Main Office | AGEG c/o EUREGIO | Enscheder Str. 362 | 48599 Gronau (Germany)
Project Office | AEBR c/o BISDN | Körnerstraße 7 | 10785 Berlin (Germany)
AEBR Antenna in the EU | Office of Extremadura in Brussels | Av. De Cortenbergh 87-89 | 1000 Brussels (Belgium)
AEBR Info Centre in the Balkans | Institute for International and CBC | Terazije 14/14 | 11000 Belgrade (Serbia)
AEBR Info Centre in Ukraine | Univ. Simon Kuznets (KhNUE) | pr. Lenina, 9a | 61001 Charkiw (Ukraine)

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FINAL REPORT BY THE EXPERT

Advice case title: Healthcare follow-up and Hospital at home

Full official name of the advised entity: EGTC Alzette Belval

Name of the expert contracted for the advice case: Health Connect Partners (subject matter experts: Isabelle Andoulsi, Petra Wilson and Anett Molnar)

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Executive summary

The economic relationship between France and Luxembourg means that many people not only live in the border region, but cross the border frequently for work, for leisure or to obtain or provide services. The European Grouping of Territorial Cooperation (EGCT) set up in the Alzette Belval region has noted that a particular issue arises in the context of healthcare when a patient living on the French side of the border who has received in-patient hospital care in Luxembourg wishes to use Hospital at Home services in France in line with common French practice. The EGCT has requested an assessment of the legal obstacles and possible solutions to the provision of Hospital at Home for patients living in France who have received in-patient care in Luxembourg.

Based on a careful assessment of the law, and detailed discussion with care providers and officials in France and Luxembourg, the present report describes the legal challenges, which hinge on four core issues:

- **Long-term care and assited living are excluded from the the Cross-Border Care Directive (2011/24/EU).** It is unclear how Hospital at Home would be classified with repsect to this exclusion.
- Hospital at Home cannot be prescribed by a physician in Luxembourg for a patient living in France, **because the Directive covers only prescription of medicines and medical devices, not services**.
- The premise of both the Cross-Border Healthcare Directive (2011/24/EU) and the Regulations on Coordination of Social Security (883/2004/EU and 987/2009) is that care may be accessed in another EU Member State that is within the basket of care in the patient's country of insurance affiliation. **Hospital at Home as defined in France is not in the Luxembourgish public health insurance package**. The difference in nomenclature and reimbursement codes makes it difficult for a patient to apply for reimbursement under the Regulations.
- Both the Directive on Cross-Border Healthcare (2011/24/EU) and the Regulations on Coordination of Social Security (883/2004/EU and 987/2009) are focussed on the **mobility of the patient, not the professional providing services**, so healthcare professionals cannot be sent over borders to provide care on the basis of either piece of legislation.

The report then sets out a number of possible actions which could be taken to address the obstacles. Ideally, several of these should be acted upon in a coordinated manner, as best results would not be achieved if these solutions were taken as stand-alone actions.

- **Test the applicability of the exclusion of long-term care** from the the Cross-Border Healthcare Directive (2011/24/EU) to Hospital at Home, in particular in the context of Article 168(2) of the Treaty on the Functioning of the EU which encourages cooperation between the Member States to improve the complementarity of their health services in cross-border areas.
- **Include the prescription of care services within the definition of cross-border prescriptions** as provided for in the the Cross-Border Healthcare Directive (2011/24/EU, rather than limiting this to prescriptions for medicines and devices.
- **Create a standardised vocabulary and nomenclature** (or reimbursement codes) between France and Luxembourg which classifies home care services in the same way in order that the Regulations on Coordination of Social Security (883/2004/EU and 987/2009) would apply to such care.
- **Develop targeted information tools** to facilitate patients' and healthcare professionals' understanding of the rules of cross-border care and its reimbursement.
- **Adopt models for the integration of digital health solutions into cross-border care.**
- **Adopt specific agreements to facilitate cross-border care in the Alzette Belval region** which build on the experiences of the Zone Organisée d'Accès aux Soins Transfrontaliers (ZOAST) as operated on the French-Belgian border **to address the mobility of the health professionals to provide continuity of care.**

2. Description of the Obstacle

2.1 Cross-border co-operation in the Alzette Belval Region

Luxembourg has borders with France, Germany and Belgium, with the French border being the shortest at just 138 km. However, despite the short length on this border, the economic relationship between the two countries means that many people not only live in the border region, but also that many cross the border frequently, some on a daily basis for work, and others less frequently for work, for leisure or to obtain or provide services. Some of these services are healthcare services for which a person might be insured in one country, but seeking to use services in the other, or indeed, to provide services in one country whilst being legally established in the other.

It is within the context of these cross-border services, including healthcare services, that the Alzette Belval region has established a legal entity to support cross-border cooperation. On 7 January 2010, an agreement on the implementation of a European Grouping of Territorial Cooperation (in abbreviated form "EGCT") was signed in the Alzette Belval territory, which entered into force three years later on 8 March 2013. The Alzette Belval EGTC covers an area of 170 km² including twelve municipalities: four on the Luxembourg side (Esch-sur-Alzette, Sanem, Mondercange, Schifflange), eight on the French side (community of municipalities Pays-Haut Val d'Alzette) and three local authorities (the Region, the General Council of Moselle and the General Council of Meurthe-et-Moselle). This cross-border instrument of cooperation between the French and Luxembourg local authorities has legal personality and the financial autonomy necessary to carry out projects in the French-Luxembourg border.

The EGTC Alzette Belval serves as a decision-making forum that unites the different levels of executive bodies involved in these projects, including the French and Luxembourg states and local authorities, with equal representation. The entity is headed by a rotating presidency, ensuring its continuous operation. The EGTC Alzette Belval has been proactive in identifying and addressing several challenges in the healthcare sector; of which one is related to home hospitalisations and home nursing services for patients who live in France but have received care in hospital in Luxembourg.

2.2 An overview of the legal challenges of Hospital at Home

The patients concerned in this case are patients who have received care in a hospital in Luxembourg and who wish to continue care, including end-of-life care, at home.

In France, a patient who has received care in a hospital may, at their request and after medical validation, continue care at home. In this case, the hospital "comes to home" and a hospital team dedicated to 'Hospital at Home' takes charge of the care with all the necessary equipment (monitors, infusion pumps, drips etc The Hospital at Home teams either send nurses from the hospital, or contract with self-employed community nurses who provide care in the patient's home on their behalf, with the hospital doctor remaining responsible for the patient's overall care plan.

