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CRS Report for Congress

Medicare: FY2008 Budget Issues

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Medicare: FY2008 Budget Issues

Summary

Each February, the President submits a detailed budget request to Congress for the following federal fiscal year, along with projections for the five-year budget window. The budget informs Congress of the President's overall federal fiscal policy, based on proposed spending levels, revenues, and deficit (or surplus) levels. The budget request lays out the President's relative priorities for federal programs, such as how much should be spent on defense, education, health, and other federal programs. The President's budget may also include legislative proposals for spending and tax policy changes. While the President is not required to propose legislative changes for those parts of the budget that are governed by permanent law, such as Medicare benefits, these changes are generally included in the budget.

The President's 2008 budget estimates current law Medicare outlays of $392 billion in FY2008 and $2.213 trillion over the five-year budget window. The budget also includes Medicare legislative proposals with estimated savings of $4.3 billion in 2008 and $65.6 billion over the five-year budget window. The President's budget also includes one Medicare administrative proposal with estimated savings of $1 billion in FY2008 and $10.2 billion over the five-year budget window, which brings the estimated savings from the total Medicare budget proposals to $5.3 billion in FY2008 and $75.9 billion over the five-year budget window.

On March 15, the Senate Budget Committee passed its FY2008 Budget Resolution (S.Con.Res. 21). The Senate Chairman's Mark assumes $384.7 billion in mandatory outlays for Medicare in 2008, with total Medicare outlays of $390 billion. The Senate passed the resolution on March 23, 2007, with three amendments related to Medicare (S.Amdt. 548, S.Amdt. 636, and S.Amdt. 639). On March 23, the House Budget Committee reported its FY2008 Budget Resolution (H.Con.Res. 99), and the House passed the bill on March 29. The House Chairman's Mark assumes $384.7 billion in mandatory outlays for Medicare in 2008, with total Medicare outlays of $389.7 billion. On May 17, the House and Senate adopted a conference agreement on the budget resolution (H.Rept. 110-153 accompanying S.Con.Res. 21). The conference agreement provides a variety of other deficit-neutral reserve funds, up to $383 million for health care fraud and abuse control, and two "sense of the Congress" provisions regarding health care cost growth and affordable health coverage.

H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act of 2007, contained many provisions that affect the Medicare program and spending. The bill was passed by the House of Representatives on August 1. This report describes Medicare provisions in the bill as passed by the House. On August 2, the Senate passed S. 1893, the Children's Health Insurance Program Reauthorization Act of 2007, as an amendment to H.R. 976, which did not include provisions that would affect the Medicare program and spending. A bicameral agreement on SCHIP reauthorization passed the House on September 25 and the Senate on September 27 as an amendment to H.R. 976, without the provisions affecting the Medicare program. Congress also passed two other bills affecting the Medicare program, which were signed into law.

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Introduction

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The President's 2008 budget estimates current law Medicare outlays of $392 billion in FY2008 and $2.213 trillion over the five-year budget window. The budget also includes Medicare legislative proposals with estimated savings of $4.3 billion in FY2008 and $65.6 billion over the five-year budget window. The President's budget also includes one Medicare administrative proposal with estimated savings of $1 billion in FY2008 and $10.2 billion over the five-year budget window, which brings the estimated savings from the total Medicare budget proposals to $5.3 billion in FY2008 and $75.9 billion over the five-year budget window. Proposals include savings in many of the Medicare payment updates.

The President's budget also includes an automatic reduction to all Medicare payments if general revenue financing is projected to exceed 45% of total Medicare financing, and only when that threshold is met and Congress fails to act on recommendations to reduce that level. In such a case, a four-tenths of 1% reduction would be made across the board to all Medicare payments. This reduction would grow by four-tenths of 1% for every year that the 45% threshold was exceeded. There are no threshold savings included in the five-year budget window.

Finally, the Program Management Budget account request for 2008 is $3.3 billion, which is an increase of $70 million above the President's FY2007 estimate.[1] Program management funds are used primarily for operating the Medicare (and Medicaid) program, including (1) paying contractors to pay claims, answer beneficiary questions and conduct appeals; (2) compensation for individuals employed at the Centers for Medicare and Medicaid Services (CMS); (3) the cost of surveys and inspections of facilities; and (4) conducting research. There is a

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[1] The President's estimate for FY2007 of $3.2 billion reflects the amounts provided by the continuing resolution and the Tax Relief and Health Care Act of 2006.

legislative proposal in the Program Management Budget to collect $35 million in user fees for any return visits to a facility that are required when a deficiency is found based on an initial survey, a re-certification, or a beneficiary complaint.

Following is a brief discussion of current and proposed law for each of the 2008 Medicare program proposals, along with **Table 1**, which details the Administration's and CBO's estimates of the costs and savings for each proposal. The President's budget reflects the passage of the Tax Relief and Health Care Act of 2006 (P.L. 109-432). **Table 2** provides a list of CRS staff contacts for this report.

Medicare Part A

Hospital Update

Current Law. Inpatient services provided by acute care hospitals are reimbursed based on the inpatient prospective payment system (IPPS). Medicare's IPPS payments are increased annually by an update factor that is determined, in part, by the projected increase in the hospital market basket (MB) index. This is a fixed price index that measures the change in the price of goods and services purchased by hospitals to create one unit of output. Typically, hospitals have received less than the MB index as an update for both inpatient and outpatient services. For FY2007 and beyond, however, hospitals that submit required quality data will receive the full MB update for inpatient services. The FY2007 full MB payment increase is 3.4%. Those that do not submit the data will receive a reduction, so that the inpatient update will be MB minus 2 percentage points starting in FY2007. The reduction for not submitting quality data would apply for the applicable year and would not be taken into account in subsequent years.

President's Proposal. Regardless of whether or not a hospital submits quality data for inpatient services, Medicare payments would be updated annually by MB minus 0.65 percentage points starting in FY2008. Hospitals that do not submit quality data will receive the additional two-percentage-point reduction. The President's budget estimates that the proposal would save $720 million in FY2008 and $13.79 billion over the five-year budget period.

Skilled Nursing Facility Update

Current Law. Skilled Nursing Facility (SNF) care is reimbursed based on a prospective payment system (PPS). The PPS payments are based on a daily ("per-diem") urban or rural base payment amount that is adjusted for case mix and area wages using the hospital wage index. The urban and rural federal per diem payment rates are increased annually by an update factor that is determined by the projected increase in the SNF market basket index. This index measures changes in the costs of goods and services purchased by SNFs. Medicare law requires that the SNF base payments be adjusted each year by the SNF market basket update — that is the measure of inflation of goods and services used by SNFs. For FY2007, the SNF payment update is the full market basket increase of 3.1%. The update for future years, without changes to current law, is also the full market basket increase.

