

AMERICAN MEDICAL ASSOCIATION PRIVATE PRACTICE PHYSICIANS SECTION

Resolution: 7  
(A-26)

Introduced by: Suzanne E. Martini, MD  
Subject: Vaccinations in Physician Offices  
Referred to: PPPS Reference Committee  
(, MD, Chair)

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1 Whereas, vaccination rates improve with physician recommendation; and  
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3 Whereas, Medicare Part B only covers influenza, pneumonia, hepatitis B, COVID, and  
4 occasionally TDAP vaccinations; and  
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6 Whereas, Medicare Part D covers all Advisory Committee on Immunization Practices (ACIP)  
7 recommended vaccines; therefore be it  
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9 RESOLVED, that our American Medical Association advocate for all Advisory Committee on  
10 Immunization Practices (ACIP)-recommended vaccines to be covered by Medicare Part B  
11 (Directive to Take Action).  
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Fiscal Note: (Assigned by HOD)

Received: 4/6/2026

## RELEVANT AMA POLICY

### Financing of Adult Vaccines: Recommendations for Action H-440.860

1. Our American Medical Association supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States: Provider-related
  - a. Develop a data-driven rationale for improved vaccine administration fees.
  - b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
  - c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
  - d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

#### Federal-related

- a. Increase federal resources for adult immunization to:
  - i. Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations.
  - ii. Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered.
  - iii. Fund an adequate universal reimbursement rate for all federal and state immunization programs.
- b. Optimize use of existing federal resources by, for example:
  - i. Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding.
  - ii. Capitalizing on public health preparedness funding.
- c. Ease federally imposed immunization burdens by, for example:
  - i. Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B.
  - ii. Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient.
  - iii. Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
- d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

#### State-related

- a. State Medicaid programs should increase state resources for funding vaccines by, for example:
  - i. Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees.
  - ii. Establishing and requiring payment of a minimum reimbursement rate for administration fees.
  - iii. Increasing state contributions to vaccination costs.

- iv. Exploring the possibility of mandating immunization coverage by third party payers.
  - b. Strengthen support for adult vaccination and appropriate budgets accordingly.
- Insurance-related
1. Provide assistance to providers in creating efficiencies in vaccine management by:
    - i. Providing model vaccine coverage contracts for purchasers of health insurance.
    - ii. Creating simplified rules for eligibility verification, billing, and reimbursement.
    - iii. Providing vouchers to patients to clarify eligibility and coverage for patients and providers.
    - iv. Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as of May 1, 2025, and national medical specialty society recommended vaccines.
      - a. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
      - b. Improve accountability by adopting performance measurements.
      - c. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as of May 1, 2025, and national medical specialty society recommended vaccines as part of the health plan.
      - d. Provide incentives to encourage providers to begin immunizing by, for example:
        - i. Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations.
        - ii. Simplifying payment to and encouraging immunization by nontraditional providers.
        - iii. Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

#### Manufacturer-related

Market stability for adult vaccines is essential. Thus:

- i. Solutions to the adult vaccine financing problem should not deter research and development of new vaccines.
  - ii. Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets.
  - iii. Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP recommend adult vaccines as of May 1, 2025, and national medical specialty society recommended adult vaccines.
  - iv. Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.
3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

### **Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875**

1. All persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as of May 1, 2025, or national medical specialty society recommended vaccines as soon as possible following publication of these recommendations.
2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.
3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.
4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of recommended vaccines, and the timely distribution of recommended vaccines to providers).
5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer recommended vaccines.
6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.
7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.
8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.
9. Until compliance of our AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.
10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines, including those from national medical specialty societies.

Citation: BOT Action in response to referred for decision: Res. 524, A-06; Reaffirmed: A-07; Appended: Res. 531, A-07; Reaffirmed: A-09; Reaffirmed: Res. 501, A-09; Reaffirmed: I-10; Reaffirmed: A-11; Reaffirmed in lieu of: Res 422, A-11; BOT action in response to referred for decision: Res. 422, A-11; Reaffirmed: I-12; Appended: Res. 227, I-12; Appended: Res. 824, I-

14; Reaffirmed: Res. 411, A-17; Reaffirmed> CMS Rep. 3, I-20; Reaffirmed: Res. 228, A-21;  
Reaffirmed: A-22; Modified: BOT Rep. 24, I-25