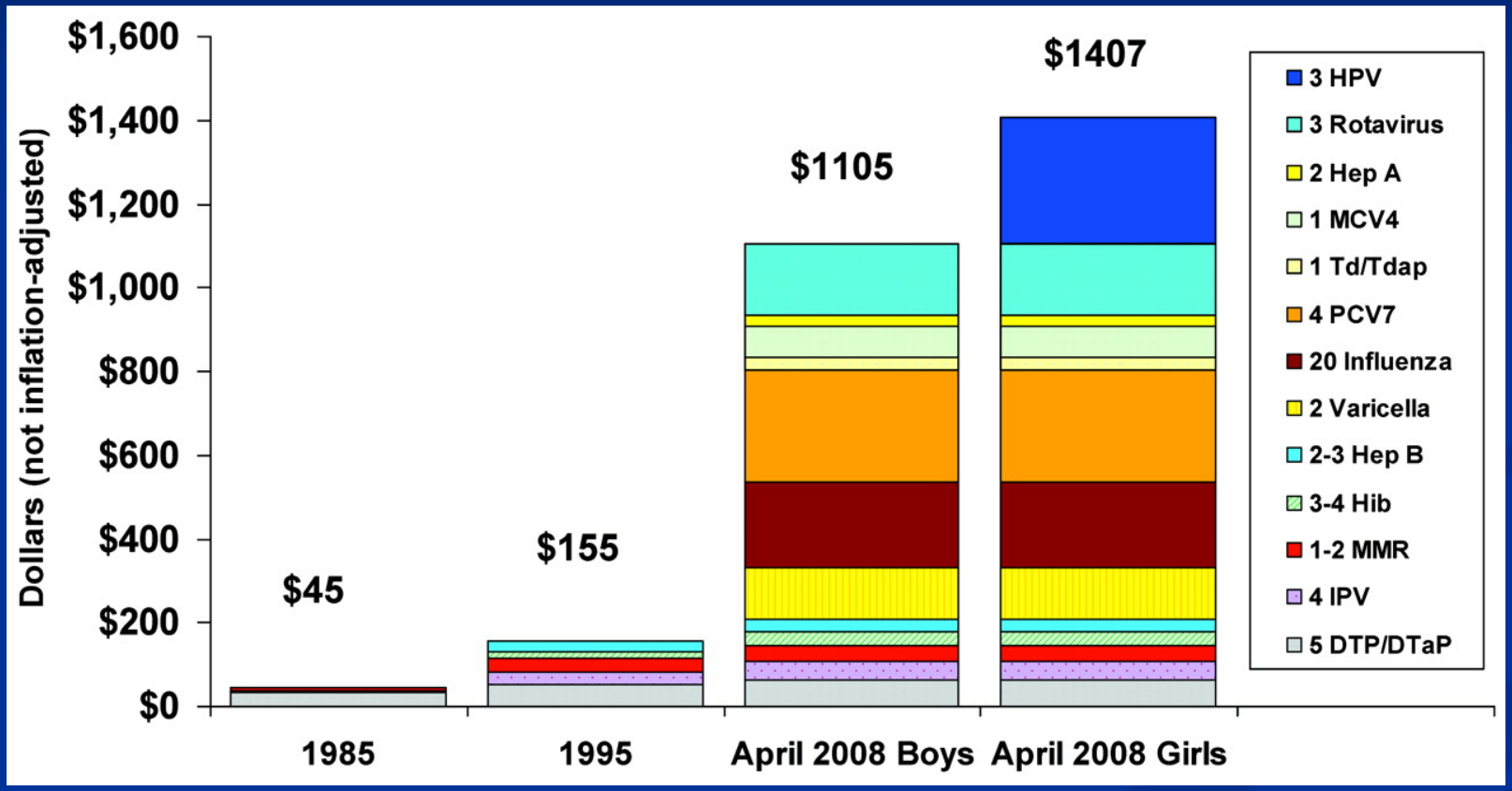
The nation's pediatricians, the foot soldiers in the campaign to vaccinate America's children, are starting to revolt…

"We cannot pay for the vaccination of the American public any longer," said Dr. Dorothy A. Levine, a pediatrician in Stamford and New Canaan, Conn. "We're not giving them with as much vigor as we should, and the main reason is financial."

Vaccine Financing Crisis
Why Now?

