HOSPITAL PRICE TRANSPARENCY IS HERE TO STAY: COMPLIANCE TIPS AND ENFORCEMENT TRENDS

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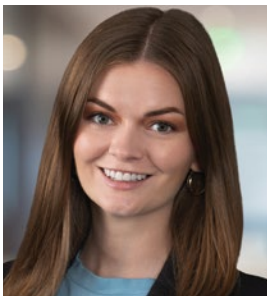

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Hospital Price Transparency Rule

"Bringing Down the Cost of Health Care Coverage," or Section 2718(e) of the Public Health Service Act enacted on March 23, 2010, obligated hospitals operating within the U.S. to publish data on the cost of care.[1] In response, the Centers for Medicare & Medicaid Services (CMS) promulgated its final rule known as the Hospital Price Transparency (HPT) on November 27, 2019, laying out specific requirements for hospitals to publish their charges for items and services provided by the hospital.[2] CMS reasoned that "hospital price transparency helps Americans know the cost of a hospital item or service before receiving it."[3] These requirements create public resources for consumers to compare costs across the healthcare sector and are intended to "empower[] patients with the individuals with the best information possible to inform their life and healthcare choices."[4]

Federally owned hospital facilities, including facilities operated by the U.S. Department of Veterans Affairs, Military Treatment Facilities operated by the U.S. Department of Defense, and hospitals operated by an Indian Health Program, are deemed by CMS to be in compliance with the established requirements.[5]

As a result, effective January 1, 2021, nonexempt institutions licensed as hospitals in the U.S. must publicly post, via a machine-readable file (MRF), a set of standard charges for all items and services provided by the hospital.[6] Hospitals have also been required to provide clear, accessible pricing information about the items and services they provide through a "consumer-friendly Display of Shoppable Services."[7] Beginning January 1, 2021, CMS monitored and enforced these price transparency requirements, and for hospitals that have not complied, CMS is authorized to issue warning notices, request a corrective action plan, and/or impose a civil monetary penalty and publicize the penalty on a CMS website.[8]

MRF: Required data elements and standard charges

The HPT established enforceable guidelines by which hospitals must establish, update, and make public a list of standard charges for all items and services online in an MRF that contains the standard charges that apply across settings within a hospital at least annually.[9] The rule defines several types of "standard charges" to be included in the MRF: (i) gross charges, (ii) discounted cash prices, and (iii) payer-specific negotiated charges, and (iv) de-identified minimum and maximum negotiated charges.[10] Each hospital location operating under a single hospital

license that has a different set of standard charges than the other locations must separately make public the standard charges applicable to that location.[11] Further rule required that the information is required to be easily accessible without barriers: the information must be free of charge; available without a user account or password; available without having to submit personal identifying information; and accessible to automated searches and direct file downloads through a link posted on a publicly available website.[12] Moreover, "the machine-readable file and standard charge information contained in that machine-readable file must be digitally searchable."[13]

January 1, 2021–June 30, 2024

Prior to July 1, 2024, a hospital was required to have all the following data elements in its list of standard charges:

- A description of each item or service provided by the hospital;
- The gross charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting;
- The payer-specific negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting, which must have been clearly associated with the name of the third-party payer and plan;
- The de-identified minimum negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting;
- The de-identified maximum negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting;
- The discounted cash price that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting; and
- Any code used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to, the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), the National Drug Code (NDC), or other common payer identifier.[14]

This information was intended to be comprehensive and available for public use.

