May 2025

A **NON-PARTISAN PROPOSAL** FROM **ASIPP** FOR

BUDGET RECONCILIATION

PRESERVING MEDICARE AND MEDICAID, AND REFORMING PHYSICIAN PAYMENT SYSTEM

AMERICAN SOCIETY OF INTERVENTIONAL PAIN PHYSICIANS
THE VOICE OF INTERVENTIONAL PAIN MANAGEMENT

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A Plan without Medicare or Medicaid Cuts

Total Savings of **$1.441 Trillion** over **10 years**. **Proposed Expenditures** of **$322 Billion**, Resulting in a **Total Net Savings** of **$1.119 Trillion**.

Alternate Plan

Total Savings of $1.69 Trillion over a Period of 10 Years with Proposed Expenditures of $322 Billion, Resulting in **Total Net Savings of $1.368 Trillion** Higher than $880 Billion Savings Required by Congress.

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ABOUT ASIPP

The American Society of Interventional Pain Physicians (ASIPP), established in 1998, is a non-profit professional organization that currently boasts a membership of over 4,500 interventional pain physicians and other practitioners. Its mission is to promote **safe, appropriate, fiscally neutral and effective pain management services** for patients nationwide who grapple with chronic and acute pain. The United States is home to approximately 8,500 proficient physicians with the requisite training and qualifications in interventional pain management. ASIPP is composed of 48 state societies of Interventional Pain Physicians, encompassing Puerto Rico, and includes the affiliated Texas Pain Society.

Interventional pain management is defined as, "the discipline of medicine devoted to the diagnosis and treatment of pain related disorders principally with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment." (The National Uniform Claims Committee. Specialty Designation for Interventional Pain Management- 09. http://www.cms.hhs.gov/transmittals/Downloads/r1779b3.pdf)

Interventional pain management techniques are defined as, "minimally invasive procedures including, percutaneous precision needle placement, with placement of drugs in targeted areas or ablation of targeted nerves; and some surgical techniques such as laser or endoscopic diskectomy, intrathecal infusion pumps and spinal cord stimulators, for the diagnosis and management of chronic, persistent or intractable pain". (Medicare Payment Advisory Commission. Report to the Congress: Paying for interventional pain services in ambulatory settings. Washington, DC: MedPAC. December 2001. https://permanent.fdlp.gov/lps21261/dec2001PainManagement.pdf)

For further information, visit our website: www.asipp.org

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EXECUTIVE SUMMARY

This non-partisan policy proposal outlines a budget reconciliation strategy focused on reforming physician payment, in accordance with the President's commitment not to reduce benefits under Medicare and Medicaid, which includes avoiding cuts to physicians and hospitals.

The American Society of Interventional Pain Physicians (ASIPP) proposes physician payment reforms with an associated cost of $322 billion. These reforms are coupled with projected savings from the Congressional Budget Office (CBO), including $229 billion from eliminating uncompensated care, $42 billion from eliminating bad debt, and $1.2 trillion in Medicare Advantage savings. These measures produce total savings of approximately $1.441 trillion, resulting in net savings of $1.119 trillion after accounting for the cost of physician payment reform.

Alternately, under the original proposal, CBO projects $490 billion in general savings including $146 billion for site neutral payment and $73 billion for 340B Drug Policy Program, along with $1.2 trillion in Medicare Advantage plan savings. This results in total savings of $1.69 trillion and net savings of $1.33 trillion after subtracting the $322 billion cost of physician payment reform.

Table 1. A non-partisan proposal for budget reconciliation of $880 billion over 10 years.

Savings **CBO Recommended and Congress Proposed**	**Costs of Physician Priorities**
• Site-neutral payments: $146 billion • 340B Drug Pricing Program: $73 billion • Elimination of uncompensated Care: $229 billion • Elimination of Bad Debt: $42 billion Total Savings: $490 billion	• Reforming Physician Payment System: $240 billion • Elimination of Sequestration Cuts: $62 billion • Telehealth Costs: $20 billion Total Costs of Proposed Policy Changes: $322 billion
Without Medicare & Medicaid Cuts	**With Cuts as Proposed Originally**
CBO/Congress Savings: $271 billion Other Savings from Medicare Advantage Plans: $1.2 trillion Total Savings: $1.441 trillion Physician Reform Costs: $322 billion Net Savings: $1.119 trillion	CBO/Congress Savings: $490 billion Other Savings from Medicare Advantage Plans: $1.2 trillion Total Savings: $1.69 trillion Physician Reform Costs: $322 billion Net Savings: $1.368 trillion

EXECUTIVE SUMMARY CONT.

Health care spending in the United States continues to escalate, reaching $4.9 trillion in 2023—a 7.5% increase from the previous year (1). Medicare remains a significant and rapidly expanding component of the federal budget. Estimates from the Medicare Payment Advisory Commission (MedPAC) (2), the Congressional Budget Office (CBO) (3), and other sources indicate that net Medicare spending—after accounting for beneficiary premiums—is projected to total $14 trillion over the next decade. The Medicare Hospital Insurance (HI) Trust Fund, which finances Part A and constitutes approximately 40% of Medicare and 20% of total national health spending, is projected to be depleted by 2036.

Simultaneously, the financial sustainability of physician practices is increasingly under pressure. Over the past 24 years, physician payment rates have declined by 33%, while practice costs have steadily risen (4) (Fig. 1). The cost of medical equipment, supplies, and technology has grown from $30.2 billion in 2017 to $57 billion in 2023, reflecting an average annual growth rate of 6.5%. In reality, the overall increase in practice expenses may be even greater, compounding the financial challenges faced by providers. Additionally, a widening gap has emerged: while physician payments have declined, other health care sector payments have continued to rise. Perhaps most striking is the contrast between insurance premium growth and physician reimbursement rates, with premiums increasing nearly 400% while physician payments have dropped by 33%.

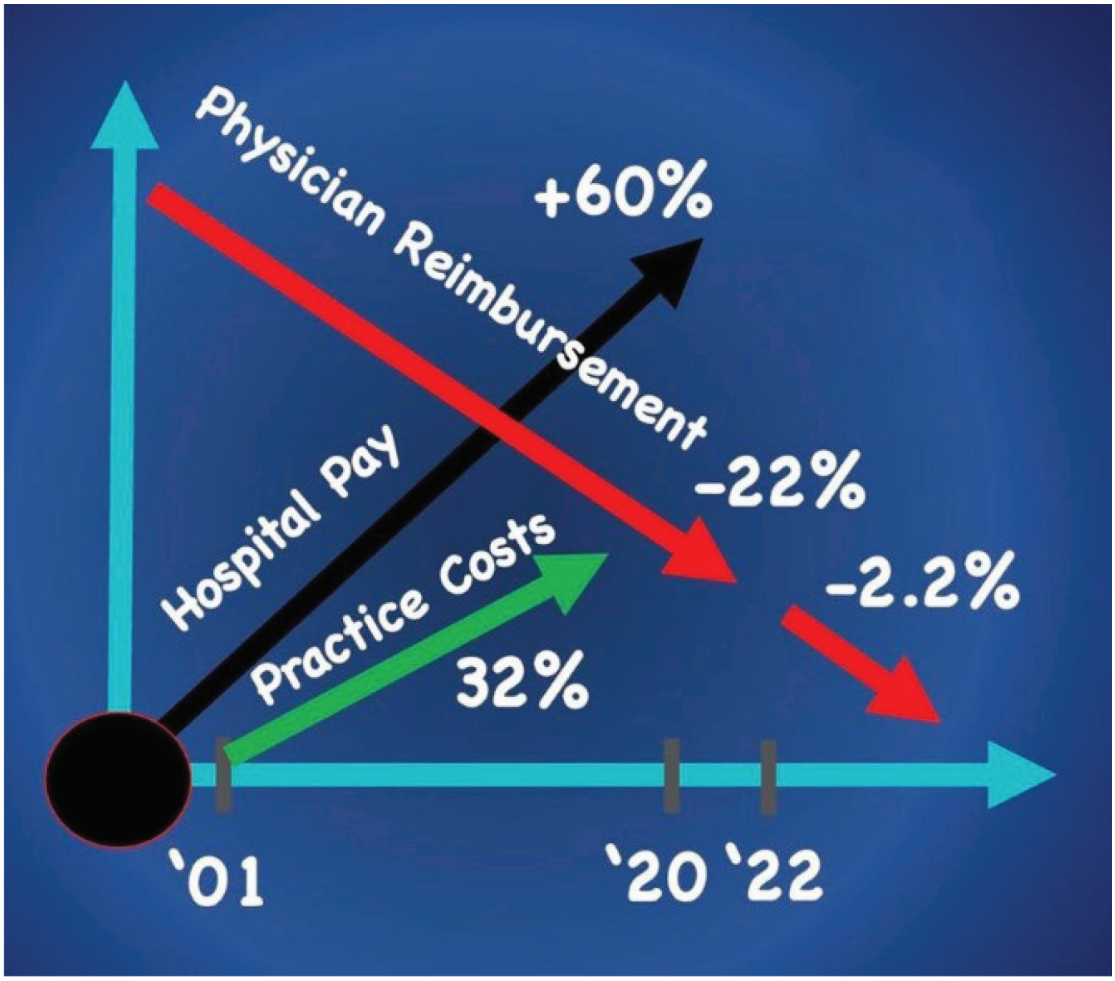

Fig. 1. Comparison of declining physician reimbursement compared to practice costs and hospital reimbursement.

Source: Green HA. The only four products of healthcare manufacture and produced with American patients. LinkedIn, January 14, 2023. https://www.linkedin.com/pulse/four-products-healthcare-manufactured-produced-howard-a-green-md/

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) released its final rule on physician payment policy (5), introducing several major changes. Notably, the rule eliminated certain telehealth services and implemented a 2.8% reduction in payments for physician services—an estimated annual cut of $20 billion.

