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Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes for Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes

August 13, 2024

Background & Summary

On August 1, the Centers for Medicare & Medicaid Services (CMS) issued the annual final rule to update the Fiscal Year (FY) 2025 Medicare payment and policies for the hospital inpatient prospective payment system (IPPS) and the long-term care hospital (LTCH) prospective payment system (PPS) ("Final Rule") (fact sheet available here). CMS finalized a 2.9 percent increase of the inpatient payment rate for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users. Based on various policy changes and circumstances described in the Final Rule, CMS anticipates hospital payments will increase by $2.9 billion in FY 2025.

The Final Rule contains a range of finalized policies, including delaying implementation of the "three-way split criteria" as related to MS-DRGs, changing the severity level designation for housing related z-codes, and increasing the outlier cost threshold for outlier payments. In addition, CMS finalized additional measures in the Hospital Inpatient Quality Reporting (IQR) Program and the Medicare Promoting Interoperability (PI) Program, as well as modifying a Condition of Participation for Acute Respiratory Illness Surveillance. CMS also finalized a new mandatory payment model, the Transforming Episode Accountability Model (TEAM).

Most policies provided the Final Rule will go into effect on October 1, 2024.

Final IPPS Payment Rate Updates for FY 2025

After accounting for adjustments required by law, the Final Rule increases IPPS operating payment rates by 2.9 percent in FY 2025 for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful Electronic Health Record (EHR) users. The Final Rule includes a market-basket update of 3.4 percentage points (up from 3.0 percentage points in the Proposed Rule), minus 0.5 percentage points for productivity as mandated by the Affordable Care Act (ACA) (down from -0.4 percentage points in the Proposed Rule). Consistent with the FY 2024 IPPS final rule, for CY 2025, there is no MS-DRG documentation and coding adjustment as these cuts were in effect from CY 2018-2023 per the American Taxpayer Relief Act.

In addition, CMS finalized four applicable percentage increases applied to the standardized amount,[1] as demonstrated in Table 1. For the final payment calculation, hospitals may be subject to other payment adjustments under the IPPS which are not reflected in the below table (e.g., reductions under the pay for performance programs).

[1] Table 1A-1E on the Final Rule website provide the FY 2025 Operating and Capital National Standardized Amounts.

Table 1. Final FY 2025 Applicable Percentage Increases for the IPPS

FY 2025	Hospital submitted quality data and is a Meaningful EHR User	Hospital submitted quality data and is not a Meaningful EHR User	Hospital did not submit quality data and is a Meaningful EHR User	Hospital did not submit quality data and is not a meaningful EHR user
Market-basket rate-of-increase	3.4	3.4	3.4	3.4
Adjustment for not submitting quality data	0	0	-0.85	-0.85
Adjustment for not being a Meaningful EHR User	0	-2.55	0	-2.55
Productivity Adjustment*	-0.5	-0.5	-0.5	-0.5
Applicable percentage increase applied to standardized amount	**2.9**	**0.35**	**2.05**	**-0.5^**

*In the Final Rule, CMS notes that the U.S. Department of Labor's Bureau of Labor Statistics (BLS) replaced the term multifactor productivity adjustment (MFP) with total factor productivity (TFP). CMS notes that the data and methods are unchanged and that the agency refers to this as the productivity adjustment.
^ Section 1886(b)(3)(B)(xi) of the Social Security Act states that application of the productivity adjustment may result in the applicable percentage increase being less than zero.

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSH) for FY 2025

The ACA required changes, which began in 2014, regarding the way disproportionate share hospital (DSH) payments are made to hospitals. Under this payment formula, hospitals receive 25 percent of the Medicare DSH funds that they would have received under the prior formula ("empirically justified"). CMS estimates the empirically justified Medicare DSH payments for FY 2025 to be approximately $3.503 billion. The other 75 percent flows into a separate pool that is reduced relative to the number of uninsured who received care and then distributed based on the proportion of total uncompensated care each Medicare DSH provides. This pool is distributed based on three factors:

- **Factor 1:** 75 percent of the Office of the Actuary (OACT) estimate of the total amount of estimated Medicare DSH payments;
- **Factor 2:** Change in the national uninsured rates; and
- **Factor 3:** Proportion of total uncompensated care each Medicare DSH provides.

