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September 15, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

Re: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency [CMS-1834-P]

Dear Administrator Oz:

The University of California Health (UC Health) appreciates this opportunity to submit the following comments regarding the Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule for fiscal year (FY) 2026.

UC Health represents six University of California academic health centers: UC San Francisco (and its affiliate, UCSF Benioff Children's Hospital Oakland ("BCH Oakland")), UC Los Angeles, UC Irvine, UC San Diego, UC Davis, and the University of California, Riverside School of Medicine. UC academic health centers are an essential part of California's health care safety net system. As designated public hospitals, UC's academic health centers provide high-quality care to those in need regardless of their insurance status or ability to pay. We provide care for patients' everyday health needs, as well as those with the most complex cases, including cancer, burn, transplant, and trauma care.

UC Health plays a leading role in California's health care safety net as one of the state's significant providers of Medicare and Medicaid inpatient and hospital outpatient services. Government payors comprise two-thirds of our payor mix, with 36% of inpatient days at UC hospitals devoted to caring for Medicare patients. In the 2022-23 fiscal year, our academic health centers provided an estimated $3.7 billion in uncompensated care to patients insured by Medicaid and Medicare. UC Health is committed to providing world class health care to Californians with limited means and limited access to care.

Overall, the proposed rule would result in a slight year-over-year decline in UC Health's OPPS payments due to declining payments of Wage Index, 340B Remedy Offset, and Hospital Outpatient Department (HOPD) Payment

Reductions. However, many of the policies considered under this proposed rule signal a direction that would lead towards much more significant cuts to Medicare payments in future years. This would jeopardize access to critical outpatient services for Medicare beneficiaries, particularly in underserved communities. UC Health urges CMS to revise its policies in the final rule to better reflect real-world cost pressures and to safeguard the financial viability of safety net hospitals, including those at UC Health. Considering the vital functions fulfilled by public health care systems like ours, we offer the following comments.

- ***OPPS Payment Update****:* UC Health urges CMS to strengthen the OPPS payment update by incorporating more current inflation data, applying a forecast error adjustment to correct for past underestimates, and reducing or eliminating the productivity cut. Without these changes, our hospitals will continue to face unsustainable shortfalls.
- ***"Site Neutral" Hospital Outpatient Department Cuts:*** UC Health opposes extending site-neutral payment to drug administration in excepted off-campus hospital outpatient departments. These policies reduce critical resources from hospitals caring for high-acuity and underserved patients, while not accounting for the higher regulatory, staffing, and safety standards hospitals must meet compared to physician offices. Such cuts put patient safety at risk, diminish access to vital infusion and oncology services, and destabilize the financial foundation of hospital outpatient departments that serve as a critical way that we extend care into our communities.
- ***Request For Information: Expanding "Site Neutral" HOPD cuts to on-campus facilities:*** UC Health opposes efforts to expand payment cuts for on-campus HOPDs, which carry all the defects of cuts to off-campus grandfathered HOPDs but could jeopardize access to patient care on a much greater scale.
- ***340B Remedy Recoupment****:* UC Health opposes the accelerated repayment schedule, and CMS should not depart from the previously finalized 0.5% approach that hospitals have already incorporated into financial planning.
- ***Survey on Hospital Drug Acquisition Costs***: UC Health opposes CMS's plan to reinstitute surveys of hospital acquisition costs for drugs. Past experience has shown that such surveys create administrative burden and produce inconsistent data.
- ***Price Transparency Requirements****:* UC Health urges CMS to delay implementation of new transparency reporting requirements, given concerns about HIPAA conflicts, specification changes, and administrative burden. The proposed updates to hospital transparency requirements do not provide information that is useful to patients in understanding their out-of-pocket costs. In addition, the new proposed attestation language should be withdrawn in favor of the prior good faith attestation standard. Insurers should be the sole source of reported negotiated rate information and hospitals should be exclusively responsible for reporting standard charge information.
- ***Virtual Supervision****:* UC Health supports continued flexibility for virtual direct supervision, recognizing its importance in maintaining patient access, alleviating workforce shortages, and ensuring hospitals can deliver outpatient services efficiently.
- ***Inpatient-Only (IPO) List****:* UC Health opposes elimination of the IPO list, stressing that certain procedures should be conducted exclusively in inpatient settings to ensure patient safety.

