



The Honorable Max Baucus  
The Honorable Charles Grassley  
United States Senate  
Committee on Finance  
Washington, D.C. 20510

*Re: Comments on Senate Finance Committee Description of Policy Options. Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*

May 15, 2009

Dear Senators Baucus and Grassley:

On behalf of the Continua Health Alliance and its members, I would like to thank you for the opportunity to provide comments on the Senate Finance Committee Description of Policy Options Paper on Transforming the Health Care Delivery System. We applaud your leadership in designing new approaches and encouraging the use of innovative technologies to improve the health care system and, therefore, the health of all Americans.

The Continua Health Alliance is a non-profit, open industry coalition of more than 190 healthcare, technology and medical device companies joining together in collaboration to improve the quality of healthcare through personal telehealth. The Continua Health Alliance is dedicated to establishing a system of interoperable personal health solutions to foster independence, empower individuals to better manage their health, and provide the opportunity for personalized health and wellness. More information about the Continua Health Alliance and its members can be found at [www.continuaalliance.org](http://www.continuaalliance.org).

The Continua Health Alliance congratulates you on designing transformative approaches to care delivery and concurs with the over-arching goals of your transformation proposals — improving care for individuals with chronic diseases and lowering the costs of the health care system. You have elegantly put forward a vision of a transformed health care delivery system that provides the right care, at the right time, for each and every patient. We would add to that vision care delivered in the right place. Increasingly, technology allows for the location of care to be at home or in the community when medically appropriate. Care provided in the home or community often allows for more timely interventions and less time lost getting to and waiting for appointments.

We believe that innovative approaches and technologies can support the transformation of the health care system, particularly for patients with multiple chronic conditions. One such



innovative approach is eCare for chronic disease, which uses interoperable remote monitoring technologies to enhance chronic care management and improve patient self-management.

This comment letter first summarizes the role and benefits of eCare for chronic disease. Second, it provides comments on how eCare for chronic disease can be incorporated into many of the innovative approaches to care delivery that are outlined in your policy options document. Third, it proposes developing an eCare benefit in Medicare that crosses payment systems. Finally, it discusses a policy option that is not related to the options paper, but is critical to improving care: allowing the use of remote monitoring technologies to improve the quality and efficiency of home health services.

## **I. eCARE FOR CHRONIC DISEASE BENEFITS PATIENTS AND LOWERS COSTS**

As you are well aware, the burden of chronic disease is large and growing. Currently, 125 million Americans have one or more chronic conditions and half of those suffer from two or more. In addition, the care of chronic illness accounts for almost 75 percent of total health care costs in the U.S.<sup>1</sup> The federal government projects that in less than a decade, health care costs will account for 20 percent of the economy.<sup>2</sup>

### **Linking Patients and Providers**

eCare for chronic disease does not replace the traditional doctor-patient relationship. It simply harnesses the benefits of interoperable technology connected by fixed, wireless or broadband solutions to improve chronic care management by individuals and their care teams.

eCare for chronic disease allows patients and care providers to use remotely collected data to make decisions on a continuous basis, rather than waiting for office visits or emergency situations. By tracking blood pressure and other health information on a more regular basis and sharing it through interoperable information systems that transmit data over fixed, wireless, or broadband connections, eCare can support many care processes, including:

- Developing trend data on medical conditions;
- Understanding the effects of living environments on health;
- Giving early warning of emerging complications; and
- Allowing providers to give medication and other health behavior reminders that support self-management of chronic diseases.

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<sup>1</sup> J Geyman. 2007. "Disease management: Panacea, another false hope, or something in between? *Annals of Family Medicine* 5(3): 257-260.

<sup>2</sup> The Centers for Medicare and Medicaid project that health spending will be 20.6 percent of gross domestic product in 2018. *National Health Expenditure Projections, 2008-2018*. Available at: [www.cms.hhs.gov/NationalHealthExpendData](http://www.cms.hhs.gov/NationalHealthExpendData).



eCare is a tool that helps individuals with chronic conditions better manage their diseases on a continuous basis and comply with complex treatment plans. For example:

- Patients with congestive heart failure can monitor fluctuations in their weight and share that data with health providers who will use it to manage medication doses and prevent costly hospitalizations.
- Patients with diabetes can track their blood sugar and use the data to better manage diet and other health habits, with support from a care team that has up-to-date information.
- Individuals with hypertension can track their blood pressure and communicate data on fluctuations to their health care providers.

