Impact of the Inflation Reduction Act on Part B provider reimbursement and potential implications for providers and patients

Commissioned by the National Infusion Center Association

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I. Executive summary

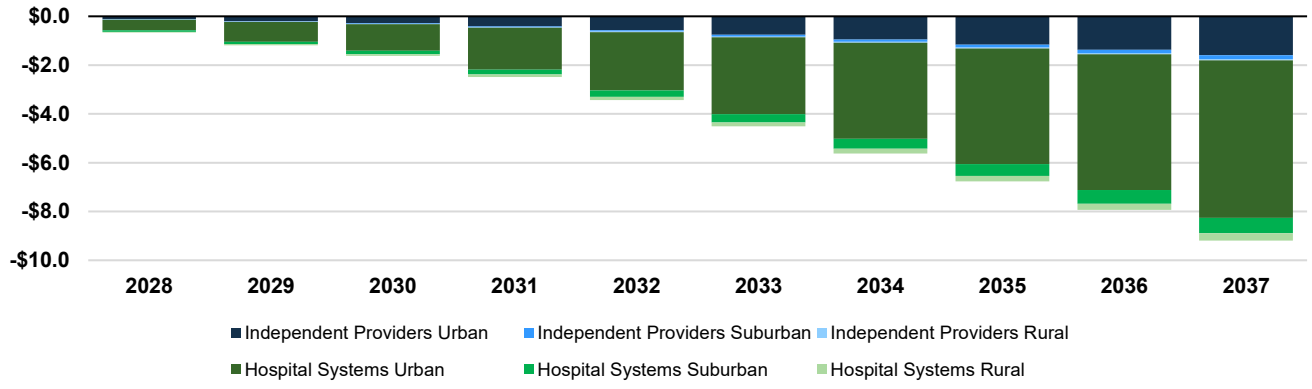
The National Infusion Center Association (NICA) engaged Milliman to quantify the potential impact of the Inflation Reduction Act (IRA) and its changes on Medicare Part B reimbursement and to evaluate the potential implications for providers and patients. NICA is a nonprofit trade association formed to support community-based infusion centers caring for patients in need of provider-administered medications. At NICA's request, this analysis excludes oncology providers and focuses on non-oncology therapies (e.g., neurology, immunology), which are most relevant to NICA's core membership.

We analyzed the financial impact of changes in Part B reimbursement resulting from the Medicare Drug Price Negotiation Program (MDPNP) enacted by the IRA, as well as the impact of an alternative scenario in which the Protecting Patient Access to Cancer and Complex Therapies Act (PACTA) is enacted. We modeled a 10-year window, beginning in 2028, which is the initial year Part B drugs are eligible for the MDPNP.

Under the IRA, provider reimbursement for Part B drugs will change from being tied to Average Sales Price (ASP) to being tied to what the Act refers to as "maximum fair prices" (MFPs) for drugs selected for the MDPNP. We estimate this change will decrease Part B provider reimbursement for non-oncology drugs by $9.2B, or 16.1% of net cost recoveries (NCRs), over 10 years.[1] PACTA would essentially be a technical fix to restore provider reimbursement to ASP-based pre-IRA levels, funded by a manufacturer rebate model that maintains MDPNP program savings. We estimate PACTA will restore $9.0B of the estimated $9.2B reduction in provider reimbursement. Providers would experience a reduction in reimbursement of $0.2B, or 0.3% of NCR, over 10 years, driven by changes in the portion of costs subject to sequestration.

Figure 1 outlines the cumulative 10-year reimbursement reduction to each provider type and region under the IRA as written, absent any behavior changes.

FIGURE 1: MDPNP CUMULATIVE IMPACT ON NON-ONCOLOGY PROVIDER REIMBURSEMENT BY YEAR AND PROVIDER TYPE ($B)



1. Provider net cost recovery (NCR) reflects claim reimbursement (allowed cost) reduced for sequestration less the drug acquisition cost and the cost of providing the medical service (i.e., margin). This estimate is lower than previous research as oncology providers are excluded from this analysis. Additionally, this analysis incorporates an updated list of Part B drugs expected to be selected for negotiation in each year underlying this analysis. We expect lower Part B volume subject to negotiation relative to the prior analysis. In particular, H.R. 1 (Public Law 119-21) was passed subsequent to prior research and delayed the selection of the two highest volume Part B drugs by one year, several other high volume Part B drugs have had recent changes to eligibility criteria, and Part D trends have outpaced Part B trends in emerging research, resulting in fewer Part B drugs expected to be selected as Part D drugs fill the selection spots.

Changes in provider reimbursement could affect provider behavior in different ways. Some providers may be able to offset lower reimbursement through other revenue streams, while others may need to consider changes to mitigate the margin reduction, which could include (but are not limited to) ceasing to offer selected therapies, renegotiating contracts for more favorable reimbursement, merging with larger health systems, reducing staffing, or shutting down.[2,3,4] Some of these behavior changes could have implications for a broader patient population than the patients currently receiving selected drugs. Based on 2023 utilization, the independent providers identified in this analysis served approximately 56 million unique Medicare patients across all services (including patients who did not receive an MDPNP-selected drug), of approximately 65 million Medicare beneficiaries.

II. Background

NICA engaged Milliman to evaluate the effect of the MDPNP, as enacted by the IRA, on reimbursement for selected Part B drugs and to compare that effect with an alternative scenario under PACTA. This report also discusses how the resulting reimbursement changes could influence provider behavior and, in turn, patient access to care.

Infusion providers typically acquire medications in advance and later bill Medicare or other payers after administering them to the patient, through a process commonly referred to as "buy-and-bill." For most separately payable Part B drugs, Medicare reimbursement is generally based on ASP plus a 6% add-on payment (before sequestration). Providers' actual acquisition costs vary, and the add-on accounts for the financial and operational costs associated with acquiring, storing, managing, and handling these complex therapies.

PACTA was first introduced in both chambers of Congress in 2023.[5] The current House version, H.R. 4299, was introduced in the 119th Congress on July 7, 2025, by Representatives Gregory Murphy, Adam Gray, and Neal Dunn.[6] A Senate version has not been reintroduced in the 119th Congress as of this report's publication. This bill maintains Part B provider payment for selected drugs on an ASP+6% basis, while keeping beneficiary coinsurance based on MFP+6%. To fund this change, manufacturers would pay Medicare a quarterly rebate calculated from the difference between the applicable ASP+6% and MFP+6% payment and coinsurance amounts. PACTA also excludes MFP from the ASP calculation methodology, protecting ASP-based provider reimbursement in the commercial market from being affected by the MDPNP.

Figure 2 below summarizes the key aspects of the historical, current, and proposed payment structures for selected Part B drugs prior to sequestration.[7]

FIGURE 2: KEY ASPECTS OF PAYMENT STRUCTURES FOR SELECTED PART B DRUGS

SCENARIO	PROVIDER REIMBURSEMENT	PATIENT COST SHARING	MANUFACTURER COST
Pre-IRA	ASP+6%	% of ASP+6%	N/A
IRA MDPNP	MFP+6%	% of MFP+6%	ASP less MFP
PACTA	ASP+6%	% of MFP+6%	ASP+6% less MFP+6%

The transition from ASP-based reimbursement to MFP-based reimbursement is expected to reduce provider reimbursement proportionally with the MFP discount. Therefore, provider reimbursement for an MFP drug would decrease approximately 50% to 70%, on average, if 2028 MFP discounts relative to ASP are in line with 2027 MFP discounts relative to list price.[8]

III. Analysis

We used the Part A and Part B claims data from the Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC) for calendar year 2023. We then trended claims to 2028 through 2037

2. Pratt, D., & Okon, T. (2026, September 16). *COA comments on proposed CY2028 IPAY effectuation* [Comment letter]. Retrieved September 21, 2026, from https://mycoa.communityoncology.org/publications/comment-letters/coa-comments-on-proposed-cy2028-ipay-effectuation.
3. Sachs, R., & Frank, R.G. (2025, April 1). *Analyzing the expansion of the Medicare drug price negotiation program to Part B*. Brookings Institution. Retrieved September 21, 2026, from https://www.brookings.edu/articles/analyzing-the-expansion-of-the-medicare-drug-price-negotiation-program-to-part-b/.
4. *Issues and challenges with the effectuation of maximum fair prices for Medicare Part B drugs* [White paper]. (2025, October). Association for Value-Based Cancer Care, Part B Drug Effectuation Work Group. Retrieved September 21, 2026, from https://avbcc.org/wp-content/uploads/2026/04/Part-B-White-Paper_FINAL.pdf.
5. See Protecting Patient Access to Cancer and Complex Therapies Act, H.R. 5391, 118th Congress. (2023, September 12). Retrieved September 21, 2026, from https://www.congress.gov/bill/118th-congress/house-bill/5391/text.
6. See Protecting Patient Access to Cancer and Complex Therapies Act, H.R. 4299, 119th Congress. (2025, July 7). Retrieved September 21, 2026, from https://www.congress.gov/bill/119th-congress/house-bill/4299/text.
7. Further background information is available in Robb, M., & Holcomb, K. (2025, May 9). *Impact of the Inflation Reduction Act on Part B provider payment and patient access to care*. Milliman. Retrieved September 21, 2026, from https://www.milliman.com/en/insight/ira-impact-on-part-b-provider-payments.
8. *Medicare Drug Price Negotiation Program: Negotiated prices for initial price applicability year 2027* [Fact sheet]. (2025, November 1). Centers for Medicare and Medicaid Services. Retrieved September 21, 2026, from https://www.cms.gov/files/document/fact-sheet-negotiated-prices-ipay-2027.pdf.

and re-adjudicated them in each year. Results reflect our best estimate of selected drugs and estimated MFPs in each year as of this report's publication. Notably, results are highly dependent on which drugs are selected and MFP levels. Since MFPs for Part B drugs have not yet been released, we used 2027 MFPs for Part D products to derive our assumption that MFPs will be 10% lower than estimated ceiling prices. If final negotiated MFPs are lower than our estimated ceiling prices, the impacts to each stakeholder would grow. Our analysis focuses on non-oncology therapies, though oncology providers would be similarly affected by the IRA and PACTA as oncology products become eligible for MFP. Oncology treatments are expected to comprise a meaningful portion of total MFP drug spend.

