Examining Provider-Focused Vaccine Policy Reforms:

Considerations for Patient Access

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Introduction

Immunization is an important component of public health and preventive care; however, for adults, uptake of Advisory Committee on Immunization Practices (ACIP)-recommended vaccines is below national targets.[1] While federal law requires coverage without cost sharing for most insured adults, barriers to comprehensive adult vaccine access persist, as insurance coverage is just one of several components that support vaccine access.[2,3] Per Goal 4 of the US Department of Health and Human Services' Vaccines National Strategic Plan, stakeholders can support broad vaccine access by (1) increasing vaccine availability in a variety of settings and (2) reducing financial and systems barriers for providers and patients.[4] However, vaccinating providers continue to cite financial and other challenges impacting their ability to offer vaccines to patients, including ongoing concerns with payment rates across payer types and sites of care. Policymakers and stakeholder advocates are considering potential reforms that aim to alleviate these challenges with the goal of increasing adult vaccine uptake.

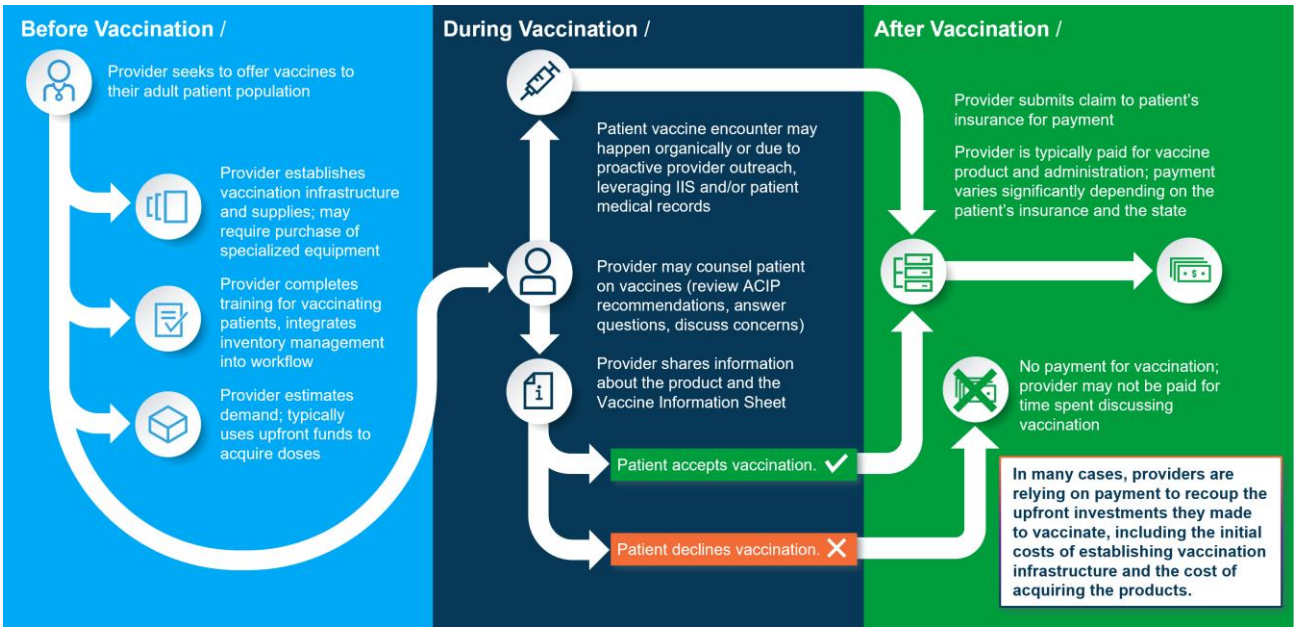
This white paper details providers' efforts to stock, administer, and receive payment for vaccines, and highlights considerations for patient access and potential future policy reform.

Background

To offer vaccinations, providers must take several steps to stock vaccines in addition to ongoing activities that occur as they integrate vaccination into their routine practice (Figure 1).

[1] Department of Health and Human Services. Healthy People 2030. Available here.
[2] Avalere Health. A Guide to Vaccine Coverage Policies. 2023. Available here.
[3] Health Affairs. The IRA Expanded Access To Adult Immunization, But There Are Opportunities To Do More. 2023. Available here.
[4] Department of Health and Human Services. Vaccines National Strategic Plan. 2021. Available here.

Figure 1. Example of a Provider Journey to Vaccinate an Adult Patient



ACIP: Advisory Committee on Immunization Practices; IIS: Immunization Information Systems

If a provider is new to vaccinating, they will first need to establish the necessary storage and handling infrastructure, including potentially acquiring or upgrading refrigeration and temperature monitoring equipment to maintain vaccine quality and potency per Centers for Disease Control and Prevention (CDC) guidance.[5] Staff may also participate in training modules or educational sessions to learn about proper storage and handling, and changes may be made to internal processes to build in staff time for ongoing inventory management.

Once the necessary equipment and staff training is established, providers will typically invest funds in acquiring doses. This upfront cost means providers must predict what vaccines and how many doses their patient population is likely to need. If they under-predict demand, they may need to refer some patients elsewhere for vaccination, creating an additional step in the process that could result in a missed vaccination opportunity. If they over-predict demand, they may be left with unused and expired doses, preventing the provider from recovering product cost.

Once doses are acquired, providers may begin vaccinating patients. They may vaccinate patients during visits for other services, or they may proactively contact patients that are due for vaccination, often relying on Immunization Information Systems (IIS) and medical records to identify these patients. During a patient encounter, providers may or may not spend time counseling a patient on the vaccine (including on associated risks and benefits) and addressing questions or concerns, particularly if the patient expresses hesitancy. If vaccination occurs, a provider is required to provide a Vaccine Information Statement to the patient.

[5] CDC. Vaccine Storage and Handling Toolkit. 2023. Available here.

Following the encounter, providers will typically submit a claim to the patient's insurance for reimbursement. In addition to the time required for claim submission, and the time between claim submission and receiving reimbursement, providers may be required to document the vaccine administration in medical records and IIS, reconcile practice dose inventory, and conduct additional patient follow-up (e.g., reminder recall, series completion, safety follow-ups). Ultimately, provider payment depends on the patient's insurance coverage, the vaccinating provider type (e.g., physician, pharmacist), and the care setting (e.g., physician office, retail pharmacy). Payment rates for the product and its administration may vary significantly from patient to patient. Additionally, if a provider spends time counseling a patient but the patient declines the vaccine, the provider might not be paid for counseling time.[6]

Overall, variation in provider payment rates may contribute to uncertainty about the provider's ability to recoup ongoing vaccination costs in a timely manner and may factor into decisions about whether to continue stocking and administering vaccines over the long-term.

Expanding Patient Vaccine Access Through Provider-Focused Reforms

Most insured populations have access to a coverage pathway for vaccines without cost-sharing; however, there are concerns about issues affecting patient access beyond insurance coverage. Vaccine stakeholders are increasingly turning toward addressing provider barriers. In the following sections, Avalere summarizes a selection of provider-focused policy reforms raised in recent years and outlines key considerations for their implementation.

Importantly, there are differences in the provider journey between medical and other providers such as pharmacists and vaccinators in federally qualified health centers (FQHCs) that result in unique payment challenges and patient vaccine access barriers.[7] While not explicitly discussed in this paper, stakeholders should account for unique dynamics within other settings and provider types when considering potential policy reforms.

Provider Payment for Vaccine Products & Administration

Provider vaccine product and administration payment rates are intended to account for the cost to acquire a vaccine product as well as the time and resources required to administer vaccines to patients. These rates vary by insurance market; in some markets, payment is established at a specific benchmark, while payment is left up to state discretion or negotiated between plans and providers in other markets (Table 1).

[6] MACPAC. Vaccine Access for Adults Enrolled in Medicaid. 2022. Available here.

[7] National Association of Community Health Centers. Strategies to Address Policy Barriers to Adult Immunizations in Federally Qualified Health Centers. 2019. Available here.

Table 1. Adult Vaccine Product and Administration Reimbursement by Market

Market/Program	Product	Administration
Medicare Part B	95% AWP	$30 ($40 for COVID-19) + MEI + GAF
Medicare Part D	Negotiated between plans and providers; rates are often based on WAC and are typically lower than those in Part B	
Medicaid FFS	Varies significantly by state; rates can be based on WAC or AWP or a percentage of Medicare amounts	Varies significantly by state, and some states do not reimburse separately for administration
Medicaid Managed Care	Negotiated between plans and providers; rates may be benchmarked to WAC or AWP, or to FFS rates	
Commercial	Negotiated between plans and providers; rates may be benchmarked to WAC or AWP and are often higher than Medicaid reimbursement rates	

AWP: Average Wholesale Price; FFS: Fee-for-Service; GAF: Geographic Adjustment Factor; MEI: Medicare Economic Index; WAC: Wholesale Acquisition Cost

Providers frequently cite Medicaid-specific payment challenges; for example, a provider administering an influenza vaccine to a Medicare beneficiary would be reimbursed at 95% of AWP for the product, whereas this same vaccine administered to a Medicaid enrollee would likely result in lower product reimbursement. In Medicaid FFS, rates vary by state and could be based on different metrics, described above.

