



---

**SHO # 22-002**

**RE: Medicaid and CHIP Coverage of  
Stand-alone Vaccine Counseling**

May 12, 2022

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing this guidance on Medicaid and Children’s Health Insurance Program (CHIP) coverage and payment for “stand-alone vaccine counseling.” The term “stand-alone vaccine counseling” refers 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 (i.e., there is no actual delivery or injection of a vaccine during the practitioner visit) because it is not appropriate to provide the vaccine dose at that time (such as when the patient and/or caregiver does not consent to the patient receiving the vaccine dose at that time).<sup>1</sup>

The policies discussed in this guidance generally apply beginning December 2, 2021, which was when they were first announced.<sup>2</sup> CMS shared further details with states on an all-[state](#) call on December 9, 2021.<sup>3</sup>

## **Overview**

CMS interprets the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (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.<sup>4</sup> This interpretation applies to stand-alone vaccine counseling related to all vaccines covered for beneficiaries eligible for EPSDT.

---

<sup>1</sup> When we refer to stand-alone vaccine counseling we do not mean that no other care or services are provided other than the vaccine counseling. Rather, we simply mean that the vaccine is not injected or delivered during the same practitioner visit as the counseling about the vaccine. Stand-alone vaccine counseling could be provided as a component of a practitioner visit in which other services are also rendered.

<sup>2</sup> <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-makes-100-federal-medicaid-matching-funds-available-state-expenditures>.

<sup>3</sup> <https://www.medicaid.gov/state-resource-center/downloads/vaccine-counseling-for-medicaid-chip-beneficiaries.pdf>

<sup>4</sup> Unless stated otherwise, all references to Medicaid beneficiaries also include beneficiaries enrolled in Medicaid-expansion CHIPs.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Additionally, section 9811 of the American Rescue Plan Act of 2021 (Pub. L. No. 117-2) (ARP) requires state Medicaid programs to cover COVID-19 vaccine administration without cost-sharing and makes a 100 percent Federal Medical Assistance Percentage (FMAP) temporarily available for state Medicaid expenditures on COVID-19 vaccines and their administration.

CMS interprets the references in ARP section 9811 to the administration of a COVID-19 vaccine, including in section 1905(a)(4)(E) and (hh) of the Social Security Act (the Act), to include stand-alone COVID-19 vaccine counseling, when this counseling is covered for Medicaid beneficiaries under the age of 21 who are eligible for EPSDT.

State expenditures on stand-alone COVID-19 vaccine counseling are federally matched at 100 percent under the ARP only when this counseling is provided to Medicaid beneficiaries who are eligible both for EPSDT and the COVID-19 vaccination coverage required under the ARP. States have the option to cover stand-alone vaccine counseling for Medicaid beneficiaries who are not eligible for EPSDT. State expenditures on stand-alone COVID-19 vaccine counseling for beneficiaries not eligible for EPSDT, and state expenditures on stand-alone vaccine counseling related to vaccines other than COVID-19 vaccines, are federally matched at the otherwise applicable FMAP, not at the ARP 100 percent FMAP.

Because EPSDT is not a requirement in a separate CHIP, different policies apply in separate CHIPs, as discussed below.

## **Background**

As of January 2022, Medicaid and CHIP enrollment totaled approximately 86.9 million individuals, including over 40.1 million children.<sup>5</sup> The number of children enrolled represents 47.3 percent of total Medicaid and CHIP enrollment. Medicaid beneficiaries currently have some of the lowest reported COVID-19 vaccination rates among those for whom the COVID-19 vaccines are recommended.<sup>6</sup>

Stand-alone vaccine counseling has been shown to help address vaccine hesitancy by helping beneficiaries and their families learn about vaccines from trusted health care providers. Coverage of stand-alone vaccine counseling could help states increase COVID-19 and other vaccination rates for Medicaid and CHIP beneficiaries, especially among children. Survey data have shown that a large percentage of parents are hesitant to have their children vaccinated, even when they have received the COVID-19 vaccination themselves, and that they are most comfortable having their children vaccinated by their trusted health care provider.<sup>7</sup> The American Academy of Pediatrics (AAP) recommends that providers address parental questions regarding vaccines and

---

<sup>5</sup> <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.

