



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Chapter IV

[CMS-2324-NC]

RIN: 0938-ZB57

Coordinating Care from Out-of-State Providers for Medicaid-eligible Children with Medically Complex Conditions

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Request for information.

SUMMARY: This document is a request for information (RFI) to seek public comments regarding the coordination of care from out-of-state providers for Medicaid-eligible children with medically complex conditions. We wish to identify best practices for using out-of-state providers to provide care to children with medically complex conditions; determine how care is coordinated for such children when that care is provided by out-of-state providers, including when care is provided in emergency and non-emergency situations; reduce barriers that prevent such children from receiving care from out-of-state providers in a timely fashion; and identify processes for screening and enrolling out-of-state providers in Medicaid, including efforts to streamline such processes for out-of-state providers or to reduce the burden of such processes on them. We intend to use the information received in response to this RFI to issue guidance to state Medicaid directors on the coordination of care from out-of-state providers for children with medically complex conditions.

DATES: *Comments:* To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [insert date 60 days after date of publication in

the **Federal Register**].

ADDRESSES: In commenting, refer to file code CMS-2324-NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this RFI to

<http://www.regulations.gov>. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address **ONLY**:

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-2324-NC

P.O. Box 8016

Baltimore, MD 21244-8010

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address **ONLY**:

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-2324-NC

Mail Stop C4-26-05

7500 Security Boulevard

Baltimore, MD 21244-1850

FOR FURTHER INFORMATION CONTACT: Nicole Gillette-Payne, 212-616-2465.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period will be made available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We will post all comments received before the close of the comment period on the following website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view public comments.

I. Background

Medicaid health homes were originally authorized under section 2703 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148, enacted March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 115-152, enacted March 30, 2010) (the ACA), which added section 1945 to the Social Security Act (the Act). Section 1945 of the Act allows states to elect a Medicaid state plan option to provide a comprehensive system of care coordination for Medicaid beneficiaries with chronic conditions. The goal of the health homes authorized under section 1945 of the Act is to integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. States may not limit enrollment by age in the health homes authorized under section 1945 of the Act, but may target chronic conditions that have a higher prevalence in particular age groups.¹

The Medicaid Services Investment and Accountability Act of 2019 (MSIA) (Pub. L. 116-16, enacted April 18, 2019), added section 1945A to the Act, which authorizes a new optional

¹ See Health Homes FAQs, December 18, 2017, <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/health-homes-faq-12-18-17.pdf>.

Medicaid health home benefit. 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 who choose to enroll in a health home. States will submit State Plan Amendments (SPAs) to exercise this option, which permits them to specifically target children with medically complex conditions as defined in section 1945A(i) of the Act. States will receive a 15 percent increase in the federal match for their expenditures on section 1945A health home services during the first 2 fiscal year quarters that the approved health home SPA is in effect, but under no circumstances may the federal matching percentage for these services exceed 90 percent. Among other required information, states must include in their section 1945A SPAs a methodology for tracking prompt and timely access to medically necessary care for children with medically complex conditions from out-of-state providers.

To qualify for health home services under section 1945A of the Act, children with medically complex conditions must be under 21 years of age and eligible for Medicaid. Additionally, they must either: (1) have at least one or more chronic conditions that cumulatively affect three or more organ systems and that severely reduce cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and that also require the use of medication, durable medical equipment, therapy, surgery, or other treatments; or (2) have at least one life-limiting illness or rare pediatric disease as defined in section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3)).

Section 1945A(i)(2) of the Act defines a chronic condition as a serious, long-term physical, mental, or developmental disability or disease. Qualifying chronic conditions listed in the statute include cerebral palsy, cystic fibrosis, HIV/AIDS, blood diseases (such as anemia or sickle cell disease), muscular dystrophy, spina bifida, epilepsy, severe autism spectrum disorder,

and serious emotional disturbance or serious mental health illness. The Secretary may establish higher levels as to the number or severity of chronic, life threatening illnesses, disabilities, rare diseases or mental health conditions for purposes of determining eligibility for health home services under section 1945A of the Act.

