

Ambulatory Infusion Therapy in the United States

How it works, who benefits, and why investment in community-based infusion improves access, quality, and total cost of care

Amerita Specialty Infusion Services

January 20, 2026

Table of Contents

<i>Executive summary</i>	<i>3</i>
<i>1. What ambulatory infusion is</i>	<i>4</i>
1.1 Definition and scope	4
1.2 How ambulatory infusion differs from hospital outpatient infusion.....	4
1.3 Why the model matters now	5
<i>2. How ambulatory infusion works</i>	<i>5</i>
2.1 Core components of an ambulatory infusion episode	5
2.2 Sterile compounding and medication safety standards	5
2.3 Accreditation and oversight landscape	5
<i>3. Who benefits from ambulatory infusion</i>	<i>6</i>
3.1 Patient profiles most likely to benefit.....	6
3.2 Referring clinician and health system benefits	6
3.3 Payer benefits.....	6
<i>4. Current population served and the expansion opportunity.....</i>	<i>6</i>
4.1 Current U.S. utilization (high-level)	6
4.2 Estimating the addressable expansion universe.....	7
4.3 Equity and access considerations	7
<i>5. Therapies and conditions treated at Amerita</i>	<i>7</i>
5.1 IV anti-infectives (OPAT)	7
5.2 Immunoglobulin therapy (IVIG/SCIG).....	7
5.3 Chronic inflammatory conditions (biologics).....	8
5.4 Nutrition support (PN/EN)	8
5.5 Clotting factor therapy	8
5.6 Inotrope therapy	8
<i>6. What an episode of care looks like.....</i>	<i>8</i>
6.1 Referring physician or advanced practice provider perspective.....	8
6.2 Patient and family/caregiver perspective.....	9
6.3 Payer perspective	9
<i>7. ROI and total cost of care impact.....</i>	<i>9</i>

7.1 Why ambulatory infusion lowers total cost of care.....	9
7.2 Evidence of site-of-care price differentials.....	10
7.3 Practical ROI framework.....	10
7.4 Medicare and Medicaid considerations.....	10
8. Quality outcomes and performance measurement	10
8.1 Why quality measurement in ambulatory infusion is different	10
8.2 Common quality indicators used in infusion services.....	11
8.3 What infusion quality looks like.....	11
9. Amerita quality outcomes.....	11
9.1 Quarterly patient safety outcomes.....	11
9.2 Therapy completion and discharge reasons.....	12
9.3 Patient experience (overall satisfaction).....	12
9.4 Benchmarking limitations and how to strengthen comparability.....	13
10. Advocacy: why reimbursement must improve to expand access	13
10.1 The policy problem.....	13
10.2 Why higher rates can save payers money	13
10.3 Workforce and infrastructure implications	13
10.4 Policy Enhancements that would help decrease costs to Medicare while better enabling community-care	14
11. Conclusion	14
Appendix A. Abbreviations	14
Appendix B. References	15

Executive summary

Ambulatory infusion therapy refers to the delivery of infused and injectable medications, biologics, and nutrition support in non-inpatient settings—most commonly in the patient’s home, in freestanding ambulatory infusion suites/centers, or in physician offices. The model combines pharmacy compounding and distribution with specialized nursing, clinical monitoring, and coordination across the treating team.

For many therapies, ambulatory infusion is clinically appropriate, preferred by patients, and materially less expensive than hospital outpatient departments (HOPDs) or inpatient care. Published analyses show sizable site-of-care price differences for infused specialty drugs. For example, AHIP-reported averages found hospital administration cost about \$7,000 more per treatment than specialty pharmacy/alternate sites, with physician offices about \$1,400 higher on average. [1]

In the U.S., home and alternate site infusion is a large and growing sector. NHIA's industry trends research has estimated the home and alternate site infusion industry serves more than 3.2 million patients annually and represents an industry of roughly \$19B in annual revenue (pre-pandemic baseline). [2]

A core driver of growth is site-of-care (SOC) optimization. Commercial payers and Medicare continue to face sustained pressure from hospital-based pricing—particularly HOPD facility fees—making clinically appropriate care in home or freestanding ambulatory sites increasingly attractive. Blue Cross Blue Shield Association analyses show hospital outpatient prices are consistently higher than ambulatory surgery centers and physician offices for common services, sometimes multiple-fold. [3]

This white paper describes the ambulatory infusion ecosystem, the Amerita model of care, the patient populations who benefit, the clinical conditions treated, and a payer-focused ROI framework that quantifies avoidable utilization and total cost savings when infusion moves from high-cost institutional settings to community-based sites. It also outlines a practical quality-measurement framework aligned to accreditation and national standards and closes with an advocacy agenda to strengthen reimbursement so the workforce and capacity can meet rising demand.

