AN ANALYSIS OF TITLE III – IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Summaries of key provisions in the "Patient Protection and Affordable Care Act" (HR 3590) as amended by the "Health Care and Education Reconciliation Act of 2010" (HR 4872) as of July 23, 2010.

Initiative	Summary	Important Dates	Participants
INNOVATION			
The Center for Medicare and Medicaid Innovation (HR 3590, Sec. 3021, as amended by Sec. 10306)	The newly-created Center for Medicare and Medicaid Innovation (CMI) within CMS will, in part, test innovative payment and service delivery models to reduce program expenditures while simultaneously preserving or enhancing the quality of care furnished.	January 1, 2011 – The Center must be established by this date. The Center will receive $ 10 billion every 10 years. During the testing phase, models tested by the center will not be subject to budget neutrality requirements.	States will test and evaluate models for fully integrating care for dual eligibles within the state, as well as payment reform models for the medical care of residents of the state, including dually eligible individuals.
Accountable Care Organizations (HR 3590, Sec. 3022, as amended by Sec. 10307)	The new legislation creates a three-year program that would enable providers of services and supplies for Medicare beneficiaries to work together in Accountable Care Organizations (ACOs) that cover a minimum of 5,000 Medicare beneficiaries. The ACOs must meet quality thresholds in order to share in the cost savings they achieve for the Medicare program. If an ACO achieves this minimum level of savings, the ACO will receive a share	2012: Qualifying providers organized as Accountable Care Organizations (ACOs) that meet quality thresholds will be able to share in the cost savings they achieve for Medicare	To qualify as an ACO, organizations must agree, in a 3-year contract with the Secretary, (i) to be accountable for the overall care of their Medicare beneficiaries,(ii) agree to have adequate participation of primary care physicians, (iii) define processes to promote evidence-based medicine, (iv) report on quality and costs, and (v) coordinate care.

	of the savings.		
Medicare Bundled Payments Pilot Program (HR 3590, Sec. 3023, as amended by Sec. 10308)	The Secretary must develop, implement and evaluate a national, five-year Medicare pilot program for integrated care, focusing on coordination, quality and efficiency improvement.	2013: By this date, the program must be implemented 2016: If the pilot program achieves stated goals of improving, or not reducing, quality and reducing spending, the Secretary must expand the program by this date	The program will provide a bulk payment to be shared by a hospital, a physician group, a skilled nursing facility and a home health agency. Bundled payment models will be applied to traditional fee-for-service Medicare for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge.
Medicare Independence at Home (HR 3590, Sec. 3024)	The three-year, Independence at Home demonstration program will provide high-need Medicare beneficiaries with primary care services in their homes, and will allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction.	2012: The demonstration year program begins. The three-year demonstration will receive mandatory appropriations of $5 million per year.	The demonstration will include up to 10,000 fee-for-service high-need Medicare beneficiaries. High-need beneficiaries are defined as those having two or more chronic conditions, a non-elective hospital admission within the past 12 months, previous acute or sub-acute rehabilitation services, and two or more functional dependencies.
Hospital Readmissions Reductions Program (HR 3590, Sec. 3025, as amended by Sec. 10309)	As an incentive to reduce readmissions and improve transitional care, Medicare payments to Medicare participating hospitals will be reduced by one percent (rising to three percent over time) for avoidable readmissions. The Secretary will specify this readmission window, and will also identify the three conditions to be	October 1, 2012: The program begins 2013: The Medicare payment will be reduced by no more than one percent 2014: The Medicare payment will be	CMS will track national and hospital-specific data on the readmission rates of Medicare participating hospitals for certain high-cost conditions that have high rates of potentially avoidable hospital readmissions. Reductions will not apply to critical access hospitals.

