



September 14, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program (CMS-1848-P)

The Infusion Providers Alliance (IPA) is pleased to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the Calendar Year (CY) 2027 Physician Fee Schedule. In this comment, IPA provides recommendations on:

- Addressing the widening site-of-service payment disparity for Part B drug administration between physician offices and freestanding infusion clinics and hospital outpatient departments (HOPDs); and
- Calculation of Practice Expense (PE) Relative Value Units (RVUs).

Background on the Infusion Providers Alliance

IPA is a national trade association and leading voice for non-hospital, community-based infusion providers, including physician offices and freestanding ambulatory infusion centers. Our members operate more than 1,000 sites across 45 states, providing convenient access to high-quality, lower-cost care for patients with complex and chronic conditions. These sites are located in the communities where patients live and work and provide flexible, convenient access to treatment for conditions such as Crohn's disease, ulcerative colitis, multiple sclerosis, rheumatoid arthritis, Alzheimer's disease, and many other chronic, complex, and rare conditions. IPA's mission is to serve as a thought leader and to educate on issues critical to safeguarding, supporting, and strengthening provider-directed, patient-focused access to provider-administered medications. More information about IPA can be found on our website: www.infusionprovidersalliance.org.

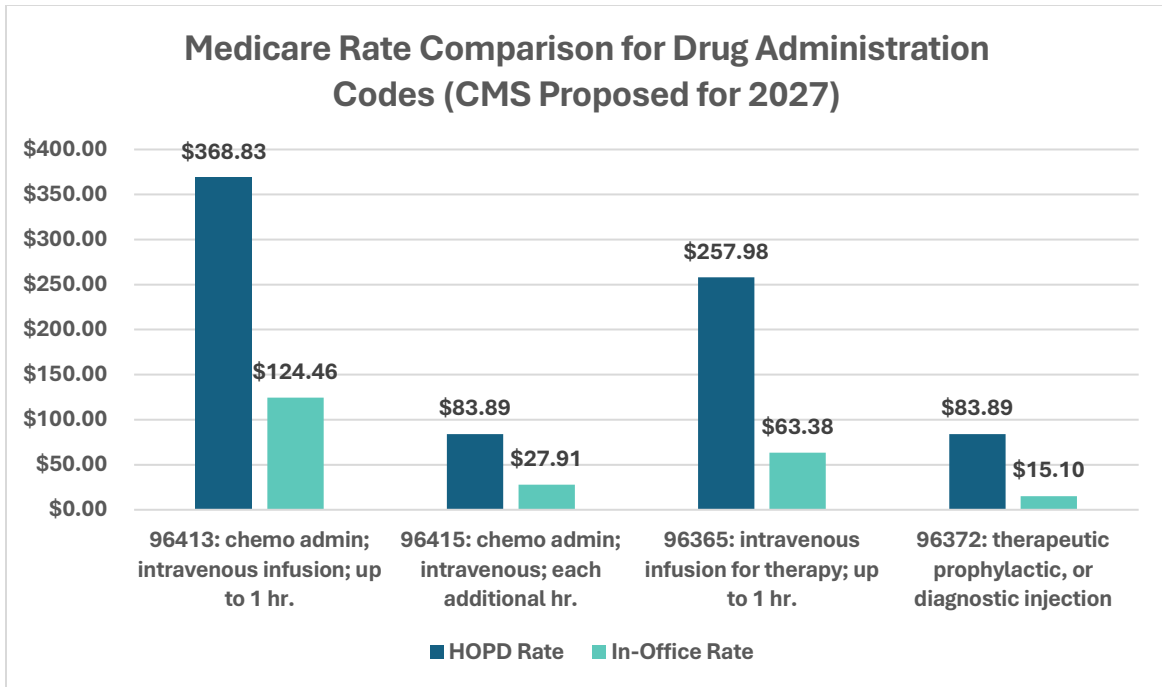
A Growing Site-of-Service Payment Disparity in Drug Administration Payments

Community-based infusion providers deliver high-quality care at a lower cost than HOPDs, yet they continue to face escalating costs associated with delivering complex biologic therapies as Medicare payments decline. The professional fee for administering these infusions has remained inadequate for years, covering only a small fraction of the actual cost of drug administration. That fee is scheduled to decline substantially in 2027, further eroding its value in nominal and real terms. While CMS proposes payment cuts for drug administration in physician offices and freestanding infusion clinics, the costs required to sustain the infrastructure and clinical resources needed to safely and effectively deliver these therapies, including specialty-trained clinical staff and associated labor costs, supplies and cold-chain handling, extended chair time and patient monitoring, pharmacy and revenue-cycle operations, inventory carrying costs, and facility overhead, among other needs, continue to rise.

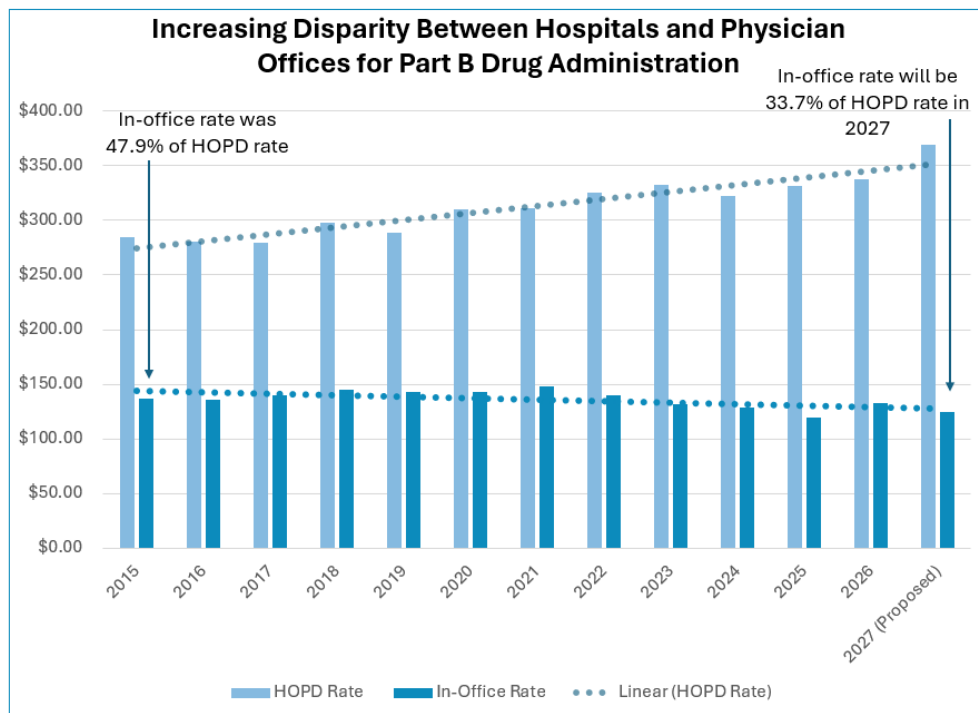
The proposed CY 2027 payment rates will further strain independent providers and widen the growing disparity between non-hospital infusion providers and HOPDs for furnishing the same Part B drug-administration services. As illustrated below, the in-office rate for CPT code 96413 (the primary infusion code for complex drugs) is slated to decline approximately 6.6 percent to \$124.46. Meanwhile, the HOPD payment rate for the same service would increase by more than 9 percent, to \$368.83.

Code	In-Office Rate		% Change CY 26 – CY 27	HOPD Rate		% Change CY 26 – CY 27
	CY 26	Proposed CY 27		CY 26	Proposed CY 27	
96413	\$133.27	\$124.46	-6.6%	\$337.46	\$368.83	9.3%
96415	\$28.39	\$27.91	-1.7%	\$73.56	\$83.89	14%
96365	\$67.13	\$63.38	-5.6%	\$217.31	\$257.98	18.7%
96372	\$15.36	\$15.10	-1.7%	\$73.56	\$83.89	14%

[CMS-1834-FC](#) | [CMS](#). Found on Addendum B, Payment Rate.



The proposed payment cut in the physician fee schedule and substantial increase in the Hospital Outpatient Prospective Payment System exacerbate the decade-long erosion of comparative drug administration fees between the two sites of care from 47.9 percent in 2015 to 33.7 percent in 2027.



Data based on Code 96413: Chemotherapy administration intravenous infusion, up to one hour
 Sources: HOPD Rate = Hospital Outpatient PPS: [Addendum B](#) / In-Office Rate = [PFS Search](#)

CMS has presented no data or evidence showing diverging costs between the two settings as justification for this growing disparity. On the contrary, CMS has acknowledged the site-of-care payment differences for drug administration are problematic, as it equalized payments for provider-based off-campus outpatient departments (PBDs) in last year's rule.¹ Yet, that policy only applies to a limited subset of HOPDs providing Part B drugs and does nothing to address the insufficient payment rates in physician offices and infusion clinic settings.

