

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

Vaccines for Children
Protecting America's children every day

The Vaccines for Children (VFC) program helps ensure that all children have a better chance of getting their recommended vaccines. VFC has helped prevent disease and save lives.

CDC estimates that vaccination of children born between 1994 and 2021 will:

- prevent **472 million** illnesses
(29.8 million hospitalizations)
- help avoid **1,052,000** deaths
- save nearly **\$2.2 trillion** in total societal costs
(that includes \$479 billion in direct costs)

more than the current population of the entire U.S.A.

greater than the population of Seattle, WA

more than \$5,000 for each American

Updated 2017. All data using most health care's Standardized Inpatient Discharge Data by the Vaccines for Children Program. Data: United States, 1999-2017.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

www.cdc.gov/vaccines/vfcprogram/

16CFR101.11602

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

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



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

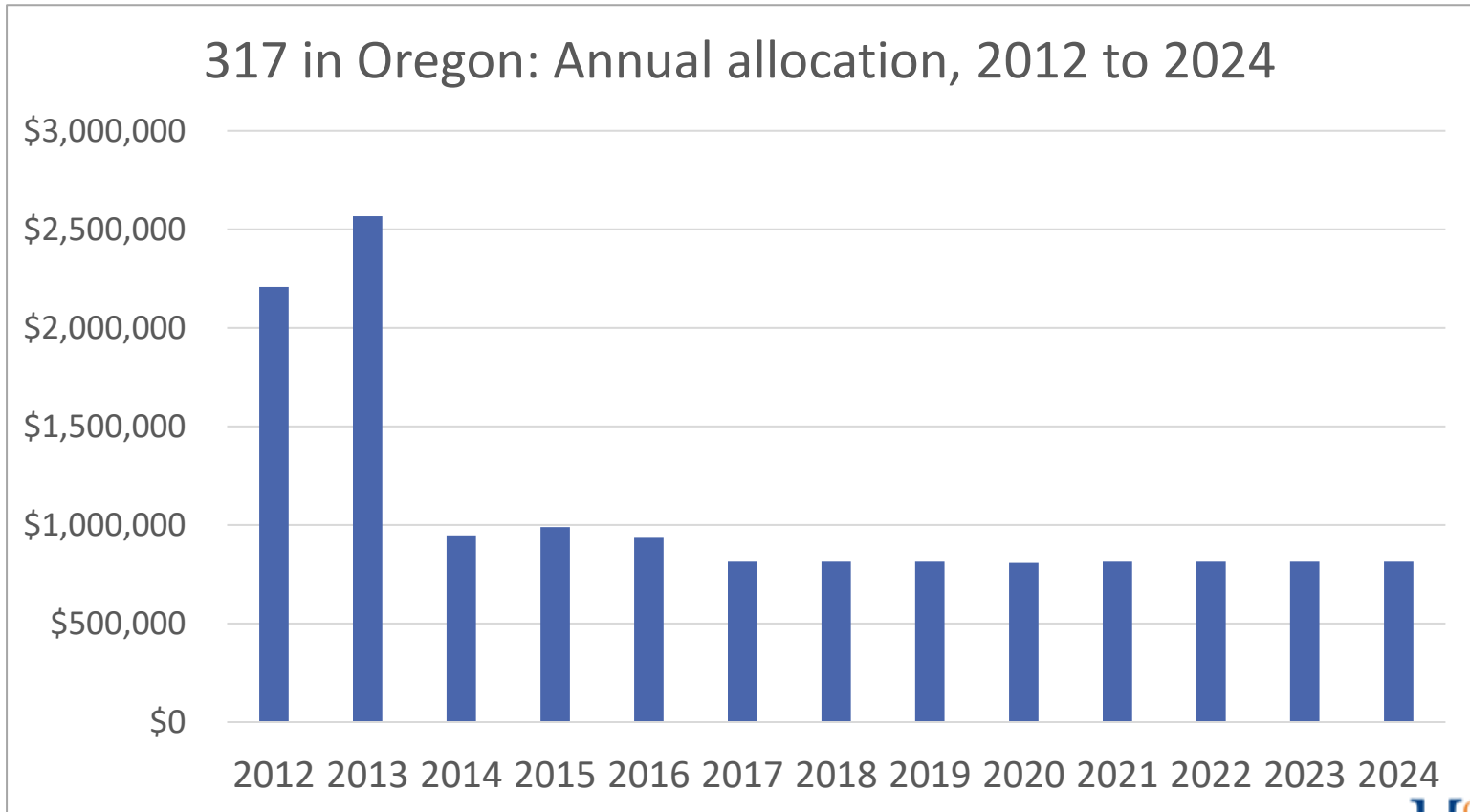
Timeframe	Total cost, 1 dose of each vaccine available	Percent increase since Dec 2005
Dec 2005	\$646.51	-
Dec 2010	\$2,065.55	219%
Dec 2015	\$2,727.35	322%
Dec 2022	\$3,939.47	509%
Dec 2024	\$5,768.09	792%

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

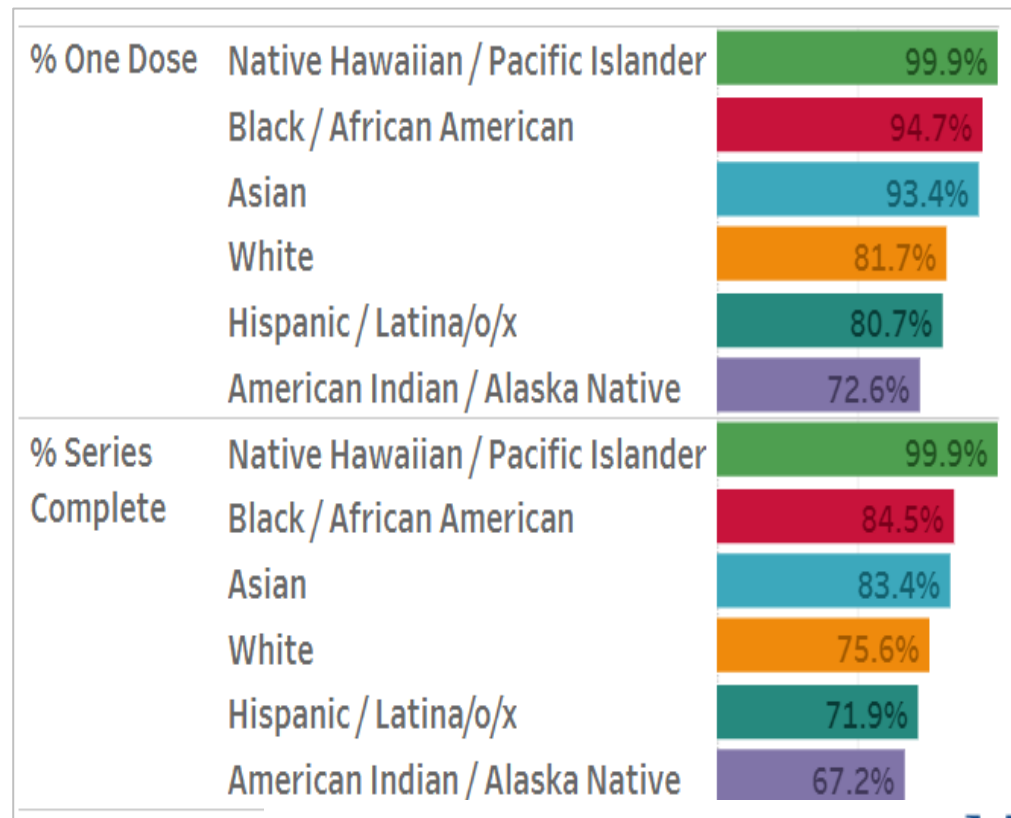
COVID-19 commercialization: then and now

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 \geq at 15 months			DTP or DTaP	Td	
<i>Haemophilus influenzae</i> 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).

Vaccine and other immunizing agents	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs	
Respiratory syncytial virus (RSV-mAb [Nirsevimab])	1 dose depending on maternal RSV vaccination status, See Notes					1 dose (8 through 19 months), See Notes												
Hepatitis B (HepB)	1 st dose	← 2 nd dose →		← 3 rd dose →														
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1 st dose	2 nd dose	See Notes													
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1 st dose	2 nd dose	3 rd dose	← 4 th dose →			5 th dose									
Haemophilus influenzae type b (Hib)			1 st dose	2 nd dose	See Notes	← 3 rd or 4 th dose, See Notes →												
Pneumococcal conjugate (PCV15, PCV20)			1 st dose	2 nd dose	3 rd dose	← 4 th dose →												
Inactivated poliovirus (IPV <18 yrs)			1 st dose	2 nd dose	← 3 rd dose →					4 th dose							See Notes	
COVID-19 (1vCOV-mRNA, 1vCOV-aPS)	1 or more doses of updated (2023–2024 Formula) vaccine (See Notes)																	
Influenza (IIV4)	Annual vaccination 1 or 2 doses										Annual vaccination 1 dose only							
OR											Annual vaccination 1 or 2 doses							Annual vaccination 1 dose only
Influenza (LAIV4)											Annual vaccination 1 or 2 doses							Annual vaccination 1 dose only
Measles, mumps, rubella (MMR)					See Notes		← 1 st dose →		2 nd dose									
Varicella (VAR)					← 1 st dose →		2 nd dose											
Hepatitis A (HepA)					See Notes		2-dose series, See Notes											
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)											1 dose							
Human papillomavirus (HPV)											See Notes							
Meningococcal (MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)											See Notes					1 st dose		2 nd dose
Meningococcal B (MenB-4C, MenB-FHbp)											See Notes							
Respiratory syncytial virus vaccine (RSV [Abrysvo])											Seasonal administration during pregnancy, See Notes							
Dengue (DEN4CYD; 9-16 yrs)											Seropositive in endemic dengue areas (See Notes)							
Mpox																		

Range of recommended ages for all children
 Range of recommended ages for catch-up vaccination
 Range of recommended ages for certain high-risk groups
 Recommended vaccination can begin in this age group
 Recommended vaccination based on shared clinical decision-making
 No recommendation/ not applicable

Into the weeds we go...

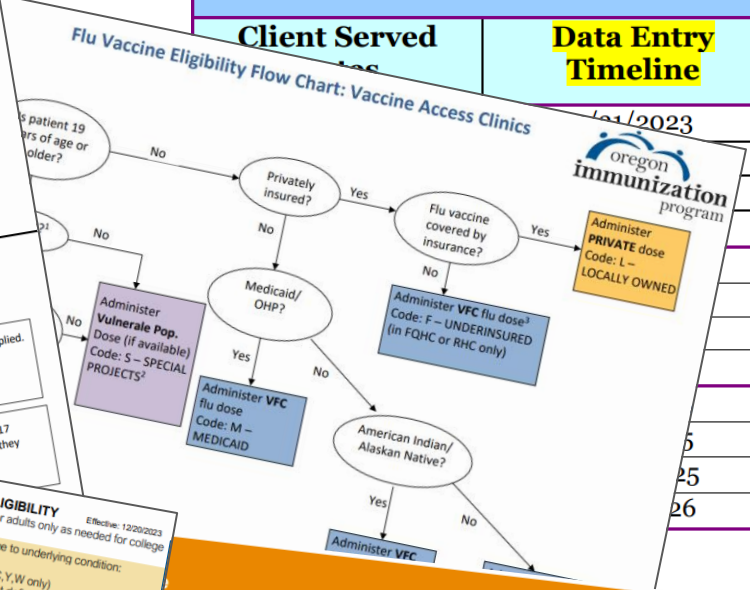
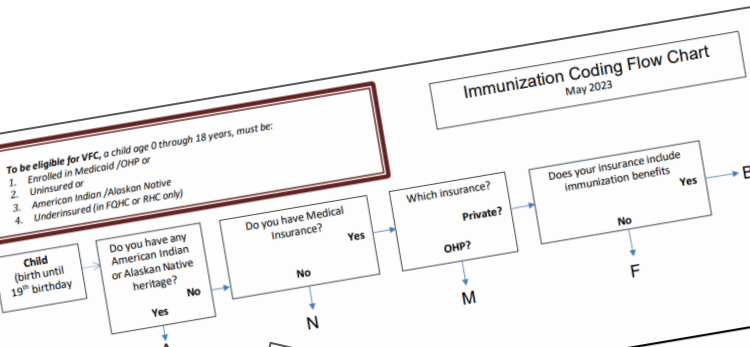


