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Prenatal Vaccines in Medicaid and CHIP

Current Reimbursement Levels and Policy Solutions to Increase Access

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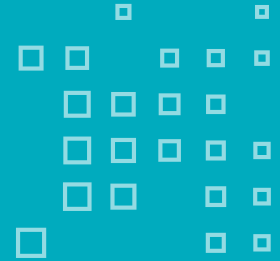
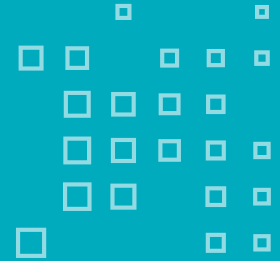


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Executive Summary

Despite the demonstrated effectiveness of prenatal vaccines, uptake remains low. This puts mothers¹ and babies at risk. Vaccines administered prenatally (i.e., during a pregnancy) provide protective antibodies to pregnant women and their unborn children. By receiving all federally recommended prenatal vaccines, pregnant women can reduce their risk of communicable diseases (such as influenza, COVID-19, or whooping cough) that would jeopardize both their own health and the health of their pregnancy. Moreover, they can protect their newborns from dangerous infections such as respiratory syncytial virus (RSV), for which a new vaccine was approved in fall 2023.

Prenatal vaccination rates are especially low among the low- and middle-income people covered by Medicaid and the Children’s Health Insurance Program (CHIP).² These disparities may reflect in part lower reimbursement rates compared to commercial insurance, resulting in reduced access to providers who offer prenatal vaccines.³

This paper reviews the current landscape of Medicaid and CHIP reimbursement for prenatal vaccines, informed by a recent assessment of relevant policies in all 50 states, plus Washington, D.C. and Puerto Rico. We examined policies for both fee-for-service (FFS) and managed care programs, with a focus on the following types of providers: physicians, advanced practice clinicians (APCs), pharmacists, and Federally Qualified Health Centers (FQHCs), updating and building upon the findings in our [2023 paper](#) (which examined state policies between November 2021 and April 2022).

The paper also describes policy strategies to improve prenatal vaccine access for Medicaid and CHIP enrollees. In addition to strategies for managed care organizations (MCOs) and the federal Centers for Medicare & Medicaid Services (CMS), we discuss strategies such as the following for state officials:

- **Ensure adequate reimbursement for prenatal vaccinations** for all vaccinators, including OB/GYNs as well as general practitioners and pediatricians; APCs, including certified nurse-midwives (CNMs) as well as nurse practitioners (NPs) and physician assistants (PAs); pharmacists; and FQHCs. To ensure robust access to this crucial service, consider matching payment rates under Medicare Part B for both the service of vaccine administration as well as the vaccine supply. Currently, average fees under Medicaid lag well behind Medicare, especially with respect to vaccine administration.
- **Optimize the value of the Vaccines for Children (VFC) Program**, through which participating providers receive vaccines for free for administration to Medicaid youth under 19. To avoid access barriers for these young people, states could consider:
 - Paying the maximum administration fee allowed under federal VFC program rules. Currently, only 12 states do so; although, an additional three states pay the maximum rate under an enhanced rate that applies specifically to obstetrician-gynecologists (OB/GYNs) and certain other practitioner types.
 - Easing VFC participation burdens for pharmacies and other underrepresented provider types; and
 - Covering prenatal vaccines delivered by OB/GYNs who do not participate in VFC, recognizing that OB/GYNs are much less likely to participate in VFC than pediatricians and family doctors.
- **Leverage MCOs to enhance prenatal vaccine access** by:
 - Requiring MCOs to match or exceed FFS reimbursement rates for prenatal vaccinations;
 - Requiring MCOs to perform member outreach and education regarding prenatal vaccines; and
 - Establishing performance metrics or quality incentives for MCOs that are tied to prenatal vaccination uptake.

Background

Prenatal Vaccines Protect Mothers and Babies

The World Health Organization describes immunization as one of the greatest triumphs in modern global health and development, preventing up to five million deaths annually from life-threatening diseases.⁴ When pregnant women receive prenatal vaccines, the antibodies they develop help protect them from infectious diseases that can threaten their health and the health of their unborn child.⁵ For example, pregnant and postpartum women are at a higher risk for severe illness and complications from vaccine-preventable diseases such as influenza, particularly during the second and third trimesters.⁶ Moreover, the antibodies passed from mother to child play a key role in fighting off flu, whooping cough and other infections for newborns until they are old enough to be vaccinated themselves.⁷

The Advisory Committee on Immunization Practices (ACIP) at the Centers for Disease Control and Prevention (CDC)—established by Congress to provide guidance on the appropriate use of vaccines—currently recommends that pregnant people receive up to four prenatal vaccines, depending on where their pregnancy falls in the seasonal cycles for certain diseases: the influenza vaccine; the Tdap combination vaccine for tetanus, diphtheria, and acellular pertussis (whooping cough); the COVID-19 vaccine; and a new vaccine for RSV, which was approved just ahead of the 2023–2024 RSV season.⁸

RSV is a common respiratory virus that causes mild, cold-like symptoms in healthy adults, but can be dangerous or even deadly for infants and toddlers, as well as older adults.⁹ RSV cases have remained high in recent winters: for children under age five, an average of one out of every 250 was hospitalized with RSV each year since 2021.¹⁰ This has contributed to the so-called “triple-demic” of overlapping seasons for RSV, flu and COVID-19. Fortunately, the new prenatal RSV vaccine is poised to make a significant impact: it has been shown to reduce RSV-related infant hospitalizations by almost 60% when administered during the third trimester of pregnancy.¹¹

Prenatal Vaccination Rates Remain Low, Especially for Pregnant Women in Medicaid and CHIP

Although early childhood vaccination rates in the U.S. are above 90% for most ACIP-recommended vaccines,¹² prenatal vaccination rates—like most adult vaccination rates—lag substantially behind.¹³ A 2023 CDC study found that fewer than one out of four pregnant women received both the flu and Tdap vaccines,¹⁴ and only one out of three received the RSV vaccine.¹⁵

More troubling still are the disparities in prenatal vaccination based on a pregnant woman’s health coverage. **Women with private health coverage are 74% more likely to receive the recommended prenatal flu and Tdap vaccines as compared to those covered by Medicaid and CHIP**, public programs jointly operated by the state and federal governments

Fewer than 1 out of 4 pregnant women receive both the flu and Tdap vaccines.



Source:
CDC 2023

for low- and middle-income people.¹⁶ Similarly, privately insured pregnant women were almost 40% more likely to receive the new RSV vaccine in its first year on the market—a larger gap than for either the flu or Tdap vaccine standing alone.¹⁷

Nationwide, Medicaid and CHIP cover more than two out of every five births.¹⁸ These programs accordingly play a crucial role for lower income pregnant women and infants, as well as for people of color and other historically marginalized groups that are disproportionately served by the Medicaid program.

Until recently, state Medicaid and CHIP programs varied in terms of which prenatal vaccines were covered for pregnant adults. As of October 2023, however, under the federal Inflation Reduction Act (IRA), states are required to cover all ACIP-recommended vaccines under all eligibility pathways, without cost sharing.¹⁹ This legislation closed the coverage gaps for prenatal vaccines in 11 states that we described in our 2023 policy paper.²⁰

Although the IRA is undoubtedly a substantial step forward, vaccine coverage does not guarantee vaccine access or vaccine uptake. Notably, the Affordable Care Act (ACA) has long guaranteed comprehensive coverage for prenatal vaccines under private insurance, but prenatal vaccination rates are suboptimal even for that population (albeit higher than for pregnant women covered by Medicaid and CHIP).²¹ It is thus essential to consider other Medicaid and CHIP policy levers to promote access and uptake.

Adequate Provider Reimbursement Is a Key Driver of Patient Access

A number of factors can influence vaccine access and uptake, including individual factors such as vaccine awareness and vaccine hesitancy.²² Also key, however, are systemic factors such as provider reimbursement rates—the focus of this paper.

To offer vaccines, providers must incur a range of costs, including:

- Acquiring the vaccine itself (i.e., the “vaccine supply”).
- Storing the vaccine (e.g., refrigerator or freezer, backup power).
- Administering the vaccine, including staff time for counseling, vaccine administration, documentation and required vaccine reporting.²³

The link between provider reimbursement levels and patient access is well documented. The Medicaid and CHIP Payment Advisory Commission (MACPAC), a non-partisan legislative branch agency that makes annual recommendations to Congress based on policy and data analyses, has compiled evidence showing that increasing Medicaid reimbursement leads to increased vaccine access and uptake.²⁴

However, MACPAC also finds that **current Medicaid reimbursement rates are often insufficient to cover the costs of vaccine administration.**²⁵ Our research confirms that in most states, Medicaid reimbursement rates lag significantly behind Medicare and commercial insurance. Accordingly, in the final section of this paper, we discuss specific strategies that states, MCOs and CMS could pursue to support access to prenatal and other vaccines.

“Providers tell me that reimbursement is the #1 factor that limits their ability to deliver prenatal vaccines.”

Erin Jones, Sr. Director, Legislative and Strategic Counsel, March of Dimes

Medicaid Vaccine Reimbursement Fundamentals

Vaccine Administration and Vaccine Supply. Medicaid vaccine reimbursement typically consists of two components: a fee for the professional service of vaccine administration and a fee for the vaccine supply. For both fees, states vary widely in their reimbursement rates and methodologies, as described in this paper. Vaccine supply is typically billed using product-specific Current Procedural Terminology (CPT) codes, but states have adopted a variety of different billing approaches for vaccine administration. Most states cover one or more of the CPT codes for administration of a vaccine by injection, as identified below in [Exhibit 1](#). But states vary in which codes they cover and which clinical scenarios are eligible for which code.

Exhibit 1. Typical Billing Codes for Vaccine Administration by Injection

Codes without age limits; no counseling included (counseling, if provided, is billed under an E/M code)		Pediatric codes (ages < 19) for vaccine administration + vaccine counseling	
90471	94072	90460	90461
First vaccine injection	Additional vaccine injections during same visit	Injection of first vaccine component	Additional components in a combination vaccine

The Vaccines for Children Program. The VFC program was established by Congress in 1993 to purchase and distribute pediatric vaccines, free of charge, to participating providers. Medicaid-enrolled youths under the age of 19 are eligible to receive VFC vaccines—including prenatal vaccines for pregnant youths—as are youth who are uninsured/underinsured, American Indian, or Alaska Native. Notably, however, and as described in more detail later in this paper, VFC vaccines cannot be used for youth enrolled in a separate CHIP program.

The VFC program is vital for the health and wellness of young mothers and their babies: together, Medicaid and CHIP cover two out of five births overall, but almost four out of five of births for mothers under the age of 20.²⁶

Because VFC vaccines are available free of charge, providers are not permitted to bill for vaccine supply. Their reimbursement for VFC vaccinations consists solely of the vaccine administration fee. Moreover, VFC administration fees are capped at a “VFC Regional Maximum” rate established for each state by CMS. These maximum rates—which currently apply equally to state Medicaid programs and uninsured patients—have not been updated [since 2012](#).²⁷

In addition, CMS has instructed states that VFC providers are limited to a single administration fee per vaccine, even if the vaccine has more than one component.²⁸ By contrast, under private insurance, providers can typically bill a separate administration fee for each component in a multi-component vaccine, such as Tdap (which includes tetanus, diphtheria, and whooping cough). As shown in [Exhibit 1](#), CPT codes 90460 and 90461 are expressly designed for this purpose.

