July 21, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

Dear Administrator Oz:

Thank you for the opportunity to provide comments on CMS's request for information focused on hospital price transparency. We appreciate the Center for Medicare and Medicaid Services (CMS) continued leadership and efforts to identify challenges and explore ways to improve the accuracy, completeness, and enforcement of hospital pricing data to ensure it's transparent and meaningful for patients, payers, policymakers, and researchers.

My name is Christopher Whaley, and I am an Associate Professor of Health Services, Policy, and Practice at the Brown University School of Public Health and Associate Director of the Center for Advancing Health Policy through Research (CAHPR). CAHPR focuses on informing policies aimed at reducing costs, improving patient well-being, and driving meaningful transformations in U.S. health care delivery. My research examines health care price transparency, the impacts of evolving health care markets, and studying employer and purchaser innovations that are enabled by price transparency information.

Our center's work focuses on the design of insurance plans and their interactions within the health care market, employing a unique approach that integrates quantitative policy analysis with legal evaluation. This combined methodology helps identify the most effective legal and regulatory changes to create a significant impact.

This public comment is informed by relevant research conducted by myself and other colleagues at CAHPR, and research from CAHPR and outside organizations[1].

[1] *The opinions and conclusions expressed in this public comment are the author's alone and do not reflect those of Brown University, the Brown University School of Public Health or any of the research sponsors.*

The Recent Impact of Health Care Price Transparency

Over the past several years, hospital price transparency policies have significantly improved access to pricing data, especially through machine-readable files (MRFs). Innovators have used these data to create public-facing tools. These policies have brought long-hidden hospital negotiated prices into the light, offering new opportunities for employers, researchers, policymakers, and other stakeholders to assess variation and inefficiencies in U.S. healthcare markets.

Although price transparency has yielded limited benefits for individual patients navigating complex billing systems, its value as a tool for promoting market accountability and system-wide reform cannot be overstated. Prior use of transparency data to inform purchasing policies includes purchasers like CalPERS[2,3,4] and SEIU 32BJ[5], which used their own claims data to identify excessive provider prices and redirect care to more cost-effective options, saving millions of dollars in the process. Researchers have similarly used the data to uncover substantial within-market pricing disparities and misaligned incentives driven by consolidation and market power.

Yet, these efforts require access to and sophisticated use of complex medical claims data. Publicly available price data can expand access to these initiatives for a broader set of employers, purchasers, and patients. In addition, entrepreneurs and innovators can use these data to redesign insurance networks and place downward pressure on health care prices[6]. These entrepreneurs currently frequently face barriers to accessing price information and creating competitive pressures to the US health care system.

However, these benefits depend on the availability of accurate, complete, and standardized data. In its current form, MRF data are often inconsistent, incomplete, or too cumbersome to use effectively. Strengthening these data through improved enforcement and technical refinements would empower purchasers, researchers, and regulators to take full advantage of transparency and drive meaningful system improvements.

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[2] Robinson JC, Brown TT. Increases in consumer cost sharing redirect patient volumes and reduce hospital prices for orthopedic surgery. *Health Aff (Millwood)*. 2013;32(8):1392-1397. doi:10.1377/hlthaff.2013.0188

[3] Robinson JC, Brown TT, Whaley C, Finlayson E. Association of Reference Payment for Colonoscopy With Consumer Choices, Insurer Spending, and Procedural Complications. *JAMA Intern Med*. 2015;175(11):1783-1789. doi:10.1001/jamainternmed.2015.4588

[4] Robinson JC, Brown TT, Whaley C. Reference Pricing Changes The 'Choice Architecture' Of Health Care For Consumers. *Health Aff (Millwood)*. 2017;36(3):524-530. doi:10.1377/hlthaff.2016.1256

[5] SEIU 32BJ Healthcare Savings Case Study. PatientRightsAdvocate.org. Accessed July 8, 2024. https://www.patientrightsadvocate.org/seiu-32bj-healthcare-savings-case-study

[6] Whaley CM. *Health Care Price Transparency: Opportunities to Lower Costs and Improve Competition*. Testimony of Christopher M. Whaley presented before the United States Senate Special Committee on Aging; 2024. https://cahpr.sph.brown.edu/sites/default/files/documents/7.11.24_Whaley%20(Senate%20Aging).docx%20.pdf

Improving Hospital Price Transparency to Continue to Empower Purchasers, Patients, Researchers, and Policymakers

1. Should CMS define "accuracy of data" and "completeness of data" in the context of HPT requirements?

Clear definitions would improve consistency and compliance[7]. "Accuracy" should refer to the extent to which a hospital's MRF reflects the actual negotiated rates and standard charges for all billed services, as defined in contracts with payers. "Completeness" should mean that MRFs include all required data elements for every service the hospital provides, across all payer types, with no intentional omissions or use of placeholder values (e.g., $0.00 or "N/A") where a negotiated rate exists.

