OREGON VACCINE FINANCE REFORM STEERING COMMITTEE

Final Report

September 2024

This report is provided by the Vaccine Finance Reform Steering Committee, which met from May–September 2024 to examine challenges with Oregon's vaccine finance model and make recommendations for reform that reduces provider barriers and centers equitable vaccine access.

Dear Colleagues:

Over the last six months, physicians, public health officials, insurers, clinic providers, and state officials met to address the current state of vaccine finance and access in Oregon. This diverse group agreed there is **an urgent need to fix the state's vaccine finance model**, which is facing significant challenges that are **threatening provider participation** in vaccine programs and **impacting immunization access** across the state.

The severity of the problem cannot be overstated. Vaccine costs are soaring. Immunization coverage rates have decreased since the COVID-19 pandemic, yet the increased complexity and costs to provide immunizations have hindered improvement efforts. Our current system is underfunded and cannot meet the challenges before us. One stark illustration of this crisis is that Oregon is currently facing a significant pertussis outbreak and its largest measles outbreak in 33 years, with 31 cases—all in unvaccinated people.

After reviewing the state's current system, analyzing models across the country, and hearing from providers, the group is making the following recommendations to the Oregon Health Authority (OHA) and the legislature:

1. That OHA **request an informational hearing with the legislature** to discuss Oregon's vaccine finance challenges and related impacts on access
2. That the legislature **establish a formal group** to consider options to address challenges with the current vaccine finance system and related impacts on access (i.e., further evaluate and model a Universal Vaccine Purchase program fully investing in current programs), with a report back to the legislature by 2026
3. That **additional bridge funding be directed to the current programs** (Vaccine Access Program and Vaccines for Children) to maintain and expand provider participation until the formal group delivers its recommendations and those recommendations can be implemented

Without immediate action, vaccine access will continue to erode and more preventable illness will erupt, disproportionately affecting rural, uninsured, and historically marginalized communities. We know that modernizing Oregon's vaccine finance model is critical to achieving the state's goal of eliminating health disparities by 2030.

Please join us in supporting reform of the state's unsustainable vaccine finance system.

Sincerely,

Bob Dannenhoffer, MD, Chair, Vaccine Finance Reform Steering Committee
Public Health Officer, Douglas County

Supporting Organizations

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Executive Summary

Oregon's 30-year-old vaccine finance model is facing significant challenges that have threatened both provider participation in vaccine programs and equitable immunization access across the state. Vaccines are critical to public health, offering protection against infectious diseases and preventing costly medical care. Vaccine coverage rates in Oregon have declined since the COVID-19 pandemic, and the increased complexity and costs to provide immunizations have hindered improvement efforts. Disparities in vaccine coverage rates also persist, with inequities by race, ethnicity, insurance status, and geographic location. Oregon currently faces a large outbreak of pertussis, and its largest measles outbreak in 33 years, with 31 cases—all in unvaccinated people.

The Vaccine Finance Reform Steering Committee convened from May to September 2024 to examine these issues and explore solutions, with a particular focus on reducing provider barriers and centering equitable vaccine access statewide. This diverse group of clinicians, insurers, and public health officials agreed that there is an immediate need to reform the state's vaccine finance model, and that in the absence of some intervention, access will continue to deteriorate and worsen health inequities.

Steering Committee Recommendations:

1. That OHA **request an informational hearing with the legislature** to discuss Oregon's vaccine finance challenges and related impacts on access
2. That the legislature **establish a formal group** to consider options to address challenges with the current vaccine finance system and related impacts on access (i.e., further evaluate and model a Universal Vaccine Purchase program and fully investing in current programs), with a report back to the legislature by 2026
3. That **additional bridge funding be directed to the current programs** (Vaccine Access Program and Vaccines for Children) to maintain and expand provider participation until the formal group delivers its recommendations and those recommendations can be implemented

Oregon's vaccine finance system is fragmented and overly complex, resulting in operational inefficiencies, insufficient funding, and growing provider disenrollment. In addition, **modernizing Oregon's vaccine finance model is critical to achieving the state's goal of eliminating health disparities by 2030.** Without immediate action, vaccine access will continue to erode and more preventable illness will be seen, disproportionately affecting rural, uninsured, and historically marginalized communities.

The time for reform is now.

This report is provided by the Vaccine Finance Reform Steering Committee, which met from May–September 2024 to examine challenges with Oregon's 30-year-old vaccine finance model, and to make recommendations for reform that reduce provider barriers and center equitable vaccine access. There is substantial detail included in the report in order to provide ample background information and to memorialize the significant body of work the Steering Committee accomplished. The Committee also wants any future state-sponsored group to build on these accomplishments and not duplicate its efforts.

Introduction

Immunization is a safe and effective way to protect people from diseases and keep our communities healthy. The value of vaccines to our society cannot be overstated, with impacts to public health, economic stability, and individual well-being. Vaccines have dramatically reduced the incidence of many infectious diseases, including measles, polio, and pertussis, which were once common and deadly. Vaccines also prevent costly medical care, including hospitalizations and treatments associated with vaccine-preventable diseases, and reduce the number of workdays lost and the economic burden on families and communities. High vaccination rates contribute to herd immunity, protecting those who cannot be vaccinated due to medical conditions, age, or other factors.

Immunization is a safe and effective way to protect people from diseases and keep our communities healthy.

National vaccination programs, like the Vaccines for Children (VFC) program, help ensure that all children, regardless of their socio-economic status, have access to life-saving vaccines. In Oregon, approximately 350 clinics are enrolled in the VFC program, providing vaccines at no cost to those who are Medicaid-eligible, uninsured, underinsured (only in Federally Qualified Health Centers or Rural Health Clinics), or American Indian or Alaskan Native. By participating in the VFC

program, clinics contribute to higher immunization rates within their communities.

An additional 300 clinics are enrolled in Oregon's Vaccine Access Program (VAP), which was designed to support the state's safety net clinics where uninsured and OHP-covered adults access vaccines. This commitment to equity has long been the focus of the Oregon Immunization Program (OIP) and falls squarely within the Oregon Health Authority's (OHA) goal to eliminate health disparities by 2030.

Oregon's current vaccine finance system is underfunded and cannot meet the challenges before us.

This report details the many challenges that are threatening provider participation in vaccine programs and impacting immunization access across the state. Vaccine costs are increasing rapidly, immunization rates have decreased, the system is underfunded, and growing complexity in managing immunization programs has hindered improvement efforts. Oregon is experiencing vaccine-preventable disease outbreaks, such as the highest number of measles cases in 33 years—all in unvaccinated people.

Background

Oregon's 30-year-old vaccine finance model relies on a patchwork of vaccine access programs, each designed to ensure access for a particular population. The cost and complexity involved in managing the requirements of each component is challenging, both for providers and OHA.

Oregon's current model includes the following components—all with specific challenges that are detailed later in this report—which were designed to provide equitable access to immunizations based on specific eligibility for each program:

- Vaccines for Children (VFC): Federal entitlement program that provides vaccine at no cost for children birth–18 years who are Medicaid eligible,

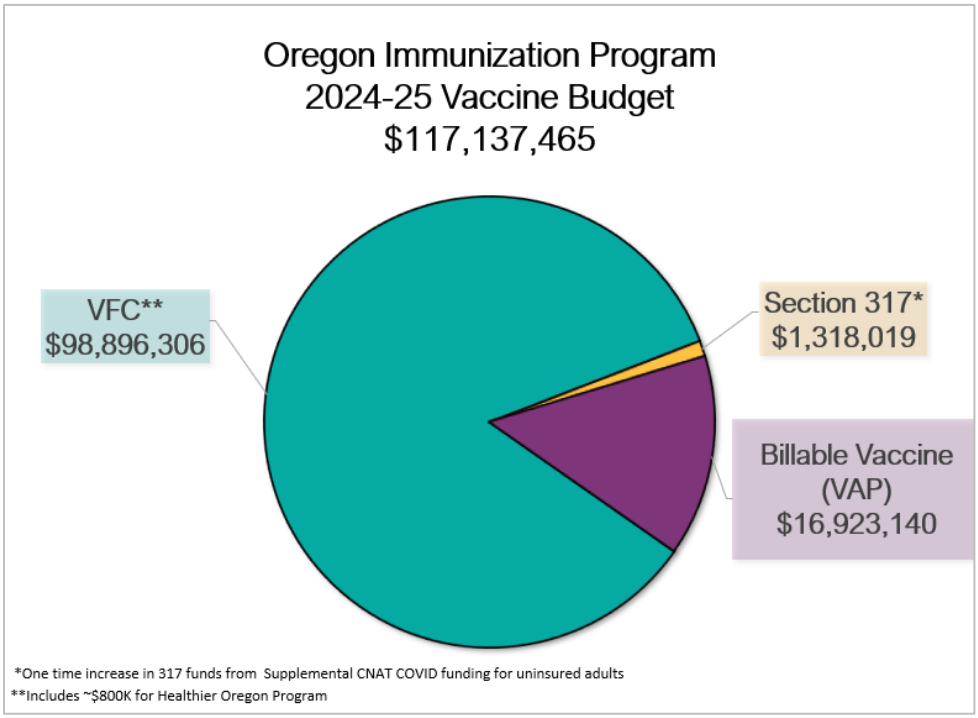
uninsured, *under*insured (only at Federally Qualified Health Centers [FQHCs], Rural Health Clinics [RHCs], and local health departments), or American Indian/Alaskan Native. Approximately half of Oregon's children are VFC eligible.

