NATIONAL INFUSION CENTER ASSOCIATION

The Nation's Advocacy Voice for In-Office Infusion
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January 16, 2025

The Honorable Greg Murphy, MD
407 Cannon House Office Building
Washington DC 20515

The Honorable Kim Schrier
1110 Longworth House Office Building
Washington DC 20515

RE: MACRA Modernization

Dear Representatives Murphy and Schrier,

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. Despite their value to the health system, infusion centers face regulatory and economic pressures that threaten their viability, including requirements associated with the Quality Payment Program (QPP) established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

What legislative reforms are most needed to ensure future CMMI models deliver real improvements in cost and quality, while also ensuring successful scaling of innovations?

Innovative care and delivery models are more likely to generate scalable improvements in cost and quality when Medicare payment policy supports sustainable, site-appropriate care and do not structurally advantage higher-cost settings. For office-based infusion, this means addressing payment distortions that drive consolidation and shift care from lower-cost community settings to hospital outpatient departments (HOPDs). NICA appreciates CMS' decision in the CY 2026 Hospital Outpatient Prospective Payment System final rule to advance site-neutral payment for certain drug administration services, which helps reduce payment-driven incentives to shift care toward HOPDs. Additional work is needed, however, to ensure Medicare Physician Fee Schedule (PFS) payment keeps pace with the real costs of furnishing these services in the office setting.

Legislative solutions are needed to stabilize the Medicare physician payment foundation on which most physician-focused CMMI models are based. Specifically, ***Congress should enact legislation that:***

- ***links physician payment updates to growth in practice costs as measured by the Medicare Economic Index (MEI);***
- ***allows retrospective correction when budget neutrality projections substantially differ from real-world utilization; and***
- ***establishes requirements for regular and timely revaluation of PE inputs under the PFS.***

Together, these reforms would provide the payment stability necessary for community-based practices to participate in, sustain, and scale innovative models.

In addition, reforms to Part B drug payment are essential to ensure innovative models do not fail because providers are unable to acquire and furnish physician-administered drugs included in the model. NICA has previously argued that ASP-based payment can fall below provider acquisition costs because it reflects manufacturer rebates to health plans and their pharmacy benefit managers. This puts infusion

practices in the position of administering therapies at a loss or referring patients to higher-cost settings. CMMI's recently proposed Global Benchmark for Efficient Drug Pricing Model ("GLOBE Model") proposed rule underscores this concern. Although the GLOBE Model maintains payment at ASP plus 6 percent, CMS anticipates that the Model will incentivize manufacturers to lower drug prices, potentially driving ASP below infusion practices' acquisition costs. This approach will limit the Model's ability to generate results that can be scaled, as providers may no longer be able to purchase or stock GLOBE Model drugs due to their underwater reimbursements. And, ultimately, this will hinder access to medically necessary therapies for *all* beneficiaries – regardless of whether they are GLOBE Model beneficiaries – that may be best suited for their condition based on clinical evidence.

Legislative solutions are needed to address these structural misalignments. Specifically, ***Congress should enact legislation that:***

- ***ensures Part B drug payment benchmarks more accurately reflect provider acquisition costs, such as excluding manufacturer rebates to health plans and PBM;***
- ***prevents payment models from incorporating Part B and Part D drugs as a cost variable when infusion practices lack control over drug selection or pricing and are required to furnish medically necessary therapies;***
- ***preserves access to clinically appropriate therapies by ensuring providers can acquire and stock drugs required to treat complex conditions in office-based settings; and***
- ***limits the use of utilization management tools, such as step therapy, in ways that interfere with access to physician-administered drugs selected based on clinical evidence, particularly when such requirements delay care or force treatment in higher-cost settings.***
- ***ensures all payments made by or on behalf of the patient count towards their cost-sharing responsibility.***

Together, these reforms would give CMS the tools needed to align payment with acquisition costs, maintain access to medically necessary therapies, and ensure that drug-related payment models test care delivery improvements rather than penalizing providers for costs outside their control.

If MIPS were to be reformed or replaced entirely, what would a new physician-led quality program look like? How can we ensure a new program reduces administrative burdens and is applicable to all types of clinicians in all settings, while focusing meaningfully on real outcomes?

Office-based infusion centers that provide a single, highly specialized service line are subject to the requirements of the Quality Payment Program (QPP), including the Merit-based Incentive Payment System (MIPS), despite the absence of relevant measures or meaningful performance benchmarks. These practices are often required to report metrics that do not reflect the care they provide, yet still bear the full financial and administrative burden of participation. Since its inception, MIPS has imposed disproportionate burdens on such providers without clear evidence that it has improved quality of care for Medicare beneficiaries.

At the same time, federal agencies (e.g., the Centers for Disease Control and Prevention (CDC), the US Food and Drug Administration (FDA)) and multiple standards development organizations and accrediting bodies, already collect extensive quality and safety data through patient safety reporting programs, adverse event monitoring, and public health surveillance systems. This raises serious questions about the incremental value of maintaining the MIPS infrastructure for highly specialized practices, particularly when those systems duplicate existing reporting without yielding actionable quality insights.

MIPS has also evolved into a costly and complex bureaucracy, consuming substantial taxpayer resources to support program administration and contractor oversight. For office-based infusion centers, especially small and rural practices, the cost of compliance and the risk of negative payment adjustments have

contributed to consolidation, shifting care into higher-cost settings and increasing costs for Medicare and beneficiaries. For these reasons, ***NICA urges the Administration to work with Congress to eliminate the MIPS program. At a minimum, office-based infusion centers that furnish a single service line (i.e., drug administration) should be exempt from MIPS participation.***

If MIPS were reformed or replaced, ***a new clinician-led quality program should be grounded in three core principles: clinical relevance, outcome-focused measurement, and low administrative burden, with reporting aligned to how care is actually delivered across settings, including highly specialized practices.***

- **Clinical relevance.** Any MIPS successor program should require that measures be specialty- and setting-appropriate, with a clear and predictable pathway for exclusion when no valid measures exist for a provider's scope of practice. Infusion practices should not be required to report measures unrelated to the drug administration services they furnish or for which meaningful benchmarks do not exist.
- **Outcome-focused measurement.** A successor program should emphasize a limited set of outcomes that are meaningful to patients and within the provider's control, such as avoidable hospitalizations, infusion-related adverse events, and continuity of therapy. Measures should focus on clinical results within the provider's control, rather than process requirements or cost variables outside the clinician's control.
- **Reduced administrative burden.** Quality measurement should rely, to the greatest extent possible, on existing data sources, such as claims data and established patient safety and surveillance systems (as noted above), rather than manual abstraction or duplicative reporting. Program design should minimize reporting complexity and compliance costs, particularly for small, rural, and single-service practices.

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Thank you for the opportunity to provide feedback on regulations that impose undue burden on infusion practices. Should you have any questions, please contact advocacy@infusioncenter.org.

Sincerely,

Brian Nyquist
CEO
National Infusion Center Association (NICA)