SUMMARY OF KEY MEDICARE PROVISIONS IN H.R. 3962, AFFORDABLE HEALTH CARE FOR AMERICA ACT

This document provides a description of key Medicare provisions in H.R.3962, Affordable Health Care for America Act, as passed by the House of Representatives on November 7, 2009. The document describes the major provisions relating to benefits, Medicare Advantage, the Medicare prescription drug benefits, provider payment reforms, health system reforms, and other Medicare-related provisions. It also includes ten-year cost estimates for these provisions, in billions of dollars, as provided by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT).[1] The document will be updated to incorporate changes made throughout the legislative process. For more information about health reform legislation, see www.kff.org/healthreform/sidebyside.cfm. For a one-page summary of key Medicare provisions, see www.kff.org/healthreform/7948.cfm.

	H.R. 3962, Affordable Health Care for America Act of 2009 (as passed on November 7, 2009)
BENEFIT CHANGES	
Eligibility, enrollment and benefits for Medicare Savings Program (MSP) and Low Income Subsidies (LIS) under Part D	• Increases the asset limit used to determine eligibility for the Medicare Savings Programs (MSP) and Part D low-income subsidy (LIS) recipients to $17,000/individual and $34,000/couple, effective January 1, 2012, and indexes the asset limit to the Consumer Price Index (CPI) in subsequent years. Under current law, the asset limit is $4,000/individual and $6,000/couple for MSP, $6,600/individual and $9,910/couple for full Part D LIS recipients and $11,010/individual and $22,010/couple for partial Part D LIS recipients in 2009. [Sec. 1201] • Eliminates Part D cost sharing for non-institutionalized full-benefit dual eligibles who would require institutional care in a facility for the mentally retarded if not for provision of home- and community-based care under Medicaid, effective January 1, 2011. [Sec. 1202] • Allows individuals to self-certify (with administrative verification) income and assets when applying for LIS under Part D, as of 2010. [Sec. 1203] • Provides for enhanced oversight of reimbursements for retroactive LIS enrollment (when the LIS benefit is retroactive to the effective date of LIS qualifying assistance) and establishes plan reporting requirements associated with such reimbursements. For beneficiaries automatically enrolled into a Part D plan, the effective date is the date on which the individual is entitled to benefits under Medicare and Medicaid. [Sec. 1204] • Requires the Secretary of HHS to take into account the coverage of drugs used by the individual, prior authorization requirements, and the overall quality rating of the plan, as measured by quality ratings established by the Secretary, if the Secretary uses an "intelligent assignment" process for automatic enrollment of full-benefit dual eligibles who do not enroll in a Part D plan, effective for contract years beginning with 2012. [Sec. 1205] • Directs the Secretary of HHS to use an "intelligent assignment" process to facilitate the enrollment of LIS-eligible individuals who do not enroll in a Part D plan during the special enrollment period after LIS eligibility is determined (individuals may decline or change such enrollment), effective for determinations made in January 2011 and thereafter. [Sec. 1206] • Requires that the calculation of the low-income benchmark premium exclude the Medicare Advantage (MA) rebate amounts and quality bonus payments from the Medicare Advantage Prescription Drug plan premiums, effective January 1, 2011. Under current law, regional benchmarks are calculated based on the average premium, weighted by low-income enrollment, for basic benefits for both stand-alone prescription drug benefits and Medicare Advantage drug plans. [Sec. 1207] [Sec. 1201-1207; +$11.8b Medicare; +$2.0b Medicaid]

[1] Available at www.cbo.gov/doc.cfm?index=10710 and http://www.jct.gov/publications.html?func=startdown&id=3633.

