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Submitted electronically via: www.regulations.gov

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

Dear Administrator Brooks-LaSure,

Vizient, Inc. appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2024 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule, as many of the proposed policies have a significant impact on our provider members and the patients they serve.

Background

Vizient, Inc. provides solutions and services that improve the delivery of high-value care by aligning cost, quality, and market performance for more than 60% of the nation's acute care providers, which includes 97% of the nation's academic medical centers, and more than 20% of ambulatory providers. Vizient provides expertise, analytics, and advisory services, as well as a contract portfolio that represents more than $130 billion in annual purchasing volume, to improve patient outcomes and lower costs. Headquartered in Irving, Texas, Vizient has offices throughout the United States.

Recommendations

In our comments, we respond to the various issues raised in the Proposed Rule and offer recommendations to constructively improve the final rule. We thank you for the opportunity to share our views on CMS's proposals. Vizient believes the following areas are important for CMS to consider when finalizing the provisions for the calendar year (CY) 2024 Medicare Physician Fee Schedule (PFS), Medicare Shared Savings Program (SSP), and Quality Payment Program (QPP) Proposed Rule.

Changes to the Physician Fee Schedule and Other Changes to Part B Payment Policies

Calculation of the Proposed CY 2024 PFS Conversion Factor

In the Proposed Rule, CMS estimates a conversion factor (CF) of $32.7476, which is approximately a 3.3 percent reduction from 2023. As a result of this reduction, Vizient is concerned that providers will continue to endure financial challenges during CY 2024 absent changes by CMS or Congress, especially as inflationary pressures persist. Vizient urges CMS to advance policies that reduce

financial strain on providers and to support any legislative efforts that may address these harmful payment reductions.

Clinical Labor Update to the Practice Expense

In the CY 2022 PFS final rule, CMS finalized a four-year, phased-in policy to update clinical labor pricing for CYs 2022 – 2025, which impacts one of the three components of the practice expense (PE). Since the PE components are budget neutral, changes to any one component impact the other components, having redistributive effects, ultimately impacting reimbursement. For CY 2024, CMS proposes to advance to year three of its four-year plan to update clinical labor pricing and welcomes additional data to improve the accuracy of the agency's final pricing. Vizient appreciates the importance of updating the clinical labor pricing and the agency's decision to implement the update over a four-year period. However, because of budget neutrality requirements, the increase in clinical labor pricing leads to other decreases, which causes reductions in payment to specific specialties. This may ultimately impact access to care. As such, Vizient suggests CMS consider strategies to mitigate risk to these specialties as they face reductions during this transitional period. In addition, Vizient suggests CMS clarify whether it is monitoring for unintended consequences of this policy, particularly regarding the impact on specialties and access.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

The COVID-19 Public Health Emergency (PHE) has had a substantial impact on the utilization of telehealth services. Telehealth visits remain a critical means of delivering care, as telehealth supports access in high need areas while also minimizing patient travel time and expense. Vizient appreciates CMS's efforts to maintain access to telehealth services and offers several recommendations for the agency's consideration.

Medicare Telehealth Services List
Consistent with prior years, CMS proposes updating the Medicare Telehealth Services List by adding four new codes, including three on a permanent basis. Among other codes, CMS proposes creating a new stand-alone HCPCS G code (GXXX5: administration of a standardized, evidence-based Social Determinants of Health (SDOH) Risk Assessment tool for 5-15 minutes) and concurrently proposes to add that new code to the Medicare telehealth services list. As discussed below, Vizient is supportive of the proposed new code to better acknowledge the time and resources expended when SDOH Risk Assessments are furnished as part of an evaluation and management (E/M) visit. Also, Vizient agrees with CMS that this risk assessment could be successfully performed through telehealth and supports its inclusion on the list to increase utilization of the code for all practitioners.

Proposed New Process for Adding Services to the Medicare Telehealth Services List
With the expiration of the PHE and the expansion of the Medicare Telehealth Services List in recent years, CMS proposes substantial revisions to the process for adding services to the Medicare Telehealth Services List and how future codes will be classified. The agency outlines a five-step process that will simplify and standardize the process for adding services to the list in future years. Additionally, CMS proposes to replace the current classifications of telehealth services from Category 1, 2, and 3 with a "permanent" list and a "provisional" list. If finalized, beginning in CY 2024, the new process will allow nominations to proceed either to the permanent or provisional list based on clinical evidence, and CMS will concurrently classify any services currently on the Category 1, 2, or 3 lists into permanent or provisional status without further need for nominations or evidence. The new process will only apply to services not currently on the Medicare telehealth services list in any capacity. CMS notes that the timeline for adding services under this new assessment will remain the same, with submissions due to the agency by February 10 of the year for the next year's rulemaking.

Vizient applauds CMS for its commitment to supporting the growth of telehealth. Outlining the new process early and ensuring stakeholders are aware of the changes will be critical to its success in future rulemaking cycles. As the agency notes that it continues to receive submissions after the February 10 deadline, Vizient recommends CMS provide additional education regarding the process and information needed to request permanently adding services to the telehealth list to ensure nominations are submitted on time and with all required information.

Implementation of Provisions of the Consolidated Appropriations Act (CAA), 2023 Pertaining to Medicare Telehealth Services

Originating Site Restrictions

The CAA, 2023 extended the temporary flexibility of permitting different types of originating sites for the purposes of telehealth coverage, including the individual's home, until December 31, 2024. Vizient appreciates this additional flexibility, but we remain concerned that patients will again be at risk of losing coverage after this provision expires.

While Vizient understands the statutory limitations associated with telehealth services, we encourage the agency to consider whether any exceptions or additional flexibility can be provided to support patient access to care or better facilitate this future transition. Vizient also encourages patient and provider communications to ensure key stakeholders are aware of, and can plan for, anticipated changes.

Telehealth for Mental Health Services

In addition, the CAA, 2023 delayed the in-person visit requirement for telehealth services furnished for the purposes of diagnosis, evaluation, or treatment of a mental health disorder and for individuals with a substance use disorder (SUD) diagnosis for purposes of treatment of the SUD or a co-occurring mental health disorder until December 31, 2024. Accordingly, CMS proposes to implement the delay of the in-person requirement. This extension is critical for mental health telehealth services because the Consolidated Appropriation Act, 2021 (CAA, 2021), which permanently expanded access to telehealth for mental health services by easing geographic and originating site restrictions, also requires that in-person (non-telehealth) visits be furnished to the beneficiary six months before the initial telehealth service. The CAA, 2021, while still a significant improvement to support access to telehealth services, is stricter than policies provided during the PHE. However, as a result of the CAA, 2023's extension until December 31, 2024, stakeholders have more time to prepare for the in-person visit requirement to go into effect. Vizient encourages CMS to work with providers to identify challenges that patients may be facing when attempting to meet this in-person requirement. To the extent those challenges can be addressed through more flexible regulations, we encourage the agency to take such steps to prevent care disruption.