President's Proposal. SNF payments would be frozen in 2008 and annually updated by MB minus 65 percentage points in FY2009 and beyond. The President's budget estimates that the proposal would save $1.01 billion in FY2008 and $9.21 billion over the five-year budget period.

Inpatient Rehabilitation Facility Update

Current Law. Inpatient Rehabilitation Facilities (IRFs) are paid based upon the IRF-PPS, and paid a fixed amount per discharge. The annual update to the payment is based on MB for rehabilitation, psychiatric, and long-term care. The update for FY2007 is 3.3%. In FY2007, the IRF-PPS includes a one-time reduction of 2.6% to account for coding changes, for a net increase of 0.6%.

President's Proposal. IRF payments would be frozen in FY2008 and increased by MB minus 0.65 percentage points in FY2009 and beyond. The President's budget estimates that the proposal would save $230 million in FY2008 and $1.91 billion over the five-year budget period.

Hospice Payment Update

Current Law. Payments for hospice care are based on one of four prospectively determined rates which correspond to four different levels of care for each day a beneficiary is under the care of the hospice. The four rate categories are: routine home care, continuous home care, inpatient respite care, and general inpatient care. The prospective payment rates are updated annually by the increase in the hospital market basket. The FY2007 payment rates are updated by the market basket increase of 3.4%. Without changes to Medicare law, the update for the 2008 and beyond will grow by the market basket.

President's Proposal. Beginning in 2008, the hospice payment would be annually updated by the MB minus 0.65 percentage points. The budget includes estimated savings of $60 million in FY2008 and $1.14 billion over the five-year budget period, for this proposal.

Eliminate Indirect Medical Education Payments for Managed Care Enrollees

Current Law. As established by the Balanced Budget Act of 1997 (BBA97), Medicare makes separate, additional direct graduate medical education and indirect medical education (IME) payments to teaching hospitals to account for the inpatient care provided to Medicare's managed care enrollees.

President's Proposal. The proposal would eliminate separate IME payments to teaching hospitals for the Medicare managed care enrollees that they serve. It would *not reduce* payments made directly to Medicare Advantage plans. The budget includes estimated savings of $381 million in FY2008 and $4.37 billion over the five-year budget period, for this proposal.

Adjust Hospital Payment for Never Events

Current Law. The Tax Relief and Health Care Act of 2006 directs the Inspector General in the Department of Health and Human Services to study and report to Congress on (1) the incidences of never events (those listed and endorsed as serious reportable events by the National Quality Forum [NQF] as of November 16, 2006) for Medicare beneficiaries; (2) the extent to which the Medicare program paid, denied payment, or recouped payment for services furnished in connection with such events, and the extent to which beneficiaries paid for them; and (3) the administrative processes of the CMS to detect such events and to deny or recoup payments for related services. According to NQF, never events are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a real problem in the safety and credibility of a health care facility. Examples of "never events" include surgery on the wrong body part, foreign body left in a patient after surgery, mismatched blood transfusion; major medication error, severe "pressure ulcer" acquired in the hospital and preventable post-operative deaths.

President's Proposal. The proposal would prohibit Medicare payment for a never event. Hospitals would also be required to report occurrences of never events or receive a reduced annual update. The budget includes estimated savings of $30 million in FY2008 and $190 million over the five-year budget period, for this proposal.

Rationalize Post-Acute Hospital Payments

Current Law. Patients receiving treatment for certain conditions such as hip and knee replacements can receive rehabilitative care in a variety of post-acute care settings, including a skilled nursing facility (SNF) and an inpatient rehabilitation facility (IRF). Generally, care provided in an IRF is paid at a higher rate than care provided in a SNF.

President's Proposal. The proposal would encourage development of site-neutral reimbursement rates for conditions that overlap in the different post-acute care settings. The proposal would limit payment differentials for the following five conditions (1) knee replacements, (2) hip replacements, (3) hip fractures, (4) chronic obstructive pulmonary disease, and (5) other pulmonary diseases. The base IRF payments for these service would begin with the SNF rate, increased by (1) 25% of the difference between the SNF and IRF overhead amount and (2) 33% of the difference between SNF and IRF patient care costs. The budget includes estimated savings of $470 million in FY2008 and $2.93 billion over the five-year budget period, for this proposal.

Medicare Part B

Physicians' Services

Current Law. Medicare payments for services of physicians and certain nonphysician practitioners are made on the basis of a fee schedule. The fee schedule is intended to relate payments for a given service to the actual resources used in providing that service. The fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The conversion factor for 2007 is $37.8975, the same level as in 2005 and 2006.

The fee schedule places a limit on payment per service but not on overall volume of services. The formula for calculating the annual update to the conversion factor responds to changes in volume. If the overall volume of services increases, the update is lower; if the overall volume is reduced, the update is higher. The intent of the formula is to place a restraint on overall increases in Medicare spending for physicians' services. Several factors enter into the calculation. These include (1) the Medicare economic index (MEI), which measures inflation in the inputs needed to produce physicians' services; (2) the sustainable growth rate (SGR), which is essentially a target for Medicare spending growth for physicians' services; and (3) an adjustment that modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target. The SGR target is not a limit on expenditures. Rather, the fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced. As a result, payments to physicians were reduced in 2002. Physician payments have been slated for reductions in each year since 2002, but Congressional actions have prevented these reductions through 2007.

For example, in November 2007, the CMS announced that the 2007 conversion factor would be cut 5% below the 2006 level. However, the Tax Relief and Health Care Act of 2006 froze the 2007 conversion factor at the 2006 level. In addition, the act also provided that, beginning July 1, 2007 and ending December 31, 2007, physicians who voluntarily report certain quality measures can receive bonus payments of 1.5%.

In the absence of further legislation, the 2008 conversion factor will be reduced by over 5% below the 2007 level. Further reductions are anticipated in subsequent years.

President's Proposal. The President's proposal does not address the physician payment update. Thus, the cut in the 2008 conversion factor would be allowed to go into effect, with no new budgetary savings or costs.