However, on the French territory of Alzette Belval, the French hospitals that provide Hospital at Home are not local. The Metz-Thionville hopsital is approximaley 30 minutes drive away, while the University Hospital in Nancy is more than one-and-a-half hours drive away. This could mean 1 hour 30 driving, only in one way, for the Hospital at Home team located in a French hospital to a patient in the French part of the Alzette Belvan region . The nearest hospital for these patients, and indeed the hospital in which in-patient care was provided, is in Luxembourg in Esch-sur-Alzette. The patient living in the French side of this border region will therefore want to receive Hospital at Home care in France under the supervision of the hospital in Luxembourg, this however presents several legal challenges as set out below.

a) Hospital at Home is not within the EU level cross-border care legislation

A person living in the EU and benefiting from social security coverage which covers healthcare has three different routes at their disposal to receive cross-border healthcare in the EU and to be reimbursed under the public health insurance schemes. They can seek treatment according to the rules and principles set by the Regulations on the Co-ordination of Social Security (Regulation 883/2004 and Implementing Regulation 987/2009); Directive 2011/24/EU on Cross-Border Healthcare; as well as bi-lateral/multilateral agreements or national legislation.

Directive 2011/24/EU on Cross-Border Healthcare provides for cross-border care for EU nationals, nationals of the European Economic Area States (Iceland, Liechtenstein and Norway), refugees and stateless persons residing in a Member State of the European Union or of the European Economic Area, who are or have been subject to the legislation of one or more Member States and their family members and survivors.

The Directive covers planned healthcare provided in a Member State other than the Member State of insurance affiliation, as well as the prescription and dispensation of medicinal products and medical devices when they are provided as part of a health service. It is aimed primarily at ambulatory care which a patient can generally travel to receive without prior authorisation in the home state. In some cases, such prior authorisation may be required, notably for care which requires at least one night of hospitalisation. The patient will be entitled to reimbursement up to the level that the care would have been reimbursed at if received in the home country (country of affiliation).

However, it is clearly stated in the Directive that: *This Directive should not apply to services the primary purpose of which is to support people in need of assistance in carrying out routine, everyday tasks. More specifically, this Directive should not apply to those long-term care services deemed necessary in order to enable the person in need of care to live as full and self-determined a life as possible. Thus, this Directive should not apply, for example, to long- term care services provided by home care services, in assisted living facilities and in residential homes or housing ('nursing homes')(Recital 14).* This is addressed in Article 3(a) which sates: *services in the field of long-term care the purpose of which is to support people in need of assistance in carrying out routine, everyday tasks.*

In the interviews with stakeholders in the region it was frequently voiced that, because of Recital 14 and Article 3(a), the Directive is not applicable to cover Hospital at Home. It is, however, not certain that this is necessarily the case. The example provided in recital 14 clearly assistive care services. It is possible that Hospital at Home could be classified as a medical service which falls within the Directive just as visit to a nurse providing services in an ambulatory care centre would be covered.

The Regulations on Social Security Co-ordination provide for patients to travel to another EU country to receive care that has been authorised by their doctor in the country of affiliation. Article 20(2) specifies: *The authorisation shall be accorded where the treatment in question is among the benefits provided for by the legislation in the Member State where the person concerned resides and where he/she cannot be given such treatment within a time limit which is medically justifiable, taking into account his/her current state of health and the probable course of his/her illness.*

Note here that the Regulation specifies that the care accessed in the state of residence must be in the package of benefits provided for in the state of affiliation. As Hospital at Home care is not generally provided for in the benefits package in Luxembourg, it will be hard to a Luxembourg insurer to issue an authorisation for such care in France. The French insurer could technically issue such authorisation for hospitalisation at home in Luxembourg, but if the healthcare system is not organised to include such care provision, it is difficult to see how it could be executed. Some EU border regions have entered into bilateral agreements between the border regions of several countries to address the special needs of border residents' access to healthcare. Some examples are

outlined in section 4 below, which could be used as examples to address the challenges of hospital at home in the Alzette Belval region.

b) EU legislation does not address care provision across borders

In order for a Luxembourg medical team to provide Hospital at Home services to a patient in France both staff and medical material would have to cross the border. It is both legally and organisationally difficult for a team of community nurses on the French side (which replaces the French hospital team in case of hospitalisation at home planned by a French hospital) to provide care in France because they are not part of the Luxemburgish health system and therefore not under the supervision of the doctors in the Luxembourg hospital. The key issue here is that neither EU nor national level legislation has provided for care and materials crossing the border, as the concept of cross border care as foreseen in the legislation is based upon a patient travelling to a country to receive care.

c) Hospital at Home is not in the Luxembourg care pathway and reimbursement nomenclature

In France, home nursing services are generally available for persons over 60 years of age or persons with disabilities, as well as all persons who need nursing care as part of a particular medical follow-up (after an operation or surgery in particular). They are self-employed community nurses whose care services are provided on the basis of a prescription issued by the treating physician. Luxembourg, however, does not routinely provide hospitalisation at home. As a result, the processes and care plans for such care are not established in the Luxembourg system and do not have standard care nomenclature and reimbursement codes in the same way as such care does in France.

Summary:

- Hospital at Home is not available for reimbursement under the Directive if the patient is insured in Luxembourg but lives in France (or vice versa) because home care is not covered by the Directive.
- Hospital at Home cannot be prescribed as a service by a physician in Luxembourg for a patient living in France (or vice versa), because the Directive covers only prescription of medicines and medical devices, not care. It would, however, be interesting to test if a prescription for a device, such as an infusion pump, would be covered even if the use of the device demands the support of a nurse. This has not been legally tested at present.
- Hospital at Home cannot be authorised under the Regulation for a patient insured in Luxembourg and living in France, because Hospital at Home is not part of the Luxembourg care package and accordingly has no applicable nomenclature or reimbursement code.
- Hospital at Home care services provided by healthcare professionals registered in one country and providing care in another cannot be accommodated under the Regulation or the Directive because the two pieces of legislation are focussed on the mobility of the patient, not the professional providing services.
- Hospital at Home could be included in bi-lateral agreements, but new models for direct payment or reimbursement would have to be established.

These issues are explored in further detail in section 3 below.

3. A deeper look at the legal/administrative provisions causing the obstacles to Hospital at Home

3.1 Absence of a common terminology between France and Luxembourg

There is a notable difference between France and Luxembourg when it comes to hospitalisation at home. It became apparent during the interviews conducted with the representatives of national authorities from both side of the border, that they were not using the same vocabulary and hence had difficulties to understand each other.

Hospital at Home is a well-established care pathway in France. When care is provided in a hospital, the hospital physician can establish a protocol of care outside of the hospital, in which the patient's general practitioner and hospital nurses to provide continuing care services to the patient at home[1].This protocol is endorsed by an organisation solely responsible for these services which has its own legal and administrative character. This care pathway is, however, virtually non-existent in Luxembourg. Hospitals in Luxembourg offer in-patient and ambulatory care, but they do not offer a care package that is equivalent to the French model of Hospital at Home, except for patients with certain long-term conditions that require home nursing services.

Home nursing services are defined in French law as services for persons over 60 years of age or persons with disabilities, as well as all persons who need nursing care as part of a particular medical follow-up (after an operation or surgery in particular). In this case, self-employed community nurses will come on prescription and provide home care for daily follow-up.

It is to be noted that in Luxembourg these cases will most probably fall under the dependency regime which is defined by Book V of the Luxembourg Social Security Code.[2], which is further detailed below. It should be noted, however that the nurses providing these home care services in Luxembourg are now licenced to provide care services and interventions to the same level as nurses providing HAD services in France[3].

As the vocabulary and indeed reimbursement nomenclature or codes used in the two countries are different, it suggests that the two countries may have different understandings of what constitutes hospitalisation at home and home nursing services. Furthermore, the services that can be provided under these different terminologies are regulated in a different way in France and in Luxembourg.

3.2 Different national legal frameworks

In France, hospitalisation at home is regulated by law. It is defined as a set of medical and paramedical services provided at home to patients with complex care needs, for whom hospitalisation in a traditional hospital setting is not appropriate. To be eligible for hospitalisation at home in France, three conditions must be met. First, the necessary care can be provided at home. Secondly, the patient and/or their family must agree to hospitalisation at home. Thirdly, the home conditions must

[1] It is regulated by Articles L-6122-1, L-6123-1 and R-6122-25 of the Code of Public Health and by its Article R-6123-139 which states the following:
"L'activité d'hospitalisation à domicile a pour objet d'assurer au domicile du patient, des soins médicaux et paramédicaux continus et coordonnés. Ces soins se différencient de ceux habituellement dispensés à domicile par la complexité et la fréquence des actes". It is also regulated by a Décret n° 2021-1954 du 31 décembre 2021 relatif aux conditions d'implantation de l'activité d'hospitalisation à domicile

[2] Code de la sécurité sociale luxembourgeoise, disponible sur https://www.secu.lu/assurance-dependance/livre-v/chapitre-i-objet-de-lassurance/

[3] This flows from interviews with the hospital representatives of Esch-sur-Alzette and the Luxembourg Ministry of Health.

allow for the provision of care.[4]

An evaluation of the patient's situation is carried out by a care team to ensure the feasibility of care and to determine infrastructural needs of the planned care, such as a special bed or infusion pump. The hospital or a service provider delivers the necessary equipment to the patient's home. It is important to note that Hosptial at Home is not limited to a particular age group and is available for patients of all ages, including children, adolescents and adults. A partnership agreement between a home hospitalisation establishment and a home nursing service or a multi-purpose home help and care service can facilitate the joint provision of care. Additionally, the patient must reside in a geographical area covered by a Hospital at Home organisation.[5]

The services provided through Hospital at Home are reimbursed by the French health insurance system. The decision to provide Hospital at Home is made by the patient's physician or the hospital doctor and requires authorization from the French health insurance system. When the initiative comes from a hospital doctor, the agreement of the patient's general practitioner is always sought. Indeed, it is the latter who plans the care project in coordination with the establishment's care team. In such cases, the patient's general practitioner and hospital doctor collaborate to organize home care. Hospital infrastructure and equipment are integrated into the patient's home, and the cost of such care is reimbursed.

In Luxembourg, according to the interviews conducted with delegates from the Ministry of Health and the Social Security Ministry, hospitalisation at home is generally not possible. Medical services are only provided to patients either as in-patients or as part of out-patient ambulatory care. In Luxembourg, therefore patients will usually have to come back to the hospital for their follow-up, whereas in France these services can be delivered at home. In Luxembourg, in some specific cases, such as patients with mental illnesses or disabilities of a duration of at least six months, nursing services will be delivered at home. This is regulated by Book V of the Luxembourg Social Security Code[6] which states at Article 347, first paragraph of this Livre V states that:
"L'assurance dépendance a principalement pour objet, dans les limites fixées par le présent livre, la prise en charge par des prestations en nature, des aides et soins à la personne dépendante fournis intégralement ou partiellement dans le cadre d'un maintien à domicile ou d'un établissement d'aides et de soins ainsi que des aides techniques et des adaptations du logement ».[The main purpose of long-term care insurance, within the limits set by this book, is to cover, by means of benefits in kind, the cost of assistance and care for the dependent person provided in full or in part within the framework of home care or an assistance and care establishment, as well as technical aids and home adaptations].

Article 348 then defines who can be qualified as a dependent person stating that:
"Est considérée comme dépendance au sens du présent livre, l'état d'une personne qui par suite d'une maladie physique, mentale ou psychique ou d'une déficience de même nature a un besoin important et régulier d'assistance d'une tierce personne pour les actes essentiels de la vie ».[For the purposes of this book, 'dependency' means the condition of a person who, as a result of a physical, mental or psychological illness or a disability of the same nature, has a significant and regular need for

[4] Code de la santé publique français, articles R-6121-4, D-6124-306 à D6124-312. ; Arrêté du 1er juin 2018 fixant la durée de la prise en charge minimale par le service de soins infirmiers à domicile ou le service polyvalent d'aide et de soins à domicile permettant une intervention conjointe avec un établissement d'hospitalisation à domicile. ; Décret n° 2022-102 du 31 janvier 2022 relatif aux conditions techniques de fonctionnement de l'activité d'hospitalisation à domicile.
[5] *Ibid*.
[6] Code de la sécurité sociale luxembourgeoise, disponible sur https://www.secu.lu/assurance-dependance/livre-v/chapitre-i-objet-de-lassurance/

assistance from a third party for the essential acts of life].