As CMS is aware, a significant number of patients receive behavioral health services via telehealth. For example, data from the Clinical Practice Solutions Center (CPSC)©, developed by the Association of Academic Medical Colleges (AAMC) and Vizient, shows that more than half of behavioral health services were provided via telehealth in 2022.[1] Vizient is concerned that some of these patients may be

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[1] A product of the AAMC and Vizient, the CPSC collects billing data from member practice plans to provide benchmarks and help them improve performance. According to CPSC data, telehealth utilization rates peaked in the second quarter of 2020 and are beginning to stabilize at a lower rate. Telehealth services for behavioral health, however, remain high despite a decline since the second quarter of 2020 (Q2 2020).

lost to follow-up because they are unable to see a provider in-person, and that when the proposed extension has expired, the six-month and twelve-month in-person visit requirements will lead to fewer patients receiving needed care. Also, Vizient notes our concern that patients with limited transportation options, those residing in rural settings or those with limited work flexibility, among other circumstances, may be less likely to be able to meet for in-person visit. Vizient encourages CMS to consider other potential exceptions and asks that the agency provide additional information to providers to improve their awareness of the exceptions policy.

Audio-only Services
The CAA, 2023 also extended temporary coverage of audio-only telehealth services included on the Medicare Telehealth Services List as of March 15, 2020. To implement this change, CMS proposes regulations to extend coverage of telehealth services that are on the Medicare telehealth services list and specified as permitted to be furnished via audio-only technology as of the date of enactment of the CAA, 2023 (December 29, 2022) until December 31, 2024. Audio-only services provide another avenue for patients to access care. As noted in a recent CPSC report regarding provider member organizations telehealth use, early in the pandemic, the mean percentage of total visits that were audio-only peaked at 20% in May 2020. While this has steadily decreased to a mean of 2% in the third quarter of 2022, it is clear some patients continue to rely on audio-only services to access care.[2] In addition, patients within some practices rely on audio-only services to a greater extent. Figure 1 illustrates the significant range in audio-only versus video visit rates across CPSC member organizations from January-September 2022. Thus, while most organizations are capable of and regularly providing video visits, patients still receive audio-only care. As such, Vizient urges CMS to permanently extend access to audio-only technology for covered telehealth services to ensure that all beneficiaries can access telehealth services in a way that best serves the patient's needs.

For example, rates of utilization for behavioral health telehealth services peaked at 77% in Q2 2020 and is at 54% in the second quarter of 2022. Alternatively, other service lines, such as cardiovascular, cancer and neurosciences, have smaller proportions (i.e., 5-17%) of services being provided via telehealth. Overall, telehealth utilization has been decreasing throughout the pandemic. While it is decreasing somewhat, there is still very high usage for behavioral health compared to all other specialties.

[2] AAMC analysis of physician claims billed by Faculty Practice Plan members of the AAMC-Vizient Clinical Practice Solutions Center. A product of the AAMC and Vizient, the Clinical Practice Solutions Center (CPSC) collects billing data from member practice plans to provide benchmarks and help them improve performance. Note: At the time of this analysis (January 2023), 80 CPSC members had shared their claims data through September 2022. "Claims" include in-person and telehealth evaluation and management (E/M) claims, including codes 99201-205, 99211- 215, and 99241-245. Telehealth encounters were identified based on place of service = 02, 10 or modifiers 95, GT, GQ, G0 on the claim; CPT codes 99441-443 were also counted as telehealth. Claims are across all payers and from service sites 02 – Telehealth, 10 – Telehealth Provided in Patient's Home, 11 – Office, 19 – Off Campus Outpatient Hospital, 22 – On-Campus Outpatient Hospital, and 99 – Other Place of Service. Claims are limited to primary care, which is defined as family medicine, general internal medicine, or geriatrics.

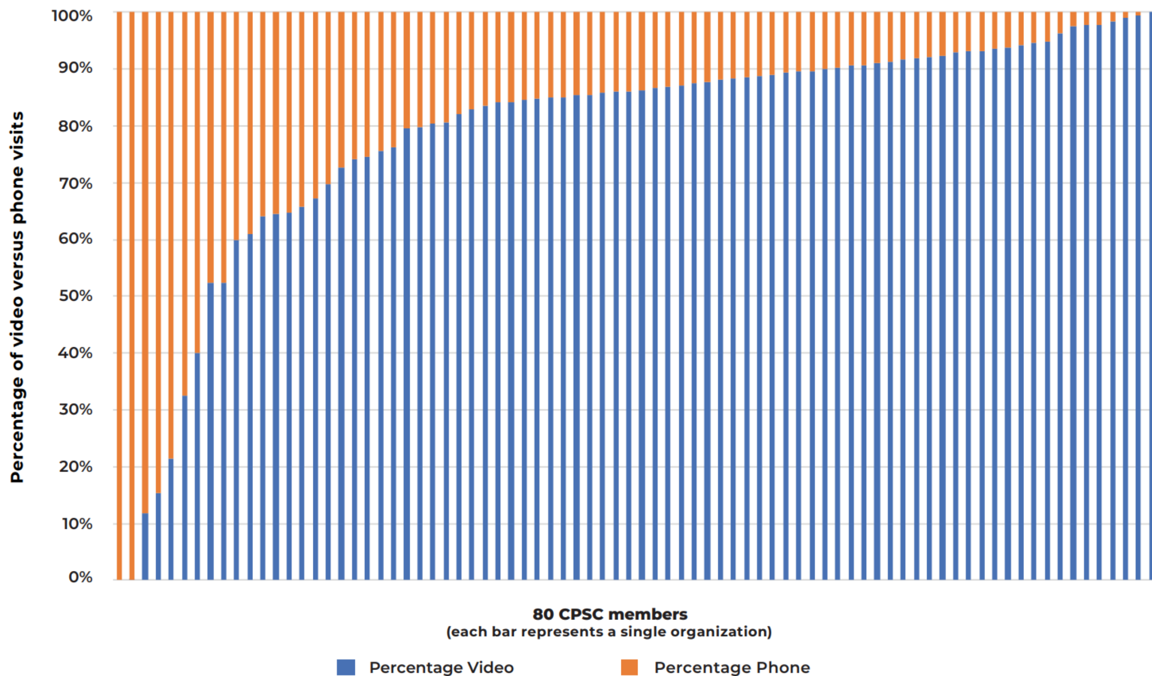

Image 1. Video versus phone telehealth use in primary care, quarters 1-3 (January-September 2022). Graph from "Effective Strategies for Sustaining and Optimizing Telehealth in Primary Care", Vizient Inc-AAMC Clinical Practice Solutions Center©.

Place of Service for Medicare Telehealth Services

In the Proposed Rule, CMS notes that because many practitioners are providing services both in the office and through telehealth, it believes these practitioners must maintain an office presence, even if they are providing a substantial amount of telehealth visits to patients located in their homes. As such, CMS believes these practitioners' practice expense (PE) costs are more accurately reflected by the non-facility rate. As a result, CMS proposes that claims billed with POS 10[3] (Telehealth provided in patient's home) be paid at the non-facility PFS rate which is higher than the PFS facility rate. Also, for CY 2024, CMS proposes that claims billed with POS 02 (Telehealth provided other than in patient's home) will be paid at the PFS facility rate.

Vizient applauds the agency for recognizing that although many practitioners are providing telehealth services, they may still be required to maintain and pay for an office presence while delivering care. Reimbursing these providers at the non-facility rate using the POS 10 code will allow these practitioners to continue delivering care in ways that best suit their patient populations.

Vizient notes that as many practitioners provide telehealth services from within their home instead of in an office, there is confusion about whether a provider's home address must be provided upon enrollment as the address of where the service is provided. Vizient urges CMS to ensure that practitioners providing services from within their home have their privacy and safety respected by not requiring the provider's home address for enrollment or billing purposes.

