

Immunization Policies and Funding in Alabama

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ABOUT ALABAMA

Alabama is a small, southern state with a population of 4.3 million residing in its 67 counties. One-quarter of its population is under the age of 18. More than 1.5 million residents live in rural areas, which means that Alabama's nonmetropolitan population of 37% is significantly higher than the national average. (Wiener, Wallin, Liska, and Soscia, Urban Institute, 1998). This is particularly noteworthy because of the poverty levels in rural Alabama.

While Alabama has historically been a poor state, it has done very well in recent years. The population increased at an annual rate close to the national average of 5.6%. Although per capita income has increased faster than the national average and the unemployment rate is slightly below the national average, Alabama remains poorer than the nation as a whole measured both by per capita income and by percentage of residents living below the federal poverty level. Less than 1% of its population is Hispanic, with 29% black and 70% Anglo (Wiener, Wallin, Liska, and Soscia, Urban Institute, 1998).

Like many southern states, Alabama's economy has changed. In the past it relied on agriculture and steel production (especially in Birmingham), but it has recently diversified into services, especially health care and high technology (Wiener, Wallin, Liska, and Soscia, Urban Institute, 1998).

According to "Kids Count 1999," Alabama ranks in the bottom 10 states in several key children's categories: percentage of low-birth-weight babies; infant mortality rate (deaths per 1,000 live births); child death rate (deaths per 100,000 children ages 1–14); rate of teen deaths by accident, homicide, and suicide (deaths per 100,000 teens ages 15–17); and percentage of families with children headed by a single parent. In a ranking of the relative healthiness of the populations in all 50 states, Alabama was forty-first in 1996 (Reliastar Financial Corporation, *The Reliastar State Health Rankings: An Analysis of the Relative Healthiness of the Populations in All 50 States*, 1996 edition).

With 86% of its 2-year-olds immunized, Alabama is substantially higher than the rest of the nation (average 78%) (Annie E. Casey Foundation, Kids Count 1999, 1997 data). This is a significant achievement and reflects favorably on the commitment in Alabama to excel in public health services (see Figures 1 and 2).

STATE GOVERNMENT

Alabama is a conservative state with a strong governor and a weak legislature. Part-time legislators meet annually for only 30 working days during a 105-calendar-day period. Much of this time is spent on local matters since Alabama's constitution greatly restricts the power of county government (Wiener, Wallin, Liska, and Soscia, Urban Institute, 1998).

As in many other southern states, Republicans have made very dramatic gains recently especially in the higher offices. However, the governor is a Democrat and the legislature remains solidly Democratic (Wiener, Wallin, Liska, and Soscia, Urban Institute, 1998).

The budgetary environment is characterized by two specific factors. First, state and local taxes per capita are very low. Alabama does have a modest state income tax and a relatively high sales tax, but property taxes are among the lowest in the nation. Second, the vast majority of taxes are earmarked for either the general fund or the Alabama Special Educational Trust Fund. Sales and income taxes, which account for the bulk of revenues, are earmarked for education. A wide variety of other less significant revenue sources funds the remainder of state government, including Medicaid, public health, social services, and public safety (Wiener, Wallin, Liska, and Soscia, Urban Institute, 1998).

THE HEALTH CARE ENVIRONMENT

Alabama's safety net, which provides health care to the uninsured and Medicaid populations, is solid. Its local public and state university hospitals and community health centers provide a substantial amount of health care to the uninsured. The Alabama Department of Public Health (ADPH) and county health departments play an important role in providing services, especially maternal and child health and home health care (Wiener, Wallin, Liska, and Soscia, Urban Institute, 1998).

