

Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration and Cost Sharing under Medicaid, the Children’s Health Insurance Program, and Basic Health Program

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Coverage and Reimbursement of Vaccines, Vaccine Administration and Cost sharing under Medicaid, the Children’s Health Insurance Program, and Basic Health Program

Focus of this Toolkit

The focus of this toolkit is to ensure that state and territorial Medicaid and Children’s Health Insurance Program (CHIP) agencies have the necessary tools to respond to the COVID-19 public health emergency (PHE) and to address the needs of the nation’s 74.6 million Medicaid and CHIP beneficiaries and the nearly 900,000 Basic Health Program (BHP) enrollees. This toolkit will help state and territorial policymakers identify the issues that need to be considered and addressed in order to provide coverage and reimbursement for vaccine administration in the Medicaid program, CHIP, and BHP. Because the Centers for Medicare & Medicaid Services (CMS) expects that the initial supply of COVID-19 vaccines will be federally purchased, this toolkit primarily focuses on coverage of vaccine administration. CMS remains available to provide technical assistance to states as they plan and prepare for COVID-19 vaccines. This toolkit will be updated as new information becomes available. CMS will also provide links to vaccine information, including data on vaccine efficacy and safety, when it becomes available.

Within this toolkit, we address:

- Clinical and operational considerations of potential COVID-19 vaccines, and the vaccination planning that should be undertaken across the three programs;
- Coverage of COVID-19 vaccines and vaccine administration under Medicaid pursuant to section 6008(b)(4) of the Families First Coronavirus Response Act (FFCRA);
- Medicaid vaccine administration coverage, reimbursement, and cost sharing policies for adults. This includes coverage under “traditional” Medicaid¹, coverage made available by states opting to implement section 1905(b) of the Social Security Act (Act)(section 4106 of the Patient Protection and Affordable Care Act), and coverage under Alternative Benefit Plans (ABP). This section also provides guidance on what actions states need to take, if any;
- Medicaid vaccine administration coverage, reimbursement and cost sharing policies for children, including the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, and the Vaccines for Children (VFC) program, along with guidance on what actions states and territories need to take, if any;
- Coverage, reimbursement, and cost sharing policies for Medicaid beneficiaries receiving limited benefit packages;
- Coverage, reimbursement, and cost sharing policies under CHIP and BHP;
- Managed care considerations;
- State Plan Amendment (SPA) templates and streamlined review process;

¹ Traditional Medicaid refers to the benefit packages available to adults who are eligible under a state Medicaid plan, waiver or demonstration based on pregnancy, status as a parent or caretaker, disability, or need for long-term services and supports. It does not include individuals eligible for Medicaid under Alternative Benefit Plans, or individuals limited by statute or an existing 1115 demonstration to a narrow range of benefits that would not ordinarily include vaccine coverage.

- Reporting requirements;
- Provider enrollment;
- Information on education and outreach;
- Additional resources for states; and
- Glossary of terms and references.

I. Clinical & Operational Considerations for Potential COVID-19 Vaccines

While this toolkit does not describe all clinical and operational considerations for COVID-19 vaccines, it highlights important details related to COVID-19 vaccines and distribution.

1. **Cold-chain:** While most COVID-19 vaccines are stored in a standard refrigerator or freezer, some potential COVID-19 vaccines will require ultra-low temperature storage (e.g., -70° Celsius). This may prove challenging for transporting, storing, and handling of the vaccines as temperature fluctuations at any point across the cold chain may influence the efficacy of the vaccine. States should identify capacities for vaccine distribution and administration based on these important distinctions, as well as in determining reimbursement for administration.
2. **Dose sequence:** Candidate vaccines may be a single-dose vaccination or be part of a two dose series. States and organizations should proactively address planning for and identifying resources to engage patients for both initial vaccination and then completion of the vaccine series in advance of vaccine receipt.
3. **Vaccination planning:** The Centers for Disease Control and Prevention (CDC) guidance² outlines what to expect for vaccination planning, including actions states can take now in order to plan for COVID-19 vaccinations. The CDC indicated that planning must be flexible as several vaccine candidates are in development and it is not yet clear which populations will be recommended initially for the vaccine(s). Likely, these priority populations will include those who are part of the critical workforce who provide healthcare and maintain essential functions of society. Guidance will also include requirements for reporting the administration of COVID-19 vaccines into a state immunization registry or other vaccine tracking system. More information can be found on the CDC's website. Links to CDC documents that provide guidance on planning, such as "The Operation Warp Speed Strategy for Distributing a COVID-19 Vaccine" (<https://www.hhs.gov/sites/default/files/strategy-for-distributing-covid-19-vaccine.pdf>) are located at the end of this toolkit under *Resources*.
4. **Priority of overall vaccine distribution:** While CMS expects that there will be a sufficient supply of vaccine to distribute to all beneficiaries, distribution may be done in phases. The Advisory Committee on Immunization Practices (ACIP) and the CDC will be issuing guidance on priority of vaccine distribution. State Medicaid and CHIP agencies should coordinate with their state health departments, as well as a wide range of other public and

² This guidance can be found at: <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html>

private sector partners and providers to implement this guidance and also start thinking now about how to outreach to populations that are traditionally hard to reach.

5. **Pharmacy and provider agreements:** To receive free supplies of the COVID-19 vaccine(s), pharmacies, retail clinics, providers, and any other site of care receiving and administering COVID-19 vaccines must sign an agreement with the U.S. government. Under the agreement, all providers must vaccinate individuals regardless of whether they have health insurance coverage or what type of coverage they have, and are prohibited from balance billing or otherwise charging vaccine recipients. Following vaccination, vaccine recipients must be provided with emergency use authorization (EUA) Fact Sheets on the vaccine and vaccination cards. Providers must also administer the vaccine in accordance with CDC and ACIP requirements, and must meet storage and recordkeeping requirements, including recording the administration of the vaccine to patients in their own systems within 24 hours, and to public health data systems as soon as practical, and within 72 hours. For more information on the CDC recordkeeping requirements, see the link located in the *Education & Outreach* section, item 4, *Immunization Reporting*, below:
https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf. Providers administering the vaccine to people without health insurance or whose insurance does not provide coverage of the vaccine, can request reimbursement for the administration of the COVID-19 vaccine through the Health Resources & Services Administration (HRSA) Provider Relief Fund, see <https://www.hrsa.gov/CovidUninsuredClaim>.
6. **Pediatric vaccine distribution:** When a pediatric COVID-19 vaccine becomes available, CDC will determine if it will be distributed through the VFC program. ACIP-recommended pediatric vaccines for children through age 18 are routinely distributed through the VFC program, which provides federally purchased vaccines to children enrolled in Medicaid (funded through both titles XIX and XXI of the Social Security Act), and to children who are uninsured, who are not insured with respect to the vaccine and who are administered pediatric vaccines by a federally qualified health center (FQHC) or rural health clinic (RHC), or who are Indians (as defined in section 4 of the Indian Health Care Improvement Act). The CDC administers the VFC program and sets national requirements and guidelines, and each state has a VFC program, which is administered by its state health department.
7. **Beneficiary incentives:** CMS will be providing more information regarding whether beneficiary incentives will be permitted in connection with COVID-19 vaccination during the PHE.
8. **Coding:** After the EUA or licensure of each COVID-19 vaccine product by the Food and Drug Administration (FDA), CMS will identify the specific vaccine code(s), by dose if necessary, and specific vaccine administration code(s). CMS and the American Medical Association (AMA) are working collaboratively on finalizing a new approach to report use of COVID-19 vaccines. Once this information is public, states are expected to alert providers to the new AMA codes.

9. **Medicare Reimbursement:** Medicare payment rates for COVID-19 vaccine administration will be \$28.39 to administer single-dose vaccines. For a COVID-19 vaccine requiring a series of two or more doses, the initial dose(s) administration payment rate will be \$16.94, and \$28.39 for the administration of the final dose in the series. These rates recognize the costs involved in administering the vaccine, including the additional resources involved with required public health reporting, conducting important outreach and patient education, and spending additional time with patients answering any questions they may have about the vaccine. These rates will also be geographically adjusted.³

II. Medicaid, CHIP, and BHP Coverage and Reimbursement⁴

A. The Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127)

Under section 6008 of the FFCRA, state and territorial Medicaid programs may receive a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP). This temporary FMAP increase could be available through the end of the quarter in which the COVID-19 PHE ends, if the state claims the increase in that quarter. To qualify for the temporary FMAP increase in a given quarter, states must meet the four conditions described in subsection (b) of section 6008 of the FFCRA during that quarter. Specifically, the state must maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020; the state may not charge premiums that exceed those that were in place as of January 1, 2020;⁵ and the state must maintain the enrollment of beneficiaries who were enrolled as of or after March 18, 2020.⁶ Additionally, under section 6008(b)(4) of the FFCRA, to receive the temporary FMAP increase, a state or territory must cover COVID-19 testing services and treatments, including vaccines and their administration, specialized equipment, and therapies for Medicaid enrollees without cost sharing. This coverage is required during any quarter for which the state or territory claims the temporary FMAP increase under FFCRA section 6008.

As of the time of the publication of this document, CMS is not aware of any states or territories not currently claiming this temporary FMAP increase, or of any states or territories that intend to cease claiming it. Accordingly, Medicaid coverage of COVID-19 vaccines and their administration, without cost sharing is expected to be available for most Medicaid beneficiaries

³ Note: these rates do not apply for entities that are reimbursed for vaccines at reasonable cost.

⁴ As the vaccine will be federally purchased, normal third party liability rules will apply for vaccine administration.

⁵ Section 3720 of the CARES Act added a new subsection (d) to section 6008 of the FFCRA in order to provide states, which have increased premiums for any Medicaid beneficiaries above the amounts in effect on January 1, 2020, with a 30-day grace period to restore premiums to amounts no greater than those in effect as of January 1 without jeopardizing the state's eligibility for the temporary 6.2 percentage point FMAP increase.

⁶ Additional detail on these conditions may be found in the preamble to CMS-9912-IFC, which includes rulemaking on the maintenance of enrollment condition at section 6008(b)(3) of the FFCRA. This IFC was put on display at the Federal Register on October 28, 2020.

through the end of the quarter in which the COVID-19 PHE ends in states and territories that continue to claim the 6.2 percentage point increase in FMAP throughout the entire period.

There are some very limited circumstances in which the FFCRA section 6008(b)(4) coverage requirements would not apply. CMS does not interpret FFCRA section 6008(b)(4) to require states to provide COVID-19 testing and treatment services without cost sharing, including vaccines and their administration, to Medicaid eligibility groups whose coverage is limited by statute or under an existing section 1115 demonstration to a narrow range of benefits that would not ordinarily include vaccine coverage (see *Section E. Medicaid Beneficiaries Receiving Limited Benefit Packages* below for more information).

The FFCRA section 6008(b)(4) requirement does not apply to separate CHIPs or the BHP. In states that use title XXI funding to expand Medicaid eligibility for children, the FFCRA section 6008(b)(4) requirements apply to these title XXI funded Medicaid beneficiaries in the same way that they do to all other Medicaid beneficiaries.

B. Adults Covered under Traditional Medicaid

1. COVID Vaccines & Vaccine Administration Coverage

As CMS expects that the initial supply of COVID-19 vaccines will be federally purchased, states would not be expected to provide Medicaid coverage and reimbursement for the vaccine itself. The following sections describe coverage of vaccine administration.

During the PHE

Coverage of COVID-19 vaccine administration is mandatory for most Medicaid beneficiaries, without cost sharing, during any quarter for which the state or territory claims the temporary FMAP increase under FFCRA section 6008. The FMAP increase is available through the end of the quarter in which the COVID-19 PHE ends, if the state claims the temporary FMAP increase in that quarter. This includes compensating Medicaid providers with a vaccine administration fee or reimbursement for a provider visit during which a vaccine dose is administered. States are not required to provide this coverage for certain beneficiaries receiving limited benefit packages. (See *Section E. Medicaid Beneficiaries Receiving Limited Benefit Packages* below for more information.)

Outside of the PHE

Outside of the period in which FFCRA section 6008(b)(4) applies, coverage of ACIP-recommended vaccinations without cost sharing will be mandatory for adults enrolled in an ABP (see *Section C. Beneficiaries Enrolled in Alternative Benefit Plans* below), but for other adult Medicaid beneficiaries vaccine administration is generally optional. In general, states could cover vaccine administration for individuals whose eligibility for Medicaid, for example, is based on pregnancy, status as a parent or caretaker, disability, or need for long-term services and supports. A state may opt to receive a one percent increase in FMAP for its expenditures on certain services under section 1905(b) of the Act for providing coverage of adult vaccines and

their administration as well as other clinical preventive services.⁷ In electing such coverage, states must adhere to the following parameters:

- States claiming the one percent FMAP increase must cover all of the services described in section 1905(a)(13)(A) and (B), without cost sharing. This includes: (1) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF) and (2) for adult beneficiaries, all ACIP-recommended vaccines and their administration.
- The one percent increase in the FMAP, pursuant to section 1905(b) of the Act, applies to expenditures for services provided through fee-for-service (FFS) or managed care, or under a benefit package under an ABP. States that seek the one percent FMAP increase would need to include coverage of ACIP-recommended COVID-19 vaccines for adults in their Medicaid programs.
- Most state Medicaid programs cover at least some of the ACIP-recommended vaccines and the administration of those vaccines for adults. Therefore, it is possible that states might cover ACIP-recommended COVID-19 vaccine(s) for adults, and, at their option, states could also cover vaccines authorized by the FDA.

