hospitals, hospices, and ambulance services by -0.65 percent annually starting in FY 2008.

- Zero percent update for skilled nursing facilities and inpatient rehabilitation facilities in 2008 and a -0.65 percent adjustment to the update annually thereafter.

- Zero percent update for home health agencies in 2008 through 2012 and a -0.65 percent adjustment to the update annually thereafter.

- Reduce the annual update for ambulatory surgical centers by -0.65 percent beginning in 2010.

Competitive Bidding: Expand the successful competitive acquisition policy to include clinical laboratory services.

Rationalize Medicare Payments and Subsidies

Indirect Medical Education (IME) Payments: Eliminate duplicate IME payments to hospitals for MA beneficiaries.

Never Events: Prohibit Medicare payment for "never" events (preventable adverse events such as surgery on wrong body part). Hospitals would also be required to report occurrences of never events or receive a reduced annual update.

Value-based Purchasing: Establish budget-neutral incentives for high-quality hospitals and create minimum benchmarks for low-quality hospitals.

Post Acute Care: Move toward site-neutral post-hospital payments to limit inappropriate incentives for five conditions commonly treated in both skilled nursing facilities and inpatient rehabilitation facilities.

Power Wheelchair Rentals: Establish a 13 month rental period for power wheelchairs to ensure that Medicare and its beneficiaries no longer pay excessively for the purchase of equipment that could have been rented.

Oxygen Rentals: Reduce the rental period for most oxygen equipment from 36 to 13 months, which will lower Medicare and beneficiary spending.

Medicare as Secondary Payer (MSP): Better align payments for working beneficiaries by extending MSP status for beneficiaries with ESRD from 30 months to five years for large employers.

Improve Program Integrity

Data Clearinghouse: Require group health plans (and other third party payers) to report MSP data, and create a federal clearinghouse for data sharing with other federal health insurance programs, such as Federal Employees Health Benefits, TRICARE, and Veterans Affairs, to identify situations where Medicare is not the primary payer.

Bad Debt: Eliminate bad debt reimbursements for unpaid beneficiary cost-sharing over four years for all providers. Medicare currently pays 70 percent of unpaid beneficiary co-pays and deductibles to hospitals and skilled nursing facilities.

Mandamus Jurisdiction: Limit Mandamus jurisdiction as a basis for obtaining judicial review, and clarify the Secretary's authority to resolve appeals of Medicare determinations.

Increase High-Income Beneficiary Awareness and Responsibility for Health Care Costs

Part B Premium Indexing: Eliminate annual indexing of income thresholds for reduced Part B premium subsidies beginning on January 1, 2008.

Part D Premium Subsidies: Reduce Part D premium subsidies based on the same income thresholds that apply to reduced Part B premium subsidies, including no annual indexing.

Medicare Prescription Drug benefit Beneficiary Cost Sharing in 2007

Beneficiary Income Level	Annual Deductible	Monthly Premium	Beneficiary Out-of-Pocket Spending For Total Drug Expenditures:	
			≤ $5,451	> $5,451
≥150% FPL (standard benefit)	$265	$22 (avg)	25% from $265-2,400 100% from $2,400-5,451	Greater of 5% or $2.15-5.35 copay
135-150% FPL*	$53	$0 - $22	15% from $53-5,451	Copayment of: $2.15 generic $5.35 brand
100-135% FPL*	$0	$0	Copayment of: $2.15 generic $5.35 brand name	$0
≤100% FPL*	$0	$0	Copayment of: $1 generic $3.10 brand name	$0

FPL=Federal Poverty Level
*At these income levels, beneficiaries must also meet an asset test.

Improve Long-Term Sustainability: Apply sequester of minus 0.4 percent to all Medicare provider payments when general fund contributions exceed 45 percent. The sequester order would increase each year by 0.4 percent until general revenue funding is brought back to 45 percent.

FY 2008 Medicare Administrative Proposals

The Medicare budget assumes administrative savings of $1.0 billion in FY 2008 and $10.2 billion over five years. Savings will result from new efforts to strengthen program integrity in Medicare payment systems, correct for inappropriate provider payments, and adjust payments to encourage efficiency and productivity.

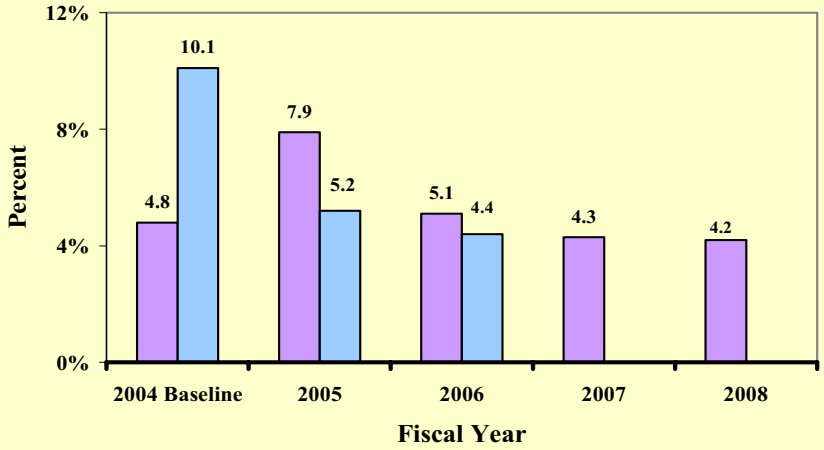
Medicare Highlights from the Tax Relief and Health Care Act of 2006

Linking Payment to Performance: Starting in 2009, outpatient hospital departments will submit data on specified quality measures or have their annual payment increases reduced by two percentage points.

Updating Physician Payments: The previously scheduled 2007 physician payment update of -5 percent is eliminated and replaced with a zero percent update. In addition, a 1.5 percent bonus payment is established for physicians who report quality measures in 2007. Also in 2007, the floor is extended for physician labor costs in certain rural areas. This Act also establishes a Physician Assistance and Quality Initiative Fund, totaling $1.35 billion in 2008, to promote physician payment and quality improvement initiatives in 2008.

Performance Highlight

Aggressive oversight and new efforts to improve payment accuracy cut the percentage of improper fee-for-service Medicare claims payments by 15 percent from 2005 to 2006. This is a $10.8 billion reduction in improper payments. For 2008, CMS targets a further reduction in the Medicare error rate to 4.2 percent.



Enhancing Program Integrity: Spending for certain parts of the Health Care Fraud and Abuse Control program for fiscal years 2007 through 2010 will increase by CPI-U inflation; after 2010, spending is capped at 2010 levels.

Expanding Recovery Audit Contractors: The recovery audit contractor program, currently running in three States, will expand to all States by 2010. Under this program, private contractors conduct audit and recovery activities with respect to payments made under Medicare Parts A or B. Recovered overpayments, less contract contingency and administration costs, are returned to the Medicare trust funds.

Reducing the Medicare Advantage Stabilization Fund: This Act reduces the funds available in the MA stabilization fund by $6.5 billion and limits the availability of the remaining $3.5 billion to expenditures during 2012 and 2013.

Establishing Coverage for Part D Vaccine Administration: In 2007, payment for the administration of Part D-covered vaccines is covered under Part B. Beginning in 2008, Part D plans will cover these costs.

Updating Payments for Dialysis Services: Payment rates for ESRD facilities increase by 1.6 percent beginning April 1, 2007.

Medicare Quality Improvement Efforts

Improving quality of care and reducing medical errors are important goals in modernizing Medicare. The Administration supports greater transparency of information about the price and quality of care. In addition, the Administration supports budget neutral payment reforms that reward improved quality of care through value-based purchasing.

Transparency: CMS is working to improve the transparency of information on price and quality of services provided to Medicare beneficiaries.

Providing Quality Data: The Medicare website now displays quality data that allows consumers to make informed choices by comparing the performance of hospitals, nursing homes, home health agencies, and dialysis facilities.

Working with Partners to Improve Quality Information: Through the Better Quality Information (BQI) for Medicare Beneficiaries initiative, CMS is partnering with the Agency for Healthcare Research and Quality to expand the Ambulatory Quality Alliance Pilots. The BQI initiative will continue to expand in FY 2008, providing information on healthcare quality, through quality "alliances" with providers, consumers, and payers. CMS is providing $27 million toward 18 BQI sites in 2007 from the Quality Improvement Organization (QIO) program.

Expanding Value-Based Purchasing and Improving Provider Quality Efforts: CMS is working to develop and implement payment systems that support high quality care – the right care for each person every time. These payment reforms can help providers deliver care that prevents complications, avoids unnecessary medical services, and achieves better outcomes at a lower overall cost.

CMS is working collaboratively with private and public organizations to stimulate high quality care and improve efficiency.

