IMMUNIZATIONS NEWSLETTER

PROVIDING GSA MEMBERS WITH UPDATES ON ADULT IMMUNIZATIONS

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Developed by The Gerontological Society of America

BREAKING NEWS

• Registration is now open for the 2017 National Adult and Influenza Immunization Summit, slated for May 9–11 in Atlanta. Conference organizers are soliciting poster presentations on best practices to improve adult and influenza immunizations, and nominations for the Summit Immunization Excellence Awards are now open, as well.

COMMUNICATIONS

Over the coming months, this e-newsletter will feature a column dedicated to helping health care professionals talk to patients about vaccines. “Health care professionals” are more than just those in the office who administer the vaccine. The term includes the physical therapist whose patient asks what they think about flu vaccine, the nurse whose parents want to know about shingles, and the social worker who helps clients maintain their health but may not know about new pneumococcal vaccine recommendations. Here we will review communication theories and apply them to vaccine decision making; we will also discuss how to approach different types of cognitive styles when discussing vaccines. Please watch this space for helpful tips in coming issues. In the meantime, more information can always be found on our website.
HELPING PATIENTS NAVIGATE THE MEDICARE PART B/PART D DIVIDE

When the goal is to get people to do something, the last thing needed is to make processes difficult, place barriers in the way, and create confusion. Yet when it comes to vaccinations under Part D of the Medicare program, that is exactly the situation encountered by providers and beneficiaries alike. Even the relatively straightforward Part B benefit has steps in the process that patients, physicians, pharmacists, and vaccine advocates must work through.

How did we get to this situation? What can we do about it? Let’s take a look.

SOCIAL RESEARCH/POLICY/PRACTICE

As discussed in depth at last year’s 3rd Immunization Congress—cosponsored by GSA with the HHS National Vaccine Program Office, American Academy of Pediatrics, and National Foundation for Infectious Diseases—Medicare vaccine coverage, administration, and payment is complicated. (Conference slides are accessible online.)

Medicare Part B, created when the program’s enabling statute was passed in the 1960s, specifies statutory coverage of vaccines when directly related to the treatment of an injury or direct exposure to a disease or condition. Those vaccines not statutorily covered under Part B are covered under Medicare Part D—created in 2003 as a pharmacy benefit program—as long as the vaccine is reasonable and necessary to prevent illness and the patient has opted for the Part D benefit.

It would literally take an act of Congress to reduce this complexity. Might that happen during the session recently convened in Washington? With health care reform back on the table as a result of the GOP sweep in the November elections, amendments modifying the Medicare act are possible. However, with the antivaccine rhetoric of the new president, whether organized medicine and other vaccine advocates can make their voices heard on this point is unknown.

HEALTH SCIENCES

For the health care provider, Part B is fairly straightforward. Getting paid is certain and as easy as it gets for third-party reimbursement. Part D is very complicated. Phone calls must be made, payment from the prescription drug plans is less reliable, and the patient many times has to front the money to the provider and then wait to be paid by the drug plan.

An 8-page brochure from the Centers for Medicare & Medicaid Services (CMS) provides the details.

The vaccines covered under Part B are influenza and pneumococcal vaccines, hepatitis B vaccine for those at medium to high risk of exposure, and tetanus toxoid when exposure has occurred. Immunizers—physicians, pharmacists, and others who can give vaccines under their state’s laws—can administer and be paid for these vaccines. Because the intervention is preventive, there is generally no copayment.

Under Part D coverage are the other adult vaccines, including herpes zoster (shingles). For these vaccines, state laws usually require the physician to write a medication order (prescription). The patient can take this to the pharmacy and get vaccinated there, or the pharmacy may provide the product back to the physician for administration. There is a dispensing
fee and an administration fee, both of which require copayments by the patient. The vaccine itself may not be included in the formulary of the patient’s prescription drug plan, but the CMS brochure notes that doesn’t necessarily mean that the vaccine won’t be covered. But without coverage, the patient must pay the dispensing and administration amounts to the providers involved.

If all these factors were not complicated enough, a new zoster vaccine is under review at the Food and Drug Administration that will require two doses. This means another trip to the pharmacy (or physician) for the second dose thereby further compromising an already-low vaccination rate for this serious disease of older adults.

The article by Williams et al. listed below (see Sources and Resources) provides the bad news on the detrimental effects of barriers to adult vaccinations. While sorting out the relative effects of the obstacles is difficult, the immunization rates for influenza (Part B) in older adults are consistently 65% or more each year. Those for herpes zoster vaccine are half that rate—fewer than 30% of older adults have received the single-dose regimen of the currently available product.

This nonadherence to adult vaccines provides opportunities and challenges to those in public health and health promotions. The Centers for Disease Control and Prevention has launched very useful age-specific pages on its website; all can be accessed from the VaxView homepage. To get ideas and create campaigns, check out the information and materials on the ChildVaxView, SchoolVaxView, TeenVaxView, AdultVaxView, and FluVaxView pages.

Vaccine advocates can also help patients in contacting payers and providers about adult vaccinations. The information in the CMS brochure provides links to other information sources and tips on whom to call in specific situations.

Does any of this mean anything to GSA members in the basic sciences? It could.

As pharmaceutical companies see the low vaccination rates for Part D products, projections for the profitability of new vaccines is reduced. Combined with the uncertainty inherent in the research and development process, some potential vaccine products could be shelved rather than be moved to clinical testing.

As vaccine advocates who want to see older adults live longer, healthier lives, GSA members should take a look at ways they can help resolve the coverage challenges for adult vaccines. Whether it’s influenza, pneumococcal disease, or herpes zoster, these conditions can move a healthy older adult to functional decline and ultimately frailty and death, all of which can be easily prevented. As vaccine advocates, we can all help simplify and explain processes, remove barriers, and eliminate confusion about adult vaccines.
SOURCES AND RESOURCES