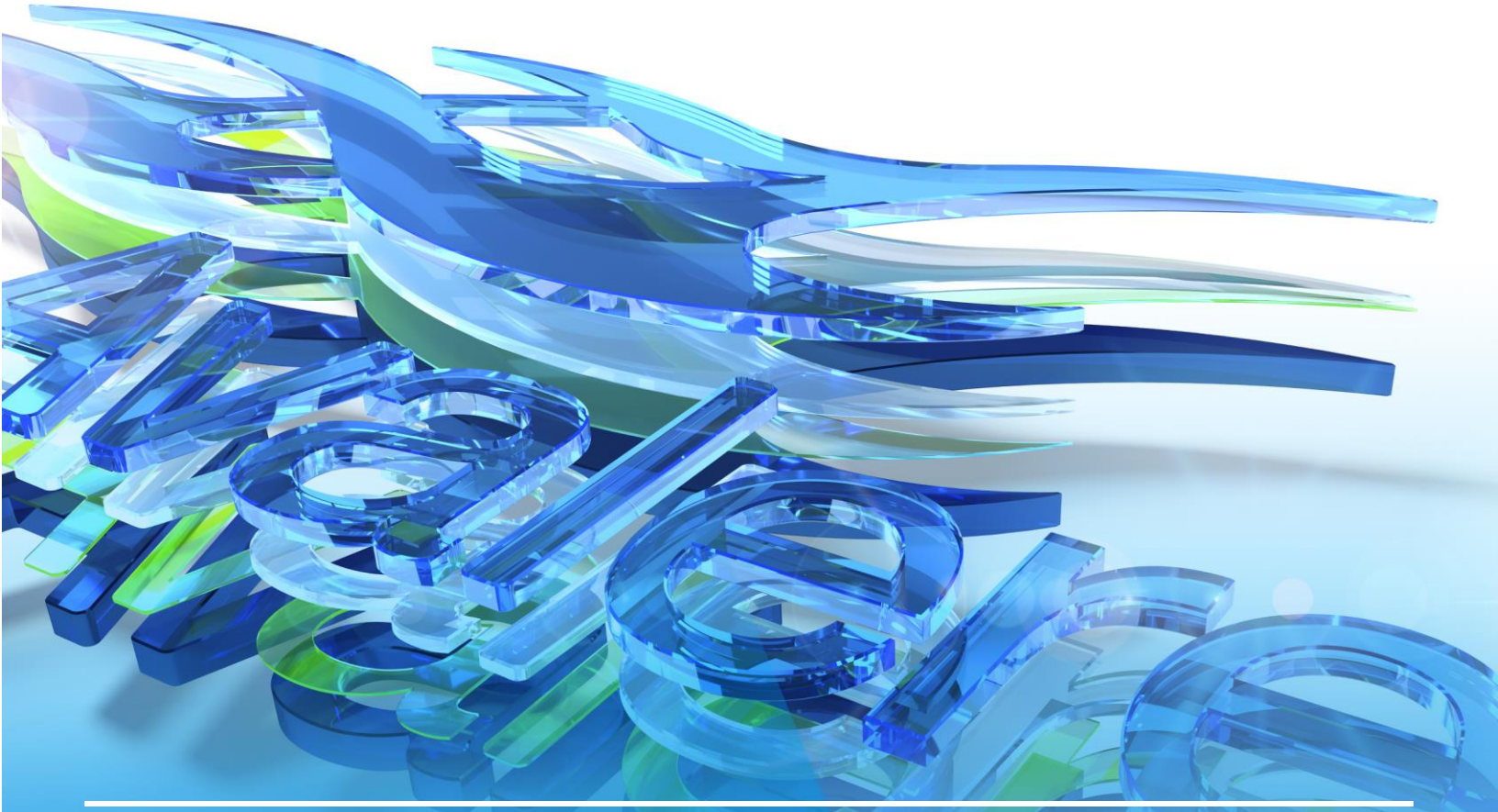
Adult Vaccine Coverage in Medicaid: Assessing Existing Gaps and Looking Ahead to Implementation of the Inflation Reduction Act



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Executive Summary

On August 16, 2022, President Biden signed the Inflation Reduction Act (IRA), which includes several provisions that will significantly impact the healthcare system in the United States. Specific to vaccines, Section 11405 of the IRA establishes federal coverage requirements across all Medicaid programs and populations, resembling existing coverage standards for the commercial insurance market. The new requirements create a pathway for all Medicaid-enrolled adults to access recommended vaccines by requiring states to provide coverage without cost sharing by October 1, 2023. Implementation of this provision will help address gaps in vaccine coverage under Medicaid.