Provider NCR reflects claim reimbursement (allowed cost) reduced for sequestration less the drug acquisition cost and the cost of providing the medical service (i.e., margin). The dollar values shown in the "A" versions of the tables in this report represent the decrease in provider margin for non-oncology products, which is equal to the decrease in reimbursement net of sequestration. The percentage values in the "B" versions of the tables represent the decrease in margin for non-oncology products as a percentage of total provider NCR across all non-oncology Part B drugs.

Figures 3A and 3B show the decreases in non-oncology provider reimbursement by year, broken out by provider specialty type in dollars and as a percentage of pre-IRA NCR, respectively. We include reimbursement for drugs administered in both outpatient and professional settings. Changes to provider reimbursement vary significantly by provider specialty, given only certain drugs are subject to MFPs under the IRA.

FIGURE 3A: IMPACT ON NON-ONCOLOGY PROVIDER REIMBURSEMENT UNDER MDPNP BY YEAR AND SPECIALTY ($M)

	YEAR										
SPECIALTY	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**TOTAL**
Neurology / Psychiatry	-$110	-$252	-$138	-$501	-$545	-$782	-$804	-$822	-$842	-$895	-$5,691
Rheumatology	-$242	-$12	-$14	-$14	-$25	-$27	-$26	-$26	-$25	-$24	-$434
Gastrointestinal	-$176	-$174	-$172	-$169	-$166	-$5	-$5	-$5	-$6	-$6	-$884
Allergy / Immunology	-$126	-$4	-$85	-$132	-$144	-$157	-$161	-$169	-$173	-$179	-$1,329
Urology	-$12	-$76	-$20	-$50	-$63	-$83	-$87	-$91	-$98	-$117	-$698
Other Non-Oncology	$0	$0	$0	-$2	-$4	-$12	-$19	-$19	-$20	-$20	-$96
Ophthalmology	-$1	-$1	-$1	-$1	-$1	-$10	-$10	-$11	-$11	-$12	-$59
Total	**-$667**	**-$520**	**-$429**	**-$869**	**-$948**	**-$1,076**	**-$1,113**	**-$1,142**	**-$1,174**	**-$1,253**	**-$9,191**
Cumulative Total	**-$667**	**-$1,187**	**-$1,616**	**-$2,485**	**-$3,433**	**-$4,509**	**-$5,622**	**-$6,764**	**-$7,938**	**-$9,191**	
Impact after PACTA	**-$12**	**-$8**	**-$8**	**-$15**	**-$17**	**-$22**	**-$24**	**-$25**	**-$26**	**-$27**	**-$185**

FIGURE 3B: IMPACT ON NON-ONCOLOGY PROVIDER NCR UNDER MDPNP BY YEAR AND SPECIALTY (%)

	YEAR										
SPECIALTY	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**Total**
Neurology / Psychiatry	-9.0%	-19.7%	-10.2%	-35.0%	-35.9%	-48.3%	-48.1%	-47.5%	-47.0%	-48.2%	-36.8%
Rheumatology	-39.7%	-1.9%	-2.0%	-2.0%	-3.5%	-3.6%	-3.5%	-3.4%	-3.3%	-3.1%	-6.1%
Gastrointestinal	-54.8%	-55.1%	-54.8%	-54.6%	-54.3%	-1.7%	-1.8%	-1.8%	-1.9%	-1.9%	-28.9%
Allergy / Immunology	-13.1%	-0.4%	-8.5%	-12.7%	-13.4%	-14.1%	-14.0%	-14.1%	-14.0%	-13.8%	-12.0%
Urology	-4.6%	-26.3%	-6.4%	-14.8%	-17.0%	-19.9%	-19.8%	-19.7%	-20.1%	-22.9%	-17.9%
Other Non-Oncology	0.0%	0.0%	0.0%	-0.2%	-0.4%	-0.9%	-1.4%	-1.3%	-1.2%	-1.2%	-0.8%
Ophthalmology	-0.2%	-0.2%	-0.2%	-0.2%	-0.3%	-2.6%	-2.8%	-3.1%	-3.3%	-3.6%	-1.5%
Total	**-14.0%**	**-10.6%**	**-8.4%**	**-16.3%**	**-17.1%**	**-18.4%**	**-18.4%**	**-18.3%**	**-18.1%**	**-18.5%**	**-16.1%**
Cumulative Total	**-14.0%**	**-12.3%**	**-10.9%**	**-12.4%**	**-13.4%**	**-14.3%**	**-15.0%**	**-15.4%**	**-15.8%**	**-16.1%**	
Impact after PACTA	**-0.2%**	**-0.2%**	**-0.2%**	**-0.3%**	**-0.3%**	**-0.4%**	**-0.4%**	**-0.4%**	**-0.4%**	**-0.4%**	**-0.3%**

Impacts to each specialty group are highly sensitive to the specific drugs chosen for negotiation. We note the list of drugs selected for negotiation in each year is very difficult to predict and the margin of error is large, particularly in later years which will be more heavily impacted by variations in drug-level trends and the introduction of drugs that are not on the market today.

Under the IRA as written, we estimate non-oncology provider reimbursement will decrease by $9.2B over the 10-year period, due to reduced reimbursement on selected drugs. Under PACTA, we estimate reimbursement will correspondingly increase by $9.0B relative to the IRA Part B MDPNP scenario. The manufacturer rebate paid under PACTA is intended to bring provider reimbursement in line with pre-IRA reimbursement; however, because it is calculated prior to the impact of sequestration, providers are not quite made whole. This dynamic occurs because under PACTA, patients pay a smaller share of costs (tied to MFP), so the government sequesters a greater share of gross costs, resulting in final net revenue less than the 4.3% of ASP collected today.

Hospitals participating in the 340B program are expected to see significant decreases in provider reimbursement under the IRA. These participating hospitals acquire drugs at a much lower cost than other providers but are reimbursed at the same rate. Thus, when reimbursement is reduced to be MFP-based, a larger share of revenue dollars is reduced for 340B providers.

RESULTS BY GEOGRAPHY

Changes to non-oncology provider reimbursement vary by geography based on the provider makeup in each area. Figures 4A and 4B below outline the IRA impact on provider reimbursement over the 10-year modeling period by region and geography type, absent any behavioral changes, in dollars and as a percentage of pre-IRA NCR, respectively.

FIGURE 4A: IMPACT ON NON-ONCOLOGY PROVIDER REIMBURSEMENT UNDER MDPNP BY YEAR AND GEOGRAPHY ($M)

		YEAR										
REGION	**GEOGRAPHY**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**Total**
Northeast	Urban	-$99	-$80	-$66	-$146	-$157	-$170	-$175	-$179	-$183	-$198	-$1,453
	Suburban	-$12	-$12	-$9	-$13	-$14	-$13	-$14	-$14	-$15	-$17	-$133
	Rural	-$8	-$3	-$3	-$6	-$6	-$5	-$5	-$5	-$5	-$6	-$52
Midwest	Urban	-$174	-$149	-$117	-$231	-$252	-$270	-$279	-$287	-$295	-$317	-$2,371
	Suburban	-$29	-$14	-$16	-$31	-$33	-$32	-$33	-$34	-$35	-$36	-$291
	Rural	-$23	-$9	-$11	-$18	-$19	-$18	-$19	-$19	-$19	-$20	-$175
South	Urban	-$162	-$168	-$113	-$245	-$272	-$342	-$355	-$366	-$378	-$409	-$2,809
	Suburban	-$18	-$10	-$11	-$22	-$24	-$27	-$28	-$29	-$30	-$31	-$231
	Rural	-$5	-$2	-$2	-$6	-$6	-$7	-$7	-$8	-$8	-$8	-$59
West	Urban	-$115	-$64	-$70	-$132	-$142	-$170	-$175	-$179	-$184	-$189	-$1,420
	Suburban	-$15	-$8	-$7	-$14	-$15	-$14	-$15	-$15	-$15	-$16	-$134
	Rural	-$7	-$2	-$3	-$6	-$7	-$7	-$7	-$7	-$8	-$8	-$63
Total		**-$667**	**-$520**	**-$429**	**-$869**	**-$948**	**-$1,076**	**-$1,113**	**-$1,142**	**-$1,174**	**-$1,253**	**-$9,191**
Impact after PACTA		**-$12**	**-$8**	**-$8**	**-$15**	**-$17**	**-$22**	**-$24**	**-$25**	**-$26**	**-$27**	**-$185**

FIGURE 4B: IMPACT ON NON-ONCOLOGY PROVIDER NCR UNDER MDPNP BY YEAR AND GEOGRAPHY (%)

