UNIVERSITY
OF
CALIFORNIA
HEALTH

University of California Health
1111 Franklin Street
Oakland, CA 94607

universityofcalifornia.health

August 31, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs [CMS-1850-P].

Dear Administrator Oz:

The University of California Health (UC Health) appreciates the opportunity to submit the following comments regarding the Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule for calendar year (CY) 2027. 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 UC Riverside School of Medicine. UC's academic health centers are an essential part of California's health care safety-net system. UC's academic health centers provide high-quality care to patients regardless of insurance status or ability to pay. UC's academic health centers provide care for patients' everyday health needs and for the most complex conditions, including cancers, burns, transplants, and trauma.

UC's academic health centers are collectively one of California's largest providers of Medicare and Medicaid inpatient and outpatient hospital services, delivering an outsized share of complex tertiary and quaternary care to low-income patients statewide and serving patients from 99% of California zip codes. In 2024-25, government payors accounted for approximately three-quarters of our payor mix, with 40% of inpatient days attributable to Medicare patients. In FY 2023-24, our academic health centers provided an estimated $4 billion in uncompensated care to Medicaid and Medicare patients. UC Health is committed to providing world-class health care to Californians with limited means and limited access to care.

As 340B providers, UC's academic medical centers serve a disproportionate share of the Medicare, Medicaid, and low-income patients whom the 340B Drug Pricing Program was designed to support. We are concerned that CMS proposes to reduce payment for 340B-acquired drugs by roughly 40% and redistribute the savings through increased payments for non-drug OPPS services furnished by all OPPS hospitals, including for-profit and other non-340B hospitals. We are also concerned that CMS proposes to reduce reimbursement for non-drug services and supplies by 3%, rather than 0.5%, to expedite recoupment of payments associated with its unlawful 2018–2022 340B payment reductions. Taken together, these proposals would undermine a program that has operated successfully for over three decades and jeopardize our ability to continue providing care to our most vulnerable patients. We are deeply concerned that CMS is basing the proposed 340B drug payment reduction on data insufficient to support a reasonable payment reduction or satisfy statutory requirements. We strongly urge CMS not to finalize these proposals for the reasons described below.

1. **CMS's proposed 340B drug-payment reduction is based on a flawed methodology that fails to account for the full cost of providing therapies to Medicare beneficiaries.**

CMS's proposed payment rate for outpatient drugs does not accurately reflect UC's acquisition costs for Medicare-covered drugs**.** The proposed across-the-board rate of average sales price (ASP) minus 33.4% fails to account for variation in acquisition costs among individual drug codes. CMS's proposed alternative of ASP minus 28% is not a viable solution either. While less severe than the proposed 33.4% cut, it would still represent a substantial reduction from the current ASP plus 6% rate and result in a significant negative financial impact on UC Health. We are also concerned that the survey underlying the proposal did not produce a sufficient sample to produce statistically reliable estimates at the drug-code level, as required by statute.[1] Only about 41% of eligible hospitals responded, and 340B hospitals were substantially underrepresented relative to non-340B hospitals (roughly 28.6% versus 53.3%). This low response rate is not evidence that hospitals were unwilling to participate; it reflects the practical constraints placed on the data collection itself. Hospitals were given a short window to compile and submit acquisition cost data, and it is administratively burdensome to track acquisition costs across multiple purchasing accounts and group purchasing organization tiers, and 340B versus non-340B purchasing streams. Reconstructing this data accurately within that timeframe is onerous even for well-resourced systems, and a survey design that imposes this level of burden on a compressed timeline will yield a low response rate. The proposal therefore falls short of the survey requirements in two respects: first, CMS did not conduct a statistically sound survey of hospitals' acquisition costs; and second, the proposed uniform reduction does not establish acquisition cost of individual drugs, as required by statute.

UC Health compared its third-quarter 2026 340B acquisition costs with the proposed ASP minus 33.4% payment rate for status K drugs[2]. For 60% of the National Drug Codes reviewed, the proposed payment rate would fall below UC Health's actual acquisition cost. Thus, for the majority of the separately payable 340B drugs reviewed, the proposed rule would not merely reduce UC Health's margin; it would

[1] Section 1833(t)(14)(D)(ii) of the Social Security Act.

[2] CMS defines K drugs as non-pass-through drugs, non-implantable biologicals, and radiopharmaceutical agents, including therapeutic radiopharmaceuticals. Paid under OPPS; separate APC payment. *See* CMS-1850-P, Addendum D1 — OPPS Payment Status Indicators for CY 2027.

reimburse UC Health less than what it pays to acquire the drug. A payment methodology that produces below-cost reimbursement for most of the affected drugs reviewed cannot reasonably be characterized as aligning payment with acquisition cost, CMS's stated rationale for the proposal. The affected 340B drugs span nearly every high-acuity specialty UC Health operates, including oncology; hemophilia and bleeding-disorder treatment; rare-disease enzyme replacement therapy; cell and gene therapy; immunoglobulin replacement; transplant medicine; and ophthalmology. This is not a narrow or peripheral group of drugs. Below-cost reimbursement at this scale would directly affect access to some of the most complex, highest-need care we provide.

