

112TH CONGRESS  
2D SESSION

# H. R. 6719

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

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## IN THE HOUSE OF REPRESENTATIVES

DECEMBER 30, 2012

Mr. THOMPSON of California introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Oversight and Government Reform, Armed Services, and Veterans' Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## 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 Promotion Act of 2012”.

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—REMOVING ARBITRARY COVERAGE RESTRICTIONS ON  
TELEHEALTH FROM FEDERAL HEALTH CARE PROGRAMS

- Sec. 101. Medicare; Medicaid; CHIP.  
 Sec. 102. Federal employees health, dental, and vision benefits programs.  
 Sec. 103. TRICARE.  
 Sec. 104. Health care provided by the Department of Veterans Affairs.  
 Sec. 105. Effective date.

TITLE II—ADDITIONAL IMPROVEMENTS TO MEDICARE

- Sec. 201. Positive incentive for Medicare’s hospital readmissions reduction program.  
 Sec. 202. Health homes and medical homes.  
 Sec. 203. Flexibility in accountable care organizations coverage of telehealth.  
 Sec. 204. Recognizing telehealth services and remote patient monitoring in national pilot program on payment bundling.  
 Sec. 205. Adjustment in Medicare home health payments to account for use of remote patient monitoring.  
 Sec. 206. Including telehealth and remote patient monitoring services as part of an intervention proposal under the Medicare Community-Based Care Transitions Program.

TITLE III—ADDITIONAL IMPROVEMENT TO MEDICAID

- Sec. 301. Medicaid option for high-risk pregnancies and births.

1 **TITLE I—REMOVING ARBITRARY**  
 2 **COVERAGE RESTRICTIONS**  
 3 **ON TELEHEALTH FROM FED-**  
 4 **ERAL HEALTH CARE PRO-**  
 5 **GRAMS**

6 **SEC. 101. MEDICARE; MEDICAID; CHIP.**

7 (a) IN GENERAL.—Title XI of the Social Security Act  
 8 is amended by inserting after section 1150B the following  
 9 new section:

10 “REMOVAL OF LIMITATION ON COVERAGE OF SERVICES  
 11 PROVIDED VIA A TELECOMMUNICATIONS SYSTEM  
 12 UNDER MEDICARE, MEDICAID, AND CHIP

13 “SEC. 1150C. (a) MEDICARE.—An item or service  
 14 under part A or part B of title XVIII furnished to a Medi-

1 care beneficiary by an individual or entity via a tele-  
2 communications system shall be covered to the same ex-  
3 tent the item or service would be covered if furnished in  
4 the same location of the beneficiary, and benefits shall not  
5 be denied under either such part solely on the basis that  
6 the item or service is being furnished via a telecommuni-  
7 cations system.

8       “(b) MEDICAID.—Medical assistance under a State  
9 plan under title XIX for an item or service furnished to  
10 a Medicaid beneficiary by an individual or entity via a tele-  
11 communications system shall be available to the same ex-  
12 tent as such assistance would be available if furnished in  
13 the same location as the beneficiary, and medical assist-  
14 ance shall not be denied under such plan solely on the  
15 basis that the item or service is being furnished via a tele-  
16 communications system, except as a State may otherwise  
17 provide in its State plan under this title. For the purposes  
18 of reimbursement, licensure, professional liability, and  
19 other purposes under such title with respect to the provi-  
20 sion of telehealth services, practitioners, suppliers, and  
21 providers of such services are considered to be furnishing  
22 such services at their location and not at the originating  
23 site.

24       “(c) CHIP.—Child health assistance under a State  
25 child health plan under title XXI for an item or service

1 furnished to a CHIP beneficiary by an individual or entity  
2 via a telecommunications system shall be available to the  
3 same extent as such assistance would be available if fur-  
4 nished in the same location as the beneficiary, and child  
5 health assistance shall not be denied under such plan sole-  
6 ly on the basis that the item or service is being furnished  
7 via a telecommunications system, except as a State may  
8 otherwise provide in its State child health plan under this  
9 title. The previous sentence applies with respect to items  
10 and services furnished through coverage provided in the  
11 form described in section 2101(a)(1). For the purposes of  
12 reimbursement, licensure, professional liability, and other  
13 purposes under such title with respect to the provision of  
14 telehealth services, practitioners, suppliers, and providers  
15 of such services are considered to be furnishing such serv-  
16 ices at their location and not at the originating site.”.

17 (b) CONFORMING MEDICARE PART B COVERAGE  
18 PROVISIONS.—

19 (1) REMOVAL OF LIMITATION ON TELEHEALTH  
20 SERVICES.—Section 1834(m)(4) of the Social Secu-  
21 rity Act (42 U.S.C. 1395m(m)(4)) is amended by  
22 striking subparagraph (F).