Clinic considerations

- 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
	01/2023	July, 2023
		October, 2023
		January, 2024
		April, 2024
		July, 2024
		October, 2024
		January, 2025
		April, 2025
		July, 2025
		October, 2025
		January, 2026
		April, 2026



317-FUNDED VACCINE ELIGIBILITY
 Vaccines listed below are covered:
 • Only for ages 19+ with no insurance or vaccine coverage and COVID vaccine (for Bridge Project Providers only).
 • If clinically indicated, unless noted in eligibility details.
 Effective: 12/20/2023

ADULT Vaccine Eligibility in Public Vaccine 317 chart is where you look when:
 • Adults with insurance are eligible

Adult (19th birthday and older)
 Does client have insurance?
 Private or public insurance type

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

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



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

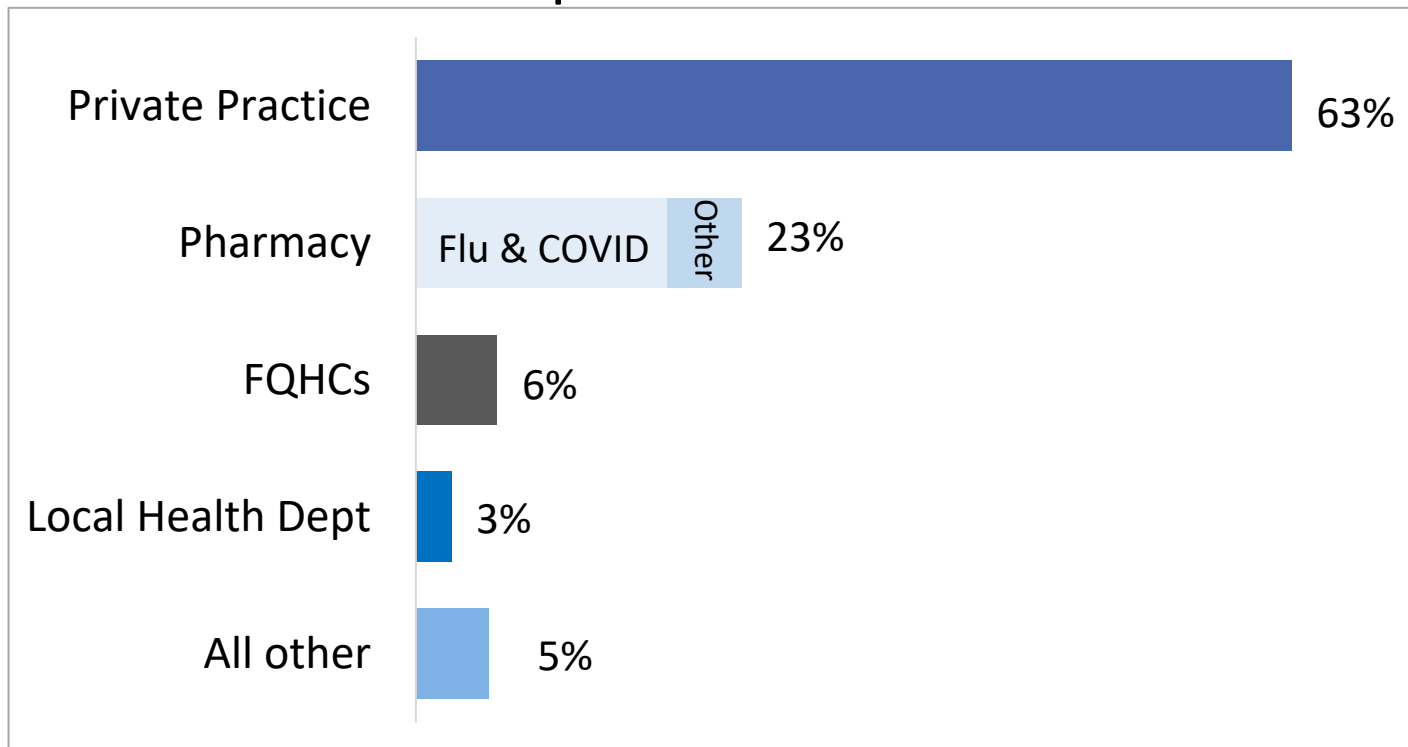


Data Trends

2-YEAR-OLD | ADOLESCENT | FLU | EXEMPTIONS

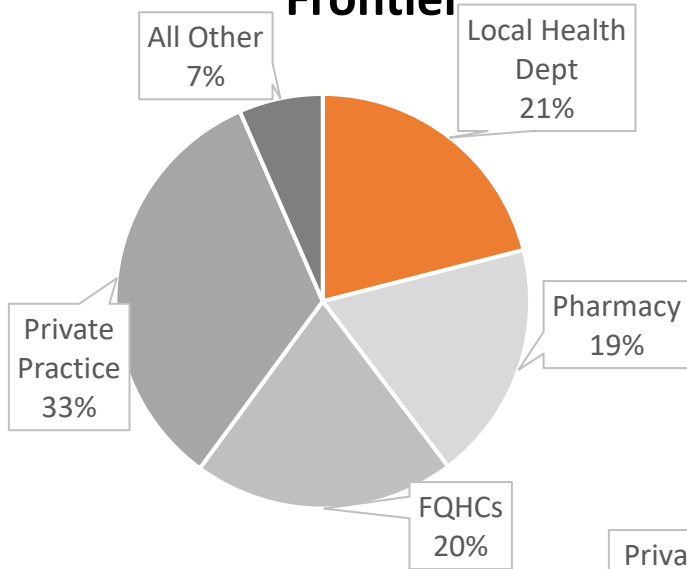
Where do people in Oregon get vaccinated?

