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State/Territory Name: **Maryland**

State Plan Amendment (SPA) #: **20-0014**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

March 7, 2022

Ms. Tricia Roddy
Maryland Department of Health
201 W. Preston St., 5th Floor
Baltimore, MD 21201

Re: Maryland State Plan Amendment (SPA) 20-0014

Dear Ms. Roddy:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 20-0014. This amendment proposes to amend the Maryland State Plan to include coverage for the administration of COVID-19 vaccinations.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations section 9811 of the American Rescue Plan (ARP) established a new mandatory benefit at section 1905(a)(4)(E) of the Social Security Act (Act) for COVID-19 vaccines and their administration. This letter is to inform you that Maryland Medicaid SPA 20-0014 was approved on March 4, 2022, with an effective date of December 18, 2020.

If you have any questions, please contact Talbatha Myatt at 215-861-4259 or via email at Talbatha.Myatt@cms.hhs.gov

Sincerely,

[redacted]

cc: Alison Donley, Medicaid Provider Services Administration
Nina McHugh, Medicaid Provider Services Administration
Adriana Allen, Medicaid Provider Services Administration

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 20 — 0014

2. STATE: MD

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: December 18, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
~~N/A~~ Title XIX-1905(a)(4)(E)

7. FEDERAL BUDGET IMPACT
a. FFY 2021 $ $41,476
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Att. 3.1A pg. 29-C-9 (20-0014)
~~Att. 4.19B pg. 2 (20-0014)~~
Att. 4.19B pg. 5, 7, 8, 10, 13, 25, and 33C-E (20-00014)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Att. 3.1A pg. 29-C-9 (12-02)
~~Att. 4.19B pg. 2 (13-07)~~
Att. 4.19B pg. 5, 7, 8, 10, 13, 25, and 33C-E (17-0006)

10. SUBJECT OF AMENDMENT
The purpose of this amendment is to amend the State Plan to include coverage for the administration of COVID-19 vaccinations. Vaccinations may be administered by providers for whom vaccine administration is within their scope of practice.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Tricia Roddy

14. TITLE
Assistant Medicaid Director

15. DATE SUBMITTED
12/22/2020

16. RETURN TO
Dennis Schrader
Acting Secretary
Maryland Department of Health
201 W. Preston St., 5th Floor
Baltimore, MD 21201

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
12/22/2022

18. DATE APPROVED
03/04/2022

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
12/18/2022

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
James G. Scott

22. TITLE
Director, Division of Program Operations

23. REMARKS

2-25-22: Per 2/17/2022 email state requested a pen and ink change to the Form 179 to include the following additional pages submitted for this SPA: Att. 4.19B pg. 5, 7, 8, 10, 13, 25, and 33C-E.

2-28-22: Per email state agreed to pen & ink change to update Box 6 to reflect Title XIX-1905(a)(4)(E).

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

F. Administration of COVID-19 Vaccinations

Covered Services:

1. The covered service is the administration of vaccination for COVID-19.

Provider Qualifications:

1. In order to receive reimbursement for the administration of vaccination for COVID-19, the provider listed in paragraph (2) must be actively enrolled with the Maryland Medical Assistance Program in good standing or provide services under the direction of an actively enrolled Maryland Medical Assistance Program provider in good standing.

2. Service delivery is limited to:
    a. Pharmacy interns and pharmacy technicians are able to function within their scope of practice when registered with the Maryland Board of Pharmacy. Pharmacy interns and pharmacy technicians must be registered with the Maryland Board of Pharmacy and working under the supervision of a licensed pharmacist. Pharmacies are qualified providers of COVID-19 vaccinations per the HHS COVID-19 PREP Act Declaration and authorizations;

    b. Paramedics legally authorized by the State of Maryland Institute for Emergency Medical Services Systems based on the following criteria: Neonatal Resuscitation Program (NRP) certification; successful completion of a Maryland ALS licensing protocol exam; and affiliation with an ALS EMS practicing or delivering services under the direction of:
        i. an EMS Service Transporter,
        ii. a qualified physician,
        iii. a local health department under the direction of the health officer who is a physician or the health officer's deputy who is a physician, or
        iv. a hospital or health system in Maryland under the direction of a physician, nurse practitioner, or physician assistant;

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Physician and Osteopath Rates

5.a All providers described in 5.b, both government and non-government, are reimbursed pursuant to the same fee schedule. Providers are paid by CPT codes which are based on a percentage of Medicare reimbursement. For dates of service between January 1, 2013 and December 30, 2014, provider rates for covered Evaluation and Management (E&M) procedure codes within the range of 99201-99499 were set at 100 percent using rates from the March 2013 Deloitte release, an agency contracted by CMS to determine the rates.

5.b The Department's original reimbursement methodology for professional services rendered by a physician or osteopath was set July 1st, 2015 and is effective for services rendered on or after that date. All providers must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. Providers will be paid the lower of either the provider's customary fee schedule to the general public or the published Medicaid fee schedule. The average Maryland Medicaid payment rate is approximately 79.5 percent of 2017 Medicare fees. In addition, the State will pay the federally calculated VFC administration charge, except as provided in 5.c. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

5.c Effective for dates of services on or after December 18, 2020, payments for the administration of COVID-19 vaccinations, based on the national Medicare rates without geographic adjustment in effect when the service is provided, are equivalent to the Medicare rate for any single dose vaccine; and equivalent to the Medicare rate for any vaccine requiring two or more doses.

5.dProfessional services rendered by physicians to a trauma patient on the State Trauma Registry, who is receiving emergency room or inpatient services in a state designated trauma center, reimbursement will be 100 percent of the Baltimore City and surrounding area Title XVIII Medicare physician fee schedule facility fee rate. All providers must be licensed in the jurisdiction in which they provide services and must be providing services within a state designated trauma center. Services are limited to those outlined in 3.1A of the Maryland State Plan. The provider will be paid the lower of either the provider's customary fee schedule to the general public or the fee methodology described above.

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Advanced Practice Nursing Reimbursement

6.a. Both government and non-government practitioners are reimbursed pursuant to the same fee schedule. All practitioners are paid by CPT codes which are based on a percentage of Medicare reimbursement.

6.b. The Agency's rates for professional services rendered by nurse practitioners, nurse midwives, and nurse anesthetists were set as of 7/1/2017 and are effective for services on or after that date. All practitioners must be licensed in the jurisdiction in which they provide services. Services are limited to those allowed under their scope of practice in Maryland. The practitioner will be paid the lower of the provider's customary fee schedule to the general public or the published fee schedule, except as provided in 6.c. The average Maryland Medicaid payment rate is approximately 88 percent of Medicare 2015 fees. All rates are published on the Department's link below:

https://health.maryland.gov/providerinfo

6.c. Effective for dates of services on or after December 18, 2020, payments for the administration of COVID-19 vaccinations, based on the national Medicare rates without geographic adjustment in effect when the service is provided, are equivalent to the Medicare rate for any single dose vaccine; and equivalent to the Medicare rate for any vaccine requiring two or more doses.

6.d. Payment limitations:

- The Department will not pay for practitioner administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included with the office visit.
- The Department will not pay a provider for those laboratory or x-ray services performed by another facility, but will instead pay the facility performing the procedures directly.
- In addition, for nurse anesthetists preoperative evaluations for anesthesia are included in the fee for administration of anesthesia and the nurse anesthetist may not bill them as consultants.
- The provider may not bill the Program for:
    - Completion of forms and reports;
    - Broken or missed appointments;
    - Professional services rendered by mail or telephone; or
    - Providing a copy of the recipient's medical record when requested by another licensed provider on behalf of recipient.

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Physician Assistant Rates

8.a The Department's original reimbursement methodology for professional services rendered by physician assistants was developed as of July 1, 2015 and is effective for services rendered on or after that date. All physician assistants must be licensed in the jurisdiction in which they provide services. Services are limited to those allowed under their scope of practice in Maryland. The physician assistant will be paid the lower of either the provider's customary fee schedule to the general public or the published Medicaid fee schedule.

8.b Both government and non-government physician assistants are reimbursed pursuant to the same fee schedule. All physician assistants are paid using CPT codes which are based on a percentage of Medicare reimbursement. The average Maryland Medicaid payment rate is approximately 79.5 percent of 2017 Medicare fees. In addition, the state will pay the federally calculated VFC administration charge, except as provided in 8.c. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

8c. Effective for dates of services on or after December 18, 2020, payments for the administration of COVID-19 vaccinations, based on the national Medicare rates without geographic adjustment in effect when the service is provided, are equivalent to the Medicare rate for any single dose vaccine; and equivalent to the Medicare rate for any vaccine requiring two or more doses.

8.d Payment limitations:

- The Department will not pay for physician assistant administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included with the office visit.
- The Department will not pay a provider for those laboratory or x-ray services performed by another facility, but will instead pay the facility performing the procedure directly. x
- The provider may not bill the Program or the recipient for:
    - Completion of forms and reports;
    - Broken or missed appointments;
    - Professional services rendered by mail or telephone; and
    - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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Podiatrist Rates

8.a All podiatrists, both government and non-government are reimbursed pursuant to the same fee schedule. Podiatrists are paid by CPT codes which are based on a percentage of Medicare reimbursement. For dates of service between January 1, 2013 and December 30, 2014, provider rates for covered Evaluation and Management (E&M) procedure codes within the range of 99201-99499 were set at 100 percent using rates from the March 2013 Deloitte release, an agency contracted by CMS to determine the rates.

8.b The Department's reimbursement methodology for professional services rendered by a podiatrist was developed as of July 1, 2015 and is effective for services rendered on and after that date. All podiatrists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. The podiatrist will be paid the lower of either the podiatrist's customary fee schedule to the general public or the published fee schedule, except as described in 8.c. The average Maryland Medicaid payment rate is approximately 79.5 percent of Medicare 2017 fees. The current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

8.c Effective for dates of services on or after December 18, 2020, payments for the administration of COVID-19 vaccinations, based on the national Medicare rates without geographic adjustment in effect when the service is provided, are equivalent to the Medicare rate for any single dose vaccine; and equivalent to the Medicare rate for any vaccine requiring two or more doses.

8.d Payment limitations:

- Preoperative evaluations for anesthesia are included in the fee for administration of anesthesia and the provider may not bill them as consultations.
- Referrals from one podiatrist to another for treatment of specific patient problems may not be billed as consultations.
- The operating podiatrist may not bill for the administration of anesthesia or for an assistant podiatrist who is not in his employ.
- Payment for consultations provided in a multi-specialty setting is limited by criteria established by the Department.
- The Department will not pay a podiatrist for those laboratory or x-ray services performed by another facility, but will instead pay the facility performing the procedure directly.
- The Department will not pay for provider-administered drugs obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included with the office visit. x The Department will not pay for services which do not involve direct, face-to- face, patient contact.
- The provider may not bill the Program or the recipient for:
    - Completion of forms and reports;
    - Broken or missed appointments;
    - Professional services rendered by mail or telephone;
    - Services which are provided at no charge to the general public; and
    - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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10. Dentist Rates

10.a The Department's reimbursement methodology for professional services rendered by a dentist and outlined per Attachment 3.1, page 23, was set as of January 1st, 2015 and is effective for services on or after that date. All dentists must be licensed in the jurisdiction in which they provide services. Services are limited to those outlined in 3.1A of the Maryland State Plan. The dentist will be paid the lower of the dentist's customary fee schedule to the general public unless it is free to individuals not covered by Medicaid or the published fee schedule, except as described in 10.c.

10.b. All dentists, both government and non-government, are reimbursed pursuant to the same fee schedule. Dentists are paid by CDT codes. Effective as of January 1st, 2015, the current fee schedule is published on the Department's website at:

health.maryland.gov/providerinfo

10.c. Effective for dates of services on or after December 18, 2020, payments for the administration of COVID-19 vaccinations, based on the national Medicare rates without geographic adjustment in effect when the service is provided, are equivalent to the Medicare rate for any single dose vaccine; and equivalent to the Medicare rate for any vaccine requiring two or more doses.

10.d. Payment limitations:

- The Department will not pay for drugs administered by dentists that have been obtained from manufacturers which do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included with the office visit.
- The Department will not pay for services which do not involve direct, face-to-face, patient contact.
- The provider may not bill for the Program or the recipient for:
    - Completion of forms and reports;
    - Broken or missed appointments;
    - Professional services rendered by mail or telephone; and
    - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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Program/Service

Pharmacist Prescriber Rates

The Department's original reimbursement methodology for professional services rendered by pharmacist prescribers was developed as of January 1, 2019 and is effective for services rendered on or after that date. All pharmacist prescribers must be licensed in the jurisdiction in which they provide services. Services are limited to those allowed under their scope of practice in Maryland. The pharmacist prescribers will be paid at the lower of either the provider's customary fee schedule to the general public or the published Medicaid fee schedule, except for administration of COVID-19 vaccinations. Effective for dates of services on or after December 18, 2020, payments for the administration of COVID-19 vaccinations, based on the national Medicare rates without geographic adjustment in effect when the service is provided, are equivalent to the Medicare rate for any single dose vaccine; and equivalent to the Medicare rate for any vaccine requiring two or more doses.

1. Equivalent to the Medicare rate for any single dose vaccine; and

2. When two or more doses are required and administered through a pharmacy provider, each dose administration shall be paid for at a rate equivalent to the sum of the total Medicare reimbursement for all doses divided by the total doses needed. For example, if two doses are required, reimbursement would be set according to the following formula: Reimbursement Rate = (Medicare Dose 1 reimbursement rate + Medicare Dose 2 reimbursement rate)/2.

Both government and non-government pharmacist prescribers are reimbursed pursuant to the same fee schedule. All pharmacist prescribers are paid using CPT codes which are based on a percentage of Medicare reimbursement. The average Maryland Medicaid payment rate is approximately 79.5 percent of 2017 Medicare fees. The current fee schedule is published on the Department's website at:

Health.maryland.gov/providerinfo

Program limitations:

- The Department will not pay for pharmacist prescribers administered drugs obtained from manufacturers who do not participate in the federal Drug Rebate Program.
- The Department will not pay for disposable medical supplies usually included in the office visit.
- The provider may not bill the Program or the recipient for:
    - Completion of forms and reports;
    - Broken or missed appointments;
    - Professional services rendered by mail or telephone; and
    - Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of a recipient.

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2.c. FEDERALLY QUALIFIED HEALTH CENTER SERVICES

Federally qualified health center (FQHC), Rural Health Centers (RHCs), and other ambulatory services furnished by these facilities are cost-based and facility-specific, except as provided in subparagraph (4)(d). Subparagraphs (1) through (3) and (4)(a) through (c) conform to the provisions of the Benefits Improvement and Protection Act of 2000.

1) Effective for dates of service occurring January 1, 2001 and after, FQHCs/RHCs were reimbursed on a prospective payment system (PPS). The initial rate is equal to 100 per cent of their average reasonable costs of Medicaid covered services provided during the clinic's fiscal years 1999 and 2000. The base PPS is tied to the average current FQHC/RHC urban/rural rate in the year the rate was set and adjusted annually by the percentage increase in the Medicare Economic Index (MEI).

2) A change in scope of services is a change in the type, intensity, duration, and/or amount of services, not just the type of services delivered. The change in a cost of service in and of itself, is not considered a change in the scope of services. In the event that the provider elects to institute a scope of services change, the provider shall:

a) Notify the Department of its intent to institute the scope of services change no later than 30 days before it begins to deliver services under the scope of services change.

b) The FQHC/RHC shall notify the Department of the change of scope. The FQHC/RHC may request a rate revision based on the change of scope of services. The FQHC/RHC must submit a cost report and supporting documentation within 90 days after the end of the first one-year period immediately following the implementation of the scope of services change. The cost report should reflect the change in costs relating to the rate revision request due to the implementation of the change of scope of services.

3) Newly qualified FQHCs/RHCs established after January 1, 2001, will have their rates established in the following manner and subject to the Alternative Payment Methodology (APM):

a) Providers shall be divided into those located in urban areas and those located in rural areas. Baltimore City and the Maryland counties of Allegany, Anne Arundel, Baltimore, Carroll, Cecil, Charles, Harford, Howard, Montgomery, Prince George's, St. Mary's and Wicomico are urban areas. All other Maryland counties are rural areas. Providers located out-of-State shall be placed in the same reimbursement class as that of the nearest Maryland county.

b) For the first two fiscal years of operation, an interim all-inclusive cost-per-visit rate shall be established for primary care and for dental care services, if applicable, for each provider, by averaging the current FQHC all-inclusive cost-per-visit rate amounts for each area, urban or rural.

c) The Department or its designee shall request from the FQHC/RHC, cost reports for the first 2 fiscal years of operation.

d) The Department or its designee shall calculate a final rate that is an average of the first two fiscal years of operation. The final rate is equal to 100% of their average reasonable costs.

e) The Department will reconcile the interim rate to the final rate for the FQHC/RHC.

f) The final all-inclusive cost-per-visit rate shall be implemented retroactively to the start date of the FQHC's operation.

