Washington Vaccine Association – Operations Committee Meeting
January 29, 2015, 2:00 PM – 3:00 PM
Location: Conference call

I. **Attendance.** Participating in the meeting were the following individuals:

Committee:	WVA:	Absent:
Kim Barringer	Margaret Lane	Maureen Broooks
Tammy Blair	Julia Walter	Chuck Levine
Sue Bride		Laura McKenna
Stephanie Crook		Marcy Nicol
Cathy Falanga		
Trevor Hammond		
Jan Hicks-Thomson		
Walter Kuiee		
Chad Murphy		
Jeri Trice		

II. **Summary of Decisions and / or Recommendations**

1. Affirmed a vaccine assessment grid increase on July 1, 2015, with the new grid changes communicated on May 1.

2. Voted to add HPV-9 to the grid effective for dates of service on or after May 1, 2015, and price using the best available information to develop an estimate by March 1, 2015. The pricing will be adjusted when changes are made to update the entire grid for the July 1 assessment change.

3. Provide analysis showing that WVA vaccine pricing continues to benefit payers economically and at what point we reach breakeven status. Margaret will follow up with Chad, Jan, and Peter Smith from the WVA.

4. Health plans will review their own internal policies on paying for new vaccines.

III. Minutes

Welcome and Update on January 20, 2015 WVA board meeting

Margaret stated that John Pierce was re-elected as WVA board chair at the annual meeting in October and Dr. Pat Kulpa and Diana Rakow were affirmed as new board members for Regence and Group Health, respectively.

Margaret reported that the WVA board has had discussions over the past year about whether it can do anything to increase immunization levels in WA. The WVA's leeway may be limited under its statutory authority, but the Board wants to explore options and will take up this discussion at its April meeting. Recent cases of Disneyland measles are a reminder that vaccine preventable diseases could return.

2015 Assessment Grid Update - Background

The most recent assessment grid change was the increase effective on December 1, 2013. The timing of the increase was necessary because the CDC changed the method of state vaccine purchasing on the federal CDC contract. As of October, 2013, the WVA changed from the "advance credit model," which allowed WVA to reimburse for non-federal vaccines after they were ordered and shipped to providers' offices, to the current "advance purchase model," which requires the WVA to purchase vaccines in advance. In order to meet the cash requirements of over $13 million, the board obtained a line of credit from KeyBank and increased assessment levels to 110% of the CDC contract rate, effective as of December 1, 2013.

The current assessment levels, at 110% of the CDC contract rate, remain significantly less than the CDC private market survey price of vaccines (current assessments are approximately 78% of the private market survey prices).

Over the early part of 2014, the WVA experienced payment delays caused by payer system issues and providers failing to bill on updated claim forms. This trend led to concerns that WVA could be out of compliance with financial covenants in its Key Bank Letter of Credit, The board discussed these financial stability concerns at its October, 2014 board meeting and debated advancing the assessment increase or restoring the full line of credit. The board determined to stay with the planned July 1, 2015 assessment increase date, and move forward to restore the line of credit, which means that the date when the letter of credit will be paid off is extended to December, 2016, and the increase will be higher to include paying off the letter of credit.

The recommendation for the July 1, 2015 increase is to move from 110% of the CDC contract rate to 130% of the CDC contract rate. Even after the recommended July 1 increase, WVA rates should be on average 6.6% lower than the CDC private market survey rates. Chad noted that we want to continue to monitor the financial value of the program and review the difference between the private market rate and the CDC contract rate.

The grid will be published on the WVA website with the effective dates announced and notifications before May 1 to provide the 60 days-notice to providers and payers, for an effective date of July 1.

Margaret and Jan noted that the level of the July assessment level increase is temporary, about 18 months. This period will allow us to pay down the letter of credit and rebuild the reserve that the Board has suggested to assure adequate funding is available to manage the fund transfers to support the program.

New HPV-9 Gardasil Vaccine

Jan addressed the process for a vaccine to be added to the childhood vaccine program. First a product needs to be approved by the FDA (the FDA approved HPV-9 in December, 2014). Then the Advisory Committee on Immunization Practices (ACIP) votes and develops a schedule for usage, and the CDC adds the vaccine to the Vaccine for Children Program. Then CDC posts written documentation of the ACIP recommendations in the Morbidity and Mortality Weekly Report (MMWR). After that the vaccine has to be added to the CDC contract, which the CDC negotiates with manufacturers. Each year negotiations occur and new pricing for vaccines is announced on April 1.

Once the vaccine is available on the CDC contract, it is available for the state to purchase in the vaccine program and is added to the VFC program. The DOH needs to take a number of steps to update their systems and introduce it into the program. Jan noted that the licensure is different than the current product. For males, the new HPV is licensed only from 9 – 15 years of age; for the state program the recommendation is for 9 – 18. Both HPV products will need to stay on the market. Most providers would wait until the new vaccine is available through the Childhood Vaccine Program, rather than order it privately only for one month.

The Operations Committee's criteria for adding a new vaccine is a CPT code, FDA approval, vaccine availability and pricing or a reasonable proxy for pricing. In the case of HPV-9, all criteria are met. The vaccine is expected to be available in the market this spring, possibly May 1, and will be on the CDC contract on April 1, so we will have CDC pricing as of April 1.

The Committee considered waiting until the July 1 assessment changes are implemented to add HPV-9 so providers and payers only need to update the grid once. The Committee determined, however, that this introduced too much financial risk to the WVA. For the period from when HPV-9 is available in the state program providers could use it, no assessment would be coming in to cover that cost.

The new HPV-9 Gardasil vaccine, covers nine HPV types, five more than the Gardasil versions available today. This is an expensive vaccine, up to $137.00 / dose. Because we assess for vaccines on a dosage basis, providers could administer the vaccine when available in the program around May 1, but no funds would come in to support the purchase of the vaccine because the CPT code and pricing is not on the current grid. The cost could be $1M / month.

The Committee agreed that due to the financial implications, the new HPV vaccine should be added to the grid as of May 1, 2015. HPV-4 would continue to be available due to the licensure differences. The Department will try to educate providers not to order equal amounts of HPV-4 and HPV-9. Jan said we will have the final contract price April 1, the DOH will not start distributing the vaccine until May 1.

The Operations Committee has agreed to a 60-day notice but in this case we won't have pricing information until April 1. The Committee agreed to use proxy pricing so we have a reasonable rate as of March 1 Then we can adjust in rate in July. The payers agreed on this approach.

The committee agreed to develop and communicate a reasonable rate as of March 1, so plans can adjust their systems and be ready as of May 1 to pay assessments that come in, knowing that the assessment level would be adjusted in July.

Plans agreed to review their internal policies on paying for new vaccines.

There being no further business, the meeting was adjourned at 2:50 p.m.