



The Nation's Voice for
Community-Based Infusion

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September 14, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically via www.regulations.gov

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

Dear Administrator Oz,

The National Infusion Center Association (NICA) is a nonprofit organization formed to support non-hospital, community-based infusion centers caring for patients in need of provider-administered medications. To improve access to medical benefit drugs that treat complex, rare, and chronic diseases, we work to ensure that patients can access these drugs in safe, more efficient, and cost-effective alternatives to hospital care settings. NICA supports policies that improve drug affordability for beneficiaries, increase price transparency, reduce disparities in safety across care settings, and foster patient access to the highest-quality, lowest-cost setting.

On behalf of the infusion providers we represent throughout the country, we write to provide feedback on the aforementioned rule.

Conversion Factor Update

For CY 2027, as required under the *Medicare Access and CHIP Reauthorization Act* (MACRA), CMS proposes two conversion factors: \$33.1693 for qualifying participants (QPs) in advanced alternative payment models (APMs) and \$32.8409 for non-QPs. Both represent payment cuts from CY 2026 – approximately 1.19% for QPs and 1.68% for non-QPs. These reductions reflect the expiration of the temporary, one-time 2.5% increase provided for CY 2026, a 0.53% budget neutrality adjustment, and the MACRA statutory updates of 0.75% for QPs and 0.25% for non-QPs. Unfortunately, most office-based infusion providers have limited opportunities to achieve QP status through an advanced APM and therefore will receive only the 0.25% statutory update. The result is a nearly 1.7% reduction in the PFS conversion factor for these practices in CY 2027, even as the costs of operating an infusion practice, including staffing, supplies, technology, and other overhead, continue to rise.

As we have repeatedly stated, Medicare physician payment updates continue to lag far behind those provided to other Medicare providers, such as hospitals, and the recurring cycle of temporary

payment relief followed by subsequent cuts creates significant instability for physician practices. ***CMS should prioritize policies that sustain positive adjustments to the conversion factor and work with Congress on a long-term fix to the PFS, including a mechanism that accounts for rising practice costs as measured by the Medicare Economic Index (MEI). CMS should also explore potential offsets, such as applying a higher Medicare Advantage coding intensity adjustment than the current statutory minimum, which could generate savings to help finance meaningful physician payment reform while improving Medicare's fiscal outlook.***

Practice Expense

CMS proposes several significant changes to the indirect practice expense (PE) methodology, including phasing out the indirect practice cost index (IPCI) over two years and replacing it with a new stabilization adjustment that would generally limit annual changes in PE RVUs to 5 percent. ***NICA is deeply concerned with these substantial changes to the indirect PE methodology and urges CMS to withdraw the proposals until a more thoughtful and transparent alternative can be developed and proposed for consideration.***

While CMS has expressed concerns with the age and reliability of the data underlying the current methodology, it has not identified a better source that accurately reflects the indirect costs of furnishing services in the office setting. This is particularly important for infusion centers, which have long relied on other specialties to derive their indirect costs because infusion centers do not have a distinct Medicare specialty designation. Infusion practices incur substantial indirect expenses associated with maintaining physical space, administrative and billing staff, information technology, regulatory compliance, credentialing, prior authorization and utilization management, inventory and revenue-cycle functions, and other infrastructure necessary to furnish complex infused and injected therapies safely and efficiently. Under the proposed methodology, the primary services furnished by independent infusion centers would experience steep PE reductions. Unlike physician practices that furnish a broader range of services in addition to infused and injected therapies, independent infusion centers have few, if any, other services through which they can offset these losses.

In addition, and while we appreciate the intent behind the proposed stabilization factor, it does not address the fundamental problem: CMS has not identified reliable data that reflect differences in indirect costs across specialties and practice types. Eliminating the IPCI without an adequate replacement risks making PE payments less reflective of the actual resources required to maintain independent, office-based practices. This is especially concerning given CMS's stated interest in supporting independent practices and lower-cost community-based sites of care.

NICA is also concerned with the number of PE methodology changes CMS is proposing simultaneously and the lack of transparency regarding their individual and cumulative impacts. Stakeholders cannot meaningfully evaluate what is driving significant payment changes when multiple components of the methodology are altered at the same time without sufficient analyses, particularly across service lines. ***Therefore, NICA urges CMS to maintain the current methodology while it identifies appropriate, current practice-cost data and transparently evaluates the individual and cumulative effects of any proposed changes, including the specific impact on independent infusion centers and other non-facility providers.***

Quality Payment Program

Office-based infusion centers offer a single, highly specialized service line – drug administration – and there are few, if any, quality and cost measures relevant to these services. However, many of these practices are still subject to the requirements of the Quality Payment Program (QPP), including the Merit-based Incentive Payment System (MIPS), and are forced to report measures that do not

meaningfully reflect the quality of infusion care, while bearing the significant financial and administrative burden of participation.

At the same time, office-based infusion providers have limited opportunities to participate in APMs and achieve QP status. In fact, existing population health and accountable care models can present significant challenges for providers whose patients require high-cost physician-administered therapies because Part B expenditures are included in the spending for which they are financially accountable. This can make participation by infusion providers less attractive within these models, leaving them largely confined to MIPS. Beginning in CY 2026, this lack of access to the Advanced APM pathway has had direct implications for PFS payment, as QPs receive a higher statutory conversion factor update than clinicians who do not achieve QP status.

More broadly, MIPS has grown into a complex and costly administrative infrastructure without clear evidence that it improves care for Medicare beneficiaries. For independent infusion centers, the current MIPS measure set does not meaningfully assess the quality or value of infusion care, yet these practices must bear the administrative and financial burden of reporting measures that are largely irrelevant to the services they furnish. ***Therefore, NICA urges CMS to explore all available authorities, including whether the low-volume threshold can be expanded or modified, to exempt single-service-line infusion practices for which existing MIPS measures do not meaningfully assess the quality or value of care furnished.***

RFI on AMA and CPT

NICA supports efforts to improve transparency and reduce unnecessary costs associated with the American Medical Association (AMA) CPT coding system. However, replacing CPT or introducing a competing coding system could create significant disruption and administrative burden for physician practices, including independent infusion centers. The existing Medicare physician payment system, including the assignment of relative values and payment rates, is built around CPT, and transitioning to a new coding system would require substantial changes to billing systems, payer policies, and practice workflows. ***Toward that end, NICA urges CMS to carefully weigh these significant implementation costs and burdens against any potential benefits before pursuing fundamental changes to CPT as the national coding standard for professional services.***

Thank you for the opportunity to comment on these important issues. We would welcome the opportunity to connect with you if we can provide any other information about our concerns. Please do not hesitate to contact me, should you have any questions or wish to further discuss these issue: Brian.nyquist@infusioncenter.org

Sincerely,

A handwritten signature in black ink that reads "Brian Nyquist". The signature is written in a cursive, flowing style.

Brian Nyquist, MPH
Chief Executive
Officer
National Infusion Center Association