	targeted when the program begins.	reduced by no more than two percent 2015 and beyond: The Medicare payment will be reduced by no more than three percent, and he program will be expanded to seven conditions	
Community Based Care Transitions Program (HR 3590, Sec. 3026)	There will be a new, five-year program under which the Secretary will make grants to hospitals with high readmission rates and qualifying community based organizations. Grantees will be required to deliver at least one transitional care intervention, and services will be targeted to high-risk beneficiaries in traditional fee-for-service Medicare.	2011: The program will begin. The program will receive mandatory appropriations of $500 million over five years	Selected hospitals with high readmission rates, in partnership with community based organizations, will receive funding to provide improved care transition services to high risk Medicare beneficiaries. Applicants will receive preference if they serve the medically underserved, small communities, rural areas, or AoA programs that provide transitional care to multiple providers.
Community Health Teams (HR 3590, Sec. 3502, as amended by Sec. 10321)	Interdisciplinary Community Health Teams will be established to support Medical Homes. These teams will target patients with chronic conditions, regardless of payor type. Services will include chronic care coordination, discharge planning, transitions care management, mental health referrals, and medication therapy management.	March 23, 2010: This program is authorized	Grants or contracts will be made by the Secretary to eligible entities for the establishment of health teams. Eligible entities include states, state designated entities and Indian tribes or tribal organizations. The health team will provide support services to primary practices, and may include specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers, and physicians' assistants.
Medication Management Services in the treatment of Chronic Disease	A new grant program will provide support for licensed pharmacists, as part of an interdisciplinary team, to work with targeted individuals with chronic conditions.	May 1, 2010: The program is authorized	A targeted individual is one taking four or more prescription medications for the treatment of chronic disease.

(HR 3590, Sec. 3503)			
Medicare Hospice Demonstration Program (HR 3590, Sec. 3140)	The three-year Medicare Hospice concurrent care demonstration program will allow 15 hospice providers to combine home health and hospice provider services. Under the program, patients who are eligible for hospice care will also receive all other Medicare covered services.	March 23, 2010: This program is authorized	The demonstration program will be established at hospices that furnish care to Medicare beneficiaries, in both urban and rural areas.
ACCESS TO COVERAGE			
Post-hospital extended care services (HR 3590, Sec. 3108)	The new legislation authorizes clinical nurse specialists or physician assistants, in addition to nurse practitioners, to order skilled nursing care services in the Medicare program.	2011: The program begins	The Social Security Act is amended to allow physician assistants or clinical nurse specialists to order Medicare post-hospital extended care services.
Rural Community Hospital Demonstration Program (HR 3590, Sec. 3123, as amended by Sec. 10313)	The existing five-year demonstration program is being conducted by CMS to test the feasibility and advisability of reasonable cost reimbursement for small rural hospitals (those with fewer than 51 beds) in low population density areas. The Affordable Care Act extends the demonstration for an additional five years, and eligible sites are also expanded to include additional hospitals.	March 23, 2010: The program is extended and expanded	Currently, 10 hospitals are participating in the program, and the maximum number of participants is set at 15. Under the Affordable Care Act, the maximum number of hospitals is increased to 30, and the 20 states with low populations densities will participate in the project. The Secretary is to provide for the continued participation of the hospitals engaged in the original demonstration, unless the hospital opts out.

Medicare Dependent Hospital Program (HR 3590, Sec. 3124)	The classification date for the Medicare-Dependent Hospital Program (MDH) is extended for one year. MDHs receive special treatment, including higher payments, under Medicare's inpatient prospective payment system.	October 1, 2012: The MDH is extended through this date	A Medicare-Dependent Hospital is a small rural hospital with a high proportion of patients who are Medicare beneficiaries. The hospitals must have at least 60 percent of acute inpatient days or discharges attributable to Medicare in FY1987, or in two of the three most recently audited cost reporting periods. These hospitals cannot be a sole community hospital, and must have 100 or fewer beds.
Cost-Sharing and MA Plans (HR 3590, Sec. 3202, as amended by HR 4872, Sec. 1102).	MA Plans are prohibited from imposing higher cost-sharing requirements than traditional fee-for-service Medicare for chemotherapy, renal dialysis, skilled nursing care, and other services the Secretary designates. Plans may charge non-discriminatory cost-sharing for services that have no cost-sharing under traditional fee-for-service Medicare.	2011: These provisions take effect	The Medicare Advantage (MA) program allows Medicare beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO), preferred provider organization (PPO) or private fee-for-service (PFFS) plan. MA Plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in some cases, prescription drug benefits. These plans offer combined coverage of Medicare Part A (hospital insurance), Part B (medical insurance), and in some cases, Part D (prescription drug) benefits.
Annual Enrollment Period for MA and Part D (HR 3590, Sec. 3204)	Currently, Medicare beneficiaries may enroll in or change their enrollment in MA from November 15 to December 31 each year, during the annual enrollment period (AEP). Changes made during this time go into effect January 1 of the following year. Under the Affordable Care Act, the AEP for MA and Medicare Part D will be changed to October 15 through December 7 of each year, beginning in the fall of 2011.	2011 and beyond: The AEP will be October 15 – December 7 2012: The first plan year to be affected by the new AEP	The Medicare Advantage (MA) program allows Medicare beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO), preferred provider organization (PPO) or private fee-for-service (PFFS) plan. MA Plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in some cases, prescription drug benefits. These plans offer combined coverage of Medicare Part A (hospital insurance), Part B (medical insurance), and in some cases, Part D (prescription drug) benefits.
45 Day disenrollment period	Currently, during the first three months of the calendar year, beneficiaries can enroll in an MA plan, and individuals enrolled in an	2011 and beyond: The 45 day period will begin on January 1 of each year, starting in 2011	The Medicare Advantage (MA) program allows Medicare beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO), preferred provider

(HR 3590, Sec. 3204)	MA plan can either switch to a different MA plan, or return to original Medicare, during the continuous open enrollment and disenrollment period. Under the Affordable Care Act, beneficiaries will not be permitted to switch from one MA plan to another, or to enroll in an MA plan after the start of the benefit year, January 1. However, during the first 45 day period of the new benefit year (January 1 – February 15), beneficiaries who enrolled in MA during the AEP may disenroll and return to original Medicare, and these beneficiaries may also enroll in a Part D plan during this 45 day period.		organization (PPO) or private fee-for-service (PFFS) plan. MA Plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in some cases, prescription drug benefits. These plans offer combined coverage of Medicare Part A (hospital insurance), Part B (medical insurance), and in some cases, Part D (prescription drug) benefits.
Extension for Specialized MA Plans (HR 3590, Sec. 3205)	Special Needs Plans (SNPs) will be offered to beneficiaries for an additional three years, until 2014, but must be approved by the National Committee for Quality Assurance (NCQA) beginning in 2012. SNPs for dual eligibles will be able to operate without established contracts with the state Medicaid programs until 2013.	2014: SNPs will be available until this date 2012: SNPs must be approved by the NCQA	Medicare Special Needs Plans are a type of Medicare Advantage Plan (Part C) for people with certain chronic diseases and conditions or who have specialized needs, such as dual eligibles. SNPs provide beneficiaries with all Medicare Part A (hospital insurance) and Part B (medical insurance) benefits, and Part D (prescription drug coverage).
Extension of reasonable cost contracts (HR 3590, Sec. 3206)	Prior to the passage of the Affordable Care Act, Reasonable cost plans were allowed to operate indefinitely, unless two other MA plans of the same type (local or regional) offered by different organizations operate for the entire year in the cost contract's service area. As of January 1, 2010, the Secretary did not have the authority to renew or extend a reasonable cost contract for such a service area. The new law	January 1, 2010 – January 1, 2013: The length of time reasonable cost plans may continue operating regardless of any other MA plans serving the area is extended	Reasonable cost plans are MA plans that are reimbursed by Medicare for the actual cost of providing services to enrollees.

