CMS Hospital Price Transparency Accuracy and Completeness Request for Information

RESPONSES PROVIDED BY CLEVERLEY + ASSOCIATES
July 21, 2025
www.cleverleyassociates.com

QUESTION ONE RESPONSE

Should CMS specifically define the terms “accuracy of data” and “completeness of data” in the context of HPT requirements, and, if yes, then how?

Q1: Should CMS specifically define the terms “accuracy of data” and “completeness of data” in the context of HPT requirements, and, if yes, then how?

CLEVERLEY + ASSOCIATES QUESTION ONE COMMENT

First, we appreciate the opportunity to comment on these important questions. We fully support healthcare price transparency and are committed to helping achieve more clarity and simplicity for patients. We thank CMS for continually reviewing and collaborating with stakeholders to achieve these common goals.

To specifically address the first question, we do not believe definitions of “accuracy of data” and “completeness of data” need to be further defined. With the addition of the attestation statement in the file schema released on July 1, 2024, hospital administrators understand that all required data elements must be provided. We do believe, however, that CMS could continue to clarify how these data elements are derived. We will comment in a future question on how industry alignment on the data sources and methods to extract required data elements would address the perception that MRF data is inaccurate and/or incomplete.

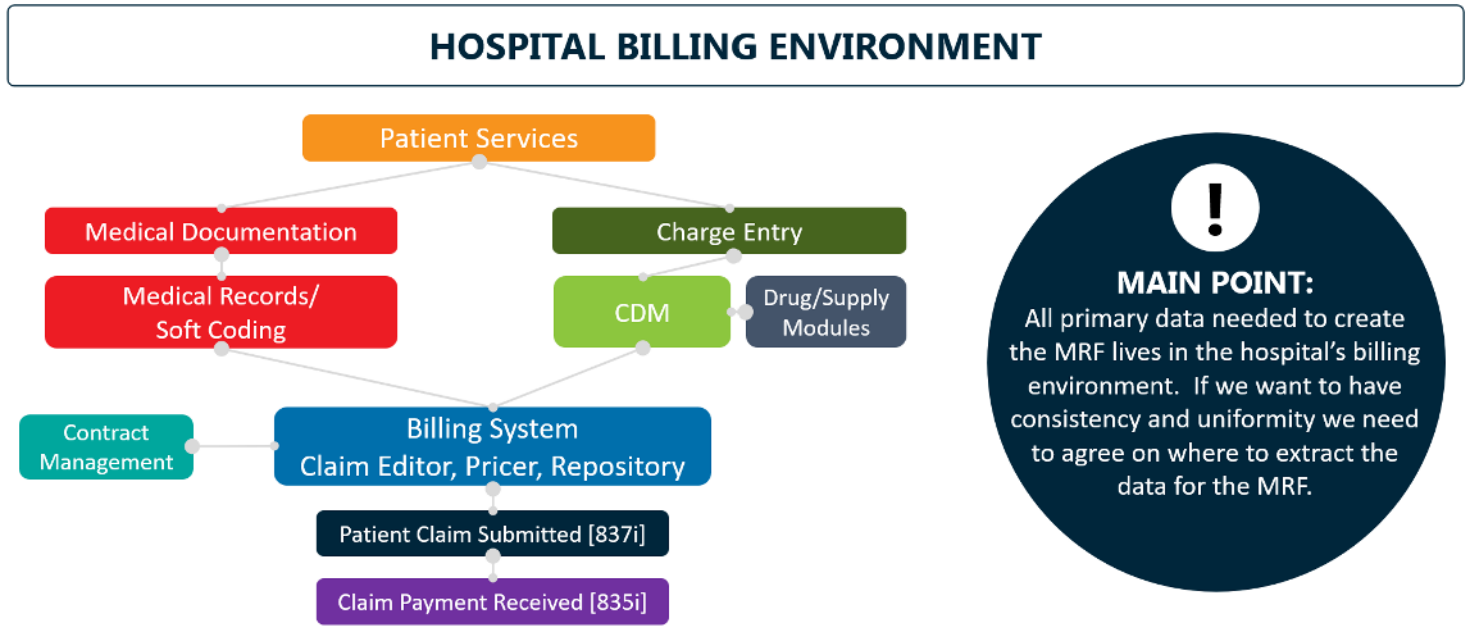
QUESTION TWO RESPONSE

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

Q2: What are your concerns about the accuracy and completeness of the HPT MRF data? Please be as specific as possible.

CLEVERLEY + ASSOCIATES QUESTION TWO COMMENT

We believe that a critical reason for MRF data being perceived as inaccurate or incomplete is driven from a lack of alignment on the data sources and methods used to extract the required MRF data elements. Hospital administrators are utilizing data within the hospital billing environment to construct the MRF but can derive the values from different sources.

