615 East 4th Street | Pierre, SD 57501 P605.773.3737 F605.773.5509
SOUTH DAKOTA DEPARTMENT OF HEALTH
Division of Health and Medical Services
Community Health Services
Disease Prevention
Family Health
Health Promotion
State Epidemiologist

MEMORANDUM 2022-02

TO: All Vaccine Providers

FROM: Tim Heath

DATE: 11/09/2021

RE: Annual Re-Enrollment

It is that time of year again. The new contract needs to be signed and returned. Enclosed is the provider profile and agreement that needs to be completed and mailed back in the prepaid envelope provided. **To prevent delays in vaccine shipment, please return the completed, signed original form by December 06, 2021.** Please make a copy of the completed document and retain in your files for three years.

Please ensure that the VFC Vaccine Coordinators, both Primary and Back-up, are listed and have completed the annual training requirements for 2021. Types of training that would meet this annual requirement:

- Attended your clinic compliance visit in 2021
- Attended a VFC program educational visit in 2021

Completed the VFC and Storage and Handling modules of the CDC's "You Call the Shots" training series – **Reminder: This is required training annually for all primary and backup vaccine coordinators. Please submit certificates of completion once the training is complete. The training modules can be found here:**
https://www.cdc.gov/vaccines/ed/youcalltheshots.html

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

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

SOUTH DAKOTA DEPARTMENT OF HEALTH

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

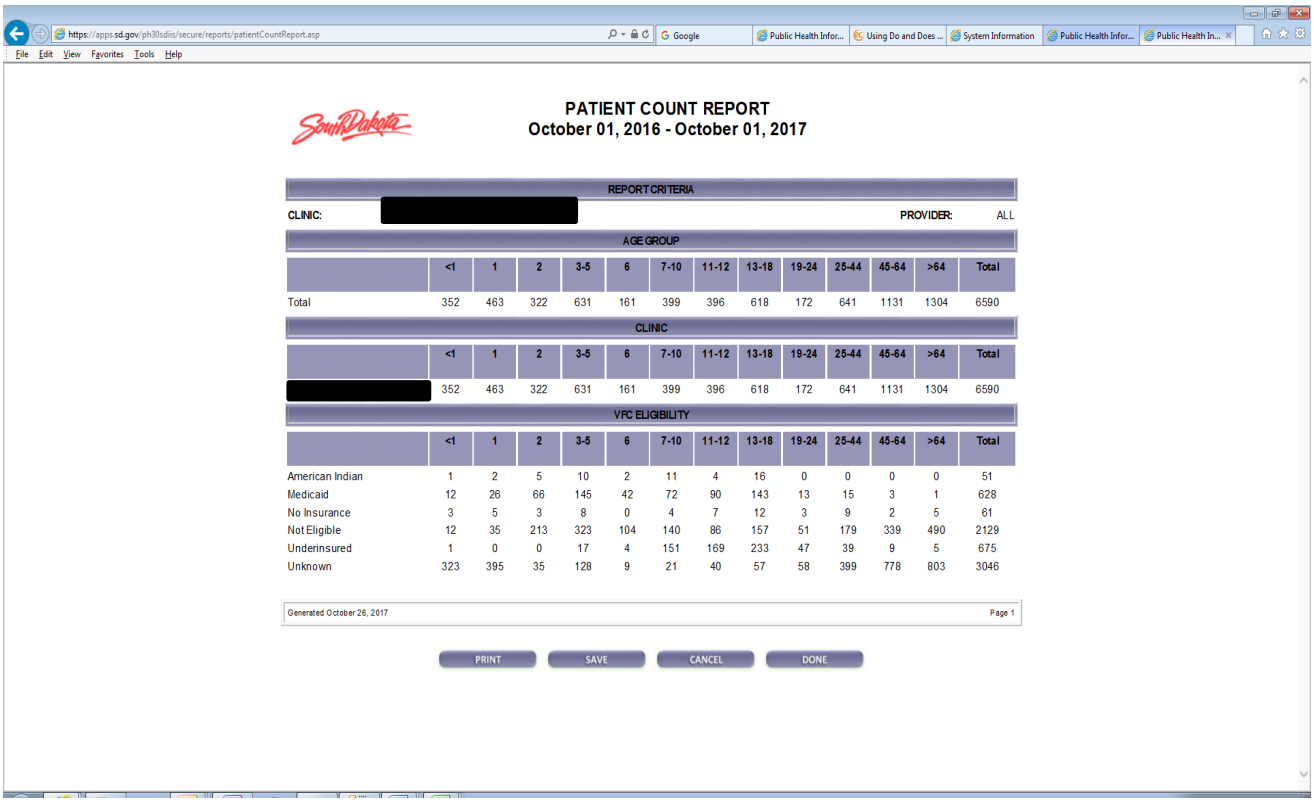
return with your enrollment form. Instructions on running the Patient Count Report are enclosed. If you are electronically exchanging immunization data from your electronic medical record system to SDIIS, you may need to pull the data from your electronic medical record system.

