

Funding for Vaccine Administration

- Will there be funding allocated to states to assist with distribution of the vaccine and other vaccine efforts?
- Without additional state and local funding to implement COVID-19 vaccine plans, we will be hampered in what we can accomplish. When can we expect more definitive information about resources related to this response?
- What are the plans for any federal contracts and/or additional funding to support “boots on the ground” to vaccinate in tiers 2 and beyond?
- How will vaccine administration costs be covered for people who are uninsured?
- Will the federal government be setting guidelines around allowable vaccine administration costs for those with health insurance (whether that is state insurance, Medicaid, Medicare, CHIP, or some other state funded health insurance)?
- How will funding/reimbursement for vaccines be handled?
- We understand that the vaccine will initially be provided at no cost, as was remdesivir. However, states now must pay for remdesivir on the commercial market. How long will the federal government commit to providing the vaccine to states cost-free?

Allocation and Supply Chain:

- How will the vaccine be allocated to states? What formula will be used?
- How will the vaccine be distributed? What mechanism will the federal government use?
- Can the administration provide more guidance on what prioritization requirements will be a condition of vaccine release and to what extent will states have latitude to guide these decisions?
- Are any further PREP Act changes anticipated beyond authorizations for pharmacists and interns to administer vaccine?
- How is CDC planning to manage vaccine distribution to Federal entities such as Federal Prisons, the VA and other Federal organizations? Will these entities receive a vaccine supply directly from the CDC or will states manage it?
- Similarly, when can states expect guidance from the federal government on the states’ responsibility to vaccinate federal employees (e.g., who is vaccinating National Guard, USPS employees, FBI, etc.
- How will tribal sovereignty be respected? The CDC sent a template asking how many vaccine doses need to be sent to each IHS/tribal health facility rather than asking states where each tribe wants their vaccine doses sent (which could be one of those facilities, a DOH public health office, a private provider that they’d like to contract with, etc.)
- What will be the national strategy for vaccine prioritization when supply is short?
- How will management of supplies (i.e. needles, syringes, alcohol pads, band aids, etc.) work?

- Will there be further guidance documents on handling ultra-cold vaccine (i.e. thawing, storage after thawing, reconstitution, etc.?)
- We are aware of concerns that there is already a shortage of dry ice, which is being used to store the ultracold storage vaccines during the clinical trials.
 - o If that is true, does that shortage impact plans for shipping of ultracold storage vaccine using dry ice and containers that could store the vaccine for up to a week?
 - o If there is a shortage of dry ice, does this change the guidance to states to not purchase additional ultracold storage freezers?
- We also need guidance on redistribution of ultracold storage vaccines. If they will come in 1,000 dose shipments as indicated by the federal government, we likely will need to distribute them further in our rural areas. What will the guidelines be to do that without compromising the vaccine?
- How long will the product be viable outside of the original packaging that the 1,000 doses will be shipped in? Can/will smaller volume packaging be provided in the shipment as well?
- What will the federal guidance be on sub-prioritization among the initial priority groups since there will not be enough vaccine at first for even healthcare workers as a group?

Communication and Information Requirements:

- There has been some indication that large pharmacy chains and possibly interstate healthcare systems will register directly with the federal government. We need the specific details since many of them are also reaching out to the states. This affects our targeted enrollment of these stakeholders to onboard as Covid-19 vaccine providers. When can we expect clarification on which stakeholders will contract directly with the federal government?
- Will there be coordinated multi-state process for monitoring vaccination effects (adverse effects, lack of immunity responses, etc) to ensure early warning signs are identified as quickly as possible?
- Will the federal government provide current/real time information about tribal nations enrolling with the CDC for direct shipments, versus enrolling through the state?
- Can the administration provide more information around long term care facilities? Specifically, are they planning to mandate vaccines in nursing homes through CMS? For example, will the use of vaccines be connected to continued Medicaid funding? If so, when would such requirements take effect?
- Is the federal government going to request that states report personally identifiable COVID vaccine data? We have concerns that this may create a lack of trust and discourage people from getting vaccinated.
- What is the state's role in safety monitoring after people have been vaccinated?
- How many states are using VAMS as their Immunization Information System (IIS)?
- Will states share their micro-prioritization within Phase 1b?
- What communication/messaging materials have been developed?
- How will complex scientific data be messaged and shared publicly? What type of educational material, and in what languages, will be developed?



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- What information will be shared publicly on each approved vaccine? How will transparency be ensured?
- CDC is planning to require reporting to the IIS within 24 hours of administration of the vaccine. We know for flu vaccine there is a dramatic lag in data coming in – how will COVID-19 vaccine data reporting be any different?