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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: October 20, 2021

FROM: Daniel Tsai, Deputy Administrator and Director

SUBJECT: Guidance on Coordinating Care Provided by Out-of-State Providers for Children with Medically Complex Conditions

The Centers for Medicare & Medicaid Services (CMS) is releasing this Informational Bulletin and accompanying guidance document in accordance with section 1945A(e)(1) of the Social Security Act (the Act), as added by the Medicaid Services Investment and Accountability Act of 2019 (Pub. L. No. 116-16, enacted April 18, 2019). Section 1945A(e)(1) requires the Secretary of Health and Human Services (HHS) to issue guidance to states, and to update it as the Secretary determines necessary, on the following topics:

> (A) Best practices for using out-of-state providers to provide care to children with medically complex conditions;
> (B) Coordinating care for children with medically complex conditions provided by out-of-state providers (including when provided in emergency and non-emergency situations);
> (C) Reducing barriers that prevent children with medically complex conditions from receiving care from out-of-state providers in a timely fashion; and
> (D) Processes for screening and enrolling out-of-state providers in the respective state plan (or a waiver of such plan), including efforts to streamline these processes or reduce the burden of these processes on these providers.

The attached *Guidance on Coordinating Care Provided by Out-of-State Providers for Children with Medically Complex Conditions* provides a description of best practices and other implementation considerations related to coordination of care from out-of-state providers for children with medically complex conditions. These best practices and other considerations were informed by public comments received in response to a Request for Information (RFI) issued by CMS in January 2020, in accordance with section 1945A(e)(2) of the Act.

Background

Under section 1945A of the Act, beginning October 1, 2022, states have the option to cover health home services for Medicaid-eligible children with medically complex conditions. A child with medically complex conditions is defined in section 1945A(i)(1) to be an individual under 21 years of age who is eligible for medical assistance under the state Medicaid plan (or under a waiver of such plan), and who has at least (1) one or more chronic conditions that cumulatively

affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments; or (2) one life-limiting illness or rare pediatric disease, as defined at 21 U.S.C. 360ff(a)(3). Often, children with medically complex conditions require specialized diagnostic or treatment services that may not always be readily available from providers within their state of permanent residence (home state).

January 2020 Request for Information

Section 1945A(e)(2) of the Act directed the Secretary to issue an RFI to seek input from children with medically complex conditions and their families, states, providers (including children's hospitals, hospitals, pediatricians, and other providers), managed care plans, children's health groups, family and beneficiary advocates, and other stakeholders with respect to coordinating the care provided by out-of-state providers to children with medically complex conditions. On January 21, 2020, CMS issued this RFI (85 Fed. Reg. 3330). The initial comment period on this RFI closed on March 23, 2020, but, in light of the COVID-19 pandemic and stakeholder requests for additional time, on May 4, 2020, CMS reopened and extended the comment period on this RFI for 30 days, until June 3, 2020 (85 Fed. Reg. 26438), https://www.federalregister.gov/documents/2020/05/04/2020-09392/coordinating-care-from-out-of-state-providers-for-medicaid-eligible-children-with-medically-complex.

The full RFI can be found here: https://www.federalregister.gov/documents/2020/01/21/2020-00796/coordinating-care-from-out-of-state-providers-for-medicaid-eligible-children-with-medically-complex and the fact sheet can be found here: https://www.medicaid.gov/state-resource-center/downloads/technical-assistance/cms-2324-ifc3-fact-sheet.pdf

Guidance for States

The *Guidance on Coordinating Care Provided by Out-of-State Providers for Children with Medically Complex Conditions* includes CMS recommendations for best practices based on the comments received in response to the CMS RFI. These best practices align with the topics specified in section 1945A(e)(1) of the Act. Stakeholders also provided other suggestions for consideration related to coordination of care for children with medically complex conditions who receive care from out-of-state providers. CMS is also sharing some of these suggested implementation considerations in the guidance document in an effort to be helpful to states. Overall, the guidance is aimed at assisting states as they develop protocols, procedures, and agreements that will help to ensure that children with medically complex conditions receive prompt, high-quality care from out-of-state providers when needed.

As further discussed in the guidance document, CMS recommends the following best practices:

1. *Person-Centered Service Plan.* States, managed care plans, and providers should ensure person-centered service planning; this planning should include a multi-disciplinary treatment team using an interoperable electronic health record to allow the individual, family members or guardians, and the entire care team to access information in real-time.