Payment for administration services also varies by market and, like product payment, varies significantly in Medicaid. For example, Medicare providers are reimbursed approximately $30 for administration of influenza vaccination, while Medicaid FFS rates range from $3.72 to $25.62 for physician administration.[8] Further, some state Medicaid programs do not reimburse for administration services.

Research from the Medicaid and CHIP Payment and Access Commission (MACPAC) indicates that Medicaid reimbursement rates may be particularly inadequate to cover costs associated with vaccination.[9] Providers also report financial hurdles associated with purchasing and managing vaccine inventory that may not be accounted for in these rates.[10] Inadequate reimbursement could disincentivize providers from stocking and offering vaccines to patients, particularly for those with Medicaid coverage and other types of coverage.

Several provider reimbursement metrics have been proposed in the context of payment reform. One way to reduce variation across state Medicaid programs while ensuring payment that reflects provider costs is by benchmarking payment rates to transparent, verifiable data sources. Viable sources include the Medicare Average Sales Price/AWP file, which is used for Part B product reimbursement, and the CDC vaccine price list, which used for other adult vaccines.[11,12]

[8] Avalere Health. Medicaid Adult Vaccine Provider Reimbursement in 2021: Comparison Across 50 States and Washington, DC. 2023. Available here.
[9] Ibid (pg. 3)
[10] Health Affairs. Increased Reimbursement May Help Overcome Barriers To Administration Of Seasonal And Routine Vaccines. 2020. Available here.
[11] CMS. ASP Pricing Files. 2024. Available here.
[12] CDC. CDC Vaccine Price List. 2024. Available here.

These sources are publicly available and could provide a foundation for potential new payment metric decisions. While stakeholders acknowledge potential benefits and drawbacks associated with each metric, advocates note that product and administration payment should together account for the full range of provider costs. These costs are outlined in the American Academy of Pediatrics' Business Case for Pricing Vaccines and the Business Case for Pricing Immunization Administration.[13,14] While vaccine pricing may differ between pediatrics and adults, these resources can provide a foundation for adult reimbursement reform.

Stakeholders have also proposed solutions to ensure that these costs are fully covered to alleviate the risk of financial losses for providers. These proposals include implementing federal vaccine infrastructure funding, which could be modeled after state programs.[15] These grants could cover provider costs associated with stocking vaccines (e.g., purchasing appropriate refrigeration and monitoring equipment), similar to COVID-19 vaccination supplemental funding provided via the Coronavirus Response and Relief Supplemental Appropriations Act of 2021.[16]

Payment for Vaccine Counseling

Stakeholders argue that because vaccine administration often requires providers to spend time counseling patients, they should be paid for this time. However, current coding and reimbursement policies are not designed to support adult vaccine counseling.

Advocates often contrast the simplicity of pediatric reimbursement policy with the complexity of adult reimbursement. For example, when a provider administers a vaccine to a child and counsels their parent or guardian, the provider can use an administration code that compensates vaccine administration and time spent counseling (i.e., 90460-90461). A similar streamlined mechanism does not exist for adult providers; instead, providers must use multiple codes depending on the services performed during the patient visit.[17] This complexity is amplified for pharmacists, who are often unable to bill for medical visits, as well as for FQHCs, which are unable to separately bill for adult vaccine counseling due to their bundled payment methodology.

Compensation for time spent counseling is more complex when a vaccine is not administered (i.e., standalone counseling). For children, Medicaid providers can be reimbursed via the Early and Periodic Screening, Diagnosis, and Treatment benefit.[18] Conversely, Medicaid programs are not required to reimburse providers for adult standalone vaccine counseling. Outside of Medicaid, billing is available, but requires the use of time-based codes and can result in denied claims due to confusion interpreting complicated billing policy.[19]

Varied counseling reimbursement mechanisms, or lack thereof, contribute to provider payment disparities, potentially influencing provider stocking and administration decisions and reducing

[13] American Academy of Pediatrics. Business Case for Pricing Vaccines. 2012. Available here.
[14] American Academy of Pediatrics. Business Case for Pricing Immunization Administration. 2019. Available here.
[15] Great Plains Quality Innovation Network. Funding Available in North Dakota for Vaccine Storage and Handling Equipment. Available here.
[16] CDC. COVID-19 Vaccination Supplemental Funding. 2021. Available here.
[17] National Adult and Influenza Immunization Summit. Adult Current Procedural Terminology Coding Case Scenarios. Available here.
[18] CMS. Biden-Harris Administration Makes 100% Federal Medicaid Matching Funds Available for State Expenditures on Certain COVID-19 Vaccine Counseling Visits for Children and Youth. 2021. Available here.
[19] Ibid (pg. 5)

adult vaccine access. In recognition of this dynamic, the Vaccines National Strategic Plan notes supporting adequate payments for vaccine counseling as a strategy to reduce provider vaccine delivery barriers.[20] Policymakers may further consider how the details of counseling payment reform could support access.

Access Across Care Settings and Provider Types

Payment reforms aim to support increased vaccine access across different care settings and provider types, including both physician offices and pharmacies. Beyond payment rates, certain policies dictating which provider types may administer vaccines and in what types of settings may affect access, particularly for low-income adults.[21]

- **Access in Pharmacies and Other Care Settings**: The majority (90%) of the US population lives within five miles of a community pharmacy; however, access to vaccines in these settings can be restricted by pharmacy benefit coverage parameters.[22] For example, some state Medicaid programs cover vaccines exclusively under the medical benefit, which requires Medicaid enrollees to get vaccinated in physician offices to avoid obtaining prior authorization or paying out-of-pocket costs. Further, some payers may reimburse pharmacists at lower rates than medical providers for vaccine administration and some state Medicaid programs, for example, do not allow pharmacist reimbursement.[23] In response to these challenges, MACPAC recommended that the Centers for Medicare and Medicaid Services (CMS) issue guidance "encouraging the broad use of Medicaid providers in administering adult vaccinations," citing successful implementation of Public Readiness and Emergency Preparedness Act amendments authorizing vaccination across multiple settings.[24,25]
- **Network Flexibility**: Most payers establish provider and facility networks that dictate where plan members can receive care, including vaccination. Individuals that seek vaccination in an out-of-network setting may be required to obtain prior authorization or pay out-of-pocket costs. Some stakeholders argue that prior authorization creates administrative barriers to access, as well as care delays and negative health outcomes, on top of cost barriers resulting from out-of-pocket payment for vaccination.[26] In response to these challenges, stakeholders have proposed "No Wrong Door" policies to support vaccine availability in patients' preferred care settings.[27]

[20] Ibid (pg. 1)
[21] Health Affairs. Enhancing Access to Routine Vaccines for Adults in Medicaid. 2023. Available here.
[22] Journal of the American Pharmacists Association. Access to community pharmacies: A nationwide geographic information systems cross-sectional analysis. 2022. Available here.
[23] Vaccine. Medicaid provider reimbursement policy for adult immunizations. 2015. Available here.
[24] MACPAC. Acting to Improve Vaccine Access for Adults Enrolled in Medicaid. 2022. Available here.
[25] ASPR. Public Readiness and Emergency Preparedness (PREP) Act. 2023. Available here.
[26] AMA. 2022. AMA Prior Authorization Physician Survey. 2022. Available here.
[27] CapView Strategies. Optimizing Adult Immunizations in the US – Building on Recent Coverage Expansions. 2023. Available here.

Looking Ahead

Providers must take several steps, investing time and resources, to stock vaccines and support patient access. The payment challenges discussed above may influence provider decisions to start or continue vaccinating as part of their routine practice. In response to stakeholder concerns, CMS has taken several regulatory actions, including undertaking a multi-year process to develop and implement the current Medicare Part B product and administration payment rates.[28]

More recently, CMS acknowledged payment barriers in its toolkit clarifying existing requirements, discussing novel payment approaches for state Medicaid programs, and encouraging states to "review their payment policies for vaccine and vaccine administration payment to determine if rates are sufficient and if they are accurately reflected in the Medicaid state plan, provider materials, and published fee schedules."[29]

To address provider barriers and promote adult vaccine uptake, stakeholders have contemplated several potential policy reforms of product and administration payment rates. Further, payment reform may become increasingly relevant as new vaccine delivery methods are introduced, including adult combination vaccines. To advance these and other reforms, including those addressing FQHCs' unique vaccine payment barriers, stakeholders may need to coordinate alignment with partner advocates and generate additional evidence to garner policymaker support.

[28] Avalere Health. Vaccine Incentives for Providers Would Change Due to 2 MPFS Proposals. 2022. Available here.

[29] CMS. Coverage and Payment of Vaccines and Vaccine Administration under Medicaid, the Children's Health Insurance Program, and Basic Healthcare Program. 2024. Available here.

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