Vaccine Finance Reform Steering Committee
June 5th, 2024, 12:00-4:30 (In-person)
Meeting Summary

Introductions and agenda overview

The Vaccine Finance Reform Steering Committee ("Steering Committee") met on June 5, 2024, from 12:00-4:30pm for an in-person meeting at the Monarch Hotel in Clackamas, OR. The meeting goals were to:

- Select a Steering Committee chair
- Review the problem statement
- Determine criteria/goals for proposed recommendations
- Brainstorm initial ideas for potential recommendations
- Learn more about the universal vaccine purchase (UVP) model, as requested at the May 16, 2024, meeting

Meeting attendance

Steering Committee staff have received requests as to whether individuals *not* on the Steering Committee can listen to our meetings. While these are not officially public meetings, Steering Committee members can invite colleagues and members of the community/communities they represent to listen in. We expect observers to stick to that role - observation without engagement to allow the Steering Committee members to do their work.

Group agreements

The Steering Committee reviewed the group agreements they approved at their first meeting.

- Be present and participate.
    - When we are virtual, keep your camera on if at all possible.
- Listen actively -- respect others when they are talking and avoid interrupting.
- Be genuinely curious and open to learning.
- Respect the group's time -- keep your comments concise and to the point.
- Speak with authenticity and grace.
- Collaborate, create and build.
    - Consider "both/and."
- Lean in/Lean back: If you tend not to talk, challenge yourself to participate more. If you tend to dominate the conversation, step back and give space for others.

- Varied and opposing ideas are welcome. Challenge ideas, not people.
- Consider, and be considerate of, perspectives that are different than yours.
- Avoid using acronyms and/or try to remember to explain them.
- Share responsibility for the process.
- Strive to meet the stated purpose and expected outcomes of each meeting.
- Everyone is responsible for following and upholding the group agreements.

Review of draft problem statement

Steering Committee members reviewed and approved the problem statement, taken from language in the charter:

- Significant challenges threaten the health and sustainability of Oregon's vaccine finance model and add increased cost for immunization providers.
- Federal and state immunization program requirements are burdensome and costly, preventing some providers from joining the programs and resulting in others leaving.
- The overall cost of vaccines has increased steadily, and several new high-cost vaccines have recently come onto the market.
- Funding for some state-supplied vaccine programs has not kept pace with the need, resulting in a pause in Vaccine Access Program enrollment and a reduction of some vaccine orders.
- Vaccine coverage rates have declined since the COVID-19 pandemic; the increased complexity and costs to provide immunizations have hindered improvement efforts.
- Historically marginalized communities, as well as rural and frontier regions, particularly bear the downstream impact of these barriers.
- People in Oregon seeking vaccination services are experiencing access challenges that result in missed opportunities for vaccination.

Chair election/appointment

Steering Committee member Bob Dannenhoffer volunteered to chair the committee. Committee members approved Bob as chair.

Criteria or goals for proposed recommendations

We had small group discussions about criteria for recommendations and then had groups report out. The summary of potential criteria is below.

Note that these draft criteria may need further refinement and prioritization.

Steering Committee recommendations must do the following:

- Increase access for all, with a particular emphasis on children, and include timely access to new vaccines
- Improve efficiency
    - Reduce complexity and simplify for all (payers, providers, patients)
        - Including billing
        - Decrease administrative burden
- Address cost issues
    - Ensure affordability and predictable costs
    - Standardize reimbursement and ensure fair compensation for providers
    - Ensure proportional payment (those who can pay should pay)
    - Consider shared accountability for cost across the system
- Provide a way to measure changes in vaccination rates, etc.
- Ensure changes in vaccination rates (and other data) can be collected
- Avoid adverse unintended consequences
    - Avoid breaking systems that are working
- Be realistic and actionable
- Be sustainable and durable (not a band aid approach)
- *Need to clarify what is meant by the following*
    - Contain transparency for the administrative process
    - Federal players should cooperate and agree with our system
    - Minimize legislative impacts to the health system

Brainstorm of potential recommendations that the Steering Committee might consider

The full Steering Committee brainstormed potential recommendations. The group suggested the following:

- Invest in current programs
- Incentivize providers and organizations to continue Vaccines for Children (VFC) participation
- Use a company or organization like VaxCare as third party
- Implement a Universal Purchase model
- Invest in pain points for communities and practices focused on workforce and infrastructure
- Use technology for inventory tracking

- Have one entity in charge that is accountable *(need better understanding of what this means)*
- Create a “no wrong door” for patients and providers *(need better understanding of what this means)*
- Integrate public structures with existing private solutions (*need better understanding of what this means)*

The list generated by the Steering Committee is not a final list and can be added to as the group continues its deliberations.

Information needed to consider potential recommendations

The Steering Committee broke into small groups to consider what information they needed to consider potential recommendations and reported on their discussions. The group is interested in the information summarized below.

⇒ **Idea: Invest in current programs (with a lot of money)**
- How much money would it take to do this (including flu and COVID vaccines)?
- Where could the money come from? The state? What other funds might be available?