Removing such protections risks inappropriate shifts to outpatient care that compromise quality and safety for patients.

"Site Neutral" Cuts to Hospital Outpatient Department Payments Drug Administration

UC Health opposes the proposal to reduce Medicare payment for drug administration services furnished in excepted off-campus hospital outpatient departments (HOPDs) to the Physician Fee Schedule (PFS)-equivalent rate (approximately 40% of the OPPS rate). This payment cut for grandfathered HOPDs undermines patient care by not accounting for the higher complexity and regulatory requirements of hospital-based care. **CMS should withdraw this proposal, as it would jeopardize access to critical outpatient services, especially in underserved communities**.

HOPDs Provide Higher-Acuity Care Under More Stringent Clinical Standards

HOPD payment cut proposals do not account for differences between hospital outpatient departments and independent physician offices or clinics. Hospitals and their outpatient departments are designed, equipped, and regulated to provide a higher acuity level of care to patients with serious conditions and complex needs. **Cutting HOPD reimbursement to match physician offices** does not **recognize the different level of care provided by hospitals and the needs of the patients they serve**. Key differences that justify higher outpatient payments for HOPDs include:

- **More Complex Patients and Safety Net Role: HOPDs treat sicker and more vulnerable patients than physician offices**. Medicare beneficiaries seen in HOPDs are far more likely to be elderly with multiple chronic conditions, disabled, or dually eligible for Medicaid than those treated in independent physician offices.[1] In addition, an American Hospital Association (AHA) study found HOPD patients were 1.6 times more likely to qualify for Medicare due to disability/End Stage Renal Disease and significantly more likely to have comorbidities than patients in physician offices.[2] HOPD patients are also more likely to be low-income or from underserved populations and are nearly twice as likely to be dual Medicare-Medicaid eligible.[3] In short, hospital clinics serve as a critical safety net, caring for patients who are older, poorer, and in worse health on average. **These patients often cannot be safely or effectively treated in lower-acuity settings. It is the mission of UC Health to serve all who come through their doors, regardless of complexity or ability to pay.**

- **Emergency Capabilities and Care Coordination**: Unlike freestanding offices, hospital outpatient departments operate within a 24/7 acute-care infrastructure. HOPDs are integrated with full hospital support services – including on-site emergency care, rapid response teams, diagnostic imaging, labs, pharmacy, and more. If a complication occurs during an infusion or procedure, physicians and emergency equipment are immediately available to manage it. In addition, HOPDs often provide multidisciplinary care coordination that standalone offices cannot.

[1] https://www.aha.org/system/files/media/file/2023/03/Comparison-of-Medicare-Beneficiary-Characteristics-Between-Hospital-Outpatient-Departments-and-Other-Ambulatory-Care-Settings.pdf
[2] https://www.aha.org/system/files/media/file/2023/03/Comparison-of-Medicare-Beneficiary-Characteristics-Between-Hospital-Outpatient-Departments-and-Other-Ambulatory-Care-Settings.pdf
[3] https://www.aha.org/system/files/media/file/2023/03/Comparison-of-Medicare-Beneficiary-Characteristics-Between-Hospital-Outpatient-Departments-and-Other-Ambulatory-Care-Settings.pdf

For example, an oncology patient at a hospital outpatient infusion center can access social workers, nutritionists, or other specialists during their visit – a level of coordinated, wraparound care that improves outcomes. Hospital outpatient pharmacies can adjust medication dosages based on lab results or patient condition on the day of treatment and ensure no delays in therapy. Hospitals also provide access 24/7 – many have outpatient clinics with extended or weekend hours, and the hospital's emergency department backstops care at all times. Crucially, hospitals are legally required (under the Emergency Medical Treatment and Labor Act) to treat anyone who seeks emergency care, regardless of ability to pay, and in practice this commitment extends to other hospital services patients need. Physician offices have no such obligation. **The justifiably higher payments supported by OPPS help hospitals maintain this "always open" readiness and comprehensive care coordination that benefit patients and communities**.

- **Rigorous Clinical Quality and Safety Standards**: Hospitals must meet far more stringent regulatory and safety standards than independent clinics.[4] For drug administration services (infusions, injections, etc.), HOPDs must comply with U.S. Pharmacopeia (USP) Chapter 797 sterile compounding standards, Joint Commission accreditation, state licensure rules, and other requirements ensuring patient safety. Medications are prepared in hospital clean-room pharmacies with specialized air filtration and environmental monitoring to maintain sterility – measures rarely found in physician offices. Every infusion is typically overseen by a licensed pharmacist who checks dosing, allergies, and drug interactions before administration. Hospitals utilize advanced safety technologies such as electronic health record (EHR) integration and barcode medication scanning to prevent errors. A physician is onsite or immediately available in case a patient has an adverse reaction or needs urgent intervention. Furthermore, hospitals adhere to extensive oversight from bodies like the Food and Drug Administration, state pharmacy boards, the USP, and The Joint Commission for their compounding and administration practices. These layers of regulation and oversight create a safety envelope in HOPDs that ambulatory offices are generally not equipped or required to provide. **Hospital payment rates must be sufficient to support the higher standard of care that CMS and other regulators require hospitals to meet for drug administration.** HOPDs incur substantial operational costs to meet these gold-standard safety requirements – costs that the OPPS was designed to support.

CMS should not finalize the proposal to pay excepted off-campus HOPDs at the PFS-equivalent rate for drug administration services. This policy would reduce resources for hospitals that serve the most complex and vulnerable patients, without evidence of volume reduction or efficiency. **Hospitals are already facing financial challenges – a 60% payment cut for vital infusion and injection services will undermine the ability of HOPDs to keep their doors open to all who need care**. Especially in communities with limited access to care — hospital outpatient departments are often the only option for patients requiring chemotherapy, advanced infusions, or emergency-level oversight during treatment. Cutting payments in these settings threatens to reduce access to care for patients.

[4] https://news.ashp.org/-/media/assets/advocacy-issues/docs/2023/Site-Neutral-Payments-infographic-final.pdf

RFI: Expanding "Site Neutral" HOPD cuts to on-campus facilities

UC Health shares a goal with CMS to ensure that all patients are seen in the most appropriate setting. Patients, payers and providers all stand to benefit from transitioning care out of high-cost environments like the emergency room and inpatient settings to outpatient. HOPDs are a critical component of the long-term trend of moving care toward these lower cost settings. UC Health providers deliver care in HOPDs that cannot be safely delivered in unlicensed facilities with lower levels of equipment and staffing. That higher level of care has allowed us to serve patients closer to home who would otherwise have to travel to the hospital. For example, in recent years treatments for sickle cell, bone marrow treatment, and CAR-T (Chimeric Antigen Receptor T-cell therapy) cell therapies, have all moved to outpatient care. This transition from inpatient settings to outpatient settings reduces costs for Medicare over time in addition to improving the lives of the patients we serve.

Without the additional financial resources that pay for the infrastructure and staffing to support advanced clinical care, we would expect to see new and complex care services stay in the inpatient setting longer – making those services more costly and more difficult to access. UC Health acute care hospitals are generally at capacity, so hospital beds occupied by these patients would unnecessarily reduce overall capacity. Likewise, eliminating the higher level of clinical support in the HOPD setting is likely to drive physicians to increase inpatient admissions for complex patients such as those with multiple conditions rather than sending them to lower acuity settings for similar procedures.