Such dependent persons can receive nursing services and a specific assistance with their daily activities. The services are provided by regulated and accredited services and nursing services providers. The services will be paid by the dependency insurance which is valid for each person affiliated in Luxembourg. This means that patients who require ongoing medical care or monitoring, but who do not meet the strict criteria of the Book V of the Social Security Code, will be unable to receive the care they need at home.

This also creates a problem of interoperability between France and Luxembourg. Indeed, while hospitalisation at home is a common practice in France and is included in the French nomenclature, it does not exist in Luxembourg and is hence not included in the nomenclature. This lack of uniformity in care provision organisation and nomenclature poses a considerable challenge to patients who require hospitalisation at home in France and may find themselves without access to this service when at first hospitalised in Luxembourg.

Differences in the vocabulary used on both side of the France-Luxembourg border and differences in their respective legal frameworks are even the cause for misunderstandings between the French and the Luxembourg national authorities, as nursing services are encompassed under the Book V of the Luxembourg Social Security Code and reimburse according to these provisions, when home hospitalisation is not covered at all.

3.3 Cross-border healthcare under the European legal framework

Cross-border healthcare occurs when an individual seeks medical care in a country that is different from his/her affiliation country. To regulate this process, the European Union has created the social security coordination Regulations - Regulation 883/2004 and Implementing Regulation 987/2009.

a) Directive 2011/24/EU on the application of patients' rights in cross- border healthcare

The Regulations were found however, not to be best suited to ambulatory care, which resulted in several cases being raised by patients and being ultimately addressed in the European Court of Justice. These include *Kohll* and *Decker* cases[7] which established the principle that EU citizens have the right to seek healthcare services in other Member States and receive reimbursement for the costs under certain conditions; and the *Smits* case[8] which clarified that the right to seek healthcare in another Member State extends to planned healthcare as well. The *Peerbooms* case[9] then established the principle that prior authorization for cross-border healthcare may not be systematically refused and must be assessed on a case-by-case basis, while the *Watts* case[10] confirmed the importance of ensuring that cross-border healthcare is accessible to all, regardless of their financial situation.

Directive 2011/24/EU on the application of patients' rights in cross-border[11] codifies and clarifies the jurisprudence of the European Court of Justice in the case noted above. The Directive does not deal

[7] CJCE, *Raymond Kohll v. Union des caisses de maladie*, case of 28 April 1998, C-158/96. ; CJCE, *Nicolas Decker v. Caisse de maladie des employés privés*, case of 28 April 1998, C-120/95.
[8] CJCE, *B.S.M. Geraets-Smits v. Stichting Ziekenfonds VGZ* and *H.T.M. Peerbooms v. Stichting CZ Groep Zorgverzekeringen*, cases of 12 July 2001, C-157/99.
[9] CJCE, *B.S.M. Geraets-Smits v. Stichting Ziekenfonds VGZ* and *H.T.M. Peerbooms v. Stichting CZ Groep Zorgverzekeringen*, cases of 12 July 2001, C-157/99.
[10] CJCE, Yvonne Watts v. Bedford Primary Care Trust and Secretary of State for Health, case of 16 May 2006, C-327/04.
[11] Directive (EU) No 2011/24 of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, *O.J.*, L 88/45, 4 April 2011, available at https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32011L0024&from=EN.

solely with the rights to reimbursement, but also introduces a number of significant flanking measures to support patients in using these rights in practice. As part there is now a minimum set of requirements which applies to all health care provided to patients in the EU. These requirements relate to transparency, information to patients, and safety and quality of care.

The Directive provides that patients who are entitled to a particular health service under the statutory healthcare system in their home country - Member State of affiliation -, are generally also entitled to be reimbursed if they choose to receive such treatment in another Member State. The Directive applies to care delivered by private or public sector healthcare establishments. The Directive requires that the patient should generally receive the same level of reimbursement as if the treatment had been received in the Member State of affiliation. However, the level of reimbursement can never exceed the actual costs of the healthcare received, even if a higher amount would have been reimbursed if the care had been provided in the Member State of affiliation.

The Directive allows Member States to adopt rules that require patients to seek Prior Authorisation for certain types of treatments. Such Prior Authorisation is limited to treatment requiring at least one overnight stay in hospital, or treatment requiring highly specialised or cost-intensive medical equipment or infrastructure. Prior Authorisation may be refused under certain circumstances of these the most significant is that the requested treatment is not included in the 'basket of care' of the Member State of affiliation. Member States only have the obligation to reimburse cross-border healthcare under the Directive if such healthcare is among the benefits to which the patient is entitled within the Member State of affiliation. In addition, if the patient can be offered the treatment in the Member State of affiliation within a time limit which is medically justifiable, or if particular risks to the patient or the general population have been identified, Prior Authorisation may also be refused.

In addition to the grounds for refusal of Prior Authorisation outlined above, Article 4(3) of the Directive provides the opportunity to Member States to adopt special mechanisms to limit access to public or private providers to citizens from outside their territory where such mechanisms are necessary and proportionate to fulfilling its fundamental responsibility to ensure sufficient and permanent access to healthcare within its territory. In practice however, very few Member States have made use of this provision.

It should be noted that the Directive was developed primarily to address cases of reimbursement for care received in a Member State other than the state of affiliation for which no Prior Authorisation is required - that is, Prior Authorisation is the exception, not the rule.

However, the majority of the Member States has chosen to introduce a system of Prior Authorisation (which is the case for Luxembourg)[12] for health care which involves overnight hospital accommodation or requires use of highly specialised and cost intensive medical infrastructure or medical equipment. It should be noted however that despite the fact that the Directive provides the possibility of requiring Prior Authorization, the Directive also provides that claims for reimbursement for care provided in a Member State other than the Member State of affiliation may not be unreasonably rejected.

It is however to be noted that Recital 14 of the Directive provides that "*This Directive should not apply to services the primary purpose of which is to support people in need of assistance in carrying out routine, everyday tasks. More specifically, this Directive should not apply to those long-term care services deemed necessary in order to enable the person in need of care to live as full and self-*

[12] This information was given by the representative of the Luxembourg Ministry of Social Security who explained that patient affiliated in Luxembourg but living in France could be reimbursed for the care received in France based on the S1 formulary.

determined a life as possible. Thus, this Directive should not apply, for example, to long-term care services provided by home care services, in assisted living facilities and in residential homes or housing ('nursing homes')". This exclusion of long-term care services from the scope of the Directive creates a significant obstacle for cross-border healthcare, particularly for individuals who were first hospitalised in Luxembourg and who then require hospitalisation at home or home nursing services as defined in France.

