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Medicaid and CHIP Coverage of COVID-19 Vaccine and Treatment: A Roadmap for State Action During and After the Public Health Emergency

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Since the early days of the COVID-19 pandemic, the federal government has required states to cover COVID-19 vaccines and treatments for certain eligibility groups under Medicaid and the Children's Health Insurance Program (CHIP). Congress significantly enhanced those coverage requirements with the American Rescue Plan Act of 2021 (ARP):

- States must now cover COVID-19 vaccines without cost sharing for virtually *all* Medicaid and CHIP eligibility groups, including "limited benefit" groups whose coverage does not normally include vaccines. The federal government will, moreover, fully fund Medicaid and CHIP expenditures related to COVID-19 vaccines.
- ARP requires states to cover, without cost sharing, treatments for COVID-19 and certain other conditions for most "full benefit" Medicaid and CHIP populations.
- The optional COVID-19 Medicaid group, which previously covered only COVID-19 testing and testing-related services, now includes coverage for COVID-19 vaccines and treatments, as well as treatment for conditions that may seriously complicate COVID-19. The federal government will continue to pay for 100 percent of the costs of medical assistance and related administrative expenditures for this optional coverage group, which was originally created under the Families First Coronavirus Response Act (FFCRA).

These coverage provisions took effect on March 11, 2021 (the date of ARP's enactment) and will remain in effect for more than a year after the end of the federal public health emergency (PHE). The administration has announced that the PHE will likely be extended, at a minimum, through the end of 2021;[1] if so, ARP's coverage requirements will remain effective until spring 2023 or beyond.

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[1] For additional discussion of the PHE and the various federal flexibilities that are linked to the PHE period, see *Federal Declarations and Flexibilities Supporting Medicaid and CHIP COVID-19 Response Efforts Effective and End Dates*.

This toolkit provides a roadmap for states to identify the types of Medicaid and CHIP policy changes that may be needed to ensure compliance with ARP's requirements for coverage of COVID-19 vaccines and treatment. The Centers for Medicare & Medicare Services (CMS) has advised that *all* states must amend their state plans to incorporate the new mandatory benefits, and potentially also to modify their policies on cost sharing and reimbursement. Depending on their current policies, states may also need to revisit their managed care contracts or the terms of their section 1115 demonstration projects. CMS is expected to release additional guidance on state plan amendments (SPAs), and has invited states to reach out for technical assistance.

In addition to ensuring compliance with ARP, states may use this opportunity to reexamine their approaches to vaccine coverage in general, and could seek opportunities to further support both routine immunizations and pandemic preparedness.

This SHVS product has been updated to reflect the May 5, 2021 version of CMS's Medicaid COVID-19 Vaccine Toolkit.

Enhanced Federal Requirements for Medicaid and CHIP Coverage of COVID-19 Vaccines and Treatments

Before ARP, states already operated under certain COVID-19-related coverage requirements in connection with FFCRA, which was enacted in March 2020. As compared to FFCRA, however, ARP's requirements affect additional Medicaid and CHIP eligibility groups, include additional services, and extend for an additional 15 months. These distinctions are discussed below and summarized in Table 1.

FFCRA's Coverage Requirements. Section 6008(b) of FFCRA offered states a 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP) for many Medicaid expenditures, conditioned on states satisfying certain "maintenance of effort" requirements. Among other conditions, states must provide Medicaid coverage, without cost sharing, for all COVID-19 vaccines and treatments until the end of the calendar quarter in which the PHE expires. CMS guidance directed states to cover *all* vaccines, drugs, and biologicals authorized by the Food & Drug Administration (FDA) for the prevention or treatment of COVID-19, including products that receive an Emergency Use Authorization (EUA).

