CY26 OPPS PROPOSED RULE
HOSPITAL PRICE TRANSPARENCY SUMMARY & COMMENT

WEBINAR PROVIDED BY CLEVERLEY + ASSOCIATES
AUGUST 27, 2025
www.cleverleyassociates.com

Hospital Price Transparency Timeline

FY19 IPPS Final Rule

- Initiated requirements for hospitals to comply with language in the Affordable Care Act
- Required hospitals to make available a list of their current standard charges via the Internet in a machine-readable format and to update this information at least annually

CY20 OPPS FINAL RULE ON TRANSPARENCY

- Introduced clarifications and definitions for language in the FY19 IPPS Final Rule
- A definition of "hospital" that requires nearly all hospitals to comply with the rule,
- Definitions for five types of "standard charges" – including, payer negotiated charges
- A definition of hospital "items and services" that includes employed professional fees
- Requirements for disclosing data in two formats: a machine-readable file (MRF) and a "consumer friendly" display
- Non-compliance monitoring, actions, civil monetary penalties, and appeal process

CY22 OPPS Final Rule

- Significantly increased the monetary penalties for non-compliance
- Language to prohibit the use of barriers to automatic download of the MRF on a hospital's website

CY24 OPPS Final Rule

- New requirements for website footer and .txt file for easier access to the MRF
- Implemented a required file schema in either .JSON or .CSV for the MRF. Among the new fields included in the template are charge method, algorithm, estimated allowed amounts, modifiers, and drug unit and type of measurement

HPT TIMELINE: 2025

February 2025

- Trump Executive Order
- Call for action within 90 days on HPT

May 2025

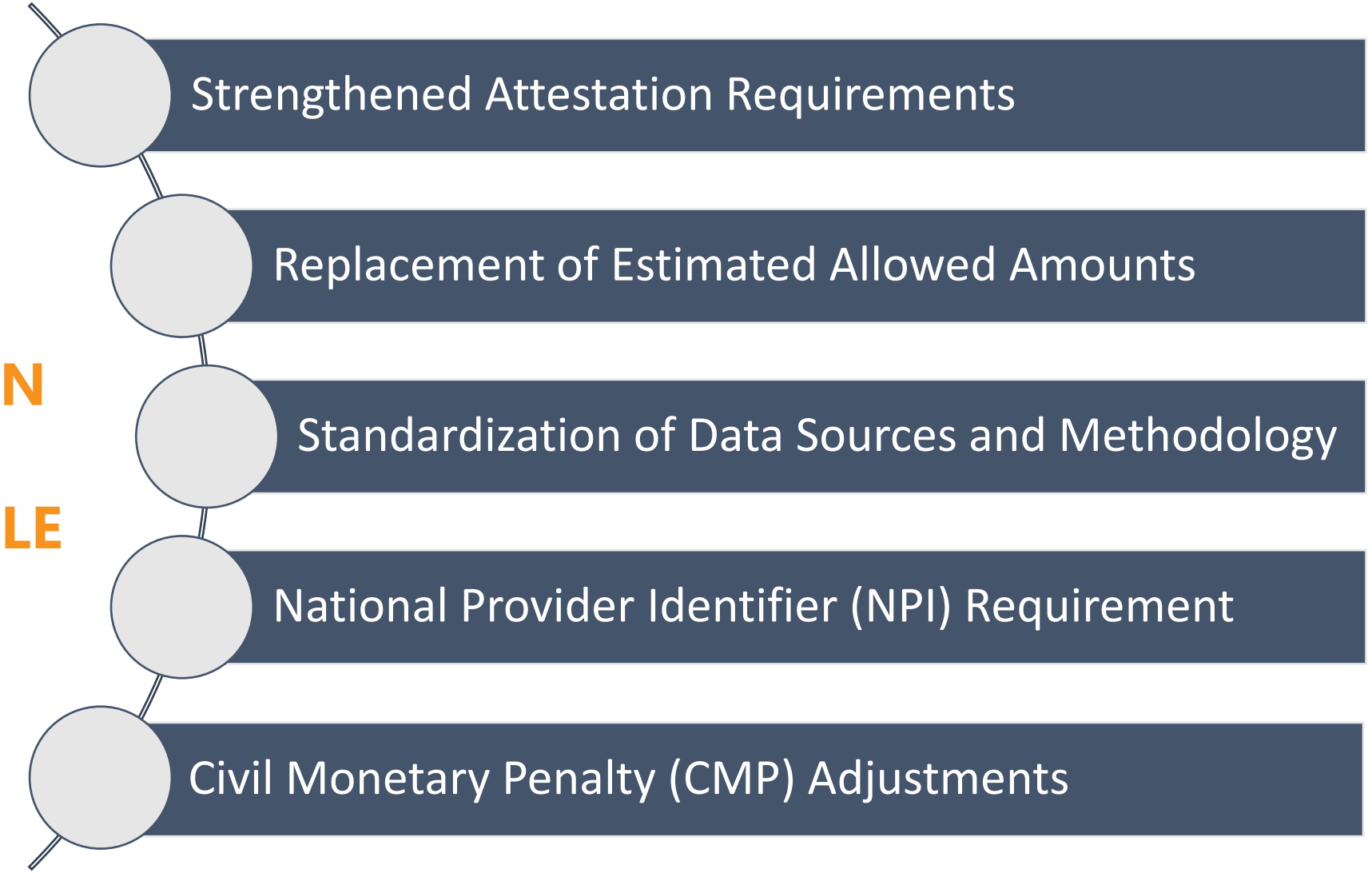
- HPT Guidance for constructing MRF to address February EO
- RFI regarding Accuracy & Completeness of MRF data