- CMS will publish a report this year, as required by the Deficit Reduction Act of 2005 (DRA), on how to implement hospital value-based purchasing in 2009.
- The DRA requires hospitals to report an expanded set of quality measures or see their payment updates reduced by 2 percent. CMS is requiring hospitals to report on 21 measures.
- Building off its successful efforts among hospitals, CMS will continue to expand its voluntary quality reporting program for physicians in 2007.
- The new Tax Relief and Health Care Act of 2006 establishes a quality reporting requirement for physicians, outpatient, and ambulatory surgical centers, and CMS is developing an implementation plan.
- CMS has multiple research demonstrations in the field that will test various value-based purchasing methods for hospitals, physicians, and disease management plans.

Quality Improvement Organizations: The QIO program serves the following functions:

- Improve the quality of care for Medicare beneficiaries by ensuring that all professions meet recognized standards of care;
- Enhance program integrity by ensuring that Medicare only pays for items that are reasonable and medically necessary; and
- Protect beneficiaries by addressing individual beneficiary's complaints, appeals, and case reviews.

QIOs are a central player in this Administration's efforts to improve the quality of care provided to Medicare beneficiaries. QIOs assist providers seeking to improve the quality of care delivered in nursing homes, home health agencies, hospitals, and physicians' offices. These quality improvement efforts are essential to the Administration's goals to modernize and strengthen the Medicare program.

Health Care Fraud and Abuse Control (HCFAC)

(B.A. in millions)

	2006	2007	2008
Discretionary Cap Adjustment Proposal			
Department of Justice/FBI	-	-	17.5
HHS Inspector General	-	-	17.5
Medicaid and SCHIP Financial Management	-	-	10.1
Medicare Integrity Program (MIP)	-	-	137.8
Total Proposed Discretionary Funds	**-**	**-**	**183.0**
Current Mandatory Funds (including TRHCA)			
Medicare Integrity Program (MIP)	832.0	744.0	756.0
FBI	114.0	118.2	120.6
OIG and Wedge Funds	240.6	249.5	254.4
Total Current Mandatory Funds	**1,186.6**	**1,111.7**	**1,131.0**
Total Proposed HCFAC Funds	**1,186.6**	**1,111.7**	**1,314.0**
Memorandum			
HHS Program Level Portion of HCFAC Total	*1,023.1*	*942.2*	*1,124.8*

In FY 2008, CMS will begin the next cycle of contracts called the 9th Scope of Work (SoW). The 8th SoW, funded at $1.231 billion over 2005-2008, focused on clinical quality improvements, public reporting and quality information, and protecting beneficiaries and the Trust Funds. Work on the 9th SoW will build on the 8th SoW and recommendations made by the Institute of Medicine. The Administration is working to improve quality, oversight, and efficiency, and better target resources in the QIO program.

Program Integrity Oversight

Health Care Fraud and Abuse Control (HCFAC): The FY 2008 budget proposes to fund the HCFAC program through both mandatory and discretionary funding streams. The FY 2008 HCFAC program level is $1.3 billion, over $200 million more than in FY 2007. Of this total program level, $1.1 billion is mandatory and $183.0 million is discretionary.

HCFAC Mandatory Funds: The $1.1 billion in mandatory funds are financed from the Medicare Part A Trust Fund. This funding is allocated into three major parts: 1) the Medicare Integrity Program (MIP); 2) the Federal Bureau of Investigation; and 3) the HCFAC Account, which is divided among the Department of Justice (DOJ), the HHS Office of Inspector General (OIG), and other HHS agencies through an annual negotiation process. Activities financed by this funding are used to detect and prevent heath care fraud, waste and abuse through investigations, audits, educational activities, and data analysis. The mandatory HCFAC funding has a proven record of returning money to the Medicare Trust Fund for each dollar spent. For the MIP program, the return on investment (ROI) is 13 to 1, and for the HCFAC Account, the ROI is 4 to 1. From 1997 to 2005, HCFAC activities have returned approximately $8.85 billion to the Trust Fund.

HCFAC Discretionary Funds: As part of a governmentwide proposal to fund proven program integrity activities through an adjustment to discretionary spending totals, the FY 2008 budget requests $183 million in discretionary HCFAC funding. This total will be allocated among the Medicare and Medicaid programs at CMS, as well as the OIG and DOJ. These funds are intended to complement the program integrity activities funded with mandatory HCFAC dollars.

The Medicare program has experienced significant transformation since 2003, and Medicaid spending is now on par with Medicare, thereby elevating the need for enhanced program integrity oversight. The HCFAC discretionary funds will be used to safeguard the new Medicare prescription drug benefit and MA plans against fraud and abuse, as well as to expand financial management oversight of the Medicaid program.

