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(Original Signature of Member)

113TH CONGRESS
1ST SESSION

H. R.

To promote and expand the application of telehealth under Medicare and other Federal health care programs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. HARPER (for himself, Mr. THOMPSON of California, Mr. NUNES, and Mr. WELCH) introduced the following bill; which was referred to the Committee on _____

A BILL

To promote and expand the application of telehealth under Medicare and other Federal health care programs, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Telehealth Enhancement Act of 2013”.

6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—STRENGTHENING MEDICARE THROUGH TELEHEALTH

- Sec. 101. Positive incentive for Medicare’s hospital readmissions reduction program.
- Sec. 102. Health homes and medical homes.
- Sec. 103. Flexibility in accountable care organizations coverage of telehealth.
- Sec. 104. Recognizing telehealth services and remote patient monitoring in national pilot program on payment bundling.
- Sec. 105. Additional sites to be considered originating sites for purposes of payments for telehealth services under Medicare.

TITLE II—ENHANCING MEDICAID THROUGH TELEHEALTH

- Sec. 201. Medicaid option for high-risk pregnancies and births.

TITLE III—IMPROVING TELECOMMUNICATIONS FOR MEDICAL DELIVERY

- Sec. 301. Additional providers considered health care providers for purposes of universal service support.
- Sec. 302. No consideration of provider location in rules enhancing health care provider access to advanced telecommunications and information services.

1 **TITLE I—STRENGTHENING**
 2 **MEDICARE THROUGH TELE-**
 3 **HEALTH**

4 **SEC. 101. POSITIVE INCENTIVE FOR MEDICARE’S HOSPITAL**
 5 **READMISSIONS REDUCTION PROGRAM.**

6 Section 1886(q) of the Social Security Act (42 U.S.C.
 7 1395ww(q)) is amended by adding at the end the following
 8 new paragraph:

9 “(9) POSITIVE INCENTIVE FOR REDUCED RE-
 10 ADMISSIONS.—

11 “(A) IN GENERAL.—With respect to pay-
 12 ment for discharges occurring during a fiscal
 13 year beginning on or after October 1, 2014, in
 14 order to provide a positive incentive for hos-
 15 pitals described in subparagraph (B) to lower

1 their excess readmission ratios, the Secretary
2 shall make an additional payment to a hospital
3 in such proportion as provides for a sharing of
4 the savings from such better-than-expected per-
5 formance between the hospital and the program
6 under this title.

7 “(B) HOSPITAL DESCRIBED.—A hospital
8 described in this subparagraph is an applicable
9 hospital (as defined in paragraph (5)(C)) not
10 subject to a payment change under paragraph
11 (1) and for which the positive readmission ratio
12 (described in subparagraph (C)) is greater than
13 1.

14 “(C) POSITIVE READMISSION RATIO.—The
15 positive readmission ratio described in this sub-
16 paragraph for a hospital is the ratio of—

17 “(i) the risk adjusted expected re-
18 admissions (described in subclause (II) of
19 paragraph (4)(C)(i)); to

20 “(ii) the risk adjusted readmissions
21 based on actual readmissions (described in
22 subclause (I) of such paragraph).”.

23 **SEC. 102. HEALTH HOMES AND MEDICAL HOMES.**

24 (a) MEDICARE CHRONIC CARE COUNTERPART TO
25 MEDICAID “HEALTH HOME”.—

1 (1) IN GENERAL.—Title XVIII of the Social Se-
2 curity Act is amended by adding at the end the fol-
3 lowing new section:

4 **“SEC. 1899B. MEDICARE HEALTH HOME FOR INDIVIDUALS**
5 **WITH CHRONIC CONDITIONS.**

6 “(a) IN GENERAL.—In the case of a State that has
7 amended its State plan under title XIX in accordance with
8 the option described in section 1945, the Secretary may
9 contract with the State medical assistance agency with a
10 program under such section to serve eligible individuals
11 with chronic conditions who select a designated provider,
12 a team of health care professionals operating with such
13 a provider, or a health team as the individual’s health
14 home for purposes of providing the individual with health
15 home services in the same manner as provided under its
16 State plan amendment.

17 “(b) HEALTH HOME QUALIFICATION STANDARDS.—
18 The standards established by the Secretary under section
19 1945(b) for qualification as a designated provider shall
20 apply under this section for the purpose of being eligible
21 to be a health home for purposes of section 1945.

22 “(c) PAYMENTS.—Payments shall be made under this
23 section in the same manner to a provider or team as pay-
24 ments are made under subsection (c) of section 1945, in-

1 cluding the use of the payment methodology described in
2 paragraph (2) of such subsection.