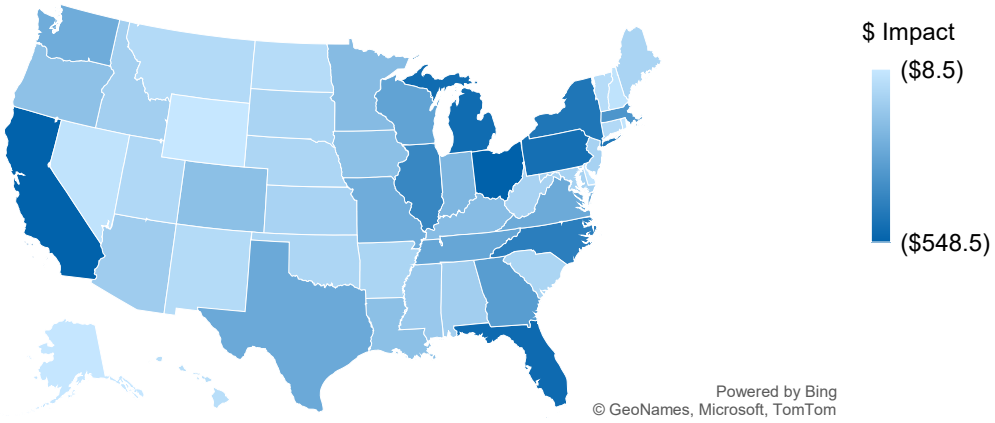
		YEAR										
REGION	**GEOGRAPHY**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**Total**
Northeast	Urban	-13.5%	-10.7%	-8.4%	-18.0%	-18.7%	-19.3%	-19.3%	-19.1%	-18.8%	-19.6%	-16.8%
	Suburban	-17.5%	-16.7%	-12.1%	-17.4%	-17.9%	-15.6%	-15.7%	-15.6%	-15.4%	-17.2%	-16.1%
	Rural	-21.8%	-7.0%	-9.0%	-14.0%	-14.2%	-12.0%	-12.0%	-11.8%	-11.6%	-11.3%	-12.4%
Midwest	Urban	-15.4%	-12.8%	-9.6%	-18.2%	-19.0%	-19.3%	-19.3%	-19.1%	-18.9%	-19.4%	-17.4%
	Suburban	-18.0%	-8.2%	-9.4%	-17.1%	-17.6%	-16.5%	-16.4%	-16.2%	-16.0%	-15.8%	-15.3%
	Rural	-21.5%	-8.2%	-9.7%	-15.7%	-16.0%	-14.3%	-14.2%	-14.0%	-13.8%	-13.8%	-14.1%
South	Urban	-11.3%	-11.3%	-7.3%	-15.2%	-16.1%	-19.1%	-19.2%	-19.1%	-19.0%	-19.7%	-16.2%
	Suburban	-14.3%	-7.3%	-8.3%	-15.8%	-16.3%	-17.8%	-18.0%	-17.8%	-17.5%	-17.4%	-15.3%
	Rural	-11.7%	-3.8%	-4.8%	-11.2%	-11.5%	-12.4%	-12.4%	-12.0%	-11.7%	-11.3%	-10.5%
West	Urban	-14.4%	-7.8%	-8.2%	-14.9%	-15.4%	-17.6%	-17.5%	-17.3%	-17.0%	-16.7%	-15.0%
	Suburban	-16.4%	-8.6%	-7.6%	-13.8%	-14.2%	-13.4%	-13.4%	-13.3%	-13.1%	-13.1%	-12.7%
	Rural	-19.9%	-6.0%	-9.0%	-17.6%	-17.9%	-18.3%	-18.2%	-17.9%	-17.6%	-17.3%	-16.1%
Total		**-14.0%**	**-10.6%**	**-8.4%**	**-16.3%**	**-17.1%**	**-18.4%**	**-18.4%**	**-18.3%**	**-18.1%**	**-18.5%**	**-16.1%**
Impact after PACTA		**-0.2%**	**-0.2%**	**-0.2%**	**-0.3%**	**-0.3%**	**-0.4%**	**-0.4%**	**-0.4%**	**-0.4%**	**-0.4%**	**-0.3%**

In 2028, the impact on rural providers will be significantly greater, on a percentage basis, than on urban or suburban providers, due to greater use of the products selected for the MDPNP in 2028 among rural providers. However, this dynamic will flip in later years, as the MFP products selected shift toward those with a smaller share of utilization by rural providers.

Figures 5A and 5B show the impact on provider reimbursement by state, in dollars and as a percentage of pre-IRA NCR, respectively. Further state-level results are included in Appendices A and B.

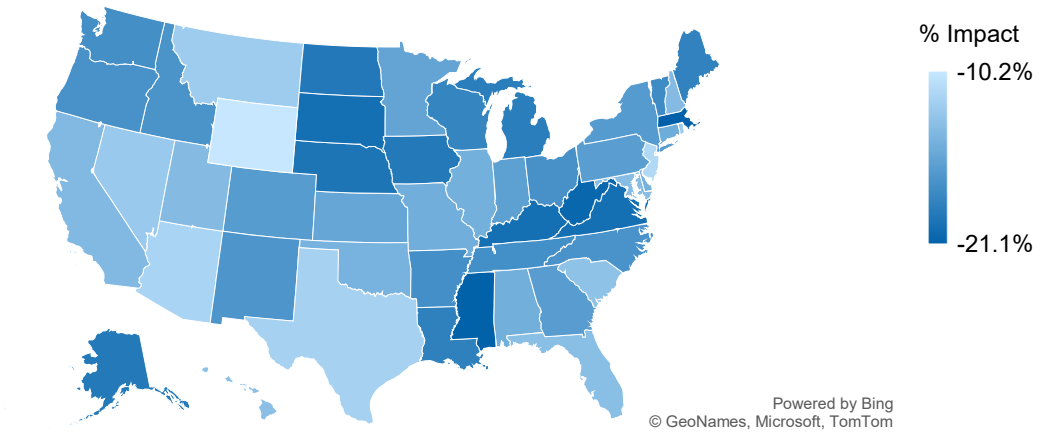
On a dollar basis, the states with the largest provider reimbursement impacts are Ohio, California, Florida, Michigan, and Pennsylvania. On a percentage basis, the states with the largest impacts to margin are Massachusetts, Mississippi, West Virginia, South Dakota, and Kentucky. Variation by state is likely driven by population size, the mix of 340B hospitals, and the presence of major specialty hospitals.

FIGURE 5A: TEN-YEAR IMPACT ON NON-ONCOLOGY PROVIDER REIMBURSEMENT UNDER MDPNP BY STATE ($M)



TEN-YEAR IMPACT ON PROVIDER REIMBURSEMENT UNDER MDPNP, BY STATE ($M)									
STATE	IMPACT	STATE	IMPACT	STATE	IMPACT	STATE	IMPACT	STATE	IMPACT
AK	-$11.0	HI	-$45.6	ME	-$85.6	NJ	-$92.3	SD	-$85.0
AL	-$107.5	IA	-$167.1	MI	-$506.0	NM	-$57.0	TN	-$269.3
AR	-$82.2	ID	-$104.0	MN	-$184.1	NV	-$25.8	TX	-$256.5
AZ	-$115.4	IL	-$395.0	MO	-$245.5	NY	-$463.2	UT	-$67.9
CA	-$544.8	IN	-$204.4	MS	-$132.1	OH	-$548.5	VA	-$253.2
CO	-$166.6	KS	-$87.1	MT	-$61.7	OK	-$76.0	VT	-$51.9
CT	-$63.7	KY	-$181.1	NC	-$430.0	OR	-$162.4	WA	-$244.5
DE	-$22.3	LA	-$165.7	ND	-$52.1	PA	-$491.5	WI	-$282.8
FL	-$510.4	MA	-$339.1	NE	-$76.8	RI	-$22.1	WV	-$91.1
GA	-$308.3	MD	-$92.6	NH	-$26.5	SC	-$81.7	WY	-$8.5

FIGURE 5B: TEN-YEAR IMPACT ON NON-ONCOLOGY PROVIDER NCR UNDER MDPNP BY STATE (%)



TEN-YEAR IMPACT ON NON-ONCOLOGY PROVIDER NCR UNDER MDPNP, BY STATE (%)									
STATE	**IMPACT**	**STATE**	**IMPACT**	**STATE**	**IMPACT**	**STATE**	**IMPACT**	**STATE**	**IMPACT**
AK	-19.1%	HI	-13.4%	ME	-18.4%	NJ	-11.3%	SD	-20.0%
AL	-14.8%	IA	-19.1%	MI	-18.7%	NM	-16.8%	TN	-17.4%
AR	-17.3%	ID	-16.9%	MN	-15.6%	NV	-12.6%	TX	-11.9%
AZ	-11.7%	IL	-14.7%	MO	-14.8%	NY	-16.3%	UT	-13.8%
CA	-13.9%	IN	-15.9%	MS	-21.0%	OH	-17.2%	VA	-19.9%
CO	-16.3%	KS	-15.5%	MT	-12.4%	OK	-14.4%	VT	-17.6%
CT	-15.0%	KY	-20.0%	NC	-17.0%	OR	-17.1%	WA	-17.3%
DE	-14.5%	LA	-18.5%	ND	-19.2%	PA	-16.1%	WI	-18.2%
FL	-13.5%	MA	-21.1%	NE	-19.5%	RI	-12.5%	WV	-20.6%
GA	-16.2%	MD	-13.6%	NH	-13.8%	SC	-13.2%	WY	-10.2%

RESULTS BY PROVIDER TYPE

Changes to provider reimbursement vary by provider type. Independent providers account for roughly two-thirds of non-oncology Part B drug spend today, though they account for only one-fifth of the overall provider reimbursement impact. This difference is driven by the lower pre-IRA acquisition costs for Part B drugs administered at large hospital systems that are more likely than independent providers to be purchasing drugs under the 340B program. Impacts to independent providers are discussed further in the following section. Figures 6A and 6B outline the IRA impact on provider reimbursement over the 10-year modeling period by provider type, absent any behavioral changes.

Figure 6A: **MDPNP** Impact on Non-Oncology Provider REIMBURSEMENT by YEAR, PROVIDER, AND GEOGRAPHY TYPE ($M)

PROVIDER TYPE	GEOGRAPHY	YEAR 2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	TOTAL
Independent Providers	Urban	**-$117**	**-$83**	-$78	-$134	-$157	-$189	-$200	-$207	-$213	-$223	-$1,601
	Suburban	**-$12**	**-$9**	-$7	-$14	-$16	-$17	-$18	-$18	-$19	-$19	-$148
	Rural	**-$7**	**-$2**	-$3	-$5	-$6	-$6	-$6	-$6	-$6	-$6	-$55
	Total	**-$135**	**-$94**	-$88	-$154	-$179	-$212	-$224	-$231	-$238	-$248	-$1,804
Hospital Systems	Urban	**-$434**	**-$378**	-$287	-$619	-$667	-$763	-$785	-$804	-$827	-$890	-$6,453
	Suburban	**-$63**	**-$34**	-$37	-$66	-$70	-$70	-$72	-$74	-$75	-$80	-$641
	Rural	**-$36**	**-$13**	-$17	-$31	-$32	-$32	-$32	-$33	-$34	-$35	-$294
	Total	**-$532**	**-$425**	-$341	-$715	-$769	-$864	-$889	-$911	-$936	-$1,005	-$7,387
Total		**-$667**	**-$520**	**-$429**	**-$869**	**-$948**	**-$1,076**	**-$1,113**	**-$1,142**	**-$1,174**	**-$1,253**	**-$9,191**
Impact After PACTA		**-$12**	**-$8**	**-$8**	**-$15**	**-$17**	**-$22**	**-$24**	**-$25**	**-$26**	**-$27**	**-$185**

FIGURE 6B: MDPNP IMPACT ON NON-ONCOLOGY PROVIDER NCR BY YEAR, PROVIDER, AND GEOGRAPHY TYPE (%)

PROVIDER TYPE	GEOGRAPHY	YEAR 2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	TOTAL
Independent Providers	Urban	-8.8%	-6.0%	-5.5%	-9.0%	-10.0%	-11.3%	-11.5%	-11.4%	-11.2%	-11.1%	-9.8%
	Suburban	-10.4%	-7.6%	-5.8%	-11.3%	-11.9%	-12.2%	-12.2%	-12.0%	-11.7%	-11.3%	-10.8%
	Rural	-13.8%	-4.7%	-5.6%	-9.3%	-9.7%	-9.2%	-9.1%	-8.8%	-8.5%	-8.1%	-8.7%
	Total	-9.1%	-6.1%	-5.5%	-9.2%	-10.1%	-11.3%	-11.5%	-11.4%	-11.2%	-11.0%	-9.8%
Hospital Systems	Urban	-15.7%	-13.3%	-9.7%	-20.1%	-20.8%	-22.7%	-22.6%	-22.4%	-22.3%	-23.2%	-19.6%
	Suburban	-18.5%	-9.9%	-10.3%	-17.8%	-18.2%	-17.5%	-17.6%	-17.4%	-17.3%	-17.7%	-16.3%
	Rural	-20.9%	-7.4%	-9.4%	-16.4%	-16.7%	-15.7%	-15.6%	-15.5%	-15.3%	-15.2%	-14.9%
	Total	-16.2%	-12.6%	-9.7%	-19.7%	-20.3%	-21.8%	-21.8%	-21.6%	-21.4%	-22.2%	-19.1%
Total		**-14.0%**	**-10.6%**	**-8.4%**	**-16.3%**	**-17.1%**	**-18.4%**	**-18.4%**	**-18.3%**	**-18.1%**	**-18.5%**	**-16.1%**
Impact After PACTA		**-0.2%**	**-0.2%**	**-0.2%**	**-0.3%**	**-0.3%**	**-0.4%**	**-0.4%**	**-0.4%**	**-0.4%**	**-0.4%**	**-0.3%**

IV. Behavior Impacts

PROVIDER CONSOLIDATION

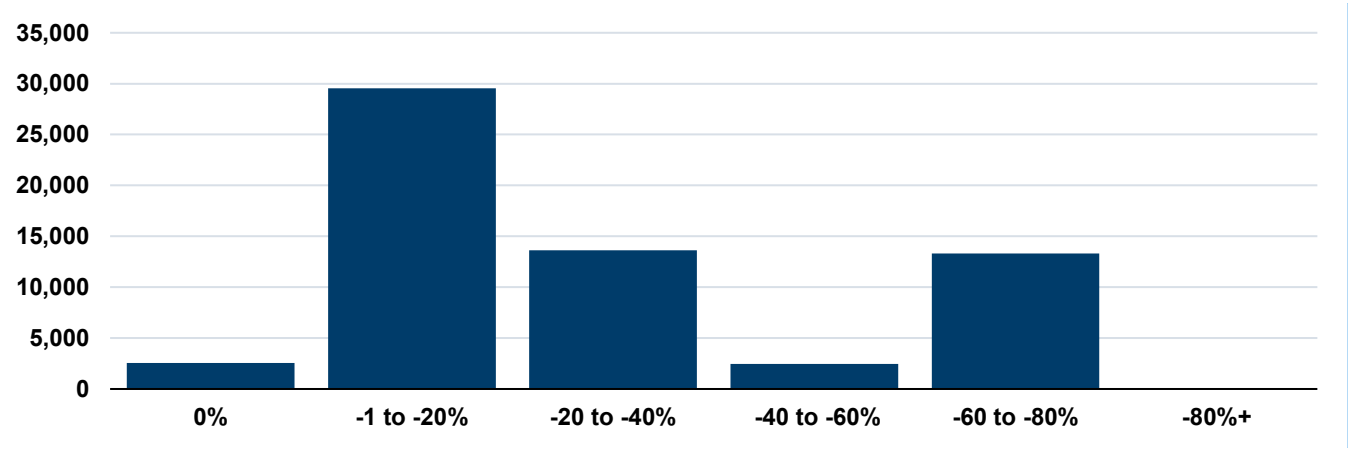
MFP-based reimbursement introduces additional complexity into the reimbursement system. Under the IRA, providers continue to purchase drugs at the same price but receive lower reimbursement and must track chargebacks (i.e, the difference between acquisition cost and MFP) collected from each manufacturer of selected drugs. The combination of higher administrative burden and lower reimbursement could impact provider staffing and budgets, especially for small, independent practices.[9] Historically, similar pressures have been associated with increased provider consolidation.[10] Providers may also consider other options, such as renegotiating contracts for more favorable reimbursement. Under PACTA, the reimbursement mechanism remains the same as pre-IRA, so these complexities do not apply.

9. Hughes, S. (2026, August 17). *Re: CMS Medicare Drug Price Negotiation Program and Medicare Prescription Drug Benefit Program proposed rule* [Comment letter]. American Hospital Association. Retrieved September 21, 2026, from aha-comments-on-cms-medicare-drug-price-negotiation-program-and-medicare-prescription-drug-benefit-program-proposed-rule-8-17-2026.pdf.
10. Patzman, A., & Neeck, M. (2026, January 29). *Health care provider consolidation* [Issue brief]. Bipartisan Policy Center. Retrieved September 21, 2026, from https://bipartisanpolicy.org/issue-brief/health-care-provider-consolidation/.

Over the 10-year modeling period, we expect $1.8B of the projected $9.2B decrease to provider reimbursement to affect independent providers, with an average decrease to NCR of 9.1%. Although this percentage decrease is less than the overall average across all non-oncology providers, smaller providers may be less able to absorb the reduction in reimbursement. We identified approximately 62,000 National Provider Identifiers (NPIs) (representing approximately 58% of non-oncology MFP spend) as independent providers. These include providers who are not associated with a hospital system and who had at least one Part B drug claim. Providers who do not administer Part B drugs were excluded from this group.

We expect independent providers to see a wide range of decreases to provider reimbursement attributable to the MDPNP, with 48% of these providers (based on NPI counts) seeing a decrease of between 1% and 20% of NCR for non-oncology Part B drugs and another 48% seeing a decrease between 20% and 80%. Approximately 4% of independent providers see no impact because they have very little or no volume of spend attributable to non-oncology MDPNP drugs, and less than 1% of providers will see a decrease above 80%. These impacts are summarized in Figure 7 below.

FIGURE 7: DISTRIBUTION OF INDEPENDENT PROVIDER NPIS BY 10-YEAR NCR IMPACT



Looking further at independent providers, Figure 8 shows a more detailed view of how providers are impacted in each geographic area.