- Cost of vaccines
  - Cost of the vaccine itself
  - Cost to handle and store the vaccine
  - Cost to administer the vaccine
- Both private and public sources of funding for vaccines are threatened
- Growing discrepancy between states

U.S. Federal Contract Prices for Vaccines Recommended Universally for Children and Adolescents: 1985, 1995, April 2008*

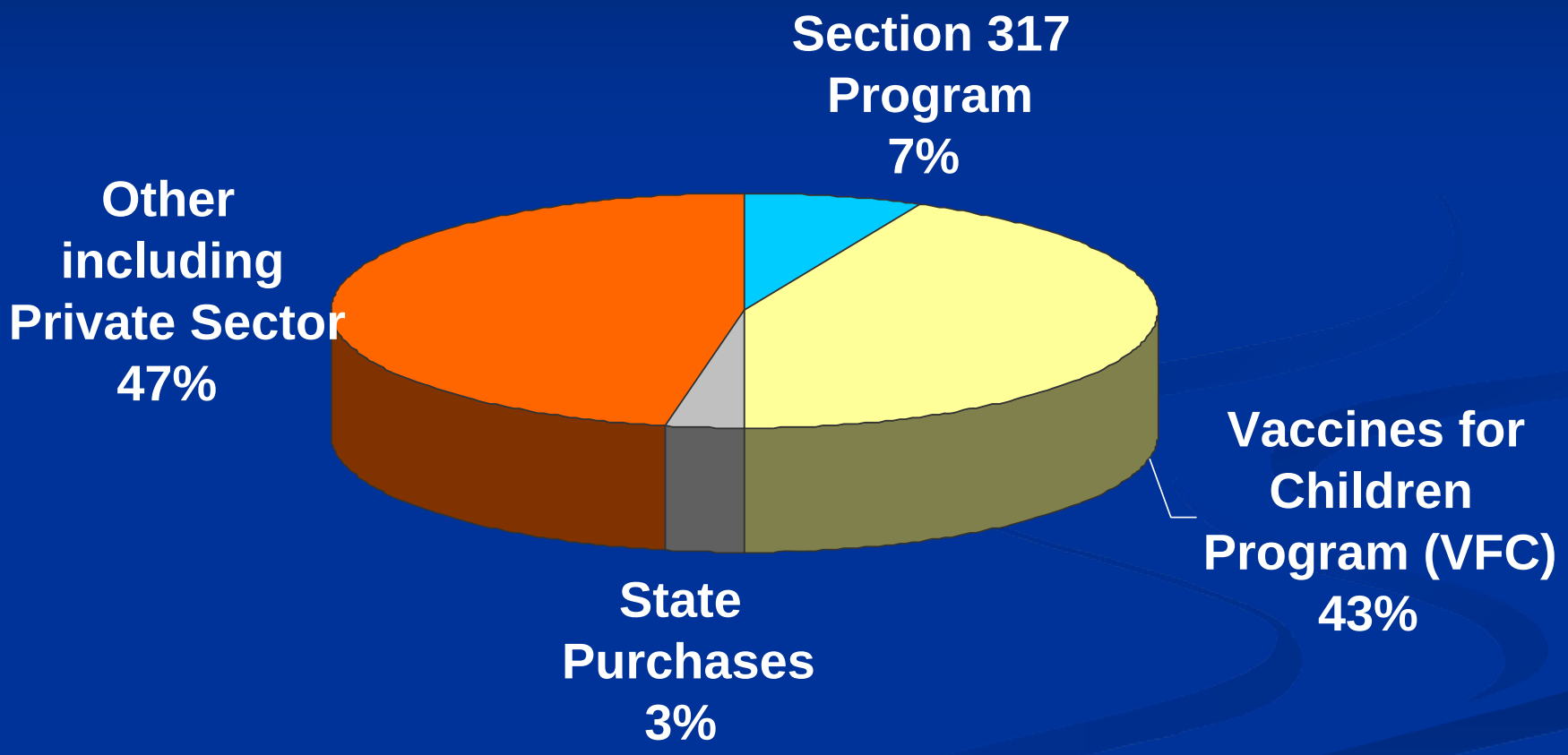


1985 and 1995 represent the average federal contract price to account for price changes within the respective year.

April 2008 represents the minimum cost to vaccinate children and adolescents and is based on the federal contract price as of April 2, 2008. Does not consider the new permissive recommendation for boys for HPV.

