vizient

July 21, 2026

Submitted electronically via: https://www.regulations.gov/

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee For-Service Targeted Medicaid Practitioner Payments (CMS-2449-P)

Dear Administrator Oz,

Vizient, Inc. appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule on Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee For-Service Targeted Medicaid Practitioner Payments (CMS-2449–P) (hereinafter, "Proposed Rule"). Vizient is concerned that, if finalized, the Proposed Rule would result in significant and unnecessary disruption to state Medicaid programs, Medicaid beneficiaries and the hospitals who serve these patients. Given these and other concerns detailed below, Vizient urges CMS to reconsider many aspects of the Proposed Rule.

Background

Vizient is 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.vizient.com.

Recommendations

Throughout the Proposed Rule, CMS seeks to implement statutory changes from Section 71116 of the Working Families Tax Cut (WFTC) legislation[1] by setting reduced payment rate limits on certain state-directed payments (SDPs) and providing additional guidance on the phase down for grandfathered SDPs.[2] However, the Proposed Rule includes changes that are outside the scope of

[1] CMS refers to Public Law 119-21 as the "Working Families Tax Cut" (WFTC) legislation. This law is also known as the One Big Beautiful Bill Act (OBBBA).
[2] Section 71116 of the WFTC legislation directed the Secretary of Health and Human Services (HHS) to reduce the total payment rate limit for certain SDPs for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center (AMC). Section 71116 also included a provision allowing a temporary grandfathering period for certain SDPs until the rating period beginning on or after January 1, 2028, at which point such SDPs would be required to gradually transition down to the new payment limit. https://www.congress.gov/bill/119th-congress/house-bill/1/text

the WFTC's statutory requirements, such as extending the reduced payment rate limits to all SDPs for all services in all states and territories, providing targeted Medicaid practitioner payment limits in Medicaid fee-for-service (FFS), eliminating uniform increase SDPs and replacing average commercial rate (ACR)-based limits on targeted supplemental payments to practitioners with current law limiting SDP payments.[3] These proposed policies will unnecessarily limit and disrupt state flexibility to operate their Medicaid programs, disrupt provider funding and adversely affect beneficiary access to care. Accordingly, Vizient urges CMS to withdraw several proposals and offers recommendations to limit disruptions to care.

Regulatory Revisions for Other SDPs, Services and Territories

Scope of Services

Section 71116 of the WFTC legislation, requires the initial reduction of the maximum payment rate for non-grandfathered SDPs for certain types of services provided in existing regulations (i.e., inpatient hospital services, outpatient hospital services, nursing facility services and qualified practitioner services at academic medical centers).[4] However, CMS proposes additional policy that is not required by the WFTC legislation including broadening the application of the maximum payment rate to all types of services for rating periods beginning on or after January 1, 2029. Medicare payment rates are frequently below hospitals' costs of furnishing care.[5] Therefore, expanding Medicare-based payment limits to all Medicaid services would further reduce provider reimbursement, compounding existing financial pressures, limiting access to care for Medicaid beneficiaries. To prevent disruptions to care and to support patient access, Vizient urges CMS to withdraw this proposal.

Geographic Impact

Section 71116 of the WFTC legislation applies to expansion and non-expansion states and the District of Columbia (D.C.). The law does not include U.S. territories in the definition of "state". Yet, CMS proposes to apply the Medicare-based payment limits to all fifty states, Washington, D.C. and the U.S. territories. CMS's proposal to expand payment limits to the U.S. territories is not consistent with the law. In addition, the proposal will add unnecessary burden for both territories and CMS, among others. Given our concerns that the proposal differs from requirements provided in the WFTC legislation and that it will add burden, Vizient urges CMS to withdraw the proposal to include territories.

