



A MEDICARE LEARNING NETWORK® (MLN) EVENT

Hospital Price Transparency (HPT): Reviewing the CY 2026 Hospital Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) Payment System Final Rule.

February 11, 2026

Presenter:

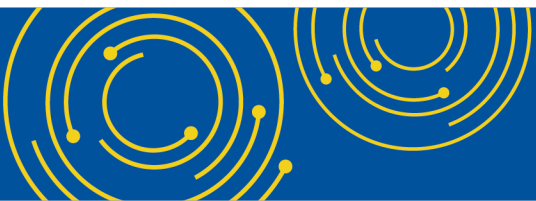
Sarah Wheat
Centers for Medicare & Medicaid Services (CMS)



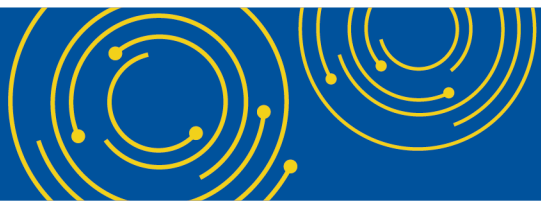
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Poll

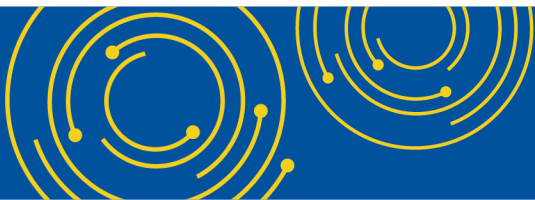


CY 2026 OPPS/ASC Final Rule Regulatory Updates

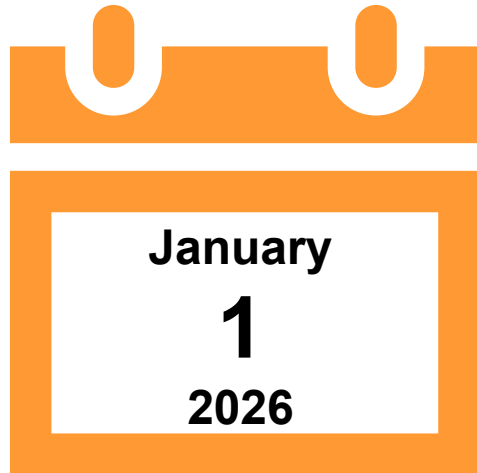
CMS finalized new [Hospital Price Transparency](#) requirements in the [CY 2026 Hospital Outpatient Prospective Payment System \(OPPS\)/Ambulatory Surgical Center \(ASC\) Payment System Final Rule](#).

These new requirements include:

- Type 2 National Provider Identifier (NPI) now required in general data elements (45 CFR §180.50(b)(2)(i)(A)).
- Attestation Statement replaces Affirmation Statement and now requires the name of the Attester (45 CFR §180.50(a)(3)(iii) and 45 CFR §180.50(a)(3)(iv)).
- Estimated Allowed Amount removed and replaced with four allowed amount data elements (45 CFR §180.50(b)(2)(ii)(C)):
 - Median Allowed Amount
 - 10th Percentile Allowed Amount
 - 90th Percentile Allowed Amount
 - Count of Allowed Amounts
- Reducing the amount of a civil monetary penalty (CMP) by 35 percent when a hospital waives its right to an ALJ hearing (45 CFR §180.90(c)(4)).



Important Dates: CY 2026 OPPS/ASC Final Rule Regulatory Updates



Effective Date for New
and Updated
Requirements at 45
CFR 180.50 and
180.90



Enforcement Date for New
and Updated
Requirements at 45 CFR
180.50

Reminder: HPT Resources Available to Help



**Review HPT
Resources**



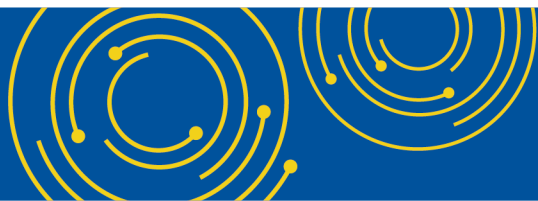
**Follow the Data
Dictionary**



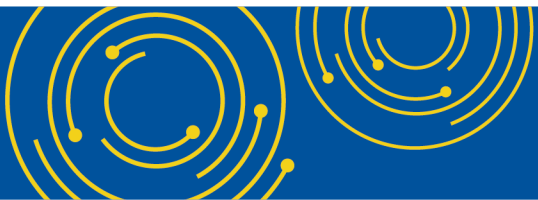
**Reference the
Examples**



**Check Work with
HPT Tools**



CY 2026 Regulatory Updates to HPT Machine-Readable Files (MRFs)



