

**DRAFT Minutes IKK Access Workgroup Meeting  
May 8, 2007**

**Members Present:**

Laura Sanchez, Carolyn Williams, Dennis Cooley, Pam Shaw, Sandy Perkins, Jo Ann Harris, Howard Rodenberg, Laura Harrington, Nancy Tausz, Deborah Baumgartner, Harry Hull, Ida Nesmith, Carolyn Gaughan, Chip Wheelen, Aaron Dunkel

During the plenary session, Gianfranco Pezzino distributed an Action Item worksheet with instructions. He requested that the IKK Committee review the form. The form is to be used by the Working Groups to provide specific action steps that will be recommended in the final IKK report. It is expected that the working groups will submit forms for consideration at the Aug 28 IKK meeting. Working groups need to recommend specific outputs to say “this is what needs to get done”

Dr. Rodenberg emphasized that the recommended actions need to be realistic and attainable. Consideration should be given as to what the IKK group can manage. Items should be under our control and for which we are in a position to advocate. Harry distributed the form electronically after the meeting. Individual members of the committee and the organizations that they represent may wish to submit items for consideration by the working group. The ultimate goal is to have the final IKK report ready in advance of the next legislative session. This will require that consensus be built through conference calls and email to the extent possible. Howard and Harry can distribute draft action items electronically so they can be discussed at the conference calls and finalized prior to the Aug 28 meeting. The next conference calls are currently scheduled for May 24 and June 20.

Questions were raised as to what was the overall mission of the IKK process. Improved funding and increased access were cited as goals. The focus of the committee is immunization as the primary goal. Both short-term and long-term goals should be considered. Solutions proposed should be sustainable.

The second agenda item discussed was proposed changes to Medicaid in Kansas. Dr. Rodenberg felt that the system fared well as far as immunizations is concerned. However, changes are in the wind and a number of reports will be prepared for next year’s legislative session.

The third agenda item was supplemental funding for WIC. KDHE’s initial proposal was to expand the WIC immunization support out to 8-9 other counties and to hire more immunization registry trainers. Budget was cut back to \$200,000 in final budget passed by the legislature. This smaller

amount will be used to hire 3 nurses for WIC immunization outreach. No registry trainers will be hired. Placement of these staff is yet to be finalized.

Articles were presented during the morning session indicating that children who were eligible for WIC but had dropped out or were not enrolled were at the highest risk of being unimmunized or underimmunized. Sandy Perkins reported that WIC enrollment was declining, but the reasons for the decline were unclear. Possible causes mentioned were that families in the country illegally may no longer be coming for services. High price of gas may make it not worthwhile to travel long distance for small WIC reimbursements. WIC had food dollars to enroll additional clients, but could not use that money for outreach to enroll clients. One task for the new staff would be to find the kids who are not enrolled in WIC or have dropped out. It was pointed out that it difficult to find kids when you don't know who they are. How the WIC immunization link money will be used is not completely defined, but it can be used in a number of ways to support enrolling WIC children and getting them immunized. One of the intentions would be to follow up with every WIC referral and see what actually happened.

The major item for discussion was the Impending Vaccination Crisis in Kansas. There were two major issues brought forward from the last conference call: looking seriously at going forth with universal purchase and administration fees. What is clear is that there is not a formula that covers the entire cost of vaccinating children and physicians are losing interest the immunization business because they are losing money.

Reimbursement by insurance companies for immunizations is not standardized in Kansas and sometimes does not cover the actual cost of purchasing the vaccine. The administration fee is also highly variable. In some cases, there is no administration fee. Overall, reimbursement does not provide adequate funding to cover the cost of storage, wastage, insurance, plus supplies and nursing time. The cost of maintaining inventory is an important issue with the new and very expensive vaccines, particularly with long lag times for reimbursement from health insurance companies. Another issue cited is that some pediatricians were not using combination vaccines because they got better reimbursement from using individual antigens. This is a disservice to the child, who then receives multiple injections. It also results in missed opportunities for immunization and lower immunization coverage. Low administration fees may be a factor in physicians not participating in the VFC program.