	extends for three years the length of time the reasonable cost plans may continue operating regardless of any other MA plans serving the area.		
MA Senior Housing Facility Demonstration (HR 3590, Sec. 3208)	Section 1859 of the Social Security Act is amended to make permanent the MA Senior Housing Facility Demonstration Plans.	January 1, 2010: The Demonstration is permanent, retroactive to this date. This applies to all plan years beginning on or after this date	MA Senior Housing Facility Demonstration plans serve individuals living in a continuing care retirement community by providing onsite primary care services and transportation to offsite providers.
Medicare Donut Hole Rebate Checks (HR 3590, Sec. 3301, as amended by HR 4872, Sec. 1101)	Medicare beneficiaries who reach the Part D coverage gap in 2010 will automatically receive a one-time, tax-free, $250 rebate.	2010: Beneficiaries reaching the donut hole during this year will receive the rebate	The "donut hole" refers to the gap in Medicare prescription drug coverage that occurs once the standard level of coverage has been reached ($2,830 in 2010). While in the donut hole, enrollees are responsible for all out-of-pocket prescription drug costs, up to a limit ($3,610 in 2010), at which point Medicare Part D catastrophic coverage will pay a percentage of the enrollee's drug costs (95 percent in 2010).
Medicare Donut Hole Brand Name Drug Discount (HR 3590, Sec. 3301, as amended by HR 4872, sec. 1101)	The Medicare coverage gap discount program will provide a 50 percent discount on brand-name drugs to Part D enrollees in the coverage gap.	2011: Beginning this year, drug manufactures must provide a 50 percent discount on brand-name drugs and biologics covered under Part D for Part D enrollees in the coverage gap	The "donut hole" refers to the gap in Medicare prescription drug coverage that occurs once the standard level of coverage has been reached ($2,830 in 2010). While in the donut hole, enrollees are responsible for all out-of-pocket prescription drug costs, up to a limit ($3,610 in 2010), at which point Medicare Part D catastrophic coverage will pay a percentage of the enrollee's drug costs (95 percent in 2010).
Medicare Donut Hole Generic Drug	A phased-in reduction in coinsurance for generic drugs in the coverage gap will	2011: The phased-in reduction begins	The "donut hole" refers to the gap in Medicare prescription drug coverage that occurs once the standard level of

Coinsurance (HR 3590, Sec. 3301, as amended by HR 4872, Sec. 1101)	reduce the beneficiary coinsurance rate from 100 percent in 2010 to 25 percent in 2020.	2020: The beneficiary coinsurance rate will be 25 percent	coverage has been reached ($2,830 in 2010). While in the donut hole, enrollees are responsible for all out-of-pocket prescription drug costs, up to a limit ($3,610 in 2010), at which point Medicare Part D catastrophic coverage will pay a percentage of the enrollee's drug costs (95 percent in 2010).
Medicare Donut Hole Brand Name Coinsurance (HR 3590, Sec. 3301, as amended by HR 4872, Sec. 1101)	A phased-in reduction in coinsurance for brand name drugs in the coverage gap will reduce the beneficiary coinsurance rate from 100 percent in 2010 to 25 percent in 2020.	2013: The phased-in reduction begins 2020: The beneficiary coinsurance rate will be 25 percent	The "donut hole" refers to the gap in Medicare prescription drug coverage that occurs once the standard level of coverage has been reached ($2,830 in 2010). While in the donut hole, enrollees are responsible for all out-of-pocket prescription drug costs, up to a limit ($3,610 in 2010), at which point Medicare Part D catastrophic coverage will pay a percentage of the enrollee's drug costs (95 percent in 2010).
Medicare Donut Hole Catastrophic Threshold (HR 3590, Sec. 3301, as amended by HR 4872, Sec. 1101)	The threshold that beneficiaries must meet to trigger catastrophic coverage will be reduced to provide additional support for those with relatively high drug costs.	2014 – 2019: The threshold will be reduced	Medicare Part D beneficiaries who reach the coverage gap are responsible for all of their prescription drug costs, up to a limit ($3,610 in out-of-pocket expenses in 2010). Once beneficiaries reach this limit, Medicare Part D catastrophic coverage is triggered, and Medicare will pay a percentage of the beneficiary's drug costs (95 percent in 2010).
Medicare Part D LIS Benchmarks (HR 3590, Sec. 3302, as amended by HR 4872, Sec. 1102)	The determination of Part D low-income subsidy (LIS) benchmark premiums will exclude any reductions in premium amounts that result from rebates or bonus payments to plans.	2011: The change in determination is effective	The LIS subsidy helps pay for some Medicare Part D premiums, and is available to qualifying Medicare Part D or Medicare Advantage prescription drug plan enrollees. Some individuals are automatically enrolled in the LIS program, while others must apply for it. There are different levels of subsidies, tied to the percentage of the enrollee's income in relation to the federal poverty level (FPL).

LIS Eligibility for Widows and Widowers (HR 3590, Sec. 3304)	To prevent individuals from losing LIS coverage due to the death of a spouse, the LIS eligibility of an individual whose spouse dies will be extended for one year.	2011: The extension is effective	This applies to situations in which the death of a spouse would otherwise affect the income or asset calculations for LIS eligibility. LIS eligibility is tied to income level, in relation to the federal poverty level (FPL), and the subsidies can help pay for some Medicare Part D premiums.
LIS Funding Outreach and Assistance (HR 3590, Sec. 3306)	To help improve access to Part D for LIS beneficiaries, funds are appropriated to enhance outreach and assistance for low income programs.	FY 2010 – FY 2012 SHIPs, through the CMS Program Management Account, will have access to $15 million. AoA will receive $15 million for AAAs, another $10 million for ADRCs and $5 million for AoA to contract with the National Center for Benefits and Outreach Enrollment.	State Health Insurance Counseling and Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging Disability and Resource Centers (ADRCs) and the National Center for Benefits and Outreach Enrollment (NCBOE) are resources available to provide information, assistance and counseling to organizations and individuals.
Elimination of cost-sharing for certain dual eligibles (HR 3590, Sec. 3309)	Cost-sharing for full benefit dual eligibles receiving home and community based care will be equal to the cost-sharing for those receiving institutionalized care.	2012: Cost-sharing will be eliminated for certain dual eligibles	Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B, and are also eligible for some form of Medicaid. Non-institutionalized dual eligibles receiving home and community based care will no longer be subject to cost-sharing requirements.
Patient Navigator Program (HR 3590, Sec. 3510)	The Patient Navigator Program is reauthorized through 2015. As defined in Section 340A of the Public Health Service Act (42 U.S.C. 256a), the program focuses on improving patient's health outcomes through enhanced chronic disease	2011 – 2015: The demonstration program will operate. The program is extended at its current funding level of $3.5 million per year	Grant recipients must both define and assure that the potential navigators recruited, assigned, trained or employed using grant funds meet minimum core proficiencies that are tailored for the main focus or intervention of the navigator involved. The Public Health Service Act defines eligible applicants for the Program as public and non-profit private

	management by using patient navigators.		health centers, Indian Health Service hospitals, cancer centers, rural health clinics, academic health centers, and non-profit entities that enter into a partnership or coordinate referrals with such centers, clinics, facilities or hospitals to provide navigation services.
PAYMENT ADJUSTMENTS AND SUSTAINABILITY			
Rebasing home health payments (HR 3590, Sec. 3131, as amended by Sec. 10315)	Home health payment amounts will be rebased, using a phased-in approach. The Secretary will take into account the number, mix and intensity of services provided, as well as the average cost of providing care and differences between providers, such as hospital or free-standing, for-profit or non-profit, and urban or rural. The adjustments will be capped at 3.5 percent per year, relative to payment levels in 2010.	2010: The payment levels in 2010 will be the baseline 2014 – 2017: The payment adjustments will be phased-in	Medicare pays for certain home health services if beneficiaries meet the eligibility criteria and if the services are considered reasonable and necessary, such as limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language pathology services, medical social services, medical supplies, and durable medical equipment. Home health agencies are Medicare-certified and the providers may be for-profit, non-profit or hospital-based.
Home health outlier payments (HR 3590, Sec. 3131, as amended by Sec. 10315)	The law modifies payments for outliers by capping the outlier payments at 10 percent per home health agency, and by setting target total aggregate outlier payments at 2.5 percent of all home health prospective payment system payments.	2011: Payments for outliers will be modified	Home health agencies receive additional payments, or outlier payments, for 60-day home care that carry unusually high costs.
Payment adjustment for rural home health providers (HR 3590, Sec. 3131, as amended	This provision temporarily reinstates a three percent add-on payment for rural home health providers.	April 1, 2010 – January 1, 2016: The add-on payment will be reinstated with respect to episodes and visits during this period	Medicare pays for certain home health services if beneficiaries meet the eligibility criteria and if the services are considered reasonable and necessary, such as limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language pathology services, medical social services, medical supplies, and durable medical equipment. Home