ARP's Coverage Requirements. ARP did not amend or replace FFCRA's coverage requirements; rather, sections 9811 and 9821 of ARP layered on a set of new, more expansive coverage requirements, as described below. Additionally, whereas FFCRA's coverage requirements last only until the *end of the calendar quarter* in which the PHE expires, ARP's requirements last for

an additional *one year plus one quarter* (15 months) after the end of the PHE. ARP's new coverage requirements took effect on March 11, 2021.[2]

Federally funded COVID-19 vaccine coverage, without cost sharing, for all Medicaid and CHIP eligibility groups. ARP requires states to fully cover COVID-19 vaccines and vaccine administration for the following eligibility groups:

- "Full benefit" Medicaid groups, including:
    - Children
    - Adults covered under the Affordable Care Act (ACA) Medicaid expansion; and
    - Non-expansion adults, such as pregnant women, parents with young children, and people with disabilities.

  These are the same groups that fall within the scope of FFCRA's existing coverage requirement.
- "Limited benefit" Medicaid groups that receive a restricted benefit package, such as:
    - Individuals eligible for a defined set of family planning benefits;
    - The optional COVID-19 group created under FFCRA (which was previously limited to coverage of COVID-19 testing); and
    - Eligibility groups that receive a limited set of benefits through a demonstration project authorized under the so-called "expenditure authority" in section 1115(a)(2);[3] and
- Children and pregnant women covered under CHIP. (Even before ARP, these CHIP eligibility groups received coverage for COVID-19 vaccines, as described below.)

ARP also increases federal funding for COVID-19 vaccines and vaccine administration by offering 100 percent FMAP for all such services under both Medicaid and CHIP. State CHIP allocations and territorial funding caps will be increased as necessary to offset these vaccine-related costs. Although the mandate for states to cover COVID-19 vaccines took effect on March 11, 2021, the 100 percent FMAP did not take effect until April 1 (the first day of the following calendar quarter). CMS intends to provide guidance for states regarding implementation of the 100 percent FMAP.

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[2] CMS has advised that states may request authority under section 1115 of the Social Security Act to retroactively extend coverage for COVID-19-related services prior to ARP's effective date. In addition, the Health Resources & Services Administration (HRSA) COVID-19 Claims Reimbursement Program may be available for reimbursement of certain COVID-19 vaccine and treatment costs prior to March 11, 2021 for individuals whose coverage did not, at that time, include coverage for such costs.

[3] Other "limited benefit" groups include individuals receiving tuberculosis-related coverage and individuals who qualify for "medically needy" coverage. However, ARP's vaccine coverage requirement does *not* apply to dually eligible individuals for whom Medicaid pays certain costs related to Medicare [as described in sections 1902(a)(10)(E) and 1933 of the Social Security Act, or to individuals who receive Medicaid support for COBRA premiums (as described in section 1902(a)(10)(F)].

Coverage of COVID-19 treatments, without cost sharing, for many Medicaid and CHIP eligibility groups. ARP builds on FFCRA by requiring states to fully cover COVID-19 treatments for:

- "Full benefit" Medicaid groups (as under FFCRA)
- The optional COVID-19 Medicaid group (but no other "limited benefit" Medicaid groups)
- Children and pregnant women covered under CHIP

ARP requires states to cover "specialized equipment and therapies (including preventive therapies)" for COVID-19. Moreover, prescription drugs and biologicals for the treatment of COVID-19 will be included in the Medicaid Drug Rebate Program if they are furnished on an outpatient basis. States are not permitted to exclude these products from their formularies, but will be entitled to federal rebates from manufacturers (potentially including rebates for products approved under an EUA).

Protection against cost sharing for treatment of conditions that may "seriously complicate" COVID-19. In addition to guaranteed coverage for COVID-19 therapies, ARP provides an additional protection for the eligibility groups listed above ("full benefit" Medicaid groups, the optional COVID-19 Medicaid group, and CHIP eligibility groups). If an individual has a confirmed or suspected case of COVID-19, states may not impose cost sharing on treatments for any condition that may "seriously complicate" treatment for COVID-19.[4]

This provision does not require states to add coverage that doesn't already exist, but states must eliminate any cost sharing that would otherwise apply to an applicable treatment when furnished to an individual who (1) is a member of one of the eligibility groups listed above, and (2) has a confirmed or suspected case of COVID-19.

