# CMS Can Fix Medicare Vaccine Coverage to Protect Seniors from RSV

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**Richard H. Hughes, IV,** Strategic Advisor with EBG Advisors and Member of the Firm at Epstein Becker Green, authored an article in *Health Affairs,* titled "CMS Can Fix Medicare Vaccine Coverage to Protect Seniors from RSV."

Following is an excerpt:

The Inflation Reduction Act has eliminated out-of-pocket payments for vaccines for millions of US seniors. Yet, challenges remain under a coverage framework that splits vaccine benefit part placement between Medicare Part B and Part D. Unlike commercial health insurance or Medicaid, Congress determines the specific services that will be covered under medical and pharmacy benefits for these plans. Rather than deferring to evidence-based recommendations to determine which vaccines are covered, Congress has statutorily prescribed coverage for vaccines under Part B since the 1980s. As a consequence, vaccines are not uniformly accessible across care settings. The Centers for Medicare and Medicaid Services (CMS) has the administrative authority to resolve these challenges for current and future vaccines through three potential pathways: its National Coverage Determination process, existing Part D rules, or demonstration authority.

*Medicare Vaccine Coverage*

Following the development of vaccines for older adults, Congress amended the Medicare Part B (the physician or medical benefit) statute throughout the late 1970s and 1980s to ensure beneficiary access. Medical benefit coverage of new vaccines

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made imminent sense in an era when health care delivery centered on the physician office. Vaccines for adults were a relatively new concept, and Congress naturally sought to ensure that each was covered by the Medicare program by writing them into the statute.

After the licensure of a pneumococcal vaccine in 1977, Congress provided for its coverage under Section 1861(s)(10)(A) of the Social Security Act in 1980. In 1984, it did the same for hepatitis B for those at intermediate to high risk, and in 1987, for the influenza vaccine. Until the COVID-19 pandemic, 33 years later, these were the only preventive vaccines covered under Medicare Part B.

Throughout the late 1980s and 1990s, the US began to grapple with the challenges of ensuring access to and uptake of these vaccines. Along the way, states began to recognize pharmacists as immunizers under state scope-of-practice laws. Medicare began to permit pharmacists to submit claims for immunization via a roster billing pathway to Part B as a "Mass Immunization Center." This enabled the delivery of Part B-covered vaccines in the pharmacy setting.

Few additional advancements were made in adult vaccine development until the early 2000s. In the intervening period, Congress passed the Medicare Modernization Act, which created Part D—also known as prescription drug coverage. Among the "covered outpatient drugs" that Part D sponsors must cover, Congress included newly licensed vaccines. This created the peculiar split benefit part placement of vaccines we have today, with some vaccines covered in the physician office and others covered in the pharmacy (exhibit 1).

Thus, with the Part B roster billing pathway and Part D coverage of remaining vaccines, pharmacies have been able to offer the full complement of recommended vaccines to Medicare beneficiaries. However, physician offices, without the ability to bill claims to Part D, must either refer patients to a pharmacy for certain vaccines or vaccinate the patient and have the patient submit a paper claim. These dynamics disincentive physicians from buying and managing vaccine inventory, and referral to the pharmacy or paper claims may result in patient attrition. As a result, the Medicare Payment Advisory Commission has recommended that Congress move coverage of all vaccines to Part B.

To date, this challenge has predominantly impacted access to the shingles vaccine, but as new vaccines for older adults are approved, the missed opportunities to protect patients may increase. For example, four vaccine candidates are in development for the prevention of respiratory syncytial virus (RSV), and two are expected to launch this year. RSV incidence has been relatively high during the current season of respiratory illness, and older adults are particularly vulnerable to the virus. As the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices discussed how it will approach recommending these vaccines in the near future, they considered the access challenges for patients seeking vaccination in physician offices.

Awareness of RSV disease is markedly lower among health care providers serving older adults relative to pediatricians. This low awareness only adds to the challenges associated with vaccinating older adults.