799 9th Street NW
Suite 210
Washington, DC 20001

T (202) 354-2600
vizientinc.com

vizient®

October 5, 2020

Submitted electronically via: www.regulations.gov

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

Re: Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy (CMS-1734-P)

Dear Administrator Verma,

Vizient, Inc. appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2021 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule, as many of the proposed policies have a significant impact on our 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 50% of the nation's acute care providers, which includes 95% 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 $100 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 proposal. Vizient believes the following areas are important for CMS to consider when finalizing the provisions for the calendar year (CY) 2021 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule.

Telehealth and Other Services Involving Communications Technology

Medicare Telehealth Service List

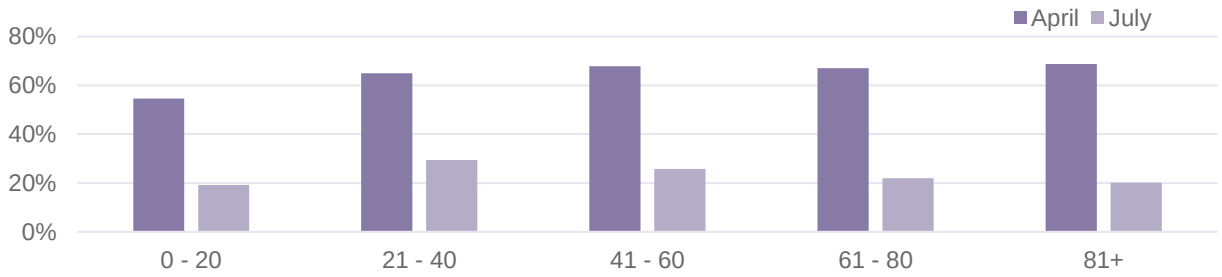
For CY 2021, CMS proposes to add nine services to Category 1 of the telehealth services list by internally reviewing requests and flexibilities provided during the COVID-19 public health emergency (PHE). These proposed new additions include codes for certain office/outpatient evaluation and management (E/M) visits, prolonged visits, group psychotherapy and home visits. CMS also proposes to create a third category of services ("Category 3") which describes services added to the Medicare telehealth list during the PHE, but where CMS does not yet believe there is currently enough evidence to support making these services permanent. CMS proposes to add 13 codes for service types ranging from home visits (established patient), emergency department visits (levels 1-3) and psychological and neuropsychological testing, among others, to Category 3. That leaves at least 74 services that are capable of being provided today subject to removal when the PHE ends. Vizient appreciates the agency's decision to permanently add services to Category 1 of the telehealth list and provide continuity of some services until more information is learned. **However, in the interest of patient access, as described in more detail below, Vizient recommends the agency more carefully consider adding all the telehealth services that were made available during the PHE to Category 1 or Category 3.**

As CMS is aware, a significant range of services have been made available and are being utilized via telehealth during the PHE. For example, data from the Association of American Medical Colleges' (AAMC) Vizient Clinical Practice Solutions Center© (CPSC), showed that in April 2020, 65 of 75 academic medical center faculty practice plans were performing more than 50 percent of visits via telehealth. In contrast, by the end of July 2020, as states reopened, members had just over 20 percent of visits via telehealth. This information demonstrates that even as in-person care has again become more commonplace, telehealth still plays an important role in maintaining patient access to care.

The following graph highlights these differences by age group, making clear the important role telehealth plays for patients of all ages. Although the below information does not distinguish specific codes being utilized, the graph shows that patients of all ages, including those eligible to participate in Medicare, continue to rely on telehealth. As a result, to prevent a sudden disruption to clinical practice and provide an opportunity to gain more information, CMS should, at minimum, include more services

in Category 3 given the use of telehealth services overall. Doing so will also provide more time to determine the clinical benefit of providing these services via telehealth.

Percent of office and outpatient visits via telehealth by age group, April and July 2020



Telehealth visits include all phone or online specific CPT codes, as well as other visits with a place of service or modifier indicating telehealth. Visits from service sites 02 – Telehealth, 11 – Office, 19 – Off Campus Outpatient Hospital and 22 – On-Campus Outpatient Hospital were included

Also, CPSC data found that increases in telehealth utilization in April 2020 were apparent across a variety of physician specialty groupings including psychology, hematology/oncology, neurology, cardiology, primary care, OB-GYN, surgical specialties, orthopedics, ENT and dermatology.[1] Again, while this data does not distinguish between codes, it supports the need to maintain access to telehealth services from different physician specialty groups after the PHE ends.