⇒ **Idea: Incentivize participation in Vaccines for Children Program (VFC)**
- What barriers are there to accessing these programs for providers?
- How can Oregon incentivize participation and attract more providers and pharmacies?
- What are the requirements of VFC?
- Are there resources to do this and, if not, where would dollars come from?

⇒ **Idea: Use company like VaxCare**
- Need a better understanding of how companies such as VaxCare function
    - What specific models are there?
    - Have using these types of companies resulted in positive outcomes (increased access, improved efficiency, lowered costs, etc.)?
    - Can parts of what companies like VaxCare do be replicated?
    - What software do these companies use?

⇒ **Idea: Implement a Universal Vaccine Purchase model**
- What other states are doing this?
- Who do they serve (all populations or just kids)?
- What mistakes have they made?
- Who is the accountable organization?
- How does inventory tracking work?

⇒ **Idea: Invest in addressing pain points for communities and practices, focused on workforce and infrastructure** (Provide grants or other ways of investing in workforce/infrastructure, for providers, others, etc.)
- What are the pain points for providers and workforce?
- Where would funding/resources come from for this?

⇒ **Idea: Use technology for inventory tracking**
- What technology is available?
- Primer on ALERT IIS - how does it work? Who uses it?
  - Have other states expanded IIS for all immunization providers? Is it working?
  - How much does cost?

⇒ **Idea: Have one entity in charge that is accountable**
- *Need more information about what this means*
- Are there models like this elsewhere?
- If so, what do they look like?
  - What is the entity?
  - What are accountability mechanisms?

⇒ **Idea: Create no wrong door for patients and providers**
- *Need more information about what "no wrong door" means*
- What are the doors now?
- Which populations are being served?
- What barriers are there for providers?
- Are there access issues among certain populations? Or areas to focus?

General questions that need to be answered

The following are questions that need to be answered:
- What is the landscape of federal and state programs?

- Need to understand:
  - Current programs and populations they serve (*Note – this was largely covered in the first meeting. We need to clarify what else is needed here.)*
    - Where dollars are going now
    - Populations *not* covered by current programs
  - Can Oregon opt out of federal programs?
  - What legal/statutory requirements do we have to abide by?
- Are there successful state models we can learn from (in addition to universal vaccine purchase)?
- What lessons learned from COVID can we draw on?
- Who is the Steering Committee making recommendations to?

<u>Universal Vaccine Purchase presentation and discussion</u>

John Sobeck, MD, MBA of Sobeck Healthcare Consulting (a consultant to OHA) provided an overview of the Universal Vaccine Purchase (UVP) model and how it works in other states. This information was provided in response to Steering Committee requests during the May 16th, 2024, meeting to learn more about the UVP model. The presentation included the basics of the UVP model, different state approaches, scope, and considerations, questions to consider, and allowed time for a Q&A discussion. Dr. Sobeck's slides will be sent to Steering Committee members with the meeting summary.

Below is a list of the questions and responses:

1) What states have tried this and failed?

- John knew of only one example: North Dakota was unable to implement UVP after failing to pass it through their state legislature.

2) Is distrust in government a reason that OHA should not be the entity accountable for a UVP model?

- It is important to note that UVP is about *financing* (i.e., how vaccines are paid for). It is not related to school requirements or any other type of vaccine mandate. Also, setting the program up with an outside administrator provides a degree of separation between the program and state government.

3) For the states with a UVP model that serves only children, what are some reasons they did not include adults? What were the barriers?

- John explained that costs associated with including adults were the primary reason, and that the “value equation” for adults versus kids is not as strong.

4) Under a UVP model, is it possible to allow parents to receive vaccines at pediatric clinics when their children get vaccinated?
- In theory that’s possible, though there are many considerations that would impact the feasibility and likelihood of this taking place.

5) How does Oregon’s Vaccine Access Program (VAP) differ from the UVP model of using payer assessments to purchase vaccines for insured clients?
- Kelly McDonald (OHA) explained that VAP-enrolled providers can serve all clients regardless of insurance type with one stock of vaccine ordered from OHA (exceptions are flu vaccine and some frozen, direct ship vaccines). The clinic codes the dose(s) administered as a “B-Billable” dose in Oregon’s statewide immunization registry, ALERT IIS, bills the appropriate health plan/payer, and then pays OHA back for the cost of the vaccine after payment is received from the health plan/payer (the clinic keeps the vaccine administration fee). John added that under UVP, the health plans/payers are assessed to fund a pool for purchasing all vaccine for insured clients. Federal vaccine funds (e.g., VFC, Section 317) are still used to purchase vaccine for eligible clients under a UVP model.

6) How does the UVP model impact federal or state vaccine funding programs already in place?
- Federal funds are provided to states to purchase vaccines for eligible clients. State legislatures can allocate additional state funding to support state-level vaccine access programs if desired. The UVP model does not put state or federal vaccine funding at risk.

7) How does Washington track UVP vaccine?
- Washington uses a statewide immunization information system (IIS), like Oregon’s ALERT IIS. Mimi Luther (OHA) added that Oregon law requires all pharmacies and providers using state-supplied vaccine to report doses administered to ALERT IIS within 14 days. Approximately 90% of those doses are reported almost immediately through electronic data exchange.

