

Deputization of Local Health Departments Underinsured Children Q&A Fact Sheet

Centers for Disease Control (CDC) Background:

Children from birth through 18 years of age who meet at least one of the following criteria are eligible to receive Vaccine for Children (VFC) vaccine at any VFC provider site: 1) Medicaid eligible, 2) uninsured, 3) American Indian or Alaska Native. Underinsured children are also eligible for VFC vaccine, but only when administered at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). Currently, less than ten percent nationally of VFC provider sites are FQHCs or RHCs, both of which, for reasons of geography, have limited access and capacity to serve this population. The CDC reports that historically, in more than 20 states, including Kansas, FQHCs and RHCs have extended access to VFC vaccines for underinsured children through deputization arrangements (sometimes referred to as “delegation of authority”) with local health departments and, in some cases, private-sector VFC-enrolled providers.

Underinsured is defined as: A person who has health insurance, but the coverage does not include vaccines or a person whose insurance covers only selected vaccines or whose insurance caps vaccine coverage at a certain dollar amount. Children who are underinsured for selected vaccines or who have exceeded their capped amount are VFC-eligible for non-covered vaccines only at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputization agreement.

The Patient Protection and Affordable Care Act (ACA) requires that non-grandfathered private health plans provide coverage for routine ACIP-recommended immunizations without cost-sharing. However, health plans that currently do not offer vaccinations retain their “grandfathered” status until they make a significant change in coverage. Thus, it is likely to take several years before all grandfathered plans lose this status and this form of underinsurance is completely addressed.

Data from CDC’s 2008 National Immunization Survey shows that 11% of young children (0-6 years) and 20% of teens (7-18 years) are not fully insured for vaccines. Until underinsurance among children is eliminated, extending VFC authority to other VFC providers serves as a safety net ensuring that access to VFC vaccine for eligible underinsured children will not be a barrier to vaccination.

Kansas Facts:

In 2004, Kansas FQHCs and RHCs “delegated” the authority to vaccinate underinsured children to all LHDs. These delegation agreements will no longer be valid after December 31, 2012. In order to assure that underinsured children don’t miss opportunities for recommended and needed vaccinations, deputization will extend the VFC authority of FQHCs and RHCs to LHDs beginning in 2013. The CDC requires notification from KIP by October 1, 2012, of the LHDs to be recommended for deputization. KIP plans to recommend that all LHDs be deputized.

Kansas 2012 census data suggests there are approximately 100,000 underinsured children in Kansas. All together Kansas VFC providers reported serving approximately 17,000 underinsured children in 2011. Of these 17,000 children who received immunizations, 49% were immunized at LHDs. Most commonly this is due to lack of an established medical home and because FQHCs and RHCs do not offer walk-in services for non-established patients. One mandate in the new deputization requirement is that deputized clinics serve underinsured children on a walk-in basis for immunizations. There are seventy eight (78) FQHCs and RHCs enrolled as Kansas VFC providers representing 21% of the 370 total VFC providers. There are 105 LHD in Kansas and all are enrolled in the VFC program. Access to care will be significantly limited for underinsured children if LHDs are not deputized.

Deputization is not replacing the “medical home” for children but is intended to help assure access to immunizations services for children who might not otherwise be vaccinated. KIP and the LHD recognize that care within a medical home is a best practice to meet the needs of Kansas children. Unfortunately, not all children have a medical home and not all providers offer vaccinations in their practice. Children who lack access to care will be exposed to vaccine-preventable diseases, may be excluded from school, and will place others at risk for vaccine-preventable disease.

It is an ongoing requirement that all VFC providers screen each child for VFC eligibility at every visit, including determination of underinsurance status. This eligibility must be documented in the child’s permanent record. All VFC providers currently report monthly the numbers of children screened for eligibility by age and eligibility status. KIP, in turn, reports these numbers to the CDC by provider type, eligibility status and doses administered. This data collection practice will not change with deputization.

