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Not All Selected Hospitals Complied With the Hospital Price Transparency Rule

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REPORT HIGHLIGHTS

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Not All Selected Hospitals Complied With the Hospital Price Transparency Rule

Why OIG Did This Audit

- Health care spending is projected to account for almost 20 percent of the American economy by 2027.
- CMS believes that one reason for this upward spending trajectory is the lack of transparency in health care pricing, and that improving transparency will increase market competition and drive down the cost of health care services.
- Several media reports have stated that hospitals appeared slow to comply with CMS's Hospital Price Transparency rule (HPT rule). Members of Congress expressed concern that some hospitals were either not taking any action to comply with the requirements of the HPT rule or were acting slowly.
- This audit assessed whether selected hospitals made their standard charges available to the public as required by Federal law.

What OIG Found

Not all of the selected hospitals made their standard charges available to the public as required by Federal law. Of the 100 hospitals in our stratified random sample, 63 complied with the HPT rule requirements; however, 37 did not comply with 1 or both of the following HPT rule requirements:

- 34 hospitals did not comply with 1 or more of the requirements associated with publishing comprehensive machine-readable files.
- 14 hospitals did not comply with 1 or more of the requirements associated with displaying shoppable services in a consumer-friendly manner.

On the basis of our sample results, we estimated that 46 percent of the 5,879 hospitals that were required to comply with the HPT rule did not comply with the requirements to make information on their standard charges available to the public.

What OIG Recommends

We recommend that CMS:

1. review noncompliant hospitals associated with our findings and, if CMS determines that the hospitals are noncompliant, execute CMS's enforcement measures as applicable;
2. use the information in this report and consider implementing changes suggested by hospitals, including providing written guidance clarifying the definition of "shoppable services" and developing a training and compliance program that is tailored for smaller hospitals; and
3. continue to strengthen its internal controls, to include allocating sufficient resources to maintain a robust program of reviews of the hospitals and their compliance with the HPT rule.

CMS concurred with all of our recommendations and described corrective actions taken before, during, and after our audit work.

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INTRODUCTION

WHY WE DID THIS AUDIT

As health care costs continue to rise, affordability of those services has become an area of intense focus in the eyes of consumers and other stakeholders. Health care spending is projected to account for almost 20 percent of the American economy by 2027.[1] The Centers for Medicare & Medicaid Services (CMS) believes that one reason for this upward spending trajectory is the lack of transparency in health care pricing (see footnote 1). Accordingly, CMS has implemented various legislation to improve transparency, which it believes will increase market competition and drive down the cost of health care services. These measures include issuing a final rule, effective January 1, 2021, that directs hospitals to make their pricing information readily available to patients so that they can compare costs and make more informed health care decisions (see footnote 1) and revising the rule twice. In this report (unless otherwise noted), the Hospital Price Transparency rule (HPT rule) refers to the original rule as revised by the first revision, effective January 1, 2022 (see footnote 11 later in this report). The HPT rule requires hospitals, among other things, to establish, update, and make public a list of their standard charges for the items and services that they provide.[2] It specifies that hospitals provide their standard charges in two ways: (1) a machine-readable file (MRF) containing a list of all standard charges for all items and services and (2) a consumer-friendly list of standard charges for a limited set of shoppable services.

In recent years, several media reports have stated that in response to the final rule, hospitals appeared slow to comply with the HPT rule.[3] Shortly after publication of these media reports, members of Congress expressed concern that some hospitals were either not taking any action to comply with the requirements of the HPT rule or were acting slowly to comply with those

[1] 84 Fed. Reg. 65524, 65525 (Nov. 27, 2019) (citing to the Centers for Medicare & Medicaid Services [CMS], National Health Expenditures Projections, 2018–2027).

[2] The term "standard charge" refers to the regular rate established by a hospital for an item or service provided to a specific group of paying patients. This rate includes gross charge, payer-specific negotiated charge, de-identified minimum negotiated charge, de-identified maximum negotiated charge, and discounted cash price (45 CFR § 180.20). (We explain the meaning of "de-identified" later in this report.)

[3] See for instance Morgan A. Henderson and Morgane C. Mouslim, "Low Compliance From Big Hospitals On CMS's Hospital Price Transparency Rule," *Health Affairs*, Mar. 16, 2021. Available online at https://www.healthaffairs.org/content/forefront/low-compliance-big-hospitals-cms-s-hospital-price-transparency-rule. Accessed on June 3, 2024. Tom McGinty, Anna Wilde Mathews, and Melanie Evans, "Hospitals Hide Pricing Data From Search Results," *The Wall Street Journal*, Mar. 22, 2021. Available online at https://www.wsj.com/articles/hospitals-hide-pricing-data-from-search-results-11616405402. Accessed on June 3, 2024. Michael Brady, "Hospitals slow to disclose their payer-negotiated rates," *Modern Healthcare*, Jan. 8, 2021. Available online at https://www.modernhealthcare.com/transformation/hospitals-slow-disclose-their-payer-negotiated-rates. Accessed on June 3, 2024.

requirements.[4] Furthermore, various organizations and consumer advocacy groups also raised concerns regarding hospitals' low compliance rates with the HPT rule.[5]

OBJECTIVE

Our objective was to determine whether selected hospitals made their standard charges available to the public as required by Federal law.

BACKGROUND

Federal Requirements and CMS Final Rule

Section 1001 of the Affordable Care Act, as amended by section 10101 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), amended Title XXVII of the Public Health Service Act (PHS Act), in part, by adding section 2718, "Bringing Down the Cost of Health Care Coverage," to the PHS Act. Specifically, section 2718(e) of the PHS Act requires hospitals to establish, update, and make public (in accordance with guidelines developed by the Secretary of Health and Human Services) a list of their standard charges for the items and services that they provide, including for diagnosis-related groups (DRGs) established under section 1886(d)(4) of the Social Security Act.[6] Section 2718(e) applies to each hospital operating within the United States, even those not enrolled in Medicare.[7]

Initially, in the fiscal year (FY) 2015 Inpatient Prospective Payment Systems (IPPS)/Long-Term Care Hospital Prospective Payment Systems (LTCH PPS) proposed rule and in a final rule, CMS reminded hospitals of their obligation to comply with the provision of section 2718(e) and provided guidelines for its implementation. Specifically, CMS stated that hospitals are required to "either make public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice), or their policies for allowing the public to view a list of those

[4] The U.S. Congress Committee on Energy and Commerce sent a letter to the Honorable Xavier Becerra, Secretary of Health and Human Services, on Apr. 13, 2021.