State Medicaid programs that currently impose cost sharing or do not cover all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines will be required to make changes to comply with this provision. The process for implementing coverage changes varies by state and could involve legislation, regulation, or administrative action.

Avalere assessed Medicaid adult vaccine coverage in all 50 states plus Washington DC to understand coverage for ACIP-recommended vaccines pre-IRA implementation. Avalere reviewed publicly available resources and identified state coverage policies for five ACIP-recommended adult vaccines: (1) influenza; (2) tetanus, diphtheria, and acellular pertussis (Tdap); (3) human papillomavirus (HPV); (4) pneumococcal polysaccharide vaccine (PPSV23); and (5) pneumococcal conjugate vaccine (PCV13). Avalere's analysis found 19 state policies that clearly do not cover at least one of these vaccine products or impose cost sharing for the recommended populations.

Avalere's findings can inform stakeholder and policymaker engagement in states that are not currently compliant with the IRA coverage standards as these states take steps to implement the new requirements next year. As policymakers consider what changes are required in their states, stakeholders may also help them to identify and address remaining barriers to vaccine access not addressed in the IRA, such as provider reimbursement, pharmacy access, vaccine hesitancy, and immunization data collection.

Introduction

Childhood vaccine coverage is guaranteed across all insurance markets and under the Vaccines for Children (VFC) program in the United States, whereas adult vaccine coverage varies by payer type. Under Medicaid, the Medicaid Drug Rebate Program (MDRP) provides manufacturer rebates on most prescription drugs to Medicaid programs that cover those prescription drugs. The MDRP does not include vaccines, thus states have less incentive to cover vaccines than to cover prescription drugs. As a result, vaccine coverage has historically been fragmented across Medicaid eligibility groups.

Although the Affordable Care Act (ACA) and subsequent regulations mandate vaccine coverage without cost sharing for the Medicaid expansion[1] and commercial markets, these requirements do not apply to the traditional adult Medicaid population (e.g., low-income families, qualified pregnant women, and individuals receiving supplemental security income). Therefore, each state forms its own policy on adult vaccine coverage for the traditional Medicaid population, with Medicaid enrollees in some states paying variable out-of-pocket costs for non-covered vaccines. Vaccine coverage can also vary between Medicaid fee-for-service (FFS) and Medicaid managed care (MMC) because many states' MMC and FFS programs have differing coverage policies.

The IRA requirements take effect on October 1, 2023 and will address gaps in coverage for ACIP-recommended vaccines for adults enrolled in Medicaid. These changes will align vaccine access across the traditional and expansion Medicaid populations and will expand access to all ACIP-recommended adult vaccines, without cost sharing, to an estimated 23.8 million adults enrolled in traditional Medicaid. Based on the number of traditional Medicaid enrollees in the 19 states Avalere identified as having non-compliant coverage policies under the IRA, roughly 8.7 million people will gain access to at least one of the vaccines included in the analysis.[2] To comply with these new requirements, states will need to review their existing coverage policies and identify gaps in vaccine coverage.

Approach

To identify current gaps in the adult vaccine coverage landscape, Avalere assessed Medicaid FFS and MMC coverage policies in all 50 states plus Washington DC. This research occurred from April through December 2021 and included five ACIP-recommended adult vaccines—influenza, Tdap, HPV, PPSV23, and PCV13 (Table 1). Avalere researched publicly available resources, including fee schedules, provider and patient manuals, coverage policies, and prescription drug lists. For MMC, Avalere identified the largest MMC plan in each state based on 2020 enrollment and used that plan as the basis for research. If Avalere could not confirm a coverage policy based on publicly available resources, it attempted to contact the Medicaid

[1] Expansion states extend Medicaid eligibility to adults younger than 64 years old and who have incomes below 138% of the federal poverty level.
[2] Based on Avalere's analysis of September 2021 CMS, State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data.

agency to understand that state's policy. Avalere was unable to determine coverage policies in some states because of lacking, incomplete, or ambiguous publicly available resources, and/or lack of response from Medicaid agencies.

