



615 East 4th Street | Pierre, SD 57501 P605.773.3737 F605.773.5509

SOUTH DAKOTA  
DEPARTMENT OF HEALTH

**Division of Health and Medical Services**  
Disease Prevention  
Family and Community Health Services  
Health Promotion  
State Epidemiologist

MEMORANDUM 2014-04

TO: All Vaccine Providers

FROM: Tim Heath

DATE: November 10, 2014

RE: Program Changes, Provider Re-enrollment

**As we have mentioned in previous memos, beginning on January 1, 2015 the state's vaccine program will be converting to only supplying vaccine for children eligible for the federal Vaccines for Children (VFC) program. As a reminder the eligible categories are:**

- **Children on Medicaid,**
- **Children without insurance,**
- **Native American/Alaskan Native children,**
- **Underinsured - Children that have insurance that doesn't cover vaccine. These children must receive vaccine at a Rural Health Clinic, Federally Qualified Health Center, or at one of the state's Community Health offices.**

**Additionally on January 1, 2015 we will be offering brand choice for all vaccines with the exception of influenza vaccine. The state will still be supplying influenza vaccine for all children for the 2015-16 flu season.**

The South Dakota Department of Health's 2020 Plan outlines the targets/goals for immunizing South Dakota children. . The 2020 Plan reads as follows:

- Improve South Dakota's age-appropriate immunization rates
  - Increase percent of two-year olds who are age-appropriately immunized from 77% in 2012 to 90% by 2020
  - Increase percent of adolescents ages 13-17 who have received at least one dose of Tdap from 67% in 2012 to 80% by 2020.

It is that time of year again when the new contract needs to be signed and returned. Enclosed is a copy of the contract and an envelope you can use to send back to Pierre. **To prevent delays in**

**vaccine shipment, please return the completed, signed original form by December 15.** Please make a copy of the completed document and retain in your files for three years.

The form is a bit different than past years. There is a check box asking if the VFC Manager and Backup VFC Manager have completed the annual training enrollment. You can check it if one or more of the following is true:

- You received a clinic audit in 2014
- You had an education visit in 2014
- You completed the VFC and Storage and handling modules of the CDC's "You Call the Shots" training series.

It is a requirement for a Backup VFC manager to be listed.

Additionally you are required to submit patient count information by eligibility category. If you utilize SDIIS a report can be run to easily generate a Patient Count Report. You will need to run and print the report and return with you enrollment form. Instructions on running the Patient Count Report are enclosed. If you are electronically exchanging immunization data from your electronic medical record system to SDIIS, you may need to pull the data from your electronic medical record system.

Thank you to each of our providers for your part in continuing to improve South Dakota's childhood immunization rates.

Tim Heath

## Use this report for completing annual provider profile:

**PATIENT COUNT REPORT**  
November 01, 2013 - November 01, 2014

**REPORT CRITERIA**

CLINIC: Avera Pierre - #1109 PROVIDER: ALL

**AGE GROUP**

	<1	1	2	3-5	6	7-10	11-12	13-18	19-24	25-44	45-64	>64	Total
Total	274	332	237	452	102	201	198	411	220	695	741	673	4536

**VFC ELIGIBILITY**

	<1	1	2	3-5	6	7-10	11-12	13-18	19-24	25-44	45-64	>64	Total
American Indian	40	71	43	98	23	30	27	53	26	9	1	0	421
Medicaid	54	65	38	85	15	43	26	51	12	3	0	0	392
No Insurance	8	3	4	6	2	4	0	3	2	5	0	1	38
Not Eligible	169	193	151	256	61	120	139	292	171	655	720	669	3596
Underinsured	0	0	1	5	1	3	4	10	7	1	0	0	32
Unknown	3	0	0	2	0	1	2	2	2	22	20	3	57

Generated November 06, 2014 Page 1

PRINT SAVE CANCEL DONE

### Click on Print Reports

In the lower right hand corner of the screen select **Patient Count** report.

### Click on Generate

As of Date: **Enter the date you are running the report**

From Date: **11/01/2013**

To Date: **11/01/2014**

Select: **VFC Eligibility ONLY**

Remove all other check Marks

Select: **Submit**

**\*\*Disregard the error message that appears at the bottom of the screen, as the report is accurate.**

2015

Vaccines for Children (VFC) Program Provider Profile Form

All health care providers participating in the Vaccines for Children (VFC) program must complete this form annually or more frequently if the number of children served changes or the status of the facility changes during the calendar year.

