Coverage and Payment of Vaccines and Vaccine Administration under Medicaid, the Children's Health Insurance Program, and Basic Health Program

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Introduction

Vaccines are essential for preventing disease and promoting the health of individuals and communities. Medicaid and Children's Health Insurance Program (CHIP) agencies play a pivotal role in ensuring that beneficiaries can access recommended vaccines.[1] Vaccinations have long served as a critical tool for the prevention of disease, as a deterrent for outbreaks, and, over the past few years, as a response to public health emergencies (PHE) such as for COVID-19 and mpox. In recent years, federal statute, regulations, and guidance has mandated coverage requirements for COVID-19 vaccinations, as well as for certain vaccinations for adult Medicaid and CHIP beneficiaries.[2] With these mandates, states must navigate complex interrelated and overlapping vaccine coverage rules.

The purpose of this toolkit is to equip states with the tools necessary to meet the needs of the nation's Medicaid and CHIP beneficiaries, and Basic Health Program (BHP) enrollees, so they may better understand coverage, cost-sharing, and payment for vaccines and vaccine administration under Medicaid, CHIP, and BHP, including the requirements applicable to Medicaid and CHIP under section 11405 of the Inflation Reduction Act (IRA) (Pub. L. 117-169).[3] Furthermore, acknowledging that states are navigating vaccination coverage requirements after the expiration of the COVID-19 PHE, this toolkit includes guidance regarding the commercialization of COVID-19 vaccines and the end of the American Rescue Plan Act (ARP) COVID-19 vaccination coverage period, which extends through September 30, 2024.

The Centers for Medicare & Medicaid Services (CMS), Center for Medicaid and CHIP Services (CMCS) remains available to provide technical assistance as states continue to navigate the post-COVID-19 PHE era, respond to the current needs of beneficiaries, and plan for future PHEs.

Background

According to the Centers for Disease Control and Prevention (CDC), for Americans born between 1994 and 2013, it is estimated that vaccines will prevent 322 million illnesses, 21 million hospitalizations, and 732,000 deaths over the course of their lifetimes.[4] As has been demonstrated during the COVID-19 pandemic, vaccines play a critical role in protecting individuals and communities from infectious diseases.

Recent data has shown that vaccination rates have decreased among individuals of all ages, even as vaccinations have reduced morbidity and mortality.[5] Additionally, the vaccination rate for the 2020-21

[1] Note: Under Section 1101 of the Social Security Act "state" includes the territories in Medicaid.

[2] In this document, CMS uses the term "vaccination" to refer both to a vaccine product and its administration. Similarly, "immunization," as used in the document, includes both a product and its administration.

[3] State Health Official (SHO) Letter #23-003 Mandatory Medicaid and Children's Health Insurance Program Coverage of Adult Vaccinations under the Inflation Reduction Act. https://www.medicaid.gov/federal-policy-guidance/downloads/sho23003.pdf.

[4] https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6316a4.htm

[5] See the Vaccine and Immunization Landscape in the HHS Strategic Plan for Vaccines: https://www.hhs.gov/sites/default/files/HHS-Vaccines-Report.pdf

Vaccines play a critical role in protecting individuals and communities from infectious diseases.

school year among kindergartners nationwide for all vaccines were 94%, an approximately one percentage point decrease from the 2019-20 school year.[6] Preliminary data indicate that, among Medicaid and CHIP beneficiaries under age 19, vaccination rates declined for all vaccines except for influenza from March 2020, through August 2021, compared with the same period two years prior.[7]

While vaccination rates have been decreasing, the prevalence of vaccine preventable diseases (VPDs), and spending on VPDs has been increasing. In 2019, two VPDs, influenza and pneumonia, were together the ninth leading cause of death in the United States.[8] Additionally, researchers estimate that VPDs among adults in the United States cost between $9 billion and $26 billion annually.[9]

Medicaid, CHIP, and BHP coverage can help to ensure access to vaccinations. Collaboration between local, state, and territorial public health agencies and Medicaid, CHIP, and BHP programs is vital to expanding access, increasing vaccination rates, and overcoming challenges in protecting communities against VPDs.

Disparities in Vaccination Rates

Preliminary data indicate that, among Medicaid and CHIP beneficiaries under age 19, vaccination rates declined for all vaccines except for influenza from March 2020, through August 2021, compared with the same period two years prior.

Disparities in vaccination rates exist by race, ethnicity, gender, geography, and other demographic characteristics.[10] According to an analysis from the Medicaid and CHIP Payment and Access Commission (MACPAC), the differences across racial and ethnic groups vary by vaccine.[11] National survey data indicate that, even after adjusting for socioeconomic factors, adult vaccine uptake among certain racial and ethnic groups is generally lower compared with non-Hispanic white populations.[12] Disparities may be due to a number of factors, such as unequal access to healthcare, limited provider access, vaccine hesitancy, and distrust of the medical system. To address disparities, national, state, and local governments often employ

[6] National vaccination coverage among kindergartners for two doses of measles, mumps, and rubella (MMR) vaccine was 93.9%, 93.6% for state-required doses of diphtheria, tetanus, and acellular pertussis vaccine (DTaP), and 93.6% for state-required doses of varicella vaccine. For additional detail, see https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7116a1-H.pdf

[7] https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot-08-31-2021.pdf

[8] Xu, J., S. Murphy, K. Kochanek, and E. Arias. 2021. Deaths: Final data for 2019. National Vital Statistics Reports 70, no. 8. https://stacks.cdc.gov/view/cdc/106058/cdc_106058_DS1.pdf

[9] Ozawa, S., A. Portnoy, H. Getaneh, et al. 2016. Modeling the economic burden of adult vaccine-preventable diseases in the United States. Health Affairs 35, no. 11: 2124–2132. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0462.

[10] https://www.hhs.gov/sites/default/files/HHS-Vaccines-Report.pdf

[11] See pages 32-33 of MACPAC Vaccine Access of Adults Enrolled in Medicaid: https://www.macpac.gov/wp-content/uploads/2022/03/Chapter-2-Vaccine-Access-for-Adults-Enrolled-in-Medicaid.pdf.

[12] https://www.sciencedirect.com/science/article/pii/S0264410X15013079?viewFullText=true#bib9

targeted outreach and education campaigns to increase vaccine uptake among underserved communities.

The Advisory Committee on Immunization Practices

As outlined in coverage sections below, Medicaid and CHIP coverage of vaccinations may vary based on the types of recommendations made by the Advisory Committee on Immunization Practices (ACIP). The ACIP is a federal advisory committee composed of medical and public health experts, as well as a consumer representative, that provides advice and guidance to the Director of the CDC on the most effective means to prevent VPDs in the United States. Recommendations made by ACIP are reviewed by the CDC Director and, if adopted, are published as official CDC recommendations in the Morbidity and Mortality Weekly Report.[13, 14]

Vaccination recommendations that are listed on the CDC/ACIP immunization schedules are considered routine. Recommendations not listed are considered non-routine.

ACIP also develops written recommendations—subject to adoption by the CDC Director—for the routine use of vaccines for both pediatric and adult populations for inclusion on the CDC/ACIP's immunization schedules.[15] To inform its advice to the CDC Director, ACIP considers disease epidemiology, burden of disease, vaccine efficacy and effectiveness, vaccine safety, the quality of evidence reviewed, economic analyses, and implementation issues.

Additionally, ACIP makes vaccination recommendations for different groups of people. Recommendations are by age group or by risk group, including risk due to underlying condition, occupation, or travel.[16] Some of ACIP's recommendations are not considered routine (that is, are not included on the adult or pediatric immunization vaccine schedules) but reflect the same considerations as vaccines included on the immunization vaccine schedules.

Most of ACIP's recommendations, including those both on and off the pediatric or adult vaccine immunization schedule as described above, are for vaccinations for everyone (without contraindication) in a designated age or risk group (standard recommendations). ACIP also makes recommendations for shared clinical decision-making, in which the healthcare provider and the patient or parent/guardian consider whether or not to vaccinate. These other recommendations are not always included on the annual immunization schedules and therefore would not be considered routine. Vaccination recommendations for shared clinical decision-making that are listed on the CDC/ACIP immunization schedules are considered to be for routine use. The key distinction between standard

[13] https://www.cdc.gov/vaccines/acip/committee/role-vaccine-recommendations.html

[14] ACIP also has a statutorily defined role with respect to the Vaccines for Children (VFC) program. For more information, please see: https://www.cdc.gov/vaccines/programs/vfc/index.html; https://www.cdc.gov/vaccines/programs/vfc/providers/resolutions.html.

[15] As defined for purposes of the vaccination coverage that must be included in BHP and Medicaid Alternative Benefit Plan coverage, ACIP recommendations for "routine use" are those that are listed on the CDC/ACIP immunization schedules. See 45 CFR 147.130(a)(1)(ii). References to "routine" vaccinations or "routine" ACIP recommendations in this toolkit have that same meaning.

[16] https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html

recommendations and shared clinical decision-making recommendations relates to whether there should be a default decision to vaccinate. For standard recommendations, the default decision should be to vaccinate the patient based on age group or other indication, unless contraindicated. For shared clinical decision-making recommendations, there is no default—the decision about whether or not to vaccinate may be informed by the best available evidence of who may benefit from vaccination, the individual's characteristics, values, and preferences, the healthcare provider's clinical discretion, and the characteristics of the vaccine being considered.[17]

Current, Temporary Changes to the COVID-19 Vaccination Coverage and Payment Landscape

While responding to the COVID-19 PHE, states have had to implement numerous changes in federal law and policy, including requirements meant to increase access to COVID-19 vaccines, treatments, and other countermeasures. The COVID-19 PHE declared by the Secretary of Health and Human Services (HHS) under section 319 of the Public Health Service Act expired on May 11, 2023, other COVID-19-related statutes and authorities are still in effect, and some are set to sunset in 2024. Additionally, with the commercialization of COVID-19 vaccines in September 2023, they are no longer exclusively federally purchased and distributed through the universal CDC COVID-19 Vaccination Program which ended in September 2023, and are instead purchased and distributed like other vaccines, including through private purchase and through more limited federal vaccination programs.[18] For the latest information on COVID-19 vaccination recommendations, please see the CDC website,[19] and for the latest on COVID-19 vaccine commercialization, please see the HHS website.[20] Given the evolving law and policy related to COVID-19 and other vaccinations, it is imperative that states review vaccination coverage and payment to ensure adequate coverage for all vaccines moving forward. Additional information on Medicaid, CHIP, and BHP coverage and payment following the ARP coverage period and the IRA implementation can be found later in this toolkit. Table 1 below provides a brief description of these COVID-19 vaccination policies and their respective key dates.

