

VACCINATION RECOMMENDATIONS

Q. When will a VIS be available for the 2023–2024 updated COVID-19 vaccines?

A Vaccine Information Statements (VIS) for the 2023–2024 updated COVID-19 vaccines is available here: <https://www.cdc.gov/vaccines/hcp/vis/vis-statements/covid-19.html>.

Q. Can providers co-administer the 2023–2024 updated COVID-19 vaccine with the influenza and/or the respiratory syncytial virus (RSV) vaccine?

Flu, COVID-19, and RSV vaccines may be co-administered (given at the same visit). Co-administration of these vaccines might be especially important when the patient has risk factors for severe respiratory illness (including but not limited to advanced age, cardiopulmonary disease, immunocompromising conditions, and residence in a long-term care facility) and there might not be an opportunity to vaccinate the patient with all of their recommended vaccines in the near future.

To optimize protection for the fall and winter virus season, providers should consider offering the patient all recommended respiratory virus vaccines during their current visit. Patients should be aware that they may experience more side effects, like fever and fatigue, if multiple vaccines are given together; however, these side effects are generally mild or moderate and only last a day or two.

Current evidence from multiple studies supports the safety of co-administering flu and COVID-19 vaccines. There are fewer data on co-administering RSV with other vaccines; however, in clinical trials, coadministration of RSV and flu vaccines was safe. For patients at high risk of becoming seriously ill from one of these diseases, the benefits of timely protection from coadministration of more than one vaccine likely outweigh the possible risks of increased side effects.

If the provider is confident there will be additional opportunities to vaccinate the patient, and the patient prefers to receive these vaccines during different visits, there is no minimum wait period between these vaccines.

The most important thing is that patients receive all their recommended vaccines in a timely way to help protect them against these major respiratory diseases this fall and winter virus season.

Q. What are the data on coadministration of flu, COVID, and RSV vaccines?

Current evidence from multiple studies supports the safety of co-administering flu and COVID-19 vaccines. There are fewer data on co-administering RSV with other vaccines; however, in clinical trials, coadministration of RSV and flu vaccines was safe. For patients at high risk of becoming seriously ill from one of these diseases, the benefits of timely protection from coadministration of more than one vaccine likely outweigh the possible risks of increased side effects.

Q. How do we administer three or more vaccines at the same visit?

Best practices for multiple injections include:

- Prepare each injectable vaccine using a separate syringe.
- Label each syringe with the name and the dosage (amount) of the vaccine, lot number, the initials of the preparer, and the exact beyond-use time, if applicable.
- Do NOT mix more than one vaccine in the same syringe in an effort to create a “combination vaccine.”
- Separate injection sites by 1 inch or more, if possible.
- Administer vaccines that are known to be painful when injected last. Because pain can increase with each injection, the order in which vaccines are injected matters. Injecting the most painful vaccine last when multiple injections are needed can decrease the pain associated with the injections.
- Administer vaccines that may be more likely to cause a local reaction (e.g., pneumococcal conjugate [PCV]) in different limbs, if possible.



Q. If vaccines are not co-administered, do they need to be separated by a specific interval when administered?

No, if flu, COVID-19 and/or RSV vaccines are not administered the same day, there is no minimum wait period between these vaccines.

Q. What does CDC now consider being “up to date” with COVID-19 vaccination?

Being up to date depends on your age group and what vaccine you received.

Everyone aged 5 years and older

You are up to date when you get 1 updated COVID-19 vaccine.*

Children aged 6 months—4 years

You are up to date when you get all recommended doses, including at least 1 dose of updated COVID-19 vaccine.

People who got the Johnson & Johnson/Janssen COVID-19 vaccine

You are up to date when you get 1 updated COVID-19 vaccine.

*12 years and older: People aged 12 years and older who have not previously gotten any COVID-19 vaccine doses and choose to get Novavax should get 2 doses of updated Novavax vaccine to be up to date.



VACCINE DISTRIBUTION

Q. How does COVID-19 vaccine distribution work on the commercial market?

In September 2023, COVID-19 vaccines transitioned from sole distribution by the U.S. government to distribution through multiple channels as part of the commercial market. This makes ordering and distribution for COVID-19 vaccines similar to other routine vaccines. Depending on the vaccine, commercial purchase of vaccine can occur by (1) direct purchase from the manufacturer or (2) purchase from a wholesaler or distributor.

