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Medicaid Adult Vaccine Provider Reimbursement in 2025: Comparison Across 50 States and Washington, DC



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Executive Summary

Vaccination remains a foundational component of public health; however, adult immunization rates in the United States continue to be below national goals. Since 2021, Avalere Health has analyzed Medicaid provider reimbursement for vaccines to inform policy discussions concerning barriers and facilitators of access. The 2025 assessment builds on prior analyses and reflects a markedly different policy landscape shaped by the Inflation Reduction Act of 2022 (IRA), evolving Advisory Committee on Immunization Practices (ACIP) guidance, and fiscal pressures introduced by the One Big Beautiful Bill Act of 2025 (OBBBA). Together, these changes highlight ongoing challenges in facilitating vaccine access.

Avalere Health's 2025 review included Medicaid fee-for-service (FFS) reimbursement for five vaccine categories: respiratory syncytial virus (RSV), tetanus diphtheria and acellular pertussis (Tdap), pneumococcal conjugate vaccine (PCV), shingles, and COVID-19. We examined reimbursement across physician offices, pharmacies, and Federally Qualified Health Centers (FQHCs), with two key findings:

- There have been relatively few changes in the Medicaid vaccine reimbursement landscape compared to prior assessments. In most states:
 - Physician offices continue to be reimbursed less by Medicaid than Medicare.
 - Pharmacies continue to receive wholesale acquisition cost (WAC)-based reimbursement for vaccine products and relatively low rates for vaccine administration.
 - FQHCs are not able to separately bill from the Prospective Payment System (PPS) for vaccine products and administration.
- Several targeted changes in Medicaid reimbursement were observed in 2025:
 - Administration rates for non-COVID-19 vaccines have increased modestly, whereas reimbursement for COVID-19 immunization administration has declined in multiple states.
 - The number of vaccines for which pharmacies are permitted to seek reimbursement has expanded.
 - A greater number of states now allow FQHCs to bill separately for vaccine products and administration under defined circumstances.

Looking ahead, Medicaid vaccine reimbursement policy is poised to face additional stressors. ACIP's planned re-review of immunization recommendations could alter federal coverage requirements, potentially restricting access in some states. Moreover, provisions in OBBBA are expected to constrain state budgets. As stakeholders look to safeguard vaccine access, ensuring adequate reimbursement for vaccine products and administration can help support ongoing access for Medicaid beneficiaries.

Introduction

Vaccination remains one of the most cost-effective and impactful interventions in public health, yet adult immunization rates in the United States continue to be below national goals.¹ Since 2021, Avalere Health has been conducting assessments of Medicaid provider reimbursement rates to inform policy discussions on how these rates may facilitate or inhibit vaccine access. The key access concerns in 2025 are significantly different from those debated when Avalere Health conducted its first review in 2021,² and its second, 2024³ review of Medicaid reimbursement rates.

Since then, the federal government has introduced major new policies that profoundly affected the vaccine ecosystem. The IRA required coverage without cost sharing for all ACIP-recommended adult vaccines in Medicaid, reinforcing the federal role in supporting vaccine access.⁴ This year, changes in federal leadership and ACIP membership have generated uncertainty about the effectiveness of these reforms. Professional medical societies, including the American Academy of Family Physicians, have issued guidance that differs from federal recommendations, particularly on the use of COVID-19 vaccines.⁵

Also this year, Congress enacted the One Big Beautiful Bill Act,⁶ which included provisions restricting Medicaid funding and placing new pressures on state budgets. As a result, state Medicaid agencies are once again considering how best to implement coverage policies in the context of evolving federal guidance, constrained resources, and their beneficiaries' preventive care needs.

A constant across these years is that "[reducing] financial and systems barriers for health care providers...facilitates [the] delivery of routinely recommended vaccines," as recognized in Strategy 4.4 of the National Vaccine Plan.⁷ Multiple published studies underscore the importance of Medicaid vaccine reimbursement in determining vaccine access.^{8,9} Comparing vaccine product and administration reimbursement across states therefore remains important to support state Medicaid FFS programs and other stakeholders as they consider policy changes to improve adult vaccine uptake.

¹ Centers for Disease Control and Prevention (CDC). Vaccination Coverage among Adults in the United States, National Health Interview Survey, 2022. (accessed October 8, 2025)

² Avalere Health. Medicaid Adult Vaccine Provider Reimbursement in 2021: Comparison Across 50 States and Washington, DC. Washington, DC: Avalere Health. 2023.

³ Avalere Health. Medicaid Adult Vaccine Provider Reimbursement in 2024: Comparison Across 50 States, Puerto Rico, and Washington, DC. Washington, DC: Avalere Health. 2024.

⁴ U.S. Congress. 2022. Inflation Reduction Act of 2022. Public Law 117-169, 117th Cong., 2d sess. (August 16, 2022).

⁵ American Academy of Family Physicians. "AAFP Announces Fall Immunization Recommendations, Reaffirming Commitment to Vaccine Safety and Public Health." *American Academy of Family Physicians*, September 8, 2025.

⁶ Congress.gov. "H.R.1 - 119th Congress (2025-2026): One Big Beautiful Bill Act." July 4, 2025. <https://www.congress.gov/bill/119th-congress/house-bill/1/summary/53>.

⁷ US Department of Health and Human Services. "Vaccines National Strategic Plan: 2021-2025". 2021. (accessed September 15, 2025).

⁸ Polaris JJZ, Eiden AL, DiFranzo AP, Pfister HR, Itzkowitz MC, Bhatti AA. State Medicaid Coverage and Reimbursement of Adult Vaccines Administered by Physicians and Pharmacists. *AJPM Focus*. 2024 Jun 13;3(4):100252. doi: 10.1016/j.focus.2024.100252. PMID: 39070136; PMCID: PMC11279260.

⁹ Moss E, Eiden AL, Hartley L, Carrico J, Farkouh R, Poston S, Gabriel M, Golden AH, Bhatti A. Factors impacting vaccine uptake among adult Medicaid beneficiaries: a systematic literature review. *Health Aff Sch*. 2024 Nov 12;2(11):qxae143. doi: 10.1093/haschl/qxae143. PMID: 39584147; PMCID: PMC11583532.

Background

Over 50 million adults in the United States receive health insurance coverage through Medicaid. Both Medicaid FFS and managed care plans are required to cover all ACIP-recommended vaccines for adults with zero patient cost sharing.¹⁰ While recent changes in federal immunization policy have renewed attention on vaccine coverage, state Medicaid programs also play a central role in shaping vaccine access. States govern the three primary sites of vaccine care (physician offices, pharmacies, and FQHCs), and their policies can have an outsized impact on whether beneficiaries are able to receive vaccines from their providers.

Reimbursement is an important factor in increasing vaccine coverage rates. A recent study from the Global Healthy Living Foundation showed that a \$13 increase in Medicaid FFS pharmacy reimbursement for influenza vaccination is associated with a 5.6% increase in vaccine uptake among Medicaid beneficiaries.¹¹ When considering reimbursement rate reforms, it’s important to consider the provider type and the provider service (e.g., product, administration, visit). In this white paper, Avalere Health reviews payment rates for the two components of vaccine reimbursement (product and administration) and three provider types (physician offices, pharmacies, and FQHCs).

Components of vaccination reimbursement

Vaccination reimbursement often consists of payment for both a vaccine product and its administration. According to the American Academy of Pediatrics (AAP),¹² sufficient reimbursement for both vaccine products and immunization administration are essential (Table 1).

Table 1: Components of vaccination reimbursement and AAP-recommended rates¹³

	Vaccine product	Immunization administration
Costs to be accounted for in reimbursement	Acquisition, ordering time, storage expenses, insurance, and inventory management system	Provider time and effort, practice expense (e.g., syringe), and professional liability
AAP recommended reimbursement rate	125% of private sector cost (i.e., 125% WAC)	100% of the Medicare Physician Fee Schedule (i.e., 100% geographically adjusted National Payment Amount)

¹⁰ Inflation Reduction Act of 2022, Pub. L. No. 117-169, § 11405, 136 Stat. 1818 (2022).
¹¹ IQVIA Institute for Human Data Science. Trends in Adult Vaccination in the U.S.: Impact of reimbursement to health care providers on influenza vaccination for Medicaid FFS population. February 2024
¹² American Academy of Pediatrics. The Business Case for Pricing Vaccines. AAP. 2012.
¹³ American Academy of Pediatrics. The Business Case for Pricing Vaccines. AAP. 2012.

Benchmarks for vaccine reimbursement

State Medicaid programs set rates for vaccination reimbursement; most states rely on available benchmarks to determine their reimbursement rates. These benchmarks include:

- **Average Sales Price (ASP):** A Centers for Medicare and Medicaid Services (CMS) reported, market-based price that reflects the weighted average of all manufacturer sales for a drug. CMS only reports ASP data for certain vaccines covered by Medicare Part B (i.e., tetanus diphtheria and acellular pertussis [Tdap], tetanus diphtheria, rabies, and hepatitis A).
- **Average Wholesale Price (AWP):** A manufacturer-determined price reported by pricing compendia, generally about 20% higher than WAC.
- **Wholesale Acquisition Cost (WAC):** A vaccine's list price reported in pricing compendia and included on the Centers for Disease Control and Prevention (CDC) Vaccine Price list as the "private sector price."

Immunization administration benchmarks

- **National Payment Amount (NPA):** The base rate (i.e., not adjusted for geography) published in the Medicare Physician Fee Schedule (MPFS) for Part B services. While the benchmark is not used by Medicare, other payers, including some state Medicaid agencies, use the NPA in their methodologies. In 2025, the NPA for Current Procedural Technology (CPT) code 90471 (immunization administration; one vaccine) is \$20.05. At the time of this analysis, there is no NPA for CPT 90480 (COVID-19 immunization administration).
- **National Fee Schedule for Medicare Part B Immunization Administration:** The administration reimbursement amount published annually on CMS's Vaccine Pricing website for Medicare Part B providers. In 2025, the rate is \$33.71 for influenza, pneumococcal, and hepatitis B vaccines and \$44.95 for COVID-19 vaccines.

Provider specific reimbursement methodologies

Physician office

Most payers, including Medicaid programs, permit physician offices to bill for an Evaluation and Management (E/M) visit (if applicable), a vaccine product, and immunization administration. Some states deviate from this approach and may restrict reimbursement for immunization-only visits, include reimbursement in the product fee, or have a policy to not separately reimburse an administration fee.

For vaccine products, state reimbursement methodologies often rely on fee schedules that may be developed based on a vaccine product reimbursement benchmark. Fee schedules are manually updated with varying frequency depending on the state. A fee schedule may become outdated if a state ties vaccine product

reimbursement to a benchmark such as WAC or AWP and uses out-of-date prices that do not reflect changes in the fee schedule that would be published in the next update (Figure 1). This can result in reimbursement that is lower than the provider's acquisition cost. This is especially prevalent in states that only update their fee schedule annually (e.g., CO, FL). In these states, almost all vaccine products are reimbursed below the list price at some point during the year. In contrast, some states update their fee schedule quarterly (e.g., ID), which results in more accurate reimbursement rates.

For immunization administration, states that reimburse physician offices for administration generally use one of three methodologies: (1) the physician fee schedule (e.g., NPA), (2) percentage of Medicare's maximum payment amount, or (3) state-specific rates.

Pharmacy

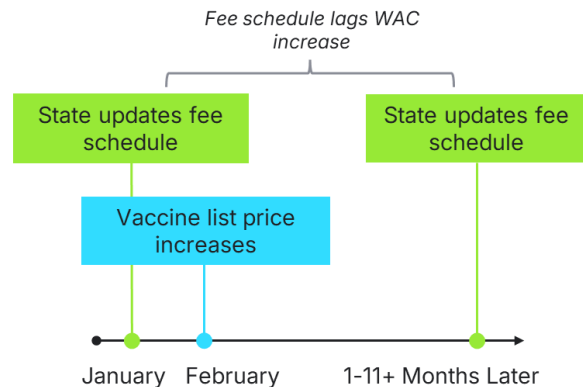
While all states reimburse physician offices for administering vaccines to Medicaid beneficiaries, some states restrict pharmacies from billing for some or all vaccines. For states that permit pharmacy billing, reimbursement may only be available under a certain benefit (i.e., medical or pharmacy benefit), which could affect reimbursement rates and billing and coding procedures.

Under the medical benefit, Medicaid programs may reimburse pharmacies for vaccine products the same as physician offices or based on a different methodology. Under the pharmacy benefit, states traditionally apply a "lesser of" methodology that compares billed charges from the pharmacy with established pricing benchmarks and pays the lowest. For example, the pharmacy may submit its usual and customary price, which the system compares to benchmarks such as WAC or ASP. In these "lesser of" methodologies, many states reimburse vaccines at WAC, since it is traditionally the lowest applicable reimbursement benchmark. Some states require pharmacies to submit their invoiced cost or actual acquisition cost, which is likely to be lower than WAC, to determine reimbursement. Medicaid programs also may reimburse an administration fee, a dispensing fee, or both, in addition to the product cost.

Federally Qualified Health Centers

Approximately 50% of patients who visit FQHCs are covered by Medicaid. In 2024, more than 22 million adults received care at an FQHC.¹⁴ Unlike physician offices and pharmacies that are typically paid individually for each

Figure 1: Illustrative example of an out-of-date fee schedule



¹⁴ Health Resource Services Administration. [National Health Center Program Uniform Data System \(UDS\) Awardee Data](#). (accessed September 16, 2025)

Figure 2: Illustrative example

A 45-year-old healthy patient with Texas Medicaid coverage visits Atascosa Health Center for a primary care visit.

	Scenario 1: Primary Care Visit, No Vaccine Administered [^]	Scenario 2: Primary Care Visit, COVID-19 & Influenza Vaccines Administered [†]
Physician Office Reimbursement	\$76.37	\$269.93
FQHC Reimbursement	\$175.78 (+\$99.41)	\$175.78 (-\$94.15)

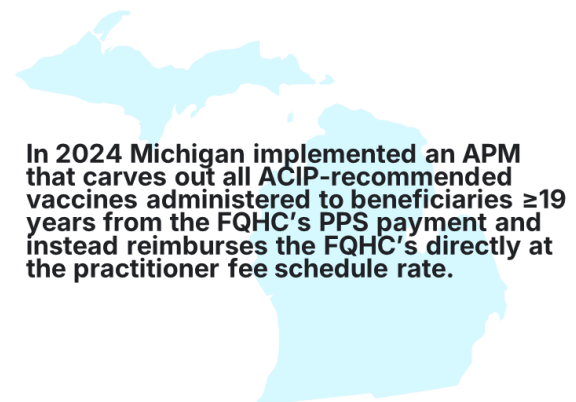
[^]Based on Texas Medicaid FFS reimbursement rates to family practice physicians for a 40–64-year-old periodic comprehensive preventive medicine visit for an established patient (CPT: 99396); [†]Based on Texas Medicaid FFS reimbursement rates to family practice physicians for a 40–64-year-old periodic comprehensive preventive medicine visit for an established patient (CPT: 99396), COVID-19 vaccine (CPT: 91320), COVID-19 immunization administration (CPT: 90480), influenza vaccine (CPT: 90686), and immunization administration; one vaccine (90471)¹⁵

service performed under Medicaid, many state Medicaid programs reimburse FQHCs using the PPS, also known as an encounter payment. The PPS is a payment system that reimburses a single, bundled rate for each qualifying patient visit, and is intended to cover the cost of all services and supplies provided during that visit. Although the PPS technically accounts for vaccine expenditures in the calculation of the base rate, the payment is sometimes lower than the cost of the vaccine provided during a visit. This means that for the full patient visit, the FQHC may be reimbursed less than the amount it spent to acquire the vaccine (Figure 2).