In addition, Vizient recently conducted a survey during a panel discussion with patient and family advisors from our member hospitals. Data from the 68 respondents showed that a majority wanted to see telehealth services remain once this crisis abates.[2] This survey data suggests telehealth services are needed to support patient and family needs. Even as some patients are returning to in-person care, telehealth remains an important avenue by which patients may choose to receive care. Vizient reiterates our recommendations that CMS maintain access to a wide range of telehealth services.

As noted above, CMS proposes to create a third category of services (Category 3) which describes services added to the Medicare telehealth list during the PHE that will remain on the list through the calendar year in which the PHE ends. CMS notes that there is not enough data for the agency to add these services to Category 1 currently. Yet, CMS also indicates it will stop covering several telehealth services as soon as the PHE ends. Vizient believes CMS misses an opportunity to effectively utilize information learned during the PHE and gain significant insights to the clinical value of certain telehealth services by not including them in either Category 1 or 3. To make better

[1] AAMC-Vizient Clinical Practice Solutions Center© (July 2020). Data insights brief: Expansion of telehealth use across provider specialties, available at: https://www.clinicalpracticesolutionscenter.org/member-resources, last accessed: September 29, 2020.
[2] Vizient (July 2020). Connecting With Patients During COVID-19: A Panel Discussion, https://www.vizientinc.com/-/media/Documents/SitecorePublishingDocuments/Public/DisasterResources/Connecting_with_Patients_During_COVID19.pdf, accessed online: September 28, 2020.

informed decisions, Vizient encourages CMS to extend the opportunity for more information to be accrued for telehealth services that are not proposed to be included in Category 1 or 3, but which were made available during the PHE.

Lastly, regarding the Medicare telehealth services list, Vizient strongly supports CMS's consideration of any additional "guardrails" or limitations either to ensure patient safety/clinical appropriateness or to prevent fraud or inappropriate use. Vizient believes guardrails can serve different functions, such as enhancing patient safety, supporting quality of care and protecting the integrity of the Medicare program as a means to more effectively provide access to telehealth services. Vizient believes any additional protections should be capable of being integrated into existing standards, rather than in addition to those standards. **Vizient urges CMS to work with stakeholders, including hospitals and group purchasing organizations, in developing and implementing these safeguards and standards.**

Proposed Technical Amendment to Remove References to Specific Technology
During the PHE, CMS has provided additional flexibility regarding which technologies and technology requirements could be used to provide telehealth services. Before the PHE, the use of telephones, facsimile machines, and electronic mail systems for purposes of furnishing Medicare telehealth services were prohibited. In the Proposed Rule, CMS aims to maintain flexibility regarding specific technologies that can be used to provide telehealth and makes technical amendments to remove outdated references to specific technology. In doing so, CMS makes it clear that, for example, use of telephones, including smartphones, may be permissible. Vizient appreciates CMS's clarification, as we believe it reduce confusion and help ensure smartphones' audio and video real-time capabilities can continue to be used for telehealth services.

Proposed Clarification of Existing PFS Policies for Telehealth Services
Consistent with policy CMS provided in the May 1st COVID-19 Interim Final Rule (IFC), CMS proposes to clarify that services that are billed incident-to may be provided via telehealth incident-to a physician's service and under the direct supervision of the billing professional. In other words, a physician can provide direct supervision without having to be on-site when care is provided incident-to that supervising physician's service. This flexibility helps increase access, supports team-based care and helps conserve personal protective equipment (PPE). Based on these benefits, Vizient supports CMS's decision to retain its interpretation regarding direct supervision for services billed incident-to a physician's service.

Also consistent with the May 1st COVID-19 IFC, CMS clarifies that if audio/video technology is used in furnishing a service when the beneficiary and the practitioner are in the same institutional or office setting, then the practitioner should bill for the service furnished as if it was furnished in person. In addition, the service would not be subject to any of the telehealth requirements, such as geographic or site restrictions. This flexibility helps conserve personal protective equipment (PPE) and supports access to care, among other benefits during the PHE. Vizient also supports CMS's clarification because it appropriately recognizes resource utilization and does not unnecessarily constrain

access (e.g., by imposing geographic or site restrictions) when the practitioner and beneficiary are in the same institutional or office setting.

Communication Technology-Based Services (CTBS)
In the Proposed Rule, CMS reiterates its clarification that for all CTBS, patient consent to receive the services can be documented by auxiliary staff under general supervision, as well as by the billing practitioner. CMS also notes that while beneficiary consent is necessary (e.g., beneficiary is notified of cost sharing requirements), the agency does not believe the timing or manner in which consent is acquired should interfere with the provision of one of these services. Vizient encourages CMS to retain this interpretation as it helps facilitate and streamline access to CTBS without imposing unnecessary burdens on providers.

Direct Supervision by Interactive Telecommunications Technology
During the PHE, through an IFC, CMS adopted an interim policy that permits direct supervision to include virtual presence (excluding audio-only) of the supervising physician or practitioner using interactive audio/video real-time communications technology. CMS proposes to extend this policy until the end of the calendar year in which the PHE ends or December 31, 2021 (whichever is later). **Vizient encourages CMS to make this policy permanent as it can help increase patient access to care, particularly in rural communities, and has helped reduce COVID-19 exposure risks for beneficiaries and health care providers**. Given that infectious diseases (e.g., influenza, COVID-19), will remain after the PHE ends, permanently adopting this policy could help limit the further spread of infectious diseases.

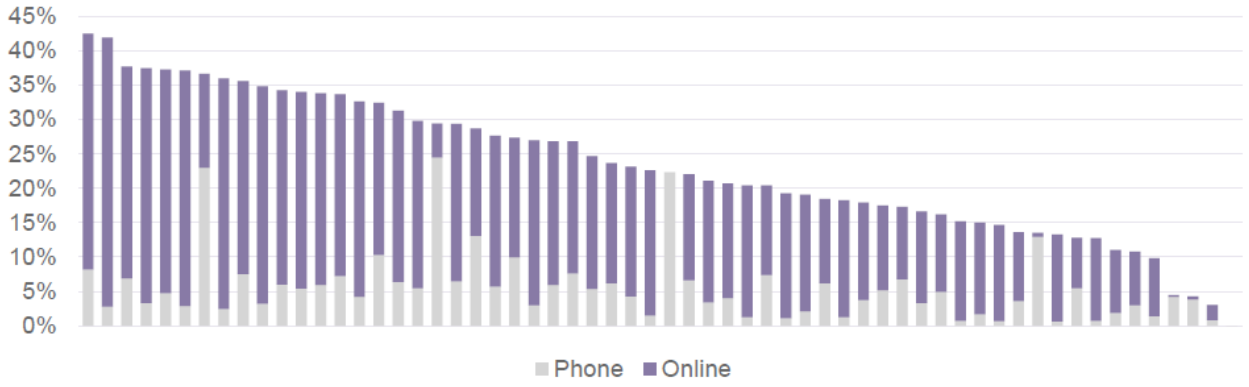
In addition, like telehealth services, CMS seeks comment as to whether there should be any additional "guardrails" or limitations to ensure patient safety/clinical appropriateness or to prevent fraud or inappropriate use. Vizient appreciates CMS's efforts to protect patients and prevent fraud or inappropriate use, especially given the emerging role technology is playing in expanding access to care. Vizient encourages CMS to work with stakeholders, including hospitals, to identify and implement such additional guardrails when direct supervision is provided by interactive telecommunications technology.