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	H.R. 3962, Affordable Health Care for America Act of 2009 (as passed on November 7, 2009)
BENEFIT CHANGES (continued)	
Eligibility, enrollment and benefits for Medicare Savings Program (MSP) and Low Income Subsidies (LIS) under Part D (continued)	Requires the Internal Revenue Service (IRS) to disclose to the Social Security Administration (SSA), upon written request, information from tax returns, including wages and retirement income, unearned income, number of dependents, filing status, information regarding spousal income, and other information that might indicate whether the individual is likely to be ineligible for LIS, effective 12 months after the date of enactment. [Sec. 1801; $0b] Extends through December 2012 the Qualified Individual (QI) program that provides Part B premium assistance to Medicare beneficiaries with incomes between 120% and 135% of poverty; eliminates the limit on federal matching funds, effective January 1, 2011. [Sec. 1782; +$1.5b]
Additional coverage for low-income Medicare beneficiaries under age 65 and low-income people in the 24-month waiting period for Medicare	• Provides Medicare cost-sharing under Medicaid, subject to regular federal matching rate, for Medicare beneficiaries under age 65 whose income is less than 150% of poverty but who otherwise would meet the eligibility criteria for Qualified Medicare Beneficiaries (QMB), effective 2013. • Provides full Medicaid benefits (with 100% federal match in 2013 and 2014 and 91% thereafter) for individuals who are not on Medicare, and are under age 65 with incomes below 150% of poverty, which would include individuals receiving SSDI payment in the 24-month Medicare waiting period. [Sec. 1701; +$5.3b Medicare; +$7.2b Medicaid]
Preventive services	Waives deductible and coinsurance for Medicare-covered preventive benefits, effective January 1, 2011. Clarifies that coinsurance and deductibles are waived for beneficiaries undergoing screening colonoscopy and ancillary tissue removal, regardless of original diagnosis, effective January 1, 2011. Requires the Secretary of HHS to report to Congress on beneficiary barriers to preventive services, within 12 months of the date of enactment, and to implement policies promoting proper use of abdominal aortic aneurysm screening among at-risk beneficiaries. [Sec. 1305-1306; +$2.7b] Provides Medicare coverage for all federally recommended vaccines, as of January 1, 2010. [Sec. 1310; +$1.5b]
Other services	Requires Medicare to cover immunosuppressive drugs indefinitely for kidney transplant recipients, lifting the current law 36-month limit, effective 2012, and makes changes to the bundled payment system for dialysis services. [Sec. 1232; -$0.1b] Provides coverage of voluntary consultations for advanced care planning, which may include formulating an order for life-sustaining treatment, for a beneficiary who has not had a consultation within 5 years, effective January 1, 2011. Permits more frequent consultations if there is a significant change in the health of an individual. Permits consultations to be provided by physicians, nurse practitioners, and physician assistants with authority under state law to sign orders for life-sustaining treatments. [Sec. 1233; +$2.0b] Allows beneficiaries to elect to take ownership or decline ownership of certain durable medical equipment after the end of the 13-month rental period. [Sec. 1141A; $0b] Provides coverage for post-mastectomy external breast prosthesis garments regardless of whether garments are supplied prior to or after the breast cancer surgical procedure, effective no later than January 1, 2011. [Sec. 1149; $ n.s.]
Disparities and culturally appropriate services	Requires the Secretary of HHS to study the extent to which language services are available for beneficiaries with limited English proficiency and the development of Medicare payments for language services. Establishes a demonstration program to reimburse providers for language services to promote access for beneficiaries with limited English proficiency. Requires the Institute of Medicine (IOM) to study the impact of language services on access to care, quality of care, and reduction in medical errors and costs. [Sec. 1221-1224; $ n.s.]

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	H.R. 3962, Affordable Health Care for America Act of 2009 (as passed on November 7, 2009)
MEDICARE ADVANTAGE REFORMS	
Payment reforms	Phases in a change in payment for Medicare Advantage plans (except for PACE plans) to 100% of Medicare fee-for-service (FFS) costs using a blended benchmark by 2013: • 2011 benchmark = 2/3 local benchmark for the area + 1/3 of FFS costs for the area; • 2012 benchmark = 1/3 local benchmark for the area + 2/3 FFS costs for the area; • 2013 benchmark = 100% of FFS costs for the area. In no case would the blended benchmark be less than 100% of the FFS amount. For all years, the FFS cost amount is adjusted to account for the phase-out in indirect medical education from the Medicare Advantage capitation payment rates. Provides bonus payments to high-quality qualifying plans in qualifying counties equal to an increase in the blended benchmark amount of 1.5% in 2011, 3.0% in 2012 and 5.0% in 2013 and subsequent years. Defines a qualifying plan as a plan that had a quality ranking of 4 stars or more in a preceding year. Defines a qualifying county as a county that (1) ranked within the lowest third of counties in the FFS costs for an area, for a year to be specified by the Secretary of HHS; and (2) had at least 20 percent of Medicare beneficiaries in the county enrolled in Medicare Advantage plans as of June of the specified year. Requires the Secretary to determine a methodology for computing quality performance scores that will be based on HEDIS, CAHPS, and other risk-adjusted quality measures. Requires the Secretary to collect outcome measures for Medicare Advantage plan enrollees, which may include measures on hospital admission and readmission rates, prevention, quality, surgical mortality and morbidity, health functioning, survival of patients with chronic diseases, patient safety, and others as determined by the Secretary. Quality bonus payments would be based on a blend of the quality performance scores and the outcomes of care. Requires the Secretary to notify organizations if they are offering a qualifying plan in a qualifying county. Provides the Secretary the authority to disqualify plans for noncompliance. [Sec. 1161; -$154.3b] Extends indefinitely the Secretary's authority to adjust Medicare Advantage plan risk adjustment payments for coding intensity; the authority expires in 2010. [Sec. 1162; -$15.5b] Requires the Secretary of HHS to submit a report to Congress that evaluates the adequacy of the risk adjustment system in predicting costs for dual eligibles, beneficiaries with low incomes, and beneficiaries with chronic conditions. Requires the Secretary to implement any changes in the risk adjustment system by January 1, 2012. [Sec. 1166; $0b] Eliminates the Medicare Advantage Regional Plan Stabilization Fund; transfers remaining amounts to the Medicare Supplementary Medical Insurance (SMI) Trust Fund. [Sec. 1167; -$0.2b] Requires CMS to conduct a study (and report to Congress within one year of enactment) to determine potential effects of calculating Medicare Advantage payments rates on a more aggregated geographic basis (e.g., MSAs) rather than using county boundaries. [Sec. 1168; $0b]
Special Needs Plans (SNPs)	Limits enrollment in chronic care special needs plans (SNPs) to either the annual, coordinated open enrollment period or during a special enrollment period, beginning in January 2011. Extends the authority of chronic care or institutional SNPs to restrict enrollment to defined special needs populations from January 1, 2011 to January 1, 2013, and to January 1, 2016 for SNPs serving dual eligibles. Requires the Secretary of HHS to analyze the impact of SNPs for the dually eligible on the cost of care, quality of care, patient satisfaction, and other factors, and to identify statutory changes needed to simplify access to services, improve coordination of benefits and services, and ensure protection of duals; the report would be submitted to Congress no later than December 31, 2011. Extends the moratorium on service area expansions for dual eligible SNPs that do not meet certain requirements. Creates Medicare Senior Housing Facility plans, similar to the Erickson demonstrations, for individuals residing in a continuing care retirement community that provides onsite primary care services and transportation services to providers outside the facility. Plans must be offered by a Medicare Advantage organization that offered a plan under the Erickson demonstrations. For periods before January 1, 2013, the service area may be limited to the senior housing facility and may not be expanded. [Sec. 1176-1178; $0.1b]