July 1, 2024, and beyond

CMS subsequently expanded the required data elements in the list of standard charge information. Effective July 1, 2024 (unless otherwise specified), each hospital must encode the following additional data elements in its MRF:

- "Hospital name, license number, and location name(s) and address(es) under the single hospital license to which the list of standard charges applies . . . location name(s) and address(es) [including], at minimum, all inpatient facilities and stand-alone emergency departments";[15]
- "The version number of the CMS template and the date of most recent update to the standard charge information in the machine-readable file";[16]
- "For payer-specific negotiated charges, additional data elements include payer and plan names, the method used to establish the standard charge, and whether the standard charge indicated should be interpreted by the user as a dollar amount, or if the standard charge is based on a percentage or algorithm ("If the standard charge is based on a percentage or algorithm, the machine-readable file (MRF) must also describe the percentage or algorithm that determines the dollar amount for the item or service, and, beginning January 1, 2025, calculate and encode an estimated allowed amount in dollars for that item or service.");[17]
- "A description of the item or service that corresponds to the standard charge established by the hospital, including: (A) A general description of the item or service; (B) Whether the item or service was provided in connection with an inpatient admission or an outpatient department visit; and (C) Beginning January 1, 2025, for drugs, the drug unit and type of measurement."[18]
- "Coding information, including: (A) Any code(s) used by the hospital for purposes of accounting or billing for the item or service; (B) Corresponding code type(s). Such code types may include, but are not limited to, the CPT code, the HCPCS code, the DRG, the NDC, Revenue Center Codes (RCC), or other common payer identifier; and (C) Beginning January 1, 2025, any modifier(s) that may change the standard charge that corresponds to a hospital item or service, including a description of the modifier and how it changes the standard charge."[19]

Further, the MRF must conform to CMS's template layout, data specifications, and data dictionary for purposes of making public the standard charge information

required.[20] The MRF must use the following naming convention specified by CMS: "**<ein>_<hospital-name>_standardcharges.[json|csv]**" (emphasis added).[21] The public website hosting the MRF needs to be a ".txt file in the root folder that includes: (A) the hospital location name that corresponds to the machine-readable file; (B) the source page URL that hosts the machine-readable file; (C) A direct link to the machine-readable file (the machine-readable file URL); and (D) hospital point of contact information."

In addition, the hospital must have a link in the footer of its website (including, but not limited to, the home page) directly to the publicly available web page that hosts the link to the MRF labeled "Price Transparency."[22]

Initially, hospitals only needed to ensure that the standard charge information encoded in the MRFs was true, accurate, and complete as of the date indicated in the MRF.[23] Starting July 1, 2024, hospitals must also affirm in their MRF that, to the best of their knowledge and belief, the hospital included all applicable standard charge information in accordance with the requirements of the rule, and that the information encoded was true, accurate, and complete as of the date indicated in the MRF.[24]

Consumer-friendly list of shoppable services

In addition to posting the MRF discussed above, hospitals must maintain an internet-based price estimator tool for at least 300 shoppable services in a consumer-friendly manner.[25] CMS specifies a list of 70 shoppable services that every hospital must include (or as many of the 70 that the hospital provides), and the individual hospital may select the other 230-plus shoppable services. It should account for how often that service is performed and billed.[26] If the hospital provides less than 300 shoppable services, it must then make the information available for all the shoppable services that it provides. This information must be prominently displayed on the hospital's website for consumers to access for free, without any registration requirements, and without having to submit any personal identifying information.[27]

The following information is required for each shoppable service:

- A plain language description of the services;
- An indication when any of the 70 CMS specified services are not offered;
- The discounted cash prices or gross charges as applicable, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges (along with any corresponding ancillary services, as applicable)
- The location at which the shoppable service is provided, and whether the standard charges apply at that location to the provision of the service in the inpatient setting, the outpatient department setting, or both; and
- Any primary code used for purposes of accounting or billing for the shoppable service.[28]

This information must be updated at least annually.

Enforcement mechanisms

CMS has three main avenues for monitoring and assessing hospitals' noncompliance with the HPT: (1) evaluating complaints made by individuals or entities; (2) review of individuals' or entities' analysis of noncompliance; and (3) internal audits of hospitals' websites.[29] CMS has explained that it "prioritizes hospitals for comprehensive reviews based on the degree to which the hospital appears to be out of compliance with the Hospital Price Transparency regulation."[30] Further, "when initially evaluating [consumer submitted] complaints, if a hospital has alleged egregious violations, such as failure to publish any machine-readable file, that case is prioritized."