SDP Payment Limits

To calculate the SDP payment limit, CMS proposes that the total published Medicare payment rate would serve as the basis of the payment limit and that the payment limit cannot be calculated at

[3] CMS adopted the ACR as the standard benchmark for all SDPs in 2018 and approved SDPs up to the average commercial rate under 1902(a)(30)(A) of the Social Security Act.
CMS explains that after 2018, a larger number of states designed programs that push payments right up to the ACR and in response, in 2024, CMS clarified policy by finalizing formally setting ACR as the maximum allowable payment cap for certain key services (hospital, nursing facility, and academic medical center services). CMS explains ACR is appropriate as it reflects private market rates and helps Medicaid plans compete for providers. https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf and https://www.ssa.gov/OP_Home/ssact/title19/1902.htm
[4] Pub. L. 119-21
[5] https://www.aha.org/system/files/media/file/2026/03/Costs-of-Caring-2026.pdf

an aggregate level.[6] CMS explains that their decision not to calculate the payment limit at an aggregate level is because the WFTC legislation does not reference aggregate Medicare-equivalent rates. As a result, the agency proposes that the SDP payment limit would be calculated at the level of each specific service or discharge, using either Healthcare Common Procedure Coding System (HCPCS) codes or Medicare Severity Diagnosis-Related Groups (MS-DRGs), based on the Medicare-calculated payment amount.[7] Requiring compliance at the individual service or discharge level would impose substantial operational and administrative burden on states which would have downstream, negative consequences for providers and patients. Many state Medicaid programs do not use Medicare-based payment structures (e.g., use of an All Patient Diagnosis Related-Group), and aligning Medicaid payments with Medicare at the HCPCS or MS-DRG level would require complex crosswalks between different payment systems. This would introduce significant administrative complexity and increase the risk of applying Medicare rates that do not accurately reflect the Medicaid services provided. Allowing states to assess SDPs at an aggregate level, rather than service level, would help alleviate some of these challenges.

Additionally, Medicare payment rates are established under distinct frameworks and are not intended to serve as a universal benchmark for Medicaid services. Medicare reimburses hospitals below the cost of care and expanding Medicare-based payment limits to Medicaid services that were reimbursed at a higher rate due to SDPs would introduce further reductions in provider payment, compounding existing financial pressures.[8] Limiting reimbursement to below-cost of care levels may also have direct implications for access to care, as hospitals may be forced to discontinue certain services, such as behavioral healthcare or serve a smaller proportion of Medicaid beneficiaries due to under-reimbursement. Vizient supports efforts to ensure Medicaid payments are sufficient to protect beneficiary access to care and appropriately reimburse providers and urges CMS to avoid policies that could further strain providers and limit access for Medicaid beneficiaries. As such, Vizient urges CMS to provide states with more flexibility in how they determine the “Total Medicare Payment Rate”.

One way that CMS could offer additional flexibility to states is by maintaining their ability to structure payments to reflect the specific needs of their communities, including targeting funding to priority areas, such as supporting behavioral health, rural providers or other high-cost services. The proposed approach adopts a more restrictive framework that limits state flexibility and eliminates distinctions that allow states to tailor payments to local needs. While CMS has indicated in the Proposed Rule that the proposal is intended to better align SDPs with quality goals, Vizient believes that preserving flexibility in payment design is essential to achieving these same outcomes. Enabling states to direct resources toward specialized or high-cost services supports access to care and helps ensure that providers can meet the needs of Medicaid beneficiaries. By constraining how states can structure payments, the proposal risks undermining these objectives rather than advancing them. Vizient recommends CMS reconsider this proposal and provide states with continued flexibility to structure SDPs without imposing additional or unnecessary burden.

[6] Aggregate level calculations have been used for Medicaid fee-for-service upper payment limit demonstrations.
[7] CMS proposes to use the most recent complete Medicare cost report and cost-based methodology payment approach as the Medicare rate for purposes of the limit for providers paid on a cost basis. Further, CMS also proposes to require states to use CMS validated tools (e.g., web pricers or the Medicare Physician Fee Schedule (PFS)) when calculating the applicable payment limit for provider payments under an SDP.
[8] https://www.aha.org/system/files/media/file/2026/03/Costs-of-Caring-2026.pdf

Phase Down of Grandfathered SDPs

To implement Section 71116 of the WFTC legislation, CMS proposes that grandfathered SDPs would be subject to a 10 percentage point annual phase down beginning with the first rating period on or after January 1, 2028, until the total payment rate equals the statutory payment limit.[9] CMS proposes that the 10 percentage point phase down of the grandfathered SDP amount is based on the original grandfathered total dollar amount rather than an annually compounding reduction. However, CMS also outlines alternative approaches it considered. Vizient notes that states may prefer alternative phase-down approaches, including options not already contemplated in rulemaking, reflecting the individuality and complexity of SDPs in each state. Therefore, Vizient recommends that CMS consider allowing multiple phase-down approaches so states can utilize the approach that minimizes administrative burden and is least disruptive.