3 “(d) HOSPITAL REFERRALS.—Hospitals that are
4 participating providers under this section shall establish
5 procedures for referring any eligible individuals with
6 chronic conditions who seek or need treatment in a hos-
7 pital emergency department to designated providers in the
8 same manner as required under section 1945(d).

9 “(e) MONITORING AND REPORT ON QUALITY.—The
10 methodology and proposal required under subsection (f)
11 of section 1945 and the report on quality measures under
12 subsection (f) of such section shall also apply under this
13 section.

14 “(f) REPORT ON QUALITY MEASURES.—As a condi-
15 tion for receiving payment for health home services pro-
16 vided to an eligible individual with chronic conditions, a
17 designated provider shall report, in accordance with such
18 requirements as the Secretary shall specify, including a
19 plan for the use of remote patient monitoring, on all appli-
20 cable measures for determining the quality of such serv-
21 ices. When appropriate and feasible, a designated provider
22 shall use health information technology in providing the
23 Secretary with such information.

24 “(g) DEFINITIONS.—In this section, the provisions
25 and definitions contained in subsection (h) of section 1945

1 shall also apply for purposes of this section except that,
2 instead of the requirement specified in clause (i) of sub-
3 section (h)(1)(A) of such section, an individual must be
4 eligible for services under parts A and B and covered for
5 medical assistance for health home services under section
6 1945 in order to be an eligible individual with chronic con-
7 ditions.

8 “(h) EVIDENCE-BASED AND REPORTING.—In con-
9 tracting with a State under this section, the State—

10 “(1) shall follow evidence-based guidelines for
11 chronic care; and

12 “(2) shall report at least by the end of every
13 month data specified by the Secretary, including an
14 assessment of the use of remote patient monitoring
15 and quality measures of process, outcome, and struc-
16 ture.

17 “(i) WAIVER AUTHORITY.—

18 “(1) IN GENERAL.—The limitations on tele-
19 health under section 1834(m) shall not apply for
20 purposes of this section.

21 “(2) SECRETARY AUTHORITY.—The Secretary
22 may waive such other requirements of this title and
23 title XIX as may be necessary to carry out the pro-
24 visions of this section.”.

25 (2) REPORTING.—

1 (A) IN GENERAL.—Not later than 2 years
2 after the date of the enactment of this Act, the
3 Secretary of Health and Human Services shall
4 survey States contracting under section 1899B
5 of the Social Security Act, as added by para-
6 graph (1), on the nature, extent, and use of the
7 option under such section particularly as it per-
8 tains to—

- 9 (i) hospital admission rates;
10 (ii) chronic disease management;
11 (iii) coordination of care for individ-
12 uals with chronic conditions;
13 (iv) assessment of program implemen-
14 tation;
15 (v) processes and lessons learned (as
16 described in subparagraph (B));
17 (vi) assessment of quality improve-
18 ments and clinical outcomes under such
19 option; and
20 (vii) estimates of cost savings.

21 (B) IMPLEMENTATION REPORTING.—Such
22 a State shall report to the Secretary, as nec-
23 essary, on processes that have been developed
24 and lessons learned regarding provision of co-
25 ordinated care through a health home for bene-

1 ficiaries with chronic conditions under such op-
2 tion.

3 (b) SPECIALTY MEDICAL HOMES.—Title XVIII of
4 the Social Security Act, as amended by subsection (a), is
5 further amended by adding at the end the following new
6 section:

7 **“SEC. 1899C. SPECIALTY MEDICAL HOMES.**

8 “(a) IN GENERAL.—Beginning not later than 30
9 days after the date of the enactment of this section, the
10 Secretary may contract with a national or multi-state re-
11 gional center of excellence with a network of affiliated
12 local providers to provide through one or more medical
13 homes for targeted, accessible, continuous, and coordi-
14 nated care to individuals under this title and title XIX
15 with a long-term illness or medical condition that requires
16 regular medical treatment, advising, and monitoring.

