Oregon Vaccine Finance Model and Impacts to Access

BACKGROUND | CURRENT STATE | LOOKING AHEAD

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Topics to cover

- Introduction
- Background
- Current state
- Data Trends
- Looking forward

Introduction

LEVEL SETTING

Why focus on our vaccine finance model?

- Impact to multiple health system sectors
  - Immunizing clinics, pharmacies, hospitals
  - Local public health
  - Health plans / payors
  - Health system
- Costs of inaction
  - Missed opportunities
  - Cost to treat, care for vaccine-preventable disease

What is **equitable** access?

- **Equity** (World Health Organization, abridged): the absence of avoidable or remediable differences among groups of people
- **Equitable vaccine access**: Every person is able to access vaccine, regardless of socioeconomic status, race, language, geography, insurance status, or citizenship.

OHA's 2030 goal

Oregon Health Authority:
Strategic goal to **eliminate health inequities** in Oregon by 2030.

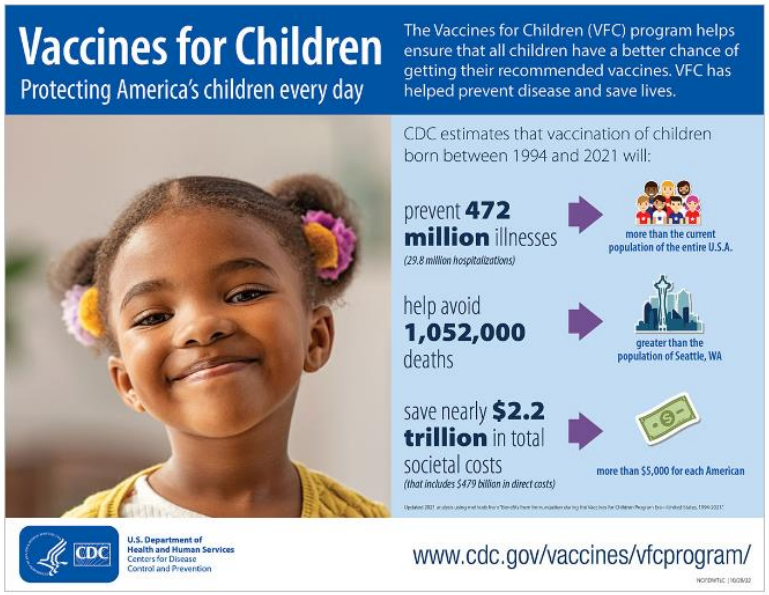
Background

30-YEAR VACCINE FINANCE MODEL

30-year vaccine finance model

Vaccination programs

- Vaccines for Children (VFC) program
- Section 317
- Vaccine Access Program (VAP) and “Billable” vaccine
- Other, as needed



Vaccine Access Program (VAP)

- 2002: State program, designed to improve access
- Allowed local public health clinics to:
  - Serve all clients, regardless of insurance type
  - Bill payors for well insured “Billable” clients
  - Avoid up-front costs of vaccine purchasing
  - Maintain a single stock of vaccine
- Later expanded to other provider types:
  - Federally Qualified Health Centers (FQHCs)
  - Some private clinics serving special populations

Oregon Health Authority

Current State

BARRIERS TO PARTICIPATION & ACCESS

Challenges

- The patchwork of vaccine supply programs
- Rising vaccine costs
- Insufficient public health funding – state/local
- ALERT IIS technology needs
- COVID commercialization and new vaccines
- Growing complexity
- Others…

The “patchwork”

- Vaccines for Children (VFC) program
- 317-funded vaccine
- Vaccine Access Program (VAP)
- Bridge Access Program
- Others, as needed

Vaccine financing: Oregon

Federal

- **Vaccines for Children (VFC)**
  - Uninsured
  - Medicaid eligible
  - AI/AN
- **317**
  - Uninsured adults

State

- **Billable Vaccine**
  - Adults on OHP, Medicare
  - Children & adults w/ private insurance

Vaccine Access Program (VAP)

- All LPHAs
- Most FQHCs
- Tribal clinics
- Some private clinics serving special populations
- = 46% (~300 clinics)

- Other 54% are private VFC only clinics

VFC

Provider types

- VFC only
- Vaccine Access Program (VAP)
- Specialty
- Not enrolled but vaccinate
- Refer patients out

Determines:

1. Where providers get vaccine
2. How it's paid for
3. What piece of the patchwork they can access for patients

Vaccine Access Program no longer sustainable

- Significant vaccine cost increases
- Direct ship vaccines
- Waitlist for enrollment
- Reduction to some vaccine orders
- No dedicated funding to support operations, yet growing complexity to manage

Increased vaccine costs, Billable doses, Dec 2005 to Jan 2024

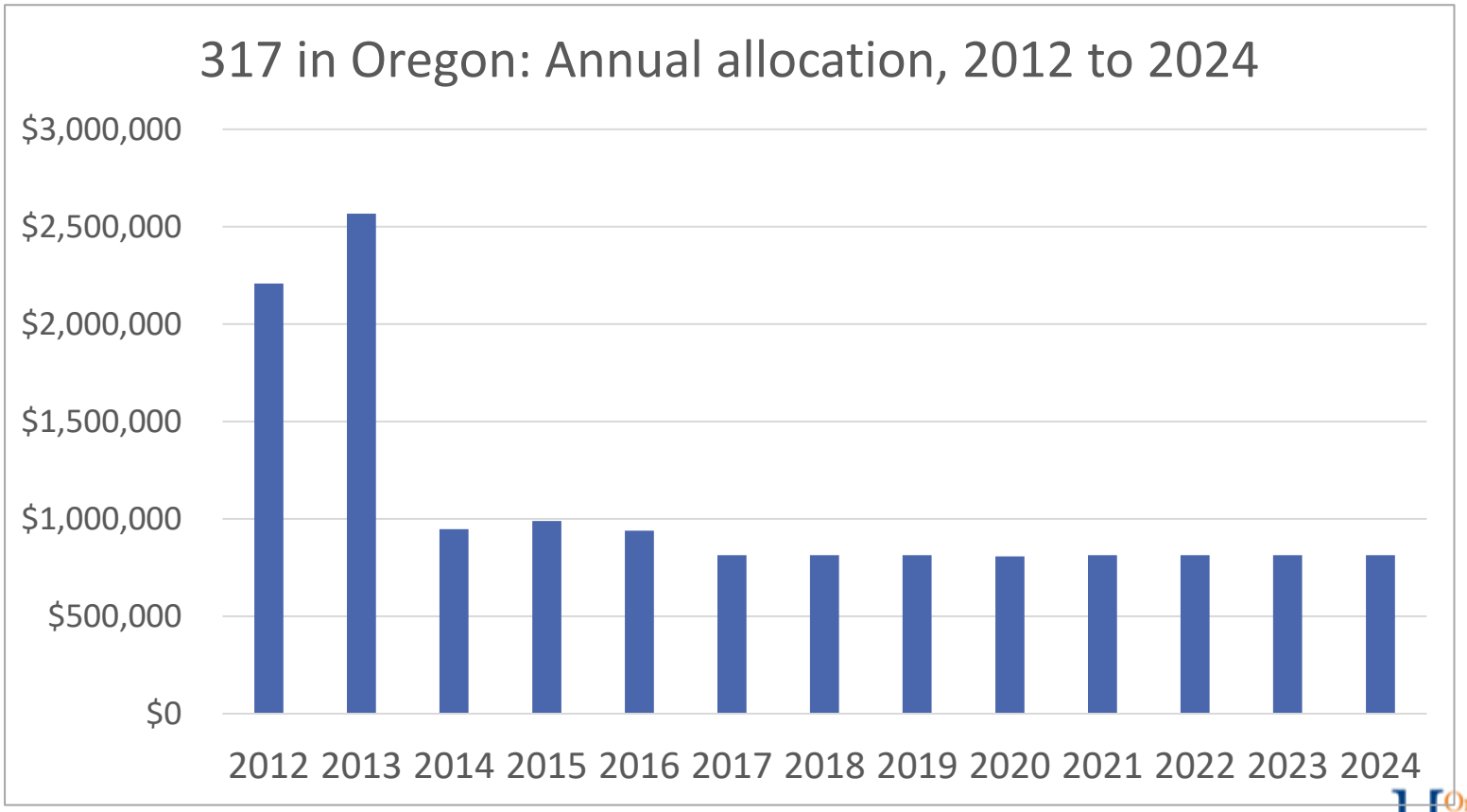
Timeframe	Total cost, 1 dose of each vaccine available	Percent increase since Dec 2005
Dec 2005	$646.51	-
Dec 2010	$2,065.55	219%
Dec 2015	$2,727.35	322%
Dec 2022	$3,939.47	509%
Dec 2024	$5,768.09	792%

Insufficient public health funding – state

OHA's Immunization Program

	1999	Today
Staffing levels	33	40
Enrolled clinics	150	650
Vaccines to manage	5	22
Vaccine budget	$750,000	$117,137,465
Oregon population	3,393,410	4,239,379

Section 317 flat funding



Insufficient public health funding – local

Oregon's decentralized public health structure

- Role to assure access
- Statutorily-required activities
- Contracted activities with OHA/Immunization Program

Downstream impact of challenges to LPH

- School exclusion and increased exemptions
- Risk of disease outbreak
- Role as safety net

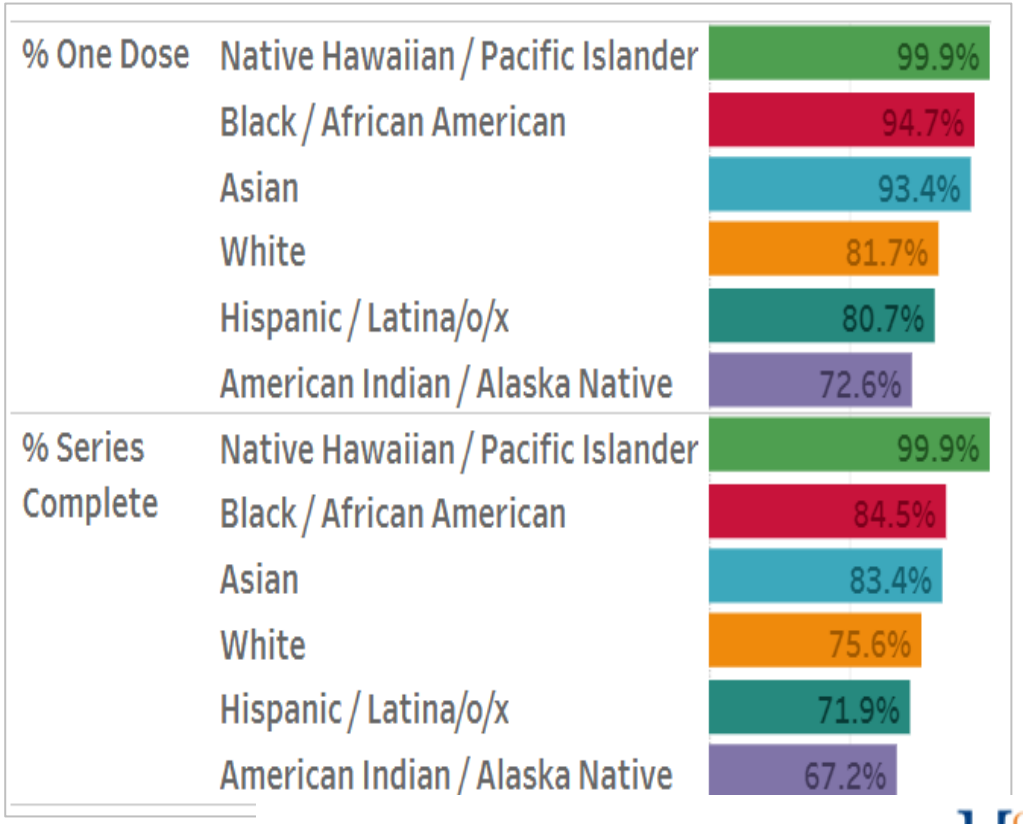
COVID-19 commercialization: then and now