Concern over financial losses from immunizing children is rising among pediatricians and FPs. Vaccines run 17-20% more than what is typically reimbursed for a private provider. Physicians have to upfront large amounts of money for vaccines, some of which may expire before they are used. There will be a large meeting of pediatricians in Kansas City in the near future to

talk about getting out of the immunization business because it is not even financially neutral, but it's a loss. On the east coast, kids are becoming unimmunized again. If the private providers aren't providing vaccinations, it's going to put more of a burden on local health departments. HPV vaccine really brought this to the forefront. OB/Gyn's – who are seeing many women who are recommended for vaccination - are generally not giving HPV vaccine.

AAP Maximizing Office Based Immunization (MOBI) project will be working on some of the financial issues. Concern was raised that if children end up going to pharmacists to be vaccinated, they will not be getting normal, routine check-ups and significant health problems may be missed.

In the good old days, some physicians used to even provide immunizations for free. As the number and cost of vaccines increased, this practice was discontinued, with more and more referring patients to health departments for immunization. There was a proposal in the past to have universal purchase of vaccines in Kansas. This was opposed by the manufacturers, with the political compromise being mandatory coverage for immunization by health insurance.

Suggestion put forward for the state to provide volume of scale purchasing, absolutely avoiding the term universal purchase. KDHE could purchase vaccines directly so that there would be a standardized and lower cost per unit for all physicians. This step might not only lower cost, but might make it easier to negotiate administration fees. Overall, it simplifies the system if purchases all came from the same source, reducing paperwork etc.

Concerns on volume of scale purchase:

1. In a competitive bidding situation, manufacturers might lose the bid and be off the contract. This possibility would be a source of opposition from the companies.
2. Funds would have to be mobilized by the state to do this. Costing out the proposal will be important. However, once established, it should be cost neutral with physician payments covering cost of purchase.
3. Contracting out the running of the program could reduce state funds required for the program and could provide a source of political support.
4. Volume of scale purchase may be confused with Universal purchase. Universal purchase implies getting the CDC price. Volume of scale would be competitive bidding and contracting with individual pharmaceutical companies.
5. Benefits of volume of scale could be that it extends to all vaccines so that it could improve vaccination of Kansans of all ages – Immunize Kansas as opposed to Immunize Kansas Kids.

6. There are different combinations of combination vaccines: would this bother doctors if they had no choice in which combination vaccines they could use? Drs. Cooley and Shaw say most doctors don't care.
7. If structured properly, volume of scale purchasing could be seen as a private sector solution to the problem.

Harry Hull will draft up Volume of Scale Purchase action item. Howard Rodenberg recommended that the IKK workgroup create a model of what this would look like. He can recommend that the secretary take it to the governor for political consideration. This will take time. Howard will meet with Laura Harrington to discuss the details of how Universal Purchase has been structured elsewhere. The argument will need to be phrased so that it helps all kids. We need to sell this from providers as something that is going to help the providers save time and money. We may need to change the name of the group eventually to "Immunize Kansas" rather than "Immunize Kansas Kids" and buy vaccines for all ages. It's all about the message.

On the issue of improving reimbursement for vaccine to cover the total cost of vaccinations, it may be easier to negotiate administrative fees rather than actual shot. Standardizing the cost of purchasing vaccine may make it easier to negotiate a standardized administration fees. Vaccine costs tend to be higher than administrative fees. CMS set Medicaid fees based on RBRBS units.

Chip Wheelen thought it would be worthwhile to ask for an opinion of the insurance commissioner on the extent the insurance commission could mandate the amount of vaccine reimbursement. Howard Rodenberg will raise the question to the insurance commissioner.

Another issue that was raised was the federal prohibition on mixing VFC and private vaccines. CDC decided a long time ago that they didn't want them mixing the product. It should be acceptable so that you can mix your product so that you can mix your product, and reduce spoilage, etc.

A final issue discussed is barriers for parents. We still can't define who are the unimmunized children are and why they are not immunized. Who are the kids who are not being immunized in WIC? With development of the new WIC immunization system, WIC could define the profile for a high risk Mom likely to have unimmunized children. As the Registry becomes populated, registry data can be used to both target children who are not immunized and define who the unimmunized children are. Need to advocate for the immunization registry to be populated. Use of kindergarten immunization data discussed. KDHE does school entry survey, but this provides old data on what the situation was several years ago. Possibilities discussed for local HDs to use school surveys and registry data to define local pockets of unimmunized children.