Outpatient Hospital Update

Current Law. Hospital Outpatient Department (HOPD) services are paid based on a prospective payment system. The unit of payment is the individual service or procedure as assigned to one of about 570 ambulatory payment classifications (APCs). Medicare's payment for HOPD services is calculated by multiplying the relative weight associated with an APC by a conversion factor. The conversion factor is updated on a calendar year schedule. These annual updates are based on the hospital MB. Starting in CY2009, however, the outpatient update for hospitals that do not submit required quality data will be the MB minus 2 percentage points. The reduction for not submitting quality data would apply for the applicable year and would not be taken into account in subsequent years.

President's Proposal. Regardless of whether or not a hospital submits quality data for outpatient services, Medicare payments would be updated by MB minus 0.65 percentage points annually starting in FY2008. The budget includes estimated savings of $120 million in FY2008 and $3.36 billion over the five-year budget period, for this proposal.

Ambulatory Surgery Center Update

Current Law. Medicare uses a fee schedule to pay for the facility services related to a surgery provided in an ambulatory surgery center (ASC). The associated physician services (surgery and anesthesia) are reimbursed under the physician fee schedule. The ASC fee schedule was periodically increased by the consumer price index for all urban consumers (CPI-U). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, MMA) changed the update cycle from a fiscal year to a calendar year and eliminated updates for calendar years 2006 though 2009. MMA also established that a revised payment system for surgical services furnished in an ASC will be implemented on or after January 1, 2006 and not later than January 1, 2008. As established by the Tax Relief and Health Care Act of 2006, starting in CY2009, the annual increase for ASCs that do not submit required quality data may be the required update minus 2 percentage points.

President's Proposal. Beginning in 2010, the annual update for ASCs would be reduced by 0.65 percentage points. If applicable, ASCs that do not submit quality data will receive the additional two-percentage-point reduction. The President's budget does not include savings in FY2008, but does include estimated savings of $90 million over the five-year budget period.

Ambulance Services

Current Law. Ambulance services are paid on the basis of a national fee schedule, which is being phased in. The fee schedule establishes seven categories of ground ambulance services and two categories of air ambulance services. The payment for a service equals a base rate for the level of service plus payment for mileage. Geographic adjustments are made to a portion of the base rate. Additionally, the base rate is increased for air ambulance trips originating in rural

areas and mileage payments are increased for all trips originating in rural areas. There is a 25% bonus on the mileage rate for trips of 51 miles and more.

The national fee schedule is fully phased in for air ambulance services. For ground ambulance services, payments through 2009 are equal to the greater of the national fee schedule or a blend of the national and regional fee schedule amounts. The portion of the blend based on national rates is 80% for 2007-2009. In 2010 and subsequently, the payments in all areas will be based on the national fee schedule amount.

The fee schedule amounts are updated each year by the CPI-U. The update for 2007 was 4.3%.

President's Proposal. Beginning in 2008, payments for ambulance services would be annually updated by the CPI-U minus 0.65 percentage points. The budget includes estimated savings of $10 million in FY2008 and $360 million over the five-year budget period, for this proposal.

Competitive Bidding for Laboratory Services

Current Law. Section 302(b) of the MMA required the CMS to conduct a demonstration project on the application of competitive acquisition for payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule. Pap smears and colorectal cancer screening tests are excluded from this demonstration.

The CMS has outlined how the competitive bidding process is expected to work when the demonstration program begins operation in 2007. Only those laboratory firms with $100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year 2005 for demonstration tests provided to beneficiaries residing in the competitive bidding areas (CBAs), regardless of where the laboratory firm is located, will be required to bid in the demonstration. These laboratory firms will be referred to as required bidders. Small laboratories or laboratory firms with less than $100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBAs will not be required to bid in the demonstration.

Both required and non-required bidders that *bid and win* will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBAs. Both required and non-required bidders that *bid and do not win* will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs. Similarly, required bidders that do not bid will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs. Non-required bidders that do not bid will be paid the demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBAs.

President's Proposal. The proposal would extend the use of competitive bidding to all laboratory services. The budget includes estimated savings of $110

million in FY2008 and $2.38 billion over the five-year budget period, for this proposal.

Short-Term Power Wheelchair Rentals

Current Law. In general, Medicare pays for certain durable medical equipment (DME) items, such as hospital beds, nebulizers and power-driven wheelchairs under the capped rental category. Suppliers are required to transfer the title of DME equipment in the capped rental category to the beneficiary after a 13-month rental period. Beneficiaries have the option to purchase power-driven wheelchairs when they are initially furnished.

President's Proposal. The proposal would establish a 13-month rental period for power wheelchairs to ensure that a chair is not purchased if the period of medical need is less than 13 months. The budget includes estimated savings of $70 million in FY2008 and $530 million over the five-year budget period, for this proposal.

Limit Oxygen Rental Period

Current Law. Rental payments for oxygen equipment, including portable oxygen equipment, are converted to ownership at 36 months. The supplier is required to transfer the title of the equipment to the beneficiary at that time. Medicare will continue to make payments for oxygen contents (in the case of gaseous and liquid oxygen), for the period of medical need.

President's Proposal. The proposal would move oxygen and oxygen equipment from a 36-month rental period to a 13-month period, the same as the capped rental category. Medicare would continue to pay for refills of gaseous and liquid oxygen, as medically necessary. Additionally, the proposal would reduce the payment for oxygen equipment by about $77 per month. It would not affect payments of oxygen tanks. The budget includes estimated savings of $110 million in FY2008 and $2.38 billion over the five-year budget period, for this proposal.

Medicare Parts A and B

Home Health Update

Current Law. Home health agencies (HHAs) are paid under a prospective payment system. Payment is based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The payment covers skilled nursing, therapy, medical social services, aide visits and medical supplies. The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the home health market basket index. This index measures changes in the costs of goods and services purchased by HHAs. For HHAs that submit the required quality data, the home health MB update is the full 3.3 percent for FY2007. For HHAs that do not submit this quality data, their increase will be

reduced by 2 percentage points to 1.3 % for CY 2007. Payments for 2008 would continue to be updated by the market basket.

President's Proposal. Payments for HHAs would be frozen in 2008 through 2012 and thereafter, annually updated by the MB minus 0.65 percentage points. The budget includes estimated savings of $410 million in FY2008 and $9.68 billion over the five-year budget period, for this proposal.