By monitoring their own data, individuals and their caregivers become more engaged in self-care. eCare can also improve consumers' access to care, particularly in rural areas, by easing logistical burdens and reducing or eliminating the need to travel to a provider's office for care. In addition, providers have more information to make medical decisions rather than only a single or quarterly office visit.

In addition to supporting chronic care management, eCare strategies can play a significant role in preventive care. Individuals can use interoperable technology to collect and transmit biometric and other health data over fixed, wireless, and broadband channels. That data can populate personal health records and be shared with health care providers. Similarly, public health agencies may use technology to transmit prevention messages. For example, the Centers for Disease Control and Prevention (CDC) have begun using wireless video, voice and text applications to get health information to individuals when and where they need it, such as providing personalized health messages on the importance of flu vaccines and where they can be obtained.<sup>3</sup> In addition, remotely collected data can be used as part of a biosurveillance system for tracking dangerous infectious diseases or environmental contaminants.

## eCare Works

The Veterans Administration (VA) has shown a dramatic decrease in hospital admissions with the use of eCare for veterans with multiple chronic diseases. The VA found that the 17,000 patients participating in its Care Coordination/Home Telehealth (CCHT) program experienced a 19 percent reduction in the number of hospital admissions and a 25 percent reduction in bed days of care. Furthermore, the costs of caring for patients with home telehealth averaged 87 percent **less** than VA's home-based primary care services. The veterans enrolled in the VA's home telehealth program were very accepting of the services provided, with an 86 percent satisfaction

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<sup>3</sup> See, for example, Mobile Health at the CDC, an interview with Dr. Jay M. Bernhardt, Director of the National Center for Health Marketing, Center for Disease Control and Prevention, available at: [http://www.ctia.org/consumer\\_info/wow/index.cfm/2009/3/%20](http://www.ctia.org/consumer_info/wow/index.cfm/2009/3/%20).



score. Given the remarkable success of this program, the VA plans to expand it to more than 50,000 veterans by 2011 (see chart).<sup>4</sup>

Comparisons made from one year prior to enrollment to 6 months post enrollment in remote patient monitoring program:

- 19.74% reduction in hospital admissions
- 25.31% reduction in bed days of care
- Patient acceptance high – only 10% declined remote monitoring
- Patient satisfaction 86%
- Average cost \$1,600 per patient per annum compared to \$13,121 for primary care and \$77,745 for nursing home care

**Table 5. Reduction in Utilization by Condition Monitored (Single and Multiple Diagnoses)**

CONDITION	NUMBER OF PATIENTS	% DECREASE IN UTILIZATION
Diabetes	8,954	20.4
Hypertension	7,447	30.3
Chronic heart failure	4,089	25.9
Chronic obstructive pulmonary disease	1,963	20.7
Posttraumatic stress disorder	129	45.1
Depression	337	56.4
Other mental health condition	653	40.9
Single condition	10,885	24.8
Multiple conditions	6,140	26.0

In addition to the experience of the VA, other research has shown that eCare for patients with common chronic illnesses, including congestive heart failure, diabetes and chronic obstructive pulmonary disease, can improve health outcomes. For example, remote monitoring of heart failure patients has been shown to reduce hospitalizations, clinic and emergency department visits and overall costs by allowing physicians to adjust medications and manage potential complications before they become acute.<sup>5</sup> In a randomized trial of 280 patients from 16 U.S. heart failure centers, use of a home monitoring device that captured and transmitted weight of heart failure patients reduced the six-month mortality rate 56.2 percent, as compared with a group of patients who did not use home monitoring.<sup>6</sup> Another randomized trial involving 240 patients with chronic respiratory illnesses found that remote monitoring led to 36 percent fewer hospitals and 71 percent fewer acute exacerbations of the underlying disease.<sup>7</sup>

<sup>4</sup> A Darkins, et al. Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions. *Telemedicine and e-Health* 14:10 (December 2008): 1118-1126.

<sup>5</sup> RA Clear, SC Inglis, FA McAlister, JG Cleland, S Stewart. 2007. Telemonitoring or structured telephone support programmes for patients with chronic heart failure: systematic review and meta-analysis. *British Medical Journal* 334; 942. Available at [www.bmj.com](http://www.bmj.com).

<sup>6</sup> LR Goldberg et al. 2002. Randomized trial of a daily electronic home monitoring system in patients with advanced heart failure: the Weight Monitoring in Heart Failure (WHARF) trial. *American Heart Journal*. 2003 Oct;146(4):705-12.