2. *Provider screening and enrollment.* States should screen and enroll out-of-state providers within an abbreviated timeframe to help ensure that Medicaid-eligible children with medically complex conditions can access care from these providers in a timely fashion.
3. *Agreements between states*. States should develop standard agreements with other states governing coverage and payment for services furnished to Medicaid-eligible children with medically complex conditions living in each state by providers screened and enrolled in the other state(s). For example, states could streamline the process of enrolling out of state providers by relying on the enrollment screening conducted by other states based on criteria outlined in agreements between states.
4. *Telehealth.* States should take steps to encourage arrangements to promote access to services provided via telehealth from out-of-state providers, when appropriate, to improve access to care from these providers and enhance care coordination for children with medically complex conditions.
5. *Electronic health records (EHR) and data interoperability.* States should encourage both home state and out-of-state providers to use EHRs and other interoperability methods to automate access to and sharing of health information and to support other care-related activities directly or indirectly using various technology tools, as is consistent with sections 1945A(f)(2) and 1945A(i)(4)(B)(vi) (e.g., data sharing networks can provide care alerts regarding patients).
6. *Economic and efficient provider payment rates.* States must establish economic and efficient provider payment rates to ensure access to care and services available under the state plan and, under certain circumstances, provide coverage and payment when services are provided by out-of-state providers who serve children with medically complex conditions, consistent with section 1902(a)(30)(A) of the Act and 42 CFR § 431.52. States use a variety of payment methods to set rates paid to out-of-state providers and these methods should be clearly described in the Medicaid state plan.

It is important to note that states that elect to offer a health home under section 1945A of the Act will need to report on their use of the best practices described in the guidance, as required in the statute. Specifically, states will need to submit to CMS no later than 90 days after a state has an approved state plan amendment under section 1945A, and make publicly available on the state's website, a report on how the state is implementing this guidance, including through any best practices adopted by the state.

CMS expects to issue future guidance to states on the development of health homes serving children with medically complex conditions in accordance with section 1945A of the Act and will also be available to provide technical assistance to states. For technical assistance, please contact Sara Rhoades, Technical Director for the health homes program at sara.rhoades@cms.hhs.gov.

Guidance on Coordinating Care Provided By Out-of-State Providers for Children with Medically Complex Conditions

Guidance on Coordinating Care Provided by Out-of-State Providers for Children with Medically Complex Conditions

Purpose

Under section 1945A(e)(1) of the Social Security Act (the Act), as added by the Medicaid Services Investment and Accountability Act of 2019 (Pub. L. No. 116-16, enacted April 18, 2019), the Secretary of Health and Human Services (HHS) is required to issue guidance to states, and to update it as the Secretary determines necessary, on the following topics:

(A) Best practices for using out-of-state providers to provide care to children with medically complex conditions;
(B) Coordinating care for children with medically complex conditions provided by out-of-state providers (including when provided in emergency and non-emergency situations);
(C) Reducing barriers that prevent children with medically complex conditions from receiving care from out-of-state providers in a timely fashion; and
(D) Processes for screening and enrolling out-of-state providers in the respective state plan (or a waiver of such plan), including efforts to streamline these processes or reduce the burden of these processes on these providers.

This guidance, which is required under section 1945A(e)(1) of the Act, provides a description of best practices and other implementation considerations related to coordination of care from out-of-state providers for children with medically complex conditions. Consistent with section 1945A(e)(2) of the Act, these best practices and other considerations were informed by public comments received in response to a Request for Information issued by the Centers for Medicare & Medicaid Services (CMS) in January 2020.

Background

Under section 1945A of the Act, beginning October 1, 2022, states have the option to cover health home services for Medicaid-eligible children with medically complex conditions. A child with medically complex conditions is defined in section 1945A(i)(1) to be an individual under 21 years of age who is eligible for medical assistance under the state Medicaid plan (or under a waiver of such plan), and who has at least: (1) one or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments; or (2) one life-limiting illness or rare pediatric disease, as defined at 21 U.S.C. 360ff(a)(3). Often, children with medically complex conditions require specialized diagnostic or treatment services that may not always be

readily available from providers within their state of permanent residence (which CMS refers to below as the child's "home state").

General Overview: Medicaid Services and Out-of-State Provider Provisions

Early and Periodic Screening, Diagnostic and Treatment Benefit

Medicaid generally provides broad coverage to eligible children, both through required benefits packages for eligible children, and through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Through the EPSDT benefit, states must provide any service listed in section 1905(a) of the Act to eligible beneficiaries under age 21, when the service is determined to be necessary to correct or ameliorate an identified condition, and in any amount that is medically necessary, regardless of whether the service is covered in the state plan. For example, the state must cover under EPSDT medically necessary services to correct or ameliorate health conditions, including physical and mental illnesses, discovered through screening. This includes services that maintain or improve a child's current health condition, or that prevent conditions from worsening, prevent development of additional health problems, or reduce pain, if deemed medically necessary through the screening process. Examples of such services may include adaptive equipment to prevent ulcers or pressure sores, bed/bathroom rails, augmentative communication devices, rehabilitative services, and physical or occupational therapy. In some cases, children with medically complex conditions may require specialized diagnostic or treatment services that are not available from providers in their home state.

Out-of-State Providers

Federal statutory and regulatory provisions govern coverage of services provided by out-of-state providers under Medicaid. The statutory provision at section 1945A of the Act, which creates the new state option to cover health home services for children with medically complex conditions, specifically mentions services provided by out-of-state providers, as is further discussed below. In addition, section 1902(a)(16) of the Act requires states to include provisions in the state plan with respect to the furnishing of medical assistance under the state plan to individuals who are residents of the state, but are absent from the state; the state plan provisions on this topic should be consistent with CMS regulations at 42 CFR § 431.52.

Under 42 CFR § 431.52, any one of the following circumstances requires a state to pay for out-of-state services furnished to beneficiaries who are residents of the state, to the same extent the state would pay for services furnished within its boundaries:

- Medical services are needed because of a medical emergency.
- Medical services are needed and the beneficiary's health would be endangered if required to travel to their state of residence.
- The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state.

- It is general practice for beneficiaries in a particular locality to use medical resources in another state.

These provisions governing out-of-state providers also apply with respect to services provided to Medicaid-eligible children with medically complex conditions as defined under section 1945A of the Act, who may need access to out-of-state care based on circumstances mentioned above, such as when the state has determined that the beneficiary needs unique, innovative specialty services that are more readily available outside the home state. Cooperation among states is necessary to assure they establish procedures to facilitate the furnishing of medical services to individuals who are present in the state and are eligible for Medicaid under another state's plan.

Managed Care

Under Medicaid managed care, 42 CFR § 438.206(b)(4) provides that if the provider network of a plan is unable to provide necessary services covered under the contract to an enrollee, the managed care plan must adequately and timely cover the services out-of-network for the enrollee for so long as the managed care plan's network is unable to provide those services. Furthermore, 42 CFR §§ 435.930(c) and 438.114(c), require coverage by state Medicaid agencies (SMAs) and Medicaid managed care plans of needed emergency services as defined in regulations. In the case of an individual with an "emergency medical condition," managed care plans must cover and pay for emergency services, and in some instances post-stabilization care services, "regardless of whether the provider that furnishes the services has a contract" with the managed care plan, whether in-state or out-of-state, when the managed care contract requires the plan to be responsible for those services.

Health Homes for Children with Medically Complex Conditions

Section 1945A of the Act includes provisions specific to out-of-state providers. Section 1945A(b) of the Act lists health home qualification standards, including, at paragraph (b)(5), a requirement that health homes be able to coordinate care for children with medically complex conditions with out-of-state providers furnishing care to such children to the maximum extent practicable for the families of such children and where medically necessary, in accordance with CMS guidance issued under section 1945A(e)(1) (including this document) and 42 CFR 431.52. Under section 1945A(f)(3), a state must develop and include in its section 1945A health home state plan amendment a methodology for tracking prompt and timely access to medically necessary care for children with medically complex conditions from out-of-state providers.

Section 1945A(g)(2)(A)(v) of the Act requires states to report on the number and characteristics of designated providers, teams of health care professionals operating with such providers, and health teams selected as health homes pursuant to section 1945A, including the number and characteristics of out-of-state providers, teams of health care professionals operating with such providers, and health teams who have provided health care items and services to children receiving services from section 1945A health homes. Section 1945A(i)(4)(B)(ii) of the Act defines health home services for children with medically complex conditions to include (among other services) care coordination, health promotion, and providing access to the full range of

pediatric specialty and subspecialty medical services, including services from out-of-state providers, as medically necessary.

Request for Information (RFI)

Section 1945A(e)(2) of the Act directed the Secretary to issue an RFI to seek input from children with medically complex conditions and their families, states, providers (including children's hospitals, hospitals, pediatricians, and other providers), managed care plans, children's health groups, family and beneficiary advocates, and other stakeholders with respect to coordinating the care provided by out-of-state providers to children with medically complex conditions. On January 21, 2020, CMS issued this RFI (85 Fed. Reg. 3330). The initial comment period on this RFI closed on March 23, 2020, but, in light of the COVID-19 pandemic and stakeholder requests for additional time, on May 4, 2020, CMS reopened and extended the comment period on this RFI for 30 days, until June 3, 2020 (85 Fed. Reg. 26438), https://www.federalregister.gov/documents/2020/05/04/2020-09392/coordinating-care-from-out-of-state-providers-for-medicaid-eligible-children-with-medically-complex.

The full RFI can be found at: https://www.federalregister.gov/documents/2020/01/21/2020-00796/coordinating-care-from-out-of-state-providers-for-medicaid-eligible-children-with-medically-complex, and the fact sheet can be found at: https://www.medicaid.gov/state-resource-center/downloads/technical-assistance/cms-2324-ifc3-fact-sheet.pdf.

