March 18, 2026

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Ranking Member Frank Pallone
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Ranking Member Diana DeGette
U.S. House of Representatives
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RE: Comments from the Infusion Providers Alliance (IPA); House Energy & Commerce Committee, Health Subcommittee Hearing, "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"

Dear Chairman Guthrie, Ranking Member Pallone, Chairman Griffith, and Ranking Member DeGette,

Thank you for holding this important hearing examining the U.S. provider landscape. The Infusion Providers Alliance (IPA) appreciates the opportunity to submit comments for the record as part of the Committee's ongoing work to improve health care affordability and patient access.

As the Committee examines policies to improve health care affordability and strengthen the provider landscape, IPA urges Congress to prioritize solutions such as **H.R. 4299 – the Protecting Patient Access to Cancer and Complex Therapies Act**, which would help ensure that Medicare beneficiaries maintain access to provider-administered Part B therapies in community-based settings as negotiated drug pricing policies are implemented.

About the Infusion Providers Alliance

The IPA is a leading voice for community-based, non-hospital affiliated physician practices and freestanding ambulatory infusion clinics that directly administer complex biologic therapies to patients. Our members operate more than 1,000 community-based locations across 45 states, expanding convenient access to high-quality, lower-cost care for patients living with complex and chronic conditions. IPA is committed to preserving the integrity of the provider-patient relationship in a manner that delivers exceptional care to patients and value to the health care system. Evidence demonstrates that care delivered in these settings achieves comparable or

improved outcomes[1] while also generating savings compared with administering the same drug infusion in hospital outpatient departments (HOPDs)[2], typically saving Medicare more than $200 per Part B drug infusion encounter.

IPA member facilities are major access points for care in communities large and small. Located where patients live and work, they provide flexible, convenient access to treatment for conditions such as Crohn's disease, ulcerative colitis, multiple sclerosis, rheumatoid arthritis, and many other chronic, complex, and rare conditions. IPA's mission is to serve as a thought leader and to educate on issues critical to safeguarding, supporting, and strengthening provider-directed, patient-focused access to infused medications.

Opportunity for Congress to Save Medicare Resources and Encourage Provider Competition: Enact the Protecting Patient Access to Cancer and Complex Therapies Act

Congress has a significant opportunity to reduce Medicare spending by advancing policies that encourage the administration of Part B drugs in the most efficient care settings. As detailed below, Medicare pays a professional fee of $133.27 for Part B drug administration in physician office settings, compared to $337.46 in HOPDs. As a result, Medicare spends more than twice as much when the same therapy is furnished in hospital settings.