- Section 317 funding for uninsured adults: Federal discretionary program that provides limited federal funding to vaccinate uninsured adults. The funding is set through the annual appropriations process and is not guaranteed from year to year. Oregon, like all states, has seen flat 317 funding for over ten years, which limits the vaccines OHA can provide for this population. Uninsured adults access 317-funded vaccine at local health department clinics, FQHCs, and other Vaccine Access Program providers.
- Vaccine Access Program (VAP): State program designed to improve access for all, regardless of insurance type. VAP simplifies ordering and significantly reduces the upfront cost of vaccination services for enrolled providers by making vaccines available for well-insured "Billable" clients that the VAP clinic pays back to OHA after billing and obtaining reimbursement from the payor. This includes adults covered by the Oregon Health Plan and Medicare, as well as children and adults who are privately insured.

  VAP clinics include all local public health authority (LPHA) clinics, most FQHCs, and some specialty providers such as naturopaths, community health clinics, substance use disorder clinics, street medicine providers, small providers in rural and frontier areas, and many providers whose clients include populations such as refugees, LGBTQ+ individuals, students, and safety net patients.
- Temporary, time-limited programs: Temporary programs designed to address a specific need (e.g., COVID-19 pandemic, H1N1 pandemic). These programs allow for an investment in staffing and infrastructure to meet an emergent threat and create new pathways for immunization access. As the funding period ends, much of this work is unsustainable.

The Oregon Immunization Program's (OIP) Vaccine Supply and Access team oversees the planning, purchase, and distribution of over $117 million in state and federally funded vaccines for people of all ages to 650 enrolled healthcare providers. The team ensures the implementation, maintenance, evaluation, and continuous

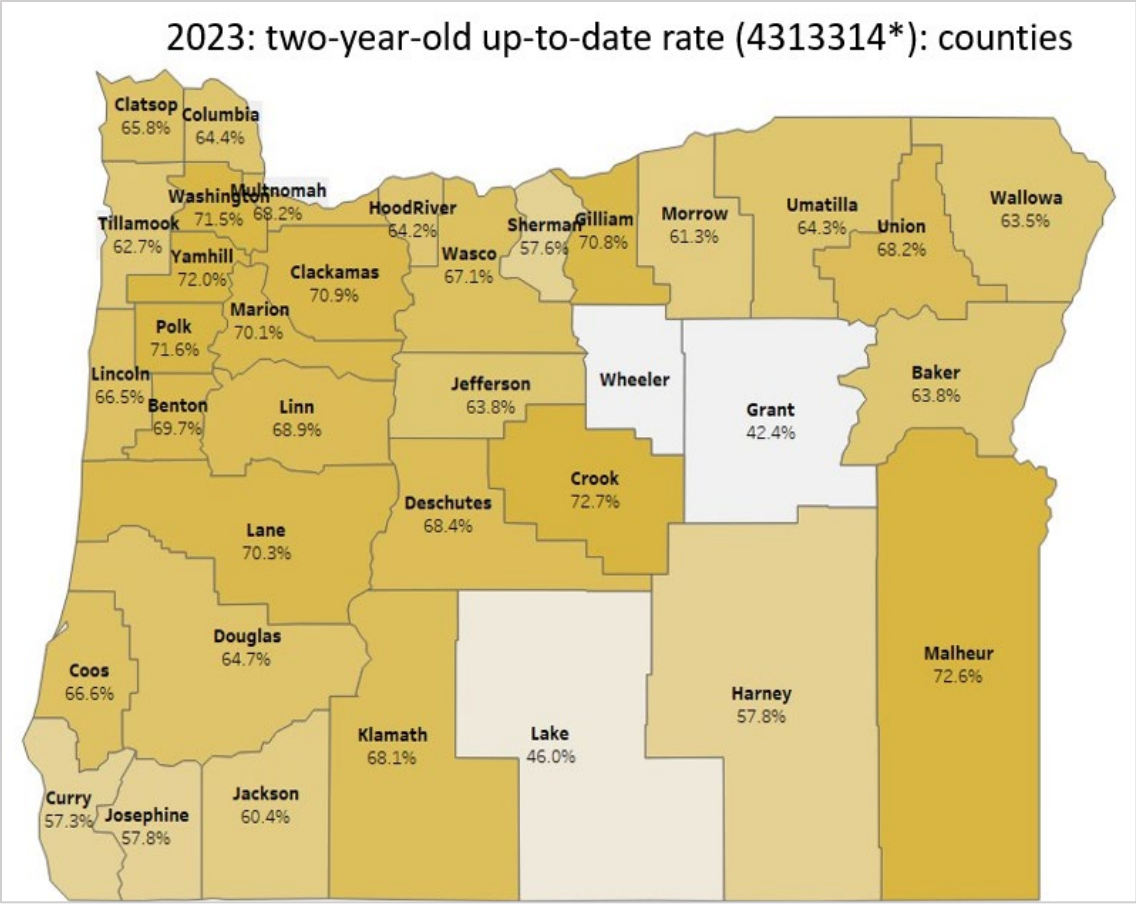
quality improvement of the VFC program and VAP so that safe, effective vaccines are available and equitably accessible across Oregon.



There are also many vaccination sites that are *not* enrolled, only utilizing privately purchased vaccines, including most pharmacies, non-VFC clinics, and other non-enrolled immunization clinics or organizations. An unknown number of clinics opt out of providing immunization services and instead refer their patients out to the local health department or other clinics.

Immunization Data and Disparities

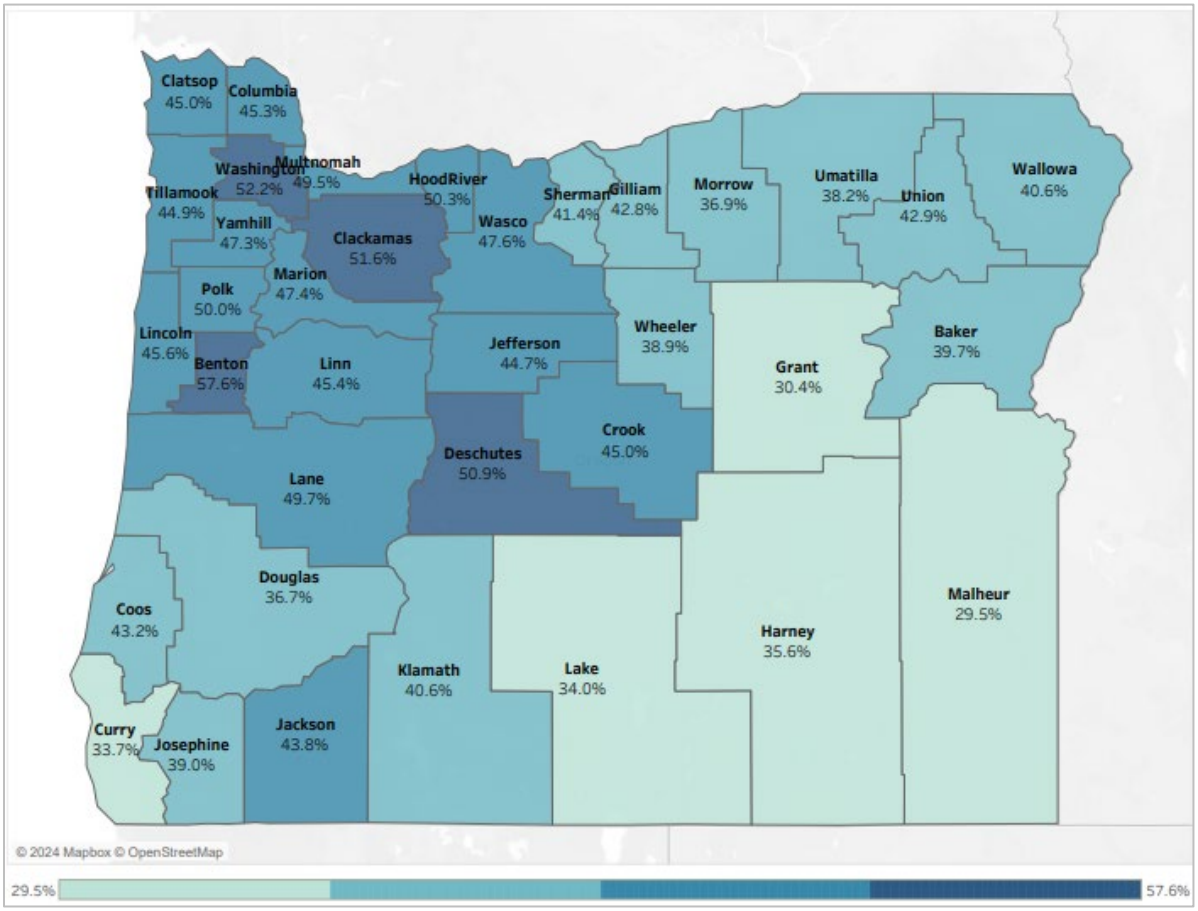
Vaccination rates in Oregon have long been a focus of public health investment, with a Medicaid Coordinated Care Organization (CCO) incentive metric for two-year-olds and adolescents, as well as a state health improvement plan measure. This commitment led to an increase in two-year-old vaccination rates of 10 percentage points from 2014 to 2019. The COVID-19 pandemic brought a sharp reduction in the routine immunization of children, adolescents, and adults by disrupting preventive healthcare visits. As a result, the statewide two-year-old up-to-date rate has decreased by 3%, from 71% in 2019 to 68% in 2023. In many Oregon counties, the two-year-old rate is significantly lower.