CMS has not issued guidance concerning the specific conditions or treatments that fall within the scope of this provision. Absent such guidance, states may wish to consult other authorities, such as the list published by the Centers for Disease Control & Prevention (CDC) of medical conditions that increase the risk of "severe illness" from COVID-19.

[4] States may eliminate cost sharing under these circumstances without running afoul of the standard for "comparability of services" under section 1902(a)(10)(B) of the Social Security Act.

Table 1. Comparison of FFCRA and ARP's Requirements for States to Cover COVID-19 Vaccines and Treatment in Medicaid and CHIP

	THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA) *(SECTION 6008(B)(4))*	THE AMERICAN RESCUE PLAN ACT (ARP) *(SECTIONS 9811 & 9821)*
Required Benefit	**Eligibility Groups That Must Receive This Benefit**	
COVERAGE OF COVID-19 VACCINES WITHOUT COST SHARING	"Full benefit" Medicaid groups	• All Medicaid eligibility groups *(including "limited benefit" groups)* • Children and pregnant women covered under CHIP *Note: States receive 100 percent federal match for COVID-19 vaccines*
COVERAGE OF COVID-19 TREATMENTS WITHOUT COST SHARING	"Full benefit" Medicaid groups	• "Full benefit" Medicaid groups • The optional COVID-19 Medicaid group *(but no other "limited benefit" groups)* • Children and pregnant women covered under CHIP
NO COST SHARING FOR TREATMENT OF CONDITIONS THAT MAY SERIOUSLY COMPLICATE COVID-19*	*N/A*	• "Full benefit" Medicaid groups • The optional COVID-19 Medicaid group *(but no other "limited benefit" groups)* • Children and pregnant women covered under CHIP
Duration of COVID-19 Coverage Requirements		
EXPIRATION TIMELINE	End of the calendar quarter in which the PHE expires⁺	One year plus one calendar quarter after the PHE expires⁺
EXAMPLE TIMELINE IF THE PHE ENDS ON JANUARY 1, 2022	FFCRA's coverage requirement ends March 30, 2022	ARP's coverage requirement ends June 30, 2023

* *States are not required to add coverage for new services. However, if an applicable service is covered under the state plan, the state must waive cost sharing for this service when furnished to an individual with a confirmed or suspected case of COVID-19.*

⁺ *The statutory authority for states to cover the optional COVID-19 group expires at the end of the PHE. Thus, when the PHE ends, states will no longer receive federal funding for any expenditures related to this group.*

Implication for States

State Plan Amendments (SPAs) will be necessary to effectuate ARP's coverage requirements.

- ARP creates new mandatory benefits for COVID-19 vaccines and treatment in sections 1905(a)(4) and 2103(c)(11) of the Social Security Act. According to CMS's Medicaid COVID-19 Vaccine Toolkit, all states *must* submit SPAs to add coverage for the mandatory vaccine benefit under Medicaid and CHIP. CMS intends to provide additional guidance regarding the particulars of these SPAs. This guidance may, in addition, address ARP's requirement for coverage of COVID-19 treatment, which CMS has not yet commented on in any detail.
- In addition to adding coverage for these mandatory benefits, states may require SPA authority to:
    - Implement ARP's prohibition on cost sharing for COVID-19 vaccines and treatment
    - Establish or modify reimbursement rates for COVID-19 vaccines and treatment. For example, the Medicaid COVID-19 Vaccine Toolkit notes that a SPA is necessary if a state seeks to establish a new payment methodology specific to COVID-19 vaccines, or to amend its existing vaccine administration payment methodology or rates.
- Because each state's Medicaid state plan is different, CMS recommends that states contact CMS for technical assistance, including with respect to any eligibility groups that are covered through a limited benefit demonstration under section 1115(a)(2).
- CMS's Disaster Relief SPA template is available for states to rapidly implement certain changes. (Note: the state may need to follow up with a standard SPA to preserve these changes past the end of the PHE.)
    - A Disaster Relief SPA allows states to bypass certain SPA public notice and Tribal consultation requirements when implementing benefit enhancements, reimbursement increases, or reductions in cost sharing.
    - In addition, CMS may extend the retroactive effect of an approved Disaster Relief SPA. Normally, a SPA may take effect no earlier than the beginning of the quarter in which the SPA was submitted. But if a state submits a Disaster Relief SPA in May 2021 that is designed to ensure compliance with ARP's requirements, CMS could approve that SPA retroactive to ARP's effective date of March 11, 2021, even though this date falls in the previous calendar quarter.
    - Disaster Relief SPAs expire automatically at the end of the PHE, but ARP's coverage requirements last for an additional one year plus one calendar quarter. Thus, a state that implements ARP-compliant policies using a Disaster Relief SPA may need to eventually follow up with an ordinary SPA to preserve those

