II

113TH CONGRESS
2D SESSION

S. 2662

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

IN THE SENATE OF THE UNITED STATES

JULY 24, 2014

Mr. COCHRAN (for himself and Mr. WICKER) introduced the following bill; which was read twice and referred to the Committee on Finance

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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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Telehealth Enhancement Act of 2014''.

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

TITLE I—STRENGTHENING MEDICARE THROUGH TELEHEALTH

SEC. 101. POSITIVE INCENTIVE FOR MEDICARE'S HOSPITAL READMISSIONS REDUCTION PROGRAM.

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

''(9) POSITIVE INCENTIVE FOR REDUCED READMISSIONS.—

''(A) IN GENERAL.—With respect to payment for discharges occurring during a fiscal year beginning on or after October 1, 2014, in order to provide a positive incentive for hospitals described in subparagraph (B) to lower their excess readmission ratios, the Secretary shall make an additional payment to a hospital

in such proportion as provides for a sharing of the savings from such better-than-expected performance between the hospital and the program under this title.

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

''(C) POSITIVE READMISSION RATIO.—The positive readmission ratio described in this subparagraph for a hospital is the ratio of—

''(i) the risk adjusted expected readmissions (described in subclause (II) of paragraph (4)(C)(i)); to

''(ii) the risk adjusted readmissions based on actual readmissions (described in subclause (I) of such paragraph).''.

SEC. 102. HEALTH HOMES AND MEDICAL HOMES.

(a) MEDICARE CHRONIC CARE COUNTERPART TO MEDICAID ''HEALTH HOME''.—

(1) IN GENERAL.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

"SEC. 1899B. MEDICARE HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.

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

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

"(c) PAYMENTS.—Payments shall be made under this section in the same manner to a provider or team as payments are made under subsection (c) of section 1945, in-

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

''(d) HOSPITAL REFERRALS.—Hospitals that are participating providers under this section shall establish procedures for referring any eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers in the same manner as required under section 1945(d).

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

''(f) REPORT ON QUALITY MEASURES.—As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report, in accordance with such requirements as the Secretary shall specify, including a plan for the use of remote patient monitoring, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the Secretary with such information.

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

shall also apply for purposes of this section except that, instead of the requirement specified in clause (i) of subsection (h)(1)(A) of such section, an individual must be eligible for services under parts A and B and covered for medical assistance for health home services under section 1945 in order to be an eligible individual with chronic conditions.

''(h) EVIDENCE-BASED AND REPORTING.—In contracting with a State under this section, the State—

''(1) shall follow evidence-based guidelines for chronic care; and

''(2) shall report at least by the end of every month data specified by the Secretary, including an assessment of the use of remote patient monitoring and quality measures of process, outcome, and structure.

''(i) WAIVER AUTHORITY.—

''(1) IN GENERAL.—The limitations on telehealth under section 1834(m) shall not apply for purposes of this section.

''(2) SECRETARY AUTHORITY.—The Secretary may waive such other requirements of this title and title XIX as may be necessary to carry out the provisions of this section.''.

(2) REPORTING.—

(A) IN GENERAL.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall survey States contracting under section 1899B of the Social Security Act, as added by paragraph (1), on the nature, extent, and use of the option under such section particularly as it pertains to—

(i) hospital admission rates;

(ii) chronic disease management;

(iii) coordination of care for individuals with chronic conditions;

(iv) assessment of program implementation;

(v) processes and lessons learned (as described in subparagraph (B));

(vi) assessment of quality improvements and clinical outcomes under such option; and

(vii) estimates of cost savings.

(B) IMPLEMENTATION REPORTING.—Such a State shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for bene-

ficiaries with chronic conditions under such option.

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

"SEC. 1899C. SPECIALTY MEDICAL HOMES.

''(a) IN GENERAL.—Beginning not later than 30 days after the date of the enactment of this section, the Secretary may contract with a national or multi-state regional center of excellence with a network of affiliated local providers to provide through one or more medical homes for targeted, accessible, continuous, and coordinated care to individuals under this title and title XIX with a long-term illness or medical condition that requires regular medical treatment, advising, and monitoring.

''(b) MEDICAL HOME DEFINED.—In this section, the term 'medical home' means a medical entity that—

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

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

''(3) has a network of affiliated personal physicians and patient treatment facilities;

''(4) maintains an online Web site for patient and provider communication and collaboration and patient access to the patient's health information;

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

''(6) provides deidentified demographic data sets for clinical, statistical, and social science research to develop culturally competent best practices and clinical decision support mechanisms for the long-term illness or medical condition;

''(7) uses a health assessment tool for the individuals targeted, including a means for identifying those most likely to benefit from remote patient monitoring; and

''(8) provides training programs for personnel involved in the coordination of care.