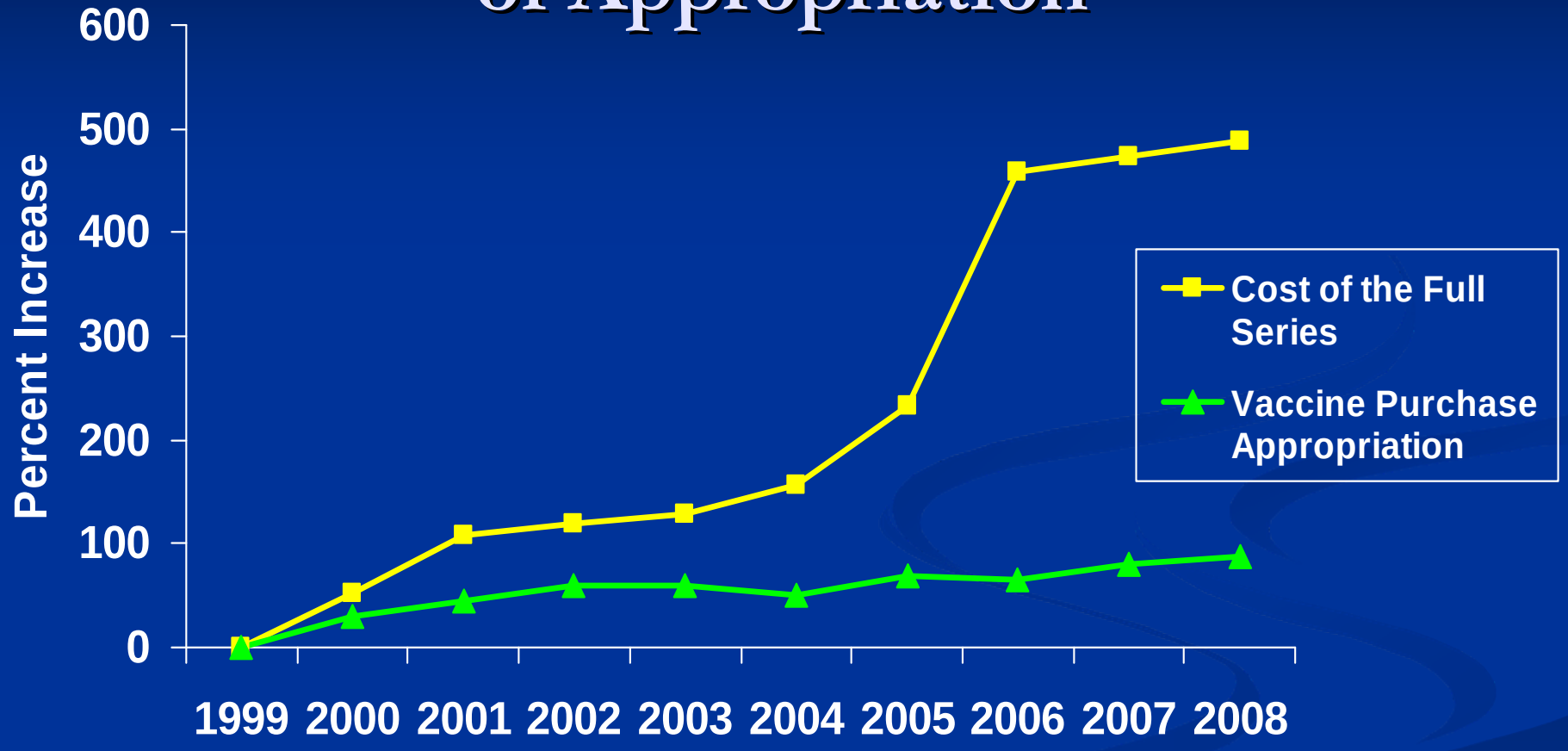
*Lindley, M. C. et al. Pediatrics 2009;124:S548-S557.

Pediatric and Adolescent Vaccine Doses Distributed by Funding Source Calendar Year 2007



Source: Biologics Surveillance Data 2007.
Other is all purchases not on CDC contracts, including private, health insurance, and government purchases through other mechanisms.
Data include the following new adolescent vaccine doses: Tdap, MCV4 and HPV. It does not include influenza vaccine doses.

Percent Increase of the Cost of Full Series vs. Percent Increase of Appropriation



Percentage Calculations: % increases are cumulative using 1999 as the base year.

Beginning 2006 series costs are an average of the cost to vaccinate a male and a female. Estimates are based on inflationary increases and this figure reflects April 1, 2007 federal contract prices.

Number of Children and Adolescents Who Could Potentially Receive Full Series with 317 funds

2006 and 2007 estimates include HPV vaccine and are estimated on a 1:1 ratio of males to females vaccinated.

In 2007 it cost $924 to vaccinate a male and $1214 to vaccinate a female.

FY 2008 and 2009 estimates are based on output levels as published in the FY 2009 CJ.

From the front lines…

“I have noticed that in administering vaccines, I am carrying a financial loss. …

Because of this I am seriously considering not updating my patients' vaccine after I am done with my current supply. I will just send my patients to the County Health Department to get their vaccines…

in reality how many of these patients even have time to call the health department and fall in line to get their vaccine?”

What Does It Cost to Immunize?

- Vaccine purchase
  - Ordering
  - Tracking inventory
  - Deferred reimbursement
- Vaccine storage
  - Refrigerator/Freezer
  - Back-up power/Alarms
  - Insurance
  - Opportunity cost of inventory
- Vaccine administration
  - Staff time
  - Supplies
  - Documentation
  - Figuring out the billing

Issues with the Purchase of Vaccines

- Newer vaccines are more expensive
- There is no federal vaccine purchase program for adults
- Vaccine prices can vary as much as 3-fold from provider to provider depending on negotiated prices, which are confidential

What are Different Providers Paying?

Vaccine	Brand	Public Sector Price ($)	Average Sales Price ($)	Average Wholesale Price ($)	Cost per Dose ($)		
					Mean	Max	Min
Hep B	*Recombivax*	9.50	24.36	23.20	12.23	23.20	8.25
	Engerix	9.10		21.37	10.32	13.06	4.26
DTaP	*Daptacel*	13.25	31.08	22.04	16.13	21.40	12.63
	Tripedia	12.65		21.40	18.31	22.40	13.40

Freed, et al. 2009. Pediatrics; 124: S459-S465.

What are Different Providers Paying?

Vaccine	Brand	Public Sector Price ($)	Average Sales Price ($)	Average Wholesale Price ($)	Cost per Dose ($)		
					Mean	Max	Min
Tdap	*ADACEL*	30.75	35.17	37.43	33.23	36.34	29.20
	BOOSTRIX	30.75		36.25	35.80	38.61	34.41
MCV4	*Menactra*	73.09	86.10	89.43	86.61	93.43	80.36
HPV	*GARDASIL*	96.75	NA	120.50	120.06	129.57	116.00

Freed, et al. 2009. Pediatrics; 124: S459-S465

Which Provider Type pays the Most?

- Small 1-2 physician offices
- Physicians who do not participate in some form of group purchasing
- Physicians practicing in rural areas
- Physicians who are not skilled at business negotiations

Issues with the Payment of Providers

- Provider has to pay manufacturer in 30-60 days but may not get reimbursed by health plan for months
- How many patients are cared for under negotiated capitated contracts?
- Some plans won't pay for some new uses of existing vaccines (2nd dose VZV) in mid-contract and some contracts are for 2 years
- Patients change health plans and providers sometimes are left holding the bag

What are Providers being reimbursed for the cost of vaccine?

Vaccine	Brand	Cost Reimbursement per Dose ($)		
		Mean	Max	Min
Hep B	*Recombivax*	25.95	35.94	15.97
	Engerix	25.19	34.33	16.00
DTaP	*Daptacel*	26.05	43.05	20.60
	Tripedia	24.95	30.50	22.26

Freed, et al. 2009. Pediatrics; 124: S459-S465

What are Providers being reimbursed for the cost of vaccine?

Vaccine	Brand	Cost Reimbursement per Dose ($)		
		Mean	Max	Min
Tdap	*ADACEL*	39.80	50.84	29.74
	BOOSTRIX	39.79	46.23	33.83
MCV4	*Menactra*	95.98	121.95	82.00
HPV	*GARDASIL*	135.14	170.00	119.25

Freed, et al. 2009. Pediatrics; 124: S459-S465

Price paid for vaccine vs. payment received for vaccine

Vaccine	CPT Code	Price Paid for Vaccine ($/dose)			Payment Received for Vaccine ($/dose)		
		Min	Avg	Max	Min	Avg	Max
Hep B	90744	5.53	13.23	35.00	12.76	24.96	47.76
DTaP	90700	8.77	16.78	30.00	17.32	24.32	33.71
MCV4	90734	40.00	79.87	92.00	54.45	95.52	112.72
HPV	90649	114.96	121.81	155.00	76.31	123.49	147.23

Coleman, et al. 2009. Pediatrics; 124: S472-S491.

Which Provider gets Reimbursed Best?

- Higher average reimbursement for most vaccines
  - Practices in metropolitan areas
- Lower average reimbursement for most vaccines
  - Solo and 2-physician practices

New Vaccines: Availability may Depend on Funding Source

- VFC vaccine often delayed because of federal price negotiations
- Some vaccines not available through federal/state programs resulting in "2-tiered states"
- Some vaccines become available through VFC before they are covered by private plans and vice versa
- All these factors place providers in a difficult position if they can't immunize all of their patients with same vaccines

Cost of Vaccine Storage and Handling

- Equipment: refrigerator/freezer, temperature monitoring devices
- Up front purchase costs
- Labor costs to order, track, maintain supply
- Backup power
- Insurance for inventory
- Opportunity cost of hundreds of thousands of dollars tied up in inventory
- Ideally these cost should be built into the administration fee paid to providers for giving vaccines
  - But many are not!

Costs of vaccine administration

- Staff time:
  - Discussions with parents
  - Vaccine administration
  - Documentation
  - Training
- Supplies
- Billing

Administration Fee often does not cover costs to give vaccination

Scenario	Administration Cost, $	Administration Payment, $	Vaccine Cost, $	Vaccine Payment, $	Net Gain/Loss $
1 dose, hepatitis B	29.77	18.01	13.23	24.96	-0.03
1 dose, HPV	29.77	14.28	121.81	123.49	-13.81
2 doses, MCV4, TDaP	30.84	27.54	114.37	134.97	17.30
2 doses, DTaP, hepatitis A	30.84	32.82	46.97	57.73	12.74
3 doses, PCV7, MMR, varicella	31.92	47.63	191.82	205.21	29.10

Coleman, et al. 2009. Pediatrics; 124: S472-S491.

Administration Fee often does not cover costs to give vaccination

- Private pediatric medical practices break even or achieve small gains with privately insured patients
  - However, private insurance vaccine administration payments did not cover administration costs unless a child received 3 doses of vaccine in 1 visit
- Practices mostly lose money administering vaccines to VFC-eligible children
  - No administration fee if uninsured
  - Medicaid administration fee are very low
- When net returns for privately and publicly insured children are combined, the vaccination process becomes a business loss for most practices

Coleman, et al. 2009. Pediatrics; 124: S472-S491.