[5] See, for instance, Patient Rights Advocate (PRA), *Third Semi-Annual Hospital Price Transparency Report*, August 2022. Available online at https://www.patientrightsadvocate.org/august-semi-annual-compliance-report-2022. Accessed on June 3, 2024. Health Care Cost Institute, "The Insanity of U.S. Health Care Pricing: An Early Look at Hospital Price Transparency Data," Apr. 1, 2021. Available online at https://healthcostinstitute.org/hcci-originals-dropdown/all-hcci-reports/hospital-price-transparency-1. Accessed on June 3, 2024.

[6] The Public Health Service Act, P.L. No. 78-410 (July 1, 1944), as amended and as codified at 42 U.S.C. chap. 6A, and The Patient Protection and Affordable Care Act of 2010, P.L. No. 111-148 (Mar. 23, 2010). A DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the patient's stay.

[7] Additionally, certain Federal and State-owned hospitals are deemed to be in compliance, including facilities operated by the U.S. Department of Veterans Affairs and hospitals operated by the Indian Health Service.

charges in response to an inquiry."[8] Effective January 1, 2019, CMS updated its guidelines to require that hospitals' lists of standard charges be made available to the public via the internet in a machine-readable format and that hospitals update this information at least annually, or more often as appropriate.[9]

Subsequently, CMS issued the HPT rule, which requires hospitals to establish, update, and make public a list of their standard charges for the items and services that they provide, effective January 1, 2021 (see footnotes 1 and 2). Federal regulations state that each hospital must make public: (1) an MRF containing a list of all standard charges for all items and services, as provided in 45 CFR § 180.50, and (2) a consumer-friendly list of standard charges for a limited set of shoppable services, as provided in 45 CFR § 180.60 (45 CFR § 180.40).[10] A hospital is deemed to be compliant with the shoppable services requirements under 45 CFR § 180.60 if it maintains a price estimator tool on its website. For this report, we collectively refer to the MRF, shoppable services file, and price estimator tool as "pricing files."

To date, CMS has revised the HPT rule twice. For this audit, we used the version of the HPT rule as amended by the first revision that was effective on January 1, 2022.[11] We did not use the version that included changes made by the second revision (88 Fed. Reg. 81540, 82184–85 (Nov. 22, 2023)) because that version became effective after we had downloaded pricing files from sampled hospitals' websites (between January 17 and March 14, 2023).

CMS Reviews and Enforcement of Hospital Price Transparency Rule

In accordance with Federal regulations, CMS reviews hospitals' compliance with the HPT rule by evaluating hospitals for which individuals or entities have submitted complaints, reviewing individuals' or entities' analysis of noncompliance, and auditing hospital websites (45 CFR § 180.70(a)). If CMS concludes that a hospital is not complying with one or more of the requirements to make public a list of its standard charges or shoppable services, it may take any

[8] See the preambles to the FY 2015 hospital IPPS/LTCH PPS proposed and final rules at 79 Fed. Reg. 27978, 28169 (May 15, 2014) and 79 Fed. Reg. 49854, 50146 (Aug. 22, 2014), respectively. The term "chargemaster" is a commonly used term that refers to a list of all individual items and services maintained by a hospital for which the hospital has established a charge.

[9] See the preambles to the FY 2019 hospital IPPS/LTC PPS proposed and final rules at 83 Fed. Reg. 20164, 20549 (May 7, 2018) and 83 Fed Reg. 41144, 41686 (Aug. 17, 2018), respectively.

[10] 84 Fed. Reg. 65524 (Nov. 27, 2019). The term "shoppable service" refers to a service that can be scheduled by a health care consumer in advance (45 CFR § 180.20). Such services are routinely provided in nonurgent situations that do not require immediate action or attention to the patient, thus allowing patients to compare prices before scheduling a service. Examples of shoppable services include imaging and laboratory services, medical and surgical procedures, and outpatient clinic visits.

[11] 86 Fed. Reg. 63458, 63997 (Nov. 16, 2021) (effective Jan. 1, 2022). In this report, we refer to the regulations implementing hospital price transparency at 45 CFR part 180, as amended by 86 Fed. Reg. at 63997, as the "HPT rule" (unless noted otherwise).

of the following actions, which generally, but not necessarily, would occur in the following order:

- provide a written warning notice to the hospital of the specific violation(s);

- request that the hospital develop and submit a corrective action plan if noncompliance constitutes a material violation of one or more requirements, according to 45 CFR § 180.80; and/or

- impose a civil monetary penalty on the hospital and publicize the penalty on a CMS website if the hospital fails to respond to CMS's request to submit a corrective action plan or comply with the requirements of a corrective action plan, according to 45 CFR § 180.90 and 45 CFR § 180.70(b).

HOW WE CONDUCTED THIS AUDIT

We identified 5,879 unique hospitals that were required to comply with the HPT rule and that had Medicare inpatient claims for hospital stays with ending dates of service from January 1, 2021, through June 30, 2022. We separated these hospitals into 2 strata: (1) hospitals from the 3 largest hospital systems,[12] which represented 375 hospitals (we refer to these hospitals as "stratum 1 hospitals" in this report), and (2) the remaining 5,504 hospitals (we refer to these hospitals as "stratum 2 hospitals" in this report).[13]

We selected for audit a stratified random sample of 100 hospitals, which consisted of 30 hospitals from stratum 1 and 70 hospitals from stratum 2.

We accessed the websites of the sampled hospitals and obtained MRFs and shoppable services files from those websites during searches that we conducted between January 17 and March 14, 2023. If a hospital did not have a shoppable services file on its website, we analyzed its price estimator tool. We compared pricing files for each hospital in our sample with the requirements of the HPT rule based on the requirements in 45 CFR Part 180.

We discussed the results of our audit work with representatives from the sampled hospitals and asked for input regarding implementation of the HPT rule, including suggestions for how CMS could improve hospitals' compliance with the HPT rule.[14] We also provided the results of

[12] These hospital systems are identified on page 5 of PRA's August 2022 *Third Semi-Annual Hospital Price Transparency Report* (see footnote 5). We chose to include these hospitals in our first stratum because of their low compliance rate with the HPT rule, as noted in PRA's report.

[13] We did not consider certain other hospital characteristics, such as size, type, and revenue, when developing our sampling methodology.