HPT MRF Data Element Overview

<i>MRF Information</i>
MRF Date
CMS Template Version
Attester Name*
Attestation Statement*

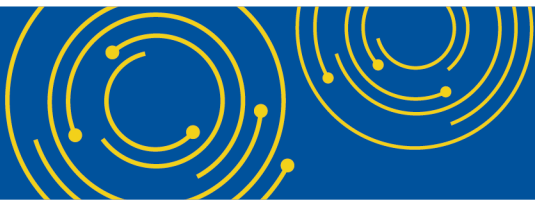
<i>Hospital Information</i>
Hospital Name
Hospital Location(s)
Hospital Address(es)
Hospital Licensure Information
Type 2 Organizational NPI(s)*

<i>Standard Charge Information</i>
Gross Charge
Discounted Cash Price
Payer Name
Plan Name
Standard Charge Methodology
Payer-Specific Negotiated Charge: Dollar Amount
Payer-Specific Negotiated Charge: Percentage
Payer-Specific Negotiated Charge: Algorithm
Estimated Allowed Amount
Median Allowed Amount*
10th Percentile Allowed Amount*
90th Percentile Allowed Amount*
Count of Allowed Amounts*
Additional Generic Notes
Additional Payer-Specific Notes
De-identified Minimum Negotiated Charge
De-identified Maximum Negotiated Charge

<i>Item & Service Information</i>
General Description
Setting
Drug Unit of Measurement
Drug Type of Measurement

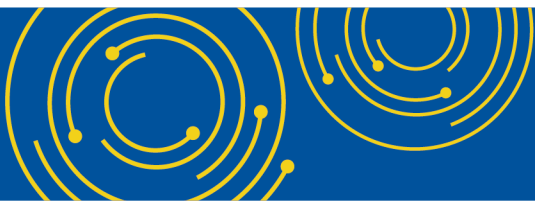
<i>Coding Information</i>
Billing/Accounting Code
Code Type
Modifiers

*- New required data elements in the CY 2026 OPPS/ASC Final Rule



Type 2 Organizational National Provider Identifiers (NPIs) Data Element: 45 CFR §180.50(b)(2)(i)(A)

- Hospitals must:
 - Encode their organizational, or Type 2, NPI(s) in a newly created general data element in the MRF.
 - Include any Type 2 NPI(s) that is associated with a primary taxonomy code starting with '28' (indicating hospital) or '27' (indicating hospital unit).
 - If your hospital has more than one Type 2 NPI that meets these criteria, your hospital is required to report in the general data element all the active Type 2 NPIs meeting the criteria.
 - Only include the Type 2 NPI(s) that are active as of the date of the most recent update to the standard charge information.
- Do not include Type 1 NPIs in this general data element.



Encoding the Type 2 Organizational National Provider Identifiers (NPIs) in .CSV Formats

- If there are multiple Type 2 NPIs in the MRF, separate each NPI with a "|" when encoding these values into the MRF in the CSV formats.

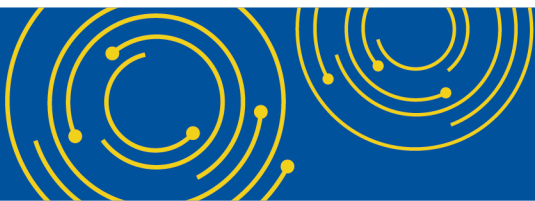
The screenshot shows an Excel spreadsheet with a formula bar at the top displaying 'hospital_name'. The spreadsheet contains a table with columns A through M. Row 1 contains headers: A: hospital_name, B: last_update, C: version, D: location_name, E: hospital_address, F: license_number, G: type_2_npi, H: is the best attester, I: general_contract_provisions, J: When total claim charges exceed \$200,000, K: standard_1, L: standard_2, M: standard_3. Row 2 contains data: A: West Merc, B: #####, C: 3.0.0, D: West Merc, E: 12 Main St, F: 5005, G: 0000000001 | 0000000002 | 0000000003, H: TRUE, I: Leigh Atte, J: When total claim charges exceed \$200,000, K: standard_1, L: standard_2, M: standard_3. Row 3 contains headers: A: description, B: code_1, C: code_1_type, D: code_2, E: code_2_type, F: modifiers, G: setting, H: drug_unit, I: drug_type, J: standard_1, K: standard_2, L: standard_3, M: standard_4. Row 4 contains data: A: Major hip, B: 470, C: MS-DRG, D: 175869, E: LOCAL, F: inpatient, G: inpatient, H: drug_unit, I: drug_type, J: standard_1, K: standard_2, L: standard_3, M: standard_4. The 'type_2_npi' cell in row 2 is highlighted with a blue box.