Vaccine Cost and Payment - Potential solutions

- Vaccine Purchase
  - Universal purchase by states or federal government
  - Set standards for payment
  - Broaden use of VFC vaccine for underinsured
  - Vaccine for Adults program
  - Work with manufacturers to achieve more favorable terms for payment for vaccines
  - Help providers negotiate better contracts
    - Through group purchasing?
  - Adequate incentives for pharmaceutical companies to get into the vaccine business

Vaccine Cost and Payment - Potential solutions

- Vaccine Administration
  - Good data on true vaccine administration costs
    - Ensure administration fees reflect these true costs
  - Achieve equity in Medicaid reimbursement

Vaccine Cost and Reimbursement Potential solutions

- Legislation to mandate adequate payment for vaccines.
- Legislation to make managed care organizations responsible for verifying eligibility
- Larger healthcare reform packages
  - Patient Protection and Affordable Care Act!

AAP/AMA Immunization Congress

- February/March 2007
- Stakeholders and interested parties/organizations
  - First gathering of pediatric, adolescent, and adult stakeholders to understand each other's issues and work to common solutions
- Discussed real and perceived problems in vaccine delivery
  - Financial issues
    - Public sector
    - Private sector
  - Medical home
  - Organization and administration
- Recommendations from Congress figured prominently into NVAC's Pediatric Vaccine Financing recommendations

The National Vaccine Advisory Committee (NVAC)

- Its purpose is to advise and make recommendations to the Director of the National Vaccine Program
- The NVAC recommends ways to achieve optimal prevention of human infectious diseases through vaccine development, and provides direction to achieve optimal prevention of adverse reactions to vaccines
- National Vaccine Program Office - Coordinates and integrates activities of all Federal agencies involved in immunization efforts

NVAC Pediatric Vaccine Financing White Paper

- Created by the NVAC Vaccine Finance Work Group
- Feedback obtained from multiple stakeholder groups
- Examined the cost to vaccinate children and adolescents, the earnings from doing so to determine if there was a successful business model
- What determines the costs associated with vaccines and their administration?

General Conclusions I

- The current system is experiencing challenges in delivering all vaccines (especially post 2000)
- Current success is due to public and private sector collaboration
  - Public sector alone is inadequate
  - Tie to medical home is beneficial
- Vaccines provide both individual and community protection

General Conclusions II

- Current system of financing does not assure access for all children without barriers
- All financing changes should anticipate additional vaccines added to the schedule
- Vaccine preventable diseases are not constrained by geographic boundaries

General Conclusions III

- Current financing system combines public and private efforts. Implementation of new vaccines must take this into account
- Medical provider payment must cover costs of vaccine purchase and administration
- A better understanding of costs associated with efficient vaccination services is needed
- Since problems are multi-factorial, likely solutions will be as well
- 24 sector-targeted recommendations made.
  - Pediatrics 2009; 124: S558-S562
  - http://pediatrics.aappublications.org/cgi/content/full/124/Supplement_5/S558

What about Adult Vaccination?!

AMA/AAP IZ Congress – Adult IZ, General Conclusions I

Provider-related Issues

- Vaccine-related costs are not fully accounted for in either vaccine reimbursement or administration fees
- Difficult to verify the eligibility of patients, leading to denied claims
- Providers are often left with unused inventory and even in the best of cases, incur high costs for inventory management.

AMA/AAP IZ Congress – Adult IZ, General Conclusions II

Federally-related Issues

- No specific vaccine financing programs for adults under age 65 exist.
  - Programs such as Section 317, which might provide some financing for vaccines, have not been sufficiently funded to supply vaccines to uninsured and underinsured adults in need.
- Part D benefit under the Medicare Modernization Act creates a complex system with unclear coverage that creates barriers to the use of new vaccines in this population.

AMA/AAP IZ Congress – Adult IZ, General Conclusions III

State-related Issues

- Medicaid administration fees vary from state to state and are inadequate in most states to cover the costs incurred by providers.

AMA/AAP IZ Congress – Adult IZ, General Conclusions IV

Insurance-related Issues

- Insurance companies' lack of knowledge about overhead and administrative costs of vaccine delivery for private providers.
- Providers lack of data regarding eligibility and coverage for their patients for adult vaccines
  - Coverage of permissive ACIP recommendations still require clarification
- Increasing numbers and costs of vaccines.

AMA/AAP IZ Congress – Adult IZ, General Conclusions V

Manufacturer-related Issues

- With adult vaccine, vaccine manufacturers are faced with the challenge of maintaining a private market *and* promoting the public good of vaccines.
  - R&D is costly and involves increasingly difficult clinical trials
  - Universal payment by one payer therefore can be perceived as challenging
- Companies face legislative, legal and liability challenges.
- Complex, evolving regulatory environment and varying regulatory requirements.