In response to the RFI, families, providers and other stakeholders noted various challenges that could prevent children with medically complex conditions from receiving prompt care from out-of-state providers. The overarching theme across the comments was that there is a need to reduce unnecessary burdens and streamline administrative processes in order to support expedited approval of and timely access to services from out-of-state providers for children with medically complex conditions. Families and advocates noted challenges such as delays in treatment due to prior authorization requirements, the expense of traveling out-of-state, difficulties sharing electronic health records (EHRs) across all treating providers to ensure appropriate medical treatment, and inconsistent utilization of telehealth to allow for access to out-of-state expertise. The providers who serve children with medically complex conditions noted administrative and fiscal barriers that prevent children from receiving care in a timely fashion from out-of-state providers. Providers commented that they spend significant time and resources to overcome the administrative burdens related to enrolling in Medicaid across state lines, due to complex enrollment processes and requirements that can vary significantly across states.

GUIDANCE ON COORDINATING CARE FOR CHILDREN WITH MEDICALLY COMPLEX CONDITIONS

I. BEST PRACTICES

CMS recommends the specific best practices described below, based on the comments received in response to the CMS RFI. These best practices align with the four topics listed in section 1945A(e)(1) of the Act.

Person-Centered Service Plan

States, managed care plans,[1] and providers should ensure person-centered service planning; this planning should include a multi-disciplinary treatment team using an interoperable electronic health record (EHR) to allow the individual, family members or guardians, and the entire care team to access information in real-time.

States and providers commented that successful health outcomes can result from implementing a multidisciplinary, person-centered care model for children with medically complex conditions in accordance with systematically reviewed, data-driven clinical practice guidelines. This model employs a team of dedicated health care professionals, such as primary care providers, mental health specialists, pulmonologists, respiratory therapists, dieticians, social workers, program coordinators, and other specialists as needed. Care management teams that help the child and family navigate the health care system can ensure timely and appropriate care that promotes wellness. Establishing a team of providers and specialists to best meet the needs of the child is the foundation of appropriate person-centered planning. Such a team could include both in-state and out-of-state providers, to ensure access to out-of-state providers who provide specialty services not readily available in the home state of the child.

Health home qualification standards in section 1945A(b)(2) of the Act require section 1945A health home providers to demonstrate to the state their ability to develop an individualized comprehensive pediatric family-centered care plan for children with medically complex conditions that accommodates patient preferences. CMS recommends that all states encourage or require the use of a person-centered service planning process when any type of Medicaid provider, including a section 1945A health home, develops a care plan for children with medically complex conditions. A person-centered service plan is generally understood in the health care community and by CMS to mean a written record of the agreements and decisions reached through a person-centered service care planning approach by the enrollee, the enrollee's family member or guardian (if applicable), and the interdisciplinary team. The person-centered service plan should reflect services to address enrollee needs identified on the basis of a comprehensive needs assessment and should reflect the enrollee's values, preferences, and goals. The care planning process should be directed by the individual enrollee, with assistance, as needed or requested, from a representative of the individual's choosing (including a family member or guardian responsible for the minor child). It should identify the strengths, capacities, preferences, and needs of the individual enrollee, and desired measurable outcomes for the

[1] "Managed care plans" is used here to collectively reference managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans as defined in 42 C.F.R. § 438.2.

individual. The process may include other persons, freely chosen by the individual, who are able to serve as important contributors to the process.

The principles of whole-person care and person-centered care planning support the incorporation into the service plan of all care providers and specialists who best meet the needs of the child, including out-of-state providers and the services they provide. As part of care coordination, health home providers should assist children with medically complex conditions and their families and caregivers to identify and consider out-of-state treatment options to be included in the person-centered service plan. Care coordination includes attention to all areas of a person's life and should be provided in a manner that is interdisciplinary, family-centered, community based, and culturally competent. CMS recommends, based on RFI comments, that all states, including those with health homes for children with medically complex conditions, encourage or require Medicaid providers, including section 1945A health homes, to develop a person-centered service plan like that described in 42 CFR § 441.725(a) and (b) for children with medically complex conditions.

To ensure that a child's care team can readily access information in real-time, CMS also recommends that the care team use an interoperable EHR in service planning. More information is provided below about best practices related to EHRs and section 1945A health homes.

Provider Screening and Enrollment

States should screen and enroll out-of-state providers within an abbreviated timeframe to help ensure that Medicaid-eligible children with medically complex conditions can access care from these providers in a timely fashion. For example, states could streamline the process of enrolling out-of-state providers by relying on the enrollment screening conducted by other states based on criteria outlined in agreements between states.

Another best practice for states seeking to reduce barriers to timely access to out-of-state providers for children with medically complex conditions is to screen and enroll out-of-state providers within an abbreviated timeframe. SMAs should consider an expedited screening and enrollment process with respect to out-of-state providers, to help ensure that beneficiaries, including Medicaid-eligible children with medically complex conditions, who need out-of-state care can receive it promptly.

