PETERSON CENTER ON HEALTHCARE

VIA ELECTRONIC SUBMISSION

July 21, 2025

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS Hospital Price Transparency Accuracy and Completeness Request for Information

Dear Administrator Oz:

The Peterson Center on Healthcare ("the Center") appreciates the opportunity to respond to your Request for Information to identify challenges and improve compliance with the transparent reporting of complete, accurate, and meaningful pricing data by hospitals.

The Center is a nonprofit, nonpartisan organization dedicated to making higher-quality, more affordable healthcare a reality for all Americans. We are working to create a more efficient and cost-effective healthcare system in the United States and believe that price transparency is foundational to competitive markets, smart policies, and accessible, quality care.

Through our partnerships and grants, the Center is helping equip employers with the pricing data they need to be more effective managers of healthcare benefits for their employees. For example, a project led by the Purchaser Business Group on Health (PBGH) finds that employers' access to claims data and price comparisons are restricted by insurers and third-party administrators due to the data gaps and complexity of price transparency files. A policy brief recently published by the Peterson-KFF Health Tracker provides examples of health plan data that is incomplete, missing, and—when available—unstructured and confusing. Meanwhile, research recently published by David Muhlestein in *Health Affairs* shows that while insurers' price data could provide employers with insights into their spending, preparing that data for analysis takes months of painstaking work.

System-wide price transparency is important to increase market competition to enhance the quality of patient care and reduce healthcare spending. We offer the following contributions to inform transparency efforts for both private and public payers. Our recommendations will improve the usability of data for intermediaries, who then in turn can make use of the data to negotiate on behalf of patients, make better public policy, and reduce the financial friction so many patients experience today when interacting with the health system.

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We share CMS's commitment to improving price transparency and data usability and we appreciate the opportunity to contribute to this important work. For any questions or follow-up, please contact Natalie Joyce, Vice President of Advocacy at njoyce@petersonsolutions.org.

Sincerely,

Caroline Pearson

Executive Director, Peterson Center on Healthcare

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1. **Should CMS specifically define the terms "accuracy of data" and "completeness of data" in the context of HPT requirements, and, if yes, then how?**

   There are many opportunities to enhance the accuracy and completeness of the Hospital Price Transparency (HPT) data. In June, the Center responded to HHS's RFI on digital health technologies and recommended that CMS standardize the healthcare price data schema. CMS should ensure that accuracy and completeness of data under the HPT rules are aligned, where applicable, with definitions under the Transparency in Coverage (TiC) transparency rules. Inaccurate and incomplete responses diminish public confidence in the value of transparency and the transparency rules by limiting the abilities of employers, researchers, policymakers and consumers to leverage the data to drive choice, promote market competition, and better inform healthcare decision making.

   Accuracy and completeness should be defined, assessed, and rated separately or in a composite fashion to determine a degree of compliance by each hospital reporting entity—e.g., fully compliant, non-compliant, partially compliant. CMS should also consider redundancy of data, meaning instances of repeated or duplicative entries that are identical and provide no additional information.

2. **What are your concerns about the accuracy and completeness of the HPT MRF data? Please be as specific as possible.**

   The Center supports CMS's CY2026 Hospital Outpatient Prospective Payment (OPPS) proposed rule requiring hospitals to display payer-specific standard charges as dollar amounts in their machine-readable files (MRFs) whenever calculable, discontinue encoding nine 9s and encode actual dollar amounts in the estimated allowed amount within the MRF, and use electronic remittance advice data from the previous 12 months to calculate the "estimated allowed amount."

   Beyond CMS's refinement of "estimated allowed amounts" and the discontinuation of nine 9s, we recommend CMS continue to clarify reporting schema for other fields to make clear the distinction between failure of the reporting entity to provide data and the legitimate absence (e.g., inapplicability) of relevant data for those fields. Below are examples of data accuracy challenges experienced by the Center's grantees and consultants in using the HPT data:

   - Some hospitals have failed to report complete data, such as not including prices for certain services they are known to provide or including blank/missing fields.
   - Some hospitals have failed to differentiate data where all other information is identical. For example, they may mention the same billing code, payer, plan and methodology, but have multiple different standard charges or estimated amounts reported.

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- Some hospitals release significant redundant data, increasing file sizes and making them more difficult to work with. For example, 34% of reported rates from the MRF from Stanford University Hospital are duplicate data.
- When comparing rates reported between MRFs from payers' TiC to rates reported by hospitals, the prices regularly do not match. Sometimes the differences can be quite significant (>20% different).