Providers must enroll in the VFC program in order to receive free VFC vaccines, and must comply with a variety of federal and state program requirements related to, for example, vaccine acquisition, storage and reporting. All states permit physicians to enroll. However, enrollment is much higher among pediatricians

and family doctors, who routinely administer vaccines to youth, compared to OB/GYNs, who administer a relatively low volume of pediatric vaccines. Most, but not all, states allow pharmacies to enroll as VFC providers. However, pharmacy participation rates have historically been low.²⁹

Managed Care Delivery Systems. Most states now contract with privately operated MCOs to administer most Medicaid benefits for most covered populations, including pregnant women. MCOs are generally free to establish reimbursement rates with their network providers as they see fit unless the state Medicaid program requires otherwise.

Research Methods for State Survey and Policy Recommendations

This paper describes the current landscape of state Medicaid and CHIP reimbursement for prenatal vaccines and presents policy recommendations for consideration by states, MCOs and CMS to increase prenatal vaccine access for Medicaid and CHIP enrollees.

Between November 2023 and March 2024, we analyzed publicly available Medicaid and CHIP reimbursement policies for prenatal vaccines in all 50 states, plus the District of Columbia and Puerto Rico (collectively referred to as “states”).

- We examined reimbursement for vaccine administration and supply for the following provider types: physicians; three types of APCs (CNMs, NPs and PAs); registered pharmacists; and FQHCs.
- With respect to vaccine supply, we specifically examined the following four vaccine products: RSV vaccine (CPT code 90678), Tdap (90715), and two influenza vaccines—Flucelvax (ccIV4) (90674) and Fluzone (IIV4), single-dose (90686).
- In addition to updating the findings from our 2023 policy paper, we researched reimbursement policies for OB/GYNs and pharmacists, recognizing that prenatal visits and trips to the pharmacy may be the most convenient occasions for a pregnant woman to receive a vaccine.
- Consistent with our 2023 paper, we did not examine policies specific to COVID-19 vaccines, recognizing that many states have carried forward pandemic-era policies that define enhanced rates and other flexibilities for COVID-19 vaccinations (prenatal and otherwise).

We were able to identify Medicaid and CHIP FFS policies for the provider types included in our survey in all but two states/territories:

- Puerto Rico operates Medicaid and CHIP entirely under managed care and does not publish FFS policies.
- Tennessee similarly operates its entire medical benefit under managed care and does not publish associated FFS policies. However, Tennessee’s pharmacy benefit is carved out of managed care and administered on an FFS basis. Thus, our survey was able to capture Tennessee’s FFS policies for pharmacist-administered vaccines.

For the 42 states that have adopted managed care programs, we also reviewed MCO contracts and other managed care program guidance.

Finally, to support our development of policy recommendations, we conducted stakeholder interviews with:

- Erin Jones, Senior Director, Legislative & Strategic Counsel, March of Dimes.
- The National Association of Chain Drug Stores.

Reimbursement for Prenatal Vaccines Under Medicaid and CHIP: State Research Findings

This section opens with an analysis of overarching themes from our state research on reimbursement policies, then provides additional detail on the specific policies that pertain to each provider type included in our survey (physicians, APCs, pharmacists, and FQHCs).

Overarching Themes

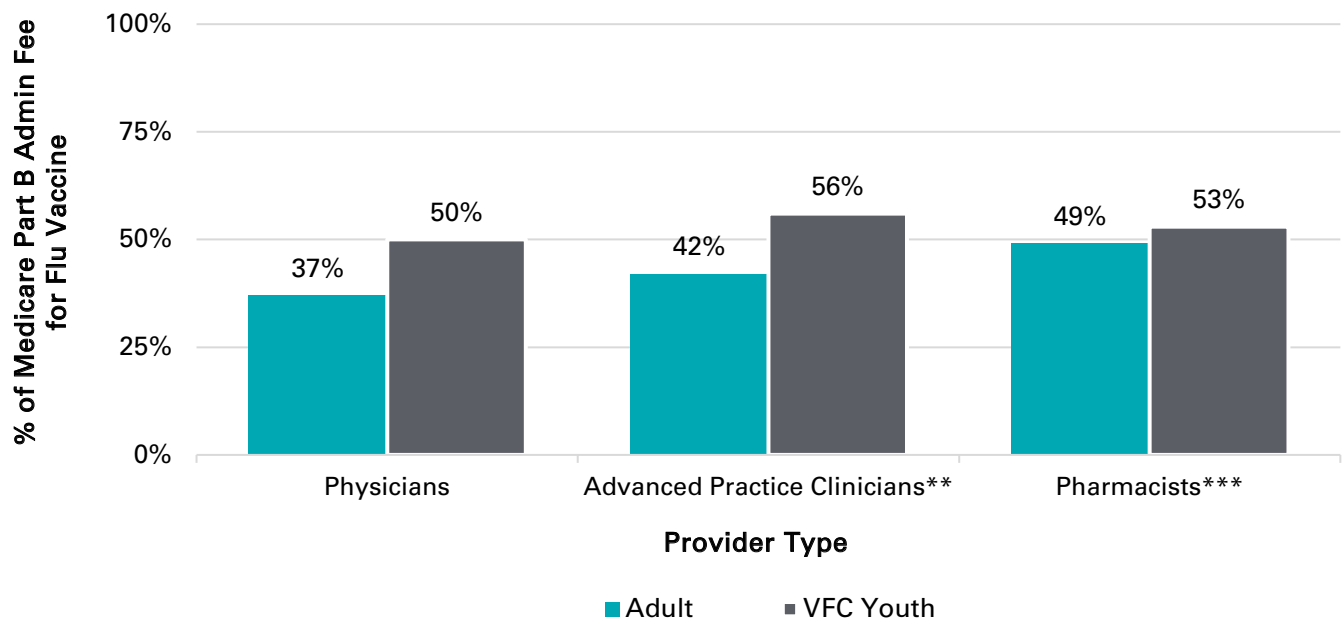
- **We identified significant variation across states with respect to vaccine reimbursement rates and methodologies, as well as variation within states based on factors such as provider type or patient age** (adult vs. youth). However, with limited exceptions, state reimbursement policies do not distinguish between prenatal and non-prenatal vaccines. Thus, for example, a flu vaccine is generally reimbursed the same way regardless of whether the recipient is pregnant, although reimbursement may still vary based on patient age or other factors.
- **Across all practitioner types (physician, APC, and pharmacist), Medicaid and CHIP reimbursement for vaccine administration is typically much lower than under Medicare and private plans.** Moreover, some states go several years without updating their FFS administration fees. By contrast, reimbursement for vaccine supply tends to be more consistent across payers.
 - **Medicare FFS.** Most states reimburse significantly below Medicare for vaccine administration. In 2024, Medicare Part B's national rate for administering influenza and other high-priority vaccines was \$32.57 for physicians and \$27.68 for other practitioners (85% of the physician rate). See [Exhibit 2](#), below, for comparisons of average Medicaid rates against Medicare Part B rates for each practitioner type. (Note: the other vaccine products we examined as part of our survey, Tdap and RSV, are covered under Medicare Part D rather than Part B.)

“Reimbursement varies so much from state to state. But overall, **providers know that payment for a Medicaid patient may only be a fraction of the commercial rate.**”

Erin Jones, Sr. Director, Legislative and Strategic Counsel, March of Dimes

- **Private health plans.** Reimbursement rates for private plans are generally not publicly available. However, a recent analysis by the Congressional Budget Office concluded that private plans “pay much higher prices” than Medicare FFS for physician services,³⁰ suggesting an even larger gap between private plans and Medicaid.
- **We identified modest increases in reimbursement rates across provider types since our last survey,** published in 2023 (for which the research was conducted between November 2021 and April 2022).³¹ Significant progress is needed, however, for Medicaid and CHIP reimbursement to catch up to Medicare Part B.

Exhibit 2. Vaccine Administration Fees for Adults 21+ and VFC Youth Age <19 Under Medicaid FFS: Comparison Against Medicare Part B Rate for Administering Flu Vaccine*



* Manatt Health researched publicly available Medicaid and CHIP policies in all 50 states, plus D.C. and Puerto Rico, between November 2023 and March 2024. In 2024, the Medicare Part B administration fee for flu vaccines is \$32.57 for physicians and \$27.68 for APCs and pharmacists (85% of the physician rate).

** Manatt Health’s study examined payment for three types of APCs: CNMs, NPs and PAs.

*** The average pharmacist vaccine administration rate includes reimbursement for counseling in the two states that authorize a counseling fee on top of vaccine administration (California and Oregon).

Physician Reimbursement

This section reviews our findings on physician Medicaid/CHIP FFS reimbursement for vaccine administration and vaccine supply. Given the significant role OB/GYNs can play in ensuring that prenatal vaccines are available and administered, it also includes a comparative analysis of total expected FFS reimbursement under Medicaid/CHIP vs. Medicare for an OB/GYN who administers both the Tdap and flu vaccines during an office visit. This section concludes with a discussion of state requirements for MCO reimbursement of physician vaccinations.

Fee-for-Service

Vaccine Administration. Our study found that although most state FFS Medicaid and CHIP programs pay a separate fee for vaccine administration during a billable office visit, these rates vary significantly across states, and also vary within many states based on factors such as patient age or physician specialty, as described in [Exhibit 3](#). For full state-by-state details on physician vaccine administration fees for youth and adults, see [Appendix Exhibit 7](#).

- **Adults.** The average physician administration fee is \$12.05 (ranging from \$0–\$31.39). This represents an increase of 15% since our prior study (conducted between November 2021 and April 2022), but nonetheless represents only 37% of the Medicare Part B rate for administering the influenza vaccine. For OB/GYNs specifically, the average administration fee rises to \$12.48 after accounting for the enhanced rates available in four states for OB/GYNs (as described in [Exhibit 3](#) below).

- **VFC Youth <19.** The average physician administration fee is \$16.19 (ranging from \$0–\$27.44). The average rate has increased 12% since our previous study but is only 50% of the Medicare Part B rate for administering the influenza vaccine. For OB/GYNs, the average administration fee rises to \$16.61 after accounting for the enhanced rates available in three states. Even taking these enhanced rates into account, only 15 states currently reimburse at the maximum VFC rate established by CMS.

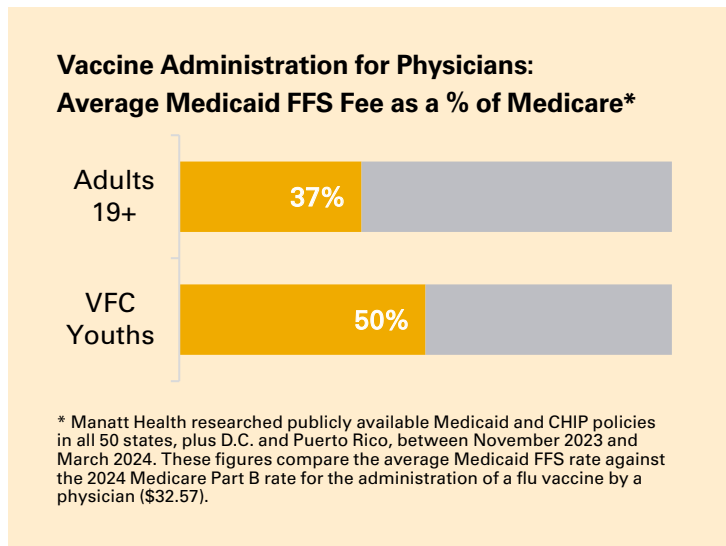


Exhibit 3. Factors Influencing Medicaid and CHIP FFS Reimbursement for Vaccine Administration by Physicians*

Factor	Areas of State Variation
Type of Visit	<ul style="list-style-type: none"> • One of the most convenient times for prenatal vaccination is during a prenatal appointment or other physician visit, when the patient is already with their provider and can receive counseling. • However, eight states (15%) do not pay an administration fee for adult vaccinations during a billable office visit. Some (but not all) of these states will pay an administration fee only for vaccine-only visits in which no other professional services are rendered.
Patient Age	<ul style="list-style-type: none"> • Forty states (77%) pay different rates depending on patient age. • Typically states pay a higher rate for adults 19+ vs. youth <19, although one state (NC) distinguishes between patients 21+ vs. <21. • Some states pay a higher fee for adult vaccinations than for youth because their adult administration fee exceeds the VFC Regional Maximum Rate.

* Manatt Health researched publicly available Medicaid and CHIP policies in all 50 states, plus D.C. and Puerto Rico, between November 2023 and March 2024.

Factor	Areas of State Variation
Physician Specialty	<ul style="list-style-type: none"> Eleven states (21%) pay an FFS enhanced administration fee for providers in certain specialties. All 11 states include pediatricians and other primary care providers. Only four of these states include OB/GYNs in their enhanced rates. In the four states that include OB/GYNs in their enhanced rate, the enhanced fee represents an average increase of \$5 over the base fee for both adult and youth vaccine administration.
Multiple Vaccines Administered in the Same Encounter	<ul style="list-style-type: none"> For adults 21+, 26 states (50%) pay a lower rate for additional vaccinations administered in the same encounter compared to the initial vaccination. The average decrease for OB/GYNs is \$5.69 (taking enhanced rates into account). For VFC vaccines, only four states (8%) pay a lower rate for additional vaccinations, with an average decrease of \$3.63 for OB/GYNs.

Spotlight: Disparate Treatment of Youth Vaccines Between Medicaid and CHIP

Approximately three out of four states operate a separate CHIP program, which covers middle-income children above the income cut-off for Medicaid (as opposed to using CHIP funding to enhance child eligibility under Medicaid).³² As noted earlier in this paper, children enrolled in Medicaid receive vaccines through the VFC Program, but children enrolled in separate CHIP programs do not. Due in large part to federal restrictions on VFC reimbursement, **the middle-income youths enrolled in separate CHIP programs sometimes have more favorable vaccine policies than the lower-income youths enrolled in Medicaid.** This is a health equity issue.

- Medicaid-enrolled pregnant youths may be unable to receive vaccines at the same convenient times and places as higher-income youths enrolled in CHIP (or those with commercial coverage).** Whereas CHIP enrollees are often able to receive vaccinations from any participating provider, Medicaid-enrolled youth are typically restricted to receiving vaccines only from providers that participate in VFC. Although prenatal visits and trips to the pharmacy may be the most convenient occasions for a pregnant woman to receive a vaccine, OB/GYNs and pharmacies are significantly less likely than pediatricians to participate in VFC due to their relatively low volume of pediatric vaccines, the relatively low reimbursement for VFC vaccine administration, and the relatively high administrative costs associated with VFC participation. Our survey identified only two states (KY and MS) that expressly allow non-VFC providers to bill Medicaid for certain vaccines that are available through VFC.

- In some states, vaccine reimbursement for CHIP youth is higher than for lower-income Medicaid youth.**

Several states:

- Pay a higher administration fee for CHIP vaccines than for VFC vaccines (typically because the CHIP fee exceeds the VFC Regional Maximum); and/or
- Allow providers to bill a separate administration fee for each component in a multi-component vaccine (which CMS currently prohibits in VFC).

These disparities highlight the inequitable impacts of CMS’s current restrictions on VFC reimbursement.

Vaccine Supply. Our study examined FFS reimbursement for vaccine supply with respect to RSV, Tdap and two influenza vaccines (for non-VFC vaccines only, since no reimbursement is available for VFC vaccine products). State rates varied significantly, as summarized below in [Exhibit 4](#); for state-level detail, see [Appendix Exhibit 8](#). This variation in rates reflects variation in states’ reimbursement methodologies. States commonly establish their FFS rates using publicly available price benchmarks, such as the average sales price (ASP)—the same benchmark used under Medicare Part B—or wholesale acquisition cost (WAC). Other states, by contrast, reimburse based on the provider’s actual acquisition cost (AAC) for the vaccine, or at the lesser of AAC or various public benchmarks. Meanwhile, a few states build an administration fee into reimbursement for vaccine supply rather than reimbursing under a separate code for vaccine administration.

Exhibit 4. Physician Reimbursement for RSV, Tdap, and Influenza Vaccine Supply Under Medicaid and CHIP FFS, Medicare, and Private Insurance*

Vaccine	RSV**	Tdap	Flucelvax (ccIV4)	Fluzone (IIV4), single-dose
	CPT Code 90678	CPT Code 90715	CPT Code 90674	CPT Code 90686
Medicare ASP Drug Pricing File	Not Listed	\$38.31	\$34.17	\$22.35
Private Sector Rate	\$356.67	\$47.61	\$29.31	\$19.10
Medicaid FFS: U.S. Average Rate	\$311.10 Medicare N/A 87% of Private	\$40.11 105% of Medicare 84% of Private	\$31.64 93% of Medicare 108% of Private	\$21.36 96% of Medicare 112% of Private
Lowest Rate State	\$280.02 IL	\$28.80 AR	\$14.61 NJ	\$9.79 NJ
Highest Rate State	\$506.47 AZ	\$67.41 WI***	\$49.17 WI***	\$37.35 WI***

* Manatt Health researched publicly available Medicaid and CHIP policies in all 50 states, plus D.C. and Puerto Rico, between November 2023 and March 2024. The calculation of average, minimum and maximum rates excludes states for which a numerical rate is unavailable because the state defines a reimbursement methodology without providing a specific rate. For state-by-state detail, see [Appendix Exhibit 8](#). Medicare vaccine supply rates were collected from the CMS [January 2024 Medicare ASP Pricing File](#). The private sector vaccine supply rates were collected from the CDC [March 2024 Vaccine Price List](#). Where multiple products exist for a single code, we calculated Medicare and private rates by averaging the available codes.

** As of March 1, 2024, RSV was not yet listed in the ASP Pricing File. In our state research, we found RSV rates listed in only 22 states.

*** Wisconsin Medicaid includes a \$15 “administration fee” in its FFS vaccine supply rates.

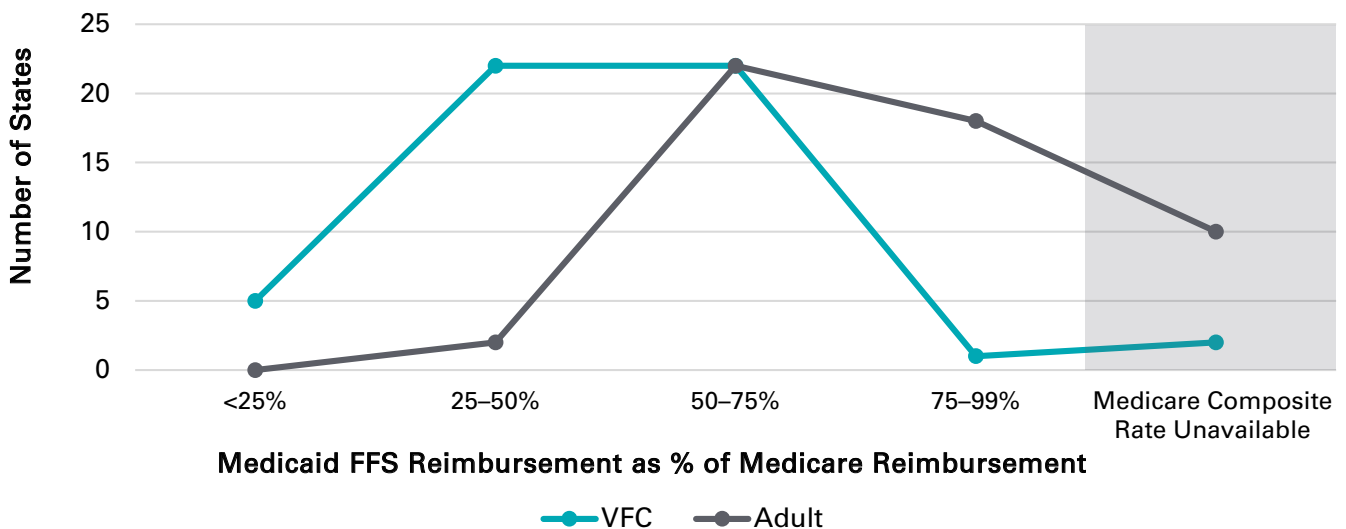
Payment Sufficiency Analysis: Total Reimbursement for Vaccine Administration and Supply. When providers assess whether they can cover their costs for stocking and administering vaccines, they consider the combined reimbursement for vaccine administration plus vaccine supply. For this reason, a higher administration fee could help to offset lower reimbursement for vaccine supply, or vice versa.

To assess overall payment adequacy, we compared total reimbursement under Medicaid FFS and Medicare for the following scenario: an OB/GYN administering both the Fluzone and Tdap vaccines during a billable office visit (one of the most convenient times for a pregnant woman to receive her prenatal vaccines). We found that all states reimburse less than Medicare in this scenario. Moreover, most states reimburse **significantly** less than Medicare, with particularly stark disparities for youth vaccinations.

- **Adults.** We were able to calculate a composite Medicaid FFS rate for 42 states. Of these, the majority pay between 25% and 75% of the comparable Medicare rate (\$118.37),³³ including all eight states that do not pay an administration fee for vaccines administered during a billable office visit.
- **Youth.** Focusing solely on vaccine administration, the Medicare Part B rate for administering a pediatric flu vaccine plus a three-component vaccine like Tdap is \$72.18. With respect to VFC, the majority of states reimburse less than 50% of Medicare for this scenario, including five states that reimburse less than 25% of Medicare. This comparison highlights the impact of low vaccine administration fees, which represent the provider’s sole source of reimbursement for VFC vaccinations. Even if all states paid the VFC maximum rate for vaccine administration, that would still only achieve 67% of the Medicare rate for flu vaccinations, reflecting the combined effect of CMS’s current cap on state rates and the current prohibition on enhanced Medicaid reimbursement for multi-component VFC vaccines.

For additional details, see [Exhibit 5](#) (below) and [Appendix Exhibit 9](#).

Exhibit 5. Comparison of Total Reimbursement for Fluzone and Tdap Vaccinations (Administration + Supply) Under Medicaid FFS vs. Medicare, by Patient Age*



* Manatt Health researched publicly available Medicaid and CHIP policies in all 50 states, plus D.C. and Puerto Rico, between November 2023 and March 2024. With respect to Medicare, Flu vaccines are covered under Medicare Part B, while Tdap is covered under Medicare Part D. To calculate the Medicare composite rate for adults, we combined: (1) the 2024 Medicare flu vaccine administration fee (G0008); (2) the 2024 Fluzone supply fee (90686); and (3) the weighted average for [Part D reimbursement](#) of Tdap (90715), based on the 2022 rates for the Adacel and Boostrix vaccines (the more recent data available; note that Part D reimbursement combines both the administration and supply fees). For VFC youth, there is no Medicaid reimbursement for the supply. Therefore, we calculated a hypothetical Medicare composite using the Part B codes for: (1) administration of the flu vaccine (G0008) and (2) the non-vaccine-specific codes for administering a combination vaccine with counseling to youth age <19 (90460 for the initial component, plus 90461 for each additional component).

Managed Care

As discussed earlier, MCOs generally have discretion to negotiate reimbursement rates with their network providers unless the state directs otherwise. Our study identified MCO reimbursement requirements for prenatal vaccinations by physicians in 17 out of the 42 states with managed care programs (40%).

Examples include:

- **FFS as Reimbursement Floor.** Eight states require MCOs to reimburse physicians at or above the FFS rate for some or all of their professional services, including prenatal vaccine administration (DC, IN, KS, LA, MS, MO, NC, and OK).
- **Extending FFS Enhanced Rates to Managed Care.** Among the 11 states that offer enhanced FFS rates to certain practitioners for vaccine administration, five of those states require MCOs to match those enhanced rates for primary care providers and (if applicable) OB/GYNs (DC, DE, HI, MS, and NE).
- **Benchmarking Against Medicare.** Puerto Rico requires MCOs to reimburse professional services at 75% of Medicare Part B rates.

Advanced Practice Clinician Reimbursement

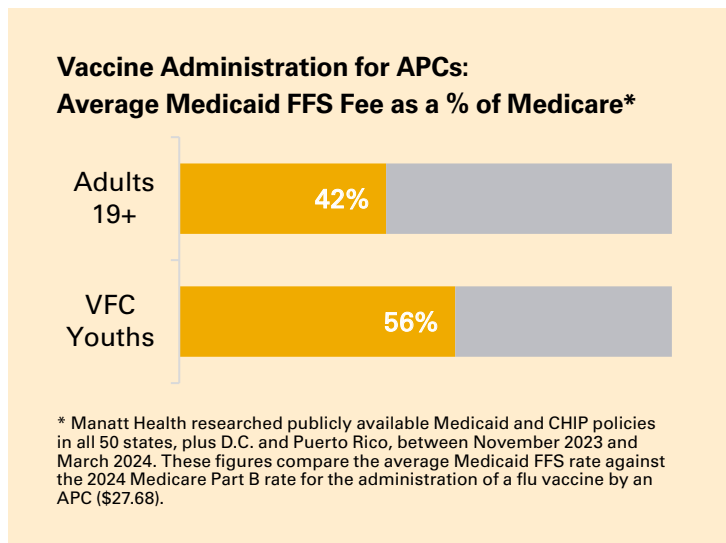
This section reviews our findings on Medicaid/CHIP FFS and MCO reimbursement for vaccines administered by three types of APCs: CNMs, NPs and PAs.

Fee-for-Service

In all states, FFS reimbursement for APCs is benchmarked against the physician rate.

Vaccine Administration. Nationwide, the average APC vaccine administration fee during a billable office visit for adults is \$11.49 (ranging from \$0–\$26.68), representing 42% of the Medicare Part B rate for APC flu vaccine administration (\$27.68, or 85% of the fee for physicians). For VFC youth, the average APC vaccine administration fee is \$15.38 (ranging from \$0–\$23.85), representing 56% of the Medicare Part B rate. In addition, our study found that:

- All states reimburse APCs at 75% to 100% of the physician rate for vaccine administration. Most states reimburse APCs for vaccine administration at 100% of the physician rate, including some states that generally reimburse APC services at a lower percentage of the physician rate for other services, as illustrated in the state example below.
- The majority of states pay the same vaccine administration fee to all three types of APCs.



- Among the 11 states that pay an enhanced FFS vaccine administration fee for providers with certain specialties, eight states (73%) extend these rates to correspondingly specialized APCs for prenatal vaccinations.

For state-by-state detail, see [Appendix Exhibit 10](#).

State Example: APC Vaccinations



In **Montana**, APCs are generally reimbursed at 90% of the physician rate for other services, but receive 100% of the physician rate for vaccine administration.

Vaccine Supply. All states pay APCs and physicians the same reimbursement rate for vaccine supply. This makes sense because the cost of vaccine acquisition for a medical practice does not vary based on the type of practitioner who administers those vaccines.

Managed Care

We found MCO reimbursement requirements for prenatal vaccinations by APCs in 16 out of the 42 states with managed care programs (38%). These states generally apply the same reimbursement policy for both physicians and APCs. The only state with requirements for physicians and not APCs is New Jersey.

Pharmacist Reimbursement

Pharmacies play a crucial role in expanding access to vaccines at convenient places and times. Ninety percent of Americans live within five miles of a pharmacy,³⁴ and the vast majority of Americans have either already received a vaccine at a pharmacy or are open to receiving one in the future.³⁵ Moreover, pharmacies support **equitable** access: as compared to physician offices, pharmacies are more prevalent in lower-income neighborhoods and are more likely to offer services during evenings and weekends—an important consideration for people with inflexible jobs during normal business hours.³⁶

“Millions of Americans receive vaccines at pharmacies every year. Pharmacists play an important role in improving access to care for all populations, including pregnant people covered by Medicaid and CHIP.”

National Association of Chain Drug Stores

This section reviews our findings on Medicaid/CHIP reimbursement for pharmacist vaccinations, including certain coverage restrictions that are unique to the pharmacy setting.

Fee-for-Service

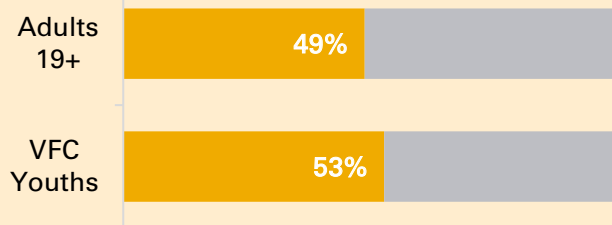
Coverage of Pharmacist Vaccinations. Of the 51 states with available FFS policies (all but PR), we found that pharmacist vaccinations are covered in all but three states (KY, NE, and NJ). An additional four states cover adult vaccinations for pharmacists, but not vaccinations for youth under 19 (NH, VT, VA, and WV).

- **Restrictions on the Types of Covered Vaccines.** Unlike for physicians and APCs, some states restrict coverage for pharmacists to a subset of vaccines, instead of covering the full set of vaccines that pharmacists are authorized to administer under state law. Notably, of the 48 states that cover pharmacist vaccinations, we identified seven states (15%) that excluded coverage for prenatal RSV vaccines when administered by pharmacists (GA, IN, KS, KY, LA, SC, WV).
- **Pharmacy Benefit vs. Medical Benefit.** Approximately three out of four states cover pharmacist vaccinations under the pharmacy benefit, using the same point-of-sale billing system that pharmacies use for dispensing prescription drugs. The remaining states cover pharmacist vaccinations under the medical benefit. These states typically require pharmacists to use the same CMS-1500 claim form that physicians and other practitioners use to bill for professional services, which may be less familiar to pharmacy personnel. The state's choice of benefit also tends to drive choices regarding reimbursement, as discussed below.

Vaccine Administration. In the 48 states that cover pharmacist vaccinations, we found that all but two states (CT and IL) reimburse pharmacists for vaccine administration, with about half of the states (54%) paying pharmacists at or above the rate for OB/GYNs (after taking into account any enhanced rate available to OB/GYNs). However, we identified only two states (CA and OR) that allow pharmacists to bill for counseling or similar services in addition to the fee for vaccine administration. (Note: This is different from standalone counseling, which allows a practitioner to bill for counseling on a day when no vaccine is administered.)

- **Adults.** For adults aged 21 and older, the average pharmacist administration fee is \$13.45 (ranging from \$0–\$61.79). This rate is 8% higher than the corresponding average for OB/GYNs, but represents only 49% of the Medicare Part B rate for the administration of influenza vaccinations by pharmacists.
- **Youth.** For VFC vaccines administered to youth under 19, the average pharmacist administration fee is \$14.78 (ranging from \$0–\$67.44). This rate is 12% lower compared to the average OB/GYN fee for VFC vaccines, and represents only 53% of the Medicare Part B rate for the administration of influenza vaccinations by pharmacists.

Vaccine Administration for Pharmacists: Average Medicaid FFS Fee as a % of Medicare*



* Manatt Health researched publicly available Medicaid and CHIP policies in all 50 states, plus D.C. and Puerto Rico, between November 2023 and March 2024. These figures compare the average Medicaid FFS rate against the 2024 Medicare Part B rate for the administration of a flu vaccine by a pharmacist (\$27.68).

Notably, we found that administration fees billed under the pharmacy benefit were, on average, approximately 40% lower than administration fees billed under the medical benefit. This disparity is due in part to policies in two states (CA and OR) allowing pharmacists to bill under the medical benefit for vaccine counseling in addition to vaccine administration. In addition, administration fees under the medical benefit tend to be paid at the physician rate, whereas under the pharmacy benefit, administration fees are more often set at the (lower) standard pharmacy dispensing fee. For full state-by-state details on pharmacist vaccine administration fees, see [Appendix Exhibit 10](#).

Vaccine Supply. Our study found that states generally reimburse vaccine supply based on the benefit under which the vaccines are covered. Under the pharmacy benefit, states typically apply the same reimbursement methodology that applies to dispensed prescription drugs—often a “lesser of” methodology that pays out the lowest among several publicly available benchmarks. By contrast, states that reimburse for vaccine supply under the medical benefit typically use the same methodology as for physician-administered vaccines, which in many states is benchmarked against the Medicare ASP Drug Pricing File, as noted above.

Spotlight: Medicaid Enrollment Is Required for Some Pharmacist Vaccinators

Federal law requires most providers to enroll in the Medicaid program as a condition of payment. For dispensing prescription drugs, the pharmacy enrolls as an organizational provider. However, for vaccinations, some states require pharmacists to enroll as individual practitioners, which creates an additional administrative step. Among the 48 states that cover pharmacist vaccinations in FFS, we identified **15 states (31%) that explicitly require individual pharmacist enrollment for vaccination services**. Additionally, individual pharmacist enrollment is likely required in any scenario where the pharmacist has the authority to independently prescribe vaccines (as opposed to administering vaccines pursuant to a statewide standing order or physician-executed protocol), pursuant to a federal law requiring enrollment for any provider involved in “ordering, referring, or prescribing” treatment.*

* Section 1902(a)(78) of the Social Security Act.

Managed Care

Among the 42 states with managed care programs, we found publicly available information regarding MCO reimbursement for pharmacist vaccine administration in 16 states (38%). These states fall into two categories:

- **Payment Requirements for MCOs.** We identified ten states (24%) that establish standards for MCO payment of pharmacist vaccination services, such as expressly requiring MCOs to cover vaccines administered by pharmacists, or requiring that pharmacist vaccination services be reimbursed at or above the FFS rate.
- **Managed Care Pharmacy Carve-Outs.** A number of states have decided to carve their pharmacy benefit out of managed care, meaning that the pharmacy benefit continues to be administered—and reimbursed—through the FFS program while the MCO administers the medical benefit. Our research identified six managed care states (14%) in which pharmacist-administered vaccines fall within a carve-out (CA, MO, NY, TN, WV, and WI). As a result, in those states, pharmacists can bill the FFS program for administering

vaccines without the need to enroll in MCO provider networks or negotiate rates with each individual MCO. (Note: While additional states have pharmacy carve-outs, these states either exclude pharmacy vaccinations from the carve-out or cover them under the medical benefit instead.)

State Examples: MCO Coverage and Reimbursement of Pharmacist Vaccinations



Kentucky requires its MCOs to cover both pharmacist vaccinations and pharmacist vaccine counseling (even though Kentucky’s FFS program does not cover pharmacist vaccinations).



Louisiana requires its MCOs to cover the full set of vaccines for pharmacists as well as requiring MCOs to identify for members which pharmacies offer vaccination services.



Oklahoma requires MCOs to reimburse pharmacies at the FFS rate, which is well above the national average for vaccine administration.