SMAs may reimburse otherwise payable claims from out-of-state providers not enrolled in their Medicaid programs if the following four criteria are met:

1) The item or service is furnished by an institutional provider, individual practitioner, or pharmacy at an out-of-state/territory practice location (i.e., located outside the geographical boundaries of the reimbursing state/territory's Medicaid plan);

2) The National Provider Identifier (NPI) of the furnishing provider is represented on the claim;

3) The furnishing provider is enrolled and in an "approved" status in Medicare or in another state/territory's Medicaid plan; and

4) The claim represents services furnished and covered under the state plan. This includes medically necessary services for eligible children under age 21 under the EPSDT benefit, even if such services are not otherwise covered under the state plan (consistent with the definition of EPSDT at section 1905(r)).

Additionally, the claim must represent one of the following: 1) a single instance of care furnished over a 180-day period or 2) multiple instances of care furnished to a single participant over a 180-day period. For instances of care that exceed these thresholds, or for SMAs that are unable to reimburse providers not enrolled in their Medicaid programs due to system limitations, those SMAs should refer to the sub-regulatory Medicaid provider enrollment guidance found in the Medicaid Provider Enrollment Compendium (available here: https://www.medicaid.gov/sites/default/files/2019-12/mpec-7242018.pdf) for guidance on the enrollment of out-of-state providers. CMS encourages states to upgrade and/or update systems as needed when feasible.

For emergency/urgent care, states can also refer to 42 CFR § 435.930 and the Medicaid Provider Enrollment Compendium, which instruct SMAs to furnish Medicaid promptly without delay, to all eligible individuals, and to make arrangements to assist applicants and beneficiaries to get emergency medical care whenever needed. The regulation at 42 CFR § 431.52 and the Compendium further instruct SMAs to pay for services furnished in another state to the same extent they would pay for services furnished within their boundaries to a beneficiary that is a resident of the state, under conditions including and not limited to emergency services and services that are more readily available in another state.[2]

Pursuant to 42 CFR § 455.410(c), as part of the enrollment process, the SMA may, but is not required to, rely on provider screening performed by another state's Medicaid Program or by Medicare. If the state Medicaid agency opts not to rely on screening performed by either another state's Medicaid agency or by Medicare, the state Medicaid agency must perform screening in compliance with the requirements within 42 CFR part 455, subpart E, as further detailed in the Compendium. However, to ensure timely treatment for children with medically complex conditions, arrangements between states such as those identified in the next section will assist SMAs with the proper and efficient processing of non-urgent care provided by out-of-state providers for this population.

CMS also reminds states to work with the CMS Center for Program Integrity (CPI) in order to rely on Medicare screenings to facilitate provider enrollment in the Medicaid program. States can leverage CMS/CPI in the following ways: 1.) using the Provider Enrollment Chain and Ownership System (PECOS), 2.) taking advantage of the Medicare data compare service for provider screening, or, 3.)

[2] https://www.ecfr.gov/cgi-bin/text-idx?SID=4cc33b916dc4ccdcf0e0735e840cbd41&mc=true&node=se42.4.431_152&rgn=div8

participating in the CPI pilot project to screen Medicaid-only providers on behalf of states. For more information please contact MedicaidProviderEnrollment@cms.hhs.gov.

Agreements between States

States should develop standard agreements with other states governing coverage and payment for services furnished to Medicaid-eligible children with medically complex conditions living in each state by providers screened and enrolled in the other state(s).

In order to facilitate and expedite access to care, states have had success in developing memoranda of understanding (MOU), state compacts or other types of arrangements or agreements with other states, in which two or more states agree on key topics related to coverage and payment for care furnished to children with medically complex conditions living in each state by providers screened and enrolled in the other state(s). The topics in the agreement could also include the following: care management, prior authorization, care coordination, and service delivery arrangements. With regard to provider screening, states could streamline this process by relying on screening conducted by another state as permitted under 42 CFR § 455.410(c). States may also be able to leverage, in their enrollment processes, information collected by another state such as the disclosures required under 42 CFR part 455, subpart B. However, each state must still separately enroll and execute provider agreements with each provider.

Agreements between states could be used in developing each state's guidelines regarding out-of-state providers. When developing these types of arrangements, it is important to consider whether all statutory and regulatory requirements for out-of-state care are met for the type of care being covered (i.e., urgent vs. standard). Further, utilizing agreements with other states will not only help states develop protocols for covering emergent and non-emergent care provided by out-of-state providers but also help them establish expedited timelines for accessing out-of-state care and provide clear care coordination guidelines.

Telehealth

States should take steps to encourage arrangements to promote access to services provided via telehealth from out-of-state providers, when appropriate, to improve access to care from these providers and enhance care coordination for children with medically complex conditions.

Section 1945A(f)(2) of the Act specifies that a state must include in its section 1945A health home state plan amendment a proposal for use of health information technology (health IT) in providing health home services and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider). Section 1945A(i)(4)(B)(vi) of the Act also includes in the definition of health home services for children with medically complex conditions use of health IT to link services, as feasible and appropriate.