[14] We received feedback from 99 out of our 100 sampled hospitals. The hospital that did not respond was, according to our analysis, compliant with the HPT rule, so its lack of response therefore did not affect our findings.

our reviews of the sampled hospitals, which included identifying the sampled hospitals that were out of compliance with the HPT rule, to CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

Not all of the selected hospitals made their standard charges available to the public as required by Federal law. Of the 100 hospitals in our stratified random sample, 63 complied with the HPT rule requirements; however, 37 did not comply with 1 or more of the HPT rule requirements. Specifically, 34 hospitals did not comply with 1 or more of the requirements associated with publishing comprehensive MRFs, and 14 hospitals did not comply with 1 or more of the requirements associated with displaying shoppable services in a consumer-friendly manner. (Several of the selected hospitals were out of compliance with both requirements.)

On the basis of our sample results, we estimated that 2,711 hospitals (46 percent of the 5,879 hospitals that were required to comply with the HPT rule) did not comply with the HPT rule to make information on their standard charges available to the public, which limited the public's use of the data, including the public's ability to actively shop for health care services with full knowledge of the standard charges for those services.

This notable level of noncompliance with the provisions of the HPT rule resulted from the fact that CMS's controls were generally not adequate to ensure that all hospital standard charges were available to the public as required by Federal law. Specifically, CMS's controls included procedures that CMS had in place to review hospitals' compliance with the HPT rule; however, CMS officials told us that its ability to execute these procedures initially was limited, primarily by an inability to devote sufficient staffing resources to its hospital reviews. Notwithstanding the large number of noncompliant hospitals in our sample, CMS had improved its controls between September 2022 and February 2024—which represented the timeframe of our data collection and analysis—to include reviewing a considerably larger number of hospitals and imposing a higher number of civil monetary penalties on noncompliant hospitals during 2023 than it did in prior years. Additionally, CMS has taken steps through rulemaking to improve standardization of MRFs, which CMS anticipates will further streamline its enforcement capabilities (see footnote 23).

FEDERAL REQUIREMENTS

As explained in this section, hospitals that are subject to the HPT rule are required to publish their pricing information for use by employers, researchers, policy officials, and other members of the public to drive competition and help bring more value to health care, and for use by patients and other health care consumers to compare costs and make more informed health care decisions. Specifically, hospitals must: (1) make publicly available a comprehensive MRF that lists all items and services and (2) display shoppable services in a consumer-friendly format or provide a price estimator on its website. In addition, hospitals must update their standard charge information at least once annually and must clearly indicate the date on which the information was most recently updated (45 CFR § 180.60(d)).

For additional details on the Federal requirements and guidance that we summarize below, see Appendix D.

Requirements for Publishing Comprehensive Machine-Readable Files

A hospital must publish its standard charges in an MRF that is a single digital file (45 CFR § 180.50(c)) and must ensure that the standard charge information is easily accessible to the public, without barriers. To comply with this accessibility requirement, the hospital must ensure that the information is accessible free of charge and does not require a viewer to establish a user account or password or to submit personally identifiable information (PII) (45 CFR § 180.50(d)(3)).[15] These regulations require MRFs to include the following data elements, among others:

- a description of each item or service provided by the hospital;
- the gross charge that applies to each individual item or service;
- the payer-specific negotiated charge that applies to each item or service and that is clearly associated with the name of the third-party payer and plan;
- the de-identified minimum and maximum negotiated charges that apply to each item or service;[16]
- the discounted cash price that applies to each item or service; and

[15] PII, as defined in Office of Management and Budget Memorandum M-07-1616, refers to information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual.

[16] The minimum negotiated charge is also referred to as the "de-identified minimum negotiated charge," which is the lowest charge that a hospital has negotiated with all third-party payers for an item or service. Hospitals are also required to list the de-identified maximum charges, which are the highest charges a hospital has negotiated.

- any code(s) 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 DRG (see footnote 6), the National Drug Code (NDC), or other common payer identifier (45 CFR § 180.50(b)).[17]

Requirements for Displaying Shoppable Services in a Consumer-Friendly Manner

A hospital must also make public a consumer-friendly list of certain standard charges for as many of the 70 CMS-specified shoppable services[18] that are provided by the hospital and as many additional hospital-selected shoppable services as is necessary to populate this list with a combined total of at least 300 shoppable services (45 CFR § 180.60).

A hospital is deemed to be compliant with the shoppable services requirements under 45 CFR § 180.60 if it maintains a price estimator tool on its website that meets the following requirements:

- The tool provides estimates for as many of the 70 CMS-specified shoppable services that are provided by the hospital and as many additional hospital-selected shoppable services as is necessary for a combined total of 300 shoppable services.

- The tool allows health care consumers to obtain an estimate, at the time they use the tool, of the amount that they will be obligated to pay the hospital for the shoppable service.

- The tool is prominently displayed on the hospital's website and is accessible to the public without charge and without requiring a viewer to register or establish a user account or password (45 CFR § 180.60(a)(2)).

NOT ALL SELECTED HOSPITALS COMPLIED WITH THE HOSPITAL PRICE TRANSPARENCY RULE

Of the 100 hospitals in our stratified random sample, 37 did not comply with 1 or more of the HPT rule requirements. Specifically, 34 hospitals did not comply with 1 or more of the requirements associated with publishing comprehensive MRFs, and 14 hospitals did not comply with 1 or more of the requirements associated with displaying shoppable services in a

[17] The health care industry uses HCPCS codes to standardize coding for medical procedures, services, products, and supplies. Drug products are identified and reported using a unique three-segment number, called the NDC, which is a universal product identifier for human drugs.

[18] The 70 CMS-specified shoppable services were finalized through the notice-and-comment rulemaking process and were based on an analysis of State price transparency requirements, a review of services that frequently appear in web-based price transparency tools, an analysis of high-volume services and high-cost procedures derived from External Data Gathering Environment server data, and a review by CMS medical officers (84 Fed. Reg. 65524, 65568 (Nov. 27, 2019)).

consumer-friendly manner. (Several of the selected hospitals were out of compliance with both requirements.)

On the basis of our sample results, we estimated that 2,711 of the 5,879 hospitals (approximately 46 percent of those hospitals) did not comply with the HPT rule.

Some Hospitals Did Not Comply With All Requirements for Publishing Comprehensive Machine-Readable Files

Of the 100 hospitals in our stratified random sample, 34 hospitals did not comply with 1 or more of the requirements associated with publishing comprehensive MRFs in accordance with the HPT rule requirements. We evaluated the sampled hospitals' compliance with 11 different HPT rule requirements. Table 1 lists these 11 requirements and the results of our analysis of the sampled hospitals' compliance with those requirements. Appendix D provides additional details about the HPT rule requirements summarized in this table.