<sup>6</sup> <https://www.commonwealthfund.org/blog/2021/how-can-states-improve-covid-19-vaccination-rates-in-medicaid>

<sup>7</sup> <https://www.medicaid.gov/state-resource-center/downloads/cmcs-all-state-call-11092021.pdf>

notes the importance of counseling to address parental anxiety and misinformation.<sup>8</sup> This is particularly vital for parents of children with disabilities and chronic conditions, many of whom the Centers for Disease Control and Prevention (CDC) advises may be at higher risk than their peers for severe outcomes of COVID-19.<sup>9</sup> Additionally, data indicates that people from racial and ethnic minority groups are more likely to die from COVID-19 at younger ages than non-Hispanic white people.<sup>10</sup>

During the COVID-19 Public Health Emergency (PHE), there has been a decline in the number of all childhood vaccines provided to Medicaid and CHIP populations, except for influenza.<sup>11</sup> Vaccine counseling is an important tool available for all vaccinations, but is particularly important during the COVID-19 PHE, as families seek to have their children receive routine vaccinations and well-child visits.

## **Coverage of Stand-alone Vaccine Counseling**

### *Medicaid Coverage of Stand-alone Vaccine Counseling*

States have long had the option to cover stand-alone vaccine counseling in Medicaid. State expenditures on this counseling have historically been federally matched at the regularly applicable FMAP.

### *Coverage of Stand-alone Vaccine Counseling for Beneficiaries Eligible for EPSDT*

As of December 2, 2021, CMS interprets the Medicaid 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. This interpretation 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. Under this updated interpretation of the EPSDT benefit, states **must** cover stand-alone vaccine counseling for all vaccines covered under EPSDT, including both COVID-19 and non-COVID-19 vaccines, regardless of the federal matching percentage for their expenditures on the stand-alone vaccine counseling. States may establish limits on the number of times stand-alone vaccine counseling is covered for a beneficiary eligible for EPSDT, 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.<sup>12</sup>

### *Coverage of Stand-alone COVID-19 Vaccine Counseling for Beneficiaries Eligible for EPSDT*

Section 9811 of the ARP established a mandatory Medicaid benefit at section 1905(a)(4)(E) of the Act for COVID-19 vaccines and their administration and amended various sections of the

---

<sup>8</sup> <https://publications.aap.org/pediatrics/article/138/3/e20162146/52702/Countering-Vaccine-Hesitancy>

<sup>9</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/underlyingconditions.html#accordion-1-card->

<sup>10</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/underlyingconditions.html#accordion-1-card->

<sup>11</sup> <https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot-08-31-2021.pdf>

<sup>12</sup> States generally have a great deal of flexibility with respect to covering Medicaid services provided via telehealth. See <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf>.

Act, including sections 1902(a)(10), 1905, 1916(a)(2), 1916(b)(2), 1916A(b)(3)(B), and 1937 of the Act.<sup>13</sup> Under the ARP’s amendments, state Medicaid programs must cover COVID-19 vaccine administration without cost-sharing, for a specified period of time, and 100 percent FMAP is available for state Medicaid expenditures on COVID-19 vaccine administration.<sup>14</sup> The requirement to cover COVID-19 vaccines and their administration without cost-sharing generally applies beginning 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 PHE (referred to herein as the “ARP coverage period”).<sup>15</sup> The applicable period for the 100 percent FMAP is slightly different, as discussed further below.

CMS’s interpretation of the EPSDT benefit to include stand-alone vaccine counseling affects how CMS interprets the amendments made by the ARP. Specifically, as of December 2, 2021, CMS interprets the references in ARP section 9811 to the administration of a COVID-19 vaccine, including in section 1905(a)(4)(E) and (hh) of the Act, to include stand-alone COVID-19 vaccine counseling, when this counseling is covered for Medicaid beneficiaries under the age of 21 who are eligible both for EPSDT and the ARP COVID-19 vaccination coverage.<sup>16</sup> This means that states are required to cover this counseling for those beneficiaries, without cost-sharing. An overview of how CMS interprets the Medicaid statute to require coverage of this stand-alone COVID-19 vaccine counseling was provided to states on the CMS All-State Call held on December 9, 2021 and the corresponding presentation can be accessed on [Medicaid.gov](https://www.medicaid.gov).<sup>17</sup>

Additionally, CMS will match state expenditures on stand-alone COVID-19 vaccine counseling for Medicaid beneficiaries who are eligible both for EPSDT and the ARP COVID-19 vaccination coverage at the 100 percent FMAP available under the ARP for state expenditures on COVID-19 vaccine administration. This 100 percent FMAP is available beginning on April 1, 2021 and ending on the last day of the first quarter that begins one year after the last day of the COVID-19 PHE (referred to herein as the “ARP FMAP period”).<sup>18</sup>

---

<sup>13</sup> 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>.