Telehealth can be a useful tool to help coordinate and access care. Based on the comments received on the RFI, CMS recommends the use of telehealth as a best practice to facilitate treatment from out-of-state providers, when appropriate. Telemedicine or telehealth seeks to improve a patient's health by permitting two-way, interactive communication between the patient and a physician or practitioner. Although the dominant form of telehealth is generally thought of as two-way audio/visual communication, or a video chat, telehealth can be much broader than that. Other forms such as store-and-forward and remote patient monitoring have existed alongside this two-way modality. Federal Medicaid policy supports the use of audio-only communications to deliver services, as noted in the toolkit link below. Telehealth may be a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient).

The Rehabilitation Act of 1973 (Section 504), the Americans with Disabilities Act (ADA) and Section 1557 of the Affordable Care Act (ACA) prohibit discrimination in health care services. In 2016, the HHS Office for Civil Rights published *Guidance and Resources for Electronic Information Technology: Ensuring Equal Access to All Health Services and Benefits Provided Through Electronic Means* [3] reminding covered providers that inaccessibility to their services through electronic information and technology may constitute disability discrimination.

When providing services via telehealth, providers should practice within the scope of their State Practice Act; some states have also enacted legislation that requires providers using telemedicine technology across state lines to have a valid state license in the state where the patient is located. States should follow their state plan regarding payment to qualified Medicaid providers for services provided via telehealth. States should also consider applicable federal and state privacy and consent laws and policies for services provided via telehealth. The CMS Medicaid & CHIP Telehealth toolkit may also be helpful in developing telehealth agreements between states.

States may request enhanced federal financial participation for certain state systems expenditures to support telehealth, provided they meet the conditions under 42 CFR part 433 subpart C.

Electronic Health Records (EHR) and Data Interoperability

States should encourage both home state and out-of-state providers to use EHRs and other interoperability methods to automate access to and sharing of health information and to support other care-related activities directly or indirectly using various technology tools, as is consistent with sections 1945A(f)(2) and 1945A(i)(4)(B)(vi) (e.g., data sharing networks can provide care alerts regarding patients).

Providers and states have identified EHRs as a useful way to easily access a beneficiary's information, allowing home state and out-of-state providers to coordinate care in real time. An EHR is an electronic version of a beneficiary's medical history that is maintained by a health

[3] https://www.hhs.gov/sites/default/files/ocr-guidance-electronic-information-technology.pdf

care provider over time, and it may include all of the key clinical data relevant to that person's care from that particular provider, such as demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports.[4]

An EHR automates access to information and has the potential to streamline the clinician's workflow. An EHR also has the ability to support other care-related activities through various interfaces, including evidence-based decision support, quality management, and outcomes reporting. There are critical functionalities, data elements, and other requirements that should be present in health IT products to address health care needs specific to the care of children. More information can be found in the *Pediatric Health Information Technology: Developer Informational Resource* and corresponding resource for providers.[5]

The health home services listed in statute at section 1945A of the Act include "use of health [IT] to link services, as feasible and appropriate." Thus, under the health home service delivery model, care coordination could include the sharing of centralized information to coordinate integrated care by multiple providers through the use of EHRs that can be shared among all providers on the child's interdisciplinary care team. It is important that the data across the entire health care system is shared with all treating providers to ensure "whole person" care is provided. The use of EHRs allows the sharing of health information in real-time with the beneficiary and the interdisciplinary team to identify potential issues or gaps in treatment to promote wellness. States should encourage the use of certified electronic health record technology (CEHRT) that utilizes common technology standards to ensure information is seamlessly shared across different systems, including EHRs and other health IT tools. States may request enhanced federal financial participation for certain state Medicaid Enterprise Systems (MES) expenditures that support care coordination, provided they meet the conditions described in 42 CFR part 433 subpart C and 45 CFR part 95.

An EHR is considered a type of electronic information technology that is required to be accessible under Section 504, the ADA, and Section 1557 of the ACA. An EHR must be accessible to people with disabilities in a way so that all patients are able to access their records and communicate effectively with their providers.

Economic and Efficient Provider Payment Rates

States must establish economic and efficient provider payment rates to ensure access to care and services available under the state plan and, under certain circumstances, provide coverage and payment when services are provided by out-of-state providers who serve children with medically complex conditions, consistent with section 1902(a)(30)(A) of the Act and 42 CFR

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[4] https://www.cms.gov/Medicare/E-Health/EHealthRecords#:~:text=An%20Electronic%20Health%20Record%20(EHR,progress%20notes%2C%20problems%2C%20medications%2C

[5] https://www.healthit.gov/topic/health-it-pediatric-care-and-practice-settings

§ 431.52. States use a variety of payment methods to set rates paid to out-of-state providers and these methods should be clearly described in the Medicaid state plan.