The FQHC/RHC is not held liable for the actions of the deputized LHD. Each provider is accountable for their vaccine practices to KIP. KIP is, in turn, accountable to the CDC for monitoring and reporting these practices. The CDC has the ultimate authority over the VFC program.

In order to deputize or be deputized, each FQHC, RHC and LHD must have a 2012 VFC Provider Enrollment on file with KIP and must re-enroll in the VFC program annually by January 1 of each year. The CDC has provided a template agreement, called a Memorandum of Understanding (MOU) to be used in the deputizing process. The MOU will remain in effect unless there are material changes in the status of the FQHC/RHC or LHD. The FQHC/RHC may also withdraw granting authority with 90 days written notice to KIP and to the deputized LHD. Deputization guidance from the CDC applies to FQHC “Look Alikes.” These clinics are certified by the Centers for Medicare and Medicaid Services (CMS) to serve underinsured children and can sign a deputizing MOU.

The Deputization process is not complicated and will include these steps:

1. KIP submits to CDC for approval by October 1, 2012 the list of LHDs to be deputized along with the proposed MOU.
2. KIP sends the approved MOU, with the list of FQHCs and RHCs who have agreed to deputize any LHD to all LHDs.
3. The LHD contacts the FQHC or the RHC in their county, or a surrounding county, to ask the FQHC or RHC to deputize them.
4. The LHD signs the MOU and returns the signed document to KIP, noting which FQHC or RHC has agreed to deputize them.
5. KIP sends the signed MOU to the deputizing FQHC or RHC for their signature.
6. The FQHC or RHC sends the signed MOU back to KIP who signs it and sends the original MOU to the deputizing FQHC or RHC, a copy to the LHD and keeps a copy on file.
7. KIP notifies CDC of executed MOUs by December 31, 2012.

8. If a material change in the FQHC, RHC or LHD (e.g., ownership or management changes, loss of Medicaid or Medicare status, cease operations, etc.), the MOU is terminated or may be re-signed, depending on the circumstances.
9. The FQHC or the RHC may, with 90 days written notice to KIP and to the deputized LHDs, withdraw their granting authority.
10. KIP reports annually to the FQHC or RHC and CDC the number of children immunized at the LHD under each MOU.

It is the position of the CDC that extending access to VFC vaccine through deputization may expose the deputizing FQHC/RHC to liability. The National Vaccine Injury Compensation Program (NVICP) greatly reduces the legal liabilities involved in administering most vaccines. The NVICP is a no-fault alternative to the traditional tort system for resolving vaccine injury claims that provides compensation to people found to be injured by certain vaccines. Generally, persons with claims of vaccine-related injuries or deaths resulting from covered vaccines must first exhaust their remedies under the NVICP before they can pursue alternative legal actions against vaccine administrators. In addition, for certain vaccines to prevent diseases, health conditions, and threats that constitute or threaten a public health emergency and that are not covered by NVICP, the Public Readiness and Preparedness Act of 2005 (PREP Act) may provide liability protection to providers administering such vaccines, and the Countermeasures Injury Compensation Program established by the PREP Act may provide compensation to eligible individuals who are injured by these vaccines.

Q&A:

1. What is deputization?
 - a. Deputization is the process of a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) extending to a Local Health Department (LHD) the VFC authority to vaccinate underinsured (0 through 18 years) children.
2. Why deputize LHDs?
 - a. The federal government has directed the CDC to require all immunization program grantees (e.g., The Kansas Immunization Program, KIP) to seek formal deputization agreements between FQHCs, RHCs and LHDs, in the form of an MOU, to help assure immunization services for underinsured children. Nationally, 20% of all providers are FQHCs/RHCs and their capacity to see all underinsured children is limited. By deputizing LHDs, access to immunization services for these children is improved.
3. Kansas LHDs were ‘delegated’ this authority in 2004. Why can’t these agreements continue?
 - a. The Centers for Medicare and Medicaid Services (CMS) via Health and Human Services (HHS) directed the CDC to formalize this process across all immunization programs in the country. The prior “delegation” will no longer be valid and new “deputization” MOUs need to be signed.
4. Will deputizing LHDs adversely impact the “medical home” concept?
 - a. No. Deputizing LHDs is a tool to maintain access to immunization services only. KIP and the LHD both support and work to encourage families to seek out and establish medical homes for all care. Unfortunately, many children do not have a medical home and many providers do not offer immunization services in their practices. In a few Kansas counties, the LHD is the only provider of immunizations.
5. Is the FQHC/RHC required to monitor the LHD vaccine practices?
 - a. No. KIP is accountable for monitoring all VFC provider immunization practices. The MOU requires all deputized LHDs report to KIP, monthly, the numbers of underinsured children immunized by age and vaccine antigen. Monthly reporting of vaccine use is required from all VFC providers.
6. Can the FQHC/RHC deputize other non-LHD providers?
 - a. No. Kansas is only seeking deputization for LHDs. The CDC requires extensive justification for deputizing a provider that is not a LHD. Kansas LHDs serve each county and this system

provides sufficient opportunity to help assure the access to immunization services for the underinsured children.

7. Can non-FQHC/RHC clinics immunize underinsured children?
 - a. Yes. A non-FQHC/RHC clinic may immunize an underinsured child but they cannot use VFC vaccine.
8. Will the Affordable Care Act decrease the numbers of underinsured children?
 - a. Yes. However, the CDC projects this will take several years since grandfathered plans must make significant changes to their coverage before they are required to offer coverage for all ACIP recommended vaccines to children.
9. How many children are underinsured?
 - a. Nationally, the CDC suggests 20% of teens (7-18 years) and 11% of children (0-6 years) are underinsured. In Kansas, the 2010 census data would indicate there may be as many as 100,000 underinsured children. 2011 immunization data submitted by VFC providers suggests approximately 17,000 underinsured children received immunizations from all enrolled VFC providers.
10. Why don't FQHCs/RHCs see all underinsured children?
 - a. Most FQHCs/RHCs offer immunization services to established patients. They rarely see non-established patients on a walk-in basis. Many underinsured children do not have medical homes and also cannot be seen at the FQHC/RHC.
11. Does deputization require seeing underinsured children on a walk-in basis?
 - a. Yes. The deputized provider must offer walk-in immunization services to the underinsured child during hours of operation.
12. When can the MOU be signed?
 - a. The MOU must be approved by the CDC prior to its being signed by Kansas FQHCs, RHCs or LHDs. KIP will submit the proposed MOU to the CDC by October 1, 2012, and once approved, will send to the FQHCs, RHCs and LHDs for execution.
13. How do we know which FQHCs and RHCs will deputize a LHD?
 - a. KIP has provided an "Intent to Deputize" sheet to all FQHCs and RHCs with this communication. A list of those FQHCs or RHCs who are willing to deputize one or more LHDs will be communicated to the LHDs by September 30, 2012. The LHD will be responsible to contact one of the FQHCs or RHCs who have agreed to deputize a LHD after October 1, 2012. This process will facilitate continuing partnerships between the FQHC, RHC and LHD.
14. What does LHD do once they have a deputizing FQHC or RHC?
 - a. The LHD will sign the CDC approved MOU (KIP will send out the final MOU following CDC approval). LHDs send their signed copy of the MOU to KIP. KIP forwards the MOU to the deputizing FQHC or RHC for signature. The deputizing FQHC or RHC signs and sends to KIP for signature. Once all parties have signed, KIP sends the original signed MOU to the FQHC or RHC, a signed copy to the LHD and keeps a copy on file. This process will occur during late October through mid-December.
15. What if the LHD does not want to be deputized?
 - a. The LHD is asked to notify Martha Froetschner, Deputy Immunization Program Director at 785-925-1990 or mfroetschner@kdheks.gov of this decision no later than September 10, 2012.