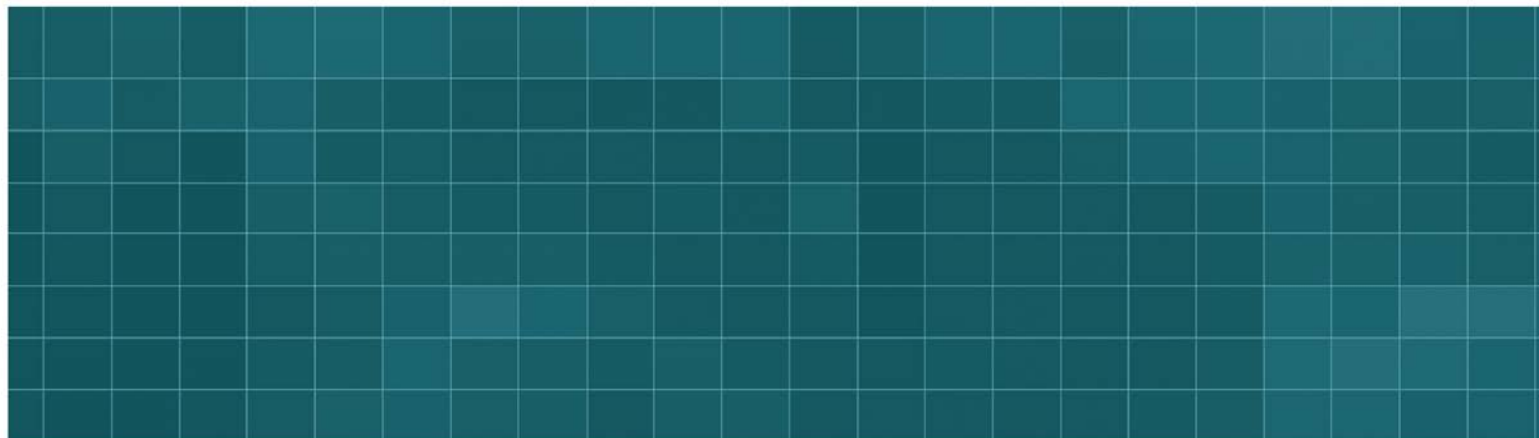


Increase in Vaccine Administration Rates

Summary of State Stakeholder Meetings



Introduction

Life-saving vaccines have had a significant impact on the health and well-being of the entire nation. Today, children, adolescents, and adults can receive immunizations to protect against 17 infectious diseases once common in the United States.

Achieving and maintaining high vaccination rates remain a public health priority; however, an increasing number of vaccine administration barriers experienced by healthcare providers have proved to be a significant obstacle. Cold chain management, coordinating appropriate vaccine supply, and keeping track of confusing new and alternative immunization schedules can be challenging. Furthermore, administering vaccination programs by healthcare providers can be a costly endeavor. In some instances, due to uncertain demand for vaccine, providers may have to throw out overstocked expired vaccine and sustain a financial loss, or risk an upfront investment to purchase vaccines without certainty of adequate reimbursement. Providers also acknowledge that counseling vaccine hesitant adult patients can take a significant amount of time, but is not sufficiently reimbursed. Additionally, in many states, Medicaid agencies reimburse healthcare providers at an exceedingly low rate, causing doctors to lose money when vaccinating their patients. Collectively, these barriers may cause some providers to abstain from supplying vaccines in their office.



In order to address the noted financial barriers, a two-year provision contained in the Affordable Care Act (ACA) permits the use of federal funds to cover the discrepancy between the state Medicaid reimbursement rate for the administration of vaccine and the Medicare rate. The impact of this provision could reduce financial loss among vaccine providers and potentially improve vaccination coverage rates. The Association of State and Territorial Health Officials (ASTHO), in collaboration with the U.S. Department of Health and Human Services' National Vaccine Program Office (NVPO), held a series of information gathering sessions with state stakeholders to gain important baseline information on state perspectives and vision for impact of this provision.

Overview of the ACA Provision

On November 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to implement a provision that permits certain physicians that provide eligible primary care services to be paid at the Medicare rate during calendar years 2013 and 2014 instead of their usual state-established Medicaid rate. This would result in a payment increase that applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, pediatric medicine, or related subspecialists who are either board certified in those specialties or provide primary care within their overall scope of those categories. In addition, practitioners (e.g., nurse practitioners) who provide primary care services while working under the personal supervision of a qualifying physician are eligible for the payment increase.

During this time, states will receive one hundred percent federal financial participation for the difference between the Medicaid State plan payment amount as of July 1, 2009 and the applicable Medicare rate.

