Turquoise Health

Public Comment

42 CFR Parts 410, 412, 413, 415, 416, and 419
45 CFR Part 180
[CMS-1834-P]
RIN 0938-AV51

Proposed Rule: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

Introduction

Turquoise Health thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on CMS-1834-P (the Proposed Rule), which, in part, seeks comments on hospital price transparency.

Turquoise Health is in full support of CMS' commitment to creating methodical, comprehensive, and accurate hospital machine-readable files (MRFs). In our detailed responses below, we seek additional clarification and specificity with regards to the new percentile fields and methodology. We also provide recommendations on the utility of EDI 835 ERA transaction data.

Turquoise Health Responses to Questions About Price Transparency

Excerpt from the Proposed Rule

"We seek comment on our proposal, as well as any additional, or alternative, taxonomy codes that commenters believe would be necessary or helpful to consider. We also seek comment on other standard identifiers that may be useful in providing needed context and streamlining the alignment of price transparency data."

Turquoise Health Response

We observe that most entities downloading, parsing, and streamlining the alignment of price transparency data en masse already have the capability to cross walk NPIs present in the MRFs with other standard identifiers such as CCN. CMS should weigh the increase in file size that comes with any new additional column requirement against the net benefit of a potential increase in functionality the new column could provide. Turquoise Health, like many other technology partners and healthcare organizations, has access to additional identifier data sets and thus does not believe any new taxonomy codes beyond Type 2 NPIs would materially impact file alignment

Excerpt from the Proposed Rule

"We solicit comment on our proposed revision to § 180.50(b)(2)(ii)(C) to require hospitals to calculate and encode the count of allowed amounts used to calculate the median, 10th, and 90th percentile allowed amounts, as well as on our proposal that hospitals encode this data element with the actual number of allowed amounts used within the EDI 835 ERA transaction data. We also solicit comment on the alternative we considered of encoding the count of allowed amounts using a standardized range of the number of allowed amounts used within the EDI 835 ERA transaction data, rather than the actual number of allowed amounts, and seek comment on standardized range values of counts of allowed amounts that would be useful."

Turquoise Health Response

The Turquoise Health team currently utilizes EDI 835 ERA transaction data to populate multiple required fields within hospital MRFs. We note that 835 data is industry standard and the most comprehensive source of transaction data for the purposes of calculating allowed amounts based on algorithm-based pricing methodologies.

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Turquoise Health Response cont.

Should CMS finalize this Proposed Rule with the exact requirements around the 10th, 90th, and median percentile allowed amounts, we note there is no specific off ramp for hospitals currently adhering to the "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'" that went into effect on May 22, 2025. We are interested in additional clarity from CMS with regards to the rationale of not addressing any of the requirements from May 22 in this Proposed Rule. For example, the May 22 guidance laid out three specific scenarios hospitals must follow to eliminate any 999999999s reported in the Estimated Allowed Amount (EAA) field. As a result of the EAA's cessation noted in this Proposed Rule, hospital MRF teams have spent the past year diligently preparing data points that CMS has only recently begun assessing for compliance — data that would already become obsolete in 2026.

By contrast, despite an upcoming schema change that will be enforced on February 2, 2026, payers creating their own mandated MRFs in adherence to the Transparency in Coverage (TiC) final rule have not been required to make any material changes in their required fields since TiC went into effect on July 1, 2022. It is critically important that both hospitals and payers provide timely and accurate price transparency data. To ensure operational feasibility and enhance compliance, we recommend CMS works to maintain consistent requirements with purposeful changes and reasonable implementation timelines for all stakeholders publishing MRFs. If the rules change too much too often, it makes it difficult for entities to comply.