Proposals to cut on-campus HOPD reimbursement are particularly concerning. These cuts have not been widely contemplated or endorsed by Congress. The size and scope of their impact on access to health care services would be much greater than similar proposals at off-campus grandfathered HOPDs, and they risk cutting off access to critical health care services on a massive scale. Finally, CMS lacks the statutory authority to make service-specific adjustments to payment rates for services provided at on-campus HOPDs. Outside of the regular rate setting process, which includes determining weights for Ambulatory Payment Classifications (APCs) based on the resource intensity of the services within that APC. CMS cannot arbitrarily reduce rates under the guise of "site neutrality". In enacting Section 603 of the Bipartisan Budget Act of 2015, Congress made a clear distinction that "site neutral" policies were to apply only to off-campus HOPDs (and specifically, non-excepted HOPDs that were not billing for services furnished before November 2, 2015). Congress chose to specifically reference "off-campus outpatient departments of a provider" and within that category of HOPDs, distinguished between excepted and non-excepted departments. Services furnished at on-campus HOPDs continue to be treated as "covered OPD services" under the OPPS and paid under Section 1833(t)(1)(B)—that is, they are not subject to payment under another applicable payment system under Section 1833(t)(21). **UC Health urges CMS not to pursue cuts to reimbursement for on-campus HOPDs.**

Accelerated Recoupment of 340B Remedy

CMS proposes to accelerate the timeline for the OPPS 340B remedy recoupment by increasing the offsetting payment cut from 0.5% to 2.0% starting in CY 2026. In the OPPS 340B Final Remedy rule published in November 2023, CMS finalized a plan to recoup an estimated $7.8 billion by applying a 0.5 percentage point reduction to all non-drug OPPS payments each year from 2026 onward. This 0.5% annual offset was expected to take approximately 16 years to claw back the $7.8 billion, targeting

completion by 2041. CMS noted that this approach balanced budget neutrality with reliance interests and attempted to spread the repayment out over many years to reduce the burden on hospitals. Now, CMS proposes to quadruple the annual offset to 2%, condensing the repayment timeline to only 6 years (through 2031). **UC Health opposes CMS's proposal to accelerate the clawback of funds under 42 CFR § 419.32(b)(1)(iv)(B)(*12*). We urge CMS to rescind subsection 419.32(b)(1)(iv)(B)(*12*) for the reasons outlined below.**

If CMS were determined to proceed with a clawback of some kind, we urge it to keep the previously finalized repayment timeline. A 2% annual adjustment for six or more years would be burdensome to UC Health and at odds with CMS's prior acknowledgement of hospitals' substantial reliance interests and increasing financial strain. The proposed rule asserts that hospitals have minimal reliance interest in the existing 0.5% offset because the policy has not yet taken effect. This does not reflect how hospitals operate. Hospitals plan their budgets and service lines years in advance based on published Medicare payment updates and implementation policies. UC Health began factoring the 0.5% clawback into its multi-year financial forecasts as soon as CMS finalized it in 2023. Many hospitals incorporated this change into their budgets with the knowledge that OPPS payments would be slightly lower (by 0.5% annually) for the next decade and a half. This change adversely impacts hospital budgets. Hospitals relied on the promulgated policy as soon as it was finalized in crafting future budgets and strategic plans, and an abrupt change of this magnitude will result in lost dollars in expected Medicare revenue over the next 6 years.

CMS's proposal also does not account for the worsening financial conditions hospitals face in 2025, after the passage of the *One Big Beautiful Bill Act* (OBBBA) and upcoming Medicaid cuts. As noted above, in the Final Remedy Rule, CMS calibrated the 0.5% offset in part to avoid over-burdening hospitals, implicitly based on financial condition of hospitals in 2023. Since then, hospitals' financial challenges have grown. The OBBBA – signed into law July 4, 2025 – imposes nearly $1 trillion in reductions to Medicaid funding nationally over the next decade. The Congressional Budget Office projects this law will result in about 10 million Americans losing health coverage by 2034, including an estimated 7.5 million current Medicaid enrollees who will become uninsured due to new coverage restrictions.[5] The California Hospital Association estimates that approximately 1.8 million Californians will lose coverage over the next 10 years. For California's hospitals, including UC Health, these Medicaid cuts and coverage losses will increase uncompensated care and reduce Medicaid reimbursement. The rulemaking's failure to acknowledge and consider these critical facts in arriving at the proposed accelerated recoupment makes this decision arbitrary and capricious.

