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JANICE K. BREWER, GOVERNOR
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December 15, 2014

Re: Vaccine Financing and Availability Advisory Committee

On behalf of the Arizona Department of Health Services and the volunteers who comprised the Vaccine Financing and Availability Advisory Committee, I am pleased to present the Committee's Report of Findings and Recommendations as directed by the passage of House Bill 2491 in 2014. The report was passed by a 9-0 vote with 1 member (representing vaccine manufacturers) abstaining and 2 members (representing an Arizona company and nurse practitioners) not present for the vote.

Members of this multi-disciplinary Committee actively collaborated over the past five months to provide you with the most comprehensive information available regarding vaccine financing and availability in Arizona. Record of the Committee's work is available through the Committee's website, <http://azdhs.gov/phs/immunization/financing-advisory-committee.php>.

I would like to extend my thanks to the Committee for their diligence in completing this task and their interest in this critical public health issue. Arizona is fortunate to have relationships between, and the cooperation of, a diverse array of professionals that makes this type of collaborative effort possible.

Sincerely,

A handwritten signature in black ink, appearing to read "W. Humble". The signature is written in a cursive, flowing style.

Will Humble, MPH, Director
Arizona Department of Health Services

WH:JR:jr

Arizona Department of Health Services

Vaccine Financing and Availability Advisory Committee Report of Findings and Recommendations



December 2014

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Executive Summary

Vaccines are one of the most effective public health interventions and have led to near elimination of a staggering number of infectious diseases in the United States over the course of the last century. Unfortunately, challenges with vaccine cost, payment, and financing systems have resulted in a decrease in the number of healthcare providers offering vaccines. This reduction in vaccine availability in the private setting has two immediate consequences: an increase in the number of patients obtaining vaccines at county public health departments, which are required to provide school entry-required vaccines to children; and an increase in the number of patients not receiving indicated vaccines in a timely manner or at all. Over the long term, if the underlying issues of vaccine financing persist, additional state and local tax dollars will need to be directed to county public health departments to sustain required vaccination activities or immunity will wane in Arizona communities and we could be faced with resurgence of vaccine-preventable diseases.

Major issues impacting vaccine delivery in Arizona can be summarized as follows:

- Elimination of \$10 million of State funding for immunizations in 2008/2009
- Subsequently, Centers for Disease Control and Prevention (CDC) prohibition against statewide deputization of private providers to use Vaccines for Children (VFC) vaccine for underinsured children
- Reduction of the Federal immunization grant (Section 317) by more than 50%
- Costs to purchase and maintain vaccines rising to be a top overhead expense for a pediatric practice
- Increased complexity for private providers to participate in the VFC program (e.g., increased record keeping and equipment requirements)
- Reinforcement of the prohibition against using 317 funds for privately insured children in public health clinics
- Wide variation in contracted payment rates provided to immunizers (from 22% below to 35% above cost)
- Increasing cost of vaccine without time for increased costs to be reflected in and paid out by health plan systems

A significant amount of work has occurred over the past several years to identify and remedy challenges surrounding vaccine financing and availability, but more remains to be done. The recent passage of House Bill 2491 established a Vaccine Financing and Availability Advisory Committee to study the issues and make recommendations. After five months of study and discussion, the Committee presents the following recommendations targeted toward vaccine manufacturers, insurers, and other vaccine stakeholders who all have a role in solving the vaccine financing and delivery challenges. The recommendations pertain to all vaccines recommended by the CDC's Advisory Committee on Immunization Practices (ACIP).

Cost

- Payers should use the CDC Private Sector Cost list as the standard to estimate vaccine cost
- To reduce the negative financial impact on vaccine providers, vaccine manufacturers are encouraged to provide a 90 day "grace" period for vaccine price changes by providing payers prior notice of price changes and allowing providers to purchase the vaccines at the previous price:
 - Vaccine manufacturers are encouraged to notify payers at least 60 days prior to the beginning of a quarter that the vaccine price will change in order to give them time to adjust their systems to pay providers based on the new price.

- Vaccine manufacturers are encouraged to allow providers a longer window to purchase vaccines at the old price to allow time for payers to adjust their systems. Providers should be allowed a minimum of 30 days from the time payers are notified of price changes to purchase vaccines at the old price.

Purchasing

- The Arizona Partnership for Immunization (TAPI) and the Arizona Academy of Pediatrics (AzAAP) should create a list of buying groups using the national contacts for manufacturer contracting
- TAPI should provide training and education about available purchasing options to multiple provider types (e.g., internal medicine, family physicians, pediatricians, OB/Gyn), especially to providers who do not currently provide vaccines
- TAPI should explore volume buying discounts through a purchasing group with county public health departments

Payment

- All payers are encouraged to use the CDC Private Sector Cost list as the reference for provider payment
- All payers are encouraged to pay the same amount for vaccines regardless of practice size or provider type, due to the community benefit from vaccines
- For commercial vaccine, payers are encouraged to pay, at a minimum, 123% of CDC Private Sector Cost to providers in addition to the administration payment. Medicare-based Relative Values should be used as a reference level for minimum recommended administration payment.
- A minimum administration fee should be developed for public plans, congruent with Medicare-based Relative Values. Committee members recognize that an increase in administration fees would increase cost to the state General Fund for patients insured by AHCCCS.
- Payers should encourage all employers to provide plans that pay adequately for all required and recommended vaccines.
- Employers should be encouraged to review immunization benefits in their plans based on community benefit. This should include review of self-insured plans in other states with members in Arizona.
- TAPI should produce an educational tool for employers to identify the value, cost, and trend of physician provision of vaccines, with proposed solutions to declining physician provision of vaccines.

Availability/Access

- All childhood vaccines given in Arizona must be entered into the Arizona State Immunization Information System (ASIIS). Vaccine providers should use the ASIIS system to verify patients' immunization status to prevent the need for them to return for vaccinations and reduce the chance of duplicate vaccination.
- Public and private plans should emphasize the importance of a medical home that focuses on the whole child while ensuring a focus on efforts to capture information on immunizations that are provided through alternative sources.
- If a vaccine is given outside of the medical home, the vaccine must be entered into ASIIS, a copy of the visit sent to the primary care physician when possible or required, and the parent/child referred back to their medical home. If the child has no medical home, the parent should be given names of providers in their community or referred to their health plan, if insured, for a list of providers in their network.

This Committee advises against pursuing these recommendations in a legislative or regulatory manner but expects ongoing stakeholder actions on each of the above categories.

1.0 Statutory Authority and Committee Activity

1.1 Statutory Authority for the Committee

House Bill 2491 amended Section 36-694 of the Arizona Revised Statutes, which directed the Arizona Department of Health Services (ADHS) to establish a Vaccine Financing and Availability Advisory Committee (Committee) to study the financing and availability of vaccines for newborns, children, and adolescents. The Committee was charged with developing recommendations regarding the following on or before December 15th, 2014:

1. The existing system of the financing, storage, distribution and availability of newborn, childhood and adolescent vaccine products and the potential impacts on the healthcare system, taxpayers and the community at large.
2. The costs associated with, and the adequacy of reimbursement levels for, newborn, childhood, and adolescent vaccines administered by private and public providers in all counties in this state.
3. The vaccine financing, storage, distribution and reimbursement models utilized in other states.

In accordance with the law, the Committee was comprised of the following members (named list is available in Appendix 1), appointed and chaired by the ADHS Director:

1. Two members who are representatives of different healthcare insurers that are licensed pursuant to title 20, Arizona Revised Statutes, and that offer products in the commercial market that include coverage for newborn, childhood, and adolescent vaccines
2. Three health professionals who are licensed pursuant to title 32, Arizona Revised Statutes, whose current practice includes administering newborn, childhood, or adolescent vaccines as follows:
 - a. A physician who is licensed pursuant to title 32, chapter 13 or 17, Arizona Revised Statutes and who specializes in pediatrics
 - b. A physician who is licensed pursuant to title 32, chapter 13 or 17, Arizona Revised Statutes and who specializes in family medicine
 - c. A nurse practitioner who is licensed pursuant to title 32, chapter 15, Arizona Revised Statutes
3. Two directors of local health departments, one of whom shall be from a county having a population of at least three million persons
4. One member who is a representative of an Arizona nonprofit statewide coalition whose mission is to foster a comprehensive, sustained community program for the immunization of residents of this state against vaccine-preventable diseases
5. One member who is a representative of a vaccine manufacturer or a national association of vaccine manufacturers and who has experience in vaccine policy
6. One member who is a representative of a statewide association of pharmacists
7. One members who is a representative of an Arizona company that is not a health care insurer or a self-insured employer and that offers its employees a health insurance product in the commercial market that includes coverage for newborn, childhood and adolescent vaccines

In addition, the directors of the Arizona Health Care Cost Containment System (AHCCCS) and the Department of Insurance, or their designees shall serve as non-voting members of the Committee.

1.2 Record of Business

The Committee prepared agendas and kept minutes for each meeting in accordance with Arizona's Open Meeting Law (A.R.S Title 38, Chapter 3, Article 3.1). The Committee created a website (Appendix 2; <http://azdhs.gov/phs/immunization/financing-advisory-committee.php>) to serve as a repository for all information reviewed, presented and discussed. Agendas and minutes are included on the Committee website. The initial meeting took place on August 1, 2014. Subsequent meetings were held monthly on Fridays for two hours, with intermittent meetings scheduled as necessary.

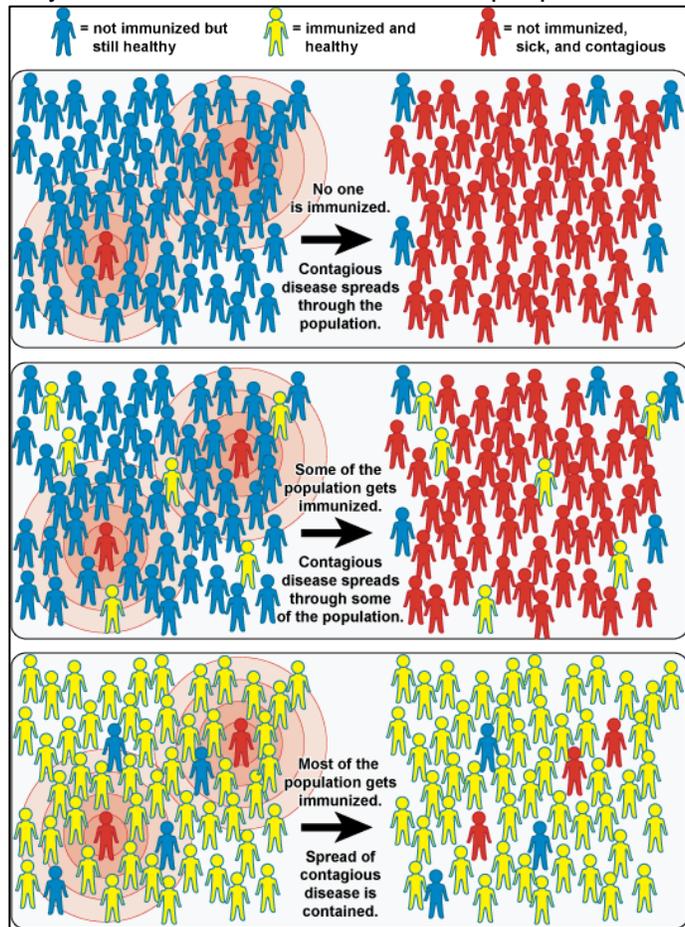
1.3 Committee Activity

The Committee held meetings where individual Committee members researched and reported on various aspects under study, including the existing system of vaccine financing, storage and distribution; the costs associated with and adequacy of reimbursement of vaccine administration by public and private providers; and the vaccine financing, storage, distribution, and reimbursement models utilized in other states. These findings are reported in detail in subsequent sections of this report. Materials presented to the Committee regarding each of these topic areas are available on the Committee website (<http://azdhs.gov/phs/immunization/financing-advisory-committee.php>).

2.0 Background

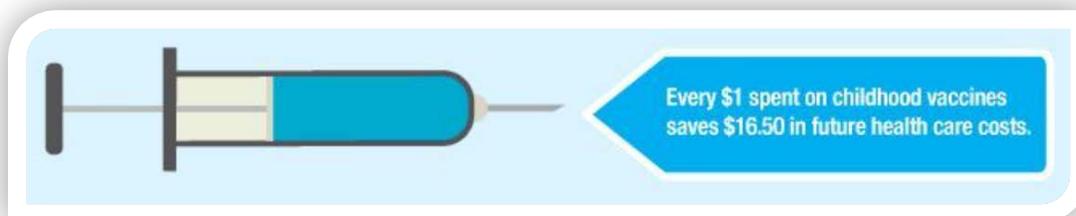
Vaccines are the most successful preventive health care service, decreasing healthcare provider office visits, hospitalizations, and days of work/school missed; preventing development of acute and chronic conditions; and reducing morbidity and mortality. Vaccines provide a community benefit by establishing “herd immunity” – the increase in the number of people who are vaccinated against a disease reduces the chance of that disease spreading from person to person. In 1900, 53% of people died from infectious disease. Since the introduction of vaccines, today, only 3% of Americans die from infectious diseases.