As reimbursement gaps widen and payments decline to physician practices, independent infusion clinics face growing pressure to sell, merge, or close, often leaving hospital systems as the only remaining option for patient access to needed drug infusions. This dynamic accelerates provider consolidation and shifts patients toward higher-cost, less convenient sites of care,² undermining the local access points that patients and communities rely on for treatment of chronic, complex, and rare conditions. Just as concerning, our members report that many hospitals in their communities are already facing infusion chair capacity constraints and cannot accept additional patients. For patients, particularly those in rural or underserved areas, the loss of a nearby infusion clinic can mean longer travel times, delayed treatment, and reduced continuity with the clinical staff who know their care history best.

The inadequate payment for drug-administration services also underscores the importance of the “add-on” payment to average sales price (ASP), which provides the principal source of funding needed to support the infrastructure and offset the financial risks associated with purchasing, storing, and administering Part B drugs in physician offices and infusion centers. For more than a decade, that 6 percent statutory add-on has been reduced to just 4.3 percent due to sequestration and will continue at that reduced level for the foreseeable future. Nevertheless, the add-on payment remains critical to the financial viability of community-based infusion providers and, in turn, access to care for both Medicare beneficiaries and commercially insured patients.

With that in mind, we call your attention to scheduled reimbursement cuts to add-on payments that will occur starting in 2028 due to the Inflation Reduction Act's anticipated payment reductions for negotiated Part B drugs. The Congressional Budget Office has projected these cuts to be as high as 50 percent, and the add-on payments, which are critical to the economic viability of community-based infusion sites, will be cut commensurately. That is why IPA and a broad coalition of patient and provider organizations support enactment of the *Protecting Patient Access to Cancer and Complex Therapies Act* (H.R. 4299), which would preserve ASP-based provider reimbursement for

¹ [Calendar Year \(CY\) 2026 Hospital Outpatient Prospective Payment System \(OPPS\) and Ambulatory Surgical Center Final Rule](#)

² [Vertical integration and market consolidation in healthcare: Policy drivers and impact on physicians and patient care - ScienceDirect](#)

selected drugs, maintain beneficiary coinsurance based on the lower Maximum Fair Price (MFP), and allow Medicare to realize negotiated savings through manufacturer rebates. H.R. 4299 has broad bipartisan support, and we encourage CMS to work with Congress to enact it without delay so that patient access to negotiated drugs can be preserved.

In summary, IPA strongly recommends CMS re-evaluate payment rates to community-based providers and recognize that costs of providing community-based infusion care are increasing. Continued cuts will reduce access, place further strain on the system, and worsen outcomes for patients.

Calculation of Practice Expense Relative Value Units

In this rulemaking process, CMS has proposed various changes to the calculation of practice expense (PE) relative value units (RVUs). Specifically, CMS proposes removing the indirect practice cost index (IPCI) from the PE RVU methodology. CMS proposes phasing in this new payment approach over a two-year period, along with a stabilization factor to limit the impact to codes that exceed a five percent gain or cut.

We understand CMS's desire to use updated data to determine appropriate practice expenses for various payment codes, as the IPCI data was based on 2007 survey cost data. CMS rejected the data AMA collected on practice expense data presented to CMS in 2025 on the argument that it was not robust enough.³ If that data is insufficient, then newer, more comprehensive data should be collected before major reforms in payment are implemented. Without additional, more recent information, an overhaul of practice expense methodology in this rulemaking seems premature. This is underscored by the opacity of CMS's new payment methodology which does not provide transparency on which codes are subject to the 5 percent payment cap and will be subject to reductions in future years.

We request that CMS delay implementation of the practice expense proposal until additional information can be collected and the impacts of the proposed methodology on specific codes can be shared publicly. Additionally, IPA recommends that CMS consider maintaining specialty-level data that reflect current, real-world experience in furnishing complex infusions to patients with chronic conditions.

Conclusion

IPA strongly urges CMS to address the growing site-of-service payment disparity between community-based providers and HOPDs as the continued strain on independent infusion clinics will adversely affect patients and the health care system.

³ [Federal Register :: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program](#)

IPA also recommends that CMS delay modifications to the PE RVU methodology until additional and more comprehensive data are available to better understand the effects on specific codes.

Thank you for your consideration of our comments and we look forward to working with CMS.

Sincerely,

A handwritten signature in black ink, appearing to read "Elliott Warren". The signature is fluid and cursive, with the first name "Elliott" and last name "Warren" clearly distinguishable.

Elliott Warren
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