Comment Solicitation on Continuation of Payment for Audio-only Visits
During the PHE, CMS established payment for audio-only telephone E/M services (CPT codes 99441-99443) but the agency notes in the Proposed Rule that it does not believe it can permanently waive the requirement that telehealth services be furnished using an interactive telecommunications system. Given stakeholders' efforts to engage with Congress to address this issue, **Vizient encourages CMS, to the extent possible, to work with lawmakers to support passage of legislation that would permit audio-only telehealth visits.**

Despite potential regulatory limitations related to audio-only visits, Vizient agrees with CMS that in the interest of patient access, it is important to maintain audio-only visits even if they would not be considered a "telehealth service". As shown below, data from

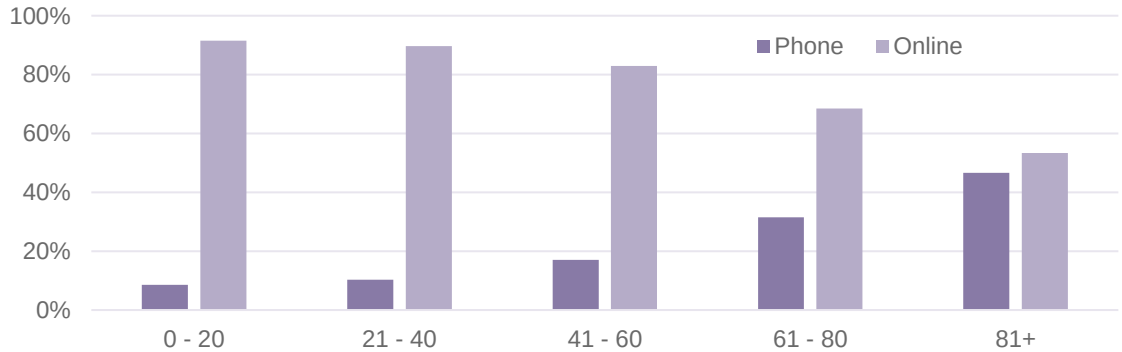
CPSC highlights that providers consistently, but not always, provided both phone and online telehealth visits in July 2020. Vizient believes this comparative information demonstrates the uptake and importance of permanently having an audio-only visit option to support patient choice and access to care, especially as online options may not always be available, such as in rural communities, when patients lack certain resources (e.g., smart phones), or prefer audio communications for different personal reasons.

July Percent of Outpatient Visits via Telehealth by Member (N = 59)



Additional CPSC analysis further demonstrates the importance of maintaining access to audio-only services. As demonstrated below, older patients are more likely to utilize the telephone for telehealth services. This is particularly apparent for those 81 and older where the phone (audio-only) was used nearly as often as online for telehealth visits. Should CMS cease covering audio-only services, Medicare beneficiaries would be most harmed, given their use of audio-only services. **Vizient believes this information highlights the need for CMS to ensure that access to audio-only services is maintained.**

Percent of office and outpatient telehealth by delivery method, by age group, July 2020



Telehealth visits include all phone or online specific CPT codes, as well as other visits with a place of service or modifier indicating telehealth. Phone reflects voice call specific CPT codes only. Visits from service sites 02–Telehealth, 11–Office, 19–Off Campus Outpatient Hospital and 22–On-Campus Outpatient Hospital were included.

Comment Solicitation on Coding and Payment for Virtual Services
In the Proposed Rule, CMS seeks comments on any impediments that contribute to health care provider burden that may result in practitioners being reluctant to bill for CTBS. In recent years, CMS started making separate payments for certain services that use telecommunications technology (e.g., certain kinds of remote patient monitoring, a virtual check-in and a remote asynchronous service) but are not considered Medicare telehealth services. **While Vizient believes some progress has been made to increase access to CTBS, there is an opportunity to learn from the PHE to more permanently increase the provision and utilization of these services.**

Vizient is aware of several barriers related usage of CTBS by providers, including challenges in improving technology integration, restructuring programs, developing a growth strategy, and technology limitations (e.g., broadband issues, costs to acquire technology) among others. A recent publication by the AAMC and Vizient[3] provides an overview of member collaboratives[4], several of which utilized different technologies to achieve certain goals (e.g., decrease wait times, improve patient outcome in telehealth). For example, the "Improving Care Access Through a Virtual Health Care Design Collaborative", identified barriers related to virtual care including shortcomings in a system's infrastructure (e.g., technology platforms, telehealth program maturity, data capabilities, alignment with organizational goals), collaborative partnerships (e.g., with post-acute providers), and virtual services (e.g., robust online support for customers, physician engagement and acceptance of virtual health strategy). **While the PHE has highlighted the potential value to patients and providers of virtual services, Vizient encourages CMS to identify opportunities to overcome such barriers, including aligning the regulatory landscape to include virtual services and providing clear information regarding reimbursement, compliance and licensure requirements.**