As noted in the Final Rule (pg. 834), CMS estimated Medicare DSH expenditures for FY 2025 to be $14.013 billion.

For Factor 1, CMS finalized an amount of approximately $10.510 billion.

For Factor 2, CMS considered OACT's projections for the percentage of individuals without insurance in recent years (e.g., CY 2024: 7.3%, CY 2025: 7.7%), finding the final Factor 2 to be 54.29%. Based on this, the final FY 2025 uncompensated care payment amount is $5.705 billion. According to a CMS fact sheet, CMS estimates total Medicare uncompensated care payments to disproportionate share hospitals will decrease by approximately $200 million compared to FY 2024.

For Factor 3, CMS continues to use the three most recent years (i.e., FYs 2019-2021) of audited data on uncompensated care costs.

In the FY 2024 IPPS final rule, CMS also finalized changes related to the per discharge amount of interim uncompensated care payments. Since FY 2014, CMS has made interim uncompensated care payments during the FY on a per discharge basis. Traditionally, CMS used a three-year average of the number of discharges for a hospital to produce an estimate of the amount of the hospital's uncompensated care payment per discharge. However, due to the COVID-19 public health emergency (PHE) potentially leading to discharge underestimations, beginning with FY 2024, CMS excluded FY 2020 from the three-year average (CMS similarly excluded FY 2020 data in the FY 2023 IPPS final rule). In the FY 2025 proposed rule, CMS proposed to calculate the per-discharge amount for interim uncompensated care payments using the average of the most recent 3 years of discharge data (i.e., discharge data from FY 2021, FY 2022, and FY 2023). However, in the Final Rule, in response to stakeholders' concerns regarding a trend of decreasing discharge volume and possible overestimations in prior years, CMS finalized alternative policy. Specifically, for FY 2025, CMS will calculate the per-discharge amount for interim uncompensated care payments using the average of the most recent two years of discharge data and omit FY 2021 data. For FY 2026 and subsequent fiscal years, CMS will use the most recent three years of available discharge data.

In addition, CMS provides a FY 2025 IPPS Final Rule Medicare DSH supplemental data file on the Final Rule website.

Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights

Application of the Non-Complication or Comorbidity (NonCC) Subgroup Criteria to Existing MS-DRGs with a Three-Way Severity Level Split

In the Final Rule, CMS restates its FY 2021 IPPS final rule policy to expand the criteria to create a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within a base MS-DRG to include the NonCC subgroup for a three-way severity level split. In the FY 2022 IPPS final rule, due to the volume of MS-DRG changes associated with implementing this policy and the COVID-19 PHE, CMS delayed applying the updated criteria until FY 2023 or in future rulemaking. In the FY 2023 IPPS final rule, CMS again delayed application of the NonCC subgroup criteria due to the COVID-19 PHE and until additional analyses could be performed to assess the impacts of the policy. For FY 2025, CMS finalized another delay, indicating that it will not apply the NonCC subgroup criteria to existing MS-DRGs with a three-way severity level split for FY 2025. CMS does not indicate an alternative date to apply the criteria to existing MS-DRGs.

Comprehensive CC/MCC Analysis

In the FY 2008 IPPS final rule, CMS provided a process for subdividing diagnosis codes into three different levels of CC severity (i.e., MCC, CC, or NonCC). In the FY 2021 IPPS final rule, given significant diagnosis code changes had occurred since 2008, CMS indicated it would continue plans for a comprehensive CC/MCC analysis, using a combination of claims data analysis and the application of nine guiding principles. Based on information from prior rulemaking and comments in response the FY 2025 IPPS Proposed Rule, CMS finalized the nine guiding principles.[2] As a result,

[2] The nine guiding principles are: 1. Represents end of life/near death or has reached an advanced stage associated with systemic physiologic decompensation and debility; 2. Denotes organ system instability or failure; 3. Involves a chronic illness with susceptibility to exacerbations or abrupt decline; 4. Serves as a marker for advanced disease states across multiple different comorbid conditions; 5.

the agency will use of both mathematical analysis of claims data and the nine guiding principles when evaluating the extent to which a diagnosis code that is included as a secondary diagnosis increases hospital resource use, which impacts severity levels.

Policy to Change the Severity Level Designation for Housing-Related Z-Codes

For FY 2025, CMS finalized policy to change the severity level designation from NonCC to CC for Z59.10 (inadequate housing, unspecified), Z59.11 (inadequate housing environmental temperature), Z59.12 (inadequate housing utilities), Z59.19 (other inadequate housing), Z59.811 (housing instability, housed, with risk of homelessness), Z59.812 (housing instability, housed, homelessness in past 12 months), and Z59.819 (housing instability, housing unspecified).

Proposed Add-On Payments for New Services and Technologies for FY 2025

CMS finalized policy to change how the agency will determine whether to provide add-on payments for new services and technologies. Specifically, CMS is changing the April 1 cut off to October 1 for determining whether a technology would be within its 2- to 3-year newness period (beginning in FY 2026, effective for technologies that are approved for new technology add-on payments (NTAPs) starting in FY 2025 or a subsequent year). Based on information from applicants at the time of the Final Rule, CMS estimates that this change will increase IPPS spending by approximately $459 million in FY 2027.[3]

In addition, CMS will no longer consider a hold status to be an inactive status for purposes of eligibility of the new technology add-on payment (NTAP), but the agency could not determine the cost impact of this provision.

Also, CMS finalized policy for certain gene therapies indicated for and used in the treatment of sickle cell disease (SCD). Specifically, CMS is temporarily increasing the new technology add-on payment percentage to 75 percent. CMS estimates that for the two new gene therapy technologies approved for a new technology add-on payment in the Final Rule that are used for the treatment of SCD, these changes will increase the IPPS spending by approximately $38 million in FY 2025.

Separate IPPS Payment for Establishing and Maintaining Access to Essential Medicines

CMS finalized as proposed a policy to establish separate payments (biweekly or lump sum at cost report settlement) under the IPPS to small (100 beds or fewer), independent hospitals for the estimated additional resource costs of voluntarily establishing and maintaining access to a 6-month buffer stock of at least one essential medicine (for cost reporting periods beginning on or after October 1, 2024). A more detailed summary of this policy is available here.

Outlier Payments

Costs incurred by a hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the MS-DRG, any IME and DSH

Reflects systemic impact; 6. Post-operative/post-procedure condition/complication impacting recovery; 7. Typically requires higher level of care; 8. Impedes patient cooperation or management of care or both; 9. Recent (last 10 years) change in best practice, or in practice guidelines and review of the extent to which these changes have led to concomitant changes in expected resource use.

[3] CMS indicates this estimate of $459 million in FY 2026 under the assumption that all of the FY 2025 new technology add-on payment applications that have been FDA-approved or -cleared or have a documented delay in market availability between October 1, 2023 and March 30, 2024 and that are first approved for new technology add-on payments in FY 2025, would continue to meet the specified criteria for new technology add-on payments for FY 2026 and FY 2027.

payments, uncompensated care payments, any new technology add-on payments, and the "outlier threshold" or "fixed-loss" amount. For FY 2025, CMS aims to pay approximately, 5.1 percent of aggregate payments under IPPS as outlier payments and finalized an outlier fixed-loss cost threshold of $46,152, which is a 7.9 percent increase from the FY 2024 threshold of $42,750.

Changes to the Core-Based Statistical Areas (CBSAs)

The wage index is calculated and assigned to hospitals based on the labor market area in which the hospital is located. CBSAs are based on delineations from the Office of Management and Budget (OMB), which updates delineations based on the results of the census. In 2023, OMB finalized a schedule for future updates. CMS finalized policy to implement the revised OMB delineations of CSBAs to calculate wage indexes beginning with the FY 2025 IPPS wage index.

