National Home Infusion Association

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EXECUTIVE SUMMARY

- Home infusion is a mainstream part of modern healthcare delivery. Every year, over a million patients rely on home infusion to treat serious infections, immune disorders, cancer, heart failure, and other complex conditions that require infused medications over days, weeks, or even years.
- Home infusion is often preferred by patients because it helps them receive needed therapies with less disruption to daily life, supports earlier discharge from the hospital, and can reduce exposure to risks that come with institutional care, including drug-resistant infections.
- Despite these well-established benefits, home infusion has been largely out of reach for many patients with traditional Medicare because the Medicare home infusion benefit covers only a limited set of therapies and a narrow set of professional services tied to in-person visits in the home.
- The Preserving Patient Access to Home Infusion Act (H.R. 2172) is a targeted fix that helps ensure the Medicare home infusion benefit works as Congress intended and aligns Medicare payment with how home infusion care is delivered in practice. By encouraging broader beneficiary access, the bill would support timely discharge planning and reduce unnecessary reliance on higher-cost facility settings, particularly for patients in rural and underserved communities.
- NHIA urges the Subcommittee to advance the Preserving Patient Access to Home Infusion Act to improve access to home infusion care for Medicare beneficiaries and to promote fiscally responsible site-of-care decisions.

Introduction

Chairman, Ranking Member, and Members of the Subcommittee, thank you for the opportunity to testify today. My name is Connie Sullivan. I serve as President and Chief Executive Officer of the National Home Infusion Association (NHIA) and am also a licensed pharmacist. NHIA represents the providers that coordinate and deliver home infusion care to over a million patients across the country every year.

Home infusion is coordinated care delivered outside the hospital. A physician determines the therapy, writes the order, and oversees the plan. Home infusion pharmacies then carry out that plan, including patient education and training, medication and supply delivery, ongoing monitoring and coordination, and in-person nursing services when needed.

Today, NHIA is testifying in support of the Preserving Patient Access to Home Infusion Act. This bill is a targeted, practical solution that will make Medicare's home infusion benefit work as Congress intended—improving access for beneficiaries while supporting responsible site-of-care decisions and avoiding unnecessary, high-cost facility care.

Why Home Infusion Matters and How It Works

Home infusion therapy allows patients to receive intravenous (IV) and other infused medications in their homes rather than in more costly institutional settings such as hospitals, hospital outpatient departments, or nursing facilities. These therapies include treatments for serious infections, cancer, heart failure, immune system diseases, and many other conditions that require medications delivered directly into the body.

A Coordinated Care Model

Home infusion is not "hands-off" care. It is coordinated, clinically supported care delivered outside of the hospital. Home infusion includes careful transition planning, medication preparation and

delivery, patient and caregiver education, clinical monitoring for adverse events and progress toward therapy goals, and prompt communication with the prescriber when issues arise. Periodic in-person visits in the patient's home remain essential, including for initial assessments and education, vascular access device management, and ongoing clinical assessments. At the same time, many services that keep patients safe and treatment on track occur outside the home or remotely across the course of treatment. These services include care coordination with hospital discharge teams and prescribers, ongoing monitoring and troubleshooting, reinforcement of patient and caregiver education, and 24/7 availability for patients and caregivers.

When patients are given the choice, many prefer receiving infusion therapy at home because it reduces disruption to daily life. Home infusion can also reduce exposure to facility-acquired infections and other institutional risks for patients who are immunocompromised or medically fragile.

To understand why Medicare's benefit design matters, it is helpful to describe how home infusion typically works in practice. While details vary by therapy and patient, the model generally includes the following elements:

- **Referral and patient selection.** A physician, often with a hospital discharge team, identifies a patient who can safely receive home infusion, writes treatment orders, and refers the patient to a home infusion pharmacy.

- **Care coordination and transition planning.** The home infusion team coordinates with the hospital, prescriber, and other clinicians to plan the transition, confirm dosing and duration, align lab and monitoring needs, and establish escalation pathways.

- **Patient and caregiver education.** The patient and caregiver receive training on medication administration, device use, line care, and symptom recognition, with reinforcement as needed over the course of therapy.

- **Medication preparation and delivery logistics.** Medications, supplies, and equipment are prepared and delivered to the patient in a timely manner, aligned to dosing schedules.

