



Charles N. Kahn III
President and CEO

July 21, 2025

Via electronic submission at <https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/accuracy-and-completeness-rfi>

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244–8016

Re: CMS Hospital Price Transparency and Completeness Request for Information

Dear Dr. Oz:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. The FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the above-referenced "CMS Hospital Price Transparency and Completeness Request for Information," available at <https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/accuracy-and-completeness-rfi>.

The FAH continues to support price transparency initiatives that provide patients with access to clear, accurate, and actionable information. Since President Trump issued his June 24, 2019, Executive Order on "Improving Price and Quality Transparency in American Health Care," hospitals' obligations to make public a list of standard charges have undergone a complete transformation. Hospitals went from making gross charge data public to engineering and posting vast data on payer-specific rates, gross charges, and discounted cash pricing and then standardizing and further expanding included data elements. The frequency and extent of changes in the rules for making public standard charges since 2019, however, have imposed significant costs and burdens on hospitals—particularly those hospitals that prioritized compliance from the outset and then had to revamp their processes as changes were adopted. The most recent changes to the Hospital Price Transparency rule (*e.g.*, inclusion of the estimated allowed amount) only took effect on January 1st of this year, and hospitals have not yet undergone a full update cycle under the new requirements.

Against this backdrop, the FAH does not recommend further regulatory changes at this time and believes both hospitals and users of hospital price transparency data would benefit from a period of relative regulatory stability during which the already widespread hospital compliance achieved by CMS may be deepened. ***Therefore, the FAH recommends that CMS maintain the hospital price transparency rules in their current form.*** In addition, we note that the Transparency in Coverage regulations for payers (health plans), 45 C.F.R. §§ 147.210–147.212, hold the potential to provide the most comprehensive and actionable data for patients, employers, and other users of health care price transparency data because it requires pricing information for all provider types. This rule, however, has not been amended since originally promulgated and CMS has not made public any data about enforcement activity and industry compliance. This presents a ripe opportunity to promote meaningful price transparency by requiring that the data posted by payers be true, complete, and accurate; expanding and refining the data elements; and robustly enforcing the Transparency in Coverage regulations.

Meaning of Complete and Accurate (Question 1). At this time, the FAH does not believe that definitions are required for the terms “accurate” and “complete” within the context of the hospital price transparency regulations. Since July 1, 2024, hospitals have been required to affirm in the machine-readable file “that the information encoded is true, accurate, and complete as of the date indicated in the machine-readable file.” 45 C.F.R. § 180.50(a)(3)(ii). The terms “accurate” and “complete” in this requirement have a readily understandable, plain meaning and echo language used elsewhere in Federal regulations for Medicare hospitals.

The FAH, however, is concerned that recent CMS guidance requires hospitals to encode inaccurate data. On May 22, 2025, CMS reversed its prior guidance instructing hospitals to encode nine 9s for the estimated allowed amount where the payer uses a percentage or algorithm to determine payment for an item or service and the hospital lacks the historical data necessary to derive an estimated allowed amount for that item or service. Under the new guidance, hospitals are instructed to encode the average dollar amount reported in electronic remittance advice transaction data from the payer for items or services rendered within the 12 months prior to posting, even if the data is minimal or presents accuracy concerns. If no such data exists, hospitals are instructed to encode its expectation of the dollar amount for that item or service. The FAH believes that where hospital data is insufficient to reliably calculate an estimated allowed amount, users of the machine-readable file should rely on the accurate data regarding the percentage or algorithm that is the basis of payment and that the encoding of an estimated allowed amount based on a low volume of claims or hospital expectations diminishes the accuracy of the machine-readable file.

Effectiveness of the Machine-Readable File and Additional Data Elements (Question 3). CMS has effectuated rapid and systemic change with respect to hospital price transparency since it first revised hospitals’ compliance obligations under section 2718(e) of the Public Health Services Act in the FY 2019 IPPS Proposed Rule (83 Fed. Reg. 20,164, 20,548-49 (May 17, 2018)) and then promulgated the initial Hospital Price Transparency Rule (84 Fed. Reg. 65,524 (Nov. 27, 2019)). These include amendments adopted in the CY 2022 OPSS Final Rule (86 Fed. Reg. 63,458 (Nov. 16, 2021)) and the CY 2024 OPSS Final Rule (88 Fed. Reg. 81,540 (Nov. 22, 2023)), and CMS implemented the most recent tranche of changes effective January 1, 2025. At the same time, CMS has undertaken significant education, monitoring, and enforcement

activities, effectively promoting widespread, good faith compliance among hospitals. These activities have produced machine-readable files that are effective for their intended purposes—the standardized compilation of at times enormously complicated pricing data. At the same time, hospitals have continued to devote significant resources to other activities that are focused on providing consumers with individualized and actionable pricing information, including internet-based price transparency tools, good faith estimates for uninsured and self-pay patients, and one-on-one financial counseling with patients.