When establishing Medicaid payment rates, states must consider the impact on access to care for beneficiaries receiving care from out-of-state providers. Establishing economic and efficient rates ensures access to services provided by out-of-state providers who serve children with medically complex conditions. Federal regulations at 42 CFR § 431.52 require state Medicaid programs to cover out-of-state care for beneficiaries when medical services are needed because of a medical emergency, when medical services are needed and the beneficiary's health would be endangered if he or she were required to travel to his or her state of residence, when the state determines on the basis of medical advice that needed medical services or necessary supplemental resources are more readily available in another state, or when it is general practice for beneficiaries in a particular locality to use medical resources in another state. In such circumstances, the Medicaid agency must pay for services furnished in another state to a beneficiary who is a resident of the state.

States not only cover section 1905(a) benefits that are included in the state plan for children, but must also cover medically necessary screening and follow-up services for eligible children under age 21 under the EPSDT benefit, even if such services are not otherwise covered under the state plan (consistent with the definition of EPSDT at section 1905(r)). For example, the state would cover under EPSDT medically necessary services to correct or ameliorate health conditions including physical and mental illnesses discovered through screening.

States might not be able to ensure that such children receive the full scope of coverage to which they are entitled unless states improve access to certain care and services offered by out-of-state providers. For example, if providers in the home state do not offer innovative specialty services a child needs, an out-of-state provider could provide those services, consistent with 42 CFR § 431.52. Additionally, when it is the general practice of beneficiaries in a particular locality to use medical resources in another state (as may occur when the locality closely borders another state), the out-of-state care must be covered to the same extent it would be within the boundaries of the state, consistent with 42 CFR § 431.52. And, if the state determines, based on medical advice, that a particular form of needed specialty care is more readily available in another state, the same regulation requires the state to cover the out-of-state care.

Under Medicaid managed care, 42 C.F.R. § 438.206(b)(4) provides that if the provider network of a managed care plan is unable to provide necessary services covered under the contract to an enrollee, the managed care plan must adequately and timely cover the services out-of-network for the enrollee for so long as the managed care plan's network is unable to provide those services that includes the obligation to cover all but plan cost-sharing amounts, meaning the plan must pay the out of network provider a sufficient amount so there is no balance billing.

Consistent with section 1902(a)(30)(A) of the Act, states have the flexibility to negotiate rates that are economic and efficient with out-of-state providers, including through state agreements

with other states and as set forth in the home states' state plan. SMAs must include a comprehensive description of their rate-setting methodologies in their state plan including payment methodologies for out of state providers, which must ensure that payments under the plan are consistent with requirements under section 1902(a)(30)(A) of the Act to be economic, efficient, and consistent with quality of care, and to ensure sufficient beneficiary access to care.

II. OTHER IMPLEMENTATION CONSIDERATIONS FOR STATE MEDICAID PROGRAMS IDENTIFIED BY STAKEHOLDERS

Commenters on the CMS RFI offered multiple suggestions and additional areas for states to consider when developing proposals for a section 1945A health home for children with medically complex conditions. In this section, CMS is sharing some of these suggestions for states' consideration. States will not be required to report on their implementation of these suggestions as part of the report required under section 1945A(g)(2)(B). CMS expects to provide future guidance on implementing a health home for children with medically complex conditions to meet the statutory requirements in section 1945A of the Act.

Sharing Information with Stakeholders

Commenters on the RFI also had the following suggestions about information that states could share with stakeholders:

Contact Lists/ Registries
States, themselves or through contracted Medicaid managed care plans, may want to develop lists with contact information of providers for caseworkers that are readily available to families of children with medically complex conditions, to allow caseworkers, families, and/or other team members to quickly locate specialists who know about their child's specific conditions and rare diseases. Another idea commenters suggested was for the state to establish a registry of specialty out-of-state providers that would indicate in which states the provider is enrolled in Medicaid and in good standing. States should ensure that they compile any provider lists, registries, or networking resource materials in a fair and equitable manner.

Websites for Stakeholders
States may want to consider making networking resources available on state websites for beneficiaries, providers, and other stakeholders, noting which providers are available in the home state or out-of-state. For example, states could provide newsletters for stakeholders and information about providers who serve rare and specialized conditions. This information might help identify specialty providers and the type of care provided. This might help providers and families to pre-plan for specific specialty care needs. As a reminder, states should ensure that they compile any provider lists, registries, or networking resource materials in a fair and equitable manner.

Specialty Networks

Commenters on the RFI noted that states may want to consider utilizing provider agencies that employ specialized hospital contracting teams to coordinate care from out-of-state providers when necessary for children with medically complex conditions. For example, commenters suggested that these types of specialty agencies could be identified by states as part of the designated health home team in the health home state plan amendment. In addition, commenters posited that these types of arrangements could help to provide children with medically complex conditions and their family members with access to the most appropriate out-of-state care, and help to provide them with follow-up care options, both in and out-of-state. Another suggestion was to establish a specialty care coordination program that identifies high-risk beneficiaries and tiered support based on medical and social complexity.