Establish Federal Data Sharing Clearinghouse for Medicare Secondary Payer

Current Law. The law authorizes a data match program intended to identify cases where an insurer other than Medicare is the primary payer. This information is used to both facilitate recoveries when incorrect Medicare payments have been made and identify secondary payer situations before Medicare payments are made. Medicare recipients are matched against data contained in Social Security Administration and Internal Revenue Service files to identify cases in which a working beneficiary (or working spouse) may have employer-based health insurance coverage. The CMS sends questionnaires to certain identified employers to determine which of them offers health insurance, and to determine the insurance status of specific beneficiaries. Currently, Medicare has a voluntary arrangement with about 40% of employers.

President's Proposal. The proposal would establish a federal data sharing clearinghouse to clarify and expand Medicare secondary payer instances. This proposal would require all employers to provide CMS with coverage information. This information would be used to ensure that proper payments were made by the responsible insurer and to recover improperly made payments. The data would be shared with Medicare, Medicaid, TRICARE, the Department of Veterans Affairs, the Federal Employees Health Benefits Program, Indian Health Service and others. The budget includes estimated savings of $50 million in FY2008 and $640 million over the five-year budget period, for this proposal.

Extend Medicare Secondary Payer Status for End Stage Renal Disease

Current Law. The Medicare Secondary Payer (MSP) program prohibits Medicare payments for any item or service when payment has been made or can reasonably be expected to be made by a third party payer. Medicare is the secondary payer to insurance plans and programs under certain conditions for beneficiaries covered through a group health plan based on either their own or their spouse's current employment. For individuals with Medicare entitlement based on End Stage Renal Disease (ESRD), Medicare is the secondary payer for the first 30 months of ESRD benefit eligibility. After 30 months, Medicare becomes the primary insurer. Medicare entitlement based on ESRD usually begins with the third month after the month in which the beneficiary starts a regular course of dialysis.

President's Proposal. Medicare secondary payment status for ESRD enrollees would be extended from 30 to 60 months. The budget includes estimated

savings of $160 million in FY2008 and $1.08 billion over the five-year budget period, for this proposal.

Limit Use of Mandamus Jurisdiction

Current Law. Mandamus jurisdiction involves a plaintiff going to court to seek injunctive relief in the form of a writ of mandamus to compel a governmental agency or officer of an agency to comply with a statutory obligation (such as issuing a fee schedule that is required in a statutory provision). Mandamus is only available where (1) the plaintiff has a clear right to relief, (2) the defendant has a clear duty to act, and (3) there is no other adequate remedy available to the plaintiff. The Supreme Court has stated that "[t]he common law writ of mandamus, as codified in 28 USCS 1361, is intended to provide a remedy for a plaintiff only if he has exhausted all other avenues of relief and only if the defendant owes him a clear, nondiscretionary duty." *Heckler v. Ringer, 466 U.S. 602 (U.S. 1984).*

President's Proposal. The President's budget would limit mandamus jurisdiction as a basis for obtaining judicial review and clarify the Secretary's authority to resolve appeals of Medicare determination. The President's budget does not include savings in FY2008, but does include estimated savings of $80 million over the five-year budget period. These savings are for existing cases only and do not include projected savings from future cases.

Medicare Bad Debt Payments

Current Law. Medicare pays the costs of certain items on a reasonable cost basis (outside the applicable prospective payment system) including the unpaid debt for beneficiaries' coinsurance and deductible amounts. While some providers receive 100% reimbursement for allowable bad debt, since 2001, acute care hospitals receive 70% of the reasonable costs. SNFs also receive 70% for only those beneficiaries who are not dually eligible for Medicare and Medicaid. For the dual eligibles, the bad debt reimbursement will remain at 100%. Other providers currently receiving reimbursement for bad debt include critical access hospitals, rural health clinics, ESRD facilities, federally qualified health clinics, community mental health clinics, and certain health maintenance organizations, among others.

President's Proposal. This proposal would phase out bad debt reimbursement to all providers over four years (FY2008-FY2011). The budget includes estimated savings of $180 million in FY2008 and $7.15 billion over the 5-year budget period, for this proposal.

Value-Based Purchasing and Quality Incentive Payments

Current Law. Section 501(b) of the MMA provided an incentive for eligible hospitals to submit quality data for ten quality measures known as the "starter set" in order to avoid a 0.4 percentage point reduction in its annual payment update from the CMS for FY2005, 2006 and 2007. Section 5001(a) of the Deficit Reduction Act of 2005 (P.L. 109-171, DRA) requires hospitals to report additional quality measures to receive the full market basket increase to their payment rates. Payment rates will

be reduced by 2 percentage points for any hospital that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

The Tax Relief and Health Care Act of 2006 introduced a voluntary bonus program for physicians who report quality measures to the CMS. For covered professional services furnished beginning July 1, 2007 and ending December 31, 2007, eligible professionals who furnish services for which there are established quality measures and satisfactorily submit quality measures would be paid a single additional bonus payment amount equal to 1.5% of the allowed charges for covered professional services furnished during the reporting period. These payments would be paid from the Supplementary Medical Insurance Trust Fund (Part B).

The DRA requires the CMS to develop and implement a method for hospital value-based purchasing in 2009. The value-based purchasing system must be budget-neutral while creating incentives for high-quality hospitals and minimum benchmarks for low-quality hospitals. The CMS will publish a report this year on how such a program will be implemented. For physician payments, the CMS will expand the voluntary quality reporting program for physicians and develop an implementation plan for the quality reporting and bonus incentive program covering the second half of 2007 created by the Tax Relief and Health Care Act of 2006.

President's Proposal. The President's budget discusses value-based purchasing programs for hospitals and physicians, and CMS plans to implement the programs as required by law. Therefore, there are no budgetary impacts for this proposal.

Premiums and Interactions

Part B Premiums

Current Law. Medicare Part B is financed through a combination of beneficiary premiums and federal general revenues. In general, beneficiary premiums equal 25% of estimated program costs for the aged. (The disabled pay the same premium as the aged.) Federal general revenues account for the remaining 75%.

Beginning in 2007, higher-income enrollees pay a higher percentage of Part B costs. The increase is phased in over three years. In 2007, individuals whose modified adjusted gross income (AGI) exceeds $80,000, and couples whose modified AGI exceeds $160,000, are subject to higher premium amounts. In 2007, higher-income enrollees pay total premiums ranging from 28.3% to 43.3% of the value of Part B. In 2008, total premiums for these individuals will range from 31.7% to 61.7% of the program's value. When fully phased-in in 2009, higher-income individuals will pay total premiums ranging from 35% to 80% of the value of Part B.

In 2007, the basic Part B premium is $93.50 per month. Individuals with modified AGI between $80,001 and $100,000 (and couples with incomes between $160,001 and $200,000) pay $105.80. Individuals with incomes between $100,001 and $150,000 (and couples with incomes between $200,001 and $300,000) pay

$124.40. Individuals with incomes between $150,001 and $200,000 (and couples with incomes between $300,001 and $400,000) pay $142.90. Individuals with incomes above $200,000 and couples with incomes above $400,000 pay $161.40. The CMS estimates that approximately 4% of Part B enrollees will pay a higher premium in 2007, with less than 1% paying the highest premium amount of $161.40.

Beginning in 2008, the income thresholds for higher Part B premiums are increased by the percentage increase in the CPI-U.

President's Proposal. The proposal would eliminate the annual CPI-U adjustments. Consequently, each year the number of beneficiaries subject to the higher premium would increase. The budget includes estimated savings of $543 million in FY2008 and $7.135 billion over the five-year budget period, for this proposal.

Part D Premiums

Current Law. In 2006, Medicare Part D began providing coverage for outpatient prescription drugs for Medicare beneficiaries. Coverage is provided through private prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. The program relies on these private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies covering the bulk of the risk is provided to encourage participation. Unlike other Medicare services, the benefits can only be obtained through private plans. Further, while all plans have to meet certain minimum requirements, there are significant differences among them in terms of benefit design, drugs included on plan formularies (i.e., list of covered drugs) and cost-sharing applicable for particular drugs.

Medicare Part D is financed through a combination of beneficiary premiums and federal general revenues. In addition, certain transfers are made from the states. Beneficiaries pay different premiums depending on the plan they have selected. On average, beneficiary premiums account for 25.5% of expected total Part D costs for basic coverage. The CMS estimates that the average premium for both PDP and MA-PD plans is $22 per month in 2007. Except for persons entitled to low-income subsidies, all persons selecting a particular Part D plan pay the same monthly premium amount.

President's Proposal. The proposal would establish income-related premiums for Part D. Under the proposal, the income thresholds would be the same as those established for income-relating Part B premiums (see above). Further, as proposed for Part B, the income thresholds would not be updated in future years. Consequently, each year the number of beneficiaries subject to the higher premium would increase. The budget includes estimated savings of $357 million in FY2008 and $3.242 billion over the five-year budget period, for this proposal.

Interaction with Medicaid

Current Law. The BBA97 added another mandatory eligibility group of low-income Medicare beneficiaries who receive assistance with Medicare premiums

known as "Qualifying Individuals 1 (QI-1)." The QI-1 group was originally set to expire in December 2002; however, Congress has subsequently extended the expiration date, most recently until September 30, 2007 in P.L. 109-91.

Individuals are eligible as a QI-1 if they are entitled to Medicare Part A and their incomes are at least 120% of the Federal poverty level, but less than 135% and also have limited assets. The Medicaid benefit for QI-1s consists of payment of the full Medicare Part B premium. QI-1s are entitled to three months of retroactive coverage if they were eligible during those months and the retroactive month does not fall before January of a calendar year.

President's Proposal. The President's budget includes a one-year extension of the Qualified Individuals (QI) program through September 30, 2008. The Medicare costs reflect program expenditures for this group of individuals. The budget includes estimated *costs* of $425 million in FY2008 and $425 million over the five-year budget period, for this proposal.

Premium Interactions

The savings for the individual proposals listed in **Table 1** are the "gross" savings. However, there is an "offsetting" cost associated with Part B benefit savings that occurs because any savings to the program are shared between the Medicare program and beneficiaries, as beneficiaries pay a share (generally 25% of program costs, or beginning in 2007 for certain higher income beneficiaries a larger share) of program costs. For example, for those beneficiaries paying 25% of premiums, for every dollar saved, the Medicare outlays will be reduced by about $0.75 and beneficiaries will save about $0.25. The estimated offsetting costs are shown in the interaction line of the table; $325 million in FY2008 and $5.605 billion over the 5-year budget period.

Forty-Five Percent Rule (The Medicare Trigger)

Current Law. The Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds are overseen by a board of trustees who make annual reports to Congress. The MMA (Section 801) requires the trustees' report to include an expanded analysis of Medicare expenditures and revenues. Specifically, a determination must be made as to whether or not general revenue financing will exceed 45% of total Medicare outlays within the next seven years. General revenues financing is defined as total Medicare outlays minus dedicated financing sources (i.e., HI payroll taxes; income from taxation of Social Security benefits; state transfers for prescription drug benefits; premiums paid under Parts A, B, and D; and any gifts received by the trust funds). The 2006 trustees' report projected that the 45% trigger would first be exceeded in 2012 which is included in the required seven-year test period (i.e., 2006-2012). The 2006 report, therefore, includes a determination of

excess general revenue funding. A second such finding in the 2007 report for both 2012 and 2013 would result in a Medicare funding warning.[2]

The MMA (Sections 802-804) further requires that if an excess general revenue funding determination is made for two successive years, the President is required to submit a legislative proposal to respond to the warning. The Congress is required to consider the proposal on an expedited basis. However, passage of legislation within a specific time frame is not required.

President's Proposal. The President's budget includes an automatic reduction to all Medicare payments if general revenue financing is projected to exceed 45% of total Medicare financing, and only when that threshold is met and Congress fails to act on recommendations to reduce that level. In such a case, a four-tenths of 1% reduction would be made across the board to all Medicare payments and would increase each year by 0.4 percent until general revenue is brought back to 45%. There are no threshold savings included in the five-year budget window. The CBO estimate of the President's budget assumes that the trigger will be reached in FY2016.

Medicare Administrative Proposals

Medicare Integrity Program

Current Law. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established the Medicare Integrity Program (MIP) to carry out activities related to the investigation and deterrence of health care fraud and abuse in the Medicare program.[3] The Medicare Part A trust fund finances these activities. The types of fraud prevention activities include 1) medical reviews of claims to determine if services are medically reasonable and necessary, 2) financial audits, 3) investigations of potential fraud cases, 4) provider education to inform providers of Medicare billing procedures, and 5) Medicare secondary payer activities. HIPAA capped mandatory funding for the MIP program at $720 million for fiscal years 2002 and beyond. In 2006, the DRA appropriated additional funds to MIP for fiscal years' 2006 through 2010 for the establishment of a Medicare-Medicaid data matching program. These additional MIP appropriations amounted to $24 million in FY2007 and $36 million in FY2008, for a total of $744 million in FY2007 and $756 million in FY2008.

President's Proposal. The President's FY2008 budget includes a discretionary request of $138 million to assist the MIP program in conducting oversight activities related to the Medicare prescription drug benefit and Medicare

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[2] In April 2007, the Trustees did report a second fund warning.

[3] The Medicare Integrity Program is only one component of the Secretary's fraud and abuse control efforts. HIPAA established the Health Care Fraud and Abuse Control Program (HCFAC) which also funds fraud-related activities of the Federal Bureau of Investigation, the Department of Justice, and the HHS Office of the Inspector General.

Advantage plans. The budget assumes savings would result from new efforts to improve payment accuracy and to adjust payments to encourage efficiency and productivity. The President's budget estimates that these efforts would save $1.0 billion in FY2008 and $10.235 billion over the five-year budget period.

CBO Estimate

The CBO estimates current law Medicare outlays of $390 billion in FY2008 and $2.224 trillion over the five-year budget window, slightly higher than the President's estimate. As shown in **Table 1**, CBO has slightly different estimates of the Medicare savings proposals included in the President's budget. However, the CBO estimates have a separate savings estimate for the Medicare Advantage program as a result of the savings in fee-for-service spending. According to the Department of Health and Human Services (HHS), the Administration incorporated the MA savings into the individual proposals, making a direct comparison of individual savings, such as hospital update, difficult. Therefore it is more appropriate to compare overall savings rather than looking at individual proposals. CBO estimates also do not include an estimate for the savings of the President's Medicare Integrity Program administrative proposal. Looking at only the legislative proposals, for the five-year budget window, CBO estimates savings of $57.2 billion, compared with the Administration's estimate of $65.6 billion, a difference of $8.4 billion. The different estimates may be due to differing assumptions regarding the Medicare population and other influential factors. Adding in savings for the administrative proposal increases the difference between the CBO and the Administration by another $10.2 billion.

Congressional Activity

FY2008 Budget Resolution

Senate Activity. The Senate Budget Committee passed its FY2008 Budget Resolution (S.Con.Res. 21) on March 15, 2007, and the Senate passed the Resolution on March 23, 2007. The Chairman's Mark assumes that the authorizing committees, which for Medicare is the Senate Finance Committee, will continue to examine and reform programs to achieve savings and demonstrate continued progress toward deficit reduction. However, the Mark does not provide the Senate Finance Committee with reconciliation instructions.

The Chairman's Mark provides $384.7 billion in mandatory outlays for Medicare in 2008, an increase of $2.7 billion over 2007, or less than 1%. Total Medicare outlays for 2008 are $390 billion. The Mark provides $15 billion in Medicare savings over five years by reducing payments to health care providers. Additionally, the Mark rejects the President's proposal for across-the-board provider payment cuts if general revenue financing exceeds 45% of Medicare costs in the future.

The Mark also includes a new point of order against long-term deficit increases in the four decades beyond the next 10 years. The point of order applies to any net

deficit increase in excess of $5 billion in any of the four 10-year periods (2018-2027, 2028-2037, 2038-2047, and 2048-2057). The provision sunsets at the end of FY2017 and repeals Section 407 of H.Con.Res. 95 from the 2006 budget resolution conference report. Direct spending proposals will not be subject to points of order if new spending is offset by changes in spending, receipts, or revenues.

Section 207 of the budget resolution establishes several discretionary spending limits, including a limit of $383 million in FY2008 for health care fraud and abuse at the HHS, which oversees Medicare and Medicaid Services. If legislation is introduced that appropriates up to $383 million in FY2008 for health care fraud and abuse, then discretionary spending limits, allocations to the Senate Committee on Appropriations, and aggregates may be adjusted by the amounts necessary.

Section 304 of budget resolution establishes a deficit-neutral reserve fund for comparative effectiveness research. If legislation is introduced that establishes a new federal or public-private initiative for comparative effectiveness research, then the fund allows the Chairman of the Senate Budget Committee to revise committee allocations, budgetary aggregates, and other levels in the resolution to offset the spending. The Chairman's Mark notes that the purpose of such legislation would be to fund objective, transparent, and rigorous comparative effectiveness research of technologies, devices, procedures, and pharmaceuticals.

Section 308 establishes a deficit-neutral reserve fund for Medicare. The reserve fund includes prescription drug price negotiation, Part B physician reimbursement, and improvements to Medicare Part D. The prescription drug price negotiation reserve fund allows legislation to repeal the non-interference clause (Section 1860D-11(i)(1) of the Social Security Act) per H.R. 4, which was passed by the House of Representatives on January 12, 2007. The prescription drug price negotiation reserve fund requires all savings from the measure to be used to either improve the Part D benefit or to reduce the deficit. The Part B physician reimbursement reserve fund allows the Chairman to change the allocations, aggregates, and other levels in the resolution for legislation that increases the reimbursement rate for physician services, provided that the increased spending is offset. The reserve fund for improvements to Medicare Part D includes $5 billion to be used for improvements, which, as specified in the Chairman's Mark, may include such modifications as changing asset requirements for the low-income subsidy, improving outreach efforts, or providing coverage for mental health medications currently excluded under the Medicare Modernization Act. The Chairman's Mark specifies that the improvements are to aid beneficiaries who qualify for the low-income subsidy under Medicare Part D. The reserve fund allows the Chairman to change the allocations, aggregates, and other levels in the resolution by up to $5 billion, provided that the spending is offset.

The Chairman's Mark restores the pay-as-you-go, or PAYGO, rule in the Senate, which requires that new mandatory spending and tax cuts be offset unless the legislation receives at least 60 votes. The PAYGO rule requires the Senate to not consider any direct spending or revenue legislation that increases the on-budget deficit or causes an on-budget deficit for either FY2008, budget year 2008, FY2008-FY2012, or FY2013-FY2017. The Mark would extend the PAYGO rule through 2017, and assumes that existing balances on the ledger would be eliminated and the scorecard set to zero for all time periods. All net savings enacted in the reconciliation

are to be dedicated solely to deficit reduction. The PAYGO rule affects Medicare legislation requiring additional spending to be offset by savings.

During the Senate debate, three amendments related to Medicare were passed and added to the Senate Budget Resolution — S.Amdt. 548, S.Amdt. 636, and S.Amdt. 639. The stated purpose of S.Amdt. 548 is to ensure that Medicare payments to physicians include incentives to improve the quality and efficiency of care furnished to Medicare beneficiaries through the use of consensus-based quality measures. S.Amdt. 636 establishes a deficit-neutral reserve fund for improving the accuracy of Medicare payments for hospitals. If legislation is introduced that (1) addresses the disparity in Medicare hospital reimbursement, (2) includes provisions to reform the area wage index used to adjust payments to hospitals, and (3) includes a transition to the reform, then the fund allows the Chairman of the Senate Budget Committee to revise committee allocations, budgetary aggregates, and other levels in the resolution so that the spending is offset. S.Amdt. 639 establishes a deficit-neutral reserve fund for access to Medicare data. If legislation is introduced that addresses access to Medicare data for conducting research, public reporting, and other activities, while also addressing beneficiary privacy, then the Chairman of the Senate Budget Committee may revise committee allocations, budgetary aggregates, and other levels in the resolution so that the spending is offset.

House Activity. The House Budget Committee reported its FY2008 Budget Resolution (H.Con.Res. 99) on March 23, 2007. The House passed the bill on March 29. The House budget resolution makes several assumptions pertaining to the Medicare program. The resolution assumes the federal government will continue to provide Medicare premium assistance to low-income individuals who have incomes between 120 and 135% of the federal poverty level. The resolution assumes the federal government will provide assistance to hospitals with at least 100 beds that have faced a reduction in Medicare disproportionate share hospital payments as a result of assignment to a Micropolitan area. The resolution does not include reconciliation instructions for the House Ways and Means Committee, which has jurisdiction over Medicare as well as many other programs, or the House Energy and Commerce Committee.

The Chairman's Mark provides $389.7 billion in total outlays for Medicare in 2008, an increase of $19.5 billion over 2007. The resolution includes the PAYGO rule, but does not include the point of order against long-term deficit increases that is included in the Senate resolution.

Section 301 of the House budget resolution establishes several discretionary spending limits for program integrity initiatives, including a limit of $183 million in FY2008 for health care fraud and abuse. The health care fraud and abuse discretionary spending limit is broadly defined to include all programs under the Department of Health and Human Services, including Medicare. The discretionary spending limit is $200 million less than the corresponding health care fraud and abuse discretionary spending limit established in the Senate budget resolution (Section 207). Section 301 also directs all House committees to review the performance of programs within their respective jurisdictions for waste, fraud, and abuse, giving particular scrutiny to issues raised by Government Accountability Office (GAO) reports. The committees are directed to annually report program

performance recommendations resulting from these reviews to the House Committee on the Budget.

Section 206 establishes a deficit-neutral reserve fund for improvements to the Medicare program, such as (1) increasing the reimbursement rate for physicians while protecting beneficiaries from associated premium increases, and (2) making improvements to the Part D prescription drug program. (Similarly, the Senate Budget resolution in S.Amdt. 99 mentions increasing the reimbursement rate for physicians and improvements to Medicare Part D.) The House Committee Report mentions federal investments in health information technology as another example of an improvement to the Medicare program. If legislation is introduced for improving the Medicare program, the reserve fund allows the Chairman to change the allocations, aggregates, and other levels in the resolution, provided that the spending is offset.

Conference Report. On May 17, the House and Senate adopted a conference agreement on the budget resolution (H.Rept. 110-153, accompanying S.Con.Res. 21). Relevant provisions in the conference report include

- deficit-neutral reserve funds for (1) health information technology; (2) comparative effectiveness research; (3) the use of Medicare data to evaluate a variety of health care issues in federal programs and the private health care system; (4) small business health insurance; (5) Medicare improvements, including prescription drug price negotiation, physician payments, improvements to Part D, and Medicare hospital payments ; and (6) mental health parity;
- up to $383 million in FY2008 discretionary funding for the health care fraud and abuse control program at HHS; and
- two "sense of the Congress" provisions regarding health care cost growth and affordable health coverage.

Congressional Action on Comprehensive Medicare Reform

House Activity. H.R. 3162, the Children's Health and Medicare Protection Act of 2007, was passed by the House of Representatives on August 1, 2007. The bill's Medicare provisions would address a number of issues. Some of the bill's provisions are changes to physicians payments, reduction in payments to Medicare Advantage plans, and elimination of Medicare cost-sharing for certain preventive benefits. Physician payment changes include a 0.5% increase in Medicare physician fees for 2008 and 2009, with substantive changes to the calculation of updates to the Medicare physician fee schedule in future years, establishing bonus payments for physicians practicing in low Medicare per capita expenditures, requiring the Secretary to implement a resource use feedback program for physicians to identify efficient providers, expanding a medical home demonstration project, repealing the Physician Assistance and Quality Initiative fund, and requiring CMS to modify physician payment localities, beginning with California.

Among many other provisions, the bill would also repeal the 45% rule (i.e., the Medicare trigger); eliminate the market basket update for FY2008 for Medicare payments for skilled nursing facilities, home health agencies, and long-term care

hospitals; reduce the annual update for certain hospitals; establish a bundled payment system for Medicare renal dialysis services; create a new entity for comparative effectiveness research; and change the Low-Income Subsidy Program for Medicare Part D. The Congressional Budget Office estimates 5-year Medicare savings (2008-2012) of $26.9 billion and 10-year Medicare savings (2008-2012) of $76.6 billion.

Senate Activity. On August 2, the Senate passed S. 1893, the Children's Health Insurance Program Reauthorization Act of 2007, as an amendment to H.R. 976, which did not include provisions that would affect the Medicare program and spending.

Bicameral Agreement. A bicameral agreement on SCHIP reauthorization passed the House on September 25 and the Senate on September 27 as an amendment to H.R. 976, without the provisions affecting the Medicare program. The President vetoed the bill.

Other Congressional Action

On July 18, 2007, legislation was enacted (S. 1701, P.L. 110-48) that, effective July 31, 2007, eliminated the limited continuous enrollment provision granting beneficiaries currently enrolled in traditional Medicare the option to enroll in a Medicare Advantage Private -fee-for-Service (PFFS) plan or a non-drug MA plan anytime during the year. The legislation also reduced initial funding for the Medicare advantage stabilization fund in 2012 from $3.5 billion to $1.6 billion and added $1.79 billion to be available during 2013.

On September 29, 2007, the "health extenders package" (H.R. 3668, P.L.110-90), which includes three Medicare provisions, was enacted. One provision would increase to $325 million the amount available to the Medicare Physician Assistance and Quality Initiative Fund for expenditures during 2009 and provide for $60 million to be made available during or after 2013.[4] The second provision would provide $100 million to extend the Medicare's Qualifying Individual (QI) program through December, 2007.[5]

The final provision would halve the payment adjustments scheduled for acute care hospitals in FY2008 and FY2009. Absent this legislation, Medicare payments to IPPS hospitals would have been reduced by 1.2% in FY2008 and 1.8% in FY2009 because of anticipated increases in measured severity of illness because of coding

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[4] The Medicare Physician Assistance and Quality Initiative Fund was established by the Tax Relief and Health Care Act of 2006 (TRHCA) to provide the Secretary of HHS with monies that could be used "for physician payment and quality improvement initiatives." In total, $1.35 billion are to be made available for the fund; for fiscal years 2007, 2008, and 2009, TRHCA instructed the Secretary to move $60 million from the Federal Supplementary Medical Insurance Trust Fund to the Medicare Physician Assistance and Quality Initiative Fund.

[5] This program pays the Part B premium for eligible low-income beneficiaries with incomes between 120% and 135% of poverty.

changes or documentation improvements (coding creep). The legislation reduces the adjustment to 0.6% and 0.9%, respectively, but permits offsets to IPPS rate increases in FY2010, FY2011, and FY2012 to account for coding creep increases in FY2008 and FY2009 above these amounts. The scheduled adjustment of an additional 1.8% in FY2010 is not addressed. CBO estimates that this change will be budget-neutral for hospitals but attributes a $190 savings to the program because of its impact on Medicare Advantage rates.[6]

[6] CBO's preliminary score shows increased spending of $570 million in FY2008 and $1,855 million in FY2009, offset by decreased spending of $720 million in FY2010 and $1,895 million in FY2011, for a net five-year savings of $190 million. Savings in FY2010 and FY2011 are attributed to hospital offsets and an expected interaction with Medicare Advantage.

Table 1. President's Budget Medicare Proposals

(dollars in millions)

Proposals	HHS estimates		CBO estimates	
	FY2008	FY2008 - FY2012	FY2008	FY2008-FY2012
Legislative Proposals				
Medicare Part A				
Hospital update	-720	-13,790	-600	-9,300
Skilled nursing facility update	-1,010	-9,210	-400	-4,200
Inpatient rehabilitation facility update	-230	-1,910	-200	-1,500
Hospice payment update	-60	-1,140	-100	-1,200
Eliminate IME payments for managed care enrollees	-381	-4,370	-500	-5,200
Adjust hospital payments for never events	-30	-190	[a]	-100
Rationalize post-acute hospital payments	-470	-2,930	-500	-2,700
Limit use of mandamus jurisdiction	0	-80	0	100
Medicare Part B				
Outpatient hospital update	-120	-3,360	-100	-2,600
Ambulatory Surgical Center update	0	-90	0	-100
Ambulance services	-10	-360	[a]	-300
Competitive bidding for laboratory services	-110	-2,380	0	-1,100
Short-term power wheelchair rentals	-70	-530	-300	-600
Limit oxygen rental period	-110	-2,380	-100	-1,900
Medicare Parts A and B (dollars for combined A and B spending)				
Home health update	-410	-9,680	-300	-7,500
Establish federal data sharing clearinghouse for Medicare secondary payer	-50	-640	[a]	-500
Extend Medicare secondary payer status for ESRD	-160	-1,080	[a]	-700
Medicare bad debt payments	-180	-7,150	-300	-5,400
Required Medicare spending reduction	0	0	0	0
Value-based purchasing and quality incentive payments	0	0	0	0
Premiums and interactions				
Part B premiums	-543	-7,135	-200	-4,300
Part D premiums	-357	-3,242	-100	-2,800
Interaction with Medicaid	425	425	400	500
Medicare Advantage Interactions	N/A	N/A	0	-9,700
Premium Interactions	325	5,605	100	4,000
Total Legislative Proposals	**-$4,271**	**-$65,618**	**-$3,400**	**-$57,200**
Administrative Proposals				
Medicare Integrity Program	-1,000	-10,235	N/A	N/A
Total Administrative Proposals	**-$1,000**	**-$10,235**	**N/A**	**N/A**
Total, Medicare Budget Proposals	**-$5,271**	**-$75,853**	**-$3,400**	**-$57,200**

Notes: Total may not add due to rounding.
a. Indicates costs or savings of less than $50 million.
N/A indicates data not available.

Table 2. Staff Medicare Contacts for this Report

Topic	Staff member	Phone number
Part A		
Hospice Care	Julie Stone	7-1386
Inpatient Hospital Services	Sibyl Tilson	7-7368
Inpatient Rehabilitation Facilities	Sibyl Tilson	7-7368
Medical Devices	Gretchen A. Jacobson	7-1686
Skilled Nursing Facilities	Julie Stone	7-1386
Part B		
Ambulatory Surgical Center Services	Sibyl Tilson	7-7368
Drugs	Jennifer O'Sullivan	7-7359
Durable Medical Equipment	Paulette C. Morgan	7-7317
Outpatient Hospital Services	Sibyl Tilson	7-7368
Physicians and Other Part B Providers	Jennifer O'Sullivan	7-7359
Premiums	Jennifer O'Sullivan	7-7359
Parts A&B		
Beneficiary Issues	Jennifer O'Sullivan	7-7359
End Stage Renal Disease (ESRD)	Hinda Chaikind	7-7569
Home Health Services	Julie Stone	7-1386
Part C		
Medicare Advantage	Hinda Chaikind Paulette C. Morgan Holly Stockdale	7-7569 7-7317 7-9553
Part D		
Benefits & Premiums	Jennifer O'Sullivan Jim Hahn	7-7359 7-4914
Drug Pricing	Gretchen A. Jacobson Jim Hahn	7-1686 7-4914
Administration		
Integrity (fraud, waste, and abuse)	Holly Stockdale	7-9553
Quality Improvement Organizations	Holly Stockdale	7-9553
Other		
Medicare Secondary Payer	Hinda Chaikind	7-7569
Medicare Trigger	Hinda Chaikind	7-7569
Medicare HI & SMI Trust Fund Financing	Jennifer O'Sullivan	7-7359
Pay for Performance	Jim Hahn	7-4914
Price Transparency	Jim Hahn	7-4914
Rural Issues	Sibyl Tilson	7-7368