VFA Program Webinar Q&A Session

"Bridging Policy and Practice: ACIP Immunization, Eligibility, and Registry Documentation Updates"

Thursday, April 24, 2025

I. VFA Program Updates

Q: Does Family PACT cover any vaccines?

A: Effective for dates of service on or after July 1, 2022, the Human Papillomavirus (HPV) vaccine is a clinic benefit under the Family Planning, Access, Care and Treatment (Family PACT) Program for women and men, ages 19 through 45.

Q: I know VFA enrollment is closed, but I would like to know when or if that will change. We are a VFC location, a small clinic, and would also like to offer vaccines to adult patients.

A: VFA enrollment is driven by the available 317 budget. The 317 budget has remained stagnant over the past few years. The current budget is able to support those currently enrolled in the program. As we review VFA provider sites and those who are not active, there is a possibility of limited enrollment in the future. Please feel free to send an email to my317vaccines@cdph.ca.gov with your interest so we may keep your clinic in mind.

Q: Would any co-payment for a vaccine qualify a patient for VFA vaccines?

A: Given the updated definition for underinsured, an adult patient is now eligible for VFA vaccines if their insurance requires any co-payment for the vaccine itself. The patient would qualify for 317-funded vaccines if they have any copay, co-insurance, and/or deductible for the cost of the vaccine. This policy does not apply for any co-pay, etc., for administration or office visit fees.

Q: Do we need proof of documentation to verify a patient's eligibility for VFA vaccines?

A: Eligibility is self-reported by the patient and verification of eligibility can be obtained verbally from the patient.

Q: Does having a copay for the main visit itself count as being eligible for VFA?

A: The updated definition for underinsured would only make a patient eligible for a VFA vaccine if the copayment is for the vaccine. It does not apply for copayments for the office visit or administration fees. Eligibility is self reported by the patient and can be obtained verbally.

Q: How to access Annual VFA report for 2024, if it hasn't been sent you your agency?

A: Please check your Spam/Junk folder just in case. If you don't locate the report, please feel free to send an email to my317vaccines@cdph.ca.gov.

II. Clinical Updates

Q: For Abrysvo for immunocompromised patients 19-59, does VFA allow us to give for this age range?

A: ACIP currently does not recommend Abrysvo for immunocompromised ages 19-59. For those under the age range, Abrysvo is an RSV vaccine approved for pregnant individuals to protect their babies from severe RSV disease. It's administered between 32 and 36 weeks of pregnancy.

Q: Some providers order titers for MMR prior to vaccination, is this required prior to vaccinating or optional?

A: This is not required.

Q: For patients that get a live vaccine, such as MMR, can they get a non-live vaccine 2 weeks after or have to wait the 28 days to get another vaccine?

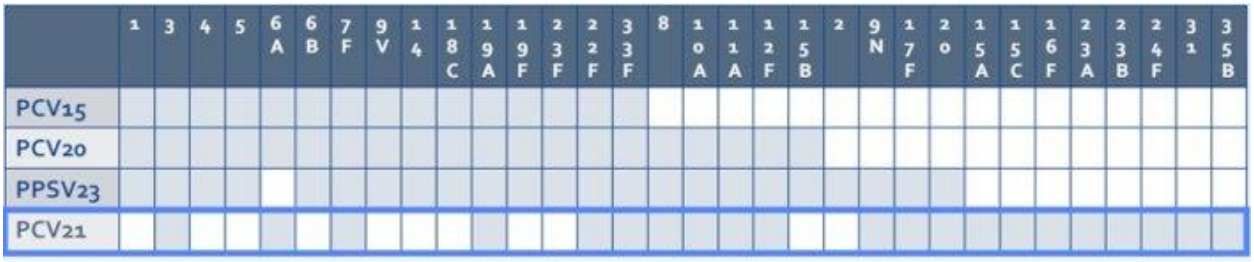
A: Per ACIP: "Any non-live vaccine can be administered either simultaneously or at any time before or after a different non-live vaccine or live vaccine."

Q: At my clinic site, we don't give MMR very often, but to providers doing titers instead. Any suggestions around this?

A: Per CDC, for adults: "One dose of MMR vaccine, or other presumptive evidence of immunity, is sufficient for most adults. Providers generally do not need to actively screen adult patients for measles immunity in non-outbreak areas in the United States. After vaccination, it is also not necessary to test patients for antibodies to confirm immunity."

Q: PCV21 is new, and we have little information. However, we are unsure which product would be best for our region. How to determine which is the most appropriate for our clinic?

A: There are no preferential recommendations between products of PCV20, PCV21, PCV15 + PPSV23 among adults. Refer to the table below for serotypes covered within each product.