by Sec. 10315)			health agencies are Medicare-certified and the providers may be for-profit, non-profit or hospital-based.
Reduction in Medicare Disproportionate Share Payments (HR 3590, Sec. 3133, as amended by Sec. 10316 and HR 4872, Sec. 1104)	Medicare Disproportionate Share Hospital (DSH) payments will be reduced to 25 percent of the amount that would otherwise be made.	October 1, 2014 and beyond: DSH payments will be reduced	Medicare has traditionally paid most hospitals under the Medicare inpatient prospective payment system (PPS). Under this system, Medicare pays fixed amounts per discharge, subject to certain adjustments. One such adjustment is the DSH payment, which provides special funding to hospitals treating significant populations of indigent patients in order to encourage these hospitals to provide such services.
Additional DSH Payment (HR 3590, Sec. 3133, as amended by Sec. 10316 and HR 4872, Sec. 1104)	In addition to the DSH payment reduction, there will be a supplemental payment to reflect uncompensated care costs. The payment will be based on a formula that takes into account (i) the aggregate reduction in payments to all hospitals as a result of the reduction in DSH payments, (ii) the reduction in uninsured individuals in a year, using 2013 as a baseline, and (iii) each hospitals share of uncompensated care.	October 1, 2014 and beyond: The Secretary will pay acute care hospitals this additional, formulaic amount	Medicare has traditionally paid most hospitals under the Medicare inpatient prospective payment system (PPS). Under this system, Medicare pays fixed amounts per discharge, subject to certain adjustments. One such adjustment is the DSH payment, which provides special funding to hospitals treating significant populations of indigent patients in order to encourage these hospitals to provide such services.
Medicare Advantage Payment Restructuring (HR 3590, Sec. 3201 as amended by HR 4872, Sec.	The restructured payment system will be determined on a county basis, and will be gradually reduced to levels closer to the costs of enrollees in traditional Medicare in each county. Depending on the level of reductions, the new system will be phased in over either three, five, or seven years	2012:The phased-in payment reduction will begin	The Medicare Advantage (MA) program allows Medicare beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO), preferred provider organization (PPO) or private fee-for-service (PFFS) plan. MA Plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in some cases, prescription drug benefits. These plans offer combined coverage of Medicare Part A

1102)			(hospital insurance), Part B (medical insurance), and in some cases, Part D (prescription drug) benefits.
Medicare Advantage Benchmarks (HR 3590, Sec. 3201 as amended by HR 4872, Sec. 1102)	Benchmarks will be calculated at the county level, and will necessarily vary from county to county, as they will be set to different percentages of fee-for-service (FFS) rates. The range will vary from 95 to 115 percent of Medicare spending. Specifically, the benchmarks will be 95 percent of Medicare spending in high-cost areas, or counties that are in the top quartile of FFS costs. Counties in the second highest quartile will receive a 100 percent benchmark, the third quartile will be set at 107.5 percent, and in low-cost areas, or counties in the bottom quartile of FFS costs, the benchmarks will be 115 percent.	2011: MA payments for 2011 will freeze, remaining at their 2010 levels. 2012: The benchmarks will begin to be gradually reduced	The Medicare Advantage (MA) program allows Medicare beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO), preferred provider organization (PPO) or private fee-for-service (PFFS) plan. MA Plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in some cases, prescription drug benefits. These plans offer combined coverage of Medicare Part A (hospital insurance), Part B (medical insurance), and in some cases, Part D (prescription drug) benefits.
Medicare Advantage Quality Increases to Benchmarks (HR 3590, Sec. 3201 as amended by HR 4872, Sec. 1102)	Using the current five-star quality rating system, MA Plans receiving four or more stars will receive bonuses, with double bonuses awarded to high quality plans in certain counties.	2012: Bonus payments will be 1.5 percent 2013: Bonus payments will be 3 percent 2014 and later years: bonus payments will be 5 percent	The Medicare Advantage (MA) program allows Medicare beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO), preferred provider organization (PPO) or private fee-for-service (PFFS) plan. MA Plans receive payments from Medicare to provide Medicare-covered benefits, including hospital and physician services, and in some cases, prescription drug benefits. These plans offer combined coverage of Medicare Part A (hospital insurance), Part B (medical insurance), and in some cases, Part D (prescription drug) benefits. MA Plans receiving four or more stars will be affected by this bonus.
Income-related increase in Part D	The law establishes a new income-related monthly Part D premium requiring higher-	2011: The new income-related premium will take effect	Individuals whose modified adjusted gross incomes (MAGI) exceed the threshold for the calendar year. For 2010, higher-

Premium (HR 3590, Sec. 3308)	income Part D enrollees to pay a higher income-related premium. This provision also expands the current authority of the IRS to disclose income information to the Social Security Administration for purposes of adjusting the Part B subsidy and to include the Part D subsidy adjustments.		income enrollees are individuals with incomes greater than $85,000, or $170,000 per couple.
Reductions in Annual Market Basket Updates (HR 3590, Sec. 3401, as amended by Sec. 10319 and HR 4872, Sec. 1105)	The annual market basket updates are reduced for several types of Medicare services.	2010: The annual market basket updates for inpatient and outpatient hospital services, long-term care hospitals, and inpatient rehabilitation facilities and psychiatric hospitals and units will be reduced 2012: The annual market basket updates for home health agencies, skilled nursing facilities, hospices, and other Medicare providers will be reduced	Providers and suppliers of the following types of Medicare services will be impacted by these updates: inpatient hospital services, and outpatient hospital services, long-term care hospitals, and inpatient rehabilitation facilities and psychiatric hospitals and units, home health agencies, skilled nursing facilities, hospices, and clinical laboratory services.
Productivity Adjustment for Annual Market Basket Updates (HR 3590, Sec. 3401, as amended by Sec. 10319 and HR 4872, Sec. 1105)	A productivity adjustment will be applied to certain market basket updates. This is designed to bring the payment updates of providers of the affected Medicare services more in line with those given physicians, whose Medicare fee schedule's annual updates are determined through a formula that incorporates a productivity measure.	October 1, 2012: The adjustment will be applied to updates for inpatient and outpatient hospitals, inpatient rehabilitation facilities, psychiatric hospitals and units, long term care hospital services and skilled nursing facilities October 1, 2013: The adjustment will be applied to	Providers and suppliers of the following types of Medicare services will be impacted by this productivity adjustment: inpatient and outpatient hospitals, skilled nursing facilities, long-term care hospital services, dialysis, ambulance services, ambulatory surgical center services, clinical laboratory services, inpatient rehabilitation facilities, psychiatric hospitals and units, hospice services, home health agencies, certain durable medical equipment, prosthetic devices, orthotics and prosthetics.

		updates for hospice services October 1, 2014: The adjustment will be applied to home health	
Temporary Adjustment to Part B premiums (HR 3590, Sec. 3402)	The income-related threshold for higher-income beneficiaries who pay a higher Part B premium will be temporarily frozen at the 2010 income levels through 2019.	2010: income thresholds will be frozen at 2010 levels 2011 – 2019: The temporary freeze will be in effect	The 2010 Part B (medical insurance) premium levels are $85,000 for an individual or $170,000 for a couple.
Independent Medicare Advisory Board (HR 3590, Sec. 3403, as amended by Sec. 10320)	A new Independent Payment Advisory Board will recommend ways to reduce Medicare spending if the increase in Medicare per capita growth rates exceeds certain targets. If the Board fails to submit a proposal, the Secretary must do so. The Board is the first time that the Medicare program will be subject to spending limits, with statutory requirements to achieve savings targets.	January 15, 2014: The Board may develop sand submit to Congress advisory reports on matters related to Medicare. $15 million is appropriated to fund the Board in FY 2012, with future funding to be indexed by the CPI	The Board will consist of fifteen full-time members, appointed by the President and confirmed by the Senate for six-year terms. A ten-member consumer advisory council will be established to advise the Board. The Secretary is required to implement the Board's proposals to achieve Medicare savings, subject to alternative action by Congress or a Presidential veto. The Secretary's implementation of the recommendations is not subject to administrative or judicial review. The Board does not affect MedPAC's role as a Congressional advisory body.