4) Alternative Payment Methodologies. All FQHCs must agree to receive the APM.

a) As of January 1, 2005, the Department implemented an APM for a primary care and dental rate. As of January 1, 2010 all existing FQHCs/RHCs elected to be reimbursed with the APM.

(i) The payment rate under the APM for covered FQHC/RHC services furnished to Medicaid beneficiaries is equal to 100 per cent of their average reasonable costs.
(ii) Reimbursement shall occur on a per-visit basis with one rate for primary care and another for dental. The primary care rate equals primary care costs divided by primary care visits. The dental rate equals dental care costs divided by dental care visits. For both services, providers will be grouped as urban or rural centers.
(iii) Allowable costs will be determined in accordance with Medicare principles of reasonable cost reimbursement as contained in 2 CFR 200.
(iv) Allowable costs relating to covered Maryland Medical Assistance services are included in the federally qualified health center's reimbursement methodology and will continue to be used in the calculation of the baseline APM rate.
(v) The rates are adjusted annually to reflect the increase or decrease in the Medicare Economic Index (MEI).
(vi) Rates paid under this cost-based reimbursement methodology must be at least equal to the payment under the payment methodology included in subparagraph (1).
(vii) The all-inclusive cost-per-visit rate for primary care visits covers the allowable costs associated with covered primary care, mental health, and substance abuse services. FQHCs may not charge the program, other than an all-inclusive cost-per-visit rate, for any ambulatory service. Primary care services costs are composed of those costs, including supplies, associated with health care staff, including laboratory technicians, who provide direct care to patients;
(viii) The all-inclusive cost-per-visit rate for dental care visits covers only those services that are reimbursed by the Program. Other dental services are not reimbursable. Dental services costs are the costs of supplies and health care staff associated with the provision of dental services to patients; and

b) Under the APM, the FQHCs/RHCs are paid their full per-visit rate by the Managed Care Organization (MCO) when the service is rendered. The MCO shall receive an interim supplemental payment once every 3 months (quarterly). Each FQHC must agree to receive full payment through the MCO under this APM.

c) Effective with dates of service December 18, 2020, the Department will pay only FQHCs and RHCs that agree to accept this APM and agree that the Medicaid rate covers their increased costs associated with COVID-19 vaccine only visits in supplement to their PPS rate. The Department will pay the Medicaid rate for the administration of COVID-19 vaccines administered during a COVID-19 vaccine-only visit by staff who have authority under state law to administer the vaccine and are covered under the Maryland Medicaid State Plan. The supplemental amounts made under this APM are in addition to the PPS paid to

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FQHCs/RHCs for an encounter. The amount in total paid to FQHC and RHC providers is at least their provider-specific PPS rate.

This APM was developed to support FQHCs/RHCs, as a key COVID-19 vaccine provider identified in the Maryland COVID-19 vaccination strategy. Payments under this APM are to cover the additional costs associated with the administration of COVID-19 vaccines by FQHCs/RHCs during COVID-19 vaccine-only visits as the PPS cost base for FQHCs/RHCs did not include these costs. The supplemental amount paid under this APM is the Medicaid rate for the administration of COVID-19 vaccines, which is equivalent to the Medicare rate developed by CMS to account for the additional costs associated with the administration of COVID-19 vaccines. This rate is being used as FQHC/RHC cost data history is not available for rate development and is the same rate paid to other outpatient clinics that have comparable costs for the administration of COVID-19 vaccines. FQHCs/RHCs that opt-in to this APM must agree that the Medicaid rate covers their increased costs associated with COVID-19 vaccine only visits in supplement to their PPS rate.

FQHCs/RHCs will receive the Medicaid rate for each administration of a COVID-19 vaccine administered during a COVID-19 vaccine-only visit. Payments made to the FQHCs/RHCs under this APM will be made per submitted claim for the administration of a COVID-19 vaccine during a COVID-19 vaccine-only visit, effective for dates of service beginning December 18, 2020.

The supplemental payments under this APM are only for COVID-19 vaccine-only visits. If the COVID-19 vaccine is administered as part of a billable encounter visit, then the FQHC/RHC will only receive their provider-specific PPS/APM rate. FQHCs/RHCs may not receive a supplemental payment under this APM and a PPS payment for encounters that include COVID-19 vaccine administration.