	1	3	4	5	6A	6B	7F	9V	14	18C	19A	19F	23F	22F	33F	8	10A	11A	12F	15B	2	9N	17F	20	15A	15C	16F	23A	23B	24F	31	35B
PCV15																																
PCV20																																
PPSV23																																
PCV21																																

Regarding pneumococcal serotype 4 (which is not in PCV21), recent 2019-2023 data from California Emerging Infections Program Active Bacterial Core (ABC) surveillance sites do ***not*** show an increase in serotype 4 IPD. Note: CA ABC surveillance sites are based in the Bay area.

Prior 2010-2018 data did show an increase in serotype 4 IPD cases in California, both in the general population and persons experiencing homelessness: Upsurge of Conjugate Vaccine Serotype 4 Invasive Pneumococcal Disease Clusters Among Adults Experiencing Homelessness in California, Colorado, and New Mexico | The Journal of Infectious Diseases. ACIP has discussed this topic in recent ACIP pneumococcal meetings, slide #9 referenced the previous article.

In the MMWR Use of 21-Valent Pneumococcal Conjugate Vaccine Among U.S. Adults: Recommendations of the Advisory Committee on Immunization Practices — United States, 2024 | MMWR. ACIP does ***not*** include California as one of the western states in which serotype 4 is highly prevalent.

BOX. Clinical guidance on selection of pneumococcal conjugate vaccine in communities with high proportions of serotype 4 pneumococcal disease — United States, 2024

- PCV21 contains eight pneumococcal serotypes that are not included in previously recommended pneumococcal vaccines (i.e., PCV15, PCV20, and PPSV23). However, PCV21 does not contain certain pneumococcal serotypes that are contained in previously recommended pneumococcal vaccines, one of which is pneumococcal serotype 4.
- In certain adult populations in the western United States, high percentages (i.e., ≥30%) of IPD caused by serotype 4 have occurred. The available IPD serotype data from CDC's Active Bacterial Core surveillance, as well as similar surveillance from Alaska and the Navajo Nation, indicate that these high percentages are particularly prevalent in Alaska, Colorado, the Navajo Nation, New Mexico, and Oregon. Typically, persons living within these geographic areas who develop serotype 4 IPD are adults aged <65 years with specific underlying conditions or risk factors, such as alcoholism, chronic lung disease, cigarette smoking, homelessness, and injection drug use. Importantly, these persons usually have not received a pneumococcal conjugate vaccine containing serotype 4. In such populations, other recommended pneumococcal vaccines (e.g., PCV20 alone or both PCV15 and PPSV23) are expected to provide broader serotype coverage against locally circulating strains compared with PCV21.
- The percentages of serotype 4 IPD cases in other areas of the western United States without IPD surveillance are currently unknown. IPD surveillance from other geographic areas in the United States (e.g., midwestern, eastern, and southern regions) has not detected significant percentages of serotype 4.
- This clinical guidance will be reviewed and updated as pneumococcal disease epidemiology evolves.

III. CAIR

Q: What do we do when patients decline to answer race/ethnicity?

A: Reporting Race/Ethnicity is required under AB1797. CAIR has a new category "prefer not to say" as a value that can be submitted via data exchange.

Q: What happens if a provider is not 100% compliant with AB1797? Will there be fines or order rejection on myCAvax?

A: VFA providers have always been required to enter doses in CAIR. CDPH will be reviewing this during site visits and we will work with you the best we can. I strongly suggest working with your EHR vendor and CAIR data exchange to get compliant now. Eventually, accountability for vaccines will be pulled from CAIR. Continued non-compliance will result in ineligibility for VFA vaccines.

Q: For the CAIR Data Exchange team, what is the turn-around time for responses?

A: Please reach out to the CAIR Data Exchange Team about this. It would depend on the issue that needs to be addressed.

Q: Is there a way to find out which patient or fields (NDC, Funding, Lot) were missed on CAIR?

A: The doses administered report in CAIR is a good resource to start with.

Q: For the NDC code, do you use the NDC from the product box or the actual vial/syringe as those are different?

A: CAIR will accept both NDC codes.

Q: How can we confirm that our location is properly reporting vaccines?

A: You can run the doses administered report in CAIR and find instructions on how to run the report on Page 50 of the CAIR User Guide.

Q: When inputting VFA vaccines on CAIR inventory, do we always have to put the NDC Code?

A: It is recommended that you submit the NDC code when reporting doses administered to CAIR.

Q: Are we only going into CAIR and input vaccines if they don't transfer? Or with all vaccines whether they transfer or not?

A: You should be able to see the percentage of vaccines transferring to CAIR within your order. Thank you for entering the ones that do not transfer; however we highly recommend to do an overview for other vaccines as well by running a vaccine dose administered report in CAIR, if you download report in excel format you will be able to sort them to identify blank information for multiple fields (example: 317 eligibility, vaccine administrator...) This will help address missing information. You may reach out to your Local CAIR. Representative for assistance. You can also run the doses administered report. You can find instructions on how to run the report on Page 50 of the CAIR User Guide.

Q: How will we know the patient actually receives the self-administered FluMist and count it as a valid dose in the registry?

A: This is currently under discussion with the CAIR team and hope to provide more information soon.