Outside of the period in which FFCRA section 6008(b)(4) applies, states have flexibility to determine the benefit category under which COVID-19 vaccine administration is covered for adults. States could opt to cover vaccine administration under state plan benefits that are mandatory for many Medicaid eligibility groups, such as inpatient hospital services (42 CFR § 440.10), outpatient hospital services (42 CFR § 440.20(a)), rural health clinic services (42 CFR § 440.20(b)), Federally Qualified Health Centers (FQHCs), and physicians' services (42 CFR § 440.50), depending on how the state defines the amount, duration, and scope parameters for these benefits.

Vaccine administration could also be covered as a service under optional state plan benefits, such as preventive services (42 CFR § 440.130(c)), other licensed practitioners (OLP) (42 CFR § 440.60), or clinic services (42 CFR § 440.90).

Tribal facilities are facilities operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act, P.L. 93-638. These providers are subject to the Medicaid benefit requirements under which they operate (inpatient hospital, outpatient hospital, clinic, FQHC and nursing facility).

The following table is intended to assist states with identifying options and is meant to be a general reference tool. States should contact CMS for technical assistance about their program.

⁷ <https://www.medicare.gov/federal-policy-guidance/downloads/SMD-13-002.pdf>

Benefit	Is a SPA Required to Cover the Service “Vaccine Administration” Outside of the PHE?
Inpatient Hospital	No
Outpatient Hospital	No
Rural Health Clinic	No
Federally Qualified Health Center	No
Physicians’ Services	No
Clinic	No
Preventive Services	Possibly, if service not already covered
Other Licensed Practitioners	Possibly, if services of licensed practitioner not already covered

Gaps in Coverage

As described above, after the period when FFCRA section 6008(b)(4) applies, states have discretion to cover COVID-19 vaccine administration to many adult eligibility groups outside of the PHE that are not eligible for mandatory coverage. In addition, even during the period when FFCRA section 6008(b)(4) applies, coverage is not available for beneficiaries receiving limited benefit packages as described further below.

The COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program (COVID-19 Claims Reimbursement program) administered by HRSA is available for reimbursement of a COVID-19 vaccine and vaccine administration costs for individuals who would not receive Medicaid coverage for a COVID-19 vaccine or its administration.

SPA/Waiver Requirements for Coverage

A SPA is not required for coverage of the initial supply of COVID vaccine(s) as they will be federally purchased.

A state may need to submit a SPA to newly add or amend coverage of the administration of the vaccine under the preventive services or OLP benefits. If a state includes vaccine administration under one of the mandatory benefits noted above, or under the optional clinic benefit, a state would not need to submit a SPA, as CMS does not require states to enumerate all the services or items covered under these benefits.

For the period of the PHE, a state can elect to use the [Medicaid disaster relief SPA template](#) (section D. Benefits and section E. Payments) to add coverage and reimbursement for administration of the vaccine.

States should contact CMS for technical assistance to discuss their program.

2. Cost Sharing

Coverage of the COVID-19 vaccine(s) administration is mandatory for most adults, without cost sharing, during any quarter for which the state or territory claims the temporary FMAP increase under section 6008(b)(4) of FCCRA, including through the end of the quarter in which the COVID-19 PHE ends, if the state claims the temporary FMAP increase in that quarter.

Outside of the period when FFCRA section 6008(b)(4) applies, coverage of ACIP-recommended vaccines and vaccine administration is mandatory and must be provided without cost sharing to populations receiving coverage through an ABP, and to adults in states that have opted to implement section 1905(a)(13)(A) and (B) of the Act. Otherwise, states can opt to impose cost sharing on vaccine administration for adults in other populations, unless the beneficiary is in an eligibility group that is exempt from cost sharing under section 1916 or section 1916A of the Act and regulations at 42 CFR § 447.56 (e.g., most children under age 18, most pregnant women, most children in foster care, individuals receiving services in an institution that already had their medical assistance reduced by their income, individuals receiving hospice care, and American Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services).

SPA/Waiver Requirements for Cost Sharing

States may need to submit a SPA to impose cost sharing where permitted, outside of the PHE.

States should contact CMS for technical assistance to discuss their program.

3. Reimbursement of the Vaccine and Vaccine Administration

Since CMS expects that the initial supply of COVID-19 vaccines will be federally purchased, Medicaid would not reimburse providers for the vaccine; as such, no SPA submission would be necessary to describe reimbursement of the vaccine product.

States have significant discretion in determining vaccine administration reimbursement rates that are paid to qualified providers that have a provider agreement with the Medicaid agency. For vaccine administration provided by physicians and OLPs, rates are set by states. States are strongly encouraged to use a uniform billing standard for vaccine claims (e.g., the National Council for Prescription Drug Programs (NCPDP) standard for pharmacy billings). The rates for vaccine administration and associated billing procedures are typically found on the state agency published fee schedules for the applicable professional benefit category. States should review their payment policies for vaccine administration reimbursement to determine if the rates are sufficient and if they are accurately reflected in the Medicaid state plan, provider materials and published fee schedules.

For facility services, such as hospitals, nursing facilities, FQHCs, and Indian Health Service and tribal facilities, vaccine administration is usually included within the prospective payment system (PPS) or per diem rate applicable to services provided at the facilities. States may set higher payment rates for vaccine administration to recognize circumstances where costs exceed the established state plan rates and are encouraged to set rates at levels that incentivize access to and

availability of vaccines. For example, states could pay higher rates for the administration of a COVID-19 vaccine that requires multiple doses or based upon the qualifications of the administering practitioner or the site of service. Additionally, states may adjust or add-on to rates provided within facility settings to account for higher costs associated with COVID-19 vaccine administration that are not otherwise included within the existing state plan rates.

States may also want to consider using Medicare's policies and rates for vaccine administration, outlined earlier in this toolkit. States should also consider whether their billing manuals appropriately reflect policies to streamline and facilitate vaccine administration (e.g., through roster billing) and explain that, in accordance with regulations at 42 CFR § 447.15, providers may not balance bill Medicaid beneficiaries amounts additional to the amount paid by the state agency plus any deductible, coinsurance or copayment required by the state plan to be paid by the beneficiary.

SPA/Waiver Requirements for Reimbursement

States will need to submit SPAs to describe payment for the vaccine administration to the extent that the payment is different from what is otherwise approved under the state plan. For example, a state may choose to pay higher rates for COVID-19 vaccine administration than what is already approved in the state plan for influenza vaccination due to additional complexity associated with COVID-19 vaccine administration.

States may authorize the payments through the disaster relief SPA template, which would be effective through the expiration of the PHE (section E. Payments of the template) or through a non-disaster relief SPA submission (as applicable, attachments 4.19-A, 4.19-B and 4.19-D). CMS remains available for technical assistance on these issues.

C. Beneficiaries Enrolled in Alternative Benefit Plans (ABPs)

All Medicaid beneficiaries enrolled in the Medicaid expansion group described at section 1902(a)(10)(A)(i)(VIII) of the Act must receive their benefits through an ABP authorized under section 1937 of the Act. States may also choose to provide benefits to other eligibility groups through an ABP. Depending on the eligibility group, the state may optionally or mandatorily enroll them in the ABP. ABPs provide states the flexibility to design a benefit package for specific populations that is based on commercial market benefits, the state's approved Medicaid state plan or a combination of both. The EPSDT benefit applies to children under age 21 enrolled in ABPs, including 19 and 20 year olds covered as part of the expansion group.