If you have questions you may reach me at 605-773-5323 or email at tim.heath@state.sd.us

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

Tim Heath
Immunization Program Manager

Patient Count Report



PATIENT COUNT REPORT
October 01, 2016 - October 01, 2017

REPORT CRITERIA

CLINIC: [redacted] 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	352	463	322	631	161	399	396	618	172	641	1131	1304	6590

CLINIC

	<1	1	2	3-5	6	7-10	11-12	13-18	19-24	25-44	45-64	>64	Total
[redacted]	352	463	322	631	161	399	396	618	172	641	1131	1304	6590

VFC ELIGIBILITY

	<1	1	2	3-5	6	7-10	11-12	13-18	19-24	25-44	45-64	>64	Total
American Indian	1	2	5	10	2	11	4	16	0	0	0	0	51
Medicaid	12	26	66	145	42	72	90	143	13	15	3	1	628
No Insurance	3	5	3	8	0	4	7	12	3	9	2	5	61
Not Eligible	12	35	213	323	104	140	86	157	51	179	339	490	2129
Underinsured	1	0	0	17	4	151	169	233	47	39	9	5	675
Unknown	323	395	35	128	9	21	40	57	58	399	778	803	3046

Generated October 26, 2017 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: **10/01/2020**

To Date: **10/01/2021**

Select: **VFC Eligibility Only**

Remove all other check marks and **click** on **Submit**

****If your clinic is currently interfacing data between your E.H.R. and the SDIIS, the E.H.R. may not send the patients' VFC Eligibility data to the SDIIS. VFC Eligibility counts may not be accurate. The number of records without a designation of VFC Eligibility are indicated in the row titled UNKNOWN. If you have a high number of records with UNKNOWN VFC Eligibility, you will need to produce the information utilizing your E.H.R.**

SOUTH DAKOTA DEPARTMENT OF HEALTH

2022 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:**
Telephone:	**Email:**	

FACILITY TYPE (select facility type)

Private Facilities	Public Facilities	
❍ Private Hospital	❍ Public Health Department Clinic	❍ STD/HIV
❍ Private Practice (solo/group/HMO)	❍ Public Health Department Clinic as agent for FQHC/RHC-deputized	❍ Family Planning
❍ Private Practice (solo/groups as agent for FQHC/RHC-deputized)	❍ Public Hospital	❍ Juvenile Detention Center
❍ Community Health Center	❍ FQHC/RHC (Community/Migrant/Rural)	❍ Correctional Facility
❍ Pharmacy	❍ Community Health Center	❍ Drug Treatment Facility
❍ Birthing Hospital	❍ Tribal/Indian Health Services Clinic	❍ Migrant Health Facility
❍ School-Based Clinic	❍ Woman Infants and children	❍ Refugee Health Facility
❍ Teen Health Center	❍ Other_____	❍ School-Based Clinic
❍ Adolescent Only Provider		❍ Teen Health Center
❍ Other_____		❍ 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:

❒ DTaP	❒ Meningococcal Conjugate	❒ TD
❒ Hepatitis A	❒ MMR	❒ Tdap
❒ Hepatitis B	❒ Pneumococcal Conjugate	❒ Varicella
❒ HIB	❒ Pneumococcal Polysaccharide	❒ Other, specify:
❒ HPV	❒ Polio	
❒ Influenza	❒ 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 FQHC/RHC or deputized facility[1]				
Total VFC:				
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)[2]				
Total Non-VFC:				
Total Patients (must equal sum of Total VFC + Total Non-VFC)				

[1]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 (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate these underinsured children.