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MEDICARE ADVANTAGE REFORMS (continued)	
Enrollment	Moves up the annual coordinated election period for Medicare Advantage and Part D plans by two weeks (to November 1 through December 15) to provide CMS and plans additional time to process enrollment applications beginning in 2011. Eliminates the one-time change of enrollment option under which new Medicare Advantage enrollees are currently permitted to change their selection one time during the first three months of the year. [Sec. 1163; $0b] Restricts the Secretary's authority to waive or modify plan requirements for employer group plans to only counties in which at least 90% of the group plans' enrollees reside (in effect, restricting the ability of group plans to offer coverage outside their service area). This restriction would only apply to employer group plans beginning on or after January 1, 2011. [Sec. 1165; $0b] Allows beneficiaries to select a different Medicare Advantage plan outside of the open enrollment period if they are enrolled in a plan in which enrollment is suspended. Permits the Secretary of HHS to take into account the health or well-being of the individual in determining other exceptional circumstances in which a beneficiary could change plans outside of the open enrollment period. [Sec. 1172; $0b]
Benefits, cost sharing and premiums	Limits the cost sharing that a Medicare Advantage plan may impose to no more than would apply under FFS Medicare, beginning in 2011. Extends current law to prohibit Medicare Advantage plans from imposing cost-sharing requirements that exceed amounts imposed under FFS Medicare or Medicaid for beneficiaries dually eligible for Medicare and Medicaid and Qualified Medicare Beneficiaries (QMBs). Permits cost sharing under Medicare Advantage plans to take the form of coinsurance, copayments, or per-diem rates. [Sec. 1171; $0b] Extends the time during which reasonable cost contracts may operate in areas with other Medicare Advantage plans until January 1, 2012. [Sec. 1164; $ n.s.]
Oversight and other consumer protections	Requires plans to submit data on plan medical loss ratios beginning in 2012. Requires the Secretary of HHS to publish the data elements required in the plan submission by December 31, 2010. Requires the Secretary to publish, by November 1 of each year, standardized information on medical loss ratios and other information for each Medicare Advantage plan. Requires plans with medical loss ratios below 85% to give enrollees a rebate of premiums by such amount as would provide for a ratio of at least 85% beginning in 2014. Prohibits plans with medical loss ratios below 85% for 3 consecutive years from enrolling new enrollees under the plan for coverage during the second succeeding contract year. Terminates plans that fail to have an 85% medical loss ratio for 5 consecutive years. [Sec. 1173; $0b] Permits the Secretary of HHS to require a periodic audit of information related to data submitted for risk adjustment, and to take actions necessary to address identified deficiencies beginning for the 2011 contract year and years thereafter. [Sec. 1174; $0b] Clarifies the Secretary's authority to not accept every plan bid, effective January 1, 2011. [Sec. 1175; $0b] Permits States to impose monetary penalties against Medicare Advantage organizations, Part D sponsors, or agents or brokers of the organizations or sponsors for violations of marketing requirements, except if the Secretary of HHS has initiated action against the organization or sponsor for the violation. Prohibits the Secretary from initiating action if action for the violation has been initiated by a State. [Sec. 1175A; $0b] Increases penalties for MA and Part D plans that provide false information or violate marketing rules, effective January 1, 2010. [Sec. 1616 and 1617; cost estimates not available for individual provisions] *[See "Other Provisions" below for additional provisions related to fraud and abuse]*
PRESCRIPTION DRUG BENEFIT (PART D) REFORMS	
Coverage gap and rebates for dual eligibles	• Provides for a $500 increase in the initial coverage limit, reducing the size of the coverage gap by $500, effective January 1, 2010. Under current law, the coverage gap will be $3,610 in 2010. Progressively increases the initial coverage limit and decreases the annual out-of-pocket threshold from the amounts otherwise computed, beginning in 2011, until there is continuous coverage; eliminates the coverage gap by 2019. • Requires drug manufacturers to provide Medicaid rebates for any covered outpatient drug dispensed to full-benefit dual eligible and low-income subsidy eligible Medicare Part D enrollees for which payment was made by a Part D plan, effective January 1, 2010.