1. COVID-19 Vaccine and Vaccine Administration Coverage

As CMS expects that the initial supply of COVID-19 vaccines will be federally purchased, states would not be expected to provide Medicaid coverage and reimbursement for the vaccine itself. The following sections describe coverage of vaccine administration.

During the PHE

As mentioned earlier, coverage of COVID-19 vaccine administration without cost sharing is mandatory for most Medicaid beneficiaries, including all children and adults enrolled in ABPs, during any quarter for which the state or territory claims the temporary FMAP increase under FFCRA section 6008. In addition, due to updates made to 45 CFR §147.130 in the Interim Final Rule to Address the Impact of COVID-19 released on October 28, 2020, Medicaid ABPs must provide coverage for and must not impose any cost sharing for “qualifying coronavirus preventive services,” including a COVID vaccine during the PHE. For managed care, this applies regardless of whether the vaccine is delivered by an in-network or out-of-network provider.

Outside of the PHE

Regardless of the benefit design, all ABPs must include the ten essential health benefit (EHB) categories. One of the ten categories of EHB is “preventive and wellness services and chronic disease management”. Under this category, current law and regulations require specific vaccines (including administration) to be covered as an EHB without cost sharing, when ACIP recommends them.

Gaps in Coverage

There are no gaps in coverage when a beneficiary is covered under an ABP and a vaccine is recommended by ACIP.

SPA/Waiver Requirements for Coverage

No SPA is necessary to amend the coverage provisions of an ABP when a state implements coverage of new ACIP recommendations, either during or outside the period in which FFCRA section 6008(b)(4) applies.

States should contact CMS for technical assistance to discuss their program.

2. Cost Sharing

There is no cost sharing for ACIP-recommended vaccines provided through an ABP.

3. Reimbursement

Since CMS expects that the initial supply of COVID-19 vaccines will be federally purchased, Medicaid would not reimburse providers for the vaccine so no SPA submission would be necessary to describe reimbursement of the vaccine product.

For populations enrolled in ABPs, including the Medicaid expansion population, states may rely on the same policy options as are discussed above under *Section B. Adults in Medicaid*.

SPA/Waiver Requirements for Reimbursement

A state will need to amend its reimbursement page if the state uses a vaccine administration reimbursement methodology that is different from the currently approved methodology or establishes vaccine administration under the ABP specific to a COVID-19 vaccine product that is not otherwise covered and paid as a Medicaid state plan service.

States should contact CMS for technical assistance to discuss their program.

D. Children Covered under Medicaid

1. COVID-19 Vaccine and Vaccine Administration Coverage

At the time of the development of this toolkit, it is likely that a pediatric COVID-19 vaccine will follow approval of an adult COVID-19 vaccine(s). When a pediatric COVID-19 vaccine is available, as for adults, the initial supply of the COVID-19 vaccines will be federally purchased; therefore, states would not be expected to provide Medicaid coverage and reimbursement for the vaccine itself. The following sections describe coverage of vaccine administration when pediatric COVID-19 vaccines are available.

During the PHE

As discussed above, under section 6008(b)(4) of FFCRA, coverage of COVID-19 vaccine administration without cost sharing is mandatory for most Medicaid beneficiaries, including most children, without cost sharing, during any quarter for which the state or territory claims the temporary FMAP increase.

In general, coverage of vaccine administration for ACIP-recommended vaccines is mandatory for Medicaid-enrolled children under age 21 who are eligible for the EPSDT benefit, including children enrolled in the Medicaid-expansion portion of CHIP (funded through title XXI). Therefore, ACIP-recommended COVID-19 vaccine administration is mandatory for children enrolled in Medicaid through age 20.

Outside of the PHE

As stated above, coverage of administration for all ACIP-recommended vaccines is mandatory for Medicaid-enrolled children under age 21 who are eligible for the EPSDT benefit, including children enrolled in the Medicaid-expansion portion of CHIP (funded through title XXI). In general, ACIP-recommended vaccines are provided through the VFC program for Medicaid-eligible children through age 18; thus, the Medicaid program would cover administration of the VFC-covered vaccines. CDC will determine if a COVID-19 vaccine recommended for children through age 18 is distributed through the VFC program.

Gaps in Coverage

There are no gaps in coverage of a COVID-19 vaccine approved by ACIP for Medicaid-enrolled children through age 20 who are eligible for the EPSDT benefit, either during or outside the period in which FFCRA section 6008(b)(4) applies.

SPA/Waiver Requirements for Coverage

No state action is required to cover any newly ACIP-recommended vaccine added to the pediatric vaccine schedule. However, a state may choose to submit a SPA to explicitly detail coverage provisions.

States should contact CMS for technical assistance to discuss their program.

2. Cost Sharing

During the period in which FFCRA section 6008(b)(4) applies, cost sharing may not be imposed for vaccine administration during any quarter for which the state or territory claims the temporary FMAP increase under FFCRA section 6008.

Outside of the period in which FFCRA section 6008(b)(4) applies, states may impose cost sharing on 19 and 20 year olds who are not enrolled in an ABP. However, cost sharing may generally not be imposed for vaccines services provided to beneficiaries under age 18.

SPA/Waiver Requirements for Cost Sharing

A SPA would be required if a state opts to change state policy to exempt 19 and 20 year olds not enrolled in ABPs from cost sharing requirements for vaccine administration.

States should contact CMS for technical assistance to discuss their program.

3. Reimbursement of the Vaccine and Vaccine Administration

Since CMS expects that the initial supply of COVID-19 vaccines will be federally purchased, Medicaid would not reimburse providers for the vaccine so no SPA submission would be necessary to describe reimbursement of the vaccine product.

As mentioned earlier, the CDC will determine if a COVID-19 vaccine recommended for children through age 18 is distributed through the VFC program.

State Medicaid programs pay providers a state-determined administration fee for administering a vaccine. Because pediatric vaccines for children through age 18 are generally provided through the VFC program, states are required to identify an administration fee in their Medicaid state plan that is at or below the VFC regional rate. The regional maximum vaccine administration fees are established by CMS pursuant to statute (see section 1928(c)(2)(C)(ii) of the Act), based on regional costs for vaccine administration. The current maximum administration fees are between \$19 and \$27.⁸ There are no limits on the administration fee rates for Medicaid-enrolled 19 and 20 year olds as they are not eligible for the VFC program and would not receive vaccines through that program.

As noted earlier, when a pediatric COVID-19 vaccine becomes available, CDC will determine whether to distribute COVID-19 vaccine(s) outside of the VFC program. If the COVID-19

⁸ Federal Register, 11/6/2012, Final Rule: Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration under the Vaccines for Children Program, RIN 0938-AQ63.
<https://www.federalregister.gov/documents/2012/11/06/2012-26507/rin-0938-aq63>

vaccine(s) is distributed outside of the VFC program, the VFC administration fee regional limits do not apply.