Federally Qualified Health Center Reimbursement

FQHCs are federally designated outpatient health clinics that provide primary and preventive care and other services to medically underserved areas and populations. FQHCs are required to provide their services on a sliding fee scale, and must accept all patients, regardless of ability to pay. In 2023, FQHCs served more than 31 million patients nationwide, including almost 600,000 pregnant patients seeking prenatal care.³⁷ The vast majority of those patients have incomes below 200% of the Federal Poverty Level, and are either uninsured or covered by Medicaid or CHIP.³⁸

Fee-for-Service

Federal law requires state Medicaid programs to reimburse FQHCs under a prospective payment system (PPS) methodology pursuant to which each FQHC receives a fixed rate per office visit, regardless of the volume or value of services rendered. The PPS rate for each FQHC is based on its historical cost of providing covered services, and is adjusted annually to reflect changes in the Medicare Economic Index (a measure of medical practice cost inflation). An FQHC may also request an adjustment in its PPS rate when the FQHC changes the scope of its service offerings.³⁹

Federal law permits states to implement alternative payment methodologies (APMs) for FQHCs under Medicaid FFS as long as the FQHCs agree to the APM and reimbursement under the APM is at least as high as the reimbursement the FQHCs would have received under the PPS methodology.⁴⁰ This study collected data on APMs only when the state confirmed that all FQHCs have opted into the APM.

Under the PPS methodology, FQHCs receive the same rate for an office visit regardless of whether any vaccines are administered. However, by allowing FQHCs to bill additional fees for vaccine administration and/or vaccine supply, states can both incentivize comprehensive vaccine access at FQHCs and support the financial sustainability of these crucial community providers.

We identified only 15 out of 50 states (30%) that allow FQHCs to bill for vaccines outside the PPS rate. These states vary in terms of whether they:

- Pay for vaccinations on top of the PPS rate (e.g., an add-on payment) or in lieu of the PPS rate (e.g., billing under the physician fee schedule for a vaccine-only visit that does not qualify for the PPS rate).
- Allow this non-PPS payment:
 - For vaccine administration, vaccine supply, or both.
 - For youth vaccines only, or for all age groups.
- Reimburse non-PPS payments under the physician fee schedule or an FQHC-specific fee schedule.

In addition, we identified three states that make cost-based payments for all FQHC services, including vaccinations (IA, MD, and MO).

For additional details, see [Appendix Exhibit 11](#).

State Examples: FQHC Vaccinations



In **Massachusetts**, vaccine administration and supply are billable under the applicable practitioner fee schedule (physician or APC), whether for a vaccine-only visit or as an add-on to the PPS if other services are provided that day.



In **Maryland**, all FQHCs participate in the state's APM, under which FQHCs are reimbursed at 100% of their average reasonable costs, including with respect to vaccine supply and administration.

Managed Care

Under federal law, states must ensure that FQHCs are reimbursed at least as much under managed care as they would have been reimbursed under the PPS methodology. States may do this by requiring MCOs to pay FQHCs at or above the PPS rate. Alternatively, states may permit MCOs to negotiate rates with FQHCs

(as long as the FQHCs receive at least as much as other provider types for similar services), in which case the state must pay FQHCs the difference between the reimbursement the FQHC received from MCOs and the amount the FQHC would have received for the same services under the PPS methodology.

With respect to vaccines, our study found that two states require MCOs to separately reimburse FQHCs for vaccine administration and/or supply outside the PPS rate (FL and NH). Additionally, in the three states with a statewide APM for cost-based FFS reimbursement (IA, MD, and MO), all three states require MCOs to reimburse FQHCs under the same cost-based model.

Policy Opportunities to Promote Access to Prenatal Vaccines Under Medicaid and CHIP

To maximize opportunities for vaccination, federally recommended prenatal vaccines should be made readily available during a wide range of interactions with the healthcare system, whether at routine prenatal appointments with an OB/GYN, during primary care visits at an FQHC, or when visiting the pharmacy to fill a prescription.

Our study identified significant variation across states in their Medicaid and CHIP policies concerning prenatal vaccines, as well as meaningful gaps in reimbursement between Medicaid and Medicare. These findings may help to explain current disparities in vaccination rates for pregnant enrollees in Medicaid and CHIP as compared to commercially insured individuals. **Our findings suggest at least four priority areas for policy action to promote access to prenatal vaccines:**

1. Ensure adequate reimbursement for prenatal vaccinations
2. Optimize the value of the VFC program
3. Leverage MCOs to enhance prenatal vaccine access in states with managed care
4. Support state vaccinator capacity using policy levers outside Medicaid and CHIP

The following sections discuss specific policy strategies to support each of these priorities areas for state officials, MCO administrators, and CMS. These strategies are summarized at a high level in [Exhibit 6](#), below. Policies along these lines can play an important role in making prenatal vaccines as accessible as possible and, in turn, enhancing uptake, thereby contributing to healthier pregnancies and healthier babies.

Exhibit 6. Policy Strategies to Promote Access to Prenatal Vaccines in Medicaid and CHIP

Policy Priority	State Policy Strategies	Federal Strategies for CMS
1. Ensure Adequate Reimbursement for Prenatal Vaccinations	<ul style="list-style-type: none"> • Benchmark against Medicare Part B's physician reimbursement rates for vaccine administration and vaccine supply • Cover all pharmacist vaccinations within scope of practice • Reimburse pharmacists for counseling services in addition to vaccine administration • Allow FQHCs to bill for vaccine administration and supply separate from the PPS rate 	<p>Issue guidance that:</p> <ul style="list-style-type: none"> • Outlines best practices for states to support access to prenatal vaccines as part of high-quality perinatal care • Clarifies federal requirements for coverage and reimbursement of: <ul style="list-style-type: none"> – Vaccine administration services; and – Vaccinations administered by pharmacists
2. Optimize the Value of the VFC Program	<ul style="list-style-type: none"> • Reimburse vaccine administration at the VFC Regional Maximum Rate • Facilitate VFC participation by all potential vaccinators, including pharmacies • Cover prenatal vaccines when furnished by OB/GYNs outside of the VFC program, recognizing that OB/GYNs are less likely to participate in VFC 	<ul style="list-style-type: none"> • Repeal the regulatory cap on VFC administration fees for Medicaid enrollees • Work with CDC to revisit VFC provider requirements and facilitate participation by underrepresented provider types, seeking to streamline procedures and minimize low-value participation burdens
3. Leverage MCOs to Enhance Prenatal Vaccine Access	<ul style="list-style-type: none"> • Establish minimum provider reimbursement levels • Require MCOs to perform member outreach and education • Define MCO performance measures and incentives tied to prenatal vaccination 	<p>Issue guidance outlining best practices for states and MCOs to support access to prenatal vaccines as part of high-quality perinatal care</p>
4. Support State Vaccinator Capacity Using Policy Levers Outside Medicaid and CHIP	<ul style="list-style-type: none"> • Ensure that administration of prenatal vaccines is within scope of practice for a variety of practitioner types (with training and supervision, as appropriate) • Leverage other sources of federal funds to support vaccine access • Strengthen Immunization Information Systems • Invest in culturally competent education and outreach materials on prenatal vaccines 	<p>In partnership with CDC, support states with funding, guidance on best practices, and templates for:</p> <ul style="list-style-type: none"> • Using federal funds to support vaccine access • Strengthening Immunization Information Systems • Developing culturally competent education and outreach materials on prenatal vaccines

Ensure Adequate Provider Reimbursement for Prenatal Vaccinations

Ensuring adequate reimbursement for vaccinations is essential to increasing vaccine access and uptake.⁴¹ Providers are less likely to offer prenatal vaccines to Medicaid and CHIP enrollees if they lose money on each vaccine they administer. To ensure that providers are adequately compensated for vaccinations, public officials and MCOs should consider the following strategies.

Vaccine Administration. Reimbursement for vaccine administration should reflect the time that a provider spends not only preparing and administering the vaccine, but also assessing the patient’s vaccine history, educating the patient about the vaccine—a critical tool to address uncertainty or vaccine hesitancy—and performing required vaccine reporting. This is particularly important in prenatal visits where the provider must address the health of both the pregnant woman and the unborn child. In prior studies, OB/GYNs have specifically cited low vaccine administration fees as a barrier to purchasing and administering prenatal vaccines.⁴² And indeed, our study found that average vaccine administration fees in Medicaid FFS range from 37–56% of Medicare, depending on provider type and patient age.

To ensure adequate reimbursement for non-VFC vaccine administration, states should match the Medicare rate for administering vaccines under Part B (currently \$32.57). (See below for a discussion of VFC-related policy strategies).

In addition, states should implement the following policies:

- Practitioners should be reimbursed for vaccine administration during billable office visits, not just for “vaccine-only” visits.

Opportunity for CMS Guidance

Federal law requires states to cover ACIP-recommended vaccines and their “administration.” CMS could clarify in guidance that states must cover administration fees, including for vaccines administered during a billable office visit.

- Although Medicare reimburses APCs and pharmacists at 85% of the physician rate for professional services, states that do not already do so should consider matching the physician rate for vaccine administration and other high-priority services. As primary care physician and OB/GYN shortages continue to grow, APCs are playing an ever larger role in prenatal health care.⁴³
- In states that offer an enhanced vaccine administration fee for certain provider specialties, the enhanced rate should include OB/GYNs and APCs furnishing prenatal care.
- For states that benchmark against Medicare, the state’s fee schedule should be updated in a timely manner to reflect increases in Medicare’s reimbursement rates.

Vaccine Supply. Vaccine supply reimbursement should be sufficient to ensure that providers recoup the cost of vaccine acquisition and storage. Among other potential pricing benchmarks, states could consider adopting the rates in the Medicare Part B [ASP Drug Pricing Files](#). As with administration fees, supply fees should be updated in a timely manner to reflect changing market conditions. CMS's ASP Drug Pricing File, for example, is updated quarterly.

Additional Considerations for Pharmacists

Many people visit their pharmacy more often than they visit their doctor, making pharmacists key players in supporting the accessibility of vaccines. In addition to ensuring adequate rates for pharmacist vaccine administration and supply, as discussed above, states should consider the following additional strategies to promote vaccine access in the pharmacy setting:

- **Cover all pharmacist-administered vaccines that are within the state's pharmacist scope of practice, including for youth.**

Opportunity for CMS Guidance

In accordance with the federal "free choice of provider" requirement, **CMS could issue guidance clarifying requirements for states and MCOs to cover vaccines administered by pharmacists** within their authorized scope of practice. CMS issued guidance along these lines during the COVID-19 pandemic with respect to temporary expansions in pharmacist vaccination authority under the Public Readiness and Emergency Preparedness Act, but has not extended its guidance to permanent state laws on provider scope of practice.

- **Allow pharmacists to bill for vaccine counseling services**, or build a counseling fee into the vaccine administration fee.

Reimbursement for FQHCs

States should consider allowing FQHCs to bill separately for vaccine administration and vaccine supply, over and above the PPS rate. This additional reimbursement would incentivize vaccine education and outreach, and would help support the financial sustainability of these crucial safety-net providers.

Optimize the VFC Program's Value for Prenatal Vaccinations

The VFC program supplies free vaccines to participating providers for administration to Medicaid enrollees under the age of 19. As described above, however, the VFC

"Sometimes, physicians recommend a vaccine and tell the patient to get it at a pharmacy, whether because the physician doesn't have it in stock or faces payment issues for particular payers. That's probably particularly true for prenatal vaccines. **Patients arrive at the pharmacy counter with questions, looking for advice and information. You absolutely want to make sure the pharmacist is compensated for that counseling.**"

National Association of Chain Drug Stores

program offers many opportunities to strengthen access and address reimbursement disparities between youths covered by Medicaid as opposed to those covered by CHIP or commercial insurance. To optimize the VFC program, states should consider the following:

- **Reimburse vaccine administration at VFC Regional Maximum Rate.** Currently, only 12 states reimburse at the VFC maximum rate; an additional three states do so under an enhanced fee schedule available to OB/GYNs (and certain other practitioner types). If all states matched the VFC maximum rate, the average VFC administration fee for physicians would climb from \$16.19 to \$21.71—a 34% increase.