Additionally, CMS notes that these delineations may impact a hospital's eligibility for urban- and rural-specific programs, such as the low volume hospital adjustment. Also, on the CMS Website, the agency has provided files that include the revised CBSA delineations for FY 2025.

Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

For FY 2025, CMS is updating the wage index values based on the most recent available data (e.g., data from cost reporting periods beginning during FY 2021) and the revised core-based statistical area (CBSA) labor market area delineations (based on the new Office of Management and Budget Delineations) that CMS is adopting in the Final Rule. On the CMS Website, the agency has provided FY 2025 Wage Index Public Use Files.

Low Wage Index Hospital Policy

CMS acknowledged that on July 23, 2024, the Court of Appeals for the D.C. Circuit held that the Secretary lacked authority to adopt the low wage index hospital policy for FY 2020, and that the policy and related budget neutrality adjustment must be vacated.[4] However, CMS notes it is evaluating the decision and considering options for next steps. Beginning in FY 2025, CMS finalized policy to extend the low-wage hospital policy for three years. CMS indicates this extended policy and related budget neutrality adjustment will be effective for at least three more years.

Extension of the Medicare-dependent Hospital (MDH) Program and the Temporary Changes to the Low-Volume Hospital Payment Adjustment

Beginning in FY 2005, an additional payment to each qualifying low-volume hospital (LVH) under the IPPS was made (referred to as the LVH adjustment).[5] Additional changes to temporarily expand eligibility for the LVH adjustment and adjust the payment methodology were provided in the ACA and the Bipartisan Budget Act of 2018 (BBA, 2018) (Pub. L. 115-123). The BBA, 2018 also provided that the adjustment would apply only for discharges occurring in FYs 2019-2022. However, the Consolidated Appropriations Acts (CAA), of 2023 and 2024 extended the provisions from FY 2019-2022 through FYs 2024 and the portion of FY 2025 occurring before January 1, 2025. CMS finalized policy to extend the changes to the qualifying criteria for LVHs in accordance with the provisions of the CAA, 2024. These proposals would be in effect for discharges made during FY 2025 on or before December 31, 2024.

[4] Bridgeport Hosp. v. Becerra, Nos. 22-5249, 22-5269, 2024 WL 3504407, at *7-*8 & n.6 (D.C. Cir. July 23, 2024)
[5] The LVH adjustment is based on total per discharge payments (e.g., capital, DSH, IME and outlier payments).

Similarly, the CAA, 2024 extended the MDH program through December 31, 2024. CMS finalized policy to implement this extension.

Indirect and Direct Graduate Medical Education

Distribution of Additional Residency Positions Under Provisions of the CAA, 2023

In 2021, the CAA authorized Medicare payments for more than one thousand additional GME resident slots. The CAA, 2023 required the distribution of 200 additional residency positions to hospitals for FY 2026 with at least half to be distributed to psychiatry or psychiatry subspecialty residency training programs. CMS finalized several policies and procedures for the application cycle of these 200 residency slots, including deadlines and what hospitals must demonstrate to qualify for these additional slots. Hospitals will also need to meet specific criteria based on whether the slots will be used for a new residency program or to expand an existing program. More information is available in the Final Rule (pg. 944-1042) regarding the distribution of the additional residency positions, in addition to other policies and a request for information regarding the definition of "new program".

Hospital Value-Based Purchasing (VBP) Program

Under the Hospital VBP Program, value-based incentive payments are made to hospitals that meet performance standards during specific performance periods. There are four Hospital VBP domains: Safety; Clinical Outcomes; Efficiency and Cost Reduction; and Person and Community Engagement. Typically, the applicable incentive payment percent is required by statute (e.g., 2 percent). In the Final Rule, CMS indicates that in fall of 2024 it will update Table 16B on the CMS website with the actual value-based incentive payment adjustment factor and estimated amount available for the FY 2025 Hospital VBP Program.

In the Final Rule, CMS finalized updates to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measures beginning with the FY 2030 program year where CMS will adopt the updated HCAHPS Survey measure in the Hospital VBP. CMS also finalized the modification to the Hospital VBP Program's scoring of the HCAHPS Survey's Person and Community Engagement Domain for FY 2027-2029 program years to score hospitals only on the six dimensions of the survey that will remain unchanged from the current version. Also, CMS finalized modified scoring the HCAHPS Survey measure beginning in FY 2030.