July 2025

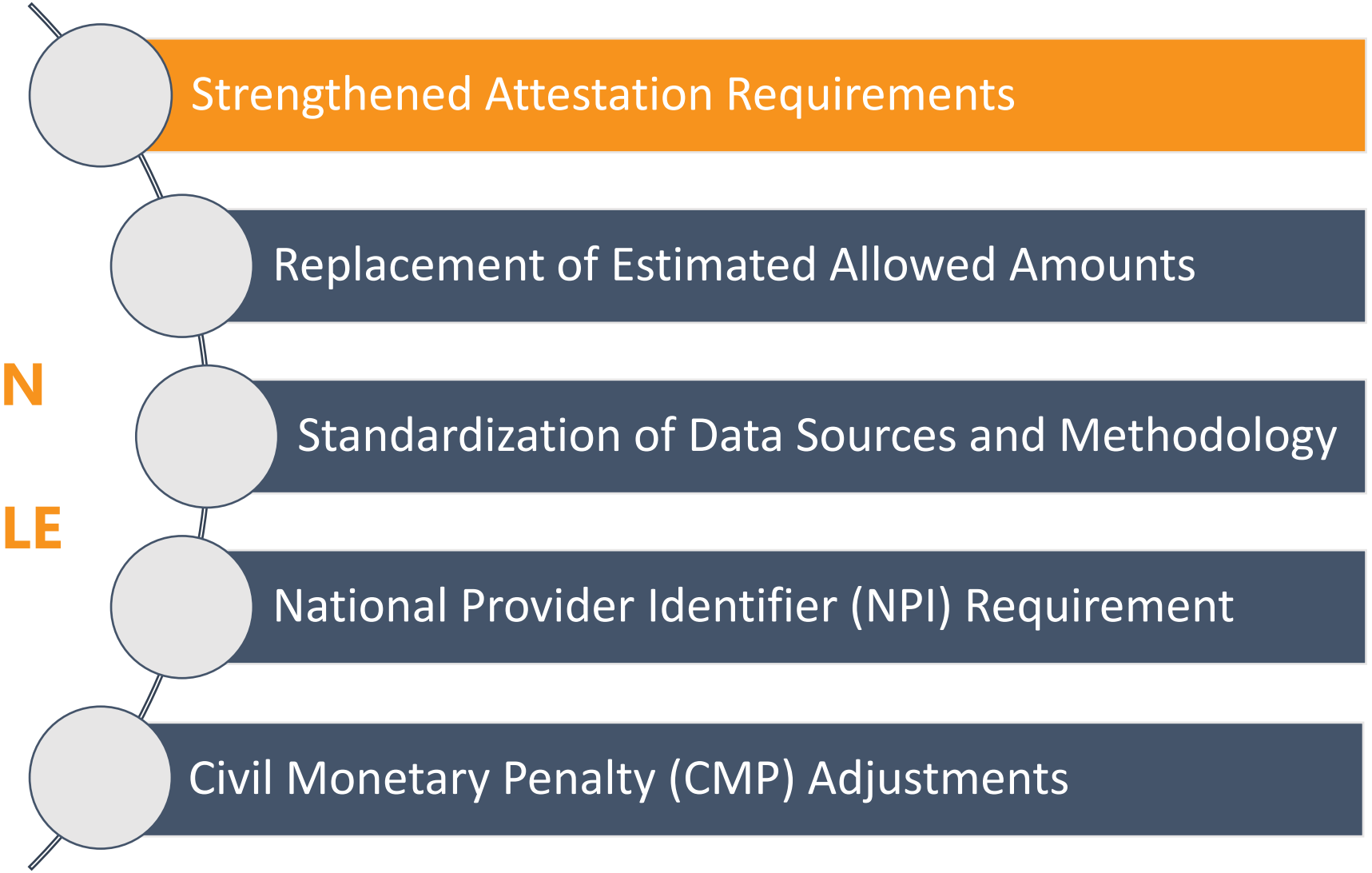
- Accuracy & Completeness RFI Due to CMS
- CY26 OPPS Proposed Rule containing significant updates to HPT

SIGNIFICANT HPT ACTIVITY IN 2025

KEY HPT PROVISIONS IN CY26 OPPS PROPOSED RULE



KEY HPT PROVISIONS IN CY26 OPPS PROPOSED RULE



Strengthened Attestation Requirements

SUMMARY

Beginning January 1, 2026, CMS proposes that hospitals include a revised attestation in their machine-readable files (MRFs) confirming that all standard charge data is complete, accurate, and compliant with CMS requirements. This includes:

- A new mandate to name a **senior official** (e.g., CEO or president) responsible for data integrity.

- Additionally, if a payer-specific negotiated charge is expressed as a percentage or algorithm, hospitals would be required to **encode all necessary components**—such as fee schedules, formulas, or referenced values—**so that the public can derive an actual dollar amount from the algorithm**.

Strengthened Attestation Requirements

Proposed Attestation Statement:

"The hospital has included all applicable standard charge information in accordance with the requirements of § 180.50, and the information encoded is true, accurate, and complete as of the date in the file. The hospital has included all payer-specific negotiated charges in dollars that can be expressed as a dollar amount. For payer-specific negotiated charges that cannot be expressed as a dollar amount in the machine-readable file or not knowable in advance, the hospital attests that the payer-specific negotiated charge is based on a contractual algorithm, percentage or formula that precludes the provision of a dollar amount and has provided all necessary information available to the hospital for the public to be able to derive the dollar amount, including, but not limited to, the specific fee schedule or components referenced in such percentage, algorithm or formula."

Strengthened Attestation Requirements

How does CMS define "algorithm" situations? From CY24 OPPS Final Rule:

"At other times, however, hospitals and payers establish the payer-specific negotiated charge by agreeing to an algorithm that will determine the dollar value of the allowed amount on a case-by-case basis after a pre-defined service package has been provided. This means that the standard charge that applies to the group of patients in a particular payer's plan ***can only*** *prospectively* ***be expressed as an algorithm****, because the resulting allowed amount in dollars will be individualized on a* ***case-by-case basis*** *for a pre-defined service package, and thus cannot be known in advance or displayed as a rate that applies to each member of the group."*

Strengthened Attestation Requirements

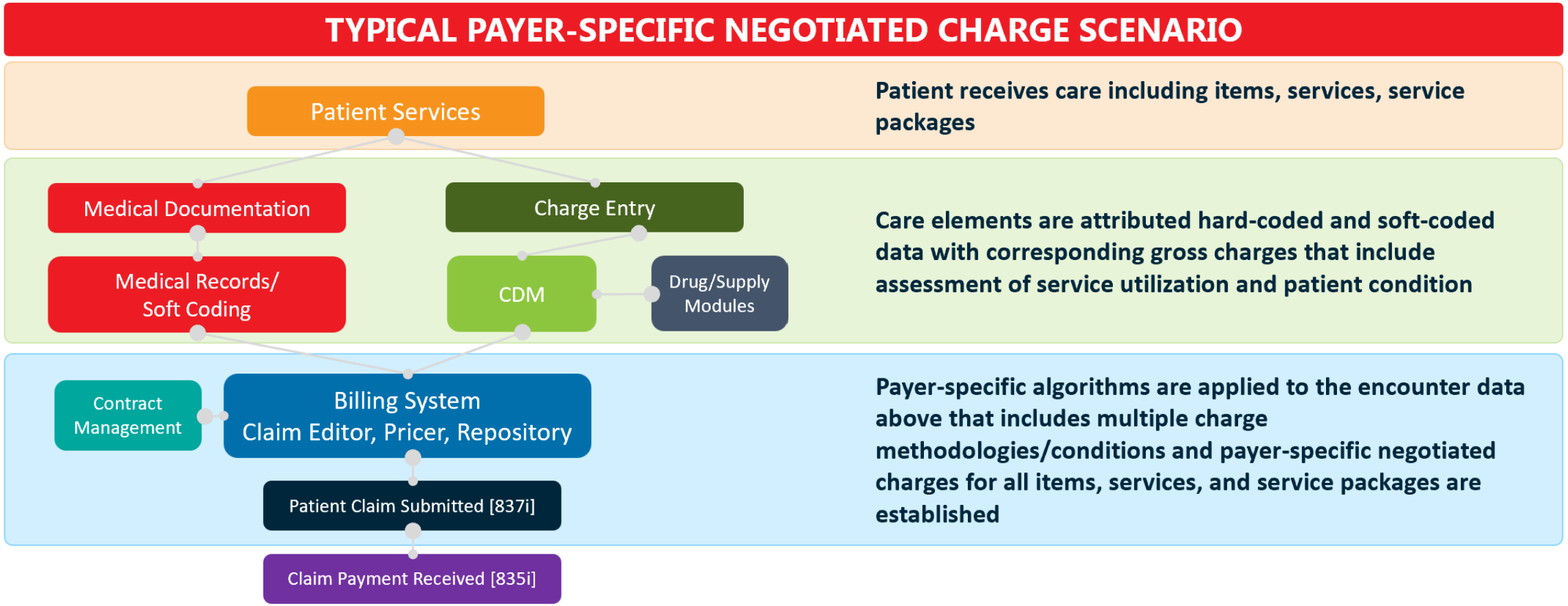
COMMENT CONSIDERATIONS

1) **Senior official:** hospitals may want to consider commenting on legal and public exposure sensitivities to having a named senior executive contained within the MRF