The NVAC Adult IZ Working Group

Mission

To develop recommendations for a comprehensive, sustainable, national adult immunization program that will lead to vaccine preventable disease reduction by improving adult immunization coverage levels.

First task: Financing of Adult Vaccines!

The NVAC Adult IZ Working Group - Work Plan

- Monthly conference calls
- Face-to-face meetings at NVAC
  - June 2, 2010 7 -9 PM next meeting
- Reference Materials
  - Healthy People 2010 and 2020 objectives
  - Summary of vaccine preventable diseases among adults
  - Adult IZ Coverage data
  - What is the CDC Plan for adult IZ?
  - Existing recommendations for improving adult IZ in US?
- Possible Stakeholder Meetings
  - Professional organizations, vaccine manufacturers, pharmacies
  - Advocacy groups, federal agencies, etc

The NVAC Adult IZ Working Group - Work Plan

- SDI financing survey currently underway
  - Inform missing data and provide future recommendations
  - Goal: Understand payment and reimbursement practices, particularly for private providers
  - Analysis will also include reimbursement and compensation rates for Medicare and Medicaid beneficiaries
- Assess whether a duplication of Gary Freed's survey of pediatric providers, but centered on adult providers, is necessary
  - Are similar data as Freed's are available for providers who see adult patients
  - If not, are additional surveys of adult providers are necessary?
- Follow up with CDC on its Adult IZ plans underway

Impact of the Patient Protection and Affordable Care Act (PPACA)

Some things to consider:

- PPACA sets out an intent through legislation.
  - HR 4872 Reconciliation Act reconciled House bill with Senate bill
  - Note that intent was to improve access, not to improve payment
    - While improving payment can improve access, that is not the primary motivation in PPACA
- HHS will be tasked to enforce that intent through regulation
- Advocacy needed with Secretary for HHS to clarify intent and ensure immunizations are covered benefits

Impact of the Patient Protection and Affordable Care Act (PPACA)

Title I, Sub C, Sec 1251, pp 99- 101

- This section reviews the rules with regard to keeping existing coverage and serves as the language for grandfathered plans
- Nothing in the Act shall mean that an individual should terminate their coverage
- Nothing in the Act shall apply to an individual already enrolled in an existing health plan on the date of enactment
  - This appears to grandfather out a considerable number of plans
  - Need a clearer definition of "grandfathered" plan

Impact of the Patient Protection and Affordable Care Act (PPACA)

Title I, Sub A, Sec 1001 (2713), pp 20-22

- Coverage of preventive health services in private health plans
  - Insurance companies must cover preventive services recommended by the USPSTF and ACIP
  - Health plans shall not impose any cost-sharing requirements
  - Newly recommended preventive health services must be added within a year of recommendation
  - Effective in 6 months except for grandfathered plans
    - When is a plan "new" and not eligible for grandfathering?

Impact of the Patient Protection and Affordable Care Act (PPACA)

Title I, Sub A, Sec 1001 (2714), pp 22-23

- Health plans that offer dependent coverage shall continue to make coverage available for an adult child until that child turns 26 years old as long as the child is not eligible on their own for employer-sponsored health plan
  - Effective date is 6 months from passage; **applies** to grandfathered plans through Reconciliation Act.
  - Offers an opportunity for coverage of/access to adult vaccines for persons 18-26

Impact of the Patient Protection and Affordable Care Act (PPACA)

Title I, Sub C, Sec 1201 (2707), pp 98- 99

- States with health plans that offer insurance coverage shall ensure that such coverage includes the "essential benefits package" (defined in Sec 1302 – next slide).
  - Need to ensure that the definition of this package includes immunizations
- The section also limits cost-sharing
- Effective date is 2014.

Impact of the Patient Protection and Affordable Care Act (PPACA)

Title I, Sub D, Sec 1302, pp 104-118

- The Secretary of HHS shall define a set of essential benefits with limited cost-sharing
- One category in the benefits is preventive and wellness services and chronic disease management
- The Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the typical benefits offered
- Requires the Secretary to periodically review the package and report updates to Congress
- Limits annual cost-sharing beginning in year 2014 with alterations in the calculation beginning in 2015
- Defines 4 levels of benefit packages – bronze, silver, gold and platinum

Impact of the Patient Protection and Affordable Care Act (PPACA)

Title I, Sub F, Sec 1501, pp 317-337

- Requires all Americans (with exceptions) to maintain minimum essential coverage
  - Needs clarification with HHS whether "minimum essential coverage" means first dollar coverage for immunizations and preventive services

Impact of the Patient Protection and Affordable Care Act (PPACA)

Title I, Sub F, Sec 1562, pp 389-390

- Applies the provisions of Title I, subtitle A, section 1001 (required first dollar coverage of all ACIP recommended vaccines) to group health plans and ERISA plans
  - Contradicts somewhat with language in Section 1251 that existing plans are grandfathered out
  - Need to emphasize to Secretary of HHS that intent of the bill was for Section 1001 to apply to all plans
  - Need to ensure permissive ACIP recommendations are also included