Medicaid

Almost 550,000 Alabamians received Medicaid services in 1996, and more than one-half (57%) of the births in Alabama are covered by Medicaid (Alabama Department of Public Health). Alabama has been aggressive in maximizing federal Medicaid funds, in conjunction with inter-governmental transfers and provider taxes, to provide the vast majority of the state's match for Medicaid. The federal Medicaid rate (FMAP) is 70% for the Alabama program. Total Medicaid expenditures increased at an annual rate of 19.2% from 1990 to 1995, above the national average. In 1995, while Medicaid accounted for 17.5% of total state expenditures from all sources (including federal), state general fund expenditures were only 5% (Wiener, Wallin, Liska, and Soscia, Urban Institute, 1998). Like the rest of the country, enrollment growth has leveled out, and enrollment levels are projected to stay fairly constant over the next several years.

The Medicaid program in Alabama reimburses providers \$8 per dose for administration costs when immunizing children. This administration fee is a few dollars higher than that of most other states and has assisted in motivating many providers into offering and giving Medicaid eligibles all vaccines they may be eligible for at each visit (Alabama Department of Public Health, Immunization Division).

State Children's Health Insurance Program

With almost 17% of its children uninsured, Alabama is slightly above the national average. As with immunizations, Alabama has been very aggressive in establishing this new health insurance program. On January 30, 1998, Alabama became the first state to gain approval of its State Children's Health Insurance Program (SCHIP) from the federal government (Wiener, Wallin, Liska, and Soscia, Urban Institute, 1998).

It is projected that Alabama is eligible to receive approximately \$400 million in federal funds for the implementation of SCHIP during 1998–2002. This is important because the state does not currently have any other state-funded insurance programs for persons ineligible for Medicaid (Wiener, Wallin, Liska, and Soscia, Urban Institute, 1998).

The regular Medicaid program covers children aged 5 and under up to 133% of the federal poverty level (FPL), and children born after September 30, 1998, up to 100% of FPL. The Medicaid expansion part of SCHIP covers children between 16 and 19 up to 100% of FPL. The private insurance portion of Alabama's CHIP program, ALLKids, covers children above the Medicaid eligibility limits up to 200% of FPL through age 18. In the early implementation stages of SCHIP, almost all of the enrollees were 5 years of age and older and thus basically up-to-date in their immunizations. The one exception is hepatitis B (Hep B) in adolescents. It is anticipated that immunizations will increase under SCHIP as new recruitment methods identify those less than 5 years of age (Alabama Department of Public Health).

One particular sticking point in Alabama with regard to SCHIP has been the recent notification by the Centers for Disease Control and Prevention (CDC) that Section 317 funding cannot be utilized for routinely vaccinating SCHIP enrollees. This may result in children being referred back to private providers from county health departments (CHDs).

In addition, some SCHIP providers may not offer all vaccines but refer the parent back to a local CHD for some immunizations. Alabama public health officials are concerned that CDC guidance about the use of 317-funded vaccines will result in lower immunization levels of SCHIP-enrolled infants (Alabama Department of Public Health, Immunization Division).

Managed Care

Although Medicaid managed care enrollment was approximately 65% in 1997, only 11% of the state's privately insured population is enrolled in health maintenance organizations (HMOs), about half the national rate (American Academy of Pediatrics, Medicaid State Report for Alabama, FY 1996; Wiener, Wallin, Liska, and Soscia, Urban Institute, 1998).

Medicaid Primary Care Case Management (PCCM) was implemented in Alabama on a county-by-county basis starting in early 1997 and was completed in the fall of 1998. Many previously but incompletely immunized infants who had been served by CHDs were now under an assigned private provider, or "gatekeeper," many of whom had just started offering vaccines and lacked the ability to obtain a child's previous documented vaccine history. In addition, PCCM implementation caused much confusion for parents and providers alike. This may have directly contributed to Alabama's decline in National Immunization Survey (NIS) immunization levels from 87% in June 1998 to 82% by December 31, 1998 (Alabama Department of Public Health, Immunization Division).

Immunizations

The renewed emphasis on increasing immunization rates began in 1990. At that time Alabama had a statewide 24-month-old completion level of only about 58%. In 1997, Alabama's immunization rate of 86% for 2-year-olds was essentially the same as that of the New England states, which are universal purchase states with a higher-educational-level and socioeconomic-status population. The success of the program can be attributed to several factors—initiative, funding, education, outreach, and commitment (see Figures 1 and 2).