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PRESCRIPTION DRUG BENEFIT (PART D) REFORMS (continued)	
Coverage gap and rebates for dual eligibles (continued)	• Requires drug manufacturers to provide to Part D plan sponsors, which in turn are required to provide to beneficiaries, a 50% discount off the negotiated price of covered brand-name drugs dispensed to individuals in the "original" coverage gap, effective January 1, 2010. Provides that the discount amount is counted towards the true out-of-pocket (TrOOP) threshold (which triggers the catastrophic benefit). Savings attributable to discounts would continue to accrue to the federal government over time, as if the coverage gap thresholds established under current law were retained. [Sec. 1181 and 1182; -$42.3b] Counts costs incurred by AIDS Drug Assistance Programs (ADAP) and the Indian Health Service (IHS) in providing prescription drugs to a beneficiary enrolled in a Part D plan toward the calculation of the enrollee's true out-of-pocket costs, effective January 1, 2011. [Sec. 1184; +$0.8b]
Drug price negotiation	Requires the Secretary of HHS to negotiate with pharmaceutical manufacturers the prices (including rebates, discounts, and other price concessions) that may be charged to Part D plan sponsors, beginning in 2011. Permits plan sponsors to obtain discounts or price reductions below the price negotiated by the Secretary. Requires the Secretary to report to Congress on negotiations and prices achieved as a result. [Sec. 1186; $0b]
LIS changes	*See Sections 1205-1207 under "Benefit Changes" above.*
Enrollment and other consumer protections	Prohibits Part D plans from making any formulary changes that reduce coverage or increase cost sharing after the plan marketing period begins, effective January 1, 2011. [Sec. 1185; $0b] Requires Part D plans to develop utilization management techniques to reduce prescription drug waste in long-term care facilities, effective January 1, 2012. [Sec. 1187; -$5.7b] Allows Part D plans to reduce or waive drug copayments to encourage beneficiaries to switch to generic drugs, effective January 1, 2011. [Sec. 1188; -$3.0b] Restricts the circumstances under which the Secretary of HHS may waive the requirement that entities seeking to offer a Part D plan in a state be licensed in that state by only allowing the requirement to be waived if the entity has a substantially complete application pending in the state, effective January 1, 2010. [Sec. 1189; $0b]
Retiree drug subsidy	Repeals the deduction from income currently allowed for qualified retiree prescription drug expenses for which employers receive Medicare Part D retiree drug subsidy payments from the federal government, effective December 31, 2012. [Sec. 534; generates revenue of +$2.2b]
PROVIDER PAYMENT REFORMS	
Market basket updates and productivity adjustments	Modifies market basket update to incorporate productivity improvements for inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals, skilled nursing facilities (SNF) and hospice care, and sets a floor for the inpatient hospital market basket so the combined effects of the productivity adjustments and adjustments for quality reporting and use of electronic medical records does not result in a market basket less than zero. [Sec. 1103; -$102.0b] Modifies market basket update to incorporate productivity adjustment for outpatient services (outpatient hospitals, ambulance services, ambulatory surgical center services, laboratory services, and certain durable medical equipment), beginning in 2010. Sets a floor for outpatient hospital services so the combined effects of the productivity adjustments and adjustments for quality reporting and use of electronic medical records do not result in a market basket less than zero. Incorporates productivity adjustment beginning in 2010 for ambulance services, ambulatory surgical centers and durable medical equipment (not subject to competitive bidding). Replaces existing update for laboratory services with an update of CPI minus productivity. [Sec. 1131; -$42.1b] Incorporates productivity adjustment into the market basket for home health services, beginning in 2011. Freezes market basket update for home health agencies for 2010. Accelerates the case mix adjustment scheduled for 2011 to 2010 and directs the Secretary of HHS to rebase the home health prospective payment system for 2011, taking into account changes in the average number and types of visits per episode, the change in intensity of visits and growth in cost per episode. [Sec. 1153-1155; -$54.7b]

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PROVIDER PAYMENT REFORMS (continued)	
Medicare Disproportionate Share Hospital (DSH) payments	Directs the Secretary of HHS to adjust Medicare disproportionate share hospital (DSH) payments, starting in FY 2017, if the uninsured rate drops a certain number of percentage points (defined as a decrease in the national rate of uninsurance exceeding eight percentage points) between 2012 and 2014, based on an empirically justified level, and taking into account uncompensated care costs. [Sec. 1112; -$10.3b]
Skilled nursing facility (SNF) and rehabilitation facility payments	Freezes market basket update for SNF payment rates for the second, third, and fourth quarters of fiscal year 2010. [Sec. 1101; -$23.9b] Codifies the recalibration factor included in the FY2010 Final Rule for the skilled nursing facility prospective payment system. Applies budget neutrality factor for change in the patient classification system. Revises payments for non-therapy ancillary services. [Sec. 1111; $0b]
Inpatient rehabilitation facility payments	Freezes market basket update for inpatient rehabilitation facility payments for the second, third, and fourth quarters of fiscal year 2010. [Sec. 1102; -$5.3b]
Hospice provider payment	Extends one-year moratorium on regulatory changes that would phase out the budget neutrality adjustment factor for hospice providers, maintaining the same wage reimbursement rate for 2010. [Sec. 1113; +$0.1b]
Graduate medical education	Reallocates residency positions to support training of primary care physicians and directs the Secretary of HHS to redistribute residency slots from hospitals that close to others in the same state. Modifies rules governing when hospital can receive indirect medical education (IME) and direct graduate medical education (DGME) funding for residents who train in non-provider settings. [Sec. 1501-1505; +$1.5b]
Physician fee schedule reform	*Changes to the Medicare physician fee schedule (Sustainable Growth Rate) are incorporated in H.R. 3961, "Medicare Physician Payment Reform Act of 2009"*
Other physician payment reforms	Provides for a 5% payment bonus for evaluation and management services without regard to the specialty of the physician providing that service, and for prevention services provided by a physician or other practitioner who specializes in family medicine, general internal medicine, general pediatrics or geriatrics and has allowed charges for primary care services that account for at least 50% of the practitioner's total allowed charges, effective January 1, 2011. Physician assistants, under the supervision of an eligible physician, are eligible for primary care incentive payments. Applies another 5% bonus if a practitioner predominantly furnishes such services in a health professional shortage area. [Sec. 1303; +$4.7b] Provides a 5% add-on to payment for services provided under the physician fee schedule in 2011 and 2012 rendered in counties or equivalent areas in the lowest fifth percentile of utilization (based on Part A and Part B per capita spending standardized to eliminate the effect of geographic adjustments). [Sec. 1123; +$0.4b] Extends payments to physicians under the Physician Quality Reporting Initiative (PQRI) through 2012. [Sec. 1124; +$1.3b] Modifies method used to determine localities used for Medicare geographic adjustment factor in California, based on metropolitan statistical areas. [Sec. 1125; +$0.3b] Increases the payment rate for psychiatric services by 5% through 2011. [Sec. 1309; +$0.1b] Prohibits certain referrals made by physicians to hospitals in which they have a direct financial interest. [Sec. 1156; -$1.0b] Increases the practice expense units for imaging services to reflect a presumed utilization of 75% instead of 50% (excluding low-tech imaging such as ultrasound); reduces payment for advanced diagnostic imaging services. [Sec. 1146; -$3.4b]
Other Part B payment reforms	Establishes methodologies under Medicare Part B for payment of interchangeable and biosimilar products, effective the first day of the second calendar quarter after the date of enactment. [Sec. 1149A; -$6.2b (includes both Medicare and non-Medicare savings)] Permits certified diabetes educators to be providers of Medicare diabetes outpatient self-management training. [Sec. 1313; $ n.s.]