If CMS finds that a hospital is noncompliant with one or more of the public disclosure requirements, it will send a notice with instructions to correct the deficiencies within 90 days. The hospital must acknowledge 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.[31] If a hospital has not come into compliance after 90 days, CMS will request that the hospital submit a corrective action plan (CAP) 45-days.[32] Hospitals should include a completion date for the CAP with the submission for CMS's approval. On average, these CAPs range from 30 to 90 days. For hospitals that have not completed the necessary steps and come into compliance, CMS may issue a civil monetary penalty (CMP). During 2021, the CMP was limited to $300 "even if the hospital is in violation of multiple discrete requirements" of the regulation.[33] As of January 1, 2022, penalties were tailored based on the size of the hospital.[34]

Starting January 1, 2023, the CMP is adjusted annually based on the Office of Management and Budget's multiplier.[35]

In addition to imposing CMPs, CMS may publicize information related to CMS's assessment of a hospital's compliance, any compliance taken against a hospital, the status of any compliance action, or the outcome of such compliance

Table 1. Maximum Penalties Based on Hospital Size

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 (no. beds x $10)	$113,150– $2,007,500 per hospital
> 550	$5,500 per hospital	$2,007,500 per hospital

action, and notifications sent to health system leadership on its website.[36]

In the first two years of the HPT's implementation, CMS reported a substantial increase in hospitals meeting the requisite criteria.[37, 38] Specifically, compliance increased from 27% in 2021 to 70% percent in 2022. Of the remaining 30% that failed to meet the criteria, 27% partially met the assessment criteria.

In April 2023, CMS announced updates to the enforcement process to increase the rates of compliance.[39] These updates included the addition of CAP completion deadlines and imposition of CMPs earlier and automatically.

Summary of compliance trends/ enforcement trends

From 2021 through 2023, CMS conducted compliance reviews of 1,746 hospitals and initiated enforcement actions against 1,287 (74%) of the reviewed hospitals for noncompliance with HPT requirements.[40] From 2021 through 2023, CMS issued more than $4 million in civil monetary penalties to 14 hospitals that did not take timely corrective actions in response to CMS corrective action plan requests.

While the number of enforcement actions decreased from 2021 to 2022, enforcement activity significantly increased in 2023, with a total of 851 actions initiated. CMS issued two of the civil monetary penalties in 2022, and 12 in 2023. This shift is likely attributable to CMS engaging a contractor and implementing a new IT system to help better track and automate certain review activities.

Of all CMS enforcement actions initiated from 2021 through 2023 and closed as of May 2024, about one-third were taken against hospitals that had not posted an MRF. In other cases, hospitals posted prices that did not comply with price transparency requirements. More than 40% of the enforcement actions in this analysis were associated with hospitals that posted MRFs but did not fully provide data for all five types of required prices. Of the hospitals that did not fully provide data for all five types of required prices, the most common deficiency was not posting all plan-specific negotiated prices. Specifically, 35% of the CMS enforcement actions were associated with hospitals whose files had no or missing plan-specific negotiated prices.

Common errors found in the MRF included:

- Missing pricing data
- Listing only the payer name and not the specific plan
- Not following CMS's file naming convention
- Not passing the CMS Validator Tool

Related, hospitals listed more "accepted insurance plans" on their websites than they included in the MRF.

With respect to compliance with the shoppable services display, 97% of the hospitals published a price estimator tool (up from 90% in February 2024), but 78% of them were still noncompliant with the HPT requirements due to issues with their MRF.

What's next for HPT?

HPT has now become a centerpiece of federal health care policy under both Republican and Democratic administrations. Specifically, the policy has seen renewed momentum under the current Trump administration through Executive Order (EO) 14221, "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information."[41] This EO builds on President Donald Trump's push for "radical transparency" in medical billing and directs federal agencies to issue more stringent regulations, strengthen enforcement, and standardize cost disclosures across hospitals, insurers, and pharmacy benefit managers.

