Trinity Health

July 21, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS Hospital Price Transparency Accuracy and Completeness Request for Information

Submitted electronically via http://www.regulations.gov

Dear Administrator Oz,

Trinity Health appreciates the opportunity to comment on questions set forth in the price transparency request for information. Our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all. In addition, the comments below are recommendations on modifications to the Medicare fee-for-service payment system.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 127,000 colleagues and more than 29,000 physicians and clinicians caring for diverse communities across 26 states. Nationally recognized for care and experience, the Trinity Health system includes 93 hospitals, 107 continuing care locations, the second largest PACE program in the country (a total cost of care program), 142 urgent care locations and many other health and well-being services. Trinity Health has 15 medical groups with 8,200 medical group physicians and providers. Based in Livonia, Michigan, its annual operating revenue is $23.9 billion with $1.3 billion returned to its communities in the form of charity care and other community benefit programs.

Trinity Health has 12 Clinically Integrated Networks (CINs) that are accountable for 2 million lives across the country through alternative payment models. Our health care system participates in 12 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes 10 markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. All of these markets participated in the “enhanced track”, which qualifies as an advanced alternative payment model (AAPM). Two of the 12 markets also participate in the Comprehensive Primary Care Plus Model. In addition, we participated for many years in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative and the Comprehensive Care for Joint Replacement (CJR) program across 37 hospitals. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

In addition, Trinity Health owns a non-profit, mission-focused Medicare Advantage plan—MediGold—that plays a vital role in our integrated delivery network and provides care coordination for patients while using fair practices. Serving 56,000 beneficiaries across 6 states, MediGold is a highly-effective best practice plan model. In order to place a better emphasis on care and outcomes rather than profit, MediGold has a lower profit margin and lower administrative costs compared to commercial for-profit plans because they say “yes” more to providers and

beneficiaries. In addition, MediGold utilizes standard and transparent guidelines for decisions on precertification and other authorization approval processes, removing ambiguity of guidelines for providers.

Trinity Health fully supports price transparency and ensuring that patients have access to meaningful information about the price and quality of their care to foster decision-making and predictability. Patients need an understanding of in-network providers, including physicians, hospitals, and outpatient centers, and information on what their out-of-pocket costs and cost sharing for services are.

We are in compliance to the price transparency requirements to the best of our ability given the complexity of health care contracts and the combination of rates, figures, and logic necessary to determine inputs into the machine-readable file—there can be multiple rates for each Diagnostic Related Group.

We discuss the following comments and recommendations to CMS in more detail below:

- 45 CFR 180.50(a)(3) creates an appropriate standard for hospitals to meet for creating and maintaining machine readable files ("MRFs") and as such, definitions for "accuracy of data" and "completeness of data" are unnecessary. Should CMS develop definitions, we urge the agency to include language included in the definition of the good faith effort standard attestation.
- Setting a standard for MRF data that exceeds that of a good faith effort will unfairly penalize hospitals despite their significant and continuous efforts in creating and maintaining these complex files.
- Adding data elements to hospital MRFs would adversely affect their accuracy and completeness and we encourage CMS to allow for continued flexibility and investment in price estimator tools.
- External sources of information should not be used to evaluate the accuracy and completeness of MRFs.
- To the extent CMS issues a hospital a warning notice or requests a corrective action plan, the agency should include specific information about the nature of the violation identified and make available personnel with whom hospitals may discuss the violation.
- Outline certain concerns with the guidance CMS released on May 22, 2025, titled "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."

We urge CMS to provide more detail in notice letters of noncompliance to ensure there's enough information included so that providers know what needs to be addressed to ensure continued compliance.

<u>Trinity Health Responses to the Request for Information</u>

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?

    a. **Trinity Health believes 45 CFR 180.50(a)(3) created an appropriate standard for hospitals to meet for creating and maintaining machine readable files ("MRFs") and as such, definitions for "accuracy of data" and "completeness of data" are unnecessary**. Specifically, 45 CFR 180.50(a)(3) requires hospitals to "make a good faith effort" to ensure their MRFs are true, accurate, and complete and requires hospitals to include a statement in the MRF attesting to the same. The good-faith-effort standard recognizes that hospitals must identify, collect, aggregate, and re-form voluminous and complex data, and avoids penalizing hospitals for amalgamation-related errors while also holding hospitals accountable for producing usable information.

Should CMS develop definitions, we urge the agency to include language included in the definition of the good faith effort standard attestation.

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

    a. Trinity Health endeavors to provide patients with meaningful and accurate pricing information. Various teams across Trinity Health continuously meet to review and improve this information in order to ensure compliance with Hospital Price Transparency requirements. **Nevertheless, we are concerned that setting a standard for MRF data that exceeds that of a good faith effort will unfairly penalize hospitals despite their significant and continuous efforts in creating and maintaining these complex files.**

    Moreover, given the complexity of the underlying data sets, the difference in information systems, and payer adjudication processes, we would be concerned about hospital MRFs being reviewed for accuracy and completion by comparing the files to health plan MRFs.

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

    a. Trinity Health believes that adding data elements to hospital MRFs would adversely affect their accuracy and completeness. Health care reimbursement is complex. Depending on the service line, a given contract may require the use of multiple reimbursement methodologies (e.g., diagnosis-related group rates, fixed amounts per day, percentage of billed charges, etc.). In addition, the formulas that underpin these methodologies are often altered by the amount and complexity of required care a patient receives (e.g., outlier cases, stop-loss requirements, etc.). In other instances, the methodologies may be based on proprietary payer software to which a hospital does not have access.

    This makes amalgamating and recording MRF information challenging, as file formats are unable to accurately capture these case-specific factors, nor present them in a way that's meaningful to patients. **As a result, Trinity Health believes that price estimator tools, like those we make available, are better equipped to provide patients with more meaningful and digestible information about shoppable items and services. We therefore encourage CMS to allow for continued flexibility and investment in relation to these tools.**

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

    a. Trinity Health believes that using external sources of information to evaluate a hospital's MRF's for accuracy and completeness would lead to erroneous review results. Unlike external sources of information, which may not be held to any accuracy and completeness standard, 45 CFR 180.50(a)(3) already requires the information hospitals encode in their MRFs to be true, accurate, and complete, thus allowing it to be evaluated on its own. In addition, even if the external source of information was held to a standard similar to that reflected 45 CFR

180.50(a)(3), hospitals have no control over such information, including the manner in which it is stored and manipulated, but would nevertheless be forced to evaluate it and identify inaccuracies therein to the extent it was used to review the hospitals MRFs. This would add a significant amount of administrative burden and expense to hospital HPT compliance efforts.

It is also difficult to foresee how such external sources of information could be leveraged as they do not have access to data foundational to the MRFs, e.g., hospital contracts. **As such, due to the lack of known accuracy standards, hospital control, and external entity access to the sources of information from which MRFs are generated, we do not recommend external sources of information be used to evaluate the accuracy and completeness of MRFs.**

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?

    a. **To the extent CMS issues a hospital a warning notice or requests a corrective action plan pursuant to 45 CFR 180.70(b), Trinity Health recommends that CMS include specific information about the nature of the violation identified.** This will better enable hospitals to more quickly and accurately correct such violations. **Similarly, Trinity Health recommends CMS make available personnel with whom hospitals may discuss the violation.**

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

    a. Trinity Health appreciates the continued guidance and clarifying information released by CMS regarding the HPT regulations, including the MRF. Trinity Health hopes CMS and the hospital community can maintain a dialogue that allows continued discussion and collaboration on this topic. In that vein, **Trinity Health has certain concerns with the guidance CMS released on May 22, 2025, titled "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." These concerns include the following:**

        i. "Estimated Allowed Amount" ("EAA") is currently defined at 45 CFR 180.20 to mean "the average dollar amount that the hospital has historically received from a third party payer for an item or service." However, the May 22, 2025, guidance requires hospitals to encode an EAA in those instances when an item or service negotiated as a percentage or algorithm was "not used within the 12-month time period prior to posting the [MRF] . . ." that is "related to the expectation of what the charge would be for that item or service . . . ." This requirement is seemingly at odds with the EAA definition, as hospitals are unable to calculate an average dollar amount in those instances when an item or service has not been provided. Similarly, the hospital's "expectation of what the charge would be" would not be a calculation of what the hospital had historically received from an applicable third-party payer for the item or service, as no historical information would exist.

ii. In guidance released on October 21, 2024, CMS advised hospitals to use the "CMS Cell Suppression Policy" ("Policy") as a guide for the total number of claims needed to generate an EAA. In the HPT context, the Policy would require at least 11 claims before an EAA is generated. This standard has helped hospitals and vendors set valid parameters in generating EAAs. However, the May 22, 2025, guidance conflicts with this long-standing CMS policy.

CONCLUSION

We welcome the opportunity to inform health policy and are happy to partner with CMS. If you have any questions on our comments, please feel free to contact me at jennifer.nading@trinity-health.org.

Sincerely,

/s/

Jennifer Nading
Director, Medicare and Medicaid Policy and Regulatory Affairs
Trinity Health