Particularly noteworthy is the role of the county health departments. In Alabama, CHDs are truly an extension of the state. There are only two that function quasi independently: they have their own merit system, have independent methods of obtaining revenue, and bill Medicaid directly. With regard to immunizations, they have complied with state policies to the letter. There are about 96 health department sites in the 67 counties and about 63 federally qualified health center (FQHC) sites that are treated essentially as immunization clinic satellites of CHDs. Many of these 63 FQHC clinic sites are audited annually by ADPH staff on methods to utilize improving immunization protection levels in FQHC clinic infant clientele. (Alabama Department of Public Health, Immunization Division).

By statute, Alabama school children attending grades K–12 are required to present a certificate indicating that they have received the immunizations necessary according to the state health officer. Adding or deleting vaccines or doses for an Alabama Certificate of Immunization is done by Board of Health regulation. The last immunization regulation passed was in 1996, requiring two doses of measles-containing vaccine to be added to doses of the diphtheria–tetanus–pertussis (DTP)–polio vaccine that are needed to obtain a Certificate of Immunization for grades K–12 (see Figure 3) (Alabama Department of Public Health, Immunization Division).

Women, Infants, and Children Program

The relationship with the Women, Infants, and Children (WIC) program is strong and effective. In Alabama, 60% of the state's infants receive WIC services at one time or another. The vast majority of these services are provided by all 67 counties, with a small minority (10% or less) obtaining WIC services at 16 of the 60 federally funded community health center sites (Federal Grant Application to CDC, Alabama Immunization Program).

All 67 counties have WIC sites, and staff are almost always available to give immunizations in WIC clinics. Section 317 funding has been used to staff a nurse to give immunizations in some CHD WIC sites. Even during voucher pickup encounters, a “pop-up” screen will show what immunizations each WIC-enrolled child is suspected not to have received, and referral and/or immunization service are then provided. The policy is that if a child shows up at a WIC clinic and is due for an immunization, WIC will give it even if the child normally has a private provider. An outreach program has been made possible through Section 317 to follow up on patients that are overdue for their immunization. Monthly reports produced by the computer system identified 55,000 children when this program was initiated, and the list currently averages 2,000–3,000 kids. In 1999, because of other priority needs and decreasing 317 and state infrastructure funding, there were fewer dollars available to motivate CHDs to continue to assign staff to these WIC follow-up activities. Recent changes in ADPH data information systems are not programmed to detect whether these overdue lists have increased above the monthly 2,000–3,000 children (Alabama Department of Public Health, Immunization Division).

State and Federal Funding for Immunization Services

Prior to the Vaccines for Children (VFC) program, immunization services were about 50% state funded and 50% federal 317 funding. State funding increased significantly as the Department of Public Health aggressively implemented a second measles–mumps–rubella (MMR) vaccine for kindergarten, 6th and 12th grades. Since the advent of VFC, and with fewer doses being needed for MMR, state funding has decreased annually (see Figures 4 through 8). Currently, state funding is slightly less than \$1 million annually, with almost 80% being utilized for infrastructure needs and the remaining 20% for the purchase of vaccines. With this relatively small amount of state funding, VFC funding for infrastructure and Section 317 incentive funds have been very helpful in addressing some needs that would otherwise not be met (see Figures 6 and 9–11).

For example, the 67 counties are organized into 11 public health areas, and the state pays for 10 immunization managers in these 11 areas (one manager covers two areas). Section 317 incentive funding assists in supporting the remaining 50 full-time and part-time personnel who provide a variety of services.

Currently, state funds support about 16% of the infrastructure, with Section 317 contributing more than 75% and VFC addressing the remaining 9%. When it comes to vaccine dollars, VFC provides more than 80% of the funding, 317 contributes around 18%, and the state about 2% (see Figures 4–9 and 12–15).

Innovative Strategies with Section 317 Funding (Including Outreach)

With additional federal funding in 1993–1995 (see Figures 9 and 14), the immunization program directed many new efforts in the areas of community and service group involvement, educational materials, staffing and clinic hours for immunizations, follow-up, and registry development. At that time, about 60% of infant immunizations were provided via CHDs and FQHCs, and many efforts addressed their service capacity and strategies.

In the fall of 1994, before VFC was implemented (January 1, 1995), public clinic vaccine usage data indicated that a substantial decrease in public clinic vaccine delivery was starting to occur—the first time this had happened in many years. With VFC being implemented (see Figure 12) and Medicaid managed care pending, activities were designed and implemented to enhance private providers' vaccine delivery systems and follow-up of their infant clientele. The Alabama Immunization Division used a large proportion of Section 317 funding for the following initiatives (see Figures 9, 13, and 14):

1. Additional staff were hired to follow children statewide (using birth certificate data) who were suspected to be at “high risk” of not completing their immunizations. These children were followed until they completed their basic series or turned 24 months of age, and many received vaccines from private providers.

2. CHDs were given incentive funds on the basis of obtaining the history of doses of vaccine given by private providers to WIC children and entering this information into the child's medical record and into the state's registry data base. Also, CHDs were provided incentive funding based on computer-generated data on how many of each CHD's immunization clientele turned 24 months of age each month and the percentage fully immunized at that time. The award per child was higher for greater percentages completed.

3. The PCCM follow-up program put a CHD staff person, usually a nurse, in a private provider's office to track and contact Medicaid clientele under 2 years of age. Funding levels allowed

this activity to take place in about 30 private provider offices throughout the state. Its main purposes were as follows. First, the program introduced measures within public health and private provider practices, established rapport, provided assistance in updating records, ensured that follow-up of Medicaid children was accomplished, and demonstrated the value of follow-up and recall. Second, it measured the impact of the program, in anticipation of potential Medicaid cost reimbursement for these services at a later date.

4. The state contracted with the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and Primary Care Association to provide immunization program-trained staff to audit private provider and FQHC clinic sites. These coordinators were well received and conducted 2-year-old immunization surveys of their infant clientele. Findings and recommendations were shared with staff the same day, and a formal written report—with recommendations for improvement (if needed) in their vaccine delivery systems—was distributed within two weeks of the audit. Surveys conducted a year or so later consistently found that each clinic site previously audited showed improved completion levels, fewer missed opportunities to immunize, less use of inappropriate contraindications, and improved storage and handling of vaccines.

During the last two years, decreases in Section 317 funding have resulted in (1) the state's inability to plan additional programs and expectations of future funding levels to enhance existing programs for infants, adolescents, and adults; (2) a hesitancy to fill 317-funded positions when they become vacant; and (3) a hesitancy to increase or add new vaccine requirements for day care or school attendance because decreases in 317 funding will not help CHDs ensure vaccine delivery capability (Alabama Department of Public Health, Immunization Division).

Vaccine Availability and Distribution System

Prior to 1993, the ADPH distributed vaccines only to CHDs and FQHC sites. For approximately 18 months prior to January 1, 1995, ADPH distributed vaccines to participating private providers for administration only to Medicaid-eligible clientele. Medicaid reimbursed ADPH quarterly for vaccine and shipping costs. ADPH began enrolling and shipping vaccines through the VFC program on October 1, 1994, and continues to date to take and ship vaccine orders (excluding varicella) to all public clinic sites and enrolled private providers within the state (Alabama Department of Public Health, Immunization Division).

Provision of Services: Public and Private Providers

Public Clinics. All CHDs provide immunization services including routine childhood immunizations plus MMR, tetanus and diphtheria toxoids (Td), influenza, or pneumococcal vaccine to adults. Although some CHDs offer vaccines on an appointment basis, all will accept patients on a walk-in basis. Only one CHD (Jefferson) has special evening or weekend clinics, but others do not have staff to permit this on an ongoing basis. Because of budget crises, several rural CHDs have only one clinical nurse available, and few if any CHDs now have staffing sufficient to conduct school-based clinics for such programs to administer Td boosters or hepatitis B vaccines (Alabama Department of Public Health, Immunization Division).