Opportunity for CMS Rulemaking

CMS should consider repealing the federal cap on Medicaid administration fees for VFC vaccines.

The cap should continue to apply when providers administer VFC vaccines for uninsured or underinsured youth whose families are paying out of pocket, as Congress intended. For those families, a cap on physician charges supports access. By contrast, capping Medicaid reimbursement impedes access by preventing states from paying adequate rates to providers. **This policy change would allow states to:**

- **Increase their VFC administration fees.** Our research found that 15 states already reimburse OB/GYNs at the VFC maximum, including seven states that appear to pay a higher fee for CHIP than for VFC. But even if all states reimbursed at the VFC maximum rate, the average Medicaid fee would still reach only 67% of the Medicare Part B rate for administering the flu vaccine.
- **Pay higher administration fees for multi-component vaccines,** consistent with commercial payers. Because the administration fee is the only reimbursement providers receive for a VFC vaccine, multi-component billing can make a significant difference, as illustrated in our payment sufficiency analysis (see [Exhibit 5](#) and [Appendix Exhibit 9](#)).

- **Maximize Program Eligibility and Participation for Pharmacies and Other Potential Vaccinators.**

Although many states now allow pharmacies to participate in the VFC program, pharmacy participation remains low, cutting off a convenient vaccine access point—one that remains available to youth enrolled in CHIP or commercial insurance. To maximize the number of youths who can access VFC vaccines, states should consider streamlining any state-specific VFC participation requirements to avoid low-value administrative burdens that may deter provider participation.⁴⁴

“The VFC Program was created with physician practices in mind. **Pharmacies would like to serve Medicaid enrollees and it would be good for public health if they could, but the way the VFC program is set up makes it almost impossible for pharmacies to participate**—everything from enrollment and inventory to billing and reimbursement.”

National Association of Chain Drug Stores

Opportunity for CDC Guidance

Revisit VFC provider participation requirements, seeking opportunities to streamline procedures, minimize burdens, and promote participation by diverse provider types.

- **Ensure that VFC Does Not Present Barriers to Prenatal Vaccination During Prenatal Visits.** States have flexibility to decide whether Medicaid will cover pediatric vaccines administered by non-VFC-enrolled providers. As noted earlier, OB/GYNs may be less likely to enroll in VFC than primary care providers or pediatricians, given that OB/GYNs typically do not administer pediatric vaccines other than prenatal vaccines for pregnant youths. However, prenatal visits with OB/GYNs provide a convenient opportunity for pregnant women to receive prenatal vaccines.

To enhance access to prenatal vaccines, states should cover prenatal vaccines that are administered by OB/GYNs outside the VFC program, even if the state normally excludes coverage for non-VFC vaccines administered to Medicaid-enrolled youths. Currently, only two states allow this flexibility—Kentucky for all pediatric vaccines and Mississippi specifically for prenatal vaccines.

“Shutting out OB/GYNs from the VFC Program creates a real barrier, especially in underserved areas where Medicaid patients don’t have much choice among providers to begin with.”

Erin Jones, Sr. Director, Legislative & Strategic Counsel,
March of Dimes

Leverage MCOs to Enhance Prenatal Vaccine Access and Uptake

States with managed care programs have substantial discretion to shape MCOs’ administration of Medicaid benefits, including prenatal vaccines. To ensure that managed care enrollees have every opportunity to receive recommended vaccinations during pregnancy, states should consider strategies such as:

- Requiring **MCOs to cover prenatal vaccines administered by all practitioner types and in all provider settings, consistent with state laws on provider scope of practice.**
- Requiring **MCOs to reimburse for vaccine administration and vaccine supply at or above the state’s FFS rates, including any enhanced rates** for qualifying providers.
- Directing **MCOs to perform member outreach and education related to prenatal vaccinations.** MCOs can identify when a member is pregnant, and many states define special care coordination requirements for pregnant members. States could require MCOs to proactively identify and reach out to members who are due for a vaccine, including the ACIP-recommended prenatal vaccines.
- Establishing **performance measures or quality incentives for MCOs** linked to prenatal vaccination rates or member outreach. A number of states have already defined such quality incentives with respect to certain pediatric vaccines. Similar tactics could be extended to prenatal vaccines and other high-priority vaccinations.

State Examples: Engaging MCOs



Nevada mandates its MCOs to develop culturally relevant and timely vaccine education plans tailored to their members' communities. Additionally, Nevada requires MCOs to reimburse providers at the state's VFC Regional Maximum rate for initial vaccinations in both adults and children. This ensures that providers are fairly compensated and that vaccination services remain accessible and equitable.



Louisiana incorporates adult flu vaccinations as a potential performance metric for MCO incentive payments, underscoring the state's intention to improving patient access to vaccinations.

Support State Vaccinator Capacity Using Policy Levers Outside Medicaid and CHIP

In addition to the policy reforms under Medicaid and CHIP that are discussed in this paper, state policymakers can use other policy levers to enhance access to prenatal vaccines, such as:

- **Expanding the vaccination workforce** by ensuring that prenatal vaccines are within scope of practice for a variety of practitioner types (with training and supervision, as appropriate), such as registered nurses, pharmacists and pharmacy technicians.
- **Improving Immunization Information Systems** to ensure that all potential vaccinators are able to access and update a patient's vaccination records in real time.
- **Leveraging federal funds to support vaccine access for uninsured adults**, such as CDC funding under Section 317 of the Public Health Service Act.
- **Investing in tailored and culturally competent education and outreach materials** highlighting:
 - The importance of prenatal vaccines for the health of both pregnant women and infants.
 - The fact that these vaccines are generally available at no out-of-pocket cost to pregnant women with health insurance (and, depending on the state, potentially to uninsured people as well).
 - The various locations where prenatal vaccines are available, ideally including community pharmacies as well as physician offices and public health clinics.

Conclusion

Supporting healthy pregnancies and healthy babies has been a core goal of the Medicaid and CHIP programs since their inception. Prenatal vaccines are an essential—and highly cost-effective—tool for advancing that goal. Medicaid and CHIP enrollees are, by definition, low- and middle-income, and are disproportionately likely to be people of color—groups that continue to experience serious disparities in health outcomes, including with respect to maternal and infant health.⁴⁵ By implementing appropriate vaccine reimbursement policies under Medicaid and CHIP, state and federal officials can help address those disparities. Appropriate reimbursement drives robust access, which means enrollees have opportunities to learn about and receive recommended vaccinations when it's most convenient for them. Robust access, in turn, drives robust uptake, which translates into healthier moms and babies.

Appendices

Exhibit 7. Physician Vaccine Administration: Medicaid FFS Reimbursement for Administration of Prenatal Vaccines by Injection During a Billable Office Visit, by Patient Age (State-Level Data)ⁱ

	Patient <19 Years of Age, VFC Vaccine With Counseling		Adult Patient Aged 21+ (same rate for ages 19–20 unless otherwise specified)	
	Standard Rate	Enhanced Rate for OB/GYNs, if applicable	Standard Rate	Enhanced Rate for OB/GYNs, if applicable
U.S. Averageⁱⁱ	\$16.19	\$16.61	\$12.05	\$12.48
Alabamaⁱⁱⁱ	\$8.00	—	—	—
Alaska	\$27.44	—	\$31.39	—
Arizona	\$21.33	—	\$25.62	—
Arkansas	Flu: \$15.45 Others: \$13.14	—	Flu: \$15.45 Others: \$13.14	—
California	\$9.00	—	\$4.46	—
Colorado	\$17.39	—	\$17.39	—
Connecticutⁱⁱⁱ	\$15.05	—	—	—
Delawareⁱⁱⁱ	\$8.00	—	—	—
District of Columbia	\$21.03	\$24.48	\$19.02	\$23.44
Florida	\$10.00	—	\$10.00	—
Georgia	\$10.00	\$21.93	\$10.00	\$23.78
Hawaii	\$4.00 ^{iv}	—	\$4.00 ^v	—
Idaho	\$18.76	—	Flu: \$17.36 Others: \$16.76	—
Illinoisⁱⁱⁱ	\$16.71	—	—	—
Indianaⁱⁱⁱ	\$15.00	—	—	—
Iowa	\$19.68	—	\$5.09	—
Kansas	\$20.26	—	\$14.57	—
Kentucky	\$19.93	—	\$27.49	—
Louisiana	\$14.70	—	\$14.70	—

i. Manatt Health researched publicly available Medicaid and CHIP policies in all 50 states, plus D.C. and Puerto Rico, between November 2023 and March 2024. Because this table focuses on vaccine administration during a billable office visit, we do not include administration fees that apply only during “vaccine only” visits with no other billable services.

ii. With respect to the “enhanced rate” column, this row lists the U.S. average administration fee across all states using the enhanced rate when available and the standard rate in states that do not offer an enhanced rate.

iii. There are eight states which do not pay an administration fee for adult vaccinations during an office visit. Some (but not all) of these states will pay an administration fee only for vaccine-only visits.

iv. In Hawaii, New Jersey, Pennsylvania, and Wisconsin, the administration fee for adult vaccines is included in the reimbursement for vaccine supply.

v. In Hawaii, for children and youth under 19, vaccine administration is bundled into the office visit rate for a well-child visit, but is separately payable for a prenatal visit.

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	Patient <19 Years of Age, VFC Vaccine With Counseling		Adult Patient Aged 21+ (same rate for ages 19–20 unless otherwise specified)	
	Standard Rate	Enhanced Rate for OB/GYNs, if applicable	Standard Rate	Enhanced Rate for OB/GYNs, if applicable
Maine	\$15.31	—	\$13.65	—
Maryland ⁱⁱⁱ	\$23.28	—	—	—
Massachusetts	\$20.45	—	\$20.45	—
Michigan	\$16.13	—	\$16.13	—
Minnesota	\$16.36	—	\$14.88	—
Mississippi	\$18.35	\$19.79	\$16.25	\$18.06
Missouri	\$8.07 ^{vi}	—	\$13.21	—
Montana	\$21.32	—	\$21.32	—
Nebraska	\$10.92	—	\$5.80	—
Nevada	\$22.22	—	\$22.22	—
New Hampshire	\$6.58	—	\$5.48	—
New Jersey	\$16.18	—	\$2.50 ^{iv}	—
New Mexico	\$20.80	—	\$22.79	—
New York	\$25.10	—	\$14.78	—
North Carolina	\$20.45	—	Age 19–20: \$20.45 Age 21+: \$13.30	—
North Dakota	\$17.06	—	\$17.06	—
Ohio	\$15.00	—	\$12.95	—
Oklahoma	\$18.34	—	\$17.45	—
Oregon	\$21.96	—	\$14.94	\$16.31
Pennsylvania	\$10.00	—	\$10.00 ^{iv}	—
Puerto Rico ^{vii}	N/A	N/A	N/A	N/A
Rhode Island	\$14.04	—	\$8.16	—
South Carolina	\$20.16	—	\$3.72	—
South Dakota	\$17.17	—	\$11.59	—
Tennessee ^{vii}	N/A	N/A	N/A	N/A
Texas	\$13.75	—	\$13.10	—
Utah	\$13.81	—	\$13.81	—
Vermont	\$19.71	—	\$17.85	—
Virginia ⁱⁱⁱ	\$11.00	—	—	—
Washington	\$19.69	—	\$13.75	—
West Virginia ⁱⁱⁱ	\$15.44	—	—	—
Wisconsin	\$15.00	—	\$15.00 ^{iv}	—
Wyoming	\$20.48	—	\$16.94	—

vi. Missouri directs physicians to bill \$8.07 for each component in a VFC vaccine.

vii. Puerto Rico and Tennessee both operate their Medicaid medical benefit 100% under managed care. They do not publish FFS fee schedules, nor have they published requirements for MCO reimbursement of physicians with respect to prenatal vaccine administration.