Hospital Inpatient Quality Reporting (IQR) Program

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. To receive the full payment increase, hospitals must report data on measures selected by the Secretary for each fiscal year.

In the Final Rule, CMS finalized proposals to add seven new measures with some modifications (e.g., modifications to the proposal to adopt the Patient Safety Structural measure, modifying two existing measures including the HCAHPS Survey measure) and remove of five measures. Table IX.B.1-02 of the Final Rule (pg. 1342-1343) provides the finalized statements for the Patient Safety Structural measure. Table IX.B.2.-02 of the Final Rule (pg. 1358) provides the timeline for public reporting of the HCAHPS Survey Measure in the Hospital IQR program.

CMS also finalized proposed changes to the validation process for the Hospital IQR Program data. Notably, CMS indicates that it may consider raising the minimum passing threshold from 75 percent in future years, but at this time has determined that the 75 percent threshold is appropriate for initial

scoring of electronic clinical quality measures (eCQMs) in Hospital IQR Program validation. CMS finalized the proposed reporting and submission requirements for eCQMs with modifications. Table IX.C.10 of the Final Rule (pg. 1587) provides a summary of current and newly modified validation scoring policies. Lastly, CMS finalized policy to increase the number of eCQMs hospitals must report. For the CY 2026 reporting period the number of mandatory eCQMs will be eight and for the CY 2028 reporting period this amount will increase by three to eleven mandatory eCQMs. Table IX.C.XXXX of the Final Rule (pg. 1581-1582) provides the newly finalized eCQM reporting and submission requirements for the CY 2026 reporting period/FY 2028 payment determination and subsequent years.

Medicare Promoting Interoperability Program

In 2011, the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs were established to encourage eligible professionals, eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade, and demonstrate meaningful use of certified EHR technology (CEHRT). In recent years, the Medicare and Medicaid EHR Incentive Programs have evolved and are now known as the Medicare Promoting Interoperability (PI) Program.

Under the Medicare PI Program, downward payment adjustments are applied to eligible hospitals and CAHs that do not successfully demonstrate meaningful use of CEHRT for certain associated EHR reporting periods. For FY 2025, CMS finalizes several updates to the PI program, including separating the Antimicrobial Use and Resistance (AUR) surveillance measure into two measures (Antimicrobial Use surveillance and Antimicrobial Resistance surveillance), adopting two new eCQMs, and increasing the performance-based scoring threshold for hospitals reporting to the Medicare PI program (i.e., increase from 60 to 70 points beginning with the CY 2025 EHR reporting period and to 80 points beginning with the CY 2026 EHR reporting period). CMS also finalized changes to clinical quality measures in alignment with the Hospital IQR Program (e.g., eCQM measure additions and modifications).

Conditions of Participation (CoP) Requirements for Hospitals and CAHs to Report Acute Respiratory Illness

Conditions of Participation (CoPs) set out the patient health and safety protections that providers must meet to participate in the Medicare or Medicaid programs. Currently, the CoPs require that hospitals and CAHs have active facility-wide programs for the surveillance, prevention, and control of healthcare-associated infections (HAIs) and other infectious diseases. The programs must adhere to nationally recognized infection prevention and control guidelines. In the Final Rule, CMS finalized the proposal to require ongoing respiratory illness reporting in a modified form as proposed. Hospitals and CAHs, in a standardized format and frequency, must electronically report data related to COVID-19, influenza, and RSV, including confirmed infections of respiratory illnesses among hospitalized patients, hospital bed census and capacity (both overall and by hospital setting and population group [adult or pediatric]), and limited patient demographic information, including age. Beginning November 1, 2024, hospitals and CAHs must electronically report this information to CDC's National Healthcare Safety Network (NHSN) or other CDC-owned or CDC-supported system, as specified by CMS.