3. **Do concerns about accuracy and completeness of the MRF data affect your ability to use hospital pricing information effectively? For example, are there additional data elements that could be added, or others modified, to improve your ability to use the data? Please provide examples.**

Transparent prices need context to be meaningful to policymakers, purchasers, and patients. CMS requirements can add context with additional data elements so that users are able to understand prices relative to various factors that may influence purchasing decisions. CMS should consider the following additional data elements in the MRF:

Volumes: The Center appreciates the incremental steps CMS proposes in the CY2026 OPPS rule to require the reporting of the count of allowed amounts when a price is based on an algorithm. With an algorithmic approach, the hospitals must report 10th, 50th, and 90th percentiles (previously it was just the mean amount) and the count of episodes that were used to calculate those percentiles. We encourage CMS to finalize this proposal and go further to require volume counts for codes and procedures that are paid set amounts (e.g. not by algorithm). It is our understanding that most codes are paid set amounts, and thus CMS should require hospitals to report volumes—i.e., the number of services/procedures performed, items supplied, etc. during the reporting period. CMS can accomplish this by adding a field that is called "count_services" that includes the count of times that service has been paid for by that payer in the 12-month period prior to the data being released. Volume information is critical to:

- Help distinguish between frequently performed and rarely performed services;
- Allow for volume-weighted averages to compare services;
- Estimate financial impact based on potential changes in rates;
- Help direct consumers to locations that regularly perform procedures, as higher volume providers generally have higher quality;
- Help identify outliers and/or anomalies and their relative importance;
- Prioritize higher-volume cases for auditing and evaluation; and
- Better understand real-world impact of prices on patients.

Quality metrics: CMS should require hospitals to post the data that feeds into Hospital Compare and the CMS's quality payment program (QPP) to enable employers and

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consumers to consider both price and quality information. Alternatively, CMS can post the data on behalf of hospitals.

Cash price restrictions: Because some hospitals may not offer cash prices to all patients, CMS should require hospitals to describe any limitations on availability of cash prices.

Medicare prices: Hospitals should list comparable average Medicare payments the hospital receives for each service. While Medicare pays on a prospective fee schedule, actual payment varies due to characteristics and classifications of the provider billing Medicare for the service and whether they qualify for supplemental payments such as disproportionate share (DSH), graduate medical education (GME) or other add-on payments.

Additional provider information: Beyond hospital name and address, hospitals should be required to include the hospital national provider identifier (NPI) (or multiple NPIs), tax identification number (TIN) or employer identification number (EIN). Hospitals should also be required to include a list of NPIs that are authorized to provide and bill for care within the hospital and differentiate between staff employed by the hospital and those that have admitting privileges. This would inform patients in advance if physicians were hospital employees or working for a separate organization. This would also help identify relationships that lead to surprise medical bills.

Special hospital designations: Hospitals should be required to declare whether they qualify for designations that can indicate potential sources of low-cost drug acquisition rights and supplemental payments (e.g. 340B, DSH, GME, rural referral center). These designations can impact the gross payments hospitals receive from payers and meaningfully contribute to the overall financial health of health systems. Making these designations transparent will complement the release of Medicare payments information per above.

4. **Are there external sources of information that may be leveraged to evaluate the accuracy and completeness of the data in the MRF? If so, please identify those sources and how they can be used.**

TiC data and healthcare claims data can be leveraged to evaluate the accuracy and completeness of MRF data. In response to HHS's RFI on digital health technologies, the Center recommended that CMS implement and enforce the rules around hospital and payer consumer-facing price tools, including the Advanced Explanation of Benefits provisions of the No Surprises Act to help consumers understand price implications of their provider selection decisions prior to receiving care. These regulations, and hospitals compliance with them, would offer additional sources of data to verify accuracy and completeness of the MRFs.

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5. What specific suggestions do you have for improving the HPT compliance and enforcement processes to ensure that the hospital pricing data is accurate, complete, and meaningful? For example, are there any changes that CMS should consider making to the CMS validator tool, which is available to hospitals to help ensure they are complying with HPT requirements, so as to improve accuracy and completeness?

The Center believes that lack of compliance is a significant barrier preventing transparency rules from enabling a more affordable, high quality health care system. Simplification and standardization of the HPT rules, reporting processes, and an improved schema, which began with the 2022 and 2024 rules, are important steps. More can be done, as proposed in our responses to other questions in this RFI.

Maximizing alignment with TiC reporting requirements is also useful in enhancing compliance by making it easier to identify inconsistencies or detect non-compliance. Further, CMS itself can streamline its compliance and enforcement efforts by reporting the locations of hospital data since it is currently a cumbersome step to identify where the data is stored on a hospital's website.

CMS can take additional actions that make avoiding full compliance more costly, such as the 2024 rules did by increasing penalties, threatening de-certification for non-compliance, and introducing an affirmation requirement.

One approach is to decrease the use of warning letters and to move more quickly to imposing penalties on non-compliant hospitals. Other types of penalties may also increase compliance, such as barring medical debt collection by non-compliant hospitals or encouraging and supporting whistle-blower or qui tam provisions.

Public reporting by CMS of compliance scores, as well as requiring hospitals to publicly report CMS enforcement actions against them, should provide additional incentives for hospitals to comply with the rules.

6. Do you have any other suggestions for CMS to help improve the overall quality of the MRF data?

Additional recommendations that would improve usability of the data include:

- Require hospitals to maintain historical reporting and publishing for each year they report the data.
- Require quarterly reporting. If no updates have occurred, they can repost the previous file.
- Require hospitals to provide contact information with a monitored email where the hospital is required to respond to queries about the data.
- To optimize accessibility for the widest number of people, remove the options for a JSON file and a Wide CSV, and require all hospitals to use the Tall CSV format.

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