<sup>7</sup> M Vitacca et al. 2009. Tele-assistance in chronic respiratory failure patients: a randomised clinical trial. [European Respiratory Journal](http://www.bmj.com). 2009 Feb;33(2):411-8.

**eCare also lowers costs.** A recent industry analysis of the potential cost savings from widespread use of remote monitoring for patients with chronic diseases concluded that the United States could cut \$197 billion from its health care bill over the next 25 years by spotting health problems sooner and reducing hospitalizations as well as costly re-hospitalizations after complicated surgeries.<sup>8</sup>

## **II. eCARE FOR CHRONIC DISEASES CAN SUPPORT TRANSFORMATION OF THE HEALTH CARE DELIVERY SYSTEM**

Given the proven benefits of eCare for chronic disease, it should be an integral part of the innovative strategies you have put forward to improve care delivery and lower the costs of health care in the U.S. In the comments below, we suggest how eCare for chronic disease fits into the strategies outlined in your options paper.

*The term “eCare” means the remote monitoring, evaluation, and management of an individual through the use of technology that allows a remote interface to collect and transmit clinical data between the individual and a care provider for the purposes of clinical review, care management, and patient education. Related concepts include remote monitoring, telehealth, remote chronic disease management, patient-centric remote care, and connected health.*

The options paper describes many effective approaches to improve chronic care for Medicare beneficiaries. We applaud your efforts to address chronic care management and request that you include eCare for chronic disease as an effective part of the following options:

- Transitional care activities undertaken by primary care physicians;
- The CMS Chronic Care Management Innovation Center;
- Strategies to reduce hospital readmissions through bundling;
- Accountable Care Organizations; and
- Paying for chronic care management under Medicare Advantage.

### **Section I: Payment Reform – Options to Improve the Quality and Integrity of Medicare Payment Systems**

Our comments below address the role of eCare for chronic disease in improving the quality and outcomes of care.

#### **Primary Care – Payment for Transitional Care Activities**

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<sup>8</sup> Vital Signs Via Broadband: Remote Health Monitoring Transmits Savings, Enhances Lives. Robert E. Litan. October 24, 2008. Available at: <http://betterhealthcaretogether.org>.

The proposal included in the options paper would reimburse physicians for certain care management activities performed by nurse care managers or other qualified non-physician professionals as part of care management for individuals recently discharged from the hospital for care associated with a major chronic disease.

*The Continua Health Alliance recommends that you add eCare for chronic disease to the list of qualified activities for reimbursement under transitional care. The amended list would read as follows: “Qualified activities would include providing in-person care assessment and management, eCare for chronic disease, coaching, education, and self-management support to patients.”*

eCare for chronic disease would not replace in-person care, but would augment care management by providing frequent updates on clinical measures and health behaviors and allowing exchange of health information, including health education prompts, between visits. eCare links patients and providers in a way that improves both clinical care management and self-management of chronic disease.

## **Section II: Long-Term Payment Reforms – Fostering Care Coordination and Provider Collaboration**

This section of the options paper outlines a number of new approaches for improving care management for individuals with chronic disease. Our comments outline where eCare for chronic disease could help realize the goals of improved outcomes and reduced costs.

### **CMS Chronic Care Management Innovation Center**

This option would establish a Chronic Care Management Innovation Center (CMIC) within CMS that would test and disseminate payment innovations that foster patient-centered care coordination for high-cost, chronically ill Medicare beneficiaries receiving care in the fee-for-service payment system. CMIC would act in consultation with an advisory board comprised of members from relevant federal agencies and outside clinical and analytical experts.

The options paper outlines four criteria that would direct the initial projects undertaken by the CMIC. We strongly concur with three of the four existing criteria and would suggest a slight amendment to the fourth. Specifically, we agree that CMIC projects should place the patient and his/her caregivers at the center of the care team, maintain a close relationship between care coordinators and primary care physicians, and rely on a team-based approach to interventions.

With respect to the fourth criteria that reads “focuses on in-person contact with beneficiaries,” we would recommend adding the phrase “augmented, where medically appropriate, by eCare.”