Vaccines offer individual protection, but optimal protection occurs when the entire community is vaccinated. When an entire community is protected, diseases cannot take hold and an individual’s immune response and vaccine efficacy are never put to the test. When vaccination coverage levels dip below 90%, diseases are more likely to cause outbreaks in a community, costing the health care and public health systems far more in office visits, hospitalizations, missed work/school, outbreak control and response, and treatment. For example, a healthcare-associated measles outbreak in Arizona in 2008 led to 14 confirmed cases of disease, and accounted for nearly \$800,000 in staff time and furloughs to the hospitals involved¹, and over \$1,000,000 expended in public health resources (Appendix 3).



For the 13 diseases included on the current childhood immunization schedule, the healthcare system realizes:

- \$13.6 billion savings in direct medical costs
- 42,000 saved lives
- 20 million diseases prevented



¹ Chen SY, Anderson S, Kutty PK, et al., Healthcare-Associated Measles Outbreak in the United States after an Importation: Challenges and Economic Impact. J. Infectious Diseases 2011; 203:1517-25.

When a community is effectively immunized, herd immunity results. In addition, significant health care cost savings are realized, and prevention of illness and death occurs. The cost effectiveness of vaccines has led the federal government to put into place systems to recommend, finance, distribute and promote the use of vaccines. State and local jurisdictions require vaccines for school and childcare entry to protect the students, the health care system and tax dollars.

Most public and private health organizations follow the recommendations of the Advisory Committee on Immunization Practices (ACIP), a group of medical and public health experts from groups like the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the Centers for Disease Control and Prevention (CDC). This group carefully reviews all available data about vaccines from clinical trials and other studies to develop recommendations for use based on:

- How well the vaccine works and how safe the vaccine is for specific ages
- How serious the disease the vaccine prevents
- How many children would get the disease without the vaccine
- The financial impact of disease treatment and control

Douglas Campos-Outcalt, M.D. of Arizona represents Family Physicians on the ACIP and meets regularly with Arizona health leadership to share insight and obtain feedback regarding vaccine use.

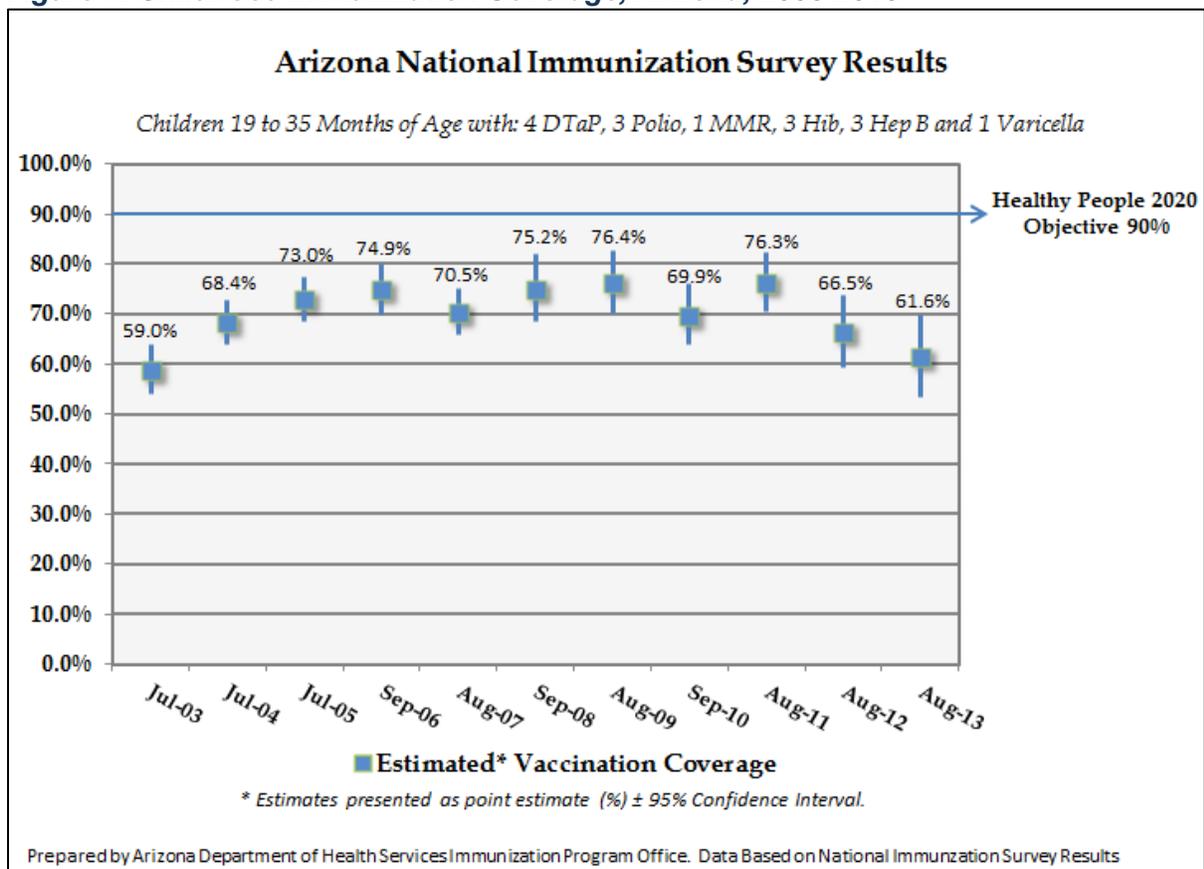
Vaccines are one of the safest and most effective public health interventions available, having saved more lives and prevented more disability through history than anything else except perhaps clean water and sanitation. Vaccines are also victims of their own success in that the diseases they prevent are now so rare that the public often does not appreciate how much protection they offer.

However, if vaccines become unavailable, their value will be quickly apparent as preventable diseases return. Policy makers should see the need to ensure that everyone has access to, and can afford, recommended vaccines as one of their highest priorities.

- Douglas Campos-Outcalt, MD

Arizona's public health and healthcare leadership has worked collaboratively for more than 20 years to improve access to life-saving vaccines for all Arizonans. The public-private partnership allows for all sectors of the vaccine industry to meet and strategize strengths and gaps in immunization delivery for effective system change. This partnership led to an increase in childhood vaccine coverage until 2011. Since 2011, complexities in the vaccine system may have led to the observed decline in coverage noted in Figure 1.

Figure 1: Childhood Immunization Coverage, Arizona; 2003-2013



3.0 Health Plans and Vaccine Coverage

In 2010, the U.S. Congress passed the Affordable Care Act (ACA), which included numerous important provisions affecting an individual's access to vaccines. These provisions should, over time, help privately insured children, adolescents and adults have full access to all ACIP-recommended vaccines in numerous healthcare settings with minimal or no financial impact on the beneficiary. Key provisions include:

- Immunization coverage standard: All non-grandfathered health plans must offer all ACIP-recommended vaccines appropriate to that individual at no cost-sharing (first dollar coverage) when administered by an in-network provider;
- State health insurance exchanges must include the same standard immunization coverage as part of the Essential Health Benefits (EHB) package for their enrollees;
- A two-year (2013-14) increase in Medicaid payment for all preventive services administered by a pediatrician, family physician or internist, equivalent with Medicare rates;
- Several other provisions intended to increase access to preventive services and vaccines for adults, especially those enrolled in Medicaid programs.

There are a wide variety of commercial health plans available in Arizona, with multiple plan options available including fully-insured or self-insured options. In Arizona, excluding publically covered individuals², approximately 66.5% of the commercial health insurance market is self-insured.³ In a self-insured health plan, the employer, rather than the insurer, assumes the risk for paying for covered services. Additionally, self-insured health plans are regulated by federal law via the Employee Retirement Income Security Act of 1974 (ERISA), and state law, as it relates to employee benefit plans, is preempted. The other 33.5% of Arizona's commercial market is considered fully-insured, meaning an individual or small group purchases insurance directly through an insurer. A fully-insured plan is regulated by both ERISA and state authority (for the business of insurance). Self-insured group plans have more flexibility in benefit design and administration than fully-insured group plans.

As part of the ACA, certain plans in the commercial market were allowed to be "grandfathered". These plans are exempt from some of ACA's consumer protection requirements. In order to qualify as "grandfathered", the plan must have been in existence on March 23, 2010 (the day the law was enacted) and cannot have changed in ways that substantially cut benefits or increase costs for consumers. In addition to grandfathered plans, there are plans that became effective in 2010 and met the 2010 ACA requirements. These plans were to be discontinued after 2014 in order to meet the newest ACA requirements, but by Presidential order were allowed to continue, at least for the next year. Finally, there are the newest plans, effective January 1, 2014, that contain the most complete set of ACA requirements.

When the ACA was first implemented, there were concerns about the high number of plans with "grandfathered" status, as this would have an impact on how quickly individuals would obtain the full preventive service benefits included in the ACA. This issue was particularly important for increasing access to adult vaccines, as many health plans had already historically placed pediatric and adolescent vaccination benefits outside of the standard deductible.

The number of grandfathered plans in the self-insured market is steadily declining. A recent study from the Kaiser Family Foundation in September 2014 showed new survey data

² Publically covered individuals include those covered under Medicare, Medicaid, and TriCare

³ Data compiled by America's Health Insurance Plans (AHIP), Center for Policy and Research, October 2013

estimating that 26% of covered workers nationally are in “grandfathered” plans as defined by the ACA, a decrease from 56% of all plans being grandfathered nationally in 2011.⁴ The Kaiser Family Foundation’s 2014 estimates indicate that 31% workers in the Western U.S. are covered by a grandfathered health plan.⁵

Health plans insuring children less than 18 years of age now, with increasing regularity, cover preventive services, including vaccines. This is especially true for children between the ages of zero to four. However, in many rural areas of Arizona, large employers provide insurance to the majority of the population.⁶ Some plans offered by these employers are grandfathered and do not always provide full coverage for all ACIP recommended vaccines. Clinicians in those areas seeing patients with grandfathered plans have a difficult time providing vaccines to the entire community due to issues with adequate payment for vaccine services.

The large number and different types of plans, combined with wide variations in benefits and cost-sharing causes greater complexity when discussing the issues surrounding vaccine benefits and payments. Commercial health plans continue to exist that apply cost-sharing to preventive services including vaccinations for adults, and in some cases, children; restrict benefit coverage to in-network providers only; do not cover vaccinations at all; or have payment methodologies that do not consider the multiple factors that are involved in pricing and paying for vaccines. However, these plans account for a decreasing percentage of the overall offerings in the post-ACA environment. Children with high deductibles or other cost share components can receive vaccines, but their parents pay out of pocket for their vaccines. As a result, parents may choose not to vaccinate, putting everyone at risk and costing the health care system more in disease treatment.

⁴ Kaiser Family Foundation and Health Research and Educational Trust. Employer Health Benefits, 2014 Annual Survey. 2014. Available at <http://kff.org/health-costs/report/2014-employer-health-benefits-survey/>.

⁵ Kaiser Family Foundation and Health Research and Educational Trust. Employer Health Benefits, 2014 Annual Survey. 2014. Available at <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.

⁶ Claims data for vaccines administered through Gila County public health clinic

4.0 The Vaccine Financing System

4.1 Vaccines for Children

Once a vaccine is approved by the ACIP and added to the recommended vaccination schedule, the vaccine is available for private purchase for insured children or through the Vaccines for Children (VFC) Program. The VFC Program was established in 1993 in order to provide vaccinations to the country's most vulnerable children in a systematic way. The VFC Program made federally purchased vaccine available at no cost to children eligible for Medicaid, Native American children, or Uninsured children. Federal 317 funding is used to support the distribution, oversight and implementation of vaccine programs at the state level. The state health department distributes VFC vaccine to private and public healthcare providers at no cost to the parent or the provider to ensure herd immunity in VFC eligible populations.

4.2 Overview of State Financing Models

For both children and adults, coverage gaps exist that create the need for alternative funding mechanisms for vaccines. States use a variety of federal, state and local funding to develop vaccine programs to fill the coverage gaps in their communities. As it relates to childhood and adolescent vaccines, most states are VFC-only, but some have developed programs that decrease the provider office's upfront investment, by providing all vaccines for all children. However, programs outside of VFC-only shift much of the administrative burden onto the state.

State Vaccine Financing Systems (2014 estimation)

VFC Only		VFC & Underinsured Select	Universal Select	Universal
Alabama	North Carolina	Georgia	Alaska	New Hampshire
Arizona	North Dakota	Maryland	Connecticut	New Mexico
Arkansas	Ohio	Michigan	Idaho	Rhode Island
California	Oklahoma	Minnesota	Maine	Vermont
Colorado	Oregon	New York	Massachusetts	Washington
Delaware	Pennsylvania	Utah	South Dakota	Wyoming
DC	South Carolina			
Florida	Tennessee			
Hawaii	Texas			
Illinois	Vermont			
Indiana	Virginia			
Iowa	West Virginia			
Kentucky	Wisconsin			
Louisiana				
Mississippi				
Missouri				
Montana				
Nebraska				
Nevada				

VFC Only – Private providers receive vaccines for federal VFC eligible children only.