This is further complicated by Recital 16 and Article 11 of the Directive which provides that *"For the purpose of reimbursing the costs of cross-border healthcare, this Directive should cover not only the situation where the patient is provided with healthcare in a Member State other than the Member State of affiliation, but also the prescription, dispensation and provision of medicinal products and medical devices where these are provided in the context of a health service. The definition of cross-border healthcare should cover both the situation in which a patient purchases such medicinal products and medical devices in a Member State other than the Member State of affiliation and the situation in which the patient purchases such medicinal products and medical devices in another Member State than that in which the prescription was issued" (Recital 16)* and in Article 11 "*If a medicinal product is authorised to be marketed on their territory, in accordance with Directive 2001/83/EC or Regulation (EC) No 726/2004, Member States shall ensure that prescriptions issued for such a product in another Member State for a named patient can be dispensed on their territory in compliance with their national legislation in force […]. This paragraph shall also apply to medical devices that arelegally placed on the market in the respective Member State."*

Thus, while a patient living in France who recevied hospital in-patient care in Luxembourg and who wishes to return home in the framework of Hospital at Home could rely on Recital 16 of the Directive for the recognition of a Luxembourg prescription of a product (a medicine or a device) they would seem to be excluded from seeking execution of prescription to provide services. Thus, even if the care were not excluded by Recital 14, the fact that Article 16 addresses prescriptions for physical products causes a further barrier.

b) Regulation (EC) No 883/2004 on the coordination of social security systems

The benefits provided under the Directive exist in parallel to benefits provided under Regulation (EC) No 883/2004 on the coordination of social security systems.[13] The procedures for implementing Regulation (EC) No 883/2004 are laid down in Regulation (EC) No 987/2009.[14] Accordingly, the two pieces of legislation are hereinafter referred to collectively as 'the Regulations'.

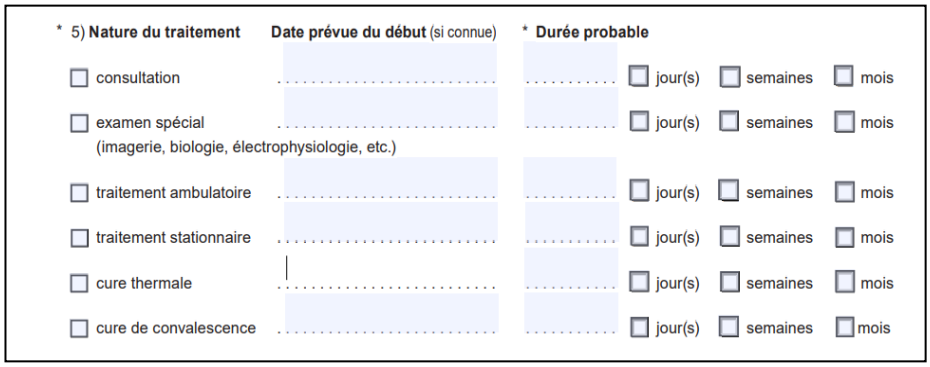
The purpose of the Regulations is to guarantee that a 'visitor' patient, who receives treatment in an EU Member other than the one in which they are insured, is treated under the same conditions as 'home' patients. It means that all people who are party to a public health insurance scheme of an EU Member State, a European Economic Area Member State (Iceland, Liechtenstein, and Norway) or Switzerland, can receive treatment in another EU or EEA country, at the expense of the public insurance scheme to which they are affiliated. Specific modalities are set out in the regulations, of which perhaps the most significant is that the care provided abroad will only be covered if such care is also covered at home and prior authorization to access the care must be obtained.

This creates the main hurdle in the Regulations which lies in the system of Prior Authorisation. If a patient living in France and working in Luxembourg (thus affiliated in Luxembourg) wishes to be

[13] Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, *O.J.*, L 166, 30 April 2004, pp. 1-123.
[14] Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination

hospitalised at home or to be provided nursing services at home, he/she much must obtain Prior Authorisation since the concept (and the nomenclature) of home hospitalisation does not exist in Luxembourg and since nursing services can only be provided by accredited nurses and health professionals which are hospital employees 'conventionned' in Luxembourg terms, while in France nursing services are provided by community nurses .

In the case of Luxembourg, it is clear that only a narrow range of healthcare services is covered, as shown by the categories listed in the application form for prior authorisation from the Luxembourg insurer for care in another EU Member State:



* 5) **Nature du traitement**	**Date prévue du début** (si connue)	* **Durée probable**			
☐ consultation	. . . . .	. . . . .	☐ jour(s)	☐ semaines	☐ mois
☐ examen spécial (imagerie, biologie, électrophysiologie, etc.)	. . . . .	. . . . .	☐ jour(s)	☐ semaines	☐ mois
☐ traitement ambulatoire	. . . . .	. . . . .	☐ jour(s)	☐ semaines	☐ mois
☐ traitement stationnaire	. . . . .	. . . . .	☐ jour(s)	☐ semaines	☐ mois
☐ cure thermale	. . . . .	. . . . .	☐ jour(s)	☐ semaines	☐ mois
☐ cure de convalescence	. . . . .	. . . . .	☐ jour(s)	☐ semaines	☐ mois

Taken from CNS Demande d'autorisation préalable d'un transfert à l'étranger

c) Directive or Regulation?

In order to understand why patients may choose to apply for care under the Regulations or Directive, it is important to understand the key similarities and differences between them:

- Both the Regulations and the Directive apply to planned and unplanned healthcare.
- Under the Regulations, Prior Authorisation is generally a requirement for receiving planned treatment in another Member State. The document to be obtained certifying Prior Authorisation under the Regulation is known as Portable Document S2.
- Under the Directive, a requirement of Prior Authorisation is not the rule. In accordance with Article 8(1) of the Directive, however the Member State of affiliation may set up a system of Prior Authorisation for certain kinds of cross-border healthcare.
- The Directive covers all providers, including private (non-contracted) providers, while the Regulations do not impose any obligation on the Member States with regards to treatment given by providers outside the public scheme.
- Under the Regulations, reimbursement of healthcare received in a Member State which is not the State of affiliation is made in accordance with the legislation and tariffs of the Member State where the treatment takes place.
- Under the Directive, reimbursement is made in accordance with the legislation and tariffs of the Member State of affiliation.
- The Directive requires up-front payment by patients to the foreign healthcare provider, while the Regulations organise reimbursement between competent institutions except co- payment existing in the Member State of treatment.