Table 1: Hospitals Not in Compliance With Machine-Readable File Requirements[19]

HPT Rule Requirements	Number of Noncompliant Hospitals in Our Sample	
	Stratum 1 (30 Hospitals)	Stratum 2 (70 Hospitals)
Description of services	0	6
Gross charge for services	0	6
Negotiated charge by payer and plan	1	19
Minimum negotiated charge (see footnote 16)	1	15
Maximum negotiated charge (see footnote 16)	1	15
Discounted cash price	1	14
Hospital accounting or billing codes	0	6
Standard charges available on public website	0	5
Easily accessible, without barriers	0	5
Appropriate naming convention	0	17
Updated annually	1	21
Total number of hospitals that did not comply with MRF requirements	**2**	**32**

[19] Of the 70 sampled hospitals in stratum 2, 5 hospitals did not provide an MRF on their website, so they did not meet any of the HPT rule requirements listed in Table 1. And because most of the 34 hospitals in strata 1 and 2 did not comply with more than 1 of the HPT rule requirements, the numbers in the 2 right-hand columns of this table do not add to the column totals.

Some Hospitals Did Not Comply With All Requirements for Displaying Shoppable Services in a Consumer-Friendly Manner

Of the 100 hospitals in our stratified random sample, 14 hospitals did not comply with 1 or more of the requirements associated with displaying shoppable services in a consumer-friendly manner in accordance with the HPT rule requirements. We evaluated the sampled hospitals' compliance with 18 different HPT rule requirements. Table 2 lists these 18 requirements and the results of our analysis of the sampled hospitals' compliance with those requirements. Appendix D provides additional details about the HPT rule requirements summarized in this table.

Table 2: Hospitals Not in Compliance With Displaying Shoppable Services Requirements[20]

HPT Rule Requirements	Number of Noncompliant Hospitals in Our Sample	
	Stratum 1 (30 Hospitals)	**Stratum 2 (70 Hospitals)**
Shoppable Services File		
Shoppable services provided in consumer-friendly manner	0	5
At least 300 shoppable services included in file	0	6
Hospital accounting or billing codes	0	5
Plain-language description of each shoppable service	0	6
Indicator if CMS-specified shoppable service is not offered	1	7
Payer-specific negotiated charge	0	5
Discounted cash price	0	5
Minimum negotiated charge (see footnote 16)	0	6
Maximum negotiated charge (see footnote 16)	0	6
Location where shoppable services are provided	0	5
Shoppable services on publicly available internet location	0	5
Easily accessible, without barriers	0	5
Updated annually	1	8
Price Estimator		
CMS-specified shoppable services in price estimator tool	0	2
Discounted cash prices	0	1
Ability to input insurance plan information to obtain payer-specific estimated charges	1	2
Estimator provided free of charge	0	1
Estimator available without requiring user ID or password	0	1
Total number of hospitals that did not comply with displaying shoppable services requirements	**2**	**12**

[20] Of the 70 sampled hospitals in stratum 2, 1 hospital did not provide a list of shoppable services or a price estimator on its website, so it did not meet any of the HPT rule requirements listed in Table 2. And because most of the 14 hospitals in strata 1 and 2 did not comply with more than 1 of the HPT rule requirements, the numbers in the 2 right-hand columns of this table do not add to the column totals.

HOSPITALS HIGHLIGHTED MULTIPLE CONCERNS REGARDING THEIR EFFORTS TO COMPLY WITH THE HOSPITAL PRICE TRANSPARENCY RULE

During our audit, we contacted each of the hospitals included in our sample and gave each hospital an opportunity to comment about its experience with its efforts to implement and comply with the provisions of the HPT rule.

Hospital officials shared concerns and provided some suggestions that they thought would increase overall compliance with the requirements of the HPT rule. Most of their concerns generally addressed confusion or uncertainty that they and their staffs had experienced in their understanding of the specific requirements. Officials also expressed a desire for further technical assistance from CMS. One suggestion was that CMS maintain a call center, which might assist hospitals more effectively than would email support, to help address areas of ambiguity regarding the HPT rule. Some of the hospitals specifically suggested that CMS provide a standardized template for the MRF and clarify the definition of "shoppable services."[21]

Additionally, some smaller hospitals (i.e., hospitals with fewer than 100 beds) said that their own limited resources, as well as inadequate assistance from contractors, contributed to their difficulties in complying with the HPT rule.[22] These hospitals suggested that they would benefit from a specific training program tailored for them, including targeted compliance reviews and CMS-published examples of pricing files that fully complied with HPT rule requirements.

CMS IS IMPROVING ITS CONTROLS AND HAS MADE CHANGES TO THE HOSPITAL PRICE TRANSPARENCY RULE

The selected hospitals' notable level of noncompliance with the provisions of the HPT rule resulted from the fact that CMS's controls were generally not adequate to ensure that all hospital standard charges were available to the public as required by Federal law. Specifically, and as directed by Federal regulations, CMS's controls included procedures that CMS had in place to review hospitals' compliance with the HPT rule; however, CMS officials told us that its ability to execute these procedures prior to and during our audit fieldwork was limited, primarily by an inability to devote sufficient staffing resources to its hospital reviews.

Importantly, CMS was taking steps, even over the course of our audit, to improve upon these procedures and thereby strengthen its controls. At the beginning of our audit work, CMS officials told us that they were assessing hospitals' compliance with the HPT rule from a list of approximately 1,800 hospitals for which CMS had received complaints about a lack of

[21] Some hospitals added that they believed that the HPT rule for shoppable services did not apply to them because their services are not offered in advance. However, the "in advance" language in the HPT rule (see footnote 10) describes services that can typically be scheduled in advance, and, therefore, hospitals that do not offer these services in advance are not excused from this requirement.

[22] Some hospitals hire third-party contractors to assist them in their efforts to comply with the HPT rule.

compliance. At this same time, CMS had assigned additional staff to expedite its review process. The large number of complaints submitted to CMS illustrated the very real potential that hospitals in general were out of compliance. By taking actions to strengthen and streamline enforcement capabilities, CMS appeared to have improved its efforts by reviewing a considerably larger number of hospitals and by imposing a higher number of civil monetary penalties on noncompliant hospitals during 2023 than it did in prior years. Between January 1, 2021, when the HPT rule became effective, and the beginning of our audit work (September 2022), CMS had, in relation to the requirements of the HPT rule, issued two civil monetary penalties totaling $1.1 million, and by the end of our data collection and analysis (February 5, 2024), it had issued 14 civil monetary penalties totaling $4 million.