1. What ambulatory infusion is

1.1 Definition and scope

Ambulatory infusion therapy encompasses the preparation and administration of infusion medications, biologics, and supportive therapies outside of the inpatient hospital. Operationally, it includes three major delivery sites:

- Home infusion (patient residence, including assisted living or other community settings where permitted).
- Ambulatory infusion suites/centers (freestanding or clinic-based), where patients travel to receive therapy and return home the same day.
- Physician-office infusions (office-based infusion).

Across these sites, safe delivery requires coordination among prescribers, infusion pharmacists, nurses, care coordinators, and payers; adherence to sterile compounding and medication handling standards; and reliable processes for monitoring, adverse event response, and therapy completion.

1.2 How ambulatory infusion differs from hospital outpatient infusion

Hospital outpatient departments (HOPDs) often provide infusion in an institutional setting with higher facility fees, broader overhead, and less flexible capacity. By contrast, ambulatory infusion in the

community is typically built around lower fixed costs, standardized protocols, and a focus on keeping clinically stable patients out of the hospital. Payer site-of-care policies increasingly steer eligible patients away from HOPDs toward home, office, or freestanding ambulatory settings. [4][5] Enforcement varies widely by market and payer strategy; some plans apply strong site-of-care programs while others rely more on guidance and incentives, and clinical/access exceptions are common. Effective site-of-care optimization typically uses transparent medical-necessity criteria, clear exception pathways, and collaboration with physician and health-system partners.

1.3 Why the model matters now

- Patient-centered care: reduced travel burden, improved convenience, and fewer disruptions to work and family life. Self-insured employers may have particularly strong incentives to adopt ambulatory infusion solutions because they directly bear allowed costs and can benefit from fewer absences and improved productivity when therapy is delivered conveniently and reliably.
- Capacity and throughput: community infusion sites can relieve hospital infusion capacity constraints.
- Total cost of care: shifting clinically appropriate therapy away from HOPDs and inpatient stays can reduce total spend while maintaining quality outcomes. [3][6]
- Population health: reliable ambulatory infusion infrastructure supports faster discharge, fewer readmissions, and better chronic disease management.

2. How ambulatory infusion works

2.1 Core components of an ambulatory infusion episode

- Referral and clinical intake (indication, therapy plan, access type, monitoring requirements).
- Benefit verification and prior authorization (medical vs pharmacy benefit; site-of-care rules; patient cost share).
- Pharmacy clinical review and sterile compounding (or procurement/distribution for manufacturer-prepared products).
- Nursing assessment and patient/caregiver training (line care, pump use, infusion reaction plan).
- Drug administration (home, ambulatory suite/center, or office).
- Ongoing monitoring (labs, symptom checks, adherence, adverse event surveillance).
- Therapy completion and discharge (de-access, documentation, outcomes reporting).

2.2 Sterile compounding and medication safety standards

Sterile compounding practices are governed by United States Pharmacopeia (USP) standards, most notably USP <797> for sterile preparations and USP <800> for hazardous drug handling. USP <797> became official on November 1, 2023, following a one-year implementation period. [7][8] Accreditation bodies commonly incorporate USP requirements into infusion pharmacy standards. [9]

2.3 Accreditation and oversight landscape

Ambulatory and home infusion programs frequently pursue accreditation to demonstrate consistent adherence to quality and patient safety standards. Relevant accrediting bodies include ACHC (home

infusion therapy, infusion pharmacy, nursing and specialty services) and URAC (Infusion Pharmacy Accreditation, Specialty Pharmacy and Medicare Home Infusion Therapy Supplier accreditation). [9][10][11] Accreditation is often a practical prerequisite for payer contracting and network participation. [12]

3. Who benefits from ambulatory infusion

3.1 Patient profiles most likely to benefit

- Patients requiring time-limited IV anti-infective therapy after hospitalization (OPAT).
- Patients with chronic inflammatory diseases receiving biologics (e.g., inflammatory bowel disease, rheumatoid arthritis).
- Patients with immune disorders requiring immunoglobulin replacement (IVIG/SCIG).
- Patients with advanced heart failure requiring chronic inotrope therapy.
- Patients requiring parenteral nutrition (PN) or enteral nutrition (EN) support.