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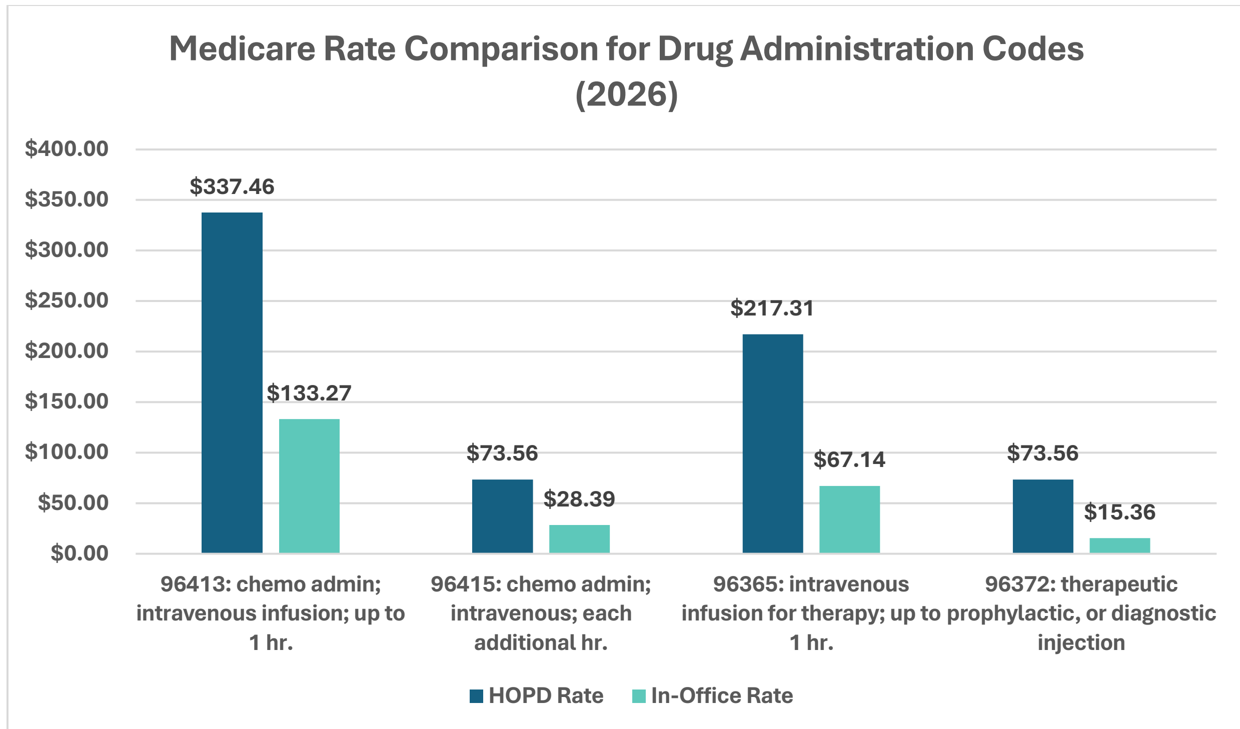
[1] Raj L., Stinson G., Langsam J.W., DeMacio J., Comparison of Specialty Injection and Infusion Adverse Events Among Hospital Outpatient Settings vs Non-Hospital Outpatient Settings, Journal of Clinical Pathways (Feb. 2025). https://www.hmpgloballearningnetwork.com/site/jcp/original-research/comparison-specialty-injection-and-infusion-adverse-events-among

[2] JMCP, *Infusion Therapy Patient Outcomes Are Similar at Reduced Costs* (Dec. 20, 2025), https://www.jmcp.org/doi/10.18553/jmcp.2025.25264

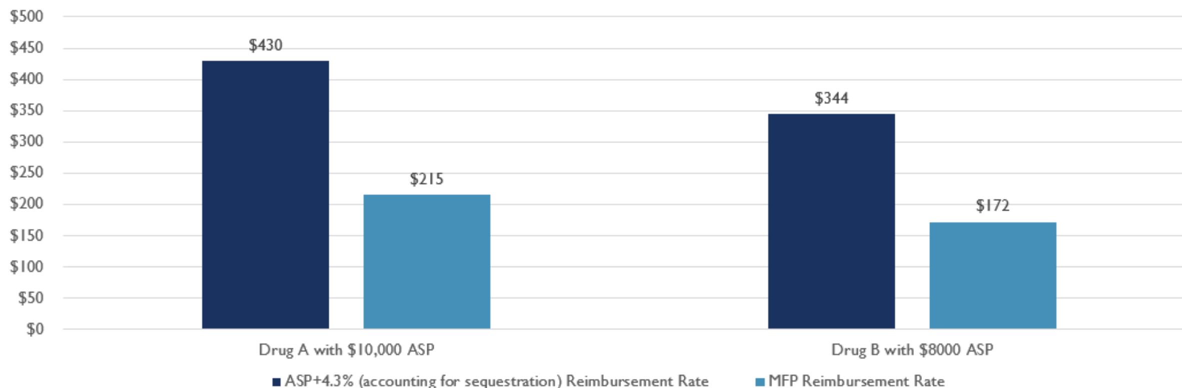


Encouraging care to be delivered in the more efficient community-based sites of care, including physician offices and infusion centers, reduces Medicare spending by more than $200 per encounter for the first hour of complex therapy administration, and even more thereafter. Hospital settings provide vital services for many patients and remain an integral part of the healthcare delivery system. IPA does not seek to diminish the role of hospitals, but rather to highlight the significant cost efficiencies and patient-centered benefits associated with delivering appropriate therapies in community-based settings, particularly for immunocompromised patients who may benefit from receiving care in non-hospital settings when clinically appropriate.

A looming policy challenge jeopardizes the ability of community-based providers to continue to administer some of the most clinically and economically important Part B therapies in their efficient care settings. Implementation of the Inflation Reduction Act's (IRA) Maximum Fair Prices (MFPs) will significantly reduce community-based providers' reimbursement for drugs subject to Secretary negotiation. As currently structured, providers administering these products face reimbursement reductions of 50 percent, according to estimates by the Congressional Budget Office (CBO), due to changes to the 6 percent (or 4.3 percent after sequestration) average sales price (ASP) "add-on" payment methodology for negotiated Part B drugs.

Under the Medicare Drug Price Negotiation Program (MDPNP), reimbursement for negotiated Part B drugs will shift from ASP + 6 percent to MFP + 6 percent. Because the add-on payment is calculated as a percentage of the underlying drug price, reductions in negotiated prices translate directly into reduced reimbursement to providers. For example, the add-on payment (after sequestration) for a $10,000 ASP drug would be cut from $430 to $215 when ASP ($10,000) falls to MFP ($5,000).

ILLUSTRATIVE EXAMPLE: ADD-ON PAYMENT CUTS TO PROVIDERS FOR DRUGS SUBJECT TO MDPNP



Because the add-on payment represents the principal source of drug administration revenue for physician practices and infusion centers that administer these therapies, reimbursement reductions of this magnitude pose significant threats to practice stability and patient access to community-based drug infusion services. As a result, many community-based providers may be forced to send patients receiving affected therapies to hospital outpatient departments, where care is more expensive. Unlike hospitals, which can offset reimbursement reductions through diversified revenue streams such as inpatient and outpatient surgery, advanced diagnostics, graduate medical education funding, Medicare bad debt payments, disproportionate share hospital payments, and endowments, community-based physician practices and infusion centers lack comparable financial flexibility to absorb these cuts.

Congress can enact bipartisan legislation to ensure that these products continue to be provided in community-based settings, where Medicare saves 60 percent or more on Part B drug administration. The legislation would also strengthen provider competition and serve as an important counterweight to the troubling trend of hospital consolidation of physician practices and other independent providers.

Specifically, we recommend that the Energy and Commerce Committee advance, and that Congress enacts, **H.R. 4299, the *Protecting Patient Access to Cancer and Complex Therapies Act***. H.R. 4299 would replace provider reimbursement reductions for Part B drugs subject to negotiation with a rebate paid by pharmaceutical manufacturers to CMS. This approach would ensure Medicare and beneficiaries obtain the savings negotiated by the Secretary but protect providers from collateral damage by maintaining payment based on ASP. Importantly, actuarial analysis conducted by Milliman found that the legislation would generate approximately $3.3 billion in savings by applying sequester to the ASP-based payment rather than to the lower

Maximum Fair Price.[3] These savings would be in addition to those associated with site-of-service payment differentials and care migration considerations.

Impact of Secretarial Negotiation on Medicare Part B Drug Administration Reimbursement

Physician practices and infusion facilities that directly administer drugs to patients typically engage in a practice known as "buy and bill." They pre-purchase drugs and bill the payer for reimbursement once the medication is administered to the patient. To maintain the viability of administering drugs in this setting, reimbursement must account for not only the drug acquisition cost, but also overhead costs such as intake and storage, equipment and preparation, clinical and administrative staff, facilities, insurance, and more. Reimbursement reductions for Part B therapies subject to Secretarial negotiation significantly reduces the add-on payment that helps cover providers' operating costs. Reductions of this magnitude may create significant access pressures in community-based care settings.

As reimbursement declines, community-based providers are likely to face increasing financial pressures that could limit their ability to furnish negotiated therapies, potentially shifting care to higher-cost hospital outpatient settings or exacerbating existing access issues, especially in rural areas. This change may also cause community-based providers to consider offers to acquire their practice from health systems.

H.R. 4299, The Protecting Patient Access to Cancer and Complex Therapies Act: A Targeted Solution to Preserve Access While Maintaining Savings

To address the access and affordability challenges associated with the implementation of MFPs in Medicare Part B, IPA strongly supports the bipartisan **Protecting Patient Access to Cancer and Complex Therapies Act.** The legislation would address structural reimbursement challenges associated with the implementation of negotiated prices while preserving both patient affordability and program savings.

The Protecting Patient Access to Cancer and Complex Therapies Act would address this by:

- Maintaining provider reimbursement at ASP + 6 percent (before sequestration), ensuring continued stability of community-based infusion providers;
- Preserving beneficiary affordability by maintaining coinsurance based on the lower negotiated Maximum Fair Price; and
- Requiring manufacturers to provide rebates to CMS to account for the differential, thereby preserving federal savings generated through negotiation.

This approach reflects long-standing policy mechanisms used successfully in Medicare and Medicaid, including manufacturer rebate structures designed to achieve savings without disrupting care delivery. By utilizing a rebate-based framework rather than reducing provider

[3] Milliman, Impact of the Inflation Reduction Act on Part B Provider Payment and Patient Access to Care (May 2025). https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2025-Articles/5-9-25_IRA-Provider-Impact_Brief.pdf

reimbursement, the legislation ensures that cost reductions do not come at the expense of patient access.

Actuarial analysis has estimated that the policy would generate approximately $3.3 billion in federal savings over ten years[4], while preserving access to lower-cost community-based sites of care. Maintaining access to these settings is critical not only for patients, but also for the long-term sustainability of Medicare spending. The same analysis also finds that H.R. 4299 would increase pharmaceutical manufacturer financial obligations by nearly $60 billion relative to current law.

Importantly, this legislation has broad support from a diverse coalition of 67 patient and provider organizations representing individuals living with cancer, autoimmune disorders, rare diseases, and other serious conditions.[5] This consensus reflects shared concern that without targeted policy adjustments, the effectuation of negotiated prices in Part B may inadvertently limit treatment options and reduce timely access to care. Policies that safeguard access to complex therapies while maintaining the stability of less expensive, community-based care are essential to achieving Congress's affordability and cost-of-care objectives.

Policies that preserve and support access to these alternative sites of care are therefore critical to maintaining patient access, safety, and system-wide affordability and should be prioritized, especially as favorable reimbursement for hospital-owned sites has been shown to encourage hospitals' acquisition of physician practices.

Provider Consolidation Drives Higher Costs; Congress Should Embrace Policies that Combat this Trend

Hospital acquisition of physician practices is escalating and results in higher costs for Medicare and patients.

Recent trends of hospitals acquiring and employing more physicians should be troubling policymakers. A study by Avalere for the Physician Advocacy Institute found that the percentage of hospital-employed physicians increased by more than 70 percent from July 2012 through January 2018 and another 5.1 percent between 2022 and 2023. More than half of physicians are now employed by hospitals:

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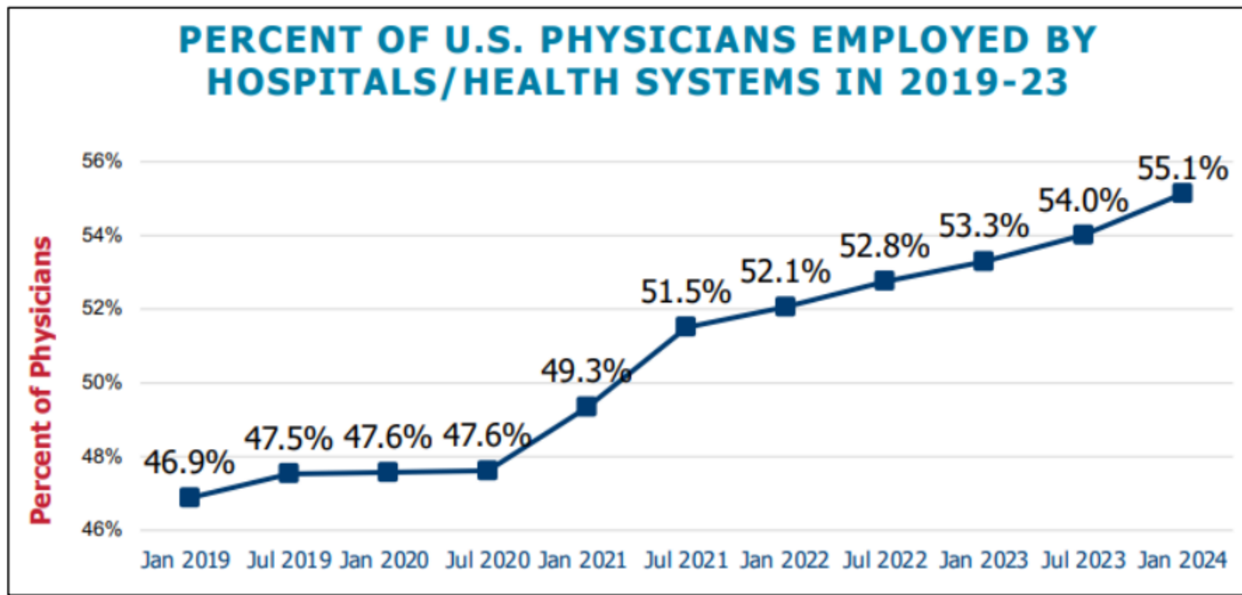
[4] Milliman, Impact of the Inflation Reduction Act on Part B Provider Payment and Patient Access to Care (May 2025). https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2025-Articles/5-9-25_IRA-Provider-Impact_Brief.pdf

