Association of
American Medical Colleges
655 K Street, NW, Suite 100, Washington, DC 20001-2399
T 202 828 0400
aamc.org

July 21, 2025

Re: AAMC Comments on the CMS Hospital Price Transparency Accuracy and Completeness Request for Information

Submitted via online form at: https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/accuracy-and-completeness-rfi

Question 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?

AAMC does not believe there is a need to define the terms "accuracy of data" and "completeness of data" in the context of hospital price transparency requirements. CMS already requires that hospitals make a 'good faith effort' for accuracy and completeness, and hospitals adhere to that requirement. Moreover, these terms are already understood and operationalized by hospitals since they are used in other contexts, such as cost report requirements. The primary objective of the CMS cost report is to give a complete picture of health care facilities' financial status and cost structure, and hospitals make every effort to ensure that the amount incorporated in the reports is accurate and the data is current. This is achieved without the specific definitions from CMS of the terms and we believe further clarification is not necessary.

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

The hospital price transparency (HPT) rule requires hospitals to publicly post via machine-readable files five different "standard charges": gross charges; payer-specific negotiated rates; de-identified minimum and maximum negotiated rates; and discounted cash prices. It also requires hospitals to provide patients with a consumer-friendly display for at least 300 shoppable services, which can be satisfied by offering an online price estimator tool that provides personalized out-of-pocket pricing information.

Building files that meet the specifications of the HPT rule, which requires sharing "standardized" negotiated rates, is challenging for AAMC-members, given the realities of hospital billing and reimbursement, and may not be feasible for some hospitals. Often contracts between health plans and providers start with a basic discount off of all gross charges billed on a claim. However, the health plan/provider contract typically has a number of different payment policies that apply to claims that may change the actual reimbursement rate for an individual patient, making it very difficult to accurately identify a single "standard" negotiated charge for a particular service. For example, the insurer may have an algorithm that bundles the reimbursement rate for certain services and results in a payment that varies according to the needs of the individual patient. Providers do not always know how the billed services will be bundled and paid until the claim has been adjudicated by the payer. As a result, the negotiated payment could change and be different than the rate the provider has included in the MRF. Volume discounts set forth in contract terms may also be applied, and as a result, the payment amounts would

change from the negotiated rates expressed in the MRF. In addition, the MRFs can become outdated quickly as contracts are frequently updated throughout the year. In fact, some types of charges can change daily based on changes to acquisition costs. All of these factors and others may impact the accuracy and completeness of the HPT MRF files.

Question 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?

CMS has made recent and significant adjustments to the Hospital Price Transparency Rule, including changes related to standardization, new data elements, file accessibility, an accuracy and completeness affirmation, as well as changes to CMS' monitoring and enforcement processes. Notably, CMS recently required hospitals to adopt a new standard format to comply with the machine-readable file requirement, which includes new data elements such as negotiated rate contracting type or methodology, an accuracy and completeness affirmation and (as of January 1, 2025) an "estimated allowed amount." CMS has also recently finalized new requirements that are designed to allow users of MRFs to find them more easily. These recent policy changes are broad in scope and take time for hospitals to operationalize. While hospitals are making progress on implementing these new requirements, operationalizing such changes is resource intensive and takes time. Additional changes at this point would threaten to derail the progress.

AAMC believes that implementation of the recently implemented MRF standard format is sufficient to allow CMS to conduct more efficient automated reviews to check for compliance with price transparency requirements. Additionally, the use of new standard format enables hospitals to improve compliance with price transparency requirements. With regard to determining the accuracy and completeness of each specific data point within an MRF, AAMC believes this would present a burdensome challenge for CMS and increase taxpayer costs without appreciable benefit.

However, CMS could pursue enforcement approaches that do not involve a comprehensive review of all data. One option would be to use risk-based and random sampling to review the accuracy of the price transparency information. CMS has implemented this approach in other programs, including the Quality Payment Program and Hospital Inpatient Quality Reporting programs. In these quality programs, CMS randomly samples providers and then reviews provider documentation for the sample, to verify the accuracy of the quality and performance data that is submitted. This approach was recommended recently to CMS by GAO.[1]

Should such an audit result in concerns related to a hospital's MRF accuracy and completeness, CMS currently has the authority to issue warning notices or request a corrective action plan (CAP) that must be completed within 45 days for hospitals that are out of compliance. As a first step, we would recommend a warning notice to enable hospitals to come into compliance. CMS' publicly posted enforcement action data suggests that over 50% of hospitals come into compliance after having been issued a warning notice, indicating that hospitals have been very responsive to these notices.[2] Prior to imposing any civil monetary penalties, we urge CMS to continue to provide hospitals with an opportunity to come into compliance.