- **Ongoing monitoring and support across infusion days.** The care team monitors response to therapy, side effects, line issues, and adherence, and communicates with the prescriber when changes are needed.

- **In-person visits when needed.** Nursing visits occur when necessary for assessments, line care, and patient support. The frequency of these visits is driven by clinical need, not paperwork.

- **24/7 availability.** Patients and caregivers have access to clinicians for urgent questions, troubleshooting, and escalation to the prescriber when appropriate.

An Alternative to Facility-Based Care

This is an access issue and a Medicare stewardship issue. When patients can safely receive infusion therapy at home, Medicare should not be structured in a way that pushes them toward the highest-cost facility setting by default. Facility-based administration carries significant overhead and often requires repeated visits or prolonged stays. Improving home infusion access is a practical way to support a better patient experience while helping Medicare avoid unnecessary spending tied to higher-cost settings.

Site of care also matters to beneficiaries and families. Facility-based infusion can mean frequent travel, time off work for caregivers, and significant physical burden for patients who are frail, immunocompromised, or not ambulatory. For beneficiaries living on fixed incomes, facility-based infusion can also mean higher out-of-pocket exposure through repeated cost sharing for hospital outpatient department services or extended post-acute stays. When the home option is workable, it can reduce both the clinical and financial burdens associated with unnecessary institutional care.

In addition, institutional settings can create risks that are particularly relevant for infusion patients, including exposure to infectious pathogens and disruptions in continuity of care. A home setting, when it is safe, can reduce the number of care transitions and touchpoints that introduce complexity, especially for patients managing central lines or complex drug regimens.

Private Coverage Standards

Commercial coverage has long treated home infusion as a standard option. Hospitals routinely discharge patients to home infusion under many coverage types because it can be a safe, effective way to complete treatment without unnecessary time in a facility.

Virtually all payers aside from Medicare recognize that safe home infusion depends on services across the course of treatment, not just on days when a clinician is physically in the home. A study conducted by the Government Accountability Office in 2010 comparing Medicare and the commercial insurance models found that Medicare coverage is incomplete and creates access barriers; while the commercial model is widely adopted, generally costs less than hospital inpatient or outpatient care, and lacked evidence of fraud, improper payments, or quality issues. These findings remain relevant today as utilization in both models remain substantially unchanged since the publication of this report.

Medicare beneficiaries should have dependable access to home infusion when their doctors and hospitals want them treated at home. The Preserving Patient Access to Home Infusion Act helps move Medicare closer to how care is actually delivered and gives beneficiaries a reliable option to receive therapy at home instead of being pushed into higher-cost facilities.

The Medicare Gap And Congressional Intent

Legislative History

Congress took important bipartisan steps to improve access to home infusion for Medicare beneficiaries in the *21st Century Cures Act* and the *Bipartisan Budget Act of 2018*. Those laws paired changes to drug reimbursement with a directive to establish a separate professional services benefit.

The clear policy objective was access: ensuring that when a beneficiary needs a Part B home infusion drug, there is a workable benefit structure that supports safe delivery at home.

In practice, however, the benefit has not operated broadly enough to achieve that objective. First, it applies only to a limited set of therapies tied to Medicare's infusion pump rules, leaving the most common infused therapies outside the benefit. Second, the current payment structure ties reimbursement too tightly to in-person visits in the home, even though safe home infusion depends on coordinated services provided across the course of treatment, including services delivered remotely or outside the patient's home.

In many cases, patients can be thoroughly trained to self-administer therapy, while the care team provides ongoing monitoring, coordination, and oversight throughout treatment. Even on days when a trained patient self-administers an infusion, the home infusion team is still coordinating care, monitoring progress, and staying available to keep treatment on track. When payment policy recognizes only in-home visits as the trigger for reimbursement, it undervalues this essential work and makes it harder to sustain home infusion programs for Medicare beneficiaries—which contributes to low provider participation and limits beneficiary access nationwide.

Medicare Lags Behind Other Coverage Types

The commercial market is not the only point of comparison. Medicaid programs, the Department of Veterans Affairs, TRICARE, and Medicare Advantage plans more commonly support home infusion in ways that reflect operational reality and enable clinically appropriate site-of-care decisions. Traditional Medicare stands out as an outlier when it comes to making home infusion consistently workable.