Vaccinations reported to ALERT IIS in 2023

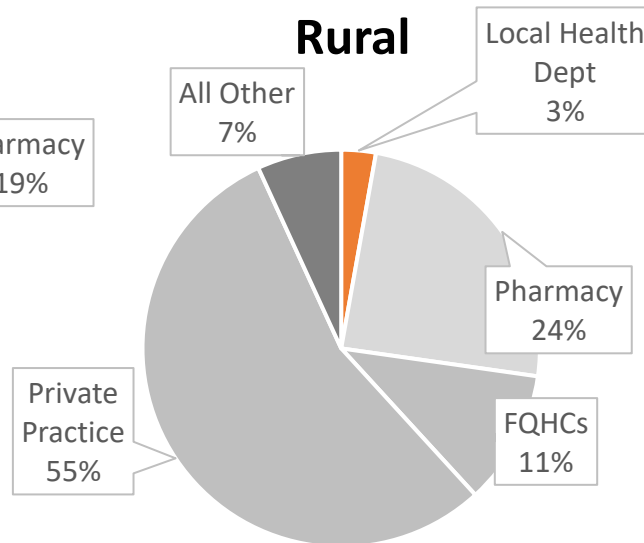


Access in frontier vs. rural and urban counties

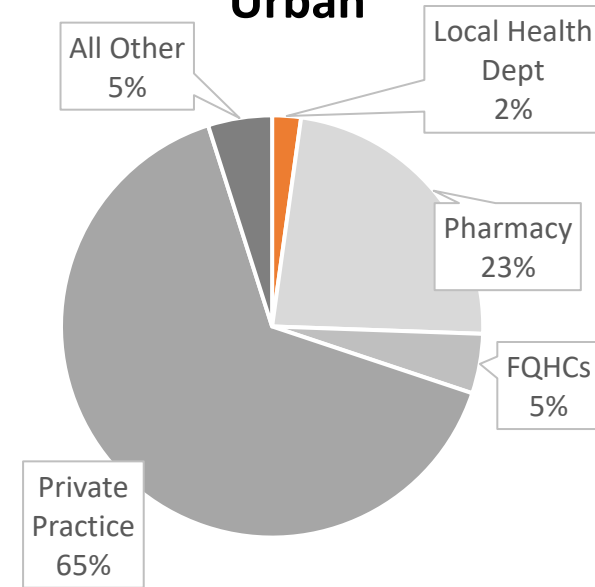
Frontier



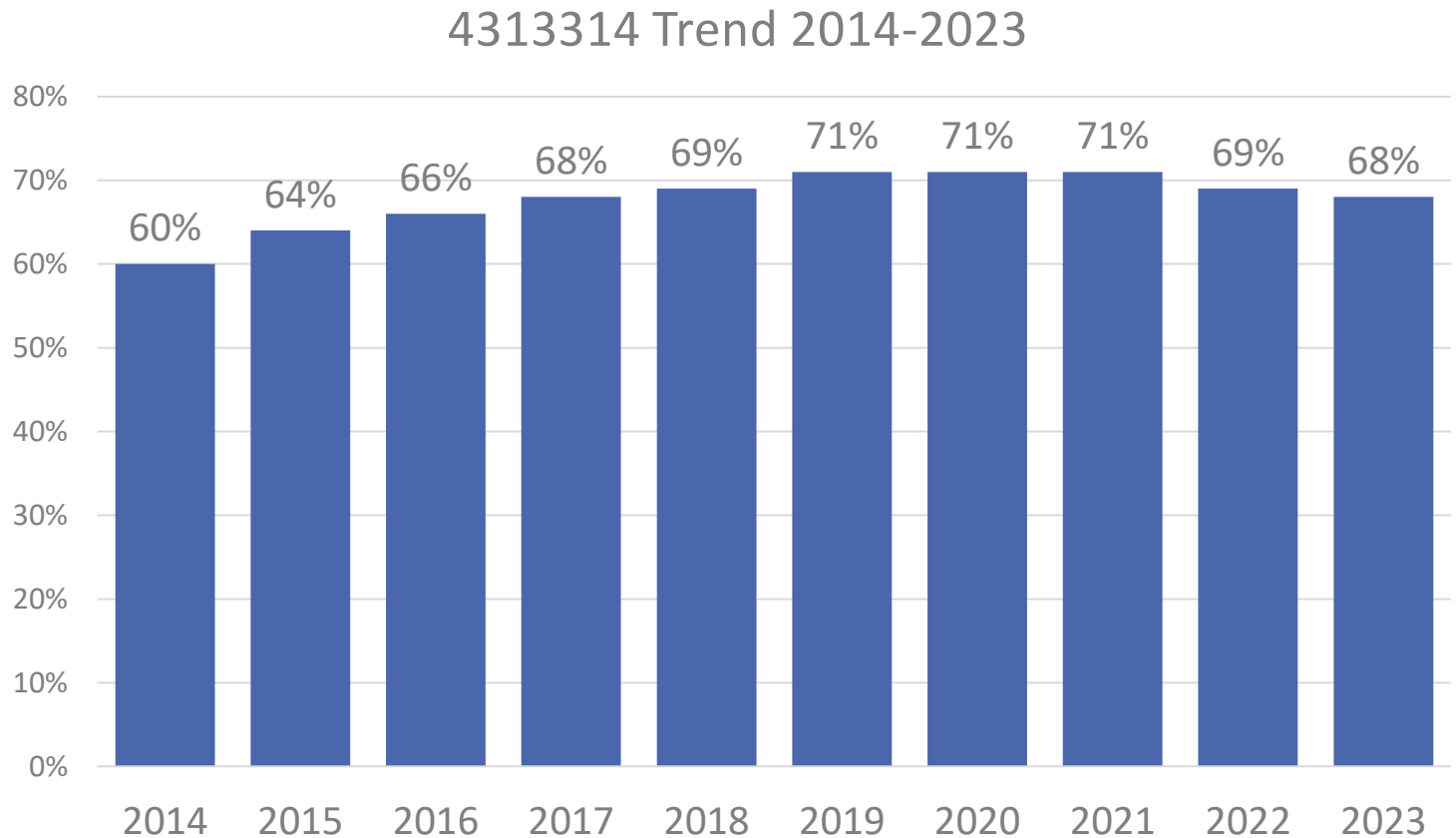
Rural



Urban



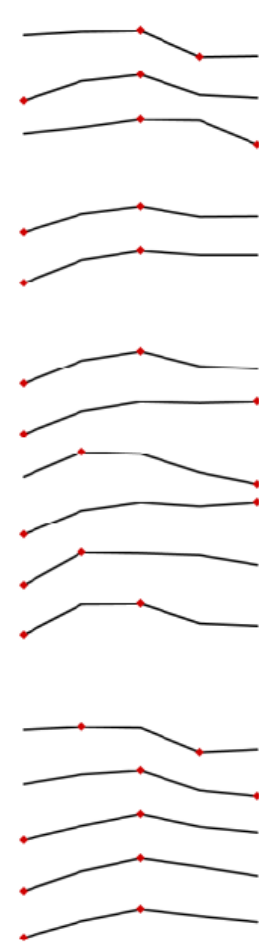
Oregon two-year-old up-to-date rate, 2014-2023