To ensure sufficient reimbursement and incentivize immunization, some states carve vaccine products and immunization administration out of the PPS. This can be done by implementing an alternative payment model (APM), which permits vaccine reimbursement for FQHCs outside the PPS under a defined set of circumstances (Figure 3). Under this system, when a provider performs a billable visit (i.e., a face-to-face encounter with a billable provider where a billable service is performed) states would reimburse vaccinations via the physician fee schedule, in addition to the FQHC receiving the PPS rate for the visit.

Some states also may reimburse vaccine products or administration separately only when there is a non-billable visit (e.g., a visit with a non-billable provider, and/or if only non-billable services are performed, which may include an immunization-only visit in some states). Stakeholders frequently cite low PPS payments as a potential barrier to vaccinating Medicaid beneficiaries at FQHCs, which may result in further immunization disparities between Medicaid FQHC patients and other Medicaid

Figure 3: APM Example: Michigan



¹⁵ Texas Department of Health. "Texas FQHC Reimbursement Rates." (accessed September 5, 2025).

beneficiaries. The low encounter payment is a recognized concern in other markets (e.g., Medicare), and policymakers for these markets have carved vaccines out of the PPS.¹⁶

Approach

Avalere Health was commissioned by Pfizer to assess Medicaid FFS vaccine reimbursement in the 50 states and Washington, DC, looking at physician office, pharmacy, and FQHC reimbursement. Avalere Health focused its research and assessment on five vaccine product categories: RSV, Tdap, PCV, herpes zoster vaccines (often referred to as a shingles vaccine), and coronavirus (COVID-19) (Table 2).

Table 2: Vaccine products and corresponding CPT codes

Product category	CPT codes		Patient population
	Product	Administration	
RSV	90678	90471	- Adults ≥75 years - Adults 50-74 years at increased risk - Pregnant people at 32–36 weeks gestation using seasonal administration
	90679		- Adults ≥75 years - Adults 50-74 years at increased risk
Tdap	90715		Individuals 10-64 years
PCV	90684		- Adults ≥50 years - Adults 19-49 years with certain risk factors
	90677		
Shingles	90750		Adults ≥50 years
COVID-19	91320	90480	Individuals six months and older
	91322		

**Patient population recommended by the ACIP to receive vaccination at the time of the assessment*

For each vaccine, Avalere Health considered the following questions in its assessment of Medicaid FFS program policies:

¹⁶ CMS. MLN Payment for Medicare Part B Preventive Vaccines & Their Administration for Rural Health Clinics & Federally Qualified Health Centers. January 16, 2025.

- What is the Medicaid physician reimbursement amount for the vaccine product and administration services?
- Are pharmacies able to bill for the vaccine product and administration services?
 - If yes, do pharmacies bill for vaccination under the medical or pharmacy benefit?
 - What is the Medicaid reimbursement methodology and/or amount for pharmacy products and administration services?
- How do FFS Medicaid programs reimburse FQHCs for vaccines?
 - Per state definition, are vaccine products and administration services included in the PPS or separately payable during billable visits?
 - Per state definition, are vaccine products and administration services included in the PPS or separately payable during *non*-billable visits?

Avalere Health’s research was informed by publicly available sources, including Medicaid program websites, fee schedules, physician office and pharmacy manuals, coverage policies, provider bulletins, billing guides, and preferred drug lists. Medicaid reimbursement policies were unable to be determined in some states due to lacking, incomplete, or ambiguous public resources. Additionally, while Medicaid Managed Care (MMC) is the predominant method of care delivery across most states, this research and assessment excluded MMC reimbursement because the information is generally not publicly available.

Findings

Physician office

In most states, Medicaid programs reimburse vaccines included in Medicare Part B’s preventive benefit at rates above WAC, while vaccines outside this benefit are typically reimbursed at or below WAC.

Product reimbursement under Medicaid FFS varies significantly by state, reflecting differences in how states set payment methodologies for physician offices. For example, NC reimburses physician offices at WAC +3%, NY reimburses at acquisition cost, and AZ reimburses at the Medicare rate if available or at WAC if not.

Across the vaccine products included in this assessment, a clear pattern emerges: most states reimburse RSV, Tdap, and shingles vaccines below WAC, while PCV and COVID-19 vaccines are typically reimbursed above WAC.

The distinction appears associated with Medicare Part B policy. Both PCV and COVID-19 vaccines are included in the Part B reimbursement file, where they are paid at 95% of AWP. States may leverage this file in their reimbursement policy since 24 states reimburse PCV and 22 reimburse COVID-19 vaccines at the Part B rate. By contrast, vaccines not included in the Part B file (but covered under Medicare Part D) tend to be reimbursed below WAC. All states reimburse these vaccines lower than 95% of AWP. Within this group, additional trends are evident:

- **RSV:** Some states do not list RSV vaccines on their fee schedules and instead indicate they are “manually priced,” likely meaning reimbursement is tied to the provider’s submitted charges. This may be due to their relatively recent entry to the market (2023).
- **Shingles:** Reimbursement is consistently low across states.
- **Tdap:** Reimbursement is generally below WAC, potentially reflecting both its extended time on the market and Medicare’s policy of reimbursing therapeutic vaccines at 106% of ASP (i.e., below WAC).

Table 3: Medicaid FFS physician office vaccine product reimbursement rates relative to WAC, 2025

Vaccine product (CPT)	State Medicaid reimbursement rate relative to WAC			States analyzed*
	Below WAC	WAC	Above WAC	
PCV (90684)	4	3	32	39
PCV (90677)	7	1	34	42
COVID-19 (91320)	14	3	26	43
COVID-19 (91322)	5	3	34	42
Tdap (90715)	39	1	4	44
RSV (90678)	24	4	13	41
RSV (90679)	20	8	12	40
Shingles (90750)	30	5	7	42

**This table only includes states that have the product reimbursement rates on their fee schedule and does not include states that have universal purchase programs (i.e., states purchase vaccines from the CDC federal contract and distribute vaccines free of charge to providers), are entirely MMC, or in which a reimbursement rate or methodology was unable to be determined.*

Product reimbursement comparison to prior findings

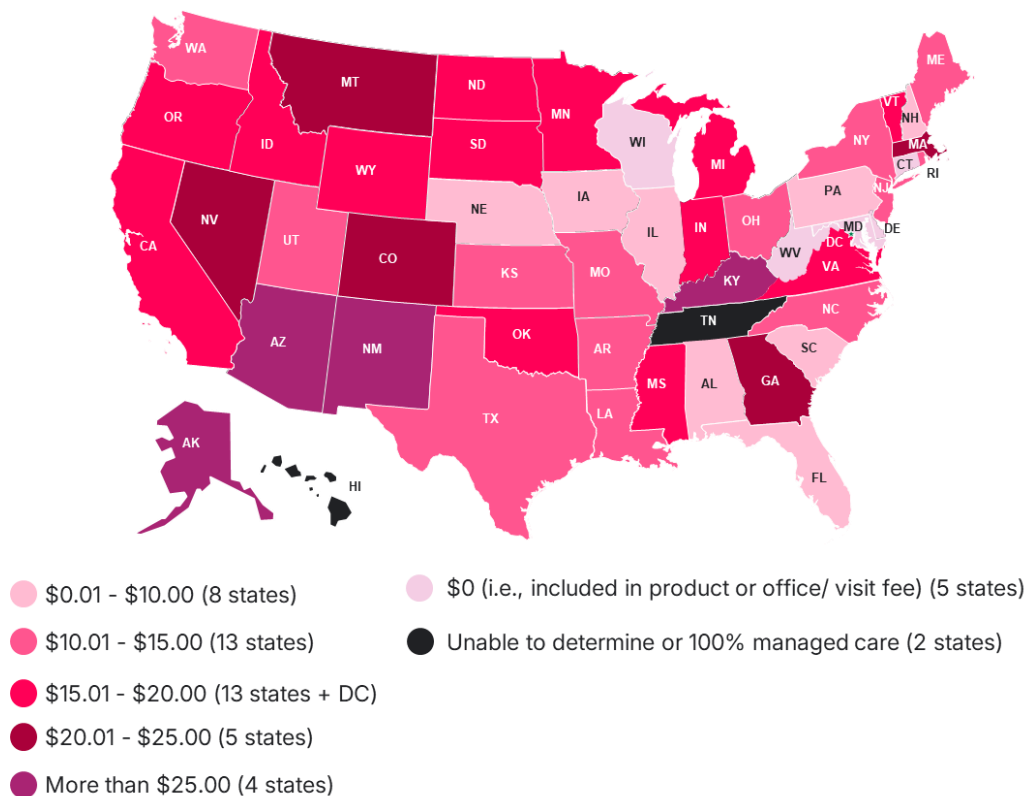
Avalere Health’s 2021 assessment examined four vaccines—PCV13, pneumococcal polysaccharide vaccine 23-valent, human papillomavirus vaccine (HPV), and Tdap. The 2024 assessment expanded the scope to include PCV20, COVID-19, maternal RSV, and shingles vaccines. Despite change in products studied over time, the overall trends and main takeaways from this assessment closely resemble those of the two prior assessments. In the current assessment, the four vaccines covered as preventive Medicare Part B products—two PCV and two COVID-19 vaccines—were reimbursed at the 95% of AWP benchmark in most states, resulting in payment levels that are generally above WAC; this is similar to the Part B vaccines reviewed in the prior assessment. By contrast, shingles and Tdap vaccines continue to receive low reimbursement from Medicaid programs. Similarly, vaccines not included in Medicare Part B—such as shingles and RSV (covered under Medicare Part D)—were reimbursed below

WAC in most states, consistent with earlier findings for HPV in the 2021 analysis and for RSV and shingles in the 2024 study. Taken together, results across all three assessments indicate that inclusion in the Medicare Part B reimbursement file is the strongest predictor of whether a vaccine will be reimbursed above its private sector benchmark price.

42% of state Medicaid programs reimburse physician offices less than 75% of the National Payment Amount for immunization administration

Similar to vaccine products, reimbursement policies for immunization administration vary across state Medicaid programs and are generally lower than immunization administration reimbursement for Medicare Part B vaccines. For example, CT separately reimburses only COVID-19 immunization administration, DE includes immunization administration in the office visit reimbursement, and WV does not separately reimburse for immunization administration. Thirty-eight states and DC reimburse immunization administration separately, and five states (i.e., CT, DE, MD, WI, WV), separately reimburse physicians for immunization administration solely for immunization-only visits (i.e., no E/M services provided). Five states (AL, IL, IN, VA, RI) include immunization administration reimbursement in the product or office/visit payment.