These reductions stem from the expiration of temporary payment increases that had been used in recent years to mitigate previous conversion factor cuts: a 3.75% increase in 2021, followed by 3% in 2022, 2.5% in 2023, and a projected 2.93% for 2024. The final rule also upheld the 0% budget neutrality requirement, which continues to trigger conversion factor reductions.

Additionally, physicians remain subject to ongoing 2% sequestration cuts mandated by the Budget Control Act of 2011. These cuts, which are expected to persist through 2034, support funding for the Affordable Care Act (ACA) through automatic, across-the-board reductions in federal spending.

While physicians narrowly avoided an additional 4% reduction under the Statutory Pay-As-You-Go (PAYGO) Act of 2010—a law signed by President Obama requiring offsetting cuts for deficit-increasing legislation—this reduction could still be reinstated in the future.

In contrast to these ongoing cuts to traditional Medicare, CMS announced on January 10, 2025, a proposed 4.3% payment increase for Medicare Advantage plans (6). This increase is expected to amount to $21 billion in 2026 alone and approximately $210 billion over the subsequent decade. The proposal comes amid growing scrutiny over Medicare Advantage overpayments, which include an estimated $44 billion due to favorable selection, $40 billion from inaccuracies in risk adjustment, and $15 billion for care of veterans already covered under Veterans Administration (VA) benefits. Meanwhile, traditional Medicare beneficiaries are shouldering higher costs, contributing an additional $198 annually per beneficiary—totaling roughly $13 billion each year, according to the Medicare Payment Advisory Commission (MedPAC) (3). In fact, OIG-HHS requested Congressional action reform Medicare Advantage with $17 billion (7).

Meanwhile, Congress has so far failed to enact reforms to the physician payment system for 2025, with any possibility of retroactive adjustments still uncertain and unlikely. Despite growing concerns, lawmakers remain largely unwilling to address Medicare Advantage spending, instead authorizing CMS to continue increasing plan payments without implementing significant oversight or structural changes.

Amid this fiscal backdrop, the Trump administration and Congress have proposed $880 billion in potential federal savings over the next decade through the budget reconciliation process. These savings would target programs under the purview of the House Energy and Commerce Committee and the Senate Finance Committee, including Medicare, Medicare Advantage, Medicaid, and other federal health care initiatives such as the VA health system (8). However, these proposals have triggered intense partisan debate, with critics arguing that such savings equate to deep spending cuts that could adversely affect patients and impose added burdens on state budgets.

The Administration's stated objective for the Energy and Commerce Committee is to achieve $880 billion in savings over 10 years without reducing patient or provider benefits—focusing instead on eliminating waste, fraud, and administrative inefficiencies.

ASIPP's recommendations build upon previous analyses from MedPAC, CMS, OIG-HHS, and the CBO. While the CBO has proposed additional cost-saving strategies—such as Medicaid cuts—the current Energy and Commerce

EXECUTIVE SUMMARY CONT.

Committee proposal notably avoids reductions to Medicaid. Instead, it aims to achieve savings through other avenues, including $62 billion from continuing sequestration cuts, $146 billion via site-neutral payment reforms, $73 billion by restructuring the 340B drug pricing program, $229 billion from eliminating payments for uncompensated care, and $42 billion through the removal of bad debt reimbursements.

The largest projected savings are expected to result from proposed reforms to the Medicare Advantage program. Estimated savings from specific changes include:

1. **Cancellation of the proposed 4.3% payment increase for 2026:**
   $21 billion per year, or $210 billion over 10 years
2. **Elimination of payments for veterans already covered by VA insurance:**
   $15 billion per year, or $150 billion over 10 years
3. **Ending favorable selection practices:**
   $44 billion per year, or $440 billion over 10 years
4. **Reforming risk adjustment mechanisms:**
   $40 billion per year, or $400 billion over 10 years

Collectively, these measures would generate an estimated $120 billion in annual savings from the Medicare Advantage program—totaling $1.2 trillion over a 10-year period.

By incorporating targeted adjustments—such as implementing physician payment reforms and reversing sequestration cuts—while preserving key recommendations from MedPAC (2), the CBO (3), and maintaining alignment with the goals of the House Energy and Commerce Committee, it is possible to meaningfully reform the physician payment system without reducing Medicaid funding. This strategy remains viable within the constraints of the current budget reconciliation framework.

Assuming the President's position of avoiding direct Medicare or Medicaid cuts remains unchanged, savings from site-neutral payment reforms ($146 billion) and restructuring the 340B drug pricing program ($73 billion), totaling $219 billion, may be excluded from the final budget package. This would remove $271 billion in potential savings from the CBO and congressional projections. However, if offsetting reforms—such as eliminating payments for uncompensated care ($229 billion) and removing bad debt reimbursements ($42 billion)—are retained, total savings would still amount to $1.441 trillion. After accounting for excluded savings, the net savings would be $1.119 trillion, which is sufficient to meet the $880 billion budget target (Table 1).

Alternatively, if the proposed hospital-related reforms, including the $146 billion from site-neutral payments and $73 billion from 340B restructuring, are maintained, these would contribute $219 billion in additional savings. Combined with the CBO-recommended and Congress-proposed measures, this would yield total projected savings of $1.69 trillion, resulting in net savings of approximately $1.368 trillion. A detailed breakdown of these projections is provided in Table 1.

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THANK YOU ONCE AGAIN FOR YOUR CONSIDERATION.

If you have any questions, please feel free to contact us one of us:
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FACT SHEET #1

REFORMING MEDICARE ADVANTAGE PLANS: BALANCING THE BUDGET, SAVING MEDICARE, AND IMPROVING PATIENT CARE

HIGHLIGHTS OF THE ISSUES

1. According to estimates from MedPAC, the CBO, and other sources, Medicare is one of the largest and fastest-growing components of the federal budget. Over the next decade, Medicare spending—net of premiums—is projected to reach $14 trillion. The Medicare Hospital Insurance (HI) Trust Fund, also known as "Part A," which accounts for about 40% of the program or 20% of total spending, is expected to become insolvent by 2036.

2. On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) proposed a 2.8% reduction in physician payments while simultaneously recommending a 4.3% increase on January 10, 2025 in payments to Medicare Advantage Plans for the 2026 calendar year. This increase equates to approximately $21 billion in a single year or $210 billion over a decade.

3. Excessive payments to Medicare Advantage plans now exceed $110 billion a year, or $1.2 trillion over a period of 10 years.

4. The higher payments to Medicare Advantage plans increase $198 more in annual Part B premiums for all beneficiaries, including those in fee-for-service (FFS) Medicare, estimated by MedPAC as $13 billion per year.

5. Despite extensive evidence from both press reports and peer-reviewed publications highlighting issues such as inappropriate utilization, unwarranted denials of services, lower quality of care, excessive copays and deductibles, as well as widespread fraud and abuse, Medicare Advantage Plans continue to receive preferential treatment.[1-14]

BUDGETARY SAVINGS

According to multiple publications and Congressional Budget Office estimates, potential budgetary savings include:

- $21 billion annually by canceling the proposed 4.3% payment increase for 2026, leading to $210 billion in savings over a decade.
- $15 billion per year without corresponding payments, insuring veterans already insured and covered by VA system, saving $150 billion over 10 years.
- $40 billion per year from risk adjustment reforms, amounting to $400 billion over a decade.
- $44 billion annually by eliminating favorable selection, totaling $440 billion over 10 years.

KEY POINTS

1. **Excessive Payments to Medicare Advantage Plans:** In its March 2025 Report to Congress, MedPAC reported that payments to Medicare Advantage (MA) plans were 22% higher than traditional Fee-for-Service (FFS) spending.
   - Administrative costs and profits account for 14% of MA plan expenditures, negating cost efficiencies.
   - Excess MA payments over FFS total $84 billion annually, with an additional $15 billion (3.2%) allocated for quality bonuses each year.
   - $21 billion per year by canceling the proposed 4.3% payment increase for 2026, leading to $210 billion in savings over 10 years.
   - $15 billion per year without corresponding payments, insuring veterans already insured and covered by VA system, saving $150 billion over 10 years.
   - $44 billion per year by eliminating favorable selection, totaling $440 billion over 10 years.
   - $40 billion per year from risk adjustment reforms, amounting to $400 billion over 10 years.

2 **Excessive Cost to All Medicare Recipients:** The relatively higher payments to MA plans are financed by the taxpayers and beneficiaries who fund the Medicare program.

   Higher MA spending increases Part B premiums for **all beneficiaries**, **including those in fee-for-service (FFS) Medicare**. MedPAC estimated that Part B premium payments will be about $13 billion higher in 2025 because of the higher Medicare payments to MA plans (equivalent to roughly $198 per beneficiary per year).

   In summary, each Medicare recipient is paying almost $200 more in plan payments per year to pay for Medicare Advantage plans of $13 billion.

3. **Escalating Out-of-Pocket Costs:** The out-of-pocket maximum for Medicare Advantage Plans has surged dramatically, rising from $976 in 1999 to $8,850 for in-network services (a 792% increase) and $13,300 for combined in-network and out-of-network services (a 1,262% increase) in 2024 (Fig. 1).