The experience of the Veterans Administration and others indicates that strategies involving a combination of in-person contact and eCare have a high rate of success in improving outcomes and reducing costs. Restricting the CMIC activities to those that focus only on in-person care would limit the ability of the Medicare program to take advantage of innovative technologies like eCare that can support care management and improve self-management and would result in more frequent visits to provider locations. Given the pace of technological change, the Medicare program must act sooner, rather than later, to take advantage of beneficial new approaches. Therefore,

***The Continua Health Alliance recommends that you modify the fourth criteria that CMIC must consider when choosing models to read: “(4) focuses on in-person contact with beneficiaries augmented, where medically appropriate, by eCare.”***

The discussion in the options paper also provides examples of models that might be tested by the CMIC, such as advanced patient-centered medical homes.

***The Continua Health Alliance recommends that you add the Veterans Administration (VA) Care Coordination/Home Telehealth (CCHT) program to the list of models that might qualify for testing under the CMIC.***

We also direct your attention to the *Independence at Home Act of 2008* (S. 3613 and H.R. 7114) which outlines a budget-neutral approach to demonstrating the benefits of eCare for chronic disease in the Medicare population.

Finally, the advisory board to the CMIC will play a key role in ensuring that the Medicare program investigates and benefits from alternative approaches to chronic care management.

***The Continua Health Alliance recommends that health reform legislation specify that the CMIC advisory board include members with expertise in the use of innovative technologies that support care management, such as eCare for chronic disease.***

## **Hospital Readmissions and Bundling**

This section of the options paper lays out a number of steps intended to reduce preventable rehospitalizations for Medicare beneficiaries:

1. Generating and sharing hospital-specific information on readmissions for high-volume conditions with high rates of readmission.
2. Beginning in 2013, adopting a withhold approach, whereby hospitals with high rates of readmissions relative to others would not receive their withheld funds.
3. On a parallel track, developing a bundled payment that would cover both the acute IPPS hospital services and any post-acute care services occurring or initiating within 30 days of discharge from a hospital (to include home health, skilled nursing facility, rehabilitation hospitals, and long-term care hospitals). The bundled payment would begin in October 2016 and be phased in over three years.

The readmission and bundling policies are aimed at incentivizing hospitals and other providers to better coordinate care and care transitions between the hospital and post-acute settings. Experiences at the VA and research studies have shown that eCare for chronic disease is an important strategy for reducing preventable re-hospitalizations. As noted above, the VA's Care Coordination/Home Telehealth (CCHT) program experienced a 19 percent reduction in the number of hospital admissions and a 25 percent reduction in bed days of care.

***The Continua Health Alliance recommends that as the Finance Committee develops the criteria that must be met to ensure quality of care under bundled payment that it include process measures involving use of eCare, where medically appropriate, to reduce preventable readmissions.***

The systems demonstrated by the VA highlight the cost advantages of using remote monitoring and eCare. As CMS moves towards a quality performance structure that includes non-payment for 'Never Events' the inclusion of eCare will become a necessity to ensure patients are monitored in a cost-effective way.

In addition, hospitals and other providers will need guidance on strategies for reducing readmissions and better coordinating care across settings.

*The Continua Health Alliance recommends that the Congress direct the Agency for Health Care Research and Quality to conduct research and provide guidance to providers to adopt innovative approaches — such as eCare for chronic disease — that can reduce the risk of readmissions. AHRQ should also evaluate these technologies as part of its Comparative Effectiveness studies.*

### **Moving from Fee-for-Service to Payment for Accountable Care**

This option would allow groups of providers that agree to be responsible for the quality and costs of care for a specific patient population to come together as accountable care organizations and share in any savings to the Medicare program that result from better coordinated, more efficient, high quality care. This option would be modeled on the Medicare Physician Group Practice demonstration project. The options document specifies seven criteria that accountable care organizations would need to meet, such as: setting up legal structures; including the primary care providers of at least 5,000 Medicare beneficiaries; and defining processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care.

In addition, as CMS moves towards a pay-for-performance model for provider payments, we see an advantage to providing care remotely to ensure quality indicators are not only met but outcomes are effectively gathered and reported. The Medicare Care Management Program offered 26 quality measures that were aligned with chronic and preventive measures. This program provided CMS with a good guide on how to implement and measure provider activities. By including an eCare component, measures could be further automated and beneficiaries could see improved outcomes. By rewarding providers for better quality outcomes as well as demonstrating performance, eCare processes extend care management capabilities beyond just office visits.

The Continua Health Alliance strongly supports the move toward accountability for care coordination and outcomes across provider settings and welcomes the creation of organizations that put the individual at the center of all care processes. As these new approaches to organizing care are developed, we urge the Congress to consider the role of technology in supporting the transformation of care delivery.

