Turquoise Health

Introduction

Turquoise Health thanks The Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the Request for Information (RFI) regarding Hospital Price Transparency Accuracy and Completeness.

Responses

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.

Accuracy of data: CMS should specifically define this in terms of compliance and enforcement. Currently, accuracy is not explicitly defined, which results in numerous parties attempting to create their own definition. Turquoise recommends consolidating around one standard definition of accuracy for hospital MRFs, one that can then be shared with payer MRFs.

Hospital MRFs should list a precise dollar amount whenever possible. If a dollar amount cannot be posted, a transparent breakdown of the Estimated Allowed Amount (EAA) or algorithm, etc, as defined by the 2024 hospital final rule, should be included. If a hospital does not provide a service, the final rules have existing requirements in place, which Turquoise Health is aligned with, that highlight the lack of a service without the use of "N/A".

Enforcement recommendations for accuracy: CMS should consider using both hospital and payer MRFs as a check on accuracy. Turquoise Health recognizes there will always be differences between both files, yet we have found success in validating rates between the files within a 10% margin of error on the same code, hospital, payer, and specific payer plan. CMS could leverage a similar system to flag rates that appear inaccurate, and then reach out to both parties to solve the discrepancies. Given the volume of data, we do not recommend tackling each individual rate, and instead, we recommend tracking accuracy based on the overall percentage of rates that do not match. CMS could begin its accuracy tracking based on shoppable services and expand accordingly. If both the hospital and payer are an outlier in their posted rates, CMS could then execute enforcement.

For example, if a data element is reported in a hospital MRF, is it within 10% of the same rate displayed in a payer MRF and claims data? If not, why? The best assessment of data accuracy is the presence of the same rate across numerous reported sources. An example definition could be:

When assessing compliance of an MRF, CMS will study the accuracy of the data as reported in an MRF across other reliable data sources. The hospital MRF data should match one, if not all, of the following additional data sources:

- *The native payer/provider contract*
- *The corresponding payer MRF*
- *Claims data*

Completeness of data: Completeness is significantly easier to define and enforce. We recommend CMS create a simple definition of completeness that could look like the following: *When assessing the completeness of a hospital MRF, CMS will study the total number of payers, payer plans, and individual billing codes associated with a hospital by cross-referencing the hospital MRF, any associated payer MRFs, and claims. By using these three data sources, CMS will define completeness as:*

- *A list price & cash price for every billing code presented in hospital & payer MRFs, and claims data.*
- *An associated negotiated rate for every payer plan associated with the hospital MRF (using payer MRFs and claims as the primary source)*

CMS can operationalize this definition of completeness by creating systems around the following questions:

- Measure the number of unique codes in a file: is there a cash price, a list price, and at least one negotiated rate for each code?
- Calculate the total number of payer & plan combinations that a hospital is expected to post, based on Transparency in Coverage (TiC) files.
- All language relevant to reimbursement included in the notes field provided, as defined by the initial and 2024 hospital final rules.

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

There are two different types of concerns about accuracy: in some cases, concerns about accuracy are really concerns about patient usage of this data. MRFs are not meant for patient usage as indicated by their machine-readable design. Through the lens of patient usage, concerns about accuracy are best showcased by the lack of accurate estimates. Questions of accuracy should thus be shifted to include Good Faith Estimate (GFE) and Advanced Explanation of Benefits (AEOB) from the No Surprises Act (NSA). The burden of creating a shoppable healthcare experience should not fall to patients, who cannot reasonably be expected to bundle rates on their own. That burden should be on health plans and hospitals within the already existing NSA framework, alongside the Patient Estimate Tool (PET) requirement in the hospital final rule.

In other cases, actual rates within a hospital MRF do not match rates as reported in other sources, which are included in our suggested accuracy definition in question 1. Turquoise supports both efforts to drive more accurate pricing in hospital MRFs and efforts to bundle the data into service packages to achieve real usability beyond healthcare billing experts.

3. **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.**

Turquoise Health utilizes MRF data in conjunction with additional data sets, including claims data, Medicare data, and other public datasets, to create the most comprehensive pricing information. When Turquoise creates hospital MRFs, we also access the actual payer/provider contracts, which provide essential context to the rates displayed in MRFs.

Alongside the MRF requirement in the final rule that went into effect on 1/1/2021, additional focus should be on the utility of PETs.The ability to bundle codes as a patient would see in a final bill is critical to data utility. For example, if a patient's episode of care will result in individual bills for institutional, professional, and technical components, those individual components may be appropriately reported in an MRF; however, it's unreasonable to expect patients to ascertain how many bills they'll receive for one service. PETs greatly affect the broader audience's ability to use hospital pricing effectively.

4. **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.**

Turquoise Health currently publishes an "MRF Technical Adoption Tracker" which measures hospital compliance with basic requirements like publishing an MRF, passing the CMS V2 schema validator tool, and posting a compliant TXT Record. Tools like this can be leveraged to execute basic compliance on the initial technical requirements.

Once this is achieved at scale, CMS could move to leveraging a mixture of hospital & payer MRFs with claims data to create the expected number of codes that each hospital & payer should post, along with expected numbers of list price, cash price, and negotiated rates.

In order to achieve this, Turquoise Health recommends that CMS explore compliance partners who can execute on the combination of price transparency data with claims, presenting it in easy-to-understand dashboards.

5. **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?

CMS maintains data on HPT enforcement activities and outcomes and updates the data quarterly. To improve compliance and enforcement processes, Turquoise recommends adding a column to the dataset specifically documenting the reason(s) for noncompliance, particularly where the "Action taken by CMS following a Hospital Price Transparency Compliance Review" indicates the hospital received a warning notice. The more visibility the public has into reasons for noncompliance, the more robust HPT resources will be in creating the most compliant files.

Regarding the CMS validator tool, Turquoise has the following recommendations:

a. Clearly define "alerts" for the Nine-9s, and when that will change to an "error"
b. Flag more in-depth errors (only-NDC codes, etc)
c. Evaluation of if the file itself is posted compliantly (location, .txt file. etc.)

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

Turquoise Health will respond separately to the requests for comments within the proposed rule released on July 15, 2025.

For this RFI, Turquoise Health has the following additional recommendations:

- Require providers to upload actual contract documents alongside MRFs. This represents a radical move to bolster the existing price transparency dataset by providing the most reliable way to measure accuracy and completeness. After all, the MRFs are effectively thousands of pages of contracts in standardized format.
- Remove the shoppable services file component and significantly bolster the Patient Estimator Tool PET) requirement to increase patient utility.
- Place focus both on MRF accuracy and on the enforcement of the AEOBs and GFEs

Conclusion

We look forward to collaborating on these continued efforts to increase clarity around cost and hospital price transparency.

Sincerely,
Chris Severn - CEO, Turquoise Health