8) What are lessons from Washington that Oregon can learn from?
- John recommended against using a dosage-based assessment model like Washington’s due to its complexity. He also highlighted the importance of having a qualified UVP program administrator, mentioning that the

Washington Vaccine Association (WVA) is administered by Helms and Company, a healthcare consulting and management firm. KidsVax is another UVP administrator used by some states. John added that it is important to include the right number and mix of people on the UVP program board, including private payers. These are just a few of the many details to be worked through while drafting legislation.

9) What is meant by the term “leakage?”

- This term refers to clinics in Washington that do not participate in the state’s UVP program in the manner required to complete the dosage-based assessment upon which the model is built. John emphasized that each UVP state developed and manages the program differently and that there are great lessons to be learned in comparing the different state approaches. Alaska, for example, includes both children and adults and uses a much simpler assessment process. It is not possible to plug one state’s model into another.

10) How is vaccine wastage tracked under Washington’s UVP model?

- Washington has a robust tracking inventory that shows where vaccine is located and whether there has been wastage. This work is managed by the WVP.

11) Does the UVP model still include the administrative burden of ordering and managing two separate vaccine stocks? How does that change if adults are included (i.e., in addition to children)?

- With UVP, one stock of vaccine can be used based on the scope of the program. For example, a children-only UVP program allows immunization providers serving children to order and manage one stock of vaccine for all children served. If adults are included in the scope of the UVP program, immunization providers serving adults will also order and manage one stock of vaccine.

12) What are the functions of the third-party administrator (TPA) in a UVP model?

- The TPA oversees the assessment process, collaborating with both state and federal regulators, as well as the state's department of health. Additionally, the TPA coordinates with the vaccine association board to establish and oversee budgets and reserves. They are also responsible for the financial modeling of decisions, such as setting grid rates.

Next steps

The next Steering Committee meeting (virtual) is scheduled for Monday, June 24, 2024, from 10:00am to 12:30pm. Steering Committee members are expected to attend all meetings or—in the event of extenuating circumstances—send a delegate who can participate on their behalf. The Steering Committee member is responsible for briefing the delegate and then, in turn, being briefed by the delegate prior to the following meeting.

Action Items and decisions

- Bob Dannenhoffer will serve as Steering Committee chair.
- Isabel will attach slides/materials to meeting holds moving forward.
- Isabel will send out meeting summaries via email.
- Steering Committee staff will review breakout session recommendations and requests for information/data needed for consideration.
    - If Steering Committee members have access to information/data being requested, they are asked to provide it to OHA for dissemination.
- Steering Committee staff will send out the slides on Universal Vaccine Purchase with this meeting summary.
- The Steering Committee requested a shared drive for accessing and sharing committee materials. OHA and ORPRN are still working on this.
- Steering Committee members who wish to include colleagues as observers to the virtual Steering Committee meetings should send the listener's name, organization, and email address to Josh Spencer (Joshua.Spencer@oha.oregon.gov), who will forward meeting details.
- Steering Committee members who have general questions or comments about committee processes or upcoming meetings should send them to Isabel (stocki@ohsu.edu).

Name	Organization	6/5/2024 Attendance	Delegate Attendance
Alanna Braun	Oregon Pediatric Society; OHSU Pediatrics	Yes	
Bob Dannenhoffer	Douglas County Public Health Network	Yes	
Christian Huber	Legacy Health System- Randall Childrens Hospital	Yes	
Danielle Shannon	WVP Health Authority	Yes	
Dawn Mautner	OHA/Health Systems Division	No	No
Deborah Rumsey	Children's Health Alliance	Yes (virtual)	
Ian Horner	Family Medical Group, NE / Optum	Yes	
Jane Quinn	Representing Biotechnology Innovation Organization	Yes	
Janet Patin	Oregon Academy of Family Physicians	Yes	
Jeanne Savage	Trillium Community Health Plan	Yes	
Jeff Fortner	Oregon State Pharmacy Association (OSPA) & Pacific University School of Pharmacy	Yes	
Jennie Seely	Kaiser Permanente	Yes	
Jennifer Stubblefield	St. Charles Health System	Yes	
Katie Russell	Jefferson County Public Health / Warm Springs	Yes	
Kim La Croix	Clackamas County Public Health	Yes	
London Manor-Petersen	Comagine Health	Yes	
Meg Olson	Oregon Families for Vaccines	Yes	
Nathan Roberts	OHA/Health Systems Division	Yes	
Rebekah Sherman	La Clinica	Yes	
Robin Canaday	Morrow County Public Health	Yes	
Sarah Andersen	Oregon Office of Rural Health	No	Maggie Tidmore; Laura Potter
Sheila Albeke	Samaritan Health Plans- InterCommunity Health Network CCO	No	Jonathan Stradling
Stephanie Saunders	Virginia Garcia Memorial Health Center	Yes	

Summer Prantl Nudelman	Eastern Oregon Coordinated Care Organization	Yes	
Tracy Muday	Regence BlueCross BlueShield	No	No
Will Clark-Shim	Oregon Health Authority	Yes	