With this background, Turquoise Health requests several considerations should CMS finalize the new requirements around percentile allowed amounts:

- ***Commitment to Percentile Calculation Clarity***: CMS should be meticulously specific in the expected calculations required for the percentile fields. We believe part of the discourse around the utility of the EAA field comes from lack of clarity around CMS' intended goal for reporting on an increasingly small subset of the MRF data. Not all rates within the MRF are based on an algorithm, and yet we observe an outsized focus on algorithm-based data points. That focus has led to increased confusion because of the ambiguous and constantly-changing requirements. We also observe a trend where CMS answers hospital questions on the GitHub by simply quoting from the current requirements. Hospitals are left to interpret vague requirements on their own when CMS cannot provide compliant examples of real contracting scenarios.
    - For example, we seek further clarity around stop loss calculations and other high cost contract provisions that are not inherently tied to a specific item or service in the CDM. These calculations are crucial to understanding negotiated rates but are challenging to reflect at a line item level. In addition, should the Proposed Rule get finalized, what is the appropriate reporting mechanism within the MRF when there is no claims data available to calculate the median field? Is a note subsequently required in the text field? ***We strongly discourage CMS from requiring a "best guess" percentile calculation when no transaction data is available for an item or service.*** Doing so is antithetical to the value that price transparency adds to patients because no patient has received the item or service in question in the preceding year.

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Turquoise Health Response cont.

- ***Consideration of Outlier Reimbursement***: We observe that the standard reimbursement methods often found in MRFs (case rates, fee schedules, per diems, and percent of billed charges) do not typically fully disclose outlier reimbursement. ***These methods miss reporting on over $100 billion in outlier costs***[1]. Stop-loss language for outlier cases is variable and complex, as seen in the two examples below:

Example A: First-Dollar Stop-Loss

Stop Loss rate applies to any admission (excluding Trauma and Burn) where billed charges reach or exceed the threshold in the rate sheet, including charges for Exclusion items (threshold may vary by facility), in lieu of the negotiated MSDRG or Per Diem rates.

Stop Loss Provisions
Stop Loss Threshold: $412,000
Stop Loss % of Charge: 57.0%

Example B: Second-Dollar Stop-Loss

When the Eligible Billed Charges for a single inpatient admission exceed the Second Dollar Stop Loss Threshold of $260,000 (excluding professional fees, implants billed separately, and excluded services as defined in Exhibit A), reimbursement shall convert from the applicable DRG or Per Diem methodology to the Second Dollar Stop Loss methodology as follows:
(a) For Eligible Billed Charges from $0 to $260,000: Payment shall be made according to the applicable DRG or Per Diem rates as set forth in Exhibit B of this Agreement.
(b) For Eligible Billed Charges exceeding $260,000: Payment shall be calculated as follows:
i. The first $260,000 in Eligible Billed Charges shall be reimbursed per the applicable DRG or Per Diem methodology; and
ii. Eligible Billed Charges above $260,000 shall be reimbursed at 80% of billed charges.

Turquoise has reviewed nearly 6,000 hospital MRFs and notes that in roughly 99.6% of those files, no stop-loss language exists in the free text field. Thus, in the absence of structured formulas containing stop-loss terms as reportable fields within the MRF, we recommend CMS consider mandating disclosure of stop-loss contract language.

- ***Consideration of Back-to-Back Requirement Changes***: Allow appropriate time for MRF teams to make the required changes. We observe the May 22 updated guidance did not explicitly state an enforcement date. MRF changes generally take an average of 90 days to complete given most teams anticipate joining a CMS-hosted webinar, creating an internal project plan to update files, securing any technical resources required to extrapolate the necessary 835 data, complete the file refresh, and post the new file to the appropriate place on the website.

[1]Outlier estimate derived from three sources: HHS Outlier payments[1], Segal SHAPE claims[2], and Turquoise Health contracts and claims. Scaled to national spend using CMS NHE[3] and Dieleman et al[4]. Source inputs combined via equal-weighted average to reduce bias from any single source.

1. https://oig.hhs.gov/documents/evaluation/2959/OEI-06-10-00520-Complete%20Report.pdf
2. https://www.segalco.com/consulting-insights/medical-stop-loss-premiums-increase-nearly-10-percent
3. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected
4. https://jamanetwork.com/journals/jama/fullarticle/2830568

Excerpt from the Proposed Rule

"We seek comment on any instances where a hospital would not have access to EDI 835 ERA transaction data and whether there are alternative data sources we should consider requiring hospitals to use to calculate the allowed amounts and count of allowed amounts."