Uniform Increase SDPs

CMS proposes that, beginning with the first rating period on or after January 1, 2028, states would be prohibited from establishing new, uniform increase SDPs or renewing any non-grandfathered uniform increase SDPs. Also, CMS proposes that states would then transition to minimum or maximum fee schedule approaches that can be structured to remain within the new payment limits.[10] In addition, CMS proposes a limited exception allowing grandfathered SDPs, including many previously approved uniform increase SDPs, to continue temporarily (e.g., until the first rating period the payment limit is met). Section 71116 of the WFTC legislation does not direct CMS to prohibit uniform increase SDPs. Also, as CMS is likely aware, uniform increase SDPs are often targeted to hospitals.[11] Under a uniform increase, states determine a fixed dollar or percentage increase that is applied to base reimbursement for every service covered under the SDP. Uniform increase SDPs allow states to achieve more predictable and equitable distribution of funding across provider systems and removing this tool will shift resources in ways that destabilize hospitals that rely on these payments to support essential services. For these reasons, Vizient urges CMS to withdraw this proposal.

Targeted Medicaid Payment Limit in a Fee-for-Service (FFS) Delivery System

As CMS proposes to replace ACR-based limits on targeted payments to align with the SDP payment limits at either 100% or 110% of the specified total published Medicare payment rate, the agency also proposes to apply these Medicare-based limits to targeted Medicaid fee-for-service (FFS) payments. However, unlike the proposed SDP-related changes, Section 71116 of the WFTC legislation did not include requirements for CMS to extend the Medicare-based limited to Medicaid FFS payments. Extending the payment limits will significantly increase burden on states that are actively attempting to implement numerous, complicated changes required by the WFTC

[9] The statutory payment limit is 100% of the total published Medicare payment rate for a Medicaid expansion state and 110% for a non-expansion state, with 100% of the state plan approved rate when no Medicare rate exists.

[10] Uniform increase SDPs are a type of Medicaid payment arrangement where states require managed care plans to pay all providers in a group the same additional amount or percentage for specific services. This means each provider receives a consistent boost on top of their existing payment rates. States use these increases to quickly raise and standardize payments, often to support hospitals and improve participation. However, CMS is concerned that in practice, some states design these payments to guarantee a fixed total amount of funding to certain providers—sometimes increasing payments per service if patient volume is lower—making them function more like a financing mechanism than a direct payment for care delivered. CMS explains that uniform increases are the most common type of SDP and expresses concern that states are increasingly designing them to ensure certain groups of providers receive a predetermined total amount of funding.

[11] https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf

legislation. This additional policy is unnecessary and strains states' already limited resources. In addition, the proposal will negatively impact provider reimbursement adequacy, which will limit patient access to care. Vizient recommends CMS to refrain from finalizing this proposal.

Provider Classes

In the Proposed Rule, CMS expresses concern that some states may define provider classes too narrowly and in ways that are not closely aligned with their Medicaid managed-care quality strategies. While CMS does not propose policy, the agency seeks comment on whether and how to define provider class to determine whether additional guardrails are warranted to ensure SDPs are focused on improving access and quality. States often rely on tailored provider class definitions to address unique local needs, such as maternal health deserts or gaps in behavioral health services. Imposing a broad definition of provider class could limit a state's ability to effectively direct resources to these high-need areas. Therefore, Vizient recommends preserving state flexibility in defining provider classes, as imposing a more restrictive definition could undermine a state's ability to target payments to providers and services that are essential to maintaining access to care.

Conclusion

Vizient appreciates CMS's efforts to gain additional feedback regarding the Proposed Rule. Vizient membership includes a variety of hospitals ranging from independent, community-based hospitals to large, integrated health care systems that serve acute and non-acute care needs. In closing, on behalf of Vizient, I would like to thank CMS for providing the opportunity to respond to this Proposed Rule. Please feel free to contact me, or Randi Gold at Randi.Gold@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these recommendations.

Respectfully submitted,

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