''(c) PERSONAL PHYSICIAN DEFINED.—

''(1) IN GENERAL.—In this section, the term 'personal physician' means a physician (as defined in

section 1861(r)(1)) who meets the requirements described in paragraphs (2) and (3). Nothing in this paragraph shall be construed as preventing a personal physician from being a specialist or subspecialist for an individual requiring ongoing care for a specific chronic condition or multiple chronic conditions or for an individual with a long-term illness or medical condition.

''(2) GENERAL REQUIREMENTS.—The requirements described in this paragraph for a personal physician for care of an individual are as follows:

''(A) The physician is board certified for care of the specific illness or condition of the individual and manages continuous care for the individual.

''(B) The physician has the staff and resources to manage the comprehensive and coordinated health care of such individual.

''(3) SERVICE-RELATED REQUIREMENTS.—The requirements described in this paragraph for a personal physician are as follows:

''(A) The personal physician advocates for and provides ongoing support, oversight, and guidance to implement a plan of care that provides an integrated, coherent, cross-discipline

plan for ongoing medical care developed in partnership with patients and including all other physicians furnishing care to the patient involved and other appropriate medical personnel or agencies (such as home health agencies).

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

''(C) The personal physician is in compliance with the standards for meaningful use of electronic health records under this title.

''(D) The personal physician participates with the State's health information exchange, as available, or the federally sponsored Direct Project.

''(E) The personal physician uses health information technology, including appropriate remote monitoring, to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health care services.

''(F) The personal physician uses electronic prescribing and provides medication management.

''(G) The personal physician encourages patients to engage in the management of their own health through education and support systems.

''(H) The personal physician utilizes the services of related health professionals, including nurse practitioners and physician assistants.

''(d) LONG-TERM ILLNESS OR MEDICAL CONDITION DEFINED.—In this section, the term 'long-term illness or medical condition'—

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

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

''(e) PAYMENT MECHANISMS.—

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

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

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

''(B) MEDICAL HOME SHARING IN SAVINGS.—The Secretary shall provide for payment under this section of a medical home based on the payment methodology applied to health group practices under section 1866A. Under such methodology, 80 percent of the reductions in expenditures under this title and title XIX resulting fro

''(C) m participation of individuals that are attributable to the medical home (as reduced by the total care management fees paid to the medical home under this section) shall be paid to the medical home. The amount of such reductions in expenditures shall be determined by using assumptions with respect to reductions in the occurrence of health complications, hospitalization rates, medical errors, and adverse drug reactions.

''(2) ALTERNATIVE PAYMENT MODEL.—

''(A) IN GENERAL.—The Secretary may provide for payment under this paragraph instead of the amounts otherwise payable under paragraph (1).

"(B) ESTABLISHMENT OF TARGET SPENDING LEVEL.—For purposes of this paragraph, the Secretary shall compute an estimated annual spending target based on the amount the Secretary estimates would have been spent in the absence of this section, for items and services covered under parts A and B furnished to applicable beneficiaries for each qualifying medical home under this section. Such spending targets shall be determined on a per capita basis. Such spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries with the size of the corridor being related to the number of applicable beneficiaries furnished services by each medical home. The spending targets may also be adjusted for such other factors as the Secretary determines appropriate.

"(C) INCENTIVE PAYMENTS.—Subject to performance on quality measures, a qualifying medical home is eligible to receive an incentive payment under this section if actual expenditures for a year for the applicable beneficiaries

it enrolls are less than the estimated spending target established under subparagraph (B) for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which actual expenditures (including incentive payments under this paragraph) for applicable beneficiaries under parts A and B for such year are estimated to be less than 95 percent of the estimated spending target for such year, as determined under subparagraph (B).

''(3) SOURCE.—Payments paid under this section shall be made in appropriate proportions (as specified by the Secretary) from the Hospital Insurance Trust Fund, the Federal Supplementary Medical Insurance Trust Fund, and funds appropriated to carry out title XIX.

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

''(g) PATIENT SERVICES QUALITY AND PERFORMANCE REPORTING.—The contracting entity shall report at least by the end of every month data specified by the Secretary on the operation of this section, including quality measures of process, outcome, and structure.

''(h) WAIVER AUTHORITY.—

''(1) IN GENERAL.—The limitations on telehealth under section 1834(m) shall not apply for purposes of this section.

''(2) SECRETARY AUTHORITY.—The Secretary may waive such other requirements of this title and title XIX as may be necessary to carry out the provisions of this section.''.

SEC. 103. FLEXIBILITY IN ACCOUNTABLE CARE ORGANIZATIONS COVERAGE OF TELEHEALTH.

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

''(l) FLEXIBILITY FOR TELEHEALTH.—

''(1) PROVISION AS SUPPLEMENTAL BENEFITS.—Notwithstanding any other provision of this section, an ACO may include coverage of telehealth and remote patient monitoring services as supplemental health care benefits to the same extent as a Medicare Advantage plan is permitted to provide coverage of such services as supplemental health care benefits under section 1852(a)(3)(A).

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

ments for remote patient monitoring and home-based video conferencing services in connection with the provision of home health services (under conditions for which payment for such services would not be made under section 1895 for such services) in a manner that is financially equivalent to the furnishing of a home health visit.''.

SEC. 104. RECOGNIZING TELEHEALTH SERVICES AND REMOTE PATIENT MONITORING IN NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

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

(1) in subparagraph (B), by striking ''10 conditions'' and inserting ''the conditions'';

(2) in subparagraph (C)—

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

(B) by inserting after clause (iv) the following new clause:

''(v) Telehealth and remote patient monitoring services.''; and

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

health and remote patient monitoring services as the Secretary may specify)''.

SEC. 105. ADDITIONAL SITES TO BE CONSIDERED ORIGINATING SITES FOR PURPOSES OF PAYMENTS FOR TELEHEALTH SERVICES UNDER MEDICARE.

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

(1) in subparagraph (C)—

(A) in clause (i), by striking ''The term'' and inserting ''Subject to clause (iii), the term''; and

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

''(iii) ADDITIONAL ORIGINATING SITES.—The term 'originating site' also includes the following sites, whether or not they are located in an area described in clause (i), insofar as such sites are not otherwise included in the definition of originating site under such clause:

''(I) A critical access hospital (as described in clause (ii)(II)).

''(II) A sole community hospital (as defined in section 1886(d)(5)(D)(iii)).

''(III) A home telehealth site (as defined in subparagraph (G)(i)).

''(IV) A site described in clause (ii) that is located in a county with a population of less than 25,000, according to the most recent decennial census or in an area that was not included in a Metropolitan Statistical Area on any date in 2000.

''(V) A site described in clause (ii) with respect to services related to the evaluation or treatment of an acute stroke.''; and

(2) by adding at the end the following new subparagraph:

''(G) HOME TELEHEALTH SITE.—

''(i) HOME TELEHEALTH SITE.—The term 'home telehealth site' means, with respect to a telehealth service described in clause (ii) furnished to an individual, in a place of residence used as the home of such individual.

''(ii) TELEHEALTH SERVICES DESCRIBED.—A telehealth service described in this clause is a telehealth service that is—

''(I) related to the provision of hospice care or home dialysis; or

''(II) furnished to an individual who is determined to be homebound (as defined for purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A)(i)), including such an individual for whom a certification or recertification described in such section is in effect with respect to home health services.''.

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

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

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

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

''(5) SITE OF CARE FOR PURPOSES OF HEALTH CARE LIABILITY.—For purposes of determining health care liability with respect to telehealth services for which payment is made under this subsection, such service shall be considered to be furnished at the distant site.''.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to services furnished on or after January 1, 2014.

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

TITLE II—ENHANCING MEDICAID THROUGH TELEHEALTH

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

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

"SEC. 1947. STATE OPTION TO PROVIDE COORDINATED CARE FOR ENROLLEES WITH HIGH-RISK PREGNANCIES AND BIRTHS.

''(a) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning 6 months after the date of the enactment of this section, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals for maternal-fetal and neonatal care who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual's birthing network for purposes

of providing the individual with pregnancy-related services.

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

''(c) PAYMENTS.—

''(1) IN GENERAL.—A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of birthing network services to each eligible individual for maternal-fetal and neonatal care that selects such provider, team of health care professionals, or health team as the individual's birthing network. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

''(2) SAVINGS TARGET.—As a condition for approval of a State plan amendment and payment

methodology under this section, the State shall provide the Secretary with assurances that the amendment and methodology shall be projected to reduce the amount of expenditures for pregnancy-related services otherwise made under this title by one percent for each 4-calendar-quarter period during the first 40 calendar quarters in which the amendment is in effect.

''(3) METHODOLOGY.—

''(A) IN GENERAL.—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of birthing network services. Such methodology for determining payment shall be established consistent with section 1902(a)(30)(A).

''(B) INNOVATIVE MODELS OF PAYMENT.—The methodology for determining payment for provision of birthing network services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment, including bundled per episode, performance incentives, and shared savings.

''(4) PLANNING GRANTS.—

''(A) IN GENERAL.—Beginning 30 days after the date of the enactment of this section, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State or a multi-state collaborative under this paragraph shall remain available until expended.