THEN: COVID-19 vaccine rollout—

- Removed barriers for providers: no “patchwork” to navigate; no cost for vaccines, testing, therapeutics
- Removed barriers for public: no cost, no insurance requirements; expanded vaccine access options
- Centered equity: community engagement and funding, culturally and linguistically appropriate materials and events

COVID-19 commercialization: then and now

THEN: COVID-19 Vaccination by race/ethnicity, September 2022



COVID-19 commercialization: then and now

NOW: COVID-19 commercialization—

- Providers: vaccine absorbed into patchwork, costs to purchase, navigating billing, Bridge Access Program
- Public: confusion, significantly reduced access, cost and insurance requirements
- Equity considerations: COVID community engagement grants ended, limited duration positions ended, infrastructure no longer supported

COVID-19 commercialization: then and now

Association of Immunization Managers:

"When this emergency funding soon expires, our immunization programs will shrink back to near pre-pandemic levels. ***This is akin to building a fleet of battleships that are sent out to win one battle, and then immediately brought back to be scrapped or mothballed."***

-March 23, 2023, testimony to the House Appropriations Committee's Subcommittee on Labor, Health & Human Services, Education, and Related Agencies

New vaccines: 2022-2023

- Pneumococcal vaccines – PCV15, PCV20
- COVID-19 – commercialization
- Respiratory Syncytial Virus (RSV)
  - 2 adult vaccines
  - New RSV MaB (nirsevimab)
- Coverage requirements

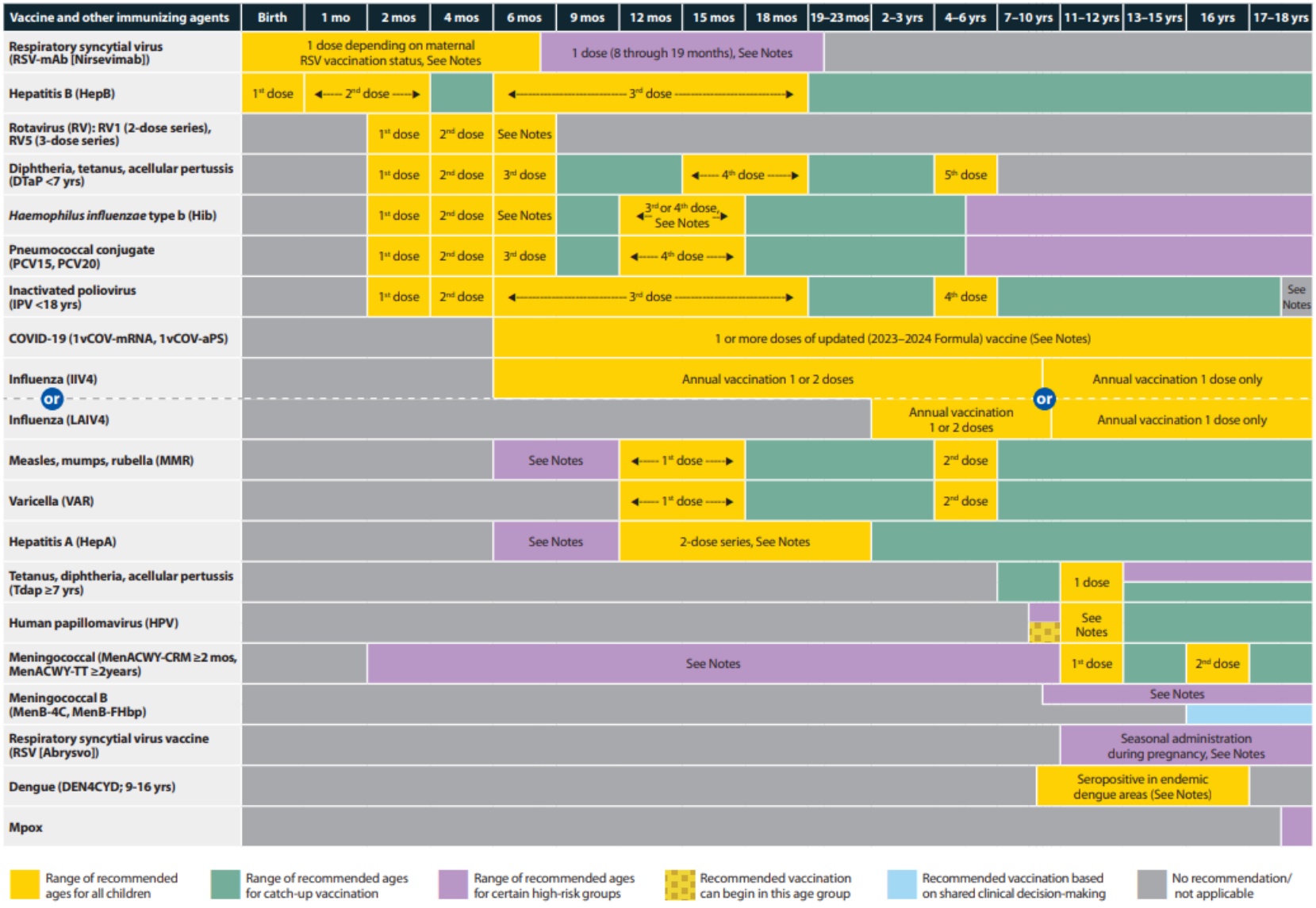
Growing complexity

1995 Immunization Schedule

Vaccine	Birth	2 Months	4 Months	6 Months	12 Months	15 Months	18 Months	4–6 Years	11–12 Years	14–16 Years
Hepatitis B	HB-1	HB-2		HB-3						
Diphtheria-Tetanus-Pertussis (DTP)		DTP	DTP	DTP	DTP or DTaP ≥ at 15 months			DTP or DTaP	Td	
Haemophilus influenzae type b		Hib	Hib	Hib	Hib					
Poliovirus		OPV	OPV	OPV				OPV		
Measles-Mumps-Rubella					MMR			MMR	or MMR	

Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars.
To determine minimum intervals between doses, see the catch-up schedule (Table 2).