Figure 4: Medicaid FFS physician office immunization administration reimbursement rates, by state, 2025



Of states that reimburse for immunization administration outside of an E/M visit or solely for an immunization-only visit, reimbursement rates ranged from \$3.72 (19% of NPA) in SC to \$32.54 (162% of NPA) in AK (Figure 4). The median immunization administration rate is \$14.78, which is 74% of NPA (\$20.05) and 44% of the Medicare

Part B immunization administration rate (\$33.71). Notably, 21 states reimburse physician offices \$15.00 or less for immunization administration.

During the COVID-19 pandemic, the American Rescue Plan Act provided federal funding to states for COVID-19 vaccines, testing, and related services, leading to most state Medicaid programs reimbursing an enhanced rate of \$40 for COVID-19 vaccine administration in physician offices. Despite the end of the public health emergency, most states retained the Medicare COVID-19 immunization administration reimbursement rate of \$40. Of states that reimburse for COVID-19 immunization administration outside of an E/M visit or solely for an immunization-only visit, reimbursement rates ranged from \$5.00 in ME to \$46.83 in NM, while 30 states and DC reimburse at or above \$25 for COVID-19 immunization administration in physician offices.

Administration reimbursement comparison to prior findings

Physician office immunization administration reimbursement has increased since 2021,^{17, 18} with 21 states increasing reimbursement between 2024 and 2025. The median Medicaid FFS reimbursement rate increased by 28.3% (\$11.46 to \$14.70) from 2021 to 2024 and 0.5% (\$14.70 to \$14.78) from 2024 to 2025. While the NPA increased 20.7% (\$17.10 to \$20.64) from 2021 to 2024, it decreased 2.9% (\$20.64 to \$20.05) from 2024 to 2025.

In 2024, all except three states reimbursed COVID-19 immunization administration at or near \$40; however, in 2025, only 30 states and DC reimburse COVID-19 immunization administration above \$25. At least 15 states substantially decreased COVID-19 reimbursement rates to be more in line with the states' reimbursement for the administration of other vaccines following the end of the American Rescue Plan Act's policy for 100% federal funding to states for COVID-19 vaccines, testing, and related services on September 30, 2024.¹⁹ Further declines in reimbursement are expected once the Medicare Part B reimbursement rate is lowered to approximately \$30, which is expected once the FDA Emergency Use Authorization Declaration is rescinded.

Pharmacy

In contrast to prior assessments, in 2025 a majority of states allow pharmacies to be reimbursed for vaccines and vaccine administration.

Thirty-nine states and DC allow pharmacies to bill for administering all assessed products. Among the 11 remaining states, Avalere Health could not identify the policy in two (HI and NJ). In RI, a Universal Purchase adult state, pharmacies are not permitted to bill for any assessed vaccine. In three states (DE, IA, MA), pharmacies can bill for all included products, but the pharmacy lookup tool/fee schedule does not include certain products. In the remaining states (KY, NE, OH, TN, TX), pharmacies can only bill for a subset of vaccines.

¹⁷ Avalere Health. *Medicaid Adult Vaccine Provider Reimbursement in 2021: Comparison Across 50 States and Washington, DC*. Washington, DC: Avalere Health. 2023.

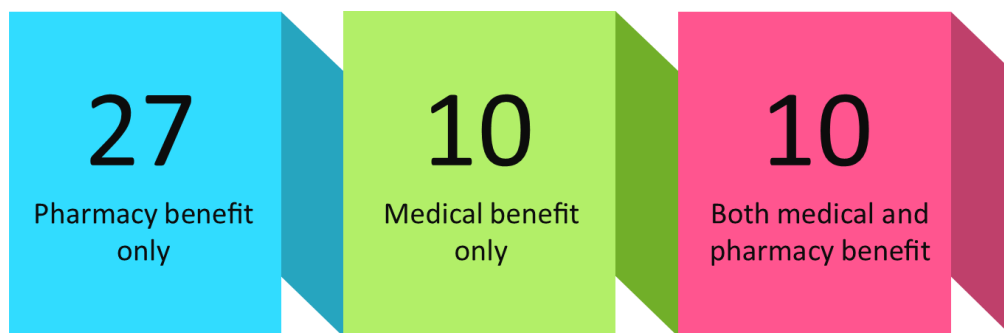
¹⁸ Avalere Health. *Medicaid Adult Vaccine Provider Reimbursement in 2021: Comparison Across 50 States and Washington, DC*. Washington, DC: Avalere Health. 2023.

¹⁹ American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 9811, 135 Stat. 4 (2021).

Pharmacies are commonly reimbursed at WAC or greater for vaccine products

Pharmacy reimbursement for vaccine products varies based on the billing pathway and state reimbursement methodology (Figure 5)

Figure 5: Number of states that permit pharmacies to bill for vaccines, by benefit type, 2025



Under the pharmacy benefit, most states determine reimbursement by the “lesser of” methodology. The most common benchmark is WAC and most states that reimburse under the pharmacy benefit use a methodology that ensures vaccine products are reimbursed at or above WAC. The 20 states that reimburse pharmacies for vaccination under the medical benefit reimburse pharmacies at the same rate as physician offices.

Pharmacy reimbursement for immunization administration is similar to physician office reimbursement

Pharmacy administration and dispensing fee rates are at least \$10 in most states. Pharmacy immunization administration service reimbursement ranges from \$5 (24% of NPA and 15% of Part B rate) to \$27.66 (134% of NPA and 84% of Part B rate) (Figure 6). Payment rates largely are identical to physician reimbursement rates, although some states reimburse pharmacies substantially less for administering vaccines (e.g., NV reimburses pharmacies about \$16 less than physician offices) and others reimburse substantially more (e.g., SC reimburses pharmacies about \$7 more than physician offices).