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

''(d) REPORT ON QUALITY MEASURES.—As a condition for receiving payment for birthing network services provided to an eligible individual for maternal-fetal and neonatal care, a designated provider shall report monthly to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

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

''(f) DEFINITIONS.—In this section:

''(1) ELIGIBLE INDIVIDUAL FOR MATERNAL-FETAL AND NEONATAL CARE.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'eligible individual' means an individual who—

''(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

''(ii)(I) is pregnant (or was pregnant during the immediately preceding 30 day period); or

''(II) is the child of an individual described in clause (i) and under 30 days old.

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall prevent the Secretary from establishing other requirements for purposes of determining eligibility for receipt of birthing network services under this section.

''(2) BIRTHING NETWORK.—The term 'birthing network' means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual to provide birthing network services.

''(3) BIRTHING NETWORK SERVICES.—

''(A) IN GENERAL.—The term 'birthing network services' means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team and are identified in a provider registry.

''(B) SERVICES DESCRIBED.—The services described in this subparagraph are—

''(i) comprehensive care coordination;

''(ii) health promotion;

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

''(iv) newborn screening, including for heart defects and to reduce newborn hospital readmissions;

''(v) patient and family support (including authorized representatives);

''(vi) referral to community and social support services, if relevant; and

''(vii) use of health information technology to link services and provide monitoring, as feasible and appropriate.

''(4) DESIGNATED PROVIDER.—The term 'designated provider' means a physician, clinical practice or clinical group practice, rural clinic, community health center, public health agency, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a birthing network for eligible individuals on the basis of documentation evidencing that the physician, practice, or clinic—

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

''(B) satisfies the qualification standards established by the Secretary under subsection (b) and paragraph (7)(B).

''(5) TEAM OF HEALTH CARE PROFESSIONALS.—The term 'team of health care professionals' means a team of health professionals (as described in the State plan amendment) that may—

''(A) include physicians and other professionals, such as a nurse care coordinator, midwife, nutritionist, social worker, behavioral

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

"(B) be free standing, virtual, or based at a hospital, community health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

"(6) HEALTH TEAM.—The term 'health team' has the meaning given such term for purposes of section 3502 of the Patient Protection and Affordable Care Act.

"(7) BIRTHING DATA AND EXCHANGE.—

"(A) PROPOSAL FOR USE OF HEALTH INFORMATION TECHNOLOGY.—A State shall include in the State plan amendment a proposal for use of health information technology in providing birthing network services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

''(B) INFORMATION REQUIREMENTS FOR BIRTHING NETWORKS.—The birthing network shall—

''(i) be in compliance with the Medicaid standards for meaningful use of electronic health records;

''(ii) participate with the State's health information exchange, as available, or operate an exchange among the birthing network;

''(iii) collect demographic information on participating newborns and mothers;

''(iv) use demographic and event-based data to identify patients that are likely going to need short or long-term follow-up; and

''(v) providing de-identified demographic data sets for statistical and social science research to develop culturally competent best practices and clinical decision support mechanisms for maternal-fetal and neonatal care.''.

(b) PATIENT SERVICES QUALITY AND PERFORMANCE REPORTING.—

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

(A) terms of pregnancies;

(B) use of prenatal fetal monitoring;

(C) use of Caesarean section procedures;

(D) use of neonatal intensive care services;

(E) incidence of birthing complications;

(F) incidence of infant and maternal mortality;

(G) coordination of maternal-fetal and neonatal care for individuals;

(H) assessment of program implementation;

(I) processes and lessons learned (as described in subparagraph (B));

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

(K) participating mothers' assessment of performance, quality, convenience, and satisfaction.

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

TITLE III—IMPROVING TELECOMMUNICATIONS FOR MEDICAL DELIVERY

SEC. 301. ADDITIONAL PROVIDERS CONSIDERED HEALTH CARE PROVIDERS FOR PURPOSES OF UNIVERSAL SERVICE SUPPORT.

Subparagraph (B) of section 254(h)(7) of the Communications Act of 1934 (47 U.S.C. 254(h)(7)) is amended—

(1) in clause (vi), by striking ''and'';

(2) in clause (vii), by striking ''clauses (i) through (vi)'' and inserting ''clauses (i) through (ix)'';

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

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

''(vii) ambulance providers and other emergency medical transport providers;

''(viii) health clinics of elementary and secondary schools and post-secondary educational institutions;

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

SEC. 302. NO CONSIDERATION OF PROVIDER LOCATION IN RULES ENHANCING HEALTH CARE PROVIDER ACCESS TO ADVANCED TELECOMMUNICATIONS AND INFORMATION SERVICES.

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

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