Table 1. Vaccines Included in Coverage Assessment

Vaccine	Summary of 2021 ACIP Adult Recommendation
Tdap (Adacel) CPT: 90715	Routine Vaccination: Previously did not receive Tdap at or after age 11 years: 1 dose Tdap, then booster of Td or Tdap every 10 years Special situations: Includes vaccination for those who did not receive the primary series, pregnant persons, and persons in treatment for wound management
Influenza CPT: Multiple	Routine Vaccination: Persons ≥6 months of age: annual dose any influenza vaccine appropriate for age and health status
PPSV23 (Pneumovax23) CPT: 90732	Routine vaccination: Immunocompetent adults: 1 dose PPSV23 (if PPSV23 was administered before 65 years of age, administer 1 dose PPSV23 at least 5 years after previous dose) Special Situations: Includes vaccination for individuals aged 19–64 years with chronic medical conditions, individuals aged 19 years and older with immunocompromising conditions and individuals with cerebrospinal fluid leak or cochlear implants
PCV13 (Prevnar13) CPT: 90670	Shared Clinical Decision Making (SCDM)*: Adults ≥65 years of age, 1 dose PCV13 if not previously administered Special Situations: Individuals ≥19 years of age with immunocompromising conditions and individuals with cerebrospinal fluid leak or cochlear implants
HPV (Gardasil 9) CPT: 90651	Routine Vaccination: All persons ≤26 years of age: 2- or 3-dose series depending on condition or age at initial vaccination SCDM: All adults 27–45 years of age

*SCDM vaccinations are not recommended for everyone in a particular age group or an identifiable risk group. Rather, SCDM recommendations are individually based and informed by a decision process between the health care provider and the patient.