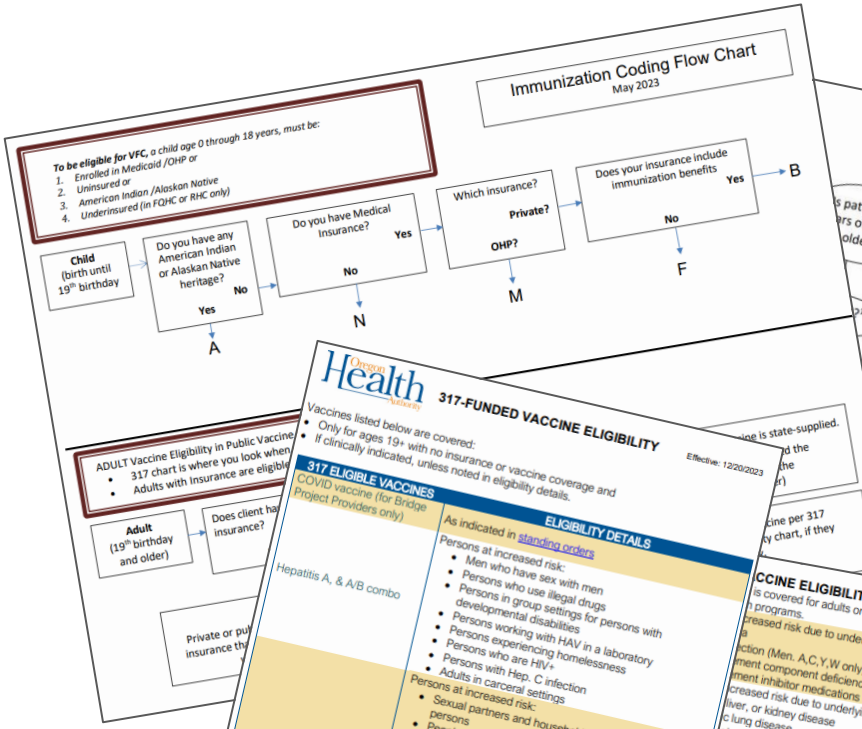
Into the weeds we go…

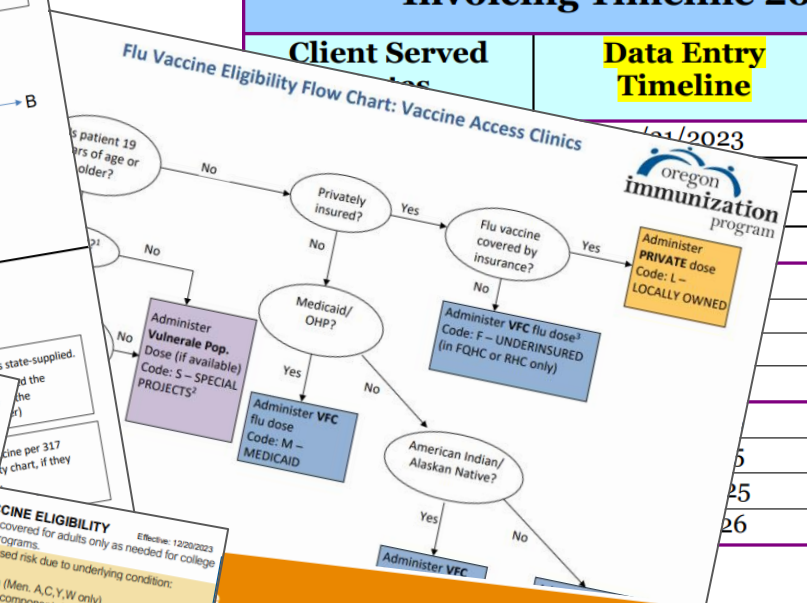
Clinic considerations

- Clinic workflow
- Eligibility coding
- Billing
- Ordering / purchasing
- Documentation
- Hesitancy / questions

State of Oregon: Billable Vaccine Project Invoicing Timeline 2023-2025

Client Served	Data Entry Timeline	Bill Issued
	/2023	July, 2023
		October, 2023
		January, 2024
		April, 2024
		July, 2024
		October, 2024
		January, 2025
		April, 2025
		July, 2025
	5	October, 2025
	25	January, 2026
	26	April, 2026





Patient Population	Eligibility Code	Vaccine Stock
No Insurance	N	State
OHP/Medicaid (children only)	M	
American Indian/Alaskan Native	A	
Underinsured (in FQHC/RHC only)	F	
Other State-supplied, 317 (uninsured, under-insured, and special exceptions*)	O	
Billable (Privately insured patients and adults on OHP/Medicaid)	B	
Special Projects	S	
Locally Owned (privately purchased vaccine)	L	Private

Patient Age		
0 through 18	No Insurance	
	OHP/Medicaid (children	
	American Indian/Alaska	
	Underinsured (in FQHC/RHC only)	S
	Billable (Privately insured patients and adults on O	
All Ages	Special Projects (rarely used, only when funds are available)	