FIGURE 8: NPI COUNT BY 10-YEAR IMPACT ON PROVIDER NCR AND GEOGRAPHY

		DECREASE IN PROVIDER NCR						
REGION	**GEOGRAPHY**	**0%**	**-1 TO -20%**	**-20 TO -40%**	**-40 TO -60%**	**-60 TO -80%**	**-80%+**	**TOTAL**
Northeast	Urban	477	5,291	2,399	435	2,470	2	11,074
	Suburban	14	218	156	15	114	1	518
	Rural	3	243	98	23	96	0	463
Midwest	Urban	357	5,131	2,423	450	2,480	7	10,848
	Suburban	70	657	292	59	288	1	1,367
	Rural	30	348	124	23	91	3	620
South	Urban	913	10,863	4,892	775	4,119	3	21,566
	Suburban	59	898	448	52	284	0	1,742
	Rural	24	402	152	9	96	0	684
West	Urban	555	5,032	2,353	582	3,049	5	11,576
	Suburban	29	328	121	27	175	1	682
	Rural	36	189	74	29	84	0	412
Total		**2,568**	**29,599**	**13,534**	**2,480**	**13,347**	**23**	**61,551**

The distribution of impacts is relatively consistent across geographic categories. Because independent providers tend to have fewer resources to absorb a material decrease in provider reimbursement, they are more likely than large systems to look for other ways to manage costs. This is most likely to be the case among those with the largest impact on reimbursement—over 13,000

independent providers are expected to have a decrease in NCR of over 60% for non-oncology MFP drugs. The South has the largest number of independent providers; however, the West has the largest concentration of providers with greater than 60% reduction in NCR (26% of independent providers in the West, compared to 22% across all regions).

Although some of these providers may be able to absorb margin reductions elsewhere, for others the reductions may affect their ability to remain in operation. Disruption to these providers' ability to provide care or remain in operation could, in turn, disrupt patients. Impacts to both providers and patients are also highly dependent on any actions from other stakeholders, including manufacturers.

POTENTIAL IMPLICATIONS FOR PATIENTS

Although patients using MDPNP products are a small portion of the population, independent providers serve 56 million patients (e.g., those with at least one claim) across other services, based on 2023 utilization.

Reduced reimbursement is likely to impact providers in different ways. Any change is likely to impact patients as well. In a situation in which a provider can no longer offer a given therapy, the provider and patient would need to consider another clinically appropriate treatment or a transfer of care to another site.

Other Considerations

- **Standard default refund amount (SDRA):** This analysis assumes manufacturers refund providers the exact difference between the MFP and the acquisition cost for selected drugs. In reality, the refund may be based on a different amount as the acquisition cost varies for each provider and may not be known in advance. To the extent manufacturers rely on the SDRA, provider reimbursement will in turn be impacted. The SDRA calculation methodology has not been finalized at the time of this report's publication, but CMS has proposed both WAC- and ASP-based approaches.[11]
- **Manufacturer behavior:** We do not model any behavioral changes manufacturers may undertake in response to changes in provider reimbursement resulting from the MDPNP or PACTA. Such reactions are difficult to predict but could include changes in R&D, production, and pricing strategy.
- **Alternate payment models:** Alternate payment models—such as the Medicare Shared Savings Program and ACO Models—are expected to continue under both the MDPNP and PACTA to encourage innovation, as well as cost and care management. These programs, or any successor programs, may require adjustment to ensure their payment structures continue to support the delivery of appropriate care. In particular, the Enhancing Oncology Model is likely to be affected, as many Part B oncology drugs are expected to be selected for negotiation. Although oncology was outside the scope of our analysis, shared savings benchmarks for this model may need to be recalibrated to reflect negotiated prices.
- **Value-based contracting:** Value-based contracting has become increasingly common among Medicare Advantage plans as a tool for managing costs and improving patient outcomes. These contracts are likely to be affected by both the MDPNP and PACTA. Under the MDPNP, reimbursement differences could affect whether providers can sustainably acquire, stock, and administer selected drugs. This may limit the therapies available in a given practice and affect treatment decisions, potentially requiring patients to seek care elsewhere. Under PACTA, however, reimbursement would remain ASP-based, reducing the likelihood that the provider's ability to administer selected drugs would be impacted. To the extent value-based contracts measure both cost and patient outcomes, adjustments will likely be needed to account for changes in provider incentives.
- **Capitated arrangements:** Unlike value-based contracting, providers in capitated arrangements with plans are incentivized to provide the lowest cost care since reimbursement does not depend on the cost of the care provided. Providers may be incentivized to prescribe MFP drugs given the material cost differential; however, cases when non-MFP drugs are more likely to have better outcomes may arise.
- **340B implications:** We expect that 340B hospitals will experience significant margin reductions under the IRA. PACTA would help preserve an operating margin for these facilities.
- **Spillover into other markets:** Many physician fee schedules in the commercial and Medicaid markets are based on a percentage of ASP. Because MFPs are incorporated into ASP calculations under the MDPNP, negotiated prices could lower ASP and, in turn, reduce provider reimbursement in those markets. PACTA would prevent this spillover by clarifying that MFPs are excluded from ASP calculations. Separately, if ASPs are no longer published for MFP drugs, contracts will need to find a different mechanism of reimbursement.

11. *Medicare top 50 negotiation-eligible drug list for IPAY 2028* [Fact sheet]. (2026, July 16). Centers for Medicare and Medicaid Services. Retrieved September 21, 2026, from https://www.cms.gov/newsroom/fact-sheets/manufacturer-effectuation-mfp-draft-guidance-2028-medicare-drug-price-negotiation.

Additionally, provider behaviors could affect other markets. Although it is difficult to predict behavioral changes, if providers cease to stock selected drugs, then commercial and Medicaid patients would also need to change therapies or site of care. Similarly, if a provider closes its doors, patients in all markets would need to seek alternative providers.

- **Time value of money and cash flow strain:** We did not explicitly model the impact of cash flow timing; however, we acknowledge that interest effects and potential cash flow strain likely exist under both the IRA and PACTA scenarios. Under PACTA in particular, there is a potential impact to CMS, as manufacturers have up to six months following the end of the calendar quarter in which a claim occurs to furnish the rebate.

  Additionally, we assume CMS will prospectively adjust Medicare Advantage benchmark payments to reflect cost reductions resulting from the MDPNP. If CMS were to forgo such adjustments, plans would be effectively overpaid for Part B costs until MFPs are incorporated into the historical experience used to set benchmarks. CMS has made prospective benchmark adjustments in the past when material cost savings were anticipated—for example, when end-stage renal disease (ESRD) beneficiaries became eligible to enroll in Medicare Advantage in 2021.[12]
- **Risk adjustment:** As of the 2027 Medicare Rate Announcement, CMS has incorporated 2026 negotiated prices into the Part D (RxHCC) risk adjustment model but has not yet incorporated 2027 prices.[13] We expect CMS to take a similar approach for the Part C (CMS-HCC) risk adjustment model, incorporating negotiated prices on a one-year lag beginning in 2029. Adjusting the risk adjustment models better aligns risk-adjusted plan payments with expected costs.

V. Methodology and Assumptions

We used the Part A and Part B claims from the CMS CCW VRDC for calendar year 2023, which we then trended to 2028 through 2037 and re-adjudicated claims in each year. We excluded claims for oncology drugs.

PART B TRENDS AND MFP ASSUMPTIONS

Per the IRA provisions, 15 drugs were selected for negotiation in 2028, and up to 20 drugs will be selected in each year thereafter. The selected drugs must be among the top 50 negotiation-eligible drugs based on the highest total Medicare expenditure of a given historical cycle. We projected drug-level trends across Part D and Part B using a combination of recent trends, industry reports, and Milliman research to identify high-expenditure drugs and assess their eligibility for potential negotiation in each projection year starting in 2029 based on available information and applicable regulations current as of May 2026. We model 2028 selections consistent with the published list.[14] We estimated MFPs as 10% lower than the ceiling price of the MFP calculation outlined in the IRA, based on the average differential between the final MFP and estimated ceiling price observed for 2027 Part D MFPs. Notably, if final negotiated MFPs are lower than our estimated ceiling prices, the impacts to each stakeholder would grow and vice versa.

OTHER MEDICAL CLAIMS

We trended medical cost and utilization in our analysis using trend assumptions from the 2025 Medicare Trustees report, which was the most recent report available at the time of our analysis. The benefit designs assumed for each market segment and year are discussed in more detail below. We projected medical trends at the service level category based on Milliman research.

OTHER ASSUMPTIONS

We used the following assumptions in our analysis:

- **Provider reimbursement:** We varied reimbursement for selected drugs in each scenario as follows:
  - **Pre-IRA:** We assumed provider reimbursement to be ASP+6%.
  - **MDPNP:** We assumed provider reimbursement to be MFP+6%.
  - **PACTA:** We assumed provider reimbursement to be ASP+6%.
- **Enrollment:** We used the total Medicare enrollment projections and MA enrollment projections from the 2025 Medicare Trustees report. We assumed beneficiaries have 12 months of Medicare enrollment. We determined the portion of Medigap beneficiaries using the historical distribution and trend information from KFF.[15]

12. Congressional Budget Office. (2024, December 12). *Reduce Medicare Advantage benchmarks*. In *Options for reducing the deficit: 2025 to 2034*.https://www.cbo.gov/budget-options/60900
13. *Advance notice of methodological changes for calendar year (CY) 2027 for Medicare Advantage (MA) capitation rates and Part C and Part D payment policies*. (2026, January 26). Centers for Medicare and Medicaid Services. Retrieved September 21, 2026, from https://www.cms.gov/newsroom/fact-sheets/2027-medicare-advantage-part-d-advance-notice.
14. *Medicare top 50 negotiation-eligible drug list for IPAY 2028* [Fact sheet]. (2026, July 16). Centers for Medicare and Medicaid Services. Retrieved September 21, 2026, from https://www.cms.gov/files/document/factsheet-medicare-top-50-negotiation-eligible-drug-list-ipay-2028.pdf.
15. Freed, M., Ochieng, N., Cubanski, J., & Neuman, T. (2024, October 18). *Key facts about Medigap enrollment and premiums for Medicare beneficiaries* [Issue brief]. KFF. Retrieved September 21, 2026, from https://www.kff.org/medicare/issue-brief/key-facts-about-medigap-enrollment-and-premiums-for-medicare-beneficiaries/.

- **Provider specialty grouping:** We assigned claims to a provider specialty grouping based on the provider taxonomy code listed on the claim. If the taxonomy code was unavailable, we used a clinician-developed mapping of drug (HCPCS code) to provider specialty based on the drug's most common indication and used that specialty for the entire claim. If the taxonomy code was unavailable for non-drug (HCPCS code) claims, we used the most common specialty code from claims on the same date for the patient.
- **Provider type:** Provider type was assigned using NPI numbers informed by Milliman research. NPIs were classified as 'Hospital Systems' when the vast majority of claims had a health system association. NPIs were classified as 'Independent Providers' in cases when the vast majority of the claims did not have a health system association.
- **Geography:** We assigned geography based on provider zip code and the 2020 Rural-Urban Commuting Area (RUCA) Codes,[16] which was the most recent listing available at the time of our analysis. If the provider zip code did not appear on the claim, we used the patient zip code to map to the appropriate RUCA code.
  - Primary RUCA codes 1, 2, and 3 indicate metropolitan areas and were mapped to "Urban" geography.
  - Primary RUCA codes 4, 5, and 6 indicate micropolitan areas and were mapped to "Suburban" geography.
  - Primary RUCA codes 7, 8, 9, and 10 indicate small town and rural areas and were mapped to "Rural" geography.
- **Region:** We assigned the regions using the provider state on each claim. If the provider state did not appear on the claim, we assigned the region using the patient state.
  - Northeast: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.
  - Midwest: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.
  - South: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.
  - West: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.
- **340B hospitals:** We used a combination of data from Health Resources and Services Administration (HRSA), Medicare IDs, and NPI numbers to identify hospitals participating in the 340B program. To be flagged as a 340B hospital, the hospital had to participate in the 340B program on calendar year 2023.
  - For drugs administered at 340B hospitals, we assumed an acquisition discount of 35% − the midpoint of a reported average discount range of 20% to 50%.[17]
  - We did not assume any changes in 340B status throughout the 10-year projection period. Notably, however, the number of hospitals participating in the 340B program has been growing over time. To the extent 340B hospitals are more affected by the IRA than non-340B hospitals, the impact of the IRA could be greater than what is indicated by our results.

VI. Caveats, Limitations, and Qualifications

This report was developed to help NICA better understand the potential impact on providers of changing provider reimbursement methodology for Part B drugs selected for negotiation.

NICA may share this information with outside entities with Milliman's permission. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work product. Any other parties should obtain their own professional advice appropriate to their specific needs. Any release of this report should be in its entirety. Milliman does not endorse any public policy or advocacy position on matters discussed in this report.

In preparing our estimates, we relied upon CMS Research Identifiable Files and other publicly available data. We accepted this information without audit, but we reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate. Actual results will certainly vary for specific health plans and patients due to factors such as differences in trends, reimbursement arrangements, formulary, utilization patterns, and rebate arrangements.

We did not attempt to evaluate every possible change in stakeholder behavior that could result from these program changes. Results could vary based on how patients and other stakeholders react to the changes if implemented, and the payment structure of the new design.

16. Dobis, E.A., & Sanders, A. (2025, December 9). *Rural-urban commuting area codes*. Economic Research Service, U.S. Department of Agriculture. Retrieved September 21, 2026, from https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.
17. Mulligan, K. (2021, October 14). *The 340B Drug Pricing Program: Background, ongoing challenges and recent developments* [White paper]. USC Leonard D. Schaeffer Institute for Public Policy & Government Service. Retrieved September 21, 2026, from https://healthpolicy.usc.edu/research/the-340b-drug-pricing-program-background-ongoing-challenges-and-recent-developments/.

Michelle Robb and Katie Holcomb are actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

This report outlines the review and opinions of the authors of this report and not necessarily that of Milliman.

APPENDICES

Appendix A: Patient Impacts

Patient counts shown in Figure 9 include patients expected to utilize a non-oncology drug selected for negotiation and administered by a provider in the relevant specialty group over the 10-year period. Patients may have claims in multiple states or years. Totals reflect unique patients based on 2023 utilization assuming no enrollment trend.

FIGURE 9: PATIENTS UTILIZING NON-ONCOLOGY MFP DRUGS FROM 2028 TO 2037 BY STATE (M)

	YEAR										
State	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**Total**
AK	361	298	320	410	415	591	628	666	666	666	773
AL	6,295	5,017	5,376	6,693	6,870	9,269	11,164	11,367	11,444	11,444	13,102
AR	4,094	3,413	3,543	4,334	4,512	5,334	5,760	5,837	5,838	5,839	6,858
AZ	11,557	9,059	9,576	11,493	11,839	13,472	17,364	17,671	17,672	17,672	20,657
CA	47,005	41,289	42,741	47,813	49,119	57,934	64,627	65,337	65,417	65,421	73,397
CO	9,754	8,574	8,737	9,911	10,083	13,034	14,977	15,169	15,173	15,176	17,309
CT	6,441	5,715	5,904	6,785	7,006	7,677	9,722	9,856	9,858	9,858	11,130
DE	2,130	1,758	1,839	2,204	2,277	2,817	4,214	4,252	4,252	4,252	4,708
FL	33,701	28,405	29,049	33,924	34,899	46,434	55,236	56,263	56,618	56,640	66,630
GA	12,302	10,363	10,911	13,528	13,894	30,963	33,928	34,331	34,454	34,455	37,236
HI	1,215	1,238	1,109	1,219	1,282	1,744	1,971	1,986	1,992	1,992	2,343
IA	5,193	4,676	4,823	5,566	5,817	6,869	8,593	8,656	8,690	8,692	9,855
ID	3,028	2,521	2,630	3,159	3,218	3,723	3,874	3,930	3,932	3,932	4,623
IL	18,064	16,436	16,344	19,276	19,992	25,497	31,102	31,469	31,530	31,542	36,122
IN	9,496	7,638	8,153	9,823	10,263	12,869	14,517	14,815	14,820	14,821	17,464
KS	5,537	4,613	4,931	5,694	5,774	7,542	8,351	8,441	8,441	8,441	9,730
KY	7,579	6,058	6,361	8,055	8,269	8,980	12,589	12,782	12,787	12,787	14,766
LA	5,826	4,958	5,043	6,386	6,527	8,372	10,384	10,511	10,528	10,528	12,018
MA	12,724	11,212	11,502	12,989	13,272	14,293	14,886	15,101	15,121	15,123	17,885
MD	7,448	6,234	6,473	7,441	7,648	9,560	11,532	11,646	11,656	11,657	13,479
ME	3,688	3,316	3,389	3,649	3,714	3,860	4,727	4,773	4,777	4,778	5,454
MI	14,393	13,259	12,918	14,992	15,462	25,307	27,197	27,461	27,477	27,491	31,638
MN	9,697	8,818	8,777	9,624	9,786	11,348	12,489	12,549	12,557	12,558	14,865
MO	11,992	10,224	10,706	12,168	12,451	15,270	17,331	17,558	17,572	17,574	20,377
MS	4,119	3,396	3,745	5,449	5,533	7,344	9,442	9,548	9,555	9,555	10,429
MT	2,446	2,098	2,163	2,504	2,515	2,906	3,187	3,211	3,214	3,214	3,691
NC	15,657	13,180	13,287	15,888	16,374	20,925	25,059	25,457	25,510	25,523	30,318
ND	1,606	1,401	1,465	1,584	1,668	1,802	1,894	1,908	1,908	1,908	2,208
NE	4,005	3,515	3,711	4,182	4,261	5,006	5,487	5,539	5,539	5,539	6,362
NH	2,708	2,351	2,392	2,577	2,666	2,833	3,573	3,596	3,596	3,596	4,274
NJ	11,105	9,255	9,725	11,970	12,378	15,580	23,545	23,823	23,929	23,929	26,590
NM	2,753	2,344	2,479	2,712	2,737	2,944	3,468	3,506	3,506	3,506	4,063
NV	2,444	2,003	2,117	2,560	2,647	3,304	4,023	4,147	4,180	4,180	4,711
NY	26,136	23,523	24,179	27,765	28,361	33,555	40,924	41,387	41,522	41,526	46,668
OH	19,409	17,305	17,824	21,082	21,598	24,918	28,776	29,215	29,223	29,224	33,140
OK	4,440	3,347	3,660	4,933	5,023	6,665	7,700	7,927	7,936	7,936	9,279
OR	6,732	5,816	6,099	6,768	6,932	8,075	8,435	8,514	8,521	8,521	9,930
PA	20,130	17,619	17,881	21,296	21,842	26,575	32,453	32,863	32,956	32,973	37,999
RI	1,341	1,170	1,221	1,376	1,449	1,491	1,575	1,593	1,593	1,593	1,885
SC	8,934	7,051	7,559	9,574	9,984	11,503	13,453	13,695	13,793	13,793	16,097
SD	2,658	2,582	2,527	2,838	2,943	3,810	4,008	4,041	4,044	4,046	4,592
TN	10,056	8,759	8,851	11,935	12,404	15,455	18,662	18,986	18,997	19,006	21,947
TX	29,382	23,470	24,736	29,502	30,456	36,916	45,282	46,245	46,322	46,323	53,537
UT	4,703	4,436	4,381	5,035	5,157	5,713	6,305	6,387	6,391	6,393	7,343
VA	10,978	8,899	9,573	11,663	11,885	14,851	17,809	18,111	18,114	18,114	20,900
VT	955	941	894	950	977	1,117	1,468	1,479	1,481	1,481	1,779
WA	11,358	9,874	10,134	11,219	11,334	12,219	13,657	13,780	13,781	13,784	16,276
WI	11,354	10,378	10,375	11,366	11,866	13,414	14,790	14,917	14,923	14,930	17,391
WV	2,242	1,903	2,035	2,460	2,476	2,673	3,353	3,407	3,407	3,407	3,849
WY	653	515	542	650	654	803	900	910	910	910	1,091
Total	**462,704**	**399,212**	**411,183**	**482,671**	**496,033**	**617,858**	**728,469**	**738,191**	**741,810**	**741,939**	**849,260**

Appendix B: State-Level Detail

Figures 10A and 10B show the provider reimbursement impact by state and year and in total dollars and as a percentage of pre-IRA NCR, respectively. The totals in these figures exclude reimbursement associated with providers in United States territories or with missing geographic information and, therefore, are slightly lower than the totals shown in the main body of the paper.

FIGURE 10A: IMPACT ON NON-ONCOLOGY PROVIDER REIMBURSEMENT UNDER MDPNP BY STATE AND YEAR ($M)

	YEAR										
State	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**Total**
AK	-$0.7	-$0.3	-$0.5	-$1.0	-$1.1	-$1.4	-$1.5	-$1.5	-$1.5	-$1.5	-$11.0
AL	-$8.7	-$2.8	-$4.4	-$10.5	-$11.3	-$13.2	-$13.7	-$14.0	-$14.3	-$14.6	-$107.5
AR	-$4.4	-$5.2	-$3.3	-$7.6	-$8.6	-$10.0	-$10.3	-$10.6	-$10.8	-$11.5	-$82.2
AZ	-$12.2	-$3.9	-$5.4	-$8.3	-$9.1	-$14.3	-$15.0	-$15.4	-$15.7	-$16.1	-$115.4
CA	-$42.7	-$25.3	-$28.9	-$50.2	-$54.2	-$65.6	-$67.3	-$68.7	-$69.9	-$72.1	-$544.8
CO	-$13.8	-$5.1	-$7.7	-$16.3	-$17.6	-$20.0	-$20.7	-$21.3	-$21.7	-$22.3	-$166.6
CT	-$3.8	-$1.6	-$2.1	-$6.5	-$7.1	-$8.1	-$8.4	-$8.6	-$8.7	-$8.9	-$63.7
DE	-$1.8	-$0.8	-$1.1	-$1.9	-$2.1	-$2.8	-$2.9	-$2.9	-$3.0	-$3.0	-$22.3
FL	-$21.0	-$55.1	-$19.2	-$39.5	-$46.0	-$58.0	-$60.9	-$63.5	-$67.2	-$79.9	-$510.4
GA	-$14.9	-$8.4	-$9.7	-$26.5	-$28.7	-$41.6	-$43.0	-$44.0	-$45.0	-$46.6	-$308.3
HI	-$1.4	-$7.1	-$1.4	-$3.0	-$3.6	-$5.2	-$5.5	-$5.7	-$6.2	-$6.5	-$45.6
IA	-$13.4	-$9.9	-$9.8	-$17.9	-$19.3	-$18.1	-$18.7	-$19.1	-$19.6	-$21.3	-$167.1
ID	-$8.1	-$3.3	-$4.5	-$9.2	-$10.0	-$13.1	-$13.5	-$13.8	-$14.1	-$14.4	-$104.0
IL	-$25.6	-$32.7	-$18.8	-$37.9	-$42.2	-$43.6	-$45.4	-$46.8	-$48.4	-$53.7	-$395.0
IN	-$20.6	-$8.8	-$10.1	-$20.1	-$22.2	-$23.1	-$23.9	-$24.5	-$25.1	-$26.1	-$204.4
KS	-$10.8	-$3.8	-$5.6	-$8.1	-$8.7	-$9.5	-$9.9	-$10.1	-$10.3	-$10.5	-$87.1
KY	-$14.5	-$8.1	-$9.7	-$18.9	-$19.9	-$21.0	-$21.6	-$22.0	-$22.4	-$22.8	-$181.1
LA	-$12.5	-$5.3	-$6.7	-$13.9	-$14.7	-$21.2	-$21.9	-$22.5	-$23.0	-$24.0	-$165.7
MA	-$28.8	-$17.3	-$18.3	-$37.2	-$39.0	-$38.2	-$38.8	-$39.4	-$40.0	-$42.1	-$339.1
MD	-$5.0	-$5.8	-$4.2	-$8.3	-$9.7	-$11.1	-$11.6	-$11.9	-$12.3	-$12.7	-$92.6
ME	-$7.3	-$4.4	-$4.8	-$8.8	-$9.3	-$9.5	-$9.7	-$10.0	-$10.2	-$11.5	-$85.6
MI	-$31.1	-$37.3	-$22.5	-$47.7	-$52.4	-$58.1	-$60.2	-$62.1	-$64.0	-$70.5	-$506.0
MN	-$18.6	-$12.7	-$10.5	-$17.5	-$19.2	-$19.4	-$20.2	-$20.8	-$21.6	-$23.4	-$184.1
MO	-$23.6	-$12.4	-$13.6	-$25.2	-$26.9	-$27.2	-$28.1	-$28.8	-$29.4	-$30.3	-$245.5
MS	-$9.3	-$2.6	-$5.2	-$11.6	-$12.5	-$17.3	-$17.9	-$18.2	-$18.5	-$18.9	-$132.1
MT	-$6.2	-$2.3	-$3.0	-$6.2	-$6.6	-$7.2	-$7.3	-$7.5	-$7.6	-$7.7	-$61.7
NC	-$20.1	-$32.8	-$15.3	-$36.8	-$41.6	-$51.8	-$54.0	-$55.9	-$57.8	-$63.8	-$430.0
ND	-$6.0	-$2.9	-$3.6	-$5.3	-$5.6	-$5.5	-$5.7	-$5.8	-$5.9	-$6.0	-$52.1
NE	-$6.1	-$3.0	-$3.8	-$7.9	-$8.4	-$9.1	-$9.4	-$9.6	-$9.7	-$9.9	-$76.8
NH	-$3.3	-$2.1	-$2.3	-$2.9	-$3.1	-$2.4	-$2.5	-$2.6	-$2.6	-$2.7	-$26.5
NJ	-$6.6	-$5.8	-$4.4	-$8.1	-$9.4	-$10.6	-$11.3	-$11.7	-$12.1	-$12.4	-$92.3
NM	-$4.2	-$2.7	-$2.9	-$5.3	-$5.6	-$6.9	-$7.1	-$7.3	-$7.4	-$7.6	-$57.0
NV	-$2.3	-$0.9	-$1.2	-$2.4	-$2.6	-$3.1	-$3.2	-$3.3	-$3.4	-$3.4	-$25.8
NY	-$31.1	-$28.1	-$22.0	-$45.0	-$48.2	-$54.2	-$56.0	-$57.5	-$58.9	-$62.2	-$463.2
OH	-$38.3	-$22.2	-$24.7	-$53.8	-$57.6	-$66.7	-$68.6	-$70.4	-$72.0	-$74.3	-$548.5
OK	-$7.2	-$1.5	-$3.3	-$6.8	-$7.4	-$9.4	-$9.7	-$10.0	-$10.2	-$10.5	-$76.0
OR	-$13.3	-$6.1	-$7.6	-$16.4	-$17.6	-$19.5	-$19.9	-$20.3	-$20.7	-$21.1	-$162.4
PA	-$31.2	-$29.3	-$19.8	-$49.6	-$54.1	-$56.7	-$58.6	-$59.9	-$61.5	-$70.9	-$491.5
RI	-$3.0	-$1.1	-$1.5	-$2.4	-$2.6	-$2.2	-$2.3	-$2.3	-$2.3	-$2.4	-$22.1
SC	-$6.1	-$2.4	-$3.9	-$7.5	-$8.5	-$10.0	-$10.4	-$10.8	-$11.0	-$11.2	-$81.7
SD	-$5.8	-$7.8	-$4.8	-$8.6	-$9.6	-$9.1	-$9.3	-$9.6	-$9.9	-$10.6	-$85.0
TN	-$10.5	-$22.2	-$10.3	-$23.9	-$27.4	-$31.5	-$32.9	-$34.0	-$35.2	-$41.4	-$269.3
TX	-$22.2	-$11.1	-$13.0	-$23.5	-$25.8	-$29.9	-$31.5	-$32.5	-$33.1	-$34.0	-$256.5
UT	-$5.1	-$4.9	-$3.9	-$6.1	-$6.6	-$7.8	-$8.1	-$8.3	-$8.5	-$8.7	-$67.9
VA	-$20.0	-$8.7	-$11.5	-$24.0	-$25.7	-$31.3	-$32.1	-$32.7	-$33.3	-$33.9	-$253.2
VT	-$4.0	-$5.0	-$2.8	-$3.9	-$4.3	-$6.0	-$6.2	-$6.4	-$6.6	-$6.7	-$51.9
WA	-$25.3	-$11.9	-$12.9	-$26.5	-$28.1	-$26.7	-$27.3	-$27.8	-$28.3	-$29.6	-$244.5
WI	-$25.8	-$18.2	-$16.5	-$29.5	-$32.2	-$29.9	-$30.9	-$31.7	-$32.6	-$35.3	-$282.8
WV	-$6.7	-$2.8	-$4.0	-$8.7	-$9.2	-$11.5	-$11.7	-$12.0	-$12.2	-$12.4	-$91.1
WY	-$1.3	-$0.2	-$0.3	-$0.8	-$0.9	-$1.0	-$1.0	-$1.0	-$1.0	-$1.0	-$8.5
Total	**-$666.5**	**-$515.7**	**-$427.1**	**-$865.6**	**-$943.8**	**-$1,070.7**	**-$1,107.7**	**-$1,136.8**	**-$1,166.9**	**-$1,244.7**	**-$9,145.6**