Public Readiness and Emergency Preparedness (PREP) Act

The HHS Secretary has legal authority to take action to prepare for and respond to public health and medical emergencies under several statutes, including the Public Readiness and Emergency Preparedness (PREP) Act of 2005.[21] The PREP Act authorizes the Secretary to issue a declaration (PREP Act declaration) that provides immunity from suit and liability (except for willful misconduct) for claims of loss caused by, arising out of, relating to, or resulting from administration or use of covered countermeasures to diseases, health conditions, or other threats to health determined by the Secretary to constitute a present, or credible risk of a future public health emergency. Immunity extends to entities and individuals involved in the development, manufacturing, testing, distribution,

[17] All ACIP recommendations by vaccine are available here: https://www.cdc.gov/vaccines/hcp/acip- recs/index.html

[18] https://aspr.hhs.gov/COVID-19/Pages/FAQ-Commercialization.aspx

[19] https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html

[20] https://www.hhs.gov/coronavirus/commercialization/index.html

[21] https://stg-aspr.hhs.gov/legal/Pages/Legal-Authority-of-the-Secretary.aspx

administration, and use of such countermeasures.[22] A PREP Act declaration is not dependent on other emergency declarations.

For example, the HHS COVID-19 PREP Act declaration was used to ensure access to COVID-19 countermeasures, including the administration of COVID-19 vaccines.[23] More on the HHS COVID-19 PREP Act declaration can be found later in this section.[24]

HHS PREP Act authorizations preempt conflicting state scope of practice or licensure laws and thus have Medicaid payment implications.

HHS PREP Act declarations can impact state Medicaid and CHIP programs because such declarations might identify certain practitioners as "covered persons" authorized to administer certain vaccines. These HHS PREP Act authorizations preempt conflicting state scope of practice or licensure laws and thus have Medicaid payment implications, as a result of the Medicaid free choice of provider requirement.[25] Specifically, when a state covers a vaccination for a beneficiary, and a practitioner (such as a pharmacist or pharmacy technician) is authorized to administer that vaccine under an HHS PREP Act declaration, the state Medicaid program would be required to provide a pathway to paying that practitioner for the covered vaccine administration when provided in accordance with the provisions of the HHS PREP Act declaration. This is true even when a state wouldn't typically recognize that provider as a provider of vaccinations. States still must meet all other applicable federal requirements for covering the applicable benefit, such as reimbursing only those providers that are enrolled as Medicaid providers and covering vaccinations only for eligible individuals.[26]

The same expectations do not apply, however, to separate CHIPs or BHPs. Importantly, separate CHIPs and BHPs are not subject to Medicaid's free choice of willing and qualified provider requirement. Indeed, the BHP statute requires coverage through managed care plans to the extent they are available in the area. Thus, states operating separate CHIPs and BHPs generally have flexibility to determine which health care providers they would reimburse for providing covered countermeasures, and in the case of BHPs, the managed care plans would be covering vaccinations and paying providers. That said, as outlined above, the HHS COVID-19 PREP Act declaration and authorizations establish that various individuals may order and/or administer covered countermeasures, if they do so consistently with the PREP Act declarations and authorizations. Accordingly, states operating separate CHIPs may not deny CHIP payment to a CHIP provider for a covered countermeasure on the basis that

[22] https://aspr.hhs.gov/legal/PREPact/Pages/default.aspx; https://aspr.hhs.gov/legal/PREPact/Pages/PREP-Act-Question-and-Answers.aspx

[23] On March 10, 2020, the Secretary issued a PREP Act declaration, effective February 4, 2020, to provide liability protections for activities related to medical countermeasures against COVID-19. See Section V. of https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf

[24] See also https://www.hhs.gov/about/news/2023/04/14/factsheet-hhs-announces-amend-declaration-prep-act-medical-countermeasures-against-covid19.html#:~:text=PREP%20Act%20immunity%20from%20liability,of%20any%20USG%20agreement%20or

[25] Section 1902(a)(23)(A) of the Act.

[26] SHO Letter #23-003 Mandatory Medicaid and Children's Health Insurance Program Coverage of Adult Vaccinations under the Inflation Reduction Act. https://www.medicaid.gov/federal-policy-guidance/downloads/sho23003.pdf.

the provider is not licensed or authorized under state law to provide a covered countermeasure if the PREP Act declarations and authorizations permit that provider to do so. Similarly, managed care plans under a BHP may not deny coverage on that basis alone. However, the PREP Act does not require BHP managed care plans or separate CHIPs to pay providers or provider types they would not otherwise pay.

HHS PREP Act declarations may be used for future PHEs or disasters and, as described above, these declarations have implications both for the practitioners who administer vaccines and with respect to payment for vaccine administration within Medicaid and CHIP programs. Additional guidance for states related to preparation for future PHEs or disasters can be found in Resources for States on Medicaid.gov.[27]

HHS COVID-19 PREP Act Declaration

The HHS COVID-19 PREP Act declaration continues to help ensure broad access to COVID-19 vaccines, tests, and treatments. The flexibility and liability protections of this declaration expanded the pool of healthcare providers available to deliver needed interventions to the public. In April 2023, the Secretary of HHS announced planned changes to the HHS COVID-19 PREP Act declaration as the COVID-19 PHE came to an end.[28] These amendments included:

- Extending authorization of certain providers to administer COVID-19 vaccines, seasonal influenza vaccines, and COVID-19 tests through December 31, 2024. PREP Act immunity from liability will extend through December 2024, to pharmacies, pharmacists, pharmacy interns, and pharmacy technicians to administer COVID-19 and seasonal influenza vaccines (to those individuals aged three and over, consistent with other requirements), and COVID-19 tests, regardless of any United States Government (USG) agreement or emergency declaration.

- Extending PREP Act liability protections through December 31, 2024 for manufacturing, development, distribution, administration, and use of commercial licensed COVID-19 vaccines and commercial countermeasures authorized for emergency use, regardless of a declared emergency or any Federal agreement.

- Extending PREP Act liability protections through December 31, 2024, for administration of vaccines related to Federal agreements. This includes all activities related to the provision of COVID-19 countermeasures that are 1) provided based on a federal agreement (including COVID-19 vaccines and treatments purchased and provided by the United States Government (USG)), or 2) directly conducted by the USG, including by federal employees, contractors, or volunteers.

[27] See home page for Disaster Response Toolkit: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/index.html

[28] https://www.hhs.gov/about/news/2023/04/14/factsheet-hhs-announces-amend-declaration-prep-act-medical-countermeasures-against-covid19.html#:~:text=PREP%20Act%20immunity%20from%20liability,of%20any%20USG%20agreement%20or; https://aspr.hhs.gov/legal/PREPact/Pages/default.aspx, https://www.medicaid.gov/sites/default/files/2023-11/covid19allstatecall11142023.pdf

- Ending of PREP Act liability protections for certain activities. When the USG no longer distributes products for COVID-19 countermeasures, the PREP Act liability protections will no longer extend to the following activities:
    - COVID-19 vaccination by non-traditional providers (e.g., recently retired providers and students).
    - COVID-19 vaccinations across state lines by licensed providers, pharmacists, and pharmacy interns.
- Ending of PREP Act liability protections for routine childhood vaccinations. PREP Act liability protections will no longer extend to all routine childhood vaccinations by pharmacists, pharmacy interns, and pharmacy technicians.[29]

For more information on the HHS COVID-19 PREP Act Declaration and related Medicaid payment policy implications, please see the *Coverage and Payment of COVID-19 Vaccines, Vaccine Administration, and Cost-Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program* toolkit.[30]

[29] https://www.hhs.gov/about/news/2023/04/14/factsheet-hhs-announces-amend-declaration-prep-act-medical-countermeasures-against-covid19.html#:~:text=PREP%20Act%20immunity%20from%20liability,of%20any%20USG%20agreement%20or

[30] https://www.medicaid.gov/sites/default/files/2022-05/covid-19-vaccine-toolkit-05062022.pdf

Table 1 - Key Considerations for COVID-19 Vaccinations Post COVID-19 PHE[31]

FEDERAL LAW AND POLICY CHANGES	Implementation date for section 11405 of the IRA	Commercialization of COVID-19 vaccines	End of ARP coverage period for COVID-19 vaccinations; end of 100% Federal Medical Assistance Percentage for COVID-19 vaccinations	Duration of HHS COVID-19 PREP Act declaration
SIGNIFICANT DATE	**October 1, 2023**	**September 2023**	**September 30, 2024**	**December 31, 2024 (current end date; can change)**
COVERAGE OF COVID-19 VACCINES IN MEDICAID AND CHIP	*All FDA-approved*[32] *ACIP-recommended vaccines, including FDA-approved ACIP-recommended COVID-19 vaccines, are covered for certain adult beneficiaries, with no cost-sharing for most adult enrollees, as required by section 11405 of the IRA. See the "Adults Covered Under Medicaid" section for more information.*[33]	*State Medicaid and CHIP programs begin purchasing COVID-19 vaccines for populations not eligible for the Vaccines for Children (VFC) program.*	*End of mandatory coverage of COVID-19 vaccinations for limited benefit eligibility groups (a state may elect to provide coverage for these groups). See Table 3 for information on coverage for other groups under other benefits (e.g., IRA coverage, ABP coverage, EPSDT, BHP, etc.).*	*Time period for immunity from liability for pharmacies, pharmacists, pharmacy interns, and pharmacy technicians in administering COVID-19 and seasonal influenza vaccines (to individuals aged three and over, consistent with other requirements).*

[31] The COVID-19 PHE ended on May 11, 2023. Additionally, ARP and IRA requirements and timelines do not apply to BHP.