For OPAT specifically, published estimates suggest approximately 250,000 U.S. patients receive outpatient parenteral antimicrobial therapy each year. [13] For context, published prevalence estimates suggest roughly 25,000 people in the U.S. receive home parenteral nutrition (HPN), underscoring the size and clinical complexity of the ambulatory infusion/nutrition population. [14]

3.2 Referring clinician and health system benefits

- Earlier discharge or avoided admission when infusion can be safely delivered in the community.
- Reduced burden on hospital infusion chairs and inpatient beds.
- Structured monitoring and communication loops (labs, adverse events, therapy modifications).

3.3 Payer benefits

- Lower site-of-care costs when infusion moves from HOPD to home or freestanding ambulatory sites.
- Reduced preventable ED visits and unplanned admissions via proactive monitoring and rapid clinical response.
- Increased adherence rate for chronic therapies achieving reduction in downstream utilization caused by exacerbations/fares. Beyond immediate site-of-care savings, ambulatory infusion can reduce downstream utilization (e.g., avoidable ED visits and admissions related to complications, missed doses, line issues, or preventable disease flares) through proactive monitoring and rapid clinical escalation. Structured outpatient parenteral antimicrobial therapy (OPAT) programs have been associated with lower OPAT-related readmissions after program strengthening. [15]

4. Current population served and the expansion opportunity

4.1 Current U.S. utilization (high-level)

NHIA's infusion industry trends research has estimated that home and alternate site infusion serves more than 3.2 million patients annually in the U.S. [2] Market-sizing analyses from multiple industry

research groups estimate the U.S. home infusion therapy market at roughly \$19–\$21B in 2024 and growing thereafter. [16][17]

4.2 Estimating the addressable expansion universe

A practical way to estimate the expansion universe is to start with high-prevalence conditions where infused therapies are common, then apply clinical eligibility and site-of-care suitability filters. Examples of relevant condition prevalence include:

- Inflammatory bowel disease (IBD): CDC estimates U.S. prevalence between 2.4 and 3.1 million people. [18]
- Rheumatoid arthritis (RA): commonly cited U.S. prevalence is approximately 1.3 million adults. [19]
- OPAT: ~250,000 U.S. patients per year. [13]

Not all patients with these conditions require infusion, and not all infusions are clinically appropriate outside institutional settings. However, the large prevalence base supports a substantial addressable population for community-based infusion, particularly as newer biologics and specialty agents expand indications and as payers apply SOC optimization policies.

4.3 Equity and access considerations

Expansion should be designed to improve equity, not widen gaps. Practical barriers include transportation, caregiver availability, broadband access for remote monitoring, and local clinician supply. Ambulatory infusion suites can provide an intermediate site between home and hospital for patients who are not ideal candidates for home infusion but do not need HOPD-level resources.

5. Therapies and conditions treated at Amerita

Amerita provides specialty infusion services across multiple settings (home, infusion suites, and ambulatory infusion centers) and supports multiple therapy categories, including IV anti-infectives, immunoglobulin therapy, biologics for chronic inflammatory conditions, specialty medications, nutrition support, clotting factor therapy, and inotrope therapy. [20]

5.1 IV anti-infectives (OPAT)

Amerita supports IV anti-infective therapy for serious infections or when oral therapy is not feasible, with pharmacist and nursing oversight. Amerita treats conditions including abscess, bacteremia, catheter-related bloodstream infection, cellulitis, cystic fibrosis, diabetic foot ulcer, meningitis, osteomyelitis, pneumonia, sepsis, UTI, and wound infection. [18]

5.2 Immunoglobulin therapy (IVIG/SCIG)

Amerita provides immunoglobulin therapy supported by trained, certified IgNS pharmacists and nurses. Amerita treats conditions treated including primary immune deficiency disorders, neurological disorders such as multiple sclerosis, immune thrombocytopenia (IT), pediatric Kawasaki disease, and multifocal motor neuropathy (MMN). [21]

5.3 Chronic inflammatory conditions (biologics)

Amerita dispenses biologics and related therapies for chronic inflammatory conditions and provides home assessments, education, and ongoing clinical support. Amerita dispenses medications including Actemra, Avsola, Entyvio, Inflectra, Orencia, Remicade, Renflexis, Rituxan, Simponi, and Stelara. [22] Amerita also treats conditions including Crohn's disease, ulcerative colitis, rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, and plaque psoriasis. [22]