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[3] In the CY 2023 PFS final rule, CMS finalized a policy that would go into effect at the end of the calendar year in which the PHE ends (2023), where physicians and practitioners would no longer bill claims with both modifier 95 and a POS code. Instead, physicians and practitioners would bill for services using only POS 02 (Telehealth provided other than in the patient's home) or POS 10 (Telehealth provided in the patient's home).

Other Non-Face-to-Face Services Involving Communications Technology under the PFS

Direct Supervision via Use of Two-Way Audio/Video Telecommunications Technology
Under Medicare Part B, certain types of services, including diagnostic tests and services furnished incident to a physician's or practitioner's professional services, must be furnished under specific minimum levels of supervision. One level of supervision is direct supervision, which requires the immediate availability of the supervising physician or other practitioner. During the PHE, CMS expanded the definition of "direct supervision" to allow the supervising professional to be immediately available using real-time audio/video technology ("virtual presence"), as opposed to requiring their physical presence. CMS proposes to continue allowing direct supervision requirements to be met through real-time audio/video telecommunications (excluding audio-only) through December 31, 2024. During the PHE, virtual supervision has helped improve access and practitioners have found that it is a safe and effective alternative to in-person supervision.

As such, Vizient recommends CMS permanently ease the definition of direct supervision for, at minimum, services for which virtual direct supervision has been permitted during the COVID-19 PHE.

Supervision of Residents in Teaching Settings
In the CY 2021 PFS final rule, CMS established a policy that, after the end of the PHE, teaching physicians may meet the requirements of being present for the key or critical portions of services furnished involving residents through a virtual presence, but only for services furnished in residency training sites located outside of a Metropolitan Statistical Area (MSA). After the PHE ended, CMS announced it would use enforcement discretion so that this flexibility would continue for physicians in all resident training sites through December 31, 2023. For CY 2024, CMS proposes to continue this policy through December 31, 2024. CMS also seeks comment on the expansion of virtual presence for all residency training sites after December 31, 2024.

Benefits of virtual supervision of residents include improved access to health care services and increased workforce capacity. Given these benefits, Vizient encourages CMS to continue the policy of allowing virtual supervision of residents in all areas of the country after December 31, 2024, and to work with stakeholders to determine the safest and most appropriate service lines for inclusion in virtual supervision.

Evaluation and Management (E/M) Visits

Split (or Shared) Visits
CMS proposes to delay implementation of the updated substantive portion definition until January 1, 2025.[4] Vizient applauds CMS for delaying the split (or shared) policy. We heard and continue to hear concerns from provider members regarding the operational challenges associated with this transition and unintended consequences related to compensation agreements. Further, Vizient emphasizes the importance of medical decision making (MDM) and believes a more flexible approach to split (or shared) visits is critical to ongoing support of team-based care. Vizient recommends CMS rescind the CY 2022 PFS final rule policy regarding the substantive portion of split (or shared) visits and opt for a

[4] In the CY 2022 PFS final rule, CMS finalized a policy for E/M visits furnished in a facility setting to allow payment to a physician for a split (or shared) visit (including prolonged visits) where a physician and NPP provide the service together (not necessarily concurrently) and the billing physician personally performs a substantive portion of the visit. CMS notes that there were stakeholder concerns regarding the agency's definition of "substantive portion" because only time (i.e., more than half of total time) would have been used for purposes of defining what is the substantive portion of the visit.

more flexible approach that is significantly less burdensome and more effectively considers the different types of contributions from the care team.

Add-On Code for Primary Care G2211
In the CY 2021 PFS final rule, CMS provided that the HCPCS add-on code G2211 Office/Outpatient (O/O) E/M visit complexity could be reported with O/O E/M visits to better account for additional resources associated with primary care or ongoing care related to a patient's single, serious condition, or complex condition. However, the CAA, 2021 imposed a moratorium on Medicare payment for the add-on code until January 1, 2024. CMS states that parties have continued to express concerns about the potential redistributive effects of the G2211 add-on code. As such, the agency has made some technical corrections to refine the code descriptor. CMS proposes to begin using the code with the technical corrections on January 1, 2024, after the statutory moratorium on the code ends.

In response to stakeholder feedback, CMS has refined the utilization analysis for this code. However, given the agency's understanding that the G2211 code contributes to the decline in the conversion factor, Vizient remains concerned that the potential impact of this proposed code may be disruptive and have variable impacts depending on the type of provider. While we agree that providers should be adequately reimbursed for the treatment of complex patients, the agency states that this code will primarily be used in primary care, and the agency does not anticipate the use of this code in specialties without longitudinal patient relationships, such as surgical specialties. To minimize disruption, Vizient encourages CMS to refrain from implementing a budget neutrality adjustment for CY 2024, especially as actual utilization of this code remains to be seen.

Medicare Economic Index (MEI)

In the CY 2023 PFS Final Rule, CMS finalized a rebased and revised MEI, but generally delayed its use in PFS ratesetting until CY 2024 due to stakeholder concerns regarding the data CMS used and the redistributive impacts of the updated MEI weights. In the Proposed Rule, CMS indicates that due to the American Medical Association's (AMA's) intended data collection of practice cost data from physician practices, the agency believes it is appropriate to continue delaying use of the rebased and revised MEI and indicates future updates, if appropriate, will be addressed in future rulemaking. Vizient supports further delaying implementation of the revised and rebased MEI until better data becomes available, including survey data from the AMA.

Medicare Part B Payment for Preventive Vaccine Administration Services

During the PHE, CMS provided an additional payment for COVID-19 vaccines administered in the home. CMS states in the Proposed Rule that the agency believes this add-on payment has increased healthcare access to vaccines, particularly in underserved populations. Accordingly, CMS proposes to maintain the add-on payment for COVID-19 vaccines administered in the home and to expand the availability of this payment to three other preventive vaccines (pneumococcal, hepatitis B, and influenza). The additional payment amount will be annually updated using the percentage increase in the MEI, adjusted to reflect geographic cost variations.

Vizient supports the proposed policy to expand the scope of vaccines for which an add-on payment is available, as we believe it will help increase access to vaccines. Should the agency finalize this policy, Vizient encourages CMS to continue to monitor how this payment impacts vaccine uptake and to work with providers to ensure the add-on payment is adequate, given the additional costs associated with at-home administration.

Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan

In the Proposed Rule, related to the electronic prescribing of controlled substances (EPCS) requirement, CMS proposes to extend the existing non-compliance action of sending letters to non-compliant prescribers until December 31, 2024. Vizient supports the agency's proposed one-year extension. In addition, given prescribers may be unfamiliar with exceptions, including those to be finalized, Vizient encourages CMS to also provide additional information to prescribers regarding exceptions and how providers can easily determine whether they are eligible for an exception, such as cases where the prescriber issues only a small number of Part D prescriptions. To the extent any exceptions may overlap, we also encourage the agency to provide education regarding application of multiple exceptions.

Services Addressing Health-Related Social Needs (Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services)

For CY 2024, CMS seeks to better recognize how an interdisciplinary team (including community health workers (CHWs)) is involved in treatment of Medicare beneficiaries by updating coding and payment policies to accurately reflect that involvement. Accordingly, CMS is proposing three new services to address health-related social needs: Community Health Integration (CHI) Services, Social Determinants of Health (SDOH) Risk Assessments, and Principal Illness Navigation (PIN) Services.

Community Health Integration (CHI) Services

CMS proposes to establish two new G-Codes describing CHI services performed by certified or trained auxiliary personnel, which may include a CHW, to be billed incident to the professional services and under the general supervision of the billing practitioner. CHI services address unmet SDOH needs that affect the diagnosis and treatment of the patient's medical problems.