<sup>14</sup> Nearly all Medicaid beneficiaries are eligible for this coverage, but there are a few limited exceptions. For example, persons eligible only for Medicaid coverage of Medicare premiums under sections 1902(a)(10)(E) or 1933 of the Act are not eligible for it. See ARP § 9811 generally, and, in particular, ARP § 9811(a)(2)(F) (adding clause XIX to the language following section 1902(a)(10)(G) of the Act).

<sup>15</sup> The optional COVID-19 group at section 1902(a)(10)(A)(ii)(XXIII) of the Act receives this coverage only through the last day of the COVID-19 PHE. No federal financial participation is available for any state expenditures on benefits for this group, including coverage of COVID-19 vaccinations, after the PHE ends.

<sup>16</sup> <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-makes-100-federal-medicaid-matching-funds-available-state-expenditures>.

<sup>17</sup> <https://www.medicaid.gov/state-resource-center/downloads/vaccine-counseling-for-medicaid-chip-beneficiaries.pdf>

<sup>18</sup> For more information about the ARP 100 percent FMAP and the ARP FMAP period, see State Health Official (SHO) Letter #21-004 at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-004.pdf>

After the ARP FMAP period expires, federal matching for state Medicaid expenditures on COVID-19 vaccine administration, including on stand-alone COVID-19 vaccine counseling for persons who are eligible both for EPSDT and the ARP COVID-19 vaccination coverage, will revert to the regularly applicable FMAP.

These policies **only** apply when stand-alone COVID-19 vaccine counseling is covered for persons who are eligible both for EPSDT and the ARP COVID-19 vaccination coverage.

*Coverage of Stand-alone Vaccine Counseling for Beneficiaries Not Eligible for EPSDT*

There is no benefit or coverage requirement comparable to EPSDT or its health education requirement for Medicaid beneficiaries age 21 and older. Additionally, some Medicaid beneficiaries under age 21 are not eligible for EPSDT. However, states continue to have the option to cover stand-alone vaccine counseling (including stand-alone vaccine counseling related to the COVID-19 vaccines) for Medicaid beneficiaries who are not eligible for EPSDT. State expenditures on stand-alone COVID-19 and other vaccine counseling for all Medicaid beneficiaries who are not eligible for EPSDT will be matched at the applicable FMAP, not at the ARP 100 percent FMAP.

*CHIP Coverage of Stand-alone Vaccine Counseling*

Section 9821 of the ARP added a mandatory COVID-19 vaccination benefit for separate CHIPs at section 2103(c)(11)(A) of the Act and amended section 2103(e)(2) of the Act. The changes require coverage of COVID-19 vaccines and their administration without cost-sharing for all separate CHIP enrollees, and apply during the same time period as the Medicaid coverage requirements under section 9811 of the ARP. Section 9821 of the ARP also amended the CHIP statute to provide for a 100 percent CHIP federal matching rate for state expenditures on COVID-19 vaccine administration during the ARP FMAP period.

Because EPSDT is not a requirement in a separate CHIP and there is no benefit or coverage requirement comparable to EPSDT or its health education requirement for individuals in a separate CHIP, CMS does not interpret the references to COVID-19 vaccine administration added to the CHIP statute under section 9821 of the ARP to include stand-alone vaccine counseling related to a COVID-19 vaccine for a beneficiary in a separate CHIP. Therefore, separate CHIPs are not required to cover stand-alone COVID-19 vaccine counseling for beneficiaries under age 21, and states will not receive 100 percent federal matching funds under section 9821 of the ARP for their expenditures on this stand-alone vaccine counseling. States may opt to cover stand-alone COVID-19 and other vaccine counseling for children and pregnant adults enrolled in a separate CHIP, but are not required to do so. Expenditures for this stand-alone vaccine counseling will be matched at the state's enhanced federal matching percentage for Title XXI beneficiaries, not at the 100 percent federal matching percentage for COVID-19 vaccine administration under section 9821 of the ARP. Even though states are not required to cover stand-alone vaccine counseling in a separate CHIP, the majority of states have elected to follow the AAP *Bright Futures* periodicity schedule for preventive pediatric health care, which emphasizes the importance of vaccine counseling as part of CHIP required well-baby/well-child