*4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella, 4 PCV

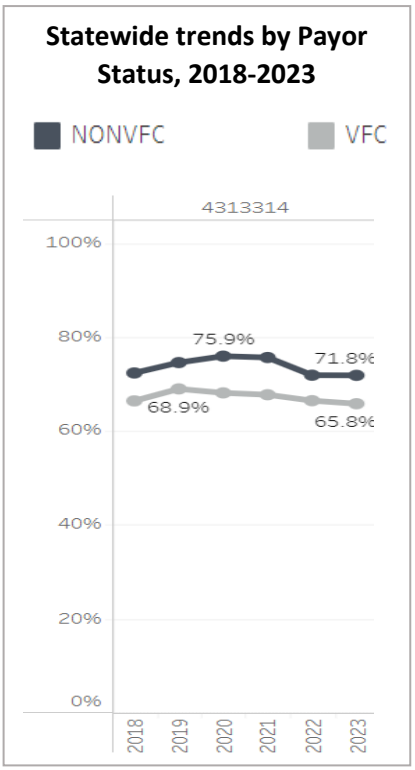
Beginning in 2014 with the implementation of a CCO incentive measure for childhood immunizations, vaccination rates saw a significant period of improvement in Oregon. This was evident across all races and ethnicities and for publicly and privately insured children. Despite these improvements, vaccination rate disparities have existed in Oregon for decades, with communities of color less likely to be vaccinated and experiencing a disproportionate burden of disease when compared to White communities. Close-knit communities in Oregon, including the Latino, Slavic, and Somali communities, have increased risk for vaccine-preventable disease outbreaks including measles and pertussis. Oregon has also seen growing disparities between urban and rural areas of the state, specifically regarding flu and COVID vaccinations.

Influenza Immunization Rates, 65 years and older, 2023-2024

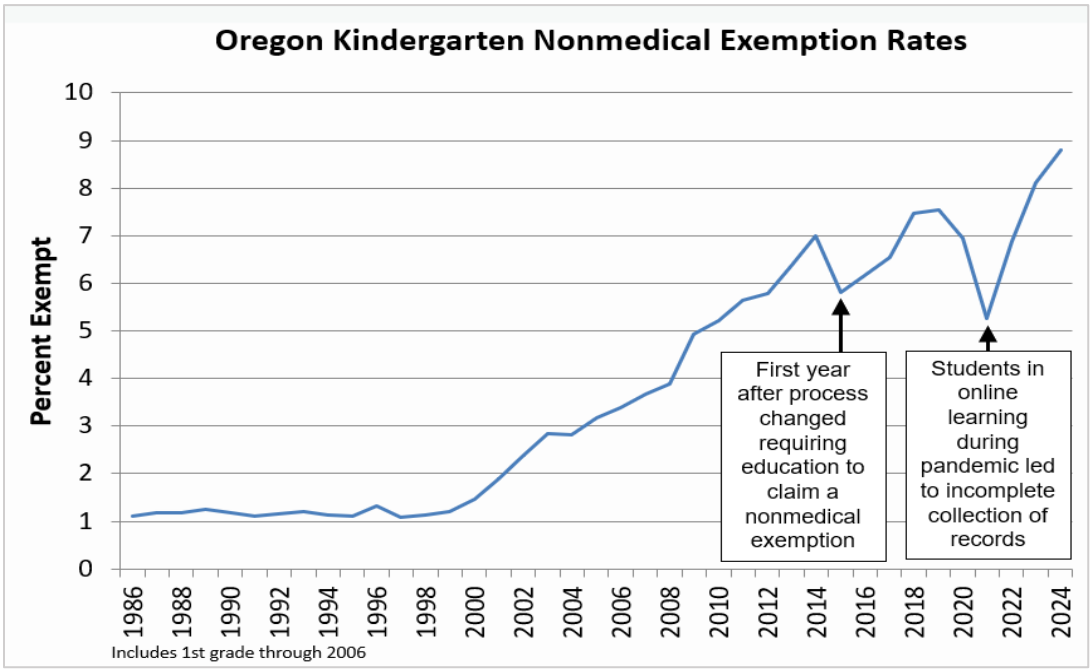


Despite recent improvements, vaccination rate disparities have existed in Oregon for decades, with communities of color less likely to be vaccinated and experiencing a disproportionate burden of disease when compared to White communities. Oregon has also seen growing disparities between urban and rural areas of the state.

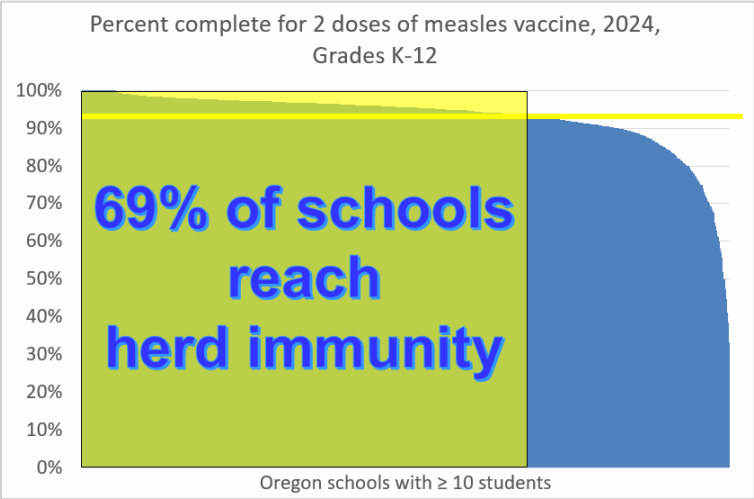
Reviewing immunization coverage rates by payor status shows that VFC-eligible children are less likely to be up-to-date than their non-VFC counterparts. This difference in coverage exacerbates existing health disparities by leaving an already vulnerable group at higher risk for preventable disease, and it undermines the goal of the VFC program to ensure that all children, regardless of financial circumstances or insurance status, have access to life-saving vaccines. It can also increase the economic burden for these families. Addressing this gap is crucial for promoting equitable health outcomes and protecting public health.



Oregon has also seen an increase in non-medical exemptions to school required vaccines. The 2024 kindergarten non-medical exemption rate was 8.8%, the highest it has been since implementation. Non-medical exemption rates have been steadily increasing in Oregon for over twenty years, putting communities at increased risk of vaccine-preventable disease outbreaks.

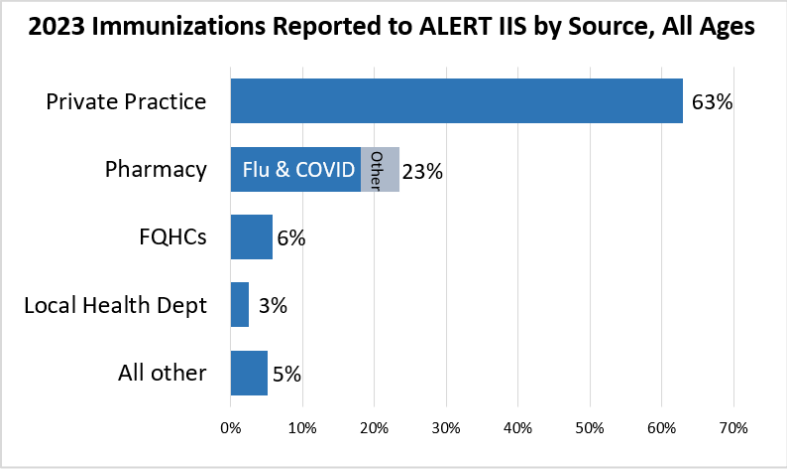


Statewide data is helpful and allows us to track trends over time. However, when considering the risk of an outbreak, it is important to examine data at the school level. The chart below depicts Oregon K-12 schools with ten or more students (n=1688). Of these, only 69% reached the herd immunity coverage rate for students with two doses of measles vaccine. That leaves 523 schools where measles immunization rates are low enough that if a case of measles were to occur in one of these schools, it could spread and cause an outbreak.



Where People in Oregon Get Vaccinated

OHA staff analyzed 2023 immunization data reported to ALERT IIS to determine where in Oregon people get vaccinated. When looking at all ages combined, most vaccines were administered in private practice clinics (63%). Pharmacies provided approximately 25% of vaccinations. Of those, the majority (75%) were flu or COVID vaccines.



This breakdown changes when analyzing specific age groups or urban versus rural and frontier parts of the state. In Oregon's frontier counties, for example, 21% of immunizations were administered by the local health department, highlighting the critical role local public health plays in ensuring access to vaccines in areas with fewer vaccine providers and/or where recent pharmacy closures have forced people to seek vaccines elsewhere.

An analysis by age (0-17, 18-64, 65+) demonstrates a clear change in vaccination access across the lifespan. Children are much more likely to be immunized in the private practice clinic setting where they receive well-child exams and other clinical care (86%), whereas adults—and especially seniors—often access vaccines in a pharmacy setting (33% and 58%, respectively).