Reducing Erroneous Medicare Payments: The significant reduction in the Medicare fee-for-service error rate from 2005 to 2006 can be attributed largely to efforts through the Comprehensive Error Rate Testing (CERT) program to educate providers about problems with medical record documentation and methods to improve their accuracy and completeness. The CERT program tracks payment accuracy data at the contractor, provider, and service levels. When data reveal a pattern indicating a payment problem, CMS works with contractors to develop corrective action plans.

In 2006, CMS began measuring the accuracy of payments to MA plans and addressing potential risks. By reviewing monthly managed care payments, CMS can examine whether beneficiaries are eligible for a plan, how payments are made, and what happens when a beneficiary's enrollment is terminated. CMS is currently developing a comprehensive Part D oversight program, building on the successful fee-for-service approach. This program will build strong safeguards in areas of particular vulnerability such as eligibility, bidding process, and retail pharmacy fraud.

(dollars in millions)

	2008 President's Budget	Five Year 2008-2012
Medicare Legislative Proposals		
Foster Productivity and Efficiency in Medicare:		
Hospital Update at Market Basket (MB) -0.65% Annually Starting FY 2008	-720	-13,790
Skilled Nursing Facility Update at 0% in 2008 and MB -0.65% Annually Thereafter	-1,010	-9,210
Inpatient Rehabilitation Facility Update at 0% in 2008 and MB -0.65% Annually Thereafter	-230	-1,910
Hospice Payment Update at MB -0.65% Annually Starting FY 2008	-60	-1,140
Outpatient Hospital Update at MB -0.65% Annually Starting FY 2008	-120	-3,360
Ambulance Fee Schedule Update at CPI-0.65% Annually Starting FY 2008	-10	-360
Ambulatory Surgical Center Update at CPI-0.65% Annually Starting FY 2010	--	-90
Home Health Update at 0% from 2008-2012 and MB -0.65% Annually Thereafter	-410	-9,680
Introduce Competitive Bidding for Clinical Laboratory Services	-110	-2,380
Subtotal, Foster Productivity and Efficiency	-2,670	-41,920
Rationalize Medicare Payments and Subsidies:		
Eliminate Duplicate Hospital IME Payments for Medicare Advantage Beneficiaries	-381	-4,370
Eliminate Payments for Never Events	-30	-190
Establish Hospital Value-Based Purchasing Program (budget neutral)	--	--
Set Base Payment for 5 Post-Acute Conditions Treated in SNFs and IRFs	-470	-2,930
Establish 13-Month Rental Period for Power Wheelchairs	-70	-530
Reduce Rental Period for Oxygen Equipment from 36 to 13 Months	-110	-2,380
Extend Medicare Secondary Payer Status for ESRD from 30 to 60 Months	-160	-1,080
Subtotal, Rationalize Medicare Payments and Subsidies	-1,221	-11,480
Improve Program Integrity:		
Establish Federal Data Sharing Clearinghouse (Medicare Secondary Payer)	-50	-640
Phase-Out Medicare Bad Debt Payments Over 4 Years	-180	-7,150
Limit Use of Mandamus Jurisdiction to Obtain Judicial Review of Medicare Determinations	--	-80
Subtotal, Improve Program Integrity	-230	-7,870
Increase High-Income Beneficiary Responsibility for Health Care Costs:		
Eliminate Annual Indexing of Income-Related Part B Premiums (Benefit & Revenue Impact)	-543	-7,135
Establish Income-Related Part D Premium Consistent with Part B (Benefit & Revenue Impact)	-357	-3,242
Subtotal, Increase High-Income Beneficiary Responsibility	-900	-10,377
Improve Long-Term Sustainability:		
Apply -0.4% Sequester When Medicare Fund Warning is Triggered	--	--
Subtotal, Improve Long-Term Sustainability	--	--
Other/Interactions:		
1-Year QI Extension/Interactions Reducing Beneficiary Part B Premiums /1	750	6,030
Subtotal, Interactions	750	6,030
Total, Medicare Legislative Proposals	**-4,271**	**-65,618**
Medicare Administrative Proposals		
Improve Medicare Efficiency, Productivity, and Program Integrity	-1,000	-10,235
Total, Medicare Administrative Proposals	**-1,000**	**-10,235**
Total, Medicare Budget Proposals	**-5,271**	**-75,853**

1/ The $425 million Medicare effect of the QI extension proposal in FY 2008 is not scoreable for PAYGO purposes.