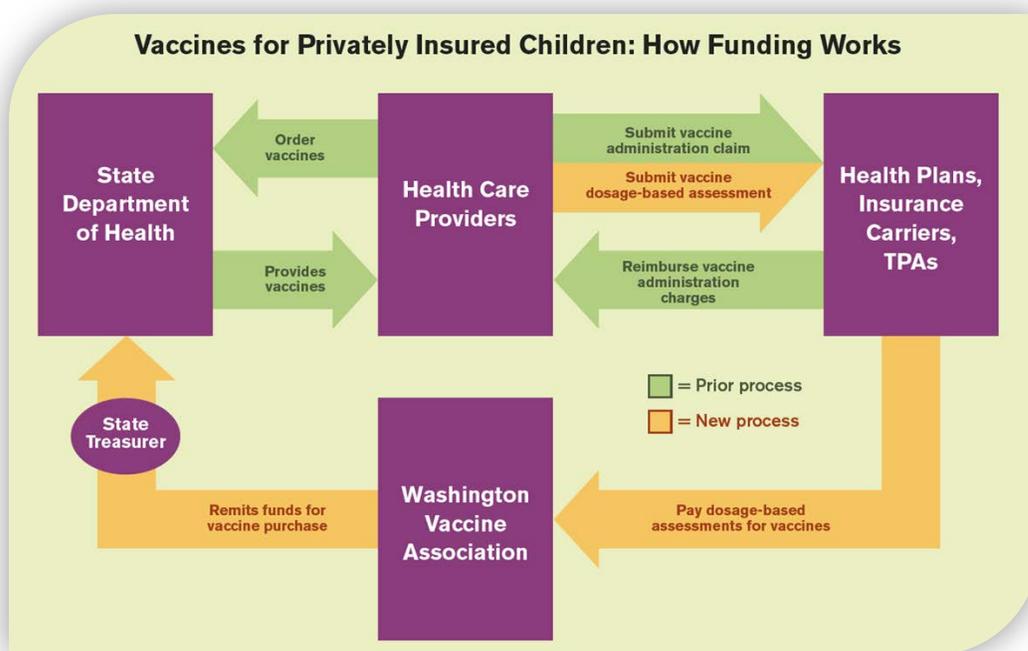
VFC & Underinsured – Private providers receive vaccines for underinsured children also. State Immunization Program uses state/local funding to provide all ACIP recommended vaccines.

Universal Select – all children, regardless of insurance status, receive all ACIP recommended vaccines for free, except for a few vaccines. State Immunization Program uses state/local funding to provide all ACIP recommended vaccines.

Universal - all children, regardless of insurance status, receive all ACIP recommended vaccines for free. State Immunization Program uses state/local or health plan funding to provide all ACIP recommended vaccines.

Over the last three decades, seven states have developed Universal vaccine systems, some in partnership with health insurance plans. The plans pay the vaccine purchase cost to the state up-front based on the number of children in the plan. The state immunization program distributes the vaccine to provider offices who administer the vaccine. Provider offices then report the vaccine dose to the state and bill the health plan for the administration fee only. Washington's model is depicted below.

Figure 2: Washington Vaccine Association Infographic: Vaccine funding model⁷



Adaptations of the WA model:

Maine - quarterly payments made to state by plan covered lives

Vermont - pilot project: primary care providers are required to participate in an assessment on the front end for each quarter

New Hampshire - does not include self-insured funds; must use any state or federal funds first, then assess each plan the remainder

Massachusetts - bill did not pass establishing a fund to cover select vaccines

Connecticut - end of year assessment based on self-report from plans; self-insured plans are not included

New Mexico - system-funded on reimbursement model to state using registry data

*All of the above states had universal vaccine systems funded at the state and local level and used these models to continue the program after funding cuts.

Arizona has never been a Universal state and would require a significant infrastructure investment to implement a similar program. As the administrator in a VFC-only state, ADHS oversees the ordering, distribution and quality controls for all government purchased vaccine in private provider offices. Almost 900 VFC providers are enrolled in the Arizona VFC program, which maintains nine full-time employees to manage the program. Federal funding changes over time have prompted Arizona public health partners to investigate a health plan-funded universal vaccine system. This model was found to be cost prohibitive for all organizations involved due to the need to expand the VFC program to manage insured vaccine doses and the necessity of a significant investment of infrastructure and State General Fund dollars to support it.

⁷ Washington Vaccine Association. Saving Universal Purchase of Childhood Vaccines in Washington State. Available at www.kidsvax.org/kidsvax.nsf/documents/wava.../WVA_timeline.pdf.

4.3 Arizona's Vaccine Financing System

Arizona's immunization program is VFC-only, meaning the State provides federally purchased VFC vaccine to healthcare providers for VFC-eligible children (AHCCCS-enrolled, Native American, and Uninsured). Healthcare providers must privately purchase vaccine for children that are underinsured, fully insured and insured with deductibles.

Most Arizona healthcare providers maintain stocks of both federally-purchased and privately-purchased vaccine that they must pre-purchase, order, inventory, maintain cold chain, insure and report. Once a vaccine is given to a child, the healthcare provider reports the dose to the Arizona State Immunization Information System (ASIS; Arizona's vaccine registry) and bills the appropriate entity. For children insured through Medicaid, the provider bills the Medicaid plan for the vaccine administration fee only; the vaccine dose is covered by VFC. For privately insured children, the healthcare provider bills the health plan for the vaccine cost *and* the administration fee. Payments from the health plans can take up to several months.

Most private physician offices function as small businesses. The complex system described herein requires significant staffing and infrastructure that many small businesses do not have readily available. Many vaccine manufacturers offer mechanisms to help offices with inventory management, and other functions that can help manage the activity of being a vaccine provider.

The table below depicts vaccine coverage for Arizona children based on their insurance status and vaccine provider type. Green boxes indicate full coverage through federal programs administered in Arizona.

Figure 3: Arizona's VFC Program

	Medicaid eligible children	Native American children	Under insured children	High Deductible insured	Fully Insured children	Uninsured children
Public Providers – non- FQHCs (ie: County Health Departments, IHS, Phx Fire, School programs)			Deputized	Funded through payments from insured patients or cash payment	Private health insurance	
Private Providers			Out of Pocket	Out of Pocket	Private health insurance	
FQHCs and Deputized FQHCs				Out of Pocket	Private health insurance	

Until recently, working collaboratively has allowed Arizona to create a comprehensive immunization program with few gaps, including implementation of the first mandatory statewide vaccine registry, early adoption of adolescent school requirements, and establishing billing programs for county health departments. However, vaccine policy changes, and challenges with vaccine cost and public and private healthcare provider payment for vaccines have introduced challenges that threaten Arizona's vaccine delivery system and the health of Arizonans.

Between 2008 and 2009, State funding for immunizations was cut from \$10 million to \$0. In response, Arizona eliminated all adult vaccine services and implemented a blanket deputization agreement with Federally Qualified Health Centers to cover all underinsured children in public clinics and medical homes, while using 317 program funds to cover vaccination of privately insured children in public clinics. Through these mechanisms, Arizona was able to provide access to vaccines, but knew the gaps would continue to grow unless other solutions were identified and implemented.

The \$10 million cut to state funding was temporarily compensated for by using Federal programs that were later modified. The deputization agreements that allowed underinsured children to stay in their medical home were discontinued in 2012 at the same time that 317 funds were prohibited from use on privately insured children. Together, these changes have resulted in some children being bounced from public to private providers, fragmenting the delivery of care that ensures on-time vaccination.

In many states, providing vaccinations in the private setting has become too expensive or too complex, and many children and adolescents are being referred to county public health departments for vaccinations. Several states are in the process of implementing public health billing programs to offset the cost of providing vaccines to privately insured children in public health clinics. Many states, including Arizona, have been successful at implementing these billing programs and off-setting some of the cost of vaccine with payment from private health plans.

5.0 Vaccine Cost and Purchasing

Clinicians have little influence over price setting in the market, and smaller practices with low volumes often experience a higher cost burden than larger practices. Numerous vaccine purchase programs exist, all with unique benefits and costs:

- Direct contracts between single providers and manufacturers
- Group purchasing organizations – networks of institutions contracting with manufacturers
- Physician buying groups – networks of providers contracting directly with manufacturers
- Third party procurement and billing – independent organizations that handle vaccine procurement and management, claims processing, and patient billing

Group Purchasing Organizations

Group purchasing organizations (GPOs) are able to combine orders from practices, hospitals, nursing homes, and other medical facilities in order to receive volume discounts from specific vendors. GPOs tend to be operated by hospital-affiliated purchasing programs, and often include supplies in addition to vaccines. GPO pricing is typically not as favorable as with Physician Buying Groups (PBGs), but there is usually no requirement to use products of a specific manufacturer; in fact, GPOs often offer vaccines from all manufacturers. The GPO option may not be available to all practices in all markets.

Physician Buying Groups

PBGs offer physicians the option of obtaining the most favorable pricing in return for only using the vaccines produced by contracted manufacturers. In most cases, PBGs offer “up-front” discounts based on their respective contract terms with the manufacturers. The PBG typically requires the practice to first use the contracted vaccines, and most programs will remove a practice from the program if it does not comply with these terms, due to the potential for decreasing the discount to other members. The practice is able to benefit from other manufacturer-based features, such as prompt pay discounts, on-line order discounts, and periodic manufacturer promotions.

Vaccine pricing and adequate payment determination can be difficult due to variations in buying contracts with manufacturers and distributors.

- Private sector prices can range greatly from contract to contract. For example, it can cost from \$100 to \$120 for different providers to purchase the same vaccine.
- Direct from manufacturer contract price is dependent on volume and bundled purchase of the brand’s other vaccines. These contracts offer lowest pricing, but exclude competitors’ products.
- Buying groups require brand loyalty for best price. This system decreases choice for clinicians and limits the availability to tailor the immunizations delivered based on the medical needs of the child.
- There is little room for negotiating best pricing when a vaccine is available from only one manufacturer.
- CDC Public Pricing is available through 340b and Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP). Both are intended for underserved populations and not available for use for insured children.

Public health departments are able to purchase vaccine at a decreased price through a government buying group, MMCAP. MMCAP is a free, voluntary group purchasing organization for government facilities that provide healthcare services. This contract is intended for government agencies to be able to provide vaccine to underserved populations and is not intended for fully insured children. At this time, public health departments in Arizona are using

the contract to acquire vaccines for insured children in order to build a billing program that is self-sustaining. Proceeds on payments obtained by billing contracted plans offset the cost for the plans not paying, or not adequately paying public health, ensuring no children are turned away. MMCAP has indicated a time limit on purchasing for fully insured patients, requiring states to look for alternative options to sustain herd immunity.

The CDC maintains a list of approved vaccines and the retail cost of each in the public and private sectors (<http://www.cdc.gov/vaccines/programs/vfc/awardees/vaccine-management/price-list>). The website is based on real-time cost fluctuation and offers email notification of price changes. This is the only transparent list of accurate vaccine pricing available to all organizations and can be used as the standard for vaccine pricing for both public programs and the private sector. The public price listed is government pricing under MMCAP contracts intended for underserved populations. The CDC Private Sector retail price list is for purchase of vaccine for insured patients and can be used as a guide when valuing payments.