Oregon Health Authority

Other barriers creating access gaps

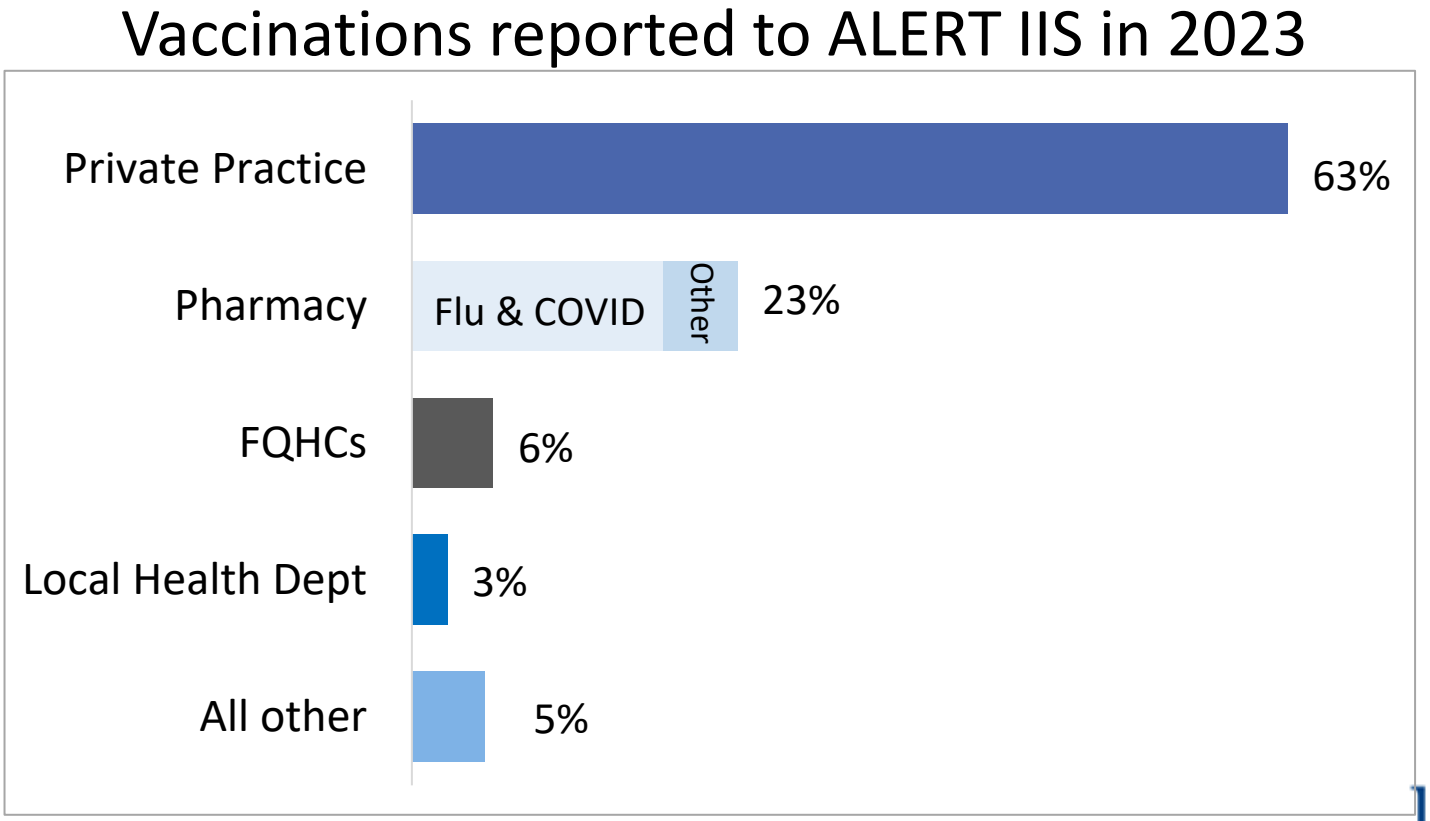
- VFC enrollment barriers
  - Clinics
  - Pharmacies
  - Hospitals
- Long-term care facility gaps
- Pharmacy closures
- Medicare contracting for local public health
- And more…