Exhibit 8. Physician Vaccine Supply: Medicaid and CHIP FFS Reimbursement for Prenatal Vaccine Supply for RSV, Tdap and Select Influenza Vaccines (State-Level Data)ⁱ

	RSV CPT Code 90678	Tdap CPT Code 90715	Flucelvax (ccIV4) CPT Code 90674	Fluzone (IIV4), Single-Dose CPT Code 90686
Medicare Average Sales Price (ASP) Drug Pricing File	Not Listed	\$38.31	\$34.17	\$22.35
Private Sector Rate	\$356.67	\$47.61	\$29.31	\$19.10
Medicaid FFS: U.S. Average	\$311.10	\$40.11	\$31.64	\$21.36
Alabama	ASP + 6%	\$38.67	\$34.17	\$22.35
Alaska	ASP + 6%	\$38.31	\$34.17	\$22.35
Arizona	\$506.47	\$38.50	\$34.17	\$22.35
Arkansas	\$336.30	\$28.80	\$22.94	\$16.14
California	ASP + 6%	\$43.21	\$38.63	\$26.81
Colorado	ASP - 3.3%	\$52.41	\$30.10	\$19.76
Connecticut	ASP + 6%	\$38.31	\$29.94	\$22.35
Delaware	AAC	AAC	AAC	AAC
District of Columbia	\$295.00	\$30.00	\$25.82	\$17.22
Florida	\$295.00	\$52.41	\$26.39	\$19.73
Georgia	\$295.00	\$38.31	\$34.17	\$22.35
Hawaiiⁱⁱ	See footnote	See footnote	See footnote	See footnote
Idaho	ASP * 95.4%	\$33.75	\$29.05	\$19.37
Illinois	\$280.02	\$38.67	\$34.17	\$22.35
Indiana	\$309.75	\$44.68	\$30.82	\$19.93
Iowa	\$298.78	\$44.99	\$25.52	\$17.50
Kansas	\$295.00	\$42.14	\$22.94	\$21.52
Kentucky	\$320.14	\$35.64	\$34.17	\$22.35
Louisiana	\$295.00	\$36.16	\$29.94	\$20.53
Maine	AAC	\$38.67	\$34.17	\$22.35
Maryland	\$295.00	\$36.16	\$29.94	\$20.53
Massachusetts	ASP + 6%	\$38.31	\$34.17	\$22.35
Michigan	\$295.00	\$38.67	\$34.17	\$22.35
Minnesota	\$295.00	\$38.67	\$34.17	\$22.35
Mississippi	ASP + 6%	\$37.50	\$32.38	\$21.52

i. Manatt Health researched publicly available Medicaid and CHIP policies in all 50 states, plus D.C. and Puerto Rico, between November 2023 and March 2024. The calculated average rates excludes states for which a numerical rate is unavailable due to the state defining a reimbursement methodology without listing a specific rate. Medicare vaccine supply rates were collected from the CMS [January 2024 Medicare ASP Pricing File](#). The private sector vaccine supply rates were collected from the CDC [March 2024 Vaccine Price List](#). Where multiple products exist for a single code, we calculated Medicare and private rates by averaging the available codes.

ii. Hawaii reimburses for single-source drugs at the lesser of WAC or National Average Drug Acquisition Cost (NADAC). For multiple-source drugs, reimbursement is the lesser of WAC, NADAC, Federal Upper Limit (FUL) or the state-defined Maximum Allowable Cost (MAC).

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	RSV CPT Code 90678	Tdap CPT Code 90715	Flucelvax (ccIV4) CPT Code 90674	Fluzone (IIV4), Single-Dose CPT Code 90686
Missouri ⁱⁱⁱ	See footnote	See footnote	See footnote	See footnote
Montana	ASP + 6%	\$38.75	\$32.28	\$21.52
Nebraska	\$315.06	\$38.30	\$34.17	\$22.35
Nevada ^{iv}	See footnote	See footnote	See footnote	See footnote
New Hampshire	\$295.00	\$49.14	\$28.52	\$20.79
New Jersey	WAC - 1%	\$47.25	\$14.61	\$9.79
New Mexico	ASP + 6%	\$45.00	\$38.73	\$25.82
New York	AAC	AAC	AAC	AAC
North Carolina	WAC + 3%	\$49.68	\$28.52	\$19.19
North Dakota	\$295.00	\$38.31	\$34.17	\$22.35
Ohio	\$315.65	\$38.31	\$34.17	\$22.35
Oklahoma	ASP + 6%	\$38.75	\$30.22	\$20.15
Oregon	ASP + 6%	\$38.75	\$34.17	\$22.35
Pennsylvania ^v	See footnote	See footnote	See footnote	See footnote
Puerto Rico ^{vi}	N/A	N/A	N/A	N/A
Rhode Island ^{vii}	ASP + 6%	\$38.31	\$34.17	\$22.35
South Carolina	\$290.28	\$41.21	\$33.50	\$22.33
South Dakota	ASP + 6%	\$38.31	\$34.17	\$22.35
Tennessee ^{vi}	N/A	N/A	N/A	N/A
Texas	\$316.83	\$33.56	\$28.89	\$19.26
Utah ^{viii}	See footnote	\$37.97	\$18.80	\$12.63
Vermont	ASP + 2.82%	\$37.90	\$33.49	\$21.90
Virginia ^{ix}	ASP + 6%	\$38.30	\$34.17	\$22.35
Washington	\$295.00	\$38.31	\$34.17	\$22.35
West Virginia	ASP + 6%	\$38.31	\$34.17	\$22.35
Wisconsin	\$310.00	\$67.41	\$49.17	\$37.35
Wyoming	AAC	\$30.00	AAC	AAC

iii. Missouri reimburses at the lesser of WAC + 10%, state MAC or FUL.

iv. In Nevada, brand-name products are reimbursed at “85% of the Medicare non-facility rate,” using the 2014 resource-based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor.

v. In Pennsylvania, brand-name products are reimbursed at WAC + 3.2%. Generic products are reimbursed at the lesser of WAC, FUL or state MAC.

vi. Puerto Rico and Tennessee both operate their Medicaid medical benefit 100% under managed care. They do not publish FFS fee schedules, nor have they published requirements for MCO reimbursement of physicians with respect to prenatal vaccine administration.

vii. Rhode Island’s State-Supplied Vaccine Program furnishes providers with certain vaccines free of charge, in which case the vaccine supply is not billable to the Medicaid program.

viii. In Utah, vaccines are reimbursed at the lesser of WAC, FUL, NADAC, Utah MAC or AAC.

ix. Virginia state guidance provides that “when billing for immunizations, only the AAC of the injectable is to be billed.” However, the fee schedule lists rates for some (but not all) of the vaccine codes of interest. Where fee schedule rates exist, the state likely reimburses at the lesser of AAC or the fee schedule rate.

Exhibit 9. Physicians: Comparison of Total Reimbursement for Administering Fluzone and Tdap Vaccinations During a Billable Office Visit Under Medicaid FFS vs. Medicare, by Patient Age (State-Level Data)ⁱ

	VFC Youth Aged <19 (Admin Fees Only)		Adult Aged 19+ (Admin + Supply Fees)	
	Total Medicaid Reimbursement	% of Total Medicare Reimbursement (\$72.18)	Total Medicaid Reimbursement	% of Total Medicare Reimbursement (\$118.37)
U.S Average	\$33.47	46%	\$83.49	71%
Alabama	\$16.00	22%	\$61.02	52%
Alaska	\$54.88	76%	\$114.98	97%
Arizona	\$42.66	59%	\$99.29	84%
Arkansas	\$26.28	36%	\$71.22	60%
California	\$18.00	25%	\$78.94	67%
Colorado	\$34.78	48%	\$106.95	90%
Connecticut	\$30.10	42%	\$60.66	51%
Delaware	\$16.00	22%	N/A	N/A
District of Columbia	\$48.96	68%	\$84.17	71%
Florida	\$20.00	28%	\$92.14	78%
Georgia	\$43.86	61%	\$97.43	82%
Hawaii	\$8.00	11%	N/A	N/A
Idaho	\$37.52	52%	\$87.24	74%
Illinois	\$33.42	46%	\$61.02	52%
Indiana	\$30.00	42%	\$64.61	55%
Iowa	\$39.36	55%	\$72.67	61%
Kansas	\$40.52	56%	\$92.38	78%
Kentucky	\$38.33	53%	\$97.44	82%
Louisiana	\$23.83	33%	\$80.52	68%
Maine	\$30.62	42%	\$84.50	71%

i. Manatt Health researched publicly available Medicaid and CHIP policies in all 50 states, plus D.C. and Puerto Rico, between November 2023 and March 2024. Composite rates were unavailable in certain states that did not list a specific rate for either vaccine supply or vaccine administration (e.g., because the state specifies a reimbursement methodology without providing a specific rate); for additional details, see [Appendix Exhibit 7](#) and [Appendix Exhibit 8](#). With respect to Medicare, Flu vaccines are covered under Medicare Part B, while Tdap is covered under Medicare Part D. To calculate the Medicare composite rate for adults, we combined: (1) the 2024 Medicare flu vaccine administration fee (G0008); (2) the 2024 Fluzone supply fee (90686); and (3) the weighted average for [Part D reimbursement](#) of Tdap (90715), based on the 2022 rates for the Adacel and Boostrix vaccines (the more recent data available; note that Part D reimbursement combines both the administration and supply fees). For VFC youth, there is no Medicaid reimbursement for the supply. Therefore, we calculated a hypothetical Medicare composite using the Part B codes for: (1) administration of the flu vaccine (G0008), and (2) the non-vaccine-specific codes for administering a combination vaccine with counseling to youth age <19 (90460 for the initial component, plus 90461 for each additional component).

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	VFC Youth Aged <19 (Admin Fees Only)		Adult Aged 19+ (Admin + Supply Fees)	
	Total Medicaid Reimbursement	% of Total Medicare Reimbursement (\$72.18)	Total Medicaid Reimbursement	% of Total Medicare Reimbursement (\$118.37)
Maryland	\$46.56	65%	\$56.69	48%
Massachusetts	\$40.90	57%	\$90.95	77%
Michigan	\$32.26	45%	\$93.28	79%
Minnesota	\$37.58	52%	\$86.31	73%
Mississippi	\$39.58	55%	\$90.16	76%
Missouri	\$32.28	45%	N/A	N/A
Montana	\$42.64	59%	\$97.55	82%
Nebraska	\$21.84	30%	\$72.25	61%
Nevada	\$44.44	62%	N/A	N/A
New Hampshire	\$10.41	14%	\$78.75	67%
New Jersey	\$27.68	38%	\$57.04	48%
New Mexico	\$41.60	58%	\$115.38	97%
New York	\$50.20	70%	N/A	N/A
North Carolina	\$40.90	57%	\$95.47	81%
North Dakota	\$34.12	47%	\$94.78	80%
Ohio	\$30.00	42%	\$83.46	71%
Oklahoma	\$36.68	51%	\$88.95	75%
Oregon	\$43.92	61%	\$89.09	75%
Pennsylvania	\$20.00	28%	N/A	N/A
Puerto Ricoⁱⁱ	N/A	N/A	N/A	N/A
Rhode Island	\$34.48	48%	N/A	N/A
South Carolina	\$40.32	56%	\$70.98	60%
South Dakota	\$34.34	48%	\$83.62	71%
Tennesseeⁱⁱ	N/A	N/A	N/A	N/A
Texas	\$27.50	38%	\$75.81	64%
Utah	\$27.62	38%	\$78.22	66%
Vermont	\$39.42	55%	\$90.26	76%
Virginia	\$22.00	30%	\$60.65	51%
Washington	\$39.38	55%	\$84.23	71%
West Virginia	\$30.88	43%	60.66	51%
Wisconsin	\$30.00	42%	\$104.76	89%
Wyoming	\$40.96	57%	N/A	N/A

ii. Puerto Rico and Tennessee’s Medicaid programs are 100% managed care and do not include a FFS rate.

Exhibit 10. APC and Pharmacist Vaccine Administration: Medicaid FFS Reimbursement Rates for Adults 21+ During a Billable Office Visit (State-Level Detail)ⁱ

	CNMs		Same Rate for All APCs?	Pharmacists	
	FFS Rate	% of Physician Rate		FFS Rate	% of Physician Rate
U.S Average	\$11.35	95%	N/A	\$13.45	112%
Alabama	—	100%	Yes	\$5.00	N/A: No physician admin fee
Alaska	\$26.68	85%	Yes	\$26.68	85%
Arizona	\$23.06	90%	Yes	\$4.10	16%
Arkansas	\$13.14	100%	Yes	\$13.14	100%
California	\$4.46	100%	Yes	\$19.18	85%
Colorado	\$17.39	100%	Yes	\$17.39	100%
Connecticut	—	100%	Yes	—	100%
Delaware	—	100%	Yes	\$10.00	N/A: No physician admin fee
District of Columbia	\$19.02	100%	Yes	\$13.00	68%
Florida	\$8.50	85%	Yes	\$8.00	80%
Georgia	\$10.00	100%	NP & PA: 90%	\$10.00	100%
Hawaii	\$3.00	75%	NP: 75% PA: 100%	\$4.00	100%
Idaho	\$14.25	85%	Yes	\$14.25	85%
Illinois	—	100%	Yes	—	100%
Indiana	—	100%	Yes	\$18.89	N/A: No physician admin fee
Iowa	\$4.32	85%	Yes	\$5.09	100%
Kansas	\$10.93	75%	Yes	\$14.57	100%
Kentucky	\$20.62	75%	Yes	N/A ⁱⁱ	N/A
Louisiana	\$14.70	100%	Yes	\$15.22	104%
Maine	\$13.65	100%	Yes	\$5.00	37%
Maryland	—	100%	Yes	\$10.67	N/A: No physician admin fee
Massachusetts	\$17.38	85%	Yes	\$17.38	85%
Michigan	\$16.13	100%	Yes	\$16.13	100%
Minnesota	\$14.88	100%	NP & PA: 90%	\$14.88	100%
Mississippi	\$14.63	90%	Yes	\$18.06	111%
Missouri	\$13.21	100%	Yes	\$12.22	93%

i. Manatt Health researched publicly available Medicaid and CHIP policies in all 50 states, plus D.C. and Puerto Rico, between November 2023 and March 2024. In addition to pharmacists, the three types of advanced practice clinicians (APCs) included in the study were certified nurse-midwives (CNMs), nurse practitioners (NPs), and physician assistants (PAs).

ii. Kentucky, Nebraska and New Jersey do not cover vaccinations administered by pharmacists.

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	CNMs		Same Rate for All APCs?	Pharmacists	
	FFS Rate	% of Physician Rate		FFS Rate	% of Physician Rate
Montana	\$21.32	100%	Yes	\$21.32	100%
Nebraska	\$5.80	100%	Yes	N/A ⁱⁱ	N/A
Nevada	\$18.82	85%	Yes	\$7.80	35%
New Hampshire	\$5.48	100%	Yes	\$5.48	100%
New Jersey	\$2.50	100%	Yes	N/A ⁱⁱ	N/A
New Mexico	\$22.79	100%	NP: 90% PA: 100%	\$22.79	100%
New York	\$14.04	95%	NP: 95% PA: 100%	\$13.36	90%
North Carolina	\$13.30	100%	Yes	\$13.30	100%
North Dakota	\$14.50	85%	NP & PA: 75%	\$17.06	100%
Ohio	\$12.95	100%	Yes	\$12.95	100%
Oklahoma	\$17.45	100%	Yes	\$18.34	105%
Oregon	\$14.94	100%	Yes	\$61.79	379%
Pennsylvania	\$10.00	100%	Yes	\$10.00	100%
Puerto Ricoⁱⁱⁱ	N/A	N/A	N/A	N/A	N/A
Rhode Island	\$8.16	100%	Yes	\$8.16	100%
South Carolina	\$3.72	100%	NP & PA: 80%	\$10.50	282%
South Dakota	\$11.59	100%	Yes	\$11.59	100%
Tennessee^{iv}	N/A	N/A	N/A	\$9.02	N/A: Physician rate unknown
Texas	\$13.10	100%	Yes	See footnote ^v	N/A
Utah	\$13.81	100%	Yes	\$13.81	100%
Vermont	\$17.85	100%	NP & PA: 90%	\$17.85	100%
Virginia	—	100%	Yes	\$16.00	N/A: No physician admin fee
Washington	\$13.75	100%	Yes	\$11.96	87%
West Virginia	—	100%	Yes	\$10.49	100%
Wisconsin	\$15.00	100%	Yes	\$15.00	100%
Wyoming	\$16.94	100%	Yes	\$10.65	63%

iii. Puerto Rico operates its entire Medicaid program under managed care, does not publish FFS fee schedules, and has not published requirements for MCO reimbursement of APCs or pharmacists with respect to vaccine administration.

iv. Tennessee operates its entire Medicaid medical benefit under managed care and publishes neither FFS fee schedules nor requirements for MCO reimbursement regarding APC vaccine administration. However, Tennessee carves its pharmacy benefit—including pharmacist-administered vaccines—out of managed care and reimburses these services under FFS. Pharmacist vaccine administration is likely reimbursed under the standard dispensing fee of \$9.02 for high-volume pharmacies (>65,000 prescriptions per year) and \$13.16 for low-volume pharmacies.

v. Texas reimburses pharmacists a base dispensing fee of \$8.10, plus additional fees based on the price of the drug product and certain pharmacy characteristics.

Exhibit 11. FQHC Reimbursement Methodology for Vaccinations Under Medicaid and CHIP FFS (State-Level Data)ⁱ

State	Are FQHCs Able to Bill for Vaccinations Outside the FQHC Prospective Payment System (PPS) Rate?
Alabama	No
Alaska	No
Arizona	No
Arkansas	Yes. For pediatric vaccines, the FQHC receives the physician administration fee as an interim reimbursement, subject to later cost settlement to the PPS rate.
California	No
Colorado	No
Connecticut	No
Delaware	No
District of Columbia	No
Florida	Yes. For youths aged <19, FQHCs receive an administration fee of \$5.50 on top of the PPS rate.
Georgia	Yes. For youths aged <21, vaccine administration and vaccine supply are separately reimbursable at the applicable practitioner rate on top of the PPS rate.
Hawaii	No
Idaho	Yes. For vaccine-only visits, FQHCs may bill for vaccine administration and supply at the physician rate.
Illinois	Yes. For non-VFC youth vaccines (i.e., for CHIP youth), the FQHC may bill for vaccine supply at the physician rate on top of the PPS rate.
Indiana	No
Iowa	N/A: No PPS Payments. Iowa pays for FQHC services (including vaccinations) through a cost-based reimbursement methodology rather than the PPS.
Kansas	No
Kentucky	No
Louisiana	No
Maine	Yes. For influenza and pneumococcal vaccines only, FQHCs receive a \$5 administration fee on top of the PPS rate.
Maryland	N/A: No PPS Payments. Maryland pays for FQHC services (including vaccinations) through a cost-based reimbursement methodology rather than the PPS.
Massachusetts	Yes. Vaccine administration and supply are separately reimbursable at the applicable practitioner rate, on top of the PPS rate.
Michigan	Yes. For specific vaccines (including prenatal RSV, but no other prenatal vaccines), FQHCs may bill for vaccine administration and vaccine supply on top of the PPS rate.
Minnesota	No
Mississippi	No

i. Manatt Health researched publicly available Medicaid and CHIP policies in all 50 states, plus D.C. and Puerto Rico, between November 2023 and March 2024. This study collected data on APMs only when the state confirmed that all FQHCs have opted into the APM.

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State	Are FQHCs Able to Bill for Vaccinations Outside the FQHC Prospective Payment System (PPS) Rate?
Missouri	N/A: No PPS Payments. Missouri pays for FQHC services (including vaccinations) through a cost-based reimbursement methodology rather than the PPS.
Montana	Yes. For youths enrolled in CHIP, FQHCs may bill for vaccine supply on top of the practitioner rate. In addition, FQHCs may bill for vaccine administration for a vaccine-only visit provided by a nurse to CHIP youths.
Nebraska	No
Nevada	No
New Hampshire	Yes. FQHCs may bill for vaccine supply at the FFS rate on top of the PPS rate. For vaccine-only visits, FQHCs may also bill for vaccine administration at the physician rate.
New Jersey	No
New Mexico	No
New York	Yes. For vaccine-only visits, FQHCs may bill for vaccine administration at an FQHC-specific rate (\$13.36 for adults and \$18.03 for youth <19), plus the acquisition cost for vaccine supply.
North Carolina	Yes. For Medicaid youths <21 and for CHIP youths <19, wellness exams (including immunizations) and vaccine-only visits are carved out of the PPS reimbursement system and reimbursed at the physician rate.
North Dakota	Yes. For vaccine-only visits, FQHCs may bill for vaccine administration and supply at the physician rate.
Ohio	No
Oklahoma	No
Oregon	No
Pennsylvania	No
Puerto Rico	N/A. Puerto Rico's entire Medicaid program is operated under managed care. Puerto Rico publishes neither FFS reimbursement guidance nor MCO reimbursement requirements regarding FQHC vaccinations.
Rhode Island	No
South Carolina	No
South Dakota	Yes. For vaccine-only visits, FQHCs may bill for vaccine administration and supply at the physician rate.
Tennessee	N/A. Tennessee operates its Medicaid medical benefit entirely under managed care. Tennessee publishes neither FFS reimbursement guidance nor MCO reimbursement requirements regarding FQHC vaccinations.
Texas	No
Utah	No
Vermont	Yes. For vaccine-only visits, FQHCs may bill for vaccine administration and supply at the applicable practitioner rate.
Virginia	No
Washington	No
West Virginia	No
Wisconsin	No
Wyoming	No

Endnotes

1. Although this paper will generally refer to “mothers” and “pregnant women,” the authors acknowledge that some pregnant individuals may not identify as women.
2. CDC, *Influenza, Tdap, and COVID-19 Vaccination Coverage and Hesitancy Among Pregnant Women — United States, April 2023* (September 29, 2023), <https://www.cdc.gov/mmwr/volumes/72/wr/mm7239a4.htm>; CDC, *Influenza and Tdap Vaccination Coverage Among Pregnant Women — United States, April 2020* (October 2, 2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6939a2.htm>.
3. The Medicaid and CHIP Payment and Access Commission (MACPAC), *Vaccine Access for Adults Enrolled in Medicaid*, Report to Congress on Medicaid and CHIP, 24–49 (March 2022), <https://www.macpac.gov/wp-content/uploads/2022/03/Chapter-2-Vaccine-Access-for-Adults-Enrolled-in-Medicaid.pdf>.
4. World Health Organization, *Vaccines and Immunization – Overview* (accessed May 23, 2024), https://www.who.int/health-topics/vaccines-and-immunization#tab=tab_1.
5. Centers for Disease Control and Prevention (CDC), *Pregnancy and Vaccines* (accessed May 23, 2024), https://www.cdc.gov/vaccine-safety/about/pregnancy.html?CDC_AAref_Val=https://www.cdc.gov/vaccinesafety/concerns/vaccines-during-pregnancy.html.
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