Vizient appreciates the agency's recognition of the additional time and resources that may be devoted to help address SDOH needs. Vizient believes that providing reimbursement opportunities for this work will help providers that are utilizing CHWs and other auxiliary personnel in their work and represents an important step in recognizing the importance of addressing SDOH needs as part of the care plan. Vizient encourages CMS to work with other payers to ensure reimbursement for these services is similarly available.

In addition, Vizient notes that it can often be costly to initially hire personnel and revise work flows to provide CHI services. As a result, even with CHI services being eligible for reimbursement, providers may still be challenged to begin offering such services. Surveys of providers have found that lack of financial resources or incentives and time are most often cited as barriers to screening.[5] Vizient encourages CMS to pursue additional policies designed to help providers identify and build relationships with community-based organizations (CBOs), and to address other challenges providers face while trying to address patients' social needs.

CMS proposes that billing for the proposed CHI codes would be limited to certain types of visits, not including inpatient/observation visits, ED visits, and SNF visits. The agency believes that CHI

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[5] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2751390

services could be most effectively provided by those practitioners providing continuing care to a patient. While Vizient understands this rationale, we have heard from members that many facilities screen for SDOH factors while in the ED, and that the information gathered in the ED can provide vital information for immediate care as well as for preventing unnecessary readmission. Further, because many patients face substantial barriers to accessing primary care,[6] Vizient is concerned that limiting this policy to only providers with continuity of care may negatively impact patients' access to these services. Vizient encourages CMS to consider opportunities to leverage auxiliary personnel providing similar services in other circumstances, such as when the patient is seen in the ED.

The agency also seeks feedback on the proposed time for the CHI visits, which CMS proposes at 60 minutes per month, along with another code for 30 additional minutes per month.[7] Vizient notes our concern that the proposed total time for CHI visits may be inadequate, as these services may be more time-intensive than CMS anticipates, particularly for patients with more than one identified social risk factor.

Social Determinants of Health (SDOH) – Proposal to Establish a Stand-Alone G-Code

CMS notes that assessing SDOH needs is a vital part of patient care and that the resources involved in these activities are not appropriately reflected in current coding. As a result, CMS proposes to add a new standalone G-Code, GXXX5, to increase the frequency of SDOH risk assessments and to promote standardization of such assessments.[8] Vizient applauds CMS for recognizing the value of SDOH risk assessments and the important role social needs screening and follow-up play in providing care to patients. Vizient believes that this proposed G-Code will support practitioners that are performing SDOH risk assessments and encourage other providers to begin incorporating SDOH risk assessments into their E/M visits. Vizient recommends that CMS ensure that this screening does not require beneficiary cost-sharing (e.g., as stated below, outside of the Annual Wellness Visit) as financial instability is a primary SDOH.[9]

In addition, CMS seeks comment on whether, as a condition of payment, the practitioner also has the capacity to furnish appropriate care management services to address the identified SDOH needs. As noted in previous comments, hospitals, providers, and CBOs do not always have the resources to support all Health Related Social Needs (HRSNs) in a given area. In many areas of the country, CBOs are not available or require time or adequate transportation to access. Requiring a follow-up to services without ensuring adequate services are available in an area puts an unnecessary burden on the provider and discourages providers from screening for SDOH needs. As previously stated, Vizient encourages CMS, as part of its expansion of policies related to addressing social needs, to find ways to help providers and CBOs that seek to furnish these services to easily make connections and establish working relationships to benefit patients.

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[6] https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care
[7] CMS proposes the following two CHI codes: GXXX1: Community health integration services performed by certified or trained auxiliary personnel, which may include a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit; and GXXX2 Community health integration services, each additional 30 minutes per calendar month
[8] GXXX5: Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months
[9] https://health.gov/healthypeople

Principal Illness Navigation (PIN) Services

In the Proposed Rule, CMS notes that experts on navigation of treatment for cancer and other high-risk, serious illnesses have demonstrated the benefits of navigation services for patients experiencing severe conditions, especially those with unmet social needs. As a result, CMS proposes two new codes, GXXX3[10] and GXXX4[11], for PIN services. PIN services will be delivered when trained or certified auxiliary personnel under the direction of a billing practitioner (which may include a patient navigator or peer specialist) are involved in a patient's health care navigation as part of the treatment plan for a serious, high-risk disease.[12]

Similar to the framework for billing care management and CHI services, the same practitioner would furnish and bill for both the PIN initiating visit and the PIN services, and PIN services must be furnished in accordance with the "incident to" regulations. An initiating E/M visit would not be required every month that PIN services are billed, only prior to commencing PIN services, to establish the treatment plan, specifically how PIN services would help accomplish that plan, and establish the PIN services as incident to the billing practitioner's service. CMS proposes to designate PIN services as care management services furnished under general supervision. Vizient agrees that peer support specialists and related auxiliary personnel can play a key role in the care team, including for patients with a serious, high-risk disease.

CMS proposes that PIN services could be furnished following an initiating E/M visit addressing a high-risk condition expected to last at least three months that places a patient at significant risk of hospitalization, functional decline, or death. However, the agency does not clarify at what point in the diagnostic process a visit would be considered "addressing a high-risk condition" so that the patient could be eligible for PIN services. For example, a patient may have received a mammogram suggesting a potential cancer diagnosis, but additional tests may be warranted to make the diagnosis. PIN services may be helpful in this circumstance to help ensure that a patient can navigate the next steps for the diagnosis, yet is unclear if the patient would be eligible for PIN services in this circumstance. Allowing PIN services to be provided earlier in the diagnostic process may help prevent high-risk conditions from progressing untreated, as patients may be lost to follow up due to complexity, stress, and costs associated with confirming a diagnosis. To increase access to care and improve patient outcomes, Vizient recommends CMS defer to provider judgment regarding patient eligibility for PIN services and that the agency make clear that a confirmed diagnosis is not needed for PIN service eligibility.

Vizient also encourages CMS to explore ways to expand this policy to significant conditions that are not associated with high morbidity or mortality but are still difficult care pathways for patients. PIN services could be helpful for prenatal care during pregnancy, which is a complex care pathway of over three months but is not expected to end in high morbidity or mortality. Vizient urges CMS to consider ways to expand this policy in the future to create more opportunities for use of PIN services.

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[10] GXXX3: Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, which may include a patient navigator or certified peer specialist; 60 minutes per calendar month, in the following activities

[11] Principal Illness Navigation services, additional 30 minutes per calendar month

[12] As noted in the Proposed Rule, a serious high-risk disease is defined as a disease expected to last at least 3 months, that places the patient at significant risk of morbidity or mortality (e.g., cancer, COPD, congestive heart failure, HIV/AIDS, several mental illness, and substance use disorder).

Social Determinants of Health Risk Assessment in the Annual Wellness Visit (AWV)

CMS proposes adding a new SDOH Risk Assessment as an optional, additional element of the AWV with an additional payment. CMS proposes that the SDOH Risk Assessment may be separately payable with no beneficiary cost sharing when furnished as part of the same visit with the same date of services as the AWV. The SDOH Risk Assessment service includes the administration of a standardized, evidence-based SDOH screening tool furnished in a manner that all communication with the patient be appropriate for the patient's education, developmental and health literacy level, and be culturally and linguistically appropriate.