CMS's methodology also overlooks the clinical, operational, and administrative resources required to furnish these therapies safely. Acquiring a drug is only one component of outpatient treatment. As 340B providers, we must also maintain the pharmacy staff, nursing services, temperature-sensitive storage, inventory management, care coordination, prior authorization processes, and regulatory compliance necessary for safe administration. These costs are incurred regardless of whether a drug is purchased through the 340B program. Medicare has historically recognized the costs associated with furnishing separately payable Part B drugs by providing an add-on payment above ASP for such drugs. Yet the proposed rule would eliminate any add-on payment for 340B hospitals while preserving one for other hospitals. By basing reimbursement primarily on estimated acquisition cost, CMS substantially understates the true cost of furnishing outpatient drug therapy. The supporting services described above cannot be eliminated without compromising patient care. We urge CMS to recognize that reimbursement for separately payable outpatient drugs supports the full process of delivering that therapy—not merely the medication’s acquisition cost—and to reconsider a proposal that, if finalized, risks reducing access to care for the Medicare beneficiaries.

2. **CMS should withdraw its proposed accelerated recoupment methodology for the 2018–2022 OPPS remedy.**

UC Health appreciates CMS's efforts to comply with the Supreme Court's decision concerning the unlawful 340B payment reductions imposed during CYs 2018–2022. Affected 340B providers were underpaid and were entitled to the remedy CMS implemented in 2023. However, CMS's proposal to accelerate substantially the recoupment associated with the temporary increase to the OPPS conversion factor would impose additional financial strain on hospitals at a time when many safety-net providers, including UC’s academic medical centers, already face substantial fiscal pressure.

The proposed timeline is particularly concerning because UC Health reasonably relied on CMS's 2023 final payment policy when making long-term financial commitments. In finalizing the remedy, CMS considered alternative recoupment timeframes and ultimately adopted a policy that would spread recoupment over approximately 16 years. Changing that methodology after hospitals have relied on it creates unnecessary financial uncertainty and undermines providers' ability to plan responsibly.

Since the original payment reductions were implemented, UC’s academic medical centers have experienced unprecedented increases in labor, pharmaceutical, and supply costs while continuing to provide increasing levels of undercompensated care. Accelerating reductions in future OPPS payments to finance the retrospective remedy would further limit the resources available to care for Medicare beneficiaries and other patients who depend on us. Combined with the proposed reduction in payment

for separately payable outpatient drugs at 340B hospitals, CMS would reduce payments for both drugs *and* non-drug items and services at safety-net providers such as UC's academic medical centers, while subjecting hospitals to year-to-year payment changes. **After accounting for all proposed OPPS payment changes – including the accelerated recoupment, the ASP minus 33.4% drug-payment reduction, the annual payment update, other standard adjustments, and the budget-neutral redistribution to non-drug OPPS services — UC Health estimates that UC's academic medical centers would lose $117 million annually in reimbursement.**

Hospitals depend on stable and predictable Medicare payment policies when making multiyear investments in facilities, workforce, and patient care. Frequent changes to finalized payment methodologies reduce providers' ability to make prudent long-term investments that ultimately benefit Medicare beneficiaries.

CMS should pursue an approach that remedies the prior unlawful payment reductions without creating new financial challenges for hospitals that continue to fulfill an essential safety-net mission. **We urge CMS to withdraw the proposed acceleration and maintain the 16-year recoupment timeline previously finalized. That approach would better protect beneficiary access to care while ensuring that UC Health retains the remedy payments to which it is entitled.**

3. **UC's academic medical centers depend on 340B savings to support patient access to care, consistent with congressional intent.**

The 340B Drug Pricing Program allows UC's academic medical centers to stretch scarce federal resources and serve more patients with comprehensive care. UC reinvests 340B savings in services that would otherwise be difficult to sustain, particularly for Medicare beneficiaries, including the dually eligible Medicare-Medicaid population UC's academic medical centers disproportionately serves. As noted above, the proposed reimbursement reductions would affect medications across nearly every high-acuity specialty UC's academic medical centers operate, including oncology; hemophilia and bleeding disorder treatment; rare disease enzyme replacement therapy; cell and gene therapy; immunoglobulin replacement; transplant medicine; and ophthalmology. If made permanent, these reductions would limit our ability to sustain current community benefits and fund critical patient care programs for the Medicare population, the uninsured and those who face significant barriers to care

340B savings support a wide range of community benefits, including specialty programs that provide lifesaving treatments—organ transplants, complex cancer care, immunological care (including stem cell transplants), neurological care, and cardiovascular care, and heart surgery—to Medicare, Medicaid, and underserved patients. These are services for which Medicare and Medicaid reimbursement frequently falls below the full cost of care. 340B savings improve access to medically necessary treatment, support treatment adherence, and reduce avoidable emergency department visits and hospitalizations. In addition, all UC Health locations offer financial assistance and charity care programs to eligible patients, further extending the reach of these savings.