SPA/Waiver Requirements for Reimbursement

No SPA is required unless the state adds or amends a payment methodology or administration fee rate.

States should contact CMS for technical assistance to discuss their program.

E. Medicaid Beneficiaries Receiving Limited Benefit Packages

1. COVID-19 Vaccine & Vaccine Administration Coverage

As the initial supply of COVID-19 vaccines will be federally purchased, states would not be expected to provide Medicaid coverage and reimbursement for the vaccine itself. The following sections describe coverage of vaccine administration.

During & Outside of the PHE

Medicaid includes several eligibility groups that receive limited benefit packages under statutory authority or existing section 1115 demonstration authority. States are not required to cover COVID-19 vaccine administration for these groups either during or after the period in which FFCRA section 6008(b)(4) applies.

Gaps in Coverage

As discussed in the Interim Final Rule to Address the Impact of COVID-19 released on October 28, 2020, CMS does not interpret FFCRA section 6008(b)(4) to require states or territories to provide coverage for COVID-19 vaccines to eligibility groups whose coverage is limited by statute or under an existing section 1115 demonstration to a narrow range of benefits that would not ordinarily include vaccine coverage. Additionally, after FFCRA section 6008(b)(4) no longer applies in a state, the state would generally lack authority to cover COVID-19 vaccinations for these groups, unless it obtains section 1115 demonstration authority to provide this coverage. Consequently, the following groups of individuals are likely to have gaps in vaccine administration coverage both during and outside of the period in which FFCRA section 6008(b)(4) applies:

- Individuals eligible only for family planning benefits: Although states may furnish vaccines under preventive services, typically these vaccines would be limited to those associated with an individual's reproductive health (e.g., human papilloma virus (HPV) vaccine) and not their general health such as a flu vaccine or a COVID-19 vaccine;
- Individuals eligible for tuberculosis-related benefits: Benefits and services for these individuals are limited to the treatment of tuberculosis and do not include vaccines;
- Individuals eligible for the optional COVID-19 testing group: Benefits and services for this group do not include vaccines; and

- Section 1115(a)(2) expenditure authority limited benefit group(s): Several states have 1115(a)(2) demonstration authority to provide a limited benefit package to select beneficiaries not otherwise eligible for Medicaid.

HRSA COVID-19 Claims Reimbursement is available for reimbursement of COVID-19 vaccine administration costs for individuals receiving Medicaid coverage for only limited benefit packages.

In addition, states wishing to address these gaps in vaccine coverage could choose to use 1115(a)(2) expenditure authority to add coverage for COVID-19 vaccines to these benefit packages, subject to federal approval. CMS is available to provide technical assistance, as needed, and states should reach out to either their CMS State Demonstrations Group project officer or their CMCS state lead for such assistance.

F. Separate CHIP Coverage & Reimbursement

1. COVID-19 Vaccine & Vaccine Administration Coverage

As the initial supply of COVID-19 vaccines will be federally purchased, states would not be expected to provide CHIP coverage and reimbursement for the vaccine itself. The following sections describe coverage of vaccine administration. As noted earlier, at the time of the development of this toolkit, it appears that a pediatric COVID-19 vaccine will follow approval of an adult COVID-19 vaccine

During and Outside of the PHE

FFCRA section 6008(b)(4) does not apply to separate CHIPs.⁹ Coverage requirements for vaccine administration in a separate CHIP are the same during and outside of the PHE.

States must provide ACIP-recommended vaccines for children enrolled in a separate CHIP, with no cost sharing, under 42 CFR §§ 457.410(b)(2) and 457.520(b)(4). Therefore, an ACIP-recommended COVID-19 vaccine and the administration fee would be a mandatory benefit for children enrolled in a separate CHIP.

Gaps in Coverage

Vaccines are not required for pregnant women covered through a separate CHIP, although all states that cover pregnant women through a separate CHIP currently cover vaccines and their administration without cost sharing for this population. Should any state opt not to provide coverage of a COVID-19 vaccination to this population, the HRSA COVID-19 Claims Reimbursement program may be used to cover COVID-19 treatment, including the administration of vaccines, for this population.

⁹ In states that use title XXI funding to expand Medicaid eligibility for children, the FFCRA section 6008(b)(4) requirements apply to these title XXI funded Medicaid beneficiaries in the same way that they do to all other Medicaid beneficiaries.

SPA/Waiver Requirements for Coverage

No SPA is required to cover any newly recommended vaccines.

States should contact CMS for technical assistance to discuss their program.

2. Cost Sharing

Cost sharing may not be imposed on vaccines or vaccine administration for children enrolled in CHIP. There are no federal rules related to cost sharing for vaccines provided to pregnant women enrolled in CHIP.

3. Reimbursement

Separate CHIP programs determine the rate and manner of reimbursement of the administration fees. States can claim federal financial participation (FFP) against their CHIP allotment for the administration of the vaccine.

States determine the vaccine administration rates paid to providers. States may want to consider using the same policies and rates for vaccine administration that have been established by Medicare, which are identified earlier in this toolkit.

SPA/Waiver Requirements for Reimbursement

No SPA is required for reimbursement for any newly recommended vaccines.

States should contact CMS for technical assistance to discuss their program.

G. BHP Coverage & Reimbursement

BHP is an optional health benefits coverage program that states can elect to operate for certain low-income residents who would otherwise be eligible to purchase coverage through Health Insurance Exchanges. Currently, only Minnesota and New York operate a BHP.

1. COVID-19 Vaccine and Vaccine Administration Coverage

As CMS expects that the COVID-19 vaccine(s) will be federally purchased, coverage and reimbursement is not applicable for the vaccine itself. The following sections describe coverage of vaccine administration.

During the PHE

FFCRA section 6008(b)(4) does not apply to BHPs. In BHP, vaccine coverage is largely the same during and outside of the PHE.

BHP benefits include at least the ten EHBs, which include all ACIP-recommended vaccines without cost sharing under 42 CFR §§ 600.405(a) and 600.510(b). Therefore, an ACIP-recommended COVID-19 vaccine and the administration fee would be covered for individuals enrolled in BHP.

In addition, during the COVID-19 PHE, plans must provide coverage for and must not impose any cost sharing for “qualifying coronavirus preventive services,” including a COVID-19 vaccine, regardless of whether the vaccine is delivered by an in-network or out-of-network provider.

Outside the PHE

After the COVID-19 PHE ends, states must continue to cover an ACIP-recommended COVID-19 vaccine and the administration fee without cost sharing. However, plans will no longer be required to cover vaccines provided by out-of-network providers.

Blueprint Requirements for Coverage

No state action is required to cover any newly recommended vaccine.

States should contact CMS for technical assistance to discuss their program.

2. Cost Sharing

Cost sharing may not be imposed on vaccines or vaccine administration for individuals enrolled in a BHP. During the COVID-19 PHE, plans must not impose any cost sharing for “qualifying coronavirus preventive services,” including a COVID-19 vaccine, regardless of whether the vaccine is delivered by an in-network or out-of-network provider.