Under the EO, CMS and other agencies have taken a series of regulatory actions designed to close compliance loopholes and increase the utility of published pricing data:

- Hospitals must now report actual, payer-specific negotiated rates—not estimates or placeholder values—using recent claims data or reasonable projections, per CMS guidance issued May 22, 2025.[42]
- CMS is working to standardize the format and schema for MRFs, including implementation of a mandatory "schema version 2.0" by February 2, 2026.[43]
- CMS has historically been expanding auditing tools and enforcement capabilities, including increased reliance on the CMS Validator Tool to flag incomplete or inconsistent data: "CMS requires that sponsoring organizations and their selected data validation contractors use the processes and tools contained in this *Procedure Manual* and its appendices to conduct the annual data validation . . . [which] assess an organization's information systems capabilities and overall processes for collecting, storing, compiling, and reporting the required Part C and Part D data measures".[44]
- In addition to these regulatory actions, requests for information issued by CMS and the U.S. Departments of Labor and Treasury in May 2025 indicate that federal agencies are actively exploring further updates. These include:
  - Requiring hospitals and payers to adopt uniform terminology and definitions for services and pricing elements;
  - Enhancing the interoperability of hospital and payer pricing data; and
  - Aligning hospital transparency requirements more closely with Transparency in Coverage rules applicable to insurers.[45]

In response to the EO, on July 15, 2025, CMS published the proposed CY 2026 Hospital Outpatient Prospective Payment System (OPPS) rule, which includes significant updates to hospital price transparency requirements. The proposed changes aim to enhance consumers' ability to compare prices across hospitals. The public comment period is open through September 13, 2025, and as such, the final rule and its specific requirements remain uncertain at the time of writing. Among the proposed changes, however, hospitals would be required, beginning January 1, 2026, to include the 10th, median, and 90th percentile allowed amounts in their MRFs when negotiated charges are based on percentages or algorithms. Hospitals would also need to disclose the count of allowed amounts used to determine these percentiles and use EDI 835 electronic remittance advice transaction data to calculate and encode these figures, following detailed methodology instructions provided by CMS. Additionally, hospitals would be required to attest to the inclusion of all applicable payer-specific negotiated charges expressed in dollars, or, where not knowable in advance, provide sufficient information to derive such amounts along with the name of a designated senior official (e.g., CEO or president) responsible for data accuracy. Other proposed changes include the mandatory inclusion of each hospital's Type 2 National Provider Identifier in its MRF. Finally, CMS has proposed modifying the civil monetary penalty policy: if a hospital accepts CMS's noncompliance determination and waives its right to an Administrative Law Judge hearing, the civil monetary penalty would be reduced by 35%.[46]

Further, additional rulemaking is expected that will address prescription drug pricing, particularly through the proposed integration of hospital data with pharmacy benefit manager disclosures, as mandated under EO 14221.

Finally, enforcement is poised to become more aggressive. CMS has publicly committed to earlier and automatic civil monetary penalties for noncompliant hospitals and to routine public posting of violations on its website. With compliance reviews and technological oversight tools expanding rapidly, hospitals should anticipate ongoing federal scrutiny—not one-time compliance.

Taken together, these developments signal a permanent regulatory shift: HPT is no longer an experiment. It is now a central and enforceable feature of federal health policy, with growing demands for data accuracy, usability, and integration. CT

Endnotes

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Takeaways

- Hospital price transparency is now a permanent and enforceable part of federal health policy, with bipartisan and executive-level support.
- The Centers for Medicare & Medicaid Services (CMS) requires hospitals to publish machine-readable files (MRFs) and consumer-friendly price tools with specific, detailed pricing data.
- Requirements expanded July 1, 2024, adding new data fields, formatting rules, and attestation obligations for MRFs.
- CMS enforcement is intensifying, with earlier penalties, stricter audits, and millions in fines issued from 2021 to 2023. The July 15, 2025, proposed rule signals continued dedication to enforcement.
- Future rules aim to standardize terminology, align hospital and insurer data, and integrate drug pricing disclosures under Executive Order 14221.