Figure 4: CDC Vaccine Price List

CDC Vaccine Price List



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- [Adult Vaccine Price List](#)
- [Pediatric Influenza Vaccine Price List](#)
- [Adult Influenza Vaccine Price List](#)

Prices last reviewed/updated: **AUGUST 1, 2014**

Pediatric/VFC Vaccine Price List

Vaccine	Brandname/ Tradename	NDC	Packaging	CDC Cost/ Dose	Private Sector Cost/ Dose	Contract End Date	Manufacturer	Contract Number
DTaP [1]	Daptacel®	49281-0286-10	10 pack - 1 dose vials	\$15.38	\$25.98	03/31/2015	Sanofi Pasteur	200-2014-58149
DTaP [1]	Infanrix®	58160-0810-11	10 pack - 1 dose vials	\$15.76	\$20.96	03/31/2015	GlaxoSmithKline	200-2014-58151
		58160-0810-52	10 pack - 1 dose T-L syringes. No Needle	\$15.76	\$21.44			
DTaP-IPV [2]	Kinrix®	58160-0812-11	10 pack - 1 dose vials	\$38.50	\$48.00	03/31/2015	GlaxoSmithKline	200-2014-58151
		58160-0812-52	10 pack - 1 dose T-L syringes	\$38.50	\$48.00			
DTaP-Hep B-IPV [4]	Pediarix®	58160-0811-52	10 pack - 1 dose T-L syringes, No Needle	\$53.86	\$70.72	03/31/2015	GlaxoSmithKline	200-2014-58151
DTaP-IP-HI [4]	Pentacel®	49281-0510-05	5 pack - 1 dose vials	\$52.43	\$80.43	03/31/2015	Sanofi Pasteur	200-2014-58149
e-IPV [5]	IPOL®	49281-0860-10	10 dose vial	\$12.46	\$27.44	03/31/2015	Sanofi Pasteur	200-2014-58149
Hepatitis A Pediatric [5]	Vaqta®	00006-4831-41	10 pack - 1 dose vial	\$16.17	\$30.369	03/31/2015	Merck	200-2014-58150
		00006-4095-02	10 pack - 1 dose syringes	\$16.17	\$31.12			
Hepatitis A Pediatric [5]	Havrix®	58160-0825-11	10 pack - 1 dose vials	\$16.15	\$28.74	03/31/2015	GlaxoSmithKline	200-2014-58151
		58160-0825-52	10 pack - 1 dose T-L syringes. No Needle	\$16.15	\$28.74			
Hepatitis A-Hepatitis B 18 only [3]	Twinrix®	58160-0815-11	10 pack - 1 dose vials	\$52.26	\$92.50	03/31/2015	GlaxoSmithKline	200-2014-58151
Hepatitis B [5] Pediatric/Adolescent	Engerix B®	58160-0820-11	10 pack - 1 dose vials	\$11.08	\$21.37	03/31/2015	GlaxoSmithKline	200-2014-58151
		58160-0820-52	10 pack - 1 dose T-L syringes, No Needle	\$11.08	\$21.37			
Hepatitis B [5] Pediatric/Adolescent	Recombivax HB®	00006-4981-00	10 pack - 1 dose vials	\$11.00	\$23.204	03/31/2015	Merck	200-2014-58150
		00006-4093-02	10 pack - 1 dose syringes	\$11.75	\$23.95			
Hib [5]	PedvaxHIB®	00006-4897-00	10 pack - 1 dose vials	\$12.34	\$22.769	03/31/2015	Merck	200-2014-58150
Hib [5]	ActHIB®	49281-0545-05	5 pack - 1 dose vials	\$9.36	\$26.21	03/31/2015	Sanofi Pasteur	200-2014-58149
HIBMENACY [3]	MENHIBRIX®	58160-0801-11	10 pack - 1 dose vials	\$10.10	\$23.60	03/31/2015	GlaxoSmithKline	200-2014-58151
HPV - Quadrivalent Human Papillomavirus Types 6, 11, 16	Gardasil®	00006-4045-41	10 pack - 1 dose vials	\$121.03	\$141.38	03/31/2015	Merck	200-2014-58150

6.0 Vaccine Payment

Vaccine payments have three different components: the vaccine purchase cost, vaccine inventory management cost and vaccine administration cost.

Vaccines are billed using two codes, the first for the physical vaccine and the second for vaccine administration. Traditionally, vaccine payments do not always include the additional 23% margin above cost to account for maintaining the inventory.

Vaccine Purchase Cost – the price at which the vaccine is purchased through either a distribution center, buying group or direct from the manufacturer.

Vaccine Inventory Management⁸ – the practice’s management costs associated with providing vaccines, which could include:

Contracting with all health plans, credentialing the site and all providers, contracting with vaccine suppliers, ordering and paying for private vaccine supply, signing up for VFC, signing up for ASIIS, ordering VFC vaccine through ASIIS, accepting shipment for vaccine/maintaining cold chain, refrigerating vaccine, checking the refrigerator twice daily for temperatures, insuring vaccine, scheduling vaccine appointments, checking patient insurance and VFC eligibility, gathering accurate and complete patient insurance data, verifying insurance coverage for privately insured patients, reporting doses administered to ASIIS, inventorying vaccine stock in refrigerator, reporting dose by lot number and National Drug Code (NDC) to ASIIS for VFC vaccine, faxing temperature logs to VFC, sending record to billing, building claim in electronic system, sending claim to clearinghouse and payers, receiving Explanation of Benefit with payment or denial, rebilling denied claims, adjusting actual payment in billing system, reporting payment to patient, recording in billing system, billing patient directly for outstanding balance

Vaccine Administration⁹ – Based on the Centers for Medicare and Medicaid Services (CMS) Relative Value Units (RVU) (Physician Work Component, Professional Liability Insurance Expense Component, and Practice Expense Component): supplies and healthcare worker time associated with physically giving the shot to the patient including:

Checking the patient record book, checking ASIIS for vaccine history, screening patients for indicated vaccines and contraindications, counseling patient/parents, giving Vaccine Information Statement for every vaccine, getting parent signature on each vaccine, drawing up vaccine, swabbing vaccine site with alcohol, injecting vaccine, Band-Aid the vaccine site, comforting the child, giving the child a sticker, updating the parent record book, recording correct diagnosis code to patient record, recording CPT to patient record, recording NDC and lot number to patient record, updating the electronic health record

PAYMENTS

Vaccine cost :

Vaccine + Storage and Management

- Purchase price set by manufacturer
- Payment determined by health plans
- Ranges 60% below price to 30% above

Administration Fee:

Nurse time and supplies

- VFC rate set in 1983 at \$15.43
- \$10 Average admin fee AHCCCS Plans
- \$15-\$25 Private sector range

Billing:

- Each claim costs ~ \$4.50 to submit

⁸ American Academy of Pediatrics. The Business Case for Pricing Vaccines. March, 2012.

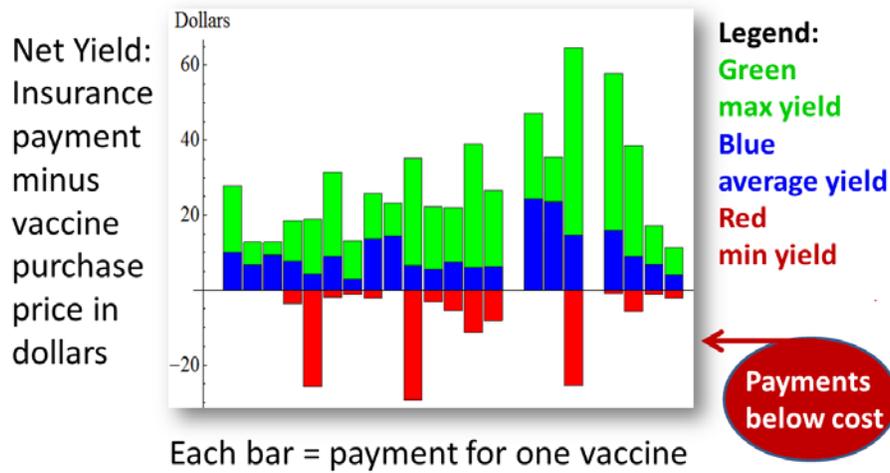
⁹ American Academy of Pediatrics. The Business Case for Pricing Immunization Administration. March, 2012.

Vaccines are one of the top overhead expenses in most pediatric offices.¹⁰ At times, health plans have inadequate time to update payment levels following vaccine manufacturers' vaccine price increases, resulting in health plan payment to providers that is less than the cost of the vaccine. This makes it difficult for Arizona private physician offices that function as small businesses to continue to provide vaccines.

The chart below¹¹ supports data from a study done in local offices where 8 out of 10 practices lost money on some vaccines and every practice lost money when billing six specific health plans. Due to legal limitations, including anti-trust laws, health care providers, health plans, and vaccine manufacturers are prohibited from disclosing payment levels and pricing actions, except under very specific circumstances.,

Figure 5: Insurance payment compared to vaccine cost

Insurance Payments vs. Vaccine Cost



Adapted from Gary Freed et al. *Pediatrics* 2008; 122:1325-1331

Admin fee from \$3.87-\$26.55

Payments to healthcare providers are often referred to as reimbursement for services; however, Arizona healthcare providers, as well as the AAP and the AAFP, prefer to label this as *payment* for vaccines and administration services. In addition to being paid for their basic vaccine costs, in order to provide vaccines without losing money, clinicians need to be paid for the liability and management of the vaccine given to the patient. Estimates of vaccine management costs range from 12-28% above the list price of the vaccine. In 2007 and 2008, the Pediatric Council of the Arizona Chapter of the AAP studied 12 practices of varying size and concluded that the regional rate to break even on vaccine services is at least 121% of the CDC Private Sector Cost.¹²

¹⁰ American Academy of Pediatrics. The Business Case for Pricing Vaccines. March, 2012.

¹¹ Adapted from Freed GL, Cowan AE, and Clark SJ., Primary Care Physician Perspectives on Reimbursement for Childhood Immunizations. *Pediatrics* 2008; 122(6):1319-1324.

¹² Couchman J. Results of AzaAAP Survey of Vaccine Costs and Payments. 2008. Available at <http://azaap.org/resources/Documents/ABSTRACTABSTRACT.pdf>.

Similarly, the AAP¹³ and the National Vaccine Advisory Committee (NVAC) have recommended that full payment for vaccine include the cost of the vaccine plus storage, handling, ordering, managing and insuring the vaccine inventory, or 125% of retail cost to break even. Many health insurance plans pay vaccine providers less than this total cost of the vaccine. Payments can range from 22% below cost to 35% above cost, depending on the vaccine and the health plan. Many vaccine providers are unable to recoup the overhead cost from the vaccine they have purchased and managed.

Vaccine payments to providers are set by each health plan's internal process with consideration of plan specifications set by employers and individuals. Thus, vaccine payments vary greatly from plan to plan. These prices are driven by lower pricing given to large provider organizations that buy in large quantities, and are often below the price offered to the average provider business or small volume healthcare providers in rural areas.

When a new vaccine is added to the CDC schedule or there has been a price increase to an existing vaccine, it can take months for the revised payment to be loaded into the health plans' systems. During that lag time, practices are not paid the increased cost for the vaccine that they purchased. During deliberations of the Committee, physician members received notification from a vaccine manufacturer of vaccine price increases occurring from the day of the notification. Advanced notice was given to health plans only four business days prior to the price increase. This does not allow adequate time for health plan systems to be updated. This will result in loss of money to physician small businesses who continue to provide this vaccine during the quarter in which the health plan systems are being updated to reflect the price increase.

Changes in vaccine prices and addition of new vaccines to the market are unpredictable and health plans do not often have ample time to react to these changes. This further discourages practices from providing vaccines because they are often in a position of losing money if they provide vaccines to their patients during this interim period when health plan systems do not have current cost data loaded.

¹³ American Academy of Pediatrics. The Business Case for Pricing Vaccines. March, 2012.

7.0 Vaccine Availability/Access

Children and adolescents need age appropriate well child or preventive health visits, which include immunizations. Well visits include screening services, vision services, dental services, hearing services, immunizations and services that correct or ameliorate physical and mental defects, conditions, and illnesses that are discovered through the screening process during the well visit. Well child or adolescent visits focus on the continuum of care by: assessing health needs, providing preventive screening, initiating needed referrals, providing anticipatory guidance and completing recommended medical treatment and appropriate follow-up care.

Immunizations are only one aspect of the preventive care delivered to a child or adolescent. The need for immunizations remains a valuable tool used to initiate well child care in primary care provider offices. Therefore, it is critical that discussions and decisions related to access to immunizations and the immunization delivery system in Arizona also consider the overall health, development and related needs of children.

The need for immunizations, such as for entry to school, remains a driver for ensuring children and adolescents complete well visits with their primary care provider or medical home. It is important to balance opportunities to increase access to and the availability of immunizations with the overall preventive health and treatment needs of the child. These visits are sometimes the only opportunity a physician has to provide proper screenings, as well as counseling parents and patients on important health issues. This is particularly true for adolescents at a crucial time in their health and development.

Access and availability are also influenced by and harder to sustain due to immunization refusals and untimely immunizations. There continue to be misperceptions regarding immunizations and the potential “harm” they can inflict on children. While there is no scientific evidence to support such claims, there are an increasingly large number of parents actively choosing to delay immunizations or to not vaccinate their children at all. Arizona should continue or enhance education efforts to overcome parental fears regarding vaccination. This includes direct communication with parents and working with providers to ensure that parents and guardians understand the potential consequences of not having children fully immunized — including seizures, meningitis, hearing impairment and even death due to infectious diseases.

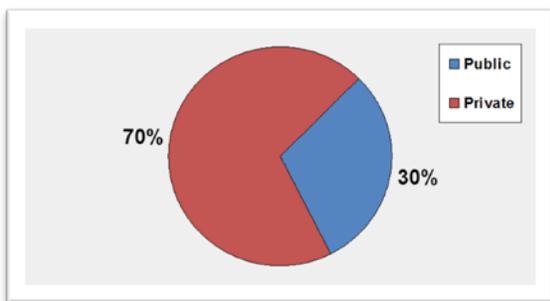
The current environmental landscape or delivery model for childhood and adolescent immunizations includes healthcare providers such as family physicians, pediatricians, nurse practitioners, obstetricians, pharmacists, county public health clinics, rural health clinics, and retail clinics. County public health departments and some health plans also work with other providers to immunize children throughout the year such as utilizing fire departments, school based delivery models, health fairs and mass immunizing providers. Children and adolescents may also receive vaccinations when they are seen in urgent care clinics and emergency departments.