3. Reimbursement

Federal funding for a BHP is on a per enrollee basis. States receive federal funding equal to 95 percent of the amount of premium tax credits and cost sharing reductions that would have otherwise been provided to eligible, enrolled individuals, if those individuals were instead enrolled in Qualified Health Plans through the Marketplace. Therefore, states that operate a BHP would not receive specific federal funding for administration of COVID-19 vaccines. There are no federal BHP guidelines regarding the reimbursement of the administration of vaccines through a BHP. States determine the BHP vaccine administration rates paid to providers.

Blueprint Requirements for Reimbursement

No state action is required for reimbursement for any newly recommended COVID-19 vaccines.

States should contact CMS for technical assistance to discuss their program.

The following table summarizes the provisions for coverage, cost sharing and reimbursement described above. The table is meant to be a general reference tool for states.

MEDICAID, CHIP AND BHP PROVISIONS FOR COVID-19 VACCINE ADMINISTRATION
During and Outside the PHE*

Population	Coverage During the PHE	Cost Sharing During the PHE	Reimbursement During the PHE	Coverage Outside the PHE	Cost Sharing Outside the PHE	Reimbursement Outside the PHE
Adults Covered Under Traditional Medicaid	Mandatory	None	State-established reimbursement rates	Mandatory in states receiving extra 1% FMAP for preventive services as described in section 1905(b); optional for others	None in states receiving extra 1% FMAP for preventive services as described in section 1905(b); otherwise at state option for certain populations**	State-established reimbursement rates
Beneficiaries Enrolled in ABPs (Including Expansion Adults)	Mandatory	None	State-established reimbursement rates	Mandatory	None	State-established reimbursement rates
Children Covered Under Medicaid	Mandatory	None	State-established reimbursement rates	Mandatory	None for individuals under age 18; at state option for individuals ages 19 and 20	State-established reimbursement rates; VFC implications for individuals under age 18
Limited Benefit Group Enrollees	Available only at state option through 1115(a)(2) authority or through HRSA's COVID-19 Claims Reimbursement program	N/A	N/A	Available only at state option through 1115 (a)(2) authority or through HRSA's COVID-19 Claims Reimbursement program	N/A	N/A

Population	Coverage During the PHE	Cost Sharing During the PHE	Reimbursement During the PHE	Coverage Outside the PHE	Cost Sharing Outside the PHE	Reimbursement Outside the PHE
CHIP Enrollees	Mandatory	None	State-established reimbursement rates	Mandatory	None	State-established reimbursement rates
BHP Enrollees	Mandatory	None	State-established reimbursement rates	Mandatory	None	State-established reimbursement rates

*The PHE is defined for purposes of this chart to encompass the period in which FFCRA section 6008 is in effect, which extends through the last day of the quarter in which the PHE expires.

**State has the option to apply cost sharing unless the beneficiary is in an eligibility group that is exempt from cost sharing under section 1916 or section 1916A of the Act and regulations at 42 CFR § 447.56.

The following table summarizes Medicaid and CHIP SPA, and BHP Blueprint submission requirements for COVID-19 Vaccine Administration. The table is meant to be a general reference tool for states.

**MEDICAID AND CHIP SPA SUBMISSION, AND BHP BLUEPRINT REQUIREMENTS FOR COVID-19 VACCINE ADMINISTRATION*
During and Outside the PHE**

Population	Is a SPA/Blueprint needed for coverage purposes?	Is a SPA/Blueprint needed for reimbursement purposes?
Adults Covered Under Traditional Medicaid	No for mandatory benefits and clinic benefit. Yes for optional benefits if not otherwise covered.	Yes, if different from approved administration rates.
Beneficiaries Enrolled in ABPs (Including Expansion Adults)	No SPA required.**	Yes, if different from approved administration rates.
Children Covered Under Medicaid	State option to submit a SPA to explicitly detail coverage provisions.	Yes, if different from approved administration rates.
Beneficiaries Receiving Limited Benefit Packages	Not applicable	Not applicable
CHIP	No	No
BHP	No	No

*The initial supply of COVID-19 vaccines will be federally purchased.

**Assumes ACIP recommendation of COVID-19 vaccine(s).

III. Medicaid & CHIP Managed Care

A. Coverage

States must ensure that all services covered under the Medicaid and CHIP state plans are available and accessible to enrollees of managed care plans in a timely manner, including the administration of covered vaccines in accordance with section 6008(b)(4) of the FFCRA (see 42 CFR §§ 438.206(a) and 457.1230(a)). Therefore, states that utilize a managed care delivery system may elect to include vaccine administration coverage in their managed care plan contracts and capitation rates. Alternatively, states may also elect to provide vaccine administration coverage and payment under their Medicaid and CHIP fee-for-service programs, and carve the vaccine benefit out of the managed care program and contracts.

If states utilize a managed care delivery system, as with all covered benefits in a managed care plan contract, Medicaid capitation rates must be developed to include all reasonable, appropriate, and attainable costs that are required under the terms of the contract, as specified in 42 CFR § 438.4(a). For CHIP, a state must use payment rates based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles, as specified in 42 CFR § 457.1203(a).

B. Credentialing & Contracting

Managed care plan network requirements for credentialing and contracting, including compliance with 42 CFR §§ 438.214 and 438.608(b), apply to providers administering vaccines. To ensure that beneficiaries enrolled in managed care plans have easy and prompt access to a COVID-19 vaccine, states are strongly encouraged to consider whether any contractual requirements under § 438.214(b)(1) on their managed care plans for credentialing and network contracting should be amended. In addition, states are strongly encouraged to amend their managed care contracts to suspend limits on out-of-network coverage for managed care enrollees to specifically improve access to COVID-19 vaccines.

Access to a COVID-19 vaccine is critical and should be maximized to the fullest extent possible regardless of the delivery system through which a beneficiary receives their Medicaid benefits. Reimbursement for vaccines and associated administration may be specified by the state in a managed care plan's contract, subject to the approval requirements for state directed payments in 42 CFR § 438.6(c), or may be determined by the managed care plan.

IV. Medicaid and CHIP SPA Templates, BHP Blueprints, and Streamlined Review Process

A. Medicaid

This section is a guide to assist states with assessing the need for SPAs and/or blueprints in the state. States should contact CMS for technical assistance about their program. In March of 2020, CMS created a Disaster Relief [Medicaid SPA template](#) to help states respond to the COVID-19 PHE. This streamlined SPA template combines multiple, time-limited state plan options into one single template, eliminating the need to submit multiple SPA actions. Coverage and payment for a COVID-19 vaccine administration can be executed through this template. However, the coverage and payment changes are effective only for the duration of the COVID-19 PHE, and any additional extensions to the PHE issued by the Secretary.

If a state uses the Medicaid Disaster Relief Medicaid SPA template for coverage and reimbursement of vaccine administration, the state can also utilize SPA process flexibilities under section 1135 of the Social Security Act, including securing a retroactive effective date, a waiver of public notice and modification of tribal consultation.

