Hospital Price Transparency Frequently Asked Questions (FAQs)

This document is designed as a resource for Hospital Price Transparency frequently asked questions (FAQs).

All FAQs presented in this document are current as of March 24, 2026.

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New 2026 Updates

New- What new Hospital Price Transparency requirements did CMS finalize in the CY 2026 OPPS/ASC final rule?

CMS finalized the following requirements in the CY 2026 OPPS/ASC final rule:

- ***Replacing the Estimated Allowed Amount with the Allowed Amounts Data Elements and the Count of Allowed Amounts Data Element***

  CMS finalized the requirement to replace the estimated allowed amount with the median allowed amount and to add the 10th and 90th percentile allowed amounts.[1] When a payer-specific negotiated charge is based on a percentage or algorithm, hospitals will now be required to encode the median allowed amount and the 10th and 90th percentile allowed amount in dollars. Hospitals are also required to calculate and encode the count of allowed amounts that were used to calculate the 10th, median, and 90th percentile allowed amount data elements. Hospitals must use electronic data interchange (EDI) 835 electronic remittance advice (ERA) or an equivalent source of remittance data to calculate and encode the 10th, median, and 90th percentile allowed amounts as well as the count of allowed amounts. Should the calculated amount for the 10th, median, and 90th percentile allowed amounts fall between two observed allowed amounts, hospitals are instructed to use the next highest observed value. Finally, CMS finalized the requirement that hospitals use a lookback period of no less than 12 months and no longer than 15 months prior to posting the machine-readable file (MRF) for the 10th, median, and 90th percentile allowed amounts, and count of allowed amounts.

- ***Modification to the MRF Affirmation Statement***

  CMS finalized requiring hospitals to attest in the MRF that, to the best of its knowledge and belief, the hospital has included all applicable standard charge information in accordance with the requirements of this section and that the information encoded is true, accurate, and complete as of the date in the file. The attestation also states that the hospital has included all applicable payer-specific negotiated charges as dollars that can be expressed as a dollar amount, and for payer-specific negotiated charges that are not knowable in advance or cannot be expressed as a dollar amount, the hospital has provided in the MRF all necessary information available to the hospital for the public to be able to derive a dollar amount, including, but not limited to, the specific fee schedule or components referenced in such percentage, algorithm, or formula. Furthermore, hospitals will be required to encode in the MRF the name of the hospital chief executive officer, president, or senior official designated to oversee the encoding of true, accurate, and complete data.

[1] Importantly, see definitions of those terms at 45 CFR § 180.20, which may require that the values be calculated in a fashion that may differ from typical arithmetic convention.

- ***Including Hospital National Provider Identifier(s) in the MRFs***

  CMS finalized the requirement that hospitals encode their organizational, or Type 2, NPIs in the MRFs. Hospitals will be required to report, in a newly created general data element in the MRF, any Type 2 NPI(s) that is associated with primary taxonomy code starting with '28' (indicating hospital) or '27' (indicating hospital unit) and that is active as of the date of the most recent update to the standard charge information.

- ***Civil Money Penalties: Waiver of Hearing, Automatic Reduction of Penalty Amount***

  To encourage faster resolution and payment of CMPs, and in acceptance of CMS's determination that the hospital violated HPT requirements, CMS updated § 180.90 to, in certain situations, reduce the amount of a CMP by 35 percent when a hospital waives its right to an ALJ hearing. CMS will not make available to hospitals the opportunity to have a CMP amount reduced where CMS imposes upon a hospital a CMP for HPT noncompliance going to the core of the HPT requirements specified as: failing to make public either (1) an MRF as required in § 180.40(a), or (2) any shoppable services in a consumer-friendly format (either in the form of a shoppable services file or an internet price estimator tool) as required in § 180.40(b). Additionally, a hospital must affirmatively waive its right to a hearing within 30 calendar days of the date of notice of imposition of the CMP in accordance with the procedures specified at § 180.90(c)(4), to avail itself of a CMP reduction for waiving its right to a hearing. Lastly, a hospital would not be eligible for an additional 35 percent reduction in the CMP amount if they receive a subsequent CMP for the same instance(s) of noncompliance.

Updated- Did CMS make any changes to the shoppable services display requirements in the CY 2024 OPPS/ASC or CY 2026 OPPS/ASC Final Rules?

No. CMS did not make any changes to the shoppable services display requirements at 45 CFR §180.60 in the CY 2024 OPPS/ASC or CY 2026 OPPS/ASC Final Rules.

New - When are the requirements CMS finalized in the CY 2026 OPPS/ASC final rule effective?

The effective date of the revisions at § 180.50, including the removal of the estimated allowed amount, disclosure of the 10th, median, and 90th percentile allowed amounts[2] and the count of allowed amounts, the attestation requirements, and the NPIs is January 1, 2026.

[2] Importantly, see definitions of those terms at 45 CFR § 180.20, which may require that the values be calculated in a fashion that may differ from typical arithmetic convention.

CMS will delay enforcement of these finalized revisions until April 1, 2026. This 3-month enforcement delay will apply solely to enforcement actions based on the new CMS requirements at revised § 180.50. We believe this 3-month enforcement delay will provide hospitals with sufficient time to update their systems, and review, validate, and post their machine-readable files.

New- Does my hospital still need to encode the estimated allowed amount in my machine-readable file (MRF)? When are the 10th, median, and 90th percentile allowed amounts and count of allowed amounts required to be encoded in the MRF?

In the CY 2024 OPPS/ASC final rule with comment period, CMS finalized a requirement for hospitals to display an estimated allowed amount which would provide needed context, in dollars, for instances where the hospital's payer-specific negotiated charge is based on a percentage or algorithm. In the CY 2026 OPPS/ASC final rule with comment period, CMS finalized, effective January 1, 2026, requiring hospitals to encode four new data elements when a payer-specific negotiated charge is based on a percentage or algorithm – the median allowed amount (which replaces the estimated allowed amount data element), the 10th and 90th percentile allowed amounts[3], and the count of allowed amounts used to calculate the median, 10th, and 90th percentile allowed amounts. As of January 1, 2026, hospitals should not calculate or encode the 'estimated allowed amount' data element.

New- If our hospital only has claims for a portion of the 12 to 15 month lookback period (if our hospital only has claims for one of the 12 months prior to posting the MRF, for example), should those claims be included in the count of allowed amounts and for the purpose of calculating the 10th, median, and 90th percentile allowed amounts?

If the hospital's payer-specific negotiated charge for an item or service was based on an algorithm or percentage that cannot be completely and fully calculated as a dollar amount, and the hospital has any claims during the 12-15 months prior to the posting of the MRF (called the 'lookback period'), the hospital must use all available remittances for that item or service during the most recent 12 months of data that is available to them prior to posting the MRF to calculate and encode the median allowed amount, 10th and 90th percentile allowed amounts, and the count of allowed amounts. In the case where hospitals need additional time to pull or prepare the data to best reflect your payer-specific negotiated charges, hospitals may use data from up to 15 months prior to the date the MRF is posted to help ensure they have an adequate number of data points to encode the allowed amounts.

[3] Importantly, see definitions of those terms at 45 CFR § 180.20, which may require that the values be calculated in a fashion that may differ from typical arithmetic convention.

New- If our hospital has no claims for an item or service during the 12 to 15 month lookback period, should the hospital encode the median, 10th percentile, and 90th percentile allowed amounts and the count of allowed amounts?

If your hospital has no claims for an item or service during the lookback period of 12-15 months prior to posting the MRF and the payer-specific negotiated charge is based on an algorithm or percentage that cannot be fully and completely be calculated as a dollar value, the hospital must:

1. encode '0' as the value for the count of allowed amounts for the item or service for that payer and plan;
2. leave the median, 10th percentile, and 90th percentile allowed amounts in the MRF blank as there is no data to encode; and
3. encode information to explain the hospital's insufficient claim remittance history in the "Additional Payer-Specific Notes" or "Additional Generic Notes" for the associated payer-specific negotiated charge.

In addition, if your hospital has zero-dollar remittances for an item or service during the 12-15 month lookback period, the hospital should exclude those from the count of allowed amounts. Please refer to discussion at 90 FR 53999.

New- If my hospital encodes a payer-specific negotiated charge as a dollar amount, do we still need to calculate and encode the 10th, median, and 90th percentile allowed amounts, and count of allowed amounts?

As indicated in the CY 2026 OPPS/ASC final rule, if a hospital has encoded a payer-specific negotiated charge in the MRF as a dollar amount, and that dollar amount represents the full payer-specific negotiated charge that is not further modified by a percentage or algorithm, the hospital would not be required to encode the allowed amounts or count of allowed amounts. For example, if the hospital's payer specific negotiated charge is 70 percent of the Medicare payment rate, then the hospital would calculate and encode the payer-specific negotiated charge as a dollar amount and would not need to further describe the percentage or algorithm and encode the allowed amounts or count of allowed amounts. If a payer-specific negotiated charge is modified by a percentage or algorithm, then the hospital must calculate and encode the payer-specific negotiated charge dollar amount and must also describe the algorithm or percentage that further modifies it and encode the allowed amounts and count of allowed amounts. For example if the service has a base rate of $3,495, and is further modified by an algorithm, then the hospital would encode the base rate of $3,495 as the payer-specific negotiated charge dollar amount, then describe the algorithm that further modifies that base rate in the payer-specific negotiated charge algorithm data element, and encode the allowed amounts and count of allowed amounts. Please see 90 FR 53992 for more information.

New- How should my hospital determine the "total allowed amount" for calculating and encoding the 10th, median, and 90th percentile allowed amount?

The "total allowed amount" should reflect the total amount the hospital was reimbursed for the item or service (or service package). The total allowed amount dollar figure used to encode the 10th, median, and 90th percentile allowed amounts[4] should be derived from the gross charge minus contractual adjustments and consist of the portion billed to a payer for a particular plan and the portion, if any, billed to the patient.

New- If our hospital is required to calculate and encode the allowed amount data elements for an item or service, should the hospital calculate these data elements across all payers?

The allowed amount data elements should be calculated based on the allowed amounts (from remittances) for each item or service for each payer. In addition, if your hospital has established different payer-specific negotiated charges for an item or service for inpatient and outpatient settings, those should also be calculated and encoded separately.

As a reminder, a hospital only needs to encode the allowed amount data elements if the data field "payer-specific negotiated charge: dollar amount" is further modified by an algorithm or percentage, and the hospital is unable to represent the payer-specific negotiated charge completely and fully as a dollar value. In other words, if a hospital has encoded a payer-specific negotiated charge in the MRF as a dollar amount, and that dollar amount represents the full payer-specific negotiated charge that is not further modified by a percentage or algorithm, the hospital would not be required to encode the allowed amounts or count of allowed amounts. Please see examples of how to encode the allowed amounts on our GitHub Repository at https://github.com/CMSgov/hospital-price-transparency/tree/master/examples.

New- What data source must my hospital use to calculate the 10th, median, and 90th percentile allowed amounts, and count of allowed amounts? Do I have to use the same data source to calculate my hospital's payer-specific negotiated charges?

Hospitals must use electronic data interchange (EDI) 835 electronic remittance advice (ERA) transaction data or an alternative equivalent source of remittance data that includes the same information as EDI 835 ERA transaction data would include, to calculate and encode the 10th,

[4] Importantly, see definitions of those terms at 45 CFR § 180.20, which may require that the values be calculated in a fashion that may differ from typical arithmetic convention.

median, and 90th percentile allowed amounts[5], and count of allowed amounts, for items and services in the machine-readable file (MRF) for which the payer-specific negotiated charge is based on a percentage or algorithm. Since EDI 835 ERA transaction data is the electronic transaction data from payers that provides claim payment information rather than the payer-specific negotiated charge for an item or service, we clarify that we would not expect, nor should hospitals use, EDI 835 ERA transaction data to encode their payer-specific negotiated charges. As indicated in the CY 2020 HPT final rule (84 FR 65551), the payer-specific negotiated charge is defined as the charge that a hospital has negotiated with a third party payer for an item or service. We noted in that rule (84 FR 65534) that the payer-specific negotiated charge can be found in other parts of the hospital billing and accounting systems than the chargemaster, or in rate tables or the rate sheets found in hospital in-network contracts with third party payers indicating the agreed upon rates for the provision of various hospital services.

New- What lookback period should my hospital use to calculate the 10th, median, and 90th percentile allowed amounts, and the count of allowed amounts?

Hospitals should use a lookback period of no less than 12 months and no longer than 15 months prior to posting the machine-readable file (MRF) to calculate and encode the allowed amounts and count of allowed amounts. We expect hospitals to use at least the most recent 12 months of data that is available to them. However, in the case where hospitals need additional time to pull or prepare the data before posting the MRF, hospitals may use data from up to 15 months prior to the date the MRF is posted to help ensure they have an adequate number of data points to encode the allowed amounts. The 12 to 15 months of data must be contiguous. In the event that a hospital renegotiates a contract during the 12-to 15-month span, the hospital must include data from both prior to and after the negotiation date. For example, if a hospital posts their MRF on March 31, 2026, the hospital's lookback period for calculating and encoding the allowed amounts would begin between December 31, 2024, and March 31, 2025, depending on how much time the hospital needs to populate the MRF prior to posting it online.

New-How should our hospital calculate the allowed amount data elements when there are variable time-based units reimbursed in the EDI 835 ERA?

A hospital should perform the necessary calculations and divide the total allowed amount from the EDI 835 ERA transaction data or alternative equivalent source of remittance data by the number of units (for example, 15-minute increments) performed. The hospital should then consider this unit-level amount as being a repeated observation corresponding to the number

[5] Importantly, see definitions of those terms at 45 CFR § 180.20, which may require that the values be calculated in a fashion that may differ from typical arithmetic convention.

of units when calculating the 10th percentile, median, and 90th percentile allowed amounts, and the count of allowed amounts must correspond to the unit level. For example, if 12 units were reported for a total of $1,200, the division would result in an observed allowed amount of $100 12 times in the distribution used to calculate the 10th percentile, median, and 90th percentile allowed amounts, and the contribution to the count of allowed amounts would be 12.

New-What data should we use if our hospital doesn't have access to EDI 835 ERA transaction data or the payer doesn't send EDI 835 ERA files with sufficient detail (i.e., not at the payer/plan level or doesn't include line-item detail)?

If EDI 835 ERA data is not available or does not include sufficient detail, hospitals should identify another source of actual remittance data, either within their systems, through their vendors, or from other available sources. This may include, but is not limited to, data maintained in revenue cycle systems, EHRs, payer portals, clearinghouses, or third-party data aggregators. Hospitals should ensure that the data source they use includes sufficient detail to calculate allowed amounts at the payer and plan level, based on actual payment data. The data must support calculation of the "total allowed amount," defined as the gross charge minus contractual adjustments, consisting of the portion billed to a payer for a specific plan and the portion, if any, billed to the patient. If a hospital's existing reports or data extracts do not include this level of detail, the hospital should work with its internal teams or vendors to obtain access to the underlying remittance data or to generate reports that include the required detail.

New-In cases where individual service lines are negotiated as a bundle, and the individual services receive zero payment because they are included in the primary bundled service, should those zero-payment line items be excluded from the allowed amount calculations, or should they be included at $0?

If the hospital has negotiated a payer-specific negotiated percentage or algorithm as a bundled service, as opposed to individual service lines, then the hospital should encode the required data elements for the bundled service for that payer/plan. As we noted in the CY 2026 OPPS/ASC Final Rule (90 FR 53999), hospitals should exclude the zero-dollar claims from the count of allowed amount calculations.

New-Who should the named attester be? What title does this person need to have?

We have provided flexibility on the title of the senior hospital executive who would attest to the file's accuracy and completeness. We expect the senior hospital official who is named as the attester in the file would be the same individual who would submit to CMS, if requested as part of CMS' monitoring oversight, a certification of the accuracy and completeness of the MRF data

under § 180.70(a)(2)(iv). While we recognize that the senior hospital executive may not be directly involved in MRF development, we expect the named attester, as part of their role in the overall governance of the hospital, would, as necessary, be able to consult with the appropriate personnel more directly involved in MRF development, such as a compliance officer or revenue cycle leader, in order to obtain the necessary information to make the required attestation.

New-Which hospital National Provider Identifiers (NPIs) do I need to include in my hospital's machine-readable file (MRF)? Do I need to include all my hospital's NPIs in the MRF?

Your hospital must report, in a newly created general data element in the MRF, all the hospital's Type 2 NPI(s) that have a primary taxonomy code starting with '28' (indicating hospital) or '27' (indicating hospital unit) and that are active as of the date of the most recent update to the standard charge information. If your hospital has more than one Type 2 NPI that meets these criteria, your hospital is required to report in the general data element all the active Type 2 NPIs meeting the criteria. Do not include Type 1 NPIs in this general data element.

New-What is a Type 2 NPI? What should we do if we do not know our hospital Type 2 NPI?

An NPI is a unique 10-digit number used to identify healthcare providers and organizations, including hospitals.[6] All healthcare providers that are HIPAA-covered entities must obtain an NPI. Health care providers who are individuals are assigned a Type 1 NPI and healthcare providers that are organizations are assigned a Type 2 NPI (69 FR 3440). Type 2 NPIs are also known as organizational NPIs. "Subparts" of organizations—which are components of the same organization that may be separately licensed or identified[7] —may also obtain a Type 2 NPI (69 FR 3441) if they conduct HIPAA standard transactions separately[8] from the main organization (45 CFR 162.410(a)(1)). Hospitals should include all Type 2 NPI(s) associated with a primary taxonomy code starting with '28' (indicating hospital) or '27' (indicating hospital unit) in their MRFs.

If you do not know the hospital Type 2 NPI, there are several internet-based NPI lookup tools available online, including CMS' NPPES NPI registry.[9] NPIs are commonly used in other CMS

[6] *https://www.cms.gov/regulations-and-guidance/administrative-simplification/nationalprovidentstand*.
[7] Guidance on NPI Enumeration; 45 CFR 162.412(b). *https://www.cms.gov/files/document/guidance-national-provider-identifier-npi-enumeration-pdf.pdf*.
[8] *https://www.cms.gov/regulations-and-guidance/administrative-simplification/nationalprovidentstand/downloads/medsubparts01252006.pdf*.
[9] CMS's NPPES registry is available online at the following website address: *https://npiregistry.cms.hhs.gov/*.

systems for financial transactions, and for other healthcare data sets, including claims, utilization, and quality data sets.

New-Are there any exceptions to the reduction of civil monetary penalty (CMP), effective January 1, 2026, if a hospital waives its right to an appeal?

In certain situations, CMS will decline to make available to hospitals the opportunity to have a CMP amount reduced. If a hospital does not affirmatively waive its right to a hearing within 30 calendar days of the date of notice of imposition of the CMP in accordance with the procedures specified at § 180.90(c)(4), a CMP amount would not be reduced. Additionally, should CMS impose upon a hospital a CMP for HPT noncompliance going to the core of the HPT requirements—specified as failing to make public either: (1) an MRF as required in § 180.40(a), or (2) any shoppable services in a consumer-friendly format (either in the form of a shoppable services file or an internet price estimator tool) as required in § 180.40(b)—the hospital would be ineligible for a penalty reduction and would be required to pay the CMP in full. Further, a hospital would not be eligible for an additional 35 percent reduction in the CMP amount if they receive a subsequent CMP for the same instance(s) of noncompliance.

Background

What is the legal basis for the Hospital Price Transparency requirements?

Section 1001 of the Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by Section 10101 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), amended Title XXVII of the Public Health Service Act (the PHS Act), in part, by adding a new section 2718(e). Section 2718 of the PHS Act, titled "Bringing Down the Cost of Health Care Coverage," requires each hospital operating within the United States (U.S.) for each year to establish and update and make public a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups (DRGs) established under section 1886(d)(4) of the Social Security Act (the Act). Section 2718(b)(3) of the PHS Act requires the Secretary of the Department of Health and Human Services (Secretary) to promulgate regulations to enforce the provisions of section 2718 of the PHS Act, and, in so doing, the Secretary may provide for appropriate penalties. Please refer to the discussion starting at 84 FR 65525.

How does the Secretary require hospitals to make public their standard charges? What is the intent of this disclosure?

Hospitals are required to make public their standard charges in two ways: (1) as a comprehensive machine-readable file (MRF); and (2) in a consumer-friendly format. We codified these requirements at 45 CFR part 180. We believe these two different methods of

making hospital standard charges public are necessary to ensure that such data are available to consumers of healthcare where and when they are needed, including through data aggregation methods (for example, via integration into price transparency tools, electronic health records (EHRs), and consumer apps), and direct availability to healthcare consumers searching for hospital-specific charge information. Additionally, data can be used specifically by employers, researchers, and policy officials, and other members of the public to drive competition and help bring more value to healthcare. Please refer to the discussion starting at 84 FR 65527.

Can hospitals choose between displaying standard charges in a machine-readable format and displaying standard charges for shoppable services in a consumer-friendly format?

No. Hospitals must make public both of the following: (1) A machine-readable file containing a list of all standard charges for all items and services as provided in 45 CFR §180.50 and (2) a consumer-friendly list of standard charges for a limited set of shoppable services as provided in 45 CFR §180.60. Please note that CMS will deem a hospital as having met the second of these two requirements if the hospital maintains an internet-based price estimator tool that meets the requirements provided in 45 CFR § 180.60(a)(2).

What changes did CMS make to the Hospital Price Transparency (HPT) requirements in the CY 2024 OPPS/ASC Final Rule?

In the CY2024 OPPS/ASC final rule with comment period, we finalized proposals to revise several HPT requirements to advance the agency's commitment to increasing price transparency and enforcing compliance. These policies strengthen and streamline our monitoring and enforcement capabilities; improve access to, and the usability of, hospital standard charge information; standardize the way hospital's standard charges are presented; reducing the compliance burden on hospitals by providing technical guidance for display of hospital standard charge information; align, where feasible, certain HPT requirements and processes with requirements and processes we have implemented in the Transparency in Coverage initiative; and make other modifications to our monitoring and enforcement capabilities that will, among other things, increase the transparency to the public. Please refer to 88 FR 81545. Details can be found in the CY 2024 OPPS/ASC HPT Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/hospital-price-transparency-fact-sheet.

Will hospitals be able to apply for a hardship waiver or exception to meeting the Hospital Price Transparency requirements?

No. The Hospital Price Transparency Final Rule contains no provisions that address waivers or hardship exemptions.

We believe displaying payer-specific negotiated rates publicly would violate the confidentiality clause of the hospital's contract with our third-party payers. Has CMS addressed this issue?

Even if a contract between a hospital and a payer contained a provision prohibiting the public disclosure of its terms, it is our understanding that such contracts typically include exceptions where a particular disclosure is required by Federal law. Please refer to the discussion at 84 FR 65544.

Definitions

How is a hospital defined under the Hospital Price Transparency Final Rule? Does the rule apply to Critical Access Hospitals (CAHs), other small or rural hospitals, state owned/operated institutions, Rural Emergency Hospitals (REHs), and non- acute hospitals such as inpatient psychiatric hospitals and inpatient rehabilitation facilities (IRFs)?

Under 45 CFR § 180.20, hospital means an institution, in any State in which State or applicable local law provides for the licensing of hospitals, which is licensed as a hospital pursuant to such law or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing. For purposes of this definition, a State includes each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. All hospital location(s) operating under the same hospital license (or approval), such as a hospital's outpatient department located at an off-campus location (from the main hospital location) operating under the hospital's license, are subject to the requirements in this rule. This definition includes all Medicare-enrolled institutions that are licensed as hospitals (or approved as meeting licensing requirements) as well as any non-Medicare enrolled institutions that are licensed as a hospital (or approved as meeting licensing requirements). Given this definition, this rule applies to every institution that meets the definition of 'hospital' established by the Hospital Price Transparency Final Rule including institutions such as critical access hospitals, specialty hospitals, and state owned or operated facilities other than those deemed compliant.

Federally owned or operated hospitals (for example, hospitals operated by an Indian Health Program, the U.S. Department of Veterans Affairs, or the U.S. Department of Defense) that do not treat the general public, except for emergency services, and whose rates are not subject to negotiation, are deemed to be in compliance with the requirements for making public standard charges because their charges for hospital provided services are publicized to their patients in advance (for example, through the Federal Register). In addition, beginning January 1, 2022, state forensic hospitals that provide treatment exclusively to individuals who are in the custody of penal authorities are deemed to be in compliance with 45 CFR Part 180 because such

hospitals are wholly funded through state general funds and treat patients who are not responsible for the cost of their care in such hospitals. Please refer to the discussion at 86 FR 63950.

Updated-Does the Hospital Price Transparency Final Rule apply to hospitals in the State of Maryland that are subject to the AHEAD model?

Yes. If the institution meets the definition of 'hospital' as defined by the Hospital Price Transparency Final Rule, then your institution must comply. However, some required standard charge information may not be applicable to the hospital. For example, under the Hospital Price Transparency Final Rule, the hospital is obligated to make public the payer-specific negotiated charges as applicable for each item and service your hospital provides. The term "payer-specific negotiated charge" is defined as the charge that the hospital has negotiated with a third party payer for an item or service. The term "third party payer" means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service. If the hospital has not negotiated a charge with a third party payer for an item or service it provides, then the hospital would not have a "payer-specific negotiated charge" to display for that item or service.

What hospital "items and services" are included by the Hospital Price Transparency Final Rule? What is a "service package"?

For purposes of complying with the hospital price transparency requirements, items and services are all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which a hospital has established a standard charge.

Examples include supplies and procedures, room and board, and use of the facility and other items (generally described as facility fees), services of employed physicians and non-physician practitioners (generally reflected as professional charges), and any other item or service for which a hospital has established a standard charge. Please refer to 45 CFR §180.20.

A service package is an aggregation of individual items and services into a single service for which the hospital has a single standard charge. "Service packages" may have charges established on, for example, the basis of a common procedure or patient characteristic, or may have an established per diem rate that includes all individual items and services furnished during an inpatient stay. Please refer to 45 CFR §180.20.

The definition of "items and services" includes services of employed physicians and non-physician practitioners. How does CMS define "employment"?

Given the variation and complexity in employment models and possible contracting

relationships that may exist between hospitals and physicians, we believe it is important to preserve flexibility for hospitals to identify employed physicians or non-physician practitioners under their organizational structure, and, for this reason, we declined to codify a definition of "employment" in the Hospital Price Transparency Final Rule. Please refer to the discussion at 84 FR 65535.

Do these requirements apply to non-employed physicians and other practitioners who provide and bill for the same services at the hospital?

No. Services provided by physicians and non-physician practitioners who are not employed by the hospital are practitioners that are practicing independently, establish their own charges for services, and receive the payment for their services. Such services, therefore, are not services "provided by the hospital."

Do these requirements apply to the services of employed practitioners whose charges are not found in the hospital chargemaster?

Yes. The Hospital Price Transparency Final Rule does not limit the requirements to only hospital standard charges that are found within the hospital chargemaster, including standard charges for items and services provided by practitioners employed by the hospital. The requirements apply to such charges that may be located elsewhere within the hospital accounting and billing system, or, in the case of payer-specific negotiated charges, in contracts and rate sheets that are specific to a particular third-party payer. Please refer to the discussion at 84 FR 65535.

What is a "base rate" for a service package?

The base rate is the payer-specific charge the hospital has negotiated for a service package. Base rates for service packages are typically not found in the hospital chargemaster but can be found in other parts of the hospital's billing and accounting systems, or in what are known as 'rate sheets' found in hospital in-network contracts with their third-party payers. The base rate is **not** the final payment or reimbursement rate for the service package received by the hospital for individual patients.

Do the standard charges for services performed by physicians and/or non-physician practitioners outside the scope of their employment by the hospital need to be included in the hospital's display of standard charges?

No, the Hospital Price Transparency Final Rule requires hospitals to post their standard charges for the items and services they provide. Items and services include, but are not limited to, the services of employed physicians and non-physician practitioners (generally reflected as professional charges). They do not include the services that physicians and non-physician practitioners perform outside the scope of their employment by the hospital.

Hospital Price Transparency Frequently Asked Questions (FAQs)

Standard Charges

What standard charges must hospitals make public?