2. What are your concerns about the accuracy and completeness of HPT MRF data?

Several concerns remain:

- **Non-standardized entries:** Hospitals report data in varying formats, making it difficult to compare prices across systems or markets.
- **Missing or placeholder data:** In many cases, hospitals list zero-dollar prices or omit negotiated rates altogether.
- **Volume and noise:** MRFs often contain extraneous or duplicative entries, which can obscure key pricing information.
- **Compliance gaps:** Despite CMS requirements, fewer than 40% of hospitals are fully compliant, and many still do not submit complete data.

These issues limit the utility of the data for those who rely on it to identify high-cost providers or assess market consolidation impacts.

3. Do these concerns affect your ability to use hospital pricing data effectively?
Researchers and employers often spend extensive time cleaning and processing MRF data before it can be analyzed. For example, one major challenge is that files often include prices for services that hospitals do not perform or duplicate prices for the same service under different identifiers[8]. Simplifying and standardizing the MRF format, paired with enforcement mechanisms to ensure complete data, is essential.

In addition, persistent noncompliance with the hospital price transparency rule can limit the generalizability and usefulness of the data. If certain types of hospitals, such as large health systems or urban academic medical centers, are consistently underreporting or failing to comply, it creates systematic gaps in the dataset. This makes it difficult for researchers, policymakers, and employers to draw meaningful conclusions across hospital types, regions, or markets.

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[7] Patient Rights Advocate. *The Seventh Semi-Annual Hospital Price Transparency Compliance Report*. Patient Rights Advocate; 2024. https://www.patientrightsadvocate.org/seventh-semi-annual-hospital-price-transparency-report-november-2024

[8] Whaley CM. *Health Care Price Transparency: Opportunities to Lower Costs and Improve Competition*. Testimony of Christopher M. Whaley presented before the United States Senate Special Committee on Aging; 2024. https://cahpr.sph.brown.edu/sites/default/files/documents/7.11.24_Whaley%20(Senate%20Aging).docx%20.pdf

4. Are there external sources that could be used to evaluate MRF accuracy and completeness?

Yes. These include:

- **Transparency in Coverage (TiC) data** from insurers, which can be cross-referenced with MRFs to identify discrepancies.
- **All-payer claims databases (APCDs)** that exist in over 20 states.[9] States like New Hampshire and Colorado, have used their APCD data to document health care price variation and create patient-friendly price shopping tools.
- **Employer claims data**, particularly from large self-funded plans, can be compared against posted prices to detect gaps or inconsistencies.

5. Suggestions to improve compliance and enforcement?

- **Automated enforcement:** CMS should expand use of automated validation tools to flag noncompliant hospitals and issue penalties more consistently. As seen in 2023, automation led to more enforcement than the two prior years combined[10].
- **Pre-submission validation tools:** Improve the CMS validator so hospitals can ensure files meet format and data requirements before submission.
- **Publish compliance dashboards:** Publicly identify hospitals with incomplete or inaccurate MRFs to apply reputational pressure and incentivize compliance.
- **Align TiC and HPT standards:** Standardize formatting and definitions across HPT and TiC data to allow easier cross-verification.

6. Other suggestions to improve MRF quality?

- **Centralize data submission and access:** CMS could act as a national hub for all MRFs to improve accessibility and reduce user burden.
- **Only include relevant services:** Require hospitals to report pricing only for services they actually perform, based on historical claims or billing records.
- **Improve metadata and searchability:** Standardizing service descriptions, codes, and payer names would make MRFs significantly easier to navigate and use.

Conclusion

The Hospital Price Transparency Rule has laid a critical foundation for increased accountability and smarter health care spending. But to fulfill its promise, CMS should consider these potential next steps: define what it means for data to be accurate and complete, hold hospitals accountable to that standard, and provide the tools and enforcement needed to make that a reality.

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[9] All-Payer Claims Database (APCD) Council. Interactive State Report Map. APCD Council. https://www.apcdcouncil.org/state/map

[10] Whaley CM, Mook C. *Health Care Price Transparency: Opportunities for Improving Efficiency and Lowering Costs*. The Center for Advancing Health Policy through Research (CAHPR); 2025. https://drive.google.com/file/d/1cJlWsPC_765SHiFfRVvJwdx1vV0_PeaN/view

We appreciate the opportunity to provide feedback on this critical issue and appreciate CMS' steps to consider policies that promote transparency and accountability. We welcome the opportunity to engage further or provide additional information as needed. Should you have any questions about our comments, please contact me at chris_whaley@brown.edu or Jared Perkins, Director of Health Policy Strategy, at jared_perkins@brown.edu.

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