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OTHER HEALTH SYSTEM REFORMS	
Reducing potentially preventable hospital readmissions	Reduces Medicare payments to PPS and critical access care hospitals, beginning October 1, 2011, to account for excess hospital readmissions, based on the greater of each hospital's ratio of excess readmissions (one minus the ratio of aggregate payments for excess readmissions and aggregate payments for all discharges) or the floor adjustment factor (0.99 in fiscal year 2012, 0.98 in fiscal year 2013, 0.97 in fiscal year 2014, or 0.95 in subsequent fiscal years) for selected conditions. Gives the Secretary of HHS the authority to select three conditions, based on high Medicare volume or expenditures, with measures endorsed by the National Quality Forum, and that exclude readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer from another hospital). Beginning in 2014, requires the Secretary to expand the list of conditions that may be used to measure excess readmissions. Requires the Secretary to monitor hospital admission practices to determine if hospitals are taking steps to avoid patients at high risk of readmissions, and permits the Secretary to impose sanctions, if the hospital continues to avoid such patients, after notice. Provides funds to certain hospitals to address factors that may result in high readmission rates; funds may be used to improve patient compliance, transitional services, and other services. For readmissions from post-acute care providers (SNF, inpatient rehabilitation facility, home health agency, or long-term care hospital), the payment to that provider would be adjusted by 0.996% in fiscal or rate year 2012, 0.997% in 2013, and 0.99% in 2014. Requires the Secretary to develop appropriate measures of risk-adjusted readmission rates for post-acute providers, effective on or after October 1, 2014. [Sec. 1151; -$9.3b]
Bundling and other post-acute care services payment reforms	Directs the Secretary of HHS to develop a detailed plan to bundle payments for post-acute care services delivered by SNFs, inpatient rehabilitation facilities, long-term care hospitals, hospital-based outpatient rehabilitation facilities, and home health agencies after discharge from a hospital, with the goal of improving the coordination, quality, and efficiency of such services, and improving outcomes for individuals, such as reducing hospital readmissions. The plan will take into account: (1) the type of post-acute provider, scope of services to be bundled, whether physician services should be included in the bundled payment and the appropriate period of time for the payment period; (2) whether the payment should be consolidated under the inpatient prospective payment system, or separate; (3) whether the bundled payment should apply broadly to providers, be limited to categories of providers, or be limited to certain types of discharges; and (4) the effects on quality of care for patients, and other factors. Requires the Secretary to convert the acute care episode (ACE) demonstration to a pilot program and to include post-acute services. Permits the Secretary to expand the pilot program to additional sites or conditions. Authorizes demonstrations of post-acute bundling or other payment reforms included in the plan. Instructs the Secretary to adopt bundled payments for inpatient and post-acute care services on a large scale geographically, to the extent that payments are found to be successful in reducing costs and improving quality. Requires the Secretary to attempt to attract 10% of all eligible providers to act as acute and post-acute bundling sites. Requires the Secretary to implement bundling reforms if they are found to be successful in improving quality and reducing costs. The legislation authorizes to be appropriated $15 million annually to the Secretary of HHS to carry out this provision for fiscal years 2010-2012. [Sec. 1152; $ n.s.]
Geographic payment adjustments: IOM Study and Medicare Payment Revisions	Requires the Secretary of HHS to contract with the Institute of Medicine (IOM) to conduct a study and provide recommendations on the accuracy of the geographic adjustment factors used by Medicare (e.g., wage index). Requires the IOM to submit a report, including recommendations to the Secretary and the Congress, within one year after the date of enactment. Requires the Secretary to take recommendations into account in proposed rules published to implement changes to Medicare payment systems for physicians and hospitals in the rulemaking cycle that follows the submission of the IOM report to the Secretary. Prohibits the Secretary from changing payment rates to be less than they would have been had this section not been enacted, and allocates up to $4 billion per year for two years for payment increases prior to 2014, with authorization for the Secretary to use funds from the Medicare Improvement Fund for this purpose. Beginning 2014, the Secretary will implement geographic adjustment in a budget neutral manner. [Sec. 1157-1158; -$14.3b]
Geographic variation in health spending: IOM Study and Medicare Payment Revisions	Requires the Secretary of HHS to contract with the IOM to conduct a study of geographic variation and growth in per capita spending among individuals covered by Medicare, Medicaid, private insurance, and the uninsured, including units of geographic measurement, an assessment of the extent to which geographic variation is attributable to differences in input prices (e.g., health status, race, and practice patterns), an evaluation of the extent to which variations in spending are correlated with patient access to care, outcomes, and other factors. The study will also evaluate the extent to which variations in Medicare spending are correlated with insurance status prior to Medicare enrollment, institutional status, coverage under Medicaid (dual eligibles), and enrollment in Medicare Advantage or traditional Medicare. Requires the IOM to recommend changes to Medicare Parts A and B to

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	H.R. 3962, Affordable Health Care for America Act of 2009 (as passed on November 7, 2009)
OTHER HEALTH SYSTEM REFORMS (continued)	
Geographic variation in health spending: IOM Study and Medicare Payment Revisions (continued)	address variations in Medicare per capita spending for services, by promoting high-value care, with attention to high-volume, high-cost conditions and specifically considering the adoption of a value-based index based on a composite of appropriate measures of quality and cost that would be used to adjust provider payments on a regional or provider-level basis. Requires the IOM to submit a report with findings and recommendations to the Secretary of HHS and each House of Congress no later than April 15, 2011. Requires the Secretary to submit to Congress a preliminary implementation plan within 90 days of receiving the IOM report, and a final implementation plan within 240 days of receiving the report, describing proposed changes in payments for items and services under Medicare Parts A and B that would not result in an increase in Medicare spending, and requires the Secretary to issue proposed rules. Gives the Secretary authority to waive requirements under Medicare to implement changes, unless a joint resolution is enacted. The plan will be implemented in 2013, unless Congress votes to disapprove it, with specified rules established for Congressional consideration. [Sec. 1159-1160; $ n.s.]
Comparative effectiveness research	Establishes a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality (AHRQ) to (1) conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. Requires the Center to also (2) conduct and support systematic reviews; (3) develop rigorous scientific methodologies; (4) submit appropriate reports to the Comparative Effectiveness Research Commission, the Secretary of HHS, and Congress; (5) encourage the development and use of clinical registries and research data networks; (6) appoint clinical perspective advisory panels; and (7) contract with the IOM to conduct an evaluation and report on standards of evidence for highly credible research. Establishes the Comparative Effectiveness Research Commission to (1) recommend priorities for research; (2) monitor the appropriateness of the use of funds from the trust fund established for this research [see below]; (3) identify methods and standards for the research; (4) promote stakeholder awareness and feedback, including holding a public meeting at least twice a year; and (5) make recommendations to the Center. Requires reports to be submitted to Congress and the President prior to being submitted to any federal agency, the executive branch, or posted on the website of the Commission. Requires the research to take into account any differences in subpopulations, and include members of subpopulations in the research. Requires reports to be posted on the website of the Center and the Commission within 90 days. Requires the Director of AHRQ to annually report to Congress on the activities of the Center, beginning within one year after enactment. Prohibits the Center or Commission from (1) mandating coverage, reimbursement, or other payment policies for public or private payers; and (2) preventing the Secretary from covering the routine costs of care that would otherwise be covered for Medicare, Medicaid, or CHIP beneficiaries enrolled in a clinical trial. [Sec. 1401; -$0.1b Medicare; +$1.2b non-Medicare] Establishes a trust fund for comparative effectiveness research through transfers from the Medicare Hospital Insurance (HI) Trust Fund, the SMI Trust Fund, the Medicare Prescription Drug Account within the SMI Trust Fund, and fees on health insurers, including self-insured health plans. Makes funds available from the trust fund for research beginning in 2010. [Sec. 1802; generates revenue of $2.0b (includes Medicare and non-Medicare funds)]
Delivery system pilot programs	Mandates an accountable care organization (ACO) pilot program, beginning no later than January 1, 2012, to test different payment incentive models designed to reduce the growth of Medicare expenditures and improve health outcomes. Payment models include performance target and partial capitation payment models and other payment models at the Secretary's discretion. Defines an ACO as "a group of physicians or other physician organizational model" meeting specified criteria. Requires the Secretary to establish annual quality targets that qualifying ACOs must meet to receive incentive payments. Authorizes the Secretary to extend pilot agreements with successful ACOs, expand the pilot to additional ACOs, and implement ACO models that are successful in improving quality and reducing costs on a permanent and large-scale geographic basis, if the CMS Chief Actuary certifies that such expansion would reduce spending. [Sec. 1301; -$2.6b] Mandates a medical home pilot program to test the independent patient-centered medical home model and the community-based medical home model, targeted at eligible beneficiaries; to be implemented within 12 months after the date of enactment and operational for 5 years. Authorizes the Secretary of HHS to establish a process for practices to qualify as medical homes and a methodology for payment for medical home services. Requires the Secretary to evaluate the pilot program and implement one or more models that are successful in improving quality and reducing costs on a permanent and large-scale geographic basis if the CMS Chief Actuary determines that spending would not increase by doing so. [Sec. 1302; +$1.8b]

"n.s." indicates exact cost estimate not specified; CBO indicates the amount is between +/- $50 million.