2) **Algorithm requirement:** providing all algorithm components in order to derive the anticipated payment for any healthcare procedure presents an unfathomable and unnecessary administrative burden that also far exceeds the MRF schema

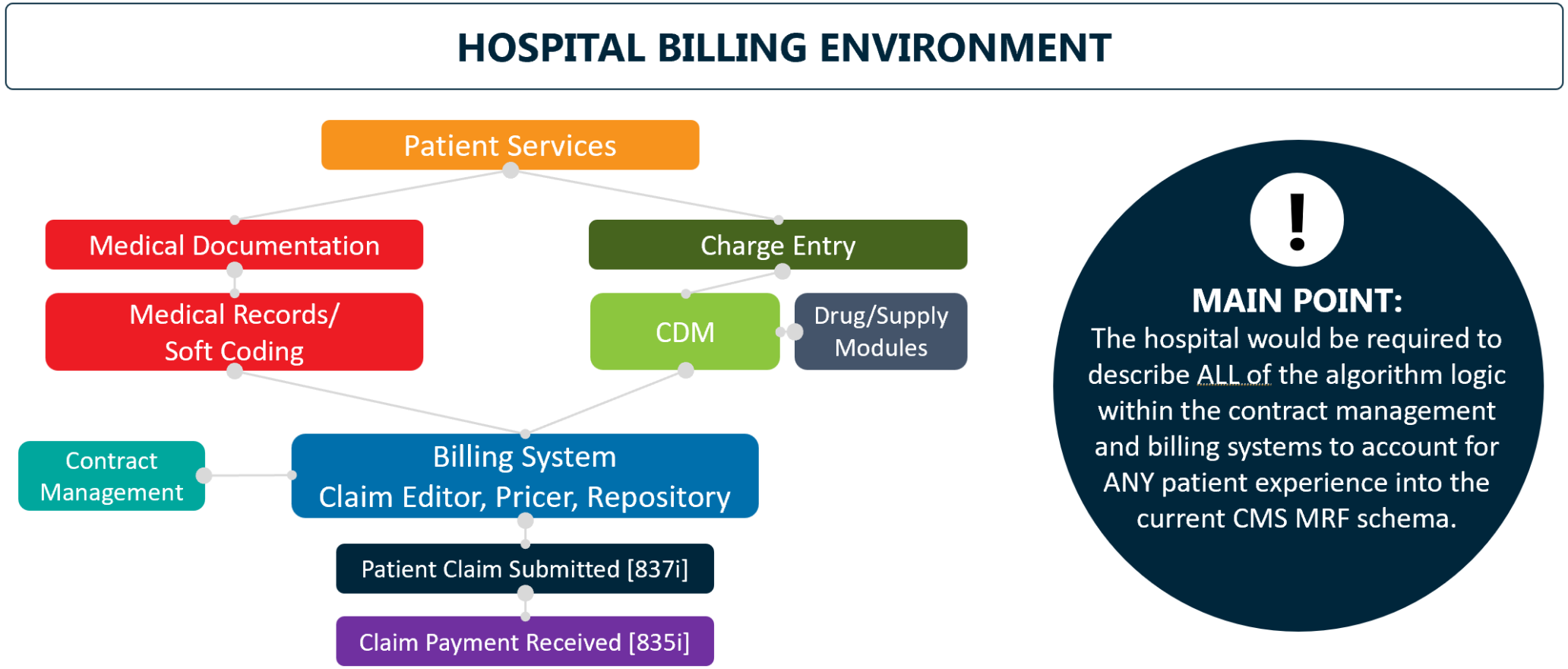
Strengthened Attestation Requirements

REQUIRING ALL ALGORITHM COMPONENTS: WHY IS IT SO BURDENSOME?



Strengthened Attestation Requirements

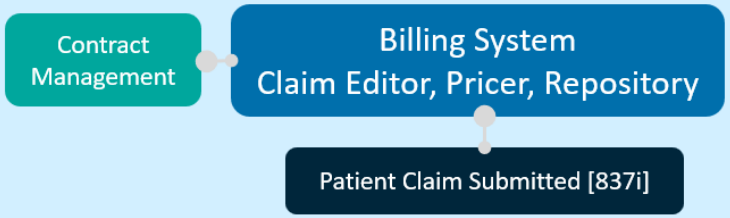
REQUIRING ALL ALGORITHM COMPONENTS: WHY IS IT SO BURDENSOME?



MAIN POINT:
The hospital would be required to describe ALL of the algorithm logic within the contract management and billing systems to account for ANY patient experience into the current CMS MRF schema.

Strengthened Attestation Requirements

REQUIRING ALL ALGORITHM COMPONENTS: WHY IS IT SO BURDENSOME?



COMMON ALGORITHM LOGIC USED TO GENERATE THE PAYER SPECIFIC NEGOTIATED CHARGE

- Payer specific code categorizations and groupers (some of which are not legally available to hospitals) with corresponding lists of HCPCS/CPT® codes and/or ranges, revenue code values/ranges, procedure and diagnosis code values/ranges, etc.
- MSDRG platform versions and corresponding lists of relative weights
- Charge threshold logic for lesser-of and stoploss provisions that is dependent on claim-level criteria
- Surgical case grouping logic dependent on relative weights of thousands of soft-coded CPT®/HCPCS conditions and multiple-procedure discounting rules that exist with corresponding lists of conditions and codes
- HIM/Medical Records policies and procedures for determining soft-coded assignments
- Packaging and exclusion logic based on claim level criteria based on lists of codes and/or code ranges
- Hierarchy rankings to determine when/how the payment is calculated based on the types of services provided and conditions listed above

Strengthened Attestation Requirements

WHAT'S THE DISCONNECT WITH OTHER CMS HPT LANGUAGE?

CY24 OPPS FINAL RULE

- "**in the interest of reducing burden and complexity of files, we will allow hospitals provide a description of the algorithm, rather than attempting to insert the specific algorithm itself in the MRF**."

CY26 OPPS PROPOSED RULE

- *Continued support for allowed amounts:* "data points with dollar amounts are necessary to support a better understanding of the costs of care, **especially given the complexities of hospital contractual arrangements with third party payers**."

