

COVID-19 vaccine administration options under Medicaid

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As states develop their COVID-19 vaccine distribution plans, they must prepare to manage the vaccine distribution through their Medicaid programs.

While the federal government is initially providing the vaccine to providers at no cost, the reimbursement for administration of the vaccine remains the responsibility of individual states. The Centers for Disease Control and Prevention (CDC) has issued guidance on who should be vaccinated in phased recommendations, as the first supply of COVID-19 vaccine is limited. Medicaid beneficiaries are most likely represented in each vaccination group and will expand to be included in more groups as the vaccine availability increases.¹ As adult vaccination rates have historically been low (see callout), wide-scale immunization is without modern-day precedent, presenting challenges for the COVID-19 vaccine distribution to be effective and equitable and achieve sufficient levels of immunity to bring on the end of the pandemic. Therefore, Medicaid has an important role to ensure coverage and access.

The vaccination rates for the seasonal influenza in 2019 and the H1N1 flu pandemic from 2009 to 2010 did not accomplish their targets of reaching more than 70% of all adults.² No state immunized more than 51% of its adult population against the flu in 2019 and some states did not reach 40%.³ Influenza immunization rates for Hispanic and Black people, who are disproportionately impacted by COVID-19, are on average 10% to 13% below those for

white populations.⁴ Black Americans have reported the most reluctance to receive a coronavirus vaccine; in a recent survey by the Pew Research Center, 42% of Black Americans reported they would receive a vaccine for COVID-19 as compared to 60% of U.S. adults overall.⁵ Overcoming historical mistrust related to immunizations within this population may be a serious hurdle.

CMS tool kit

The Centers for Medicare and Medicaid Services (CMS) issued a tool kit to provide states with information to identify and address the issues associated with providing coverage and reimbursement for vaccine administration in response to the COVID-19 public health emergency (PHE).⁶ The CMS COVID-19 vaccine tool kit offers a number of CMS recommendations to increase vaccination rates. States must consider that any change to their current vaccine administration coverage, reimbursement, and/or delivery systems for the COVID-19 vaccine will likely require state plan amendment (SPA) approval by CMS, which should be accounted for in state policy development. This paper outlines these strategies as well as other options available to states to provide broad coverage to Medicaid populations. Key considerations and potential goals for state Medicaid agencies include:

1. Ensure all Medicaid beneficiaries eligible for comprehensive benefits have coverage for vaccine administration
2. Review vaccine administration reimbursement rates to ensure provider network adequacy
3. Determine the most effective delivery system for vaccine administration benefit coverage

¹ CDC (December 31, 2020). COVID-19: When Vaccine Is Limited, Who Gets Vaccinated First? Retrieved January 7, 2021, from <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations.html>.

² Baumgartner, J.C. et al. (December 3, 2020). How Prepared Are States to Vaccinate the Public Against COVID-19? Learning From Influenza and H1N1 Vaccination Programs. Commonwealth Fund. Retrieved January 7, 2021, from <https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/how-prepared-are-states-vaccinate-public-covid-19>.

³ Ibid.

⁴ Blumenthal, D. et al. (December 16, 2020). States Need Federal Help to Get COVID-19 Vaccines Into Millions of Arms. Commonwealth Fund. Retrieved January 7, 2021, from https://www.commonwealthfund.org/blog/2020/states-need-federal-help-get-covid-19-vaccines-millions-arms?utm_source=alert&utm_medium=email&utm_campaign=Presidents%20Blog.

⁵ Funk, C. & Tyson, A. (December 3, 2020). Intent to Get a COVID-19 Vaccine Rises to 60% as Confidence in Research and Development Process Increases. Pew Research Center. Retrieved January 7, 2021, from <https://www.pewresearch.org/science/2020/12/03/intent-to-get-a-covid-19-vaccine-rises-to-60-as-confidence-in-research-and-development-process-increases>.