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[1] GAO-25-106995, CMS Nees More Information on Hospital Pricing Data Completeness and Accuracy (October 2024); available at https://files.gao.gov/reports/GAO-25-106995/index.html

[2] HealthData.gov, Hospital Price Transparency Enforcement Activities and Outcomes. (https://healthdata.gov/dataset/Hospital-Price-Transparency-Enforcement-Activities/xznk-szy5/about_data)

Additionally, we recommend CMS continue to work with stakeholders on the implementation of No Surprises Act (NSA) provisions that provide actionable and personalized healthcare pricing information that is prospective. CMS should also focus on service packages that are meaningful to consumers, rather than "standard charges" in the MRF which are used for billing purposes and not consumer friendly.

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

The AAMC supports the goal to increase health care price transparency and strongly believes patients should have the information that they need to make informed decisions about their health care. We support patient access to consumer-friendly and personalized out-of-pocket cost estimates for shoppable services. Hospitals and health systems have invested considerable time and resources to comply with the Hospital Price Transparency Rule and the No Surprises Act. Many hospitals and health systems have embraced new technologies that enable patients to obtain tailored out-of-pocket cost estimates through online tools that can be very effective.

However, we have concerns with the administration's current approach to price transparency, which is overly burdensome and costly for health systems and hospitals, does not enable patients to understand what they will actually pay for a healthcare service, and has resulted in widespread confusion for patients. Hospitals and health systems and insurers are subject to several different price transparency policies, including:

- **Hospital Price Transparency Rule.** This rule requires hospitals to publicly post via machine-readable files five different "standard charges": gross charges; payer-specific negotiated rates; de-identified minimum and maximum negotiated rates; and discounted cash prices. It also requires hospitals to provide patients with a consumer-friendly display for at least 300 shoppable services, which can be satisfied by offering an online price estimator tool that provides personalized out-of-pocket pricing information.
- **No Surprises Act - Good Faith Estimates.** The No Surprises Act requires hospitals and other providers to share Good Faith Estimates with uninsured/self-pay patients for most scheduled services. "Convening providers" are required to seek and combine information on their price estimates from other unaffiliated providers involved in the patient's care to provide uninsured/self-pay patients with a single, comprehensive Good Faith Estimate of the cost for an episode of care.
- **Advanced Explanation of Benefits.** The No Surprises Act requires insurers to share advanced explanations of benefits with their enrollees. This policy has not been implemented yet due to operational challenges. In the future, hospitals will need to provide Good Faith Estimates to health insurers under this policy.
- **Transparency in Coverage Rules.** These rules, which apply to health insurers and group health plans, require health plans to post three separate machine readable files (MRFs) each month that contain: 1) in-network negotiated rates for all covered items and services, 2) out-of-network allowed amounts and billed charges for all covered items and services, and 3) negotiated rates and historical net prices for covered prescription drugs.

Given the potential patient confusion and regulatory burden resulting from these multiple different price transparency rules, the AAMC urges the administration to review and streamline the existing price transparency policies.

The large amount of data that hospitals are required to provide results in machine-readable files that are so large that it is extremely difficult for patients to navigate to find "payer-specific negotiated charges" corresponding to their health plan issuer and health plan type. To provide context, many AAMC member-hospitals have contracts with over 100 different plans, often with multiple negotiated rates depending on the type of health plan (e.g Medicare Advantage, HMOs, individual preferred provider organizations (PPO), self-insured plans), and therefore are required to include thousands of negotiated rates in the MRF. If patients are able to locate this information, they would still be many steps away from deriving a personalized estimate of their out-of-pocket costs due to their health plan's benefit design. In fact, CMS itself has acknowledged that MRFs are not intended for direct patient care use as they are not consumer friendly. Specifically, in the CY2024 OPPS final rule, CMS stated: "The MRF format is designed to be used by machines for further processing of the data and is not tailored for direct use by individual patients. In short, MRF formats are not consumer friendly."[3]

Ultimately, for patients the information that is most important and useful to them is knowing their financial obligation or out of pocket costs for the services they receive, which will be based on their insurance coverage. These out-of-pocket costs depend on their plan-specific cost-sharing requirements such as their deductible and co-pay amounts. Where patients are in reaching their deductible and total out-of-pocket spending amounts will impact their payment amount. Additionally, the patients' insurer may cover only a portion of the services and/or bundle some of the services in ways that do not "add up" to the negotiated rates from the provider. All of these specifics make up a health plan product's benefit design, and only the insurer is in a position to make this type of information available to the patient. Therefore, we believe that the information that the insurer is required to provide to the patient under the Transparency in Coverage rules may be much more relevant than any pricing information that providers would be able to deliver to the patient. For patients that are insured, actionable pricing information can be obtained via price comparison tools that insurers are required to make available under the Transparency in Coverage rules.

For patients that are uninsured/self-pay, the No Surprises Act requires hospitals and other providers to furnish the patient with a good faith estimate of their costs for the episode of care. Therefore, much of what is required under the hospital price transparency rule is unnecessarily redundant and burdensome.

[3] CY 2024 Hospital OPPS final rule, 88 Fed. Reg 81540 (Nov. 22, 2023) available at https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf