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Appendix 1: Children and Adolescents Vaccine Financing Recommendations Adopted by NVAC - September 2008 (with approved editorial changes March 2, 2009)

NVAC RECOMMENDATIONS

Recommendation #1. The Vaccines for Children program (VFC) should be extended to include access to VFC eligible underinsured children and adolescents receiving immunizations in public health department clinics and thus not be limited to access only at Federally Qualified Health Centers and Rural Health Clinics.
(NB: In 2004, NVAC also recommended that such an expansion be considered and did support VFC coverage for underinsured children and adolescents in all public health departments.)

Recommendation #2. VFC should be expanded to cover vaccine administration reimbursement for all VFC-eligible children and adolescents. (Currently the vaccine administration fee is not covered by VFC.) This should include children on Medicaid as this would provide for a single system and uniform vaccine administration fee. The vaccine administration reimbursement should be sufficient to cover the costs of vaccine administration (as referenced elsewhere in these recommendations).

NB: Recommendation #2 and Recommendations #3-#5 are designed to accomplish similar goals with respect to improving vaccine administration reimbursement in VFC. NVAC voted to approve both sets of recommendations understanding that the latter would not be needed if legislation were passed to cover administration fees for all VFC-eligible children through VFC, as in Recommendation #2 above.

Recommendation #3. The Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) should annually update, publish, and disseminate actual Medicaid vaccine administration reimbursement rates by state.

Recommendation #4. CMS should update the maximum allowable Medicaid administration reimbursement amounts for each state and include all appropriate non-vaccine related costs as determined by current studies. These efforts should be coordinated with the American Medical Association's (AMA) review of Relative Value Unit (RVU) coding (Recommendation #6).

Recommendation #5. Increase the federal match (i.e. a larger federal proportion) for vaccine administration reimbursement in Medicaid to levels for other services of public health importance (e.g. family planning services).

Recommendation #6. AMA's RVS Update Committee (RUC) should review its RVU coding to ensure that it accurately reflects the non-vaccine costs of vaccination including the potential costs and savings from the use of combination vaccines.

Recommendation #7. 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. This may include extending payment periods (e.g. from 60 days to 90 or over 120 days), or until vaccine has been administered and reimbursed. It may also include options not related to payment terms for vaccine inventory.

Recommendation #8. Professional medical organizations should provide their members with technical assistance on efficient business practices associated with providing immunizations, such as how to contract and bill appropriately. Medical organizations should identify best business practices to assure efficient and appropriate use of ACIP recommended vaccines and appropriate use of CPT codes, including Evaluation and Management (E&M) codes, when submitting claims for vaccines and vaccine administration. These organizations may receive federal assistance from CMS or other relevant agencies.

Recommendation #9. Medical providers, particularly in smaller practices, should participate in pools of vaccine purchasers to obtain volume ordering discounts. This may be done by individual providers joining or forming purchasing collaboratives, or through a regional vaccine purchasing contract held by professional medical organizations on behalf of providers.

Recommendation #10. CDC, professional medical organizations, and other relevant stakeholders should develop and support additional employer health education efforts. These efforts should communicate the value of good preventive care including recommended vaccinations.

Recommendation #11. Health insurers and all private healthcare 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.

Recommendation #12. All public and private health insurance plans should voluntarily provide first-dollar coverage (i.e., no deductibles or co-pays) for all ACIP-recommended vaccines and their administration for children and adolescents.

Recommendation #13. Insurers and healthcare purchasers should develop reimbursement policies for vaccinations that are based on methodologically sound cost studies of efficient practices. These cost studies should factor in all costs associated with vaccine administration (including, for example, purchase of the vaccine, handling, storage, labor, patient or parental education, and record keeping).

Recommendation #14. Congress should request an annual report on the CDC's professional judgment of the size and scope of the Section 317 program appropriation needed for vaccine purchase, vaccination infrastructure, and vaccine administration. Congress should ensure that Section 317 funding is provided at levels specified in CDC's annual report to

Congress.

Recommendation #15. CDC and CMS should continue to collect and publish data on the costs and reimbursements associated with public and private vaccine administration according to NVAC standards for vaccinating children and adolescents.94 These costs include costs associated with the delivery of vaccines, such as purchase of the vaccine, handling, storage, labor, patient or parental education, and record keeping. These published data should be updated every five years and also include information about reimbursement by provider type, geographic region, and insurance status. State governments should use this information in determining vaccine administration reimbursements rates in Medicaid.

Recommendation #16. NVPO should calculate the marginal increase in insurance premiums if insurance plans were to provide coverage for all routinely ACIP-recommended vaccines.

Recommendation #17. NVAC should convene one or more expert panels representing all impacted stakeholders to consider whether tax credits could be a tool to reduce or eliminate underinsurance. The panel would determine if policy options that would be acceptable to stakeholders could be developed to address the burden of financing for private sector child and adolescent vaccinations by using tax credits as incentives for insurers, employers, and/or employees (consumers), and whether these credits would provide added value to vaccination of children and adolescents.

Recommendation #18: CDC should substantially decrease the time from creation to official publication of ACIP recommendations in order to expedite coverage decisions by payers to cover new vaccines and new indications for vaccines currently available.

Recommendation #19: Congress should expand Section 317 funding to support the additional national, state and local public health infrastructure (e.g., widespread and effective education and promotion for healthcare providers, adolescents, and their parents; coordination of complementary and alternative venues for adolescent vaccinations; record keeping and immunization information systems; vaccine safety surveillance; disease surveillance) needed for adolescent vaccination programs as well as childhood vaccination programs for new recommendations such as universal influenza vaccination.

Recommendation #20: Continue federal funding for cost-benefit studies of vaccinations targeted for children and adolescents.

Recommendation #21. State, local and federal governments along with professional organizations should conduct outreach to physicians and non-physician providers who currently serve VFC-eligible children and adolescents to encourage these providers to participate in VFC if they currently do not. Outreach directed at providers serving adolescents who may not have provided vaccinations in the past (e.g. obstetrician-gynecologists) is a particular priority.

Recommendation #22. States and localities should develop mechanisms for billing insured children and adolescents served in the public sector. CDC should provide support to states and localities by disseminating best practices and providing technical assistance to develop these billing mechanisms. (This may require additional resources not currently in CDC's immunization program budget.) Further, NVAC urges states and localities to reinvest reimbursements from public and private payers back into immunization programs.

Recommendation #23: Ensure adequate funding to cover all costs (including those incurred by schools) arising from assuring compliance with child and adolescent immunization requirements for school attendance.

Recommendation #24: Promote shared public and private sector approaches to help fund school-based and other complementary-venue child and adolescent immunization efforts.