In addition, CMS finalized as proposed a policy to require additional reporting during a declared federal, state or local PHE for an acute infectious illness. CMS notes that it has withdrawn the proposal to require additional reporting if an event is "significantly likely" to become a PHE for an infectious disease. CMS clarifies that during a declared federal, state, or local PHE for an acute infectious illness, the Secretary may require reporting of data elements relevant to confirmed infections of the acute infectious illness, facility structure and infrastructure operational status, hospital/ED diversion status, staffing and staffing shortages, supply inventory shortages (e.g.,

equipment, blood products, gases), medical countermeasures and therapeutics, and additional demographic factors.

Transforming Episode Accountability Model (TEAM)

In conjunction with the release of the Proposed Rule, on April 10, the Innovation Center announced a new mandatory 5-year, episode based alternative payment model known as the Transforming Episode Accountability Model (TEAM). In the Final Rule, CMS finalized several policies to implement the TEAM, including the following:

- **Duration:** TEAM will be a 5-year mandatory model. TEAM will begin on January 1, 2026, and end on December 31, 2030.
- **Episode categories:** TEAM includes episode categories that begin with one of the following procedures when furnished by a TEAM participant: coronary artery bypass graft surgery (CABG), lower extremity joint replacement (LEJR), major bowel procedure, surgical hip/femur fracture treatment (SHFFT), and spinal fusion.
- **Mandatory model:** Under TEAM, all acute care hospitals, with limited exceptions, located within the mandatory Core-Based Statistical Areas (CBSAs) that CMS selected for model implementation will be required to participate in TEAM. In the Final Rule (pg. 1885-1889), CMS lists the selected CBSAs.
    - CMS will allow a one-time opportunity for certain hospitals participating in the BPCI Advanced model or the CJR model to voluntarily participate in TEAM, even if not located in a mandatory CBSA.
- **Path to financial risk:** There will be a 1-year glide path opportunity for all TEAM participants and a 3-year glide path opportunity for TEAM participants that are safety net hospitals[6], which will allow TEAM participants to ease into full financial risk. Episodes will include non-excluded Medicare Parts A and B items and services and would begin with an anchor hospitalization or anchor procedure and will end 30 days after hospital discharge.
    - TEAM participants will continue to bill Medicare FFS as usual, but will receive target prices for episodes prior to each performance year. Target prices will be based on three years of baseline data, prospectively trended forward to the relevant performance year, and calculated at the level of MS-DRG/HCPCS episode type and region. Target prices will also include a discount factor, normalization factor, retrospective trend adjustment factor, and beneficiary and provider level risk-adjustment. Performance in the model will be assessed by comparing TEAM participants' actual Medicare FFS spending during a performance year to their reconciliation target price as well as by performance on three quality measures.
    - TEAM participants will earn a payment from CMS, subject to a quality performance adjustment, if their spending is below the reconciliation target price.
    - TEAM participants will owe CMS a repayment amount, subject to a quality performance adjustment, if their spending is above the reconciliation target price.
- **Voluntary Decarbonization and Resilience Initiative:** The initiative includes voluntary reporting on emissions with metrics that broadly align with those collected by the Joint Commissions for its Sustainable Healthcare Certification and CMS-provided technical assistance on reducing emissions.

More information regarding the TEAM is available from CMS here and here.

[6] As provided in the Final Rule, Safety Net hospital means an IPPS hospital that meets at least one of the following criteria: (1) Exceeds the 75th percentile of the proportion of Medicare beneficiaries considered dually eligible for Medicare and Medicaid across all PPS acute care hospitals in the baseline period. (2) Exceeds the 75th percentile of the proportion of Medicare beneficiaries partially or fully eligible to receive Part D low-income subsidies across all PPS acute care hospitals in the baseline period.

What's Next?

Most provisions of the Final Rule go into effect October 1, 2024, with a notable exception being the implementation of the TEAM on January 1, 2026.

Vizient's Office of Public Policy and Government Relations looks forward to hearing continued member feedback on this final rule. Please direct your feedback to Jenna Stern, AVP, Regulatory Affairs and Public Policy in Vizient's Washington, D.C. office.