5.4 Nutrition support (PN/EN)

Amerita supports both parenteral nutrition (PN) and enteral nutrition (EN) with a clinical team composed of nutrition-certified pharmacists, nurses and registered dietitians. PN delivers nutrients intravenously when patients cannot eat or absorb nutrition through the GI tract; EN delivers formula via feeding tube. [23]

5.5 Clotting factor therapy

Amerita supports patients with bleeding disorders using clotting factor derivatives, including emergency delivery during bleeding episodes, inventory control, dosing support, and coordination intended to keep patients out of the hospital. [24]

5.6 Inotrope therapy

For clinically appropriate patients with advanced heart failure, Amerita provides inotrope therapy with education, prescriber-approved protocols and contingency plans to prevent interruptions, and 24/7 access to experienced clinicians, with a goal of reducing ER visits and hospital readmissions. [25]

In addition to the conditions listed, ambulatory infusion commonly supports neuroimmunology and neurology-related therapies (e.g., CIDP/MMN and generalized myasthenia gravis), migraine therapies delivered as infusions (e.g., eptinezumab), and other specialty infusions that often require supervised administration (e.g., thyroid eye disease).

6. What an episode of care looks like

6.1 Referring physician or advanced practice provider perspective

From the prescriber perspective, the ideal ambulatory infusion experience includes:

- Single point-of-contact for referral submission and clinical questions.
- Rapid benefits check and prior authorization support (medical vs pharmacy benefit).
- Clear clinical acceptance criteria and site-of-care recommendations (home vs suite vs center).
- Closed-loop communication: start-of-care confirmation, lab results, adverse events, and therapy completion summary.
- Rapid scheduling start of care
- Clinical support from a team composed of pharmacist, nurses, and dietitians with specialty certifications

Amerita provides referral resources authorization support, clinical nursing visits, and 24/7 clinical support. [20][26] Specifically, Amerita supports referring clinicians with standardized referral forms, benefits verification, prior-authorization support, and start-of-care coordination.

6.2 Patient and family/caregiver perspective

- A clear plan: what therapy is, how long it lasts, and what success looks like.
- Training and confidence: line care, pump use, and how to respond to symptoms.
- Convenience: reduced travel compared to hospital outpatient infusion.
- Safety net: 24/7 access to clinical support; clear escalation pathways.
- Transparent cost expectations and financial assistance support when available.

6.3 Payer perspective

From a payer's standpoint, the infusion episode of care should be measurable, high-quality, and cost-efficient. Key payer priorities include:

- Appropriate site-of-care selection and adherence to utilization management criteria.
- Avoidance of preventable ED visits, unplanned admissions, and readmissions.
- Medication and supply integrity (cold chain, compounding quality, end-product testing when applicable).
- Network adequacy and geographic coverage.
- Member experience and safety outcomes.

7. ROI and total cost of care impact

7.1 Why ambulatory infusion lowers total cost of care

Total savings arise from three major mechanisms:

- Site-of-care price differentials (HOPD vs office/freestanding/home).
- Avoided inpatient days when infusion enables earlier discharge or admission avoidance.
- Reduced complications and downstream utilization through proactive monitoring and standardized processes.

NHIA's review of the evidence base concludes that home and outpatient infusion are consistently associated with cost savings compared to inpatient infusion across multiple drugs and conditions. In one modeled example cited by NHIA, implementation of a home infusion anti-infective Medicare benefit was associated with an estimated \$3B in Medicare savings over five years (in today's dollars). [27] Medicare reimbursement policy remains a major barrier to broader home infusion adoption for many therapies, largely due to the current definition of an "infusion drug administration calendar day" and the required in-person skilled services for payment. CMS monitoring reports have shown persistently low utilization under the current HIT benefit. [28] Bipartisan legislation—the Preserving Patient Access to Home Infusion Act—has been introduced to clarify congressional intent and preserve access. [29][30][31]

7.2 Evidence of site-of-care price differentials

A Blue Cross Blue Shield Association analysis (2023) found hospital outpatient prices for common procedures were substantially higher—sometimes up to five times—than when performed in ambulatory surgery centers or physician offices. [3] Industry groups focused on alternate site infusion report that in-office and freestanding ambulatory facilities can reduce administration costs by at least 50% for high-spend HCPCS codes compared to hospital settings. [6]

7.3 Practical ROI framework

The ROI of ambulatory infusion can be modeled at the payer or ACO level using a simple structure:

