

# Strategies to Address Policy Barriers to Adult Immunizations in Federally Qualified Health Centers

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## INTRODUCTION

This White Paper outlines policy barriers and strategies that specifically impact Federally Qualified Health Centers (FQHCs) in their efforts to increase adult immunizations rates among their medically underserved patients. In a previous White Paper published in 2019 by NACHC and sponsored by the National Adult Immunization and Influenza Summit, *Strategies to Address Policy Barriers to Adult Immunizations in Federally Qualified Health Centers*, a wide range of policy barriers and opportunities that impact FQHCs' ability to immunize adults were identified and explored.<sup>1</sup> To develop the content and focus of that paper, we spoke with: clinical, pharmacy, and administrative staff from FQHCs; state associations of FQHCs (called Primary Care Associations, or PCAs); staff of two policy-focused organizations whose work includes immunizations; staff from state and local health departments; and policy staff from the Federal Department of Health and Human Services, including the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), and the Health Resources and Services Administration (HRSA). We also reviewed relevant policy documents and incorporated qualitative information surrounding FQHC practices around adult immunization. The guiding principles for the work surrounding adult immunizations were based on the Standards for Adult Immunization Practice by the Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention (CDC.) National Vaccine Advisory Committee (NVAC).<sup>2</sup>

Our research for the 2019 publication identified a wide range of barriers and opportunities that impact FQHCs' ability to meet the Standards for Adult Immunization Practice. Many of these are specific to FQHCs, as they involve programmatic, policy, and/or reimbursement rules that generally apply only to them. However, we also identified several barriers and opportunities that impact not only FQHCs, but many other types of providers who seek to increase adult immunization rates. At that time, the White Paper focused on issues specific to FQHCs, but also may be shared among many provider types. They included:

### BARRIERS:

- Immunization Information Systems (IIS), including lack of availability, lack of bi-directional interface capabilities, lack of real-time data access, and lack of registry access across state lines.
- Physical storage of vaccines—such as the need for space, proper equipment, ongoing monitoring of temperature and the costs associated.
- Inventory management of vaccines—staff time, burden, and cost of vaccine inventory and potential wastage of short-dated vaccines or mismatched stock levels.

### OPPORTUNITIES:

- Availability of free adult immunizations under Section 317 funding.
- Universal purchasing programs, which allows for the purchase of vaccines for both adults and pediatrics at lower costs by collecting funds from health plans, insurance companies, and other payers up front.
- Training and technical assistances around vaccine storage and inventory management systems to assist with workflow and cost.
- Focus on Adult Immunizations as a quality improvement measure, similar to the pediatric measures currently required in the Patient-Centered Medical Home recognition process (ARQ11, NCQA Standards 2017.)

**The aim of this White Paper is to revisit the context in which the 2019 barriers and opportunities were explored and mostly still remain. A contrast and comparison of the opportunities and barriers between then (2019) and now (2024) will be provided, with some additional categories offered.**

## WHAT MAKES FQHCs UNIQUE?

Federally Qualified Health Centers (FQHCs)—commonly referred to as Community Health Centers—are the backbone of America’s primary care safety net. With nearly 15,000 sites nationwide, health centers provide high quality, affordable primary care to over 31 million medically underserved individuals.

### By law and by mission, all health centers:

- **Target the neediest individuals:** By law, all FQHCs serve high-need areas or populations, where poverty is high and/or caregivers are scarce. Nationally, 49.4% of FQHC patients are on Medicaid, 18.6% are uninsured, 10.9% are on Medicare, and of the 19.8% who have private insurance, many struggle to meet their deductibles and copays.
- **Offer a broad range of health care and enabling services:** FQHCs offer a broad range of services—medical, dental, behavioral, and preventive. They also provide services that enable individuals to access health care services appropriately (e.g., translation, health/nutrition education, community outreach, transportation, and patient case management) even though they are rarely covered by insurance.
- **Turn no one away due to inability to pay:** FQHCs offer the full range of services to every individual, regardless of insurance status, income, diagnosis, language, or other factors. Almost 70% of health center patients have incomes below the Federal Poverty Level (FPL); if these individuals are uninsured or underinsured, they pay no more than a nominal fee. Another 23% of FQHC patients have incomes between 101% and 200% FPL; if uninsured or underinsured, these individuals are charged based on a sliding fee scale.
- **Community-based and governed:** Each FQHC is governed by a patient-majority board, which ensures that it is both reflective of and responsive to the unique needs of its community. The fact that FQHCs are rooted in their communities makes them a trusted provider among the medically vulnerable populations they serve.

## STATUTORY AND HRSA REQUIREMENTS FOR FQHCs

### Background

*FQHCs must adhere to the requirements laid out in Section 330 of the Public Health Service Act, and overseen by HRSA*

To qualify as an FQHC, a clinic must generally be determined by the Federal government as meeting the requirements outlined in Section 330 of the Public Health Service Act (“Section 330”).

The Section 330 Program is overseen by the Health Resources and Services Administration (HRSA), an agency of the Federal Department of Health and Human Services. Within HRSA, the unit charged with Section 330 administration and oversight is the Bureau of Primary Health Care (BPHC).

Section 330 requirements are extensive and are laid out in detail in the Health Center Compliance Manual<sup>3</sup> produced by HRSA. These requirements cover a wide range of issues, including clinical care, financial management, and governance.

To bridge the healthcare gap for vulnerable populations, Section 330 directs funding strategically. **A majority** of health center funding is allocated to FQHCs serving

all medically underserved communities in their area. [Within this framework](#), two dedicated streams focus on specific needs: migrant and seasonal farmworkers and individuals experiencing homelessness. Additionally, a small percentage of funding supports Public Housing Primary Care Health Centers. Notably, all FQHCs operate under Section 330 requirements, upholding a comprehensive commitment to serving underserved populations.

### *Section 330 explicitly requires FQHCs to provide immunizations*

Section 330(b)(1)(A)(i)(III)(dd) states that all FQHCs are required to provide their patients with “immunizations against vaccine-preventable diseases”.<sup>4</sup>

### *HRSA requires FQHCs to report annually on several vaccination measures*

Section 330(k)(3)(I)(ii) requires FQHCs to report such data “as the Secretary may require”.<sup>5</sup> Based on this authority, HRSA requires FQHCs to submit detailed, standardized quantitative data on an annual basis. This data set—called the Uniform Data System (UDS)—is posted online<sup>6</sup>, and can be viewed at the national, state, and individual health center level. UDS data addresses a broad range of issues, such as patient characteristics, clinical activities, and financial performance.

As part of their annual UDS submissions, FQHCs are required to report to HRSA on three activities involving immunization:

- The number and percentage of children 2 years of age who received age-appropriate vaccines by their 2nd birthday.
- The total number of visits during which an influenza vaccine was provided, and the total number of patients who received it.

- The total number of visits during which other specified vaccines (e.g., MMR, DTap) were provided, and the total number of patients who received one or more of them.

The specific measures, along with calendar year 2022 national data, are below. Note that this data was based on a total patient population served of approximately 27 million persons, of whom around 18 million were ages 18 and above.

From UDS Table 6B, Quality of Care measures<sup>7</sup>:

<b>SECTION C—CHILDHOOD IMMUNIZATION STATUS</b>					
<b>Childhood Immunization Status</b>		<b>Total Patients with 2nd Birthday (a)</b>	<b>Estimated Number of Patients Immunized (b)</b>	<b>Estimated % patients immunized (c)</b>	
10.	Percentage of children 2 years of age who received age-appropriate vaccines by their 2nd birthday	385,264	128,032	33.23%	

From UDS Table 6A—Selected Diagnoses and Services Rendered<sup>8</sup>:

<b>CATEGORY</b>		<b>APPLICABLE ICD-10-CM CODE OR CPT4/II CODE</b>	<b>NUMBER OF VISITS (A)</b>	<b>NUMBER OF PATIENTS (B)</b>
24.	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal; diphtheria; tetanus; pertussis (DTaP) (DTP) (DT); mumps; measles; rubella (MMR); poliovirus; varicella; hepatitis B	CPT-4: 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748	4,621,374	3,418,527
24a.	Seasonal flu vaccine	CPT-4: 90630, 90653 through 90657, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90688, 90749, 90756	4,585,714	4,216,078

Please note the following points about these measures:

- The first set of measures is specific to children (2-year-olds). The other two measures incorporate adults but could also include children. For example, the total number of influenza vaccines includes those given both to children and adults.
- The child measure (percentage of children who received age-appropriate vaccines by their 2nd birthday) is a standardized, commonly used measure; the National Committee for Quality Assurance (NCQA) is the “Measure Steward”, and it is used by the Centers for Medicare and Medicaid Services (CMS). For more information, see page 91 of HRSA’s [2022 UDS Manual](#).<sup>9</sup>
- In contrast to the child measure, the two measures that include adults (influenza and other vaccines):
  - o Are not commonly used measures. NCQA does not manage them, and neither Medicare nor Medicaid requires them as standard measures.
  - o Do not mirror NVAC standards, in terms of linking specific vaccines to specific age groups or at-risk populations.
  - o Are raw numbers as opposed to a percentage of the eligible patient population.

### ***HRSA incentivizes FQHCs’ performance on the childhood immunization measure, but not the immunization measures that include adults***

Another important distinction between UDS immunization measures is the incentives for FQHCs to report complete and accurate data, and to demonstrate strong clinical performance.

Within the UDS, HRSA has identified a subset of measures as “Clinical Quality Measures” (CQMs)<sup>10</sup>. For the past several years, HRSA has provided public recognition as well as supplemental grant funding<sup>11</sup> to FQHCs based on their performance on these CQMs. For 2017, funding and recognition were provided to:

- “National Quality Leaders”—FQHCs who exceeded national clinical quality benchmarks (including Healthy People 2020 goals<sup>12</sup>) for:
  - chronic disease management,
  - specific types of preventive care, and/or
  - perinatal/prenatal care (percent of women who received care in the first trimester, and percent of infants with low birth weight)
- “Health Center Quality Leaders”—FQHCs who achieved the best overall clinical performance among all health centers for CQMs.
- Clinical Quality Improvers—FQHCs who made at least a 10% improvement in one or more CQMs between from year to year.

HRSA considers the childhood immunization measure to be CQMs, and as a result, it is one factor used to determine which FQHCs receive these recognitions and supplemental grant funding each year. In contrast, the two UDS measures that include adult immunizations are not considered CQMs, and there are no financial or programmatic consequences associated with performance on the measures.

