July 21, 2025

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Subject: Centers for Medicare & Medicaid Services (CMS) Hospital Price Transparency Accuracy and Completeness Request for Information (RFI)

To Whom It May Concern:

Covered California appreciates the opportunity to submit the following comments in response to the CMS Hospital Price Transparency Accuracy and Completeness RFI which seeks to identify challenges and improve compliance and enforcement processes related to hospital price transparency.

As the largest State-Based Marketplace under the Affordable Care Act, Covered California is dedicated to advancing affordability, transparency, and equity in healthcare for all Californians and beyond. Transparent, complete, and accurate pricing data are essential to empowering consumers, enhancing market competition, and driving affordability in health care, and we commend CMS for its continued commitment to advancing hospital price transparency. Covered California looks forward to contributing to the dialogue on how CMS can refine hospital price transparency, compliance and enforcement processes, ensuring that the pricing information contained in machine-readable files is both complete and meaningful for consumers and stakeholders alike.

Covered California submits the following comments for the CMS Hospital Price Transparency Accuracy and Completeness RFI via the CMS online portal, with the intent of contributing to ongoing efforts that improve hospital price transparency and compliance processes. We appreciate the opportunity to share our perspective as part of this important initiative.

In response to the specific questions posed by CMS, Covered California offers the following comments:

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

We strongly recommend the Centers for Medicare & Medicaid Services (CMS) specifically define the terms “accuracy of data” and “completeness of data.” An audit by the Office of Inspector General and previous assessments shared by consumer advocates report widespread data issues including posted files that failed the CMS Validator Tool, were missing payer and plan names, and did not follow CMS’ required filename format, among other problems.

Covered California’s data validation efforts focus on ensuring the accuracy and reliability of data. First, we validate whether critical data fields contain valid codes and meet an expected threshold of performance (e.g., 80% of specific field with a valid code). Covered California suggests requiring validation as a standard for determining the completeness of data in the hospital price transparency (HPT) machine-readable file (MRF). For example, this could involve requiring over 90% of the plan name fields by hospital are populated with a unique plan identifier (e.g., health insurance oversight system (HIOS) or employer identification number (EIN) identifier) rather than a non-standardized text entry.

At Covered California, data quality assessments begin after ensuring that data fields contain valid codes and meet the required threshold of completeness. We then verify that the populated information is reasonable and consistent with known benchmarks. An example application for the HPT MRF could be applied when comparing minimum and maximum negotiated charge ranges to publicly available data from all-plan state databases, and any values exceeding two standard deviations from the known range would be flagged.

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.

One of the most frequently identified barriers to broad use of MRF data is how payer and plans are represented in the files. While the rule requires that hospitals must disclose the “payer name” and “plan name,” the health plan name is very rarely listed. Instead, the most common entity that the hospitals contract is included and the plan is left blank. Even when a plan is listed, the nomenclature is not standardized and difficult to compare within or across a hospital. One hospital may list “Blue Cross”, and another may list “Blue Cross Blue Shield”. The user is then left trying to decipher if the lists are referring to the same or a different plan when comparing the prices for a procedure between hospitals.

A potential solution as referenced above is to require the inclusion of a unique plan identifier. While there is no national standard for health plan identifiers, HIOS when available or EIN identifier for group plans could be leveraged. Plans could be asked to populate a crosswalk for each state that hospitals could then leverage when completing

their transparency files. This focus on use of HIOS and EIN matches the requirements on the Payer Transparency in Coverage (TiC) 2.0 Schema.

Additional elements that would improve the ability to use the data robustly are included below:

- Require actual negotiated prices (do not allow only estimated or average prices)
- Require inclusion of a cash-pay price
- Require specification if single line item price is part of an all-inclusive or bundled case rate, part of a negotiated per-visit rate, a percent of charge master, or specific on fee schedule etc.

Of note, hospitals commonly rely on an estimated price based on average historic claims from the electronic health record. This does not help a consumer understand their potential costs nor support price shopping given the variability inherently hidden by an average.

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.

There are currently 23 all-payer claims databases (APCD), with several that report publicly on average costs for procedures and services. New Hampshire's HealthCost site allows users to enter a procedure as well as an insurance plan to compare costs. CompareMaine similarly allows for searches of hundreds of procedures and reports the cost by facility and payer. Colorado's Center for Improving Value in Health Care Shop for Care posts the statewide median cost by procedure and shows the spread between the lowest facility median cost versus highest.

These resources can be utilized to audit and check the accuracy of reported prices by the Department. Alternatively, the operators of the relevant APCD at the state-level could be asked by CMS to do an annual sample and verification. This alignment of oversight between state and federal departments will likely increase accountability and performance of submitters.

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 CMS validator tool provides submitters with a critical resource for identifying failures in their files. It is also valuable that the FAQ specify that the validator tool could be used for purposes of enforcement. To optimize the use of existing tools and infrastructure, CMS can require hospitals to submit their files annually and post them on their own websites. CMS can mandate passing the validator tool before filing, as a part

of the submission process. This approach to enforcement would likely improve the accuracy and completeness of submissions without requiring additional resources from CMS.

Subsequently, CMS would have a ready repository of all files from hospitals which could be leveraged should more advanced tools such as the application of large language models to assess compliance become available. Alternatively, if CMS does not want to maintain such a repository, then, minimally, hospitals could be required to submit the pass rates of their final posted files from the validator to CMS.

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

Covered California recommends enforcing accuracy, completeness, and the comprehensiveness of files. Historically, some hospitals have relied on services and items listed on a charge description master or fee schedule and reported only those on their MRF data. This has led to substantial variability as some hospitals may have thousands of services on a charge master while others may have only a handful. In either case, the hospital is still offering a broad set of services and charging patients for these services, even if they are not listed on the charge master, leading to notable gaps in the files due to omissions. We recommend that CMS require hospitals to submit all services provided on their MRF, not just those for which there is a corresponding charge master. The most substantial missing data from hospitals has been the price of administered drugs. CMS should include language that states hospitals may be sanctioned if not including pricing for at least 90% of the services provided from the prior year and specifically calling out the requirement to include drugs.

Sincerely,

S. Monica Soni,
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