⁶ CMS (December 17, 2020). Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing Under Medicaid, the Children's Health Insurance Program, and Basic Health Program. Retrieved January 7, 2021, from <https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf>.

4. Review beneficiary access and barriers to vaccination
5. Consider managed care financing and value-based approaches to vaccination administration
6. Coordinate education and outreach efforts across all stakeholders

The remaining sections of this brief discuss each of these topics.

1. ENSURE COVERAGE OF VACCINE ADMINISTRATION

During the PHE, states must cover COVID-19 vaccine administration for most Medicaid beneficiaries, without cost sharing, during any quarter in which the state claims the temporary 6.2% Federal Medical Assistance Percentage (FMAP) increase under section 6008 of the Families First Coronavirus Response Act (FFCRA).⁷ Outside of the PHE, vaccine administration coverage, cost-sharing, and reimbursement policies vary by Medicaid population in addition to other state options and SPA requirements. Current state vaccine coverage policies may require adjustments for the COVID-19 vaccine.

As adult immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) are included under "preventive and wellness services and chronic disease management" as an essential health benefit (EHB),⁸ states are required to cover recommended vaccinations without cost sharing for adults enrolled in Medicaid through the expansion of Medicaid eligibility via the Patient Protection and Affordable Care Act (ACA).⁹ However, adult vaccination services are not a federally mandated benefit for traditionally eligible Medicaid beneficiaries and coverage differs by state.¹⁰ States should review their state plans for vaccine administration coverage by benefit group and delivery system to assess whether Medicaid beneficiaries have vaccine administration coverage benefits and access to these benefits. In this review, states should evaluate the SPA submission requirements and submit any necessary SPAs to ensure continued access and prevent adult immunization coverage gaps after the PHE ends. Please see the appendix for a summary of the Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) provisions for COVID-19 vaccine administration during and outside the PHE.

States are not required to cover vaccine administration for Medicaid eligibility groups with limited benefit packages either during or after the PHE. Examples of these eligibility groups whose coverage is limited by statute or a Section 1115 demonstration include individuals eligible for family planning or tuberculosis-related benefits only. Therefore, these groups are likely to have gaps in vaccine administration coverage. CMS does not interpret FFCRA to require coverage and states would not have authority to provide coverage without Section 1115 demonstration authority. States should contact CMS for assistance to add COVID-19 vaccine coverage to these limited benefit packages using Section 1115(a)(2) expenditure authority.¹¹

2. REVIEW MEDICAID VACCINE ADMINISTRATION REIMBURSEMENT

As the initial supply of COVID-19 vaccines will be federally purchased, Medicaid is not required to reimburse providers for the vaccine cost and no SPA submission is necessary to describe the COVID-19 vaccine *product* reimbursement. States may need to submit a SPA to newly add or amend current vaccine *administration* coverage and reimbursement. States should review their vaccine administration reimbursement rates and payment policies for use of a uniform billing standard, sufficiency of rates, and documentation in the Medicaid state plan, fee schedules, and provider materials.¹²

States may wish to consider setting higher provider payment rates for the COVID-19 vaccine administration to encourage access to the vaccine, especially in facility settings.

As a benchmark, Medicare payment rates for COVID-19 vaccine administration have been established at \$28.39 for a single dose vaccine. For vaccines requiring two doses, Medicare reimbursement has been established at \$16.94 for the initial dose and \$28.39 for the final dose.¹³

⁷ Ibid., p. 8.

⁸ CMS (March 12, 2020). FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19). Retrieved January 7, 2021, from <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/EHB-Benchmark-Coverage-of-COVID-19.pdf>.

⁹ CMS (August 8, 2019). New State Flexibilities and Requirements Regarding Alternative Benefit Plans (ABP) and Essential Health Benefits (EHB). Retrieved January 7, 2021, from <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib080819-1.pdf>.