A standard charge means the regular rate established by the hospital for an item or service provided to a specific group of paying patients. For purposes of complying with the Hospital Price Transparency Final Rule, this includes five types of standard charges:

1. The gross charge (the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts).
2. The discounted cash price (the charge that applies to an individual who pays cash, or cash equivalent, for a hospital item or service).
3. The payer-specific negotiated charge (the charge that a hospital has negotiated with a third-party payer for an item or service).
4. The de-identified minimum negotiated charge (the lowest charge that a hospital has negotiated with all third-party payers for an item or service).
5. The de-identified maximum negotiated charge (the highest charge that a hospital has negotiated with all third-party payers for an item or service).

Our hospital does not provide a discounted cash price for items and services. How should we reflect this in the display of standard charge information in our machine-readable file?

Some hospitals may not have established a discounted cash price for self-pay consumers for the items and services it provides. In the machine-readable file (MRF), if the hospital has not established a discounted cash price, the hospital must include the required "standard charge | discounted cash" data element in their MRF but would not be required to encode any standard charge information for that data element. If a hospital has established other types of discounts, such as a financial aid policy for a subset of consumers, the hospital may elect to include optional data elements, for example, "hospital financial aid policy", in the CMS MRF template and encode a hyper link to the policy. For more guidance on how to display and encode an optional data element, please refer to the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency. Please refer to 45 CFR §180.20.

My hospital has established a gross charge for an individual item or service (as found in our chargemaster) but it has not established a payer-specific negotiated charge for that same item or service. In this case, is my hospital required to establish a payer-specific negotiated charge for that item or service?

No. The Hospital Price Transparency regulations require hospitals to make public a list of the standard charges the hospital has established for the items and services it provides and to make this standard charge information available in a single machine-readable file, *as applicable.* We recognize that a hospital may have established one type of standard charge (for example a gross charge) for a particular item or service without having established other types of standard charges (for example, a payer-specific negotiated charge with a particular payer/plan) for the same item or service. Hospitals must ensure each required data element is included in its machine-readable file and leave blanks where there is no applicable standard charge information to encode. Follow the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency.

My hospital has not established or negotiated a standard charge for an item or service. How should I display items and services for which there is no standard charge?

Your hospital should only include an item or service in its machine-readable file if your hospital has established one or more standard charges for it. For more guidance on how to display and encode your data in the MRF, please refer to the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency.

If a hospital has not provided a service in the previous 12 months, is it required to post the standard charge for that service?

Yes. CMS finalized the proposal to define hospital "items and services" to mean all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge. In other words, hospitals must post the standard charge (as applicable) for each item/service for which the hospital has established a standard charge. Refer to 45 CFR § 180.20.

Is there a limitation on the number of third-party payers for which we must make negotiated charges public? For example, does this requirement apply to contracts with our top payers only?

No. Hospitals are required to list their standard charges for all items and services with respect to all third-party payers. Please refer to the discussion at 84 FR 65551.

Updated- My hospital has negotiated a payer-specific negotiated charge of $0 for a subset of items and services, how should I encode charges for the "payer-

specific negotiated charge: dollar amount" data element in the machine-readable file?

The valid values for the "payer-specific negotiated charge: dollar amount" data element must be indicated as a numeric value. The Data Dictionary indicates that all "Numeric" data elements must be positive numbers, unless otherwise specified. Entering a negative number or "0" where not specified as permitted will generate a deficiency. If your hospital has negotiated a $0 dollar amount for a hospital item or service, you should not encode data in the "payer-specific negotiated charge: dollar amount" data element and provide additional context in either the "additional payer notes" or "additional notes" data element, depending on which CMS Template layout you choose to adopt. For more guidance on how to display and encode your data in the MRF, please refer to the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency.

Should the de-identified minimum negotiated charge and the de-identified maximum negotiated charge be based on the "Payer-specific Negotiated Charge: Dollar Amount", "Payer-Specific Negotiated Charge: Algorithm", or the "Payer-specific Negotiated Charge: Percentage"?

At 45 CFR § 180.20 we defined the "de-identified minimum negotiated charge" to mean the lowest charge that a hospital has negotiated with all third-party payers for an item or service and the ''de-identified maximum negotiated charge'' to mean the highest charge that a hospital has negotiated with all third-party payers for an item or service. In the CMS Template(s) the values for these data elements should be derived from the "Payer-specific Negotiated Charge: Dollar Amount" data element. Unlike the allowed amounts (see below FAQs and the discussion beginning at 90 FR 53985) the de-identified minimum negotiated charge and de-identified maximum negotiated charge should not be based on remittance data. Please see the examples provided on the CMS Hospital Price Transparency – Data Dictionary GitHub Repository at https://github.com/CMSgov/hospital-price-transparency for how to encode your data in one of the three required CMS Templates.

In the machine-readable file, are hospitals required only to display the payer-specific negotiated charges for each item/service that is found in the hospital chargemaster, even when the hospital has negotiated rates with some payers based on 'service packages'?

The machine-readable file posted online by the hospital should include not only the items and services listed in the chargemaster but also list any service packages for which the hospital may have established a standard charge. For example, some payer-specific negotiated rates are for 'service packages' (for example, per diem or based on a procedure). Such 'service packages' are

not typically found in the hospital chargemaster which is a list of itemized items and services, but a hospital is still required to display the payer-specific negotiated charge (and all other standard charges applicable) for which the hospital has established a standard charge regardless of whether it appears in the chargemaster. Please refer to 84 FR 65534 for further discussion.

If my hospital contracted for the same payer-specific standard charges across all a payer's plans, does my hospital need to list each individual plan in the machine-readable file?

As a result of a better understanding of hospital and commercial payer contracting, we finalized in the CY 2024 OPPS/ASC final rule that hospitals may indicate plan(s) as categories (such as "all PPO plans") for a particular payer when the established payer-specific negotiated charges are applicable to each plan in the indicated category. We believe this exception is necessary to ensure that hospitals are not penalized for displaying information that is consistent with their contracting practices. Moreover, we believe that this practice could improve access to machine-readable file data by avoiding repetition of standard charge information that would unnecessarily increase file size. Please refer to the discussion at 88 FR 82093.

Updated- Should hospital contracts using algorithms that are complex and lengthy be encoded in the machine-readable file?

Yes, if the hospital is unable to display a payer-specific negotiated charge solely as a dollar amount, such as when the payer-specific negotiated charge is further modified by a percentage or algorithm, the hospital is required to provide all necessary information available to the hospital, which would include information in the hospital's systems and payer contracts, to derive a dollar amount in a way that a reasonable MRF user can understand. Please refer to the examples of how to encode algorithms available on the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency.

Should Medicare Advantage and Medicaid Managed Care rates be included in the MRF?

Yes, hospitals are required to make public the payer-specific negotiated charges that they have negotiated with third-party payers, including charges negotiated by third-party payer managed care plans such as Medicare Advantage plans, Medicaid MCOs, and other Medicaid managed care plans. Therefore, a state's Medicaid managed care contracts may fall within this description, if such managed care contracts include rates negotiated with the hospital. Please refer to 84 FR 65551 where we finalized our definition of ''third-party payer'' as an entity that, by statute, contract, or agreement, is legally responsible for payment of a claim for a healthcare item or service.

In cases where the hospital has negotiated a payer-specific negotiated charge based on the Medicare or Medicaid FFS rate, can the hospital simply indicate that the price of the hospital item/service is set to the Medicare or Medicaid rate instead of reporting a specific dollar value?

No. The payer-specific negotiated charge is defined for purposes of the Hospital Price Transparency Final Rule as the charge that a hospital has negotiated with a third-party payer for an item or service, including a service package, and the hospital should list that standard charge. For example, if your hospital has negotiated a payer-specific negotiated charge for a service package that equals 200% of the Medicare FFS reimbursement rate for MS-DRG 123, then your hospital should determine the Medicare reimbursement rate for DRG 123, multiply it by 2 and indicate the resulting amount as its payer-specific negotiated charge for that service package.

Can CMS advise me on how to encode specific standard charge information for my hospital?

As explained in the CY2024 OPPS/ASC final rule, hospitals use different methods to establish standard charges for items and services, resulting in charge/item and charge/service combinations that are often unique to that hospital. Therefore, although CMS has recently taken steps toward standardization, each hospital will continue to have some discretion related to how it chooses to encode its standard charge information (including information related to payer-specific negotiated charges) within its machine-readable file, so long as the file conforms to the CMS template layouts and data specifications as described at 45 CFR § 180.50(c)(2).

Machine Readable File

What is a 'machine-readable' file? What formats are hospitals allowed to post their machine-readable files in? Are hospitals allowed to post their machine-readable files in a format other than the ones made available through the CMS template layout, such as Microsoft Excel, .XML, PDF?

A machine-readable file is a single digital file that is in a machine-readable format. Beginning on July 1, 2024, the hospital's machine-readable file must conform to a CMS template layout, data specifications, and data dictionary. CMS has made the CMS template available in three non-proprietary formats: CSV "tall", CSV "wide", and JSON. Hospitals must make their file available in one of these templates. Files in Microsoft Excel, .XML, or PDF are not compliant. CMS strongly recommends hospitals start with one of the template layouts to create your machine-readable files as opposed to trying to convert an existing machine-readable file to one of the templates. Refer to 45 CFR § 180.20, 45 CFR § 180.50(c), and the technical instructions available

at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at GitHub - CMSgov/hospital-price-transparency.

Where can I find the required CMS templates or more information on how to encode my hospital's standard charge information and each of the required data elements?