visits.<sup>19</sup>

Since CMS published its December 9, 2021 slide deck on this updated interpretation of the EPSDT benefit, states and other members of the public have asked about the federal matching rate for state expenditures on stand-alone COVID-19 vaccine counseling in Medicaid-expansion CHIPs. Beneficiaries enrolled in a Medicaid-expansion CHIP under 42 CFR § 435.118 or § 435.229 are eligible for EPSDT, and states are required to cover stand-alone vaccine counseling for all pediatric vaccines covered under EPSDT for all such Medicaid-expansion CHIP beneficiaries. State expenditures on stand-alone COVID-19 vaccine counseling for these Medicaid-expansion CHIP beneficiaries will be federally matched at the 100 percent federal matching rate for COVID-19 vaccine administration under section 9821 of the ARP during the ARP FMAP period. State expenditures on stand-alone vaccine counseling provided to these Medicaid-expansion CHIP beneficiaries about all other vaccines required under the EPSDT benefit (i.e., non-COVID-19 vaccines) will be federally matched at the state’s enhanced federal medical assistance percentage for Title XXI beneficiaries, not at the ARP 100 percent federal matching rate.

*Medicaid and CHIP Coverage of Visits During which Beneficiaries Receive Both Counseling about COVID-19 Vaccination and the COVID-19 Vaccine Itself*

CMS considers all visits during which a COVID-19 vaccine is actually delivered or injected to include COVID-19 vaccine administration under the ARP, regardless of whether counseling about the COVID-19 vaccine is also provided during the same visit. States are required to cover any actual delivery of a COVID-19 vaccine, without cost-sharing, for *all* CHIP beneficiaries and for *all* Medicaid beneficiaries eligible for COVID-19 vaccine administration coverage under the ARP. States’ expenditures on the COVID-19 vaccine delivery provided during such visits will be federally matched at 100 percent in both Medicaid and CHIP during the ARP FMAP period,<sup>20</sup> regardless of whether counseling about COVID-19 vaccination is also provided during the same visit, and regardless of whether the visit is provided to a person who is eligible for EPSDT.

### **Qualified Providers**

States may have licensure and scope of practice laws governing who is authorized under state law to administer vaccinations. Additionally, some federal Medicaid and CHIP regulations defining benefits under which states might opt to cover vaccine administration expressly refer to state licensure or scope of practice laws, by requiring that services be prescribed, furnished, recommended, or provided by practitioners acting within their scope of practice as defined by state law. For example, 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 42 CFR § 440.130(c) requires that Medicaid preventive services be recommended by

---

<sup>19</sup> [https://downloads.aap.org/AAP/PDF/periodicity\\_schedule.pdf](https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf);  
[https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4\\_POCKETGUIDE.pdf](https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_POCKETGUIDE.pdf) (see pp. 10-11).

<sup>20</sup> See SHO Letter #21-004 for CMS guidance about allocation methods states should follow to appropriately identify and report expenditures associated with COVID-19 vaccine administration in circumstances where states make a bundled payment to providers for services that include COVID-19 vaccine administration.  
<https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-004.pdf>.

practitioners acting within the scope of authorized practice under state law.

As is discussed in greater detail in *Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost-Sharing under Medicaid, the Children’s Health Insurance Program, and Basic Health Program* (the Vaccine Toolkit), the Secretary of Health and Human Services (HHS) issued a declaration under the Public Readiness and Emergency Preparedness (PREP) Act that authorizes certain practitioners to administer COVID-19 vaccines, subject to certain conditions set forth in the declaration.<sup>21</sup> The HHS COVID-19 PREP Act declaration also authorizes certain pharmacy practitioners to administer childhood vaccines to children ages three (3) through 18.<sup>22</sup>

The HHS Office of the General Counsel and Department of Justice Office of Legal Counsel issued advisory opinions explaining that the PREP Act and the HHS COVID-19 PREP Act declaration preempt state laws that would otherwise prohibit or effectively prohibit licensed pharmacists from ordering and administering covered countermeasures described in the HHS COVID-19 PREP Act declaration.<sup>23</sup> Based on the reasoning set forth in these opinions, state laws are also preempted if they would prohibit or effectively prohibit persons authorized to administer COVID-19 or childhood vaccines under the HHS COVID-19 PREP Act declaration from doing so. This means that states cannot rely on state law to prevent persons from administering COVID-19 or childhood vaccines if they are authorized to do so under the HHS COVID-19 PREP Act declaration.