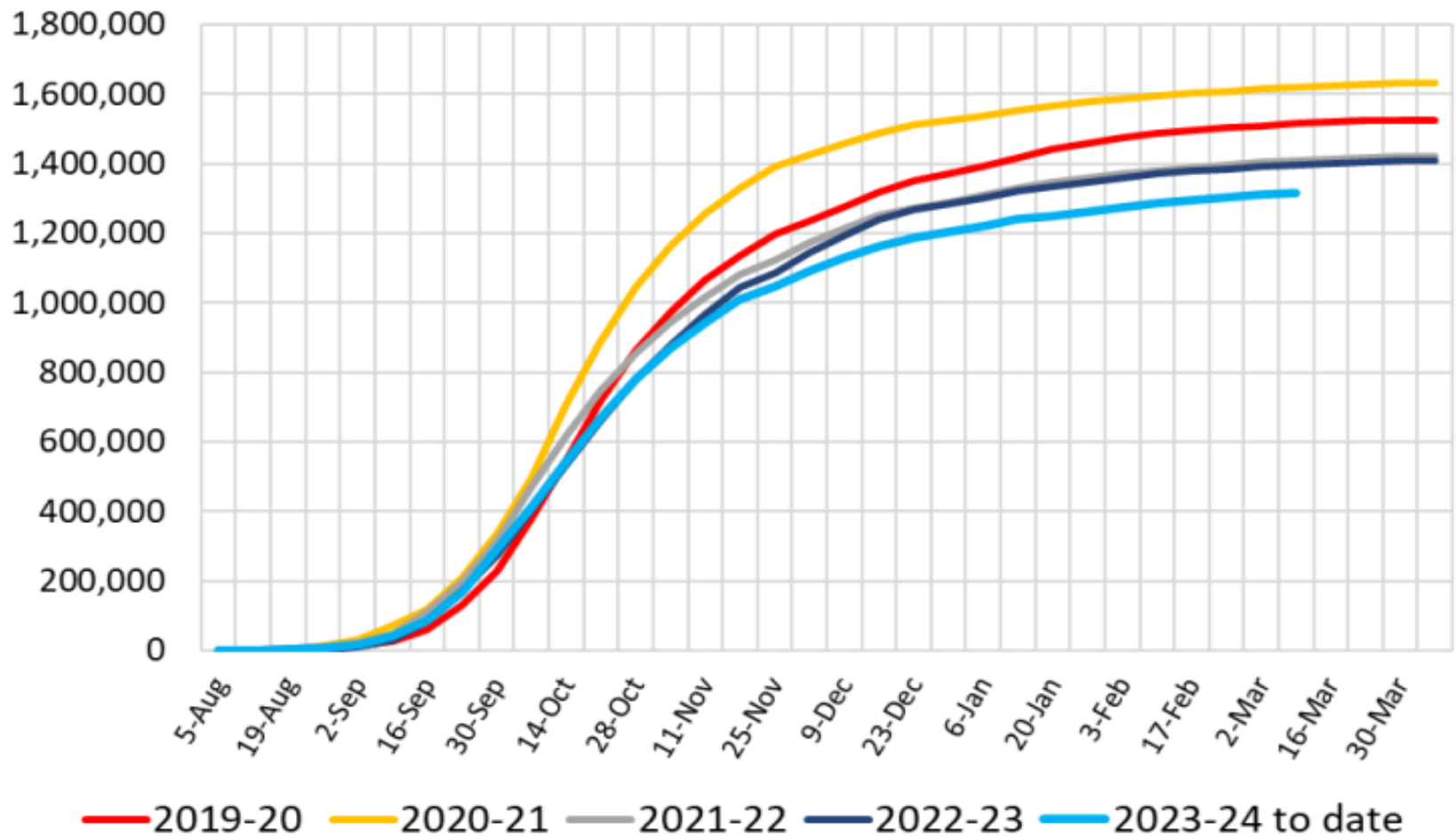
Oregon adolescent up-to-date rate, 2018-2022