CY26 OPPS PROPOSED RULE

- *Describing 10th & 90th percentile allowed amounts:* "Research demonstrates that healthcare prices for a service can vary widely even within one insurer, and are not uniformly distributed. **However, requiring a hospital to post every possible value and the frequency of those values would be highly burdensome to hospitals and would produce unmanageably large data files that are difficult to access and interpret."**

Strengthened Attestation Requirements

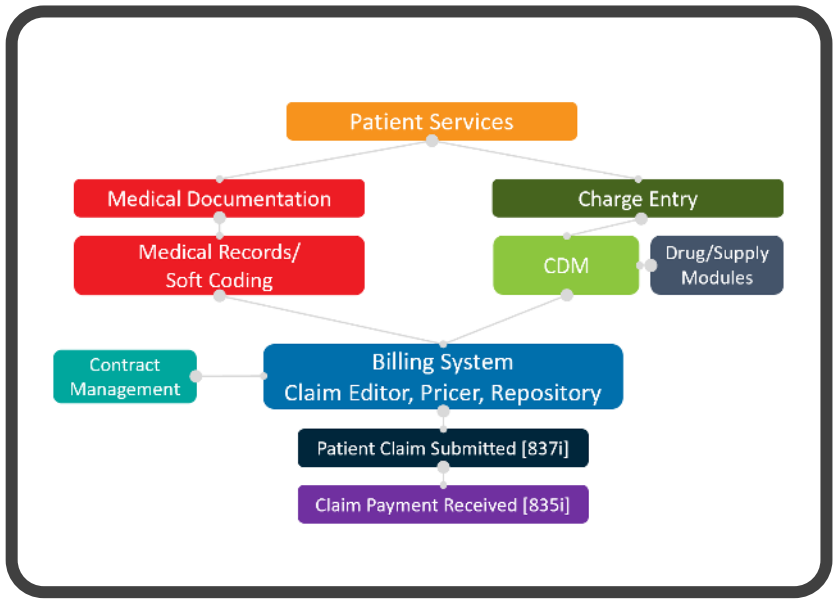
REQUIRING ALL ALGORITHM COMPONENTS: WHY UNNECESSARY?

Even if all the algorithm contents could somehow be encoded into the single MRF, claims data would still need to be infused into an externally developed pricer to arrive at the payer specific negotiated charge. This extensive process would produce values consistent with the Estimated Allowed Amount (or new Allowed Amount).

In sum, there would be an incredible administrative burden for hospitals and developers that would not yield any additional material benefit beyond what will be available in the Allowed Amount value.

Strengthened Attestation Requirements

REQUIRING ALL ALGORITHM COMPONENTS: "SO, MAYBE JUST USE A SIMPLE DOLLAR AMOUNT DISPLAY?!"



Payer Specific Negotiated Charge Approach 1: Enter Basic Charge Method Data

The hospital derives a simple value for one of the four basic charge methods: per diem, case rate, percentage of charge, fee schedule.

CHALLENGE: while these values are "accurate" they aren't "complete" because they don't describe the additional algorithm logic to derive the payer specific negotiated charge. We have not seen a hospital-payer contract where these four basic charge methods (except for an entirely POC-based contract) would *completely* describe the payer specific negotiated charge.

Payer Specific Negotiated Charge Approach 2: Use Other/Algorithm/Allowed Amount

The hospital derives the payer specific negotiate charge by appropriately using the "other" charge method with an algorithm description and corresponding allowed amount.

BENEFIT: the payer specific negotiated charge is accurate and complete as all algorithm elements have been applied.

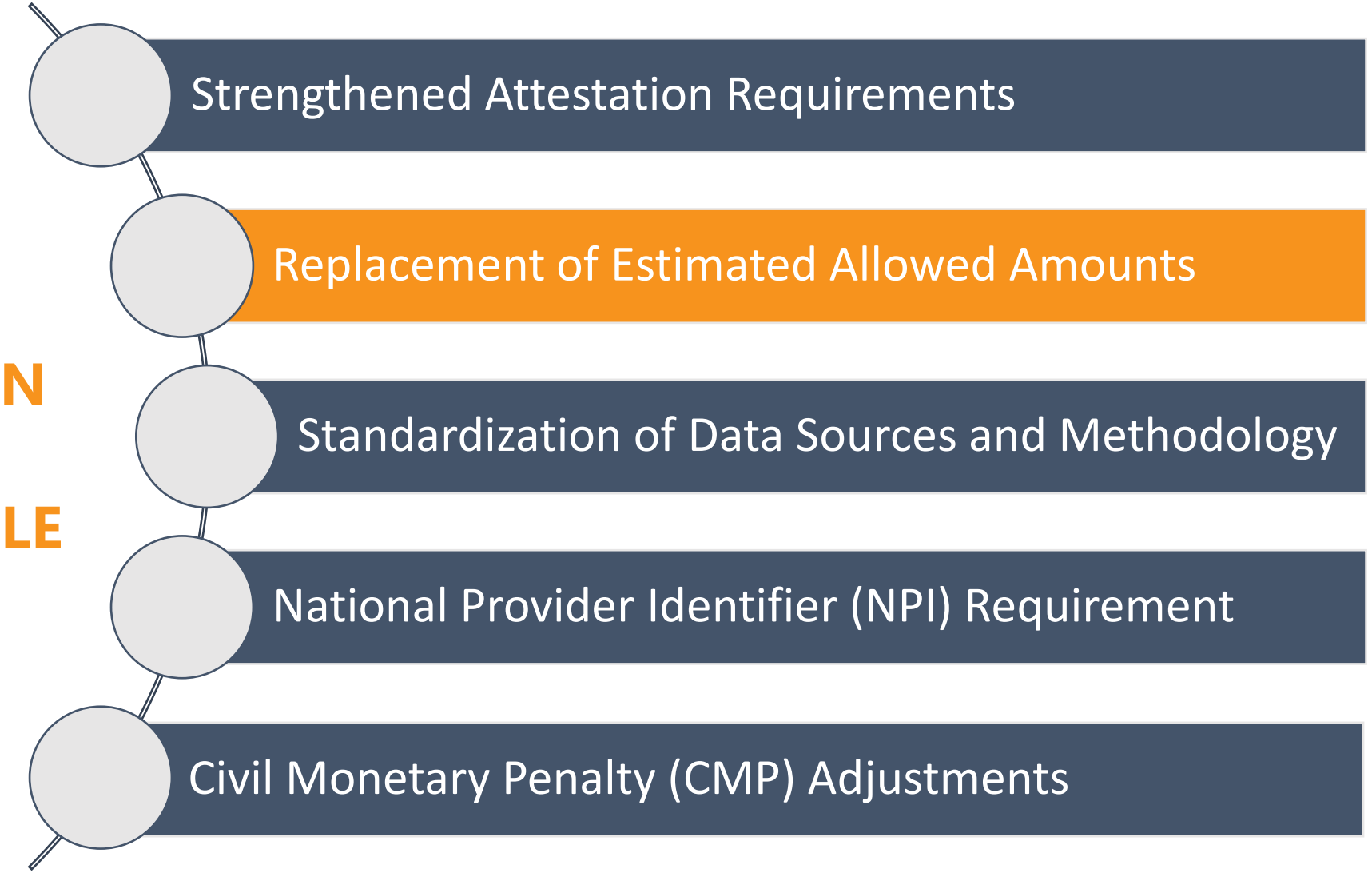
Strengthened Attestation Requirements

COMMENT CONSIDERATIONS SUMMARY

1) **Maintain the current attestation statement without the requirement for hospitals to encode all algorithm components. Implementing the proposed statement would:**
   a) Introduce an inconceivable administrative burden,
   b) overwhelm the file with conditional logic that cannot conform to the file schema,
   c) and undermine the goal of machine-readability and comparability.
   d) Further, even if all this logic could somehow be placed in an MRF, developers and researchers would still need additional claims data to determine the payer specific negotiated charge: this result is the current allowed amount so there is no additional gain to the public.