Challenges

Most children in Oregon are immunized, yet there are still people in our state who want to be vaccinated but have difficulty accessing immunizations in their communities. There are also providers in Oregon for whom the cost and complexity involved in providing immunizations is a barrier to enrollment in VFC or VAP. Some clinics opt out of providing immunizations altogether due to the cost and administrative burden.

Many small and rural providers find it difficult and cost-prohibitive to participate in the VFC program.

Several significant challenges have arisen over the last few years that have threatened the health and sustainability of the programs listed above while adding complexity and increased cost for immunization providers. Many small and rural providers find it difficult and cost-prohibitive to participate in the VFC program. In addition, funding for VAP has not kept pace with rising costs and clinic demand, resulting in a pause in new clinic enrollment until a sustainable funding model can be identified. Pharmacy access has decreased as well, due to staffing constraints and pharmacy closures across the state. Ultimately, these

challenges have resulted in an erosion of access points for those in Oregon who want to be vaccinated. As vaccine coverage rates have decreased since the COVID-19 pandemic, the increased complexity and costs to provide immunizations has likely hindered efforts to improve those rates. Many of these challenges, particularly around increased cost and administrative burden, are also being experienced by immunization programs nationwide.

This section provides an overview, though not an exhaustive list, of the challenges impacting Oregon's vaccine coverage rates and access statewide, including:

- Federal and state VFC requirements
- Increasing costs
- Flat funding for uninsured adults
- Growing complexity
- Staffing constraints
- Net decrease in clinic enrollment
- Pharmacy closures

Federal and state VFC requirements: Strict federal and state VFC requirements are burdensome and costly, preventing some providers from joining the program, and resulting in other providers leaving. Several new products have been added to the recommended schedule in recent years—including COVID vaccine, the RSV monoclonal antibody, pentavalent meningococcal vaccine, and mpox vaccines—adding significant costs and staffing time to manage. The Centers for Disease Control and Prevention (CDC) requires VFC providers to carry a separate stock of vaccine for their privately insured children, resulting in significant upfront costs and burdensome administrative duties to order, store, and manage two separate stocks.

Insufficient vaccine administration fee payments for VFC vs. privately insured patients disincentivize providers from serving VFC-eligible kids.

VFC providers also receive insufficient vaccine administration fee payments for immunizations administered to VFC-eligible children. The federal vaccine

administration fee is established by the Centers for Medicaid and Medicare Services (CMS) for each region of the country. In Oregon, that fee is $21.96 per dose. The administration fee has only been updated once, in 2013, since the VFC program was established 30 years ago. Immunization providers receive significantly less for vaccinating VFC children than they do for privately insured children. Providers who serve a higher proportion of VFC-eligible children are disproportionately impacted by these lower rates. This disparity in payment for the same service disincentivizes providers from serving VFC-eligible youth.

The low VFC vaccine administration fee payment stands in sharp contrast to the temporary incentives provided for COVID-19 vaccination. COVID vaccine providers received increased payments for vaccine administration, as well as additional per member per month compensation. The enhanced payment allowed providers to properly staff their vaccine clinics, both in their daily workflow as well as during clinics held on weekends or after hours, increasing community access points as a result.

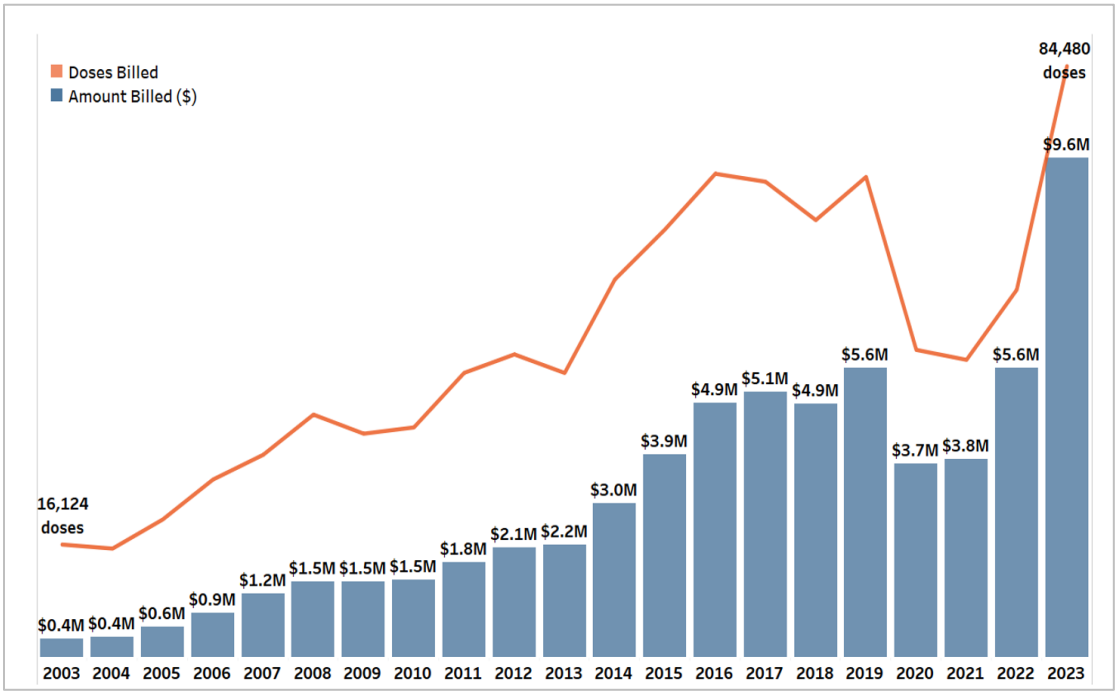
Increasing costs: The overall cost of vaccines has increased steadily, and new high-cost vaccines have been added to the recommended immunization schedule. The massive cost increase combined with more demand has increased OHA's Immunization Program vaccine budget from roughly $750,000 when the VFC program started in 1994 (approximately $1.6M in 2024 dollars), to over $117M today, a 155-fold increase.

Due to rising costs and new vaccines, OIP's vaccine budget is 155 times bigger today than when the VFC program started in 1994.

This massive increase is straining clinic budgets and is cost-prohibitive for some clinics seeking VFC enrollment. This is especially true for small-volume providers and those who serve a predominantly VFC-eligible population, since they are required to purchase a separate stock of all routinely recommended vaccines for their privately insured patients. The financial burden to stock expensive and infrequently given vaccines prevents some providers from enrolling in VFC.

For the Vaccine Access Program, funding has not kept pace with increased costs. The chart below shows the increase in Billable vaccine (cost and doses) since 2003.

Billable Vaccine Doses and Amount Billed, 2003-2023



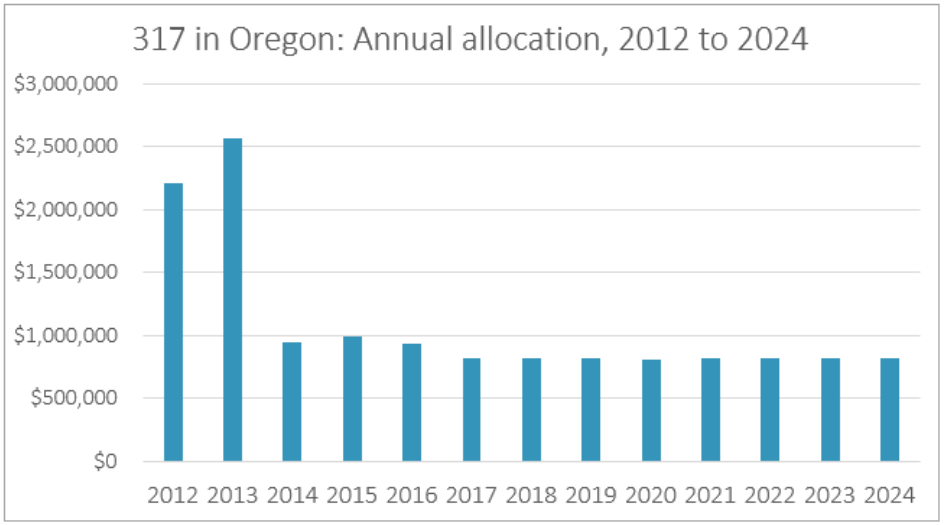
Because VAP was launched with one-time state funding, the increased demand and associated vaccine costs have resulting in a pause on VAP enrollment and a reduction of some vaccine orders. Today, about 30 clinics and pharmacies are on a waiting list to enroll in VAP, and OHA does not have resources to match the demand. This program is unable to expand without additional resources.

The Vaccine Access Program (VAP) is unable to expand without additional resources.

Without VAP, clinics must purchase all vaccines for their "billable" clients up front, a cost burden that varies depending on clinic population size—from $10,000 to more than $70,000—and cost recovery can take many months. These increased costs likely mean that some of the more than 300 VAP providers will stop providing clinical immunization services altogether.