Through these benefits, the 340B Program functions as Congress intended: it enables covered entities to stretch scarce federal resources to reach more eligible patients and provide more comprehensive services. The proposed Medicare reimbursement reductions would substantially diminish the resources

available to sustain those services. Although CMS characterizes the proposed drug-payment change as a redistribution within OPPS, the redistribution would not make individual 340B hospitals whole and would divert resources away from the safety-net providers that rely most heavily on 340B savings to care for our Medicare and dual-eligible patients we serve.

4. **CMS should withdraw the proposed "XX" placeholder drug modifier requirement for non-340B drugs.**

CMS would require the JG modifier to identify 340B-acquired drugs subject to the payment reduction and the TB modifier to identify exempt 340B drugs. Any claim line without either modifier is, by definition, already identifiable as a non-340B drug. The XX-placeholder modifier is therefore redundant: requiring hospitals to affirmatively identify what is already the logical default would add a data field without providing new information.

Implementing this provision would require UC Health to build and maintain an entirely separate list in addition to the list it already maintains. UC Health currently maintains a 340B drug group that identifies separately payable status-indicator K drugs. The list is updated quarterly to reflect changes in drug status, new Healthcare Common Procedure Coding System (HCPCS) codes, and pricing updates. The XX-placeholder modifier proposal would require UC Health to build a second, parallel list specifically for non-340B drugs and maintain it on the same quarterly cycle. This duplicative build would solve no apparent problem because the non-340B population is already fully defined by the absence of JG or TB on a claim line.

The maintenance burden would be recurring, not a one-time cost. Every quarterly HCPCS or Ambulatory Payment Classification (APC) update that adds, removes, or reclassifies a drug would require UC Health to review and rebuild the non-340B list to be reviewed and rebuilt alongside the existing 340B list, effectively doubling the maintenance workload for each future quarterly report. This would translate directly into additional staff hours spent building, validating, and reconciling a list that creates no new billing functionality and provides CMS with no new information it does not already possess.

The requirement would add administrative burden without a stated purpose. The proposed rule also does not identify what the specific policy or data gap that the XX-placeholder modifier is intended to address beyond the existing JG/TB framework. Without a clearly articulated purpose, the requirement would impose an ongoing operational cost without a corresponding benefit.

5. **UC cannot sustain 340B reductions, newly mandated costs, and growing patient need**.

By 2030, UC Health estimates that the Working Families Tax Cut Act will reduce Medicaid funding by roughly $300M annually and expects the number of uninsured Californians to increase by more than one million. We support the Inflation Reduction Act's success in lowering some drug prices, even as its implementation meaningfully reduced UC's 340B savings and will continue to do so .

We also anticipate significant new costs in 2027 under HRSA's 340B Rebate Model Pilot Program, including the shift of the cash flow burden to hospitals, expanded staffing needs, new software purchases and maintenance, and the administrative burden of tracking and appealing unpaid rebates.

HRSA has not yet prevented drug manufacturers from requiring claims data submissions, which imposes additional costs, and CMS's parallel 2027 claims data mandate would compound this burden.

Additional 340B reductions would add further pressure on top of these Medicare payment challenges. Taken together, these changes would impose a substantial cumulative burden, and we are concerned about UC's ability to sustain current levels of care if the pressures continue to compound.

6. **CMS should not expand site-neutral policies to imaging without contrast.**

UC Health is concerned with CMS's proposal to apply the Physician Fee Schedule-equivalent rate to HCPCS codes assigned to imaging without contrast ambulatory payment classifications when those services are furnished in excepted off-campus hospital outpatient departments (HOPDs). The proposal would reduce critical resources for hospitals caring for high-acuity and underserved patients without accounting for the higher regulatory, staffing, and safety standards that hospital outpatient departments must meet compared with physician offices.

UC Health opposes CMS' proposal to extend site-neutral policies to imaging without contrast services in excepted off-campus provider-based departments as these payment cuts are likely to reduce access to care, particularly for the most complex patients. Imaging without contrast services serve a critical role in patient care, and patients rely on hospitals, including off-campus departments, to provide these vital services. These off-campus departments enable patients to receive their care in locations closer to home that are integrated with the main hospital, reducing fragmentation of care. Off-campus departments are often in regions where there are a limited number of physicians available to treat patients. These locations also allow patients to maintain continuous care with their provider without having to travel extra distance. These off-campus departments are critical to enabling hospitals to improve access to care, especially for some of the most medically complex patients.

In light of these concerns and the harm the proposed reductions would cause our patients, we respectfully urge CMS to withdraw both its proposed adjustment to outpatient drug reimbursement for 340B hospitals and its proposed expansion of site-neutral payment policies in CY 2027.

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

Sincerely,

Tam M. Ma
Associate Vice President
Health Policy and Regulatory Affairs