Of the more than 5,000 primary care providers in Arizona only about 1,100 physicians administer the overwhelming majority of pediatric vaccines. About 30% of Arizona vaccines are given by county health departments, community health centers and fire departments in one of 150 public sites. About 2,800 pharmacy sites gave approximately 5,000 non-flu pediatric vaccines during 2013. In total in Arizona, over 4,200 immunizers administer pediatric vaccines, most often in primary care offices and public clinics. To establish herd immunity, it is important that solutions involve both public and private vaccine providers.

Table 1: Description of Arizona Immunizers

Arizona Immunizers 1350 Primary Care and Public Clinics - 2800 Pharmacy (estimated)			
Specialty/ Clinic Type	Vaccine Providers	Publicly Funded/ Privately Owned	Privately Purchased or Publically Funded (VFC) Vaccine Stock ¹⁴
Family Practice and Pediatrics (5,100 licensed in AZ)	1,160	Private Offices	800 VFC and Private Vaccine Providers/300 Private Vaccine Only
Pharmacy	2,800	Private	Private Vaccine/non-VFC Providers
Public Health Departments	15	Public Clinics	VFC and Private Vaccine
Community Health Centers	130	Public Clinics	VFC and Private Vaccine
Indian Health Services	25	Public Clinics	VFC and Private Vaccine
Fire Departments	6	Public Clinics	VFC Vaccine Only/No Private

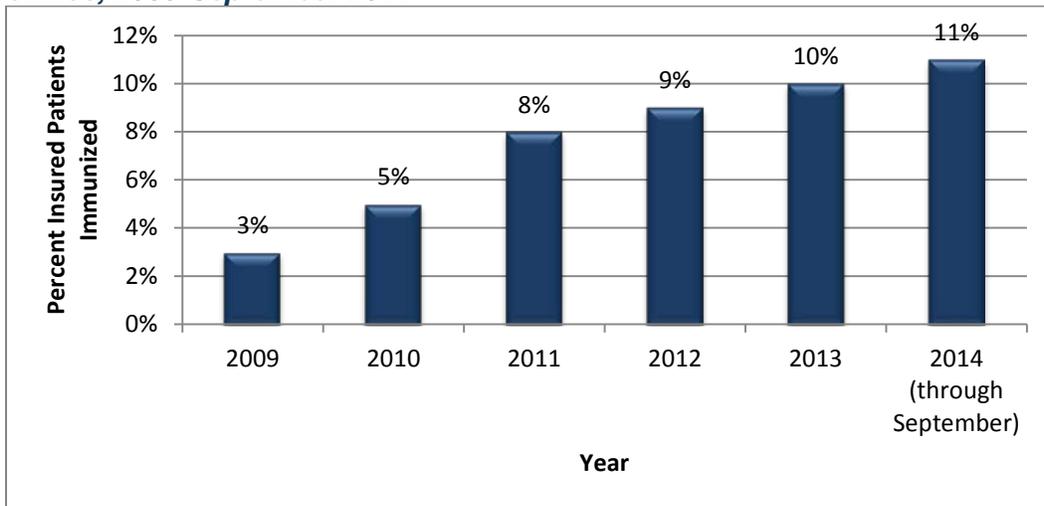
Figure 6: Estimates of percentages of vaccines given by public and private providers in Arizona:



When parents must pay out of pocket for vaccines due to high deductibles or inadequate vaccine coverage, their children are often referred by their private provider to the county public health department for certain immunizations. When surveyed, 50% of pediatric offices have referred a child to county public health for at least one vaccine, and county public health has noticed an increase in the number of privately insured children receiving vaccination in public clinics. Referrals are most often due to cost of vaccine and inadequate payments.

¹⁴ Offices that carry both VFC **and** private stock vaccine immunize uninsured, AHCCCS, Native American and privately insured children. VFC-only sites do not offer vaccines to privately insured children. Sites with only private stock do not immunize children on AHCCCS, Native American or uninsured except for cash payment.

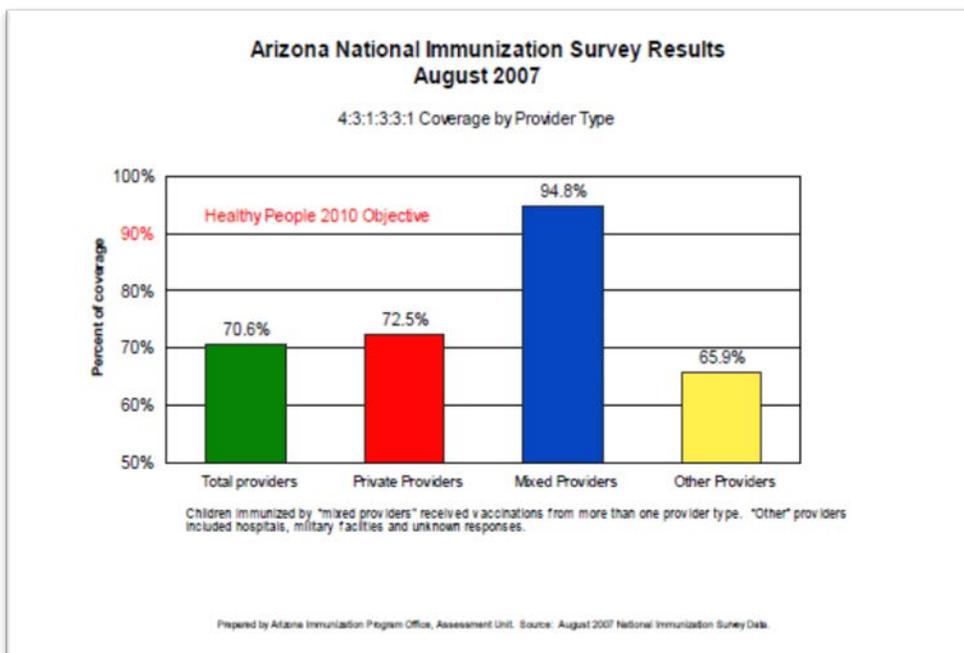
Figure 7: Percent of insured patients immunized at Maricopa County public health clinics, 2009-September 2014



While county public health departments provide safety net vaccine services to all children, the cost and payment issues plaguing private providers are also a factor in these settings. County public health departments must often vaccinate insured children at a loss due to challenges with health plan contracting and payment. Children with private insurance who are turned away from county public health departments often do not have a medical home or may experience up to a three month wait for appointments. This increases the risk of lower vaccination coverage, resulting in a decrease in herd immunity.

CDC data from the National Immunization Survey indicate that when children access both private practice and public health clinics, 20-25% are more likely to be caught up and on time for vaccines. Solutions must support both the private and public sides of vaccine delivery.

Figure 8: Childhood Vaccine Coverage by Provider Type, Arizona, 2007.



8.0 Historical Activities to Address Vaccine Financing and Delivery

8.1 National

NVAC recommends ways to achieve optimal prevention of infectious disease through the Public Health Services Act and recommends ways to encourage the availability of an adequate supply of safe and effective vaccination products in the U.S. NVAC made recommendations regarding support of vaccine financing delivery models in 2008.¹⁵

NVAC convened key stakeholders of federal, state, and local government, vaccine manufacturers, health insurance plans and other payers, providers (including AAP representation) and consumers / patients.

Recommendations:

- Public sector vaccine purchase for underinsured children in public health departments
- Improving vaccine administration reimbursement for VFC-eligible children (in Medicaid)
- Vaccine manufacturers should work with providers to reduce financial burden for initial and ongoing vaccine inventories
- Supporting delivery of vaccines in the medical home by improving private provider business practices and payments
- Reducing underinsurance and financial barriers to vaccination of privately insured children
- Developing billing mechanisms for insured children and adolescents vaccinated in the public sector
- Supporting child & adolescent vaccination in complementary venues

Progress toward goals:¹⁶

- 2008 VFC vaccine administration rates for each state are published on CMS website, and a CMS workgroup is currently working on a revision to VFC reimbursement caps
- Manufacturers lengthened payment terms and offered prompt-pay discounts etc.
- AAP & the American Medical Association (AMA), among others, created guidance related to billing and vaccine purchasing pools
- CDC funding immunization grantees for outreach to increase VFC providers
- CDC creating billing guidance and funding for public health
- First dollar coverage included in ACA

Areas that still need work:

- Increase 317 funding (Decreased)
- Decrease financial barriers for the privately insured
- Voluntary first-dollar coverage of immunization by health insurance plans
- Despite health insurance reform, health insurance coverage still does not include adequate payment
- Flexible contract language for immunization benefits that can accommodate updates to schedule or price changes mid-contract
- Payment policies that factor in all costs associated with vaccine administration

Many of the Arizona findings reflect the NVAC recommendations based on national concerns for vaccine availability.

¹⁵ Lindley MC, Orenstein WA, Shen AK, Rodewald LE, Birkhead GS. Assuring Vaccination of Children and Adolescents without Financial Barriers: Recommendations from the National Vaccine Advisory Committee (NVAC). 2008.

¹⁶ Shen AK. Financing Vaccination of Children and Adolescents: Update on the National Vaccine Advisory Committee (NVAC) Financing Recommendations of 2008. 2012.

8.2 Arizona

8.2.1 Payment Approaches

Arizona began exploring county public health billing for vaccines in 2008 and has received CDC planning and implementation grants to help with the process.

Nine counties are billing through a centralized billing office, a few are still in the process of developing business systems to allow for billing, and three are billing directly out of the county. Counties successfully bill 11 Managed Medicaid Plans -- for the administration fee only -- using Vaccines for Children vaccine. The administration fee cap for public providers vaccinating AHCCCS patients is \$15.43 and averages \$12 per vaccine.

On average, the centralized billing office is processing \$200,000 in claims per month. It appears doubtful that this will cover the full cost of privately purchased vaccine once public health begins to purchase vaccine at a retail rate instead of the discounted MMCAP pricing.

Counties have contracted with six private health plans for both the administration fee and the vaccine cost. Contracting has required legislation, public leadership meetings, negotiations with health plans, and employer leveraging in order to gain these six contracts. Meanwhile, the counties have also billed 55 private health plans for vaccine services without a contract in place, resulting in out-of-network payments that can be as little as 0-30% of the claim. These low out-of-network payments can be in part explained by benefit plans that exclude coverage for out-of-network preventive services, including vaccinations.

The six health plans currently under contract with county public health cover 80% of insured lives in Arizona, and pay health departments for patients seen. The remaining 20% of insured patients result in a loss on the \$200,000 billed each month in vaccination costs. A combination of public funds and payment from the six health plans cover the loss from the plans that will not contract with public programs.

This situation should soon improve based on recently passed legislation. In 2013, the Arizona Legislature passed House Bill 2430, amending ARS §36-673 to require county health departments to contract with private health insurers in order to receive payment for immunizations required for school attendance. Under the new legislation, insurers who decline requests to contract or who are unresponsive to such requests must pay the county health department as an in-network provider. While this legislation should improve payments to county health departments, they will continue to face similar challenges as private provider offices relating to inadequate payment to cover the total vaccine price and associated management costs. Contracted rates differ between plans and range from 22% below cost to 35% above cost. In addition, many claims are denied due to the lack of out-of-network benefits under the patient's health plan. Likewise, when a patient receives services out of network, health plans require the patient to cover more of the cost of care via deductibles or coinsurance, which means the health department must collect the difference from the patient. Proceeds from the contracted plans are used to cover the cost of services given to patients insured by plans not adequately paying public health departments.

With the loss of 317 funds for vaccine given to privately insured children and no state funding for vaccines, local health departments are forced to find local tax funds or turn children away. Arizona is utilizing a multipronged vaccine financing approach – billing when possible, using local taxes, and turning some children away.

System changes take time to implement. In the interim, there are fully insured Arizona children bouncing back and forth between public and private clinics, often not being able to receive vaccines in either setting.

8.2.2 Policy Approaches

Arizona Vaccine Congresses I, II and III were held with 75 participants in health leadership to evaluate the issues and propose appropriate interventions (Appendix 7). Recommendations from Arizona Vaccine Congresses included:

- Counties to bill for shots for Medicaid and privately insured kids
- Increase payment rates to the private sector
- Train providers on the business practice of vaccines
- Explore vaccine buying options
- Increase best-practice training for provider staff
- Meet with health plans

From those meetings, public/private stakeholders have:

- Hosted 4 Continuing Medical Education programs on the Business of Vaccines
- Met with health plans quarterly regarding public billing and adequate coverage for vaccines given in private and public clinics
- Trained more than 1,000 office staff on comprehensive vaccine delivery and best practices
- Developed a statewide central business office for billing in public clinics

A few health plans have come to the table to offer solutions for county public health contracts and appropriate payment, but system-wide changes have been slow to come.

