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September 14, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P

Sent electronically via <http://www.regulations.gov>

SUBJECT: Telehealth, Payment, and Data Reporting Proposals in the CY 2027 Physician Fee Schedule Proposed Rule

Thank you for the opportunity to comment on the CY 2027 Physician Fee Schedule (PFS) proposed rule (file code CMS-1848-P).¹ The University of California (UC) Health writes to express support for CMS' proposal to allow teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary. We are concerned, however, about proposed changes that will reduce reimbursement for certain evaluation and management (E/M) visits. Further, UC Health urges CMS to withdraw its proposal to require remote physiological monitoring (RPM) and remote therapy monitoring (RTM) services to be initiated during a separately reportable face-to-face visit. UC Health also urges CMS to reconsider its proposal to make mandatory participation in a 340B claims data repository that is currently voluntary.

UC Health's mission is to improve the health and well-being of all people living in California now and in the future by educating and training the workforce of tomorrow, delivering exceptional care, and discovering life-changing treatments and cures. UC is an integral part of the state's health care delivery system, operating one of the nation's largest health sciences education programs, which includes six academic health centers and 21 health professional schools. All of UC's hospitals are ranked among the best in California, and its medical schools and health professional schools are nationally ranked in their respective areas.

¹ Official title: Medicare and Medicaid Programs; Calendar Year 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).

UC Health is committed to providing high-quality educational experiences for the next generation of health professionals and leaders to ensure an adequately trained workforce. More than 6,500 residents and fellows receive training in UC residency programs each year.

Residents or Teaching Physicians with Virtual Presence

We appreciate CMS' reconsideration of its proposal in the CY 2026 PFS proposed rule, which would have limited virtual supervision of residents to rural areas. Virtual supervision of residents is critical in enabling expanded access to health care services. CMS' decision to continue allowing virtual supervision of residents for certain services in all geographic regions will expand the capacity of teaching institutions, increase access to care for patients, and provide valuable experience and training for the future physician workforce under appropriate supervision.

In the CY 2027 PFS proposed rule, CMS proposes to allow teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary. UC Health supports this proposal, as it will further increase patient access and appropriate resident training. CMS seeks comment on scenarios in which virtual supervision is appropriate. UC Health urges CMS to ensure that the final rule allows for billing in situations in which the teaching physician and resident are in the same clinic (but in different rooms) and the patient is in a different location.

Remote Physiological Monitoring and Remote Therapy Monitoring

CMS currently requires RPM services to be furnished only to established patients. CMS proposes to extend this requirement to RTM services. In addition, CMS proposes to require a separately reportable, in-person initiating visit before RPM and RTM services may be furnished. CMS asserts that an initiating visit is necessary to ensure the practitioner assesses clinical appropriateness of RPM or RTM services for the beneficiary and obtains the required beneficiary consent.

UC Health believes that requiring an additional initiating visit is unnecessary if RPM and RTM services are limited to established patients. Requiring an initiating visit also could lead to increased wait times for other patient visits, further restricting access to care. UC Health respectfully requests that CMS withdraw its proposal to require separately reportable initiating visits for RPM and RTM services.

Proposed Payment Change for Evaluation and Management Visits

CMS cites concern about overlap and duplication between E/M services included in a global surgery package and any additional separately identifiable E/M services furnished on the same day. In response, CMS proposes to pay the highest-valued service at 100 percent and reduce payment for other same-day E/M or procedural services by 50 percent. UC Health recognizes CMS' interest in ensuring payment accuracy; however, we are concerned that an across-the-board 50-percent reduction is not sufficiently supported by data and may be overbroad, particularly because the E/M services in question may be clinically significant and separately

identifiable from the procedure. In addition, the proposal may inadvertently penalize clinically appropriate, patient-centered care. UC Health often provides care for patients with complex conditions or multiple chronic conditions, for whom coordinating evaluation and treatment on the same day can reduce travel burden, improve care coordination, improve access, and avoid delayed care. Such a substantial reduction in reimbursement for same-day E/M services could increase the burden on patients. UC Health therefore urges CMS to reconsider this proposal. If CMS proceeds, it should use a more targeted, data-driven approach. For example, CMS could limit the policy to services furnished by physicians in the same specialty and group practice.

Medicare Part D Claims Data 340B Repository

We urge CMS to consider this requirement in the context of the full reporting landscape that 340B covered entities (CEs) already face with respect to Part D claims. Manufacturers already require CEs to submit overlapping claim-level data through two existing channels, potentially creating duplicative reporting obligations: mandatory 340B ESP reporting that certain manufacturers require for in-house pharmacy claims, which includes Part D claims, and separate contract pharmacy claims data that some manufacturers require as a condition of continued 340B pricing, which again includes Part D claims. Beginning January 1, 2027, a third channel, the HRSA Rebate Model Pilot Program, will layer on top of these existing obligations. CMS now proposes a fourth mandated submission stream, which would compound the administrative burden without reducing reporting requirements elsewhere. We ask CMS to evaluate whether elements of the repository submission could be harmonized or cross-walked with data that CEs are already required to submit through the HRSA rebate model, rather than treated as an entirely separate compliance obligation. CMS should delay additional data requirements until HHS has completed its enforcement efforts concerning drug manufacturers' unauthorized conditioning of 340B pricing on their data-reporting requirements.

If data must be submitted through the proposed process, we encourage CMS to consider an additional use. Today, when Beacon (a vendor selected exclusively by manufacturers to effectuate Maximum Fair Price (MFP) rebates) incorrectly flags a Part D claim for a drug selected under the Inflation Reduction Act as a 340B claim, CEs must open Good Faith Inquiries through a slow and cumbersome process created by Beacon to recover the MFP rebate they are entitled to on claims that were, in fact, not 340B. This is a manual, case-by-case process that pulls staff time away from other compliance work and delays legitimate rebate recovery. A mandatory, claim-level repository with dispensing pharmacy NPI, NDC-11, fill number, and covered entity ID is precisely the type of dataset that could support automated deduplication, allowing CMS and manufacturers to validate 340B status against the repository directly rather than relying on CEs to self-identify and dispute errors after the fact. This would meaningfully reduce the volume of Good Faith Inquiries and speed up accurate MFP effectuation. The need for this is only growing: with 15 additional drugs entering MFP negotiation in 2027, the volume of claims requiring accurate 340B/non-340B determination will increase substantially, and the current dispute-driven process will not scale. We recommend that CMS clarify in the final rule that it intends to explore this deduplication use case, even if implementation requires separate future rulemaking.

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Thank you for your consideration. If you have any questions, please contact Kent Springfield at (202) 993-8810 or kent.springfield@ucdc.edu.

Sincerely,



Tam Ma
Associate Vice President
Health Policy and Regulatory Affairs