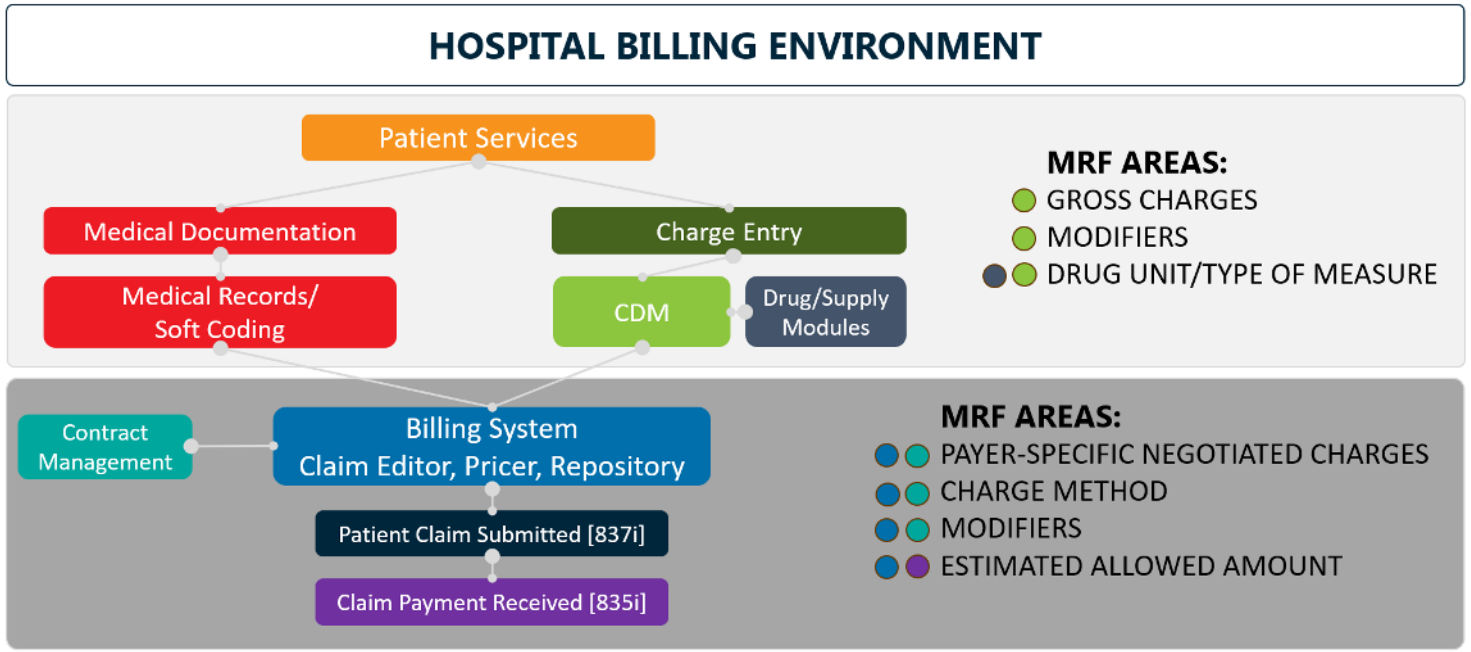


MAIN POINT:
All primary data needed to create the MRF lives in the hospital's billing environment. If we want to have consistency and uniformity we need to agree on where to extract the data for the MRF.

Q2: What are your concerns about the accuracy and completeness of the HPT MRF data? Please be as specific as possible.