Date: \_\_\_/\_\_\_/\_\_\_

Provider Identification Number# \_\_\_\_\_

**FACILITY INFORMATION**

Provider's Name: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Vaccine Delivery Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Special Shipping Instructions: \_\_\_\_\_

**FACILITY TYPE (select facility type)**

Private Facilities	Public Facilities
<input type="checkbox"/> Private Hospital <input type="checkbox"/> Private Practice (solo/group/HMO) <input type="checkbox"/> Private Practice (solo/groups as agent for FOHC/RHC-deputized) <input type="checkbox"/> Community Health Center <input type="checkbox"/> Pharmacy <input type="checkbox"/> Birthing Hospital <input type="checkbox"/> School-Based Clinic <input type="checkbox"/> Teen Health Center <input type="checkbox"/> Adolescent Only Provider <input type="checkbox"/> Other _____	<input type="checkbox"/> Public Health Department Clinic <input type="checkbox"/> Public Health Department Clinic as agent for FOHC/RHC-deputized <input type="checkbox"/> Public Hospital <input type="checkbox"/> FOHC/RHC (Community/Migrant/Rural) <input type="checkbox"/> Community Health Center <input type="checkbox"/> Tribal/Indian Health Services Clinic <input type="checkbox"/> Woman Infants and children <input type="checkbox"/> Other _____ <input type="checkbox"/> STD/HIV <input type="checkbox"/> Family Planning <input type="checkbox"/> Juvenile Detention Center <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Drug Treatment Facility <input type="checkbox"/> Migrant Health Facility <input type="checkbox"/> Refugee Health Facility <input type="checkbox"/> School-Based Clinic <input type="checkbox"/> Teen Health Center <input type="checkbox"/> Adolescent Only

**VACCINES OFFERED (select only one box)**

All ACIP Recommended Vaccines for children 0 through 18 years of age.

Offers Select Vaccines (This option is only available for facilities designated as Specialty Providers by the VFC Program)

A "Specialty Provider" is defined as a provider that only serves (1) a defined population due to the practice specialty (e.g. OB/GYN; STD clinic; family planning) or (2) a specific age group within the general population of children ages 0-18. Local health departments and pediatricians are not considered specialty providers. The VFC Program has the authority to designate VFC providers as specialty providers. At the discretion of the VFC Program, enrolled providers such as pharmacies and mass vaccinators may offer only influenza vaccine.

Select Vaccines Offered by Specialty Provider:

<input type="radio"/> DTaP	<input type="radio"/> Meningococcal Conjugate	<input type="radio"/> TD
<input type="radio"/> Hepatitis A	<input type="radio"/> MMR	<input type="radio"/> Tdap
<input type="radio"/> Hepatitis B	<input type="radio"/> Pneumococcal Conjugate	<input type="radio"/> Varicella
<input type="radio"/> HIB	<input type="radio"/> Pneumococcal Polysaccharide	<input type="radio"/> Other, specify:
<input type="radio"/> HPV	<input type="radio"/> Polio	
<input type="radio"/> Influenza	<input type="radio"/> Rotavirus	

**PROVIDER POPULATION**

Provider Population based on patients seen during the previous 12 months. *Report the number of children who received vaccinations at your facility, by age group. Only count a child once based on the status at the last immunization visit, regardless of the number of visits made. The following table documents how many children received VFC vaccine, by category, and how many received non-VFC vaccine.*

VFC Vaccine Eligibility Categories	# of children who received VFC Vaccine by Age Category			
	<1 Year	1-6 Years	7-18 Years	Total
Enrolled in Medicaid				
No Health Insurance				
American Indian/Alaska Native				
Underinsured in FOHC/RHC or deputized facility <sup>1</sup>				
<b>Total VFC:</b>				
Non-VFC Vaccine Eligibility Categories	# of children who received non-VFC Vaccine by Age Category			
	<1 Year	1-6 Years	7-18 Years	Total
Insured (private pay/health insurance covers vaccines)				
Children's Health Insurance Program (CHIP) <sup>2</sup>				
<b>Total Non-VFC:</b>				
<b>Total Patients</b> (must equal sum of Total VFC + Total Non-VFC)				

<sup>1</sup>Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance.

In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FOHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FOHC/RHC and the state/local/territorial immunization program in order to vaccinate these underinsured children.

<sup>2</sup>CHIP – Children enrolled in the state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.

**TYPE OF DATA USED TO DETERMINE PROVIDER POPULATION (choose all that apply)**

- Benchmarking
- Medicaid Claims Data
- IIS
- Other (must describe):
- Doses Administered
- Provider Encounter Data
- Billing System



## VACCINES FOR CHILDREN PROGRAM PROVIDER AGREEMENT

FACILITY INFORMATION			
Facility Name:			VFC Pin#:
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address <i>(if different than facility address)</i> :			
City:	County:	State:	Zip:
MEDICAL DIRECTOR OR EQUIVALENT			
<b>Instructions:</b> <i>The official VFC registered health care provider signing the agreement must be a practitioner authorized to administer pediatric vaccines under state law who will also be held accountable for compliance by the entire organization and its VFC providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.</i>			
Last Name, First, MI:		Title:	Specialty:
License No.:		Medicaid or NPI No.:	Employer Identification No. <i>(optional)</i> :
VFC VACCINE COORDINATOR			
<b>Primary Vaccine Coordinator Name:</b>			
Telephone:		Email:	
Completed annual training: <input type="radio"/> Yes <input type="radio"/> No		Type of training received:	
<b>Back-Up Vaccine Coordinator Name:</b>			
Telephone:		Email:	
Completed annual training: <input type="radio"/> Yes <input type="radio"/> No		Type of training received:	



## PROVIDER AGREEMENT

**To receive publicly funded vaccines at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the health care facility of which I am the medical director or equivalent:**

1.	I will annually submit a provider profile representing populations served by my practice/facility. I will submit more frequently if 1) the number of children served changes or 2) the status of the facility changes during the calendar year.
2.	<p>I will screen patients and document eligibility status at each immunization encounter for VFC eligibility (i.e., federally or state vaccine-eligible) and administer VFC-purchased vaccine by such category only to children who are 18 years of age or younger who meet one or more of the following categories:</p> <p>A. Federally Vaccine-eligible Children (VFC eligible)</p> <ol style="list-style-type: none"> <li>1. Are an American Indian or Alaska Native;</li> <li>2. Are enrolled in Medicaid;</li> <li>3. Have no health insurance;</li> <li>4. Are underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only). Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or under an approved deputization agreement.</li> </ol> <p>B. State Vaccine-eligible Children</p> <ol style="list-style-type: none"> <li>1. In addition, to the extent that my state designates additional categories of children as “state vaccine-eligible”, I will screen for such eligibility as listed in the addendum to this agreement and will administer state-funded doses (including 317 funded doses) to such children.</li> </ol> <p>Children aged 0 through 18 years that do not meet one or more of the eligibility federal vaccine categories (VFC eligible), are <b>not</b> eligible to receive VFC-purchased vaccine.</p>
3.	<p>For the vaccines identified and agreed upon in the provider profile, I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the VFC program unless:</p> <ol style="list-style-type: none"> <li>a) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the child;</li> <li>b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.</li> </ol>
4.	I will maintain all records related to the VFC program for a minimum of three years and upon request make these records available for review. VFC records include, but are not limited to, VFC screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
5.	I will immunize eligible children with publicly supplied vaccine at no charge to the patient for the vaccine.
6.	I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the administration fee cap of \$20.73 per vaccine dose. For Medicaid children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
7.	I will not deny administration of a publicly purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee.
8.	I will distribute the current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).

9.	<p>I will comply with the requirements for vaccine management including:</p> <ul style="list-style-type: none"> <li>a) Ordering vaccine and maintaining appropriate vaccine inventories;</li> <li>b) Not storing vaccine in dormitory-style units at any time;</li> <li>c) Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet South Dakota Department of Health's Immunization Program storage and handling requirements;</li> <li>d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration</li> </ul>
10.	<p>I agree to operate within the VFC program in a manner intended to avoid fraud and abuse. Consistent with "fraud" and "abuse" as defined in the Medicaid regulations at 42 CFR § 455.2, and for the purposes of the VFC Program:</p> <p><b>Fraud:</b> is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.</p> <p><b>Abuse:</b> provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, (and/or including actions that result in an unnecessary cost to the immunization program, a health insurance company, or a patient); or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.</p>
11.	<p>I will participate in VFC program compliance site visits including unannounced visits, and other educational opportunities associated with VFC program requirements.</p>
12.	<p>For providers with a signed deputization Memorandum of Understanding between a FQHC or RHC and the South Dakota Department of Health's Immunization Program to serve underinsured VFC-eligible children, I agree to:</p> <ul style="list-style-type: none"> <li>a) Include "underinsured" as a VFC eligibility category during the screening for VFC eligibility at every visit;</li> <li>b) Vaccinate "walk-in" VFC-eligible underinsured children; and</li> <li>c) Report required usage data</li> </ul> <p>Note: "Walk-in" in this context refers to any underinsured child who presents requesting a vaccine; not just established patients. "Walk-in" does not mean that a provider must serve underinsured patients without an appointment. If a provider's office policy is for all patients to make an appointment to receive immunizations then the policy would apply to underinsured patients as well.</p>
13.	<p>I agree to replace vaccine purchased with federal funds (VFC, 317) that are deemed non-viable due to provider negligence on a <u>dose-for-dose</u> basis.</p>
14.	<p>I understand this facility or South Dakota Department of Health's Immunization Program may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused federal vaccine as directed by the South Dakota Department of Health's Immunization Program.</p>

***By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Vaccines for Children enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.***

Medical Director or Equivalent Name (print):

Signature:

Date:

**CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY, AND VOLUNTARY EXCLUSION:**

Consultant agrees that neither the Consultant, nor any of Consultant's principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in transactions by any Federal department or agency. Consultant will provide immediate written notice to the Department of Health, Division of Administration (600 East Capitol Avenue, Pierre, SD 57501 (605) 773-3361), if Consultant, or any of Consultant's principals, becomes debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in transactions involving Federal funding. Consultant further agrees that if this contract involves federal funds or federally mandated compliance, then Consultant is in compliance with all applicable regulations pursuant to Executive Order 12549, including Debarment and Suspension and Participants' Responsibilities, 29 C.F.R. § 98.510 (1990).