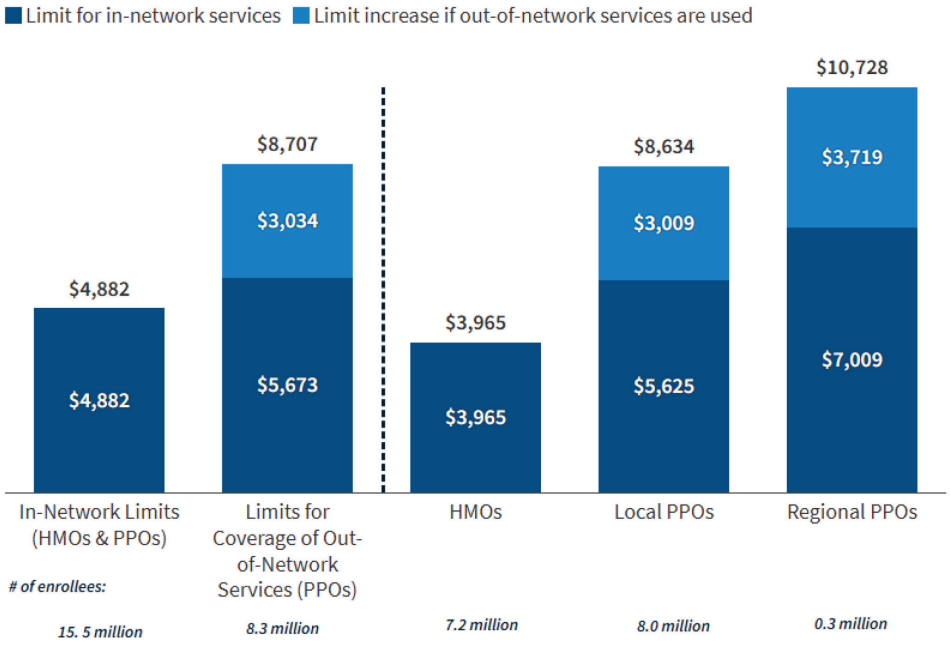

Fig. 1. Average Medicare Advantage Plan Out-of-Pocket Limits, Weighted by Plan Enrollment, 2024.

Source: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/#

3. A Wall Street Journal investigation published on December 2, 2024, revealed that Medicare Advantage Plans received $44 billion in payments from 2018 to 2021, averaging $15 billion per year—funds that were unnecessary and often unused by insurers. (Marmount M, et al. Insurers Collected Billions From Medicare for Veterans Who Cost Them Almost Nothing. The Wall Street Journal, December 2, 2024.)

4. A November 11, 2024, Wall Street Journal investigation found that the sickest patients are leaving private Medicare plans, shifting costs to taxpayers. Patients in their last year of life were far more likely to switch to traditional Medicare, transferring expenses from insurers to the federal government. (Mathew AW, et al. The Sickest Patients Are Fleeing Private Medicare Plans – Costing Taxpayers Billions. The Wall Street Journal, November 11, 2024.)

5. **Excessive Patient Costs:** Out-of-pocket expenses for Medicare Advantage enrollees can reach $300 per visit, often exceeding the reimbursement rates for interventional pain physicians and ambulatory surgery centers.

6. **Rising Enrollment in Medicare Advantage:** Medicare Advantage Plans now cover 32.8 million beneficiaries (54% of eligible Medicare enrollees)—a sharp increase from 6.9 million (16%) in 2014, representing a 120% growth. Enrollment rose by 6% from 2023 to 2024 alone (Fig. 2).

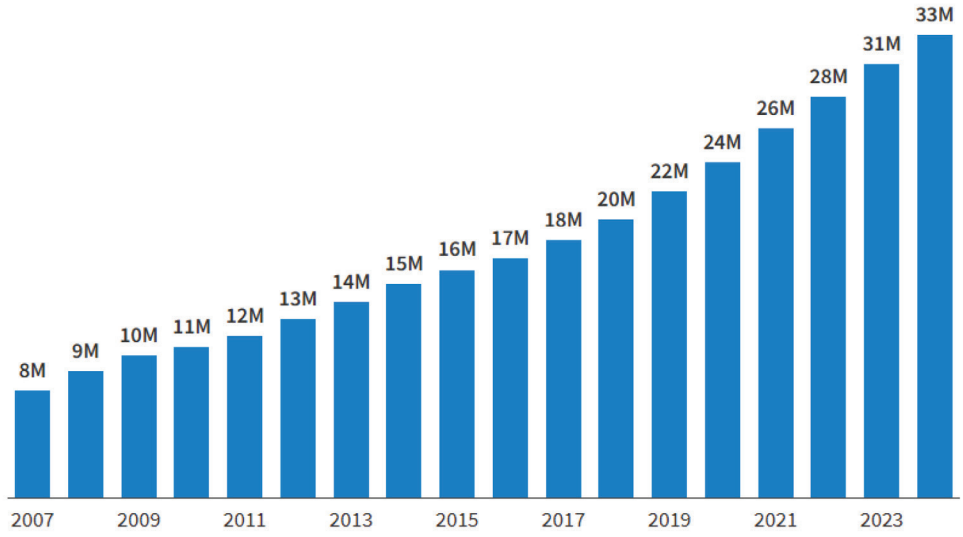

Fig. 2 . Total Medicare Advantage Enrollment, 2007-2024.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files

7. **Quality in Medicare Advantage Plans:** Medicare Advantage (MA) plans are often marketed as innovative programs designed to deliver higher-quality care at lower costs with additional benefits. However, these advantages are diminishing rapidly.

MedPAC has determined that the current Medicare Advantage quality reporting and measurement system is flawed, failing to provide a reliable basis for evaluating quality across plans. Despite these flaws, various quality measures serve as the basis for the Medicare Advantage Quality Bonus Program (QBP), which increases MA payments by approximately $15 billion annually. Studies comparing beneficiary experiences in MA and traditional Fee-for-Service (FFS) programs indicate no significant difference in overall quality. Some research suggests that complication rates may be higher in Medicare Advantage plans compared to traditional Medicare.

8. **Coverage Requirements:** Medicare Advantage Plans are required to provide a benefit package equivalent to traditional Medicare, ensuring coverage for all Medicare-approved services.

POLICY PROPOSALS

To preserve Medicare and ensure appropriate patient access under Medicare and Medicare Advantage Plans, Congress should adopt the following recommendations, as proposed by the Congressional Budget Office (CBO), MedPAC, and other policy groups:

1. Utilize Budgetary Savings
    - $21 billion per year by canceling the proposed 4.3% payment increase for 2026, leading to $210 billion in savings over 10 years.
    - $15 billion per year without corresponding payments, insuring veterans already insured and covered by VA system, saving $150 billion over 10 years.
    - $40 billion per year from risk adjustment reforms, amounting to $400 billion over 10 years.
    - $44 billion per year by eliminating favorable selection, totaling $440 billion over 10 years.

2. Align Medicare Advantage payments with Fee-for-Service (FFS) Medicare and use the savings to offset sequester cuts.

3. Provide opportunities legislating reasonable and easy availability of co-insurance.

4. Cap copays and deductibles at $100 per occurrence.

5. Enforce Medicare Coverage Requirements: Medicare Advantage Plans must fully cover all Medicare-approved services, as mandated by law.
    - Standardize Local Coverage Determinations (LCDs): Require all Medicare carriers to issue LCDs for requested procedures, ensuring uniformity.

6. Prevent Overreach by Medicare Carriers: Prohibit Medicare carriers from issuing non-coverage policies—these decisions should be made exclusively by CMS through the Medicare Coverage Advisory Committee (MCAC).

MEDICARE ADVANTAGE: A GROWING CONCERN

The Balanced Budget Act (BBA) of 1997 originally established Medicare's managed care program as Medicare+Choice, which was later renamed Medicare Advantage under the Medicare Modernization Act (MMA) of 2003. Despite payment reductions enacted by the Affordable Care Act (ACA) of 2010, Medicare Advantage enrollment continues to rise. However, MA plans have exploited the system to significantly increase out-of-pocket costs, which have surged from $976 in 1999 to over $6,800 in 2019—a 600% increase. These rising expenses are in addition to cost-sharing requirements for Part B drug benefits.

Excessive Payments to Medicare Advantage Plans: In 2024, Medicare Advantage (MA) payments are estimated to be 22% higher than traditional Fee-for-Service (FFS) Medicare spending. MA benchmarks are set at 132% of FFS spending, while plan bids average 101%. Administrative costs and profits account for 14% of MA plan expenditures, eliminating any cost efficiencies. Excess MA payments over FFS total $83 billion, with an additional $15 billion (3.2%) allocated for quality bonuses (Fig. 3).

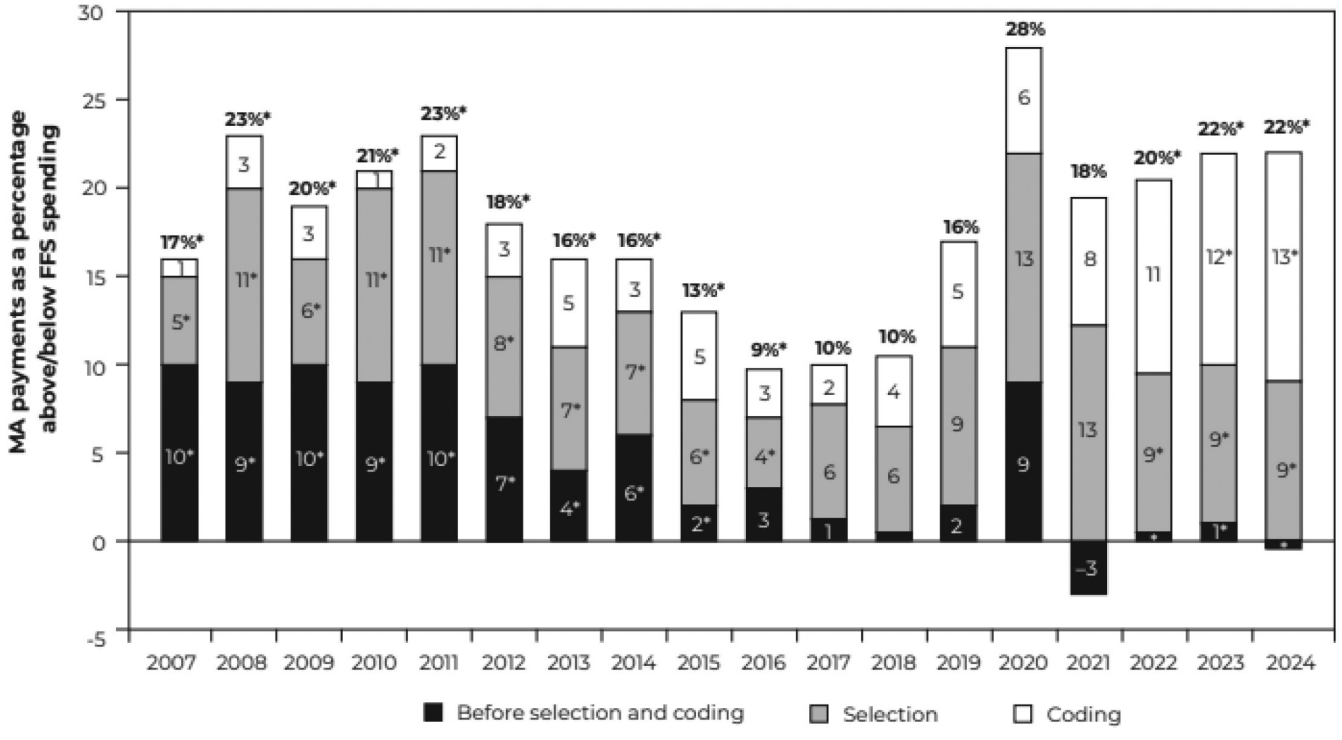

Fig. 3. Higher MA payments relative to what estimated spending would have been in FFS, 2007-2024.

Source: MedPac Report to the Congress: Medicare Payment Policy, March 2024

FACT SHEET #1 CONT.

Since the enactment of the Affordable Care Act (ACA), Medicare Advantage enrollment has surged by 71%, covering 34% of Medicare beneficiaries (20.4 million) by 2018 and reaching 54% by 2024 (Fig. 2). Enrollment rates vary significantly across states, ranging from 2% to 63%. 30 states now report Medicare Advantage enrollment exceeding 50% of total Medicare beneficiaries (Fig. 4).

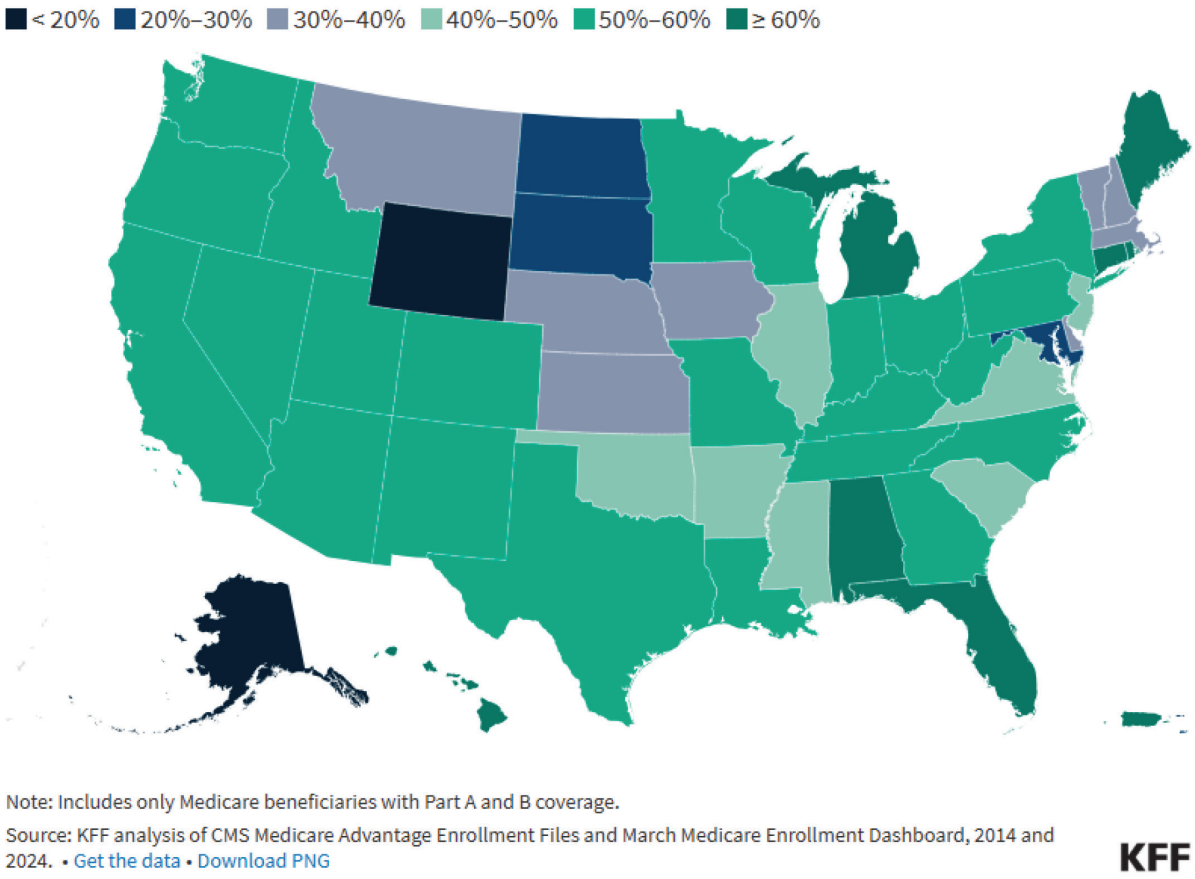

Fig. 4. Share of beneficiaries enrolled in Medicare Advantage in 2024, by state.

MEDICARE ADVANTAGE BENEFIT PACKAGE & COST LIMITATIONS

- Medicare Advantage Plans must provide a benefit package that is at least equivalent to Medicare's.
- Out-of-pocket costs for Parts A and B have risen significantly
- $976 in 1999
- $8,707 in 2024, representing a 792% increase since 1999

ISSUES IN INTERVENTIONAL PAIN MANAGEMENT (IPM)

Denial of Access: Medicare Advantage Plans frequently deny procedures without proper justification. Congress must intervene to ensure that all Medicare-covered services are included in Medicare Advantage Plans, as mandated by law.

Unauthorized National Coverage Determinations (NCDs): Certain Medicare Administrative Contractors (MACs), such as Noridian and Palmetto, have issued inappropriate National Coverage Determinations (NCDs) beyond their authority. These policies restrict procedures like percutaneous adhesiolysis, despite strong clinical evidence supporting their safety and effectiveness.

UNJUSTIFIED DENIALS AND REIMBURSEMENT ISSUES

Medicare Advantage Plans frequently deny coverage using the following justifications:

- Classifying treatments as “experimental” or “investigational”
- Citing the absence of Local Coverage Determinations (LCDs)
- Denying appeals and referring providers to generic online resources
- Ignoring contractual obligations and forcing providers out of network

MEDICARE ADVANTAGE PLANS: COMPLIANCE WITH FEDERAL LAW

As outlined in Chapter 4 of the Medicare Managed Care Manual, failure to provide required services constitutes discrimination under federal law, including the Affordable Care Act (ACA), Civil Rights Act, Age Discrimination Act, Americans with Disabilities Act (ADA), and the Genetic Information Nondiscrimination Act.

Medicare Advantage Organizations (MAOs) are prohibited from denying or conditioning enrollment based on factors such as health status, claims history, genetic information, or source of payment. Violations of these policies can result in legal consequences for Medicare Advantage Plans that discriminate against beneficiaries requiring specialized care.

LACK OF LOCAL MEDICARE COVERAGE POLICIES (LCDS)

- Local Coverage Determinations (LCDs) are not required for every procedure and apply only to high-volume, high-cost services.
- Despite numerous provider requests, many procedures remain uncovered due to the absence of LCDs, forcing providers to either absorb costs or deny essential services to patients.
- Medicare Fee-for-Service programs reimburse these procedures without LCDs, highlighting the inconsistency in Medicare Advantage’s reimbursement policies.

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FACT SHEET #2
SITE NEUTRAL PAYMENT SYSTEM

BUDGETARY IMPACT

SITE-NEUTRAL PAYMENT SAVINGS

- $160 billion in savings according to CBO estimates.
- $146 billion in savings from 2026 to 2035, based on the Policy Explainer for Spending Reform Options.
- A realistic overall savings estimate of $146 billion over 10 years, as outlined in the Policy Explainer for Spending Reform Options.

KEY POINTS

1. Hospital consolidation has surged over the last 30 years, leading to a rise in mergers, acquisitions, and physicians employed by hospitals.[1],[2] This trend has driven the formation of large mega health systems, resulting in highly concentrated markets with little meaningful competition.[3-4]
2. Medicare typically pays more for the same service when provided in a hospital outpatient department (HOPD) versus other settings, such as a physician's office or an ambulatory surgical center. Research has found that these payment differentials by site-of-care create incentives to consolidate health care markets.[5]
3. The literature shows that hospital consolidation has significantly increased health care costs and inefficiencies for patients and primary payers while essentially reducing access.[6-8]
4. Patients often face higher insurance and out-of-pocket costs, restricted choices and access to providers and clinic locations, and greater administrative barriers due to administrative complexities.[9]

SITE-NEUTRAL PAYMENT POLICIES

Congress has enacted a partial Medicare policy proposal incorporating "site-neutral payment" legislation, ensuring certain HOPDs receive the same reimbursement as independent physician practices. However, Congress, MedPAC, OIG, and CBO advocate for expanding this policy to all HOPDs. If fully implemented beginning in 2026, this expansion could generate an estimated $157 billion in savings over 10 years.

IMPLEMENT SITE-NEUTRAL PAYMENT POLICIES

- Legislate total site payment parity. Eliminate the "grandfathering" exception in Section 603 of the Bipartisan Budget Act of 2015, ensuring the site-neutral payment policy applies to all hospital-owned sites of care located off-campus from the main hospital. Reimbursement will be aligned with independent physician office rates under the Medicare Physician Fee Schedule (MPFS).

- Ban all facility fees for hospital off-campus outpatient departments. Prohibit hospital-owned off-campus outpatient departments from charging additional facility fees, thereby lowering costs for both patients and payers.
- Bundle and align radiation therapy technical payments at the hospital outpatient rate.
- Reduce payments to HOPDs to align with ambulatory surgery center (ASC) rates for certain services, as recommended in the MedPAC 2022 Report to Congress.[10]
- Expand site-neutral payment policies within Medicare, covering both Medicare Fee-For-Service (FFS) and Medicare Advantage (MA), as well as Medicaid, to enhance cost efficiency and payment equity.

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FACT SHEET #3
340B DRUG PROGRAM SPENDING

BUDGETARY IMPACT

ESTIMATED SAVINGS

- $73.5 billion from 2026 through 2035[1, 2]

THE 340B PROGRAM HAS GROWN ENORMOUSLY DRIVING CONSOLIDATION AND COSTS

The 340B program has experienced explosive growth in recent years, with no signs of slowing. A Congressional Budget Office (CBO) analysis found that 340B drug spending surged from $6.6 billion in 2010 to $43.9 billion in 2021. Seventy-three percent of this growth is attributed to spending on cancer drugs, anti-infectives, and immunosuppressants.[2] These high-cost drugs generate substantial margins for hospitals, further driving consolidation. However, a lack of legislative oversight has inadvertently created opportunities for hospitals and vertically integrated PBM pharmacies to exploit the program's well-intentioned framework, contributing to its exponential growth.

In a recent report, the Health Resources and Services Administration (HRSA), which oversees the 340B program, revealed that discounted 340B drug purchases reached a record $66.3 billion in 2023—representing a 24 percent year-over-year increase (Figure 1).[3-5] The report also found that sales for the top 10 340B drugs accounted for nearly one-third of all 340B purchases. Additionally, an Avalere analysis comparing 340B spending to Medicare spending showed that sales for the top 10 340B drugs exceeded those same drugs' sales in Medicare.[6]

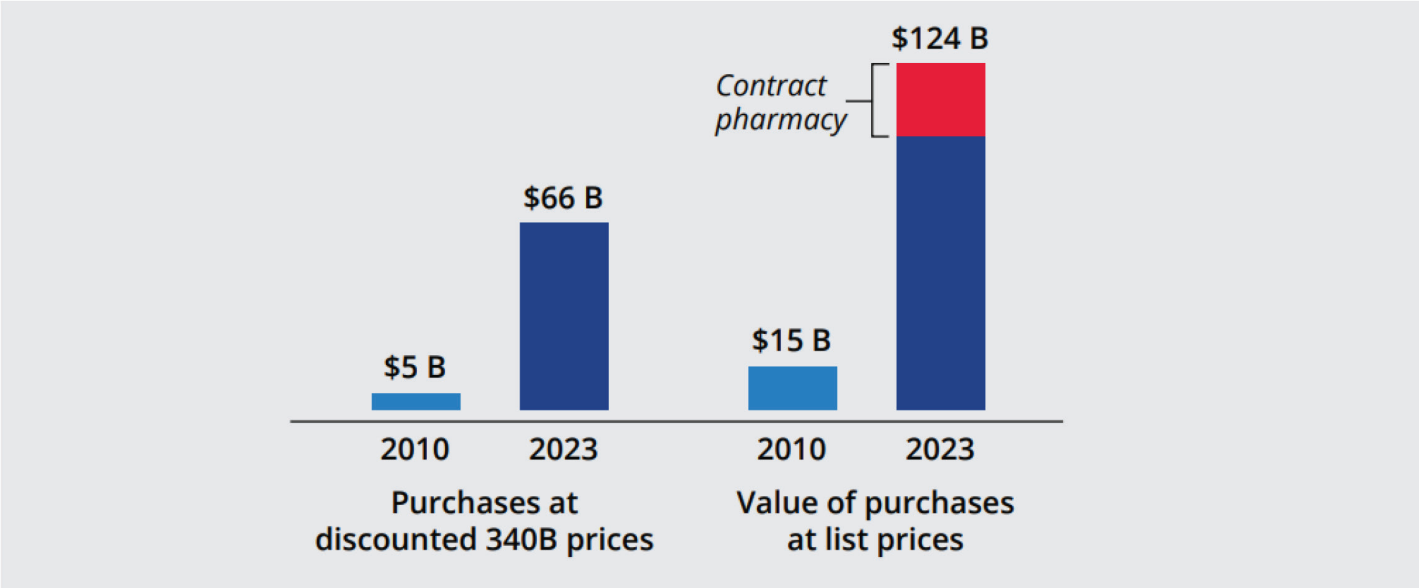

Fig. 1. 340B Drug pricing program, purchases by covered entities.[5]

Source: COA Prescription for Health Care Reform: A Policy Blueprint for Congress, from Community Oncology Alliance, February 2025.[1-3]

Growing evidence indicates that many hospitals exploit the 340B program by acquiring drugs at steep discounts and generating significant profits. Originally designed to support a limited number of safety-net hospitals, the program has expanded to include thousands of covered entities, generating billions in revenue for hospitals.[7] This expansion has led to unintended consequences that negatively impact patients and the broader health care system, driving up prices and accelerating market consolidation.

Hospitals participating in 340B profit from the spread between the drug acquisition cost—discounted to the 340B ceiling price or even lower—and the reimbursement rate. Notably, 340B hospitals are not required to pass these savings on to patients.

340B HOSPITALS PROVIDE INADEQUATE CHARITY CARE

There is limited evidence to suggest that 340B hospitals are increasing care for underserved populations or using the revenue for charitable purposes. A 2021 study found no evidence that hospitals participating in the 340B program provided more care to underserved populations than those not involved in the program, which is the core justification for receiving 340B discounts.[7] Additionally, a 2019 analysis of charity care data from hospitals in the fiscal year (FY) 2017 Medicare cost reports revealed that many 340B hospitals continue to fall short of Congress' expectations for providing care to vulnerable patients. While some 340B hospitals offer significant charity care, nearly one-third (29 percent) of 340B Disproportionate Share Hospitals (DSH) report charity care that accounts for less than one percent of total patient care costs.[8] A 2024 study on charity care in U.S. nonprofit hospitals highlighted significant variation in hospital financial assistance requirements (including extensive paperwork, inconsistent income limits, and residency requirements), creating considerable barriers to equitable access to care.[9]

It is important to note that many smaller rural hospitals use 340B as intended to benefit patients in need and rely on the program for financial viability. However, it is primarily the large mega hospital systems that are exploiting the program, which harms smaller 340B providers, such as rural hospitals, community health centers, and other 340B grantees.

THE 340B PROGRAM'S NEGATIVE IMPACT TO PATIENTS, HEALTH CARE COSTS, AND THE HEALTH CARE SYSTEM

The transition of cancer care from independent community oncology practices to hospital outpatient settings has proven costly for both patients and the health care system. Medicare Part B spending is higher in 340B Disproportionate Share Hospitals (DSH) compared to non-340B hospitals, indicating that there is a strong financial incentive for 340B hospitals to prescribe more drugs or higher-cost drugs to Medicare beneficiaries.[9] This unnecessary spending has negative consequences, not only for the Medicare program but also for Medicare beneficiaries, who face higher copayments due to receiving more drugs or more expensive treatments.

POLICY PROPOSAL AND ESTIMATED SAVINGS

BACKGROUND

In 2018, CMS implemented a policy that significantly reduced Medicare reimbursement rates for 340B outpatient drugs, from average sales price (ASP) plus six percent to ASP minus 22.5 percent. The policy aimed to better align Medicare's payments with the actual prices hospitals paid for 340B drugs, reducing what CMS viewed as excessive drug margins. Legal challenges led to the reversal of the policy, restoring the payment rate to ASP plus six percent, where it remains today.

FACT SHEET #3 CONT.

A 2024 CBO report estimates that if the ASP minus 22.5 percent payment rate for 340B drugs were implemented in January 2026, the policy would save approximately $24.2 billion from 2025 through 2029 and $73.5 billion from 2025 through 2034.[3]

In practice, the potential savings from 340B reforms are much higher. CMS conducted a survey with 340B hospitals in 2020, publishing the results in the 2021 HOPPS proposed rule. The survey found that the average acquisition cost discount for 340B drugs was 34.7 percent (a conservative estimate, according to CMS). To align reimbursement with the average acquisition cost, CMS would need to pay for Part B 340B drugs at ASP minus 28.7 percent (ASP minus 34.7 percent from the survey results plus the six percent add-on).

Implementing this lower 340B payment rate would result in savings of $93.8 billion to Medicare from 2026 through 2035. These savings would also benefit Medicare beneficiaries.

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FACT SHEET #4

MAINTAINING THE ACCESS TO TELEHEALTH SERVICES: CRUCIAL SERVICE FOR ELDERLY AND RURAL POPULATION

BUDGETARY IMPACT

The CBO estimated the cost of telehealth at $2 billion per year, totaling $20 billion from 2026 to 2035. With the inclusion of this language in the continuing resolution, the issue is temporarily addressed for the next six months.

COST OFFSET

From savings as proposed

KEY POINTS

1. For CY 2025, Medicare and Medicaid payment policies under the physician fee schedule will largely eliminate audio and video telehealth services after September 30, 2025. Stricter regulations will be enforced, requiring elderly individuals in rural areas to visit another medical office for telehealth appointments—an impractical and unrealistic requirement.
2. Telehealth, utilizing both audiovisual and audio-only methods, has been widely used across various specialties and family care settings for managing acute and chronic medical conditions, including chronic pain, with significant benefits for patients in rural areas.
3. Telehealth utilization has varied among specialties, with approximately 9% of pain medicine consultations conducted via telehealth in 2023, compared to about 38% for mental health services.
4. Surveys indicate that telehealth is used 60% of the time through video for visualization and 40% through audio-only communication.
5. No studies have demonstrated any significant fraud or abuse in telehealth services.
6. Studies have shown that patient outcomes from telehealth visits are equivalent to those from in-person visits. A recent survey found that 83% of patients expect to use virtual appointments in the future.
7. Another survey revealed that 20% of patients would switch doctors if telehealth options were not available with their current provider.
8. Telehealth is used more frequently by the most vulnerable populations.

9. Telehealth is convenient, cost-effective, and saves families time by eliminating the need to drive patients to medical appointments.
10. Medicare and Medicaid patients, particularly those in rural areas, use telehealth services far more often than urban patients with commercial insurance.
11. Telemedicine helps reduce delays in chronic therapy maintenance by allowing patients to continue their visits even when affected by communicable illnesses like influenza, COVID-19, or viral gastroenteritis.

POLICY PROPOSALS

Extend the telehealth regulations implemented during the pandemic for 10 years, at a cost of $2 billion per year, totaling $20 billion over the decade.

TELEHEALTH SERVICES

Telehealth services have become a crucial part of modern medical practice, especially since the COVID-19 pandemic. They provide numerous benefits to patients, helping to address issues like transportation barriers, missed work for caregivers, and financial strains. Medicare has played a key role in expanding access to telehealth, benefiting not only rural Americans but also the broader population, as most insurers—except United Healthcare Commercial—have adopted these policies.

However, under the Final Rule, CMS has announced that audio and video telehealth services will be nearly eliminated after March 31, 2025, with the introduction of strict and burdensome regulations.

The new rule requires that:

Starting October 1, 2025, a patient must be in an office or medical facility located in a rural area (within the U.S.) for most telehealth services. However, if a patient is in a rural health care setting, they can still receive certain Medicare telehealth services on or after April 1, including:

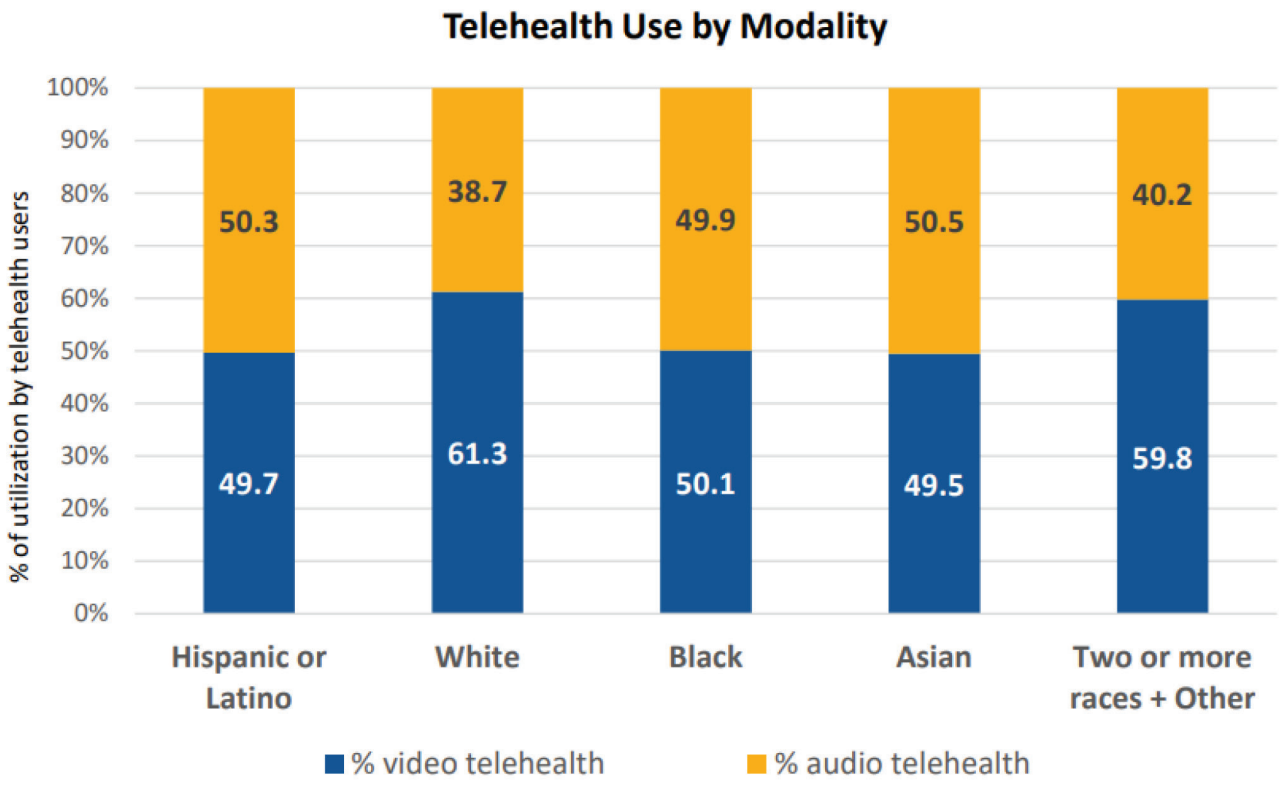
- Monthly End-Stage Renal Disease (ESRD) visits for home dialysis
- Services for the diagnosis, evaluation, or treatment of acute stroke symptoms, wherever the patient is located, including in a mobile stroke unit
- Services for the diagnosis, evaluation, or treatment of a mental and/or behavioral health disorder (including a substance use disorder) in the patient's home

This regulation effectively eliminates the benefits of telehealth services, whether through a combination of audio and video or audio-only options. As a result, this policy will disrupt medical practice and significantly limit access to telehealth services. Approximately 20% of patients currently rely on telehealth, and commercial insurers are already preparing to reduce reimbursements or eliminate coverage altogether, in line with this approach. These changes will create considerable challenges for all patients.

TELEHEALTH USAGE

As shown in the table, 25.5% of Medicare beneficiaries and 26.8% of Medicaid recipients utilized telehealth services, compared to 19.2% of those with private insurance and 23.1% of those with other health insurance.

As illustrated in the figure, about 60% of telehealth usage is through video, while 40% is through audio-only.



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FACT SHEET #5

REFORMING MEDICARE PAYMENT SYSTEM FOR PHYSICIANS WITH ELEMINATION OF SEQUESTER CUTS

REFORMING THE PHYSICIAN PAYMENT SYSTEM

The H.R.879 Medicare Patient Access and Practice Stabilization Act of 2025 is estimated to cost $200 billion over a decade. This legislation aims to reverse recent Medicare cuts, providing immediate financial relief to stabilize medical practices and preserve patient access.

ELIMINATION OF SEQUESTER CUTS

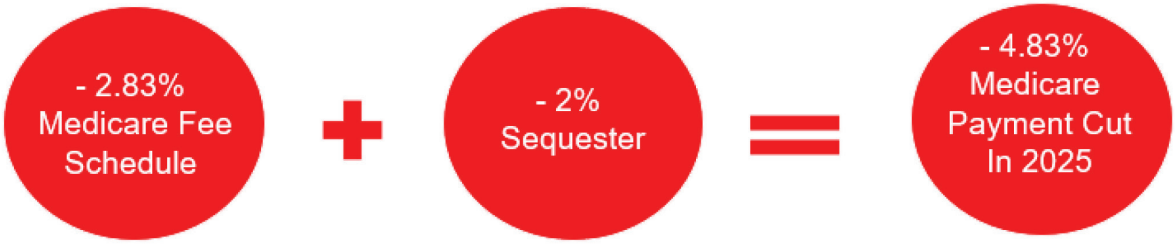
The estimated cost of reforming sequester cuts is $62 billion over a 10-year period.

COST OFFSET

From savings as proposed

KEY POINTS

1. The Centers for Medicare and Medicaid Services has implemented a 2.83% reduction in payments for services under the Medicare Physician Fee Schedule in 2025.
2. The Medicare sequestration of 2% has been extended until 2032.
3. The PAYGO cuts of 4% have been suspended until 2026.



POLICY RECOMMENDATIONS

1. Implement H.R.879:
   - Implementing an annual, permanent inflationary update in Medicare, linked to the Medicare Economic Index
   - Reforming budget neutrality policies
   - Overhauling MACRA's Merit-based Incentive Payment System (MIPS)
2. Eliminate the 2% sequester cuts.
3. Eliminate future PAYGO cuts of 4%.

MEDICARE PHYSICIAN FEE SCHEDULE CUTS = 2.83%

1. The Centers for Medicare and Medicaid Services has implemented a 2.83% reduction in payments for services under the Medicare Physician Fee Schedule in 2025.
2. The cuts encompass the expiration of temporary payment increases, including a +3.75% increase for 2021, a 3% increase for 2022, a 2.5% increase for 2023, and a 2.93% increase for 2024.
3. The cuts also include a 0.0% budget neutrality adjustment and a preemptive adjustment of 2.83% to the conversion factor in 2025.
4. Medicare physician payments have been reduced by 33% when adjusted for inflation from 2001 to 2025. A statutory freeze on annual Medicare physician payment updates is set to continue until 2026, after which updates will resume at a rate of 0.25% per year indefinitely, which is below inflation rates.
5. These cuts do not include the 2% sequester cuts, which are scheduled to last until 2033 and are proposed to be extended through 2034.

MEDICARE SEQUESTRATION = -2%

1. The Budget Control Act of 2011 mandated automatic, across-the-board reductions in federal spending, commonly referred to as sequestration.
2. On March 1, 2013, President Obama issued a sequestration order.
3. Due to the COVID-19 pandemic, Medicare sequestration was temporarily postponed from May 2021 through March 2022. A -1% Medicare payment reduction was implemented from April 2022 through June 2022, followed by a -2% reduction that has been in effect since 2022 and is set to continue until 2033, with a proposed extension through 2034.
4. The Protecting Medicare and American Farmers from Sequester Cuts Act affects payments for all Medicare fee-for-service claims.

PAYGO = -4%

1. President Obama signed the Statutory Pay-As-You-Go (PAYGO) Act of 2010, which mandates across-the-board cuts to certain types of mandatory federal spending if new legislation increases the deficit. However, a PAYGO sequester has never been implemented, as Congress has consistently acted to waive the reductions.
    - Since its enactment, Congress has waived PAYGO each time.
2. The American Rescue Plan Act, a COVID-19 relief bill passed in 2021, triggered a reduction due to $1.9 trillion in spending.
3. The Office of Management and Budget determined that the increased spending should be offset by a -4% reduction in Medicare spending. Under PAYGO, Medicare payments cannot be cut by more than 4%.

FACT SHEET #5 CONT.

4. If Congress does not intervene, a sequestration order will be issued within 15 days of the end of the congressional session, leading to a -4% reduction in Medicare reimbursement starting in 2026.

MEDICARE PHYSICIAN PAYMENT REFORM

1. Medicare physician pay has plummeted since 2001

The rising inflation rate is making it increasingly challenging for physician practices to remain financially viable. Payment rates have failed to keep pace, decreasing by 33% over the past 24 years. This decline threatens both patient access and the quality of care.

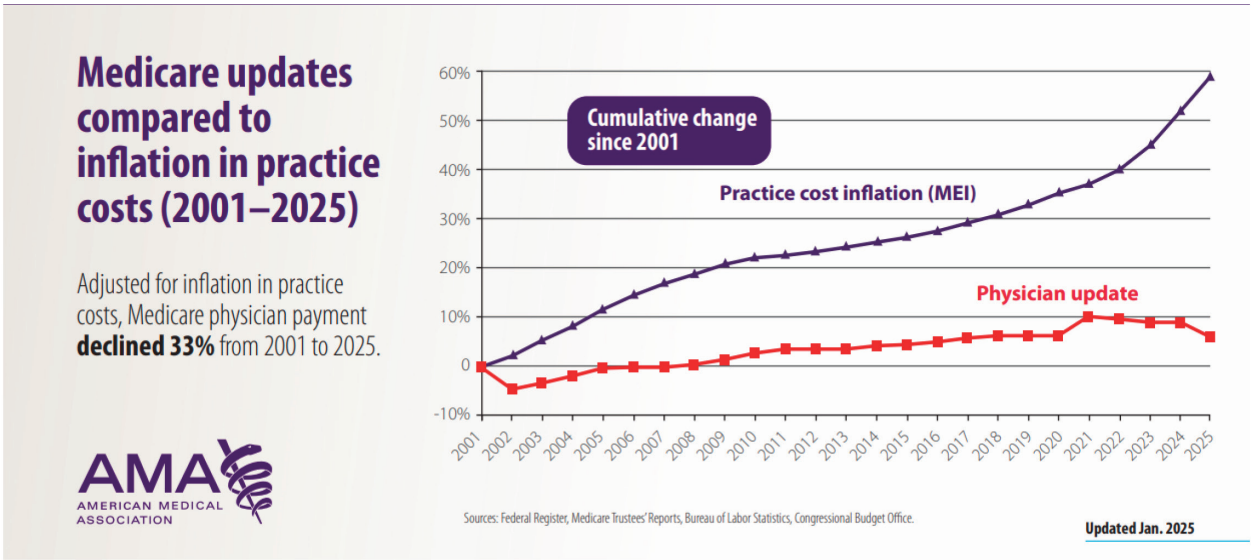


Fig. 1. Medicare updates compared to inflation in practice costs (2001-2025).

INCREASED COSTS OF MEDICAL EQUIPMENT, SUPPLIES, & TECHNOLOGY

The cost of inpatient and outpatient hospital services (7.7%) and nursing homes (3.9%) has risen more sharply than physicians' services (0.7%) and prescription drugs (0.4%). By 2021, estimates indicate that average pharmaceutical supply costs increased nearly 12% annually, rising from $10.21 million per hospital in 2014 to $18.4 million in 2021.

Medical and surgical supply costs have also grown significantly, increasing from $30.2 billion in 2017 to $57 billion in 2023—an average annual rise of 6.5%. Notably, costs increased by 3% between 2019 and 2020 but surged by 10% between 2020 and 2021. This sharp rise is driven by escalating pharmaceutical costs, physician preference items, and supply chain disruptions. Products such as artificial joints, robotic surgery systems, and advanced imaging technology rely on intricate global supply chains, further contributing to cost increases.

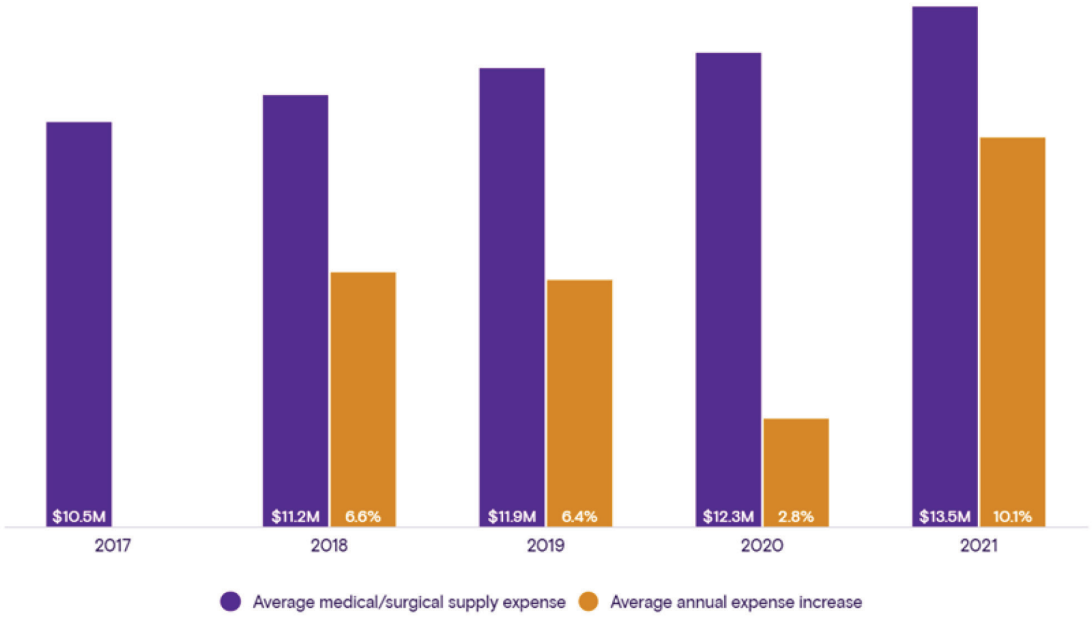


Fig. 2. Rising cost of medical and surgical supply costs.

Source: https://www.definitivehc.com/resources/healthcare-insights/changes-in-supply-costs-year-to-year

DECREASING REIMBURSEMENT FOR PHYSICIANS COMPARED TO ALL OTHER SECTORS

From 2001 to 2023, payment updates for inpatient and outpatient hospitals, skilled nursing facilities, and consumer prices experienced a cumulative increase of approximately 70%. In comparison, practice cost inflation rose by about 45%, while physician payment updates saw an increase of less than 10% over the same period (Fig. 3). Figure 4 illustrates the disparity between physician reimbursement and health insurance premium growth from 2005 to 2025.

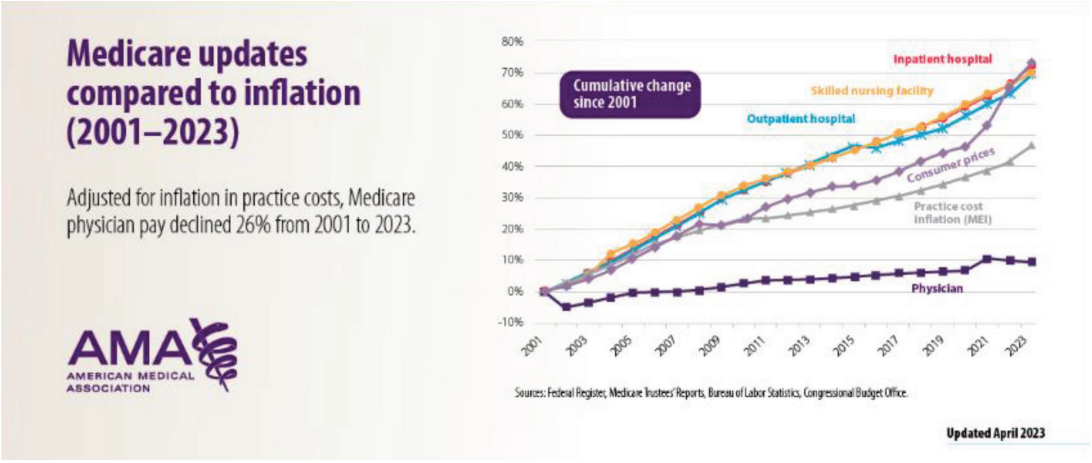


Fig. 3. Medicare Updates Compared to Inflation 2001 – 2023.

Source: https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2019-5-21-AMA-Statement-on-Surprise-Billing-FINAL.pdf

FACT SHEET #5 CONT.