Comment Solicitation on PFS Payment for Specimen Collection for COVID-19 Tests
During the PHE, CMS has allowed physicians and NPPs to use CPT code 99211 to bill for services furnished incident-to their professional services, for both new and established patients, when clinical staff assess symptoms and collect specimens for purposes of COVID–19 testing. CMS is soliciting public comment on whether to make that policy permanent. Vizient supports CMS making this policy permanent to support

---

[3] AAMC & Vizient (April 2019). Learning and Leading in Access to Care: An Overview of Member Collaboratives from the AAMC and Vizient https://www.vizientinc.com/-/media/Documents/SitecorePublishingDocuments/Public/2019_AAMC_Vizient_White_Paper.pdf, accessed online: September 28, 2020.

[4] Vizient® Performance Improvement (PI) Collaboratives provide evidence-based research and collaboration to address challenges across the health care continuum, resulting in organizations' improved performance. Collaborative projects are topic-specific, rapid-cycle improvement initiatives offer a specific, well-defined focus that keeps project teams on task to deliver better patient care, improved operations, cost savings and more. Each project is led by a Vizient collaborative director with a delivery team that includes subject matter experts and analytics.

access to testing and adequate reimbursement to help cover the resources used by hospitals to conduct testing in different community locations.

Care Management Services and Remote Physiologic Monitoring Services

Remote Physiologic Monitoring (RPM)
During the PHE, CMS has temporarily allowed RPM services to be furnished to new and established patients. In the Proposed Rule, CMS makes clear an established patient-physician relationship must already exist for RPM services to be covered by Medicare after the PHE. Given the benefits that RPM has provided during the PHE and that stakeholders continue to gain insights about such benefits to new patients, Vizient encourages CMS to allow new patients to access RPM. As with telehealth and virtual services, guardrails could be put in place to preserve quality and protect the Medicare program while maintaining access. At a minimum, CMS could temporarily allow RPM services to be provided to new patients as more information is learned. However, **Vizient believes the established patient requirement is a barrier to the provision of RPM and encourages CMS to extend the RPM flexibilities for new patients after the PHE**.

In addition, Vizient appreciates CMS's willingness to continue allowing auxiliary personnel to provide certain RPM services (CPT codes 994532 and 994543) under general supervision of the billing physician or practitioner and to allow consent to be obtained at the time RPM services are furnished.

CMS also seeks comment on whether the current RPM coding accurately and adequately describes the full range of clinical scenarios where RPM services may be of benefit to patients (e.g., shorter monitoring periods). Vizient encourages CMS to develop RPM policies that support a broad scope of clinical scenarios, including more flexible monitoring periods, similar to the flexibilities CMS provided to COVID-19 patients during the PHE.

In the Proposed Rule, CMS provides additional context regarding "interactive communication", which is concerning to Vizient. CMS clarifies that "interactive communication" (as relevant to CPT codes 99457 and 99458) "involves, at a minimum, a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission."[5] CMS also stated the interactive communication must total at least 20 minutes of interactive time with the patient over the course of a calendar month for CPT code 99457 to be reported. In addition, the agency indicated each additional 20 minutes of interactive communication between the patient and the provider is reported using CPT code 99458. Since RPM is not typically furnished in person with the patient, CMS interprets time in the 99457 and 99458 code descriptors as time spent in direct real-time interactive communication with the patient.

[5] https://www.federalregister.gov/d/2020-17127/p-405

Vizient is concerned the CMS' new clarification is a barrier to RPM services because it indicates that there must be at least 20 minutes of interactive communication with the patient, as opposed to the interactive communication being a portion of the overall 20 minutes of RPM service. Vizient believes the latter is a more reasonable interpretation, especially in the context of other care management services, such as chronic care management (CCM). For CCM, CMS has indicated that the time-based requirements consist of a combination of patient interactive communication, monitoring and management of the patient's care plan. Alternatively, the RPM code descriptors include "monitoring and management" as part of the service which, like CCM, suggests the inclusion of time spent other than purely communication with the patient. Yet, CMS outlines an interpretation for RPM that differs from CCM. **Therefore, Vizient recommends CMS make clear that for RPM services, like CCM services, the time-based requirements do not need to be satisfied solely by interactive communication with the patient.**

Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability during the COVID-19 Pandemic

In the CY 2020 PFS Final Rule, for the office/outpatient E/M visit code set (CPT codes 99201 – 99215), CMS finalized a policy to generally adopt the new coding, prefatory language and interpretive guidance framework issued by the American Medical Association's (AMA's) CPT Editorial Panel. These changes, although finalized in the CY 2020 PFS Final Rule, are set to go into effect on January 1, 2021. Generally, Vizient appreciates CMS is moving forward with adoption of this new framework and related changes, such as documentation changes and allowing code selection to be dependent on time or medical decision-making (MDM).

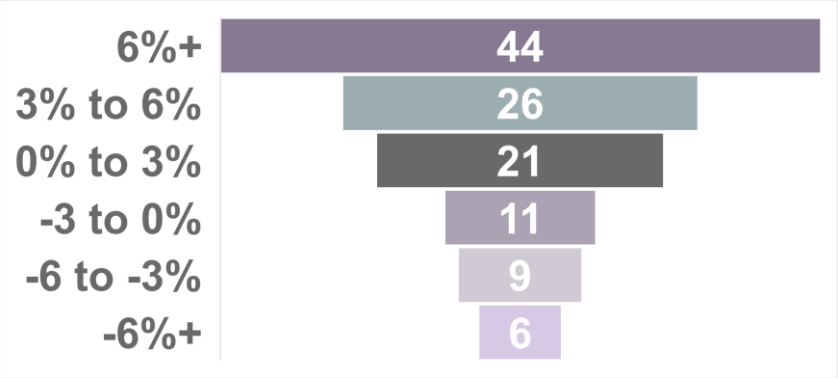
In the Proposed Rule, CMS solicits comment on HCPCS add-on code for primary care (HCPCS Code GPC1X Visit Complexity Inherent to Certain Office/Outpatient E/Ms) based on stakeholder concerns raised in prior rulemaking. Those concerns indicated confusion exists regarding the definition of this service, its application and CMS's assumption that the code will be used in every specialty visit. Given the need to gain more clarity regarding these issues and that there will likely be less notice once this year's final rule is released due to the PHE, **Vizient encourages CMS to delay implementing this add-on code.**

The Proposed Rule also includes more information regarding CMS's efforts to revalue the office/outpatient E/M visits and related codes. For budget neutrality purposes, CMS proposes to offset these and other payment changes by imposing a 10.61 percent budget neutrality adjustment. As CMS is aware, this policy is expected to have a variable effect across practice specialties, especially considering the proportion of E/M visits provided. Based on additional analysis from CPSC, as demonstrated in the below graph, the overall percentage impact across specialties for E/M services is positive 3.8 percent, but due to the conversion factor decrease, there is significant variation among

specialties for E/M services. Of 117 specialties included in CPSC's analysis, 26 would have a neutral or negative decrease across E/M activity for CY 2021 when compared to 2020. Of those specialties, 6 will have a 6 percent or greater decrease across E/M activity.

Vizient is deeply concerned these changes pose significant financial threats to providers that have already endured challenges due to COVID-19. As such, access to care can be threatened for beneficiaries if there are not sustainable reimbursement frameworks for E/M services. While Vizient urges CMS to support stakeholders' Congressional advocacy efforts to waive budget neutrality requirements, we also encourage the agency to consider other policies, such as delaying implementation of the GPC1X add-on code, to minimize the disruption to providers that is currently anticipated.

Number of Specialties Grouped by Relative Percentage Increase/Decrease Across E/M Activity



% change = 2020/2021 conversion factor * 2020/2021 NF TRVUs * 2020 Clinical Fingerprint units per 1.0 cFTE

Scope of Practice and Related Issues

Teaching Physician and Resident Moonlighting Policies
In the March 31st COVID-19 IFC, CMS temporarily allowed Medicare payment for teaching physician services when a resident furnishes Medicare telehealth services, while a teaching physician is present, using audio/video real-time communications technology. CMS is considering whether this policy should be extended on a temporary basis (e.g., until December 31, 2021) or be made permanent, and seeks comment. To help increase supervision options, Vizient encourages CMS to make this policy permanent.