[2]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

Clinic Hours of Operation

Business Hours need to be maintained in standard military time i.e. 0600 for 6am and 1800 for 6pm

		First Open Interval		Second Open Interval	
Mark Days Open	**Day**	**From**	**To**	**From**	**To**
	Monday				
	Tuesday				
	Wednesday				
	Thursday				
	Friday				

Clinic Mailing Address (If different from shipping address on page 1)

Provider's Name:		
Facility Name:		
Mailing Address:		
City:	**State:**	**Zip:**

VACCINES FOR CHILDREN PROGRAM PROVIDER AGREEMENT

FACILITY INFORMATION			
Facility Name:			VFC Pin#:
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (*if different than facility address):*			
City:	County:	State:	Zip:

MEDICAL DIRECTOR OR EQUIVALENT		
Instructions: *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.*		
Last Name, First, MI:	Title:	Specialty:
License No.:	Medicaid or NPI No.:	Employer Identification No. *(optional):*
Provide Information for second individual as needed:		
Last Name, First, MI:	Title:	Specialty:
License No.:	Medicaid or NPI No.:	Employer Identification No.: *(optional):*

VFC VACCINE COORDINATOR	
Primary Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ❍ Yes ❍ No	Type of training received:
Back-Up Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ❍ Yes ❍ No	Type of training received:

PROVIDERS PRACTICING AT THIS FACILITY *(additional spaces for providers at end of form)*

Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.*

Provider Name	Title	License No.	Medicaid or NPI No.	EIN *(Optional)*

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.	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: A. Federally Vaccine-eligible Children (VFC eligible) 1. Are an American Indian or Alaska Native; 2. Are enrolled in Medicaid; 3. Have no health insurance; 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. B. State Vaccine-eligible Children 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. Children aged 0 through 18 years that do not meet one or more of the eligibility federal vaccine categories (VFC eligible), are **not** eligible to receive VFC-purchased vaccine.
3.	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: 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; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
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.	<u>VFC Vaccine Eligible Children</u> 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. <u>Non-VFC Vaccine Eligible Children</u> I will not charge a vaccine administration fee to non-Medicaid state vaccine eligible children that exceeds the administration fee cap of $20.73 per vaccine dose.
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.	I will comply with the requirements for vaccine management including: a) Ordering vaccine and maintaining appropriate vaccine inventories; b) Not storing vaccine in dormitory-style units at any time; 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; d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration
10.	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: **Fraud:** 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. **Abuse:** 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.
11.	I will participate in VFC program compliance site visits including unannounced visits, and other educational opportunities associated with VFC program requirements.
12.	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: a) Include "underinsured" as a VFC eligibility category during the screening for VFC eligibility at every visit; b) Vaccinate "walk-in" VFC-eligible underinsured children; and c) Report required usage data 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.*
13.	I agree to replace vaccine purchased with state and federal funds (VFC, 317) that are deemed non-viable due to provider negligence on a dose-for-dose basis.
14.	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.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY, AND VOLUNTARY EXCLUSION: Provider agrees that neither the Provider, nor any of Provider's principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in transactions by any Federal department or agency. Provider will provide immediate written notice to the Department of Health, Division of Administration (600 East Capitol Avenue, Pierre, SD 57501 (605) 773-3361), if Provider, or any of Provider's principals, becomes debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in transactions involving Federal funding. Provider further agrees that if this contract involves federal funds or federally mandated compliance, then Provider 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).

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:
Name (print) *Second individual as needed*:	
Signature:	Date:

ADDITIONAL PROVIDERS

PROVIDERS PRACTICING AT THIS FACILITY *(attach additional pages as necessary)*

Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.*

Provider Name	Title	License No.	Medicaid or NPI No.	EIN *(Optional)*