*The Continua Health Alliance recommends that as the Finance Committee further specifies the criteria for accountable care organizations, it include the use of innovative technologies and approaches to care management, such as eCare for chronic disease.*



## **Section IV: Medicare Advantage – Options to Promote Quality, Efficiency and Care Management**

This section of the options paper presents numerous steps to improve Medicare Advantage.

### **Pay for Chronic Care Management**

This option would establish a financial incentive for Medicare Advantage plans to better coordinate care for high-cost, chronically ill Medicare beneficiaries by adding a bonus payment for chronic care management to the proposed competitive bidding structure.

Given the burden of chronic disease among the Medicare population, Continua believes that any chronic care management incentives should take advantage of new and innovative technologies for coordinating care and promoting self-management by the chronically ill. Therefore,

*The Continua Health Alliance recommends that as the Finance Committee further specifies the requirements for receiving a chronic care management bonus under Medicare Advantage, such bonuses should be linked to the use of innovative technologies and approaches to care management, such as eCare for chronic disease.*

Included in that payment would be the ability to utilize eCare and remote monitoring. This addition enhances providers' ability to recognize poor trends, care events, and lifestyle issues early, before they result in expensive emergency room visits or long-term care stays.

### **III. eCARE FOR CHRONIC DISEASE AS A CROSS-CUTTING MEDICARE BENEFIT**

eCare for chronic disease provides an innovative approach to care management that can be applied in many different settings. To ensure that Medicare beneficiaries can avail themselves of this technology whenever it is medically warranted, we recommend that the Senate Finance Committee establish in statute a separate eCare benefit under Medicare. The benefit would travel with the patient across settings of care, so that, for example, physicians could manage their chronically ill patients over time, hospitals could monitor patients post-discharge, home health agencies could provide home telehealth services, etc. Policies should address incentives for providers and patients to make optimal use of this technology.

Continua Health Alliance members and staff would be delighted to discuss this option further with Senate Finance Committee members and staff.

### **IV. eCARE CAN IMPROVE HOME HEALTH CARE**



This section of our comments applies to a topic that is not addressed in your options paper: barriers to the use of innovative technologies in the Medicare home health PPS. In particular, we address disincentives to home telehealth. The phrase “home telehealth” applies to the use of eCare strategies by home health agencies.

The provision of home health services to home-bound Medicare beneficiaries in need of skilled care helps to keep them out of hospitals and other institutional care settings. Use of eCare, or home telehealth, for home health patients allows home health agencies (HHAs) to continuously monitor the condition of their patients, rather than gathering information only during periodic in-home visits. Thus, the HHAs can quickly notice changes in a patients’ health status and make appropriate changes in their care to avoid more serious, adverse incidents. Demonstration and research projects have shown that in the home health sector, the use of home telehealth provides quality care while reducing costs, particularly for hospitalizations.<sup>9</sup>

Although home health is a logical sector for use of home telehealth, a recent survey found that only 17 percent of HHAs use some type of home monitoring system. The largest agencies (those with over \$6 million in annual revenues) were more likely to use home telehealth (32 percent) than the average agency.<sup>10</sup>

A simple change to the Medicare home health payment system could increase use of eCare, or home telehealth, leading to better care and improved efficiency. Currently, Medicare does not recognize a home telehealth visit as a home health visit. Rather, Medicare regulations define a home health visit as “an episode of personal contact with the beneficiary by staff of the HHA.”<sup>11</sup> This definition is based on language in Sec. 1861(m) of the Social Security Act that defines home health services as “provided on a visiting basis in a place of residence.” This definition of a home health visit effectively provides a disincentive to use of home telehealth.

In recognition of this problem, Representatives Thomas, Stupak, Terry, and Johnson introduced the Medicare Telehealth Enhancement Act of 2009 (H.R. 2068), which in Section 104 allows coverage of telehealth services in the home health sector under certain conditions. For example, home telehealth services must be ordered as part of a plan of care certified by a physician and cannot substitute for in-person home health services ordered by a physician. The provision also establishes standards for when a home telehealth visit can be considered equivalent to an in-person visit.

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<sup>9</sup> Max E. Stachura and Elena V. Kasanshina. Telehomecare and Remote Monitoring: An Outcomes Overview. Available at [www.advamed.org](http://www.advamed.org).

<sup>10</sup> Philips National Study on the Future of Technology and Telehealth in Home Care. April 2008. Available at: <http://www.philips.com/HomeCareStudy>.