23 (2) EXPANSION OF TELECOMMUNICATIONS SYS-  
24 TEM.—The second sentence of section 1834(m)(1) of  
25 the Social Security Act (42 U.S.C. 1835m(m)(1)) is

1 amended by striking “in the case of any Federal  
2 telemedicine demonstration program conducted in  
3 Alaska or Hawaii,”.

4 (3) EXPANSION OF TELEHEALTH PROVIDERS  
5 TO ALL HEALTH CARE PROFESSIONALS.—Section  
6 1834(m) of such Act (42 U.S.C. 1395m(m)) is  
7 amended—

8 (A) in paragraph (1)—

9 (i) by inserting “or other health care  
10 professional” after “(described in section  
11 1842(b)(18)(C))”; and

12 (ii) by inserting “or other health care  
13 professional” after “individual physician or  
14 practitioner”; and

15 (B) in paragraphs (2)(A), (2)(C), (3)(A),  
16 and (4)(A) by inserting “or other health care  
17 professional” after “physician or practitioner”  
18 each place it appears.

19 (4) REMOVAL OF LIMITATIONS ON ORIGINATING  
20 SITES.—Section 1834(m)(4)(C) of such Act (42  
21 U.S.C. 1395m(m)(4)(C)) is amended—

22 (A) by inserting “The term ‘originating  
23 site’ means one of the following sites:” after  
24 “ORIGINATING SITE.—”;

1 (B) by striking clause (i) and all that fol-  
2 lows up to subclause (I) of clause (ii); and

3 (C) by redesignating subclauses (I)  
4 through (VIII) of clause (ii) as clauses (i)  
5 through (viii), respectively.

6 (5) LOCATION OF FURNISHING TELEHEALTH  
7 SERVICES.—Section 1834(m) of such Act is further  
8 amended by adding at the end the following new  
9 paragraph:

10 “(5) TREATMENT OF LOCATION IN FURNISHING  
11 TELEHEALTH SERVICES.—For purposes of reim-  
12 bursement, licensure, professional liability, and other  
13 purposes under this title with respect to the provi-  
14 sion of telehealth services, physicians, practitioners,  
15 suppliers, and providers of such services are consid-  
16 ered to be furnishing such services at their location  
17 and not at the originating site.”.

18 (6) PAYMENT METHODS FOR OTHER PATIENT  
19 SITES.—Section 1834(m)(2) of such Act is further  
20 amended by adding at the end the following new  
21 subparagraph:

22 “(D) PAYMENT METHODS FOR OTHER PA-  
23 TIENT SITES.—The Secretary may develop and  
24 implement payment methods that would apply  
25 under this subsection in the case of an indi-

1           vidual who would be an eligible telehealth indi-  
2           vidual except that the telehealth services are  
3           furnished the individual at a site other than an  
4           originating site. Such methods shall be designed  
5           to take into account the costs related to the site  
6           involved and reduced costs for the distant  
7           site.”.

8   **SEC. 102. FEDERAL EMPLOYEES HEALTH, DENTAL, AND VI-**  
9                                   **SION BENEFITS PROGRAMS.**

10           (a) HEALTH BENEFITS (FEHBP).—Section 8904 of  
11 title 5, United States Code, is amended by adding at the  
12 end the following:

13           “(c) Benefits for an item or service furnished by an  
14 individual or entity via a telecommunications system shall  
15 be covered under a health benefits plan under this chapter  
16 as if it were furnished in person at the location of the  
17 beneficiary, and benefits shall not be denied under such  
18 a plan solely on the basis that the item or service is being  
19 furnished via a telecommunications system. For the pur-  
20 poses of reimbursement, licensure, professional liability,  
21 and other purposes under this chapter with respect to the  
22 provision of telehealth services, practitioners, suppliers,  
23 and providers of such services are considered to be fur-  
24 nishing such services at their location and not at the origi-  
25 nating site.”.

1           (b) DENTAL BENEFITS.—Section 8954 of title 5,  
2 United States Code, is amended by adding at the end the  
3 following:

4           “(f) Benefits for an item or service furnished by an  
5 individual or entity via a telecommunications system shall  
6 be covered under an enhanced dental benefits plan under  
7 this chapter as if it were furnished in person at the loca-  
8 tion of the beneficiary, and benefits shall not be denied  
9 under such a plan solely on the basis that the item or  
10 service is being furnished via a telecommunications sys-  
11 tem. For the purposes of reimbursement, licensure, profes-  
12 sional liability, and other purposes under this chapter with  
13 respect to the provision of telehealth services, practi-  
14 tioners, suppliers, and providers of such services are con-  
15 sidered to be furnishing such services at their location and  
16 not at the originating site.”.

17           (c) VISION BENEFITS.—Section 8984 of title 5,  
18 United States Code, is amended by adding at the end the  
19 following:

20           “(f) Benefits for an item or service furnished by an  
21 individual or entity via a telecommunications system shall  
22 be covered under an enhanced vision benefits plan under  
23 this chapter as if it were furnished in person at the loca-  
24 tion of the beneficiary, and benefits shall not be denied  
25 under such a plan solely on the basis that the item or



1 service is being furnished via a telecommunications sys-  
2 tem. For the purposes of reimbursement, licensure, profes-  
3 sional liability, and other purposes under this chapter with  
4 respect to the provision of telehealth services, practi-  
5 tioners, suppliers, and providers of such services are con-  
6 sidered to be furnishing such services at their location and  
7 not at the originating site.”.

8 **SEC. 103. TRICARE.**

9 (a) CARE PROVIDED AT MILITARY MEDICAL TREAT-  
10 MENT FACILITIES.—Section 1077 of title 10, United  
11 States Code, is amended by adding at the end the fol-  
12 lowing new subsection:

13 “(g) In providing health care to a covered beneficiary  
14 under section 1076 of this title at a military medical treat-  
15 ment facility, the Secretary may furnish an item or service  
16 to the covered beneficiary via a telecommunications sys-  
17 tem.”.

18 (b) CARE PROVIDED AT PRIVATE FACILITIES.—

19 (1) CERTAIN DEPENDENTS.—Section 1079 of  
20 title 10, United States Code, is amended by adding  
21 at the end the following new subsection:

22 “(r)(1) An item or service furnished to a covered ben-  
23 efiary via a telecommunications system shall be covered  
24 by a plan described in paragraph (2) to the same extent  
25 the item or service would be covered if furnished in the

1 same location of the covered beneficiary, and benefits shall  
2 not be denied under such a plan solely on the basis that  
3 the item or service is being furnished via a telecommuni-  
4 cations system. For the purposes of reimbursement, licen-  
5 sure, professional liability, and other purposes under this  
6 section with respect to the provision of telehealth services,  
7 practitioners, suppliers, and providers of such services are  
8 considered to be furnishing such services at their location  
9 and not at the originating site.

10 “(2) A plan described in this paragraph is a plan for  
11 which the Secretary enters into a contract under sub-  
12 section (a) to provide dependents with medical care.”.

13 (2) CERTAIN MEMBERS AND FORMER MEM-  
14 BERS.—Section 1086 of title 10, United States  
15 Code, is amended by adding at the end the following  
16 new subsection:

17 “(i)(1) An item or service furnished to a covered ben-  
18 eficiary via a telecommunications system shall be covered  
19 by a plan described in paragraph (2) to the same extent  
20 the item or service would be covered if furnished in the  
21 same location of the covered beneficiary, and benefits shall  
22 not be denied under such a plan solely on the basis that  
23 the item or service is being furnished via a telecommuni-  
24 cations system. For the purposes of reimbursement, licen-  
25 sure, professional liability, and other purposes under this

1 section with respect to the provision of telehealth services,  
2 practitioners, suppliers, and providers of such services are  
3 considered to be furnishing such services at their location  
4 and not at the originating site.

5 “(2) A plan described in this paragraph is a plan for  
6 which the Secretary enters into a contract under sub-  
7 section (a) to provide persons covered by subsection (c)  
8 with health benefits.”.

9 **SEC. 104. HEALTH CARE PROVIDED BY THE DEPARTMENT**  
10 **OF VETERANS AFFAIRS.**

11 (a) IN GENERAL.—Subchapter I of chapter 17 of title  
12 38, United States Code, is amended by inserting after sec-  
13 tion 1709A the following new section:

14 **“§ 1709B. Provision of health care via telecommuni-**  
15 **cations system**

16 “(a) DIRECT CARE.—In providing health care di-  
17 rectly to an individual under this chapter or chapter 18  
18 of this title, the Secretary may furnish an item or service  
19 to the individual via a telecommunications system.

20 “(b) CONTRACTED CARE.—(1) An item or service  
21 furnished to an individual covered by a plan described in  
22 paragraph (2) via a telecommunications system shall be  
23 covered by such a plan to the same extent the item or  
24 service would be covered if furnished in the same location  
25 of the individual, and benefits shall not be denied under

1 such a plan solely on the basis that the item or service  
2 is being furnished via a telecommunications system. For  
3 the purposes of reimbursement, licensure, professional li-  
4 ability, and other purposes under this chapter and chapter  
5 18 with respect to the provision of telehealth services,  
6 practitioners, suppliers, and providers of such services are  
7 considered to be furnishing such services at their location  
8 and not at the originating site.

9 “(2) A plan described in this paragraph is a plan for  
10 which the Secretary enters into a contract or agreement  
11 under this chapter or chapter 18 of this title to furnish  
12 health care to an individual.”.

13 (b) CLERICAL AMENDMENT.—The table of sections  
14 at the beginning of such chapter is amended by inserting  
15 after the item relating to section 1709A the following new  
16 item:

“1709B. Provision of health care via telecommunications system.”.

17 **SEC. 105. EFFECTIVE DATE.**

18 The amendments made by this title shall take effect  
19 on January 1, 2013, and shall apply to items and services  
20 furnished on or after such date and contracts for health  
21 plans entered into on or after such date, except that such  
22 amendments shall not apply to health plans for plan years  
23 for which bids were submitted before the date of the enact-  
24 ment of this Act.

1                   **TITLE II—ADDITIONAL**  
2                   **IMPROVEMENTS TO MEDICARE**

3   **SEC. 201. POSITIVE INCENTIVE FOR MEDICARE’S HOSPITAL**  
4                   **READMISSIONS REDUCTION PROGRAM.**

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

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

10                   “(A) IN GENERAL.—With respect to pay-  
11           ment for discharges occurring during a fiscal  
12           year beginning on or after October 1, 2013, in  
13           order to provide a positive incentive for hos-  
14           pitals described in subparagraph (B) to lower  
15           their excess readmission ratios, the Secretary  
16           shall make an additional payment to a hospital  
17           in such proportion as provides for a sharing of  
18           the savings from such better-than-expected per-  
19           formance between the hospital and the program  
20           under this title.

21                   “(B) HOSPITAL DESCRIBED.—A hospital  
22           described in this subparagraph is an applicable  
23           hospital (as defined in paragraph (5)(C)) not  
24           subject to a payment change under paragraph  
25           (1) and for which the positive readmission ratio

1 (described in subparagraph (C)) is greater than  
2 1.

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

6 “(i) the risk adjusted expected re-  
7 admissions (described in subclause (II) of  
8 paragraph (4)(C)(i)); to

9 “(ii) the risk adjusted readmissions  
10 based on actual readmissions (described in  
11 subclause (I) of such paragraph).”.

12 **SEC. 202. HEALTH HOMES AND MEDICAL HOMES.**

13 (a) MEDICARE CHRONIC CARE COUNTERPART TO  
14 MEDICAID “HEALTH HOME”.—

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

18 **“SEC. 1899B. MEDICARE HEALTH HOME FOR INDIVIDUALS  
19 WITH CHRONIC CONDITIONS.**

20 “(a) IN GENERAL.—In the case of a State that has  
21 amended its State plan under title XIX in accordance with  
22 the option described in section 1945, the Secretary may  
23 contract with the State medical assistance agency with a  
24 program under such section to serve eligible individuals  
25 with chronic conditions who select a designated provider,

1 a team of health care professionals operating with such  
2 a provider, or a health team as the individual’s health  
3 home for purposes of providing the individual with health  
4 home services in the same manner as provided under its  
5 State plan amendment.

6 “(b) HEALTH HOME QUALIFICATION STANDARDS.—  
7 The standards established by the Secretary under section  
8 1945(b) for qualification as a designated provider shall  
9 apply under this section for the purpose of being eligible  
10 to be a health home for purposes of section 1945.

11 “(c) PAYMENTS.—Payments shall be made under this  
12 section in the same manner to a provider or team as pay-  
13 ments are made under subsection (c) of section 1945, in-  
14 cluding the use of the payment methodology described in  
15 paragraph (2) of such subsection.

16 “(d) HOSPITAL REFERRALS.—Hospitals that are  
17 participating providers under this section shall establish  
18 procedures for referring any eligible individuals with  
19 chronic conditions who seek or need treatment in a hos-  
20 pital emergency department to designated providers in the  
21 same manner as required under section 1945(d).

22 “(e) MONITORING AND REPORT ON QUALITY.—The  
23 methodology and proposal required under subsection (f)  
24 of section 1945 and the report on quality measures under

1 subsection (f) of such section shall also apply under this  
2 section.

3 “(f) REPORT ON QUALITY MEASURES.—As a condi-  
4 tion for receiving payment for health home services pro-  
5 vided to an eligible individual with chronic conditions, a  
6 designated provider shall report, in accordance with such  
7 requirements as the Secretary shall specify, including a  
8 plan for the use of remote patient monitoring, on all appli-  
9 cable measures for determining the quality of such serv-  
10 ices. When appropriate and feasible, a designated provider  
11 shall use health information technology in providing the  
12 Secretary with such information.

13 “(g) DEFINITIONS.—In this section, the provisions  
14 and definitions contained in subsection (h) of section 1945  
15 shall also apply for purposes of this section except that,  
16 instead of the requirement specified in clause (i) of sub-  
17 section (h)(1)(A) of such section, an individual must be  
18 eligible for services under parts A and B and covered for  
19 medical assistance for health home services under section  
20 1945 in order to be an eligible individual with chronic con-  
21 ditions.