[32] "Licensed" is the statutory term under section 351 of the Public Health Service (PHS) Act for what is commonly referred to as approval of a biological product. When CMS uses the term "approval" to refer to FDA approval in this document, that term includes FDA licensure under section 351 of the PHS Act.

[33] This IRA coverage does not include EUA vaccines, but the ARP COVID-19 vaccination coverage includes EUA vaccines.

The federal statutes, HHS PREP Act declaration, and COVID-19 commercialization process - all outlined in this toolkit - have implications for the coverage and payment of COVID-19 vaccines, vaccine administration, and cost-sharing under Medicaid and CHIP. The ARP mandates coverage of all COVID-19 vaccinations, including those authorized by the Food and Drug Administration (FDA) for emergency use, for all CHIP beneficiaries and most Medicaid beneficiaries through September 30, 2024. Separately, BHPs are obligated under essential health benefit requirements to cover vaccinations that must be covered as preventive services. Table 2 below outlines coverage requirements for COVID-19 vaccinations through September 30, 2024, the end of the ARP coverage period. During the remainder of the ARP coverage period, Table 3, later in the Toolkit, outlines coverage requirements and payment for all other vaccinations for Medicaid, CHIP and BHP populations, as well as provides additional detail regarding the coverage of different categories of ACIP recommendations. After the end of the ARP coverage period, the requirements outlined in Table 3 will also apply to COVID-19 vaccines and vaccine administration.

The ARP also authorized a 100 percent Federal Medical Assistance Percentage (FMAP) for matching state Medicaid expenditures for COVID-19 vaccines and their administration. This 100 percent FMAP is available through September 30, 2024, which is the last day of the first quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act). This 100 percent federal match for expenditures on COVID-19 vaccines and their administration is also applicable to child health assistance under CHIP during that same period, with an adjustment to CHIP allotments.[34] The ARP's coverage mandates and federal matching percentage do not apply to BHP, but COVID-19 vaccinations are mandatorily covered without cost-sharing for BHP enrollees in this period, as long as they are provided by in-network providers and recommended by CDC/ACIP for routine use.

[34] https://www.medicaid.gov/federal-policy-guidance/downloads/cib060321.pdf, https://www.medicaid.gov/sites/default/files/2021-08/sho-21-004_1.pdf

Table 2 - Coverage and Payment of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing under Medicaid, CHIP, and BHP Through the Remainder of the ARP Coverage Period, Ending September 30, 2024.[35]

Population	Is coverage of COVID-19 vaccines and their administration mandatory (during the ARP coverage period)? [36]	Is cost sharing for COVID-19 vaccines and their administration allowed (during the ARP coverage period)?	What percentage of state payments for COVID-19 vaccines and their administration are matched by the federal government until the end of the ARP coverage period (September 30, 2024)?
Adult Medicaid Full Coverage/Full Benefit Enrollees	YES	NO	100% FMAP for COVID-19 vaccines and their administration.
Adults Enrolled in ABPs	YES	NO	100% FMAP for COVID-19 vaccines and their administration.
Child Medicaid Full Coverage/Full Benefit Enrollees	YES	NO	100% FMAP for COVID-19 vaccines and their administration.
Medicaid Limited Benefit Group Enrollees[37]	YES	NO	100% FMAP for COVID-19 vaccines and their administration.

[35] The "ARP coverage period" is the period for mandatory coverage for COVID-19 vaccines and their administration (without cost-sharing) in Medicaid and CHIP that is described in sections 9811 and 9821 of the ARP: beginning on the date of enactment of the ARP (March 11, 2021) and ending on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act. Because this emergency period ended on May 11, 2023, the last day of the ARP coverage period is September 30, 2024.

[36] For additional detail regarding the coverage of vaccinations following the ARP coverage period, refer to Table 3.

[37] For example, individuals eligible only for family planning benefits; individuals eligible for tuberculosis-related benefits. There are a few limited exceptions in statute for some groups which do not receive this coverage.

Population	Is coverage of COVID-19 vaccines and their administration mandatory (during the ARP coverage period)? [36]	Is cost sharing for COVID-19 vaccines and their administration allowed (during the ARP coverage period)?	What percentage of state payments for COVID-19 vaccines and their administration are matched by the federal government until the end of the ARP coverage period (September 30, 2024)?
CHIP Enrollees	YES	NO, including for those 19 years of age or older	100% for COVID-19 vaccines and their administration.
BHP Enrollees	YES, ARP does not apply to BHP, but coverage is mandatory during this period and beyond if the vaccine is recommended by CDC/ACIP for routine use and provided by an in-network provider.	NO, as long as the vaccine is recommended by CDC/ACIP for routine use and provided by an in-network provider. ARP does not apply to BHP, and the prohibition on cost-sharing that applied to this coverage when provided out-of-network expired on May 11, 2023, when the COVID-19 PHE ended.	State-established payment rates.

COVID-19 Vaccines: Funding and Commercialization

The CDC COVID-19 Vaccination Program, which distributed federally purchased COVID-19 vaccines, was in effect from the release of the initial COVID-19 vaccines in December 2020, until September 2023. The COVID-19 vaccines were commercialized in September 2023, which meant that for most children up to age 19 enrolled in Medicaid, the cost of COVID-19 vaccine doses will be borne by the Vaccines for Children (VFC) program. More information on the VFC program can be found in the *Children Covered under Medicaid* section later in the toolkit. For other Medicaid populations, and for beneficiaries enrolled in separate CHIPs, states will have to pay for COVID-19 vaccine doses, but states' payments on those doses provided to Medicaid and CHIP beneficiaries will be federally matched at 100 percent until September 30, 2024. After September 30, 2024, state expenditures on

COVID-19 vaccine doses and vaccine administration services provided to Medicaid and CHIP beneficiaries will be matched at the applicable FMAP.

Vaccine doses covered under the VFC program will still be fully federally funded. While children enrolled in separate CHIP programs are not eligible for VFC vaccines, states with separate CHIP programs have the same option to purchase COVID-19 vaccine doses through the CDC contracts for these children, as is available for other pediatric vaccines. CHIP programs are encouraged to contact their state immunization program if they are interested in pursuing this option for COVID-19 vaccine purchase.

Additionally, after September 30, 2024, Medicaid coverage of COVID-19 vaccines and their administration will vary for different groups of beneficiaries. For example, beginning October 1, 2023, under amendments made by the IRA, all adults enrolled in CHIP and most adults enrolled in traditional Medicaid[38] will have mandatory coverage of all FDA-approved vaccines recommended by the ACIP, and the administration of those vaccines, without cost sharing. This IRA-mandated coverage includes all FDA-approved ACIP-recommended COVID-19 vaccinations but does not include COVID-19 vaccinations authorized under an FDA emergency use authorization (EUA). That said, COVID-19 vaccinations authorized under an EUA are included in the Medicaid and CHIP coverage states are required to provide under the ARP until September 30, 2024, and coverage of EUA vaccines will continue after September 30, 2024 for limited groups of beneficiaries. More information regarding other populations is found later in the toolkit.

States should work to establish and communicate Medicaid, CHIP, and BHP payment rates (for vaccine products and for vaccine administration), establish vaccine distribution channels, and determine which providers can prescribe and/or administer vaccinations to limit any potential disruption in services. This could include working directly with vaccine manufacturers to order vaccines, if that is how the state chooses to purchase COVID-19 vaccines, provided that the state claims federal match only after the state has made an expenditure for a vaccine that is administered to an eligible beneficiary.

In addition to the required attestations described in the *Adults Covered under Medicaid* section, states may need to submit state plan amendments (SPAs) to make changes related to coverage and payment for vaccine products and administration. CMS is available to provide technical assistance with this transition.

Considerations for Managed Care

With commercialization of COVID-19 vaccines, states are encouraged to complete an assessment of their managed care contracts for both coverage and rate setting considerations to determine if contract modifications are needed. This may also be relevant following changes described at section 11405 of the IRA to vaccination coverage for certain adult Medicaid populations.

[38] Here and in future instances when referenced in this toolkit, "traditional Medicaid" describes Medicaid populations that don't include beneficiaries enrolled in Alternate Benefit Plans.

FMAP Increase for Certain Adult Vaccinations and Other Services

Under section 1905(b) of the Act, as amended by section 4106(b) of the Affordable Care Act (ACA), states that elected to provide Medicaid coverage for the adult vaccinations described in section 1905(a)(13)(B) of the Act, as well as for services described in section 1905(a)(13)(A) of the Act, without cost sharing, received a one percentage point increase in the FMAP for their Medicaid expenditures for these services and for their Medicaid expenditures on the tobacco cessation services for pregnant individuals described in section 1905(a)(4)(D) of the Act.[39] Section 11405(a)(3) of the IRA amended section 1905(b) of the Act to specify that states that were covering, as of the date of enactment of the IRA (August 16, 2022), vaccinations described in section 1905(a)(13)(B) of the Act without cost sharing will receive a one percentage point increase in the FMAP for their Medicaid expenditures for these vaccination services for the first eight fiscal quarters that begin on or after October 1, 2023.[40] At the conclusion of the eight fiscal quarters (September 30, 2025), these states' Medicaid expenditures for vaccines and vaccine administration described in section 1905(a)(13)(B) of the Act will be matched at the applicable regular FMAP.

Moving Forward - Considerations for Improving Vaccination Access

As highlighted above, coverage of vaccinations can be complicated and can vary by program, population, or state. As states look to the future of vaccination coverage policy after the end of the ARP coverage period and the implementation of IRA adult vaccination coverage requirements, states could consider how best to ensure adequate coverage of vaccinations for all Medicaid, CHIP, and BHP populations.

Provider Qualifications and Considerations

Provider availability for vaccination administration can be impacted by state licensure and scope of practice laws, federal regulations for the benefits under which vaccines can be covered, and state Medicaid and/or CHIP provider enrollment requirements.[41]

In order to expand access to vaccines, state Medicaid agencies should review licensure requirements and scope of practice laws and work with state licensing boards to discuss whether they can be expanded to allow additional providers to administer vaccinations. This is especially important as federal Medicaid and CHIP regulations define the benefits under which states might opt to cover vaccine administration, and some of those definitions expressly require that services be prescribed, furnished, recommended, or provided by practitioners acting within their scope of practice as defined by state law. For example, the federal regulation at 42 CFR § 440.60 requires that Medicaid "other licensed practitioner" services be provided by practitioners acting within the scope of practice as defined under state law; and the federal regulation at 42 CFR § 440.130(c) requires that Medicaid

[39] https://www.medicaid.gov/sites/default/files/2023-06/sho23003.pdf

[40] https://www.medicaid.gov/sites/default/files/2023-06/sho23003.pdf

[41] These provider enrollment requirements do not apply to BHP. For information about Medicaid and CHIP state-level requirements please refer to individual state provider enrollment policies.

preventive services be recommended by practitioners acting within the scope of authorized practice under state law. Additionally, as noted above, state scope of practice or licensure laws might be preempted by authorizations in an applicable HHS PREP Act declaration.

For states to reimburse for vaccine administration, providers must also enroll as participating providers in Medicaid and/or CHIP as applicable, and periodically revalidate that enrollment. Specifically, federal laws and regulations require the following:

- 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 are an important element of provider enrollment and require the person or institution to keep records as necessary to fully disclose the extent of the services provided to individuals receiving assistance under the Medicaid 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.

- Section 1902(a)(78) of the Act requires all states that pay for medical assistance on a fee-for-service basis to 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.

- 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. See also federal regulations at 42 CFR §§ 438.608(b) and 457.1285 (expanding the requirement to additional types of managed care plans).

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

Additionally, as highlighted in the *Provider Payment* section later in the toolkit, states have significant discretion in determining vaccine administration Medicaid payment rates that are paid to qualified providers that have a provider agreement with the Medicaid agency. 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. However, it is important to note that the pediatric vaccine administration fee cannot exceed the VFC maximum established for a state. In addition, pediatric vaccines are distributed free of charge through the VFC program, so there can be no provider payment for the pediatric vaccine product.

Vaccine Counseling

CMS uses the term “stand-alone vaccine counseling to refer to when a patient and/or caregiver receives counseling about a vaccine from a health care practitioner but the patient does not actually receive the vaccine dose at the same time as the counseling because it is not appropriate to provide the

vaccine dose at that time.[42] Stand-alone vaccine counseling can help address vaccine hesitancy by helping beneficiaries get their questions answered and receive additional information on vaccines from trusted providers.[43] Coverage of stand-alone vaccine counseling could help states increase vaccination rates for Medicaid and CHIP beneficiaries, including children. The American Academy of Pediatrics (AAP) recommends that providers address questions regarding vaccines and notes the importance of counseling to address parental and/or caregiver anxiety and misinformation.[44]

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for eligible children under age 21 who are enrolled in Medicaid. The EPSDT benefit is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. As part of this coverage, states are required to cover vaccinations that are included on the ACIP's pediatric immunization schedule or are determined to be medically necessary for the beneficiary based on an individualized assessment and state medical necessity criteria; otherwise, coverage is at state option.

CMS interprets the EPSDT benefit to require states to provide coverage of stand-alone vaccine counseling to Medicaid beneficiaries under the age of 21 who are eligible for EPSDT.[45] This interpretation applies to stand-alone vaccine counseling related to all vaccines covered for beneficiaries eligible for the EPSDT benefit. States have the option to cover stand-alone vaccine counseling for beneficiaries who are not eligible for the EPSDT benefit.[46]

The requirement to cover stand-alone vaccine counseling as part of EPSDT applies to all vaccines covered for beneficiaries eligible for the EPSDT benefit. States may establish limits on the number of times stand-alone vaccine counseling is covered for a beneficiary eligible for the EPSDT benefit, as long as the limits can be exceeded based on medical necessity. Stand-alone vaccine counseling may also be covered when provided via telehealth, at state option.[47]

State expenditures on stand-alone vaccine counseling for Medicaid beneficiaries under the age of 21 who are eligible for the EPSDT benefit are matched at the applicable FMAP.[48] During the ARP FMAP period, 100 percent FMAP is available for state expenditures for stand-alone COVID-19 vaccine

[42] As described in SHO #22-002, stand-alone vaccine counseling could be provided as a component of a practitioner visit in which other services are also rendered. See https://www.medicaid.gov/federal-policy-guidance/downloads/sho22002.pdf

[43] The World Health Organization (WHO) defines this as a motivational state of being conflicted about, or opposed to, getting vaccinated. See Understanding the behavioural and social drivers of vaccine uptake WHO position paper – May 2022. Weekly Epidemiological Record, 2022, vol. 97, 20. https://www.who.int/publications/i/item/who-wer9720-209-224. For a systematic review that discusses the prior WHO definition of vaccine hesitancy and a working model, see https://www.sciencedirect.com/science/article/pii/S0264410X14001443?viewFullText=true#bib0105

[44] https://publications.aap.org/pediatrics/article/138/3/e20162146/52702/Countering-Vaccine-Hesitancy

[45] Unless stated otherwise, all references to Medicaid beneficiaries also include beneficiaries enrolled in Medicaid expansion CHIPs.

[46] As described in SHO #22-002, coverage of stand-alone vaccine counseling is not required for Medicaid beneficiaries aged 21 and older, some Medicaid beneficiaries under age 21 who are not eligible for the EPSDT benefit, and beneficiaries enrolled in separate CHIP. See https://www.medicaid.gov/federal-policy-guidance/downloads/sho22002.pdf

[47] States generally have a great deal of flexibility with respect to covering Medicaid services provided via telehealth.

[48] If a state opts to cover stand-alone vaccine counseling for children and pregnant adults enrolled in a separate CHIP, expenditures will be matched at the state's enhanced federal matching percentage for Title XXI beneficiaries. See https://www.medicaid.gov/federal-policy-guidance/downloads/sho22002.pdf

counseling provided to Medicaid beneficiaries eligible for both EPSDT and the ARP COVID-19 vaccination coverage.

Immunization Registries

Immunization information systems (IIS), also known as immunization or vaccine registries, are confidential, population-based, computerized databases that record all immunization doses administered by participating providers to persons residing within a given geopolitical area. Pharmacies, primary care providers, urgent care centers, hospitals, public health departments, and other entities that administer vaccines may submit vaccination records to local and/or state IIS. IIS serve multiple purposes, including but not limited to:

- Providing consolidated immunization histories for use by a vaccination provider in determining appropriate client vaccinations.
- Providing aggregate data on vaccinations for use in surveillance and program operations, and in guiding public health action with the goals of improving vaccination rates and reducing vaccine-preventable disease.
- Combining immunization information from different sources into a single record and providing official immunization records for school, day care, and camp entry requirements.
- Reminding families when an immunization is due or has been missed.[49]

Enhanced federal financial participation (FFP) is available at 90 percent for the design, development, and installation, and at 75 percent for the operation, of state Medicaid Enterprise Systems (MES). These enhanced rates are available for immunization registries that are components of the state MES to the extent that the registry serves Medicaid program beneficiaries. In states where the Immunization Registry is developed, owned, and operated by a public health or other non-Medicaid agency, FFP is available at 50 percent for the state's Medicaid expenditures for the Immunization Registry associated with Medicaid eligible beneficiaries.[50]

To receive enhanced FFP from CMS for an IIS, states must meet the requirements of the Streamlined Modular Certification (SMC) process.

To receive enhanced FFP from CMS for an IIS, states must meet the applicable certification requirements in 42 C.F.R. Part 433, Subpart C, as discussed in CMS Streamlined Modular Certification (SMC) process guidance.[51] States that wish to request enhanced match for their IIS should develop an Advance Planning Document (APD) that includes measurable outcomes and metrics for the IIS that align with the desired Medicaid program goal(s) for the system. After the APD is approved by the CMS State Officer, the state then moves into procurement planning. States can consult with their CMS State Officer at any point of the procurement

[49] https://www.cdc.gov/vaccines/programs/iis/about.html

[50] https://www.medicaid.gov/federal-policy-guidance/downloads/smd070600.pdf.

[51] https://www.medicaid.gov/medicaid/data-systems/certification/streamlined-modular-certification/index.html.

process, including to help ensure the state's measurable outcomes and metrics and overall programmatic goals are clearly stated in any Request for Proposals (RFPs) or other communications to prospective vendors. Prior to releasing an RFP, the state should document the approved CMS-required outcomes, state-specific outcomes, and metrics in the SMC Intake Form Template for discussion and approval with its CMS State Officer. During the development phase of the system, until the system is certified, the state should submit monthly project status reports to its CMS State Officer showing how the project is progressing along the SMC process and discussing completed project milestones and any challenges encountered or anticipated, to demonstrate overall project health.