2) **Reconsider the emphasis on the "payer-specific negotiated charge: dollar amount" field for fee schedules, case rates, and per diems, by acknowledging that these values are components of broader algorithms, not standalone charges.**
   1) These charge methods are only a fraction of the methodologies employed in payer contracts contributing to confusion and misleading information.
   2) Instead, CMS should consider eliminating the "standard charge methodology" field in favor of a unified focus on allowed amount-based reporting, which is the only method that fully reflects the actual payment received and enables meaningful comparisons across hospitals.

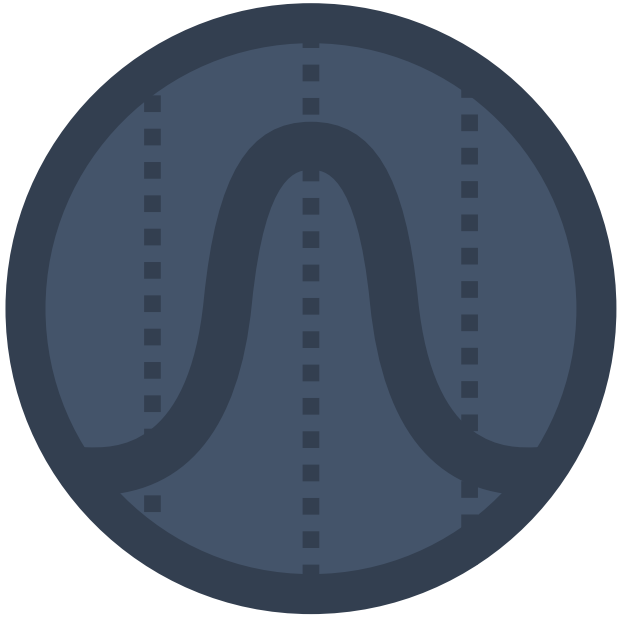
KEY HPT PROVISIONS IN CY26 OPPS PROPOSED RULE



Replacement of Estimated Allowed Amounts

SUMMARY

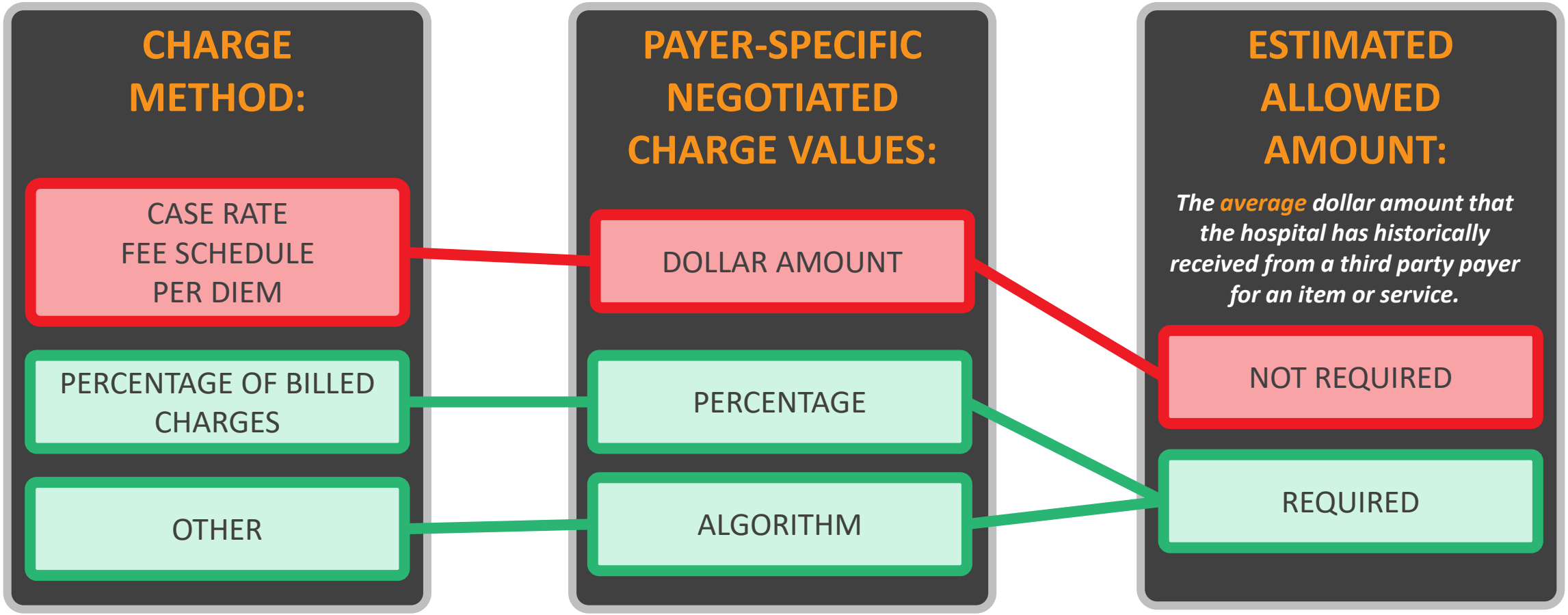
Beginning January 1, 2026, CMS proposes that hospitals report the **median, 10th percentile, and 90th percentile allowed amounts, along with the count of allowed amounts**, when negotiated charges are based on percentages or algorithms. These new data elements would replace the "estimated allowed amount" to provide a more accurate and representative view of pricing.



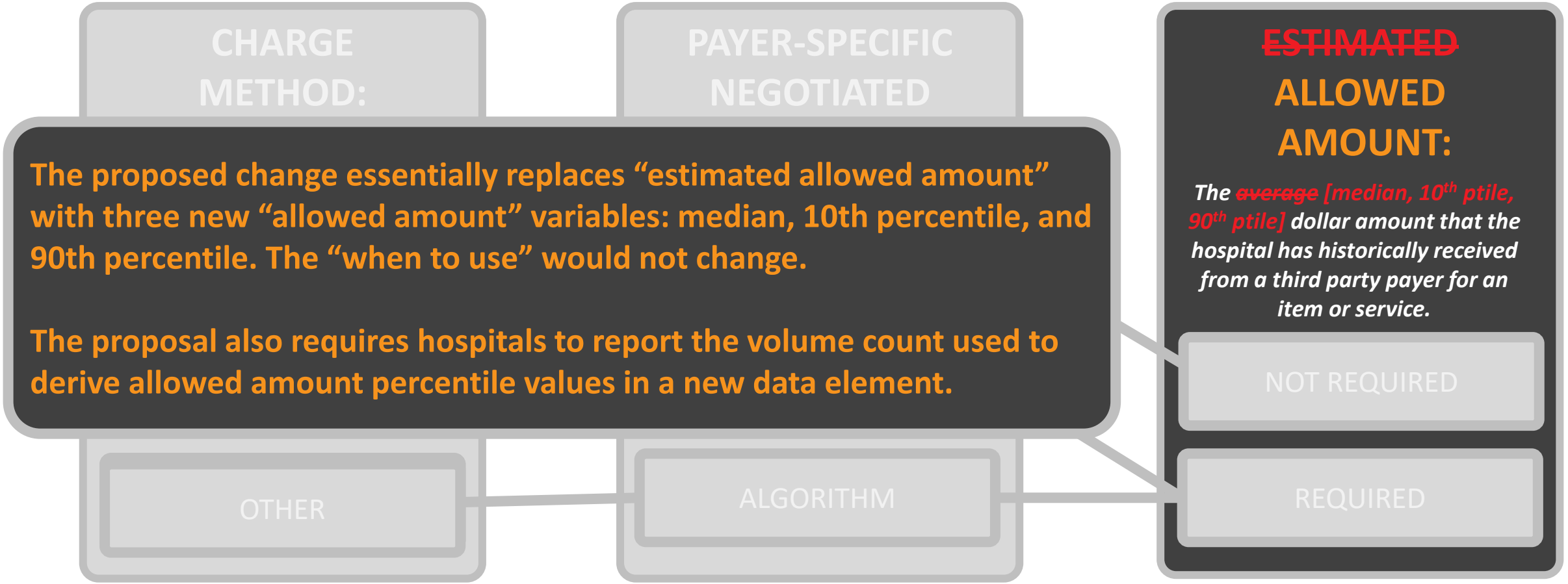
Notably, CMS proposes a **non-standard calculation method where, if a percentile falls between two observed values, the hospital must report the next highest actual allowed amount rather than averaging the two**. This method is proposed to have MRF values reflect an actual historical payment amount from the dataset.

Replacement of Estimated Allowed Amounts

Currently, after the charge method has been selected, the hospital must report the payer-specific negotiated charge value and the estimated allowed amount in the following way:



Replacement of Estimated Allowed Amounts



Replacement of Estimated Allowed Amounts

NOTE ON ABSENCE OF HISTORICAL CLAIMS DATA

CMS shares that in situations where hospitals do not have historical claims data (e.g., new facilities or new/revised payer contracts) there would not be data to calculate these new fields. CMS proposes that if no claims exist in the past 12 months for a payer/plan:

- Encode “0” for count of allowed amounts.
- Leave median, 10th, and 90th percentiles blank.
- Use additional notes to explain:
  - Example: “new or recently revised payer contract”
  - Hospitals could update MRFs once remittance data becomes available

Replacement of Estimated Allowed Amounts

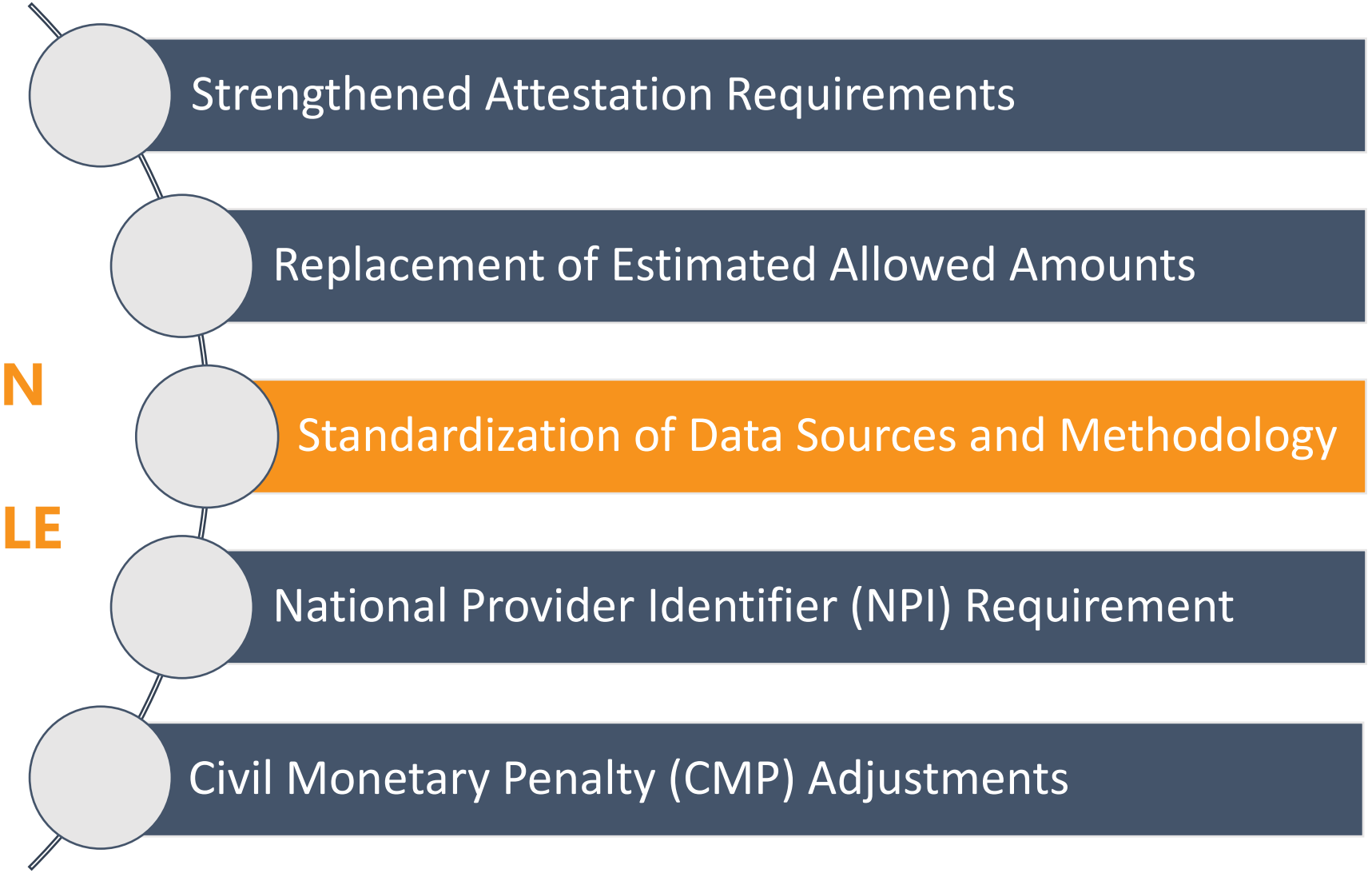
COMMENT CONSIDERATIONS SUMMARY

1) We encourage CMS to allow the use of standard percentile calculation methods to preserve methodological integrity, reduce burden, and support more accurate and meaningful comparisons across hospitals. This will allow hospitals to utilize standard statistical software to derive MRF values while also best representing the most likely payer specific negotiated charge to the public.

2) We urge CMS to consider allowing hospitals to suppress or mask counts below 11. Replacing values below this threshold with an asterisk or "<11" would balance the need for transparency with privacy concerns. In addition, we suggest only requiring the 10th and 90th percentile values when counts are 11 or greater. Doing so would better statistically capture true 10th and 90th percentile values and would also address privacy concerns among outlier situations. Median values, of course, could be statistically calculated with two claims or greater.

3) We support the proposed methodology for handling insufficient claim remittance history in the MRF, particularly the use of "0" counts and explanatory notes for new or revised payer contracts. However, we respectfully request clarification and affirmation that, in cases where there is no claim volume for a specific payer-plan for certain services (example, a small payer that had no hip replacement procedures to derive an allowed amount) that hospitals may either: exclude these payer/plan/service combinations from the MRF, or also display "0" in the count field, with the percentile fields left blank, as outlined. The former, would decrease MRF file size.

KEY HPT PROVISIONS IN CY26 OPPS PROPOSED RULE



Standardization of Data Sources and Methodology

SUMMARY

Beginning January 1, 2026, CMS proposes that hospitals be required to use EDI 835 Electronic Remittance Advice (ERA) data to calculate allowed amounts to ensure consistency and accuracy. The lookback period for data would be limited to no longer than the 12 months preceding the effective date in the MRF, and zero-dollar claims would be excluded to avoid skewed results.

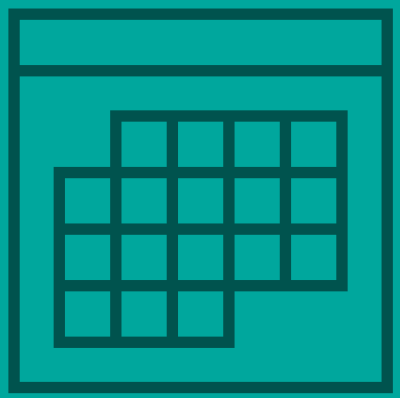
Standardization of Data Sources and Methodology

COMMENT CONSIDERATIONS SUMMARY

While we understand the intent behind limiting the lookback period to no more than 12 months prior to the MRF posting date, we are concerned that this restriction may inadvertently reduce the completeness and reliability of the data.

- Hospitals typically experience a claims adjudication lag of several weeks, meaning that the most recent months of data may be incomplete or unavailable.
- Further, hospitals require significant time to compile, validate, and publish the MRF in accordance with CMS formatting and attestation requirements.

To address this concern, we recommend that CMS allow hospitals to select a representative lookback period of up to 18 or 24 months from the MRF effective date. This approach would improve data completeness and stability while maintaining transparency and comparability.



LOOKBACK PERIOD RECOMMENDATION: 18 OR 24 MONTHS

Standardization of Data Sources and Methodology

FUTURE CONSIDERATIONS

Since CMS has identified the claim as the authoritative data source for allowed amounts, it would be a natural and logical extension to apply claim-based grouping logic to standardize how services are categorized and reported in the “Code Type” data element. We would recommend:

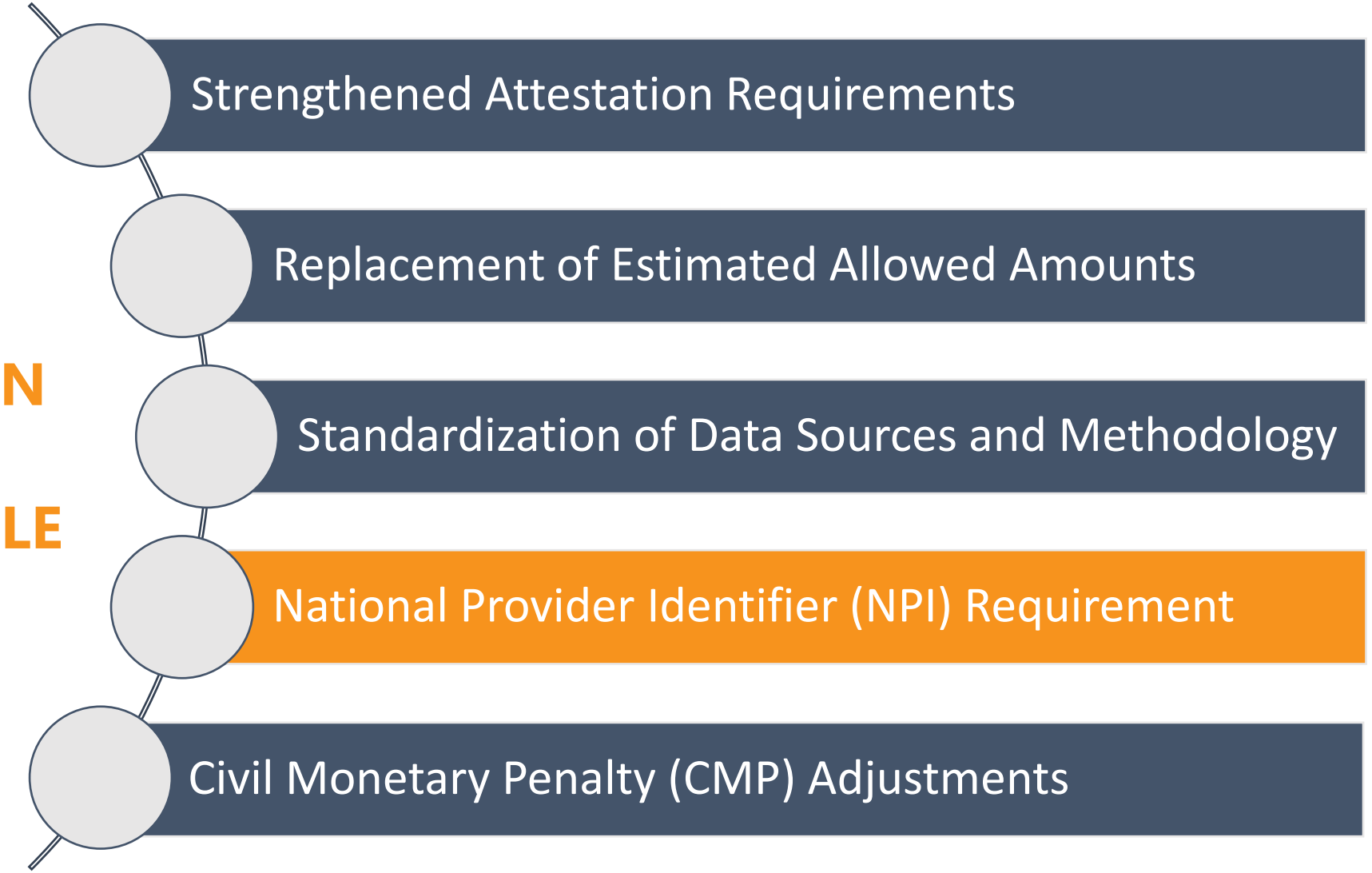
- For inpatient claims, using the Medicare Severity Diagnosis-Related Group (MS-DRG) as the standard grouping mechanism.
- For outpatient claims, using the primary HCPCS code and associated Ambulatory Payment Classification (APC).

This would:

- Improve comparability across hospitals and plans,
- Reduce variation in how services are defined, and
- Align with existing CMS payment methodologies and data structures.

Code Type Valid Values
CPT
NDC
HCPCS
RC
ICD
DRG
MS-DRG
R-DRG
S-DRG
APS-DRG
AP-DRG
APR-DRG
APC
LOCAL
EAPG
HIPPS
CDT
CDM
TRIS-DRG

KEY HPT PROVISIONS IN CY26 OPPS PROPOSED RULE



National Provider Identifier (NPI) Requirement

SUMMARY

Beginning January 1, 2026, CMS proposes that hospitals report, in a newly created general data element in the MRF, any Type 2 NPI(s) that has a 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.

CMS believes this inclusion will improve data alignment with other healthcare datasets, such as those from the Transparency in Coverage initiative.