Also in the March 31st COVID-19 IFC, CMS temporarily allowed medical residents to provide care not related to their approved Graduate Medical Education (GME) programs to inpatients at their training program's hospital as separately billable physicians' services, as long as certain conditions are met (e.g., identifiable physicians' services,

meet certain conditions for payment, resident is fully licensed by the state in which the services are performed and the services can be separately identified from those services that are required as part of the approved GME program). CMS is considering whether this policy should be extended on a temporary basis (e.g., until December 31, 2021) or be made permanent, and seeks comment. Vizient encourages CMS to make this policy permanent and recognizes that residency programs must also comply with ACGME requirements.

Medical Records Documentation

In the CY 2020 PFS Final Rule, and similarly expressed in the May 1st COVID-19 IFC, any individual who is authorized under Medicare to furnish and bill for their professional services may review and verify (sign and date) the medical record for the services they bill, rather than re-document, notes in the medical record made by physicians, residents, nurses, students (including students in therapy or other clinical disciplines) or other members of the medical team. In the Proposed Rule, CMS clarifies that the broad policy principle that allows billing clinicians to review and verify documentation added to the medical record for their services by other members of the medical team also applies to therapists. Vizient appreciates CMS's clarification and retention of this policy.

CY 2021 Updates to the Quality Payment Program

MIPS Quality Category
For the CY 2021 MIPS quality category, CMS proposes to eliminate the web interface reporting option. This option is currently available to groups and virtual groups of 25 clinicians or more. Although use of the web interface may have declined over the past two performance years, Vizient is concerned that CMS's proposal to eliminate this reporting option is unnecessary and would substantially disrupt reporting plans for providers utilizing this option. Given the administration's efforts to minimize burdens on providers, especially during the pandemic, **Vizient urges CMS to refrain from eliminating the web interface reporting option.**
MIPS Value Pathways
In the CY 2020 PFS Final Rule, CMS adopted the MIPS Value Pathways (MVPs) framework, which redesigned how clinicians participate in MIPS, which was intended to start with the CY 2021 performance period. Due to the COVID-19 PHE, CMS proposes to delay implementation until at least the CY 2022 performance period. Consistent with Vizient's previous comments[6], we believe it is critical that reasonable notice be provided for clinicians to adjust under the MVP framework and make practice changes necessary to successfully participate. As such, **Vizient supports CMS's decision to delay**

[6] Vizient comments to the Centers for Medicare and Medicaid Services, Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program, and Other Revisions to Part B for CY 2020 (CMS-1715-P), available at https://newsroom.vizientinc.com/doc_library/file/Vizient_Final_Comment_Letter_MPFS_CY_2020.pdf, last accessed: September 29, 2020

implementation and encourages the agency to continue to gain stakeholder feedback to better inform future implementation timelines and rulemaking.

In the Proposed Rule, CMS also indicates that it may eventually require all MIPS eligible clinicians to participate in MIPS either through an MVP or the Proposed APM Performance Pathway (APP). Vizient continues to believe MIPS-eligible clinician participation in the MVP, and now APP, should be provided as an option, with the alternative being to remain in traditional MIPS. Vizient suggests that CMS consider developing incentives to encourage participation.

APM Performance Pathway
In the Proposed Rule, CMS aims to sunset the APM Scoring Standard beginning with the 2021 performance period. To replace this standard, CMS proposes the APP, a new participation pathway. The APP has a predetermined set of measures and activities and is optional for all MIPS APM participants, but required for accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP). As noted above, Vizient is concerned CMS may require all MIPS-eligible clinicians to participate in MIPS either through an MVP or the Proposed APP. Vizient reiterates our recommendation that participation should be voluntary. In addition, given that both the MVP and APP are new and additional detail remains to be seen, Vizient believes it is important CMS provides enough time and resources to support effective implementation and clinician understanding of these programs.

Conclusion

Vizient welcomes CMS's extensive discussion of options and its emphasis on requesting comments, which provides a significant 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 Jenna Stern at jenna.stern@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these issues.

Respectfully submitted,

Shoshana Krilow
Vice President of Public Policy and Government Relations
Vizient, Inc.