### ***Individuals who receive immunization(s)—but no other services—from an FQHC are not considered FQHC “patients” by HRSA***

HRSA has a detailed definition about when an individual can be considered a “patient” for UDS purposes. For example, an individual who receives only an immunization(s) from an FQHC is not considered a FQHC “patient.” Note that in their applications to HRSA (which FQHCs must submit at least once every three years), FQHCs must indicate how many “patients” they expect to serve. HRSA closely monitors how FQHCs’ actual patient numbers compare to their estimates, and some FQHCs are concerned that failure to reach their estimated number of patients could put some of their HRSA grant funding at risk in the future.

### ***FQHCs likely under-report their actual immunization activity***

There are reasons to suspect that FQHCs’ UDS data around immunizations—particularly adult immunizations—may understate their actual activities in this area. These include:

- *Documentation does not “roll up” into aggregate data:* Many FQHCs document immunizations in a free-text entry field in the electronic health record (EHR). Because data entered in free-text fields does not “roll up” into aggregated data, this suggests that immunization rates could be significantly understated.
- *Immunizations provided to “non-patients” may not be counted:* Many FQHCs engage in community health fairs and outreach campaigns through which

they offer immunizations to the general public. As discussed above, individuals who are vaccinated at these types of events are not counted as “patients” unless they receive other health care services from the FQHC. For this reason, some FQHCs may not include vaccines provided at such events in their UDS reports.<sup>13</sup>

**Section 330-related strategies to increase adult vaccination rates among FQHC patients:**

- 1** *HRSA could add a composite adult immunization measure(s) to the data that FQHCs must report annually to HRSA, exploring the 2019 HEDIS Prenatal composite measure, or MIPS or MSSP recommendations.*

Including a measure of adult vaccination in UDS would likely encourage FQHCs to expand their focus on this issue. One option would be for HRSA to adopt the following composite measure, which is currently being used in the Indian Health Service:

**Vaccines Included in Adult Immunization Composite Measure**

AGE GROUP	VACCINES INCLUDED	OPTIONAL
19-59	Tdap ever; Tdap or Td within 10 years (Tdap/Td)	Influenza
60-64	Tdap/Td; Zoster	Influenza
≥ 65	Tdap/Td; Zoster; Pneumococcal polysaccharide-23 (PPSV-23) or pneumococcal conjugate (PCV-13)	Influenza

Another option would be using the new HEDIS composite measure, initiated in 2019, of prenatal immunization status, which indicates the percentage of deliveries during the measurement period in which women received both an influenza and Tdap vaccine.<sup>14</sup>

Another option could be exploring the composite measure recommended for the Medicaid Core Set that has yet to be adopted. Pointing towards the MIPS and MSSP could be a starting point. For context, the MIPS Quality ID #493 (NQF 3620): Adult Immunization Status reads: Percentage of patients 19 years of age and older who are up to date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap); zoster; and pneumococcal.<sup>15</sup>

- 2** *HRSA could consider performance on the adult immunization measure when determining which FQHCs receive supplemental grant funding and/or public recognition.*

As discussed above, HRSA provides public recognition and supplemental grant funding<sup>16</sup> to FQHCs who perform well on specified Clinical Quality Measures. For example, funding has been awarded based on FQHCs’ overall performance on CQMs, and specifically on their performance related to preventive care CQMs and already do this in the childhood immunization space.

HRSA could make a measure of adult immunization an official CQM. This would align with existing CQMs because the childhood immunization measure is already a CQM. Once this is done, performance on this measure would automatically be considered when HRSA rewards FQHCs for overall clinical performance. HRSA could also choose to make awards based specifically on this measure either alone, or in combination with related measures such as those involving preventive care. As discussed above, HRSA already makes awards based on specific areas of CQMs, such as prenatal and perinatal care.



**3** *Outside groups could incentivize FQHCs to focus on adult immunization by offering funding and/or public recognition linked to adult immunization rates.*

Even if HRSA agrees to add an adult immunization measure to mandatory UDS reporting, and to consider performance on this measure when rewarding clinical performance, it would still take several years for these changes to become effective. In the shorter term, outside groups could incentivize FQHCs to focus on adult immunization by offering funding and/or public recognition to those who significantly expand their activity and performance in this area. These funders could work directly with individual FQHCs, or could work through FQHC organizations such as:

- State-based associations of FQHCs, called Primary Care Associations (PCAs)<sup>17</sup>
- Organizations that represent FQHCs serving high-risk populations<sup>18</sup>, such as migrant and seasonal farmworkers, and individuals experiencing homelessness.

Also, as previously mentioned, EHR changes might be needed to ensure that adult immunization data can be effectively aggregated.

**4** *Outreach and support could be targeted to FQHCs that focus on specific at-risk populations.*

NCQA has a current measure around Tdap for prenatal patients. Using the workflows, outcomes, award-model and other such factors could assist more entities to recognize and award efforts.

## FTCA: FEDERALLY-SUPPORTED MEDICAL MALPRACTICE INSURANCE FOR FQHCs

### Background

#### ***Section 330 grantees receive free medical malpractice insurance through the Federal Torts Claims Act (FTCA)***

FQHCs that receive grant funding under Section 330 of the Public Health Service Act (the “grantees”, which represent roughly 85% of all FQHCs) also receive free medical malpractice insurance through the Federal government. This coverage is provided through the Federal Torts Claims Act, and it applies to the FQHC’s employees and contractors, as well as volunteer providers whom the FQHC has registered with HRSA.

The Federal government has detailed rules about which patients, services, and providers are covered under FTCA, and FQHCs must purchase supplemental insurance to cover activities that which are not eligible for FTCA coverage.

#### ***FTCA malpractice coverage applies to community-focused immunization campaigns***

As a general rule, FTCA only covers services provided to individuals who have a face-to-face visit with a provider at a standard FQHC location. However, HRSA makes an explicit exception to this rule for community-focused immunization campaigns. In its FTCA Policy Manual<sup>19</sup>, HRSA states explicitly that FTCA coverage applies when “On behalf of the health center, health center staff conduct or participate in an event to immunize individuals against infectious illnesses. The event may be held at the health center, schools, or elsewhere in the community.”

#### ***FTCA malpractice coverage is available for clinicians who volunteer at FQHCs***

Clinicians frequently cite the lack of malpractice coverage as a barrier to volunteering their services. Fortunately, Congress recently eliminated this barrier for FQHCs. Since late 2017, clinicians who volunteer at FQHCs can receive FTCA coverage, provided that the FQHC submits the appropriate documentation to HRSA in advance.<sup>20</sup>

FQHCs can bill insurers—including Medicaid and Medicare—for services provided by volunteer clinicians in the same manner that they bill for services provided by employees and contractors. (This ability predates the 2017 law extending FTCA to qualified volunteer providers.)

#### ***Updated policy since COVID-19 that positively impacts workforce***

There were great challenges but also some successes with extending workforce personnel and roles during the COVID-19 pandemic. In 2023, the Senate Appropriations committee authorized the permanent extension of FTCA



protections for certain health professional volunteers at community health centers.<sup>21</sup> This helps expand and prolong the FQHC workforce and extend important FTCA protections to volunteers, giving them and the health center unique benefits. First, by utilizing volunteers, health centers can invest in other areas of their health center (staff, supplies, provision of services, capital projects, to name a few). Second, in the rare instance of a civil lawsuit towards an individual or organization, these are considered federal employees and therefore Department of Justice, would be in place to defend (instead of private counsel). This can save a health center dramatically on legal fees.

## MEDICAID

While researching for the former 2019 White Paper, the most common barrier to increasing adult immunization rates among Medicaid patients reported by FQHCs was the “lack of Medicaid reimbursement.” Currently, per the 2022 MAC Report:

“Under current law, Medicaid enrollees in the new adult group have coverage of all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) without cost sharing, but coverage of vaccines for other adults in Medicaid is optional, and states can determine which vaccines to cover and whether to apply cost sharing.

These differences in vaccine coverage policies among adult eligibility groups have resulted in unequal access to some ACIP-recommended vaccines. For almost two out of every five (38.2 percent) Medicaid-enrolled adults, vaccine coverage is optional and varies by state. This includes adults eligible on the basis of disability, those age 65 and older, parents and caretaker relatives, and pregnant women.<sup>22</sup>

*Technically, Medicaid does pay FQHCs for vaccines, as it includes a small amount of reimbursement towards these costs every time it provides a per-visit payment under the FQHC Prospective Payment System (PPS). However, some immunization-only visits with providers such as nurses and pharmacists generally do not result in a full PPS per-visit payment, and FQHC staff often do not recognize that they are being reimbursed for these costs.*

## Background

### How FQHCs are Reimbursed Under Medicaid

#### *The FQHC Medicaid PPS rate*

Most free-standing outpatient providers are reimbursed for services provided to Medicaid

recipients according to the Medicaid “fee schedule.” Under this approach, providers submit a claim for each visit, which lists the CPT billing codes for every service provided during the visit. The Medicaid agency has a specific reimbursement amount associated with each CPT code and reimburses the outpatient provider accordingly. For example, if a claim contains three CPT codes (indicating that three distinct services were provided), Medicaid will determine the payment associated with each code, total them, subtract any patient copay amount, and reimburse the provider the remainder. Thus, the reimbursement for each visit varies based on which CPT codes were listed, and the reimbursement amount associated with each.

Federal law requires State Medicaid agencies to reimburse FQHCs and Rural Health Clinics (RHCs) differently from most free-standing outpatient providers. Section 1902(bb) of the Social Security Act establishes a unique payment system for FQHCs and RHCs. Under this system—commonly referred to as the Prospective Payment System (PPS)—FQHCs and RHCs are paid a single rate for each “billable visit,” regardless of the number or type of services provided during that visit. Thus, Medicaid pays an FQHC the same amount for a visit that generates only a single CPT code as for visit which includes multiple services such as laboratory work, X-rays, and immunizations. This per-visit payment rate is known as the FQHC’s PPS rate and is meant to reflect the health center’s average cost per billable visit.

#### *How a “billable visit” is defined under the FQHC Medicaid PPS*

Federal law requires that any visit that includes a face-to-face interaction with at least one of the six types of “core” providers (physicians, PAs, NPs, CNMs, clinical psychologists, and clinical social workers) must count as a billable visit.

Beyond this basic requirement, State Medicaid agencies have flexibility in how to define a billable visit. For example:

- FQHC patients will often have face-to-face encounters with both a physical health provider and a mental health provider on the same day. Each state’s Medicaid agency decides whether to allow the FQHC to bill for one PPS payment or two for that patient that day.
- Many state Medicaid programs cover services from outpatient providers beyond the six “core” types listed above—e.g., doula services<sup>23</sup>, treatment for substance use disorders, offer transportation to and from medical appointments, expanded adult dental benefits.<sup>24</sup>
- Marriage and Family Therapists, licensed Professional Counselors. In these situations, Federal law requires that the costs associated with these additional provider types be included in the calculation of each FQHC’s PPS rate (i.e., in the numerator above). However, each state can decide whether to count face-to-face encounters with these providers as “billable visits” (i.e., in the denominator above.)

Relevant to the discussion of adult immunizations, States have the option to count nurse-only and pharmacist-only visits as billable visits but are not required to do so. See the discussion below on the steps involved in establishing nurse-only or pharmacist-only visits once a PPS rate has been established.

Since the publication of the former paper in 2019, several Medicaid-specific reports have been produced by other entities to both inform Congress and CMS landscape, but also provide recommendations to ensure adequate payment for vaccine-only visits. These reports include the Medicaid Provider Reimbursement Rates report<sup>25</sup> and the March 2022 MACPAC Report on Medicaid and CHIP.<sup>26</sup> Those recommendations will be discussed later.

## Adult Immunizations and the FQHC Medicaid PPS

### ***Medicaid does pay FQHCs for adult immunization—but indirectly in most states.***

Technically, it is inaccurate to state the “Medicaid doesn’t pay for adult immunization.” As discussed below, all costs associated with adult immunization (including vaccine cost, supplies, and provider time) are included in the “Total Allowable Costs” used to calculate a FQHC’s PPS rate.

As a simplified example, imagine a FQHC whose total costs—excluding adult immunization—were \$1,000 in

their base year. If that FQHC had 10 “billable visits” per year, then their PPS (without adult immunization) would be \$100 per visit. Now assume their adult immunization costs for the base year were \$50, bringing total costs to \$1,050, across the same 10 billable visits. Now the PPS rate is \$105. In other words, the FQHC gets an additional \$5 for every visit to help cover its overall costs to provide adult immunization—regardless of whether any adult immunizations were provided during a specific visit.

This is why policy officials in CMS and State Medicaid Agencies disagree with claims that “Medicaid does not pay for immunizations at FQHCs.” They point out that funding to cover adult immunization costs is included in every PPS payment. On the other hand, from the FQHC perspective, it can seem like Medicaid does not pay for adult immunization because:

- The FQHC gets paid the same amount for a patient visit with a physician, etc., regardless of whether or not immunizations are provided, and
- If a patient has a separate appointment just to get immunizations, such as with a nurse or a pharmacist, FQHCs generally are not permitted to claim this as a “billable visit”—and thus do not receive any additional Medicaid payment for this appointment. (The only exception is the few states which pay for nurse-only or pharmacist-only visits, as described previously.)

### ***To make immunization-only visits with nurses and pharmacists (“nurse/pharmacist immunization-only visits”) separately billable for FQHCs, states must (re) calculate each FQHC’s PPS rate.***

Federal statute gives state Medicaid agencies the option to allow FQHCs to bill separately for immunization-only visits with nurses or pharmacists (hereafter referred to as “nurse/pharmacist immunization-only visits”). However, when implementing this option, the state must comply with these two statutory requirements:

- Payment for these visits must be made via the PPS, not the fee schedule, and
- Immunization-only visits must be included in the calculation of PPS rates.

As discussed above, making nurse/pharmacist immunization-only visits separately billable under PPS will increase the total number of visits in the PPS calculation (the denominator in the equation above)—which in turn decreases the per-visit PPS payment. If PPS rates are not adjusted to reflect this higher number of visits, then total payments to FQHCs would increase above total reasonable costs—which would be inconsistent with the statute (and also likely to be opposed by both the State Medicaid agency and CMS).

For this reason, deciding to make nurse/pharmacist immunization-only visits separately billable under PPS would require a state to recalculate all its FQHCs' PPS rates. Depending on the state, recalculating these rates often entails significant administrative effort and potential costs for the Medicaid agency, for reasons unrelated to adult immunizations.

***The administrative effort and financial impact involved in recalculating FQHCs' PPS rates varies by state.***

The level of administrative effort and the financial impact involved in recalculating FQHCs' PPS rates varies by state, as does basic Medicaid coverage. In 2023, Avalere produced a report summarizing what each state coverage policy looks like.<sup>27</sup> Some states are proactive about adhering to the statutory requirement to update their PPS rates when there are changes in the types of services health centers provide; for example, Arizona recalculates these rates every three years. In states like this:

- The Medicaid agency already has a “change in scope” process in place to handle the administrative tasks involved in updating rates—e.g., collecting and analyzing cost reports.
- Changes in reasonable costs—including those due to inflation and to changes in scope and intensity—have been factored into PPS rates regularly, so there is unlikely to be a large gap between the costs on which current PPS rates were based and reasonable costs at present.
- The Medicaid agency is more likely to have already considered requests from other groups that are interested in changing the PPS methodology (e.g., other provider types that would like to qualify for “billable visits,” such as MFTs and LPCs.)

In these types of states, convincing policymakers to make nurse/pharmacist immunization-only visits separately billable would be relatively straightforward, because the administrative, policy, and financial impacts would be relatively small.

However, other state Medicaid agencies have not updated their FQHC PPS rates in many years, and/or have updated the rates for only a few FQHCs. Medicaid agencies in these states would face many administrative and financial hurdles to updating PPS rates.

To determine the level of effort involved in recalculating FQHC PPS rates in a specific state, individuals are strongly encouraged to contact the state association of FQHCs, or their Primary Care Association. Contact information for each state’s PCA is available online.<sup>28</sup>

**Medicaid strategies to increase adult vaccination rates among FQHC patients (unchanged from 2019):**

**1 *Make nurse/pharmacist immunization-only visits “billable visits” under the FQHC Medicaid PPS.***

As discussed, State Medicaid agencies have the option to count nurse/pharmacist immunization-only appointments as “billable visits” which result in a PPS (or per-visit) payment to the FQHC.

However, few states take advantage of this option, because **adding a new category of billable visit requires recalculating each FQHC’s PPS rate** and can entail significant administrative and financial costs for many states. To determine the impact and likelihood of success in a specific state, individuals interested in this approach are strongly encouraged to contact the state’s PCA.

**2 *Permit FQHCs to bill for immunization-only visits outside of the FQHC PPS, using an APM.***

While the PPS statute requires that immunization costs be included in PPS calculations, State Medicaid agencies could establish an APM where immunizations are removed from the PPS calculations and reimbursed separately.

However, establishing this type of APM would be a significant undertaking for a state. Among other steps, the state Medicaid agency must:

- Obtain the approval of each participating FQHC.
- Recalculate participating FQHCs’ PPS rates to remove the costs of immunizations. This entails all the steps outlined above.
- Determine and implement a new methodology to reimburse for immunizations.
- Ensure that the new system will not decrease total reimbursement to the FQHCs.
- Obtain CMS approval for the change.

## MEDICARE

### The Medicare PPS for FQHCs

#### *How the Medicare FQHC PPS compares to the Medicaid FQHC PPS*

As in Medicaid, Medicare reimburses FQHCs using a flat, predetermined amount for each billable visit. This system—which is also called a PPS, as in Medicaid—is relatively new, having been implemented in 2014 and 2015. In contrast, the Medicaid FQHC PPS was implemented in 2002.

The Medicare PPS has some significant differences from the Medicaid PPS. Most notably:

- There is a single Medicare PPS rate for all FQHCs across the country. This national rate varies only as follows:
  - It is adjusted slightly to reflect cost differentials in different geographic areas; and
  - It is increased by 34.16 percent when a patient is new to the FQHC, or an Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) is furnished. Medicare has standardized, national rules regarding which types of visits trigger a PPS payment (in other words, what constitutes a “billable visits.”)

The Medicare PPS rate was set using a similar methodology as the Medicaid PPS rates, except that it was done on a national level, instead of a FQHC-specific level. CMS took total allowable costs for all FQHC services provided in a base year and divided them by total billable visits, resulting in the national Medicare PPS rate. Only encounters that meet the definition of a “billable visit” trigger a Medicare PPS per-visit payment.

#### *How a “billable visit” is defined under the FQHC Medicare PPS*

Medicare defines a billable visit as a face-to-face interaction with at least one of the six types of “core” providers. Importantly — and unlike under Medicaid — face-to-face visits with certified diabetes self-management training (DSMT) providers, and with medical nutrition therapy (MNT) providers also count as billable visits. DSMT providers may include registered nurses, registered dietitians/nutritionists, pharmacists, or other healthcare professionals holding certification as a diabetes educator (CDE) or board certification in advanced diabetes management (BC-ADM). MNT may be provided by a registered dietician or nutritionist.

Since Medicare is a national program, there is no state flexibility to expand the definition of billable visits, as there is in Medicaid. Additional information on the Medicare FQHC can be found on their website.<sup>29</sup>

### Adult Immunizations and Medicare Reimbursement

#### *The costs of most — but not all — immunizations are included in FQHCs’ PPS rates*

With two important exceptions, the cost of all immunizations is included in FQHCs’ Medicare PPS rates. The two exceptions are influenza and pneumococcal vaccines, which FQHCs can bill and be reimbursed separately from (and in addition to) their PPS payments, via the annual Cost Report process. (See the next section for a discussion of the Cost Report process.)

This is different from how Medicare reimburses most outpatient providers for vaccines. For non-FQHCs, Medicare reimburses them directly for influenza, pneumococcal, and hepatitis B vaccines under the Part B, and for other vaccines under Part D. However, FQHCs are not permitted to bill for any vaccines under Part D, or under standard Part B processes; rather, influenza and pneumococcal vaccines are reimbursed via the annual Cost Report, and other vaccines are folded into PPS reimbursement rates.

#### *How FQHCs are reimbursed for the costs of influenza and pneumococcal vaccinations*

Medicare reimburses FQHCs for influenza and pneumococcal vaccination through their annual Cost Reporting process. At the end of its 12-month “cost reporting period”, each FQHC is required to submit a Cost Report<sup>30</sup> to their Medicare Administrative Contractor (MAC). In this report, they can list 100% of their “reasonable costs” associated with both the vaccines themselves and for administering them. Once the MAC reviews and approves the Cost Report, the FQHC is reimbursed for their vaccine-related costs.

Due to this reimbursement structure, FQHCs can face significant delays between the time influenza and pneumococcal vaccines are provided, and when they receive Medicare reimbursement. As stated above, each FQHC’s Medicare cost reporting period (CRP) is 12 months, and FQHCs have five months following the end of a



CRP to submit their Cost Report to the MAC. The MAC then typically takes several weeks to review the report and issue reimbursement. Thus, up to 18 months can pass between the time an influenza or pneumococcal vaccine is administered to a Medicare patient and when the FQHC receives the reimbursement.

## Medicare-related strategies to increase adult vaccination rates among FQHC patients:

- 1 *Inflation Reduction Act ends cost sharing for ACIP-recommended vaccines (new, as of 2023)***  
 Effective January 2023, Medicare Part D plans may no longer impose cost-sharing for vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), as part of the Inflation Reduction Act.<sup>31</sup> The cost sharing activities previously included deductibles or co-insurance, posing as a financial barrier for many patients. The vaccines now covered under Medicare Part D are shingles; tetanus/diphtheria (Td); tetanus/diphtheria/pertussis (Tdap); hepatitis A; and hepatitis B. (Influenza, pneumococcal, and COVID-19 were already covered without cost-sharing under Medicare Part B).
- 2 *FQHCs could maximize nurse/pharmacist visits for influenza and pneumococcal and COVID-19 vaccines for Medicare patients***  
 Because reimbursement for influenza and pneumococcal vaccines is made outside of the Medicare PPS, this reimbursement is not subject to the PPS rules around “billable visits.” In other words, the FQHC is reimbursed separately for these services, regardless of whether they are provided in conjunction with a face-to-face visit with a “billable provider,” such as a physician. For this reason, FQHCs can focus on maximizing the use of nurse/pharmacist visits for influenza and pneumococcal vaccines with the knowledge that they will be fully reimbursed for these services.
- 3 *To reduce delays in reimbursement for influenza and pneumococcal vaccines, CMS could permit FQHCs to bill for these vaccines under the Part B fee schedule at time of service, as long as these interim payments are later reconciled with their Cost Reports***  
 CMS could permit FQHCs to bill Part B directly for the cost of these vaccines immediately following the date of service; this is similar to how FQHCs bill for other services covered under Part B. The MACs could then provide interim reimbursement to the FQHC based on national fee schedule rates for these vaccines. However, if this approach were pursued, it is important that these interim payments be reconciled to the FQHCs’ reasonable costs during the Cost Reporting process, so that FQHCs are made whole for any costs that exceed the fee schedule reimbursement.

## PHARMACY

### Background

***A growing percentage of FQHCs have “in-house” pharmacies, and many of these serve non-FQHC patients***

The term “in-house” means that the pharmacy is owned and operated by the FQHC; such pharmacies can be co-located with a care delivery site, or at a separate location. Some in-house pharmacies are “closed-door,” meaning that they serve only the FQHCs’ patients, while others are “open-door,” meaning that they also serve members of the general public as well.

***A growing number of FQHCs are implementing clinical pharmacy programs***

Clinical pharmacists generally work directly with physicians, other providers, and patients to ensure that the medications prescribed for patients contribute to the best possible health outcomes. A growing number of FQHCs are implementing clinical pharmacy programs, often with a special focus on diabetes, controlled substances, and patients taking multiple medications. These clinical pharmacists often work collaboratively with patients’ “core” providers to make medication changes, request lab work, or add additional therapeutic modalities.

## Pharmacy-related strategy to increase adult vaccination rates among FQHC patients:

Under the PREP Act during the Public Health Emergency, pharmacists and pharmacy techs were given authority to be immunizers.<sup>32</sup> This flexibility ends December 2024, but has given the opportunity to the local (pharmacy/health center), state (workforce/licensing boards) and federal workforce, and licensing boards to explore the impact that pharmacists and pharmacy techs have on vaccine access, especially for adults. Pharmacists are not currently recognized as providers by Medicare under the Social Security Act. However, 13 states recognize pharmacists as providers, including allowing reimbursement under their state Medicaid programs.<sup>33</sup>

### ***FQHCs could explore the role of in-house and clinical pharmacists in recommending and administering adult vaccines.***

According to recent research, 14% of all vaccines provided to FQHC patients were administered by in-house pharmacy staff. Given that at least one-third of FQHCs currently have in-house pharmacies, this suggests that there may be opportunities for FQHCs to expand adult immunization rates by expanding the role of in-house pharmacists in this process. Specifically, in-house pharmacists (both clinical pharmacists and those working the pharmacy) can potentially:

- Review patient records to determine which vaccines might be appropriate for each patient.
- Recommend specific vaccines to patients and/or their care providers; and
- Administer vaccines.

FQHCs considering this strategy should consider the following:

- ***Variations in state law:*** While most states allow pharmacists to provide immunizations, there are important differences in states' rules<sup>34</sup> on

issues such as the age of the patient, whether a prescription must be provided, etc

- ***Medicaid:*** As discussed above, costs associated with adult immunization are incorporated into Medicaid PPS (aka per visit) payment rates, and in most states, Medicaid will not make a separate PPS payment for services provided by a pharmacist. (This is similar to the discussion about nurse-only visits.)
- ***Medicare:*** As discussed in the section on Medicare:
  - Medicare prohibits FQHCs—and their pharmacists—from billing Part D for vaccines.
    - For influenza and pneumococcal vaccines, Medicare Part B covers the FQHC's full costs, including for vaccines administered by pharmacists (and nurses). These payments are made separately from the PPS system, and there can be a significant lag in receiving reimbursement.
    - For other covered vaccines, Medicare does not provide separate reimbursement; they trigger a PPS payment only if they are provided as part of a face-to-face visit with a billable provider.
  - ***Cost-Benefit Analysis:*** FQHC leadership should evaluate the cost and benefits of having pharmacists provide immunizations, as opposed to other uses of their time (e.g., filling prescriptions). FQHC pharmacists report anecdotally that from a financial perspective, they can earn significantly more revenue filling prescriptions than by spending the same amount of time providing immunizations.

## CONCLUSION

While there are many perceived policy-related barriers to FQHCs' ability to access, be reimbursed for, and ultimately administer adult immunizations, by exploring and taking action on low-lift, high-yield strategies, FQHCs and the associations that represent them could lower many of those barriers. Strong partnerships in this work are key; collaboration among PCAs and their FQHC members, health departments, state Medicaid offices, and private/public entities can help to move the needle on many of the strategies mentioned. Once policy is set, interdisciplinary workflows can be developed to streamline and standardize the roles each partner plays, both outside and inside the point-of-service, and ultimately improve access to adult immunizations.

## ENDNOTES

- <sup>1</sup> <https://www.nachc.org/wp-content/uploads/2023/10/adult-imm-fqhc-white-paper-11-01-2019.pdf>
- <sup>2</sup> <https://www.cdc.gov/vaccines/hcp/adults/for-practice/standards/index.html>
- <sup>3</sup> <https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html>
- <sup>4</sup> <https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html>
- <sup>5</sup> <https://bphc.hrsa.gov/sites/default/files/bphc/compliance/hc-compliance-manual.pdf>
- <sup>6</sup> <https://data.hrsa.gov/tools/data-reporting/program-data/national>
- <sup>7</sup> <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=6B&year=2022>
- <sup>8</sup> <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=6A&year=2022>
- <sup>9</sup> <https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2022-uds-manual.pdf>
- <sup>10</sup> <https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/uds-clinical-measures-handout.pdf>
- <sup>11</sup> <https://bphc.hrsa.gov/initiatives/advancing-health-center-excellence/community-health-quality-recognition-chqr-overview>
- <sup>12</sup> <https://www.healthypeople.gov/>
- <sup>13</sup> This definition also explains why the total number of visits for vaccines reported on UDS can exceed the total number of patients reported, even for vaccines such as influenza which require only a single dose. For example, an individual who comes to an FQHC only for a vaccine would count as a visit but not a patient.
- <sup>14</sup> <https://www.ncqa.org/wp-content/uploads/2019/02/NCQA-AIS-PRS-Webinar-Slides-Feb-2019.pdf>
- <sup>15</sup> [https://qpp.cms.gov/docs/QPP\\_quality\\_measure\\_specifications/CQM-Measures/2023\\_Measure\\_493\\_MIPSCQM.pdf](https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_493_MIPSCQM.pdf)
- <sup>16</sup> <https://bphc.hrsa.gov/initiatives/advancing-health-center-excellence/community-health-quality-recognition-chqr-overview>
- <sup>17</sup> <https://bphc.hrsa.gov/technical-assistance/strategic-partnerships/primary-care-associations>
- <sup>18</sup> <https://bphc.hrsa.gov/technical-assistance/strategic-partnerships/national-training-technical-assistance-partners>
- <sup>19</sup> <https://bphc.hrsa.gov/sites/default/files/bphc/compliance/ftcahc-policy-manual.pdf>
- <sup>20</sup> FTCA coverage, including for volunteer health professionals, is also available for free clinics. See <https://bphc.hrsa.gov/ftca/freeclinics/policies.html>
- <sup>21</sup> [https://www.appropriations.senate.gov/imo/media/doc/Continuing%20Resolution\\_Section%20by%20Section\\_Final.pdf](https://www.appropriations.senate.gov/imo/media/doc/Continuing%20Resolution_Section%20by%20Section_Final.pdf)
- <sup>22</sup> <https://www.macpac.gov/wp-content/uploads/2022/03/Chapter-2-Vaccine-Access-for-Adults-Enrolled-in-Medicaid.pdf>
- <sup>23</sup> <https://nashp.org/state-medicaid-approaches-to-doula-service-benefits/>
- <sup>24</sup> <https://www.commonwealthfund.org/publications/issue-briefs/2019/apr/role-medicaid-expansion-care-delivery-FQHCs>
- <sup>25</sup> <https://avalere.com/wp-content/uploads/2023/04/Medicaid-Adult-Vaccine-Provider-Reimbursement-in-2021.pdf>
- <sup>26</sup> <https://www.macpac.gov/wp-content/uploads/2022/03/Chapter-2-Vaccine-Access-for-Adults-Enrolled-in-Medicaid.pdf>
- <sup>27</sup> <https://avalere.com/wp-content/uploads/2023/04/Medicaid-Adult-Vaccine-Provider-Reimbursement-in-2021.pdf>
- <sup>28</sup> <https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/associations.html>
- <sup>29</sup> <https://www.cms.gov/center/provider-type/federally-qualified-health-centers-fqhc-center.html>
- <sup>30</sup> <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10914.pdf>
- <sup>31</sup> <https://www.cms.gov/newsroom/fact-sheets/anniversary-inflation-reduction-act-update-cms-implementation>
- <sup>32</sup> <https://aspr.hhs.gov/legal/PREPAct/Pages/default.aspx>
- <sup>33</sup> <https://www.nachc.org/resource/nachc-2022-pca-assessment-summary/>
- <sup>34</sup> <http://www.immunize.org/laws/pharm.asp>