

Hospital Price Transparency Compliance Rises Under Stricter Enforcement

On September 10, 2026, PatientRightsAdvocate.org (PRA), a nonprofit price transparency advocacy organization, released its eighth Hospital Price Transparency Compliance Report, which found that 49.4% of the 2,000 hospitals it reviewed were in full compliance with the federal Hospital Price Transparency Rule (the Rule).¹ That figure is the highest compliance rate PRA has recorded since it began tracking hospital postings in July 2021, and an increase of 28 percentage points over the 21.1% rate it reported in November 2024.² It also means that 1,012 of the hospitals reviewed, slightly over half, were not in full compliance with requirements that have been in force since January 1, 2021.³ This Health Capital Topics article reviews the report's findings, the regulatory changes that preceded them, and the enforcement exposure now facing noncompliant hospitals.

The Rule, promulgated in a November 2019 final rule, requires each U.S. hospital to make its standard charges public in two forms.⁴ First, a hospital must post a single machine-readable file (MRF) containing gross charges, payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices for all items and services it provides.⁵ Second, a hospital must display pricing information for at least 300 shoppable services in a consumer-friendly format, or offer an internet-based price estimator tool.⁶

PRA reviewed publicly available hospital websites between April 29 and May 3, 2026, and credited most of the improvement it observed to the Centers for Medicare & Medicaid Services' (CMS's) expanded technical guidance rather than to any independent change in hospital practice.⁷ The share of hospital files passing the CMS Validator Tool rose from 73.4% to 92.8%; conforming filename formats increased from 80.4% to 90.0%; the accuracy of hospital names and addresses within MRFs improved from 64.4% to 86.3%; and correctly formatted negotiated charge percentages rose from 68.6% to 92.7%.⁸ Compliance with the shoppable services requirement is now nearly universal, with 98.9% of reviewed hospitals presenting a compliant consumer-friendly display, a price estimator tool, or both.⁹

Those gains did not translate into prices a patient can read. The Rule permits a hospital to express a payer-specific negotiated charge as a percentage or algorithm when the dollar amount cannot be known in advance, but

it requires the hospital to disclose "all necessary information available to the hospital for the public to be able to derive the dollar amount," including the specific fee schedule or components the formula references.¹⁰ PRA concluded that 459 hospitals, 23.0% of its sample, posted algorithms that did not satisfy that requirement, and characterized its own standard as conservative because CMS has issued no guidance on how the requirement is to be applied.¹¹ Only 360 hospitals, 18.0% of those reviewed, posted dollar-and-cents prices for at least half the items and services in their files, and only 194 hospitals were both fully compliant and met PRA's pricing data sufficiency threshold.¹²

The divergence between technical compliance and usable pricing was sharpest among the largest systems. PRA found 85% of HCA Healthcare's 175 reviewed hospitals fully compliant, but none of them met its pricing sufficiency rating; CommonSpirit Health posted a 73% compliance rate against 24% pricing sufficiency; and Mercy, at a 74% compliance rate, led all reviewed systems with 91% of its hospitals meeting the threshold.¹³ None of the reviewed hospitals owned by Bon Secours Mercy Health, Ochsner Health, or ScionHealth were found to be fully compliant.¹⁴ The methodology has drawn objection. The Wisconsin Hospital Association, which reported 61% of the 46 Wisconsin hospitals assessed to be fully compliant, identified what it described as multiple errors in the report's validator and file header findings, and noted that the pricing data sufficiency rating is PRA's own metric rather than a regulatory requirement.¹⁵

This is the first PRA report to assess compliance under the requirements CMS finalized in the 2026 Outpatient Prospective Payment System (OPPS) final rule.¹⁶ Acting on Executive Order 14221, which directed the Secretaries of the Treasury, Labor, and Health and Human Services to require "the disclosure of the actual prices of items and services, not estimates,"¹⁷ CMS eliminated the estimated allowed amount data element. A hospital must now encode the median and the 10th and 90th percentile allowed amounts in dollars whenever a negotiated charge is expressed as a percentage or algorithm, derive those figures from electronic remittance advice data over a lookback period of no less than 12 and no longer than 15 months, encode the count of allowed amounts used in the calculation, report its organizational national provider identifiers, and name the chief executive officer,

president, or senior official responsible for overseeing the encoding in an affirmation that the data are true, accurate, and complete.¹⁸ The revisions took effect January 1, 2026, and CMS delayed enforcement of them until April 1, 2026.¹⁹

Enforcement under the Rule occurs in stages. CMS may issue a written warning notice identifying the specific violations, request a corrective action plan where the noncompliance is a material violation, and then impose and publicize a civil monetary penalty (CMP) if the hospital fails to respond to or comply with that plan.²⁰ Penalty amounts are keyed to bed count, at \$300 per day for a hospital with 30 or fewer beds, the number of beds multiplied by \$10 per day for a hospital with 31 to 550 beds, and \$5,500 per day for a hospital with over 550 beds, each adjusted annually for inflation.²¹ In June 2026, the Associated Press reported that over 500 hospitals had received warning letters or corrective action plan requests since April, with the heaviest concentrations in California, Indiana, and Texas, and that recipients faced annual exposure as high as \$2 million.²² CMS has assessed CMPs against 28 hospitals to date, up from 15 at the time of PRA's previous report.²³

The 2026 rule also added an inducement to resolve penalties without litigation, reducing a CMP by 35% where the hospital waives its right to a hearing before an administrative law judge within 30 calendar days of the notice of imposition.²⁴ That reduction is unavailable to a hospital penalized for failing to post an MRF or a consumer-friendly list of shoppable services at all.²⁵ The practical weight of the enforcement apparatus is contested. The American Hospital Association (AHA) has reported that fewer than 0.01% of the over 7,500 enforcement reviews CMS has opened resulted in a

CMP, and that 70% of the hospitals receiving CMP notices in 2025 had fewer than 50 beds.²⁶

Congress may remove the flexibility that produced PRA's central finding. The Patients Deserve Price Tags Act, introduced in July 2025 by Senator Roger Marshall (R-KS), was ordered reported favorably with an amendment in the nature of a substitute by the Senate Committee on Health, Education, Labor, and Pensions on July 22, 2026, and was placed on the Senate Legislative Calendar five days later.²⁷ As introduced, the bill would codify the posting obligations in the Public Health Service Act, extend them to clinical diagnostic laboratories and imaging providers, and require gross charges, discounted cash prices, and payor-specific negotiated charges to be expressed as dollar amounts.²⁸ Where a charge rests on an algorithm, percentage, or other formula, the provider would have to disclose that methodology together with the contract terms, schedules, and data needed to determine the charge, and the availability of a price estimator tool would not deem the provider compliant.²⁹ AHA opposed the committee's discussion draft, arguing that it would penalize hospitals for technical formatting infractions "in an additive fashion" with little enforcement flexibility left to the agencies, and has said the version reported out of committee will increase administrative burden on hospitals and health systems.³⁰

Compliance with the Rule has improved on every measure CMS can test mechanically, and least on the measure that determines whether a patient can learn a price before receiving care. The percentile and affirmation requirements now in force are the agency's answer to that gap, and the warning letters issued this spring are the first test of whether it will enforce them.

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2 *Ibid.*, p. 3.

3 *Ibid.*, p. 5.

4 "Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public" Federal Register, Vol. 84, No. 229 (November 27, 2019), p. 65524.

5 "Requirements for Making Public Standard Charges for All Items and Services" 45 C.F.R. § 180.50.

6 *Ibid.*

7 PatientRightsAdvocate.org, September 2026, p. 4.

8 *Ibid.*, p. 3-4.

9 *Ibid.*, p. 6.

10 "CSV Data Dictionary (README)" Centers for Medicare & Medicaid Services, Hospital Price Transparency GitHub Repository, <https://github.com/CMSgov/hospital-price-transparency/blob/master/documentation/CSV/README.md> (Accessed 9/14/26).

11 PatientRightsAdvocate.org, September 2026, p. 3, 5.

12 *Ibid.*, p. 6, 13.

13 *Ibid.*, p. 6-7.

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16 "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Rating; Hospital Price Transparency; and Notice of Closure of a Teaching Hospital and Opportunity To Apply for Available Slots" Federal Register, Vol. 90, No. 225 (November 25, 2025), p. 53448.

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19 Federal Register, Vol. 90, No. 225 (November 25, 2025), p. 54088.

20 "Monitoring and Enforcement" 45 C.F.R. § 180.70.

21 "Civil Monetary Penalties" 45 C.F.R. § 180.90(c)(2)-(3).

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- initiatives/hospital-price-transparency/enforcement-actions (Accessed 9/14/26).
- 24 “Civil Monetary Penalties” 45 C.F.R. § 180.90(c)(4).
- 25 *Ibid.*
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- 29 *Ibid.*
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