Under section 1945A(i)(4) of the Act, health home services for children with medically complex conditions must include the following list of comprehensive and timely high-quality services:

- Comprehensive care management;
- 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;
- Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings²;
- Patient and family support, including authorized representatives;
- Referrals to community and social support services, if relevant; and
- Use of health information technology (HIT) to link services, as feasible and appropriate.

These services are very similar to the health home services described in section 1945 of the Act, with some variations to reflect the targeted population for section 1945A health homes.

Health home services must be provided by a health home, which is a designated provider (including a provider that operates in coordination with a team of health care professionals) or a

² Many children with medically complex conditions have a disability under federal disability rights laws, including the Americans with Disabilities Act. Children covered by these laws have a right to receive services in the most integrated setting appropriate to their needs. *See Olmstead v. L.C.*, 527 U.S. 581 (1999).

health team that is selected by a Medicaid-eligible child with medically complex conditions, or by his or her family. Subject to the provider qualification standards established by the Secretary as described in section 1945A(b) of the Act, states determine which providers or entities are qualified to serve as health homes. However, section 1945A of the Act does not limit the ability of a child (or a child's family) to select any qualified health home provider as the child's health home. Per section 1945A(i)(5) of the Act, designated providers may be:

- A physician (including a pediatrician or a pediatric specialty or subspecialty provider), children's hospital, clinical practice or clinical group practice, prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) (as those terms are defined in 42 CFR 438.2);

- A rural clinic;
- A community health center;
- A community mental health center;
- A home health agency; or
- Any other entity or provider that is determined by the state and approved by the

Secretary to be qualified to be a health home for children with medically complex conditions on the basis of documentation that the entity has the systems, expertise, and infrastructure in place to provide health home services.³

Designated providers may include providers who are employed by, or affiliated with, a children's hospital.

Per section 1945A(i)(6) of the Act, a team of health care professionals may include:

- Physicians and other professionals, such as pediatricians or pediatric specialty or subspecialty providers, nurse care coordinators, dietitians, nutritionists, social workers,

³ For example, a managed care organization (MCO) as the term is defined in 42 CFR 438.2.

behavioral health professionals, physical therapists, occupational therapists, speech pathologists, nurses, individuals with experience in medical supportive technologies, or any professionals determined to be appropriate by the state and approved by the Secretary;

- An entity or individual who is designated to coordinate such a team; and
- Community health workers, translators, and other individuals with culturally-appropriate expertise.

A team of health care professionals may be freestanding, virtual, or based at a children's hospital, hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity determined to be appropriate by the State and approved by the Secretary. At section 1945A(i)(7) of the Act, a health team is defined as having the meaning given such term for purposes of section 3502 of the ACA.

Under section 1945A(b) of the Act, section 1945A health home providers must demonstrate to the state the ability to:

- Coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times;
- Develop an individualized comprehensive pediatric family-centered care plan for children with medically complex conditions that accommodates patient preferences;
- Work in a culturally and linguistically appropriate manner with the family of a child with medically complex conditions to develop and incorporate into the child's care plan, in a manner consistent with the needs of the child and the choices of the child's family, ongoing home care, community-based pediatric primary care, pediatric inpatient care, social support services, and local hospital pediatric emergency care;

- Coordinate access to subspecialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic, treatment, and critical care levels as medically necessary;
- Coordinate access to palliative services if the state provides Medicaid coverage for palliative services;
- Coordinate care for children with medically complex conditions with out-of-state providers furnishing care to these children to the maximum extent practicable for the children's families and where medically necessary, in accordance with 42 CFR 431.52 and the guidance that CMS will provide on this topic under section 1945A(e)(1) of the Act; and
- Collect and report information described in section 1945A(g)(1) of the Act, which includes provider identifying information, specific health care services to be provided to children with medically complex conditions, and information on applicable quality measures.

A. Medicaid Services and Out-of-State Providers

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. In some cases, children with medically complex conditions may require specialized diagnostic or treatment services that are not available from providers in their state. Federal regulations at § 431.52(b)(3) require that, if a state Medicaid agency, on the basis of medical advice, determines that needed medical services or necessary supplementary resources for a beneficiary

resident in the state are “more readily available” in another state, the state must pay for services furnished in the other state to the same extent that it would pay for services furnished within its boundaries. Under Medicaid managed care, § 438.206(b)(4) provides that if a managed care organization (MCO), PIHP, or PAHP (“managed care plan”) provider network 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. Furthermore, §§ 435.930(c) and 438.114(c), require, respectively, that state Medicaid agencies and Medicaid managed care plans cover 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.

Per section 1902(a)(27) of the Act and § 431.107(b), providers or organizations furnishing services under the state plan must have a provider agreement. In the February 2, 2011 **Federal Register**, we published a final rule where we established Medicaid provider screening requirements at 42 CFR part 455, subpart E (76 FR 5862). In addition, section 5005(b)(1) of the 21st Century Cures Act (Pub. L. 114–255, enacted December 13, 2016) amended section 1902(a) of the Act to require that states require enrollment by all providers furnishing, ordering, prescribing, referring, or certifying eligibility for Medicaid services and collect identifying information from enrolled providers, not later than January 1, 2017. In the case of a state that under its state plan or waiver of the plan for medical assistance pays for medical assistance on a fee-for-service basis, the state shall require each provider furnishing items or services to, or ordering, prescribing, referring, or certifying eligibility for, services for individuals eligible to

receive medical assistance under such plan to enroll with the state agency and provide to the state agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier (if applicable), federal taxpayer identification number, and the state license or certification number of the provider (if applicable).⁴ Section 5005(b)(2) of the 21st Century Cures Act amended section 1932(d) of the Act to include similar enrollment and information reporting requirements for providers participating in the network of a Medicaid managed care entity, effective no later than January 1, 2018. Only under very limited circumstances may a provider or organization bill and receive payment without being enrolled as a Medicaid provider in the reimbursing state. Specifically, a state may pay a claim to a furnishing provider that is not enrolled in the reimbursing state's Medicaid plan to the extent that the claim is otherwise payable and meets the following criteria:

- The item or service is furnished by an institutional provider, individual practitioner, or pharmacy at an out-of-state practice location— that is, located outside the geographical boundaries of the reimbursing state's Medicaid plan;
- The National Provider Identifier of the furnishing provider is represented on the claim;
- The furnishing provider is enrolled and in an “approved” status in Medicare or in another state's Medicaid plan;
- The claim represents services furnished, and;
- The claim represents either:
 - ++ A single instance of care furnished over a 180-day period; or

⁴ Section 1902(a)(78) of the Act.

++ Multiple instances of care furnished to a single participant, over a 180-day period.⁵

The payment to the out-of-state provider is subject to the same federal matching rate as the state receives when it pays an in-state provider, which means that the state pays the same share in either case.

B. Guidance on Coordinating Care from Out-of-State Providers

Under section 1945A(e) of the Act, the Secretary must issue guidance to state Medicaid directors by October 1, 2020 on:

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

Under section 1945A(g)(2)(B) of the Act, states with an approved section 1945A SPA must submit to the Secretary, and make publicly available on the appropriate state website, a report on how the state is implementing the guidance issued under section 1945A(e) of the Act, including through any best practices adopted by the state. The required report must be submitted no later than 90 days after the state's section 1945A SPA is approved.

Section 1945A(e)(2) of the Act directs the Secretary to issue this request for information (RFI) as part of the process of developing the required guidance, to seek input from children with

⁵ The Medicaid Provider Enrollment Compendium (7/24/18), pg. 42, <https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf>.

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.

II. Solicitation of Comments

This is an RFI only. Respondents are encouraged to provide complete but concise responses to the questions listed in the sections outlined below. Response to this RFI is completely voluntary. This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, for applications, for proposal abstracts, or for quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant award. Further, we are not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the United States Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request. Also, we note that we will not respond to questions from individual responders about the policy issues raised in this RFI. We may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses. Responses to this RFI are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information

that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become Government property and will not be returned. We may publicly post the comments received, or a summary thereof.

A. Public/Stakeholder Feedback

We are soliciting general comments on the coordination of care provided by out-of-state providers including but not limited to primary care providers, pediatricians, hospitals, specialists, and other health care providers or entities who may provide care for Medicaid-eligible children with medically complex conditions. We are specifically seeking input on these topics as they relate to urban, rural, Tribal, and medically underserved populations, as barriers and successful strategies may vary by geography. We also seek input on these topics with respect to both Medicaid fee-for-service and Medicaid managed care arrangements. Therefore, in responding to these comments, please differentiate between Medicaid fee-for-service and Medicaid managed care arrangements, as appropriate.

- We are seeking public comment on any best practices for using out-of-state providers to provide care to children with medically complex conditions, including specific examples of what has and has not worked in the commenter's experience.

- We are seeking public comment about coordinating care from out-of-state providers for children with medically complex conditions, including when care is provided in emergency and non-emergency situations. Discussion of specific examples of what has and has not worked, in the commenter's experience, is especially welcome.

- We are seeking information about any state initiatives that have promoted and/or improved the coordination of services and supports provided by out-of-state providers to children

with medically complex conditions.

- We are seeking public comment related to administrative, fiscal, and regulatory barriers that states, providers, beneficiaries, and their families experience that prevent children with medically complex conditions from receiving care, including community and social support services, from out-of-state providers in a timely fashion, as well as examples of successful approaches to reducing those barriers.

- We are seeking public comment related to barriers that prevent caregivers from accessing or navigating care from out-of-state providers in a timely fashion, as well as examples of successful approaches to reducing those barriers.

- We are seeking public comment related to individual financial barriers (for example, costs of travel, lodging, and work hours lost) that prevent children with medically complex conditions from receiving care from out-of-state providers in a timely fashion, as well as examples of successful approaches to reducing those barriers.

- We are seeking public comment on successful methods to inform caregivers of children with medically complex conditions about ways to access care from out-of-state providers.

- We are seeking public comment on any measures that have been, or could be employed by states, providers, health systems and hospitals to reduce barriers to coordinating care for children with medically complex conditions when receiving care from out-of-state providers.

- We are seeking public comment related to processes that states could employ for screening and enrolling out-of-state Medicaid providers, in both emergent and non-emergent

situations, including efforts to streamline these processes or reduce the administrative and fiscal burden of these processes on out-of-state providers and states.

- We are seeking public comment on challenges with referrals to out-of-state providers for specialty services, including community and social supports, for children with medically complex conditions and the impact of these challenges on access to qualified providers.

- We are seeking public comment on best practices for developing appropriate and reasonable terms of contracts and payment rates for out-of-state providers, for both Medicaid fee-for-service and Medicaid managed care.

III. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping, or third-party disclosure requirements. However, section II. of this document does contain a general solicitation of comments in the form of a request for information. In accordance with the implementing regulations of the Paperwork Reduction Act of 1995 (PRA), specifically 5 CFR 1320.3(h)(4), facts or opinions submitted in response to general solicitations of comments from the public, published in the **Federal Register** or other publications, regardless of the form or format thereof, provided that no person is required to supply specific information pertaining to the commenter, other than that necessary for self-identification, as a condition of the agency's full consideration, are not generally considered information collections and therefore not subject to the PRA. Consequently, there is no need for review by the Office of Management and Budget under the authority of the PRA (44 U.S.C. Chapter 35).

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will

consider all comments we receive by the date and time specified in the "DATES" section of this preamble. The comments provided in response to the RFI will assist CMS in developing guidance for state Medicaid directors on the coordination of care from out-of-state providers for children with medically complex conditions.

Dated: November 4, 2019.

Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: January 10, 2020.

Alex M. Azar II,

Secretary,

Department of Health and Human Services.