The final rule also updates the regional maximum fees that providers may charge for the administration of pediatric vaccines for eligible children in the federal Vaccine for Children (VFC) program. While states maintain the flexibility to set the reimbursement rate for the VFC program, qualifying primary care providers are required to be paid at the lesser of the Medicare rate or the updated state regional maximum administration fee for vaccine administration for 2013 and 2014. The rule provides information regarding identification of eligible providers and services, and how to meet the statutory requirements when making payments for services provided through managed care. [Read the final rule](http://www.gpo.gov/fdsys/pkg/FR-2012-11-06/pdf/2012-26507.pdf) (available at www.gpo.gov/fdsys/pkg/FR-2012-11-06/pdf/2012-26507.pdf).

Making the Case for a Higher Reimbursement Rate: State Stakeholder Meetings

ASTHO conducted four state stakeholder meetings in the spring of 2012 to learn from the states about existing barriers for immunization, knowledge of the new provision, how it might impact access in the state, and whether there were ways to measure the impact. The meetings were held in Massachusetts, Washington, Utah, and Mississippi.

During state meetings, stakeholders consistently identified low reimbursement rates as one of the many barriers providers confront when administering vaccine to their patients. Meeting participants suggested this provision has the potential to impact the number of healthcare providers offering vaccine, especially among practitioners who primarily work with adult patients. A survey conducted by the Massachusetts Academy of Family Physicians further illustrates this point. The results indicate an increase in payment for the administration of vaccine would likely or very likely increase the number of providers administering vaccine to the adult population at a rate of 61.1 percent as compared to 32.5 percent for the pediatric population. Stakeholders thought this outcome was in large part due to the current high immunization coverage rates among the pediatric cohort, and therefore suspected this provision may have a greater impact on the adult population than in the pediatric population.



Implementation of the Provision

While the concept of this provision is on target in terms of addressing financial barriers, many challenges were identified during state interviews in connection with implementation of this provision.

The overarching challenge for states is the volume of changes that are required in a short time frame. This provision will be one in a long line of modifications implemented by state Medicaid systems in the upcoming year. During stakeholder meetings, participants suggested states consider the following specific issues when operationalizing this provision:

- ***Implement the new fee schedule and primary care payment methodologies***

Clearly, Medicaid is a complex system, and the intricacies of this particular provision are multifaceted. There are many factors to consider when operationalizing this provision, including coding, claims processing, programming rules, and adding modifiers. In some states, the reimbursement process was originally set up to compensate by administration code, not by provider type; therefore, the new provision may create challenges when attempting to implement reimbursement for a specific provider type (e.g., family practice, internal medicine, or pediatric providers), as state Medicaid programs must first ascertain the type to provider to receive payment and then work to separate the reimbursement rate for those who qualify and those who do not.



- ***Advertise the provision to expand and maintain the provider network***

Communication tools could help explain the criteria, timing, and applicability of the increased reimbursement rates, and encourage new practitioners to enroll as Medicaid providers. Stakeholders stated they could easily communicate to providers utilizing e-mail listservers, online bulletins, or newsletters through the Board of Medicine, statewide medical societies, or professional organizations. Useful advertisements could demonstrate the cost benefits of this provision and suggest ideas for how to utilize the additional revenue (e.g., providers could use the funds to upgrade necessary refrigeration storage of the vaccines,, purchase 2D bar coders for inventory management and recordkeeping, or improve information technology.

- ***Linking enhanced reimbursement to improved access and quality standards***

Stakeholders suggested actively measuring the effects of the provision. For example, states could develop a survey to query new vaccine providers to determine if this provision removed financial vaccine administration barriers, or states could compare the number of baseline vaccine providers with the number of post-provision implementation providers. It is important to keep in mind there are limitations with type of information because it is difficult to directly link an increase in administration rates to this provision.

Potential Methods to Measure Changes in Access to Vaccination Services

Method	Description	Considerations
A targeted Campaign	Make a concerted effort to focus on a specific, visible, and targeted campaign to advertise this provision.	The provision is intended to cover a two-year period; however, stakeholders question the future of this initiative once the provision is no longer in effect. Stakeholders expressed some hesitation in promoting a provision that may be discontinued in two years.
	<p>1. <i>A focus on the adolescent and adult population</i></p> <p>Stakeholders expressed that they already have high pediatric vaccination rates so the greatest opportunity to demonstrate a significant change will be among adult providers.</p>	This provision could improve the coverage rates for adults. Stakeholders did suggest increased messaging strategies surrounding adult booster vaccination as one method to increase rates in the adult population. They also pointed out that while this provision has the potential to affect adults, there are far fewer adults than children utilizing the Medicaid system.
2. <i>Focus on a Specific Vaccination</i>	A specific measurable focus on one adult vaccine, such as Tdap, Zoster, or HPV could be highly effective.	Providers mentioned a focus on Tdap to promote cocooning strategies ¹ would be beneficial, but there are challenges with this method; Tdap is poorly covered by Medicare part D, HPV vaccine is not covered by all insurance companies, and there are some supply issues with the Zoster vaccine.
Claims Data	Pull both pre and post provision CMS claims data.	This method could be used to measure how many adult providers enrolled during the campaign period.
Potential Federal Opportunities	Work with CMMI to utilize demonstration funds to evaluate the impact of this provision on adult vaccination.	This type of evaluation measure could be performed in a homeless shelter or family planning vaccination clinic to measure HPV vaccination rates.
Using Immunization Information Systems(IIS)	Some states have an extensive and widely used immunization information system (IIS), which could be utilized to evaluate the impact of this provision.	Stakeholders suggested holding providers accountable for imputing data into the IIS as a function of this provision.
Using Case Stories	Stakeholders suggested using case stories to demonstrate the impact of this provision.	Stories could feature vaccine providers who previously did not offer vaccine because of the administrative costs or a patient that received services as a direct result of this provision.