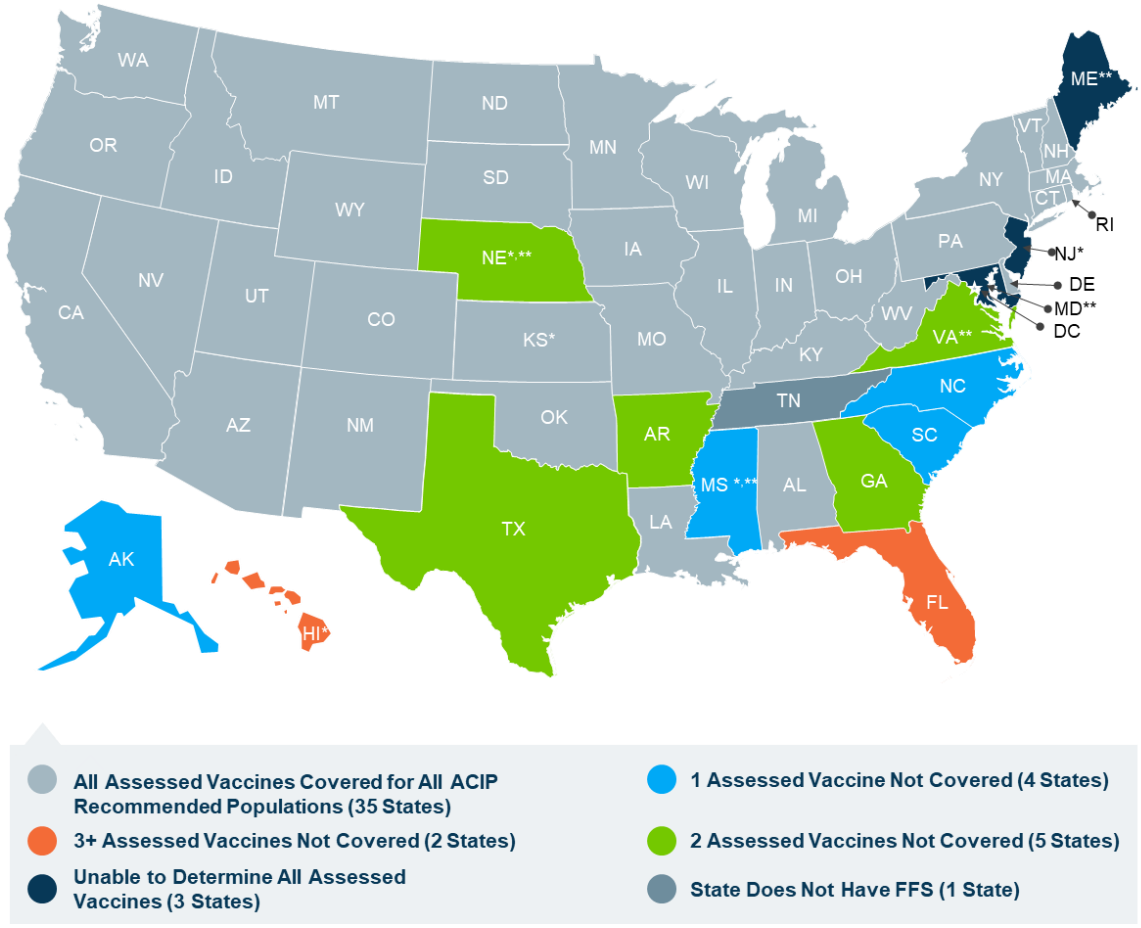
Findings

During the assessment period (April–December 2021), Avalere found 11 FFS programs (Figure 1) and 6 MMC plans (Figure 2) that did not cover one or more of the five products for all ACIP-recommended populations. Coverage gaps were more common in states that have not expanded Medicaid (e.g., TX, FL, SC, NC, and MS) compared to expansion states.

Avalere found coverage gaps most often for vaccines with risk-based and/or shared clinical decision-making recommendations, such as HPV and PCV13. Six state FFS programs and two MMC plans, in different states, did not cover the HPV vaccine. In addition, five FFS plans and one MMC plan did not cover the PCV13 vaccine. Coverage gaps were less common for

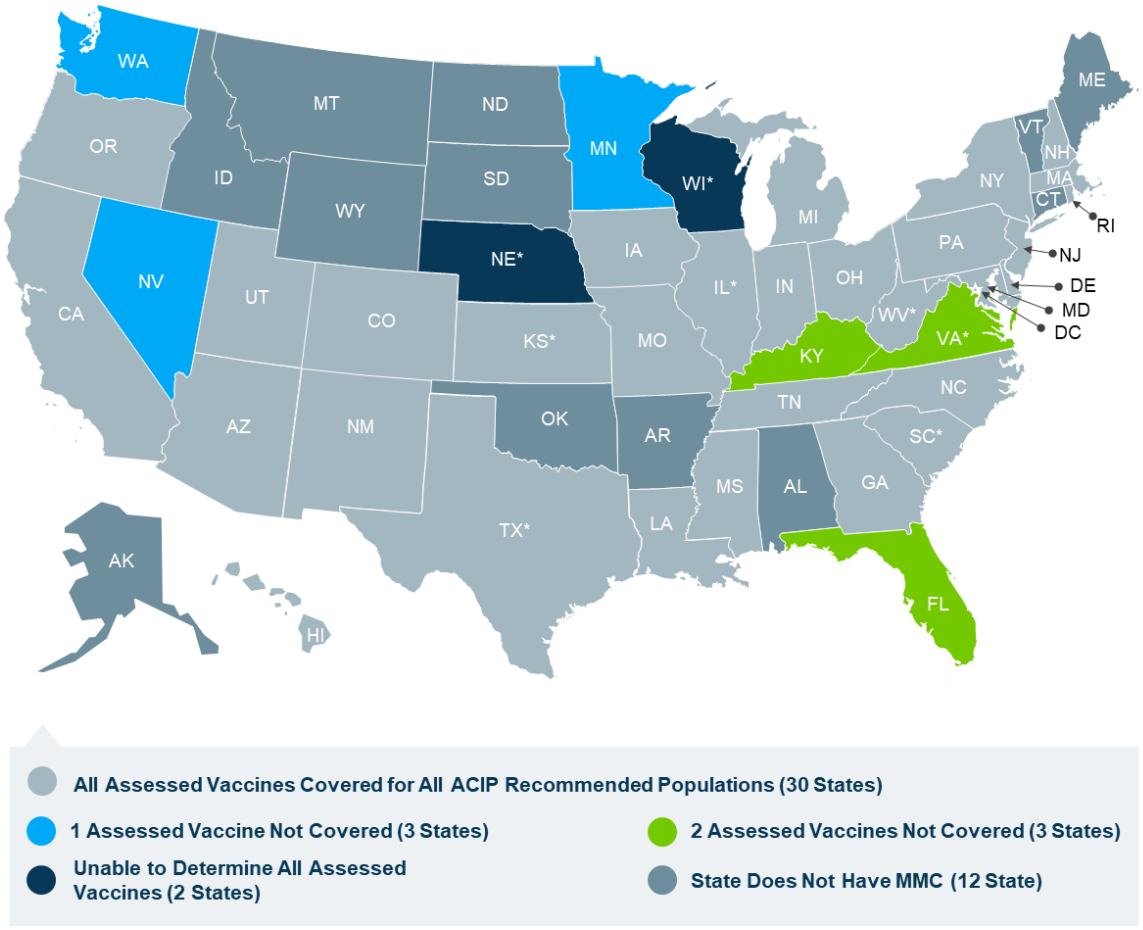
vaccines with broad and routine recommendations, and all state Medicaid FFS programs and MMC plans covered influenza vaccines.