[5] IPA Joins 67 Patient & Provider Organizations in Support of Bipartisan Bill to Protect Patient Access to Cancer and Complex Therapies. https://www.infusionprovidersalliance.org/ipa-joins-patient-provider-organizations-in-support-of-bipartisan-bill-to-protect-patient-access-to-cancer-and-complex-therapies/



When hospitals acquire an independent physician practice, services are often delivered by the same providers with essentially the same staff and even in the same location but cost substantially more. Hospitals have focused on acquiring physician practices and independent providers because the strategy reduces competition in the local market for services such as outpatient surgery and drug administration, increases their 340B revenue as prescribed drugs will become eligible for 340B discounts, and captures downstream revenue from ancillary services referrals such as radiation therapy, advanced imaging and laboratory work.

Data suggests that there has been a marked shift away from the physician's office towards the HOPD for the administration of outpatient chemotherapy.[6] In addition to the above trends, it has been demonstrated that the acquisition of physician practices by hospitals is an additional important driver of this change[7], particularly since 340B hospitals can also then benefit from the vast profit margin on administration of certain medications to the newly incorporated patient population of the acquired practice.

Congress can help mitigate these concerning trends by ensuring that physician practices and freestanding ambulatory infusion centers can still provide the most clinically and economically important products to Medicare patients.

Conclusion

The Infusion Providers Alliance **urges Congress to prioritize and advance the Protecting Patient Access to Cancer and Complex Therapies Act** to ensure that policies intended to reduce costs do not undermine patient access to physician-administered therapies. Community-

[6] Winn AN, Keating NL, Trogdon JG, et. al. Spending by Commercial Insurers on Chemotherapy Based on Site of Care, 2004-2014. JAMA Oncol. 2018;4(4):580–581.
[7] Jung J, Feldman R, Kalidindi Y. The impact of integration on outpatient chemotherapy use and spending in Medicare. Health Econ. 2019 Apr;28(4):517-528.

based infusion providers play a vital role in delivering high-quality, clinically appropriate care in settings that are often more convenient and accessible for patients, particularly those managing chronic and complex conditions.

Care delivered in non-hospital settings not only supports patient continuity of care and convenience but also generates meaningful savings for the Medicare program by avoiding higher-cost hospital outpatient care when clinically appropriate. Preserving access to these settings is therefore essential to improving affordability while maintaining quality and patient choice.

Absent targeted policy adjustments, continued reimbursement pressures risk accelerating consolidation trends that shift care toward hospital-owned systems, increasing overall program costs and reducing site-of-care options for beneficiaries. Ensuring sustainable reimbursement for community-based providers will help maintain a diverse and resilient care delivery system capable of meeting the needs of Medicare beneficiaries today and in the future.

IPA stands ready to work with Congress to advance policies that lower costs while safeguarding access for those patients our members care for.

Sincerely,

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