

CRS Report for Congress

Medicare: FY2009 Budget Issues

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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 2009 budget estimates current law Medicare net outlays of \$413 billion in FY2009. The budget includes Medicare legislative proposals with estimated savings of \$12.2 billion in FY2009 and \$178 billion over the five-year budget window. The President's budget also includes Medicare administrative proposals with estimated savings of \$645 million in FY2009 and \$4.7 billion over the five-year budget window, which brings the estimated savings from the total Medicare budget proposals to \$12.8 billion in FY2009 and \$183 billion over the five-year budget window. Proposals include savings achieved through reductions in many of the Medicare payment updates.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173) requires the Medicare Board of Trustees to examine and make a determination if general revenue Medicare funding is expected to exceed 45% of Medicare outlays for the current fiscal year or any of the next six fiscal years. An affirmative determination in two consecutive annual reports is considered to be a Medicare funding warning in the year in which the second report is made. The President has indicated that he intends to submit the required legislative proposal, due within the 15-day period following the budget submission to Congress. As part of the budget, the President has proposed reducing Medicare provider payments by 0.4% beginning in any year that the general revenue Medicare funding is expected to exceed 45% of Medicare outlays. This reduction would increase each year, until the percentage falls below the 45% trigger level.

This report will be updated.

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Medicare: FY2009 Budget Issues

Introduction

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 2009 budget estimates current law Medicare net outlays of \$413 billion in FY2009.¹ The budget includes Medicare legislative proposals with estimated savings of \$12.2 billion in FY2009 and \$178 billion over the five-year budget window. The President's budget also includes Medicare administrative proposals with estimated savings of \$645 million in FY2009 and \$4.7 billion over the five-year budget window, which brings the estimated savings from the total Medicare budget proposals to \$12.8 billion in FY2009 and \$183 billion over the five-year budget window. Proposals include savings achieved through reductions in many of the Medicare payment updates.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, P.L. 108-173) requires the Medicare Board of Trustees to examine and make a determination if general revenue Medicare funding is expected to exceed 45% of Medicare outlays for the current fiscal year or any of the next six fiscal years. An affirmative determination in two consecutive annual reports is considered to be a Medicare funding warning in the year in which the second report is made.² The President has indicated that he intends to submit the required legislative proposal, due within the 15-day period following the budget submission to Congress. As part of the budget, the President has proposed reducing Medicare provider payments by 0.4% beginning in any year that the general revenue Medicare funding is expected to exceed 45% of Medicare outlays. This reduction would increase each year, until the percentage falls below the 45% trigger level.

¹ Department of Health and Human Services, *2009 Budget In Brief*, available at [<http://www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf>]

² For additional information about the Medicare funding warning, see CRS Report RS22796, *Medicare Trigger*, by Hinda Chaikind and Christopher M. Davis.

Finally, the Program Management Budget account request for 2009 is \$3.31 billion. Of that \$3.31 billion, 70% or \$2.34 billion would be directed towards Medicare administrative operations activities such as processing and paying claims, responding to beneficiary questions, and conducting appeals. The remaining 30% of the \$3.31 billion would be directed towards compensating individuals employed at CMS, performing surveys and inspections of Medicare provider facilities, and conducting research. The President's budget also includes a legislative proposal to collect \$35 million in revisit user fees from health care facilities found to be deficient during an initial Medicare inspection or re-certification. Enactment of the revisit fee proposal is contingent upon authorizing legislation.

The rest of this report includes brief discussions of current and proposed law for each of the 2009 Medicare program proposals, along with **Table 1**, which details the Administration's estimates of the costs and savings for each proposal. The President's budget reflects the passage of the Medicare, Medicaid and SCHIP Extension Act of 2007 (P.L. 110-173). **Table 2** provides a list of CRS staff contacts for this report.

Medicare Part A

Inpatient Acute Care Hospital Update

Current Law. Inpatient services provided by acute care hospitals are reimbursed based on the inpatient prospective payment system (IPPS) on the basis of their Medicare discharges. Each year Medicare's IPPS per discharge payment amount is increased annually by an update factor that is determined, in part, by the projected increase in the hospital market basket (MB) index. The MB 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 annual update. For FY2007 and beyond, however, hospitals that submit required quality data will receive the full MB update for inpatient services. 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. Acute care hospitals would receive a zero percent update for inpatient services provided in FY2009 through FY2011, regardless of whether inpatient quality data is submitted. The inpatient hospital update would be set at MB minus 0.65 percentage points for subsequent years. The President's budget estimates that the proposal would save \$3.99 billion in FY2009 and \$64.2 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 (MB) update — the measure of inflation of goods and services used by SNFs. For FY2008, the SNF payment update is the full market basket increase of 3.3%. The update for future years, without changes to current law, is also the full market basket increase.

President's Proposal. Under the President's proposal, SNF payments would be frozen in FY2009 through FY2011, and annually updated by the MB minus 0.65% in FY2012 and beyond. The President's budget estimates that the proposal would save \$990 million in FY2009 and \$17.03 billion over the five-year budget period between FY2009 and FY2013.