17 “(b) MEDICAL HOME DEFINED.—In this section, the
18 term ‘medical home’ means a medical entity that—

19 “(1) specializes in the care for a specific long-
20 term illness or medical condition, including related
21 comorbidities;

22 “(2) leads the development of related evidence-
23 based clinical standards and research;

24 “(3) has a network of affiliated personal physi-
25 cians and patient treatment facilities;

1 “(4) maintains an online Web Site for patient
2 and provider communication and collaboration and
3 patient access to the patient’s health information;

4 “(5) has a plan for use of health information
5 technology in providing services under this section
6 and improving service delivery and coordination
7 across the care continuum (including the use of
8 wireless patient technology to improve coordination
9 and remote patient monitoring management of care
10 and patient adherence to recommendations made by
11 their provider);

12 “(6) provides deidentified demographic data
13 sets for clinical, statistical, and social science re-
14 search to develop culturally-competent best practices
15 and clinical decision support mechanisms for the
16 long-term illness or medical condition;

17 “(7) uses a health assessment tool for the indi-
18 viduals targeted, including a means for identifying
19 those most likely to benefit from remote patient
20 monitoring; and

21 “(8) provides training programs for personnel
22 involved in the coordination of care.

23 “(c) PERSONAL PHYSICIAN DEFINED.—

24 “(1) IN GENERAL.—In this section, the term
25 ‘personal physician’ means a physician (as defined in

1 section 1861(r)(1)) who meets the requirements de-
2 scribed in paragraphs (2) and (3). Nothing in this
3 paragraph shall be construed as preventing a per-
4 sonal physician from being a specialist or sub-
5 specialist for an individual requiring ongoing care
6 for a specific chronic condition or multiple chronic
7 conditions or for an individual with a long-term ill-
8 ness or medical condition.

9 “(2) GENERAL REQUIREMENTS.—The require-
10 ments described in this paragraph for a personal
11 physician for care of an individual are as follows:

12 “(A) The physician is board certified for
13 care of the specific illness or condition of the in-
14 dividual and manages continuous care for the
15 individual.

16 “(B) The physician has the staff and re-
17 sources to manage the comprehensive and co-
18 ordinated health care of such individual.

19 “(3) SERVICE-RELATED REQUIREMENTS.—The
20 requirements described in this paragraph for a per-
21 sonal physician are as follows:

22 “(A) The personal physician advocates for
23 and provides ongoing support, oversight, and
24 guidance to implement a plan of care that pro-
25 vides an integrated, coherent, cross-discipline

1 plan for ongoing medical care developed in part-
2 nership with patients and including all other
3 physicians furnishing care to the patient in-
4 volved and other appropriate medical personnel
5 or agencies (such as home health agencies).

6 “(B) The personal physician uses evidence-
7 based medicine and clinical decision support
8 tools to guide decisionmaking at the point-of-
9 care based on patient-specific factors.

10 “(C) The personal physician is in compli-
11 ance with the standards for meaningful use of
12 electronic health records under this title.

13 “(D) The personal physician participates
14 with the State’s health information exchange,
15 as available, or the federally-sponsored Direct
16 Project.

17 “(E) The personal physician uses health
18 information technology, including appropriate
19 remote monitoring, to monitor and track the
20 health status of patients and to provide patients
21 with enhanced and convenient access to health
22 care services.

23 “(F) The personal physician uses elec-
24 tronic prescribing and provides medication man-
25 agement.

1 “(G) The personal physician encourages
2 patients to engage in the management of their
3 own health through education and support sys-
4 tems.

5 “(H) The personal physician utilizes the
6 services of related health professionals, includ-
7 ing nurse practitioners and physician assistants.

8 “(d) LONG-TERM ILLNESS OR MEDICAL CONDITION
9 DEFINED.—In this section, the term ‘long-term illness or
10 medical condition’—

11 “(1) includes a chronic condition which meets
12 criteria specified by the Secretary for a specialized
13 MA plan for special needs individuals; and

14 “(2) also includes another condition that the
15 Secretary determines would provide a beneficial
16 focus for an effective and efficient medical home.

17 “(e) PAYMENT MECHANISMS.—

18 “(1) MEDICAL HOME CARE MANAGEMENT FEE
19 AND MEDICAL HOME SHARING IN SAVINGS.—Except
20 as provided in paragraph (2)—

21 “(A) MEDICAL HOME CARE MANAGEMENT
22 FEE.—Under this section the Secretary shall
23 provide for payment under section 1848 of a
24 care management fee to the medical home and
25 may include performance incentives. The med-

1 ical home shall arrange for payment for the
2 services of affiliated physicians and facilities.

3 “(B) MEDICAL HOME SHARING IN SAV-
4 INGS.—The Secretary shall provide for payment
5 under this section of a medical home based on
6 the payment methodology applied to health
7 group practices under section 1866A. Under
8 such methodology, 80 percent of the reductions
9 in expenditures under this title and title XIX
10 resulting from participation of individuals that
11 are attributable to the medical home (as re-
12 duced by the total care management fees paid
13 to the medical home under this section) shall be
14 paid to the medical home. The amount of such
15 reductions in expenditures shall be determined
16 by using assumptions with respect to reductions
17 in the occurrence of health complications, hos-
18 pitalization rates, medical errors, and adverse
19 drug reactions.