The maze

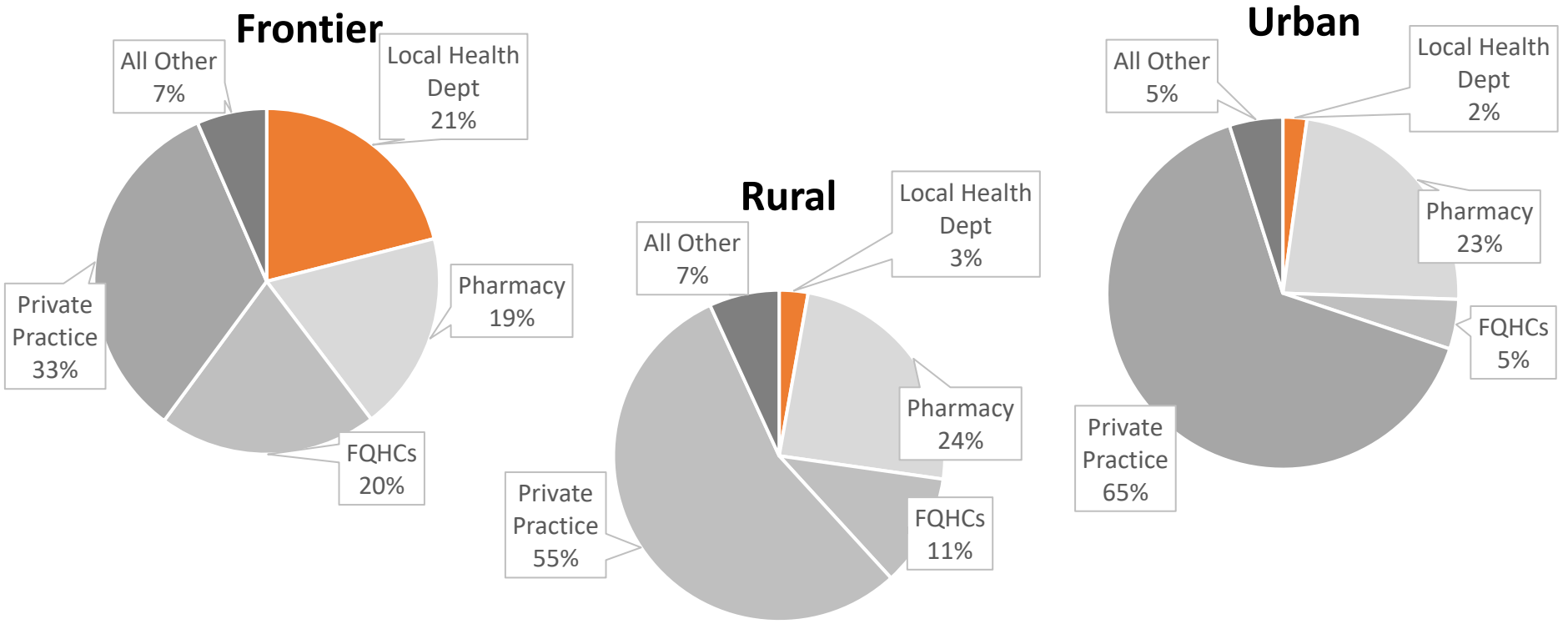
Data Trends

2-YEAR-OLD | ADOLESCENT | FLU | EXEMPTIONS

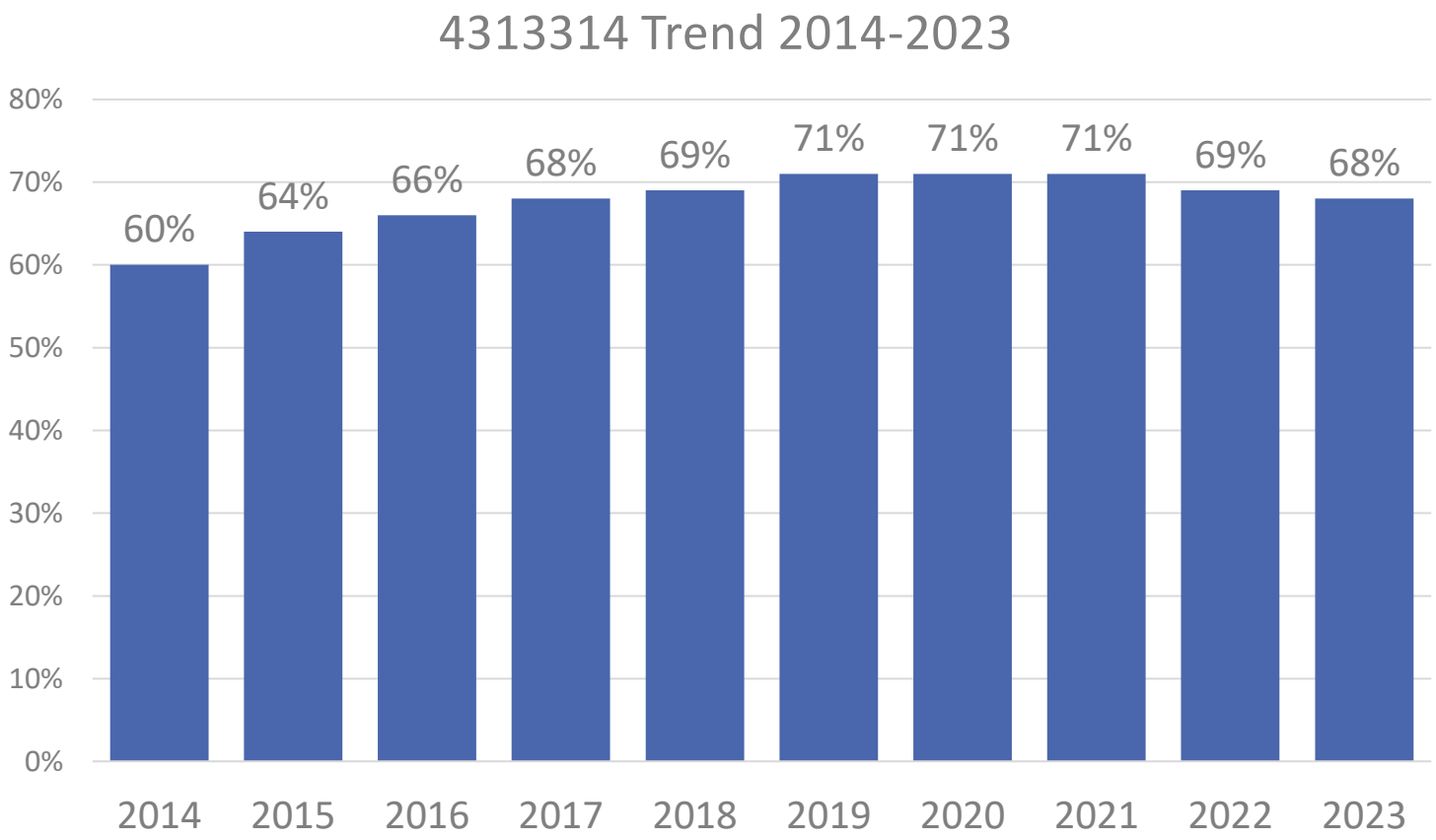
Where do people in Oregon get vaccinated?