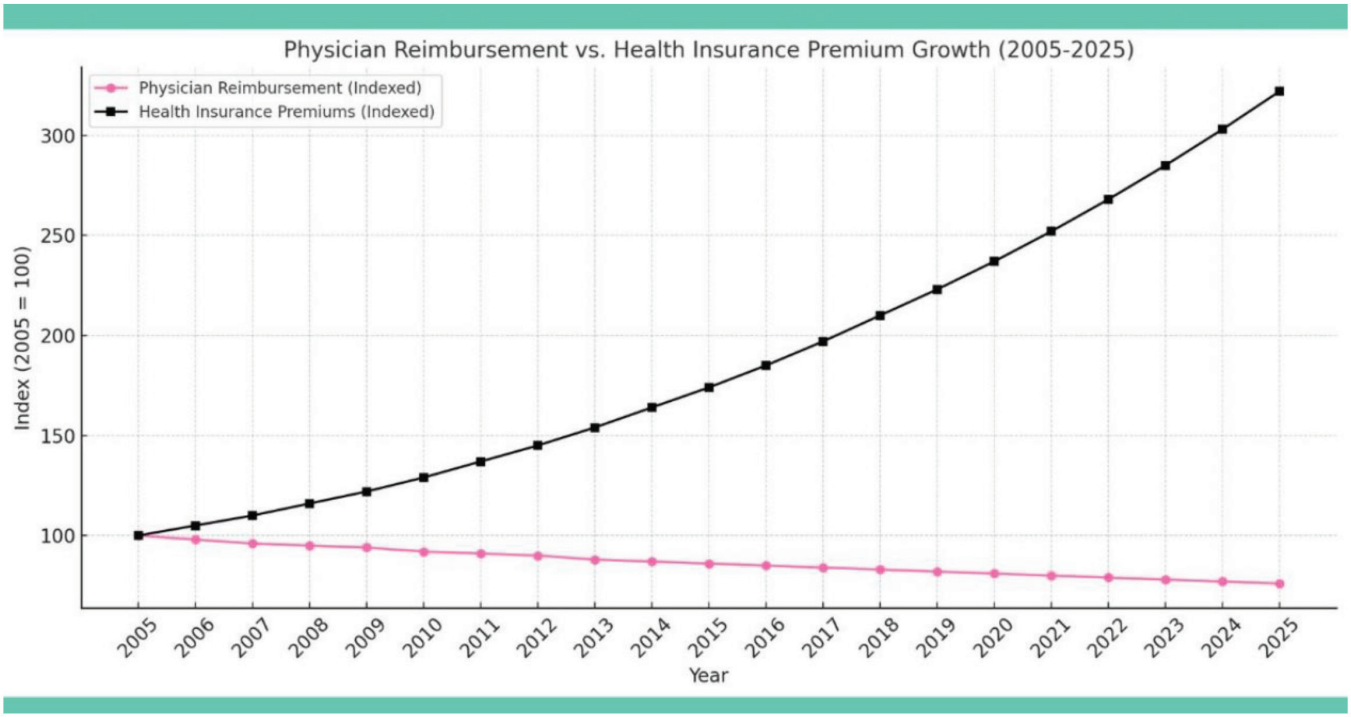


Fig. 4. Increasing insurance premiums compared to physician payments from 2005 to 2025.

SEQUESTER CUTS

As illustrated above, beyond budget neutrality challenges and annual reductions, sequestration cuts implemented following the enactment of the Affordable Care Act remain in effect. Notably, the Energy and Commerce Committee's budgetary reductions total $880 billion, including $62 billion over a 10-year period. Additionally, the decline in income shown above does not account for the ongoing 2% annual cuts that have been in place since April 2013.

PAYGO CUTS

As shown above.

- Implementing an annual, permanent inflationary update in Medicare, linked to the Medicare Economic Index
- Reforming budget neutrality policies
- Overhauling MACRA's Merit-based Incentive Payment System (MIPS)

If you have any questions, please feel free to contact us one of us:
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FACT SHEET #6

INTRODUCING INTEGRITY INTO MEDICARE ADMINISTERED AUDIT PROGRAMS

BUDGETARY ASPECTS

Cost = $0 - over 10 years.

KEY POINTS

1. The Medicare Integrity Program is a key initiative within the Centers for Medicare & Medicaid Services (CMS) dedicated to combating fraud, waste, and abuse in the Medicare program. Established under the Medicare Modernization Act (MMA) of 2003, it aims to protect the Medicare trust fund by preventing and detecting improper payments and implementing corrective actions when necessary.

2. This comprehensive initiative encompasses all aspects of program integrity, including prevention, detection, audits, investigations, and education.

3. In contrast, the Recovery Audit Contractor (RAC) program is managed by private contractors hired by CMS to identify and recover improper payments made to healthcare providers and suppliers.

4. The Medicare Integrity Program includes various contractors such as Medicare Administrative Contractors, Unified Program Integrity Contractors, Recovery Audit Contractors, and Supplemental Medical Review Contractors. These contractors utilize a range of tools and methods, including artificial intelligence, and often rely on non-medical professionals who may lack clinical expertise. Notably, aside from Medicare contractor audits, these reviews frequently occur without applying Local Coverage Determinations (LCDs) or medical policies.

5. Recovery Audit Contractors have significant authority to retrospectively review claims and make determinations without adhering to LCDs, Medicaid medical policies, or established standards of practice.

6. Operating on a contingency fee basis, Recovery Audit Contractors receive a percentage of the overpayments they identify and recover. While this incentivizes them to maximize recoveries, it also creates a financial motive that may compromise program integrity, as RACs may prioritize revenue generation over adherence to LCDs, medical policies, and standards of care for Medicare and Medicaid.

7. A 2024 survey by the Medical Group Management Association (MGMA) found that recoupment audits rank as the second greatest administrative burden for medical practices, surpassed only by prior authorization requirements.

POLICY PROPOSALS

To ensure appropriate patient care access and reduce the burden on providers, Congress should take action to mandate that CMS uphold principles of integrity by enforcing rules requiring adherence to Local Coverage Determinations (LCDs) and medical policies.

1. Recovery Audit Contractors and Supplemental Medical Review Contractors must comply with LCDs, medical policies, and documentation requirements set by the Medicare Administrative Contractor while following standard-of-care practices.
2. All agencies involved in fraud and abuse determinations must adhere to the fraudulent activity guidelines outlined in the Program Integrity Manual. Any additional activities deemed fraudulent must be explicitly defined and justified.
3. Preauthorized services shall be exempt from audits unless there is evidence of misrepresentation or integrity violations in the information provided. The use of Artificial Intelligence shall be discontinued after the initial identification of suspicious activity.
4. Recovery Audit Contractors shall be limited to auditing fee-for-service claims that have not undergone pre-certification.
5. Once suspicious activity is identified, a qualified healthcare professional with expertise in the relevant subject matter must conduct a thorough review of documentation, billing, and coding.
6. If fraud is suspected, the reviewed charts must be assessed by a board-certified, practicing physician in the same specialty. Transparency must be upheld at all levels, including full disclosure of reviewer qualifications.
7. Repeat audits shall be conducted only as follow-ups or after a minimum of five years.

MEDICARE INTEGRITY & RECOVERY AUDIT CONTRACTOR PROGRAM

The Medicare Program Integrity Manual, Chapter 4, defines the principles, values, and priorities of the Medicare Integrity Program (MIP). The primary goal of program integrity is to ensure accurate claim payments. To achieve this, Unified Program Integrity Contractors (UPICs), Investigations Medicare Drug Integrity Contractors (I-MEDICs), Supplemental Medical Review Contractors (SMRCs), and Medicare Administrative Contractors (MACs) must verify that Medicare reimburses the correct amount for properly coded and covered services provided to eligible beneficiaries by legitimate healthcare providers.

The key responsibilities of UPICs, SMRCs, and MACs include ensuring compliance with Medicare regulations, referring suspected fraud and abuse cases to law enforcement agencies, and recommending the revocation of providers who fail to adhere to Medicare policies and regulations.

To achieve these objectives, CMS employs four key strategies:

- Prevent fraud through education
- Encourage early detection

- Coordinate with partners
- Enforce fair and firm policies

While these policies may appear commendable, their implementation is often inconsistent. In practice, providers—particularly when documenting medical necessity—frequently face unfair treatment that undermines the principles of integrity. Instead of relying on Local Coverage Determinations (LCDs), medical policies, and Medicare-issued documentation checklists, auditors tend to use self-developed policies and subjective interpretations of LCDs.

Although Unified Program Integrity Contractors (UPICs) are obligated to follow the Program Integrity Manual within the boundaries of their respective task order statements of work, these statements are crafted by CMS employees who may lack a comprehensive understanding of the practical challenges providers face and often fail to adequately incorporate LCDs and medical policies.

Moreover, UPICs often emphasize aggressive, profit-driven strategies rather than upholding the core mission of program integrity. Their focus appears to shift from ensuring compliance and preventing fraud to maximizing financial gains.

To resolve these concerns, substantial revisions to the statements of work are essential—revisions that explicitly require strict adherence to LCDs, medical policies, and documentation guidelines.

The Program Integrity Manual outlines various fraudulent activities, but it also includes a disclaimer noting that the list is not exhaustive. If CMS intends to classify additional activities as fraudulent, it must either revise the manual accordingly or provide clear, justified reasoning before taking any enforcement actions against providers.

Additionally, while UPIC contractors are expected to receive adequate training, current practices indicate that their training is limited and heavily dependent on artificial intelligence and internal interpretations—rather than on LCDs, medical policies, and established medical standards.

If you have any questions, please feel free to contact us one of us:
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AMERICAN SOCIETY OF INTERVENTIONAL PAIN PHYSICIANS
THE VOICE OF INTERVENTIONAL PAIN MANAGEMENT

A **NON-PARTISAN PROPOSAL** FROM **ASIPP** FOR

BUDGET RECONCILIATION

PRESERVING MEDICARE AND MEDICAID, AND REFORMING PHYSICIAN PAYMENT SYSTEM

43

A Plan without Medicare or Medicaid Cuts

Total Savings of **$1.441 Trillion** over **10 years**. **Proposed Expenditures** of **$322 Billion**, Resulting in a **Total Net Savings** of **$1.119 Trillion**.

Alternate Plan

Total Savings of $1.69 Trillion over a Period of 10 Years with Proposed Expenditures of $322 Billion, Resulting in **Total Net Savings of $1.368 Trillion** Higher than $880 Billion Savings Required by Congress.

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THANK YOU ONCE AGAIN FOR YOUR CONSIDERATION.

AMERICAN SOCIETY OF INTERVENTIONAL PAIN PHYSICIANS
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