Turquoise Health Response

As noted above, Turquoise Health strongly believes that when no claims data exists for an item or service, that item or service was not performed at the hospital in the defined reporting period and thus, no allowed amount should be required. Any allowed amount calculation based on claims billed to other payers or similar procedures waters down MRF quality and makes it challenging to separate the definitive instances of the cost of care from the "best guess" hypothetical cost of care calculation required when no claims exist. The most transparent rates are not guesses but specific and traceable points of fact.

Excerpt from Proposed Rule

"We solicit comment on our proposal to require hospitals, beginning January 1, 2026, to use EDI 835 ERA transaction data to calculate and encode the median allowed amount, the 10th and 90th percentile allowed amounts (and count of allowed amounts, discussed in the next section)."

Turquoise Health Response

We observe the standard timeline of previous final rules as the basis of our response. For example, CMS-1786-FC, which included new requirements for hospital price transparency, was published on November 2, 2023. The requirements had staggered effective dates based on the complexity of the updates, ranging from January 1, 2024, July 1, 2024, and January 1, 2025. The changes that went into effect on January 1, 2024, were minor and administrative in nature and did not require any changes to actual rates within the MRFs.

Based on the time required to create the new percentile fields, which will require time for CMS to update the GitHub as stated in the Proposed Rule, create materials and subsequently host a webinar, and allow MRF teams time to build accordingly, Turquoise Health notes it is more reasonable to require these changes as of April 1, 2026. As noted above, most MRF teams are still working to understand the May 22 change in requirements, and should this Proposed Rule revoke those, teams will in effect be required to undue all the EAA work they have done in 2025.

Excerpt from the Proposed Rule

"We seek comment on the proposal to require that hospitals only use EDI 835 ERA transaction data to calculate and encode the allowed amounts."

Turquoise Health Response

We are in agreement that hospitals should only use EDI 835 ERA transaction data to calculate and encode the allowed amounts. We note that many teams who create MRFs also have access to a data set directly derived from EDI 835 ERA transaction data such as an EHR transaction data feed. ***We recommend CMS address that specific example in the final rule and deem it to be a compliant approach to encoding allowed amounts.***

Excerpt from Proposed Rule

"We also seek comment on whether there are instances where a hospital would not have access to EDI 835 ERA transaction data and whether there are alternative data sources we should consider requiring hospitals to use to calculate the allowed amounts and count of allowed amounts."

Turquoise Health Response

We recommend that CMS does not deem any other data sources as a compliant alternative to EDI 835 ERA transaction data. With the exception of a derivative data feed that pulls directly from 835 data, as mentioned in our previous response, we observe that any alternative data source would have such a small sample size that the results would not add material value to the overall understanding of rates or transparent pricing.

Excerpt from Proposed Rule

"Finally, we solicit comment on our proposal to require that the lookback period for the median allowed amount, the 10th and 90th percentile allowed amounts (and count of allowed amounts) be based on EDI 835 ERA transaction data from no longer than 12 months prior to posting the MRF."

Turquoise Health Response

We are in agreement with the lookback period of 12 months prior to posting the file. We seek clarification whether MRF generation teams need to limit the claims utilized in cases where a contract has become effective within the 12 month window. We note this methodology is currently in effect from the May 22 guidance and the Proposed Rule does not specify whether that methodology would remain appreciable. If it would not remain applicable, CMS should issue equally as specific guidance on which subset of claims should be utilized when contract rates change within the 12 month period.

Conclusion

Transparency is ultimately about reducing the financial complexity of healthcare and creating a healthcare ecosystem that allows patients to shop for care in advance. Ensuring MRFs are available, timely and accurate is the foundation upon which we can build tools that actually help patients navigate the cost of health care, but are not sufficient on their own. We view the final rules governing MRF creation as working in tandem with the No Surprises Act, which grants patients the right to request an Advanced Explanation of Benefits (AEOB) or Good Faith Estimate (GFE) based on their insurance coverage or self pay status, respectively. These Patient Estimate Tools (PETs), once implemented and enforced, will be what really moves the needle for patients; thus MRF guidance should be viewed alongside guidance and enforcement of AEOBs.

We look forward to a collaborative hospital, third party innovator, and government effort on the bolstered efforts to increase clarity around cost and hospital price transparency.

Sincerely,
Chris Severn - CEO, Turquoise Health