<sup>11</sup> 42 CFR 484.48(c).



***In the context of health reform, the Continua Health Alliance recommends that Congress cover eCare, or home telehealth, under the home health PPS with specific conditions, including that such services must be ordered by a physician.***

Section 104 of H.R. 2068 accomplishes these goals. The legislative language is attached.

In closing, on behalf of the members of the Continua Health Alliance, I thank you for the opportunity to comment on these proposals for transforming health care delivery in our country. We are very supportive of your objectives and greatly appreciate your leadership.

If you have questions about these comments or would like further information, please feel free to contact me at (503) 619-0867.

Sincerely,

A handwritten signature in black ink that reads "Chuck Parker". The signature is fluid and cursive, with a long horizontal stroke at the end.

Chuck Parker  
Executive Director



## **H.R. 2068 – THE MEDICARE TELEHEALTH ENHANCEMENT ACT OF 2009**

Introduced by Reps. Thompson, Stupak, Terry, and Johnson (of Texas)

April 23, 2009

### **SEC. 104. ACCESS TO TELEHEALTH SERVICES IN THE HOME.**

(a) In General- Section 1895 of the Social Security Act (42 U.S.C. 1395fff(e)) is amended by adding at the end the following new subsection:

(f) Coverage of Telehealth Services-

(1) IN GENERAL- The Secretary shall include telehealth services that are furnished via a telecommunication system by a home health agency to an individual receiving home health services under section 1814(a)(2)(C) or 1835(a)(2)(A) as a home health visit for purposes of eligibility and payment under this title if the telehealth services--

(A) are ordered as part of a plan of care certified by a physician pursuant to section 1814(a)(2)(C) or 1835(a)(2)(A);

(B) do not substitute for in-person home health services ordered as part of a plan of care certified by a physician pursuant to such respective section; and

(C) are considered the equivalent of a visit under criteria developed by the Secretary under paragraph (3).

(2) PHYSICIAN CERTIFICATION- Nothing in this section shall be construed as waiving the requirement for a physician certification under section 1814(a)(2)(C) or 1835(a)(2)(A) for the payment for home health services, whether or not furnished via a telecommunication system.

(3) CRITERIA FOR VISIT EQUIVALENCY-

(A) STANDARDS- The Secretary shall establish standards and qualifications for categorizing and coding under HCPCS codes telehealth services under this subsection as equivalent to an in-person visit for purposes of eligibility and payment for home health services under this title. In establishing the standards and qualifications, the Secretary may distinguish between varying modes and modalities of telehealth services and shall consider--

(i) the nature and amount of service time involved; and

(ii) the functions of the telecommunications.

(B) LIMITATION- A telecommunication that consists solely of a telephone audio conversation, facsimile, electronic text mail, or consultation between two health care practitioners is not considered a visit under this subsection.

`(4) TELEHEALTH SERVICE-

`(A) DEFINITION- For purposes of this subsection, the term `telehealth service' means technology-based professional consultations, patient monitoring, patient training services, clinical observation, assessment, or treatment, and any additional services that utilize technologies specified by the Secretary as HCPCS codes developed under paragraph (3).

`(B) UPDATE OF HCPCS CODES- The Secretary shall establish a process for the updating, not less frequently than annually, of HCPCS codes for telehealth services.

`(5) CONDITIONS FOR PAYMENT AND COVERAGE- Nothing in this subsection shall be construed as waiving any condition of payment under sections 1814(a)(2)(C) or 1835(a)(2)(A) or exclusion of coverage under section 1862(a)(1).

`(6) COST REPORTING- Notwithstanding any provision to the contrary, the Secretary shall provide that the costs of telehealth services under this subsection shall be reported as a reimbursable cost center on any cost report submitted by a home health agency to the Secretary.'

(b) Effective Date-

(1) The amendment made by subsection (a) shall apply to telehealth services furnished on or after October 1, 2010. The Secretary of Health and Human Services shall develop and implement criteria and standards under section 1895(f)(3) of the Social Security Act, as amended by subsection (a), by no later than July 1, 2010.

(2) In the event that the Secretary has not complied with these deadlines, beginning October 1, 2010, a home health visit for purpose of eligibility and payment under title XVIII of the Social Security Act shall include telehealth services under section 1895(f) of such Act with the aggregate of telecommunication encounters in a 24-hour period considered the equivalent of one in-person visit.