This matters because providers operate across payer types. When Medicare's structure is materially different from all other major payers, it creates administrative complexity and can reduce willingness

to participate. When Medicare does not make home infusion workable, the options for many beneficiaries are either repeated travel to a facility for administration or placement in a skilled nursing facility for the duration of therapy. Neither option is driven by patient or provider preferences or clinical need; both are often driven by logistics and coverage mechanics. For many patients, particularly those who are immunocompromised, the institutional setting can increase exposure to infections and other complications, and it imposes significant disruption on daily life.

Travel Burden and Rural Access

Home infusion therapy is particularly valuable for patients in rural and underserved areas, where access to hospitals or infusion clinics is often limited. For these patients, the burden of traveling long distances for treatment can result in delayed care, missed doses, increased complications, and higher costs for both patients and the health care system.

In many rural communities, the nearest hospital outpatient department may be an hour or more away. Daily or near-daily travel for infusions is not simply inconvenient; it can be the deciding factor between receiving care at home and ending up in an institution because it is the only practical way to complete a multi-week regimen.

These travel challenges also have real spillover effects. Family members may need to take time off work or arrange childcare to transport beneficiaries. Patients who are not ambulatory, medically fragile, or living on fixed incomes face even greater barriers. When Medicare policy does not make the home option workable, rural beneficiaries are more likely to experience avoidable and costly facility stays driven by logistics rather than clinical necessity.

Patient Case Study

Consider a patient who develops a serious infection after an injury and is hospitalized. After a few days of IV antibiotics, the patient stabilizes and is ready to be discharged—but needs to finish a 14-

day course of daily IV antibiotics to ensure the infection does not recur. If this patient has commercial insurance, hospitals often discharge the patient to receive IV antibiotics at home because it is a safe, effective way to complete treatment using the least intensive medical resources.

For many Medicare beneficiaries, discharge to home—especially for IV antibiotics—is harder to carry out because Medicare's structure does not consistently support the home-based model. As a result, patients are often directed to higher-cost institutional pathways—daily trips back to a hospital for infusions or placement in a long-term care facility for the duration of therapy—even when the patient could have completed treatment at home.

For many patients, home infusion is the most patient-centered option. It preserves independence, avoids repeated transportation and caregiver burdens, supports recovery in a familiar environment, and can reduce exposure to infections and other risks associated with institutional settings. Yet for Medicare beneficiaries, the home option is rarely viable because the benefit does not reliably support the services needed for safe and effective treatment. The predictable result is more facility-based care than patients need.

The Preserving Patient Access to Home Infusion Act

The Preserving Patient Access to Home Infusion Act (H.R. 2172) is a targeted, practical update to ensure Medicare's home infusion benefit works as Congress intended. The bill does not invent a new care model. It addresses a real-world access problem: the Medicare home infusion benefit exists, but provider participation is so limited that many beneficiaries cannot access home infusion services at all.

The Preserving Patient Access to Home Infusion Act is designed to broaden provider participation and stabilize access by modernizing Medicare policy so the benefit is workable for providers and meaningful for beneficiaries. In plain terms, the bill updates Medicare's recognition of home infusion

services so the benefit better aligns with how care is supported in practice, including services delivered remotely or outside the patient's home.

Key elements of the Preserving Patient Access to Home Infusion Act include:

- Modernizes the home infusion professional services payment to **reflect the full scope of home infusion services**, including those delivered remotely or outside the patient's home, while preserving the role of in-person visits when needed.
- Expands the benefit to improve **access to IV anti-infective therapies**, reflecting a common, high-volume clinical use case where home infusion can prevent avoidable facility utilization and reduce patient burden.
- **Bundles disposable supplies** into the services payment to create a more complete per-infusion-day-like payment structure and to streamline reimbursement in a way that aligns with private-sector standards.
- Recognizes **nurse practitioners and physician assistants in ordering** home infusion therapy, consistent with their authority for other home-based services, to reduce administrative bottlenecks while preserving prescriber oversight and clinical accountability.
- Includes a time-limited **transition to support implementation** and operational adjustments as the benefit is modernized.

In practice, the Preserving Patient Access to Home Infusion Act would help restore home infusion as a realistic option for Medicare beneficiaries when it is safe by expanding provider participation and making the benefit operational. That means fewer beneficiaries forced into repeated hospital outpatient department visits or prolonged facility stays simply because a workable home option is

not available in their community. It also means a better experience for patients who are medically fragile, immunocompromised, not ambulatory, or reliant on caregivers for transportation.

For hospitals and discharge planners, a workable home infusion benefit supports timely discharge for patients who no longer require inpatient care but still need frequent infusions. When home infusion is feasible, it expands post-discharge options, improves patient flow, and can help reduce unnecessary use of higher-cost settings. For rural communities, expanding provider participation is the most important access lever. When more providers can enroll and sustain Medicare home infusion programs, beneficiaries are less likely to face delays, gaps in care, or default placement in facilities simply because the home option is not operationally available.

In short, the Preserving Patient Access to Home Infusion Act is a focused solution that strengthens Medicare's home infusion benefit by making provider participation viable and beneficiary access real.

Responses To Common Questions

Patient Safety and Prescriber Oversight

The Preserving Patient Access to Home Infusion Act preserves the clinical safeguards that make home infusion safe and appropriate for Medicare beneficiaries.

Physician oversight remains unchanged. Home infusion therapy is ordered and overseen by the prescribing clinician. A physician or hospital team determines whether home infusion is safe, writes the prescription and treatment orders, and refers the patient to a qualified home infusion provider. The home infusion team delivers therapy under those orders, monitors the patient, communicates with the prescriber as needed, and escalates concerns promptly. The bill does not replace physician judgment with a payment policy.

Home infusion is not appropriate for every patient or every therapy. The right site of care should be driven by clinical factors, patient needs, and prescriber judgment. The bill supports the home option

when it is safe; it does not force a shift from facilities for patients who require facility-level monitoring or services.

Adequacy of Existing Coverage

A common question is whether strengthening the home infusion benefit could create duplicate payments. The intent of the Preserving Patient Access to Home Infusion Act is the opposite: to fix gaps and align payment so that Medicare can support safe home infusion without overlapping reimbursement for the same items or services.

Under current law, Medicare does not consistently recognize the professional services required to deliver and oversee home infusion outside of days when a clinician is physically in the home. The Preserving Patient Access to Home Infusion Act modernizes the services benefit so payment reflects the work that occurs across the course of treatment, without changing prescriber authority or medical necessity standards.

In other words, the bill is not layering a new payment on top of a complete existing payment. It fills gaps so Medicare can support what it expects providers to do to keep patients safe at home. This alignment supports program integrity, reduces administrative friction, and helps prevent situations where beneficiaries are pushed into higher-cost facilities because the home option is not operationally supported.

Fiscal Responsibility

The Preserving Patient Access to Home Infusion Act is a site-of-care reform that helps Medicare avoid unnecessary facility spending by making the home option workable when clinically appropriate.

Facility-based administration is expensive. When Medicare cannot reliably support home infusion, beneficiaries are often steered into higher-cost settings such as hospital outpatient departments or extended facility stays for therapy that could be delivered safely at home for many patients. Making

the home option workable supports shifts away from the highest-cost settings when it is safe. That is the primary pathway to fiscal responsibility in this policy.

There is also a track record suggesting this approach can produce savings. Historically, the Congressional Budget Office has attributed hundreds of millions of dollars in savings to policies that expand or strengthen home infusion coverage, reflecting the expectation that improving access to home infusion can reduce reliance on expensive facility sites. Independent analyses have similarly pointed to savings when home infusion becomes a practical option, particularly for therapies like IV anti-infectives where the alternative is repeated facility administration or institutional placement.

Home infusion can also reduce practical burdens for patients and caregivers, including fewer trips, less time away from work, and less disruption to family life.

Conclusion

The Preserving Patient Access to Home Infusion Act advances goals that should unite policymakers across the aisle: better patient access, care in the right setting when it is safe, and responsible stewardship of Medicare dollars.

This bill helps make Medicare's home infusion benefit work the way Congress intended. It supports patients who face transportation barriers or are medically fragile; it strengthens access in rural and underserved communities; and it reduces unnecessary facility care that increases cost and burden without improving outcomes for patients who can safely be treated at home.

NHIA appreciates the Subcommittee's consideration of this legislation and stands ready to provide any technical assistance the Committee may need. Thank you for the opportunity to testify, and I look forward to your questions.