Component	What to measure	Savings lever
Site-of-care shift	Allowed amounts by setting (HOPD vs home/suite/office) for targeted drugs/HCPCS	Lower unit price and avoided facility fees
Avoided inpatient utilization	Index admission LOS and readmission rates for infusion-eligible cohorts	Earlier discharge; fewer readmissions
Avoided ED visits	ED visits per 1,000 patient-days during therapy	Reduced acute episodes via monitoring
Complications	Catheter events, infusion reactions, med errors; cost per event	Lower event rate and lower escalation cost
Member experience	Satisfaction, complaints, therapy completion	Higher adherence; fewer therapy interruptions

To strengthen clinical credibility, outcomes reporting should be grounded in standardized definitions, clear denominators, and routine data validation (e.g., periodic chart audits), with oversight by a multidisciplinary quality committee. Amerita is re-evaluating and strengthening its clinical outcomes program to improve data reliability and alignment across the organization.

7.4 Medicare and Medicaid considerations

Medicare's Home Infusion Therapy (HIT) services benefit (effective 2021) provides payment for professional services associated with certain Part B drugs infused in the home through a pump that is an item of DME. [32][33] CMS publishes national payment rates for HIT G-codes (billed in 15-minute increments, paid as a per-day amount by category). [34] Multiple stakeholders have documented gaps and limitations in the benefit design that can discourage supplier participation and constrain beneficiary access. [35][30]

8. Quality outcomes and performance measurement

8.1 Why quality measurement in ambulatory infusion is different

Ambulatory infusion quality measurement must capture: (1) medication safety and sterile compounding integrity, (2) device/line safety, (3) avoidable acute care utilization, (4) therapy completion and

adherence, and (5) patient experience. Measures should be standardized where possible, risk-adjusted when appropriate, and transparent to payers and referral sources. Because infusion nurses and pharmacists interact with patients frequently, ambulatory infusion teams can identify emerging issues (e.g., adherence barriers, medication reconciliation problems, catheter complications, or SDOH-related barriers) and communicate actionable updates to prescribers and payers to prevent escalation.

8.2 Common quality indicators used in infusion services

- Patient safety events: adverse drug reactions, infusion reactions, medication errors.
- Device-related events: catheter-related bloodstream infections (CRBSI/CLABSI), occlusions, phlebitis, malposition, inadvertent removal, breakage.
- Acute care utilization: therapy-related ED visits and unplanned hospital admissions per 1,000 patient-days (or 30-day readmission rates).
- Process reliability: time from referral to start of care, lab monitoring compliance, documentation completeness.
- Therapy success: discharge due to completion of therapy, therapy interruption rate.
- Product quality: end-product testing results/variance; sterility testing where applicable.
- Patient experience: overall satisfaction, likelihood to recommend, education effectiveness.

CDC/NHSN surveillance definitions provide standardized language for bloodstream infections and device-associated measurement in many settings. [37][38]

8.3 What infusion quality looks like

Industry benchmarking remains limited and definitions vary, but several large providers publish national outcomes. For example, Coram’s 2024 national infusion outcomes report card reports: patient satisfaction 94.4%; all catheter complications 0.39 per 1,000 catheter days; catheter infections 0.06 per 1,000 catheter days; and 30-day unplanned readmission 9.7% (all-cause). [39]

9. Amerita quality outcomes

This section summarizes select metrics from the recent Amerita Infusion Pharmacy Services Quality dashboard provided with this draft. Metrics are presented as rates per 1,000 patient-days unless otherwise specified. Where external benchmarks exist, comparisons are described; however, some measures are not directly comparable due to differing denominators (patient-days vs catheter-days) and event definitions. Measurement governance is typically owned by a defined clinical quality structure (e.g., enterprise quality committee, data stewards, and local operational leaders) that sets definitions, validates data, and ensures consistent reporting and follow-through on improvement actions.

9.1 Quarterly patient safety outcomes

Quarterly outcomes reported include adverse drug reactions (ADR), device-related events, and emergency department (ED) visits per 1,000 patient-days.

Table 1.

Quarter	ADR / 1,000 pt-days	Device events / 1,000 pt-days	ED visits / 1,000 pt-days
Q2 2024	0.03	0.08	0.04
Q3 2024	0.03	0.05	0.04
Q4 2024	0.03	0.05	0.03
Q1 2025	0.04	0.07	0.03
Q2 2025	0.03	0.07	0.02

Interpretation: Device-related events improved from Q2 2024 (0.08) to Q3–Q4 2024 (0.05), with a subsequent increase to 0.07 in Q1–Q2 2025. ED visit rates trend downward across the series (0.04 to 0.02). ADR rates remain low and stable (0.03–0.04). Industry benchmarking remains limited and is still evolving; where external benchmarks are unavailable, the most practical approach is to trend performance over time, compare across comparable regions/lines of business, and align measures with available national standards and peer-reviewed evidence.

