Increasing Access to Routine Child Immunizations: State Approaches for Increasing Pharmacy Enrollment in the VFC Program
July 25, 2022 / by Ella Roth, Katie Greene, and Michelle Fiscus

Introduction
The COVID-19 pandemic has had a detrimental effect on child immunization rates. Almost 27 percent of surveyed households had one or more children who missed or delayed a preventive visit because of the pandemic. Additionally, during the 2020–21 school year, vaccination coverage among kindergartners nationwide was lower than during the 2019–20 school year. Children enrolled in the Medicaid program are disproportionately represented in this immunization rate gap, as individuals with public insurance generally have lower rates of vaccination than those with private insurance. Thirty-six percent of children ages 5-11 are covered by Medicaid, and over two-thirds of this group are children of color. While states are employing a variety of strategies to address gaps and disparities in vaccination coverage, increasing pharmacy participation in the Vaccines for Children Program (VFC) is one strategy that can promote access to vaccination for low-income children that may be behind on vaccinations or have difficulty in accessing a primary care provider. With relatively limited pharmacy participation in the VFC program to date, states can take steps to identify and address barriers to provider enrollment, including examining reimbursement policies, aligning program requirements with Centers for Disease Control and Prevention (CDC) requirements, addressing common provider misconceptions about the VFC program, and ensuring that vaccination in pharmacy settings can serve as a complement to regular well-child visits.

Addressing Current Gaps in Vaccine Access for Children
While the majority of routine childhood immunizations are administered in the medical home, current staffing shortages of pediatric providers may pose capacity challenges for closing coverage gaps within traditional primary care settings. Expanding access to vaccines at pharmacies can be an effective tool for states in increasing vaccination rates, particularly for children and adolescents who do not have a medical home or face barriers to accessing a primary care provider during regular hours. Pharmacies often operate seven days a week and frequently have evening and weekend hours. They are typically agnostic to insurance, often do not require appointments, and do not require an established relationship with the patient. Pharmacists have extensive training and experience in storing and handling a wide variety of medications and may help expand access in rural areas where there are few providers. Although state laws vary in age restrictions for pharmacy vaccine administration for children and adolescents, the Public Readiness and Emergency Preparedness Act (PREP Act) of 2020 authorized pharmacists to order and administer approved COVID-19 and childhood vaccines to children ages 3-18 years through 2024.
Enrolling pharmacies in the Vaccines for Children program (VFC) is an important strategy for reducing racial and ethnic disparities in vaccine access and uptake. Because very few pharmacies are enrolled in VFC and few state Medicaid programs will cover administration fees in a pharmacy setting, children who are uninsured or insured by Medicaid have fewer options for vaccinations compared to children insured through commercial plans. Enrolling pharmacies in VFC may be particularly effective in rural areas where there are very few VFC providers. However, despite the potential benefit of expanding pharmacy participation in the VFC program, very few providers are enrolled. According to the CDC, as of June 1, 2022, only 0.4 percent (160 of 37,714) of VFC providers are pharmacies.¹

The Vaccines for Children Program

- **Overview**: The Vaccines for Children program (VFC) is a federal vaccine distribution program for children’s vaccines. All children under age 19 who are Medicaid eligible, uninsured, underinsured, or are American Indian or Alaska Natives (AI/AN) are eligible. The program was established through Section 1928 of the Social Security Act and additional provider requirements were added after an audit from the Office of the Inspector General (OIG) in 2012.

- **Oversight**: The Centers for Disease Control and Prevention (CDC) oversees the purchase and distribution of vaccines and establishes procedures for the operation of VFC programs, though many states establish additional requirements past what is federally directed (CDC approval required). States are required to participate in VFC and are responsible for vaccine ordering activities, ensuring proper storing and handling of VFC-supplied vaccines, recruiting and enrolling a network of providers, completing provider site visits, and monitoring provider data.