CLEVERLEY + ASSOCIATES QUESTION TWO COMMENT, CONTINUED

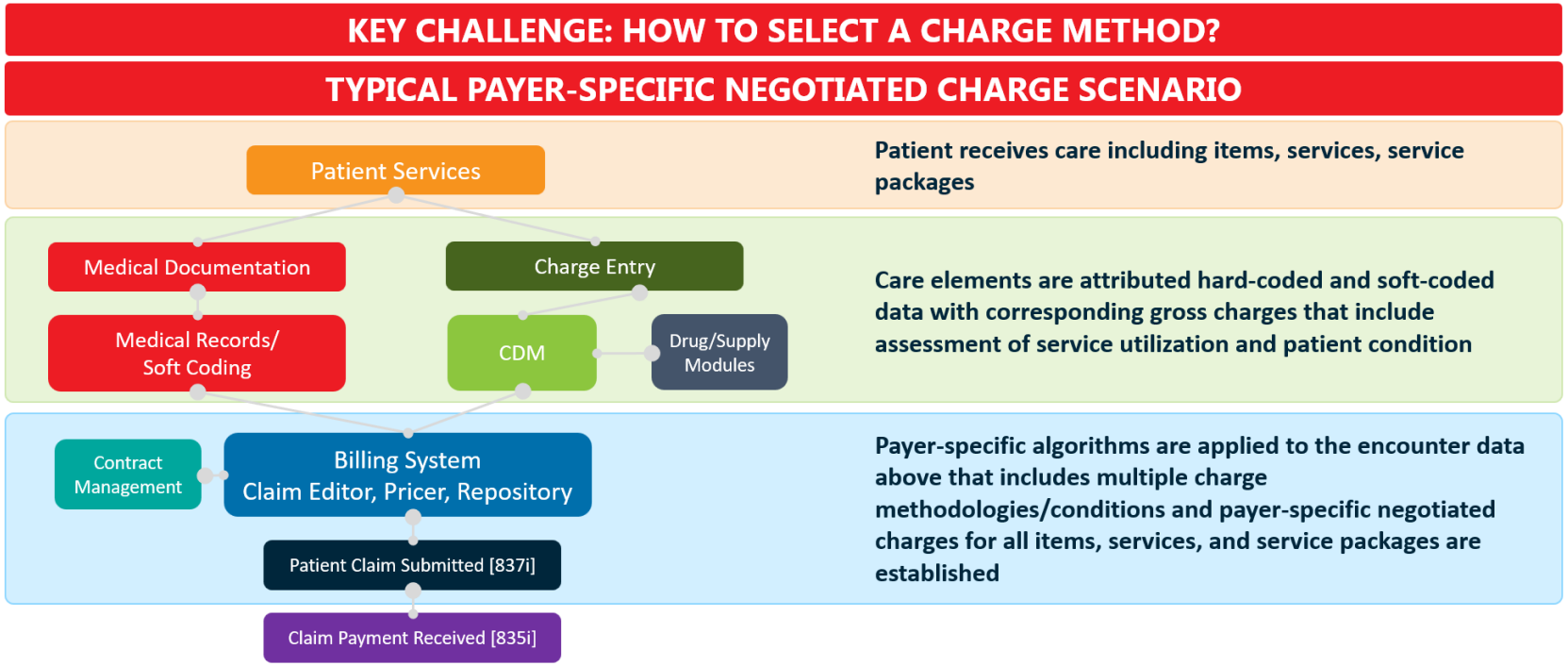
First, industry stakeholders must agree that standard gross charges and payer specific negotiated charges are separate and derived from different data sources. Standard gross charge information should be defined as information from the hospital's charge description master (CDM) and any additional drug/supply modules. Payer specific negotiated charges would come from the hospital's contract management system and claims billing environment.



Q2: What are your concerns about the accuracy and completeness of the HPT MRF data? Please be as specific as possible.

CLEVERLEY + ASSOCIATES QUESTION TWO COMMENT, CONTINUED

Perceptions of inaccuracy and incompleteness appear to be focused on the payer specific negotiated charge where the greatest amount of complexity resides. CMS appropriately recognized this complexity in adding the "Charge Method", "Algorithm", and "Estimated Allowed Amount" variables in the current MRF schema to provide additional context for the provided values. The challenge hospitals face is how to select the appropriate charge method.



Q2: What are your concerns about the accuracy and completeness of the HPT MRF data? Please be as specific as possible.

CLEVERLEY + ASSOCIATES QUESTION TWO COMMENT, CONTINUED

There has been, however, confusion in how to leverage the charge method and associated fields:

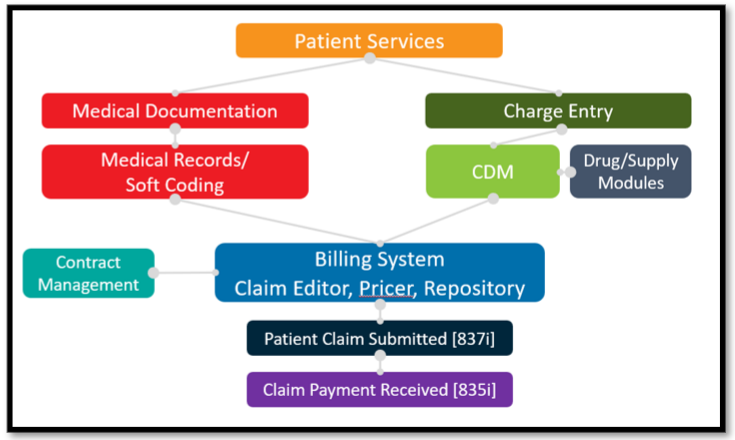
KEY CHALLENGE: HOW TO SELECT A CHARGE METHOD?

The issue: The user must choose one "charge method" and report it at one "code type" level for each line:

Charge Method Valid Values
Case rate
Fee schedule
Percent of total billed charges
Per diem
***

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

When the payer-specific negotiated charges for all items, services, and service packages includes numerous methods and types:



Q2: What are your concerns about the accuracy and completeness of the HPT MRF data? Please be as specific as possible.

CLEVERLEY + ASSOCIATES QUESTION TWO COMMENT, CONTINUED

We appreciate and agree with the definition CMS provided in the CY24 OPPS Final Rule to appropriately describe these situations where multiple methods and types occur to derive the payer specific negotiated charge: algorithm.

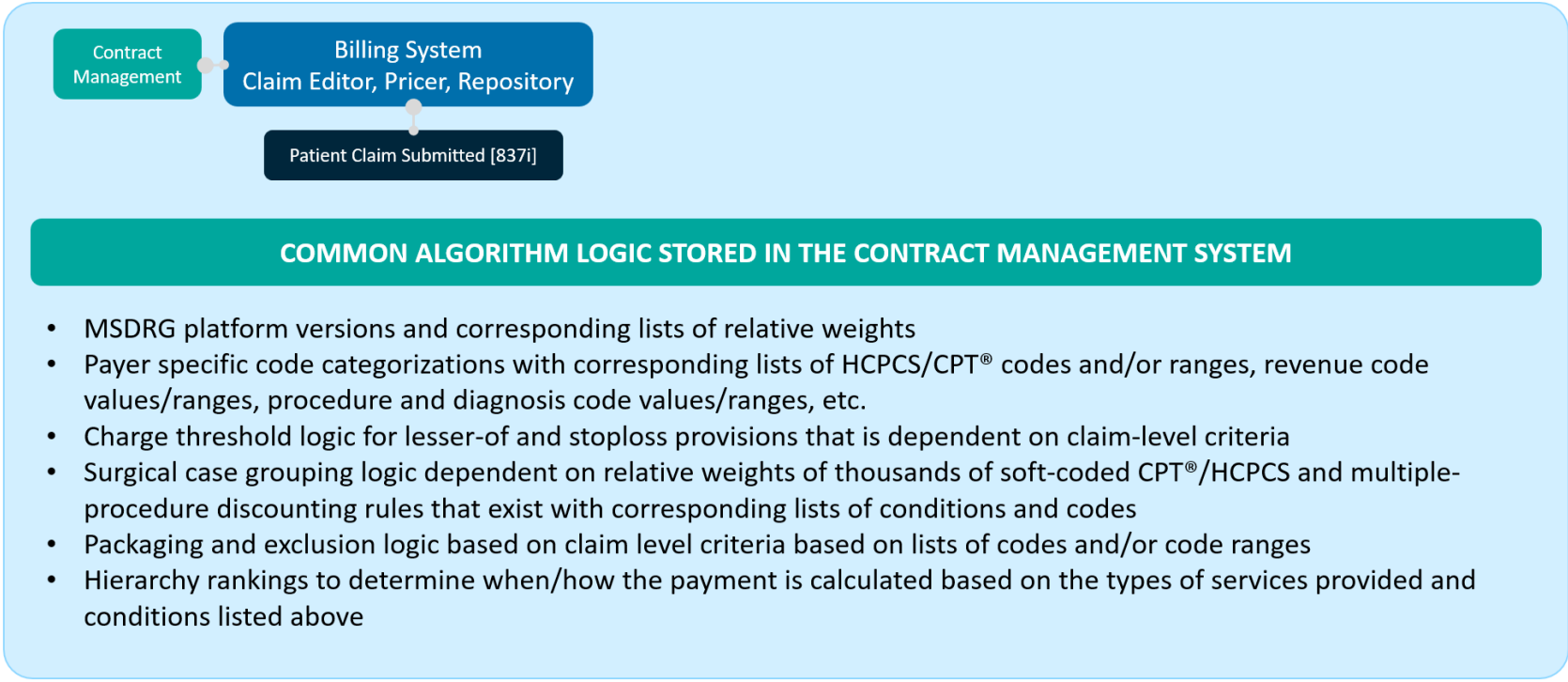
"At other times, however, hospitals and payers establish the payer-specific negotiated charge by agreeing to an algorithm that will determine the dollar value of the allowed amount on a case-by-case basis after a pre-defined service package has been provided. This means that the standard charge that 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."*

Algorithm Description: CMS CY24 OPPS Final Rule

Q2: What are your concerns about the accuracy and completeness of the HPT MRF data? Please be as specific as possible.

CLEVERLEY + ASSOCIATES QUESTION TWO COMMENT, CONTINUED

CMS also appropriately concluded “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” (CY24 OPPS Final Rule). Common algorithm logic is seen below to emphasize the prudency of this conclusion:



Q2: What are your concerns about the accuracy and completeness of the HPT MRF data? Please be as specific as possible.

CLEVERLEY + ASSOCIATES QUESTION TWO COMMENT, CONTINUED

We provide this context as we believe the main cause for variation within the payer specific negotiated charge is how hospitals are trying to derive a compliant value. The hospital can attempt to derive a portion of the algorithm contents to conform to the limited set of defined charge methods (per diem, case rate, fee schedule, percentage of charge) or it can leverage the estimated allowed amount to completely account for all the algorithm elements.