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

24 “(1) shall follow evidence-based guidelines for  
25 chronic care; and



1           “(2) shall report at least by the end of every  
2           month data specified by the Secretary, including an  
3           assessment of the use of remote patient monitoring  
4           and quality measures of process, outcome, and struc-  
5           ture.

6           “(i) WAIVER AUTHORITY.—

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

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

14           (2) REPORTING.—

15           (A) IN GENERAL.—Not later than 2 years  
16           after the date of the enactment of this Act, the  
17           Secretary of Health and Human Services shall  
18           survey States contracting under section 1899B  
19           of the Social Security Act, as added by para-  
20           graph (1), on the nature, extent, and use of the  
21           option under such section particularly as it per-  
22           tains to—

23                           (i) hospital admission rates;

24                           (ii) chronic disease management;

- 1 (iii) coordination of care for individ-  
2 uals with chronic conditions;  
3 (iv) assessment of program implemen-  
4 tation;  
5 (v) processes and lessons learned (as  
6 described in subparagraph (B));  
7 (vi) assessment of quality improve-  
8 ments and clinical outcomes under such  
9 option; and  
10 (vii) estimates of cost savings.

11 (B) IMPLEMENTATION REPORTING.—Such  
12 a State shall report to the Secretary, as nec-  
13 essary, on processes that have been developed  
14 and lessons learned regarding provision of co-  
15 ordinated care through a health home for bene-  
16 ficiaries with chronic conditions under such op-  
17 tion.

18 (b) SPECIALTY MEDICAL HOMES.—Title XVIII of  
19 the Social Security Act, as amended by subsection (a), is  
20 further amended by adding at the end the following new  
21 section:

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

23 “(a) IN GENERAL.—Beginning not later than 30  
24 days after the date of the enactment of this section, the  
25 Secretary may contract with a national or multi-state re-

1 gional center of excellence with a network of affiliated  
2 local providers to provide through one or more medical  
3 homes for targeted, accessible, continuous, and coordi-  
4 nated care to individuals under this title and title XIX  
5 with a long-term illness or medical condition that requires  
6 regular medical treatment, advising, and monitoring.

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

9 “(1) specializes in the care for a specific long-  
10 term illness or medical condition, including related  
11 comorbidities;

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

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

16 “(4) maintains an online Web Site for patient  
17 and provider communication and collaboration and  
18 patient access to the patient’s health information;

19 “(5) has a plan for use of health information  
20 technology in providing services under this section  
21 and improving service delivery and coordination  
22 across the care continuum (including the use of  
23 wireless patient technology to improve coordination  
24 and remote patient monitoring management of care

1 and patient adherence to recommendations made by  
2 their provider);

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

8 “(7) uses a health assessment tool for the indi-  
9 viduals targeted, including a means for identifying  
10 those most likely to benefit from remote patient  
11 monitoring; and

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

14 “(c) PERSONAL PHYSICIAN DEFINED.—

15 “(1) IN GENERAL.—In this section, the term  
16 ‘personal physician’ means a physician (as defined in  
17 section 1861(r)(1)) who meets the requirements de-  
18 scribed in paragraphs (2) and (3). Nothing in this  
19 paragraph shall be construed as preventing a per-  
20 sonal physician from being a specialist or sub-  
21 specialist for an individual requiring ongoing care  
22 for a specific chronic condition or multiple chronic  
23 conditions or for an individual with a long-term ill-  
24 ness or medical condition.

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

4                   “(A) The physician is board certified for  
5                   care of the specific illness or condition of the in-  
6                   dividual and manages continuous care for the  
7                   individual.

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

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

14                   “(A) The personal physician advocates for  
15                   and provides ongoing support, oversight, and  
16                   guidance to implement a plan of care that pro-  
17                   vides an integrated, coherent, cross-discipline  
18                   plan for ongoing medical care developed in part-  
19                   nership with patients and including all other  
20                   physicians furnishing care to the patient in-  
21                   volved and other appropriate medical personnel  
22                   or agencies (such as home health agencies).

23                   “(B) The personal physician uses evidence-  
24                   based medicine and clinical decision support

1 tools to guide decisionmaking at the point-of-  
2 care based on patient-specific factors.

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

6 “(D) The personal physician participates  
7 with the State’s health information exchange,  
8 as available, or the federally-sponsored Direct  
9 Project.

10 “(E) The personal physician uses health  
11 information technology, including appropriate  
12 remote monitoring, to monitor and track the  
13 health status of patients and to provide patients  
14 with enhanced and convenient access to health  
15 care services.

16 “(F) The personal physician uses elec-  
17 tronic prescribing and provides medication man-  
18 agement.

19 “(G) The personal physician encourages  
20 patients to engage in the management of their  
21 own health through education and support sys-  
22 tems.

23 “(H) The personal physician utilizes the  
24 services of related health professionals, includ-  
25 ing nurse practitioners and physician assistants.

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

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

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

10       “(e) PAYMENT MECHANISMS.—

11           “(1) MEDICAL HOME CARE MANAGEMENT FEE  
12 AND MEDICAL HOME SHARING IN SAVINGS.—Except  
13 as provided in paragraph (2)—

14           “(A) MEDICAL HOME CARE MANAGEMENT  
15 FEE.—Under this section the Secretary shall  
16 provide for payment under section 1848 of a  
17 care management fee to the medical home and  
18 may include performance incentives. The med-  
19 ical home shall arrange for payment for the  
20 services of affiliated physicians and facilities.

21           “(B) MEDICAL HOME SHARING IN SAV-  
22 INGS.—The Secretary shall provide for payment  
23 under this section of a medical home based on  
24 the payment methodology applied to health  
25 group practices under section 1866A. Under

1 such methodology, 80 percent of the reductions  
2 in expenditures under this title and title XIX  
3 resulting from participation of individuals that  
4 are attributable to the medical home (as re-  
5 duced by the total care management fees paid  
6 to the medical home under this section) shall be  
7 paid to the medical home. The amount of such  
8 reductions in expenditures shall be determined  
9 by using assumptions with respect to reductions  
10 in the occurrence of health complications, hos-  
11 pitalization rates, medical errors, and adverse  
12 drug reactions.

13 “(2) ALTERNATIVE PAYMENT MODEL.—

14 “(A) IN GENERAL.—The Secretary may  
15 provide for payment under this paragraph in-  
16 stead of the amounts otherwise payable under  
17 paragraph (1).

18 “(B) ESTABLISHMENT OF TARGET SPEND-  
19 ING LEVEL.—For purposes of this paragraph,  
20 the Secretary shall compute an estimated an-  
21 nual spending target based on the amount the  
22 Secretary estimates would have been spent in  
23 the absence of this section, for items and serv-  
24 ices covered under parts A and B furnished to  
25 applicable beneficiaries for each qualifying med-



1           ical home under this section. Such spending  
2           targets shall be determined on a per capita  
3           basis. Such spending targets shall include a risk  
4           corridor that takes into account normal vari-  
5           ation in expenditures for items and services cov-  
6           ered under parts A and B furnished to such  
7           beneficiaries with the size of the corridor being  
8           related to the number of applicable beneficiaries  
9           furnished services by each medical home. The  
10          spending targets may also be adjusted for such  
11          other factors as the Secretary determines ap-  
12          propriate.

13                 “(C) INCENTIVE PAYMENTS.—Subject to  
14          performance on quality measures, a qualifying  
15          medical home is eligible to receive an incentive  
16          payment under this section if actual expendi-  
17          tures for a year for the applicable beneficiaries  
18          it enrolls are less than the estimated spending  
19          target established under subparagraph (B) for  
20          such year. An incentive payment for such year  
21          shall be equal to a portion (as determined by  
22          the Secretary) of the amount by which actual  
23          expenditures (including incentive payments  
24          under this paragraph) for applicable bene-  
25          ficiaries under parts A and B for such year are

1 estimated to be less than 95 percent of the esti-  
2 mated spending target for such year, as deter-  
3 mined under subparagraph (B).

4 “(3) SOURCE.—Payments paid under this sec-  
5 tion shall be made in appropriate proportions (as  
6 specified by the Secretary) from the Hospital Insur-  
7 ance Trust Fund, the Federal Supplementary Med-  
8 ical Insurance Trust Fund, and funds appropriated  
9 to carry out title XIX.

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

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

18 “(h) WAIVER AUTHORITY.—

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

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

1 **SEC. 203. FLEXIBILITY IN ACCOUNTABLE CARE ORGANIZA-**  
2 **TIONS COVERAGE OF TELEHEALTH.**

3 Section 1899 of the Social Security Act (42 U.S.C.  
4 1395jjj) is amended by adding at the end the following  
5 new subsection:

6 “(1) FLEXIBILITY FOR TELEHEALTH.—

7 “(1) PROVISION AS SUPPLEMENTAL BENE-  
8 FITS.—Notwithstanding any other provision of this  
9 section, an ACO may include coverage of telehealth  
10 and remote patient monitoring services as supple-  
11 mental health care benefits to the same extent as a  
12 Medicare Advantage plan is permitted to provide  
13 coverage of such services as supplemental health  
14 care benefits under 1852(a)(3)(A).

15 “(2) PROVISION IN CONNECTION WITH HOME  
16 HEALTH SERVICES.—Nothing in this section shall be  
17 construed as preventing an ACO from including pay-  
18 ments for remote patient monitoring and home-  
19 based video conferencing services in connection with  
20 the provision of home health services (under condi-  
21 tions for which payment for such services would not  
22 be made under section 1895 for such services) in a  
23 manner that is financially equivalent to the fur-  
24 nishing of a home health visit.”.