As explained in more detail in the Vaccine Toolkit, because the authorizations in the HHS COVID-19 PREP Act declaration preempt conflicting state law, if a person is authorized to administer COVID-19 or childhood vaccines under the HHS COVID-19 PREP Act declaration, a state may not deny Medicaid or CHIP reimbursement to that person for the vaccine administration on the basis of a state law that is preempted by the declaration. CMS also interprets references to practitioners’ state-law scope of practice in federal Medicaid and CHIP laws and regulations as incorporating the PREP Act preemption of state law. In other words, if a state law is currently preempted by the PREP Act and HHS’s COVID-19 PREP Act declaration and authorizations, CMS would interpret a reference to that state law in a federal Medicaid or

---

<sup>21</sup> See Vaccine Toolkit, at section V, <https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf>. The Vaccine Toolkit contains citations to the HHS COVID-19 PREP Act declaration and related authorizations, but they are also available at <https://aspr.hhs.gov/legal/PREPact/Pages/default.aspx>.

<sup>22</sup> See Third Amendment to Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19, 85 Fed. Reg. 52,136 (Aug. 24, 2020), at <https://www.govinfo.gov/content/pkg/FR-2020-08-24/pdf/2020-18542.pdf>; Eighth Amendment to Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19, 86 Fed. Reg. 41,977 (Aug. 4, 2021), <https://www.federalregister.gov/documents/2021/08/04/2021-16681/eighth-amendment-to-declaration-under-the-public-readiness-and-emergency-preparedness-act-for>.

<sup>23</sup> Advisory Opinion 20-02 on the Public Readiness and Emergency Preparedness Act and the Secretary’s Declaration under the Act, May 19, 2020, <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/advisory-opinion-20-02-hhs-ogc-prep-act.pdf>. See also Department of Justice Office of Legal Counsel Advisory Opinion for Robert P. Charrow, General Counsel of the Department of Health and Human Services, January 19, 2021, available at: <https://www.justice.gov/sites/default/files/opinions/attachments/2021/01/19/2021-01-19-prep-act-preemption.pdf>.

CHIP statute or regulation to refer instead to the federal law preempting the state law.

Additionally, consistent with Medicaid’s freedom-of-choice of provider requirement at section 1902(a)(23)(A) of the Act, CMS will expect states to provide Medicaid coverage for COVID-19 and childhood vaccinations administered by anyone who is authorized to do so under the HHS COVID-19 PREP Act declaration, during any time period when the HHS COVID-19 PREP Act declaration authorizations are in effect and Medicaid coverage of the vaccinations is mandatory. 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.<sup>24</sup>

The authorizations under the HHS COVID-19 PREP Act declaration to administer COVID-19 and childhood vaccines extend to stand-alone vaccine counseling related to these vaccines that is provided to Medicaid beneficiaries who are eligible for EPSDT. CMS has determined that this stand-alone vaccine counseling, when provided as part of the EPSDT mandate, is “vaccine administration.” Thus, states cannot deny Medicaid payment for this stand-alone vaccine counseling to practitioners authorized to administer COVID-19 and childhood vaccines under the HHS COVID-19 PREP Act declaration on the basis that state law would not authorize the practitioner to administer the vaccine in question. Importantly, the age range for which a practitioner is authorized to administer a vaccine under the HHS COVID-19 PREP Act declaration may be broader than what is authorized under state law, and if so, the more restrictive state law would be preempted. State Medicaid programs are expected to give all provider types authorized to administer COVID-19 and childhood vaccinations under the HHS COVID-19 PREP Act declaration an opportunity to enroll as Medicaid providers and receive Medicaid payment—not only for actually delivering or injecting the vaccines, but also for stand-alone vaccine counseling about these types of vaccinations provided to beneficiaries eligible for EPSDT. It is also important to note that the HHS COVID-19 PREP Act declaration may be in effect for longer than the COVID-19 PHE.<sup>25</sup>

Providers who work in school-based settings might also be qualified providers of COVID-19 or childhood vaccine administration, and states would receive 100 percent FMAP during the ARP FMAP period in payments to these providers for COVID-19 vaccine administration, including for stand-alone COVID-19 vaccine counseling for beneficiaries eligible for EPSDT.