¹⁰ Granada, C.J. et al. (April 27, 2020). State Policies on Access to Vaccination Services for Low-Income Adults, p. 2. JAMA. Retrieved January 7, 2021, from <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764810>.

¹¹ CMS, Coverage and Reimbursement of COVID-19 Vaccines, op cit.

¹² Ibid., p. 12.

¹³ Ibid., p. 7.

To the extent that the proposed COVID-19 vaccine administration payment is different from the existing vaccine administration reimbursement methodology already approved under the state plan, states will need to submit SPAs for approval—either through the Disaster Relief Medicaid SPA template or the non-disaster relief SPA submission.¹⁴

- SPAs are only necessary if the state changes the existing payment methodology for vaccine administration.
 - Adding a new billing code for the COVID-19 vaccine would not necessitate a SPA as long as the approved vaccine administration rate did not change.
- The Disaster Relief Medicaid SPAs cannot extend beyond the end date of the PHE; however, coverage and payment for COVID-19 vaccine administration must be provided through the end of the quarter in which the PHE is terminated (e.g., coverage must continue through September 30, 2021, if the PHE ended on July 31, 2021) to the extent a state claims the temporary FMAP increase in the quarter.
 - A state may need to have another SPA in place after its Disaster Relief Medicaid SPA expires or consider making changes through a non-disaster SPA if it wishes to claim the enhanced FMAP under the FFCRA for the remaining period of the quarter in which the PHE ends.¹⁵

3. DETERMINE MOST EFFECTIVE DELIVERY SYSTEM FOR VACCINE ADMINISTRATION BENEFIT COVERAGE

Regardless of the Medicaid delivery system (fee-for-service or managed care), coverage of COVID-19 vaccine administration without cost sharing is mandatory during the PHE for most Medicaid beneficiaries. States may choose to provide coverage through their existing managed care plan contracts and capitation rates or may carve out the COVID-19 vaccine benefit and administer it through their fee-for-service programs. Outside of the PHE period, states should examine the vaccine administration benefit covered under each delivery system and ensure that coverage is adequate to support access consistent with their policy goals.

States may wish to review their Medicaid delivery systems and the overlap with the populations first targeted to receive the COVID-19 vaccinations (i.e., nursing facility residents, healthcare personnel, workers in essential and critical industries, individuals at high risk for severe COVID-19 due to underlying medical conditions, and the elderly).¹⁶ Not all states use managed care

and, even in those that do, beneficiaries residing in long-term care facilities are often excluded. It is important to note that a significant portion of the long-term care population is dually eligible for Medicare and Medicaid and, in this case, Medicare covers the cost of the vaccine administration, with no beneficiary cost sharing.¹⁷

As states review the availability of the vaccine across their covered populations, it may be most effective for some states to utilize a single coordinated distribution plan across all Medicaid populations, regardless of delivery system enrollment. Other states may decide to leverage their managed care plans to distribute the vaccines to certain populations while using their state fee-for-service infrastructure for other coverage groups. States could require standard coverage rules across both managed care plans and fee-for-service to minimize variation in service delivery. Medicaid officials should consider the specific needs of this effort unique to their states and align responsibilities accordingly. Even if a state decides to administer the vaccine through its fee-for-service delivery system, it could require its managed care plans to provide education and outreach in coordination with the state's messaging. Examples include requiring plans to use state-written materials in their communication materials (website, on-hold messaging, member newsletters, etc.).

The delivery system strategy selected by states for the COVID-19 vaccine administration benefit may require a SPA submission to CMS or managed care contract amendment. Carving the vaccine administration benefit out of the managed care program and moving it to fee-for-service delivery could require a SPA. In addition to benefit and reimbursement changes, any new administrative performance requirements should also be documented in the managed care contract.

4. REVIEW BENEFICIARY ACCESS AND BARRIERS TO VACCINATION

While reviewing and potentially updating vaccine administration coverage and reimbursement policies for the COVID-19 vaccine, states should consider beneficiary barriers to vaccine access, including cost, transportation, and provider and vaccine availability. Vaccination cost sharing is prohibited during the PHE but may apply for certain beneficiary groups after the PHE period ends. States may need a SPA to remove or exempt certain populations from cost sharing. See appendix for details.

¹⁴ Ibid., p. 12.

¹⁵ Ibid., pp. 24-25.

¹⁶ CDC (December 30, 2020). How CDC Is Making COVID-19 Vaccine Recommendations. Retrieved January 7, 2021, from <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations-process.html#:~:text=Groups%20considered%20for%20early%20vaccination%20if%20supply%20is%20limited&text=supply%20is%20limited%3A-,Healthcare%20personnel,People%2065%20years%20and%20older>.

¹⁷ CMS. Medicare COVID-19 Vaccine Shot Payment. Retrieved January 7, 2021, from <https://www.cms.gov/medicare/covid-19/medicare-covid-19-vaccine-shot-payment>.

Medicaid officials may wish to assess the provider types that can administer vaccines in their state and determine whether sufficient capacity exists. During the PHE, states can request a Section 1135 waiver to forgo certain screening, enrollment, and agreement requirements to temporarily enroll providers.¹⁸ States also may wish to consider adoption of Medicare's use of "mass immunizers" to offer vaccines to large numbers of people in supermarkets, drugstores, or senior centers.¹⁹

States may also consider reviewing the nonemergency medical transportation (NEMT) benefit to assess its potential impact on vaccine utilization. Some options to minimize access issues related to transportation include removing regulatory barriers to allow ride-share options to provide NEMT, expanding NEMT benefits to more beneficiary populations, and expanding the locations for which NEMT is eligible to include nontraditional vaccination administration sites. NEMT benefit changes may necessitate SPA submission. Delivery system coordination and cost are also important considerations for NEMT services, to the extent that they are covered either under a delivery system or a managed care arrangement that is separate from the medical benefit.

5. MANAGED CARE FINANCING CONSIDERATIONS AND VALUE-BASED APPROACHES

Across managed care delivery systems, states have multiple approaches available for vaccine administration payment.

- To the extent managed care plans are contractually responsible for vaccine coverage, states may specify the vaccine reimbursement rates through state-directed payments in the managed care plan contract or permit the managed care plan to determine the reimbursement rate.
 - Covering the COVID-19 vaccine administration costs through the managed care capitation rates may require the state to include a rate adjustment in order for the rates to remain actuarially sound in accordance with federal standards (as the COVID-19 pandemic has had direct and indirect impact on healthcare utilization and Medicaid enrollment levels, the cost of administering the COVID-19 vaccine must be considered with other factors influencing overall costs in a managed care program).
- Alternatively, states could pay for the COVID-19 vaccine administration outside of the capitation rate as a non-risk payment arrangement, with the managed care plans acting as third-party administrators.

States could also consider value-based strategies to incentivize COVID-19 vaccine utilization, reflecting historically low vaccination rates in adults cited earlier in this brief. High vaccination rates not only have the opportunity to reduce future COVID-19-related healthcare costs across payers, but may also contribute to a faster return to normal societal activity that could result in increased state and local tax revenue (relative to social distancing, business restrictions, and other pandemic-related practices being prolonged).²⁰ Therefore, reimbursement for the administration of COVID-19 vaccines may be considered a prime candidate for value-based payment arrangements, as a mechanism for driving vaccine penetration. The following value-based approaches to COVID-19 vaccine coverage may be feasible for risk-based managed care programs.

Quality withhold

One approach may be for states to implement a quality withhold tied to the delivery of the service. As an example, the capitation rate could include funding for a specified percentage of the eligible population to receive the vaccine and set the withhold amount equal to that amount. The withhold could be structured so that managed care plans earn the portion of the withhold back based on the proportion of their membership that obtains the vaccine (e.g., if funding was included for 80% of the eligible population to receive the vaccination, and 40% of the eligible population receives a vaccination, then 50% of the withhold is returned to the managed care plans). Alternatively, 100% of the withhold could be returned if the managed care organization achieves a vaccination rate above a goal specified by the state.

Bonus payment

Another option is to include a bonus payment for managed care plans to incentivize vaccination take-up. Many of the considerations noted above for a withhold could apply similarly to a bonus payment arrangement; however, the bonus payments have to be paid in addition to the certified capitation rates. This type of arrangement may provide additional funding and incentives for health plans to promote vaccine utilization, and the incentive payment is excluded from the premium revenue used for the medical loss ratio (MLR) calculation.²¹ One limitation of this approach is that the total amount paid for incentive arrangements is capped at 105% of the approved capitation rates, as specified in 42 CFR 438.6(b)(2). Depending on other incentives a state currently has in place with its managed care plans, this may not be possible to pursue and meet the incentive cap.

¹⁸ CMS, Coverage and Reimbursement of COVID-19 Vaccines, op cit., p. 39.

¹⁹ CMS. COVID-19. Retrieved January 7, 2021, from <https://www.cms.gov/covidvax-provider>.

²⁰ Miller, C.C. et al. (December 23, 2020). What you can do post-vaccine, and when. New York Times. Retrieved January 7, 2021, from <https://www.nytimes.com/2020/12/21/upshot/after-vaccine-recommendations-experts.html>.

²¹ Brostowitz, J., Jones, S., & McCulla, I. (June 2016). Medical Loss Ratio (MLR) in the "Mega Reg." Milliman Research Report. Retrieved January 7, 2021, from <https://us.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2016/medical-loss-ratio-in-mega-reg.ashx>.

Kick payment

The state and its actuaries may develop a separate “kick” payment that is paid to a health plan for vaccines administered to its members on a case rate basis. This type of payment is often used to fund maternity delivery services but could be used to fund COVID-19 vaccine administration as well. The payment could be developed and paid for each dose of the vaccine that is administered, or the state may consider developing the kick payment as a bundled rate that is paid when each beneficiary completes the course of required doses for each COVID-19 vaccine. This method would require the development of a new rate cell, which may be challenging to implement for some state capitation payment systems, especially on a timely basis. Additionally, to the extent that a single-dose vaccine receives U.S. Food and Drug Administration (FDA) approval, a mix of two-dose and single-dose COVID-19 vaccines may be available, which may create variance in vaccine administrative fees among Medicaid beneficiaries and could complicate the development and implementation of a kick payment.

6. COORDINATE EDUCATION AND OUTREACH EFFORTS ACROSS ALL STAKEHOLDERS

States should consider coordinating their outreach and education to Medicaid beneficiaries with other local, state, and federal public health campaign efforts. Developing and sharing materials can ensure consistent messaging and reach to larger audiences. Coordination with local clinics, schools, community centers, faith groups, community-based groups, and tribal organizations is another strategy for states to consider to maximize appropriate messaging.²² States should also consider dedicating outreach efforts to marginalized populations who experience higher rates of infection and adverse outcomes while also having historically lower rates of adult vaccination. In conjunction with education and outreach efforts, states and managed care organizations, as applicable, could consider funding member incentives to achieve goals for vaccination utilization rates. The CMS COVID-19 tool kit provides additional links to vaccination playbooks, flu campaigns, and social media resources for states to reference while developing their education and outreach plans.

²² CMS, Coverage and Reimbursement of COVID-19 Vaccines, op cit., p. 41.

Summary

The advent of a vaccine for COVID-19 represents an important development in the response to this pandemic. State Medicaid agencies should review their state plans for vaccine administration coverage, reimbursement, and delivery to determine what changes may be necessary to support their policy goals related to distribution of the COVID-19 vaccine for Medicaid recipients, both during and after the PHE period. Identifying and removing access barriers is an important aspect of the review as many changes may require SPA approval. Financing options in managed care delivery exist but may not reach all intended populations. Finally, coordinating education and outreach efforts and partnering with community groups is critical for consistent, accurate messaging to reach and vaccinate large numbers of the population.