However, states are encouraged to consider providing permanent coverage and payment for COVID-19 vaccine administration (to extend beyond the duration of the COVID-19 PHE). In an effort to streamline the development and submission of COVID-19 vaccine administration SPAs, such language only needs to describe the qualifications of the practitioners who may order and administer the vaccine(s) under the optional benefit(s) most appropriate to the state's Medicaid program. Further, a SPA for the vaccine administration associated with COVID-19 vaccine is only necessary if the payment methodology differs from what is already approved under the state's Medicaid plan. For example, a state may set a new methodology for vaccine administration that describes administration in multiple doses or at alternative sites of service.

If a state submits a SPA for COVID-19 coverage of vaccine administration, it should identify that SPA as a COVID-19 response SPA, and CMS will expedite its review and adjudication. State SPA submissions will need to comply with applicable federal requirements, including public notice, tribal consultation, and effective date requirements, in order to be approved timely and they should be submitted using normal SPA submittal procedures.

B. CHIP & BHP

A CHIP SPA is not necessary for coverage and payment for a COVID-19 vaccine and administration.

A BHP Blueprint is not necessary for coverage and payment for a COVID-19 vaccine and administration.

V. Medicaid & CHIP Reporting Requirements & Implications

CMS intends to publicly report about vaccinations (at an aggregated, summary level) using data from the Transformed Medicaid Statistical Information System (T-MSIS), a uniform, national data system for Medicaid and CHIP. As noted previously in this toolkit, the AMA will be issuing a separate Current Procedural Terminology (CPT) code for each vaccine. States are expected to ensure that their providers use these standard procedure codes for COVID-19 vaccination claims and encounters and are submitting data to the state in a timely manner. States will send these standard codes to CMS through their monthly T-MSIS data submissions. T-MSIS will ensure that procedure codes meet these standards. As COVID-19 vaccine coding specifics become available, CMS will provide more detailed guidance to states.

For purposes of claiming FFP associated with vaccine administration, states are expected to meet existing federal requirements regarding supporting documentation. (2 CFR Part 200 and 42 CFR §§ 430.30 and 433.32)

VI. Provider Enrollment in Medicaid & CHIP

A. Summary of Medicaid & CHIP

In order for states to reimburse for vaccine administration, providers must enroll, and periodically revalidate their enrollment in Medicaid. The same requirement applies to CHIP.¹⁰

Section 1902(a)(27) of the Act requires states to execute Medicaid provider agreements with every person or institution providing services under the Medicaid state plan. These provider agreements require the person or institution to keep records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the state plan, and to furnish the state agency with the needed information regarding any payments claimed by such person or institution for providing services under the Medicaid state plan. The provider agreement requirement does not apply to CHIP. In addition, section 1902(a)(78) of the Act requires all states that pay for medical assistance on a fee-for-service basis enroll all providers furnishing, ordering, prescribing, referring or certifying eligibility for Medicaid services. This provision is also applicable to CHIP pursuant to section 2107(e)(1)(D) of the Act.

Furthermore, as required by sections 1932(d)(6) and 2107(e)(1)(Q) of the Act, participating providers in the networks of Medicaid and CHIP managed care entities are required to be enrolled with state Medicaid and CHIP programs.

Notwithstanding these federal requirements for provider enrollment, states are encouraged to streamline their enrollment processes to the extent feasible, and work with entities such as state pharmacy boards to maximize efficiencies in registration and training processes.

¹⁰ These provider enrollment requirements do not apply to BHP.

B. Data Sharing Systems & Process for Provider Enrollment

In an effort to increase provider enrollment, CMS currently has a Medicare and Medicaid data sharing system and process in place to share the Medicare provider enrollment data with all state Medicaid and CHIP programs. The system for sharing this data is the CMS Data Exchange (DEX) system, which houses all state Medicaid termination data and Medicare revocation data. DEX also contains secure file sharing capability to allow for quick and secure transfer of Medicare screening and enrollment data.

The DEX system will be used to share data on all existing and newly enrolling providers that will be administering the COVID-19 vaccine in Medicare with the states in order to reduce the duplication of efforts across programs. CMS will also share results of provider screenings performed by Medicare, including verification of the provider's licensure and practice location, so that states are not required to rescreen these same providers and can rely on the screening conducted by Medicare as authorized under 42 CFR § 455.410(c). If states have any questions about how to access the DEX system, they can reach out to DEXsupport@cms.hhs.gov.

As an additional approach to streamlining the provider enrollment process, Medicare Administrative Contractors (MACs) will share with newly enrolling providers contact information and/or the enrollment website for each state Medicaid program in order to facilitate the provider's next steps with regard to enrollment with the state. This process will ensure more continuity of providers across both programs and reduce state and provider burden.

These data sharing systems and processes may be used to enroll mass immunizers under the Medicare program into the Medicaid program. Medicare mass immunizers offer vaccines to large numbers of people and may operate in locations like supermarkets or drug stores. The providers must be licensed in the state in which they operate and may utilize roster billing. States may consider similar processes under Medicaid.

C. Emergency Flexibilities Available during All Public Health Emergencies

States may seek various flexibilities regarding federal enrollment requirements during a PHE. In particular, states have the authority to temporarily enroll providers using provider screening that is performed by other state Medicaid agencies or Medicare.

Additionally, during the PHE, states may request a section 1135 waiver to temporarily enroll providers who are not enrolled with another state Medicaid agency or Medicare for the duration of the PHE by waiving certain screening and enrollment requirements, such as payment of application fee, criminal background fingerprint-based checks, site visits and temporarily ceasing revalidation. States may also request 1135 flexibility to waive the provider agreement requirement. However, states must cease payment to providers who are temporarily enrolled within six months from the date that the disaster designation is lifted, unless a provider has submitted an application that meets all requirements for Medicaid participation and that application was subsequently reviewed and approved by the state.

VII. Education & Outreach

Education and outreach will be critical to ensuring that beneficiaries and providers are aware of the availability of the COVID-19 vaccine(s), and that beneficiaries understand where they can receive a COVID-19 vaccine(s), the number of required doses and spacing between doses (if a multi-dose vaccine is used), and how to obtain additional information. CMS encourages states to start developing a strategy for conducting COVID-19 vaccine education and outreach. States may use Medicaid and CHIP administrative matching funds for beneficiary and provider education and outreach.

It is also essential that states emphasize the importance of immunizations in general, as data shows that there have been significant decreases in routine immunizations during the PHE. In addition, it remains critical that Americans receive their flu vaccinations during the PHE.

Highlighted below are a number of actions that states might opt to take relating to outreach and education, as well as resources available to states. In general, states are encouraged to coordinate with their state and local health departments and to partner with other stakeholders to promote coordinated messaging. This is particularly important during the COVID-19 pandemic.

In addition to recommendations to improve education, outreach, and immunization rates, this toolkit provides links to a number of resources and immunization campaigns that include ready-to-use materials that can be used for state campaigns and messaging.