1 **SEC. 204. RECOGNIZING TELEHEALTH SERVICES AND RE-**  
2 **MOTE PATIENT MONITORING IN NATIONAL**  
3 **PILOT PROGRAM ON PAYMENT BUNDLING.**

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

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

8 (2) in subparagraph (C)—

9 (A) by redesignating clause (v) as clause  
10 (vi); and

11 (B) by inserting after clause (iv) the fol-  
12 lowing new clause:

13 “(v) Telehealth and remote patient  
14 monitoring services.”; and

15 (3) in subparagraph (D)(i)(III), by inserting  
16 before the period at the end the following: “(and  
17 such longer period in the case of the use of tele-  
18 health and remote patient monitoring services as the  
19 Secretary may specify)”.

20 **SEC. 205. ADJUSTMENT IN MEDICARE HOME HEALTH PAY-**  
21 **MENTS TO ACCOUNT FOR USE OF REMOTE**  
22 **PATIENT MONITORING.**

23 (a) IN GENERAL.—Section 1895(b) of the Social Se-  
24 curity Act (42 U.S.C. 1395fff(b)) is amended by adding  
25 at the end the following new paragraph:

1           “(7) INCREASE FOR THE USE OF REMOTE PA-  
2           TIENT MONITORING.—

3           “(A) IN GENERAL.—The Secretary shall  
4           provide for an increase in the standard prospec-  
5           tive payment amount (or amounts) under para-  
6           graph (3) applicable to home health services  
7           furnished using remote patient monitoring. No  
8           such increase shall be provided unless the agen-  
9           cy furnishing the services provides the Sec-  
10          retary with such additional information on out-  
11          comes from the use of such monitoring as the  
12          Secretary may require.

13          “(B) LIMITATION.—The increase under  
14          this paragraph shall be—

15                 “(i) applied only in 2014, 2015, and  
16                 2016; and

17                 “(ii) reduced in the case of 2016.

18          “(C) USING REMOTE PATIENT MONI-  
19          TORING DEFINED.—In this paragraph, the term  
20          ‘using remote patient monitoring’ means using  
21          devices and communications networks to re-  
22          motely collect and send diagnostic data to a  
23          monitoring station for interpretation.”.

1 (b) APPLICATION ON A BUDGET NEUTRAL BASIS.—  
2 Paragraph (3) of such section is amended by adding at  
3 the end the following new subparagraph:

4 “(D) BUDGET-NEUTRALITY ADJUSTMENT  
5 TO OFFSET COST OF INCREASED PAYMENT FOR  
6 USING REMOTE PATIENT MONITORING.—The  
7 Secretary shall reduce the standard prospective  
8 payment amount (or amounts) under this para-  
9 graph applicable to home health services fur-  
10 nished during a period by such proportion as  
11 the Secretary estimates will result in an aggre-  
12 gate reduction in payments for the period equal  
13 to the total increase in payments estimated to  
14 be made based on the application of paragraph  
15 (7) for the period.”.

16 **SEC. 206. INCLUDING TELEHEALTH AND REMOTE PATIENT**  
17 **MONITORING SERVICES AS PART OF AN**  
18 **INTERVENTION PROPOSAL UNDER THE MEDI-**  
19 **CARE COMMUNITY-BASED CARE TRANSI-**  
20 **TIONS PROGRAM.**

21 Section 3026(c)(2)(B) of the Patient Protection and  
22 Affordable Care Act of 2010 (Public Law 111–148; 42  
23 U.S.C. 1395b–1 note) is amended by adding at the end  
24 the following new clause:

1 “(vi) Monitoring a high-risk Medicare  
2 beneficiary through the use of telehealth or  
3 remote patient monitoring services.”.

4 **TITLE III—ADDITIONAL**  
5 **IMPROVEMENT TO MEDICAID**

6 **SEC. 301. MEDICAID OPTION FOR HIGH-RISK PREGNANCIES**  
7 **AND BIRTHS.**

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

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

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

1 provider, or a health team (as described under subsection  
2 (h)(7)) as the individual’s birthing network for purposes  
3 of providing the individual with pregnancy-related serv-  
4 ices.

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

9 “(c) PAYMENTS.—

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



1           “(2) SAVINGS TARGET.—As a condition for ap-  
2           proval of a State plan amendment and payment  
3           methodology under this section, the State shall pro-  
4           vide the Secretary with assurances that the amend-  
5           ment and methodology shall be projected to reduce  
6           the amount of expenditures for pregnancy-related  
7           services otherwise made under this title by one per-  
8           cent for each 4-calendar-quarter period during the  
9           first 40 calendar quarters in which the amendment  
10          is in effect.