Vizient supports CMS's proposal to reimburse providers for providing an SDOH screening at the AWV. This policy will support the inclusion of SDOH factors as part of a patient's care plan and ensuring that there is no cost to the patient will create fewer barriers to incorporating screening into the patient visit. As noted above, when SDOH Risk Assessments are provided outside of the AWV, Vizient encourages CMS to consider opportunities to waive cost-sharing requirements.

Additional Considerations for Services Addressing Health-Related Social Needs

Data Collection and Evaluation
Vizient supports CMS's proposals to increase access to social needs assessments and services and appreciates that these proposals provide flexibility for providers to implement screening and referrals in a way that most benefits the patient population. As use of these new billing codes begins, Vizient recommends CMS assess how best to collect, analyze, and act on this data. Vizient supports the use of Z-Codes for coding and collection of this data, however, Vizient continues to request the agency permit more diagnosis codes on Medicare claims to support the increased documentation expectations, such as after an SDOH assessment is provided and needs are identified.

Vizient also recommends CMS consider how it intends to evaluate the impact of these new proposals. As we have noted in previous comments, some providers struggle to work with community resources because of a lack of community providers, infrastructure, or understaffing. Vizient encourages CMS to look for ways to support these providers with increased resources, access to CBOs, or financial incentives to help create a better referral network for patients with social needs.

Vizient also applauds efforts made by the Office of the National Coordinator for Health IT (ONC) to incorporate social determinants of health data into the U.S. Core Data for Interoperability (USCDI). Vizient encourages CMS and HHS to continue to work with ONC to ensure interoperability and that the exchange of health data includes the exchange of SDOH data.

Provider Support and Education
Vizient recommends CMS provide education and technical assistance for billing practitioners – both those practitioners who are already doing this work but will want to integrate the new codes into their practice, as well as those providers who want to include screening and social needs assessment into their care but are struggling to connect with CBOs or other community providers. We encourage the agency to share best practices and guidance to providers on the importance of asking and documenting information on social risk and social needs, ensure providers have the partnerships and resources to furnish these services, and help connect them to CBOs and community service providers in their areas.

Appropriate Use Criteria for Advanced Diagnostic Imaging

CMS established the Appropriate Use Criteria (AUC) for the Advanced Diagnostic Imaging program in the CY 2018 rulemaking cycle, with an intended start date of January 1, 2020. In response to the COVID-19 PHE, CMS extended the operational testing period, ultimately delaying the payment penalty phase. For CY 2024, CMS proposes to indefinitely pause the program to allow the agency to re-evaluate and consider next steps. In addition, CMS proposes to stop the testing and education period and rescind the regulations governing the program.

Since its inception, the AUC program has created significant regulatory burden for hospitals, and healthcare stakeholders have struggled to find the best way to implement the criteria. Pausing the program to allow for a thoughtful assessment will help inform potential next steps in a more meaningful way. Vizient supports CMS's proposal to indefinitely pause the program.

Drugs and Biological Products Paid Under Medicare Part B

RFI: Drugs and Biologicals Which are not Usually Self-Administered by the Patient, and Complex Drug Administration Coding

In the Proposed Rule, CMS notes that drugs included on each Medicare Administrative Contractors (MACs) "self-administered drug (SAD) list" are excluded from Part B coverage, but in those situations, are almost always covered by Medicare Part D prescription drug coverage. CMS also notes that while it has provided guidance to MACs regarding drugs that are "not usually self-administered by the patient," MACs SAD lists vary, and stakeholders have questioned whether current guidance adequately addresses the circumstances posed by newly approved drugs. Vizient appreciates this stakeholder feedback, as we agree that more complex products, in addition to unique patient circumstances, may warrant reconsideration regarding whether a product should be included on a SAD list. For example, products that require supervision after being taken to monitor for adverse side effects and products that may be challenging for certain patients to administer due to motor issues, such as subcutaneous injections, may be included on a SAD list. Also, resources such as medication guides and Risk Evaluation and Mitigation Strategy (REMS) programs may encourage certain care to be provided, which is more challenging if a medication is on a SAD list. As a result of these various circumstances, patient care may unnecessarily suffer. Vizient encourages CMS to support changes to the SAD list policy that better support unique patient needs and to better defer to provider judgment in circumstances where the provider believes coverage should be provided under Part B.

Also, CMS indicates that it has received concerns that non-chemotherapeutic complex drug administration payment is inadequate because existing coding and Medicare billing guidelines do not accurately reflect the resources used to furnish these services.[13] As a result of these concerns, CMS seeks comment and information regarding the relevant resources involved, as well as inputs and payment guidelines and/or considerations that could be used in determining appropriate coding and payment for complex non-chemotherapeutic drug administration. Vizient agrees with assertions that current reimbursement for such services (e.g., services billed using CPT code series 96360-96379)

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[13] CMS indicates in the Proposed Rule, "Interested parties have asserted that these infusion services are similar to complex and clinically intensive Chemotherapy and Other Highly Complex Biological Agent Administration ("Chemotherapy Administration") services that are billed using CPT code series 96401-96549, as opposed to Therapeutic, Prophylactic, and Diagnostic Injections and Infusion services billed using CPT code series 96360-96379."

may be inadequate. Vizient believes that certain treatments require a higher level of care and monitoring that aligns more closely with Chemotherapy Administration services than therapeutic, prophylactic, and diagnostic injections and infusion services. In addition, it has been an ongoing challenge for providers to identify the most appropriate setting of care for patients given various REMS programs, potential compounding requirements, the role of payers in limiting site of care options and patient complexity and location. Vizient released a Sites of Infusion Care report and the Vizient Pharmacy Site of Care Database to help providers identify which treatments can be safely used at alternative sites of care facilities within a health system. Vizient notes these resources, as they highlight that appropriate payment for complex non-chemotherapeutic drug administration varies by setting. Thus, while we encourage CMS to better establish payment rates for complex non-chemotherapeutic drug administration, we also believe that the agency should ensure that such payment varies depending on the site of care. In other words, as CMS continues to consider potential policy approaches, we strongly discourage CMS from advancing site neutral payment policy for complex non-chemotherapeutic drug administration services.

Implementation of Section 11402 of the Inflation Reduction Act

In the Proposed Rule, CMS proposes regulations to codify several policies provided in the Inflation Reduction Act (IRA), including Section 11402 regarding the payment limit for new biosimilars. More specifically, the law would impact the payment limit for new biosimilars furnished to beneficiaries on or after July 1, 2024 during the initial period when Average Sales Price (ASP) data is not available, setting the payment limit as the lesser of the following -- (1) an amount not to exceed 103 percent of the Wholesale Acquisition Cost (WAC) of the biosimilar or the Medicare Part B drug payment methodology in effect November 1, 2003; or (2) 106 percent of the lesser of the WAC or ASP of the reference biological, or in the case of a selected drug during a price applicability period, 106 percent of the maximum fair price of the reference biological. Given these changes, particularly related to the maximum fair price, Vizient encourages CMS to provide education to providers regarding the potential impacts of this policy for reimbursement purposes. In addition, as the calculation of the maximum fair price is used for purposes of the Medicare Drug Price Negotiation program (the "program"), which is currently the subject of litigation[14], we ask the agency to clarify how the proposed policy will be implemented should legal challenges prevent or delay implementation of the program.