National Provider Identifier (NPI) Requirement

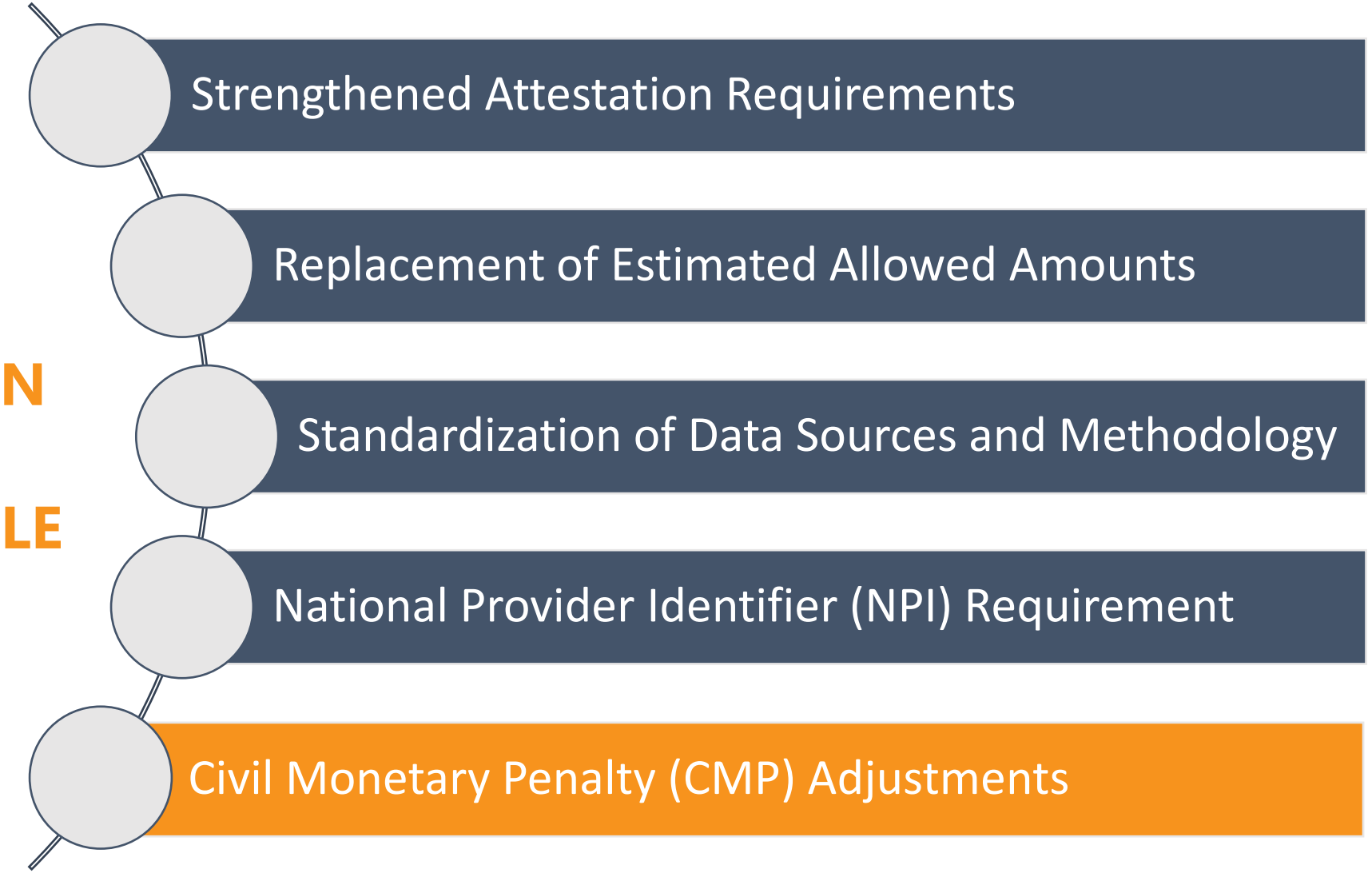
COMMENT CONSIDERATIONS SUMMARY

- We support CMS's proposal to require hospitals to report their Type 2 National Provider Identifier (NPI) in the Machine-Readable File (MRF) as a means to improve data comparability and alignment with Transparency in Coverage (TiC) files.

- We believe there is also significant value in incorporating the CMS Certification Number (CCN), aka Medicare Provider Number (MPN), and propose this be used as a replacement for the EIN in the MRF naming convention. This change would create clarity and consistency around which facilities are required to produce an MRF and address sensitivity around the use of the EIN.

In sum, we believe this dual-identifier approach—using the CCN for file naming and the NPI within the file—would enhance transparency, reduce confusion, and improve the interoperability of hospital pricing data across CMS systems.

KEY HPT PROVISIONS IN CY26 OPPS PROPOSED RULE



Civil Monetary Penalty (CMP) Adjustments

SUMMARY

Beginning January 1, 2026, CMS does not propose any new conditions under which CMPs would be imposed. The existing enforcement framework remains intact, meaning CMPs are only imposed when a hospital:

- Fails to respond to a CMS warning notice, or
- Fails to comply with a Corrective Action Plan (CAP) after receiving a request.

The only substantive change CMS proposes is the optional 35% penalty reduction if a hospital:

- Waives its right to an administrative hearing, and
- Accepts responsibility for the violation.

This is intended to streamline enforcement and encourage faster resolution of cases. However, this reduction is not available if the hospital fails to post an MRF or shoppable services file (i.e., core violations) or the hospital does not submit the waiver within 30 days of the CMP notice.

Civil Monetary Penalty (CMP) Adjustments

COMMENT CONSIDERATIONS SUMMARY

We appreciate CMS's approach in proposing a 35% reduction in civil monetary penalties for hospitals that waive their right to an administrative hearing and acknowledge noncompliance. This policy strikes a fair balance between accountability and administrative efficiency, encouraging timely resolution while reinforcing the importance of transparency. We support this change as a constructive incentive that promotes compliance and helps ensure that patients and stakeholders have access to accurate, actionable pricing information.

One Final Consideration for Comment: TIME

All proposals state: Beginning January 1, 2026…

Finally, we respectfully urge CMS to delay implementation of any reporting or schema changes related to hospital price transparency under the CY2026 OPPS Proposed Rule until January 1, 2027. While we support efforts to improve data accuracy and accessibility, the proposed effective date of January 1, 2026 presents significant operational challenges:

- **Timing of Final Rule:** The final rule is likely expected in November 2025, leaving hospitals with minimal time to interpret, test, and implement MRF updates before the January 1 deadline.
- **Production Timelines:** Many hospitals begin MRF production 4–6 months in advance of the effective date. By November, files for January 1, 2026 will already be in production or finalized.
- **Avoiding Dual File Burden:** A mid-year implementation (e.g., July 2026) would require many hospitals to produce two MRFs in one calendar year, increasing administrative burden and cost.

RESOURCES

PROPOSED RULE:
The proposed rule (CMS-1834-P) can be downloaded at the Federal Register here: https://www.federalregister.gov/d/2025-13360.

CLEVERLEY + ASSOCIATES FULL SUMMARY & COMMENT CONSIDERATION:
https://www.cleverleyassociates.com/blog/hospital-price-transparency-hpt-key-proposed-changes-for-cy-2026/

PROVIDING COMMENT:
Stakeholders wishing to provide comment should follow the information below:

DATES: Comments must be received at one of the addresses provided below, by September 15, 2025.

ADDRESSES: In commenting, please refer to file code CMS-1834-P.
Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1) Electronically: You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the "Submit a comment" instructions.
2) By regular mail: You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1834-P, P.O. Box 8010, Baltimore, MD 21244-8010. Please allow sufficient time for mailed comments to be received before the close of the comment period.
3) By express or overnight mail: You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1834-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

THANK YOU FOR PARTICIPATING IN TODAY'S PRESENTATION!

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