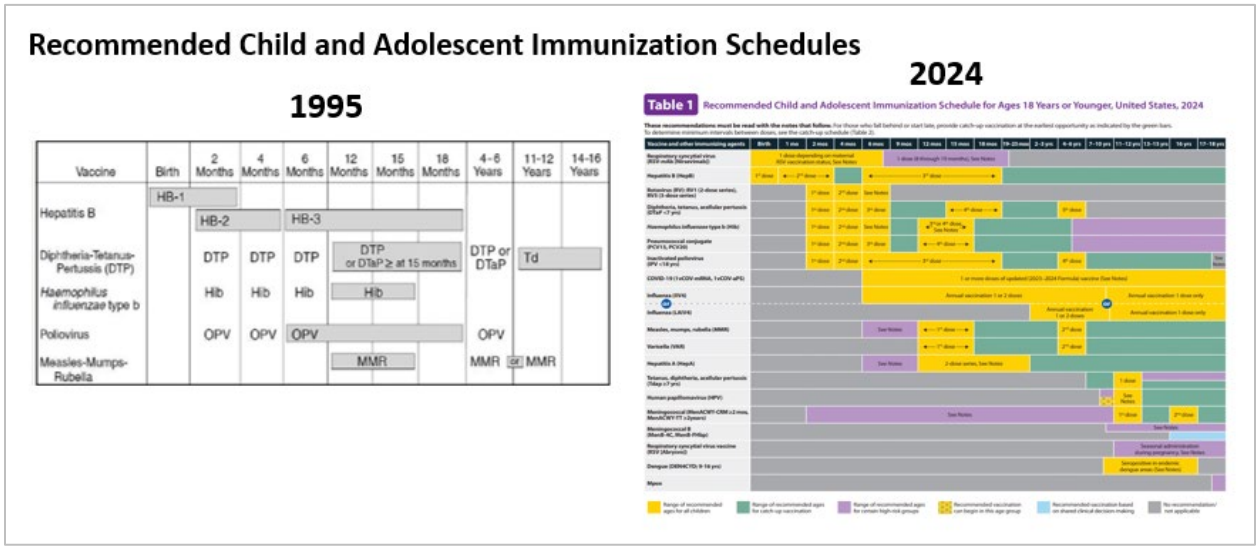
Clinics unable to enroll in a state-supplied vaccine program refer their clients out for immunizations services, typically to the local health department. However, many local public health clinics are also struggling to meet the increased cost and complexity required to provide immunizations. Many have scaled back or eliminated their clinical immunization services, resulting in a missing safety net to "catch" the referred children.

Flat funding for uninsured adults: OHA has seen limited and flat Section 317 funding for more than ten years, which is insufficient to meet the need. This, combined with new expensive vaccines that have been added to the Recommended Adult Immunization Schedule, has resulted in a reduced formulary of vaccines available for uninsured adults. This limits the no-cost vaccines that VAP clinics can offer to those listed on the most recent 317 Vaccine Eligibility Chart. Because of the limited budget, higher-cost vaccines—such as the shingles vaccine—are not included.



Growing complexity: Scientific advancements, changes in public health needs, and improvements in vaccine safety and efficacy have significantly expanded the number of vaccines available today. The number of routinely recommended vaccines has more than tripled since the inception of the VFC program 30 years ago, resulting in a more comprehensive immunization schedule designed to protect individuals across their lifespan. While the benefits of this expanded schedule are numerous and inarguable, the day-to-day cost, management, and administrative duties associated with this increase are proving challenging for

many vaccine providers and for state immunization programs tasked with coordinating and implementing vaccination efforts. Managing separate, parallel stocks of vaccine requires more staff and is susceptible to errors.



These images are included to visually represent the large increase in routinely recommended childhood and adolescent vaccines.

Staffing constraints: OHA's Immunization Program is responsible for ensuring that vaccines are widely available, accessible, and administered effectively to prevent the spread of vaccine-preventable disease. The key functions and responsibilities of the Oregon Immunization Program (OIP) include:

- Vaccine procurement, distribution, and management
- Immunization services coordination (i.e., managing the "Patchwork")
- Immunization education and outreach
- Maintaining the ALERT Immunization Information System (IIS)
- Surveillance and disease monitoring
- Policy development and implementation
- Initiatives for underserved and high-risk populations
- Funding and resource allocation
- Evaluation and quality improvement
- Response to public health emergencies
- Collaboration with state and local partners

The current patchwork system is costly for OHA as well, and staffing has not kept pace to meet the demand. An estimated 5.5 additional FTE are needed to meet VAP enrollment demand and other operational requirements, including staffing to set up and manage a new system for tracking certain direct-ship, frozen vaccines that are currently unavailable for Billable clients, as well as tracking flu "vulnerable populations" vaccines.

OIP has been funded through a CDC cooperative agreement (COAG) since the formation of the Vaccines for Children program in 1994. Cooperative agreement funding has been flat since 1998, though clinic enrollment in a state-supplied vaccine program (VFC/VAP) has ballooned from 150 clinics to 650. Funding for OIP to manage vaccine programs has been limited, including no dedicated FTE to manage day-to-day VAP operations or enroll and support new providers. Enrollment is a lengthy process, which includes significant documentation, site visits, technical assistance, and required support.

OIP is bracing to lose 44% of staff in June 2025, once COVID-funded positions end.

The increase in recommended vaccines—from six childhood and adolescent vaccines in 1999 to 22 today—adds accompanying administrative duties like vaccine budgeting, ordering, and tracking, as well as the need to communicate with providers and develop model protocols. Like immunization programs across the country, OHA is also flexing to absorb federal funding cuts at the end of our COVID-related funding. In June 2025, OHA's Immunization Program will lose nearly 50 percent staff capacity when COVID-funded limited duration positions end, further straining the state's capacity to meet the increased demand.

Oregon Immunization Program and Population Changes

	1999	2024
Enrolled clinics	150	650
Vaccines to manage	6	22
Vaccine budget	$750,000	$117,000,000
Oregon population	3.3 million	4.2 million

Net decrease in clinic enrollment: Oregon experienced a net loss of 26 clinics enrolled in a state-supplied vaccine program (VFC/VAP) between July 2022 and June 2024. Though we have enrolled new clinics during that time, there have been more disenrollments. At the county level, 12 counties have a net loss, 11 have a net gain, and 13 counties have no net change. There was a broad geographic spread of losses/gains across the state.

Pharmacy closures: Pharmacies are a critical access point for immunizations, particularly for adult vaccines. Before the COVID-19 pandemic, pharmacies primarily offered a limited range of vaccines, mainly focusing on flu shots, pneumococcal vaccines, and some travel-related vaccines. During the pandemic, pharmacies became crucial in administering COVID-19 vaccines, leading to expanded services, greater public reliance, and permanent change in regulations.

The closure of Oregon's Bi-Mart pharmacies in 2021 had a significant impact on vaccination services in the state, particularly in rural communities where these pharmacies were a primary source of immunizations. The timing of the Bi-Mart closures in 2021 came amid a still-intense COVID-19 response, creating fewer vaccination sites and confusion for clients who had relied on Bi-Mart for their immunization and prescription needs. The closure of these pharmacies increased the demand for services at remaining pharmacies, straining resources and impacting capacity to meet local needs. Oregon has continued to see additional closures, including 36 in 2023 and an unknown number in 2024, resulting in a downstream reduction in access for immunizations.

These challenges exacerbate existing disparities in vaccine access, particularly for low-income populations, rural communities, and historically marginalized groups.

Impact

The consequences of these challenges mean more clinics and pharmacies are unable to participate in state-supplied vaccine programs (VFC/VAP), which leads

to a reduction in vaccine access, more missed opportunities to prevent disease, and ultimately an impact on community health. As vaccine coverage rates decline, communities face a higher risk of vaccine-preventable disease outbreaks.

These challenges also exacerbate existing disparities in vaccine access, particularly for low-income populations, rural communities, and historically marginalized groups. These populations are more likely to rely on state-supplied vaccines and may face the greatest impact of declining access.

One of the great lessons of the COVID-19 pandemic is that vaccination opportunities must meet people where they are. Oregon's COVID-19 vaccination campaigns were remarkably successful, in large part because the state invested heavily in equitable access by getting vaccine out into the community rather than relying solely on traditional healthcare channels for distribution. OHA's Field Operations team, in collaboration with LPHAs, community-based organizations (CBOs), and other local-level partners, provided opportunities for vaccination at community locations like libraries, fairgrounds, schools, parks, businesses, and more. This broad access to vaccination did not exist in Oregon until the COVID-19 pandemic, and still doesn't for routine immunizations due to funding and staffing constraints.

These challenges lead to a reduction in vaccine access, more missed opportunities to prevent disease, and ultimately an impact on community health.

For routine vaccination, clients remain dependent on a limited provider network. Those without a medical home—or for whom convenience, appointment availability, or other factors may push them to seek vaccination elsewhere—go to LPHAs and other Vaccine Access Program sites for vaccines. These types of safety net clinics must have vaccines available to fill this need.

Missed opportunities increase the likelihood of preventable illness spreading throughout a community. Outcomes include reduced school or childcare attendance, children being excluded from school/childcare due to an inability to

obtain vaccines required for attendance, lower work attendance for adults who get sick or must take time off to care for sick children, and higher medical bills for those requiring testing and/or treatment.

