NATIONAL INFUSION CENTER ASSOCIATION

The Nation's Advocacy Voice for In-Office Infusion

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August 21, 2026

Republican Doctors Caucus
Democratic Doctors Caucus
U.S. House of Representatives
Washington, DC 20515

Sent electronically to catherine.hayes@mail.house.gov; amy.zhou@mail.house.gov

Re: Request for Information: Strengthening the Medicare Physician Payment System

Dear Members of the House Republican and Democratic Doctors Caucus:

The National Infusion Center Association (NICA) is a nonprofit organization formed to support non-hospital, community-based infusion centers caring for patients in need of provider-administered medications. To improve access to medical benefit drugs that treat complex, rare, and chronic diseases, we work to ensure that patients can access these drugs in safe, more efficient, and cost-effective alternatives to hospital care settings. Despite their value to the health system, infusion centers face significant regulatory and economic pressures that threaten their viability, including instability within the Medicare Physician Payment System.

We appreciate the opportunity to provide input on the *Request for Information: Strengthening the Medicare Physician Payment*. NICA values the ongoing engagement with stakeholders to identify key issues and assess how Medicare payment reform proposals, such as the *Patients First Act,* will impact infusion providers nationwide and the patients they serve.

SECTION 1: OFFSETS AND FISCAL RESPONSIBILITY

1. ***What specific offsets or "pay-fors" within the Medicare program or the broader health care system should the bill sponsors consider to fund a permanent, inflation-based physician payment update?***

Reining in Medicare Advantage Upcoding: A Path to Medicare Financial Stability
As bill sponsors explore potential cost offsets or "pay-fors" within the Medicare program, we urge Congress to address "upcoding" by private payers participating in Medicare Advantage. This practice exploits the program's risk adjustment system by inflating patient diagnoses to secure higher payments from the Centers for Medicare & Medicaid Services (CMS). The bipartisan *No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act (S. 1105)* aims to tackle this problem and deliver substantial cost savings to the Medicare program and taxpayers.

The issue of "upcoding" is becoming increasingly significant, as over half of the approximately 68 million Americans on Medicare receive their coverage through a Medicare Advantage plan. According to a report from the Medicare Payment Advisory Commission (MedPAC), higher risk scores due to

coding intensity alone accounted for an estimated $40 billion of the $84 billion in excess payments to Medicare Advantage plans in 2025.[1]

The *No UPCODE Act* would strengthen program integrity of Medicare Advantage by updating how risk adjustment is calculated, curbing the use of outdated or unrelated diagnoses, and ensuring payments better reflect patients' true clinical needs. The Congressional Budget Office reported that reforms aimed at addressing Medicare Advantage upcoding, like those proposed in the *No UPCODE Act,* could save the federal government $124 billion over the next decade.[2] These savings could be reinvested into the Medicare system to help fund a permanent, inflation-based physician payment fix.

Curbing PBM Abuses: A Savings Opportunity for the Broader Health Care System

NICA also recommends that the bill sponsors consider additional reforms for pharmacy benefit managers (PBMs) as a "pay-for" that will deliver health care savings to fund an inflation-based physician payment update. We were pleased to see Congress take important first steps to curb abusive PBM practices through the *Consolidated Appropriations Act of 2026*, which delinked the list price of drugs from PBM compensation for Medicare Part D and mandated that rebates be passed through to health plan sponsors for ERISA plans. However, more action is needed to address the anti-competitive and harmful business practices of PBMs that continue to increase patients' out-of-pocket costs. Specifically, NICA encourages the Doctors Caucuses to include H.R. 6283, *the Delinking Revenue from Unfair Gouging (DRUG) Act*, as a "pay-for" for an inflationary Medicare payment update. This act could improve healthcare affordability for patients and, according to the Congressional Budget Office, is projected to save the federal government $654 million over the next ten years.

The PBM industry has significantly consolidated over the past decade, as highlighted by the Federal Trade Commission.[3] Major players like Express Scripts (a subsidiary of Cigna), CVS Caremark (part of CVS Health), and OptumRx (owned by UnitedHealth Group) now cover more than 260 million patients and dominate about three-quarters of the U.S. prescription drug market.[4] This consolidation has led to a pricing system that fails patients in need of costly specialty medications – driving up costs to the greater health care system. Abusive PBM practices are increasing out-of-pocket costs, favoring expensive drugs in formulary decisions, and delaying or denying access to care through stringent utilization management.

The bipartisan *DRUG Act,* introduced by Representative Mariannette Miller-Meeks, MD (R-IA), would not only help offset the costs of an inflation-adjusted Medicare payment update but also sever the link between PBM compensation and drug list prices in the commercial and Federal Employee Health Benefits markets. By removing PBMs' financial stake in rebate or fee size, this policy would eliminate the incentive to favor higher-priced medications – delivering significant savings to our health care system.

NICA also supports the bipartisan H.R. 8779, the *Patients Before Monopolies Act (PBM Act*), which would address the vertical integration that allows dominant PBMs and insurers to own and steer

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[1] Medicare Payment Advisory Commission. (2025, March). *Report to the Congress: Medicare payment policy*. https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf

[2] Congressional Budget Office. (2024, December). *Options for reducing the deficit: 2025 to 2034*. https://www.cbo.gov/system/files/2024-12/60557-budget-options.pdf

[3] Federal Trade Commission, "Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies" (July 2024).

[4] Health Affairs, Health Policy Brief, "Pharmacy Benefit Managers" (Sept. 14, 2017).

patients toward affiliated pharmacies. By requiring the separation of PBM and pharmacy ownership, the legislation could strengthen competition, protect independent and community-based providers, and reduce incentives that increase costs or restrict patient choice. Although the legislation has not yet received a Congressional Budget Office estimate, it represents an important complementary reform with the potential to generate broader health-system savings.

SECTION 2: ADDITIONAL INFORMATION

NICA welcomes the elimination of the Merit-based Incentive Payment System (MIPS) under the *Patients First Act*, as this program has long lacked meaningful and relevant measures and performance benchmarks for infusion providers. This position aligns with NICA's earlier response to Representatives Murphy and Schrier's *Request for Information on MACRA Modernization*, where we advocated for eliminating MIPS entirely. MIPS has evolved into a costly, complex bureaucracy that drains significant taxpayer resources on administration and contractor oversight rather than improving patient care.

While we welcome this transition, we encourage careful consideration of how the new Patient Outcome Improvement National Tabulation System (POINTS) in the *Patients First Act* will be designed and implemented to avoid carrying over the challenges infusion providers face under MIPS. We would appreciate the opportunity for office-based infusion centers that provide a single service line (i.e., drug administration) to be exempt from POINTS if it is not beneficial for them. As we have noted previously, infusion practices are well suited to an expanded interpretation of the low-volume threshold, given that they deliver essentially one service — infusions. This same reasoning supports carving out flexibility under POINTS. Notably, no infusion-specific quality measures currently exist, which further reinforces the need for this kind of accommodation.

We are encouraged that POINTS will be a clinician-led quality program. To ensure that the resulting measures are clinically relevant, we urge the bill sponsors to ensure diversity in the composition of the Quality Task Force, specifically by incorporating representation from specific provider organizations such as NICA.

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Office-based and ambulatory infusion centers are essential to providing our nation's seniors with access to high-quality, cost-effective infusion treatments. NICA is committed to working with Congress and healthcare stakeholders to develop comprehensive solutions to reform the Medicare physician payment system. Thank you for the opportunity to comment on this important issue. Please do not hesitate to contact me, should you have any questions or wish to further discuss this issue: Brian.nyquist@infusioncenter.org

Sincerely,

Brian Nyquist, MPH
Chief Executive Officer
National Infusion Center Association