Social Service Supports

Commenters on the RFI suggested that states coordinate with social service agencies to help families with planning out-of-state care. Specifically, commenters suggested that families help each other by sharing resources on travel costs, lodging, meals and forming connections with other parents who have a shared experience. In addition, they suggested that states may want to establish dedicated care coordinators as part of the care team under the section 1945A health home benefit, to connect families with hospital and community resources, such as counseling services, palliative care, pastoral and social services, financial services, and out-of-state medical care. Finally, commenters suggested that states establish travel protocols between states to determine arrangements related to, among other things, the equipment, vehicles, or staffing that may be needed when transporting children with medically complex conditions between states for their care. Commenters cited family-centered Navigator programs and federally-funded Family-to-Family Information Centers as models for the kind of support families of children with medically complex conditions would benefit from and stated that additional support for training would strengthen the benefits of these programs.

Most Integrated Setting/*Olmstead*

CMS reminds states that their Medicaid programs, including coverage of services for children with medically complex conditions, must comply with the integration mandate under Title II of the ADA and the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999). Commenters on the RFI noted that the ADA integration mandate requires states to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. Further, the Supreme Court has determined that systemic failures to develop an adequate array of community-based services, resulting in unnecessary and unwanted residential and institutional placements, may violate this mandate.[6]

[6] *Olmstead v. L.C.*, 527 U.S. 581, 605-606 (1999).

Commenters who raised this issue stressed that it is important not only to cover and coordinate needed acute services for children with medically complex conditions, which might require travel out of state, but it is also important to facilitate seamless return to local communities and to ensure that these individuals can receive services locally to the maximum extent feasible.

Prescription Drugs and Durable Medical Equipment

Commenters on the RFI noted barriers to obtaining prescriptions from out of state providers for medications and durable medical equipment (DME). These include comments on the difficulty of maintaining and/or replacing DME when travelling or receiving care across state lines, as well as onerous prior authorization and other utilization management controls. States should engage in dialogue with families of children with medically complex conditions and related stakeholder groups to identify streamlined processes that help ensure continuity of care and expedite access to essential DME and prescription drugs across state lines, where appropriate (if the conditions in 42 CFR § 431.52 are met).

Conclusion

CMS reviewed and considered all stakeholder input provided through the RFI comments when developing this guidance. CMS used the comments provided through the RFI process to identify and recommend best practices that are aligned with statute, CMS regulations, and agency policy. CMS expects that these recommended best practices will help SMAs develop protocols, procedures, and agreements that will help to ensure that children with medically complex conditions receive prompt, high-quality care from out-of-state providers when needed.

CMS generally encourages states to take proactive steps to identify out-of-state providers who provide specialized services for children with medically complex conditions (as defined at section 1945A(i)(1) of the Act) and to develop guidelines and procedures for coordinating the care these providers furnish to children in their state in accordance with 42 CFR § 431.52. Additionally, CMS recommends the specific best practices discussed above and summarized below.

States should explore streamlined and abbreviated provider screening and enrollment processes for out-of-state providers to help ensure that Medicaid-eligible children with medically complex conditions can access timely care from out-of-state providers.

A person-centered service plan is recognized by CMS, based on comments on the RFI, as a best practice. Such a plan should accommodate patient preferences and be developed according to principles that support the incorporation into the service plan of all care providers and specialists who best meet the needs of the child, including out-of-state providers. To ensure that a child's care team can readily access information in real-time, CMS also recommends that the care team use an interoperable EHR in service planning.

Another best practice CMS recommends is developing and utilizing agreements between states that govern coverage and payment for services furnished to Medicaid-eligible children with medically complex conditions living in each state by providers screened and enrolled in the other state(s). These agreements could be used in developing each state's guidelines regarding out-of-state providers, and could include protocols for covering emergent and non-emergent care provided by out-of-state providers, payment rates for out-of-state providers, prior authorization for services provided by out-of-state providers, and clear guidelines for the coordination of care provided by out-of-state providers.

CMS recommends as a best practice that states encourage both home state and out-of-state providers to use EHRs and other interoperability methods to automate access to and sharing of health information, and to support other care-related activities directly or indirectly using various technology tools.

CMS recommends as a best practice that states leverage telehealth to facilitate access to Medicaid services furnished by out-of-state providers, thereby improving access to specialized services and enhancing care coordination for children with medically complex conditions.

Finally, establishing economic and efficient reimbursement rates for out-of-state providers is required under section 1902(a)(30)(A), and will help states improve access to specialized services provided by out-of-state providers for children with medically complex conditions.

States that elect to offer a health home under section 1945A of the Act will need to report on their use of the best practices described in this guidance under section 1945A(g)(2)(B). Specifically, states will need to submit to CMS no later than 90 days after a state has an approved state plan amendment under section 1945A, and make publicly available on the state's website, a report on how the state is implementing this guidance, including through any best practices adopted by the state.

CMS expects to issue future guidance to states on the development of health homes serving children with medically complex conditions in accordance with section 1945A of the Act and will also be available to provide technical assistance to states. For technical assistance, please contact Sara Rhoades, Technical Director for the health homes program at sara.rhoades@cms.hhs.gov.