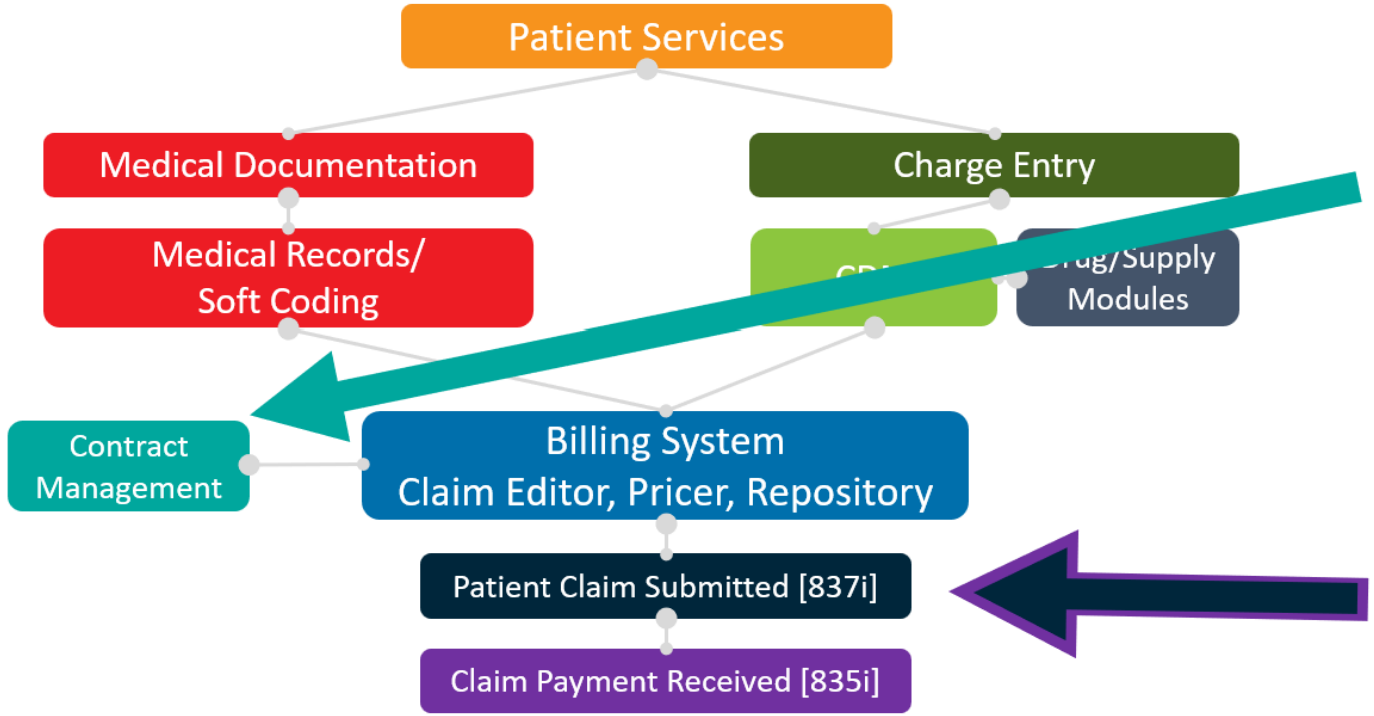
The challenge with the first method is that these values do not fully account for all charge methods and algorithm contents needed to determine the payer specific negotiated charge. Further, attempting to provide this content isn't feasible because of the incredible administrative undertaking and inability to conform to the file schema. We understand that some may believe that payment can be simplified in these basic charge method categories, however, in the thousands of hospital-payer contracts we have analyzed and modeled, we have yet to see where one of these methods are used without additional terms and conditions (absent an entirely percentage of charge contract).

In sum, the two primary ways hospitals are deriving the payer specific negotiated charge (illustrated on the following page) are limiting the usefulness of the HPT data and leading to a perception that it is incomplete and/or inaccurate. In reality, both are accurate and compliant as they are leveraging the data elements, definitions, and schema structure. However, only the other/algorithm/estimated allowed amount can truly be considered "accurate" AND "complete" as all payer specific negotiated charge methods and algorithm logic have been accounted for in the MRF values.

Q2: What are your concerns about the accuracy and completeness of the HPT MRF data? Please be as specific as possible.

CLEVERLEY + ASSOCIATES QUESTION TWO COMMENT, CONTINUED

TWO DIFFERENT WAYS HOSPITALS ARE COMPLIANTLY DERIVING NEGOTIATED CHARGE



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 technically "complete" because all additional algorithm logic to assist in understanding the payer specific negotiated charge is not able to be provided because of size and complexity. In addition, many claims include multiple methods (and many that aren't listed among these).

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

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

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

QUESTION THREE RESPONSE

Do concerns about accuracy and completeness of the MRF data affect your ability to use hospital pricing information effectively? For example, are there additional data elements that could be added, or others modified, to improve your ability to use the data? Please provide examples.

Q3: Do concerns about accuracy and completeness of the MRF data affect your ability to use hospital pricing information effectively? For example, are there additional data elements that could be added, or others modified, to improve your ability to use the data? Please provide examples.

CLEVERLEY + ASSOCIATES QUESTION THREE COMMENT

Per our response in question two, the utility of the MRF data is limited because the payer specific negotiated charge is not consistently derived among hospitals. We do not believe additional data elements are needed, but contend that the answer to addressing the accuracy, completeness, and utility of the HPT data is found in having all hospitals (and payers) report payer specific negotiated amounts using the existing estimated allowed amount.