A. Coverage & Access

- Develop coverage language for the COVID-19 vaccine(s). Add that language to coverage materials, manuals, periodicity schedules, beneficiary materials, and your state's website. Share with stakeholders for inclusion in managed care and provider materials.
- Partner with your state and/or local public health agencies and to develop and share coordinated materials regarding coverage of COVID-19 vaccines.
- Assess the provider types that can administer immunizations in your state. Consider whether there should be expansions of providers, including mass immunizers.

B. Payment

- Review vaccine/vaccine administration reimbursement rates. Determine if the rates are sufficient and if they are accurately reflected in your Medicaid state plan, provider materials, physician fee schedule, etc.
- Ensure that the Medicaid state plan as well as payment and billing policies are updated to allow qualified providers to provide for vaccine administration and that providers have provider agreements with the state Medicaid agency. Note: In order to claim FFP for vaccine administration at alternative service sites, a provider must be qualified and have a provider agreement in place.
- Consider whether state billing manuals appropriately reflect policies to streamline and facilitate vaccine administration processes (e.g., through roster billing).

- Explain that, in accordance with regulations at 42 CFR § 447.15, providers may not balance bill Medicaid beneficiaries amounts additional to the amount paid by the state agency plus any deductible, coinsurance or copayment required by the state plan to be paid by the beneficiary.
- Consider implementing payment and reimbursement incentives to encourage improvement in immunization rates.
- Consider use of a uniform billing standard for vaccine claims (e.g., the National Council for Prescription Drug Programs (NCPDP) standard for pharmacy billings).

C. Engaging with Stakeholders

- Review immunization messaging to determine if it is accurate. Review the accuracy of translated materials and determine if the languages reflect state Medicaid, CHIP and BHP populations.
- Consider coordinating with state and local health departments, Women, Infant and Children (WIC) clinics, local health clinics, FQHCs, tribal organizations, and school-based health centers on messaging. Encourage these entities to provide immunizations within the scope of their services.
- Consider coordinating with faith groups, community based groups, tribal organizations, private schools, and other groups to share messaging.

D. Immunization Reporting

- CDC requires that vaccination providers report certain data elements for each COVID-19 dose administered within 24 hours of administration. Preliminary information is available in CDC's "[COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations](#)".

E. Outreach & Education

- Section 12 of CDC's "[COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations](#)" references COVID-19 vaccination program communication. CDC recommends that COVID-19 messaging is developed prior to vaccine availability and that there is clear and consistent messaging. CDC also recommends that states and other jurisdictions regularly review the resources available at the [CDC COVID-19 Communications Resources](#).
- CDC has also emphasized the importance of flu vaccinations in order to reduce hospitalizations and therefore reserve resources for COVID-19 response. CDC's flu campaign began on October 1, 2020, and CDC's website includes a flu [campaign toolkit](#), [social media toolkit](#), and well as other information about [flu](#). In addition, CMS has information on [flu vaccinations for the Medicare population](#) on cms.gov.

COVID-19 Federal Resources from the CDC & HHS

Medicaid COVID-19 Resources:

<https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html>

From the Factory to the Frontlines - The Operation Warp Speed Strategy for Distributing a COVID-19 Vaccine:

<https://www.hhs.gov/sites/default/files/strategy-for-distributing-covid-19-vaccine.pdf>

HHS Fact Sheet: Explaining Operation Warp Speed

<https://www.hhs.gov/coronavirus/explaining-operation-warp-speed/index.html>

COVID-19-FFCRA-FAQs, 04-13-2020:

<https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf>

Version 1.0 “COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations”, 09-16-2020:

https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf (Includes information on provider enrollment to administer vaccines: “To receive/administer COVID-19 vaccine, constituent products, and ancillary supplies, vaccination provider facilities/organizations must enroll in the federal COVID-19 Vaccination Program coordinated through their jurisdiction’s immunization program. Enrolled COVID-19 vaccination providers must be credentialed/licensed in the jurisdiction where vaccination takes place and sign and agree to the conditions in the *CDC COVID-19 Vaccination Program Provider Agreement*.”)

Operation Warp Speed Vaccine Distribution Process (Graphic), 09-16-2020:

<https://media.defense.gov/2020/Sep/16/2002498504/-1/-1/1/OWS-VACCINE-DISTRIBUTION-GRAPHIC.pdf>

CDC Press Release on Funding for Vaccine Preparedness, 09-23-2020:

<https://www.cdc.gov/media/releases/2020/p0924-200-million-jurisdictions-covid-19-preparedness.html>

Glossary of Terms & Resources

Term	Resources
ABP (Alternative Benefit Plan)	More information available at https://www.medicaid.gov/medicaid/benefits/alternative-benefit-plan-coverage/index.html
ACIP (Advisory Committee on Immunization Practices)	More information available at https://www.cdc.gov/vaccines/acip/index.html . Recommendations made by the ACIP are reviewed by the CDC Director and, if adopted, are published as official CDC/HHS recommendations in the Morbidity and Mortality Weekly Report (MMWR). The CDC also publishes annual child and adult vaccine schedules, which reference ACIP recommendations. The vaccine schedules are available at https://www.cdc.gov/vaccines/schedules/index.html .
BHP (Basic Health Program)	PPACA gave states the option to offer Basic Health Programs (BHP) to certain individuals under 200% FPL; more information at https://www.medicaid.gov/basic-health-program/index.html . 42 CFR § 600.510(b) prohibits BHP from imposing cost sharing with respect to the preventive health services or items, as defined in, and in accordance with 45 CFR § 147.130.
CHIP (Children’s Health Insurance Program)	More information is available at https://www.medicaid.gov/chip/benefits/index.html . 42 CFR § 457.410 requires states with a separate CHIP to provide coverage for age-appropriate immunizations in accordance with the recommendations of the ACIP, regardless of the type of health benefits coverage; more information is available at https://www.medicaid.gov/chip/benefits/index.html
EHB (Essential Health Benefits)	More information available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ehb-2-20-2013 and https://www.healthcare.gov/preventive-care-adults/
EPSDT (Early and Periodic Screening, Diagnostic, and Treatment benefit)	Defined at section 1905(r) of the Social Security Act; more information available at https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html
FMAP (Federal Medical Assistance Percentage)	The percentage of state expenditures on items and services defined as “medical assistance” in the Medicaid statute that is paid by the Federal Government.

Term	Resources
<p>PPACA (The Patient Protection and Affordable Care Act)</p>	<p>The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this document, we refer to the two statutes collectively as the “Patient Protection and Affordable Care Act” or “PPACA.” Authorized states to expand Medicaid coverage to individuals ages 19 through 64 with income at or below 133% of the federal poverty level (referred to as Group VIII Adults); more information available at https://www.medicaid.gov/medicaid/eligibility/index.html.</p>
<p>VFC (Vaccines for Children Program)</p>	<p>Authorized under section 1928 of the Social Security Act; more information at https://www.cdc.gov/vaccines/programs/vfc/about/index.html and https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/quality-of-care-vaccines/index.html</p>