DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard Mailstop S2-26-12
Baltimore, Maryland 21244-1850

SHO# 21-003

RE: Medicaid and CHIP Coverage and Reimbursement of COVID-19 Testing under the American Rescue Plan Act of 2021 and Medicaid Coverage of Habilitation Services

August 30, 2021

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 reimbursement of COVID-19 testing under the American Rescue Plan Act of 2021 (ARP) (Pub. L. No. 117-2). Additionally, CMS is issuing this guidance to clarify that, only during the COVID-19 public health emergency (PHE), states may cover habilitation services provided to children under section 1915(c) and section 1915(i) of the Social Security Act (the Act) to facilitate the delivery of remote learning if the habilitation services are not available through the local educational agency, and the individuals are enrolled in a section 1915(c) waiver and/or 1915(i) program.

CMS will apply the interpretations of statute in this guidance on a prospective basis beginning with the date of issuance of this letter.

Mandatory COVID-19 Testing Coverage under the American Rescue Plan Act of 2021

Overview

CMS interprets the ARP to require state Medicaid and CHIP programs to cover a broad array of COVID-19 testing, including all types of U.S. Food & Drug Administration (FDA)-authorized COVID-19 tests, without cost-sharing obligations, for a period of time that begins March 11, 2021, and generally extends beyond the end of the COVID-19 PHE. In meeting these ARP requirements, states must continue to apply normal third-party liability rules and may continue to apply utilization management techniques, as further described later in this letter.[1]

ARP Sections 9811 and 9821

The ARP was enacted on March 11, 2021 and included COVID-19 testing coverage mandates specific to Medicaid and CHIP. Section 9811(a) of the ARP added a new mandatory Medicaid

[1] Use of the term "state" in this letter includes the territories, as applicable.

benefit at section 1905(a)(4)(F) of the Act. Section 9821 of the ARP added the same mandatory benefit for all CHIP enrollees at section 2103(c)(11)(B) of the Act. Sections 1905(a)(4)(F) and 2103(c)(11)(B) of the Act require states to cover testing for COVID-19 for the period beginning on 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. In addition, section 9811(a)(2)(E) of the ARP amended the statutory language following section 1902(a)(10)(G) of the Act to require coverage of additional testing for COVID-19 for individuals eligible for the optional Medicaid eligibility group described at section 1902(a)(10)(A)(ii)(XXIII) of the Act (the group CMS previously referred to as the "optional COVID-19 testing group").[2]

ARP sections 9811 and 9821 also amended sections 1916, 1916A, and 2103(e)(2) of the Act to specify that states cannot impose cost-sharing with respect to the COVID-19 testing coverage required under the ARP and described in sections 1905(a)(4)(F) and 2103(c)(11)(B). ARP section 9811(a)(5) also amended section 1937(b) of the Act to require states to include the same COVID-19 testing coverage in Medicaid alternative benefit plans, without any deduction, cost-sharing, or similar charge.

CMS interprets the amendments made by sections 9811 and 9821 of the ARP to require states to cover both diagnostic and screening tests for COVID-19 (which includes their administration), consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19. CMS is aligning its interpretation of these ARP amendments with applicable CDC recommendations because the CDC recommendations provide a national reference point for who should be tested during the COVID-19 pandemic and evolve as science evolves.[3] CMS interprets these amendments to require states to cover, without cost sharing, all diagnostic and screening testing that would be consistent with the CDC recommendations. This includes, for example, coverage of screening testing to return to school or work or to meet travel requirements. CMS is available for technical assistance as states design their testing coverage policy and as the COVID-19 pandemic evolves.

An individualized test result must be obtained for both diagnostic and screening testing covered under the amendments made by sections 9811 and 9821 of the ARP to support a Medicaid or CHIP claim. Additionally, all types of FDA-authorized COVID-19 tests must be covered under CMS's interpretation of the ARP COVID-19 testing coverage requirements, including, for example, "point of care" or "home" tests that have been provided to a Medicaid or CHIP beneficiary by a qualified Medicaid or CHIP provider of COVID-19 tests. Home tests include those where a specimen is collected at home and then sent to a clinical laboratory or other certified testing site for testing, and those that are entirely performed at home, meaning the test system includes the ability to perform the test without involvement of a laboratory. States have

[2] Under section 1902(a)(10)(A)(ii)(XXIII) of the Act and the statutory language following section 1902(a)(10)(G) of the Act, states can provide coverage to the optional COVID-19 group (previously referred to as the optional COVID-19 testing group) 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 testing, after the PHE ends.

[3] See, e.g., https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/sars-cov2-testing-strategies.html.

discretion to condition coverage of a home test on a prescription as part of their utilization management (some FDA-authorized home tests require a prescription). As states establish utilization management techniques, including possible prescription conditions, they are encouraged to do so in ways that do not establish arbitrary barriers to accessing COVID-19 testing coverage, but that do facilitate linking the reimbursement of a covered test to an eligible Medicaid or CHIP beneficiary.

Finally, states may apply medical necessity criteria and other amount, duration, and scope parameters to COVID-19 testing covered under section 1905(a)(4)(F) of the Act and the other amendments made by section 9811 of the ARP, as they may do for all Medicaid services, as a utilization management control, provided that the benefit is sufficient to reasonably achieve its purpose (consistent with 42 CFR § 440.230(b)). States may also apply utilization controls to the COVID-19 testing covered in CHIP under section 2103(c)(11)(B), consistent with 42 CFR § 457.490.

Screening Testing in Schools

Schools can be Medicaid providers of COVID-19 screening testing covered under section 1905(a)(4)(F) and the other amendments made by section 9811 of the ARP. The vast majority of schools that render school-based services covered by Medicaid are reimbursed via a methodology associated with a Certified Public Expenditure (CPE) that requires reconciliation to actual cost via a uniform cost report. If the school obtains and administers a COVID-19 test and the state plan payment methodology is reconciled to cost, the cost of the test could be recorded on a cost report as a medical supply, and any accompanying cost of administering the test, such as the salary of the administering nurse, etc., would also be recorded in the cost report.

Section 1902(a)(30)(A) of the Act requires states to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the [Medicaid state] plan at least to the extent that such care and services are available to the general population in the geographic area." If the state plan payment methodology is a rate for school-based services, the cost of the test and any cost associated with administering the test should be factored into the rate. If the school contracts with an outside entity to administer the test, the school, not the outside entity, would be considered the billing provider of the test under Medicaid. If the state plan payment methodology is reconciled to cost, the contractual rate negotiated between the school and the outside entity would be recorded as contracted services in the provider's uniform cost report. If the state plan payment methodology is a rate, the above-contracted cost should be factored into the rate.

While there is no prohibition on Medicaid qualified providers billing for Medicaid covered services and items provided to Medicaid beneficiaries that may be provided free of charge to the general public, there may be sources of federal funding that are also available to cover the cost of testing in schools, which could potentially duplicate Medicaid payments. To avoid such duplication, states should ensure that Medicaid payments are appropriately considered along with other available sources of federal funds or revenue that may be used to fund testing in schools.

All third-party payer provisions continue to apply, and we remind states of the existence of additional funding streams for COVID-19 testing reimbursement not typically available.[4]

As indicated above, states may implement utilization management techniques in the coverage of screening testing in schools.

State Plan Amendments

States will need to submit Medicaid state plan amendments (SPAs) to add testing coverage and reimbursement as required under the ARP, including under the new mandatory benefit at section 1905(a)(4)(F) of the Act. CMS will provide additional information on submission of Medicaid SPAs to reflect ARP changes. CMS is available for technical assistance on SPA development.

States will also need to submit CHIP SPAs pursuant to CMS requirements at 42 CFR § 457.60(a). States will need to indicate that they are providing testing coverage without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act. CMS will provide additional information on submission of CHIP SPAs to reflect ARP changes.

Medicaid Coverage of Individuals with Disabilities Education Act (IDEA) Services during Remote Learning

As discussed in State Health Official (SHO) letter 21-001, under the Individuals with Disabilities Education Act (IDEA), children with disabilities are eligible to receive educational and related services that will help them achieve their educational goals, as documented in the child's individualized education program (IEP) or, for infants and toddlers (children under age three), the individualized family service plan (IFSP). These educational services can help children with disabilities achieve their educational goals. Medicaid reimbursement is available for covered services that are included in the child's IEP and IFSP provided to eligible beneficiaries by qualified Medicaid providers.[5] States also have the option to cover Medicaid services furnished to eligible Medicaid beneficiaries in the school setting if the children are determined to need those services, the services are furnished by qualified Medicaid providers, and the services meet all of the requirements set forth in the State Medicaid Director Letter 14-006.[6] Typically, however, under section 1915(c) and section 1915(i) of the Act, states must not cover habilitation

[4] Third party liability provisions are found in section 1902(a)(25) of the Act and 42 CFR Part 433, Subpart D.

[5] There are a few exceptions to the general rule that Medicaid is the payer of last resort and these exceptions generally relate to federally administered health programs. For a federally administered program to be an exception to the Medicaid payer of last resort rule, the statute creating the program must expressly state that the other program pays only for claims not covered by Medicaid; or, is allowed, but not required, to pay for health care items or services. As indicated by section 1903(c) of the Act, Parts B and C of the Individuals with Disabilities Education Act (IDEA) is one example of this exception to the payer of last resort rule.

[6] State Medicaid Director Letter 14-006, Medicaid Payment for Services Provided without Charge (Free Care), issued December 15, 2014, https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

services[7] in the school setting if the services are otherwise available to the individual through a local educational agency.

CMS is clarifying that, in light of the unique circumstances presented by the COVID-19 PHE where students are relying on remote learning in whole or in part, states may cover habilitation services provided to children under section 1915(c) and section 1915(i) to facilitate the delivery of remote learning if the habilitation services are not available through the local educational agency, and the individuals are enrolled in a section 1915(c) waiver and/or 1915(i) program. For example, schools may be unable to deploy personnel to meet the needs of each individual child participating in remote education. CMS recognizes the significant advances in vaccination rates across the country, including for school-aged children eligible to be vaccinated. As schools return to in-person learning, CMS expects habilitation services will be available through local educational agencies and no longer eligible for coverage under Medicaid.

However, *to the extent necessary given local conditions*, states may choose to avail themselves of this flexibility where services are, in fact, not available through the local educational agency. Local educational agencies must prioritize use of funding available in the ARP, prior to indicating an inability to provide covered habilitation services. This flexibility is available prospectively from the issuance of this guidance. If applicable, states will need to submit an Appendix K application, disaster-related SPA, or 1115 application to implement this flexibility.

CMS notes that states must also continue to provide medically necessary services authorized under section 1905(a), in accordance with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) responsibilities.

Conclusion

This guidance describes Medicaid and CHIP coverage and reimbursement of COVID-19 testing under the ARP, and habilitation services during the COVID-19 PHE. As previously stated, CMS will apply the interpretations of statute in this guidance for both COVID-19 testing and habilitation services on a prospective basis beginning with the date of issuance of this letter. Please contact Kirsten Jensen at Kirsten.Jensen@cms.hhs.gov for additional information on COVID-19 testing and Ralph Lollar at Ralph.Lollar@cms.hhs.gov for additional information on habilitation services.

Sincerely,

[redacted]

Daniel Tsai
Deputy Administrator and Director

[7] Defined at section 1915(c)(5) as "services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings."