



SMD # 22-004

**Re: Health Homes for Children with
Medically Complex Conditions**

August 1, 2022

Dear State Medicaid Director:

This letter provides guidance on the implementation of section 1945A of the Social Security Act (“the Act”), enacted as part of the Medicaid Services Investment and Accountability Act of 2019 (P. L. 116-16), which authorizes states to cover an optional health home state plan benefit for Medicaid-eligible children with medically complex conditions. Under this provision, beginning October 1, 2022, states have the option to cover health home services for Medicaid-eligible children with medically complex conditions as defined in section 1945A(i) of the Act.

Background on Health Homes

In 2010, the Affordable Care Act (ACA)¹ added section 1945 to the Act, establishing an option for states to cover health home services for Medicaid-eligible individuals with two or more chronic conditions, with at least one chronic condition and who are at risk for a second, or with at least one serious and persistent mental health condition. Section 1945 health home services are generally care management, care coordination, and patient and family support services. Thus, states’ implementation of health homes under section 1945 of the Act has helped to ensure that certain Medicaid beneficiaries’ care is better integrated and coordinated, thereby helping to ensure these beneficiaries can receive “whole-person” care that addresses their needs. Since January 2011, 27 states and the District of Columbia have successfully implemented health home programs for Medicaid beneficiaries with chronic conditions, such as asthma, diabetes, substance use disorder (SUD), and mental health conditions, in accordance with section 1945 of the Act. As of March 2022, there are 34 active health home programs under section 1945 of the Act.²

Section 1945A of the Act provides an opportunity for states to cover care coordination, care management, patient and family support, and similar services that are expected to support a family-centered system of care for children with medically complex conditions, and that could help to improve health outcomes for these children. Often, children with medically complex conditions require specialized diagnostic or treatment services that may not always be readily

¹ The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Healthcare and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this State Medicaid Director letter, the two statutes are referred to collectively as the “Affordable Care Act.”

² See “Other Resources” section at <https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html>.

available from providers within their state of permanent residence. By implementing the section 1945A health home option, states can cover coordination of care for children with medically complex conditions, including coordination of the full range of pediatric specialty and subspecialty medical services and coordination of care and services from out-of-state providers (see discussion below of CMS's October 20, 2021 guidance on best practices for using out-of-state providers to provide care to children with medically complex conditions). CMS expects state implementation of the new health home state plan option under section 1945A of the Act to improve care coordination for children with medically complex conditions.

Eligibility Criteria for Section 1945A Health Home Services

Section 1945A of the Act gives states the option to cover health home services for Medicaid-eligible children under age 21 with medically complex conditions who choose to enroll in a section 1945A health home by selecting a designated provider, a team of health care professionals operating with a designated provider, or a health team as the child's health home services provider. Under section 1945A(i)(1) of the Act, a "child with medically complex conditions" must be under 21 years of age and eligible for medical assistance under the state plan (or under a waiver of the state plan, which CMS interprets to include eligibility under a section 1115 demonstration).³ Additionally, under section 1945A(i)(1)(A)(ii), a "child with medically complex conditions" must have at least:

- 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 that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments; or
- 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))).

A "chronic condition" is defined in section 1945A(i)(2) as "a serious, long-term physical, mental, or developmental disability or disease," including the following:

- 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/or
- Serious emotional disturbance or serious mental health illness.

³ Generally, CMS interprets statutory references to a "waiver" of the Medicaid state plan to include section 1115 demonstrations.

CMS interprets section 1945A(i)(1) to require states electing to cover section 1945A health home services to cover these services for children who meet the eligibility criteria in section 1945A(i)(1)(A)(ii)(I) based on having one or more chronic conditions that meet the statutory definition of a “chronic condition,” even if their condition(s) are not listed in section 1945A(i)(2), if they choose to enroll in a section 1945A health home. For example, other chronic conditions that meet this statutory definition may include “long COVID,”⁴ or other medical or mental health conditions nationally recognized by the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), or the American Medical Association (AMA).

CMS further interprets section 1945A(i)(1) to require states electing to cover section 1945A health home services to cover these services for children who meet the eligibility criteria in section 1945A(i)(1)(A)(ii)(I) based on having any one or more of the chronic conditions listed in section 1945A(i)(2), if they choose to enroll in a section 1945A health home.

States should demonstrate to CMS’s satisfaction, through documentation in their proposed section 1945A state plan amendments (SPAs), that they will establish a process for identifying chronic conditions that are not listed in section 1945A(i)(2) but that meet the statutory definition of a “chronic condition,” because they are serious, long-term physical, mental, or developmental disabilities or diseases. This process should ensure that the state would cover section 1945A health home services for children who are eligible for these services on the basis of having one or more chronic conditions that are not listed in section 1945A(i)(2) but that meet the statutory definition of a “chronic condition.” By including a description of this process in their initial section 1945A SPAs, states should avoid the need to submit amendments to an approved section 1945A SPA to list new chronic conditions.

Section 1945A also permits states to cover health home services notwithstanding the statewideness requirement at section 1902(a)(1) and the comparability requirement at section 1902(a)(10)(B), meaning that states can cover section 1945A health home services less than statewide and can cover section 1945A health home services only for persons who are eligible for those services under section 1945A(i)(1) and enrolled in a section 1945A health home. However, per section 1945A(h) of the Act, states may not require a child with medically complex conditions to enroll in a section 1945A health home and may not limit the child’s choice of qualified section 1945A health home services providers. States also may not reduce or modify the entitlement of children with medically complex conditions to early and periodic screening, diagnostic, and treatment (EPSDT) services as defined in section 1905(r). Additionally, states may not reduce or modify the informing, providing, arranging, and reporting requirements under section 1902(a)(43).

Health Home Services for Children with Medically Complex Conditions

Section 1945A(i)(4) of the Act defines “health home services” for children with medically complex conditions as comprehensive and timely high-quality services provided by a designated

⁴ See information from the Centers for Disease Control and Prevention (CDC) about “long COVID,” at <https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html>.

provider, team of health care professionals operating with a designated provider, or health team. Section 1945A(i)(4) further specifies that these services include:

- Comprehensive care management;
- Care coordination, health promotion, and the provision of 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 settings;
- Patient and family support (including authorized representatives);
- Referrals to community and social support services, if relevant; and
- Use of health information technology to link services, as feasible and appropriate.

CMS' recommended health home services definitions will be available in the implementation guide that CMS will provide to states. CMS expects that states will encourage their health home providers to operate under a "whole-person" philosophy that considers all the medical, behavioral, and social supports and services needed by a child with medically complex conditions. The health home services provided under section 1945A include providing access to "the full range of pediatric specialty and subspecialty medical services," which would include providing access to behavioral health services. This implementation guide will be linked to the section 1945A SPA template in the Medicaid and CHIP Program (MACPro) system.

Payment Methodologies

Section 1945A(c)(1) of the Act provides that state payments to a designated provider, a team of health care professionals operating with a designated provider, or a health team for section 1945A health home services are generally considered to be "medical assistance" for purposes of section 1903(a) of the Act. This means that, generally, state expenditures on these payments are federally matched at the federal medical assistance percentage (FMAP) described in section 1903(a)(1) of the Act and defined in section 1905(b) of the Act. However, section 1945A also makes an increased FMAP available to states for these expenditures during the first two fiscal year quarters that the state's section 1945A health home SPA is in effect, as further described below.

Section 1945A(c)(2) requires the state to specify the payment methodology used for determining payment for section 1945A health home services in its SPA that adds coverage for those services, and requires that this payment methodology be established consistent with section 1902(a)(30)(A), but otherwise permits states considerable flexibility to establish payment methodologies for section 1945A health home services. Section 1945A(c)(2)(A)(i) of the Act permits states to create a tiered payment methodology for section 1945A health home services that accounts for the severity or number of a child's chronic conditions, life-threatening illnesses, disabilities, or rare diseases, or the specific capabilities of the designated provider, team of health care professionals operating with the designated provider, or health team. In addition, section 1945A(c)(2)(B) of the Act provides that state payment methodologies for section 1945A health home services are not limited to per-member per-month payments, and permits states to propose alternate models of payment for CMS approval.

Consistent with section 1902(a)(30)(A) of the Act, CMS will review proposed SPAs establishing section 1945A health home payment methodologies for consistency with the goals of efficiency, economy, quality of care, and sufficient access to providers. Therefore, states should provide a comprehensive description of the rate-setting policies in the proposed SPA.

CMS reminds states of the requirement to provide public notice of any significant proposed changes in their methods and standards for setting payment rates for services prior to the effective date of any SPA implementing those changes, consistent with the public notice requirements at 42 CFR § 447.205. Additionally, documentation of the delivery of the health home services in the individual's health record is useful not only when billing for services, but also in the event that a government audit takes place.⁵ Additionally, consistent with 42 CFR § 433.32(a), states must maintain an accounting system and supporting fiscal records to assure that claims for federal funds are in accord with applicable federal requirements.

States interested in proposing to establish a capitated payment methodology for section 1945A health home services are encouraged to work with CMS informally prior to developing an official submission. We are happy to provide technical assistance to states interested in other payment methods or strategies.

Increased Federal Medical Assistance Percentage (FMAP)

Section 1945A(c)(1) of the Act provides that the FMAP for state expenditures on health home services for children with medically complex conditions shall be increased by 15 percentage points, but in no case may exceed 90 percent, for the first two fiscal year quarters that a section 1945A health home SPA is in effect. After the end of this increased FMAP period, states will receive the regularly applicable FMAP for their expenditures on section 1945A health home services. However, a state may be eligible for new periods of increased FMAP under section 1945A(c)(1) if the state receives approval of another section 1945A SPA to expand section 1945A health home services to new geographic areas.

After a state's section 1945A health home SPA takes effect, the state can submit a claim to CMS for federal financial participation for its expenditures on section 1945A health home services on a new Category of Service (COS) line through the quarterly Form CMS-64 in the Medicaid and Children's Health Insurance Program Budget Expenditure System (MBES/CBES). States should report their expenditures on this COS line throughout the period when the section 1945A health home SPA is in effect. The new COS line will be called "Line 49, Health Homes for Children with Medically Complex Conditions." CMS suggests that states select a SPA effective date at the beginning of a fiscal year quarter, based on when providers will be ready to implement. Please note that the increased FMAP is available only for services provided on or after the effective date

⁵ States that are considering bundled payment methodologies for section 1945A health home services should also be aware of CMS guidance on bundled payment rates, which explains that "States can only report expenditures for which all supporting documentation is available (i.e. date of service, name of recipient, Medicaid identification number), in readily reviewable form, which has been compiled and is immediately available when the claim for expenditures is filed on the CMS-64." <https://www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/bundled-rate-payment-methodology.pdf>.

of the approved section 1945A health home SPA, and only during the first two fiscal year quarters that the approved SPA is in effect. If there is a delay in implementation, a state might be able to claim increased FMAP during only part of the first two fiscal year quarters its section 1945A SPA is in effect. This is because, if the state is not covering health home services during part of that period, it would not have any expenditures on which to base a claim for the increased FMAP. There is no date by which a state's section 1945A health home SPA must take effect in order for the state to receive the two quarters of increased FMAP.

Provider Infrastructure

Section 1945A of the Act describes three distinct possible types of health home providers from which a beneficiary may receive health home services: designated providers, as defined in section 1945A(i)(5) of the Act; a team of health care professionals, as defined in section 1945A(i)(6) of the Act, that is operating with a designated provider; and a health team, as defined in section 1945A(i)(7) of the Act. Each health home provider must satisfy certain qualification standards listed in section 1945A(b) and further described below.

According to section 1945A(i)(5) of the Act, a "designated provider" includes 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 or prepaid ambulatory health plan (as defined in 42 CFR § 438.2), rural clinic, community health center, community mental health center, or home health agency. Designated providers may also include providers who are employed by, or affiliated with, a children's hospital. This is not an exhaustive list. Section 1945A(i)(5) also defines a designated provider as including any other entity or provider that is determined by the state and approved by the Secretary to be qualified as 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. States should describe all proposed designated providers in their proposed section 1945A health home SPAs for CMS' review and approval.

Section 1945A(i)(6) of the Act defines a "team of health care professionals" as a team of health care professionals that may include physicians and other professionals, such as pediatricians, pediatric specialty or subspecialty providers, nurse care coordinators, dietitians, nutritionists, social workers, behavioral health professionals, physical therapists, occupational therapists, speech pathologists, nurses, and/or individuals with experience in medical supportive technologies. States may also include on such a team any professionals determined to be appropriate by the state and approved by the Secretary. Further, a team of health care professionals may include an entity or individual who is designated to coordinate such a team, or community health workers, translators, and other individuals with culturally appropriate expertise. A provider comprising part of the team 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. The SPA should include a description of the composition of these teams.

Section 1945A(i)(7) of the Act defines “health team” to have the same meaning given this term in section 3502 of the Patient Protection and Affordable Care Act (42 U.S.C. § 256a-1), titled “Establishing Community Health Teams to Support the Patient-Centered Medical Home.” Section 3502(b)(4) of the Patient Protection and Affordable Care Act provides that a health team under that section is an interdisciplinary, inter-professional team of health care providers, as determined by the Secretary, and that the team may include medical specialists, nurses, pharmacists, nutritionists, dietitians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physician assistants.

CMS recognizes that there is diversity in provider arrangements across states. However, CMS will expect the state to apply the provider qualification standards described in section 1945A(b) of the Act to all types of section 1945A health homes operating in a state, and to be accountable for the providers adhering to and upholding those standards.

Provider Standards

CMS encourages states to propose SPAs under section 1945A that would support a “whole-person” approach to care for children with medically complex conditions and promote continuous quality improvement. A whole-person approach identifies needed services and supports through person-centered planning⁶ resulting in care and linkages to care that address an individual’s needs. Consistent with section 1945A(b)(2) of the Act, states must require that their providers of section 1945A health home services for children with medically complex conditions are able to use a family-centered care planning approach that accommodates patient preferences. In addition, health home providers, as is common practice, are expected to document the delivery of the health home services in the individual’s health record.

Section 1945A(b) of the Act provides that the Secretary shall establish standards for qualification as a section 1945A health home provider. Under these standards, section 1945A health home providers must demonstrate to the state the ability to do the following:

- (1) Coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times;
- (2) Develop an individualized comprehensive pediatric family-centered care plan for children with medically complex conditions that accommodates patient preferences;
- (3) Work in a culturally and linguistically appropriate manner with the family of a child with medically complex conditions to develop and incorporate into such child’s care plan, in a manner consistent with the needs of the child and the choices of the child’s

⁶ As discussed in an October 20, 2021 CMCS Informational Bulletin (CIB), CMS recommends that states with health homes for children with medically complex conditions encourage or require their section 1945A health home providers to develop a person-centered service plan like that described in 42 CFR 441.725(a) and (b) for children with medically complex conditions. See <https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf>

family, ongoing home care, community-based pediatric primary care, pediatric inpatient care, social support services, and local hospital pediatric emergency care;

(4) Coordinate access to—

(A) subspecialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic, treatment, and critical care levels as medically necessary; and

(B) palliative services if the state provides Medicaid coverage for such services;

(5) 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 guidance issued under section 1945A(e)(1) and 42 CFR 431.52;⁷ and

(6) Collect and report information in accordance with section 1945A(g)(1) of the Act.

States should describe in their section 1945A health home SPAs the infrastructure they expect to put in place to ensure that timely, comprehensive, high-quality health home services are available. A state with established medical home provider standards wishing to submit a SPA under section 1945A of the Act that would authorize the existing medical home providers to become section 1945A health home services providers should describe how its existing medical home standards align with the statutory health home provider qualifications listed above, and/or have been modified to address the specific provider qualifications and health home services required under section 1945A, including the use of health information technology and quality reporting.

States should also ensure that providers of health home services can perform the functions listed below.

- Demonstrating clinical competency for serving the complex needs of section 1945A health home enrollees;
- Demonstrating the application of person- and family-centered practices in the delivery of section 1945A health home services.
- Demonstrating application of the Life Course approach,⁸ integrating services in the continuum of the child's life and assisting the family to anticipate needs as the child grows and changes;
- Providing access to timely health home services 24 hours a day, 7 days a week to address any immediate care needs of health home enrollees;

⁷ See <https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf>.

⁸ See research information: <https://www.hrsa.gov/sites/default/files/ourstories/mchb75th/images/rethinkingmch.pdf> and toolkit here: <https://www.citymatch.org/mch-life-course/>

- Maintaining conflict of interest safeguards to assure that services are coordinated in accordance with enrollee needs expressed in the family-centered care plan, rather than based on financial interests or arrangements of the health home provider;
- Providing quality-driven, cost-effective, culturally appropriate, and trauma-informed health home services;
- Coordinating and providing access to high-quality health care services informed by evidence-based clinical practice guidelines;
- Coordinating and providing access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Coordinating and providing access to comprehensive care management, care coordination, and transitional care across settings (Note: Transitional care should include appropriate follow up from inpatient to other settings (such as participation in discharge planning), and facilitating transfer from a pediatric to an adult system of health care);
- Having protocols to assist in removing barriers, such as those posed by transportation, to ensure safe transition of care between providers. Protocols could include relationships between the health home provider and hospitals or other health care providers;
- Coordinating and providing access to chronic disease management, including self-management support for individuals and their families;
- Coordinating and providing access to behavioral health and recovery services;
- Coordinating and providing access to individual and family supports, including referral to home and community-based services, respite care and family support groups;
- Coordinating with school-based health services providers;
- Coordinating and providing access to long-term care services and supports;
- Demonstrating a capacity to use health information technology to link services as feasible and appropriate, including by facilitating communication among health team members and facilitating communication among the health team, individual, and family caregivers;
- Demonstrating a capacity to use health information technology to provide feedback to providers to improve service delivery across the care continuum;
- Use of health information technology that supports interoperability through alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health IT in accordance with 45 CFR part 170, subpart B, where applicable, as well as other relevant consensus-based, non-proprietary standards;⁹ and
- Establishing a continuous quality improvement program, and collecting and reporting on data that permits an evaluation of increased coordination of care, efforts to advance health equity, program performance, and the management of complex conditions.

Service Delivery System for Section 1945A Health Home Services.

States have flexibility to determine what service delivery system or combination of systems will be used in their section 1945A health homes programs. As a reminder, section 1945A(h)(2) provides that nothing in section 1945A may be construed “to limit the choice of a child with medically complex conditions in selecting a designated provider, team of health care professionals operating with such a provider, or health team that meets the health home

⁹ See ONC’s Interoperability Standards Advisory (ISA) at <https://www.healthit.gov/isa/>.

qualification standards established under [section 1945A(b)] as the child’s health home.” This means that there cannot be a closed provider network for section 1945A health home services delivered via managed care and the choice of section 1945A health home services providers through a managed care organization cannot be limited. If states’ managed care contracts need to be updated to reflect this, CMS will provide technical assistance.

Provider Reporting Requirements

Section 1945A(g)(1) of the Act requires section 1945A health home services providers to report to the state, at such time and in such form and manner as may be required by the state, the following information:

1. Provider name;
2. National Provider Identification number;
3. Provider address;
4. Specific health care services offered to children with medically complex conditions who have selected the specific provider reporting this information as their health home;
5. Information on all applicable measures for determining the quality of health home services provided by the health home services provider, including, to the extent applicable, child health quality measures and measures for centers of excellence for children with complex needs developed under titles XIX and XXI of the Act, and section 1139A of the Act; and
6. Such other information as the Secretary shall specify in guidance.

This reporting should help the state and its participating section 1945A health home providers to assess the quality of section 1945A health home services. At this time, CMS is considering the following measures for possible use as part of the section 1945A(g)(1) quality measure reporting, several of which are part of the current Child and/or Health Home Core Sets:

1. Well-Child Visits in the First 30 Months of Life (W30-CH);
2. Child and Adolescent Well-Care Visits (WCV-CH);
3. Childhood Immunization Status (CIS-CH);
4. Immunizations for Adolescents (IMA-CH);
5. Oral Evaluation, Dental Services (OEV-CH);
6. Ambulatory Care: Emergency Department (ED) Visits (AMB-HH); and
7. Inpatient Utilization (IU-HH)

These measures are expected to capture information on clinical and quality of care outcomes specific to the provision of section 1945A health home services. This list of measures will be added to the annual Health Home Quality Measures Core Set workgroup review process. CMS will provide more information in the future on these reporting requirements.

State Monitoring and Reporting Requirements

To support continued improvement and evaluation, section 1945A(f) of the Act requires states that implement section 1945A health homes for children with medically complex conditions to include in their section 1945A health home SPAs:

- (1) A methodology for tracking reductions in inpatient days and reductions in the total cost of care resulting from improved care coordination and management under section 1945A;
- (2) A proposal for the use of health information technology in providing health home services under section 1945A 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); and
- (3) A methodology for tracking prompt and timely access to medically necessary care for children with medically complex conditions from out-of-state providers.

Comprehensive Report

Section 1945A(g)(2)(A) of the Act requires a state with an approved section 1945A SPA to report to the Secretary (and, upon request, to the Medicaid and CHIP Payment and Access Commission (MACPAC)), at such time and in such form and manner determined by the Secretary to be reasonable and minimally burdensome, the following information:

- (1) Information reported by health home providers under section 1945A(g)(1) of the Act, as described on page 10 of this letter;
- (2) The number of children with medically complex conditions who have selected a section 1945A health home;
- (3) The nature, number, and prevalence of chronic conditions, life-threatening illnesses, disabilities, or rare diseases that such children have;
- (4) The type of delivery systems and payment models used to provide services to such children under section 1945A;
- (5) The number and characteristics of designated providers, teams of health care professionals operating with such providers, and health teams selected as section 1945A health homes, 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 with medically complex conditions who have selected a section 1945A health home;
- (6) The extent to which children with medically complex conditions who have selected a section 1945A health home receive health care items and services under the state plan; and

- (7) Quality measures developed specifically with respect to health care items and services provided to children with medically complex conditions.

CMS expects to provide information in the future on the requirement for states to submit the comprehensive report described in section 1945A(g)(2)(A).

Report on Best Practices for Coordinating Care from Out-of-State Providers

Federal statutory and regulatory provisions govern coverage of services provided by out-of-state providers under Medicaid. Section 1902(a)(16) of the Act requires states to include provisions in the state plan with respect to furnishing medical assistance under the state plan to individuals who are residents of the state but absent from it. These state plan provisions 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; or
- It is general practice for beneficiaries in a particular locality to use medical resources in another state.

In accordance with section 1945A(e) of the Act, CMS issued detailed guidance on October 20, 2021,¹⁰ regarding:

- Best practices for using out-of-state providers to provide care to children with medically complex conditions;
- Coordinating care for children with medically complex conditions provided by out-of-state providers (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 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.

In accordance with section 1945A(g)(2)(B) of the Act, states implementing the section 1945A health homes option must, no later than 90 days after CMS approval of the state's section 1945A health home SPA, submit to CMS and make publicly available on the appropriate state website,

¹⁰ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib102021.pdf>

a report on how the state is implementing the CMS guidance issued on October 20, 2021, including through any best practices adopted by the state.

Coordinating Care - State Assurances

In accordance with section 1945A(d), states implementing the section 1945A health home benefit must comply with all of the following requirements:

- *Hospital Notification:* A state with an approved section 1945A health home SPA must require each hospital that is a participating provider under the state plan (or waiver of such plan) to establish procedures to notify the state's section 1945A health home(s) about the treatment of any child who is enrolled in a section 1945A health home and who seeks treatment in the hospital's emergency department. Accordingly, CMS will ask states to provide an assurance in their section 1945A SPAs that they have required their Medicaid-participating hospital providers to establish these procedures.
- *Education with Respect to Availability of Health Home Services:* States must include in their section 1945A health home SPAs a description of their processes for educating providers participating in the state plan (or a waiver of such plan) on the availability of health home services for children with medically complex conditions, including the process by which providers can refer such children to a section 1945A health home provider.
- *Family Education:* States must include in their section 1945A health home SPAs a description of their processes for educating families with children eligible to receive section 1945A health home services of the availability of section 1945A health home services. This process must include the participation of family-to-family entities, other public or private organizations, or entities that provide outreach and information on the availability of health care items and services to families of Medicaid-eligible individuals.
- *Mental Health Coordination:* States with an approved section 1945A health home SPA must consult and coordinate, as appropriate, with the Secretary in addressing issues regarding the prevention and treatment of mental illness and substance use among children receiving section 1945A health home services. The Secretary will expect states, as part of this requirement, to consult with the Substance Abuse and Mental Health Services Administration (SAMHSA) about their section 1945A health home SPAs before submitting the SPA, and on an ongoing basis, as needed, once the SPA is implemented. CMS anticipates that the SPA template for the section 1945A health home benefit will include a field for the state to note the date of its initial consultation with SAMHSA.

General Information

States interested in establishing a Medicaid health home program for children with medically complex conditions should submit a SPA via MACPro for CMS review and approval. CMS will inform states when the new SPA template becomes available in the MACPro system. States will be able to work on the draft SPA submissions in the system while receiving technical

assistance from CMS prior to submitting the SPA officially. In addition to the SPA template, CMS will provide a link to the implementation guide in the MACPro system. The implementation guide will include recommended service definitions and provider standards for state consideration, which states may reference while developing their SPA submissions. States and interested parties can submit questions about the new section 1945A health home benefit for children with medically complex conditions to healthhomes@cms.hhs.gov.

Support for State Planning Activities

Section 1945A(c)(3) of the Act provides that, beginning October 1, 2022, the Secretary may award planning grants to states for purposes of developing a section 1945A SPA. The total amount of payments made to states under section 1945A(c)(3) shall not exceed \$5,000,000.

CMS expects to provide further details on these planning grants in a future, separate announcement, pending available funding.

Conclusion

We look forward to working with states to help them implement this new health home state plan option for children with medically complex conditions. For specific information about this new Medicaid state plan option please contact Sara Rhoades, Technical Director for Health Homes, Disabled and Elderly Health Programs Group, at 410-786-4484 or at Sara.Rhoades@cms.hhs.gov.

Sincerely,



Daniel Tsai
Deputy Administrator and Director
Center for Medicaid & CHIP Services

Attachment

cc:

Ann Flagg
Senior Director
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Matt Salo
Executive Director
National Association of Medicaid Directors

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