Additionally, among other improvements to its overall controls, CMS created an online validator tool for hospitals to proactively determine whether their pricing files are compliant with the HPT rule. Moreover, in the second revision to the HPT rule, in November 2023, CMS made several revisions, including: (1) requiring hospitals to use a standardized template for MRFs (thereby implementing an improvement that some of our sampled hospitals had suggested to us), (2) clarifying the information regarding payer and plan name information that hospitals must include when disclosing third-party negotiated rates, and (3) requiring each hospital to make a good faith effort to ensure that the data in the MRF are accurate and complete. Under the provisions of the updated HPT rule, each hospital is also now required to affirm in its MRF that the hospital has included all applicable standard charge information in accordance with the HPT rule.[23]

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- review noncompliant hospitals associated with our findings and, if CMS determines that the hospitals are noncompliant, execute CMS's enforcement measures, to include issuing warning notices, corrective action plans, and/or civil monetary penalties as applicable;

- use the information in this report and consider implementing changes suggested by hospitals, including providing written guidance clarifying the definition of "shoppable services" and developing a training and compliance program that is tailored for smaller hospitals; and

- continue to strengthen its internal controls, to include allocating sufficient resources to maintain a robust program of reviews of the hospitals and their compliance with the HPT rule.

[23] CMS's changes to the HPT rule are located at 88 Fed. Reg. 81540, 82184–85 (Nov. 22, 2023) and summarized at 88 Fed. Reg. at 81545–46.

CMS COMMENTS

In written comments on our draft report, CMS concurred with all of our recommendations and described corrective actions taken before, during, and after our audit work; however, CMS also expressed concerns regarding our sampling methodology. CMS stated that to assist hospitals in their compliance efforts, it has conducted webinars and published Frequently Asked Questions, compliance checklists, and step-by-step guides for hospitals, among other resources. In addition, "CMS has also responded to thousands of inquiries from hospitals and other interested parties and provided technical assistance to more than 500 hospitals that were determined by CMS to be out of compliance." CMS also explained how it prioritizes hospitals for comprehensive reviews and described informal (in February 2021) and formal (in October 2022) "website assessments" that it had undertaken. CMS added that the data from these assessments "demonstrate a significant increase in compliance in the first 18 months of the new requirements, which CMS attributed largely to its enforcement efforts . . . ."

Having offered these comments, CMS also acknowledged that "[w]hile compliance rates continue to improve with CMS outreach, education, and enforcement, we recognize that there is still work to do." Accordingly, CMS described specific corrective actions in response to our recommendations. For our first recommendation, CMS said that it had begun its own compliance review of the noncompliant hospitals identified during our audit. CMS stated that 11 of the 37 noncompliant hospitals we identified "have already received a compliance review from CMS and have corrected their deficiencies or are currently under enforcement review." CMS added that it would review the remaining 26 hospitals and follow its established enforcement procedures with respect to noncompliant hospitals.

For our second recommendation, CMS said that it had already published guidance related to its definition of "shoppable services." CMS also stated that it would "conduct additional outreach to hospitals to educate them on [this] definition . . . ." Additionally, CMS said that it had "developed and is deploying training and compliance tools and materials that are tailored for smaller hospitals (defined as hospitals having 100 beds or less)."

For our third recommendation, CMS has already undertaken efforts to strengthen its internal controls. Specifically, CMS stated that the updated HPT rule (cited earlier in this report at footnote 23), which was revised during our audit fieldwork, amended the HPT rule by: (1) requiring hospitals to use a standardized template for MRFs, (2) clarifying the information regarding payer and plan name information that hospitals must include when disclosing third-party negotiated rates, and (3) requiring each hospital to make a good faith effort to ensure that the data in the MRF are complete and accurate. CMS also said that these improvements have a "phased implementation schedule with dates ranging from January 2024 to January 2025" and that implementation and enforcement of these improvements "will be the primary focus of our work in the remainder of 2024 and 2025." CMS added that since our audit fieldwork, it had "demonstrably increased" the number of compliance reviews of hospitals initiated per year and has "reduced the time necessary to close a case."

More generally, CMS expressed concerns regarding our sampling methodology. Specifically, CMS said that our "derived rate [of compliance with the HPT rule] and conclusions [did] not appear to take into consideration factors that were discovered by the OIG [(Office of Inspector General)] in its analysis . . . ." Specifically, CMS said that it had analyzed our data and identified "a significant difference in compliance rates that depend on hospital type and size." CMS referred to our report's mention of officials from smaller hospitals (those with fewer than 100 beds) who believed that a lack of resources played a role in their ability to comply with the HPT rule and added that our findings "may suggest that larger health systems may have more resources to devote to compliance efforts." In this context, CMS commented on the sampling methodology we describe in Appendix B. That methodology weighted the hospitals from the three largest hospital systems at 30 percent of our sample and all other hospitals at 70 percent. However, according to CMS, national data show "that approximately 70 percent of hospitals are affiliated with health systems whereas only 30 percent are not."

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding technical comments, are included as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing CMS's comments, we believe that the actions CMS described, when fully executed, should resolve all three of our recommendations. Regarding CMS's concerns about our sampling methodology, we note that at the inception of our audit, we relied in part on the numerous reports of suspected noncompliance among various hospitals and hospital systems, and developed and refined our sampling methodology on that basis. We acknowledge that hospitals belonging to large hospital systems show a higher level of compliance with the provisions of the HPT rule. As a result, none of our recommendations pertain specifically to hospitals in our first stratum. Additionally, we acknowledge that hospitals with fewer than 100 beds, which have expressed to us that their lack of resources adversely affect their ability to comply fully with the HPT rule, require more technical assistance and training from CMS. Accordingly, our second recommendation focuses on those smaller hospitals, and we commend CMS for the steps it is undertaking to develop and deploy training and compliance tools and materials that are tailored for those hospitals. We also commend CMS for the other corrective actions that it has undertaken since our audit fieldwork to continue to improve its review procedures and thereby strengthen its controls.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We identified 5,879 unique hospitals that were required to comply with the HPT rule and that had Medicare inpatient claims for hospital stays with ending dates of service from January 1, 2021, through June 30, 2022. We separated these hospitals into 2 strata: (1) hospitals from the 3 largest hospital systems (see footnote 12), which represented 375 hospitals (stratum 1 hospitals), and (2) the remaining 5,504 hospitals (stratum 2 hospitals) (see footnote 13).

