July 17, 2025

VIA CMS Digital Portal: Hospital Price Transparency Accuracy and Completeness RFI
Centers for Medicare & Medicaid Services (CMS)
Attention: Hospital Price Transparency RFI
Office of the Administrator
U.S. Department of Health and Human Services (HHS)
Washington, D.C. 20201

RE: Public Comment – Request for Information on Accuracy and Completeness in Hospital Price Transparency

The Craneware Group appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' Request for Information (RFI) on hospital price transparency. As a leading provider of healthcare financial performance solutions, we support the administration's commitment to improving the accuracy, completeness, and usability of pricing data. Our responses below reflect both our technical expertise and our ongoing collaboration with hospitals navigating these evolving requirements. We respectfully submit the following recommendations to support more effective implementation and enforcement of price transparency standards.

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

Yes. Defining these terms is essential to ensure consistent compliance, reduce ambiguity, and prevent both unintentional errors and deliberate misreporting. We recommend:

- **Accuracy**: Data that truthfully reflects the actual contracted rates and pricing terms between hospitals and payers without placeholders, estimates, or omissions that could mislead consumers or regulators.
- **Completeness**: The inclusion of all required data elements for every applicable item and service, across all contracted payers, unless explicitly exempted.

Clear definitions will help CMS distinguish good-faith compliance from practices that may constitute waste or misrepresentation and will enable more targeted and fair enforcement.

2. What are your concerns about the accuracy and completeness of the HPT MRF data?

We are concerned that pressure to comply with the template, data dictionary, and validator tools may lead hospitals to submit inaccurate or misleading information.

- Certain services/supplies are not reimbursable by specific payers, yet the MRF format does not permit null or zero entries, potentially distorting results.
- Hospitals often lack reimbursement data needed to populate estimated allowed amounts and instead make assumptions. This creates variation across institutions that undermines comparability as hospitals may develop unique strategies for calculating Estimated Allowed Amount to accommodate a required positive value. This variance invalidates the usability of comparison data across systems.
- Duplicate disclosure of payer data already covered under the Transparency in Coverage (TiC) rule introduces inconsistencies between MRF and TiC files. Outdated or incomplete payer contract data—compounded by insurer unresponsiveness—further contributes to accuracy gaps.

The forthcoming TiC schema version 2.0 (per ACA FAQs Part 70) is a positive development, improving file structure and usability. However, unless reporting burdens are reduced in parallel, the system will remain inefficient and error-prone.

3. Do concerns about accuracy and completeness of the MRF data affect your ability to use hospital pricing information effectively?

Yes. The existence of two overlapping datasets, hospital MRFs and payer TiC files, creates confusion about which source is authoritative. The resulting redundancy and variance undermines the usefulness of the data for patients, payers, researchers, and regulators.

We recommend that CMS eliminate duplication by limiting hospital MRF reporting to missing fields (e.g., CPT/HCPCS codes, gross charges, discounted cash prices). This will reduce reporting burden, mitigate risk for misuse, and improve clarity and consistency.

4. Are there external sources of information that may be leveraged to evaluate the accuracy and completeness of the data in the MRF?

Yes. CMS already has access to several valuable data sources that can be leveraged for validation and fraud detection:

- **Transparency in Coverage (TiC)** files from payers
- **Qualified Entity Program (QEP)** datasets (commercial and Medicare claims)
- **CMS Standard Analytical Files**, updated quarterly and widely used in research

These datasets can be used to cross-reference hospital-reported data, flag outliers, and improve oversight, without adding redundant workload to hospitals.

5. What specific suggestions do you have for improving the HPT compliance and enforcement processes?

Specific suggestions include:

- **Streamline reporting** by requiring hospitals to report only what payers do not already disclose.
- **Enhance the CMS validator tool** with clearer guidance on how "alerts" and "errors" are handled and what corrective actions are expected. How does CMS treat Alerts differently from Errors?
- **Use Qualified Entities** to generate standard pricing comparisons, easing the burden on hospitals.
- **Apply Data Use Agreements** to govern the appropriate use of reported data, consistent with Medicare research protocols.

These steps will improve efficiency, reduce waste, and ensure enforcement targets actual noncompliance rather than complexity-related issues.

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

CMS should:

- **Prioritize shoppable services and patient estimation tools**, which have the most direct impact on patients.
- **Avoid overreliance on vendor-generated compliance reports**, some of which have been challenged by the American Hospital Association for inaccuracies and reputational harm.
- **Address the current lack of standardization** across datasets. As third parties build tools using both MRF and TiC data, and as AI is increasingly applied, misalignment in methodology can lead to flawed comparisons and public misunderstanding.
- **Leverage the Qualified Entity Program** to generate unified charge files, minimizing duplication and risk of misuse.

Finally, we encourage CMS to take full advantage of TiC schema version 2.0. By delineating responsibilities (hospitals: pricing and estimates; payers: contract logic), CMS can foster a system that is more accurate, less costly, and easier to interpret. These structured files can be merged downstream for complex payment calculations, without additional hospital burden.

This approach reflects the administration's goals of radical transparency, cost containment, and eliminating fraud, waste, and abuse in the U.S. healthcare system.