9.2 Therapy completion and discharge reasons

Discharge due to completion of therapy is reported in the mid-90% range, improving from 93.5% (Q4 2024) to 96.3% (Q2–Q3 2025). A discharge category summary indicates 96.3% of therapies completed successfully and 2.2% discharged due to unplanned hospitalization.

Quarter	% discharged due to therapy completion
Q3 2024	95.7%
Q4 2024	93.5%
Q1 2025	95.5%
Q2 2025	96.3%
Q3 2025	96.3%

9.3 Patient experience (overall satisfaction)

Overall composite satisfaction is reported at approximately 94.3–94.4% across Q3 2024 through Q2 2025. This is directionally consistent with published national results from Coram (overall satisfaction 94.4% for 2024). [39]

Survey Method and Delivery:

- Surveys are sent to all newly-onboarded patients within 45 days of starting service.
- The survey program is managed by a third-party vendor, Strategic Healthcare Programs (SHP).
- Surveys are sent to patients monthly via US Mail by SHP.
- Patients return completed surveys via US Mail to SHP for calculation, management, and reporting.
- Survey format follows the standard NHIA survey program and asks questions related to supplies, communication, courtesy, helpfulness, instruction effectiveness, overall satisfaction, and willingness to recommend to others.

9.4 Benchmarking limitations and how to strengthen comparability

- Standardize denominators where feasible (e.g., catheter-days for line events; patient-days for utilization).
- Define event taxonomy (e.g., what counts as a device-related event vs a CLABSI/CRBSI).
- Report volume context (events and total patient-days) to interpret small number variability.
- Publish a brief ‘outcomes methodology’ appendix (data sources, inclusion criteria, validation approach).

10. Advocacy: why reimbursement must improve to expand access

10.1 The policy problem

Ambulatory infusion capacity is constrained by a misalignment between the societal value of community-based infusion and the reimbursement mechanisms that pay for it—particularly for Medicare Part B HIT services. Since 2019, under Medicare Part B, payment for items and services furnished by a qualified home infusion therapy supplier are made in a single bundled payment for each infusion drug administration calendar day. [33][34] Unlike other payers, CMS has interpreted the “infusion drug administration calendar day” to be the day on which home infusion therapy services are furnished by a skilled professional in the home rather than the day that the drug is infused, thus requiring an in-person skilled presence to qualify for payment. NHIA reports that as a result of this interpretation, participation in the Part B HIT services benefit remains low and has highlighted gaps in reimbursement for pharmacy professional services. [40]

10.2 Why higher rates can save payers money

If reimbursement enables more beneficiaries and members to access safe community-based infusion, payers can realize savings through:

- Fewer inpatient days (earlier discharge; avoided admission for stable patients).
- Reduced HOPD utilization and facility fees (site-of-care shift). [3][6]
- Lower complication-driven utilization (preventable ED visits and readmissions). [27]

NHIA states that commercial insurers typically reimburse home infusion at rates that are 40–60% less than the cost of providing care for those same patients at hospitals, supporting the expectation of net payer savings when access barriers are removed. [41]

10.3 Workforce and infrastructure implications

Broader access requires investment in infusion nursing, pharmacy sterile compounding expertise, data/quality systems, and geographic expansion of infusion suites for patients who are not ideal candidates for home infusion.

10.4 Policy Enhancements that would help decrease costs to Medicare while better enabling community-care

- Modernize the Medicare Part B HIT benefit to align the home infusion drug administration calendar day definition with other payers, supporting access to community care (consistent with ongoing NHIA advocacy)[42]
- Encourage payment policies that reduce incentives for HOPD-based infusion when community sites are clinically appropriate.
- Support standardized national quality reporting for home and alternate site infusion.
- Invest in workforce development pathways for infusion RNs, pharmacy technicians, and sterile compounding pharmacists.

11. Conclusion

Ambulatory infusion is a clinically mature, patient-centered model that can improve access and experience while reducing total cost of care for many therapies. Scaling the model responsibly requires rigorous quality measurement, transparent outcomes, and reimbursement that recognizes the clinical and operational work required to safely deliver complex therapies outside the hospital.