changes past the end of the PHE, unless CMS makes some accommodation to allow states to continue relying on their Disaster Relief SPAs for ARP-related changes.

The availability of 100 percent federal funding for COVID-19 vaccines supports states' ability to set appropriate reimbursement rates. Historically, Medicaid vaccine reimbursement rates have lagged behind those under Medicare and commercial payers. Some studies have found, for example, that Medicaid's reimbursement rates are insufficient to cover providers' cost of acquiring and administering vaccines.[5] By providing appropriate reimbursement rates for COVID-19 vaccination services, states may help to encourage provider participation in the COVID-19 vaccination effort. Adequate reimbursement may be especially valuable to providers in under-resourced communities where the pandemic's effects were felt most harshly, and where providers may be undertaking heightened outreach, education, and follow-up efforts in connection with the COVID-19 immunization campaign.

- As one example, Oklahoma has opted to match Medicare rates for vaccine administration, without geographic adjustment. Currently, Medicare's unadjusted rate for COVID-19 vaccine administration is $40 per dose. (States that choose to adopt the Medicare rate should clearly identify whether they are adopting the adjusted or unadjusted rate.)
- CMS's Medicaid COVID-19 Vaccine Toolkit outlines other options that states might consider with respect to both practitioner and facility-based billing for vaccine administration services, such as enhanced rates or add-on payments (including the possibility of an add-on payment for drive-through immunization sites).
- States may, in addition, wish to modify their Medicaid reimbursement policies for vaccines administered to children. (Note: As of May 10, 2021, Pfizer's COVID-19 vaccine has received FDA authorization for use in individuals age 12 and up. Before that date, Pfizer's vaccine was authorized only for use in individuals age 16 and up. No other vaccines have yet been authorized for individuals under age 18, but clinical trials are ongoing to test the safety and efficacy of COVID-19 vaccines in adolescents and younger children.)
    - Normally, Medicaid-covered children are eligible to receive federally purchased vaccines through the Vaccines for Children Program (VFC). Program rules cap the

[5] Granade et al., State Policies on Access to Vaccination Services for Low-Income Adults, *JAMA Network Open.* 2020;3(4):e203316, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764810. For the time being, the federal government is purchasing and distributing all COVID-19 vaccines, meaning that Medicaid and CHIP need only reimburse providers for vaccine administration services (or for a provider visit during which a vaccine dose is administered). The federal government may eventually stop purchasing COVID-19 vaccines, however, at which point Medicaid and CHIP would need to reimburse providers for both vaccine supply and vaccine administration. CMS has not yet specified whether ARP requires states to cover *every* FDA-authorized COVID-19 vaccine (as under FFCRA), or whether states may satisfy ARP by ensuring adequate access to a subset of FDA-authorized vaccines.

reimbursement rates that states may pay providers who administer VFC vaccines.

  - The VFC "regional maximum administration fees" will not apply to COVID-19 vaccines, which will not flow through VFC channels; rather, the federal government intends to use the centralized COVID-19 vaccine distribution system for recipients of all ages, including children. States may thus wish to align their COVID-19 vaccine reimbursement rates across pediatric and adult populations.

The optional COVID-19 Medicaid group now provides robust COVID-related coverage, which is fully funded by the federal government. FFCRA section 6004(a)(3) offered states the option of extending Medicaid coverage to uninsured individuals, regardless of income, with respect to COVID-19 testing and testing-related services. ARP expanded coverage for this group to include COVID-19 vaccines and treatments, as well as treatments for conditions that may complicate COVID-19 (to the extent such treatments are covered under the state plan for "full benefit" Medicaid groups). States may not impose any cost sharing for these services. Crucially, states receive 100 percent FMAP for *all* covered services for this group, and also for related administrative costs.

Thus far, approximately 30 percent of states have sought permission from CMS to adopt the optional COVID-19 group, although it is not clear whether all of these states actually *implemented* coverage for this group. As a result of ARP's coverage enhancement—together with the 100 percent federal match—the optional COVID-19 group may become a more attractive prospect, particularly in states that have not adopted Medicaid expansion or that otherwise have large populations of individuals who lack health coverage. States should bear in mind the following operational implications related to adopting the optional COVID-19 Medicaid group:

- States may add coverage for the optional COVID-19 group by submitting a Disaster Relief SPA, which allows the state to bypass certain procedural requirements, as described above.
- FFCRA's authorization for the optional COVID-19 eligibility group expires at the end of the PHE. Thus, although ARP's coverage requirements generally last for more than a year following the end of the PHE, states will no longer receive federal funding for any expenditures related to the optional COVID-19 group once the PHE expires (unless Congress acts to extend the authority for this group, or a state seeks CMS permission to provide similar coverage through a demonstration project under section 1115(a)(2)).
- States that have already adopted the optional COVID-19 group should check their SPA language to determine whether any changes are needed to comply with ARP. Some states (e.g., Colorado) added coverage for this group without expressly limiting coverage to testing-related services; in this scenario, it's likely that no SPA is required to add coverage for COVID-19 vaccines and treatments.

Implications for managed care. States that rely on a managed care delivery system in their Medicaid programs will need to consider whether the state or their managed care contractors will (1) process payment for newly covered COVID-19 vaccine and treatment services, and (2) bear financial risk for these COVID-19-related services. See CMS's Medicaid COVID-19 Vaccine Toolkit for a discussion of these and other examples regarding vaccine-related payments:

- States could choose to carve COVID-19 vaccines out of their managed care contracts and provide centralized vaccine billing through the fee-for-service program, or could have managed care plans reimburse providers for vaccine administration but pass those costs on to the state.
- Alternatively, states could factor vaccine-related costs into a plan's capitation rate, although a state would need a mechanism for tracking vaccine-related costs in order to properly claim the 100 percent federal match for these services. (CMS may provide additional guidance on this point.)
- States may wish to establish value-based models that incentivize managed care plans to educate members about the importance of COVID-19 immunization, and to assist members in scheduling and accessing immunization services.
- Although states are generally permitted to apply different levels of coverage and cost sharing for services furnished by out-of-network providers, CMS's November 2020 Interim Final Rule creates certain protections to the ACA expansion group (and any other individuals covered under an Alternative Benefit Plan). For these individuals, managed care plans must cover COVID-19 vaccines without cost sharing regardless of whether the furnishing provider is in the plan's network.

Ensuring Permanent, Comprehensive Vaccine Access for Medicaid and CHIP Enrollees During and After the PHE

With FFCRA and ARP, Congress sought to ensure broad coverage of COVID-19 vaccines for all individuals enrolled in Medicaid and CHIP for at least fifteen months after the end of the PHE. Notably, for many of these individuals, federal law already guaranteed coverage, without cost sharing, of *all* vaccines recommended by the CDC's Advisory Committee on Immunization Practices (ACIP). Eligibility groups with guaranteed vaccine benefit include children in both Medicaid and CHIP, as well as adults enrolled in Medicaid expansion or otherwise enrolled in an Alternative Benefit Plan (as summarized below in Table 2). This approach to coverage ensures that enrollees are able to receive immunizations in accordance with ACIP's latest evidence-based recommendations, which supports access to both routine immunization as well as vaccines developed in response to a specific threat, such as COVID-19. Notably, each time FDA issues an emergency authorization for a new COVID-19 vaccine, ACIP convenes a meeting and issues a recommendation in a matter of days.