Impact of the Patient Protection and Affordable Care Act (PPACA)

Title II, Sub A, Sec 2001, pp 392-413 AND H.R. 4872 pp 61-64

- Expands Medicaid eligibility to include all non-elderly persons with incomes at or below 133% of the Federal Poverty Level (FPL); these persons are referred to as "newly eligible individuals."
- There is additional federal funding for "Expansion states" which is defined as a state that offers health benefits to parents and to non-pregnant, childless adults whose income is at least 100% of the FPL. To meet this definition a state has to offer benefits to both types of individuals not one or the other.
- States may phase-in extensions to eligibility however they cannot extend benefits to higher income eligibles before lower income ones
- Any benchmark package or coverage must provide at least essential health benefits as described in Section 1302, ie, preventive and wellness services (IZ not specifically mentioned)

Impact of the Patient Protection and Affordable Care Act (PPACA)

HR 4872 pp 64-67

- Increases payments for Medicaid primary care physicians to Medicare rates for years 2013 and 2014
- Primary care services are defined as those CPT codes for immunization.
- Represents an important opportunity to raise and equalize reimbursement rates for Medicaid physicians

Impact of the Patient Protection and Affordable Care Act (PPACA)

Title II, Sub I, Sec 2701, pp 516-520

- Secretary of HHS must develop and publish a core set of adult health quality measures.
- This section establishes the Medicaid Quality Measurement Program.
  - Within 1 year of release of the recommended core measures this program would begin to award grants for the development, testing and validation of innovative evidence-based measures.
- Creation of these quality measures may represent a unique opportunity to get adult immunizations included in State Medicaid plans

Impact of the Patient Protection and Affordable Care Act (PPACA)

Title IV, Sub C, Sec 4204, pp 1199-1206

- Under Section 317 of the PHSA, authorizes the Secretary to negotiate contracts for adult vaccines and allows States to purchase additional quantities of such vaccines off that contract.
- Reauthorizes the Section 317 grant funds.
- Requires that the GAO conduct a study and publish a report on Medicare beneficiary access to routinely recommended vaccines through Part D
  - Added in lieu of moving adult vaccines payment from Medicare Part D to Part B.

Impact of the Patient Protection and Affordable Care Act (PPACA)

- Continue to monitor implementation of the PPACA
  - Intent to increase access to preventive services such as immunizations
  - Advocate to ensure intent of PPACA is reflected in HHS regulations
- Advocate for continued inclusion of immunizations in preventive and wellness benefits, expressly stipulating so if deemed necessary
- Complete listing of PPACA potential impacts on immunizations can be obtained through L.J.
  - Litjen.tan@ama-assn.org

Questions?

- Extra slides

NVAC Vaccine Financing Recommendations I

- The Vaccines for Children (VFC) program should be extended to include access for VFC-eligible, underinsured children and adolescents receiving immunizations in public health department clinics
- The VFC program should be expanded to cover vaccine administration reimbursement for all VFC-eligible children and adolescents
- The CDC and CMS should annually update, publish, and disseminate actual Medicaid vaccine administration reimbursement rates according to state

NVAC Vaccine Financing Recommendations II

- CMS should update the maximal allowable Medicaid administration reimbursement amounts for each state and should include all appropriate non–vaccine-related costs
- The federal matching rate for vaccine administration reimbursement in Medicaid should be increased (ie, larger federal proportion) to levels for other services of public health importance
- The AMA's Relative Value Scale Update Committee should review its relative value unit coding to ensure that it reflects accurately the nonvaccine costs of vaccination, including the potential costs and savings with the use of combination vaccines

NVAC Vaccine Financing Recommendations III

- Vaccine manufacturers and third-party vaccine distributors should work with providers on an individual basis to reduce the financial burden for initial and ongoing vaccine inventories, particularly for new vaccines.
- Professional medical organizations should provide their members with technical assistance regarding efficient business practices associated with providing immunizations.
- Medical providers, particularly in smaller practices, should participate in pools of vaccine purchasers to obtain volume ordering discounts.

NVAC Vaccine Financing Recommendations IV

- The CDC, professional medical organizations, and other relevant stakeholders should develop and support additional employer health education efforts.
- Health insurers and all private health care purchasers should adopt contract benefit language that is flexible enough to permit coverage and reimbursement for new or recently altered ACIP recommendations as well as vaccine price changes that occur in the middle of a contract period.
- All public and private health insurance plans should voluntarily provide first-dollar coverage for all ACIP-recommended vaccines and their administration for children and adolescents.

NVAC Vaccine Financing Recommendations V

- Insurers and health care purchasers should develop reimbursement policies for vaccinations that are based on methodologically sound cost studies of efficient practices.
- Congress should request an annual report on the professional judgment of the CDC regarding the Section 317 program appropriation needed for vaccine purchase, administration, and for vaccination infrastructure, and ensure that Section 317 funding is provided at levels specified in the CDC annual report to Congress.
- CDC and CMS should continue to collect and to publish data on the costs and reimbursements associated with public- and private-sector vaccine administration according to NVAC standards for vaccinating children and adolescents.