Appendix A. Abbreviations

- ADR: Adverse drug reaction
- AIS: Ambulatory infusion suite
- CLABSI/CRBSI: Central line/catheter-related bloodstream infection
- DME: Durable medical equipment
- ED: Emergency department
- EN: Enteral nutrition
- HIT: Home infusion therapy (Medicare Part B benefit)
- HOPD: Hospital outpatient department
- OPAT: Outpatient parenteral antimicrobial therapy
- PN: Parenteral nutrition
- ROI: Return on Investment
- SOC: Site of care

Appendix B. References

[1] Cigna Healthcare Newsroom. Specialty Pharmacies Help Improve Health Care Affordability, New Research Confirms (citing AHIP findings on specialty drug site-of-care cost differentials).

Available at: <https://newsroom.cigna.com/specialty-pharmacies-improve-health-care-affordability>

[2] NHIA/NHIF Infusion Industry Trends Report (summary).

Available at: https://nhia.org/nhif/nhif_research/nhif_infusion_industry_trends_report/

[3] Blue Cross Blue Shield Association. Hospital outpatient prices far higher, rising faster than other sites of care (press release).

Available at: <https://www.bcbs.com/press-releases/hospital-outpatient-prices-far-higher-rising-faster-other-sites-care>

[4] Trilliant Health. Growth in Alternate Site Infusion Providers Raises Questions Around Cost of Care and Access.

Available at: <https://trillianthealth.com/infusion-providers>

[5] The Cigna Group. Referring patients to infusion centers reduces costs while maintaining quality of care.

Available at: <https://www.thecignagroup.com/newsroom/news-releases/2023/referring-patients-to-infusion-centers-reduces-costs-while-maintaining-quality-of-care>

[6] Infusion Providers Alliance. Cost Savings and Improved Quality in a Clinic-based Setting.

Available at: https://infusionprovidersalliance.org/wp-content/uploads/2024/08/Infusion_Providers_Alliance_WP-Aug_2024_ClinicBasedSetting.pdf

[7] USP. General Chapter <797> (sterile compounding).

Available at: <https://www.usp.org/compounding/general-chapter-797>

[8] USP–NF. Notice re: <797> official date.

Available at: <https://www.uspnf.com/notices/797-pub-announcement-20221101>

[9] ACHC. Pharmacy accreditation overview.

Available at: <https://achc.org/pharmacy/>

[10] ACHC. Home infusion therapy accreditation overview.

Available at: <https://achc.org/home-infusion-therapy/>

[11] URAC. Infusion Pharmacy Accreditation.

Available at: <https://www.urac.org/accreditation-cert/infusion-pharmacy-accreditation/>

[12] ASHP. Guidelines on Home Infusion Pharmacy Services (PDF).

Available at: <https://www.ashp.org/-/media/assets/policy-guidelines/docs/guidelines/home-infusion-pharmacy-services.pdf>

[13] Azimi SF, et al. Antimicrobial Stewardship Practices in Outpatient Parenteral Antimicrobial Therapy. 2024.

Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC11232693/>

[14] Mundi MS, Pattinson A, McMahon MT, Davidson J, Hurt RT. Prevalence of Home Parenteral and Enteral Nutrition in the United States. Nutr Clin Pract. 2017.

Available at: <https://pubmed.ncbi.nlm.nih.gov/28715295/>

[15] Agnihotri G, et al. Decreased hospital readmissions after programmatic strengthening of an outpatient parenteral antimicrobial therapy (OPAT) program. PubMed.

Available at: <https://pubmed.ncbi.nlm.nih.gov/36865701/>

[16] Grand View Research. U.S. Home Infusion Therapy Market Summary (2024–2025 estimates).

Available at: <https://www.grandviewresearch.com/industry-analysis/us-home-infusion-therapy-market>

[17] Fortune Business Insights. U.S. Home Infusion Therapy Market Size & Share (2024–2025 estimates).

Available at: <https://www.fortunebusinessinsights.com/u-s-home-infusion-therapy-market-106327>

[18] CDC. IBD Facts and Stats.

Available at: <https://www.cdc.gov/inflammatory-bowel-disease/php/facts-stats/index.html>

[19] Xu Y, et al. Prevalence Trend and Disparities in Rheumatoid Arthritis (U.S. prevalence context). 2021.

Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC8348893/>

[20] Amerita. Therapies overview.

Available at: <https://ameritaiv.com/medservices/>

[21] Amerita. Immunoglobulin Therapy.

