799 9th Street NW
Suite 210
Washington, DC 20001

T (202) 354-2600
vizientinc.com

March 13, 2026

Submitted electronically via: www.regulations.gov

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS–9883– P
7500 Security Boulevard
Baltimore, MD 21244–8016

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program

Dear Administrator Oz,

Vizient, Inc. appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program (hereinafter "Proposed Rule"). Vizient welcomes the agency's efforts to maintain the State Exchanges and State-based Exchanges on the Federal Platform (SBE–FPs) as a stable source of coverage, particularly with policies that aim to improve quality and patient access to care. Several topics in the Proposed Rule have a significant impact on our provider clients and the patients they serve. In response, Vizient offers recommendations, including several that align with the agency's interest in easing administrative burdens and increasing patient access to care.

Background

Vizient, Inc., the nation's largest provider-driven healthcare performance improvement company, provides solutions and services to more than two-thirds of the nation's acute care providers and more than one-third of ambulatory providers. Vizient offers proprietary data and analytics to deliver unique clinical and operational insights and a contract portfolio representing $156 billion in annual purchasing volume enabling the delivery of cost-effective care. With its acquisition of Kaufman Hall in 2024, Vizient expanded its advisory services to help providers achieve financial, clinical and operational excellence. Headquartered in Irving, Texas, Vizient has offices throughout the United States. Learn more at www.vizientinc.com.

Recommendations

Vizient appreciates CMS's efforts to improve healthcare outcomes and ensure coverage and care are accessible. Vizient offers feedback regarding proposals related to network adequacy standards, catastrophic health plans, non-network health plans and the Quality Improvement Strategy (QIS).

Amending Exchange Network Adequacy Standards

Beginning with the 2027 plan year (PY), CMS proposes to modify the network adequacy standards and remove the requirement that qualified health plans (QHPs) participating in State Exchanges and SBE–FPs adopt time-and-distance standards that are at least as strict as those used in Federally-facilitated

Exchanges (FFE).[1] Instead, CMS proposes that, beginning in 2027, QHPs in State Exchanges and SBE–FPs would only need to demonstrate "sufficient access" to providers under the current federal network adequacy framework, while time-and-distance standards would become optional tools that State Exchanges and SBE–FPs may choose to apply but would no longer be required to implement.[2]

While Vizient agrees that patients should have access to a sufficient number of healthcare providers, we are concerned that the proposed removal of time-and-distance standards might relax network adequacy standards to the point of limiting patient access to care, particularly in rural and underserved areas. Patients in rural communities already travel long distances to obtain specialty and sometimes primary and emergency care, so removing these minimum time-and-distance standards may exacerbate existing geographic access issues. Vizient believes QHP network standards should support the State Exchanges and SBE–FPs' goal of ensuring meaningful consumer access by requiring plan networks to include an adequate number and range of providers and facilities and to ensure enrollees can reach essential in-network services within a reasonable travel time and distance.

In addition, Vizient is concerned that removing time-and-distance standards may harm rural hospitals. The Center for Healthcare Quality and Payment Reform reports that more than 700 rural hospitals are already at risk of closing soon.[3] Maintaining time-and-distance standards, along with requiring a sufficient number and types of in-network providers, can help mitigate rural hospital closures by preventing care models that shift care away from rural providers. As such, Vizient recommends that CMS retain the time-and-distance standards when assessing whether an issuer meets network adequacy requirements.

Catastrophic Plan Cost-Sharing Requirements

To further differentiate catastrophic plans from bronze plans, CMS proposes to increase the cost-sharing limit for catastrophic plans. Specifically, beginning in PY 2027, catastrophic plans would not provide benefits in any plan year until an enrollee has paid an amount equal to 130 percent of the current maximum annual limitation on cost sharing. As a result, enrollees would pay 30 percent more than today's out-of-pocket limit before coverage begins. Given that this proposal would increase out-of-pocket costs to individuals and families before coverage becomes available, Vizient is concerned that consumers enrolling in a catastrophic plan may not fully understand this change at the time of enrollment, particularly if they are already enrolled in a catastrophic plan. If this proposal is finalized, we recommend that CMS require plans to provide clear consumer disclosures and education to ensure that individuals understand the specific coverage and costs associated with a given catastrophic health plan prior to enrollment.