- **Financing**: The VFC program is federally funded, and vaccine providers are permitted to charge Medicaid for a vaccine administration fee to offset the costs involved with administering the vaccine. State Medicaid Agencies set this administration rate, but CMS established a maximum rate that varies by region, from $19.54 in Arkansas to $27.44 in Alaska. Providers may charge vaccine administration fees to non-Medicaid patients not exceeding the current, federally defined regional maximum fee. Providers may not charge a fee for the vaccine itself.

Addressing Barriers to VFC Enrollment

States face several barriers to increasing enrollment in the VFC program, including limited staff and resources for administering the program, addressing misconceptions or concerns from providers about program requirements, and pushback from the provider community that vaccinations should be prioritized within the medical home. Below, we highlight opportunities for states to ease potential barriers to pharmacy participation in the VFC program.

¹ Information provided by CDC National Center for Immunization and Respiratory Diseases (NCIRD) via email on June 6, 2022
Address Cost Burdens for Providers

Pharmacists often report that enrolling in the VFC program poses financial risks due to the low Medicaid payments pharmacies typically receive for administering VFC vaccines. To address cost barriers to participation, states may consider increasing vaccine administration rates through an amendment to their state Medicaid plan. For example, Indiana updated its Medicaid State Plan to increase reimbursement for vaccinations from $8 to $15 based on feedback from providers that the administration fee for vaccines was not sufficient to compensate their cost of providing vaccinations. States can also consider adopting a universal vaccine purchase plan, through which the state supplies vaccines for all children in the state regardless of insurance coverage. Such universal purchase plans reduce the financial burden on providers who would otherwise have to finance the up-front costs of vaccines. Providing financially risk-free vaccines through the state enhances provider ability to administer vaccines to individuals.

Reduce Regulatory Burdens by Aligning State and CDC VFC Requirements

Ensuring compliance with storage, handling, and administration requirements of the VFC program can pose challenges for both providers and immunization program staff. State immunization program staff must dedicate resources and time to enrolling providers, conducting regular site visits to ensure compliance with VFC program requirements, and supporting routine vaccine ordering and vaccine management activities. States already face challenges with limited staff capacity, and enrolling additional pharmacies in the VFC program can place additional strains on staff who are charged with educating providers and ensuring program compliance -- especially in areas with multiple retail pharmacies, where each chain may have hundreds of locations within a single jurisdiction. To reduce program strain, immunization programs may consider starting with enrolling a small number of pharmacies or implementing a pilot program to determine the needed resources and best approach for enrollment.

Case Example: Expanding Access to Pharmacy Vaccination in Indiana

To improve access to childhood vaccines in Indiana, the Indiana Department of Health (IDOH) built on strong relationships with Medicaid and retail pharmacy chains to promote pharmacy enrollment in the VFC program and address barriers to provide participation.

Although Indiana had no pharmacies enrolled in the VFC program prior to the pandemic, COVID-19 catalyzed a new level of collaboration with pharmacy chains on issues related to testing and vaccination. To support ongoing coordination, the state assigned one point of contact for all pharmacies and hosted weekly meetings to ensure consistent messaging and build trust with these providers. Additionally, all Indiana pharmacies were enrolled in the COVID-19 vaccine program, which has requirements that closely mirror those of the VFC program, which presented a new opportunity to expand VFC participation. Strengthening these relationships during the pandemic has been foundational to Indiana’s subsequent pharmacy engagement to alleviate barriers to enrolling and build interest in VFC program participation. Thus far, Indiana has enrolled six independent and four Meijer pharmacies, with plans to enroll several others by the summer of 2022. In the future, the state hopes to get additional retail pharmacies enrolled with the program and focus efforts on immunizing children in advance of going back to school in the fall.
VFC has rigid program rules and consequentially high administrative elements for all VFC providers when it comes to sites visits, training, storage, and reporting requirements. While states are responsible for enforcing federal VFC requirements, they can take steps to reduce compliance and enforcement burdens by examining whether state VFC requirements exceed federal requirements. For example, numerous states conduct annual compliance visits, exceeding CDC’s requirement of conducting one compliance visit per 24-month period, and many VFC programs require temperature checks in excess of CDC requirements. States can reexamine requirements around issues like site visit frequency and re-enrollment that may discourage provider enrollment or place additional burdens on immunization programs. Aligning these state rules with federal VFC requirements can reduce the administrative burden that may impede pharmacy VFC participation.