UC Health urges CMS to withdraw this proposal and rescind subsection 419.32(b)(1)(iv)(B)(*12*). However, if CMS does continue to recoup the 340B remedy funds, it should adhere to the original gradual timeline (0.5% annually over 16 years) rather than aggressively accelerate the repayment timeline.

[5] https://www.cbo.gov/publication/61570

Hospital Drug Acquisition Cost Survey

CMS proposes to survey all hospitals paid under OPPS on the acquisition cost of each separately payable Part B drug purchased between July 2024 and June 2025. UC Health has concerns about this proposal.

CMS underestimates the cost and administrative workload of such a survey. The agency estimates each hospital would require over 73.5 hours to complete the survey. Hospitals would need to compile data on hundreds of drugs (about 700 HCPCS codes, many with multiple National Drug Codes per HCPCS code) and net acquisition costs after accounting for all complex discounts. This administrative workload would be higher than CMS estimates. Hospitals would need to divert significant pharmacy, finance, and IT staff resources to comply.

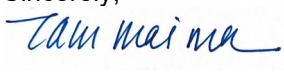
Conducting such a survey given the seismic volatility in drug pricing and policy could render survey results invalid. Covered entities were never made whole for underpayments from Medicare Advantage (MA) plans that tied their drug reimbursement rates to the unlawful CMS 340B policy. Even after the Supreme Court's ruling and CMS's reversal, most MA plans did not retroactively adjust or repay the underpayments. Hospitals continue to carry these financial losses with no mechanism for recovery.

At the same time, 340B hospitals already face heavy pressures from other programs. HRSA's newly proposed 340B rebate model requires significant new upfront capital expenditures as well as additional reporting and reconciliation, state Medicaid programs often reimburse at acquisition cost with little margin and CMS under the Inflation Reduction Act (IRA) will begin reducing Part D drug payments in 2026 and it will expand over time to include more drugs, including Part B products. This is not a one-time change - future rounds of price setting will continue lowering reimbursement and further erode the resources 340B hospitals rely on. Adding another acquisition-cost survey that will be used to reduce 340B reimbursement only compounds these challenges and undermines the safety net.

The landscape for prescription drug costs is currently in flux due to major policy shifts. For example, the Administration has launched a new Most Favored Nation pricing initiative that will require manufacturers to give U.S. purchasers prices no higher than those offered in other developed nations. At the same time, tariffs on imported pharmaceuticals – up to 250% – may disrupt the pharmaceutical market and supply chain. These policy changes (along with ongoing Medicare drug price negotiations and potential 340B program changes) create uncertainty. The survey will require hospitals to disclose sensitive purchasing and contract data that varies widely by channel and contract type. Data collected in 2026 will not reflect local market realities in 2027–2028. Many hospitals operate under complex acquisition mechanisms including group purchasing agreements, and individual pricing arrangements. Hospitals' reported drug acquisition costs in the reporting period between mid-2024 to mid-2025 could be unrepresentative of future trends, given these policy shifts. Fielding a comprehensive survey amidst such turmoil would likely yield inaccurate data. **For these reasons, we urge CMS to withdraw its plan for a broad acquisition-cost survey and instead maintain the current methodology until a more balanced, coordinated policy approach is developed in partnership with HRSA, state Medicaid agencies, and affected stakeholders.**

Thank you for the opportunity to provide feedback, UC Health is ready to collaborate on solutions that strengthen our safety net hospitals. Thank you for your consideration of our comments. If you have any questions, please contact Kent Springfield at (202) 993-8810 or kent.springfield@ucdc.edu.

Sincerely,



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