The Arizona Partnership for Immunization (TAPI), on behalf of participating Arizona county public health departments, has built an efficient billing system that bills health plans more than \$200,000 per month in vaccines claims. TAPI has been influential in bringing about change in the vaccine payment processes, but a large amount of work remains to be done in order to change the health plan system so that services given either in a private practice or public clinic are adequately and fairly paid for.

In partnership with the local AAP chapter and county public health departments, legislation was introduced during the previous two legislative sessions that would require health plans to:

- Cover vaccines at no cost to the child (first dollar coverage)
- Pay the CMS determined administration rate for nurse time and supplies
- Pay 123% of CDC retail cost for vaccine to cover the cost of managing stock
- Reimburse county health departments as an in-network provider regardless of contract status

The bill was not passed in full; the portion regarding reimbursing counties as in network providers was added to Arizona Revised Statutes 36-673. Although the legislation was not passed in full, it has helped bring small changes to vaccine payments and health department contracting. During the process, in light of the data, several health plans increased payments to both public and private providers.

9.0 Committee Recommendations

Based on the findings presented above and reflected in Committee meeting materials, and considering the benefits and value of community protection from disease through vaccination programs, the Committee makes the following recommendations. Recommendations are organized around four areas: cost, purchasing, payment, and availability/access. The recommendations pertain to all vaccines recommended by the CDC's Advisory Committee on Immunization Practices (ACIP).

Recommendations are targeted toward vaccine manufacturers, insurers, and other vaccine stakeholders who all have a role in solving the vaccine financing and delivery challenges. All recommendations are made "as guided by state law" since any implementation can only be required of plans for which Department of Insurance has oversight. However, in order to protect the health of all Arizonans, the Committee strongly urges all vaccine stakeholders to implement these recommendations.

9.1 Cost

- Payers should use the CDC Private Sector Cost list as the standard to estimate vaccine cost
- To reduce the negative financial impact on vaccine providers, vaccine manufacturers are encouraged to provide a 90 day "grace" period for vaccine price changes by providing payers prior notice of price changes and allowing providers to purchase the vaccines at the previous price:
 - Vaccine manufacturers are encouraged to notify payers at least 60 days prior to the beginning of a quarter that the vaccine price will change in order to give them time to adjust their systems to pay providers based on the new price.
 - Vaccine manufacturers are encouraged to allow providers a longer window to purchase vaccines at the old price to allow time for payers to adjust their systems. Providers should be allowed a minimum of 30 days from the time payers are notified of price changes to purchase vaccines at the old price.

9.2 Purchasing

- The Arizona Partnership for Immunization (TAPI) and AzAAP should create a list of buying groups using the national contacts for manufacturer contracting
- TAPI should provide training and education about available purchasing options to multiple provider types (e.g., internal medicine, family physicians, pediatricians, OB/Gyn), especially to providers who do not currently provide vaccines
- TAPI should explore volume buying discounts through a purchasing group with local public health departments

9.3 Payment

- All payers are encouraged to use the CDC Private Sector Cost list as the reference for provider payment
- All payers are encouraged to pay the same amount for vaccines regardless of practice size or provider type, due to the community benefit from vaccines
- For commercial vaccine, payers are encouraged to pay, at a minimum, 123% of CDC Private Sector Cost to providers in addition to the administration payment. Medicare-based Relative Values should be used as a reference level for minimum recommended administration payment.
- A minimum administration fee should be developed for public plans, congruent with Medicare-based Relative Values. Committee members recognize that an increase in

administration fees would increase cost to the state General Fund for patients insured by AHCCCS.

- Payers should encourage all employers to provide plans that pay adequately for all required and recommended vaccines.
- Employers should be encouraged to review immunization benefits in their plans based on community benefit. This should include review of self-insured plans in other states with members in Arizona.
- TAPI should produce an educational tool for employers to identify the value, cost, and trend of physician provision of vaccines, with proposed solutions to declining physician provision of vaccines.

9.4 Availability/Access

- All childhood vaccines given in Arizona must be entered into the Arizona State Immunization Information System (ASIIS). Vaccine providers should use the ASIIS system to verify patients' immunization status to prevent the need for them to return for vaccinations and reduce the chance of duplicate vaccination.
- Public and private plans should emphasize the importance of a medical home that focuses on the whole child while ensuring a focus on efforts to capture information on immunizations that are provided through alternative sources.
- If a vaccine is given outside of the medical home, the vaccine must be entered into ASIIS, a copy of the visit sent to the primary care physician when possible or required, and the parent/child referred back to their medical home. If the child has no medical home, the parent should be given names of providers in their community or referred to their health plan, if insured, for a list of providers in their network.

This Committee advises against pursuing these recommendations in a legislative or regulatory manner but expects ongoing stakeholder actions on each of the above categories.

10.0 Glossary of Terms

317 Funding – the Section-317 program, administered by the Centers for Disease Control and Prevention, is a discretionary federal grant program to all states, six cities, territories, and protectorates, which provides vaccines to underinsured children and adolescents not serviced by the Vaccines for Children program, and as funding permits, to uninsured and underinsured adults.

Accountable Care Organizations (ACO) - An ACO is a network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services.

Administration Fee – The amount a vaccine provider can charge for administering a vaccine, which generally is intended to cover the time spent by the healthcare worker administering vaccine and the supplies associated with administration of a vaccine. The administration fee varies by state and health plan.

Advisory Committee on Immunization Practices (ACIP) – The ACIP is a group of 15 medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States. The recommendations stand as public health advice that will lead to a reduction in the incidence of vaccine preventable diseases and an increase in the safe use of vaccines and related biological products. (www.cdc.gov/vaccines/acip)

Affordable Care Act (ACA) – The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law. Under the ACA, many health plans are required to cover certain preventive services, including vaccines, at no cost to the patient.

American Academy of Family Physicians (AFP) – a professional organization representing more than 115,900 family physicians, residents, and medical student members dedicated to improving the health of patients, families, and communities through advocacy, practice enhancement, and education. (www.aafp.org)

Arizona Academy of Family Physicians (AzAFP) – the Arizona Chapter of the AFP, representing around 1500 members statewide. (www.azafp.org)

American Academy of Pediatrics (AAP) – a professional organization of 62,000 pediatricians committed to the optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. (www.aap.org)

Arizona Chapter of the American Academy of Pediatrics (AzAAP) - the Arizona Chapter of the AAP, representing around 900 members statewide. (www.azaap.org)

Arizona State Immunization Information System (ASIIS) - ASIIS is an electronic immunization registry designed to capture immunization data on individuals within the state. Providers are mandated under Arizona Revised Statute (ARS) §36-135 to report all immunizations administered to children from birth to 18 years of age to ADHS. The registry serves as a receptacle for accommodating these reported data. In this capacity, the registry then provides a valuable tool for the management and reporting of immunization information to public health

professionals, private and public healthcare providers, parents, guardians and other child care personnel. (<http://www.azdhs.gov/phs/asiis/>)

CDC Vaccine Price List - The CDC Vaccine Price List provides current vaccine contract prices and lists the private sector vaccine prices for general information. Contract prices are those for CDC vaccine contracts that are established for the purchase of vaccines by immunization programs that receive CDC immunization grant funds (i.e., state health departments, certain large city immunization projects, and certain current and former U.S. territories). Private providers and private citizens cannot directly purchase vaccines through CDC contracts. Private sector prices are those reported by vaccine manufacturers annually to CDC. (<http://www.cdc.gov/vaccines/programs/vfc/awardees/vaccine-management/price-list/>)

Employee Retirement Income Security Act (ERISA) - The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. (<http://www.dol.gov/dol/topic/health-plans/erisa.htm>).

First Dollar Coverage – No out of pocket cost to patient for services; health plan inclusion of first dollar coverage for vaccines would mean that patients receiving vaccines would not have to pay out of pocket for the vaccine, regardless of whether they have met their deductible.

Grandfathered Health Plan – Used in the context of the Affordable Care Act: a group health plan that was created, or an individual health insurance policy that was purchased, on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act.

Group Purchasing Organizations (GPOs) - Group purchasing organizations (GPOs) are able to combine orders from practices, hospitals, nursing homes, and other medical facilities in order to receive volume discounts from specific vendors. GPOs tend to be operated by hospital-affiliated purchasing programs, and often include supplies in addition to vaccines. There is usually no requirement to use products of a specific manufacturer; in fact, GPOs often offer vaccines from multiple manufacturers. The GPO option may not be available to all practices in all markets. (<http://www2.aap.org/immunization/pediatricians/GPO.html>)

Health Insurance Plan – A contract for payment or reimbursement of health care costs, generally under individual contract with a health insurance company, group health plan offered in connection with employment, or a government program like Medicare or Medicaid.

Herd Immunity – Situation in which a sufficient proportion of a population is immune to an infectious disease (through vaccination and/or prior illness) to make its spread from person to person unlikely. Even individuals not vaccinated (such as newborns and those with chronic illnesses) are offered some protection because the disease has little opportunity to spread within the community. Herd immunity can be achieved on a community level within a population, or on a smaller scale, such as through “cocooning” an infant with immunity by getting all family members vaccinated.

Medical Home – A model to provide comprehensive primary care that facilitates partnership between patients, physicians, and families through care that is accessible, continuous, comprehensive, patient- and family- centered, coordinated, compassionate, and culturally effective.

Physician Buying Group (PBG) - PBGs offer physicians the option of obtaining the most favorable pricing in return for only using the vaccines produced by contracted manufacturers. In most cases PBGs offer “up-front” discounts based on their respective contract terms with the manufacturers. The PBG typically requires a practice to first use the contracted vaccines, and most programs will remove a practice from the program if it does not comply with these terms, due to the potential for decreasing the discount to other members. The practice is able to benefit from other manufacturer-based features, such as prompt pay discounts, on-line order discounts, and periodic manufacturer promotions.

(<http://www2.aap.org/immunization/pediatricians/GPO.html>)

Privately Insured – Contrast to public insurance such as Medicare, Medicaid etc., privately insured individuals are those who have purchased a health plan individually or obtain one through a group health plan offered in connection with employment.

Relative Value Units (RVUs) – Relative Value Units are a component of the Centers for Medicare and Medicaid’s determination of payment for physician services based on the resources used to provide each service (e.g., the physician’s work, the expenses of the practice, and professional liability insurance).

Self-Insured – Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees’ and dependents’ medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered. In Arizona, approximately 66.5% of the commercial health insurance marketplace is self-insured.

The Arizona Partnership for Immunization (TAPI) - TAPI is a non-profit statewide coalition of over 400 members whose mission is to foster a comprehensive, sustained community program for the immunization of Arizonans against vaccine preventable diseases.

Underinsured – The insurance status of an individual who is enrolled in a health plan that does not cover some or all vaccines or covers vaccines but has a fixed dollar limit or cap for vaccines. Underinsured children are eligible to receive Vaccines for Children vaccine at county health department clinics, Federally Qualified Health Centers, Rural Health Clinics, or other deputized providers in Arizona.

Uninsured – The insurance status of an individual who has no health insurance coverage.

Vaccines for Children – The Vaccines for Children (VFC) program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. CDC buys vaccines at a discount and distributes them to grantees—i.e., state health departments and certain local and territorial public health agencies—which in turn distribute them at no charge to those private physicians’ offices and public health clinics registered as VFC providers. Children who are eligible (Medicaid-eligible, uninsured, underinsured, American Indian or Alaska Native) for VFC vaccines are entitled to receive those vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). (<http://www.cdc.gov/vaccines/programs/vfc/index.html>)

Vaccine Management Cost – A vaccine provider’s management costs associated with providing vaccines, to potentially include: contracting with all health plans, credentialing the site and all providers, contracting with vaccine suppliers, ordering and paying for private vaccine supply,

signing up for VFC, signing up for ASIIS, ordering VFC vaccine through ASIIS, accepting shipment for vaccine/maintaining cold chain, refrigerating vaccine, checking the refrigerator twice daily for temperatures, insuring vaccine, scheduling vaccine appointments, checking patient insurance and VFC eligibility, gathering accurate and complete patient insurance data, verifying insurance coverage for privately insured patients, reporting doses administered to ASIIS, inventorying vaccine stock in refrigerator, reporting dose by lot number and National Drug Code (NDC) to ASIIS for VFC vaccine, faxing temperature logs to VFC, sending record to billing, building claim in electronic system, sending claim to clearinghouse and on to payers, receiving Explanation of Benefit with payment or denial, rebilling denied claims, adjusting actual payment in billing system, reporting payment to patient, recording in billing system, billing patient directly for outstanding balance.

Vaccine Purchase Cost - The price at which the vaccine is purchased through either a distribution center, buying group or direct from the manufacturer.

