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Submitted electronically via: www.regulations.gov

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS–4212– P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program (Docket No.: CMS-2025-1393)

Dear Administrator Oz,

Vizient, Inc. appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program (hereinafter "Proposed Rule"). Vizient welcomes the agency's efforts to improve the Medicare Advantage (MA) program, particularly policies that aim to improve patients' experiences.

Background

Vizient, Inc., the nation's largest provider-driven healthcare performance improvement company, serves more than 65% of the nation's acute care providers, including 97% of the nation's academic medical centers, and more than 35% of the non-acute market. The Vizient contract portfolio represents $140 billion in annual purchasing volume enabling the delivery of cost-effective, high-value care. With its acquisition of Kaufman Hall in 2024, Vizient expanded its advisory services to help providers achieve financial, strategic, clinical and operational excellence. Headquartered in Irving, Texas, Vizient has offices throughout the United States. Learn more at www.vizientinc.com.

Recommendations

Vizient appreciates CMS's efforts to improve MA beneficiaries' protections while considering stakeholder feedback regarding opportunities to enhance the MA program. Vizient offers feedback regarding the Medicare Advantage/Part C and the Medicare Prescription Drug Benefit (Part D) program Quality Rating System (Star Ratings), regulatory burden, utilization management (UM) and the future direction of the MA program.

Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System

Operational and Administrative Performance Measures

CMS proposes to remove seven operational and administrative performance measures from the Medicare Part C and Part D Star Ratings program (impacting the 2028 and 2029 Star Ratings) as part

of an effort to streamline and refocus the measure set.[1] Operational measures and administrative performance measures play an important role in providing transparency to beneficiaries and helping CMS monitor and improve plan compliance.[2] Transparency regarding plan performance and compliance supports more informed decision-making for individuals selecting a plan. As such, Vizient is concerned that removing these measures without a clear strategy for alternative approaches risks reducing transparency, weakens MA plan accountability and may have the downstream consequence of limiting patient access to care.

Vizient's concerns are escalated when considering measures related to complaints and appeals. For example, CMS proposes to remove the Complaints about the Health/Drug Plan measure, which measures the rate of complaints filed with Medicare about the health plan, from Medicare Part C and Part D Star Ratings.[3] CMS provides that performance on the measure is high and that the volume of complaints has decreased so there is limited variation in the measure across contracts. However, providers face significant administrative burden when filing a complaint. Further, given the administrative burden that exists with other processes, such as prior authorization (PA), the complaint process may not be fully utilized when challenges emerge which may skew results. Also, the measure offers insights that would not be easily accessible if removed. As a result, Vizient encourages CMS to work with providers and beneficiaries to streamline the complaints process to minimize burden before considering removal of the measure.

Similarly, due to high plan performance, CMS proposes eliminating two measures from the Medicare Part C Star Ratings: Plan Makes Timely Decisions about Appeals, which measures how fast a plan sends information for an independent review, and Reviewing Appeals Decisions, which measures how often an independent reviewer found the health plan's decision to deny coverage to be reasonable (collectively, "appeals measures").[4] Timely appeals decisions and appeal decision reviews are important to patient care, particularly as appeals can often delay time-sensitive care. Appeals remain a significant challenge for providers, despite plan performance on these measures. Data reported to CMS by MA plans indicated that, on average, MA plans overturn 80% of their decisions to deny claims when those claims are appealed to the plan.[5] Therefore, Vizient recommends CMS reconsider eliminating these appeals measures because protections, such as these measures, help ensure decisions are made promptly, despite other challenges with the appeals process. In addition, Vizient encourages CMS to consider opportunities to ensure that MA plans make clinically appropriate decisions before the appeals process is utilized.

Process of Care Measures

As part of the agency's efforts to streamline the measure set, CMS proposes removal of three process of care measures related to diabetes and cardiovascular disease. CMS indicates this proposal aims to simplify the Star Ratings program by placing greater emphasis on clinical quality, patient outcomes and patient experience. As CMS considers streamlining the Star Ratings, Vizient encourages the agency to ensure that these efforts do not negatively impact patient care.

For example, the proposal to remove the Part C Statin Therapy for Individuals with Cardiovascular Disease measure, which is based on the percent of plan members with heart disease who receive the correct type of cholesterol-lowering drugs, could be appropriate given its overlap with the Part D

[1] See pg. 73 of the Proposed Rule for the full list of seven operational and performance measures proposed for removal.
[2] https://www.federalregister.gov/d/2025-21456/p-894
[3] https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf
[4] https://www.cms.gov/files/document/2026-star-ratings-technical-notes.pdf
[5] https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-medicare-advantage-and-medicare-part-d-prescription-drug

Medication Adherence for Cholesterol measure.[6,7] Yet, relying solely on the Medication Adherence for Cholesterol measure presents challenges, because the measure data is based exclusively on pharmacy prescription fill claims information. This reliance on prescription fill data has limitations, particularly for patients who are statin-intolerant or who obtain medications outside Medicare Part D channels, as records only indicate that a medication was dispensed and billed, not whether the therapy was clinically appropriate or tolerated. As a result, claims data alone may not fully capture the clinical reality of statin use or the appropriateness of therapy. Vizient highlights this example, since it is unclear to what extent CMS has studied the interplay of these measures in the context of patient care as it evaluated measures for removal.

