Updated Hospital Price Transparency Guidance Implementing the President's Executive Order "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information"

May 22, 2025

On February 25, 2025, the White House issued an Executive Order 14221, "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information." The Executive Order states that the Departments of the Treasury, Labor, and Health and Human Services (HHS) shall take action to:

- Require the disclosure of the actual prices of items and services, not estimates;
- Issue updated guidance or proposed regulatory action ensuring pricing information is standardized and easily comparable across hospitals and health plans; and
- Issue guidance or proposed regulatory action updating enforcement policies designed to ensure compliance with the transparent reporting of complete, accurate, and meaningful data.

Consistent with the Executive Order and to further clarify requirements in Hospital Price Transparency (HPT) regulations, the Centers for Medicare & Medicaid Services (CMS) is providing additional guidance to ensure that hospitals provide meaningful, accurate information about their charges for health care items and services.

In the Calendar Year (CY) 2024 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule we state, "Hospitals are required to display the standard charges as they are established, such that, if the hospital established a standard charge as a dollar amount, the hospital would display the standard charge as a dollar amount." (88 FR 82996).

In order to ensure inclusion of a dollar amount in the hospital machine-readable files and to make hospital prices more transparent, CMS is issuing the following guidance:

- As required in the CY 2024 OPPS/ASC final rule, hospitals must encode a standard charge dollar amount in the machine-readable file (MRF) if it can be calculated, including the amount negotiated for the item or service, the base rate negotiated for a service package, and a dollar amount if the standard charge is based on a percentage of a known fee schedule.

- Hospitals should discontinue encoding 999999999 (nine 9s) in the estimated allowed amount data element within the MRF and should instead encode an actual dollar amount.

Hospital Price Transparency Regulation Background

Section 2718(e) of the Public Health Service Act (the PHS Act) requires each hospital operating within the United States 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. Section 2718(b)(3) of the PHS Act requires the Secretary of HHS (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.

In the CY 2020 OPPS/ASC HPT final rule (84 FR 65524), CMS adopted requirements for hospitals to make public their standard charges in two ways: (1) as a comprehensive MRF and (2) in a consumer-friendly format. CMS codified these requirements at 45 CFR section 180. CMS also explained its belief that these two different methods of making hospital standard charges public are necessary to ensure that such data are available to healthcare consumers where and when they are needed, including through data aggregation methods (for example, via integration into price transparency tools, electronic health records, and consumer apps) and direct availability to healthcare consumers searching for hospital-specific charge information. Additionally, we indicated we believe such data can be used by employers, researchers, and policy officials, and other members of the public to drive competition and help bring more value to healthcare.

Subsequently, in the CY 2022 OPPS/ASC final rule (86 FR 63941), CMS strengthened the HPT enforcement scheme in order to improve hospital compliance with the HPT regulations and made other updates to the requirements.

In the CY 2024 OPPS/ASC final rule (88 FR 81545), CMS revised several HPT requirements by: 1) standardizing the way hospital must display their standard charges; 2) aligning, where feasible, certain HPT requirements and processes with requirements and processes in the payer-required disclosures pursuant to the Transparency in Coverage initiative;[1] and 3) strengthening and streamlining our monitoring and enforcement capabilities.

Guidance: Encoding Payer-Specific Standard Charge Dollar Amounts and Contract Methodologies

CMS expects that, for most contracting scenarios, hospitals' payer-specific negotiated charges can be expressed as a dollar amount. A hospital that can derive a dollar amount from a hospital's payer-specific negotiated charge must encode that value in the "payer-specific negotiated charge: dollar amount" data element in the MRF. In particular, for items and services encoded in the MRF with a standard charge methodology[2] of a known "case rate," "fee schedule," or "per diem," CMS expects hospitals to calculate and encode a payer-specific negotiated charge as a dollar amount.

We recognize that there may be situations where the payer-specific negotiated charge is a percentage of a fee schedule that is not available to the hospital. In such instances, a hospital

[1] https://www.cms.gov/priorities/key-initiatives/healthplan-price-transparency
[2] https://github.com/CMSgov/hospital-price-transparency/tree/master/documentation/CSV#additional-standard-charge-methodology-notes

should indicate that the payer-specific negotiated charge is a percentage, provide additional information about the type of fee schedule in the appropriate additional notes data element, and encode an "estimated allowed amount." Hospitals that encode "case rate" or "per diem" for the "standard charge methodology" data element will encode the dollar amount for the service package base rate, which may be coupled with a payer-specific negotiated charge algorithm and an estimated allowed amount, if necessary. Please review the scenarios and examples on the CMS HPT – Data Dictionary GitHub Repository for examples of how to encode standard charge data.

Guidance: Calculating the "Estimated Allowed Amount" and Discontinuing Use of Nine 9s

In the CY2024 OPPS/ASC final rule (88 FR 82098-82101), we finalized requirements, codified at 45 CFR section 180.50(b)(2)(ii)(C), that beginning July 1, 2024, each hospital should encode in its MRF all standard charge information, as applicable, for the required data elements. This includes each type of standard charge as defined at 45 CFR section 180.50 (gross charge, discounted cash price, payer-specific negotiated charge, de-identified minimum negotiated charge, and de-identified maximum negotiated charge) and, for payer-specific negotiated charges, additional data elements including the method used to establish the charge and whether the charge indicated should be interpreted by the user as a dollar amount or based on a percentage or algorithm. If the standard charge is based on a percentage or algorithm, the MRF must also describe the percentage or algorithm that determines the dollar amount for the item or service and calculate and encode an estimated allowed amount in dollars for that item or service. The "estimated allowed amount" is defined as "the average dollar amount that the hospital has historically received from a third-party payer for an item or service."

CMS is aware that there are infrequent scenarios where a hospital has limited historical claims to derive the "estimated allowed amount," such as when a hospital has just negotiated contracts with new payers. In prior guidance, CMS recommended that hospitals encountering such scenarios encode nine 9s in the data element value to indicate that there is not sufficient reimbursement history to derive the estimated allowed amount.

Through observations, feedback from users of the data, and an analysis of a sample of MRF files from large acute care hospitals conducted in February 2025, CMS has determined that hospitals are encoding nine 9s much more frequently than expected. Our analysis of a sample of MRF files of 68 large acute care hospitals found that 63% of the 68 MRFs encode one or more nine 9s for their estimated allowed amount data element values. Additionally, the analysis found that 38% of the 68 MRFs sampled encoded nine 9s for more than 90% of their estimated allowed amount data element values, resulting in thousands of instances of nine 9s.

Consistent with the Executive Order and our previous rulemaking (45 CFR section 180.50(b)(2)(ii)(C)), and in the interest of providing more comparable and useful data to consumers of the files, hospitals should no longer encode nine 9s.

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In calculating the "estimated allowed amount," hospitals should instead encode the average dollar amount the hospital has received for an item or service, derived from electronic remittance advice transaction data using data from items or services rendered within the 12 months prior to posting the file. The following scenarios illustrate CMS' guidance:

1) If the currently negotiated percentage or algorithm was only used for a portion of the 12-month time period prior to posting the file, the hospital should encode the average dollar amount from the electronic remittance advice transactions for only the portion of time that the percentage or algorithm was used.
2) If an item or service that is negotiated as a percentage or algorithm was used or performed *one or more times* within the 12-month time period prior to posting the file, the hospital should encode the *average* of those charges derived from electronic remittance advice transaction data as the "estimated allowed amount," and remark in the "notes" data element that there was "one or more instances of the item or service in the 12 months prior to posting the file."
3) If an item or service that is negotiated as a percentage or algorithm was *not used* within the 12-month time period prior to posting the file, the hospital should encode a value in dollars and cents related to their *expectation of what the charge would be for that item or service*, and remark in the "notes" data element that there were "zero instances of the item or service in the 12 months prior to posting the file."

The above guidance is consistent with CY 2024 OPPS/ASC final rule (88 FR 82100), where CMS indicated that using electronic data interchange 835 electronic remittance advice transaction data meets the requirements of calculating an estimated allowed amount. We believe this will result in more meaningful information for third parties and consumers.