	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%

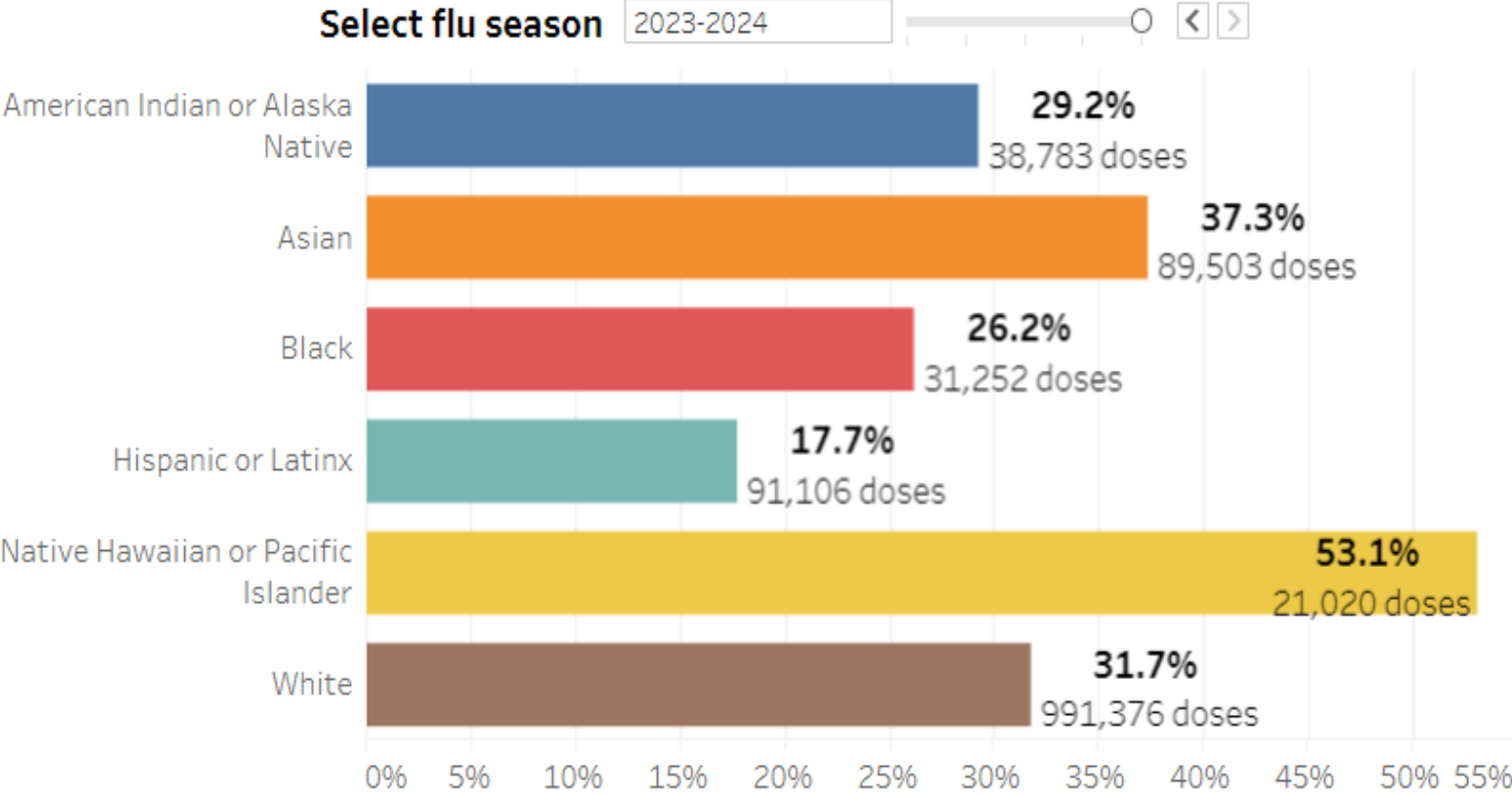
Trend 2018-2022



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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