QHP Certification of Non-Network Plans

Beginning with the 2027 PY, CMS proposes allowing non-network plans that do not have a specified contracted network to be certified as QHPs in Exchanges. To obtain QHP certification, CMS proposes that non-network plans would need to demonstrate that enrollees have a sufficient choice of providers who will accept the plan's benefit amount[4] as payment in full and ensure reasonable and timely access to care without additional provider billing beyond the plan's cost sharing.[5] Specifically, a non-network plan would set an allowed amount it will pay for a service and when an enrollee needs care, the enrollee must find a

[1] 45 CFR 155.1050(a)(2)(i), available at: https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-155/subpart-K/section-155.1050

[2] 156.230, https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-C/section-156.230

[3] How to Prevent Rural Hospital Closures – Saving Rural Hospitals

[4] In the Proposed Rule, CMS indicates, "The plan may determine the benefit amount based on an established methodology such as a percentage of a publicly available benchmark, a reference-based pricing structure, or another reimbursement standard (that is, Medicare or private payor rates, etc.)."

[5] Under § 155.20 cost sharing is defined as any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-155/subpart-A/section-155.20

provider who is willing to accept that amount as full payment. Vizient has concerns that if a provider will not accept the allowed amount for a service, the patient may experience difficulty in obtaining care or may receive care but be billed for the difference. Vizient is similarly concerned that patients might not be aware of their responsibility to find providers who will accept the plan's payment in full, which can create access barriers and subject patients to unexpected costs. Vizient recommends that, because non-network plan designs are unfamiliar to most consumers, CMS should require plans to provide consumer education and clear, standardized disclosures that explain how access to care is obtained, the potential for higher out-of-pocket costs and the circumstances under which a provider may or may not accept the plan's payment.

Further, CMS does not provide insights regarding how the proposal could impact providers. For example, it is unclear to what extent providers could face under-reimbursement, since the plan would have broad discretion in setting the allowed amount. Therefore, we encourage CMS to carefully evaluate the impact of non-network plans on providers before finalizing the proposal.

Quality Standards: Quality Improvement Strategy (QIS)

CMS proposes, beginning with the 2027 PY, to require QHP issuers to submit QISs that address any two out of five healthcare topic areas.[6] This proposal allows each issuer to choose the two topic areas it considers most relevant to its enrollees rather than mandating specific topics. Although QIS requirements apply to issuers as a condition of QHP certification, they can translate into downstream burdens and obligations for providers (e.g., new or duplicative data reporting, participation in issuer-specific quality initiatives, additional measure reporting). These challenges will be amplified if QHP issuers are given even more flexibility regarding their selected healthcare topic areas. Given these cumulative burdens and the potential for issuer-by-issuer variation, Vizient is concerned that this proposal may unintentionally increase provider burden without meaningful improvements to patient care. Therefore, Vizient discourages CMS from finalizing the proposal and instead encourages the agency to evaluate opportunities to reduce provider burdens associated with QISs while advancing improvements in patient care.

Conclusion

Vizient appreciates CMS's efforts to gain additional feedback regarding the Proposed Rule. Vizient membership includes a wide variety of hospitals ranging from independent, community-based hospitals to large, integrated healthcare systems that serve acute and non-acute care needs. Additionally, many hospitals are specialized, including academic medical centers and pediatric facilities. Individually, our members are integral partners in their local communities, and many are ranked among the nation's top healthcare providers. In closing, on behalf of Vizient, I would like to thank CMS for the opportunity to share feedback on this important Proposed Rule. Please feel free to contact me, or Randi Gold at Randi.Gold@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these recommendations.

Respectfully submitted,

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

[6] These five healthcare topic areas are found at 42 U.S.C. §18031(g)(1) and include: improving health outcomes of plan enrollees, preventing hospital readmissions, improving patient safety and reducing medical errors, promoting wellness and health, and reducing health and healthcare disparities. https://uscode.house.gov/view.xhtml?req=(title:42%20section:18031%20edition:prelim)