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 FY2008 payment rates are updated by the market basket increase of 3.3%. Without changes to Medicare law, the update will grow by the market basket for FY2009 and beyond.

President's Proposal. Hospice payments would be frozen in FY2009 through FY2011, and annually updated by the MB minus 0.65 percentage points in FY2012 and beyond. The President's budget estimates that the proposal would save \$350 million in FY2009 and \$5.14 billion over the five-year budget period between FY2009 and FY2013.

Inpatient Rehabilitation Facility (IRF) Update

Current Law. Inpatient rehabilitation facilities (IRFs) are paid based upon the inpatient rehabilitation facilities prospective payment system (IRF-PPS), and paid a fixed amount per discharge. The annual update to the payment is based on the MB for rehabilitation, psychiatric, and long-term care.

President's Proposal. The IRF per discharge payment amount would be frozen in FY2010 and FY2011 and increased by the MB minus 0.65 percentage points in subsequent years. The President's budget estimates that the proposal would save \$510 million in FY2009 and \$4.82 billion over the five-year budget period. According to the President's budget documents, these savings "include the impact of repealing certain provisions of Sections 114 and 115 of the Extension Act of 2007." However, no further details are provided.

Long-Term Care Hospital (LTCH) Update

Current Law. Long-term care hospitals (LTCHs) are paid based upon the LTCH-PPS, and paid a fixed amount per discharge. The annual update to the payment is based on the MB for rehabilitation, psychiatric, and long-term care.

President's Proposal. The LTCHs per discharge payment amount would be frozen in FY2009 and FY2011 and increased by the MB minus 0.65 percentage points in subsequent years. The President's budget estimates that the proposal would save \$320 million in FY2009 and \$2.94 billion over the five-year budget period. According to the President's budget documents, these savings "include the impact of repealing certain provisions of Sections 114 and 115 of the Extension Act of 2007." However, no further details are provided.

Reduce Acute Care Hospital Capital Payments

Current Law. Medicare pays the capital related costs of inpatient hospital services using a prospective payment system that is similar to that used to reimburse hospitals for their operating costs.

President's Proposal. The proposal would reduce capital payments made to acute care hospitals by 5% in FY2009. The budget includes estimated savings of \$490 million in FY2009 and \$3.05 billion over the five-year budget period for this proposal.

Reduce Disproportionate Share Hospital (DSH) Payments Made to Acute Care Hospitals

Current Law. Medicare provides additional funds to hospitals that qualify for a disproportionate share hospital (DSH) adjustment. Approximately 2,700 hospitals receive the additional payments for each Medicare discharge based on a formula which incorporates the number of patient days provided to low-income Medicare beneficiaries (those who receive Supplemental Security Income (SSI)) and Medicaid recipients. A few urban hospitals, known as "Pickle Hospitals," receive DSH payments under an alternative formula that considers the proportion of a hospital's patient care revenues that are received from state and local indigent care funds. The percentage add-on for which a hospital will qualify varies according to the hospital's bed size or urban or rural location.

President's Proposal. The proposal would phase in a 30% reduction in DSH payments made to acute care hospitals over two years, starting in FY2009. The budget includes estimated savings of \$1.75 billion in FY2009 and \$20.69 billion over the five-year budget period for this proposal.

Change the Budget Neutrality Requirement for Hospital Geographic Reclassifications.

Current Law. Medicare payments to acute care hospitals are adjusted by the wage index of the area where a hospital is located. In certain circumstances, a

hospital can apply for and receive a reclassification to an area with a higher wage index. Geographic reclassifications established by decisions of the Medicare Geographic Classification Review Board are required by statute to be budget neutral. Accordingly, the per discharge amount used to pay all hospitals is reduced.

President's Proposal. Under this proposal, the budget neutrality offset for all the reclassified hospitals within a state would be achieved by adjusting the wage index values for hospitals within that state (rather than reducing the per discharge amount for all hospitals in the nation.) The budget includes no savings 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 \$250 million in FY2009 and \$1.65 billion over the five-year budget period, for this proposal.

Establish Hospital Value-Based Purchasing Program

Current Law. Section 501(b) of the MMA provided an incentive for an eligible hospital 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 CMS for FY2005, 2006 and 2007. Section 5001(a) of the Deficit Reduction Act of 2005 (P.L. 109-171, DRA) required hospitals to report additional quality measures to receive the full market basket increase to their payment rates. Payment rates were reduced by 2 percentage points for any hospital that did not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

The DRA required 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 Tax Relief and Health Care Act of 2006 (P.L. 109-432 TRHCA) requires hospital outpatient departments to submit data on quality measures in order to avert a 2 percentage point reduction in their annual payments starting in 2009.

President's Proposal. The President's budget mentions value-based purchasing programs for hospitals but does not include specifics. However, the proposals are expected to achieve \$1.65 billion in savings over the five-year window from 2009 to 2013.

Adjust Hospital Payment for Never Events

Current Law. The TRHCA 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 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 President's budget does not include savings in FY2009, but does include estimated savings of \$190 million over the five-year budget period.

Medicare Part B

Physicians' Services

Current Law. Medicare payments for services of physicians and certain non-physician 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 the first half of 2008 is \$38.0870, 0.5% above the 2007 level.

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 June 2008.

On December 29, 2007, the President signed into law the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173). This law sets a minimum update of 0.5% for January-June 2008. In the absence of further legislation, the reduced conversion factor slated to go into effect January 1, 2008, will go into effect on July 1, 2008, with further reductions taken in subsequent years.

President's Proposal. The President's proposal does not address the physician payment update. Thus, the cut in the conversion factor slated to go into effect in July 2008 and the further reduction slated for January 2009 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 an outpatient prospective payment system (OPPS). The unit of payment is the individual service or procedure as assigned to an ambulatory payment classification (APC). 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. Hospitals would receive a zero percent update for outpatient services provided in FY2009 through FY2011, regardless of whether the required quality data is submitted. The HOPD update would be set at MB minus 0.65 percentage points for subsequent years. The President's budget estimates that the proposal would save \$580 million in FY2009 and \$6.05 billion over the five-year budget period.

Ambulatory Surgery Center Update

Current Law. Until January 1, 2008, Medicare used 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 through 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. The new ASC payment system, implemented on a phased basis starting January 1, 2008, is based on the OPPS used to pay for HOPD services. As established by the TRHCA, 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. The ASC conversion factor would be frozen in CY2010 and CY2011 and would be established at the CPI minus 0.65 percentage points in subsequent years. If applicable, ASCs that do not submit quality data will receive the additional 2-percentage-point reduction. The President's budget does not include savings in FY2009, but does include estimated savings of \$450 million over the five-year budget period.

Ambulance Services

Current Law. Ambulance services are paid on the basis of a fee schedule. The fee schedule establishes seven categories of ground ambulance services and two categories of air ambulance services. 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 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 fee schedule amounts are updated each year by the CPI-U. The update for 2008 is 2.7%.

President's Proposal. Payments for ambulance services would be frozen for the three-year period 2009 - 2011; thereafter they would be annually updated by the CPI-U minus 0.65 percentage points. The budget includes estimated savings of \$60 million in FY2009 and \$1.27 billion over the five-year budget period, for this proposal.

Competitive Bidding for Laboratory Services

Current Law. Section 302(b) of the MMA required 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.

CMS has outlined how the competitive bidding process will work when the demonstration program begins operation. Certain laboratories will be required to bid in the demonstration. These are laboratory firms with \$100,000 or more in annual Medicare Part B (fee-for-service) payments for tests (covered in the demonstration) provided to beneficiaries residing in the competitive bidding areas (CBAs), regardless of where the laboratory firm is located. 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 would not be required to bid. The competitively set demonstration fee schedule will be used to pay for laboratory services in the CBA for the duration of the demonstration. Multiple winners are expected in each CBA. Beneficiaries will only be able to receive services from winning bidders and entities not required to (and did not) bid.

CMS has stated that the demonstration will apply in two Metropolitan Statistical Areas (MSAs). The San Diego metropolitan area has been selected as the first location. The project has not yet begun.

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 FY2009 and \$2.29 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 \$80 million in FY2009 and \$720 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. The budget includes estimated savings of \$210 million in FY2009 and \$3.00 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% for FY2008. For HHAs that do not submit this quality data, their increase will be reduced by 2 percentage points to 1% for CY 2008. Without changes to current law, payments for FY2009 and future years would continue to be updated by the market basket.

President's Proposal. Payments for HHAs would be frozen in FY2009 through 2013, and thereafter they would be annually updated by the MB minus 0.65 percentage points. For this proposal, the HHS budget includes an estimated savings of \$440 million in FY2009 and \$11.03 billion over the five-year budget period of FY2009 through FY2013.

End-Stage Renal Disease Payment Modernization

Current Law. Medicare reimbursement for dialysis services is paid based on a basic case-mix adjusted prospective payment system for dialysis services furnished either at a facility or in a patient's home. The basic case-mix adjusted system has two components: (1) the composite rate, which covers services, including dialysis; and (2) a drug payment adjustment for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by Inspector General reports. Additionally, certain drugs, biologicals and laboratory tests are billed separately. The Secretary is required to update the basic case-mix adjusted payment amounts annually beginning with 2006, but only for that portion of the case-mix adjusted system that is represented by the add-on adjustment and not for the portion represented by the composite rate.

Dialysis services are offered in three outpatient settings: hospital-based facilities, independent facilities, and the patient's home. There are two methods for

payment. Under Method I, facilities are paid a prospectively set amount, known as the composite rate, for each dialysis session, regardless of whether services are provided at the facility or in the patient's home. The composite rate is derived from audited cost data and adjusted for the national proportion of patients dialyzing at home versus in a facility, and for area wage differences. Hospital-based dialysis facilities receive an upwards adjustment to the composite rate. Beneficiaries electing home dialysis may choose not to be associated with a facility and may make independent arrangements with a supplier for equipment, supplies, and support services. Payment to these suppliers, known as Method II, is made on the basis of reasonable charges, limited to 100% of the median hospital composite rate, except for patients on continuous cycling peritoneal dialysis, when the limit is 130% of the median hospital composite rate.

President's Proposal. Beginning CY2009, the payment for providers of dialysis services furnished by hospital-based facilities would be the same as the rate for such services furnished by renal dialysis facilities that are not hospital based. A bundled payment system under which a single payment would be made for Medicare renal dialysis services would be implemented and re-based beginning CY2011. The budget includes estimated savings of \$10 million in FY2009 and \$1.06 billion over the five-year budget period, for this proposal.

Extend Medicare Secondary Payer Status for End Stage Renal Disease

Current Law. Under Medicare Secondary Payer (MSP) rules, Medicare is prohibited from making payments for any item or service when payment has been made or can reasonably be expected to be made by a third party payer. For individuals with Medicare entitlement based solely on End-Stage Renal Disease (ESRD), MSP rules apply for those covered by an employer-sponsored group plan, regardless of the employer size or current employment status. Medicare entitlement based on ESRD usually begins with the third month after the month in which the beneficiary starts a regular course of dialysis, referred to as the three-month waiting period. In addition to the waiting period, for individuals whose Medicare eligibility is based solely on ESRD, any group health plan coverage they receive through their employer or their spouse's employer is the primary payer for the first 30 months of ESRD benefit eligibility, referred to as the 30-month coordination period. After 30 months, Medicare becomes the primary insurer.

Medicare coverage ends 12 months after the month the beneficiary stops dialysis treatment or 36 months after the month the beneficiary has a successful kidney transplant. However, if Medicare coverage ends, and then begins again, based on ESRD, the 30-month coordination period will also begin again.

A large group health plan is a plan offered by an employer that normally employed at least 100 employees on a typical business day during the preceding calendar year. This also applies to certain smaller plans that are part of a multiple or multi-employer plan.

President's Proposal. Beginning in 2009, the coordination period for ESRD MSP would be extended to from 30 months to 60 months, but only for those individuals who receive group coverage through a large group health plan. The budget includes estimated savings of \$110 million in FY2009 and \$1.11 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. In addition, the value of IME is also included in the maximum amount Medicare is willing to pay Part C plans for services to Medicare enrollees in certain locations and in certain years.

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 \$1.01 billion in FY2009 and \$8.85 billion over the five-year budget period, for this proposal.

Reduce Indirect Medical Education (IME) Adjustment

Current Law. Teaching hospitals that train physicians in approved residency programs have higher Medicare inpatient costs per discharge than non-teaching hospitals. These hospitals receive an indirect medical education adjustment (IME) based on a statutory formula that increases payments by about 5.5% for each 10% increase in teaching intensity in FY2008. MedPAC has found that the IME adjustment is set higher than the empirically estimated increase in hospitals' cost per case due to teaching.

President's Proposal. The proposal would lower the IME add on payment from 5.5% to 2.2% over a three-year transition period, starting in FY2009. The budget includes estimated savings of \$890 million in FY2009 and \$12.9 billion over the five-year budget period 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%. The 2008 premium is \$96.40.

Beginning in 2007, higher-income enrollees pay a higher percentage of Part B costs. The increase is phased in over three years. In 2008, they pay total premiums ranging from 31.7% to 61.7% of the value of Part B. When fully phased-in during 2009, higher income individuals will pay total premiums ranging from 35% to 80% of the value of Part B.

CMS estimates that 5% of enrollees will pay the higher premiums in 2008. For singles, the higher monthly premium amounts are \$122.20 for beneficiaries with incomes (in 2006) over \$82,000 and less than or equal to \$102,000, \$160.90 for incomes over \$102,000 and less than or equal to \$153,000, \$199.70 for incomes greater than \$153,000 and less than or equal to \$205,000, and \$238.40 for incomes greater than \$205,000. For couples filing joint tax returns, the premium amounts are \$122.20 for beneficiaries with incomes over \$164,000 and less than or equal to \$204,000, \$160.90 for incomes over \$204,000 and less than or equal to \$306,000, \$199.70 for incomes greater than \$306,000 and less than or equal to \$410,000, and \$238.40 for incomes greater than \$410,000.

The income thresholds for higher Part B premiums are increased each year 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 \$110 million in FY2009 and \$2.57 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. 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.³ 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 \$350 million in FY2009 and \$3.18 billion over the five-year budget period, for this proposal.

Interaction with Medicaid

Current Law. Medicaid provides coverage for Medicare Part B premiums for certain low-income persons. One coverage group is known as “Qualifying Individuals 1 (QI-1s).” Individuals are eligible as QI-1s if they are entitled to Medicare Part A, their incomes are at least 120% of the Federal poverty level but less than 135%, and they have limited assets. The benefit for the QI-1 group was originally set to expire in December 2002; however, Congress has extended the provision on several occasions. Most recently P.L. 110-173 extended the coverage through June, 2008.

President's Proposal. The President's Medicaid proposals include an extension of the QI program through September 30, 2009. The Medicare costs reflect program expenditures for this group of individuals. The budget includes estimated costs of \$270 million in FY2009 and \$270 million over the five-year budget period, for this proposal.

Use and Release of Medicare Claims Data

Current Law. The President has proposed a Healthcare Transparency Initiative, with the stated goals of making quality and price and cost information available to allow consumers, employers, and payers to choose better value in healthcare. The President's corresponding executive order emphasized the sharing of information on health care quality and cost, promoting interoperable health information technology (HIT) systems, and providing incentives for consumers to choose efficient, high quality providers.

President's Proposal. The President's proposal would seek broader authority to release Medicare fee-for-service claims and other data for purposes of quality improvement, performance measurement, and public reporting. This proposal aims to improve the transparency and availability of comparative health care cost and quality data for beneficiaries. The budget includes no savings associated with 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

³ Though specifics are not provided, it is expected that the percentage increases would be tied to a benchmark premium for basic coverage.

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 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; \$692 million in FY2009 and \$6.474 billion over the five-year budget period.

Forty-Five Percent Rule (the Medicare Trigger)

The MMA amended the Social Security Act, adding an additional responsibility that requires the Medicare Board of Trustees to examine and make a determination if general revenue Medicare funding is expected to exceed 45% of Medicare outlays for the current fiscal year or any of the next six fiscal years. An affirmative determination in two consecutive annual reports is considered to be a Medicare funding warning in the year in which the second report is made.⁴

Because the Medicare trustees issued such a warning in 2007, MMA requires that the President submit legislation to Congress responding to the warning within the 15-day period, beginning on the date of the budget submission to Congress this year. The President's budget proposal would reduce Medicare provider payments by 0.4% in beginning in any year that the general revenue Medicare funding is expected to exceed 45% of Medicare outlays. This reduction would increase each year, until the percentage falls below the 45% trigger level.

Quality Improvement Organization (QIO) Proposals

Funding for the Ninth SOW

Current Law. Medicare contracts with private organizations called quality improvement organizations (QIOs) to monitor and improve the quality of care provided to Medicare beneficiaries. To fulfill this responsibility, QIOs perform a diverse mix of activities for the Medicare program, including providing technical assistance to providers on quality improvement, investigating beneficiary complaints related to the quality of care, and reviewing the necessity of medical services delivered to Medicare beneficiaries. Operating under three-year contracts called Statements of Work (SOWs), CMS contracts with 41 organizations to provide services to Medicare beneficiaries in all 50 states, Puerto Rico, the District of Columbia, and the Virgin Islands. With an estimated budget of \$1.23 billion, the 41 QIOs are scheduled to complete the eighth SOW in July 2008.

President's Proposal. The President's budget provides \$1.1 billion to the QIOs for the ninth SOW set to begin in August 2008. For the ninth SOW, the QIOs

⁴ For additional information about the Medicare funding warning, see CRS Report RS22796, *Medicare Trigger*, by Hinda Chaikind and Christopher M. Davis.

will provide technical assistance and quality improvement assistance to providers in support of three themes: (1) prevention of chronic illness, (2) reducing unnecessary hospitalizations, and (3) patient safety. The President's budget also proposes changes to QIO oversight and management such as requiring ongoing performance management reviews, financial penalties for QIOs that do not meet certain performance thresholds, and targeted funding to areas with low performing providers.

Allowing the Secretary to Determine Geographic Scope of QIO Contracts

Current Law. The Secretary is required to establish geographic areas throughout the United States with respect to QIO contracts. Each state must be designated as a geographic area. The Secretary has the authority to establish local or regional areas as geographic areas only when the volume of medical necessity reviews or other factors warrant such an establishment. If the Secretary does decide to establish a local or regional area as a geographic area, the Secretary must establish that review activity can be conducted more efficiently at the local or regional level rather than the state level.

President's Proposal. The President's proposal would allow the Secretary to negotiate local, regional, or national QIO contracts. The President's budget does not include savings in FY2009 for this proposal, but does include estimated savings of \$50 million over the five-year budget period (FY2009-FY2013).

Expand Pool of Contractors Eligible for QIO Work

Current Law. To become a QIO, entities must meet certain requirements. Entities must be either physician-sponsored or physician-access organizations. A physician-sponsored organization is defined as an entity that is composed of a substantial number of licensed doctors practicing medicine in the area and who are representative of the physicians practicing in the area. A physician-access organization is one that has available to it the services of a sufficient number of doctors practicing medicine in the area. The Secretary is prohibited from entering into QIO contracts with a health care facility, health care facility association, a health care facility affiliate, or payer organization.

President's Proposal. The President's proposal would expand the pool of quality organizations eligible to become QIO contractors. The President's budget does not include savings in FY2009, but does include estimated savings of \$30 million over the five-year budget period (FY2009-FY2013).

Allow for Early Termination of Contracts Without Panel Review

Current Law. If the Secretary determines that a QIO is not meeting its contractual requirements, the Secretary is required to notify the QIO that its contract may not be renewed at least 90 days prior to the expiration of the contract. Upon informing the QIO of its notice of intent to terminate the contract, the Secretary is

required to provide the QIO with the opportunity to present data and other information pertinent to its performance under the contract. Such information must be reviewed in a timely manner by a panel appointed by the Secretary. The panel is required to submit a report of its findings to the Secretary in a timely manner. The Secretary is not required to accept the findings of the panel and has the authority to amend the contract to modify the QIO's functions. If the Secretary decides to terminate a QIO's contract after the panel has submitted its report, it must provide the QIO with 90 days notice.

President's Proposal. The President's proposal would allow for early termination of contracts without panel review for poor performing QIOs. The President's budget does not include any estimated savings associated with this proposal.

Establish Stricter Standards for Reviewing Beneficiary Complaints to Address Perceived Conflicts of Interest

Current Law. In addition to providing technical assistance to providers on quality improvement, QIOs are required to investigate and respond to beneficiary complaints about the quality of health care services. Specifically, QIOs review the services provided to the beneficiary to ensure that they meet professionally recognized standards of care. If after investigating the complaint, the QIO identifies a potential quality of care concern they are required to inform the beneficiary of the outcome of the investigation and provide the practitioner with reasonable notice and opportunity for discussion. QIOs are also required to implement quality improvement interventions with the provider in response to quality concerns identified during complaint investigations.

President's Proposal. The President's proposal would eliminate a perceived conflict of interest between QIOs beneficiary protection and quality improvement activities by establishing stricter contractual standards for reviewing beneficiary complaints. The President's budget does not include any estimated savings associated with this proposal.

Make QIO Authority to Conduct Quality Improvement Activities More Explicit

Current Law. Section 1154 of the Social Security Act describes the functions of Medicare QIOs. The law directs QIOs to review some or all of the professional activities of Medicare providers to ensure that the services provided to Medicare beneficiaries are reasonable and medically necessary, that the quality of services meets professionally recognized standards of care, and that the services provided could not be provided more effectively and economically in another health care setting. The statute does not make reference to the quality improvement activities QIOs undertake in conducting these medical review functions.

President's Proposal. The President's proposal would expand the statutory authority of QIOs to include quality improvement activities. The President's budget does not include any estimated savings associated with this proposal.

Program Integrity Proposals

Health Care Fraud and Abuse Control Program

Current Law. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) established the Health Care Fraud and Abuse Control Program (HCFAC) and Medicare Integrity Program (MIP) to conduct health care fraud and abuse activities. To fund these activities, HIPAA established within the Hospital Insurance Trust Fund an expenditure account called the HCFAC account. Monies are to be appropriated from the Trust Fund to the HCFAC account in amounts that the Department of Health and Human Services (DHHS) and the Department of Justice (DOJ) jointly certify as necessary to finance anti-fraud activities.

HCFAC funds enforcement and prosecution efforts impacting all federal health care programs. MIP, however, funds activities to prevent and investigate fraud in Medicare. HCFAC supports anti-fraud activities performed by the DHHS, the HHS Office of the Inspector General (OIG), the DOJ, and the Federal Bureau of Investigation (FBI). MIP funds are allocated to CMS for activities such as medical reviews of claims, provider audits, investigations, and physician education.

HIPAA capped mandatory funding for the HCFAC and MIP programs at the FY2003 level of \$355 million for HCFAC and \$720 million for MIP. The DRA appropriated additional mandatory funds for MIP (\$36 million in FY2008 and \$48 million in FY2009) for the establishment of a Medicare-Medicaid data matching program. The TRHCA increased the mandatory annual appropriation for HCFAC by the percentage increase in the consumer price index through 2010. In FY2008, mandatory HCFAC and MIP funding for health care fraud activities totaled \$1.1 billion.

The law currently mandates that HHS and the DOJ submit an annual report to Congress on HCFAC activities. The law does not require that MIP activities be included in this report.

President's Proposal. The President's FY2009 budget includes a discretionary request of \$198 million to augment the mandatory funding for health care fraud activities. Of this \$198 million, \$147 million would be allocated to MIP to conduct oversight activities related to the Medicare prescription drug benefit and Medicare Advantage plans. The remaining \$51 million would support anti-fraud activities conducted by the OIG and DOJ. To ensure funding for this proposal, the administration proposes to fund them as contingent appropriations and would employ a budget enforcement mechanism to allow for adjustments by the Budget Committees. Statutory spending limits would also be established.

The President's budget also includes a proposal to change the structure of the HCFAC account by separating the unified funding stream provided to the DHHS and DOJ into two separate funding streams. The annual negotiations process between the two agencies would be eliminated. Further, MIP would be required to contribute results of its activities to the annual HCFAC report.

Medicare Bad Debt

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 reimbursements over four years for all Medicare providers (FY2009-FY2012). The President's budget expects to save \$250 million in 2009 with this proposal and \$8.5 billion over the five year budget period.

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 "the 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 FY2009, but does include estimated savings of \$60 million over the five-year budget period (FY2009-FY2013). These savings are for existing cases only and do not include projected savings from future cases.

Include Providers in Federal Payment Levy Program

Current Law. The Federal Payment Levy Program (FPLP) authorizes the Internal Revenue Service (IRS) to collect overdue taxes through a continuous levy on federal payments made to delinquent taxpayers. The FPLP is implemented in coordination with the Department of the Treasury's Financial Management Service (FMS). FMS may reduce any federal payments subject to the levy by 15%, or the exact amount of tax owed if it is less than 15% of the payment. The Department of Health and Human Services (DHHS) does not participate in this program, which would enable it to collect tax debt from physicians and other Part B providers.

President's Proposal. This proposal would allow Medicare provider payments to be included in the FPLP. The President's budget does not include any estimated savings associated with this proposal.

Reducing Erroneous Medicare Payments

Current Law. CMS developed the Comprehensive Error Rate Testing (CERT) Program to assess how well Medicare claims administration contractors process Medicare claims. The CERT program measures the accuracy of Medicare claims processing activities by calculating national, contractor-specific, and provider-specific claims error rates. To reduce the volume of improper payments, Medicare contractors are expected to educate providers on how to correct billing mistakes and identify potential fraud. Medicare fee-for-service error rates in 2007 and 2008 were 3.9%, and 3.8% respectively.

President's Proposal. The President estimates that efforts to improve payment accuracy will result in a further reduction of the Medicare fee-for-service claims error rate from 3.8% in 2008 to 3.7% in 2009. The President's budget does not include any estimated savings associated with this proposal.

Medicare Administrative Proposals

These five provisions propose to strengthen program integrity, correct for inappropriate provider payments, and adjust payments to encourage efficiency and productivity. The budget includes estimated savings of \$645 million in FY2009 and \$4.74 billion over the five-year budget period from these proposal in aggregate.

Payment for Conditions Not Present on Admission

Current Law. As required by the DRA, starting October 1, 2008, acute care hospitals will not receive additional payment when one of the identified conditions is acquired during hospitalization. For patients where the specified condition was not present on admission, the hospital would be paid as though the secondary diagnosis was not present.

President's Proposal. The budget proposal would expand the policy and withhold Medicare payment for certain conditions if they were not present at the time of the hospital admission.

Increase Inpatient Length of Stay Threshold

Current Law. Under IPPS, Medicare reduces payment to an acute care hospital if a patient in a given diagnostic related category (DRG) is admitted to a post acute setting and receives clinically related care within three days of discharge from the hospital. The post acute settings covered by the transfer policy include LTCHs, IRFs, inpatient psychiatric or skilled nursing facilities, and home health care.

President's Proposal. The budget proposal would increase the inpatient length of stay threshold that would trigger the transfer payment adjustment.

Change Hospice Wage Index

Current Law. Payments for hospice care are adjusted to reflect local differences in area wage levels by the hospice wage index. The hospice wage index has been developed using the most current hospital wage data, including any changes to the Metropolitan Statistical Areas (MSAs) definitions. The original hospice wage index was based on the 1981 Bureau of Labor Statistics hospital data and had not been updated since 1983. On April 13, 1995, the Hospice Wage Index Negotiated Rulemaking Committee signed an agreement for the methodology to be used for updating the hospice wage index. In the August 8, 1997 Federal Register (62 FR 42860), CMS published a final rule implementing a new methodology for calculating the hospice wage index based on the recommendations of the negotiated rulemaking committee. The hospice wage index is updated annually and is published in the Federal Register. It is based on the most current available hospital wage data, as well as any changes by the Office of Management and Budget (OMB) to the definitions of MSAs.

President's Proposal. This proposal would phase-out the hospice-specific wage index adjustment over three years.

Case Mix Adjustment to Payments for Skilled Nursing Facilities

Current Law. Skilled Nursing Facility (SNF) care is reimbursed based on a prospective payment system. The PPS payments are based on a daily ("per-diem") urban or rural base payment amount that is adjusted for case mix using a resident classification system (Resource Utilization Groups III) based on data from resident assessments and relative weights developed from staff time data. The PPS payments are also adjusted by area wages using the hospital wage index.

President's Proposal. The President proposes to correct for case mix distribution in the skilled nursing payment system but the budget does not include any specifics.

Strengthen Program Integrity

Current Law. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established the Medicare Integrity Program (MIP) to reduce improper payments and conduct activities to prevent health care fraud and abuse in the Medicare program. 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.

President's Proposal. This proposal would strengthen program integrity in Medicare payment systems to root out excessive or inappropriate payments. The specifics of this proposal were not available at the time this report was published.

Overall these five proposals are estimated to save \$0.6 billion in 2009 and \$4.7 billion over the five year budget period (2009-2013).

Permanently Base Part D Risk Scores on Eligible Enrollees

Current Law. Medicare makes payments to Part D plans based on plan bids, adjusted for expected case mix of enrollees. Per capita monthly direct subsidy payments equal to the adjusted amount minus the beneficiary premiums. Following the close of the calendar year, CMS makes retroactive adjustments to reflect actual plan experience. Direct subsidy payments are adjusted to reflect updated status about beneficiary health status and enrollment.

President's Proposal. The proposal would permanently base Part D risk adjustment scores on eligible enrollees rather than on actual enrollees. The budget includes estimated costs of \$400 million in FY2009 and \$3.2 billion over the five-year budget period.

Table 1. President's FY2009 Budget Medicare Proposals
(dollars in millions)

Proposals	HHS estimates	
	FY2009	FY2009- FY2013
Legislative Proposals		
Medicare Part A		
Hospital Update	-3,990	-64,200
Skilled Nursing Facility Update	-990	-17,030
Hospice Update	-350	-5,140
Inpatient Rehab Facility Update ^a	-510	-4,820
Long-Term Care Hospital Update ^a	-320	-2,940
Eliminate Duplicate Hospital IME Payments for MA	-1,010	-8,850
Reduce Indirect Medical Education Add-On	-890	-12,900
Reduce Hospital Capital Payments by 5% in FY2009	-490	-3,050
Reduce Hospital Disproportionate Share Payments	-1,750	-20,690
Set Base Payment for 5 Post-Acute Conditions	-250	-1,650
Establish Hospital Value-Based Purchasing Program	—	-1,650
Eliminate Payments for Never Events	—	-190
Budget Neutrality for Purposes of Geographic Reclassification	—	—
Medicare Part B		
Outpatient Hospital Update	-580	-6,050
Ambulance Update	-60	-1,270
Ambulatory Surgical Center Update	0	-450
Competitive Bidding for Clinical Laboratory Services	-110	-2,290
Establish 13-Month Rental Period for Power Wheelchairs	-80	-720
Reduce Rental Period for Oxygen Equipment from 36 to 13 Months	-210	-3,000
Medicare Parts A and B (dollars or combined A and B spending)		
Home Health Update	-440	-11,030
End-Stage Renal Disease (ESRD) Payment Modernization	-10	-1,060
Extend Medicare Secondary Payer Status for ESRD	-110	-1,110
Improve Program Integrity		
Phase-Out Medicare Bad Debt Payments Over four Years	-250	-8,460
Limit Use of Mandamus Jurisdiction	—	-60
Include Medicare Providers in FPLP	—	—
Premiums and interactions		
Eliminate Annual Indexing of Income-Related Part B Premiums	-110	-2,570
Establish Income-Related Part D Premium Consistent with Part B	-350	-3,180
QI Extension/Interactions Reducing Beneficiary Part B Premiums ^b	692	6,474
Seek Broader Authority to Release Medicare FFS Claims Information	—	—

Proposals	HHS estimates	
	FY2009	FY2009- FY2013
Improve Long-Term Fiscal Sustainability		
Apply -0.4% Sequester When Medicare Fund Warning is Triggered	—	—
QIO proposals		
Allow Secretary to Determine Geographic Scope of Contracts	—	-50
Expand Pool of Contractors Eligible for QIO Work	—	-30
Allow for Early Termination of Contracts without Panel Review	—	—
Eliminate Conflict of Interest	—	—
Make QIO Authority More Explicit		
Total, Medicare Legislative Proposals	-12,167	-177,965
Medicare Administrative Proposals		
Improve Medicare Efficiency, Productivity, and Program Integrity	-645	-4,739
Total, Medicare Administrative Proposals	-645	-4,739
Total, Medicare Budget Proposals	-12,812	-182,704

Source: Department of Health and Human Services, *2009 Budget in Brief*, available at [<http://www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf>].

Notes: Totals may not add due to rounding.

- a. Includes the impact of repealing certain provisions of Sections 114 and 115 of the Extension Act of 2007.
- b. The \$270 million Medicare effect of the QI extension proposal is not scoreable for PAYGO purposes.

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 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 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
SGR options	Jennifer O'Sullivan Jim Hahn	7-7359 7-4914
Parts A&B		
Beneficiary Issues	Jennifer O'Sullivan	7-7359
End Stage Renal Disease (ESRD)	Hinda Chaikind Gretchen Jacobson	7-7569 7-1686
Home Health Services	Julie Stone	7-1386
Part C		
Medicare Advantage	Hinda Chaikind Paulette 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 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/Value-Based Purchasing	Jim Hahn	7-4914
Price Transparency	Jim Hahn	7-4914
Rural Issues	Sibyl Tilson	7-7368