## **Payment and Claims**

Within the parameters of section 1902(a)(30)(A) of the Act, states have flexibility to set payment rates for stand-alone vaccine counseling. States may establish separate payment rates for stand-alone vaccine counseling, or explore other payment methodologies to recognize additional costs

---

<sup>24</sup> See discussion in section V.C of the Vaccine Toolkit for more information and examples. Although the Vaccine Toolkit is focused on COVID-19 vaccinations, the same principles would apply with respect to the HHS COVID-19 PREP Act declaration authorizations related to administration of childhood vaccines.

<https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf>.

<sup>25</sup> See section XII of the HHS COVID-19 PREP Act declaration, at 87 Fed. Reg. 982, 988 (Jan. 7, 2022), <https://www.federalregister.gov/documents/2022/01/07/2022-00151/tenth-amendment-to-declaration-under-the-public-readiness-and-emergency-preparedness-act-for-medical>.



associated with vaccine counseling that are not otherwise paid as part of the state’s usual payment rate for vaccine administration or for a comprehensive office visit.

CMS encourages states to develop a payment methodology for stand-alone COVID-19 vaccine counseling that will enable them to identify and document which state expenditures can be claimed at 100 percent FMAP because CMS considers them to be COVID-19 vaccine administration under the ARP provisions. For example, states could explore establishing a new, additional COVID-19 vaccine administration payment rate that would apply only to stand-alone counseling about the COVID-19 vaccines provided to beneficiaries who are eligible both for EPSDT and the ARP COVID-19 vaccination coverage. Such a rate could be separate from, and/or in addition to, any rate for COVID-19 vaccine administration that a state might have developed for actual injection of the vaccines, provided that the state would not pay a provider twice for any costs already built into the state’s existing rate for COVID-19 vaccine administration. Establishing a separate payment rate for this stand-alone COVID-19 vaccine counseling would enable states to make separate payments to providers for that counseling, and thus might help states identify and document which expenditures should be claimed at the ARP 100 percent FMAP during the ARP FMAP period. States could also modify existing billing codes designed to help states and other payers reimburse practitioners for stand-alone COVID-19 vaccine counseling (see Coding discussion below) to identify when stand-alone COVID-19 vaccine counseling was furnished to EPSDT-eligible beneficiaries.

States that choose not to establish separate payment rates and associated billing codes for stand-alone COVID-19 vaccine counseling provided to beneficiaries who are eligible both for EPSDT and the ARP COVID-19 vaccination coverage could reimburse for this mandatory coverage through existing payment methods such as the payment rate for a comprehensive office visit or the payment rate that the state has already established for vaccine administration. In such cases, however, states claiming the ARP 100 percent FMAP must still be able to determine when their expenditures on such payments can be matched at 100 percent FMAP during the ARP FMAP period. Not having a separate Healthcare Common Procedure Coding System (HCPCS) code, Current Procedural Terminology (CPT) code, or modifier for state expenditures on stand-alone COVID-19 vaccine counseling provided to beneficiaries who are eligible both for EPSDT and the ARP COVID-19 vaccination coverage could present significant challenges in determining which state expenditures can be matched at 100 percent FMAP during the ARP FMAP period. States that do not pay a separate fee or use a separate code for stand-alone COVID-19 vaccine counseling furnished to EPSDT-eligible beneficiaries will need to work directly with their practitioner communities to determine an approach to use to document and identify which state expenditures qualify for the 100 percent FMAP. Alternatively, states may opt not to claim the ARP 100 percent FMAP for this stand-alone COVID-19 vaccine counseling, if claiming that FMAP would be too administratively and/or operationally burdensome.

States currently covering stand-alone COVID-19 vaccine counseling for Medicaid beneficiaries who are eligible both for EPSDT and the ARP COVID-19 vaccination coverage will be able to retroactively adjust claims back to April 1, 2021, to receive the 100 percent FMAP for these expenditures during the ARP FMAP period. States that newly implement Medicaid coverage of stand-alone COVID-19 vaccine counseling for beneficiaries who are eligible both for EPSDT and the ARP COVID-19 vaccination coverage can claim the 100 percent FMAP for their

expenditures on this stand-alone COVID-19 vaccine counseling on or after April 1, 2021, and throughout the ARP FMAP period.