Medicare Enrollment

CMS proposes several changes to the revocation policies for Medicare providers and suppliers, such as those related to reporting changes in practice location, non-compliance revocation grounds, misdemeanor convictions, and False Claims Act civil judgments, among other topics, which impact Medicare enrollment eligibility. Should the agency finalize revocation policy changes, Vizient urges CMS to publish more detailed guidance for providers, and proactively communicate the changes with states and providers. Vizient also notes that hospitals are still facing significant workforce shortages and urges CMS to monitor whether any of these new policies exacerbate the existing workforce issues.

[14] https://www.healthaffairs.org/content/forefront/current-and-future-legal-attacks-against-medicare-drug-price-negotiation-program

Medicare Shared Savings Program

New Proposed Collection Type: Medicare Clinical Quality Measure (CQM)

CMS proposes a new collection type to help some accountable care organizations (ACOs) transition to eventually reporting all payer/all merit-based incentive payment system (MIPS) CQMs and eCQMs. The new proposed collection type, which is for SSP ACOs only, is the Medicare CQMs for Accountable Care Organizations Participating in the Medicare Shared Savings Program ("Medicare CQMs") which is for SSP ACOs under the Alternative Payment Model Performance Pathway (APP). Since the APP currently allows reporting of eCQMs and MIPS CQMs across all patients and payers, Medicare CQMs may be more attractive since the measurement population would be narrowed to a subset of Medicare fee-for-service beneficiaries.[15]

Vizient applauds the agency for working to support existing ACOs by addressing issues through new policy. Vizient anticipates that this proposal may help providers who are struggling to report all payer/all MIPS CQMs and eCQMs. For ACOs with participants that do not use the same electronic medical record (EMR) platform, it is challenging to merge the data from each system. Providers also struggle with the data completeness standards because the quality scoring for eCQMs is based on the ACO's patients from all payers. Vizient supports the addition of the Medicare CQM collection type, as it addresses some of the existing issues ACOs face with reporting all payer CQMs and eCQMs.

However, because CMS indicates the Medicare CQM is intended to help ACOs transition to report all payer/ally MIPS CQMs and eCQMs, it is unclear whether CMS plans for the Medicare CQM to be available for a limited duration. Vizient suggests that CMS clarify that the Medicare CQM reporting option will be permanently available as it may impact ACO decisions regarding collection type.

Data Completeness Threshold

CMS proposes to raise the data completeness threshold to at least 75 percent for the CY 2024-2026 performance periods/2026-2028 payment years, and to at least 80 percent for the CY 2027 performance period/2029 MIPS payment year. Vizient continues to express concern that facilities are unable to meet the current thresholds because the quality scoring for eCQMs is based on the ACO's patients from all payers. Increasing the data completeness thresholds before addressing this problem will only continue to strain these organizations. Vizient recommends CMS delay increasing these thresholds until the agency has better addressed the issues facilities, especially large multispecialty groups, are encountering when submitting all payer data.

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[15] CMS proposes to define a beneficiary eligible for Medicare CQM as a beneficiary identified for purposes of reporting Medicare CQMs for ACOs participating in the Medicare Shared Savings Program who is either of the following:
- A Medicare fee-for-service beneficiary (as defined at § 425.20) who—
  - ++ Meets the criteria for a beneficiary to be assigned to an ACO described at § 425.401(a); and
  - ++ Had at least one claim with a date of service during the measurement period from an ACO professional who is a primary care physician or who has one of the specialty designations included in § 425.402(c), or who is a PA, NP, or CNS.
- A Medicare fee-for-service beneficiary who is assigned to an ACO in accordance with § 425.402(e) because the beneficiary designated an ACO professional participating in an ACO as responsible for coordinating their overall care.

Proposal to Align the Certified Electronic Health Record Technology (CEHRT) Requirements for SSP ACOs with MIPS

Currently, the MIPS CEHRT requirements are more comprehensive than the SSP requirements. To align the SSP with MIPS, CMS proposes to remove the SSP CEHRT threshold requirements beginning performance year (PY) 2024 and add a new requirement for PYs beginning on or after January 1, 2024. Under this proposal, all MIPS eligible clinicals, Qualifying Alternative Payment Model (APM) Practitioners (QPs), and Partial QPs participating in the ACO would report the MIPS Promoting Interoperability (PI) performance category measures and requirements to MIPS, at the individual, group, virtual group, or APM level, and earn a MIPS performance category score.

Currently not all ACOs submit PI measures, and instead submit CEHRT acknowledgments in place of the PI measures. Generally, Vizient is concerned that this proposal would put an unnecessary burden on MSSP ACOs. Should the agency finalize this proposal, Vizient encourages CMS to monitor the impact of this proposal on facilities that are not already submitting PI measures to ensure that the burden of submission is not substantially more than the burden of submitting the CEHRT acknowledgment. Additionally, Vizient urges CMS to provide significant communication to participating facilities about this change, as well as provide technical support for ACOs that may not have previously submitted PI measures to help ensure a smooth transition.

MIPS Value Pathway (MVP) Reporting for Specialists in Shared Savings Program ACOs-Request for Information

Beginning in CY 2023, specialists who reported under MIPS, including specialists in SSP ACOs, had the option to register to report MVPs for the applicable performance period as a group, subgroup, or individual and to report on relevant MVP measures, specifically the Quality measure MVPs. CMS states that there is a need for specialists to report more relevant data to allow patients and referring clinicians to make more informed decisions regarding the specialists involved in a patient's care. CMS seeks feedback on how the agency could encourage more specialists to report MVPs to collect quality data that is comparable to data reported by other specialty providers reporting MVPs.

Vizient understands the need to support specialists' integration into SSP ACOs and recognizes that these providers face challenges that those in primary care do not. For example, many providers struggle with utilization reporting because the provider may not have access to data from facilities outside of their network. Vizient encourages CMS to explore ways to support providers, including specialists, seeking to participate in the SSP by providing better education about the varying levels of data available for those members.

Proposal to Modify the Health Equity Underserved Multiplier

In the CY 2023 PFS final rule, CMS finalized a health equity adjustment to reward providers who provided high quality care to vulnerable populations. As a correction to the calculation to better account for these vulnerable patients, CMS proposes to use the number of beneficiaries, rather than person years, for calculating the proportion of the ACO's assigned beneficiaries who are enrolled in the low-income subsidy program or who are dually eligible for Medicare and Medicaid, starting in the performance year 2024.

As stated in last year's comments, and reiterated below, Vizient urges CMS to remove the Area Deprivation Index (ADI) from the Health Equity Adjustment. The ADI is heavily weighted toward income and home values with very little contribution from other variables. This weighting provides a poor fit to life expectancy and masks urban poverty, particularly in large cities where home values

tend to be higher. Vizient recommends CMS remove the ADI from the Health Equity Adjustment calculation.

Proposals to Improve ACO Risk Adjustment and Alignment

CMS proposes policies related to the revised risk adjustment model meant to incentivize ACO participation and minimize the risk of distortion from the transition to a revised CMS-Hierarchical Condition Coding (HCC) risk adjustment model (V28), which would begin in CY 2024. Vizient encourages CMS to ensure changes meaningfully encourage and support current and future ACO participants.

Proposal to Cap Regional Service Area Risk Score Growth for Symmetry with ACO Risk Score Cap
CMS proposes to modify the calculation of the regional component of the three-way blended benchmark update factor[16] for agreement periods beginning on January 1, 2024. The proposal would cap prospective HCC risk score growth in an ACO's regional service area between benchmarking year three and the performance year using a similar methodology as the one adopted in the CY 2023 PFS final rule for capping ACO risk score growth. Vizient supports this proposal to better account for regional risk score growth when applying the regional update factor to ACO benchmarks.