	H.R. 3962, Affordable Health Care for America Act of 2009 (as passed on November 7, 2009)
OTHER HEALTH SYSTEM REFORMS (continued)	
Delivery system pilot programs (continued)	Requires the Secretary of HHS to conduct the "Independence at Home" demonstration program to test a home-based primary care model designed to reduce expenditures and improve health outcomes in the provision of care for high-cost chronically ill beneficiaries, beginning no later than January 1, 2012. Permits qualifying practices to receive a portion of the program's savings in excess of 5%, to be determined by the Secretary. No qualifying practice may receive more in Medicare payment than what otherwise would have been provided in the absence of the pilot program. [Sec. 1312; $ n.s.]
Nursing home quality reforms	Requires reforms to increase the transparency of skilled nursing facilities (SNFs), nursing facilities (NFs) and other long-term care facilities' with respect to governance, finances and quality. Authorizes civil monetary penalties for deficiencies. Requires facilities to have compliance and ethics programs to prevent and detect criminal, civil and administrative violations and promote quality of care. Requires Secretary to implement quality assurance and performance and improvement program (QAPI) for SNFs. Requires the Secretary to develop, test, and implement a two-year pilot program on the use of an independent monitor to oversee chains of NFs and SNFs. Requires 60-day notification before facility closure, including a plan for transfer and relocation of residents prior to closure. Requires the Secretary to incorporate additional information on the Nursing Home Compare website. Establishes standardized complaint forms for use by residents. Establishes nationwide program for national and state background checks on employees of long-term care facilities. Allows the Secretary to require dementia and abuse prevention training, and requires a study on training content. Establishes new qualifications for directors of food services in SNFs and NFs (conforming changes for nursing facilities under Title XIX). [Sec. 1411-1432; +$0.1b]
Quality measurement and reporting	• Requires the Secretary of HHS to establish and update national priorities for performance improvement, and solicit and consider recommendations from outside entitles, including a consensus-based entity and other stakeholders. Lists considerations in setting national priorities, including the contribution to the burden of disease, potential to decrease morbidity and mortality, and addressing health disparities, effective 2010. [Sec. 1441] • Requires the Secretary of HHS to contract with qualified entities to develop patient-centered and population-based quality measures for the delivery of health care services and determine areas in which quality measures are needed; Secretary may contract with qualified public, private, or academic institutions with technical expertise in health quality measurement to test the feasibility and usability of proposed measures, effective 2010. Requires the GAO to conduct periodic evaluations of the implementation of the data collection processes for quality measures used by the Secretary and to determine their effectiveness in quality improvement and cost savings. [Sec. 1442] • Requires the Secretary of HHS to make public the list of quality measures being considered for use in setting Medicare payments and to consider the recommendations of multi-stakeholder groups, consisting of hospitals, physicians, nurses, health plans, patient groups, employers and others, regarding the selection of specific quality measures, in advance of rulemaking that incorporates the quality measures. [Sec. 1443] • Requires the Secretary of HHS to develop quality indicators for the provision of medical services to people with Alzheimer's disease and other dementias and a plan to measure the quality of care they receive; requires the Secretary to submit a report to Congress on progress implementing this provision, no later than 24 months after the date of enactment. [Sec. 1446] *[Manager's amendment]* [Sec. 1441-1446; +$0.3b] Requires public reporting by hospitals (including critical access hospitals) and ambulatory surgical centers on health care-associated infections. Requires the Secretary to produce an annual report to Congress on the number and types of health care-associated infections, the increase or decrease in health care costs, and best-practices recommendations. [Sec. 1461; $ n.s.]
OTHER MEDICARE-RELATED PROVISIONS	
	Increases funding to fight waste, fraud, and abuse in Medicare; enhances penalties on providers for activities related to fraud and abuse; enhances the authority of CMS to monitor providers in "high-risk" program areas and authorizes the Secretary of HHS to establish screening procedures for new providers; various effective dates beginning in 2010. [Sec. 1601; 1611-1621; 1631-1647; 1651-1652; -$1.6b] Repeals the Medicare Solvency Trigger, established under the Medicare Modernization Act of 2003, effective upon enactment of the Act. [Sec. 1901; $0b] Repeals the comparative cost adjustment program (otherwise known as "premium support demonstration project") as added by the MMA of 2003. [Sec. 1902; -$0.1b]