NVAC Vaccine Financing Recommendations VI

- The National Vaccine Program Office should calculate the marginal increase in insurance premiums if insurance plans were to provide coverage for all vaccines routinely recommended by the ACIP.
- The NVAC should convene 1 expert panel representing all affected stakeholders, to consider whether tax credits could be a tool to reduce or to eliminate underinsurance.
- The CDC should substantially decrease the time from creation to official publication of ACIP recommendations.

NVAC Vaccine Financing Recommendations VII

- Congress should expand Section 317 funding to support the additional national, state, and local public health infrastructure needed for adolescent vaccination programs, as well as child vaccination programs for new recommendations such as universal influenza vaccination.
- Federal funding for cost/benefit studies of vaccinations targeted to children and adolescents should be continued.
- State, local, and federal governments and professional organizations should conduct outreach to providers who serve VFC-eligible children and adolescents, to encourage those providers to participate in the VFC program.

NVAC Vaccine Financing Recommendations VIII

- States and localities should develop mechanisms for billing insured children and adolescents served in the public sector.
- Adequate funding should be ensured to cover all costs (including those incurred by schools) arising from ensuring compliance with child and adolescent immunization requirements for school attendance.
- Shared public/private-sector approaches to help fund school-based and other complementary-venue child and adolescent immunization efforts should be promoted.

AMA and Congress Recommendations – Adult Vaccine Financing I

- Provider Related
  - Support IDSA's Working Principles on Adult Immunization
  - Develop rationale for increased fees
    - Gather data on actual cost of providing adult immunizations
  - Financial Relief
    - Vaccine company replacement systems/deferred payment/funding for physician inventories
    - Buyback for unused inventory – influenza?
    - Patient assistance programs plus admin fee

AMA and Congress Recommendations – Adult Vaccine Financing II

- Provider Related
  - Encourage adult immunization at all appropriate points of patient contact, eg, hospitals, visitors to LTC facilities, etc
  - Develop new CPT coding to encourage immunization counseling of adults
    - Facilitate vaccine counseling even by physicians who do not vaccinate but can refer.

AMA and Congress Recommendations – Adult Vaccine Financing III

- Federally Related
  - Increase federal resources for adult IZ
    - Fund and Use Section 317 to improve adult vaccines
      - Is an earmark necessary? Do not raid pediatrics? What about sustainability?
      - Per pediatric recs, section 317 funding should increase proportionate to each new adult vaccine
    - Provide universal coverage for adult vaccines
      - Vaccines for Uninsured Americans?
    - Fund an adequate universal reimbursement rate for all federal and state immunization programs

AMA and Congress Recommendations – Adult Vaccine Financing IV

- Federally Related
  - Optimize existing resources
    - Vaccinate eligible adolescent before 19 – VFC
    - Capitalize on existing bioterrorism funding?
  - States need to strengthen support for adult vaccination and appropriate budgets accordingly

AMA and Congress Recommendations – Adult Vaccine Financing V

- Federally Related
  - Ease federally-imposed immunization burdens
    - Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B
    - Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time, handle the claim
    - Simplify the reimbursement process to eliminate payment related barriers to immunization
  - Medicaid should raise and fund the maximum reimbursement rate for vaccine administration fees
    - Admin fees should be increased consistent with increasing cost of providing vaccines

AMA and Congress Recommendations – Adult Vaccine Financing VI

- Insurance Related
  - Create efficiencies in vaccine management
    - Provide model vaccine coverage contracts for purchasers of health insurance
    - Simplified rules for eligibility verification, billing, and reimbursement
    - Provide vouchers to patients to clarify eligibility and coverage for patients and providers
    - Cover all ACIP-recommended vaccines

AMA and Congress Recommendations – Adult Vaccine Financing VII

- Insurance Related
  - Increase resources for funding vaccines
    - Provide first-dollar coverage
  - Improve accountability
    - Performance measurements
  - Work with businesses who purchase private insurance to include all ACIP-recommended immunizations as part of the health plan

AMA and Congress Recommendations – Adult Vaccine Financing VIII

- Insurance Related
  - Provide incentives to encourage providers to begin immunizing
    - Start up costs – freezer, back up alarms/power supply, reminder-recall systems, etc.
    - Simplify payment to, and incentivize immunization by, non-traditional providers
    - Facilitate coverage of vaccines administered in complementary locations, eg, relatives visiting a LTC resident.

AMA and Congress Recommendations – Adult Vaccine Financing IX

- Manufacturer Related
  - Assure market stability
    - Solutions should not deter R & D of new vaccines
    - Maintain vibrant public and private sector markets?
    - Assure liability protection
      - VICP coverage for all ACIP recommended adult vaccines
    - Improve outreach to help counter resistance from providers