Proposal to Update How Benchmarks are Risk Adjusted
In the CY 2024 MA Capitation Rates and Part C and Part D Payment Policies, CMS finalized the transition to a revised CMS-HCC risk adjustment model (V28). To minimize the risk of distortion from using different CMS-HCC risk scores for benchmark years and the performance year that could occur under the current policy, CMS proposes an alternative approach to making such calculations for agreement periods beginning on January 1, 2024. Vizient appreciates CMS's commitment to retaining ACOs and supports this policy to minimize the impact to those most likely to be adversely impacted by the transition to V28. However, to ease the transition for those ACOs most likely to be negatively impacted by the shift to the revised CMS-HCC risk adjustment model, Vizient suggests CMS provide all ACOs the option to change how benchmarks are risk adjusted beginning on January 1, 2024, and not requiring those ACOs with existing performance agreements to wait several years for this change.

Proposed Changes to the Benchmarking Methodology to Encourage Participation by ACOs Treating High Numbers of Medically Complex Patients
CMS proposes to modify the policies adopted in the CY 2023 PFS final rule to prevent any ACO from receiving an adjustment that would cause its benchmark to be lower than it would have been in the absence of a regional adjustment. The agency believes that this will incentivize participation by ACOs caring for medically complex, high-cost beneficiaries. Vizient supports CMS's proposals to bolster ACOs caring for complex beneficiaries, as these patients often have multiple conditions, higher rates of mortality, and high rates of social need.[17] However, Vizient encourages CMS to identify more practical ways to support these facilities, such as facilitating partnerships with community organizations.

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[16] Weighted one-third accountable care prospective trend (ACPT) and two-thirds national-regional blend.
[17] https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05160

Proposal to Revise the Definition of Assignable Beneficiary

CMS also proposes to revise the definition of assignable beneficiary to include beneficiaries who receive primary care from non-physician ACO professionals (i.e., nurse practitioners, physician assistants, and clinical nurse specialists). The agency believes this would especially benefit patients in rural and underserved areas. However, non-physician practitioners are not required to enroll under a specialty designation, and CMS may not differentiate between non-physician practitioners that deliver primary care and non-physician practitioners that deliver specialty care. Vizient supports the expansion of assignment to more providers but encourages CMS to build out specialty designations for advanced practice providers to ensure that non-physician practitioners in primary care can be distinguished to reflect primary care relationships with the ACO.

Comment Solicitation on Potential Future Developments to the SSP Policies

CMS seeks comment to inform future policy developments to advance progress towards its goal of having all Medicare beneficiaries enrolled in value-based care models by 2030, including whether the agency should develop a higher risk track than the ENHANCED track. Vizient generally supports the addition of a higher risk track than the ENHANCED track to encourage more ACO participation. Some prospective participants may wish to enroll in a higher risk track but are not interested in the ACO REACH or Next Generation programs. Vizient encourages CMS to assess and incorporate findings from the ACO REACH and Next Generation ACO models into a higher risk track, specifically related to best practices to retain facilities in the SSP model. Should any future higher risk tracks be developed, Vizient urges CMS to ensure they remain optional, and that ACOs are not required to step from the ENHANCED track into a higher risk option if a provider does not wish to take on higher levels of risk.

Updates to the Quality Payment Program

Transition from Traditional MIPS to MIPS Value Pathways (MVPs)

In the CY 2022 PFS Proposed Rule, the agency requested comment regarding the potential sunsetting of traditional MIPS and the transition to MIPS Value Pathways (MVPs), but no sunset policy was included in the CY 2022 PFS Final Rule or the 2023 PFS final rule. While CMS does not provide more information regarding this transition in the Proposed Rule, Vizient encourages the agency to work closely with providers before establishing a timeline and to ensure that there are enough MVPs before the transition occurs.

Subgroup Reporting Proposals

CMS proposes several changes related to subgroup reporting, including clarifications to policies finalized in CY 2023 related to the facility-based scoring, the targeted review policy, and the complex patient bonus for subgroups. Vizient remains concerned that physician practices, especially those affiliated with large multi-specialty practice groups, do not understand the requirements for subgroup participation. Vizient encourages CMS to provide proactive education about the finalized policies for subgroups, especially as the agency seeks to implement further changes to the requirements.

Regulatory Impact Analysis

In the Proposed Rule, CMS considers what framework could provide insight into the relationship between PFS policies and health equity. As shown in Table 107 of the Proposed Rule,[18] CMS includes statistics by specialty type in terms of different beneficiary characteristics including income, race and ethnicity, social determinants of health, behavioral health, disability, end-stage renal disease and geography. CMS indicates that is believes identifying a baseline is critical to measuring the impact of PFS policies on health equity. CMS seeks comment on how it might structure a PFS impact analysis that, among other uses, could examine how changes in the PFS would impact beneficiaries of particular groups. In addition, CMS specifically indicates it welcomes suggestions about alternative measure of health equity, "in particular with regard to the ADI as a proxy for disparities related to geographic variation." Vizient supports CMS's strong commitment to health equity and the agency's efforts to indicate how a policy may impact beneficiaries with different characteristics. However, Vizient offers several recommendations for the agency's consideration and again urges the agency to replace the ADI with the Vizient Vulnerability Index™, which is now free and publicly available.

Use of the Area Deprivation Index
As stated in numerous previous comments, Vizient has significant concerns regarding the ADI and recommends that CMS reconsider its use. Although the ADI includes seventeen different factors related to education, income, employment, housing, and household characteristics, the relationships among the specific variables chosen result in an index that is heavily weighted toward income and home values with very little contribution from the other variables. The estimates provided by this algorithm can underestimate the vulnerability of neighborhoods where housing prices do not reflect broader trends and other specific obstacles to health and healthcare. In particular, much of the rural South and rural Midwest are estimated as less vulnerable than their life expectancy would suggest, while the Northeast and parts of the Midwest are estimated as more vulnerable.

Additionally, as shown in Figures 3-5, cities with extreme housing costs are broadly estimated to be of very low vulnerability regardless of actual variability in specific neighborhoods. Among these are neighborhoods with some of the lowest life expectancies and highest burden of chronic disease in the nation.

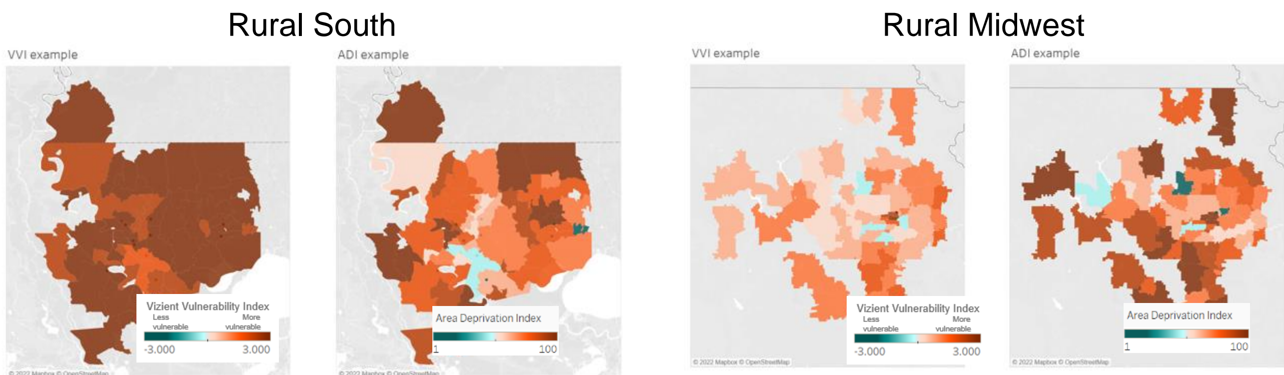

Figure 2. Maps comparing the Vizient Vulnerability Index's insights with the Area Deprivation Index's insights.