Figure 1. States with Medicaid FFS Programs that Do Not Cover One or More Assessed Vaccines for All ACIP-Recommended Populations, 2021



*FFS programs contain less than 2% of state Medicaid beneficiaries; most Medicaid beneficiaries in these states are enrolled in a MMC plan.
**Avalere was unable to determine if a coverage policy aligned with ACIP recommendation for one or more assessed vaccines

Figure 2. States with MMCs that Do Not Cover One or More Assessed Vaccines for All ACIP-Recommended Populations, 2021



*Avalere was unable to determine if a coverage policy aligned with ACIP recommendation for one or more assessed vaccines

Avalere also identified five FFS programs (AL, KS, ME, OK, and NC) and one MMC plan (SC) that impose cost sharing on at least one assessed vaccine, although relevant information was often ambiguous (e.g., a manual may not specify whether the state plan's copay policy applies to vaccines). Cost sharing amounts ranged from $0.65 to $4.

State Considerations

Although IRA requirements will not take effect until October 1, 2023, states that do not already cover all ACIP-recommended vaccines without cost sharing for their full adult Medicaid populations will need to act quickly and modify coverage policies in the coming months to meet the IRA timeline. Avalere's analysis found that at least 19 states will need to revise their Medicaid coverage policies and/or ensure that MMC plans in these states cover all ACIP-recommended adult vaccines without cost sharing.

Implementation of IRA requirements will vary based on each state's process for modifying Medicaid coverage of products and services. States may enact legislation, promulgate regulations, submit a state plan amendment (SPA), modify managed care organization contracts, and/or update administration documents.

The timeframe for states to implement coverage changes may depend on the policy vehicle. State legislative calendars may also impact a state's ability to comply with the IRA requirements if Medicaid coverage is codified in state statute. For example, some states (e.g., TX) are not scheduled to convene a regular session in 2022 and others may hold an abbreviated session, necessitating prompt action to introduce and advance a bill. For states that modify coverage policies through rulemaking, timing may depend on whether a notice and comment period is required. All states that use the SPA process to alter Medicaid coverage must do so by the end of the quarter in which the changes become effective (i.e., by December 31, 2023).

For all state changes to vaccine coverage, administrative changes and/or system updates by Medicaid programs and/or MMC plans will be necessary to facilitate patient coverage and provider billing. Such actions may include establishing provider reimbursement rates, updating fee schedules, modifying claims processing systems, and revising provider manuals. Some states may also disseminate communications alerting beneficiaries of changes in their vaccine coverage policies. CMS will likely provide guidance to Medicaid programs as they work to implement the coverage changes. This guidance can also help stakeholders understand the federal government's expectations and may inform their state-by-state engagement strategies.

Looking Ahead

Once Section 11405 of the IRA is implemented, all Medicaid beneficiaries will have a coverage pathway without cost sharing for all ACIP-recommended vaccines. This coverage requirement will also apply to future vaccines currently in development once they are approved and recommended.[3] However, other factors may continue to impact Medicaid patients' ability to access vaccines. For example, providers frequently cite low reimbursement rates for vaccine product and administration as a disincentive to stocking and administering vaccines.[4] Further, some states may allow only physicians—not pharmacists—to be reimbursed for vaccine administration or may create different vaccine coverage policies for pharmacy and medical benefits, which could limit patient access in the pharmacy setting and create billing barriers. These barriers may also extend to safety net providers which disproportionally serve vulnerable individuals and families, like Federally Qualified Health Centers. These barriers could lead to increased health disparities for patients. Some Medicaid-related vaccine topics are likely to be addressed in forthcoming implementation guidance; interested stakeholders should consider whether and how to engage CMS to shape that guidance.

[3] Avalere Health. Vaccines 2020 Mid-Year Outlook.
[4] Medicaid and CHIP Payment and Access Commission. June 2022 Report to Congress on Medicaid and CHIP.

About Us

A healthcare consulting firm for more than 20 years, Avalere Health partners with leading life sciences companies, health plans, providers, and investors to bring innovative, data-driven solutions to today's most complex healthcare challenges. For more information, please contact info@avalere.com. You can also visit us at **avalere**.com.

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