20 “(2) ALTERNATIVE PAYMENT MODEL.—

21 “(A) IN GENERAL.—The Secretary may
22 provide for payment under this paragraph in-
23 stead of the amounts otherwise payable under
24 paragraph (1).

1 “(B) ESTABLISHMENT OF TARGET SPEND-
2 ING LEVEL.—For purposes of this paragraph,
3 the Secretary shall compute an estimated an-
4 nual spending target based on the amount the
5 Secretary estimates would have been spent in
6 the absence of this section, for items and serv-
7 ices covered under parts A and B furnished to
8 applicable beneficiaries for each qualifying med-
9 ical home under this section. Such spending
10 targets shall be determined on a per capita
11 basis. Such spending targets shall include a risk
12 corridor that takes into account normal vari-
13 ation in expenditures for items and services cov-
14 ered under parts A and B furnished to such
15 beneficiaries with the size of the corridor being
16 related to the number of applicable beneficiaries
17 furnished services by each medical home. The
18 spending targets may also be adjusted for such
19 other factors as the Secretary determines ap-
20 propriate.

21 “(C) INCENTIVE PAYMENTS.—Subject to
22 performance on quality measures, a qualifying
23 medical home is eligible to receive an incentive
24 payment under this section if actual expendi-
25 tures for a year for the applicable beneficiaries

1 it enrolls are less than the estimated spending
2 target established under subparagraph (B) for
3 such year. An incentive payment for such year
4 shall be equal to a portion (as determined by
5 the Secretary) of the amount by which actual
6 expenditures (including incentive payments
7 under this paragraph) for applicable bene-
8 ficiaries under parts A and B for such year are
9 estimated to be less than 95 percent of the esti-
10 mated spending target for such year, as deter-
11 mined under subparagraph (B).

12 “(3) SOURCE.—Payments paid under this sec-
13 tion shall be made in appropriate proportions (as
14 specified by the Secretary) from the Hospital Insur-
15 ance Trust Fund, the Federal Supplementary Med-
16 ical Insurance Trust Fund, and funds appropriated
17 to carry out title XIX.

18 “(f) EVIDENCE-BASED.—The contracting entity shall
19 follow evidence-based guidelines for care of the long-term
20 illness or medical condition under this section.

21 “(g) PATIENT SERVICES QUALITY AND PERFORM-
22 ANCE REPORTING.—The contracting entity shall report at
23 least by the end of every month data specified by the Sec-
24 retary on the operation of this section, including quality
25 measures of process, outcome, and structure.

1 “(h) WAIVER AUTHORITY.—

2 “(1) IN GENERAL.—The limitations on tele-
3 health under section 1834(m) shall not apply for
4 purposes of this section.

5 “(2) SECRETARY AUTHORITY.—The Secretary
6 may waive such other requirements of this title and
7 title XIX as may be necessary to carry out the pro-
8 visions of this section.”.

9 **SEC. 103. FLEXIBILITY IN ACCOUNTABLE CARE ORGANIZA-**
10 **TIONS COVERAGE OF TELEHEALTH.**

11 Section 1899 of the Social Security Act (42 U.S.C.
12 1395jjj) is amended by adding at the end the following
13 new subsection:

14 “(l) FLEXIBILITY FOR TELEHEALTH.—

15 “(1) PROVISION AS SUPPLEMENTAL BENE-
16 FITS.—Notwithstanding any other provision of this
17 section, an ACO may include coverage of telehealth
18 and remote patient monitoring services as supple-
19 mental health care benefits to the same extent as a
20 Medicare Advantage plan is permitted to provide
21 coverage of such services as supplemental health
22 care benefits under section 1852(a)(3)(A).

23 “(2) PROVISION IN CONNECTION WITH HOME
24 HEALTH SERVICES.—Nothing in this section shall be
25 construed as preventing an ACO from including pay-

1 ments for remote patient monitoring and home-
2 based video conferencing services in connection with
3 the provision of home health services (under condi-
4 tions for which payment for such services would not
5 be made under section 1895 for such services) in a
6 manner that is financially equivalent to the fur-
7 nishing of a home health visit.”.

8 **SEC. 104. RECOGNIZING TELEHEALTH SERVICES AND RE-**
9 **MOTE PATIENT MONITORING IN NATIONAL**
10 **PILOT PROGRAM ON PAYMENT BUNDLING.**

11 Section 1866D(a)(2) of the Social Security Act (42
12 U.S.C. 1395cc-4(a)(2)) is amended—

13 (1) in subparagraph (B), by striking “10 condi-
14 tions” and inserting “the conditions”;

15 (2) in subparagraph (C)—

16 (A) by redesignating clause (v) as clause
17 (vi); and

18 (B) by inserting after clause (iv) the fol-
19 lowing new clause:

20 “(v) Telehealth and remote patient
21 monitoring services.”; and

22 (3) in subparagraph (D)(i)(III), by inserting
23 before the period at the end the following: “(and
24 such longer period in the case of the use of tele-

1 health and remote patient monitoring services as the
2 Secretary may specify”.

3 **SEC. 105. ADDITIONAL SITES TO BE CONSIDERED ORIGI-**
4 **NATING SITES FOR PURPOSES OF PAYMENTS**
5 **FOR TELEHEALTH SERVICES UNDER MEDI-**
6 **CARE.**

7 (a) IN GENERAL.—Section 1834(m)(4) of the Social
8 Security Act (42 U.S.C. 1395m(m)(4)) is amended—

9 (1) in subparagraph (C)—

10 (A) in clause (i), by striking “The term”
11 and inserting “Subject to clause (iii), the
12 term”; and

13 (B) by adding at the end the following new
14 clause:

15 “(iii) ADDITIONAL ORIGINATING
16 SITES.—The term ‘originating site’ also in-
17 cludes the following sites, whether or not
18 they are located in an area described in
19 clause (i), insofar as such sites are not oth-
20 erwise included in the definition of origi-
21 nating site under such clause:

22 “(I) A critical access hospital (as
23 described in clause (ii)(II)).

1 “(II) A sole community hospital
2 (as defined in section
3 1886(d)(5)(D)(iii)).

4 “(III) A home telehealth site (as
5 defined in subparagraph (G)(i)).

6 “(IV) A site described in clause
7 (ii) that is located in a county with a
8 population of less than 25,000, ac-
9 cording to the most recent decennial
10 census or in an area that was not in-
11 cluded in a Metropolitan Statistical
12 Area on any date in 2000.

13 “(V) A site described in clause
14 (ii) with respect to services related to
15 the evaluation or treatment of an
16 acute stroke.”; and

17 (2) by adding at the end the following new sub-
18 paragraph:

19 “(G) HOME TELEHEALTH SITE.—

20 “(i) HOME TELEHEALTH SITE.—The
21 term ‘home telehealth site’ means, with re-
22 spect to a telehealth service described in
23 clause (ii) furnished to an individual, the
24 in a place of residence used as the home of
25 such individual.

1 “(ii) TELEHEALTH SERVICES DE-
2 SCRIBED.—A telehealth service described
3 in this clause is a telehealth service that
4 is—

5 “(I) related to the provision of
6 hospice care or home dialysis; or

7 “(II) furnished to an individual
8 who is determined to be homebound
9 (as defined for purposes of sections
10 1814(a)(2)(C) and 1835(a)(2)(A)(i)),
11 including such an individual for whom
12 a certification or recertification de-
13 scribed in such section is in effect
14 with respect to home health services.”.

15 (b) NO ORIGINATING SITE FACILITY FEE FOR NEW
16 SITES.—Section 1834(m)(2)(B) of the Social Security Act
17 (42 U.S.C. 1395m(m)(2)(B)) is amended by inserting
18 after “the originating site” the following: “(other than an
19 additional originating site described in paragraph
20 (4)(C)(iii))”.

21 (c) APPLICATION OF TELECOMMUNICATION SYSTEMS
22 DEFINITION TO CRITICAL ACCESS HOSPITALS AND SOLE
23 COMMUNITY HOSPITALS.—The second sentence of section
24 1834(m)(1) of the Social Security Act (42 U.S.C.
25 1395m(m)) is amended by inserting “any telehealth serv-

1 ices furnished or received at a critical access hospital (as
2 described in paragraph (4)(C)(ii)(II)) or a sole community
3 hospital (as defined in section 1886(d)(5)(D)(iii)) or of”
4 after “in the case of”.

5 (d) SITE OF CARE FOR PURPOSES OF DETERMINING
6 HEALTH CARE LIABILITY.—Section 1834(m) of the So-
7 cial Security Act (42 U.S.C. 1395m(m)) is amended by
8 adding at the end the following new paragraph:

9 “(5) SITE OF CARE FOR PURPOSES OF HEALTH
10 CARE LIABILITY.—For purposes of determining
11 health care liability with respect to telehealth serv-
12 ices for which payment is made under this sub-
13 section, such service shall be considered to be fur-
14 nished at the distant site.”

15 (e) EFFECTIVE DATE.—

16 (1) IN GENERAL.—Except as provided in para-
17 graph (2), the amendments made by this section
18 shall apply to services furnished on or after January
19 1, 2014

20 (2) CHANGE IN MSA RULE.—The amendment
21 made by subsection (a)(1)(B)(ii) shall apply with re-
22 spect to telehealth services furnished on or after
23 February 28, 2013.

1 **TITLE II—ENHANCING MED-**
2 **ICAID THROUGH TELE-**
3 **HEALTH**

4 **SEC. 201. MEDICAID OPTION FOR HIGH-RISK PREGNANCIES**
5 **AND BIRTHS.**

6 (a) IN GENERAL.—Title XIX of the Social Security
7 Act is amended by adding at the end the following new
8 section:

9 **“SEC. 1947. STATE OPTION TO PROVIDE COORDINATED**
10 **CARE FOR ENROLLEES WITH HIGH-RISK**
11 **PREGNANCIES AND BIRTHS.**

12 “(a) IN GENERAL.—Notwithstanding section
13 1902(a)(1) (relating to statewideness), section
14 1902(a)(10)(B) (relating to comparability), and any other
15 provision of this title for which the Secretary determines
16 it is necessary to waive in order to implement this section,
17 beginning 6 months after the date of the enactment of
18 this section, a State, at its option as a State plan amend-
19 ment, may provide for medical assistance under this title
20 to eligible individuals for maternal-fetal and neonatal care
21 who select a designated provider (as described under sub-
22 section (h)(5)), a team of health care professionals (as de-
23 scribed under subsection (h)(6)) operating with such a
24 provider, or a health team (as described under subsection
25 (h)(7)) as the individual’s birthing network for purposes

1 of providing the individual with pregnancy-related serv-
2 ices.

3 “(b) QUALIFICATION STANDARDS.—The Secretary
4 shall establish standards for qualification as a designated
5 provider for the purpose of being eligible to be a birthing
6 network for purposes of this section.

7 “(c) PAYMENTS.—

8 “(1) IN GENERAL.—A State shall provide a des-
9 ignated provider, a team of health care professionals
10 operating with such a provider, or a health team
11 with payments for the provision of birthing network
12 services to each eligible individual for maternal-fetal
13 and neonatal care that selects such provider, team of
14 health care professionals, or health team as the indi-
15 vidual’s birthing network. Payments made to a des-
16 ignated provider, a team of health care professionals
17 operating with such a provider, or a health team for
18 such services shall be treated as medical assistance
19 for purposes of section 1903(a), except that, during
20 the first 8 fiscal year quarters that the State plan
21 amendment is in effect, the Federal medical assist-
22 ance percentage applicable to such payments shall be
23 equal to 90 percent.

24 “(2) SAVINGS TARGET.—As a condition for ap-
25 proval of a State plan amendment and payment

1 methodology under this section, the State shall pro-
2 vide the Secretary with assurances that the amend-
3 ment and methodology shall be projected to reduce
4 the amount of expenditures for pregnancy-related
5 services otherwise made under this title by one per-
6 cent for each 4-calendar-quarter period during the
7 first 40 calendar quarters in which the amendment
8 is in effect.

9 “(3) METHODOLOGY.—

10 “(A) IN GENERAL.—The State shall speci-
11 fy in the State plan amendment the method-
12 ology the State will use for determining pay-
13 ment for the provision of birthing network serv-
14 ices. Such methodology for determining pay-
15 ment shall be established consistent with section
16 1902(a)(30)(A).

17 “(B) INNOVATIVE MODELS OF PAYMENT.—
18 The methodology for determining payment for
19 provision of birthing network services under
20 this section shall not be limited to a per-mem-
21 ber per-month basis and may provide (as pro-
22 posed by the State and subject to approval by
23 the Secretary) for alternate models of payment,
24 including bundled per episode, performance in-
25 centives, and shared savings.

1 “(4) PLANNING GRANTS.—

2 “(A) IN GENERAL.—Beginning 30 days
3 after the date of the enactment of this section,
4 the Secretary may award planning grants to
5 States for purposes of developing a State plan
6 amendment under this section. A planning
7 grant awarded to a State or a multi-state col-
8 laborative under this paragraph shall remain
9 available until expended.

10 “(B) LIMITATION.—The total amount of
11 payments made to States under this paragraph
12 shall not exceed \$25,000,000.

13 “(d) REPORT ON QUALITY MEASURES.—As a condi-
14 tion for receiving payment for birthing network services
15 provided to an eligible individual for maternal-fetal and
16 neonatal care, a designated provider shall report monthly
17 to the State, in accordance with such requirements as the
18 Secretary shall specify, on all applicable measures for de-
19 termining the quality of such services. When appropriate
20 and feasible, a designated provider shall use health infor-
21 mation technology in providing the State with such infor-
22 mation.

23 “(e) EVIDENCE-BASED.—The birthing network shall
24 adapt, update, and follow evidence-based guidelines for
25 maternal-fetal and neonatal care.

1 “(f) DEFINITIONS.—In this section:

2 “(1) ELIGIBLE INDIVIDUAL FOR MATERNAL-
3 FETAL AND NEONATAL CARE.—

4 “(A) IN GENERAL.—Subject to subpara-
5 graph (B), the term ‘eligible individual’ means
6 an individual who—

7 “(i) is eligible for medical assistance
8 under the State plan or under a waiver of
9 such plan; and

10 “(ii)(I) is pregnant (or was pregnant
11 during the immediately preceding 30 day
12 period); or

13 “(II) is the child of an individual de-
14 scribed in clause (i) and under 30 days old.

15 “(B) RULE OF CONSTRUCTION.—Nothing
16 in this paragraph shall prevent the Secretary
17 from establishing other requirements for pur-
18 poses of determining eligibility for receipt of
19 birthing network services under this section.

20 “(2) BIRTHING NETWORK.—The term ‘birthing
21 network’ means a designated provider (including a
22 provider that operates in coordination with a team
23 of health care professionals) or a health team se-
24 lected by an eligible individual to provide birthing
25 network services.

1 “(3) BIRTHING NETWORK SERVICES.—

2 “(A) IN GENERAL.—The term ‘birthing
3 network services’ means comprehensive and
4 timely high-quality services described in sub-
5 paragraph (B) that are provided by a des-
6 ignated provider, a team of health care profes-
7 sionals operating with such a provider, or a
8 health team and are identified in a provider
9 registry.

10 “(B) SERVICES DESCRIBED.—The services
11 described in this subparagraph are—

12 “(i) comprehensive care coordination;

13 “(ii) health promotion;

14 “(iii) a call center to offer 24-hour
15 physician support for consultations with
16 maternal-fetal medicine specialists, when
17 requested, regarding patient management
18 issues;

19 “(iv) newborn screening, including for
20 heart defects and to reduce newborn hos-
21 pital readmissions;

22 “(v) patient and family support (in-
23 cluding authorized representatives);

24 “(vi) referral to community and social
25 support services, if relevant; and

1 “(vii) use of health information tech-
2 nology to link services and provide moni-
3 toring, as feasible and appropriate.

4 “(4) DESIGNATED PROVIDER.—The term ‘des-
5 ignated provider’ means a physician, clinical practice
6 or clinical group practice, rural clinic, community
7 health center, public health agency, home health
8 agency, or any other entity or provider (including
9 pediatricians, gynecologists, and obstetricians) that
10 is determined by the State and approved by the Sec-
11 retary to be qualified to be a birthing network for
12 eligible individuals on the basis of documentation ev-
13 idencing that the physician, practice, or clinic—

14 “(A) has the systems and infrastructure in
15 place to provide birthing network services; and

16 “(B) satisfies the qualification standards
17 established by the Secretary under subsection
18 (b) and paragraph (7)(B).

19 “(5) TEAM OF HEALTH CARE PROFES-
20 SIONALS.—The term ‘team of health care profes-
21 sionals’ means a team of health professionals (as de-
22 scribed in the State plan amendment) that may—

23 “(A) include physicians and other profes-
24 sionals, such as a nurse care coordinator, mid-
25 wife, nutritionist, social worker, behavioral

1 health professional, or any professionals deemed
2 appropriate by the State; and

3 “(B) be free standing, virtual, or based at
4 a hospital, community health center, rural clin-
5 ic, clinical practice or clinical group practice,
6 academic health center, or any entity deemed
7 appropriate by the State and approved by the
8 Secretary.

9 “(6) HEALTH TEAM.—The term ‘health team’
10 has the meaning given such term for purposes of
11 section 3502 of the Patient Protection and Afford-
12 able Care Act.