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[18] See page 1304 of the Proposed Rule.

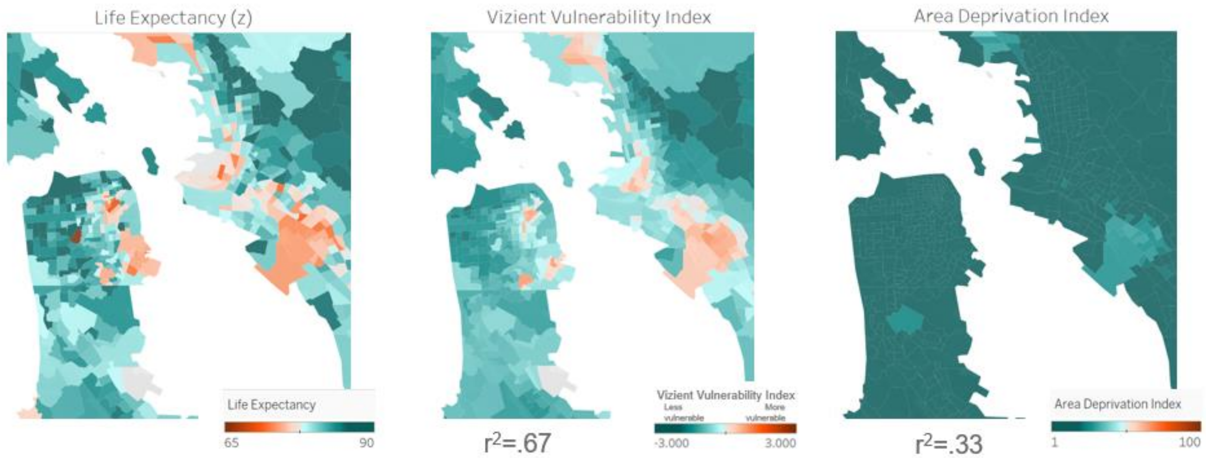

Figure 3. Maps showing San Francisco's life expectancy and insights from the Vizient Vulnerability Index and ADI.

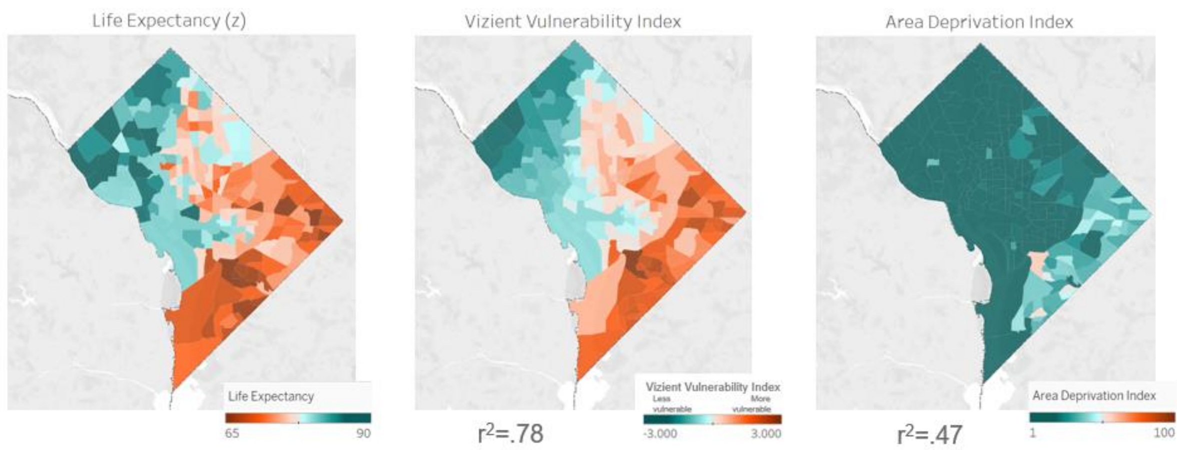

Figure 4. Maps showing Washington, D.C.'s life expectancy and insights from the Vizient Vulnerability Index and ADI.

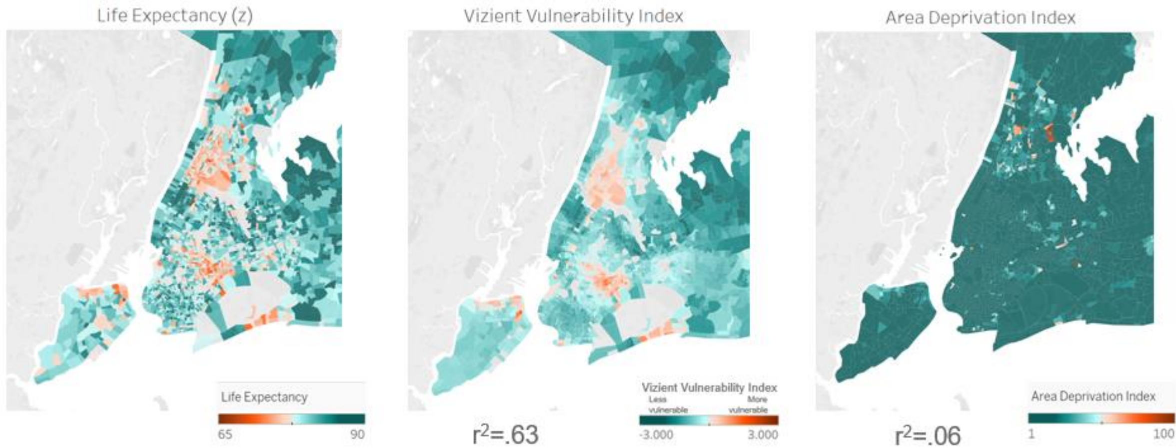

Figure 5. Maps showing New York City's life expectancy and insights from the Vizient Vulnerability Index and ADI.

Although several other indicators are included in the regulatory impact analysis, Vizient urges CMS to reconsider use of the ADI in this analysis. Recent research reinforces these concerns about the ADI, and Vizient urges CMS to reconsider its use in this and all other CMS programs.

Clarification Regarding Application
In the Proposed Rule, CMS indicates the "information contained in Table 107 is provided solely to demonstrate beneficiary utilization by provider specialty impact across a number of health equity dimensions" and "does not form the basis or rationale for the proposed policies in this proposed rule." While Vizient appreciates the agency's efforts to share information, it is unclear how the agency may use this information to inform future policy. As such, Vizient encourages the agency to elaborate on potential future uses of this information, as this information may impact stakeholder comments.

Conclusion

Vizient welcomes CMS's efforts to update the PFS and other payment policies impacting providers. We appreciate the agency's various requests for comments, which provides an opportunity for stakeholders to inform the agency on the impact of specific proposals.

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 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 providing us the opportunity to comment on this important Proposed Rule. Please feel free to contact me, or Emily Jones at Emily.Jones@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these issues.

Respectfully submitted,

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Vizient, Inc.