Access in frontier vs. rural and urban counties



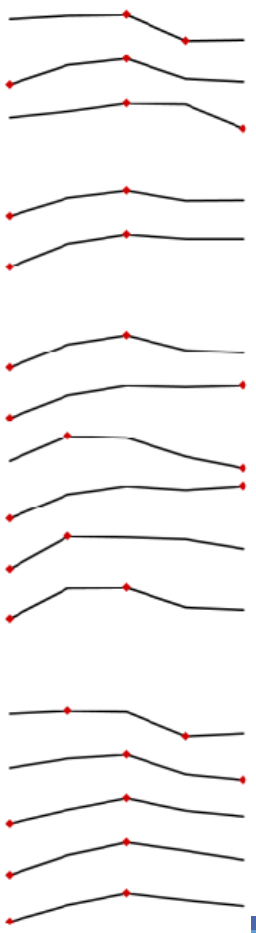
Oregon **two-year-old** up-to-date rate, 2014-2023



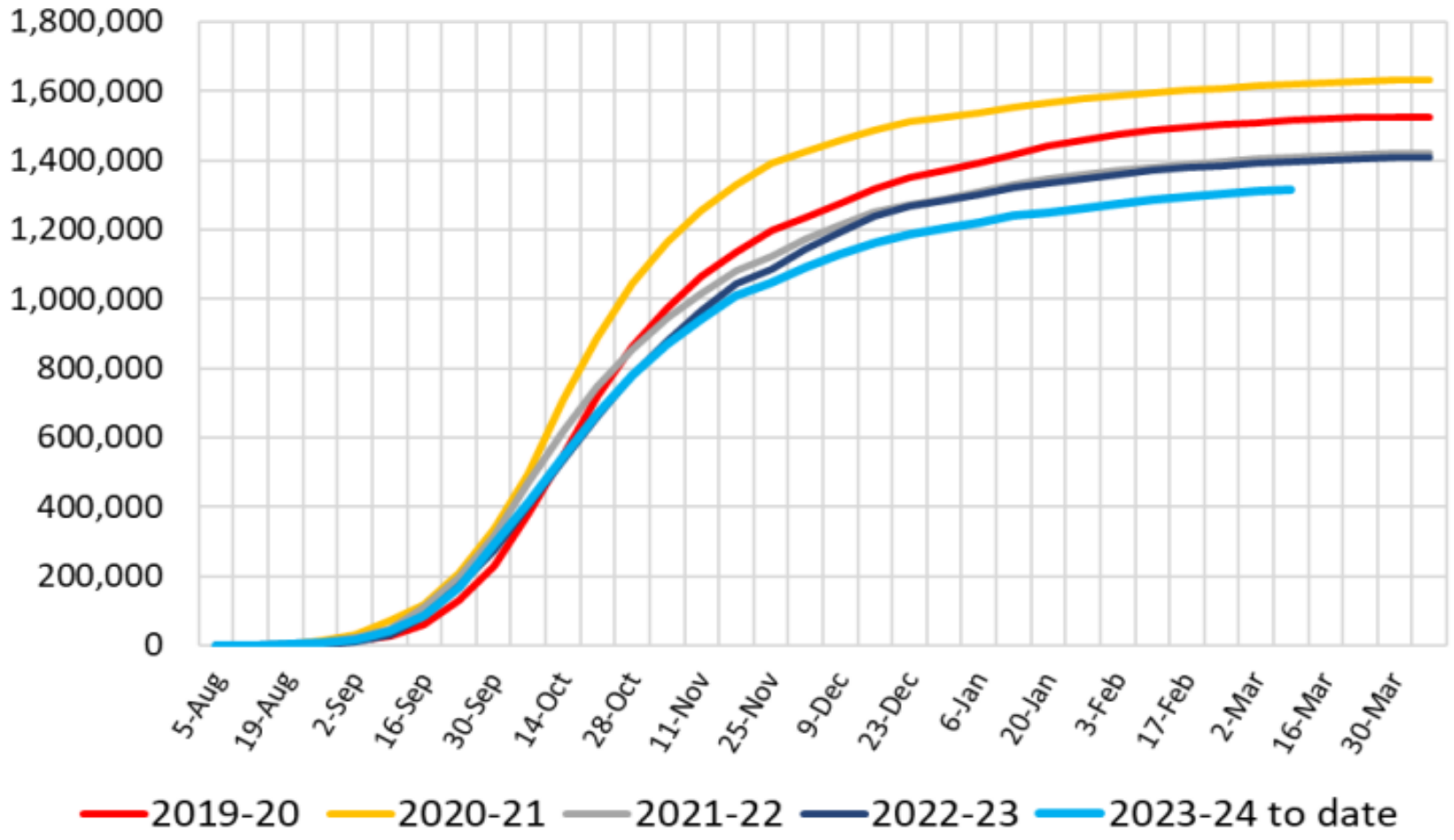
Oregon **adolescent** up-to-date rate, 2018-2022

	2018	2019	2020	2021	2022
Thirteen- to Seventeen-Year-Old[a,b] Vaccination Rates					
Tdap (1 dose)	93%	94%	94%	91%	91%
Meningococcal A,C,W,Y (1 dose)	79%	81%	82%	80%	80%
Flu (1 dose in most recent complete season)	29%	31%	34%	34%	25%
COVID (1+ dose)	NA	NA	NA	58%	60%
HPV initiation (1+ dose)	71%	73%	74%	73%	73%
HPV completion (2-3 doses)[c]	51%	55%	56%	55%	55%
HPV completion[c] by race/ethnicity[d]					
Hispanic[d]	61%	64%	65%	63%	63%
White[d]	52%	55%	57%	57%	57%
Black/African American[d]	57%	59%	59%	58%	57%
Asian[d]	58%	62%	63%	62%	63%
American Indian and Alaskan Native[d]	63%	66%	66%	66%	65%
Native Hawaiian/Pacific Islander[d]	56%	60%	60%	58%	57%
Thirteen-Year-Old[e,f] Vaccination Rates[g]					
Tdap (1 dose)	87%	88%	88%	82%	83%
Meningococcal A,C,W,Y (1 dose)	72%	74%	75%	71%	70%
HPV initiation (1+ dose)	62%	64%	66%	64%	63%
HPV[c] completion (2 doses)	33%	35%	37%	36%	35%
Teen series[h]	30%	32%	34%	33%	32%