FIGURE 10B: IMPACT ON NON-ONCOLOGY PROVIDER NCR UNDER MDPNP BY STATE AND YEAR (%)

	YEAR										
State	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**Total**
AK	-12.9%	-6.4%	-9.0%	-18.5%	-18.8%	-24.6%	-24.6%	-24.6%	-24.4%	-24.1%	-19.1%
AL	-14.2%	-4.4%	-6.7%	-15.3%	-15.8%	-17.7%	-17.8%	-17.7%	-17.5%	-17.2%	-14.8%
AR	-11.4%	-12.9%	-8.0%	-17.4%	-18.6%	-20.4%	-20.4%	-20.1%	-19.8%	-20.0%	-17.3%
AZ	-14.5%	-4.5%	-6.1%	-9.0%	-9.4%	-14.3%	-14.4%	-14.3%	-14.1%	-13.9%	-11.7%
CA	-12.9%	-7.5%	-8.2%	-13.8%	-14.3%	-16.5%	-16.3%	-16.0%	-15.7%	-15.4%	-13.9%
CO	-16.4%	-5.9%	-8.4%	-17.2%	-17.7%	-19.1%	-19.1%	-18.8%	-18.5%	-18.2%	-16.3%
CT	-10.8%	-4.3%	-5.4%	-16.4%	-17.2%	-18.6%	-18.6%	-18.4%	-18.0%	-17.6%	-15.0%
DE	-13.3%	-5.9%	-7.6%	-13.0%	-14.2%	-17.9%	-18.0%	-17.7%	-17.4%	-17.0%	-14.5%
FL	-7.0%	-17.7%	-5.9%	-11.5%	-12.6%	-14.9%	-15.0%	-15.0%	-15.2%	-17.2%	-13.5%
GA	-9.4%	-5.1%	-5.7%	-14.9%	-15.5%	-21.2%	-21.2%	-20.9%	-20.6%	-20.5%	-16.2%
HI	-5.8%	-26.6%	-4.8%	-9.9%	-11.1%	-14.9%	-14.8%	-14.5%	-14.8%	-14.5%	-13.4%
IA	-18.3%	-13.0%	-12.4%	-21.9%	-22.5%	-20.3%	-20.3%	-20.1%	-19.8%	-20.7%	-19.1%
ID	-17.3%	-6.8%	-8.7%	-16.7%	-16.9%	-20.8%	-20.3%	-19.7%	-19.0%	-18.3%	-16.9%
IL	-11.6%	-14.3%	-7.9%	-15.2%	-16.2%	-15.8%	-15.8%	-15.7%	-15.6%	-16.5%	-14.7%
IN	-19.1%	-7.9%	-8.7%	-16.7%	-17.7%	-17.6%	-17.6%	-17.5%	-17.3%	-17.3%	-15.9%
KS	-21.4%	-7.6%	-10.7%	-15.2%	-15.7%	-16.7%	-16.8%	-16.8%	-16.6%	-16.4%	-15.5%
KY	-18.0%	-9.9%	-11.6%	-22.0%	-22.5%	-22.9%	-23.0%	-22.7%	-22.4%	-22.1%	-20.0%
LA	-16.5%	-6.9%	-8.3%	-16.5%	-16.8%	-23.1%	-23.2%	-23.0%	-22.7%	-22.9%	-18.5%
MA	-20.2%	-12.0%	-12.3%	-24.4%	-24.7%	-23.4%	-23.2%	-22.9%	-22.6%	-23.1%	-21.1%
MD	-9.0%	-10.2%	-7.0%	-13.3%	-14.8%	-15.9%	-16.0%	-15.7%	-15.6%	-15.4%	-13.6%
ME	-18.8%	-11.0%	-11.5%	-20.3%	-20.5%	-20.0%	-19.9%	-19.6%	-19.3%	-21.0%	-18.4%
MI	-14.1%	-16.3%	-9.4%	-19.0%	-19.9%	-20.9%	-21.0%	-20.8%	-20.6%	-21.8%	-18.7%
MN	-19.0%	-12.4%	-9.9%	-15.9%	-16.6%	-16.1%	-16.2%	-16.1%	-16.2%	-16.8%	-15.6%
MO	-16.6%	-8.5%	-9.0%	-16.2%	-16.7%	-16.2%	-16.2%	-16.0%	-15.8%	-15.7%	-14.8%
MS	-16.6%	-4.6%	-9.0%	-19.5%	-20.3%	-27.1%	-27.3%	-27.2%	-26.9%	-26.6%	-21.0%
MT	-14.0%	-5.0%	-6.5%	-13.0%	-13.5%	-14.1%	-14.1%	-14.1%	-14.0%	-13.9%	-12.4%
NC	-9.8%	-15.3%	-6.9%	-15.7%	-16.9%	-19.9%	-20.0%	-19.9%	-19.8%	-20.9%	-17.0%
ND	-24.0%	-11.4%	-13.9%	-20.1%	-21.0%	-20.1%	-20.2%	-20.2%	-20.2%	-20.1%	-19.2%
NE	-18.7%	-8.8%	-10.7%	-21.3%	-21.8%	-22.3%	-22.4%	-22.1%	-21.8%	-21.5%	-19.5%
NH	-19.6%	-12.2%	-13.0%	-16.0%	-16.5%	-12.2%	-12.6%	-12.5%	-12.4%	-12.2%	-13.8%
NJ	-9.6%	-8.3%	-6.0%	-10.6%	-11.9%	-12.7%	-13.2%	-13.1%	-13.0%	-12.7%	-11.3%
NM	-14.1%	-8.7%	-9.4%	-16.4%	-16.8%	-20.2%	-20.2%	-20.1%	-19.9%	-19.7%	-16.8%
NV	-12.5%	-4.6%	-6.4%	-12.6%	-13.2%	-15.1%	-15.3%	-15.2%	-15.0%	-14.7%	-12.6%
NY	-12.9%	-11.4%	-8.6%	-16.9%	-17.4%	-18.7%	-18.8%	-18.7%	-18.4%	-18.7%	-16.3%
OH	-15.0%	-8.3%	-8.8%	-18.3%	-18.7%	-20.4%	-20.2%	-19.8%	-19.3%	-18.9%	-17.2%
OK	-15.8%	-3.1%	-6.8%	-13.8%	-14.4%	-17.6%	-17.6%	-17.6%	-17.4%	-17.1%	-14.4%
OR	-16.3%	-7.3%	-8.8%	-18.3%	-18.9%	-20.1%	-20.0%	-19.7%	-19.4%	-19.0%	-17.1%
PA	-12.2%	-11.2%	-7.3%	-17.5%	-18.2%	-18.2%	-18.1%	-17.9%	-17.7%	-19.5%	-16.1%
RI	-18.4%	-7.0%	-9.1%	-14.5%	-15.1%	-12.6%	-12.5%	-12.3%	-12.0%	-11.8%	-12.5%
SC	-11.5%	-4.4%	-6.9%	-12.9%	-14.0%	-15.8%	-16.0%	-16.0%	-15.9%	-15.6%	-13.2%
SD	-16.7%	-21.3%	-12.5%	-21.5%	-23.0%	-20.6%	-20.6%	-20.5%	-20.4%	-21.1%	-20.0%
TN	-8.4%	-17.2%	-7.6%	-16.8%	-18.1%	-19.6%	-19.8%	-19.7%	-19.5%	-22.1%	-17.4%
TX	-12.2%	-5.9%	-6.7%	-11.6%	-12.3%	-13.6%	-13.9%	-13.8%	-13.6%	-13.4%	-11.9%
UT	-12.1%	-11.3%	-8.7%	-13.1%	-13.7%	-15.5%	-15.6%	-15.5%	-15.3%	-15.1%	-13.8%
VA	-18.4%	-7.8%	-10.0%	-20.1%	-20.6%	-24.0%	-24.0%	-23.7%	-23.4%	-23.0%	-19.9%
VT	-15.9%	-19.5%	-10.7%	-14.3%	-14.9%	-20.0%	-20.0%	-19.8%	-19.8%	-19.5%	-17.6%
WA	-20.6%	-9.4%	-9.9%	-19.8%	-20.3%	-18.6%	-18.5%	-18.3%	-18.1%	-18.3%	-17.3%
WI	-19.2%	-13.2%	-11.7%	-20.1%	-21.2%	-18.9%	-18.9%	-18.8%	-18.7%	-19.5%	-18.2%
WV	-18.1%	-7.2%	-10.1%	-20.8%	-21.1%	-25.2%	-25.1%	-24.8%	-24.4%	-24.0%	-20.6%
WY	-17.5%	-3.0%	-4.4%	-10.6%	-10.8%	-11.3%	-11.2%	-11.0%	-10.8%	-10.5%	-10.2%
Total	**-14.0%**	**-10.5%**	**-8.4%**	**-16.3%**	**-17.1%**	**-18.4%**	**-18.4%**	**-18.3%**	**-18.0%**	**-18.5%**	**-16.1%**

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