The points set out above indicate that in practice planned and unplanned care may often be provided more favourably under the Regulations. Accordingly, patients will often choose to receive care in another Member State under the provisions of the Regulations rather than the Directive, because

doing so means they do not have to make an up-front payment and then claim a reimbursement afterwards.

This issue is recognised within the Directive, which provides that the Directive applies without prejudice to, and in coherent application with, the Regulations. As a general principle therefore, when the terms of the Regulations are met, treatment should be delivered under the Regulations, unless a patient (who has been fully informed about his/her rights), requests otherwise.

It should be noted also that the Regulations and the Directive are not the only routes by which care may be provided in another Member State. Several Member States have adopted bi-lateral and multi-lateral parallel procedures (agreements addressed to particular areas of medicine and bi-lateral agreements between hospitals) to address the particular needs of care in their countries. The impact of such parallel procedures on the delivery of cross-border healthcare should not be under-estimated.

4. Description of possible solution(s)

The above sections have explored cross-border healthcare legislation and the obstacles preventing French patients who have received in-patient hospital care in Luxembourg to continue their care pathway by Hospital at Home or by receiving home nursing services in France. It is therefore essential to address this issue by advocating for changes in the legislation, or at least its interpretation, to ensure that these patients have access to the care they require and that they can receive it in the setting that best meets their needs.

The following sections list the actions that could be deployed at national and regional levels to lift the obstacles to a smooth and patient-oriented care pathway.

4.1 Test the validity of the interpretation of Artilce 3 and Recital 14 of the Directive

The Cross-Border Healthcare Directive includes Recital 14 and Article 3 which exclude long term care and home care services. In our interivews with local stakeholders this was interpreted to mean that Hospital at Home services could not be reimbursed under the Directive. It has, however not been tested legally to see if this is the correct interpreation of the Directive.

Although Recital 14 references care provided in nursing homes and general services in assisted living,it could be argued that these are very different from the medical services provided by nurses in the French Hospital at Home model which are clinical services ordered by medical doctors. It is important that this is read in context of Articles 2 and 3(a) which state:

> *Article 2 This Directive shall apply to the provision of healthcare to patients, regardless of how it is organised, delivered and financed.*
> *Article 3 . This Directive shall not apply to:*
> *(a) services in the field of long-term care the purpose of which is to support people in need of assistance in carrying out routine, everyday tasks;*

It could be argued therefore that where a care package similar to Hospital at Home is part of the benefits a patient would be able to receive in Luxembourg (albeit with a different name), such care could be interpreted as falling within Article 2 and could be reimbursed. It might be of value to the community as a whole for EGCT Alzette Belval to explore this issue with local lawyers and to potentially bring a test case to court. This line of action could however only be useful if a case could be made that a service similar to Hospital at Home is included in the Luxembourg public insurance system, since Artilce 7 of the Directive clearly states that *the Member State of affiliation shall ensure*

the costs incurred by an insured person who receives cross-border healthcare are reimbursed, if the healthcare in question is among the benefits to which the insured person is entitled in the Member State of affiliation.

A key basis for this argument legally would be that Article 168(2) of the Treaty on the Functining of the EU calls upon EU and Member States action to encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas. It could be argued therefore that in border regions and more generally the interpretation of cross-border care should be extended to include the movement of the care, and not be limited to patients who have the capacity to move across border to receive care.

4.2 Allow cross-border prescription of care services under the Cross-Border Care Directive

On the 12 of May 2022, the European Commission published its report on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare.[15]

In its evaluation of the findings the Commission writes that the Directive has been moderately effective in delivering its objectives to facilitate access to safe and high-quality healthcare in another EU country and that the Directive's potential for improving access to cross-border healthcare continues to be hampered by some issues. These include, in particular: the low level of awareness over patients' rights to cross-border healthcare; inadequate patient information; disproportionate administrative burdens; and uncertainty over healthcare costs abroad and reimbursement. One of the main findings is that the complex legal relationship between the Directive and the Regulation is too difficult for the general public to understand and for health insurers to communicate to patients.

One of the key elements of the report is the recognition of prescriptions. On this specific topic, the Commission states the following:

> *"Under Article 11(1) of the Directive, Member States, under certain conditions, must make sure that prescriptions for medicinal products or medical devices issued in another Member State for a named patient can be dispensed on their territory. Implementing Directive 2012/52/EU[16] gives effect to the principle of mutual recognition of prescriptions. The Court of Justice has clarified that the Directive (2011/24/EU) does not require a pharmacist to recognise order forms issued by a health professional in another Member State that do not contain the name of the patient concerned"[17].*

The Commission's conclusion is that while the recognition of prescriptions has considerably improved, patients continue to experience issues in relation to the recognition of prescription in another EU country, mainly due to problems with verification of authenticity and language. This can create a problem for a patient who wishes to continue their care at home through self-care, but as the Directive address only medicines and devices, it does little to help a patient exercise a prescription for nursing care at home.

An action could therefore be taken by France or Luxembourg to adopt a bi-lateral decision that

[15] Report from the Commission to the European Parliament and the Council on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, Brussels, 12.5.2022, COM(2022) 210 final, available at https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=COM:2022:210:FIN#document2

[16] Commission Implementing Directive 2012/52/EU of 20 December 2012 laying down measures to facilitate the recognition of medical prescriptions issued in another Member State, *O.J.* L 356, 22.12.2012, p. 68.

[17] CJUE, judgment of 18 September 2019, VIPA, C-222/18, EU:C:2019:751, paragraph 47.

prescriptions for services should be executable in another Member State, as well as prescriptions for medicines and devices.

An argument could also be made that Hospital at Home is in fact a presciption, indeed this would be particualarly relevant where medical device, such as an infusion pump is prescribed, but where the use of the device demands the intervention of a nurse. The home care, or Hospital at Home service could therefore be argued to be part of the prescription for the device. Here again, EGCT Alzette Belval could explore the issue with local lawyers, including the potential for a test case.

4.3 Create a standardised common vocabulary

As previously explained , one of the major hurdles to the continuity of care between representatives of national and local authorities, is the fact that home hospitalisation is very common in France, while being not used as defined in France in the healthcare practice in Luxembourg. As regards home nursing services, there are defined differently on both sides of the border, mainly because the services that can be rendered by a nurse outside of an hospital differ from France to Luxembourg (the acts a nurse is able to pose in Luxembourg being much narrower than in France).

The solution to this problem could be the development of a common definition of the terms “home hospitalisation” and “home nursing services”. In other words, one could think about a standardisation of what kind of services can be delivered under “home hospitalisation” and “home nursing services”.[18]

Another important element in this process of standardisation is the creation of the same care pathways for “home hospitalisation” and “home nursing services” on both sides of the border. The majority of health care professionals we met, underlined that as some elements were missing in the way the care pathway was designed on the other side of the border, it is preventing all actors of a patient journey to understand each other and from being able to organise this patient journey.

The standardisation of the elements contained in both wording could also help create a dialogue between healthcare professionals on both side of the border. It was frequently underlined, during interviews, that this dialogue between healthcare professional was quasi not existent.

4.4 Develop information tools for cross-border care

, As mentioned above, the European Commission published its report on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare in 2022.[19]

[18] Please note that the European Commission has recognised the importance of standardisation for the benefit of the European Union single market. Moreover on 2 February 2022, the Commission presented its new standardisation strategy and future legislative adjustment to the standardisation regulation in its communication ‘Updating the 2020 New Industrial Strategy: Building a stronger Single Market for Europe's recovery'; See Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of Regions, An EU Strategy on Standardisation Setting global standards in support of a resilient, green and digital EU single market, Brussels, 2.2.2022 COM(2022) 31 final, available at https://ec.europa.eu/docsroom/documents/48598

[19] Report from the Commission to the European Parliament and the Council on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, Brussels, 12.5.2022, COM(2022) 210 final, available at https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=COM:2022:210:FIN#document2

Critical points of the report such as low level of awareness over patients' rights to cross-border healthcare, inadequate patient information, disproportionate administrative burdens as well as uncertainty over healthcare costs abroad and reimbursement could be addressed by user-friendly manual for patients. A good example of such a solution was developed by the Upper Rhine region between the French-Germany-Switzerland border. It serves as a model of good practice in cooperation between National Contact Points and health insurers to provide clear information to meet the specific needs of the patients. The TRISAN[20] project coordinates networking activities in the healthcare sector, and has recently developed a recent initiative to develop a comprehensive on-line information tool, the ' Guide de Mobilite', which may provide a useful model for adaptation and replication in the Alzette Belval region.

4.5 Integrate digital health solutions into cross-border care

The Cross-Border Healthcare Directive clearly addressed the potetial of digital healthcare services to be part of the service scoverd by cross-border care. The definitions in Article 3 contain the guidance that states: *'Member State of treatment' means the Member State on whose territory healthcare is actually provided to the patient. In the case of telemedicine, healthcare is considered to be provided in the Member State where the healthcare provider is established.* The Directive also created the eHealth Network, an informal committee to advice the European Commission on digital health. Its fosus has been mainly on the adoption of technical and legal standards to promote the use of ePresciptions and Patient Summaries to support cross-border care. The eHealth Network still exists, but is planned to be replaced by a new formal committee created under the draft European Health Data Space Regulation[21], the advent of which bodes well for a more digitally empowered approach to cross-border care.

In the context of hospitalisation at home, many opportunities exist for remote patient monitoring and support which could complement in-person nursing care. France has already adopted several remote monitoring programmes with significant success, an example of which is seen in the Telemedicine Experimentation Program for the Improvement of Health Care Pathways (ETAPES) programme)[22], which was formally created in 2016 based on 2014 legislation[23] for the national health insurance funding strategy for four chronic diseases (CHF, chronic respiratory failure, chronic kidney failure and diabetes). The ETAPES programme was evaluated as successful and was replaced on31 December 2023 by the Decree defining the reimbursement of medical telemonitoring activities via the new framework which was published in the Official Journal of the French Republic. It determines the methods of evaluation of digital solutions, registration for reimbursement, modification of the registration conditions, removal and invoicing of medical telemonitoring activities, as well as the conditions for setting the reimbursement packages.

The adoption of telemedicine, remote monitoring and digital health solutions generally should be brought into the cross-border domain to allow healthcare professionals to provide care across borders in an efficient manner which address both growing desertification of healthcare in under populated regions, and recognises that an ageing population demands new models of care.

[20] more details are available at https://www.trisan.org/english

[21] The proposal for a Regulation on EHDS can be found at https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A52022PC0197

[22] Pages N, Picard F, Barritault F, et al. Remote patient monitoring for chronic heart failure in France: When an innovative funding program (ETAPES) meets an innovative solution (Satelia® Cardio). DIGITAL HEALTH. 2022;8. doi:10.1177/20552076221116774

[23] LOI n° 2013-1203 du 23 décembre 2013 de financement de la sécurité sociale pour 2014 ; Arrêté du 6 décembre 2016 portant cahiers des charges des expérimentations relatives à la prise en charge par télésurveillance mises en œuvre sur le fondement de l'article 36 de la loi n° 2013-1203 de financement de la sécurité sociale pour 2014

4.6 Adopt specific agreements to address cross-border care needs in the region

Several Mmeber States have adopted agreements on cross-border care in border regions which address the special needs that arise in their region. An example of this is the *Zone Organisée d'Accès aux Soins Transfrontaliers* (in abbreviated form "ZOAST") and the other is the implementation of a framework agreement between two or more countries.

A ZOAST is often seen as a solution to the obstacles that residents living in border regions face when seeking healthcare services near to their home and across national borders. Some border areas are indeed so close to each other - as it is the case for the Esch-Sur-Alzette border region - that the population, healthcare institutions and health professionals express a desire to develop the provision of cross-border health care services. Seven ZOASTs have already been established all along the French-Belgian and the French-Luxembourg borders with the objective to improve the access to healthcare services for patients leaving on the border. [24] To this end, administrative and financial arrangements for the treatment of patients in hospitals on both sides of the border have been simplified.

Creating a ZOAST between France and Luxembourg, more specifically in the Alzette-Belval territory, would provide residents of this border region with access to healthcare services on either side of the border. This would be particularly beneficial for residents living in smaller towns and villages near the border, where nearby healthcare services may be limited. A ZOAST would also help to address the shortage of healthcare professionals in some areas, as healthcare professionals from neighbouring countries could provide services in the region.

It would seem that introducing a ZOAST could potentially disrupt the existing national community care networks.[25] A possible solution could be to work on specific areas such as Hospital at Home without disturbing the current care networks. This would require extensive research to define these networks and ensure they function smoothly. In these networks, doctors from both Luxembourg and France would be reimbursed at the same rate. An example of such a network is the one created by the MOSAR convention, which operates between France and Germany.[26] Signed on June 12, 2019, it is a health agreement between France and Germany that aims to facilitate cross-border healthcare and improve access to care for residents of the cross-border region. Its main objective is to ensure that patients receive the most appropriate care within an optimal timeframe, while taking into account their health condition. This agreement allows residents to access the nearest medical and technical platform and care in the fields of cardiac emergencies, emergencies in the event of polytrauma, and neurosurgical care. Under the framework agreement, the patient will not face any additional administrative procedures and will always benefit from the usual healthcare reimbursement system.

Whether it is through a regional agreement like a ZOAST or a medical field specific agreement like MOSAR, Alzette-Belval has the potential to provide significant benefits to residents of the border region by adopting an agreement on cross-border care in their region. By facilitating access to specific healthcare services on either side of the border, it could help to overcome the current obstacles faced by patients and healthcare providers in accessing cross-borbder healthcare. It would

[24] See amongst others https://www.ofbs.org/cooperation-franco-belge/zoast/

[25] This was particularly underlined by Veronique Guillotin during the interview we had on the 19 of April 2023, which also mentioned as a solution the possibility to create networks in specific fields of healthcare.

[26] Please see : http://www.espaces-transfrontaliers.org/ressources/projets/projects/project/show/mosar-convention-sanitaire-transfrontaliere-moselle-saar/

also promote greater integration and cooperation between healthcare systems in France and Luxembourg, while also providing patients with greater choice and flexibility in how they receive care.

Conclusion

Alzette Belval and its EGCT have already shown the political will to take positive steps to address the challenges of providing home care similar to the French Hopsital at Home model for citizens livigng in their region. The report has set out a number of legal challenges in providing such care and outlined possible actions that could be taken. On a strict interpreation of the law, the Regulations and Directive are not well placed to foster home based care across borders. Therefore it is crucial that the principles of access to care for all EU citizens as set out in the Treaty on the Functioning of the EU is used as a basis for challenging the current legislation to ensure that the spirit of Article 168(2) can be met.

> *The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.*

Annex 1 - List of legal provisions relevant to the case

- Consolidated version of the Treaty on the Functioning of the European, OJ C 326, 26 October 2012, p. 47-390, link: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A12012E%2FTXT
- Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, *O.J.*, L 166/1, 30 April 2004, link: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:32004R0883. ;
- Implementing Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems, *O.J.*, L284/1, 30 October 2009 link : https://eur-lex.europa.eu/legal content/EN/TXT/?uri=CELEX:32009R0987;
- Directive (EU) No 2011/24 of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, *O.J.*, L88/45, 4 April 2011, link: https://eur-lex.europa.eu/legal content/EN/TXT/PDF/?uri=CELEX:32011L0024&from=EN. ;
- Articles L-6122-1, L-6123-1 and R-6122-25 and R-6123-139 of the Code of Public Health, Official Journal of the French Republic (JORF), 7 October 1953; Consolidated version 1 June, 2023, link : https://www.legifrance.gouv.fr/download/pdf/legiOrKali?id=LEGITEXT000006072665.pdf&size=14,9%20Mo&pathToFile=/LEGI/TEXT/00/00/06/07/26/65/LEGITEXT000006072665/LEGITEXT000006072665.pdf&title=Code%20de%20la%20sant%C3%A9%20publique
- Arrêté du 1er juin 2018 fixant la durée de la prise en charge minimale par le service de soins infirmiers à domicile ou le service polyvalent d'aide et de soins à domicile permettant une intervention conjointe avec un établissement d'hospitalisation à domicile / Decree of 1 June 2018 setting the minimum length of care by the home nursing service or the polyvalent home help and care service allowing joint intervention with a home hospital establishment Official Journal of the French Republic (JORF) No. 0125 of 2 June 2018, link: https://www.legifrance.gouv.fr/loda/id/JORFTEXT000036975314#:~:text=Arr%C3%AAte%20%3A,La%20dur%C3%A9e%20de%20la%20prise%20en%20charge%20minimale%20par%20le,fix%C3%A9e%20%C3%A0%20sept%20jours%20cons%C3%A9cutifs
- Décret n° 2022-102 du 31 janvier 2022 relatif aux conditions techniques de fonctionnement de l'activité d'hospitalisation à domicile/ Decree No. 2022-102 of 31 January 2022 relating to the technical operating conditions for home hospitalisation. Official Journal of the French Republic (JORF) No. 0027 of 2 February 2022 https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000045100212
- Code de la sécurité sociale luxembourgeoise/ Luxembourg Social Security Code, Official Journal of the Grand Duchy of Luxembourg, Consolidated version 2023, https://gouvernement.lu/fr/publications.gouv_igss%2Bfr%2Bpublications%2BCSS%2B2023.html

Annex 2 - Interviews Conducted

- 28 March 2023 – Dr René Metz, Director of the Centre hospitalier Emile-Mayrich Esch-Sur-Alzette, as well as members from the legal department (Luxembourg)
- 28 March 2023 – Mr Laurent Jomé, Luxembourg Ministry of Health (Luxembourg)
- 28 March - Mrs Friedrich, Head of the liberal nursing practice of Audun-le-Tiche (France) and Mrs Gaelle Fisch, Liberal Nurse (France)
- 19 April 2023 - Mrs Carine Pigeon, Luxembourg Ministry of Social Security(Luxembourg)

- 19 April 2023 – Dr Véronique Guillotin, Senator, Member of the Regional Council and of the GECT Board (France)
- 24 May 2023 – Mr Jouin – Agence Régionale de Santé (ARS) du Grand-Est and Mr Orcier, Agence Régionale du Grand-Est, Direction Meurthe et Moselle (France)

Annex 3 - Other References

- Pages N, Picard F, Barritault F, et al. Remote patient monitoring for chronic heart failure in France: When an innovative funding program (ETAPES) meets an innovative solution (Satelia® Cardio). DIGITAL HEALTH. 2022;8. doi:10.1177/20552076221116774
- Report from the Commission to the European Parliament and the Council on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, Brussels, 12.5.2022