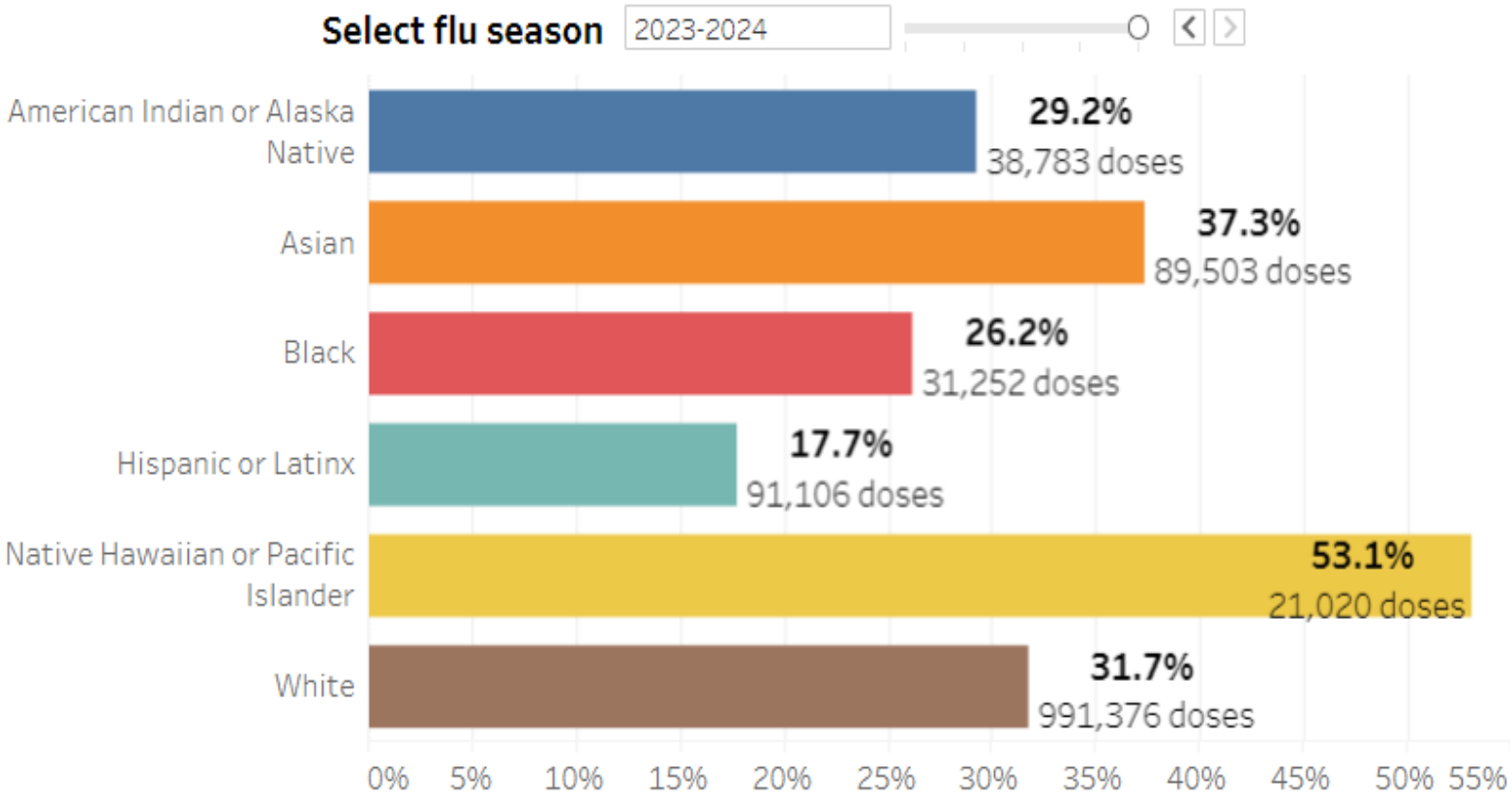
Trend 2018-2022



Cumulative OR ALERT IIS-reported flu immunizations per season, 2019-2020 to 2023-2024



Statewide flu vaccine uptake by rarest race and ethnicity, Jan 24, 2024



School Immunizations

Looking forward

STRATEGIES | NEXT STEPS

"What if we don't change at all ...
and something magical just happens?"

Vaccine Finance Summit

January 25, 2024

- DoubleTree Hilton Hotel Portland
- In person event
- Presentations and panel discussions to support the modernization of Oregon's vaccine finance and delivery model

Attendees – 160+

- Local public health
- Public and private clinics
- Provider associations
- Health systems
- Health plans- pub/pvt
- Government relations
- Child health advocates
- OHA leadership
- Industry/private sector

Vaccine Finance Summit

January 25th

- Opening presentation – background, current state, challenges
- 3 panel discussions
  - Providers – LPH, FQHC, large peds, clinical pharmacist
  - Other state models – payor-sponsored vaccine funding
  - Payors – CCO, FFS, commercial
- Breakout discussions – 5 rooms, followed by debrief

Next steps

- Multi-disciplinary Vaccine Finance Reform steering committee tasked with developing framework for a new model:
  - Reduces provider barriers
  - Supports equitable vaccine access statewide
- Meeting twice/month, June-Sept 2024
- Will deliver recommendations to OHA by Sept 30, 2024
- Will provide strategy recommendations for introduction of any legislative concept resulting from the Committee's work

Thank you!

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