Demystify Provider Misconceptions
Beyond cost or administrative barriers to participation, some pharmacists express misconceptions or fears about VFC participation that may be alleviated by clear communication and guidance from immunization programs. For example, Indiana’s immunization program staff identified key provider misconceptions around administrative burden as a major barrier to participation and clarified the program requirements through close communication with pharmacies. Below are a few examples of how Indiana worked to address common provider concerns and misconceptions about the VFC program:

- **Storage:** The idea that pharmacies must have a separate storage unit for VFC vaccines to participate in the VFC program is a common misconception and frequently raises concerns due to limited floor space and financial resources in pharmacies. The CDC requires that providers have a stand-alone storage unit, which is defined as storage unit that operates independently of any other device or system for its desired function. Accordingly, rather than having a separate unit for VFC vaccines, pharmacies are permitted to have one unit for all vaccines with a separate shelf for the VFC vaccines. In Indiana, refuting this misconception and clarifying the requirement helped ease concerns among pharmacies. Though pharmacies initially believed they would have to buy an additional unit as a VFC provider, Indiana’s DOH worked with individual pharmacies to resolve these concerns and identify resources to purchase a bigger storage unit to accommodate all vaccines, including the VFC vaccine stock.

- **Financial risk:** Many pharmacies see potential fines that can be levied for failure to comply with VFC requirements as a large financial risk and barrier to participation. The state helped alleviate these concerns by clarifying that the immunization program typically works closely with pharmacies to ensure their successful participation in the program, rather than issuing enforcement fines. States may also share messaging that pharmacy chains can elect to only participate in VFC at certain locations and for specific vaccines.

- **Temperature Monitoring:** The CDC requires VFC providers to use vaccine storage units that have temperature monitoring devices to protect vaccines. Before using a unit for vaccine storage, providers are required to record the minimum and maximum temperatures for at least two consecutive days to ensure that the temperatures are in the appropriate range. Indiana officials cited concerns from pharmacies that their existing temperature monitoring systems would not meet VFC requirements. To alleviate this perceived barrier for pharmacies, Indiana’s DOH worked
closely with pharmacies to obtain digital temperature monitoring equipment that was calibrated and met CDC's storage and handling requirements.

Address Pediatric Provider Concerns about Vaccination Outside of the Medical Home
Pediatricians may have concerns about the increasing role of pharmacies delivering childhood immunizations due to concerns that children will miss out on well-child visits and lose connection with their medical homes. States can work to address these concerns by focusing on the need to catch kids up on immunizations—emphasizing that widening vaccination access can level the playing field between children insured through public and private insurance—and work with pharmacy partners to encourage regular well-child visits. From Indiana’s experience, making the case that pharmacy vaccination will get children caught up on immunizations more quickly is compelling to pediatricians. Indiana has worked closely with the American Academy of Pediatrics (AAP) to address concerns and has had success by highlighting that enrolling pharmacies in VFC program allows children on Medicaid to be vaccinated in more locations, narrowing disparities in vaccine access. Further, Indiana and several other immunization programs across the U.S. have mandatory reporting to their state’s immunization information system to ensure that immunization data is all in one place and that medical homes can still access vaccine information for children who are vaccinated in pharmacies.

Conclusion
Increasing enrollment of pharmacies as VFC providers can be a powerful tool for expanding access to routine childhood immunizations and addressing disparities in coverage rates for low-income populations. While current pharmacy participation in the VFC program remains limited, states can work to close these gaps by engaging pharmacy partners and addressing barriers to enrollment. Indiana’s close collaboration with pharmacies and steps to address cost and logistical concerns can serve as a model for engaging pharmacists as critical partners during the COVID-19 pandemic and beyond.