Some may contend that another path could be to require all algorithm elements from the contract management system to be provided. There are two key objections to this, though:

1) The administrative burden to compile this information would be prohibitively high. Further, it is difficult to imagine the required effort to create a uniform file schema to account for this complexity of thousands of variables and conditions within a single MRF.
2) Most striking, even if the first point could somehow be solved, developers and researchers leveraging this massive database would then also require patient claims data from the hospital to understand how that hospital's treatment patterns create the final payer specific negotiated charge. So, why not use the estimated allowed amount where the application of the hospital's unique contract management database has already been applied to patient claims to create the payer specific negotiated charge?

We present an illustration of these two paths on the following page.

Q3: Do concerns about accuracy and completeness of the MRF data affect your ability to use hospital pricing information effectively? For example, are there additional data elements that could be added, or others modified, to improve your ability to use the data? Please provide examples.

CLEVERLEY + ASSOCIATES QUESTION THREE COMMENT, CONTINUED

TWO PATHS FORWARD FOR THE PAYER-SPECIFIC NEGOTIATED CHARGE

INCREASING MRF COMPLEXITY, NEW DATA	
Determine a way to uniformly get all algorithm elements in a hospital's contract management system into a single MRF	Does not exist, high admin cost
Apply the algorithm contents of the MRF to patient claims – also submitted by the hospital (HIPAA concern) – to understand the payer specific negotiated charges for patients at that hospital	Does not exist and would require claims
Determine a way to uniformly group and report the payer specific negotiated charges on the MRF	Logic available

LEVERAGE EXISTING RULES, AVAILABLE DATA	
Apply the algorithm contents from the contract management system to patient claims to understand the payer specific negotiated charges for patients at that hospital – the Estimated Allowed Amount	Already available through 837/835 data used by providers and payers
Determine a way to uniformly group and report the payer specific negotiated charges on the MRF	Logic available

Q3: Do concerns about accuracy and completeness of the MRF data affect your ability to use hospital pricing information effectively? For example, are there additional data elements that could be added, or others modified, to improve your ability to use the data? Please provide examples.

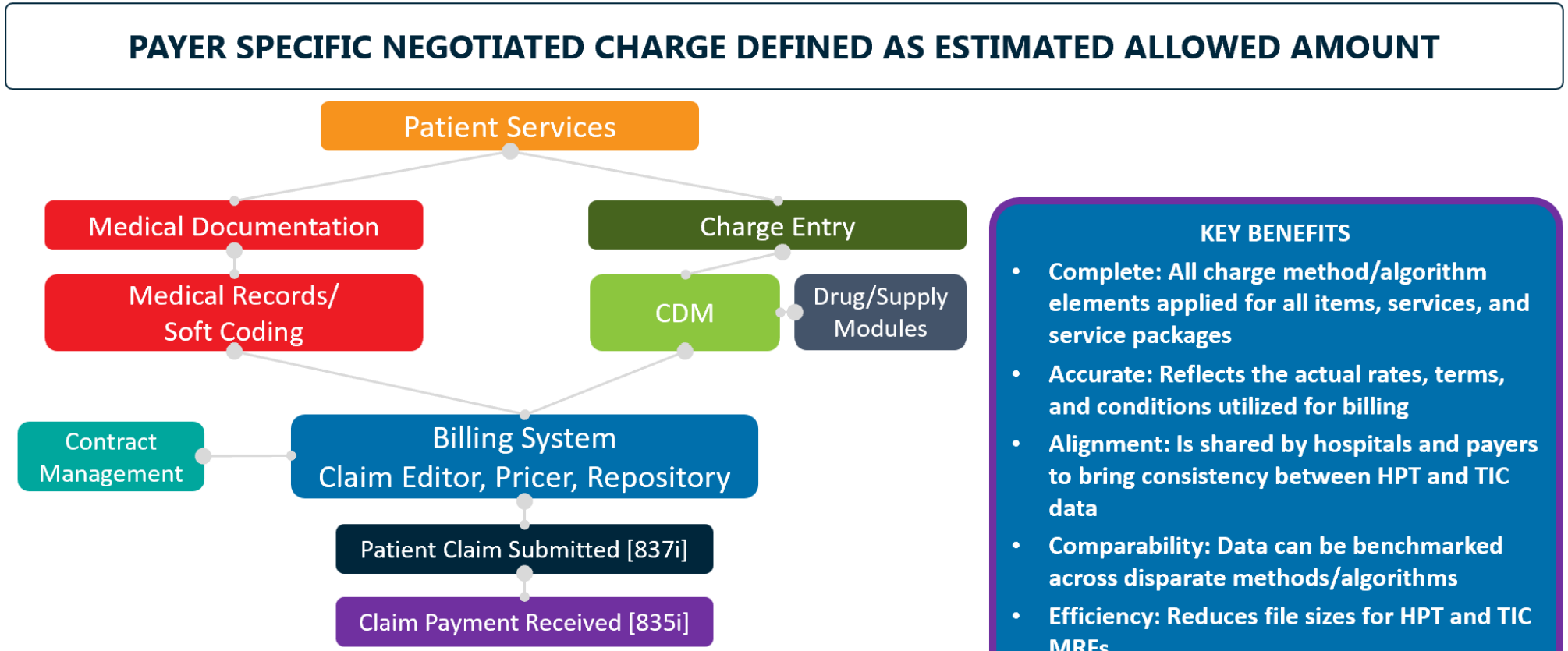
CLEVERLEY + ASSOCIATES QUESTION THREE COMMENT, CONTINUED