Map of the United States showing the percentage of retail drug sales covered by third-party payers by state. The map is color-coded according to the following legend:

- \$0.01 - \$10.00 (9 states)
- \$10.01 - \$15.00 (12 states +DC)
- \$15.01 - \$20.00 (11 states)
- > \$20.00 (5 states)
- Pharmacies cannot bill for any of the included products, except COVID-19 vaccines (6 states)
- \$0, (i.e., included in product or not separately reimbursed) (3 states)
- Unable to determine (4 states)

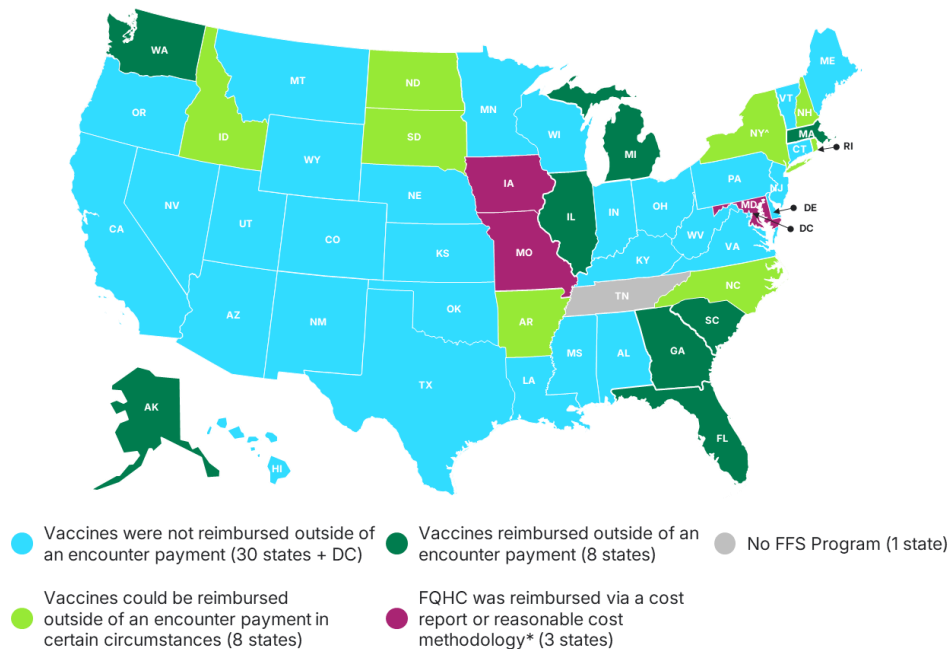
The number of states reimbursing pharmacies for vaccinations has grown; all assessed vaccines were reimbursed in 23 states in 2021, 37 states in 2024, and 38 states in 2025. In addition to having greater ability to receive reimbursement, an increasing number of states are permitting pharmacies to bill under the medical benefit (14 states in 2024 and 20 states in 2025), potentially because of expanded scope of practice for pharmacists (e.g., prescriptive authority).

Most states include Medicaid vaccine product and immunization administration service reimbursement in the FQHC PPS encounter payment

15

previous years. For example, reimbursement rates for FQHCs in TX ranged from \$153.76 to \$480.15 in 2025.²⁰ Although this assessment did not include comprehensive review of encounter rates paid to each FQHC, encounter rates were often below WAC for certain adult vaccines (e.g., adult RSV vaccine list prices range from \$290.00 to \$306.80).

Figure 7: Medicaid FFS FQHC vaccine product reimbursement methodology, by state, 2025



^ NY has an APM that applies to only certain FQHCs and vaccines; *Defined as an amount calculated on a per-visit basis that is equal to the reasonable cost the services provided at the visit.

Eight states permit vaccines to be reimbursed outside the encounter rate in all circumstances (e.g., via APM or program policy). An additional eight states permit vaccines to be reimbursed outside the encounter payment in certain circumstances if the visit met the billable visit requirements. Of those eight states, seven permitted vaccines to be reimbursed outside of the encounter payment for immunization-only visits, while NY permits vaccine reimbursement outside the PPS in certain instances not determined by immunization-only visit. A common reason why a vaccination does not meet the billable visit requirements was that it was classified as a non-immunization-only visit and a non-billable provider administered the vaccine. For example, ND Medicaid notes that vaccines administered concurrently with a medical encounter is incident to the encounter and thus reimbursed through the encounter rate, while for immunization-only visits, vaccines are reimbursed in accordance with the fee schedule.

For immunization administration, 28 states and DC did not reimburse the service separately from the PPS encounter payment under any circumstances. Four states (AK, MI, SC, and WA) permit immunization administration to be reimbursed outside the encounter rate under all circumstances, and 14 states (AR, ID, IL, IN,

²⁰ Texas Department of Health. "Texas FQHC Reimbursement Rates." (accessed September 5, 2025).

GA, MA, ME, NC, NH, ND, NY, PA, SC, and SD) permit immunization administration to be reimbursed outside the encounter rate in some circumstances. For example, both IL and IN Medicaid permit only administration of COVID-19 vaccines to be reimbursed outside of the encounter payment.