We selected for audit a stratified random sample of 100 hospitals, which consisted of 30 hospitals from stratum 1 and 70 hospitals from stratum 2.

Our audit objective did not require an understanding or assessment of the complete internal control structure of CMS. We limited our review of internal controls to obtaining an understanding of CMS's controls related to determining hospitals' compliance with the HPT rule.

We conducted our audit from September 2022 to June 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance related to the HPT rule;
- met with CMS officials to obtain an understanding of CMS's controls, to include the CMS hospital reviews, regarding hospitals' compliance with the HPT rule;
- identified a population of hospitals that were required to comply with the HPT rule, from which we selected a stratified random sample of 100 hospitals to determine whether they complied with the HPT rule (Appendix B);
- obtained pricing files for the sampled hospitals from the hospitals' websites (during searches that we conducted between January 17 and March 14, 2023) and compared the display and content of these files to the HPT rule requirements and the checklists CMS uses during its hospital reviews;
- notified sampled hospitals regarding areas of noncompliance, discussed the results of our audit work with officials from those hospitals, and solicited feedback from them about implementation of the HPT rule, to include asking whether the HPT rule requirements are clearly defined and requesting any ideas for improvement; and

- discussed the results of our audit with CMS officials, which included identifying the sampled hospitals that were out of compliance with the HPT rule.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 5,879 unique hospitals that were required to comply with the HPT rule and that had Medicare inpatient claims for hospital stays with ending dates of service from January 1, 2021, through June 30, 2022. The sampling frame consisted of 375 hospitals from the 3 largest hospital systems (see footnote 12) and all other (that is, 5,504) hospitals (see footnote 13).

SAMPLE UNIT

The sample unit was a hospital.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. We stratified the sampling frame into two strata consisting of: (1) hospitals from the three largest hospital systems (see footnote 12) and (2) all other hospitals (see footnote 13). We selected a total of 100 hospitals for review, as shown in Table 3.

Table 3: Hospitals by Stratum

Stratum	Stratum Description	Frame Size	Sample Size
1	Three largest hospital systems	375	30
2	Remaining hospitals	5,504	70
	Total	**5,879**	**100**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS) statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We sorted the items in each stratum by provider number and then consecutively numbered the hospitals in each stratum in the stratified sampling frame. We generated the random numbers for our sample according to our sample design, and we then selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the number of hospitals in the sampling frame that were not in compliance with the HPT rule. We also estimated the upper and lower limits of the corresponding two-sided 90-percent confidence interval (see Appendix C).

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 4: Sample Details and Results

Stratum	Frame Size (Number of Hospitals)	Sample Size	Number of Noncompliant Hospitals in Sample
1	375	30	3
2	5,504	70	34
Total	**5,879**	**100**	**37**

Table 5: Estimated Number of Noncompliant Hospitals in the Sampling Frame

(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	2,711
Lower Limit	2,169
Upper Limit	3,253

APPENDIX D: HOSPITAL PRICE TRANSPARENCY RULE REQUIREMENTS

REQUIREMENTS PERTAINING TO MACHINE-READABLE FILES

Federal regulations (45 CFR § 180.50(b)) state that hospitals must include all of the following corresponding data elements in their lists of standard charges, as applicable:

(1) Description of each item or service provided by the hospital.

(2) Gross charge for each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(3) Payer-specific negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting. Each payer-specific negotiated charge must be clearly associated with the name of the third-party payer and plan.

(4)(5) De-identified minimum and de-identified maximum negotiated charge (see footnote 16) for each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(6) Discounted cash price for each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.

(7) Any code used by the hospital for purposes of accounting or billing, including, but not limited to, the CPT code, the HCPCS code, the DRG, the NDC, or other common payer identifier.

Hospitals must ensure that the standard charge information is easily accessible, without barriers, including but not limited to ensuring that the information is accessible: (1) free of charge, (2) without having to establish a user account or password, (3) without having to submit PII, and (4) to automated searches and direct file downloads through a link posted on a publicly available website. MRFs must use the following naming convention: <ein>_<hospital-name>_standardcharges.[json|xml|csv] (45 CFR §§ 180.50(d)(3) and (d)(5)).

Hospitals must update the standard charge information included in MRFs at least once annually. Hospitals must clearly indicate the date on which the standard charge data was most recently updated (45 CFR § 180.50(e)).

REQUIREMENTS PERTAINING TO SHOPPABLE SERVICES FILES AND PRICE ESTIMATORS

Hospitals must make public the standard charges for as many of the 70 CMS-specified shoppable services as are provided by the hospital and as many additional hospital-selected

shoppable services as is necessary for a combined total of at least 300 shoppable services (45 CFR § 180.60(a)(1)).

A hospital must (as required by 45 CFR § 180.60(b)) include, as applicable, all of the following corresponding data elements:

(1) A plain-language description of each shoppable service.

(2) An indicator when a CMS-specified shoppable service(s) is not offered by the hospital.

(3) The payer-specific negotiated charge that applies to each shoppable service (and to each ancillary service, as applicable). Negotiated charges must be clearly associated with the name of the third-party payer and plan.

(4) Discounted cash price for each shoppable service (and corresponding ancillary services, as applicable). If the hospital does not offer a discounted cash price for a service(s), the hospital must list its undiscounted gross charge.

(5)(6) De-identified minimum and de-identified maximum negotiated charge (see footnote 16) for each shoppable service (and for each corresponding ancillary service, as applicable).

(7) Location where the shoppable service is provided, including whether the standard charges identified for the shoppable service apply at that location to the provision of that shoppable service in the inpatient setting, the outpatient department setting, or both.

(8) Any primary code used by the hospital for purposes of accounting or billing for the shoppable service, including, as applicable, the CPT code, the HCPCS code, the DRG, or other common service billing code.

Hospitals have discretion to choose a format for making public the information online (45 CFR § 180.60(c)).

Hospitals must select an appropriate publicly available internet location for purposes of making public the information. The shoppable services information must be easily accessible, without barriers, including but not limited to ensuring that the information is: (1) free of charge; (2) accessible without having to register or establish a user account or password; (3) accessible without having to submit PII; and (4) searchable by service description, billing code, and payer (45 CFR § 180.60(d)(1) and (d)(3)).

The hospital must update the standard charge information at least once annually. The hospital must clearly indicate the date on which the information was most recently updated (45 CFR § 180.60(e)).

A hospital is deemed to meet the shoppable services file requirements if it maintains an internet-based price estimator tool that meets the following requirements:

(1) Provides estimates for as many of the 70 CMS-specified shoppable services as are provided by the hospital and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.

(2) Allows users to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay the hospital for the shoppable service.

(3) Is prominently displayed on the hospital's website and accessible to the public without charge and without having to register or establish a user account or password (45 CFR § 180.60(a)(2)).

UPDATED REQUIREMENTS OF THE HOSPITAL PRICE TRANSPARENCY RULE

The requirements described in this appendix do not include the revisions that CMS made in 88 Fed. Reg. 81540, 82184–85 (Nov. 22, 2023) because we obtained pricing files from sampled hospital websites between January 17 and March 14, 2023, which was before these revisions were made.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: July 18, 2024

TO: Juliet T. Hodgkins
Principal Deputy Inspector General

FROM: Chiquita Brooks-LaSure
Administrator

SUBJECT: OIG Draft Report: *Not All Selected Hospitals Complied With the Hospital Price Transparency Rule*, A-07-22-06108

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. Hospital price transparency lays the foundation for a patient-driven health care system by making hospital standard charges information available to the public. CMS is committed to enforcing hospital price transparency requirements to ensure that such data are available to consumers of healthcare where and when they are needed.

Section 2718(e) of the Public Health Service Act requires hospitals to, for each year, establish, update, and make public a list of the hospital's standard charges for items and services provided by the hospital. Section 2718(e) further require the Secretary to promulgate regulations establishing guidelines by which hospitals must make public the standard charges they have established, and to enforce such guidelines. In the calendar year (CY) 2020 Hospital Price Transparency Final Rule (84 FR 65524), effective on January 1, 2021, CMS implemented section 2718(e) by requiring that hospitals make these standard charges public in two ways or be subject to a specified monetary penalty: by posting a single comprehensive machine-readable file (MRF) with all standard charges established by the hospital for all the items and services they provide, and via a consumer-friendly display of standard charges for as many of the 70 CMS-specified shoppable services they provide, and as many additional hospital-selected shoppable services as is necessary, for a combined total of at least 300 shoppable services. The consumer-friendly display requirement can be satisfied through the release of a shoppable services file or by offering a price estimator tool that generates a personalized out-of-pocket estimate that takes into account the individual's insurance information.

As a result of early enforcement experience and internal analysis suggesting a high rate of noncompliance among hospitals, CMS undertook further rulemaking, effective with calendar year 2022, through which the Agency finalized an increase in the penalty amount, which varies based on hospital bed count. Under this approach, for a full calendar year of noncompliance, the minimum total penalty amount is $109,500 per hospital, and the maximum total penalty amount is $2,007,500 per hospital.

CMS issued another final rule in November 2023 to further advance the Agency's commitment to increasing price transparency and enforcing compliance. By virtue of that rulemaking, and with a phased implementation schedule with dates ranging from January 2024 to January 2025, hospitals are or will be required to: conform to a CMS template layout, data specifications, and data dictionary; link directly to the MRF from their internet website home pages; and, make a

good faith effort to ensure the accuracy and completeness of the data encoded in the MRF and make an affirmation of accuracy and completeness within the MRF file. Additionally, that November 2023 rulemaking finalized provisions to improve CMS' enforcement activities and their transparency. These provisions include requiring hospitals to submit a certification by an authorized hospital official attesting to the accuracy and completeness of the data in its MRF; requiring hospitals to submit additional documentation as needed to determine hospital compliance and allowing the publication of enforcement activities and their outcomes on a CMS website. These changes improve hospitals' ability to comply, enhance the public's ability to access and aggregate information (for example, for use in consumer-friendly displays), streamline CMS' ability to enforce the requirements, and demonstrate CMS' responsiveness to public complaints alleging hospital noncompliance.

CMS continues to update and improve this program, to streamline reviews and help hospitals come into compliance. In the CY2024 OPPS/ASC final rule, CMS updated the hospital price transparency regulations by: (1) requiring hospitals to use a standardized template for MRFs, (2) clarifying the information regarding plans that hospitals must include when disclosing third-party negotiated rates, and (3) requiring each hospital to make a good faith effort to ensure that the data in the MRF are accurate. Under the provisions of the updated hospital price transparency regulations, each hospital is also now required to affirm in its MRF that the hospital has included all applicable standard charge information in accordance with the hospital price transparency regulations. There is a phased implementation schedule with dates ranging from January 2024 to January 2025. These changes took place after the OIG's audit period, and implementation and enforcement of these changes will be the primary focus of our work in the remainder of 2024 and 2025. Additionally, since the date of OIG's analysis, CMS has demonstrably increased the number of enforcement actions per month and reduced the time necessary to close a case.

To assist hospitals in complying with these requirements, CMS has conducted over 20 webinars and published Frequently Asked Questions, compliance checklists, sample templates, technical specifications and guidance, step-by-step guides for hospitals, and more. CMS has also responded to thousands of inquiries from hospitals and other interested parties and provided technical assistance to more than 500 hospitals that were determined by CMS to be out of compliance.

CMS prioritizes hospitals for comprehensive reviews based on the degree to which the hospital appears to be out of compliance with the hospital price transparency regulations. If CMS identifies deficiencies, CMS has authority to issue a warning notice, a request for corrective action, or both. If the deficiencies are not corrected following a request for corrective action, CMS may issue a civil monetary penalty (CMP). This process has proven to be effective for bringing hospitals into compliance as, thus far, CMS has closed more than 50 percent of cases after issuing a warning notice, and more than 99 percent of hospitals ultimately come into compliance after having completed corrective action plans. CMS may use methods to monitor and assess hospital compliance with the hospital price transparency requirements including, but not limited to CMS audit, review of individuals' or entities' analysis of noncompliance, or evaluation of complaints made by individuals or entities to CMS. To date, CMS' compliance reviews have been focused primarily on the hospitals that the public alleges are out of compliance as they are submitted through CMS' website.[1] From 2021 through 2023, CMS conducted oversight reviews on 1,746 hospitals and took enforcement actions against 1,287, or 74 percent of reviewed hospitals, for noncompliance with one or more of the hospital price transparency requirements. In other words, 26 percent of those hospitals that were alleged to be

[1] https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/contact-us

noncompliant were found by CMS to be in compliance with the law. Additionally, during the same time period, CMS issued CMP notices to 14 hospitals.

Separate from its formal compliance activities, in February 2021, CMS undertook an informal 'website assessment' on a randomized sample of 235 medium to large acute care hospitals in order to monitor nationwide compliance due to concerns and assertions that a large percentage of hospitals would be non-compliant. In October 2022, CMS conducted a more formal 'website assessment' on a randomized sample of 600 general acute care hospitals with greater than 30 beds in order to monitor the impact of CMS' enforcement and the updates it had made to increase the CMP amount through rulemaking. As a result, CMS estimated that 27 percent of hospitals were in full compliance with all of the tested criteria for both the MRF and the consumer-friendly display in February 2021, but that by November 2022, 70 percent were in full compliance with all the tested criteria for both.

When looking at posting of MRFs alone, CMS found in its February 2021 website assessment that just 51 percent of sampled general acute care hospitals posted files, which increased to 93 percent in its October 2022 assessment. The overall compliance rate for all MRF posting requirements increased from 30 percent to 81 percent between these two assessment periods. These data demonstrate a significant increase in compliance in the first 18 months of the new requirements, which CMS attributed largely to its enforcement efforts and the policy to increase the CMP amount,[2] and have been corroborated by independent researchers.[3]

CMS has several concerns about the accuracy of OIG's derived findings in describing the rate of compliance among all hospitals nationwide as well as the OIG's conclusion that CMS' "inadequate controls" are wholly responsible for the derived noncompliance rate. First, the derived rate and conclusions do not appear to take into consideration factors that were discovered by the OIG in its analysis or in discussions with sampled hospitals, nor do they take into consideration factors that OIG used as a basis for its recommendations to CMS. For example, a sub analysis performed by CMS on the OIG data shows a significant difference in compliance rates that depend on hospital type and size. Additionally, the OIG's finding that compliance may vary significantly based on a hospital's affiliation with a health system may suggest that larger health systems may have more resources to devote to compliance efforts. Indeed, the OIG indicates in its report that it heard from smaller hospitals (those less than 100 beds) that they believed lack of resources played a role in their ability to comply. If resources are a determining factor in hospital compliance, then a sub analysis and extrapolated findings based on size of hospital may be warranted and provide a more accurately weighted estimate of overall hospital noncompliance. Second, the sampling and weighting method were performed based on three specific selected health systems vs "all other hospitals" which introduced a weighting error that is not applicable to the whole. Specifically, the OIG's analysis weighted the compliance rate for "hospitals in health systems" at 30 percent and the "all other hospitals" compliance rate at 70 percent. However, national data shows that the reverse is true; that approximately 70 percent of hospitals are affiliated with health systems whereas only 30 percent are not.

While compliance rates continue to improve with CMS outreach, education, and enforcement, we recognize that there is still work to do. CMS is committed to continuing to seek ways to streamline and strengthen hospital price transparency implementation in order to ensure that hospital standard charge information is available to the public.

[2] https://www.healthaffairs.org/content/forefront/hospital-price-transparency-progress-and-commitment-achieving-its-potential?_hsmi=246955043&_hsenc=p2ANqtz-982AQemg96cDmeBpAm5tTR8T706k4LOoydUCY81U5XRIemJ94Xud-jr232Mxd22Kt_XV5MNK5fIKgseWTgDqCQOZSZKw

[3] https://data.cms.gov/resources/hospital-price-transparency-enforcement-activities-and-outcomes-methodology

OIG's recommendations and CMS' responses are below.

OIG Recommendation

CMS should review noncompliant hospitals associated with our findings and, if CMS determines that the hospitals are noncompliant, execute CMS' enforcement measures, to include issuing warning notices, corrective action plans, and/or civil monetary penalties as applicable.

CMS Response

CMS concurs with this recommendation. Eleven of the 37 hospitals identified by the OIG to be out of compliance with one or more of the hospital price transparency regulatory requirements have already received a compliance review from CMS and have corrected their deficiencies or are currently under enforcement review. CMS will review the remaining hospitals that the OIG determined were out of compliance and follow our established enforcement procedures if we find that these hospitals are not fully compliant with the hospital price transparency requirements.

OIG Recommendation

CMS should use the information in this report and consider implementing changes suggested by hospitals, including providing written guidance clarifying the definition of "shoppable services" and developing a training and compliance program that is tailored for smaller hospitals.

CMS Response

CMS concurs with this recommendation. CMS has already published guidance related to "shoppable services," and defined this term as a service that can be scheduled by a healthcare consumer in advance. As part of this requirement, a hospital must make public standard charges for 70 specified shoppable services as finalized in the CY2020 OPPS/ASC final rule. The hospital must select additional services as are necessary for a total of at least 300 shoppable services. We will conduct additional outreach to hospitals to educate them on the definition of "shoppable services." In 2024, as a result of the updates made in the CY2024 OPPS/ASC final rule, CMS developed and is deploying training and compliance tools and materials that are tailored for smaller hospitals (defined as hospitals having 100 beds or less).

OIG Recommendation

CMS should continue to strengthen its internal controls, to include allocating sufficient resources to maintain a robust program of reviews of the hospitals and their compliance with the hospital price transparency rule.

CMS Response

CMS concurs with this recommendation. In the CY2024 OPPS/ASC final rule, CMS amended the hospital price transparency requirements by: (1) requiring hospitals to use a standardized template for MRFs, (2) clarifying the information regarding plans that hospitals must include when disclosing third-party negotiated rates, and (3) requiring each hospital to make a good faith effort to ensure that the data in the MRF are complete and accurate. Under the provisions of the amended rules, each hospital is also now required to affirm in its MRF that the hospital has included all applicable standard charge information in accordance with the hospital price transparency rule. There is a phased implementation schedule with dates ranging from January 2024 to January 2025. These changes took place after the OIG's audit period, and implementation and enforcement of these changes will be the primary focus of our work in the remainder of 2024 and 2025. Additionally, since the date of OIG's analysis, CMS has demonstrably increased the number of investigations initiated per year and reduced the time necessary to close a case. Specifically, in 2021 and 2022, CMS opened investigations on a

combined total of 436 unique hospitals whereas in 2023, CMS opened investigations on 851 unique hospitals. For investigations initiated in 2021, CMS took an average of 356 days to close the actions. The average number of days to close the actions decreased to 207 for investigations initiated in 2022 and further decreased to 153 for those initiated in 2023.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

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