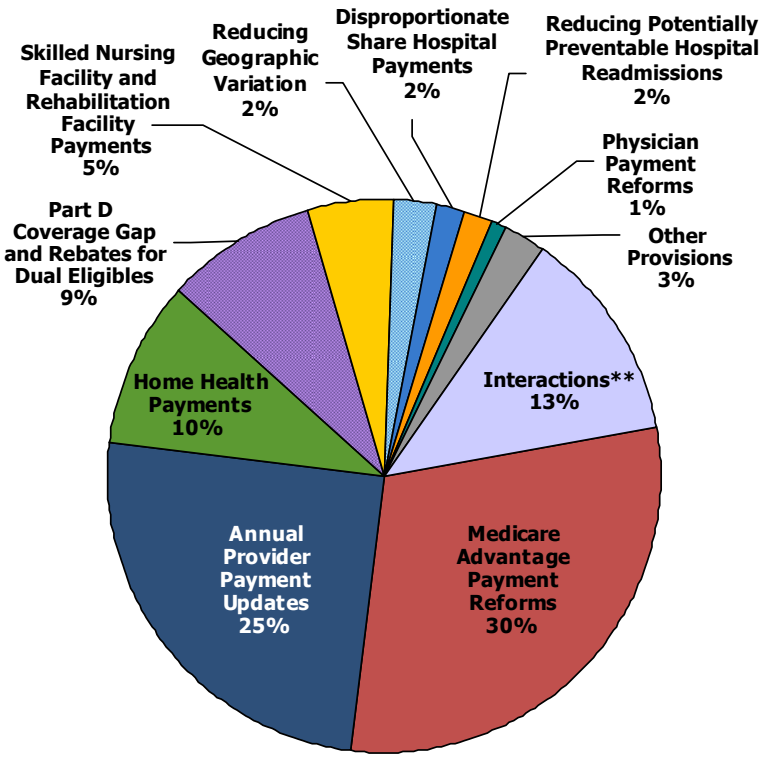
"n.s." indicates exact cost estimate not specified; CBO indicates the amount is between +/- $50 million.

	H.R. 3962, Affordable Health Care for America Act of 2009 (as passed on November 7, 2009)
OTHER MEDICARE-RELATED PROVISIONS (continued)	
	Requires CMS to create a dedicated office or program to improve coordination of benefits and other policies for beneficiaries dually eligible for Medicare and Medicaid. [Sec. 1905; $0b] Requires the CMS Administrator to conduct an assessment of the diseases and conditions that are most cost-intensive for the Medicare program, and review and update that assessment; creates a fund for research into such diseases and conditions. [Sec. 1906; $0b] Creates a Center for Medicare and Medicaid Innovation within CMS to test and evaluate models for provider payment that affect the cost and quality of care received under Medicare and Medicaid. All models must improve the quality of care without increasing spending; reduce spending without reducing quality; or improve the quality of care and reduce spending. Authorizes the Secretary of HHS to expand the duration and scope of models that meet these criteria; new Center to be operational January 1, 2011. [Sec. 1907; +$6.5b for funding; -$8.2b on Medicare benefits spending]

"n.s." indicates exact cost estimate not specified; CBO indicates the amount is between +/- $50 million.

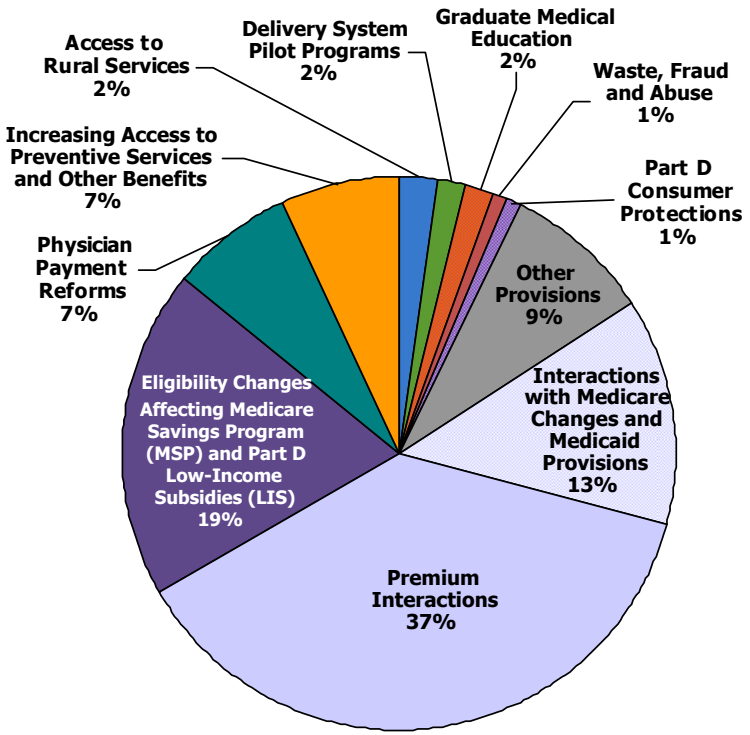
Medicare Savings and Spending in House Bill (H.R. 3962)
"Affordable Health Care for America Act of 2009"
Based on CBO 10-Year Estimates (2010-2019)

Medicare Savings



Ten-Year Savings = $573.4 Billion

Medicare Spending



Ten-Year Spending = $96.8 Billion

Source: Kaiser Family Foundation analysis of Congressional Budget Office (CBO) cost estimates as provided on November 5, 2009, and Joint Committee on Taxation (JCT) estimates as provided on October 29, 2009 for H.R. 3962.
Notes: *Medicare savings for the Part D coverage gap and rebates for dual eligibles includes the spending to close the coverage gap; CBO does not display these estimates separately.
**Savings include interactions with TRICARE and Medicare Advantage.
Spending and savings amounts exclude up to $0.6 billion that may be used from the Medicare Trust Funds for comparative effectiveness research and some Medicare savings that may result from the licensure of biological products; CBO does not display these estimates separately.

This publication (#7948) is available on the Kaiser Family Foundation's website at www.kff.org.

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