FQHC comparison to prior findings

Since 2021,²¹ an increasing number of states have begun to reimburse outside of the encounter payment for vaccines administered at an FQHC. In 2021, only three states (NC, NH, RI) reimbursed FQHCs outside of the PPS for vaccine products, compared to eight states that reimburse separately for vaccine product and four that reimburse separately for administration in 2025. In fiscal year 2025, MI began reimbursing FQHCs separately for all ACIP-recommended vaccines administered to beneficiaries age 19 years and older at the practitioner fee schedule rate.²²

Implications and looking ahead

Consistent with Avalere Health's 2021 and 2024 reports, the 2025 assessment found significant variability in state Medicaid FFS reimbursement rates for physician offices, pharmacies, and FQHCs.^{23,24}

Provider reimbursement for vaccines and related administration services is a critical factor that influences vaccine access and uptake.²⁵ Providers have frequently cited the financial challenges associated with vaccine purchasing, and inventory management is often not accounted for in reimbursement rates for vaccines and administration.²⁶ Based on this assessment, 34 states and DC reimburse below the NPA of \$21.05 for non-COVID-19 vaccine administration services. The remaining 16 states may not reimburse providers at a rate that covers the cost of administering vaccines. Research suggests that ensuring adequate provider reimbursement for vaccine product and administration can increase provider willingness to stock and administer vaccines, which could increase vaccine access and reduce vaccine-preventable diseases.²⁷ Moreover, in the FQHC setting, where many Medicaid patients receive most of their health services including vaccines, PPS reimbursement policies can act as a disincentive to offering all recommended vaccines to adults.

Looking ahead, there are several key policy changes that may impact reimbursement of vaccines and administration in Medicaid that should be monitored by stakeholders:

²¹ Avalere Health. *Medicaid Adult Vaccine Provider Reimbursement in 2021: Comparison Across 50 States and Washington, DC*. Washington, DC: Avalere Health. 2023.

²² Michigan Department of Health and Human Services. "Medicaid Program Rate Updates Fiscal Year (FY) 2025; Federally Qualified Health Center (FQHC) Reimbursement Update." (accessed September 12, 2025).

²³ Avalere Health. *Medicaid Adult Vaccine Provider Reimbursement in 2021: Comparison Across 50 States and Washington, DC*. Washington, DC: Avalere Health. 2023.

²⁴ Avalere Health. *Medicaid Adult Vaccine Provider Reimbursement in 2024: Comparison Across 50 States, Puerto Rico, and Washington, DC*. Washington, DC: Avalere Health. 2024.

²⁵ Avalere Health. *Examining Provider-Focused Vaccine Policy Reforms: Considerations for Patient Access*. Washington, DC: Avalere Health: 2024.

²⁶ Health Affairs. Belowich, E et al. "Increased Reimbursement May Help Overcome Barriers To Administration Of Seasonal And Routine Vaccines." (accessed September 12, 2025).

²⁷ Lin, Cheryl, Jewel Mullen, Danielle Smith, Michaela Kotarba, Samantha J. Kaplan, and Pikuei Tu. 2021. "Healthcare Providers' Vaccine Perceptions, Hesitancy, and Recommendation to Patients: A Systematic Review" *Vaccines* 9, no. 7: 713. <https://www.mdpi.com/2076-393X/9/7/713>.

- In June and September 2025, the ACIP announced it intends to review several existing immunization recommendations, including many recommendations related to the childhood and maternal immunization schedules. Modifications to these recommendations could significantly decrease access to vaccines in Medicaid, as federal law only requires Medicaid to cover vaccines without patient cost-sharing if the vaccine is recommended by ACIP. Additionally, the ACIP determines which vaccines are offered in the Vaccines for Children Program. Changes to ACIP recommendations could also restrict access to vaccines in the pharmacy setting in states where pharmacist authority to administer vaccines is limited to ACIP recommendations.
- In July 2025, President Trump signed the One Big Beautiful Bill Act (OBBBA), which includes future changes to Medicaid funding and eligibility. Changes as a result of OBBBA could place increased pressure on state Medicaid budgets, which may prompt states to delay provider increases, or even reduce provider reimbursement for vaccine products and immunization administration services. In addition, the law adds eligibility requirements that the Congressional Budget Office estimates will decrease Medicaid enrollment by 7.8 million by 2034.²⁸
- Moving into 2026, many states may continue to decrease Medicaid immunization administration rates for COVID-19 vaccines. Medicaid's 100% federal funding for COVID-19 vaccines, testing, and related services ended in September 2024, meaning states are now responsible for a portion of the product cost and administration fee and may decrease administration reimbursement as a cost saving measure.
- CMS proposed in the 2026 MPFS to develop three new CPT codes to be used in commercial and Medicaid markets for immunization counseling when an immunization is not administered.²⁹ If finalized for calendar year 2026, these codes could facilitate increased provider counseling, which may encourage more patients to receive vaccines.

In the future, policymakers could expect additional focus on Medicaid vaccine reimbursement given the environmental factors that may make vaccine access or funding for reimbursement more limited. Moving forward, it will be critical for stakeholders to continue to engage with policymakers to underscore the importance of maintaining vaccine access for Medicaid beneficiaries and support sufficient reimbursement for providers administering vaccines.

²⁸ Congressional Budget Office. "[Information Concerning Medicaid-Related provisions in Title IV of H.R. 1](#)." (accessed September 15, 2025).

²⁹ "[Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program](#)," *Federal Register*, vol. 90, no. 134 (July 16, 2025): 32431. [FR Doc. 2025-13271].