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Automated Screening for Influenza Vaccination

To the editor—The recent report on *Automated Screening for Influenza Vaccination* is very interesting [1]. Pollack et al [1] noted that "an automated, hospital-based influenza vaccination program integrated into the EMR can increase vaccinations of hospitalized patients." In fact, to increase vaccination rate of hospitalized patients is an important issue. There are several attempts to increase the rate. The use of automated screening can be useful, but there are many concerns. First, the cost for implementation of the automated screening should be discussed. Whether it is cost-effective or not is questionable. Second, Pollack et al. [1] noted that the tool could facilitate "vaccine ordering without requiring involvement of a physician or other provider." This process is of concern. The automated tool might be used to identify the cases that do not get vaccination; however, the tool might not be able to judge the benefit and risk for individual cases. Third, the decision to get vaccine or not is based on the patient's decision. The automated tool cannot promote or stimulate the patient and parent for acceptance of vaccination.

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The Medicaid Cost of Palivizumab

To the editor—Borse et al. [1] describe an economic analysis of respiratory syncytial virus (RSV) prophylaxis for infants in Alaska's Yukon-Kuskokwim Delta. The authors should be congratulated for evaluating this important question with a robust analysis. As these infants are almost entirely insured by Medicaid, we wish to clarify the net Medicaid cost of palivizumab. Based on the 2010 average wholesale price (AWP), Alaska Medicaid's published reimbursement rate, and the minimum Medicaid rebate, the authors estimated a cost of $1055 per 50 mg [1]. However, using Alaska Medicaid's reported pre-rebate expenditures for palivizumab and incorporating all components of the Medicaid rebate yields a more accurate estimate, which is substantially lower at $588 per 50 mg [2, 3].

AWP is determined by drug reference companies and does not reflect a price at which manufacturers sell products to wholesalers. The US Office of the Inspector General has described AWP-based reimbursement as "fundamentally flawed" and has recommended payment based on a single national pricing benchmark

based on average drug acquisition costs [4]. Given this, a better source is wholesale acquisition cost (WAC), or the list price for a drug sold by a manufacturer to wholesalers. The 2010 WAC for 50 mg of palivizumab was $1074. For Alaska Medicaid specifically, the reported pre-rebate palivizumab expenditure for 2010–2011 was $1082 per 50 mg [2].

Precise estimates of Medicaid rebates for drugs are difficult to calculate because rebate payments are not publicly available. However, they can be estimated based on the two components of the Medicaid rebate [5]. The authors note that the first component is 17.1% of average manufacturer price. However, there is a second consumer price index (CPI)–based component, which effectively precludes drug cost increases in excess of changes in CPI [5]. Based on data from 10 large states, these two rebate components were estimated to result in a 41% reduction in the 2010 palivizumab cost for Medicaid [6]. Other drugs have rebates of similar magnitude; Medicaid rebates recouped 45% of expenditures on 100 brand-name drugs in 2009 [4]. For Alaska Medicaid specifically, the estimated net 2010–2011 cost of palivizumab after rebates is $588 per 50 mg [2, 3]. This cost is considerably lower than the Borse et al. estimate and approaches one of the modeled cost-neutral thresholds of $486 [1].

Lastly, the authors incorrectly state that palivizumab AWP increased by 184% from 2001–2010 (20% annually), referencing Red Book data [7, 8]. Red Book [7, 8] reports a palivizumab AWP increase of 78% from 2001 to 2010, a 7% annual increase. After Medicaid rebates, the net US cost increase was approximately 60% from 2001 to 2010, or 5.5% annually. This increase is lower than the 83% inflation rate for US inpatient hospital services from 2001 to 2010 [9]. Similarly, the cost of an RSV hospitalization among US infants increased by 89% from 2000 to 2009 [10].

In closing, we congratulate the authors on a robust analysis and hope that this additional information regarding the net Medicaid costs of palivizumab will help inform policy decisions and future research regarding RSV prophylaxis in the United States.

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Interferon Gamma Release Assays to Diagnose Latent Tuberculosis Infection in Pediatric Dialysis Patients

To the Editor— Dialysis patients have a 10- to 25-fold increased risk of