However, for certain eligibility groups, federal law does *not* guarantee coverage of all ACIP-recommended vaccines without cost sharing:

- **Non-expansion adults age 21+.** Vaccine coverage is an optional benefit for non-expansion adults enrolled in one of Medicaid's "full benefit" eligibility groups under the state plan, including mandatory and optional pregnant women, parents and caretaker relatives, people with disabilities, and the elderly.[6] Each state may decide which vaccines to cover and whether cost sharing will apply. To incentivize broad coverage, section 4106 of the ACA offers a one percentage point FMAP increase with respect to preventive services (including ACIP-recommended vaccines), but only for states that cover *all* federally recommended preventive services with no cost sharing.[7]

- **Non-expansion adults age 19 or 20.** These young adults are entitled to coverage of all ACIP-recommended vaccines as part of the Early Periodic Screening, Diagnosis and Treatment (ESPDT) benefit. However, states are able to impose cost sharing (unless the state has opted to receive the FMAP enhancement under ACA section 4106, as described above).

- **Pregnant women covered under CHIP.** Currently, all states that provide CHIP coverage to pregnant women offer comprehensive coverage, without cost sharing, of all ACIP-recommended vaccines. CMS has suggested in guidance, however, that this level of coverage may not be required under federal law.

Table 2. General Federal Vaccine Coverage Requirements Under Medicaid and CHIP

Eligibility Group	Does Federal Law Guarantee Coverage for All ACIP-Recommended Vaccines Without Cost Sharing?
Medicaid⁺	
CHILDREN	✓ **Yes**, under the ESPDT benefit.
ADULTS COVERED UNDER THE ACA EXPANSION	✓ **Yes**, under the Alternative Benefit Plan "preventive services" benefit.
NON-EXPANSION YOUNG ADULTS AGE 19 OR 20*	× **No.** States must cover all ACIP-recommended vaccines, but states may impose cost sharing.
NON-EXPANSION ADULTS AGE 21+*	× **No.** States decide which vaccines to cover, and whether to impose cost sharing.

[6] For "limited benefit" groups, vaccines may be covered only if they fall within the scope of the statutory benefit package. For example, states may cover the HPV vaccine as part of the limited family planning benefit. Under ARP, "limited benefit" groups are entitled to coverage without cost sharing of COVID-19 vaccine until one year plus one quarter after the end of the PHE, as described above.

[7] ACA § 4106; SMD 13-002. The increased FMAP applies with respect to both fee-for-service and managed care programs. In addition to ACIP-recommended vaccines, the federally recommended preventive services include any service assigned a grade of "A" or "B" by the United States Preventive Services Task Force (USPSTF), as well as certain prescribed services for the "reduction of physical or mental disability and restoration of an individual to the best possible functional level."

CHIP		
CHILDREN	✓	**Yes**, under the "well child" benefit.
PREGNANT WOMEN *(IF THE STATE COVERS PREGNANT WOMEN UNDER CHIP)*	×	**No.** All states currently provide full ACIP vaccine coverage without cost sharing, but [CMS guidance](#) suggests that this level of coverage may not be required under federal law.

+ This chart includes only "full benefit" Medicaid groups. For "limited benefit" groups, vaccines may be covered only if they fall within the scope of the statutory benefit package. For example, states may cover the HPV vaccine as part of the limited family planning benefit.

** If a state chooses to cover non-expansion adults under an Alternative Benefit Plan, these adults are entitled to coverage of all ACIP-recommended vaccines without cost sharing, consistent with the coverage standard that applies to the ACA expansion group.*

States that have not already adopted the ACA's incentive for coverage of preventive services may wish to reexamine the merits of this policy. Comprehensive coverage would promote access to routine immunizations, thereby helping to avoid the adverse health outcomes and health care costs associated with vaccine-preventable diseases. Moreover, by linking vaccine coverage for all Medicaid and CHIP groups to ACIP's evidence-based recommendations, states will be laying the foundation for swift coverage updates and enrollee access when the need next arises for a new vaccine in response to a new, highly communicable disease.

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