In sum, exclusively using the Estimated Allowed Amount for the payer specific negotiated charge would:

1) Satisfy the “letter” and the “spirit” of the transparency requirements to convey a complete picture of payer specific negotiated charge that also captures the hospital’s typical treatment pathways
2) Increase the utility of these values as they could be directly compared
    a) Essentially, the estimated allowed amount is indifferent to all the numerous contracting methods and values across hospitals and payers creating an ability to benchmark across disparate rates, methods, and conditions
3) Address the concerns of inaccurate or incomplete data by providing a standardized definition and data source for both hospitals and payers.

Q3: Do concerns about accuracy and completeness of the MRF data affect your ability to use hospital pricing information effectively? For example, are there additional data elements that could be added, or others modified, to improve your ability to use the data? Please provide examples.

CLEVERLEY + ASSOCIATES QUESTION THREE COMMENT, CONTINUED



KEY BENEFITS

- **Complete: All charge method/algorithm elements applied for all items, services, and service packages**
- **Accurate: Reflects the actual rates, terms, and conditions utilized for billing**
- **Alignment: Is shared by hospitals and payers to bring consistency between HPT and TIC data**
- **Comparability: Data can be benchmarked across disparate methods/algorithms**
- **Efficiency: Reduces file sizes for HPT and TIC MRFs**

Q3: Do concerns about accuracy and completeness of the MRF data affect your ability to use hospital pricing information effectively? For example, are there additional data elements that could be added, or others modified, to improve your ability to use the data? Please provide examples.

CLEVERLEY + ASSOCIATES QUESTION THREE COMMENT, CONTINUED

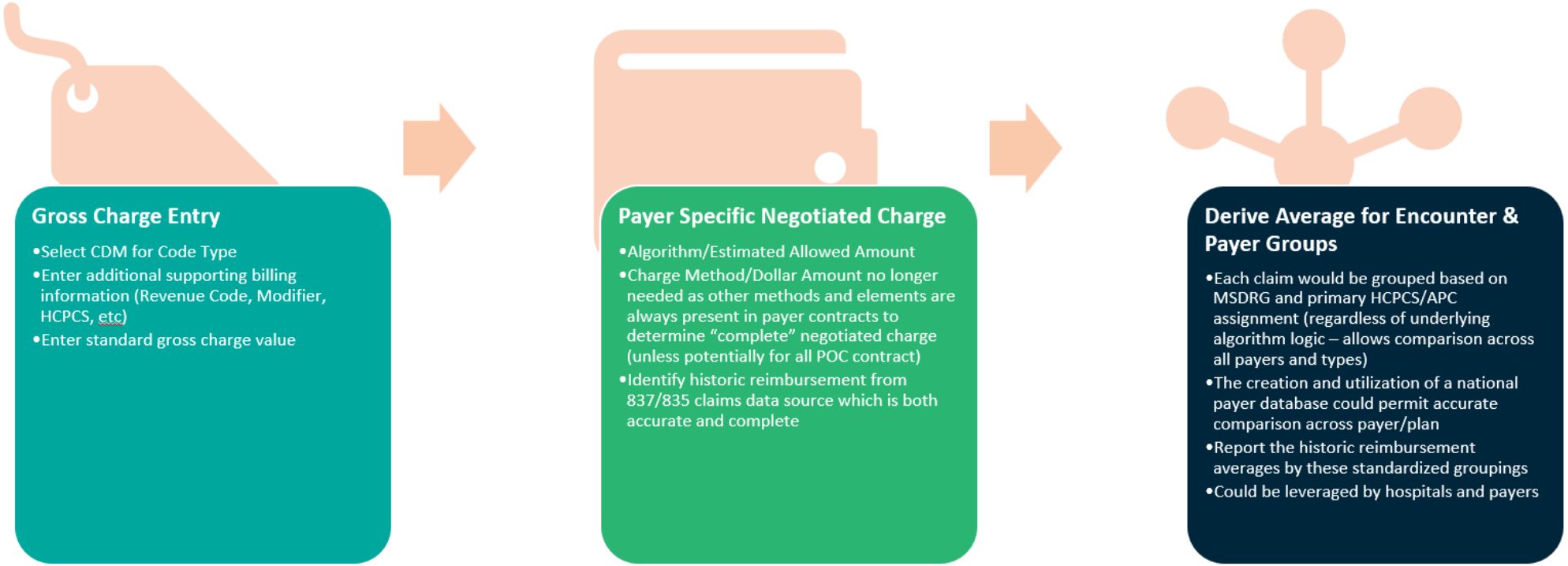
Several final comments regarding the use of the estimated allowed amount:

1) First, defined this way, hospitals and payers could then leverage a straight-forward grouping logic to report payer specific negotiated charges by a single inpatient and outpatient code type (MSDRG for inpatient and primary APC/HCPCS for outpatient, as example). This would permit consistency across HPT and TIC files, dramatically reduce file size, and permit seamless comparison across hospitals and payers regardless of differing contract structures, rates, conditions, and methods.
2) Second, this definition would also permit the elimination of the "Charge Method" variables as these values do not "completely" describe any payer specific negotiated charge (percentage of charge could be the only exception where there are still some contracts that can be entirely POC).
3) While not a new field, we would support the creation of a national payer code database to be able to provide more comparability for the payer variable.
4) Finally, we offer a suggestion to change the name from "estimated allowed amount" to simply "allowed amount." Because the values are derived using billed claims the results are not based on "estimates" but "actual" patient encounters. We believe the use of the term "estimate" could cause confusion among the public that the results are somehow inaccurate.

Q3: Do concerns about accuracy and completeness of the MRF data affect your ability to use hospital pricing information effectively? For example, are there additional data elements that could be added, or others modified, to improve your ability to use the data? Please provide examples.

CLEVERLEY + ASSOCIATES QUESTION THREE COMMENT, CONTINUED

STANDARDIZED GROSS AND NEGOTIATED CHARGE MRF REPORTING



QUESTION FOUR RESPONSE

Are there external sources of information that may be leveraged to evaluate the accuracy and completeness of the data in the MRF? If so, please identify those sources and how they can be used.

Q4: Are there external sources of information that may be leveraged to evaluate the accuracy and completeness of the data in the MRF? If so, please identify those sources and how they can be used.

CLEVERLEY + ASSOCIATES QUESTION FOUR COMMENT

Per our responses in questions two and three, if estimated allowed amount (or simply, “allowed amount”) became the definition for the payer specific negotiated charge then average historic reimbursement could become the single source of truth for this variable.

CMS could then define how to derive average historic reimbursement from a claims source – 837/835 claims data, as primary example – for a given time period and under certain conditions to permit appropriate and accurate reporting. We do express concern over recent guidance on May 22, 2025, to instruct hospitals to create this average from as little as one claim (not technically an average) or in the absence of claims data (not feasible to create historic reimbursement where no historic claims exist). We do understand the reason for the guidance to reduce the number of reported nine 9s in hospital MRFs which may have resulted from hospitals implementing previous CMS guidance to restrict values where HIPAA thresholds of less than eleven claims were present. We believe CMS could amend that guidance to using at least two claims in order to maintain an average (minimum for an arithmetic mean) and thereby creating more values in the MRF. Null or single claim volume instances should not be viewed as problematic as their exclusion in the file would not dramatically impact the vast majority of services that patients at that hospital would be interested in seeing. In fact, excluded cases could help inform patients that the treatment is not common at that hospital.

In sum, using 837/835 claims data to derive the payer specific negotiated charge could create alignment between hospital and payer MRF files to permit accuracy, completeness, consistency, and comparability.

QUESTION FIVE RESPONSE

What specific suggestions do you have for improving the HPT compliance and enforcement processes to ensure that the hospital pricing data is accurate, complete, and meaningful? For example, are there any changes that CMS should consider making to the CMS validator tool, which is available to hospitals to help ensure they are complying with HPT requirements, so as to improve accuracy and completeness?

Q5: What specific suggestions do you have for improving the HPT compliance and enforcement processes to ensure that the hospital pricing data is accurate, complete, and meaningful? For example, are there any changes that CMS should consider making to the CMS validator tool, which is available to hospitals to help ensure they are complying with HPT requirements, so as to improve accuracy and completeness?

CLEVERLEY + ASSOCIATES QUESTION FIVE COMMENT

We commend CMS for releasing the online validator tool to help hospitals and interested stakeholders understand a hospital's adherence to the compliant file schema. As mentioned in previous responses, solidifying a data source and methodology to derive all elements for the payer specific negotiated charge would improve the accuracy, completeness, and meaningfulness of the data. We believe that the estimated allowed amount (or simply "allowed amount") remains the most viable option to accomplish these goals.

QUESTION SIX RESPONSE

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

Q6: Do you have any other suggestions for CMS to help improve the overall quality of the MRF data?

CLEVERLEY + ASSOCIATES QUESTION SIX COMMENT

We appreciate the opportunity to share our responses to the previous questions and would welcome an opportunity to discuss further. Thank you for creating this RFI as a means to promote dialogue on this important topic.

Cleverley + Associates
121 W Wilson Bridge Road, Fourth Floor
Worthington, Ohio 43085
www.cleverleyassociates.com

Individual Contact:
Jamie Cleverley, President
jcleverley@cleverleyassociates.com