A recent case of tetanus in Oregon highlighted the potential—and costly—repercussions of non-vaccination, when a 42-year-old man with a work-related exposure became extremely ill and required 50 days in the hospital for treatment. The man very nearly lost his life, and the estimated financial costs of his extended hospitalization are staggering.[1]

More recently, Oregon is grappling with its largest measles outbreak in 33 years, with 31 cases of measles by September 30, 2024, all in unvaccinated people. There has also been an upswing in pertussis cases (whooping cough), another highly contagious and vaccine-preventable illness, with 614 cases reported to OHA's Acute and Communicable Disease Program, the most since 2012. On September 14th, 2024, Portland State University canceled its football game against University of South Dakota due to an outbreak of pertussis.

Oregon is grappling with its largest measles outbreak in 33 years.

Public health modernization provided a framework to ensure that vital public health protections are in place for every person in Oregon and that the system is prepared to address emerging health threats and eliminate health disparities. The VAP was an early example of modernization that allowed local public health clinics and other VAP sites to serve all clients regardless of insurance status while also billing for and recovering the costs of services provided when feasible. From an access perspective, Oregon cannot afford to lose or have weakened a key program that fills access gaps for many who are at risk of disproportionate health outcomes, especially when the costs of the program are small relative to the benefit the program provides.

[1] The total hospitalization costs associated with this case are unknown, however a 2017 Oregon tetanus case also requiring a lengthy hospital stay totaled $811,929 in inpatient costs.

Vaccine Finance Reform Steering Committee

Over the last eighteen months, OHA has engaged with statewide partners to share information about Oregon's current vaccine funding model and the associated challenges impacting provider capacity to offer clinical immunization services and vaccine access statewide.

On January 25, 2024, OHA brought partners together for the Oregon Vaccine Finance Summit to identify systems-level strategies that could reform Oregon's model, reduce provider barriers, and center equitable access. Attendees from across the healthcare system gathered for this statewide, day-long event to learn about and discuss challenges impacting provider participation and vaccine access.

Survey data from the event showed clear support for a new model and a long list of partners that were interested in exploring the issues further. OHA leveraged that momentum to recruit a steering committee tasked with developing recommendations for a new vaccine finance model for Oregon. In May 2024, the 26-member multidisciplinary Vaccine Finance Reform Steering Committee was formed, including representatives from OHA, state and local public health, Coordinated Care Organizations (CCOs), commercial payors, large clinic organizations, rural providers, health systems, Tribal clinics, provider associations, and more (see Appendix A for the Steering Committee roster). The Committee was staffed by OIP, and meetings were facilitated by an outside consultant, Diana Bianco with Artemis Consulting. OHA also contracted with Sobeck Healthcare Consulting to provide subject matter expertise regarding Universal Vaccine Purchasing programs.

The Steering Committee was tasked with making recommendations for a sustainable vaccine finance model that reduces provider barriers and centers equitable vaccine access.

The Steering Committee held an introductory call on May 16, 2024, to review the Committee charge, draft charter, and group agreements. OIP staff shared background information and data in a "state of the state" presentation to frame

up the challenges the Committee was convened to address (see Appendix B for the charter and group agreements). After the introductory call, the Steering Committee met twice per month, June–September 2024. All meeting agendas, presentations and summaries can be found on the Committee's shared drive.

Vaccine Finance Reform Steering Committee Charge

The Oregon Vaccine Finance Reform Steering Committee will make recommendations for a sustainable vaccine finance model for Oregon that reduces provider barriers and centers equitable vaccine access.	The Steering Committee will also provide recommendations on a strategy for introduction of any legislative concept resulting from the Committee's work.

An in-person Steering Committee kick-off meeting was held on June 5, 2024, in Clackamas, OR. This half-day event was intended to finalize the problem statement and begin talking through potential solutions. The problem statement was agreed to as follows:

Problem Statement
➢ 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.

Criteria and Recommendations Development

The Steering Committee was asked to answer the question, "What do you want the vaccine finance system to do?" Establishing criteria at the outset helped ensure that the Committee's recommendations were focused, objective, efficient, and aligned with the overarching goals. This approach leads to more effective and sustainable outcomes while fostering transparency, trust, and consensus among invested partners. The criteria were further refined over subsequent Committee meetings and finalized on July 8, 2024 (see Appendix C for the final list).

Criteria: Small Group Discussions

- What do we want the vaccine finance system to do?
- What criteria must the Steering Committee recommendations meet?
    - Our proposed recommendations must do the following…

Like the criteria development process, the Steering Committee also spent several meetings brainstorming and then narrowing down their list of proposed recommendations. This work occurred through an iterative process involving structured feedback, with discussion periods and support from OHA staff. As Committee members requested information to inform their discussions, program staff provided data and insights related to the issue at hand. Consultant and meeting facilitator, Diana Bianco, ensured alignment with broader goals and criteria.

One of the early recommendations was to offer "no change" to the current system. While the group was unanimous in their agreement that the current model is untenable, they also felt it was important to consider the impact of no change as they progressed through the process. By July, the Committee had narrowed the list of proposed recommendations to two options for further exploration:

- Option 1: Fully invest in current programs (VFC and VAP)
- Option 2: Implement a Universal Vaccine Purchase program

Option 1: Fully Invest in Current Programs (VFC and VAP)

The current state-supplied vaccine programs—VFC and VAP—were designed to ensure that immunizations are accessible to all, regardless of insurance status or coverage type. OHA's ability to support these programs has waned over time due to funding that has not kept pace with increased costs. The challenges facing the current model are numerous and summarized in the *Challenges* section of this report. A full investment in the current programs would require significant additional funding to support increased vaccine costs and the requisite staffing to support the Vaccine Access Program:

Billable vaccine costs (VAP): While VFC vaccine is funded by the federal government, the State of Oregon fronts the cost of vaccines for Billable clients served at VAP sites. Fully funding VAP would require purchasing enough Billable vaccines for all currently enrolled VAP locations, plus the approximately 30 waitlisted sites, birthing hospitals (birth dose Hepatitis B vaccine and Nirsevimab), and any new providers for whom the cost of maintaining VFC-only enrollment is cost-prohibitive.

Billable vaccine costs are estimated to be $5 million, though the true total depends on numerous factors, including staffing capacity to enroll clinics, new clinic enrollment (number and provider type), and the populations served by newly enrolled providers. Notably, additional funding would be necessary in the future to keep pace with increased prices, new vaccines, and a growing population. These costs grow annually and are difficult to predict, though some mechanism for this estimation and assured funding would need to be determined.

To fully fund current programs, OIP estimates a minimum of 5.5 additional FTE, plus a 6-month contractor to build a new vaccine tracking system ($1.8M per biennium).

Staffing costs: Fully funding the current programs would require support for additional FTE to manage day-to-day VAP operations, including vaccine planning, purchasing, and distribution, as well as staffing to enroll and support new providers and handle the overall increased administrative workload. To fully fund

current programs, OIP estimates a minimum of 5.5 additional FTE, plus a 6-month contractor to build the new tracking system ($1.8 million per biennium).

Option 2: Implement a Universal Vaccine Purchase Program

A statewide Universal Vaccine Purchase (UVP) program is a public health initiative designed to ensure that vaccines are available to all people, regardless of their financial situation or insurance coverage. A UVP program is funded by a base of available federal and state funds (e.g., VFC, Section 317 [if adults are included], and any state funds as applicable). This funding is then augmented with an assessment methodology wherein commercial payors contribute funds based on covered lives. A UVP program is a financing mechanism that stabilizes vaccine funding and access. Due to the large population covered, the state can leverage Centers for Disease Control (CDC) vaccine contract rates to purchase in bulk at significantly lower prices.

UVP programs are funded with a mix of federal and state funds, plus an assessment methodology wherein commercial payors contribute funds based on covered lives.

Currently there are eleven states that have UVP programs; eight of those cover children <19 years of age (ID, CT, MA, ME, NH, NM, WA, WY), and three states cover children and adults aged 19-64 (AK, RI, VT). Programs adhere to CDC Advisory Committee on Immunization Practice (ACIP) recommendations.

A UVP program implemented in Oregon would pay for the cost of vaccines, staff to manage the program, and associated program administrative costs. The budget for the program would include current public funds in combination with private assessments to cover vaccine costs for commercially insured individuals. Based on the experience of other state UVP programs, the cost to commercial payors would be less than under the current fragmented system.

To build a UVP program, Oregon would need the support of numerous invested partners, including OHA, Oregon Division of Financial Regulation, commercial payors, and vaccine providers (e.g., hospitals, independent providers,

multispecialty groups, integrated delivery systems, vaccine advocates, legislative champions, and potentially pharmacies).

Depending on the timeline for UVP program implementation, the Vaccine Access Program would likely need additional funding to sustain VAP in the short term. This would prevent the scaling back of VAP-enrolled sites and possibly allow some enrollment of waitlisted clinics and pharmacies.

Potential Impacts of Each Option

The Steering Committee explored the benefits and drawbacks of both potential recommendations, including by their impact to vaccine access and to individual sectors of the healthcare system. Among the criteria developed early in the Committee's work was to avoid adverse unintended consequences or otherwise negatively impact systems that are currently working. OHA staff provided an impact analysis for each recommendation, including potential downstream effects if implemented.

Fully funding the current VFC and VAP programs would require staffing OIP at capacity to enroll the approximately 30 waitlisted immunization providers and possibly expand VAP to some pharmacies and birthing hospitals, plus a selection of other clinics for whom participation in the VFC program is currently cost prohibitive. This increase in access points would maintain critical safety net sites where uninsured and OHP-covered adults access vaccines, centering equity for Oregon's marginalized and underserved communities. A fully funded VAP program would also allow OIP to resume provision of direct-ship frozen vaccines. The challenge to this approach is that it requires an ongoing investment of state funding for both Billable vaccines and staffing to support the program.

Impacts of UVP implementation depend in part on the scope of the program (children only, or children and adults up to 65 years). Most notably, the model eliminates upfront vaccine purchasing (and subsequent billing) for participating providers. This allows clinics to order and manage just one stock of vaccines, reducing the administrative burden and complexity of managing multiple stocks, and simplifying storage and inventory control. A UVP program would support the capability of small practices to carry inventory without the upfront costs and the financial risks that currently prevent many from joining the VFC program. Because operational costs are built into the UVP payor assessments, OIP would be staffed

at levels sufficient to enroll new providers, including Oregon's birthing hospitals, which would ensure equitable access to newborn immunizations and better clinical practice to administer Nirsevimab before discharge. Commercial payors typically save money under a UVP model, as state vaccine programs leverage CDC contract pricing for vaccine purchasing.

The biggest challenge to UVP implementation is ensuring a solution that helps mitigate the vaccine serum-related revenue loss for Oregon's largest immunization providers. These practices, typically large pediatric groups with combined purchasing power, use their margin on vaccines to cover the cost of administering high volumes of vaccine (not covered by the current vaccine administration fee) and other clinical services that are either reimbursed poorly or not at all. A solution is needed that offsets the revenue loss and addresses costs for those who vaccinate a large volume of patients. Examples include increasing the vaccine administration fee paid for commercially insured children, adding incentive payments, and/or some other per member per month (PMPM) compensation. As referenced above, during the COVID pandemic, increased administration fees and a PMPM improved the financial calculus for providers, resulting in increased access.

A UVP program that includes adults must also consider the best way to incentivize large pharmacy chains to participate, given the higher proportion of vaccines they provide to adults.

The Steering Committee also explored the expected impact of *no change* to the current system. Most importantly, the Vaccine Access Program would need to be significantly scaled back. Without additional funding to support vaccine and operational costs, OIP will likely begin limiting participation in the program after July 1, 2025. This would mean some provider types, such as Federally Qualified Health Centers, being transitioned to VFC-only sites. This change could lead to disruptions in care and decreased access points as these clinics adjust to new costs and enrollment requirements.

As VAP sites, FQHCs currently operate as critical safety nets where uninsured adults access 317-funded vaccines at no cost. Vaccines for Billable clients, including OHP-covered adults, would need to be purchased up front by the clinics rather than utilizing state-supplied vaccine that they pay back after receiving

reimbursement from the payor. This change would significantly increase their costs for providing immunization services.

> ***No change** to the current system will result in a significant scaling back of VAP, leading to disruptions in care and decreased access points.*

OHA would also expect to see a decline in VFC clinic enrollment (i.e., a continued net loss), especially for clinics serving predominantly VFC-eligible children for whom enrollment in VFC is cost-prohibitive due to the significant outlay of funds required to purchase vaccine for their privately insured patients. There would also be potential for a widening disparity in immunization coverage rates between VFC and non-VFC children (see graph titled 'Statewide Trend by Payer Status' at the bottom of the webpage). Any opportunities for expansion of providers enrolled in VAP, or a new vaccine program like UVP, would be eliminated.

Financial Assessment Workgroup

The Steering Committee convened a Financial Assessment Workgroup to further explore the fiscal requirements and impacts of each option, with a particular emphasis on the UVP model. The Workgroup was comprised of five Committee members and four external partners with healthcare finance expertise. See Appendix D for a list of Workgroup members.

The Workgroup met twice in August 2024 to discuss the financial viability of UVP to examine whether the recommendations would be economically feasible and sustainable. They explored potential impacts on state budgets, healthcare providers and payors, and learned about the operational costs associated with implementing a UVP model.

Workgroup members shared a pediatric practice example of costs and considerations under the current model versus the potential impact of UVP, highlighting concerns about poor reimbursement for vaccine administration fees that do not cover the cost of providing immunization services. This is particularly true for the federally established VFC vaccine administration fee, but also applies to commercial rates in varying degrees. The elimination of vaccine serum-related

margins for these high-volume providers would exacerbate reimbursement concerns and negatively impact Oregon's largest pediatric providers.

UVP subject matter experts provided a rate-setting overview and cost projections that included covered population cohorts, assessment methodologies, administrative costs, and a "straw man" annual assessment rate analysis based on other states' UVP programs. They then applied these to Oregon's population and coverage estimates. The UVP experts also presented options to mitigate revenue loss for large-volume immunization providers under UVP.

A Steering Committee member representing Biotechnology Innovation Organization (BIO) shared the financial impact of UVP on vaccine manufacturers. BIO is a trade association representing biotechnology companies, academic and research institutions, state biotechnology centers, and related organizations across the United States and in 30 nations. Because UVP states can leverage CDC vaccine contract prices, the manufacturers typically experience some revenue loss when states transition to UVP.

After discussing the considerations identified by the Financial Assessment Workgroup, the Steering Committee determined the need for additional modeling and exploration before moving ahead with a UVP model.

Recommendations

Steering Committee members unanimously agreed that the current state of vaccine financing in Oregon is untenable; in the absence of some intervention, vaccine access will continue to deteriorate, which will worsen health inequities by disproportionately impacting uninsured, rural, and otherwise marginalized communities. There is consensus among the group that prompt action is needed.

The Vaccine Finance Reform Steering Committee unanimously agreed that the current state of vaccine financing in Oregon is unsustainable and that prompt action is needed.

The group concluded that the most viable options are the adoption of a Universal Vaccine Purchase model or a significant strengthening of the current VAP and VFC

programs. While nearly all Steering Committee members agreed that the UVP model may be the optimal path forward, there are factors in program design that require considerable deliberation. UVP would reduce the costs and administrative burden for many providers and provider types in Oregon, but concerns about the potential revenue impact for large pediatric providers are unresolved. The Committee also did not have sufficient time to examine impacts of a children-only model (versus one that includes adults), or to explore opportunities and challenges for engagement of large pharmacy chains in UVP if adults were included in the scope of the model.

Steering Committee Recommendations
1. That OHA **request an informational hearing with the legislature** to discuss Oregon's vaccine finance challenges and related impacts on access 2. That the legislature **establish a formal group** to consider options to address challenges with the current vaccine finance system and related impacts on access (i.e., further evaluate and model a Universal Vaccine Purchase program and fully investing in current programs), with a report back to the legislature by 2026 3. That **additional bridge funding be directed to the current programs** (Vaccine Access Program and Vaccines for Children) programs to maintain and expand provider participation until the formal group delivers its recommendations and those recommendations can be implemented

Given time constraints and the outstanding considerations mentioned above, the Steering Committee recommends three actions to move their work forward. First, that OHA request an informational hearing during the 2024 legislative session to share Oregon's vaccine finance challenges and related impacts on access statewide. This hearing would raise awareness of the complexities and urgent challenges facing the state's immunization providers and OHA. It would also provide an opportunity to build legislative support for the Committee's other recommendations.

Second, the Committee recommends establishing a formal state-convened workgroup to propose a sustainable vaccine finance model for Oregon. The workgroup should build on the research, analysis, and findings of the Steering Committee. Specifically, this workgroup should evaluate the merits of both UVP and fully investing in current programs. It should include a thorough analysis of the impacts of each option on different provider types and payors, both public and private, as well as a review of the disparities in vaccine administration fees among different eligibility categories, such as VFC, commercially-insured, and OHP-covered adults. For current programs, this workgroup needs to delve into sustainable financing and reduction of complexity. For UVP, the workgroup needs to examine how alternate vaccine administration fee models may affect various practice types, in particular how to lessen the impact on large pediatric providers.

Third, because resources have not kept pace with the growth of program enrollment and rising vaccine costs, the Steering Committee recommends that current state-supplied vaccine programs be funded sufficiently to sustain VAP and support VFC providers until UVP or an alternate new model can be implemented. Without additional funding for vaccine and staffing, access in Oregon will continue to erode. We must protect our critical safety net providers and ensure equitable vaccine access statewide.

In addition to the three formal recommendations listed above, the Steering Committee suggests that OHA conduct a comprehensive provider assessment that includes a VFC/VAP provider landscape assessment and evaluation of provider barriers. This data will be useful for OHA staff and local level partners, and will also benefit the work of a possible future vaccine finance workgroup.

Conclusion

Oregon's current vaccine finance model is outdated, fragmented, and burdensome for both providers and the Oregon Health Authority. Over the past 30 years, the state's patchwork of funding mechanisms—dependent on age, insurance status, and federal or state programs—has created significant challenges. These barriers, ranging from rising vaccine costs, insufficient staffing, and growing administrative complexity, have limited access to vaccines, particularly for vulnerable populations.

Without immediate reform, the state risks further loss of immunization providers, reduced vaccine access points, and declining vaccination rates. The Vaccine Access Program and Vaccines for Children program, once the cornerstones of equitable vaccine distribution, are now struggling to keep pace with growing demand and operational costs. Meanwhile, non-medical exemptions and decreasing vaccine coverage rates continue to increase the risk of vaccine-preventable disease outbreaks.

If no changes are made, vaccine access will continue to erode, disproportionately affecting rural, uninsured, and historically marginalized communities.

The Steering Committee's recommendations underscore the urgent need for Oregon to reform its immunization funding structure. This includes exploring solutions such as the Universal Vaccine Purchase model or significant investments in existing programs. Both options offer pathways to reducing provider barriers and ensuring equitable access to vaccines in Oregon.

Modernizing Oregon's vaccine finance model is essential for safeguarding public health and achieving the state's goal of eliminating health disparities by 2030. Without reform, vaccine access will continue to decline, disproportionately affecting rural, uninsured, and historically marginalized communities.

Appendix

Appendix A: Steering Committee Roster

Name	Title	Organization
Alanna Braun, MD	Associate Professor, General Pediatrics at OHSU; Immediate Past President, Oregon Pediatric Society	Oregon Pediatric Society; OHSU Pediatrics
Bob Dannenhoffer, MD (Chair)	Administrator and Health Officer	Douglas County Public Health Network
Christian Huber, MBA, BSN, RN	RN Manager	Legacy Health System- Randall Children's Hospital
Danielle Shannon, PharmD, MSCR	Clinical Pharmacist	WVP Health Authority
Deborah Rumsey	Executive Director	Children's Health Alliance
Helen Noonan-Harnsberger, PharmD	Vice President, Pharmacy Division	Providence Health Plan
Ian Horner, DO	Family Medicine	Family Medical Group, NE / Optum
Jane Quinn	Consultant to Biotechnology Innovation Organization (BIO)	Representing Biotechnology Innovation Organization
Janet Patin, MD		Oregon Academy of Family Physicians
Jeanne Savage, MD	Chief Medical Officer	Trillium Community Health Plan
Jeff Fortner, PharmD	Treasurer of OSPA, Registered Pharmacist and Professor	Oregon State Pharmacy Association (OSPA) and Pacific University School of Pharmacy
Jennie Seely, PharmD	Director, Pharmacy Service Area	Kaiser Permanente
Jennifer Stubblefield	Pharmacy Revenue Integrity Specialist	St. Charles Health System
Katie Russell, BSN, MPH, RN	Deputy Director	Jefferson County Public Health / Warm Springs
Kim La Croix, MPH, RD	Deputy Public Health Director	Clackamas County Public Health
London Manor-Petersen	Population Health Manager	Comagine Health
Meg Olson	Director	Oregon Families for Vaccines
Nathan Roberts	Manager, Medicaid Programs	OHA/Health Systems Division
Rebekah Sherman, MPH, RN	Nursing Director	La Clinica
Robin Canaday, RN	LPHA Administrator	Morrow County Public Health
Sarah Andersen, MPH	Director of Field Services	Oregon Office of Rural Health
Sheila Albeke, PharmD, MBA	Director of Pharmacy	Samaritan Health Plans- InterCommunity Health Network CCO
Stephanie Saunders	Vaccine and Lab Programs Manager	Virginia Garcia Memorial Health Center
Summer Prantl Nudelman	Director of Medicaid Programs	Eastern Oregon CCO
Tracy Muday, MD	Executive Medical Director	Regence BlueCross BlueShield
Will Clark-Shim, FSA, MAAA	Chief Actuary	Oregon Health Authority

Oregon Vaccine Finance Reform Steering Committee
Charter and Group Agreements

Charge and deliverables

The Oregon Vaccine Finance Reform Steering Committee will make recommendations for a sustainable vaccine finance model for Oregon that reduces provider barriers and centers equitable vaccine access. This effort is aligned with the Oregon Health Authority's (OHA) goal to eliminate health inequities in Oregon by 2030. The Steering Committee will also provide recommendations on a strategy for introduction of any legislative concept resulting from the Committee's work. The Steering Committee will deliver its recommendations to OHA by September 30, 2024.

Background/Problem statement

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. Rural and frontier regions, as well as historically marginalized communities, 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.

Goal and scope

The goal of this project is to reform Oregon's vaccine finance model to reduce provider barriers and support equitable vaccine access statewide. Without

significant reform to the current model, the state risks losing additional immunization providers, as well as a continued erosion in vaccine access. The Vaccine Finance Reform Steering Committee is tasked with recommending a new vaccine finance framework that addresses these challenges in a way that centers vaccine equity and creates a meaningful reduction in barriers (i.e., cost, complexity) for all immunization providers.

In scope:

- Strategies/approaches for a sustainable statewide vaccine financing system

Out of scope:

- Vaccine mandates and/or exemptions
- Vaccine distribution unrelated to financing
- Clinical decision-making regarding immunizations
- Federal requirements of the Vaccines for Children program or Section 317 funding

Roles and responsibilities

Steering Committee members will:

- Make recommendations for a sustainable vaccine financing system for Oregon.
- Review all materials provided by OHA or other Steering Committee members.
- Contribute knowledge, expertise, or information relevant to discussions.
- Represent their respective sectors by sharing and discussing committee work with—and soliciting feedback from—the group or health system sector they represent.
- Conduct listening sessions with relevant special communities they are affiliated with as appropriate (e.g., CCOs will engage Community Advisory Councils).
- Attend all meetings. The Steering Committee will meet twice a month from June through September. Meetings will be approximately 2 ½ hours in duration.
    - If a Steering Committee member is going to miss a meeting, they can send a delegate. This shouldn't be a consistent practice unless there are extenuating circumstances. The Steering Committee member is

responsible for briefing the delegate and then, in turn, being briefed by the delegate before the next meeting.

- The Steering Committee will appoint a chair. The chair is responsible for working with the Committee, staff and consultants on the Committee's workplan and meeting agendas as well as providing guidance to the overall process. The chair also will assist in determining the process for moving the recommendations forward.

The staff team and consultants will:

- Create a project and Steering Committee workplan.
- Prepare and distribute meeting materials, including agendas and meeting summaries.
- Facilitate Steering Committee meetings to elicit input from all members and utilize a consensus-based decision-making process.
- Draft and finalize recommendations based on Steering Committee input, review and approval.
- Respond to information requests from the Steering Committee.
- Provide subject matter expertise, as necessary.

Decision making

The Steering Committee will use a consensus decision-making approach to develop its recommendation(s). Consensus decision making means that the Committee's recommendation must be one that all members can accept, support, live with, or agree not to oppose.

If a consensus-based recommendation cannot be achieved despite the Steering Committee's best efforts, then a recommendation will be based on a majority vote. Members who disagree with the resulting recommendation may state their disagreement and their reason(s) for disagreeing. The Steering Committee's final recommendations will include any minority opinions.

Subcommittees

The Steering Committee may establish time-limited subcommittees to explore certain topics and bring back information or recommendations to the full Committee.

OHA will convene a subcommittee on special populations to investigate and collaborate with representatives of specified population groups (e.g., PEBB/OEBB, carceral populations, substance use disorder service providers, Disability Rights Oregon).

Invested parties

- Oregon Health Authority (OHA), Immunization Program
- Immunization providers of all types (clinics, pharmacies, hospitals, etc.) practicing in Oregon
- Oregon Local Public Health Authorities (LPHAs)
- Public and private payors, health plans, and insurance companies that do business in Oregon
- Immunization advocacy organizations, community-based organizations that promote and/or organize vaccination events
- Vaccine seekers
- Vaccine manufacturers

Staff support

- Kelly McDonald, OHA/Immunization Program, Project manager
- Diana Bianco, Artemis Consulting, Facilitator and planning lead
- Isabel Stock, ORPRN, Steering Committee logistics lead
- Josh Spencer, OHA/Immunization Program, Project support lead
- Jessica LeRoux, ORPRN, Project Support

Group Agreements for Vaccine Finance Reform Steering Committee

- 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.

Appendix C: Criteria

Vaccine Finance Reform Steering Committee
Criteria to Evaluate Recommendations

Not ranked in order of preference (though first three scored highest on Committee member survey)

- Improve access for all, with a particular emphasis on children, Tribes and other historically marginalized or underrepresented groups
- Improve efficiency
    - Reduce complexity and simplicity 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
- Have the potential to build in mechanisms for evaluation and data collection
    - Develop key metrics to measure success—data source(s), how to score
- Avoid adverse unintended consequences
    - Avoid breaking systems that are working
- Align with federal requirements on all existing vaccine programs
- Maximize federal dollars
- Be realistic and actionable
- Be sustainable and durable (not a Band-Aid approach)

Appendix D: Financial Assessment Workgroup Members

Name	Title	Organization
Dan Boeder, FSA, MAAA	Chief Actuary	Regence BlueCross BlueShield
Will Clark-Shim, FSA, MAAA *	Chief Actuary	Oregon Health Authority
Bob Dannenhoffer, MD* (Chair)	Administrator and Health Officer	Douglas County Public Health Network
Mitch Holman	Budget Analyst	Oregon Health Authority
Tracy Muday, MD*	Executive Medical Director	Regence BlueCross BlueShield
Patrick Miller, MPH	Principal	Helms & Company
Carlos Pangelinan	Fiscal Analyst	Oregon Health Authority
Trinh Perkins	Fiscal Analyst	Oregon Health Authority
Jane Quinn*	Consultant to BIO	Biotechnology Innovation Organization (BIO)
Deborah Rumsey*	Executive Director	Children's Health Alliance

*Indicates Steering Committee member