The state must undergo an Operational Readiness Review (ORR) with its CMS State Officer prior to releasing its system into production. The state will need to demonstrate - with appropriate evidence - that the system is ready to be released, that it is likely to achieve the approved CMS-required and state-specific outcomes, and that it can support the generation and reporting of metrics that were approved in the APD. Once the system has been in production for at least six months, and the state can report on approved metrics, a Certification Review (CR) will be conducted with the state's CMS State Officer. A CR is necessary for the state to receive the enhanced federal matching rate for system operation. The state will need to demonstrate - with appropriate evidence - that the approved CMS-required and state-specific outcomes and metrics are being achieved by the system in production. In contrast to the ORR (which is focused on the demonstration of functionality associated with the applicable CMS-required and state-specific outcomes in pre-production), the CR is focused on demonstrating the impact of functionality in production, as assessed by metrics. After the CR, the state will receive a Certification Decision Letter. If CMS certifies the IIS and the state continues to meet ongoing reporting requirements after certification, the state can claim FFP in expenditures for the operation of the IIS at the 75 percent enhanced federal matching rate, effective from the first day of the calendar quarter after the date the system met the conditions of initial approval.[52]

In lieu of requesting FFP from CMS to develop and operate an IIS, states can apply for an annual cooperative agreement through the CDC's Immunization and Vaccines for Children Cooperative Agreement program. The Immunization and Vaccines for Children Cooperative Agreement program is funded by annual appropriations in the Departments of Labor, HHS, Education, and Related Agencies Appropriations Act as authorized by section 317 of the Public Health Service Act, and some funding from the VFC program under section 1928 of the Act. Through the Immunization and Vaccines for Children Cooperative Agreement program, states receive a base award to conduct immunization related activities, including developing, implementing and/or enhancing an IIS. Some states have also received additional funds through the program to complete specific IIS-related projects.[53]

[52] For additional information, see: Streamlined Modular Certification | Medicaid; smd22001.pdf (medicaid.gov); https://www.medicaid.gov/medicaid/data-and-systems/downloads/smc-certification-guidance.pdf.

[53] https://crsreports.congress.gov/product/pdf/R/R47024/2

Medicaid, CHIP, and BHP Vaccination Coverage and Cost Sharing

Most people enrolled in Medicaid, CHIP, and BHP have coverage of vaccines and vaccine administration, without cost-sharing. There are a number of coverage requirements that states must meet for different populations. This section provides information about the specific coverage and payment requirements for vaccinations in Medicaid, CHIP, and BHP. Program-specific information is discussed below, with a high-level overview in Table 3 included at the conclusion of the section. Note that this overview does not include a description of the time-limited coverage requirements for COVID-19 vaccinations during the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2) coverage period, as that coverage is outlined above.

Additionally, this section describes when a SPA might be needed to effectuate or enhance coverage for each population. As each Medicaid state plan, CHIP program, and BHP Blueprint is different, CMS recommends that states contact CMS for technical assistance about their program.

Children Covered under Medicaid

Coverage Overview – Children Aged 18 and Younger

States must cover, for beneficiaries under age 21 who are eligible for the EPSDT benefit, appropriate immunizations (according to age and health history) on the CDC/ACIP pediatric immunization schedule.[54] Separate CHIP programs that choose to provide EPSDT coverage to qualifying individuals must also follow EPSDT requirements. Most children under age 18 (under age 21 at state option) are mandatorily exempted from Medicaid cost sharing, including for immunizations. In addition, ACIP-recommended vaccinations that are not on the CDC/ACIP pediatric immunization schedule and non-ACIP-recommended vaccinations are covered for beneficiaries eligible for the EPSDT benefit, if the vaccination is determined to be medically necessary for the beneficiary based on an individualized assessment and state medical necessity criteria.[55] State Medicaid agencies are also required to inform all Medicaid-eligible individuals under age 21 that EPSDT services are available and of the need for age appropriate immunizations.[56] Additionally, as described in the *Vaccine Counseling* section above, states are

[54] https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html. Coverage of these immunizations is under the "screening services" category of EPSDT. The pediatric immunization schedule identifies CDC/ACIP-recommended vaccines for those through age 18 and is available at: https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf.

[55] Section 1905(r)(1)(B)(iii) and (5) of the Social Security Act. See SHO Letter #23-003 Mandatory Medicaid and Children's Health Insurance Program Coverage of Adult Vaccinations under the Inflation Reduction Act. https://www.medicaid.gov/federal-policy-guidance/downloads/sho23003.pdf.

[56] https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

required to cover stand-alone vaccine counseling to Medicaid beneficiaries under the age of 21 who are eligible for the ESPDT benefit.[57]

Vaccines for Children (VFC)

Medicaid-enrolled children through age 18, as well as children who are uninsured, underinsured, and American Indian/Alaska Native, generally receive vaccines through the federally funded VFC program, per section 1928 of the Act. Under the VFC program, the CDC purchases vaccines at a discount and distributes them at no charge to private physicians' offices and public health clinics that are registered as VFC providers. Because the federal government pays for the vaccine, VFC providers are not paid for the cost of the vaccine product. The VFC program includes a fee schedule that identifies the maximum vaccine administration fee by state that may be charged by a VFC registered provider for vaccinating a VFC federally vaccine-eligible child (i.e., Medicaid enrolled, uninsured, underinsured, American Indian/Alaska Native). For children enrolled in Medicaid, Medicaid providers are paid an administration fee established by the Medicaid program in the state plan for administering a VFC vaccine to a Medicaid enrolled child at a rate up to the state's fee ceiling, and therefore there are no out of pocket costs.[58] The federal government and states do not cover administration fees for non-Medicaid enrolled federally vaccine-eligible children.

Coverage Overview − Children Ages 19 and 20

As with children ages 18 and younger, states must cover, for beneficiaries under age 21 who are eligible for the EPSDT benefit, appropriate immunizations (according to age and health history) on the CDC/ACIP pediatric immunization schedule.[59] In addition, other vaccinations recommended by ACIP (including those that are recommended on the CDC/ACIP adult immunization schedule for beneficiaries aged 19 or 20) and non-ACIP-recommended vaccinations are covered for beneficiaries eligible for the EPSDT benefit, if the vaccination is determined to be medically necessary for the beneficiary based on an individualized assessment and state medical necessity criteria. Beneficiaries under age 21 who are enrolled in Medicaid alternative benefit plans (ABPs) continue to receive EPSDT coverage under CMS regulations at 42 CFR 440.345.

Finally, as further outlined in the section *Adults Covered Under Medicaid*, as of October 1, 2023, statutory amendments made by section 11405 of the IRA require that state Medicaid and CHIP programs must cover all FDA-approved adult vaccines recommended by ACIP under any type of ACIP recommendation (including ACIP recommendations based on travel or occupation), and their

[57] As described in SHO #22-002, this requirement is based on section 1905(r)(1)(B)(v) of the Act, under which states are required to cover "health education" as part of the EPSDT benefit. As beneficiaries enrolled in Medicaid-expansion CHIP under 42 CFR § 435.118 or § 435.229 are eligible for EPSDT, this requirement applies to these Medicaid-expansion CHIP beneficiaries. See https://www.medicaid.gov/federal-policy-guidance/downloads/sho22002.pdf and https://www.medicaid.gov/state-resource-center/downloads/vaccine-counseling-for-medicaid-chip-beneficiaries.pdf

[58] https://www.cdc.gov/vaccines/programs/vfc/index.html

[59] https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html. Coverage of these immunizations is under the "screening services" category of EPSDT. The pediatric immunization schedule identifies CDC/ACIP-recommended vaccines for those through age 18 and is available at: https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

administration, without cost sharing.[60] These adult vaccines must be covered for most individuals ages 19 and older enrolled in traditional Medicaid (i.e., not in ABPs). See the *Adults Covered Under Medicaid* for more information on adult vaccination coverage.

Additionally, as described in the *Vaccine Counseling* section above, states are required to cover stand-alone vaccine counseling to Medicaid beneficiaries under the age of 21 who are eligible for the ESPDT benefit.[61]

SPA Considerations

States are generally not required to submit a SPA to cover any CDC/ACIP-recommended vaccines added to the pediatric vaccine schedule under EPSDT. If preferred, a state may also choose to explicitly detail coverage provisions.

Adults Covered under Medicaid

Coverage Overview

As of October 1, 2023, as required by the statutory amendments made by section 11405 of the IRA, state Medicaid and CHIP programs must cover all approved adult vaccines recommended by ACIP, and their administration, without cost sharing for all full-benefit categorically needy beneficiaries enrolled in traditional Medicaid, and, depending on state Medicaid benefit packages, certain medically needy beneficiaries enrolled in traditional Medicaid, if the beneficiary is aged 19 and older.[62] This mandatory coverage applies to FDA-approved adult vaccines that are administered in accordance with any category of ACIP recommendations. The IRA coverage requirement is therefore not limited to vaccines that the ACIP includes on the immunization schedules or recommends for routine use.[63] This includes ACIP recommendations for shared clinical decision-making and those based on occupational and travel risk. See the *Advisory Committee on Immunization Practices* section above for more information on

[60] State Health Official (SHO) Letter #23-003 Mandatory Medicaid and Children's Health Insurance Program Coverage of Adult Vaccinations under the Inflation Reduction Act. https://www.medicaid.gov/federal-policy-guidance/downloads/sho23003.pdf.

[61] As described in SHO #22-002, this requirement is based on section 1905(r)(1)(B)(v) of the Act, under which states are required to cover "health education" as part of the EPSDT benefit. As beneficiaries enrolled in Medicaid-expansion CHIP under 42 CFR § 435.118 or § 435.229 are eligible for EPSDT, this requirement applies to these Medicaid-expansion CHIP beneficiaries. See https://www.medicaid.gov/federal-policy-guidance/downloads/sho22002.pdf and https://www.medicaid.gov/state-resource-center/downloads/vaccine-counseling-for-medicaid-chip-beneficiaries.pdf

[62] Section 11405(a)(1) of the IRA amended sections 1902(a)(10)(A) and 1902(a)(10)(C)(iv) of the Act to require Medicaid coverage, effective October 1, 2023, of the items and services described in section 1905(a)(13)(B) of the Act for all full-benefit categorically needy beneficiaries and (depending on the state's decisions about its Medicaid benefit packages) certain medically needy beneficiaries. Section 11405(b)(1) of the IRA added mandatory coverage of the services described in section 1905(a)(13)(B) for CHIP enrollees at section 2103(c)(12) of the Act. Section 11405 also amended sections 1916(a)(2), 1916(b)(2), 1916A(b)(3)(B), and 2103(e)(2) of the Act to specify that states cannot impose cost-sharing with respect to the vaccination coverage that is described in sections 1905(a)(13)(B) and 2103(c)(12) of the Act. See SHO Letter #23-003 Mandatory Medicaid and Children's Health Insurance Program Coverage of Adult Vaccinations under the Inflation Reduction Act. https://www.medicaid.gov/federal-policy-guidance/downloads/sho23003.pdf.

[63] See note 43.

ACIP recommendations. Adults not in the above-listed populations and adults in alternative benefit plans do not receive this coverage.

Adults in Alternative Benefit Plans

Adults in alternative benefit plans do not receive the IRA-required vaccination coverage. Instead, coverage of routine ACIP-recommended vaccinations found on the CDC/ACIP adult immunization schedules (also referred to as routine vaccinations), without cost-sharing, is also required for adults in ABPs. This coverage includes those in the Medicaid expansion group described at section 1902(a)(10)(A)(i)(VIII) of the Act, who receive their services through an alternative benefit plan (ABP) authorized under section 1937 of the Act. In accordance with section 1937(b)(5) of the Act and federal regulation at 42 CFR § 440.347(a), ABPs must include coverage of benefits in each of 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 coverage, without cost-sharing, of vaccinations that have in effect a recommendation for routine use from ACIP with respect to the individual involved.[64] [65] [66] States also have flexibility to expand vaccination coverage in their ABPs and to align their ABP coverage with traditional Medicaid coverage.

In addition, as established by Section 3203 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), plans and issuers must cover qualifying coronavirus preventive services without cost sharing, starting no later than 15 business days (not including weekends or holidays) after the date the USPSTF or ACIP makes an applicable recommendation regarding a qualifying coronavirus preventive service. A recommendation from ACIP is considered in effect after it has been adopted by the Director of the CDC. Qualifying coronavirus preventive services include ACIP-recommended COVID-19 vaccines and their administration. These requirements apply to group health plans and health insurance issuers that are subject to the preventive services requirements of the Affordable Care Act, including issuers required to cover preventive services as essential health benefits (EHB).[67] [68]

Finally, in accordance with federal regulations at 42 CFR § 440.345(a), states with ABPs must assure access to EPSDT services for eligible individuals under 21 years of age (including those aged 19 and 20) who are receiving coverage through an ABP. This would include vaccinations covered under

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[64] As defined for purposes of the vaccination coverage that must be included in Medicaid ABP coverage, ACIP recommendations for "routine use" are those that are listed on the CDC/ACIP immunization schedules.

[65] The adult immunization schedule identifies ACIP-recommended vaccines for those age 19 and older and is available at: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf.

[66] 42 CFR § 440.347(a)(9), 45 CFR §§ 156.110(a)(9), 156.115(a)(4), 147.130(a)(1)(ii). The requirement to cover recommended vaccines generally takes effect on or after the date that is one year after the date the recommendation or guideline is issued, except for vaccines related to COVID-19, which have a shorter implementation timeline.

[67] For more, see FAQs About Affordable Care Act Implementation Parts 50 and 58, Health Insurance Portability and Accountability Act and Coronavirus Aid, Relief, and Economic Security Act Implementation https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-50.pdf, https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-58.pdf

[68] For more, see FAQs About Affordable Care Act Implementation Part 50, Health Insurance Portability and Accountability Act and Coronavirus Aid, Relief, and Economic Security Act Implementation https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-50.pdf

EPSDT that would not otherwise be covered under the ABP, such as vaccinations that are medically necessary for the beneficiary regardless of the type of ACIP recommendation, as discussed above under *Children covered under Medicaid*.

Adults in Limited Benefit Groups

Vaccinations are generally not included in state plan coverage for limited-benefit Medicaid eligibility groups, such as individuals eligible only for family planning benefits. Additionally, vaccinations might not be covered for certain groups receiving only limited benefits through a section 1115 demonstration. However, limited benefit state plan and demonstration groups do receive coverage of COVID-19 vaccinations, without cost sharing, under amendments made by the ARP, through the end of the ARP coverage period.[69] [70]

States wishing to address gaps in vaccination coverage for limited-benefit groups following the ARP coverage period could choose to submit section 1115 requests to use section 1115(a)(2) expenditure authority to add coverage for COVID-19 or other vaccines and their administration to the benefits provided to limited benefit populations. 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.

SPA Considerations

Traditional Medicaid Coverage

To align with IRA requirements, states must submit a coverage SPA to include an attestation in the Medicaid state plan stating that they cover the vaccines and vaccine administration described in section 1905(a)(13)(B) of the Act for all relevant eligibility groups with an effective date of no later than October 1, 2023. On the supplement to attachments 3.1-A and (if applicable) 3.1-B coverage pages for the preventive services benefit, states should attest to coverage under the Medicaid state plan of vaccines and vaccine administration described in section 1905(a)(13)(B) of the Act. States should provide an additional assurance stating that they have a method to ensure that, as changes are made to ACIP recommendations, they will update their coverage and billing codes to comply with those revisions. States that do not have an approved payment methodology for these services must also submit a payment SPA with an effective date of no later than October 1, 2023. As with any SPA submission, CMS expects states to comply with all applicable federal Medicaid SPA requirements. Once a SPA submission is approved, states do not need to submit new SPAs for every new ACIP recommendation.

States should generally not need to submit a Medicaid cost sharing SPA to attest to compliance with the IRA vaccination requirements, because standard language in the cost sharing state plan templates already specifies that the state is compliant with requirements at sections 1916 and 1916A of the Act.

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[69] See note 20.

[70] For more information on the COVID-19 vaccination coverage requirements under the ARP, see section II of Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost-Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program (Vaccine Toolkit), https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf

These were amended by section 11405 of the IRA to prohibit cost sharing for the vaccines described in section 1905(a)(13)(B) and administration of such vaccines.

ABP Coverage

ABPs must include coverage of benefits in each of the ten EHB categories. This coverage of benefits in the EHB categories does not include ACIP recommended vaccines that are non-routine. Therefore, there may be states that do not need to update their ABP coverage pages. States also have flexibility to expand vaccination coverage in their ABPs and to align their ABP coverage with traditional Medicaid coverage. States that align their benefit package may need to submit updated ABP pages if they align their ABP coverage with state plan coverage, in order to add vaccines recommended by ACIP for non-routine use. States should contact CMS for technical assistance to discuss their program. Once a SPA submission is approved, states do not need to submit new SPAs for every new ACIP recommendation.

Children and Qualifying Individuals Covered under CHIP

Coverage Overview

States are required to provide coverage for age-appropriate, ACIP-recommended vaccines and their administration to all enrollees in CHIP, without cost sharing, under various authorities. [71] Coverage of ACIP-recommended vaccines has been a longstanding requirement for children enrolled in CHIP, either through a Separate CHIP or a Medicaid-expansion CHIP.[72] In addition, the IRA expanded this requirement to include all adults enrolled in CHIP effective October 1, 2023.

Vaccines for Children

In CHIP, states may choose between a Medicaid expansion program, a separate CHIP, or a combination of both types of programs. The type of program selected dictates whether the state can receive vaccines through the VFC Program. Children under 19 years of age in states with Medicaid expansion CHIP programs are eligible for the VFC program.[73] However, children enrolled in separate CHIP programs are not eligible for the VFC program and states must finance vaccines for enrolled children as they would any other benefit, using CHIP federal and state matching funds.[74][75]

Vaccine coverage for adults aged 19 and older in CHIP

CHIP enrollees aged 19 and older receive FDA-approved adult vaccines recommended by ACIP and their administration, without cost-sharing, per the statutory amendments made by section 11405 of the

[71] https://www.medicaid.gov/chip/benefits/index.html

[72] See 42 CFR 457.410(b)(2) and 457.520(b)(4).

[73] https://www.cdc.gov/vaccines/programs/vfc/providers/questions/qa-medicaid.html

[74] https://www.medicaid.gov/chip/benefits/index.html; For guidance related to the purchasing and claiming for vaccines administered to separate CHIP children, see https://www.medicaid.gov/sites/default/files/2019-11/chip-vaccines.pdf

[75] https://www.cdc.gov/vaccines/programs/vfc/providers/eligibility.html

IRA.[76] [77] CMS interprets these coverage requirements to include all categories of ACIP recommendations, including those for shared clinical decision-making and recommendations based on occupational or travel risk.[78]

SPA submission

To demonstrate compliance with both the IRA and the longstanding requirement to cover childhood vaccines, all states with a separate CHIP will need to submit a CHIP SPA pursuant to CMS requirements at 42 CFR § 457.60. States that elect to cover pregnant individuals and/or the from-conception-to-end-of-pregnancy population (previously referred to as the "unborn") population under the CHIP state plan should indicate that they are covering, without cost sharing, all approved adult vaccines that are administered in accordance with ACIP recommendations, per sections 2103(c)(12) of the Act. States that elect to cover children under the CHIP state plan should indicate that they are covering, without cost sharing, all age-appropriate vaccines and their administration in accordance with ACIP recommendations, per section 2103(c)(1)(D) of the Act.

Once a SPA submission is approved, states do not need to submit new SPAs for every new ACIP recommendation.

Individuals Covered under a BHP

Coverage Overview

Individuals covered under a BHP receive, at a minimum, the EHBs, which include all routine ACIP-recommended vaccines under 42 CFR §§ 600.405(a) and 600.510(b).[79] These services are assured of being covered without cost-sharing only when delivered by a doctor or other provider in the plan's network.[80]

In addition, as established by Section 3203 of the CARES Act, plans and issuers must cover qualifying

[76] Section 11405(b)(1) of the IRA added mandatory coverage of the services described in section 1905(a)(13)(B) for CHIP enrollees at section 2103(c)(12) of the Act. Section 11405 also amended sections 1916(a)(2), 1916(b)(2), 1916A(b)(3)(B), and 2103(e)(2) of the Act to specify that states cannot impose cost-sharing with respect to the vaccination coverage that is described in sections 1905(a)(13)(B) and 2103(c)(12) of the Act. See SHO Letter #23-003 Mandatory Medicaid and Children's Health Insurance Program Coverage of Adult Vaccinations under the Inflation Reduction Act. https://www.medicaid.gov/federal-policy-guidance/downloads/sho23003.pdf.

[77] All states that cover pregnant adults through a separate CHIP under section 2112 of the Act voluntarily covered ACIP-recommended vaccines and their administration for these beneficiaries, without cost-sharing, prior to the IRA coverage requirement (effective October 1, 2023).

[78] To the extent possible, CMS has aligned its interpretation of section 11405 of the IRA with its interpretation of similar language added to the Medicare statute by section 11401 of the IRA. See https://www.cms.gov/files/document/irainsulinvaccinesmemo09262022.pdf.

[79] https://www.medicaid.gov/basic-health-program/index.html; https://www.healthcare.gov/coverage/preventive-care-benefits/; https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ehb-2-20-2013; https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/essential-health-benefits12162011a#:~:text=Essential%20health%20benefits%20must%20include%20items%20and%20services,services%20and%20devices%208%20Laboratory%20services%20More%20items

[80] https://www.healthcare.gov/coverage/preventive-care-benefits/

coronavirus preventive services without cost sharing, starting no later than 15 business days (not including weekends or holidays) after the date the USPSTF or ACIP makes an applicable recommendation regarding a qualifying coronavirus preventive service. A recommendation from ACIP is considered in effect after it has been adopted by the Director of the CDC.[81] Qualifying coronavirus preventive services include ACIP-recommended COVID-19 vaccines and their administration.

Coverage Blueprint Considerations

A BHP Blueprint is not necessary for coverage for vaccines and their administration. Thus, no state action is required to cover any newly recommended vaccine. States should contact CMS for technical assistance to discuss their program.

Payment for Vaccines and Vaccine Administration and Additional Considerations

Medicaid Provider Payment

States have significant discretion in determining Medicaid vaccine and vaccine administration payment rates that are paid to qualified providers (e.g., physicians and other licensed practitioners) that have a provider agreement with the Medicaid agency. States are strongly encouraged to require use of a uniform billing standard for enrolled provider 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 benefit category. States should review their payment policies for vaccine and vaccine administration payment 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, Federally Qualified Health Centers (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. In some cases, states may set higher payment rates for FQHCs for vaccine administration to recognize costs of administering certain vaccines; states are encouraged to set rates at levels that incentivize access to and availability of vaccines. For example, if permitted, states could pay higher rates for the administration of a 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 any vaccine administration that are not otherwise included within the existing state plan rates. FQHCs in states that do not include the vaccine product itself in the FQHC benefit can, instead, provide these vaccines pursuant to ARP and IRA under a separate benefit category (e.g., preventive services). The vaccine product would be paid to FQHCs according to the states' approved per dose payment rate under the separate benefit category and would not be paid at the FQHC PPS rate. States may want to consider using Medicare's rates for vaccine administration. States should also consider whether their billing manuals

[81] For more, see FAQs About Affordable Care Act Implementation Part 50, Health Insurance Portability and Accountability Act and Coronavirus Aid, Relief, and Economic Security Act Implementation https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-50.pdf

appropriately reflect policies to streamline and facilitate vaccine administration (e.g., through roster billing) and explain that, in accordance with the federal regulation at 42 CFR § 447.15, providers may not balance bill Medicaid beneficiaries amounts additional to the amount paid by the state agency plus any applicable beneficiary deductible, coinsurance or copayment.

Special rules about payment for vaccine administration apply to the VFC program; please see the next section for more information on VFC payment.

Medicaid Payment and SPA Considerations

State expenditures both for vaccine product and vaccine administration for beneficiaries enrolled in Medicaid are generally matched at the applicable FMAP rate.[82] For beneficiaries aged 19 and older, there may be a one percentage point FMAP increase for ACIP-recommended vaccinations if the state was meeting requirements under section 1905(b) of the Act, as amended by section 4106 of the ACA and section 11405 of the IRA, as of August 16, 2022. The 1 percentage point FMAP increase will be phased out after the first eight fiscal quarters that begin on or after October 1, 2023. At the conclusion of the eight fiscal quarters (September 30, 2025), these states' Medicaid expenditures for vaccines and vaccine administration described in section 1905(a)(13)(B) of the Act will be matched at the applicable regular FMAP. See the *Adults Covered Under Medicaid* section for more information.

VFC Considerations for Childhood Vaccines

As previously noted, VFC vaccines are federally purchased and free to providers, so providers cannot bill for them. Providers do receive payment for vaccine administration, but they cannot charge above the state maximum administration fee in the CMS established fee schedule[83] when vaccinating a VFC federally vaccine-eligible child (i.e., Medicaid enrolled, uninsured, underinsured, American Indian/Alaska Native). The VFC statute limits payment to one payment per vaccine dose administered. Therefore, providers cannot receive more than one payment for a combination vaccine.

State Medicaid agencies set their own provider administration fee, up to the state maximum, and providers receive payment at this rate when vaccinating a Medicaid-enrolled child. States are required to submit a Medicaid SPA to CMS when changing the VFC administration rate.

Additional Payment SPA Considerations for Vaccine Product and Administration

A new SPA is required if a state wants to establish a new payment rate or methodology for payment for vaccine products or for vaccine administration.

In addition, states are encouraged to review their existing approved state plan to determine whether a SPA is needed to update their payment methodologies for the COVID-19 vaccines since they are generally no longer federally purchased. The same applies in determining whether a SPA is needed for the IRA provisions for adult vaccines that went into effect on October 1, 2023.

[82] Note exception for COVID-19 vaccinations during the ARP period.

[83] Current Fee Schedule: https://www.federalregister.gov/documents/2012/11/06/2012-26507/rin-0938-aq63

CHIP Payment and SPA Considerations

Vaccination expenditures for individuals enrolled in CHIP are matched at the applicable state enhanced FMAP (E-FMAP) rate for CHIP financing.[84]

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

States are not required to submit a SPA to be reimbursed for a newly-recommended vaccine. States should reach out to their CHIP Project Officer with any questions.

BHP Payment and Blueprint Considerations

Federal funding for a BHP is on a per enrollee basis, and specific costs are not matched by HHS. 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. There are no federal BHP guidelines regarding the payment of the administration of vaccines through a BHP. States determine the BHP vaccine administration rates paid to providers.

States are not required to submit a BHP Blueprint revision to be reimbursed for newly-recommended vaccines and their administration. States should contact CMS for technical assistance to discuss their program.

Additional Considerations for States to Cover and Pay for Vaccine Product and Administration

As states make decisions about payment for vaccine products and the administration of vaccines, they may consider the options below to either amend existing state plan authority and/or create a new payment methodology under the Medicaid state plan.

- For long-term care facilities, including nursing facilities (NF), states may cover and pay for vaccine products and administration through the Medicaid NF benefit, either as part of the per diem rate or as a carve-out service. In the instance of a carve-out service, the NF would make arrangements for beneficiaries to be vaccinated and would be paid directly for the vaccine products and administration as a NF service, separately from and in addition to the NF per diem rate. States also have the option to cover and pay for the product and administration of the vaccine under other Medicaid benefit categories, such as: physician, other licensed practitioners (OLP), and the preventive services benefit categories. Under those options, states would pay for the service provided by practitioners under those benefit categories directly for administering vaccines to NF residents. States would need to ensure that their payment policies are aligned so that payments are not duplicated and in line with their Medicaid state plan, waiver, or demonstration authority, as applicable. This includes ensuring there is no duplicate

[84] https://www.medicaid.gov/chip/financing/index.html

payment for the vaccine products when the products are covered by another source (e.g., the VFC program for pediatric NF residents).

- For FQHCs and Rural Health Clinics (RHCs), vaccine administration may be included within the PPS rate for Medicaid and CHIP enrollees. States should review their current definitions of FQHC/RHC encounters to ensure appropriate guidance is provided to FQHC/RHC providers. In some cases, a state may be able to pay for vaccine administration through an Alternative Payment Methodology for Medicaid and CHIP enrollees. Also, as mentioned earlier, FQHCs in states that do not include the vaccine product itself in the FQHC benefit can, instead, provide these vaccines pursuant to ARP and IRA under a separate benefit category (e.g., preventive services). CMS is willing to work with states on any vaccine- related FQHC or RHC payment methodologies.

- To limit the time necessary for CMS to review the SPA submissions, states can create a stand-alone SPA page that describes payment methods for mandatory and optional benefits through which states will pay for vaccine administration. The amendment would list the Medicaid benefit(s) and the associated payment methodology the state will use to pay for vaccine administration. The new state plan page would be located at the front of each applicable Medicaid state plan attachment (i.e., 4.19-A, 4.19-B, 4.19-D) that includes a benefit under which the state would authorize payment for vaccine administration. CMS recommends this approach as it would significantly reduce CMS SPA processing time, in addition to eliminating the requirement for a same page review.

- A similar approach that would also limit the time necessary for CMS review is to submit a stand-alone page that describes the payment rate for multiple eligible providers covered by the state plan Attachment. For example, an Attachment 4.19-B submission could describe the initial and additional or final dose administration rate paid under the 1905(a)(13)(B) benefit category to eligible providers, while also including add-on rates that cover alternate site and cold storage costs. The rates and associated add-ons must be consistent with section 1902(a)(30)(A) of the Act.

- CMS does not currently collect provider reimbursement information for CHIP. States should reach out to their CHIP Project Officer with any questions.

*Table 3 - Coverage and Payment of Vaccines, Vaccine Administration, and Cost-Sharing under Medicaid, CHIP, and BHP **After** the ARP Coverage Period (September 30, 2024)* [85]

Population	Is coverage of vaccines and their administration mandatory (after the ARP coverage period)?	Is cost sharing for vaccines and their administration allowed (after the ARP coverage period)?	What percentage of state payments for vaccines and their administration are matched by the federal government? [86]
Adult Medicaid Full Coverage/Full Benefit Enrollees (IRA Coverage Requirements)	YES, for all categories of ACIP recommendations.[87]	NO	Regularly applicable FMAP rate
Adults Enrolled in ABPs	YES, for all routine ACIP recommendations. States that align ABP coverage with state plan coverage will need to cover all ACIP recommended vaccinations per the IRA coverage requirements.[88] [89]	NO, as long as the vaccination is from an in-network provider	Regularly applicable FMAP rate

[85] The "ARP coverage period" is the period for mandatory coverage for COVID-19 vaccines and their administration (without cost-sharing) in Medicaid and CHIP that is described in sections 9811 and 9821 of the ARP: beginning on the date of enactment of the ARP (March 11, 2021) and ending on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act (September 30, 2024).

[86] States that provided Medicaid coverage for services described in sections 1905(a)(13)(A) and (B) of the Act, without cost-sharing, receive a one percentage point increase in their FMAP for their Medicaid expenditures for these services, as well as for their Medicaid expenditures for tobacco cessation services for pregnant individuals. This enhanced FMAP will expire for vaccination services described in section 1905(a)(13)(B) on September 30, 2025. See the *FMAP Increase for Certain Adult Vaccinations and Other Services* for more information.

[87] CMS interprets section 1905(a)(13)(B) of the Act to describe coverage of FDA-approved adult vaccines that are administered in accordance with any category of ACIP recommendations. The IRA coverage requirement is therefore not limited to vaccines that ACIP includes on the immunization schedules or recommends for routine use. See https://www.medicaid.gov/federal-policy-guidance/downloads/sho23003.pdf.

[88] As defined for purposes of the vaccination coverage that must be included in Medicaid ABP coverage, ACIP recommendations for "routine use" are those that are listed on the CDC/ACIP immunization schedules. Additionally, under current regulations, if ACIP recommends a new vaccine for routine use, states are not required to cover the vaccine until the beginning of the year that is 12 months after ACIP issues the recommendation. However, states may voluntarily choose to cover a vaccine, with or without cost-sharing, prior to that date.

[89] Coverage of vaccinations for ABP populations includes vaccinations authorized by the FDA for emergency use in line with EHB requirements as long as those vaccinations are ACIP-recommended for routine use.

Population	Is coverage of vaccines and their administration mandatory (after the ARP coverage period)?	Is cost sharing for vaccines and their administration allowed (after the ARP coverage period)?	What percentage of state payments for vaccines and their administration are matched by the federal government? [86]
Child Medicaid Full Coverage/Full Benefit Enrollees Aged 18 and Younger	YES, for all vaccines on the CDC/ACIP pediatric schedule and those vaccinations determined to be medically necessary as established by the state.[90]	NO	Regularly applicable FMAP rate
Child Medicaid Full Coverage/Full Benefit Enrollees Aged 19 and Older	YES, for all categories of ACIP recommendations[91]	NO	Regularly applicable FMAP Rate
Medicaid Limited Benefit Group Enrollees[92]	NO	YES	Regularly applicable FMAP Rate if the state chooses to offer vaccines to these individuals through 1115 authority
CHIP Enrollees	YES, for all ACIP-recommended vaccines and their administration.	NO	State's E-FMAP Rate
BHP Enrollees	YES, for all routine ACIP recommendations as long as provided by in-network providers.[93]	NO, as long as provided by in-network providers.	There is no specific federal funding for vaccine administration because BHP funding is based on a fixed payment formula.

[90] See Section 1905(r)(1)(B)(iii) and (5) of the Act and the *Children Covered under Medicaid* section for more information.

[91] See note 54 and 80

[92] For example, individuals eligible only for family planning benefits; individuals eligible for tuberculosis-related benefits.

[93] As defined for purposes of the vaccination coverage that must be included in BHP coverage, ACIP recommendations for "routine use" are those that are listed on the CDC/ACIP immunization schedules. Additionally, under current regulations, if ACIP recommends a new vaccine for routine use, states are not required to cover the vaccine until the beginning of the year that is 12 months after ACIP issues the recommendation (15 days for COVID-19 vaccinations as noted above). However, states may voluntarily choose to cover a vaccine, with or without cost-sharing, prior to that date.

Appendix A: Additional Resources

Vaccines – General:

- HHS Vaccines & Immunizations: https://www.hhs.gov/vaccines/index.html
- CMS Immunization and Vaccine Resources: https://www.cms.gov/about-cms/agency-information/omh/resource-center/immunization-resources
- CMS Medicaid and CHIP, Quality of Care Vaccines: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/quality-of-care-vaccines/index.html
- CDC Vaccines & Immunizations: https://www.cdc.gov/vaccines/index.html
- Advisory Committee on Immunization Practices (ACIP): https://www.cdc.gov/vaccines/acip/index.html
    - ACIP Recommendations: https://www.cdc.gov/vaccines/acip/recommendations.html
    - Immunization Schedules: https://www.cdc.gov/vaccines/schedules/index.html

Medicaid, CHIP, and BHP:

- Mandatory Medicaid and Children's Health Insurance Program Coverage of Adult Vaccinations under the Inflation Reduction Act State Health Official (SHO) Letter #23-003 (June 27, 2023): https://www.medicaid.gov/federal-policy-guidance/downloads/sho23003.pdf
- SPA and 1915 Waiver Processing: https://www.medicaid.gov/resources-for-states/spa-and-1915-waiver-processing/index.html
- CHIP: https://www.medicaid.gov/chip/index.html
- BHP: https://www.medicaid.gov/basic-health-program/index.html
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

Vaccines for Children (VFC):

- CDC VFC Program: https://www.cdc.gov/vaccines/programs/vfc/index.html
    - Eligibility Criteria: https://www.cdc.gov/vaccines/programs/vfc/providers/eligibility.html
    - How Medicaid and VFC Work Together: https://www.cdc.gov/vaccines/programs/vfc/providers/medicaid.html
    - Current Fee Schedule: https://www.federalregister.gov/documents/2012/11/06/2012-26507/medicaid-program-payments-for-services-furnished-by-certain-primary-care-physicians-and-charges-for#:~:text=This%20final%20rule%20updates%20the,for%20Children%20(VFC)%20program.

Vaccine Counseling for Medicaid and CHIP:

- State Health Official (SHO) Letter #22-002 (May 12, 2022): https://www.medicaid.gov/federal-policy-guidance/downloads/sho22002.pdf
- Vaccine Counseling for Medicaid and CHIP Beneficiaries (December 9, 2021): https://www.medicaid.gov/state-resource-center/downloads/vaccine-counseling-for-medicaid-chip-beneficiaries.pdf

Medicaid Management Information System (MMIS) and Immunization Registries:

- Streamlined Modular Certification for Medicaid Enterprise Systems Certification Guidance (April 2022): https://www.medicaid.gov/medicaid/data-and-systems/downloads/smc-certification-guidance.pdf
- State Medicaid Director Letter MMIS Immunization Registries (July 6, 2000): https://www.medicaid.gov/federal-policy-guidance/downloads/smd070600.pdf

Public Health Emergency (PHE) and Disaster Response:

- Medicaid Disaster Response Toolkit: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/index.html
- Public Readiness and Emergency Preparedness (PREP) Act: https://aspr.hhs.gov/legal/PREPact/Pages/default.aspx
- Public Health Emergency Preparedness (PHEP) Program and Guidance: https://www.cdc.gov/orr/readiness/phep/index.htm

COVID-19 Specific Information:

- Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost-Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program (May 6, 2022): https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf
- Medicaid and CHIP: Guidance and FAQs (COVID-19) https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/medicaid-and-chip-resources/guidance-and-faqs/index.html
- Commercialization of COVID-19 Medical Countermeasures Fact Sheet: https://aspr.hhs.gov/COVID-19/Pages/FAQ-Commercialization.aspx#:~:text=Commercialization%20is%20the%20transition%20of,both%20public%20and%20private%20payers
- Fact Sheet: HHS Announces Intent to Amend the Declaration Under the PREP Act for Medical Countermeasures Against COVID-19 (April 14, 2023): https://www.hhs.gov/about/news/2023/04/14/factsheet-hhs-announces-amend-declaration-prep-act-medical-countermeasures-against-covid19.html#:~:text=PREP%20Act%20immunity%20from%20liability,of%20any%20USG%20agreement%20or

- COVID-19 Vaccination Strategies: https://www.cdc.gov/vaccines/covid-19/vaccinate-with-confidence/community.html
- Available Flexibilities and Funding Opportunities to Address COVID-19 Vaccine Hesitancy (March 8, 2021): https://www.medicaid.gov/state-resource-center/downloads/avail-flex-fund-oppo-addr-covid-19-vac-hesit.pdf

Appendix B: Acronym List

Acronym	Definition
AAP	American Academy of Pediatrics
ABP	Alternative Benefit Plan
ACA	Affordable Care Act
ACIP	Advisory Committee on Immunization Practices
APD	Advance Planning Document
ARP	American Rescue Plan Act of 2021
BHP	Basic Health Program
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CR	Certification Review
E-FMAP	Enhanced Federal Medical Assistance Percentage
EHB	Essential Health Benefit
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FFP	Federal Financial Participation
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Center
HHS	Department of Health and Human Services
IIS	Immunization Information Systems
IRA	Inflation Reduction Act
MACPAC	Medicaid and CHIP Payment and Access Commission
MES	Medicaid Enterprise Systems
MMIS	Medicaid Management Information Systems
NF	Nursing Facilities
OLP	Other Licensed Practitioners
ORR	Operational Readiness Review
PHE	Public Health Emergency
PPS	Prospective Payment System

Acronym	Definition
PREP Act	Public Readiness and Emergency Preparedness Act
RHC	Rural Health Clinic
RFP	Request for Proposal
SHO	State Health Official
SMC	Streamlined Modular Certification
SPA	State Plan Amendment
VFC	Vaccines for Children Program
VPD	Vaccine-Preventable Disease