CMS will work to ensure appropriate oversight of states' claiming and allocation methodologies and will place special emphasis on state expenditures claimed at the ARP 100 percent FMAP while conducting quarterly and annual financial reviews.

## **State Plan Amendments (SPAs)**

### **Medicaid SPAs**

#### *Stand-alone COVID-19 Vaccine Counseling for Beneficiaries Eligible for EPSDT*

CMS released [streamlined templates](#) for states to utilize to make state plan changes related to COVID-19 vaccine administration, testing, and treatment under the ARP.<sup>26</sup> States must utilize these streamlined templates to comply with the required coverage and reimbursement for stand-alone COVID-19 vaccine counseling for beneficiaries eligible for EPSDT that is discussed in this SHO Letter during the ARP coverage period. States may seek waivers under section 1135 of the Act with respect to public notice timeframes, tribal consultation timeframes, and SPA effective dates when submitting SPAs using these templates, but only during the COVID-19 PHE. CMS cannot waive or modify statutory or regulatory requirements under section 1135 of the Act after the COVID-19 PHE ends. Unlike the current disaster relief SPA templates, these new templates will allow states to extend their coverage after the end of the COVID-19 PHE through the end of the ARP coverage period without submitting a second SPA when the PHE ends.

#### *Stand-alone Vaccine Counseling for All Other Pediatric Vaccines for Beneficiaries Eligible for EPSDT*

All states should already be covering EPSDT, which requires states to cover health education and all medically necessary services that could be covered under the benefits listed in section 1905(a) of the Act for eligible children under age 21. States in compliance with this requirement are not required to submit SPA coverage pages to specifically reflect that the required stand-alone vaccine counseling is covered as part of the EPSDT benefit. States that do not currently cover and reimburse for stand-alone vaccine counseling for all other pediatric vaccines covered under EPSDT for persons eligible for the EPSDT benefit will need to submit a reimbursement SPA. A comprehensive description of the payment methodology for stand-alone vaccine counseling must be included in the reimbursement section of the Medicaid state plan.

#### *CHIP SPAs*

There is no SPA required to cover stand-alone vaccine counseling in CHIP. Coverage and

---

<sup>26</sup> <https://www.medicaid.gov/resources-for-states/spa-and-1915-waiver-processing/medicaid-spa-processing-tools-for-states/index.html>

payment for stand-alone vaccine counseling in Medicaid-expansion CHIPs, including when covered for beneficiaries eligible for EPSDT, would be pursuant to the state’s Medicaid state plan. CMS is available to provide technical assistance to states interested in covering stand-alone vaccine counseling. States should reach out to their CHIP project officer for more information.

### **Coding**

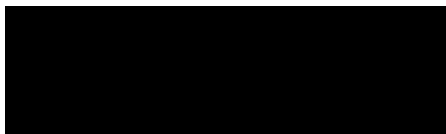
States should alert Medicaid and CHIP providers to the American Medical Association (AMA) and AAP published codes for reporting stand-alone COVID-19 vaccine counseling. The AMA publishes codes for all vaccines (including COVID-19 vaccines).<sup>27</sup> The AAP also has information on billing codes that can be used for stand-alone COVID-19 vaccine counseling on its COVID-19 vaccine administration dedicated website.<sup>28</sup> In addition, the AAP has information on billing codes for pediatric vaccines and vaccine counseling.

To further assist states with coding for stand-alone vaccine counseling, CMS is developing new HCPCS codes that providers may use to bill for stand-alone vaccine counseling. CMS anticipates providing more information about these codes soon.

### **Conclusion**

CMS is eager to work with states on the implementation of Medicaid and CHIP coverage for stand-alone vaccine counseling to help increase vaccination rates for COVID-19 and other diseases. CMS is committed to increasing vaccine confidence and the promotion of vaccinations for Medicaid and CHIP beneficiaries. If you have any questions regarding this letter or would like to request technical assistance, please contact your respective CMS State Lead.

Sincerely,



Daniel Tsai  
Deputy Administrator and Director

---

<sup>27</sup> <https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-vaccine-and-immunization-codes> and <https://www.ama-assn.org/practice-management/cpt/covid-19-immunization-administration-and-em-visits>.

<sup>28</sup> <https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/covid-19-vaccine-for-children/covid-19-vaccine-administration-getting-paid/>