¹ The Advisory Committee on Immunization Practices has recommended tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) booster vaccines to unvaccinated postpartum mothers and other family members of newborn infants to protect infants from pertussis, a strategy referred to as cocooning.

Measure by Provider Type	Measure increased access by provider type, those who do and do not qualify for this provision.	A comparison between obstetric/gynecology providers and general internist vaccination rates could provide some insight into the effects of this provision; however, stakeholders did recognize this might not adequately reflect the results of this provision.
Survey	Stakeholders thought a provider satisfaction survey could help determine if the increased reimbursement helped to improve coverage.	Stakeholders thought they could gain information on pre and post data on family practice and internal medicine doctors to see if this provision made an impact.
Collaborative Measures	Select a sample number of states to perform a similar targeted approach. Compare pre and post implementation data.	The risk would be that this strategy could take energy away from other efforts.
VFC Providers	Measure an increase in the number of VFC providers.	Since the number of VFC providers is already high, this would be very limiting.
Prospective Studies	Stakeholders thought there could be the potential to develop a study where they can follow a provider group or age group over time to determine how this provision affects vaccination rates.	This could be difficult given the two-year timeframe of this provision.

Conclusion

It has been stated over the years that the lack of adequate reimbursement for the administration of vaccines is a barrier to access. This new ACA provision to increase the administration rate for a two-year period provides an opportunity to test the reimbursement barrier. However, as outlined above from the state information, the devil is in the details. While the intention of this provision is right on the mark, the specifics of the rule may hinder the ability to accurately test its impact.

It is clear from the state stakeholders that were interviewed that the measurement of this provision will not be cut and dried. There is no easy way to demonstrate a direct correlation between the two-year increase and a change in immunization rates due to many of the challenges listed above—such as short implementation time, the two-year time limit, and confusion about which providers are eligible—as well as a dynamic healthcare delivery system that is undergoing a variety of changes simultaneously.

However, this is the best opportunity available to gather some information about the impact of an increased reimbursement rate. It may be too difficult to demonstrate a direct link to rates, but there may be good opportunities to measure the increased quality of service provided, upgrades in cold-chain storage, increased training of staff, or increased time to discuss the benefits of vaccines with patients. It may also be possible to test the willingness of new providers to participate in immunizations through interviews or surveys.

While this provision may not be the definitive solution to a long-identified barrier, it should provide an opportunity to evaluate some improvements in the delivery of immunizations.

ASTHO would like to thank the states that participated in these interviews (Massachusetts, Washington, Utah, and Mississippi) to provide suggestions for all states for communicating about the provision, considerations for implementation, and potential ways to measure its impact.

Example Provider Newsletter

[Pick the date]

FROM

COMPANY

[Type the sender company address]

[Type the recipient name]

[Type the recipient address]

Dear Provider:

A two-year provision by the Affordable Care Act (ACA) permits the use of federal funds to cover the discrepancy between the state Medicaid and Medicare reimbursement rate for certain primary care services. Under this provision, primary care physicians serving Medicaid recipients would see their Medicaid payments rise to Medicare levels in calendar years 2013 and 2014. This rate increase applies to Evaluation and Management (E/M) procedure codes and immunization administration services provided by physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine. In addition, qualified services rendered by practitioners working under the supervision of an eligible physician and billing under that physician's Medicaid provider number will also meet the criteria for the rate increase.

The impact of this provision could potentially reduce financial loss among primary care providers and improve access to care for the nation's most vulnerable populations. This increase in reimbursement could help practices invest in essential infrastructure to sustain critical prevention services. For example, providers could advance immunization information systems, 2D bar-coders, or update refrigerators to maintain or improve immunization services.

Medicaid is a vital service and we appreciate your continued participation in this program. We hope the higher reimbursement rates may encourage an even greater provider interest in the Medicaid program. Thank you for meeting the needs of Medicaid recipients in your practice and for encouraging your colleagues to serve this population.

Sincerely,

FROM

[Type the sender title]

COMPANY



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