Prior to the implementation of VFC, 70% of children received their immunizations through county health departments, 28% through private providers, and 2% in military clinics. Similar to what is occurring nationally, these percentages have pretty much reversed. Now 35% of the children receive their immunizations in the public sector, 63% in the private sector, and 2% in mili-

tary clinics. The transition has been very smooth as well as dramatic; at one time, only one of the 79 pediatricians then practicing in Birmingham saw Medicaid children (see Figure 16).

In addition to lots of hard work, two other factors were key in this transition. Alabama operated a Vaccine Replacement Program for about 18 months before VFC was implemented. In essence, it was a mini-VFC program. The immunization program purchased the vaccine; shipped it to Medicaid providers; and kept records of vaccine and shipping costs. It would then notify Medicaid quarterly, and Medicaid would reimburse for these costs. Second, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screening rate was increased (from \$40 to \$80), and the administration fee for immunizations was also increased (from \$2 to \$8 per dose). Medicaid does not require providers to enroll in VFC but has discontinued vaccine cost reimbursement (for children 0–18 years), and the Health Care Financing Administration (HCFA) has set a cap of \$14.26 for vaccine administration fees that can be charged to non-Medicaid VFC-eligible children.

Finally, the ADPH continues to supply private providers (VFC) with Td and DT that are no longer available on federal contract. This is being done with state and Section 317 financial assistance funds to minimize private provider disenchantment with the VFC program (Alabama Department of Public Health, Immunization Division).

Registries

State law makes the Department of Public Health responsible for developing the registry and it is a high priority of the state Health Officer. Currently, the State Immunization Information System (SIIS) registry operates statewide for county health departments only. The next phase will be the entry of Blue Cross and Blue Shield (the dominant provider in the private sector) and Medicaid billing data. Private participation should occur later in 1999. Promotion of the SIIS to private providers is planned through professional organizations such as the Alabama chapters of the AAP and AAFP. Approximately 80% of WIC children have their immunizations recorded in the system currently.

The system was developed in-house at a cost of approximately \$1 million in state funds. Funding from Section 317 provided about \$2 million to address equipment costs. Discussions are going on with HCFA and Medicaid to reimburse the state for its commitment or to assist in the maintenance costs of the system.

Providers can release immunization information to others with a need to know without the written consent of parents, and this has not raised issues for the registry.

Enforcement and Surveillance

The Department of Education is responsible for enforcing school requirements, which are at least four DTP, three polio, and two MMR doses. Age-appropriate Haemophilus influenzae type B (Hib) vaccination is required for day care attendance in addition to age-appropriate DTP, polio, and MMR. Medical and religious exemptions are authorized but constitute only 0.2% for each type of exemption.

All kids must have an up-to-date “blue slip,” which expires when the next immunization is due. In this manner, schools and day care centers have a very practical understanding and do not have to learn immunization schedules. The Department of Human Resources enforces the day care standards and has the authority to suspend licenses. Schools and day care centers do self-surveys, and the state follows up with validation audits in the fall for schools and in the winter

for day care centers and Head Start. This has been done annually since 1990. There have been no major problems in this area.

Audits in private provider offices include assessment of 2-year-old coverage levels. This also involves an assessment of what the coverage levels would have been if opportunities had not been missed. A follow-up is conducted a year later to determine if there has been improvement.

Outbreak assessments are conducted by state and area staff who are highly trained to conduct and contain vaccine-preventable disease outbreaks. For example, during the late 1980s, Alabama successfully contained the measles outbreak to only about one-sixth the rate of cases reported per 100,000 population by the rest of the country.

Adult Immunizations

The adult population has only recently been targeted for increased immunization. Increasing immunization levels in this group has been hampered by a lack of funding and a lack of public and professional awareness of the need. Current activities are focused on providing influenza vaccine to all citizens and pneumococcal pneumonia vaccine to patients at risk (Federal Grant Application to CDC, Alabama Immunization Program).