Available at: <https://ameritaiv.com/medservices/immunoglobulin-therapy/>

[22] Amerita. Chronic Inflammatory Conditions.

Available at: <https://ameritaiv.com/medservices/chronic-conditions/>

[23] Amerita. Nutrition Support.

Available at: <https://ameritaiv.com/medservices/nutrition-support/>

[24] Amerita. Clotting Factor.

Available at: <https://ameritaiv.com/medservices/clotting-factor/>

[25] Amerita. Inotrope Therapy.

Available at: <https://ameritaiv.com/medservices/inotrope-therapy/>

[26] Amerita. Specialty Medications (reimbursement support).

Available at: <https://ameritaiv.com/medservices/specialty-medications/>

[27] NHIA. Cost Savings: Home Versus Inpatient Infusion Therapy (literature review).

Available at: <https://nhia.org/cost-savings-home-versus-inpatient-infusion-therapy/>

[28] Centers for Medicare & Medicaid Services (CMS). HIT Monitoring Report February 2025 (PDF).

Available at: <https://www.cms.gov/files/document/hitmonitoringreportfeb272025sxf508.pdf>

[29] Congress.gov. S.1058 – Preserving Patient Access to Home Infusion Act (119th Congress).

Available at: <https://www.congress.gov/bill/119-congress/senate-bill/1058>

[30] Congress.gov. H.R.2172 – Preserving Patient Access to Home Infusion Act (119th Congress).

Available at: <https://www.congress.gov/bill/119th-congress/house-bill/2172>

[31] National Home Infusion Association (NHIA). NHIA Applauds Growing Bipartisan Support for the Preserving Patient Access to Home Infusion Act (Dec 1, 2025).

Available at: <https://nhia.org/nhia-applauds-growing-bipartisan-support-for-the-preserving-patient-access-to-home-infusion-act/>

[32] CMS. Home Infusion Therapy overview.

Available at: <https://www.cms.gov/medicare/payment/fee-for-service-providers/home-infusion-therapy>

[33] CMS. Home infusion therapy services benefit FAQs (PDF).

Available at: <https://www.cms.gov/files/document/home-infusion-therapy-services-benefit-beginning-2021-frequently-asked-questions.pdf>

[34] CMS. CY 2025 National Home Infusion Therapy Rates (PDF).

Available at: <https://www.cms.gov/files/document/cy-2025-national-home-infusion-therapy-rates.pdf>

[35] NHIA. Fixing Medicare's Part B HIT Services Benefit.

Available at: <https://nhia.org/advocate/fixing-part-b-hit-benefit/>

[36] Noridian Medicare. External Infusion Pumps Open Meeting (notes on payment gaps).

Available at: <https://med.noridianmedicare.com/web/jadme/policies/lcd/open-meeting/eip-open-meeting-082725>

[37] CDC/NHSN. Bloodstream infection (BSI) / CLABSI protocols.

Available at: <https://www.cdc.gov/nhsn/psc/bsi/index.html>

[38] CDC/NHSN. Patient Safety Component Manual (PDF).

Available at: https://www.cdc.gov/nhsn/pdfs/validation/2024/pcsmanual_2024.pdf

[39] Coram CVS Specialty. 2024 Outcomes Report Card (PDF).

Available at: <https://www.coramhc.com/sites/default/files/2024-06/Coram%202024%20Outcomes%20Report%20Card.pdf>

[40] NHIA. Member Value Report 2023 (participation low due to lack of reimbursement for pharmacy professional services) (PDF).

Available at: <https://nhia.org/wp-content/uploads/2024/05/Member-Value-Report-2023.pdf>

[41] NHIA. Home Infusion Creates Savings for Patients and Taxpayers (PDF).

Available at: https://nhia.org/wp-content/uploads/2020/03/Home_Infusion_Creates_Savings_for_Patients_Taxpayers.pdf

[42] NHIA. Fixing Part B HIT Benefit – Preserving Patient Access to Home Infusion Act support page.

Available at: <https://nhia.org/advocate/fixing-part-b-hit-benefit/support-the-preserving-patient-access-to-home-infusion-act/>

[43] Amerita. IV Anti-Infectives (conditions supported).

Available at: <https://ameritaiv.com/medservices/iv-anti-infectives/>

[44] Infusion Nurses Society / Infusion Nurses Certification Corporation. CRNI® Exam Overview.

Available at: <https://www.ins1.org/crni/exam/overview/>

[45] National Association of Specialty Pharmacy (NASP). The CSP Credential.

Available at: <https://naspnet.org/certification>