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Appendix

FIGURE 1: SUMMARY OF MEDICAID, CHIP, AND BHP PROVISIONS FOR COVID-19 VACCINE ADMINISTRATION²³

Coverage Group	Coverage During PHE	Coverage Outside PHE	SPA Required for Coverage?	SPA Required for Cost Sharing?	SPA Required for Reimbursement?
Adults Covered Under Traditional Medicaid	Mandatory coverage; no cost sharing	Coverage mandatory with no cost sharing in states receiving extra 1% FMAP for preventive services. Coverage optional for other states; cost sharing permitted unless eligibility group exempt.	No, if state opts to cover vaccine administration under mandatory benefits or optional clinic benefit. Yes, if state opts to cover vaccine under optional benefits not otherwise covering vaccination.	Yes, SPA may be required to implement cost sharing; states should contact CMS.	Yes, SPA required if proposed payment for COVID-19 vaccination administration is different from what is otherwise approved in state plan.
Beneficiaries Enrolled in Alternative Benefit Packages (ABPs), ACA Expansion, Other Eligibility Groups	Mandatory coverage; no cost sharing	Mandatory coverage; no cost sharing. Vaccination coverage is an essential health benefit (EHB). All ABPs must include without cost sharing.	No.	N/A; cost sharing not permitted.	Yes, SPA required if proposed payment for COVID-19 vaccination administration is different from what is otherwise approved in state plan.
Children Covered Under Medicaid	Mandatory coverage; no cost sharing	Mandatory coverage. Vaccination coverage is a mandatory Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for Medicaid-enrolled children under age 21. Cost sharing is permitted for those aged 19 and 20 who are not enrolled in an ABP.	No. State may wish to submit SPA to detail coverage provisions.	SPA required if state opts to exempt those aged 19 and 20 who are not enrolled in ABPs from vaccine coverage cost sharing.	Yes, SPA required if state adds or amends a payment methodology or administration fee rate. Pfizer-BioNTech Vaccine for those aged 16 to 18 will be distributed outside Vaccines for Children (VFC) program; VFC regional maximum administration fees do not apply.
Adults Receiving Limited Benefit Packages	Coverage not required through FFCRA section 6008(b)(4)	Coverage authority generally lacked; state must obtain Section 1115 demonstration authority to add COVID-19 vaccines to limited benefit packages. The COVID-19 Claims Reimbursement Program of the Health Resources and Services Administration (HRSA) is available for beneficiaries without coverage.	N/A	N/A	N/A
Separate CHIP	FFCRA section 6008(b)(4) does not apply to separate CHIPs. Coverage requirements are the same during and outside the PHE. Coverage is mandatory for children enrolled in a separate CHIP, with no cost sharing, under 42 CFR 457.410(b)(2) and 457.520(b)(4). Coverage is not required for pregnant women under a separate CHIP; however, all states that cover pregnant women through a separate CHIP currently cover vaccines without cost sharing.			Cost sharing not permitted for children; no federal rules related to cost sharing for vaccines provided to pregnant women enrolled in CHIP.	No. Separate CHIP programs determine the rate and manner of vaccine administration reimbursement fees. States determine the vaccine administration rates paid to providers.
Basic Health Program (BHPs)	FFCRA section 6008(b)(4) does not apply to BHPs. Coverage requirements are largely the same during and outside the PHE. Vaccination coverage is an EHB all BHPs must include without cost sharing. During the PHE, BHP must provide out-of-network COVID-19 vaccine coverage. After the PHE, BHPs will no longer be required to cover vaccines provided by out of network providers.			N/A; cost sharing not permitted.	No state action required. No federal BHP guidelines regarding vaccine administration; states determine vaccine administration rates to providers.

²³ Ibid., pp. 20-21.