11          “(3) METHODOLOGY.—

12                 “(A) IN GENERAL.—The State shall speci-  
13                 fy in the State plan amendment the method-  
14                 ology the State will use for determining pay-  
15                 ment for the provision of birthing network serv-  
16                 ices. Such methodology for determining pay-  
17                 ment shall be established consistent with section  
18                 1902(a)(30)(A).

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

1 including bundled per episode, performance in-  
2 centives, and shared savings.

3 “(4) PLANNING GRANTS.—

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

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

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

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

4       “(f) DEFINITIONS.—In this section:

5           “(1) ELIGIBLE INDIVIDUAL FOR MATERNAL-  
6 FETAL AND NEONATAL CARE.—

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

10           “(i) is eligible for medical assistance  
11 under the State plan or under a waiver of  
12 such plan; and

13           “(ii)(I) is pregnant (or was pregnant  
14 during the immediately preceding 30 day  
15 period); or

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

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

23           “(2) BIRTHING NETWORK.—The term ‘birthing  
24 network’ means a designated provider (including a  
25 provider that operates in coordination with a team

1 of health care professionals) or a health team se-  
2 lected by an eligible individual to provide birthing  
3 network services.

4 “(3) BIRTHING NETWORK SERVICES.—

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

13 “(B) SERVICES DESCRIBED.—The services  
14 described in this subparagraph are—

15 “(i) comprehensive care coordination;

16 “(ii) health promotion;

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

22 “(iv) newborn screening, including for  
23 heart defects and to reduce newborn hos-  
24 pital readmissions;

1                   “(v) patient and family support (in-  
2                   cluding authorized representatives);

3                   “(vi) referral to community and social  
4                   support services, if relevant; and

5                   “(vii) use of health information tech-  
6                   nology to link services and provide moni-  
7                   toring, as feasible and appropriate.

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

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

20                  “(B) satisfies the qualification standards  
21                  established by the Secretary under subsection  
22                  (b) and paragraph (7)(B).

23                  “(5) TEAM OF HEALTH CARE PROFES-  
24                  SIONALS.—The term ‘team of health care profes-

1       sionals’ means a team of health professionals (as de-  
2       scribed in the State plan amendment) that may—

3               “(A) include physicians and other profes-  
4               sionals, such as a nurse care coordinator, mid-  
5               wife, nutritionist, social worker, behavioral  
6               health professional, or any professionals deemed  
7               appropriate by the State; and

8               “(B) be free standing, virtual, or based at  
9               a hospital, community health center, rural clin-  
10              ic, clinical practice or clinical group practice,  
11              academic health center, or any entity deemed  
12              appropriate by the State and approved by the  
13              Secretary.

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

18             “(7) BIRTHING DATA AND EXCHANGE.—

19             “(A) PROPOSAL FOR USE OF HEALTH IN-  
20             FORMATION TECHNOLOGY.—A State shall in-  
21             clude in the State plan amendment a proposal  
22             for use of health information technology in pro-  
23             viding birthing network services under this sec-  
24             tion and improving service delivery and coordi-  
25             nation across the care continuum (including the

1 use of wireless patient technology to improve  
2 coordination and management of care and pa-  
3 tient adherence to recommendations made by  
4 their provider).

5 “(B) INFORMATION REQUIREMENTS FOR  
6 BIRTHING NETWORKS.—The birthing network  
7 shall—

8 “(i) be in compliance with the Med-  
9 icaid standards for meaningful use of elec-  
10 tronic health records;

11 “(ii) participate with the State’s  
12 health information exchange, as available,  
13 or operate an exchange among the birthing  
14 network;

15 “(iii) collect demographic information  
16 on participating newborns and mothers;

17 “(iv) use demographic and event-  
18 based data to identify patients that are  
19 likely going to need short or long-term fol-  
20 low-up; and

21 “(v) providing de-identified demo-  
22 graphic data sets for statistical and social  
23 science research to develop culturally-com-  
24 petent best practices and clinical decision

1 support mechanisms for maternal-fetal and  
2 neonatal care.”.

3 (b) PATIENT SERVICES QUALITY AND PERFORMANCE  
4 REPORTING.—

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

12 (A) terms of pregnancies;

13 (B) use of prenatal fetal monitoring;

14 (C) use of Caesarean section procedures;

15 (D) use of neonatal intensive care services;

16 (E) incidence of birthing complications;

17 (F) incidence of infant and maternal mor-  
18 tality;

19 (G) coordination of maternal-fetal and neo-  
20 natal care for individuals;

21 (H) assessment of program implementa-  
22 tion;

23 (I) processes and lessons learned (as de-  
24 scribed in subparagraph (B));



1           (J) assessment of quality improvements  
2           and clinical outcomes under such option; and

3           (K) participating mothers' assessment of  
4           performance, quality, convenience, and satisfac-  
5           tion.

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

○