Q. COVID-19 vaccine distribution seems slow. Does this mean there is a vaccine shortage?

There is not a vaccine shortage. There is enough COVID-19 vaccine supply to meet demand. Distribution has transitioned from the federal government to the commercial market, and there are differences between the two. During the Public Health Emergency (PHE) when there was a federal distribution system, millions of doses were distributed within a very short amount of time. With the transition to the commercial market, distribution of COVID-19 vaccines is now similar to that of routine vaccines. Supply is distributed over time to meet demand, rather than all at once. Additionally, timelines for ordering and distribution may be longer than during the COVID-19 Vaccine Program as part of the PHE.

Q. Why aren't long-term care facilities prioritized for vaccine distribution?

CDC does not control the timeline for commercial vaccine distribution. The primary reason for the variation in timing is because different types of vaccine providers order from different sources. A provider may order COVID-19 vaccine through (1) direct purchase from the manufacturer or (2) purchase from a wholesaler or distributor. The timing of vaccine delivery for each method can vary.

VACCINE ACCESS

Q. I run a group disability home in a rural area, how can I get vaccine for the residents?

Updated 2023–2024 COVID-19 vaccines are widely available in the United States. Visit [vaccines.gov](https://www.cdc.gov/vaccines) or call 1-800-232-0233 (TTY 1-888-720-7489) to find a provider near you. You can also contact the local (city or county) health department or state [immunization program](#). Vaccination providers should ensure that they are prepared to accommodate the needs of older adults and people with disabilities when they receive vaccination services.

Transportation and other support can be provided by contacting the Disability Information and Access Line (DIAL). Connect with a DIAL Information Specialist from 8:00 a.m. to 9:00 p.m. ET, Monday–Friday, by phone, text message, or videophone at 888-677-1199.

Q. Can residents and staff receive a COVID-19 vaccine at an existing vaccination site, such as a nearby pharmacy or healthcare provider’s office?

Long-term care (LTC) providers are encouraged to consider the option that works best for residents and staff when coordinating access to COVID-19 vaccines. Visit [vaccines.gov](https://www.cdc.gov/vaccines) to find COVID-19 vaccines near you. If your residents attend a day program, visit a senior center, or participate in a congregate nutrition program, check and see if those programs are offering on-site vaccinations. LTC administrators and managers may visit [Eldercare Locator](#), a public service of the U.S. Administration on Aging or call 1-800-677-1116 for more information on transportation for older adults and people with disabilities. CDC does not endorse a particular service provider and cannot verify the quality and scope of services offered.



Q. What is the role of hospitals, emergency departments, and urgent care facilities in COVID-19 vaccine uptake?

Hospitals, emergency departments (EDs), and urgent care facilities (UCs) in the United States can play an influential role in building confidence in, and improving, COVID-19 vaccine uptake, as healthcare providers are the most trusted source of health information. Hospitals, EDs, and UC facilities are encouraged to offer vaccination to every eligible person at discharge and avoid missed opportunities for vaccination. Some best practices include:

- Addressing vaccine hesitancy with all patients and those that accompany them as part of routine practice.
- Strongly encouraging and offering vaccination to all eligible patients and any friends or family who are accompanying them.
- Utilizing personnel not involved in the direct care of the patient, if available, to administer vaccines if the department is very busy and it would help workflow.
- Offering vaccination services either at bedside or in special vaccination areas during discharge process.
- Documenting each recipient’s vaccine administration information in the medical record, immunization information system, and a vaccination record for the recipient.

BRIDGE ACCESS PROGRAM

Q. What is the new CDC Bridge program and how can I use it to get no-cost vaccine for my uninsured staff?

CDC’s Bridge Access Program is a public-private partnership to help maintain access to no-cost COVID-19 vaccines for adults who are underinsured or uninsured through their local pharmacies, the existing public health infrastructure, and their local health centers. CDC’s Bridge Access Program provides no-cost COVID-19 vaccines to adults without health insurance and to adults whose insurance does not cover all COVID-19 vaccine costs. This is a temporary program which will end by December 31, 2024.

COVID-19 vaccines through this program are available at locations such as pharmacies, local health centers, and other participating local healthcare providers. Visit [vaccines.gov](https://www.cdc.gov/vaccines) for find a provider that offers no-cost COVID-19 vaccines through the Bridge Access Program.

Q. How can long-term care facility staff who are uninsured or underinsured get vaccine at no cost?

There are a few ways in which long-term care facilities can leverage the Bridge Access Program for staff who are uninsured or underinsured:

1. Walgreens pharmacies are participating in the Bridge Access Program and long-term care facility staff who are uninsured or underinsured can schedule no-cost COVID-19 vaccination at Walgreens locations at a time that is convenient to them. Additionally, some Walgreens locations may be able to provide temporary, [“pop up” vaccine clinics](#) in coordination with long term care facilities.
2. CVS pharmacies and Minute Clinics are participating in the Bridge Access Program. Staff who are uninsured or underinsured can get no-cost COVID-19 vaccination at CVS locations.
3. Long-term care pharmacies can enroll in the Bridge Access Program through:
 - a. eTrueNorth, a pharmacy aggregator. This option would be a direct route to becoming a Bridge provider, not requiring enrollment in the state’s adult program.
 - i. After enrolling in the Bridge Access Program through eTrueNorth, pharmacies can order Bridge doses and administer them to qualifying recipients, including uninsured staff. Under this option, pharmacies order and pay for vaccines doses up front and then get reimbursed for both the cost of vaccine and vaccine administration after the doses have been administered and all records submitted to eTrueNorth.
 - b. The jurisdictional immunization program, first enrolling as a Section 317 provider (a program that authorizes the federal purchase of vaccine to meet the needs of priority populations, such as under or uninsured adults), then signing a provider agreement to participate in the Bridge Program. This option would be a longer route to becoming a provider. Under this option, pharmacies would not have to pay for doses up front, though pharmacies would need to await allocation of any remaining Bridge Access Program doses through their jurisdictional immunization program.
4. COVID-19 vaccines through this program are also available at participating local healthcare providers, local health centers, and pharmacies. Staff can visit [Vaccines.gov](#) for find a provider that offers no-cost COVID-19 vaccines through the Bridge Access Program.

Q. How do pharmacies that are already partnered with long-term care facilities enroll through eTrueNorth?

Contact eTrueNorth at <https://etruenorth.com/connect> to start the enrollment process.

Q. Can my state health department conduct a vaccination clinic at my facility to get no-cost COVID-19 vaccine for underinsured and uninsured staff?

Vaccination activities vary by jurisdiction. Please contact your [jurisdictional immunization program](#) if interested in a vaccination clinic through the Bridge Access Program.

Q. How do non-pharmacy community partners enroll in the Bridge Program?

Any provider that is currently or becomes enrolled as a 317 adult provider and signs a provider agreement with their state health department immunization program to participate in the program is eligible to order and receive CDC-procured COVID-19 vaccines and administer them to adults without health insurance.

Please contact your state health department’s [immunization program](#) for further information.

Q. We have staff that are insured indicating they are being charged out-of-pocket for their COVID-19 vaccine. Can you provide insight?

Updated COVID-19 vaccines are available to most adults living in the U.S. at no cost through their private health insurance, Medicare, and Medicaid plans. For most people with private insurance, COVID-19 vaccines will be covered without cost sharing for in-network providers. Individuals can check with their insurance provider on what they cover. If the LTC pharmacy is not in-network, for staff, they will need to access COVID vaccines through an in-network provider. The Bridge Program may not be used to cover costs for receiving a vaccine from an out-of-network pharmacy or provider.

Q. Can people who are uninsured or underinsured go to any enrolled provider to access vaccine through the Bridge Program?

Patients who are uninsured (i.e., without any insurance coverage) can find free COVID-19 vaccination at any participating Bridge Access Program sites, including locations such as pharmacies – like CVS Health, Walgreens, and eTN pharmacies, local health centers, and other participating local healthcare providers.

People who are underinsured (i.e., people whose insurance requires co-pays for COVID-19 vaccination) can find free COVID-19 vaccine at participating Bridge Access Program sites which are in network with their insurance. Patients may not have co-pays waived at Bridge sites which are NOT in network with their insurance. It is important that patients with insurance understand where they are in network for vaccination and seek vaccination at those locations. This may involve seeking vaccination:

- Within a specific system (e.g., Kaiser Permanente)
- Within a specific state (e.g., the state of Virginia)
- Within a specific set of retail pharmacies (e.g., Walgreens)
- Within a specific type of provider (e.g., outpatient pharmacies)

Patients do risk receiving bills for vaccination if they accidentally misrepresent their insurance coverage when seeking vaccination through the Bridge Access Program.

Q. What general resources are available for the Bridge Program?

An overview of the resources available through the Bridge Program can be found at [Bridge Access Program | CDC](#).

MEDICARE REIMBURSEMENT

Q. What is the status of Medicare Vaccine Payment in LTC Facilities?

Many nursing homes engage long-term care pharmacies or other vaccinators to come on-site to administer vaccines for residents. By statute, the Medicare Part B preventive vaccine benefit covers the pneumococcal, influenza, hepatitis B and COVID-19 vaccines and their administration. Because of the Inflation Reduction Act, vaccines that are not listed in the Part B statute must be covered by Medicare Part D after a CDC recommendation. This includes the RSV vaccine for people over the age of 60, which now must be covered without cost-sharing by Part D plans.

During the COVID-19 PHE, CMS allowed third parties, like these vaccinators, to directly bill Medicare Part B for administering COVID, flu and pneumococcal vaccines to nursing home patients during a Medicare Part A-covered stay. Because CMS did not have the legal authority to extend this flexibility without a PHE, this flexibility ended after the conclusion of the PHE.

Now, without the PHE flexibility, vaccinators will either need to seek payment from LTC facilities (who are responsible for billing Medicare for these vaccines) or the appropriate insurance plan instead of directly billing Medicare. The American Health Care Association/ National Center for Assisted Living (AHCA/NCAL) developed a summary that can be found here: [Medicare Billing Guidance \(ahcanal.org\)](#)



VACCINE CONFIDENCE AND DEMAND

Q. Why was the bivalent COVID-19 vaccine replaced? Does this mean COVID-19 vaccines aren't effective?

Protective antibodies from vaccination, infection, or both weaken over time. Recent CDC data show that among adults, the bivalent vaccine was 62% effective against COVID-19-hospitalization in the first 2 months after getting the dose but decreased to 24% by 5–6 months. However, bivalent vaccines continued to protect against intensive care unit admission or death at least 6 months after receiving a bivalent vaccine dose.

The 2023–2024 updated COVID-19 vaccine more closely targets the XBB lineage of the Omicron variant and could restore protection against severe COVID-19 that may have decreased over time. We anticipate the updated vaccines will be better at fighting currently circulating variants. Thousands of Americans are still hospitalized due to COVID-19 each week. Vaccination will help protect people against serious illness this fall and winter.

Q. Are COVID-19 vaccines licensed?

The updated mRNA COVID-19 vaccines are each approved (i.e., licensed) by the Food and Drug Administration for individuals 12 years of age and older. The updated mRNA COVID-19 vaccines for individuals 6 months through 11 years of age and the updated Novavax COVID-19 Vaccine for individuals 12 years of age and older are authorized under emergency use. More information on emergency use authorization can be found here: <https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization>.

Q. Can you explain the discrepancy between how COVID-19 vaccine is supposed to help reduce hospitalizations, serious illness, deaths and local observations of few serious illness, hospitalizations, and deaths?

Although lower than at the beginning of the pandemic, COVID-19 still causes a significant burden of disease. As of October 2023, we are still seeing about 18,000 COVID-19-associated hospitalizations reported weekly in the U.S., and the majority are in older adults (65 years of age and older). Also, we are seeing “waves” of COVID-19 severe disease usually in late summer and in fall/winter. To mitigate the impact of the fall/winter wave, we recommend the updated 2023–2024 COVID-19 vaccine for everyone 6 months of age and older. Most residents are at an age where they are at high risk of disease and should be vaccinated. If they get sick, they should be treated to prevent hospitalizations and deaths. Facilities should do what they can to limit exposures to residents during the fall/winter respiratory virus season as well.

Q. Does vaccination for healthcare workers prevent spread to residents?

Initial studies from people vaccinated with the updated COVID-19 vaccine show strong immune responses to the SARS-CoV-2 variants that predominate in the U.S. We don't have vaccine effectiveness (VE) estimates for the updated 2023–2024 COVID-19 vaccine yet but based on past experience, we know that the vaccine does offer some protection against infection (see resources below). VE data on bivalent doses demonstrated ~50% VE against symptomatic infection in adults ages 18–49 years and ~40% VE in adults ages 50–64 years for 2–3 months following immunization. However, we have seen VE wane over time. Additionally, the updated 2023–2024 COVID-19 vaccine offers the best protection from illness due to the current circulating variants.

We generally recommend vaccination of healthcare workers because they are at high risk of acquiring pathogens and also of further spread. SARS CoV-2 is most infectious 1–2 days prior to symptoms and well before a positive test. Therefore, vaccination is important to ensure some protection against infection as exposures can happen before healthcare workers know they are sick and start isolating. We should remind LTCF staff to stay home if they are sick and consider treatment if they are eligible.

Resources:

<https://www.sciencedirect.com/science/article/pii/S0264410X23001469>

<https://covid.cdc.gov/covid-data-tracker/#vaccine-effectiveness>