Appendix 1 – Committee Roster

The Vaccine Financing and Availability Advisory Committee (VFAAC), established pursuant to HB2491, is composed of the following individuals:

Committee members serve under appointment by the Director

Name	Representing
Phyllis Arthur	Vaccine Manufacturer
Daniel Aspery	Health Care Insurer
Andrew Carroll	Family Medicine
Bob England	Local Health Director
Chad Heinrich	Arizona Company offering a health insurance product
Craig Newton	Health Care Insurer
Michael O’Driscoll	Local Health Director
Kelly Ridgway	Statewide Association of Pharmacists
Merrie Rheingans	Nurse Practitioner
Jessica Rigler (Chairperson)	ADHS Director Designee
Amy Shoptaugh	Pediatrician
Jennifer Tinney	Non-Profit Statewide Coalition

Nonvoting members of the committee

Name	Representing
Kim Elliott	Arizona Health Care Cost Containment System
Erin Klug	Department of Insurance

Appendix 2 – Committee Website

The screenshot shows a web browser window displaying the Arizona Department of Health Services website. The page title is "Arizona Immunization Program Vaccine Financing and Availability Advisory Committee". The main content area includes a description of the committee, a list of committee members (both voting and nonvoting), and information about the committee's responsibilities and historical information. A sidebar on the left contains navigation links, and a "Customer Feedback" button is visible on the right.

Arizona Department of Health Services
Health and Wellness for all Arizonans

Home About News A to Z Index Divisions En Español

Enter Search Term(s) [Search]

Bureau of Epidemiology & Disease Control Home
Arizona Immunization Program Home
Get Vaccinated
Parents & Public
Schools & Childcare Centers
Vaccines for Children (VFC)
ASIIS
Healthcare Professionals
Statistics & Reports
Yellow Fever
Perinatal Hepatitis B Program
Newsletters
Annual Conference
Vaccine Financing & Availability Advisory Committee
Vaccine Preventable Diseases (VPD)
Additional Resources

Arizona Immunization Program Office
150 N. 18th Avenue,
Suite 120
Phoenix, AZ 85007
(602) 364-3630
(602) 364-3285 Fax

Arizona Immunization Program Vaccine Financing and Availability Advisory Committee

The Vaccine Financing and Availability Advisory Committee (VFAAC), established pursuant to HB2491, is composed of the following individuals:

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Amy Shoptaugh	Pediatrician
Jennifer Tinney	Non-Profit Statewide Coalition

Nonvoting members of the committee

Name	Representing
Kim Elliott	Arizona Health Care Cost Containment System
Erin Klug	Department of Insurance

The VFAAC is charged with the developing recommendations regarding the following on or before December 15, 2014:

1. The existing system of the financing, storage, distribution and availability of newborn, childhood and adolescent vaccine products and the potential impacts on the healthcare system, taxpayers and the community at large
2. The costs associated with, and the adequacy of reimbursement levels for newborn, childhood, and adolescent vaccines administered by private and public providers in all counties in this state.
3. The vaccine financing, storage, distribution and reimbursement models utilized in other states.

Vaccine Financing and Availability Advisory Committee Historical Information

- December 9th, 2014 Meeting | [Agenda](#)
- December 5th, 2014 Meeting | [Agenda](#)
- November 21, 2014 Meeting | [Agenda](#)
- October 17, 2014 Meeting | [Agenda](#) | [Minutes](#)

For Copies of Immunization Records
Please fill out [this form](#) and send via the following:
Fax: 602-364-3285
Email: ASISrequest@azdhs.gov
Phone: 602-364-3899 or toll free 1-877-491-5741

Customer Feedback

<http://www.azdhs.gov/phs/immunization/financing-advisory-committee.php>

The Journal of Infectious Diseases

Measles Outbreak Underscores Need for Continued Vigilance in Health Care Settings

04/29/2011

The U.S. measles vaccination program has been successful in eliminating endemic measles in the United States; yet this success has provided challenges that require ongoing vigilance for the rapid identification and response to measles cases in health care settings. In 2008, the largest reported health care-associated measles outbreak in the United States since 1989 occurred in Tucson, Arizona, costing approximately \$800,000 in response and containment efforts. In a report published in *The Journal of Infectious Diseases* and now available [online](#), researchers identify preventive measures hospitals and health care facilities can implement to reduce the likelihood and decrease the economic impact of a future measles outbreak in these settings.

Due to a highly effective vaccine and high vaccine coverage, measles was declared eliminated in the United States in 2000; however, the potential for measles infection still exists in this country. Non-adherence to U.S. vaccination recommendations and infection among unvaccinated travelers coming into the United States continue to pose potential threats to the public and to health care personnel. In the 2008 Tucson outbreak, an unvaccinated, infected Swiss traveler visited a hospital emergency department on February 12. The traveler was admitted to the hospital the next day, but a measles diagnosis was not confirmed until February 20. This ignited an intense and lengthy public health investigation and response to persons with suspected and confirmed measles as well as contacts of those persons.

From February 13 through July 21, 2008, there were 363 suspected, 8 probable, and 14 confirmed measles cases in Tucson. All 14 confirmed case-patients were unvaccinated. Seven of the 14 cases were classified as health care-associated infections, and 6 of those cases occurred in a single hospital. Health care-associated transmission included transmission from patient to health care personnel, from health care personnel to patient, from patient to patient, and from patient to visitor.

As part of the investigation, health care facilities attempted to access records documenting evidence of measles immunity for 14,844 health care personnel at seven hospitals. However, none of the hospitals maintained electronic records of health care personnel immunity status, so they were instead forced to review paper records. Without readily accessible electronic records clearly showing immunity status, unnecessary serologic testing was conducted for some personnel who were immune to measles. A total of 4,448 health care personnel at the seven hospitals received immediate measles vaccinations because they lacked documentation of measles immunity. About 15,120 employee hours were lost in furloughs because of presumptive exposure, disease, or lack of evidence of immunity. Overall, the estimated economic impact for just two of the hospitals was almost \$800,000, with furloughs for health care personnel accounting for 56 percent of that cost.

In this report, Sanny Y. Chen, PhD, along with colleagues at the Centers for Disease Control and Prevention and Arizona health authorities show the high costs hospitals can incur when responding to measles outbreaks in their facilities. To minimize these costs and to prevent the health care-associated spread of measles, they stress that hospitals must (1) ensure rapidly retrievable measles immunity records for health care personnel, (2) consider measles as a diagnosis, especially among patients presenting with fever, rash, and a recent history of international travel or contact with a person with a clinically consistent rash illness, and (3) institute immediate airborne isolation of patients with suspected and confirmed measles.

The authors believe that a number of factors contributed to the Tucson outbreak, including the following:

- lack of adherence to U.S. vaccine policy recommendations,
- delayed implementation of infection-control procedures in health care settings with patients/personnel experiencing respiratory symptoms,

- delayed implementation of isolation procedures in health care settings with patients with an illness clinically compatible with measles, and
- delayed diagnosis of cases by health care personnel and delayed laboratory confirmation due to lack of awareness of measles.

In an accompanying editorial, Stephen M. Ostroff, MD, of the Pennsylvania Department of Health, calls the report a sobering wake-up call for health departments and hospitals across the country. Recounting the percentage of health care personnel who lacked immunity to measles in the Tucson outbreak, Dr. Ostroff concludes that the same situation most likely exists among other U.S. hospital personnel. International travel and the decision by some individuals to opt out of vaccination increase the risk of future outbreaks, he notes.

The editorial emphasizes major challenges in measles in the post-elimination era in the United States: late diagnosis of cases and delayed reporting to the health department. Prompt reporting of the suspected case could have prevented the spread of infection and minimized the expense incurred to investigate the outbreak, notes Dr. Ostroff, who adds that it is essential to prevent health care personnel from acting as vehicles of infection transmission to others by ensuring that all staff are appropriately vaccinated unless they have other acceptable evidence of measles immunity.

Health Care–Associated Measles Outbreak in the United States After an Importation: Challenges and Economic Impact
<http://jid.oxfordjournals.org/content/early/2011/04/25/infdis.jir115.full>

Measles: Going, Going, But Not Gone
<http://jid.oxfordjournals.org/content/early/2011/04/25/infdis.jir125.full>

- See more at: http://www.idsociety.org/Measles_Outbreak_PR/#sthash.Qsa75w7V.dpuf

Appendix 4 – Arizona Academy of Pediatrics: Pediatric Council

HOME ABOUT US MEMBERS ADVOCACY COMMITTEES PROGRAMS RESOURCES



THE AMERICAN ACADEMY OF
PEDIATRICS
ARIZONA CHAPTER

DEDICATED TO THE HEALTH
OF ARIZONA CHILDREN

OUR PROGRAMS



Best Care
for Kids
We measure up!



Pediatric Prepared
Emergency Care
Making the emergency visit for parents easier



5 2 1 0
AZ Way
To Go!



Reach
Out
& Read
where great stories begin!



MEDICAL
SERVICES PROJECT

Vaccine Acquisition and Administration

To ensure that important childhood immunizations continue to be provided in the [medical home setting](#), the Pediatric Council educates health plans about the true costs of immunization. The AzAAP position is outlined in the 2012 bill introduced to the legislature (see below). Likewise, the Pediatric Council provides tools to our members about how to advocate for timely and appropriate payment when negotiating new contracts, in the event of vaccine price increases, and when new codes are introduced. They provide regular updates in the [AzAAP Pediatric Update](#) and [bi-annual newsmagazine](#) and collaborate to host the annual Practice Efficiency and the Business of Vaccines Conference. Realizing that immunization is a public health issue with multiple stakeholders, they also collaborate to host Immunization Congresses.

2012 Vaccine Funding Changes

- [October 4, 2012 Webinar](#) (may take a few minutes to download)
- [VFC Dose by Dose Accountability Instructional Video](#) (October, 2012)

2012 Vaccine Legislation: HB2739

- [HB2739 Key Points](#) (February, 2012)
- [HB2739 Fact Sheet](#) (February, 2012)

Vaccine Advocacy:

- [New Vaccine Administration Codes Update](#) (March, 2011)
- [Pevnar13 Update](#) (August, 2010)
- [National Immunization and the AAP](#) (January, 2010)
- [2008 Vaccine Survey - PowerPoint Presentation](#) (May, 2009)
- [2007 Vaccine Survey - Abstract](#) (April, 2008)
- [2007 Vaccine Survey - PowerPoint Presentation](#) (April, 2008)

Visit the following links for other resources:

- [Vaccine Resources](#) (this section requires member login to view)
- [Private Payer Advocacy Updates](#) (this section requires member login to view)
- [Health Information Technology Resources](#) (this section requires member login to view)

[JOIN or RENEW](#)

[INVEST](#)

790

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UPCOMING events

[SPEAK UP FOR KIDS - Holiday Soirée](#)

Monday, December 08, 2014 6:15 PM • ASU Karsten Golf Course - Trophy Room Restaurant - 1125 East Rio Salado Parkway Tempe, Arizona 85281

[East Valley Pediatric Society Meeting](#)

Tuesday, December 09, 2014 12:30 PM • Floridino's Pizza and Pasta (Alma School and Chandler Blvd.)

[Cardon's Pediatric Grand Rounds](#)

Wednesday, December 17, 2014 12:30 PM • Rosati Education Center on the Banner Desert campus, 1400 S. Dobson Road, Mesa, AZ 85202.

MEMBERSpotlight



Pamela Villar, MD, FAAP

Dr. Villar says, "I am very thankful to be a part of the AzAAP because it has been so helpful to belong to a community that is so supportive."