The FAH does not support the addition of further data elements or modification of existing data elements at this time in light of the extraordinary costs and burdens imposed to date and the significant costs of implementing further changes. CMS estimated that hospitals would expend approximately \$250 million in the aggregate on price transparency compliance work between 2020 and 2025. These prospectively estimated expenses include per-hospital costs of nearly \$12,000 for initial work in 2020, over \$3,600 annually from 2021 to 2023, an additional \$10,600 for significant revisions in 2024, and over \$4,500 in recurring annual expenses after 2024. FAH members report, however, that actual expenses have exceeded these prospective CMS estimates. Hospitals' price transparency compliance expenses include retaining full-time employees, vendors, and consultants as well as direct technology development costs, the full extent of which are not captured by CMS' estimates. Moreover, the hospitals that have incurred the greatest expenses are those that prioritized and invested in compliance from the start, building their own format for the machine-readable file before any template was available. These hospitals then incurred the additional expense of re-engineering (rather than merely updating) the machine-readable file when CMS acted to standardize machine-readable files.

Now that CMS has achieved standardization of machine-readable files and refined hospital price transparency requirements, a period of regulatory stability for hospital price transparency would reduce confusion, maximize the value of already-invested resources, and avoid unnecessary costs and burdens. Such stability would be of significant value now, as hospitals confront growing cyber security challenges, navigate an inflationary economic environment, incur the additional costs of caring for a growing uninsured population, and address unprecedented health care cuts in Medicaid and other programs.

Compliance, Enforcement, and the CMS Validator Tool (Question 5). FAH members appreciate CMS' development of the hospital price transparency validator tool and report that they are able to use it as part of larger internal quality control processes that assess and improve the accuracy and completeness of their machine-readable files. We do not have any changes to recommend to the validator tool at this time but will share opportunities for improvement when they do arise.

In terms of overall enforcement activities, the FAH appreciates this Administration's results-oriented approach and active engagement with hospitals. FAH members report that CMS is expeditiously closing enforcement actions when an appropriate corrective action plan has been initiated and completed. Some of these enforcement matters involve simple issues like unexpected website glitches, and CMS' approach to these cases has ensured that access to a compliant machine-readable file is restored quickly through a cooperative enforcement process. The FAH also believes that CMS' current enforcement approach maximizes compliance by including critical opportunities for education. In particular, initial warning letters have opened

up cooperative dialogue between hospitals and CMS that allowed both to develop a more sophisticated understanding of hospital pricing and price transparency. This process of using initial warning letters also provides the most expeditious path to promptly resolving minor and inadvertent issues with machine-readable files. The FAH therefore requests that CMS maintain its current orientation toward education and impactful results in its monitoring and enforcement activities.

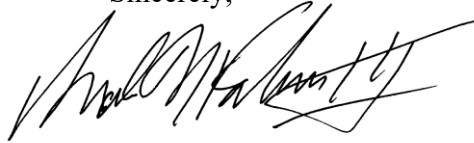
Overall Improvements in Price Transparency (Question 6). Taking a broader view with respect to price transparency in health care, the FAH urges CMS to prioritize the accuracy and completeness of payers' machine-readable files. Payers operate with the benefit of more comprehensive information relevant to patient costs, including information about their members, their plans, network provider pricing (including for non-hospital settings), and out-of-network pricing. Therefore, activities that promote the accuracy, completeness, and usability of pricing data from payers would provide the greatest value to patients, employers, providers, and others. This work would involve modernizing some aspects of the Transparency in Coverage Rule as well as publicly prioritizing monitoring and compliance with respect to payers' machine-readable files.

With respect to refining payers' transparency obligations, the FAH appreciates that the Departments of Labor, Health and Human Services, and Treasury are developing a schema version 2.0 that addresses some issues with the current payer files¹ and have issued a request for information focused on improvements to the prescription drug machine-readable file (90 Fed. Reg. 23,303 (June 2, 2025)). The FAH, however, believes that there are further opportunities for high-value improvements to the Transparency in Coverage requirements. For example, the FAH strongly supports refining the Transparency in Coverage rules to account for the intervening passage of the No Surprises Act (Pub. L. 116-260, Div. BB) by requiring public disclosure of the qualifying payment amount (QPA) for each item and service in each geographic region where the plan or issuer is not subject to a specified state law for that item or service. Because the QPA for an established item or service is generally calculated based on the median contracted rate on January 31, 2019, and only changes based on the CPI-U, plans and issuers should already have internal QPA data that can be used consistently and uniformly in the adjudication of claims under the No Surprises Act. Therefore, the expansion of plans' and issuers' machine-readable files to include QPA information would impose only a marginal additional burden on plans and issuers, while providing patients, providers, and facilities with critical information that will aid in assessing the plan's or issuer's initial payment on a claim subject to the No Surprises Act.

¹ FAQs About Affordable Care Act Implementation, Part 70 (May 22, 2025), at <https://www.cms.gov/files/document/aca-faqs-part-70.pdf>.

The FAH appreciates this opportunity to submit these comments. If you have any questions or if we can assist CMS as it considers these recommendations, please contact me or any member of my staff at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to be "A. M. ...", written in a cursive style.