CMS has created a GitHub repository to house the required CMS templates, in a CSV "tall", CSV "wide" and JSON format, and provides the data dictionary, or technical instruction, on how hospitals must encode standard charge information into machine-readable files for each required data element. The CMS Hospital Price Transparency - Data Dictionary GitHub repository is available at https://github.com/CMSgov/hospital-price-transparency.

Will changing the order of the CSV headers or JSON attributes in the CMS templates result in a deficiency or cause my MRF to be considered noncompliant with the form and manner prescribed by CMS for encoding standard charge information?

Changing the order of the CSV headers or JSON attributes in the CMS template layouts will not generate a deficiency. Please refer to the documentation and examples on the CMS Hospital Price Transparency - Data Dictionary GitHub repository for more information at https://github.com/CMSgov/hospital-price-transparency.

How can my hospital ensure that its machine-readable file is "prominently displayed"? What requirements must hospitals adopt to improve automated access to machine-readable files because of the CY 2024 amendments to the Hospital Price Transparency Final Rule?

In the CY 2024 OPPS/ASC Final Rule, CMS finalized the following accessibility requirements, effective January 1, 2024, the hospital must ensure that the public website it selects to host its machine-readable file establishes and maintains, in the form and manner specified by CMS:

- A .txt file in the root folder that includes a standardized set of fields including the hospital location name that corresponds to the machine-readable file, the source page URL that hosts the machine-readable file, a direct link to the machine-readable file (the machine-readable file URL), and hospital point of contact information. For more information, access the Hospital Price Transparency TXT File Frequently Asked Questions (FAQs).
- A link in the footer on its website, including but not limited to the homepage, that is labeled "Price Transparency" and links directly to the publicly available web page that hosts the link to the machine-readable file.

In addition, we recommend that hospitals review and use, as applicable, the HHS Web Standards and Usability Guidelines (available at https://webstandards.hhs.gov/), which are research-based and are intended to provide best practices over a broad range of web design and digital communications issues.

What updates did CMS make to the accessibility requirements of the machine-readable file in the CY 2022 OPPS/ASC Final Rule?

As of January 1, 2022, CMS requires that the machine-readable file must be accessible to automated searches and direct downloads through a link posted on a publicly available website (45 CFR § 180.50 (d)(3)(iv)). Specific examples of barriers to automated searches and direct downloads that CMS identified include, but are not limited to, lack of a link for downloading a single machine-readable file, using ''blocking codes'' or CAPTCHA, and requiring the user to agree to terms and conditions or submit other information prior to access. Refer to the discussion at 86 FR 63951.

Can my hospital zip or compress for storage our machine-readable file (MRF)? If we do so, how should we name our MRF?

Yes. Any hospital MRF can be zipped or compressed regardless of size. If you choose to zip or compress your MRF, CMS recommends, but does not require, that you use the CMS-specified naming convention and append ".zip" or ".gz" after the file type (either .json or .csv). For example, "123456789_hospitalname_standardcharges.csv.zip" or "123456789_hospitalname_standardcharges.csv.gz".

What naming convention should hospitals use when making public the machine-readable file? How can I find the EIN and associated hospital legal name?

Hospitals must use the following CMS naming convention as specified in the regulations at 45 CFR § 180.50(d)(5) for the machine-readable file:

<ein>_<hospital- name>_standardcharges.[json| |csv] in which the EIN is the Employer Identification Number of the hospital, followed by the hospital name, followed by "standardcharges" followed by the hospital's chosen file format (84 FR 65562).

It is important that you follow the rule's naming convention. Specifically, hospitals must use the following schema:

- Write out "standardcharges" as a single word, without capitalization.
- Finish by using. json or .csv as applicable to the CMS Template you have selected.

- Separate the EIN, hospital name, and "standardcharges" by using an underscore: 12345678_example-hospital-name_standardcharges.csv

In addition, hospitals may do the following:

- Exclude dashes from the EIN (use "12345678", not "12-345678")
- Use the legal name of the hospital without capitalization and include dashes between words (use "example-hospital-name", not "Example Hospital Name")
- Hospital EINs and legal names can be found using lookups hosted by the IRS (https://apps.irs.gov/app/eos/) and SEC (https://www.sec.gov/edgar/search/)

We have multiple facilities and locations, each with its own list of standard charges, functioning under the same EIN and legal name. CMS regulations require that "Each hospital location operating under a single hospital license (or approval) that has a different set of standard charges than the other location(s) operating under the same hospital license (or approval) must separately make public the standard charges applicable to that location." In this case, what naming convention should we use for these machine-readable files?

Hospitals must use the CMS naming convention as specified in the regulations at 45 CFR § 180.50(d)(5) but may also add "-<NPI>" following the EIN (where "#" is the National Provider Identifier that corresponds to the hospital location). NPIs and hospital names can be found using this lookup: https://npiregistry.cms.hhs.gov/. For example, "Example Hospital Name" with EIN of 12345678 has two locations with NPIs of "1011121314" and "1516171819", each with its own set of standard charges. This hospital could name its two csv-formatted machine-readable files as "12345678-1011121314_example-hospital-name_standardcharges.csv" and "12345678- 1516171819_example-hospital-name_standardcharges.csv", respectively.

My hospital establishes the same set of standard charges across all our 30 locations. Must I list each location in the machine-readable file when using the CMS Template?

Beginning July 1, 2024, hospitals are required to encode the name(s) and address(es) of each hospital inpatient location and each standalone emergency department in the machine-readable file. While strongly encouraged, it is not required to encode all outpatient locations. We note, however, that even though we are making this practical accommodation, hospitals must still include all standard charge information in the machine-readable file, including standard charge information for outpatient locations not encoded for this data element. In other words, this accommodation should not be interpreted to mean that hospitals need not include the standard charges that apply to outpatient locations that operate under the single hospital license but whose location names and addresses are not required to be encoded. Please refer to the discussion at 88 FR 82092.

New-How should multiple addresses be encoded in the hospital_address data element of the MRF?

The "hospital_address" data element must include the physical address for each hospital location listed in "location_name." Each hospital location must have a corresponding hospital address listed in the same order. For example, the first hospital location matches the first address, the second hospital location matches the second address, and the third hospital location matches the third address. If you list four hospital locations, you must list four physical addresses.

If two or more hospital locations share the same physical address, repeat that address for each location.

How you encode multiple addresses depends on the file format:

For CSV files:

- List each physical address separated by a pipe symbol: |
- The addresses must appear in the same order as the hospital locations listed in location_name.

Example (CSV)

location_name
ABC Hospital – Main Campus | ABC Hospital – Inpatient Rehabilitation Unit | ABC Hospital – East Campus

hospital_address
2000 Medical Center Drive, River City, ST 12345 | 2000 Medical Center Drive, River City, ST 12345 | 3000 Test Center Drive, River City, ST 12345

For JSON files:

- Encode the physical addresses as an array.
- The number of addresses must match the number of hospital locations listed in location_name, and the addresses must appear in the same order as the hospital locations.

Example (JSON)

```
{
  "location_name": [
```

```
   "ABC Hospital – Main Campus",
   "ABC Hospital – Inpatient Rehabilitation Unit",
   "ABC Hospital – East Campus"
  ],
  "hospital_address": [
   "2000 Medical Center Drive, River City, ST 12345",
   "2000 Medical Center Drive, River City, ST 12345",
   "3000 Test Center Drive, River City, ST 12345"
  ]
}
```


In both formats, each hospital location must have a corresponding physical address listed in the same order. Even though the first two hospital locations share the same address, it is repeated to maintain alignment.

New-How should our hospital encode the 'version' of the template in the MRF?

The value encoded in the "version" data element should reflect the version of the CMS template used to create your MRF. This applies to all three CMS-supported formats: JSON, CSV-wide, or CSV-tall. The version value is pre-populated in the CMS MRF templates[10] available on the CMS Hospital Price Transparency Data Dictionary GitHub repository. Hospitals should not replace this value with terms such as "csv-tall", "csv-wide", or similar file format descriptions.

Do all modifiers need to be included in the Machine-Readable File (MRF)?

As indicated in the CY 2024 OPPS/ASC Final Rule, a hospital is required to include modifiers only to the extent that the standard charge is dependent on the modifier, or the modifier is necessary to provide additional context for the standard charges it has established. It is not necessary to include modifiers that do not impact or change the standard charge indicated for an item or service. Please refer to the CY 2024 OPPS/ASC Final Rule at 88 FR 82104.

How should we encode modifiers in the machine-readable file (MRF)? Should each modifier be listed on a separate row in the MRF, or should we encode each item/service and the many different modifier combinations that are possible?

Your hospital has some flexibility to choose what method works best for the development of your MRF. CMS has suggested two possible approaches for encoding modifiers into your MRF:

[10] https://github.com/CMSgov/hospital-price-transparency/tree/master/documentation/CSV/templates, https://github.com/CMSgov/hospital-price-transparency/tree/master/documentation/JSON/schemas

- The first and recommended approach would be to separately encode each of the modifiers and describe how each modifier affects the standard charges established by the hospital, as demonstrated in the “Examples” found on the Hospital Price Transparency – Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency/tree/master/examples.

- The second approach would be to encode the standard charge that results from each possible combination of codes and modifiers for each item/service provided by your hospital.

Updated- Our hospital offers items or services that do not have an associated HCPCS or CPT code. Are we required to list such services? If so, what should be indicated next to the item or service?

Yes. The Hospital Price Transparency Final Rule requires hospitals to disclose the standard charges for each item or service it provides, therefore, all hospital items and services for which the hospital has established a standard charge must be listed regardless of whether all the required corresponding data element values are available. Corresponding common billing and accounting codes must be included. The value "LOCAL" may be used for internal accounting codes in conjunction with another billing code for that item or service. However, if no other code types are available for a particular item or service, "LOCAL" may be used as a valid value. Please refer to the discussion at 88 FR 82104. Please refer to the technical instructions available at the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency.

New-When should my hospital use DRG as a code type?

While DRG is currently a valid value for the code type data element in the CMS Hospital Price Transparency – Data Dictionary GitHub Repository, there are other more specific valid values you may use. The CMS Hospital Price Transparency – Data Dictionary lists the following DRG types as valid values for code type:

- Medicare Severity Diagnosis Related Groups (MS-DRG)
- Refined Diagnosis Related Groups (R-DRG)
- Severity Diagnosis Related Groups (S-DRG)
- All Patient, Severity-Adjusted Diagnosis Related Groups (APS-DRG)
- All Patient Diagnosis Related Groups (AP-DRG)
- All Patient Refined Diagnosis Related Groups (APR-DRG)
- TriCare Diagnosis Related Groups (TRIS-DRG)
- Medicare Severity Long-Term Care Diagnosis Related Groups (MS-LTC-DRG)

We encourage hospitals to use the most specific code type valid value available for their hospital items or services and to only use DRG when the list of valid values does not contain a more specific DRG code type that applies to a hospital item or service.

What value should the drug unit of measurement reflect (e.g. the billable unit, the reimbursable unit, Medicare billing quantity, amount administered to patient, etc.)?

The drug unit of measurement should reflect the quantity of the drug an individual would receive at the standard charge amount your hospital has established, which is typically (but may not always be) expressed as a dose, leveraging values reflecting industry standards such as HCPCS or NDC dosing descriptions. For example, if a hospital establishes a gross charge of $2 for a drug it describes as `each aspirin 81 mg chewable tablet', the unit of measurement would be "1" and the type of measurement would be "UN" (unit). Please refer to the discussion starting at 88 FR 82102, and the examples on the CMS Hospital Price Transparency –Data Dictionary GitHub Repository at https://github.com/CMSgov/hospital-price-transparency/tree/master/examples.

Must we include a particular billing code type, like NDC, for drugs listed in our machine-readable file (MRF)?

To the extent your hospital uses one or more billing or accounting codes for items and services (including drugs) for which you have established a standard charge, your hospital must include each code in your MRF because more than one code may be necessary to contextualize the standard charge established by your hospital. The CMS templates are designed to allow for hospitals to associate more than one code and code type with a standard charge. There may be times that a hospital has established a standard charge for an item or service for which there is no generally recognized code type. In such cases, your hospital should use "LOCAL" as the valid value. Please refer to the discussion at 88 FR 82103 and the valid values for "code type" on the Hospital Price Transparency – Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency/tree/master/documentation.

Why did CMS abbreviate "Milligrams" as "ME" in the valid values listed on GitHub for drug type of measurement? Why are there two different abbreviations for "Gram"?

As indicated in the CY 2024 OPPS/ASC Final Rule, the current data dictionary valid values for drug type of measurement reflect industry standards. Specifically, we adopted both the National Drug Code (NDC) standards (which include UN (unit), ML (milliliter), GR (gram), F2 (International Unit), ME (milligram)) and the National Council for Prescription Drug Programs

(NCPDP) standards (which include ''EA'' (each), ''ML'' (milliliter), and ''GM'' (gram)). Please refer to the discussion at 88 FR 82103.

I would like to propose additional valid values for the CMS machine-readable file template, how do I do that?

You may propose additional valid values by creating a new discussion post on the CMS Hospital Price Transparency - Data Dictionary GitHub repository at https://github.com/CMSgov/hospital-price-transparency, or by emailing the CMS Hospital Price Transparency team at PriceTransparencyHospitalCharges@cms.hhs.gov.

Consumer-Friendly Display

What is a shoppable service? Are medications considered shoppable services?

A shoppable service means a service that can be scheduled by a healthcare consumer in advance. Procedures such as joint replacements and services such as physical therapy are examples of shoppable services. Hospital administration of a medication could be considered a shoppable service if it can be scheduled in advance. Examples of administration of a medication that could be considered a shoppable service are the administration of flu shots or medication infusions for chronic conditions. The definition of 'shoppable service' can be found at 45 CFR §180.20.

What if a hospital does not provide one or more of the 70 CMS-specified shoppable services or provides less than 300 shoppable services in total? How can the requirements of this regulation be met?

If a hospital does not provide one or more of the 70 CMS-specified shoppable services, the hospital must select additional shoppable services such that the total number of shoppable services is at least 300. If a hospital does not provide 300 shoppable services, the hospital must list as many shoppable services as they provide. The hospital must clearly indicate any CMS-specified shoppable service that it does not provide. The hospital may use "N/A" for the corresponding charge or use another appropriate indicator to communicate to the public that the shoppable service is not provided by the hospital. Refer to 84 FR 65569 and 84 FR 65574 for further discussion.

What is an 'ancillary item and service'?

Ancillary services, defined at 45 CFR §180.20, are any item or service a hospital customarily provides as part of, or in conjunction with, a shoppable primary service and may include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room

(including post-anesthesia and postoperative recovery rooms), therapy services (physical, speech, occupational), hospital fees, room and board charges, and charges for employed professional services. Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge. For example, an outpatient procedure may include many services that are provided by the hospital, for example, local and/or global anesthesia, services of employed professionals, supplies, facility and/or ancillary facility fees, imaging services, lab services and pre- and post-op follow up. To the extent that a hospital customarily provides (and bills for) such ancillary services as a part of, or in conjunction with, the primary service, the hospital should group the ancillary service charges along with the other standard charges that are displayed for the shoppable service.
For further discussion of ancillary services refer to 84 FR 65564.

How should a hospital display charges for shoppable services in a consumer-friendly manner when the hospital offers them as a service package or when the hospital already includes all ancillary services as part of the service package charge?

To the extent that a hospital includes in its public display a shoppable service that it commonly provides as a service package, the hospital must display the charge the hospital has established for the service package as a whole. In other words, if the hospital has established a standard charge for a service package, the hospital must display that standard charge as opposed to displaying a manufactured charge for each of the individual items and services that make up the service package. For example, when displaying the charge for a shoppable service identified by a DRG, the hospital would display the payer-specific negotiated charge (the "base rate") negotiated with a third-party payer for the DRG. To be consumer friendly, the hospital may elect to communicate the individual items and services included in the standard charge for the service package, but this is not required under the Hospital Price Transparency Final Rule. However, should a hospital customarily provide any items or services beyond those already included in a service package, the rule does require hospitals to list any such additional ancillary services the hospital customarily provides with the shoppable service. In other words, the hospital must provide a description of the ancillary service along with its standard charge(s) and other required data elements, as applicable.

What does CMS consider to be a plain-language description for purposes of the consumer-friendly display?

The regulations at 45 CFR § 180.60(b)(1) require hospitals to include a plain-language description for each of the 70 CMS-specified and 230 hospital-selected shoppable services in its consumer-friendly display. We invite hospitals to review the Federal plain language guidelines that can be found here: https://plainlanguage.gov/guidelines/. Refer to 84 FR 65573.

Examples that we would consider plain-language descriptions:

- Direct Admission to the Hospital from Observation Status
- CT of the Head or Brain with Contrast
- MRI of Orbit, Face, or Neck with and without Contrast

Examples that we would *not* consider plain-language descriptions:

- OBSRV ASMT DIRECT ADMIT1
- CT HEAD/BRAIN W/CON 42
- MRI ORB/FACE/NK W/WO CON 43

Can a price estimator tool be used to meet the requirement to display shoppable services in a consumer-friendly format? If yes, what requirements must the price estimator tool meet?

Yes. In the Hospital Price Transparency Final Rule, we stated that we had been persuaded by commenters' suggestions that hospitals offering online price estimator tools that provide real-time individualized out-of-pocket cost estimates should receive consideration. For further discussion on the requirements of a price estimator tool, please see 45 CFR §180.60(a)(2).

Although we recognize that some hospital price estimator tools may not display consumer-friendly standard charge information in the precise ways we are requiring under the rule, they do appear to accomplish the goal and intent of ensuring such information is available in a consumer-friendly manner by allowing individuals to directly determine their specific out-of-pocket costs in advance of committing to a hospital service. We emphasize, however, that hospitals must still publish their standard charges for the items and services they provide in a comprehensive machine-readable file (45 CFR §180.50). In other words, offering a price estimator tool can satisfy the requirement to post shoppable service information in a consumer-friendly format but does not satisfy the requirement to display hospital standard charges in a comprehensive machine-readable file.

Further, if a hospital chooses to exercise this option, the hospital Internet-based price estimator tool must meet the following criteria to be deemed in compliance:

- Provide estimates for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.
- Allow healthcare consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service.
- Is prominently displayed on the hospital's website and accessible to the public without charge and without having to register or establish a user account or password.

Please refer to 84 FR 65577 for further discussion on this topic.

If a hospital chooses to use a price estimator tool as an alternative to meeting the requirements for making public the standard charges for shoppable services in a consumer-friendly manner, may hospitals collect patient insurance information or other PII to generate a real-time out-of-pocket estimate for the patient?

Yes. In the Hospital Price Transparency Final Rule, we specifically did not include a requirement that no PII be collected because we recognize that insurance information may be necessary to provide patients with real-time personalized out-of-pocket price estimates. To ensure there is flexibility for the data elements, format, location, and accessibility of a price estimator tool that would be considered to meet the requirements of 45 CFR §180.60, we established minimum data and functionality requirements at 45 CFR §180.60(a)(2). Please refer to 84 FR 65577 for further discussion on this topic.

For the price estimator tool, would a display of an estimated range across all commercial payers for each of the 300 shoppable services meet the requirements?

No. As clarified in the CY 2022 OPPS/ASC final rule, if a hospital chooses to offer a price estimator tool in lieu of displaying standard charges in a consumer-friendly manner, the hospital must ensure (among the other requirements at 45 CFR §180.60(a)(2)) that the tool allows healthcare consumers to, at the time they use the tool, obtain an estimate of the amount that the hospital anticipates the individual would be obligated to pay. This means that the estimated amount is a personalized estimate of ''the amount'' the individual would be obligated to pay and is therefore represented as a single out-of-pocket dollar amount that takes into account the individual's insurance status (86 FR 63954). We note, however, that Hospital Price Transparency final rule is not prescriptive regarding the method by which a hospital's price estimator tool estimates the individual's single out-of-pocket dollar amount, and nothing in the rule prevents a hospital from developing an accurate and reliable cost estimate using prior claims information or from providing additional information that may be useful to the end-user, such as the range of out-of-pocket costs for the population to which the individual belongs.

Does CMS have an example of disclaimer language that a hospital could use on its price estimator tool?

No. Each hospital is unique and serves a unique patient population. We encourage, but do not require, hospitals to provide disclaimers as applicable and appropriate in their price estimator tools, including disclaimers acknowledging the limitation of the presented standard charge information and advising the user to consult, as applicable, with his or her health insurer to

confirm individual payment responsibilities and remaining deductible balances.

Similarly, we encourage, but do not require, that hospital standard charge information include the following:

- Notification of the availability of financial aid, multiple procedure discounts, payment plans, and assistance in enrolling for Medicaid or a state program.
- An indicator for the quality of care in the healthcare setting.
- Making the standard charge information available in languages other than English, such as Spanish and other languages that would meet the needs of the communities and populations the hospital serves.

We discussed the flexibility to provide disclaimers in hospital price estimator tools at 84 FR 65578-65579.

Can CMS provide a list of internet-based price estimator tool vendors?

No, we do not have an available list of vendors who provide price estimator tool application software.

Enforcement and Compliance

What happens if a hospital does not comply with the Hospital Price Transparency Final Rule?

CMS has the authority to monitor hospital compliance with section 2718(e) of the Public Health Service Act, by evaluating complaints made by individuals or entities to CMS, reviewing individuals' or entities' analysis of noncompliance, and auditing hospitals' websites. Should CMS conclude a hospital is noncompliant with one or more of the requirements to make public standard charges, CMS may provide a warning notice to the hospital, request a corrective action plan (CAP) from the hospital if its noncompliance constitutes a material violation of one or more requirements, and may assess on a hospital a civil monetary penalty, and publicize the penalty on a CMS website, should the hospital fail to respond to CMS' request to submit, or comply with the requirements, of a CAP. Please refer to amended 45 CFR § 180.90 for adjusted penalty amounts under Subpart C- Monitoring and Penalties for Noncompliance.

What is CMS' process for enforcing the Hospital Price Transparency rules?

The enforcement process is established in the Hospital Price Transparency regulations and occurs in a phased manner. The process typically involves a comprehensive compliance review in response to CMS audit or a complaint received through the Hospital Price Transparency website. If CMS concludes a hospital is noncompliant with one or more of the requirements to make public standard changes, CMS may take any of the following actions, which generally, but not necessarily, will occur in the following order:

- Provide a written warning notice to the hospital of the specific violation(s)
- Request a Corrective Action Plan (CAP) if noncompliance constitutes a material violation of one or more requirements
- Impose a civil monetary penalty

In accordance with 45 CFR 180.80(c), if CMS issues a request for a hospital to submit a CAP, it must be submitted by the date specified in the request and must specify the process the hospital will take to address the deficiency(ies) identified by CMS and the timeframe by which the hospital will complete the corrective action. A CAP is subject to CMS review and approval. For reference, CMS has developed a CAP Response Sample as an optional format for submitting a CAP. Should a hospital that CMS has identified as noncompliant fail to respond to CMS' request to submit a CAP or comply with CAP requirements, CMS may impose a CMP in accordance with 45 CFR §180.90(a). Once CMS issues a CMP, CMS will post the notice of imposition of a CMP on a CMS website (45 CFR §180.90(e)).

How does CMS assess compliance?

During a comprehensive compliance review, CMS assesses whether the hospital's disclosure of standard charges meet the requirements specified at 45 CFR Part 180. Specifically, CMS assesses whether the hospital has displayed standard charges in a machine-readable file in accordance with the criteria established at 45 CFR §180.50 and shoppable services in a consumer-friendly manner in accordance with the criteria established at 45 CFR §180.60.

What is CMS doing to educate hospitals and assist them with compliance?

CMS has, to date, engaged in several education and outreach activities to help prepare hospitals for compliance:

- held several National Open Door Forums to review the requirements of the Hospital Price Transparency final rule;
- established a dedicated hospital price transparency website at Hospital Price Transparency | CMS with extensive FAQs, guides, webinar presentations and recordings for hospitals;
- established a hospital price transparency tools website at Hospital Price Transparency - Tools (cmsgov.github.io) with tools to support hospitals in meeting some of the machine-readable file (MRF) requirements;
- established the Hospital Price Transparency- Data Dictionary GitHub repository which houses the required CMS MRF templates, provides the data dictionary (or technical instruction) on how hospitals must encode standard charge information into machine-readable files starting July 1, 2024, and provides technical support; and

- established an inquiry email box (PriceTransparencyHospitalCharges@cms.hhs.gov) and (HPTCompliance@cms.hhs.gov).

Transcripts of National Open-Door Forums can be found here: https://www.cms.gov/Outreach-and- Education/Outreach/OpenDoorForums/PodcastAndTranscripts.

My hospital received a warning notice or request for a Corrective Action Plan (CAP) from CMS. How do I contact CMS with questions about the deficiencies outlined in the notice?

An authorized official from your hospital may contact CMS via email at: HPTCompliance@cms.hhs.gov. When contacting CMS regarding the Hospital Price Transparency warning letter or CAP request your hospital received, please submit detailed questions in writing. CMS cannot offer anything that could be construed as legal advice. We therefore recommend that individuals consult with hospital counsel and/or compliance officials.

Do I need to respond to a warning notice my hospital received?

Yes. As indicated in the CY 2024 OPPS/ASC Final Rule, CMS requires a hospital to submit an acknowledgement of receipt of the warning notice in the form and manner, and by the deadline, specified in the notice of violation issued by CMS to the hospital. Please refer to the discussion at 88 FR 82118.

Do I need to notify CMS when my hospital has corrected any deficiencies identified in the warning notice?

No. CMS will review the hospital website after the close of the indicated period to determine if the deficiencies have been remedied or if further compliance actions are warranted.

My hospital is part of a larger hospital system. What happens if one of the hospitals in our health system received a warning notice from CMS outlining deficiencies?

As indicated in the CY 2024 OPPS/ASC Final Rule, in the event CMS takes an action to address hospital noncompliance and the hospital is determined by CMS to be part of a health system, CMS may notify health system leadership of the action and may work with health system leadership to address similar deficiencies for hospitals across the health system. Please refer to the discussion at 88 FR 82119.

How will CMS calculate the Civil Monetary Penalty (CMP), beginning January 1, 2022, and with respect to that timeframe forward? What is the CMP calculation?

The maximum daily CMP amount for hospitals with 30 or fewer beds is $300, even if the hospital is in violation of multiple discrete requirements. The maximum daily CMP amount for hospitals with at least 31 and up to 550 beds is the number of beds times $10. For hospitals with greater than 550 beds, the maximum daily CMP amount is $5,500, even if the hospital is in violation of multiple discrete requirements. Refer to 45 CFR §180.90(c)(2).

Ex. A noncompliant hospital with a bed count of 200 would be assessed a maximum daily CMP of $2,000/day ($10*200/day) or $730,000/year.

Number of Beds	Maximum Penalty Applied Per Day	Total Maximum Penalty Amount for full Calendar Year of Noncompliance
30 or fewer	$300 per hospital	$109,500 per hospital
31 up to 550	$310 - $5,500 per hospital (number of beds times $10)	$113,150 - $2,007,500 per hospital
>550	$5,500 per hospital	$2,007,500 per hospital

Note: In subsequent years, amounts will be adjusted according to 45 CFR 180.90(c)(3).

Why is a scaling factor being used?

A scaling factor is being used to address a trend towards a high rate of hospital noncompliance identified by CMS through sampling and reviews to date, and the reported initial high rate of hospital noncompliance with 45 CFR part 180. Several factors informed our decision to use a scaling factor to determine the CMP, including: the ability to penalize based on a sliding scale method that relates to the hospital's characteristics, such as using the hospital's number of beds as a proxy for the size of the patient population; the use of scaling factors in other Federal programs to determine CMP amounts; and the availability of a reliable source of data that can be used to establish a CMP amount across most hospitals. We believe a scaling factor approach strikes an appropriate balance and provides for the assessment of a CMP that is commensurate with the level of severity of the potential violation. Please refer to the discussion at 86 FR 63948.

Updated- What is the source of data used to determine bed count for scaling the CMP and where is that information located? How will CMS determine the bed count for a hospital that is not a Medicare-enrolled hospital?

The scaling factor for the CMP amount uses the most recently available, finalized hospital cost

report data. The cost report contains provider information such as facility characteristics and financial statement data. CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS). Further, the chief financial officer or administrator of the provider certifies the content of the submitted cost report is true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions.[11] The website is available here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost- Reports. Please refer to the discussion at 86 FR 63944.

If the bed count information cannot be determined using Medicare hospital cost report data, CMS will specify the conditions for CMS' receipt of documentation from the hospital to determine its number of beds, and if the hospital does not provide CMS with such documentation (in the prescribed form and manner, and by the specified deadline), CMS will impose a CMP on the hospital at the highest, maximum daily dollar amount ($5,500 per day). Please refer to 45 CFR § 180.90(c)(2)(ii)(D)(2).

Is there a public list of non-compliant hospitals that have been assessed a civil monetary penalty (CMP)?

The public list of non-compliant hospitals that have been assessed a CMP is located on the CMS Price Transparency website: https://www.cms.gov/hospital-price-transparency/enforcement-actions.

Appeal of Civil Monetary Penalties

Can a hospital appeal a civil monetary penalty related to hospital price transparency?

Yes. A hospital upon which CMS has imposed a penalty may request a hearing before an Administrative Law Judge (ALJ) in accordance with 45 CFR part 180, subpart D. In deciding whether the amount of a civil monetary penalty is reasonable, the ALJ may only consider evidence of record related to the following: hospital's posting(s) of standard charges, if available; material the hospital timely previously submitted to CMS (including with respect to corrective actions and corrective action plans), and material CMS used to monitor and assess the hospital's compliance.

How long does a hospital have to request a hearing?

[11] 42 CFR 413.24(f)(4)(iv). See also, Form CMS-2552-10. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935, Chapter 40-(T16)-- Hospital & Hospital Health Care (Form CMS-2552-10) (ZIP), file "R16P240f.pdf", Part II – Certification.

A hospital must request a hearing within 30 calendar days after the date of issuance of the notice of imposition of a civil monetary penalty. The "date of issuance" is no more than five (5) days after the filing date postmarked by the U.S. Postal Service, or deposited with a carrier for commercial delivery, unless there is a showing that the document was received earlier. Please refer to 45 CFR §150.401 and 45 CFR §150.405(a).

Can a hospital request an extension of time for filing a request for a hearing?

A request for an extension of time must be made promptly by written motion. The ALJ may extend the time for filing a request for hearing only if the ALJ finds that the hospital was prevented by events or circumstances beyond its control from filing its request within 30 calendar days after the date of issuance of the notice of imposition of a civil monetary penalty. Please refer to 45 CFR §150.405(b).

Updated- What happens if a hospital does not request a hearing within the required timeframe?

If a hospital does not request a hearing within 30 calendar days of the issuance of the notice of imposition of a CMP, CMS may impose the CMP indicated in such notice and may impose additional penalties pursuant to continuing violations according to 45 CFR §180.90(f) without right of appeal. 45 CFR §180.110(b) provides that the hospital has no right to appeal a penalty for which it has not requested a hearing in accordance with 45 CFR §150.405, unless the hospital can show good cause, as determined at 45 CFR §150.405(b), for failing to timely exercise its right to a hearing.

Beginning January 1, 2026, hospitals may be eligible to receive a 35 percent reduction in the civil monetary penalty amount by requesting to waive its right to a hearing under § 180.100 within 30 calendar days of the issuance of the notice of imposition of a CMP. Please refer to 45 CFR § 180.90(c)(4) for more information.

Questions for Consumers

How does the hospital price transparency initiative support consumers of healthcare services?

We believe the policies requiring public release of hospital standard charge information are a necessary and important first step in ensuring transparency in prices of healthcare services for consumers, however, we recognize that the release of hospital standard charge information is not itself sufficient to achieve our ultimate price transparency goals. The regulations are designed to begin to address some of the barriers that limit price transparency, with a goal of increasing competition among healthcare providers to bring down costs. Competition in the healthcare industry benefits consumers because it helps contain costs, improve quality, expand

choice, and encourage innovation. Please refer to the discussion at 88 FR 82080 for more information.

Where can I find information about other federal price transparency initiatives?

The hospital price transparency regulations are one tool to address barriers that limit price transparency. In addition to the hospital price transparency regulations, CMS is also providing consumers with the tools to access pricing information through their health insurance plans through the Transparency in Coverage Final Rules (TiC Final Rules). Under the TiC Final Rules, plans and issuers must make price comparison information available through an internet-based self-service tool and in paper form, upon request. Under the TiC Final Rules, plans and issuers must also post pricing information for covered items and services. This pricing information can be used by third parties, such as researchers and app developers to help consumers better understand the costs associated with their health care. More information about the Transparency in Coverage Final Rules can be found at https://www.cms.gov/priorities/key-initiatives/healthplan-price-transparency.

In addition, the No Surprises Act (NSA) includes additional requirements that relate to price transparency and protect uninsured and self-pay individuals from unexpectedly large medical bills. The NSA requires providers and facilities, upon an individual's scheduling of items or services, or upon request, to provide a good faith estimate of the expected charges for furnishing the scheduled item or service and any items or services reasonably expected to be provided in conjunction with those items and services. Should that estimate be off by more than $400, patients may be able to dispute the charge through the patient-provider dispute resolution process. Once implemented, upon receiving a good faith estimate plans and issuers will be required to send an Advanced Explanation of Benefits to the participant, beneficiary, or enrollee.

To help consumers understand their rights and protections under the NSA, CMS updated information and resources on CMS.gov. These updates give consumers who receive unexpected or high medical bills information on the protections they have and may not be aware of. New sections help consumers identify what actions are appropriate to their billing situation and provide tools for them to take next steps. The consumer content can be found at https://www.cms.gov/medical-bill-rights.

Does the Hospital Price Transparency regulation require hospitals to tell me the cost of services prior to receiving care?

The Hospital Price Transparency regulation requires hospitals to make standard charge information available to the public online in two ways: a machine-readable file and a consumer-friendly list for a limited set of shoppable services. Although critical for determining an

individual's out-of-pocket obligation, hospital standard charges do not represent either an individual's out-of-pocket obligation or a "guaranteed price." However, we note that individualized estimates in dollars may be obtained directly, in many circumstances, from providers and payers through other Federal price transparency efforts such as those implementing the No Surprises Act and Transparency in Coverage requirements. As such, we strongly encourage individual consumers to utilize hospital and payer price estimator and comparison tools, and to request 'good faith estimates' from hospitals and providers to provide up-front pricing that can be used to dispute final charges that are substantially in excess of the up-front amounts. Please refer to the discussion at 88 FR 82081.

I received a hospital bill that doesn't match the hospital's standard charges posted online or what the hospital billing department told me. Can the CMS Hospital Price Transparency program help me?

Hospital standard charges do not represent either an individual's out-of-pocket obligation or a guaranteed price, as they do not factor individual circumstances for each patient. As such, we strongly encourage individual consumers to utilize hospital and payer price estimator and comparison tools, and to request "good faith estimates" from hospitals and providers which may provide up-front pricing that can be used to dispute final charges. Please refer to the discussion at 88 FR 82081. Learn more about the protections that apply to you or find an action plan for your medical bill at https://www.cms.gov/medical-bill-rights.

Where can I look to find a hospital's standard charges? Can CMS provide me with the standard charges for a particular hospital?

Effective January 1, 2024, hospitals must ensure the public website that hosts the machine-readable file includes a link in the footer on its website, including but not limited to the homepage, that is labeled "Price Transparency" and links directly to the publicly available web page that hosts the link to the machine-readable file. Please refer to the discussion at 88 FR 82111. Hospitals' consumer-friendly displays may be located on the same web page that hosts the machine-readable file.

We did not propose, nor did we finalize, any requirement for hospitals to submit or upload a link to their standard charge information to a CMS-specified centralized website. At this time, we believe such an effort could be unnecessarily duplicative of ongoing State and private sector efforts to centralize hospital pricing information and potentially confuse consumers who may reasonably look to a hospital website directly for standard charge information. Please refer to the discussion at 84 FR 65561.

There are hospital machine-readable files (MRFs) that contain many blank cells when I open and view the file in a spreadsheet format. Does this mean the

hospital has not fulfilled its requirement to display its standard charge information accurately and completely as required under the regulation?

Under the hospital price transparency regulations, if a hospital has established standard charge information for a required data element, the hospital is required to display that information accurately and completely in its MRF.

Within the CSV format, a hospital MRF may have many 'blank' cells signifying the hospital did not have any applicable data to encode in the cell. In the CY 2024 OPPS/ASC final rule, we recognized that a 'blank' cell within a human-readable spreadsheet does not necessarily mean that the MRF is incomplete or inaccurate. We illustrated this point with a specific example where a hospital may have established a gross charge for an item or service but has not established a payer-specific negotiated charge that corresponds to the same item or service (88 FR 82108).

I can't find standard charges for a hospital where I have received or will be receiving care. Should I file a complaint? What happens after I file a complaint?

The hospital price transparency team is only able to address concerns related to the specific requirements of the hospital price transparency initiative. If you are seeking a personalized price for healthcare services you received or are scheduled to receive, we recommend you contact the hospital. If you are looking for hospital standard charge information made public online in a machine-readable file format but are unable to find it, you may submit a complaint to CMS. CMS does not respond to the original complaint. Enforcement actions can be found here: https://www.cms.gov/hospital-price-transparency/enforcement-actions.