13 “(7) BIRTHING DATA AND EXCHANGE.—

14 “(A) PROPOSAL FOR USE OF HEALTH IN-
15 FORMATION TECHNOLOGY.—A State shall in-
16 clude in the State plan amendment a proposal
17 for use of health information technology in pro-
18 viding birthing network services under this sec-
19 tion and improving service delivery and coordi-
20 nation across the care continuum (including the
21 use of wireless patient technology to improve
22 coordination and management of care and pa-
23 tient adherence to recommendations made by
24 their provider).

1 “(B) INFORMATION REQUIREMENTS FOR
2 BIRTHING NETWORKS.—The birthing network
3 shall—

4 “(i) be in compliance with the Med-
5 icaid standards for meaningful use of elec-
6 tronic health records;

7 “(ii) participate with the State’s
8 health information exchange, as available,
9 or operate an exchange among the birthing
10 network;

11 “(iii) collect demographic information
12 on participating newborns and mothers;

13 “(iv) use demographic and event-
14 based data to identify patients that are
15 likely going to need short or long-term fol-
16 low-up; and

17 “(v) providing de-identified demo-
18 graphic data sets for statistical and social
19 science research to develop culturally-com-
20 petent best practices and clinical decision
21 support mechanisms for maternal-fetal and
22 neonatal care.”.

23 (b) PATIENT SERVICES QUALITY AND PERFORMANCE
24 REPORTING.—

1 (1) IN GENERAL.—Not later than 3 years after
2 the date of the enactment of this Act, the Secretary
3 of Health and Human Services shall survey States
4 that have elected the option under section 1947 of
5 the Social Security Act, as added by section (a), on
6 the nature, extent, and use of such option, particu-
7 larly as it pertains to—

8 (A) terms of pregnancies;

9 (B) use of prenatal fetal monitoring;

10 (C) use of Caesarean section procedures;

11 (D) use of neonatal intensive care services;

12 (E) incidence of birthing complications;

13 (F) incidence of infant and maternal mor-
14 tality;

15 (G) coordination of maternal-fetal and neo-
16 natal care for individuals;

17 (H) assessment of program implementa-
18 tion;

19 (I) processes and lessons learned (as de-
20 scribed in subparagraph (B));

21 (J) assessment of quality improvements
22 and clinical outcomes under such option; and

23 (K) participating mothers' assessment of
24 performance, quality, convenience, and satisfac-
25 tion.

1 (2) IMPLEMENTATION REPORTING.—A State
2 that has elected the option under such section shall
3 report to the Secretary, as necessary, on processes
4 that have been developed and lessons learned regard-
5 ing provision of coordinated care through a birthing
6 network for Medicaid beneficiaries for maternal-fetal
7 and neonatal care under such option.

8 **TITLE III—IMPROVING TELE-**
9 **COMMUNICATIONS FOR MED-**
10 **ICAL DELIVERY**

11 **SEC. 301. ADDITIONAL PROVIDERS CONSIDERED HEALTH**
12 **CARE PROVIDERS FOR PURPOSES OF UNI-**
13 **VERSAL SERVICE SUPPORT.**

14 Subparagraph (B) of section 254(h)(7) of the Com-
15 munications Act of 1934 (47 U.S.C. 254(h)(7)) is amend-
16 ed—

17 (1) in clause (vi), by striking “and”;

18 (2) in clause (vii), by striking “clauses (i)
19 through (vi)” and inserting “clauses (i) through
20 (ix)”;

21 (3) by redesignating clause (vii) as clause (x);
22 and

23 (4) by inserting after clause (vi) the following
24 new clauses:

1 “(vii) ambulance providers and other
2 emergency medical transport providers;

3 “(viii) health clinics of elementary and
4 secondary schools and post-secondary edu-
5 cational institutions;

6 “(ix) sites where telehealth services
7 are provided under section 1834(m) of the
8 Social Security Act (42 U.S.C. 1395m(m))
9 or under a State plan under title XIX of
10 such Act (42 U.S.C. 1396 et seq.); and”.

11 **SEC. 302. NO CONSIDERATION OF PROVIDER LOCATION IN**
12 **RULES ENHANCING HEALTH CARE PROVIDER**
13 **ACCESS TO ADVANCED TELECOMMUNI-**
14 **CATIONS AND INFORMATION SERVICES.**

15 Section 254(h)(2)(A) of the Communications Act of
16 1934 (47 U.S.C. 254(h)(2)(A)) is amended by inserting
17 “(regardless of the location of such providers)” after
18 “health care providers”.