Lastly, in the Proposed Rule, CMS does not provide detail regarding future measure changes. Vizient encourages CMS to clarify whether the agency anticipates more substantial modifications to remaining process of care measures to ensure that the measures effectively account for clinical nuance, patient preference, intolerance, contraindications or shared decision-making – factors that are essential to delivering high-quality care.

Additional Considerations

In the Proposed Rule, CMS highlights suggestions from a technical expert panel (TEP) related to the focus of the measure set, including that CMS consider "gameability," attribution issues, provider burden and the sensitivity of measures to small changes.[8] While CMS proposes various changes to the measure set which may ease burden, it is unclear whether the agency also considered these TEP suggestions as each measure proposal was contemplated. For example, regarding attribution issues, the process to correct errors (e.g., a beneficiary assigned to the wrong primary care provider) remains challenging, particularly for providers when high-risk or complex patients are being attributed to them. Additional safeguards, such as patient-affirmed attributions or streamlined mechanisms to correct attribution issues could help address this issue, yet it is unclear how CMS weighed this feedback, if at all. Vizient encourages CMS to carefully consider opportunities to address attribution and other issues identified by the TEP in future quality measurement policies.

Reducing Regulatory Burden and Costs in Accordance With Executive Order (E.O.) 14192

In the Proposed Rule, CMS includes proposals that aim to ease regulatory, operational, and administrative burdens on MA plans, including proposals to remove certain Star Ratings measures, as discussed above. While reducing unnecessary burden is an important objective, doing so without corresponding safeguards to protect beneficiaries and minimize disruptions to providers could unintentionally exacerbate existing health care challenges by reducing MA plan accountability. As CMS evaluates additional opportunities to streamline requirements, it is essential that the agency remains attentive to the negative downstream effects that deregulation can have on patient care.

In addition, as CMS considers opportunities to reduce burden, it is also important that the agency identify policies that must be protected, despite potential burdens on plans. For example, providers still report significant challenges in delivering timely, effective care to MA beneficiaries due to PA challenges with plans.[9] While MA plans indicate that these techniques are meant to help ensure patients receive appropriate care, providers frequently indicate that PA policies lead to delays in treatment and add

[6] Medicare 2026 Part C & D Star Ratings Technical Notes
[7] The Medication Adherence for Cholesterol measure calculates the percentage of plan members with a prescription for a cholesterol medication (e.g., a statin drug) who fill their prescription often enough to cover 80% or more of the time they are taking the medication.
[8] https://www.federalregister.gov/d/2025-21456/p-891
[9] https://www.govinfo.gov/content/pkg/FR-2025-04-15/pdf/2025-06008.pdf; https://www.govinfo.gov/content/pkg/FR-2024-02-08/pdf/2024-00895.pdf

significant administrative burden and workload. Although these policies can be strengthened, the previously finalized policies to improve PA processes (e.g., as of January 1, 2026, MA plans are required to respond to urgent PA requests within 72 hours and non-urgent PA requests within seven calendar days and plans cannot reopen previously approved inpatient hospital admissions except in cases of clear error or fraud),[10,11] represent important safeguards. These protections should not be weakened or reconsidered as part of deregulation efforts. Rather, Vizient encourages CMS to work with providers to monitor plan implementation of these recent PA changes, particularly as some payers have announced significant changes to peer-to-peer processes which may result in more appeals rather than a more effective PA process.[12]

Request for Information (RFI) on Future Directions in Medicare Advantage

In the Proposed Rule, CMS includes several RFIs seeking input on opportunities to modernize and strengthen the MA program, including potential updates to MA risk adjustment, both short-term refinements to the current methodology and new approaches that reflect recent technological advancements. As risk adjustment themes or concepts may have implications for other CMS policies involving risk adjustment, Vizient recommends that CMS provide stakeholder comment opportunities regarding future MA risk adjustment models, particularly if CMS anticipates such changes or concepts could have impacts for other healthcare stakeholders, such as hospitals.

Conclusion

Vizient membership includes a wide variety of hospitals ranging from independent, community-based hospitals to large, integrated health care systems that serve acute and non-acute care needs. Additionally, many hospitals are specialized, including academic medical centers and pediatric facilities. Individually, our members are integral partners in their local communities, and many are ranked among the nation's top health care providers. In closing, on behalf of Vizient, I would like to thank CMS for the opportunity to share feedback on this important Proposed Rule.

Please feel free to contact me, or Randi Gold at Randi.Gold@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these recommendations.

Respectfully submitted,

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[10] See CMS Interoperability and Prior Authorization Final Rule: https://www.govinfo.gov/content/pkg/FR-2024-02-08/pdf/2024-00895.pdf
[11] See CY 2026 MA and Part D Final Rule: https://www.govinfo.gov/content/pkg/FR-2025-04-15/pdf/2025-06008.pdf
[12] See https://providernewsroom.com/medicare-network-insider/reducing-prior-authorization-response-times-for-healthspringsm-medicare-advantage-members-effective-january-1/