[Read more >>>](#)

http://www.azaap.org/Vaccine_Acquisition_and_Administration

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LEAD COMMENTARIES

Reducing Financial Barriers to Vaccination in the United States: Call to Action

Guthrie S. Birkhead, Walter A. Orenstein, and Jon R. Almquist

Pediatrics December 2009; 124:Supplement 5 S451-S454; doi:10.1542/peds.2009-1542B

Immunization Financing: Key Area for American Academy of Pediatrics Advocacy

David T. Tayloe, Jr

Pediatrics December 2009; 124:Supplement 5 S455-S456; doi:10.1542/peds.2009-1542C

Financing Vaccines: Cornerstone of Prevention

Bruce G. Gellin and Angela K. Shen

Pediatrics December 2009; 124:Supplement 5 S457-S458; doi:10.1542/peds.2009-1542D

ORIGINAL RESEARCH

Variation in Provider Vaccine Purchase Prices and Payer Reimbursement

Gary L. Freed, Anne E. Cowan, Sashi Gregory, and Sarah J. Clark

Pediatrics December 2009; 124:Supplement 5 S459-S465; doi:10.1542/peds.2009-1542E

Primary Care Physician Perspectives on Reimbursement for Childhood Immunizations

Gary L. Freed, Anne E. Cowan, and Sarah J. Clark

Pediatrics December 2009; 124:Supplement 5 S466-S471; doi:10.1542/peds.2009-1542F

Net Financial Gain or Loss From Vaccination in Pediatric Medical Practices

Margaret S. Coleman, Megan C. Lindley, John Ekong, and Lance Rodewald

Pediatrics December 2009; 124:Supplement 5 S472-S491; doi:10.1542/peds.2009-1542G

Cost of Vaccine Administration Among Pediatric Practices

Judith E. Glazner, Brenda Beaty, and Stephen Berman

Pediatrics December 2009; 124:Supplement 5 S492-S498; doi:10.1542/peds.2009-1542H

Cost of Universal Influenza Vaccination of Children in Pediatric Practices

Byung-Kwang Yoo, Peter G. Szilagyi, Stanley J. Schaffer, Sharon G. Humiston, Cynthia M. Rand, Christina S. Albertin, Phyllis Vincelli, Aaron K. Blumkin, Laura P. Shone, and Margaret S. Coleman

Pediatrics December 2009; 124:Supplement 5 S499-S506; doi:10.1542/peds.2009-1542I

Underinsurance and Pediatric Immunization Delivery in the United States

Philip J. Smith, Noelle-Angelique Molinari, and Lance E. Rodewald

Pediatrics December 2009; 124:Supplement 5 S507-S514; doi:10.1542/peds.2009-1542J

Underinsurance and Adolescent Immunization Delivery in the United States

Philip J. Smith, Megan C. Lindley, Abby Shefer, and Lance E. Rodewald

Pediatrics December 2009; 124:Supplement 5 S515-S521; doi:10.1542/peds.2009-1542K

Role of Health Insurance in Financing Vaccinations for Children and Adolescents in the United States

Angela K. Shen, John Hunsaker, Julie A. Gazmararian, Megan C. Lindley, and Guthrie S. Birkhead
Pediatrics December 2009; 124:Supplement 5 S522-S531; doi:10.1542/peds.2009-1542L

Health Insurance Plans and Immunization: Assessment of Practices and Policies, 2005–2008

John Hunsaker, German Veselovskiy, and Julie A. Gazmararian
Pediatrics December 2009; 124:Supplement 5 S532-S539; doi:10.1542/peds.2009-1542M

Perspective of Vaccine Manufacturers on Financing Pediatric and Adolescent Vaccines in the United States

Angela K. Shen, Lance E. Rodewald, and Guthrie S. Birkhead
Pediatrics December 2009; 124:Supplement 5 S540-S547; doi:10.1542/peds.2009-1542N

NATIONAL VACCINE ADVISORY COMMITTEE REPORT

Financing the Delivery of Vaccines to Children and Adolescents: Challenges to the Current System

Megan C. Lindley, Angela K. Shen, Walter A. Orenstein, Lance E. Rodewald, and Guthrie S. Birkhead
Pediatrics December 2009; 124:Supplement 5 S548-S557; doi:10.1542/peds.2009-1542O

Financing Vaccination of Children and Adolescents: National Vaccine Advisory Committee Recommendations

National Vaccine Advisory Committee
Pediatrics December 2009; 124:Supplement 5 S558-S562; doi:10.1542/peds.2009-1542P

STAKEHOLDER COMMENTARIES

Industry Perspectives: Ensuring Vaccination of Children and Adolescents Without Financial Barriers

Mark B. Feinberg and Lance Gordon
Pediatrics December 2009; 124:Supplement 5 S563-S564; doi:10.1542/peds.2009-1542Q

Vaccination in the United States: Payer Perspective on the Working Group and Its Recommendations

Alan B. Rosenberg
Pediatrics December 2009; 124:Supplement 5 S565-S566; doi:10.1542/peds.2009-1542R

Ensuring Access to Vaccines Without Financial Barriers: View of Consumers

Deborah L. Wexler, Lisa H. Randall, and Amy Pisani
Pediatrics December 2009; 124:Supplement 5 S567-S568; doi:10.1542/peds.2009-1542S

National Vaccine Advisory Committee 2008 Vaccine Financing Recommendations: Different Point of View

Jon S. Abramson
Pediatrics December 2009; 124:Supplement 5 S569-S570; doi:10.1542/peds.2009-1542T

Maintaining the Vaccine Safety Net

Claire Hannan, Anna DeBlois Buchanan, and Judy Monroe
Pediatrics December 2009; 124:Supplement 5 S571-S572; doi:10.1542/peds.2009-1542U

ADDITIONAL RESOURCES

Vaccine Finance Resources for Physicians

Elizabeth Sobczyk
Pediatrics December 2009; 124:Supplement 5 S573-S576; doi:10.1542/peds.2009-1542V

Appendix 6 – What it Takes to Give a Shot

WHAT IT TAKES TO GIVE A SHOT...

Contract with all health plans
Credential site and all providers
Contract with vaccine suppliers
Order and pay for private vaccine supply
Sign up for VFC
Sign up for ASIIS
Order VFC vaccine through state registry
ASIIS
Accept shipment for vaccine
Maintain cold chain
Refrigerate vaccine
Check refrigerator twice daily for temps
Insure vaccine
Schedule vaccine appointment
Check insurance and VFC eligibility
Gather accurate and complete insurance data
Verify insurance coverage for private
Check the patient record book
Check ASIIS for shot history
Screen patients for what's needed and contraindications
Counsel patient
Give VIS for every vaccine

Get parent signature on each vaccine
Change the exam table paper
Draw up vaccine
Swab with alcohol
Inject vaccine
Band-Aid the site
Appropriately dispose of sharps
Comfort the child
Give child a sticker
Update the parent record book
Record correct diagnosis code for record
Record cpt to record
Record NDC and lot number to record
Update EHR
Report to ASIIS
Inventory vaccine
Stock in refrigerator
Report dose by Lot number and NDC to ASIIS for VFC
Fax temp logs to VFC
Send record to billing
Build claim in electronic system all 33 boxes
Send claim to clearinghouse and on to payers
Receive EOB with payment or denial
Rebill 15% of claims for denial
Adjust actual payment in billing system
Report payment to patient record in billing system
Bill patient directly for outstanding balance

PAYMENTS

Administration Fee:

Nurse time and supplies

- VFC rate set in 1983 at \$15.43
- \$10 Average admin fee AHCCCS Plans
- \$15-\$25 Private sector range

Vaccine cost :

Vaccine + Storage and Management

- Purchase price set by manufacturer
- Payment determined by health plans
- Ranges 60% below price to 30% above

Billing:

- Each claim costs ~ \$4.50 to submit

Appendix 7 – Arizona Vaccine Congress Agendas



Arizona Immunization/Vaccine Congress October 7, 2008 Agenda

- 8:30-9:00 Continental Breakfast - Meet and Greet
Opening Session
- 9:00-9:05 Welcome: Ron Fischler, MD, FAAP, AzaAAP President
- 9:10 – 9:30 AAP Task Force on Immunizations: Jon Almquist, MD
- 9:30-1:15 Immunization/Vaccine Overview - National to Local
- ❖ 9:30-10:00 Vaccine Safety and Public Health
Karen Lewis, MD (30 minutes)
 - ❖ 10:00-10:30 Vaccine Funding in Public Health
Kathy Fredrickson (30 minutes)
 - ❖ 10:30-10:50 ASIIS Tools and Limited Resources
Debbie McCune Davis (20 minutes)
 - ❖ 10:50-11:15 The Cost of Providing Vaccines in AZ Practices
Jeff Couchman, MD (25 minutes)
 - ❖ 11:15-11:30 Challenges and Complexities in Vaccine Development
Jim Seiboldt, Pharm D (15 minutes)
 - ❖ 11:30-12:15 Dialogue on Payment and Educational Initiatives with Vaccine
Manufacturers (30 minutes)
 - GlaxoSmithKline
 - MedImmune
 - Merck Vaccines
 - sanofi pasteur
 - Wyeth Vaccines
 - Novartis Vaccines
 - ❖ 12:15-12:30 Immunization Coverage Goals for Health Plans
Kim Elliott, PhD (AHCCCS) (15 minutes)
 - ❖ 12:30-1:15 Dialog on Coverage, Reimbursement and Best Practice in Arizona
 - Blue Cross Blue Shield of Arizona
 - Health Choice
 - Aetna
 - AHCCCS
- Brief Questions and Answers during each segment***
- 1:15-2:30 Lunch with Round Table Discussion
 - Immunization Delivery Solutions
 - Immunization Insurance Coverage Solutions
- 2:30-3:15 Recap and Action Items
- 3:15-3:30 Closing Remarks



Arizona Immunization/Vaccine Congress II
January 27, 2010
Draft Agenda

- 8:30-9:00 Continental Breakfast - Meet and Greet
- 9:00-9:15 Opening Session
Welcome: Keith Dveirin, MD, FAAP, AzAAP
Overview of the first Congress
- 9:15-1:45 Vaccine Overview - National to Local, Developing a Work Plan
- ❖ 9:15-10:00 Ethics in Healthcare Leadership
Dr. Jack Gilbert, ASU (45 minutes)
 - ❖ 10:00-10:15 State Budget Shifts and Impact to Immunizations
Patty Gast, AZDHS (15 minutes)
 - ❖ 10:15-10:30 County Public Clinic Reimbursement Project
TAPI (15 minutes)
 - ❖ 10:45-11:00 NVAC recommendations
Megan Lindley, CDC (15 minutes)
 - ❖ 10:30-10:45 National Vaccine Coding and Antigen Reimbursement Discussions
Isabelle Claxton, GlaxoSmithKline (15 minutes)
 - ❖ 11:15-11:30 National AHIP Roundtable meeting and overview
June Fisher, sanofi pasteur (15 minutes)
 - ❖ 11:00-11:15 Impact of budget cuts to immunizations in AHCCCS health plans
Tom Betlach, AHCCCS (15 minutes)
 - ❖ 11:30-11:45 National AAP Initiatives
Amy Shoptaugh, MD, FAAP, AzAAP (15 minutes)
 - ❖ 11:45-12:00 ACIP Perspective in Vaccine Financing
Doug Compose Outcalt, MD, FAAP, U of A [invited] (15 minutes)
- Brief Questions and Answers during each segment***
- 12:00-1:15 Lunch/Round Table Discussion: Identifying next projects
- Identifying Arizona's Vaccine Financing Priorities
 - Engaging Employers in Preventative Health Converge
- 1:15-1:45 Recap and Action Items
- 1:45-3:00 Flu Vaccine Distribution, Mapping Next Season
- ❖ 1:45-2:45 H1N1 Flu Response: Future Recommendations
Flu Panel (60 minutes)
Will Humble, ADHS
Dr. Bob England, Maricopa County
Dr. Jeff Couchman, AzAAP
John Roehm, Mollen Clinics
 - ❖ 2:45-3:00 Round Table Discussion and reports (15 minutes)
- 3:00 Closing Remarks



**Arizona Vaccine Congress III
May 14, 2012
Agenda**

- 8:00-9:00 Registration Continental Breakfast - Meet and Greet
9:00-9:10 Opening Session Welcome: Arturo Gonzalez, MD, FAAP, AzAAP President
9:10-9:20 Doug Campos Outcalt, MD, ACIP (invited)
9:20-9:35 Vaccine Funding Changes in Public Health,
Patty Gast, ADHS

Immunization/Vaccine Delivery System Overview

- ❖ 9:35-9:50 Vaccines in County Health Departments
Dr. Bob England (15 minutes)
- ❖ 9:50-10:00 Billing in Public Health/Physician Surveys
Jennifer Tinney (10 minutes)
- ❖ 10:00-10:15 The Cost of Providing Vaccines in AZ Practices
Mike Perlstein, MD (15 minutes)
- ❖ 10:15-10:30 Vaccine Legislation 2012
Representative Nancy McLain and Representative Debbie McCune Davis
15 minute break
- ❖ 10:45-11:00 Summary of Gaps and Potential risks to AZ kids
AD Jacobson, MD, TAPI President (15 minutes)

Setting the Stage for Proposed Solutions

- ❖ 11:00-11:15 Vaccine Association Proposal for Universal or Group Purchase State
David Childers, AHIP (15 minutes)
- ❖ 11:15-11:30 Immunization Coverage Goals for AHCCCS Health Plans (Assessment)
Marc Leib, MD (15 minutes)
- ❖ 11:30-11:45 HEDIS Immunization Measures
Karlene Wenz, AHIP (15 minutes)
- ❖ 11:45-12:00 Payment Initiatives with Vaccine Manufacturers
Phyllis Arthur, BIO (15 minutes)
- ❖ 12:00-12:30 Dialog on Proposals for Immunization Best Practice in Arizona
Panel Moderated by Will Humble, ADHS (30 minutes)
AHIP AzAAP
BIO ArMA
Health Officers AHCCCS

Brief Questions and Answers During Each Segment

- 12:30-2:00 Lunch with Round Table Discussion
- Proposed Immunization Funding Solutions
 - Avoiding Potential Gaps in Immunization Coverage
- 2:00-2:30 Recap and Action Items
2:30-3:00 Closing Remarks