A	B	C	D	E	F	G	H	I	J	K	L	M
hospital_name	last_update	version	location_name	hospital_address	license_number	type_2_npi	is the best attester	general_contract_provisions	When total claim charges exceed \$200,000	standard_1	standard_2	standard_3
West Merc	#####	3.0.0	West Merc	12 Main St	5005	0000000001 0000000002 0000000003	TRUE	Leigh Atte	When total claim charges exceed \$200,000	standard_1	standard_2	standard_3
description	code_1	code_1_type	code_2	code_2_type	modifiers	setting	drug_unit	drug_type	standard_1	standard_2	standard_3	standard_4
Major hip	470	MS-DRG	175869	LOCAL	inpatient	inpatient	drug_unit	drug_type	standard_1	standard_2	standard_3	standard_4

Affirmation Replaced by New Attestation Statement: 45 CFR §180.50(a)(3)(iii)

- “Attestation Statement” data element replaces “Affirmation Statement” data element.
- The “Attestation Statement” data element for CSV will require the following text in the column header:

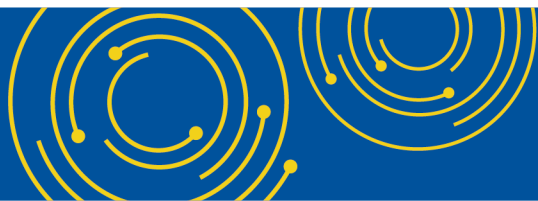
To the best of its knowledge and belief, this hospital has included all applicable standard charge information in accordance with the requirements of 45 CFR 180.50, and the information encoded is true, accurate, and complete as of the date in the file. This hospital has included all payer-specific negotiated charges in dollars that can be expressed as a dollar amount. For payer-specific negotiated charges that cannot be expressed as a dollar amount in the machine-readable file or not knowable in advance, the hospital attests that the payer-specific negotiated charge is based on a contractual algorithm, percentage or formula that precludes the provision of a dollar amount and has provided all necessary information available to the hospital for the public to be able to derive the dollar amount, including, but not limited to, the specific fee schedule or components referenced in such percentage, algorithm or formula.



How to Encode the Attestation Statement Data Element in .CSV Formats

- The data element column header is the Attestation Statement (see previous slide).
- Hospitals will encode either “TRUE” or “FALSE” as a valid value.
- While “TRUE” or “FALSE” is accepted from a form and manner perspective, a value of “TRUE” is required to meet the Attestation Statement regulatory requirement (45 CFR 180.50(a)(3)(iii)).

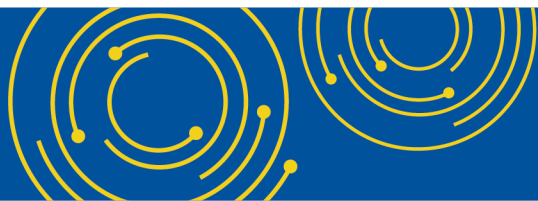
	II	I	J
	To the best of its know	attester_name	general
0000	TRUE	Leigh Attester	When to
	drug unit of measur	drug type of measureme	standar



Encoding the Attester Name Data Element in .CSV Format: 45 CFR §180.50(a)(3)(iv)

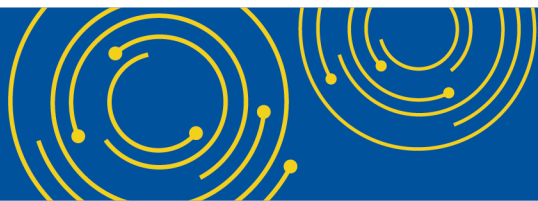
- Hospitals are required to encode in the MRF the name of the hospital chief executive officer, president, or senior official designated to oversee the encoding of true, accurate, and complete data.
- Use “attester_name” as column header.
- Encode the first and last name of the attester.

	H	I	J
	To the best of its knowl	attester_name	general
0000	TRUE	Leigh Attester	When to
	drug unit of measur	drug type of measureme	standar



Estimated Allowed Amount Replaced with Four Allowed Amount Data Elements: 45 CFR §180.50(b)(2)(ii)(C)(2)

- The Estimated Allowed Amount has been **replaced** with the following allowed amount data elements:
 - Median Allowed Amount
 - 10th Percentile Allowed Amount
 - 90th Percentile Allowed Amount
 - Count of Allowed Amounts



Definitions of the Median, 10th Percentile, and 90th Percentile Allowed Amounts: 45 CFR § 180.20

- **Median Allowed Amount:**

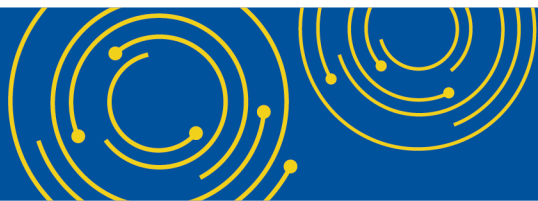
- The median of the total allowed amounts the hospital has historically received from a third party payer for an item or service for a time period no less than 12 months and no longer than 15 months prior to posting the machine-readable file. Should the calculated median fall between two observed allowed amounts, the median allowed amount is the next highest observed value.

- **10th Percentile Allowed Amount:**

- The 10th percentile of the total allowed amounts the hospital has historically received from a third party payer for an item or service for a time period no less than 12 months and no longer than 15 months prior to posting the machine-readable file. Should the calculated percentile fall between two observed allowed amounts, the 10th percentile allowed amount is the next highest observed value.

- **90th Percentile Allowed Amount:**

- The 90th percentile of the total allowed amounts the hospital has historically received from a third party payer for an item or service for a time period no less than 12 months and no longer than 15 months prior to posting the machine-readable file. Should the calculated percentile fall between two observed allowed amounts, the 90th percentile allowed amount is the next highest observed value.



Count of Allowed Amounts Data Element: 45 CFR §180.50(b)(2)(ii)(C)(2)

- **What is it?**

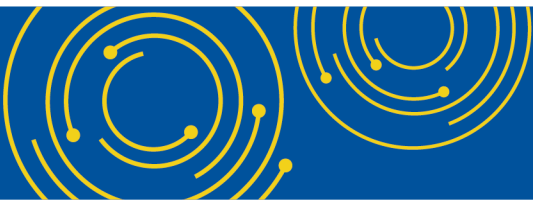
- The total number of allowed amount remittances from the remittance data used to calculate the allowed amounts.

- **When do I need to encode this data element?**

- If a value is encoded in the “Payer-Specific Negotiated Charge: Percentage” or the “Payer-Specific Negotiated Charge: Algorithm” data elements, then the “Count of Allowed Amounts” is required to be encoded in the MRF.

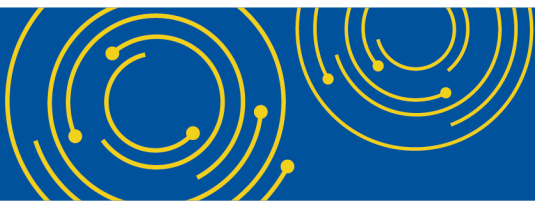
- **What are the valid values?**

- If the total number of allowed amount remittances is 11 or greater, encode the value as a whole number absent any thousands separator. For example, “2,025” includes a thousands separator (comma) and is not accepted.
- If the number of allowed amount remittances is greater than 0 but less than 11, encode “1 through 10”.
- If there are no allowed amount remittances for the time period reflecting no less than 12 months and no more than 15 months prior to posting the MRF, encode “0” in the “Count of Allowed Amounts”, and explain why there are no remittances in the “Additional Generic Notes” in the CSV Tall or the “Additional Payer-Specific Notes” in the CSV Wide and JSON. The Online Validator will produce an error if “0” is encoded for the “Count of Allowed Amounts” and nothing is encoded in “Additional Generic Notes” or “Additional Payer-Specific Notes.”



When do I Need to Encode the Allowed Amounts Data Elements?

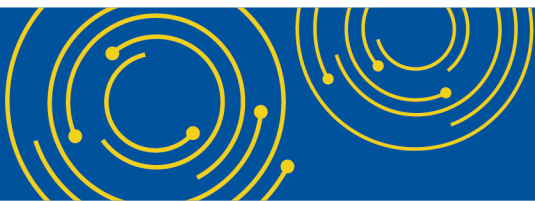
- **When are the allowed amounts required?**
 - Hospitals are required to encode allowed amount data elements when a payer-specific negotiated charge is based on a percentage or algorithm, for example when the payer-specific negotiated charge cannot be expressed as a dollar or when the value encoded as a “Payer-Specific Negotiated Charge: Dollar” is further modified by an algorithm.
 - If there is a value encoded in the “Payer-Specific Negotiated Charge: Percentage” or “Payer-Specific Standard Charge: Algorithm” data elements, then you must also have corresponding 10th, median, and 90th percentile allowed amounts encoded, as well as the count of allowed amounts, unless the count of allowed amounts is zero.



When do I Need to Encode the Allowed Amounts: Percentage

- If the payer-specific negotiated charge is based on a percentage that precludes the provision of a dollar amount, the hospital is required to encode the percentage in the “Payer-Specific Negotiated Charge: Percentage” data element and encode the four allowed amount data elements.
- For example, if the payer-specific negotiated charge is based on a percentage that cannot be calculated as a standard charge dollar, for example, 87% of total billed charges where the payer-specific negotiated charge is not known until after the services are rendered, the hospital should encode 87 in the “Payer-Specific Negotiated Charge: Percentage” data element and then encode the allowed amount data elements.

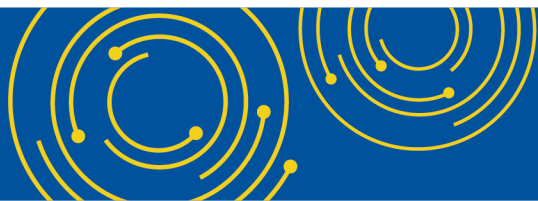
If the hospital can “do the math” and use the percentage of a known fee schedule to calculate a “Payer-Specific Negotiated Charge: Dollar,” the hospital must do so.



When do I Need to Encode the Allowed Amounts: Algorithms

- If the payer-specific negotiated charge is based on, or further modified by, an algorithm, the hospital is required to:
 - (1) provide all necessary information available to the hospital, in a way that a reasonable MRF user can understand, in the “Payer-Specific Negotiated Charge: Algorithm” data element for the public to be able to derive a dollar amount, and
 - (2) encode the allowed amount data elements.
- All necessary information available to the hospital would include, among other things, information in the hospital’s systems and payer contracts.
 - Examples of all necessary information include, but are not limited to, patient and hospital demographics, clinical characteristics, length of stay, resource utilization, and adjustments based on mix of services performed.

For payer contract provisions that are negotiated at an aggregate level across multiple items and services (for example, claim level or episode of care), hospitals may use the optional data element, “General Contract Provisions,” to convey this information.

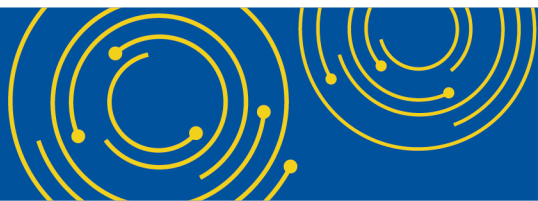


When Don't I Need to Encode the Allowed Amounts?

- If the count of allowed amounts is “0”. In this instance, you must also encode in the “Additional Generic Notes” or “Additional Payer-Specific Notes” data element the reason why the count is “0”.
- If a hospital has encoded a payer-specific negotiated charge in the MRF as a dollar amount, and that dollar amount represents the full payer-specific negotiated charge **that is not further modified** by a percentage or algorithm, the hospital **would not be required** to encode the allowed amounts.

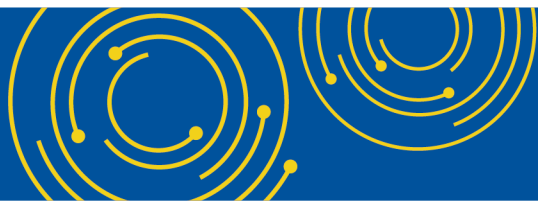
For example, if a hospital negotiated a price for an item or service using a percentage of a known fee schedule, like Medicare (e.g., 130% of Medicare), and there is no algorithm further modifying the price, the hospital would:

1. Calculate what 130% of the Medicare fee schedule is for that item or service and enter that dollar figure under the “Payer-Specific Negotiated Charge: Dollar Amount” data element as the complete price for the item or service
2. Would not encode 130% under the “Payer-Specific Negotiated Charge: Percentage” as the full dollar amount can be calculated and encoded
3. Select “fee schedule” as the value for the “Standard Charge Methodology” data element



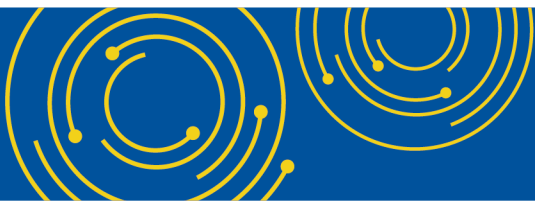
Data Source for Calculating the Allowed Amounts: 45 CFR § 180.20

- Hospitals must use electronic data interchange (EDI) 835 electronic remittance advice (ERA) transaction data or an alternative, equivalent source of **remittance data** that includes the same information as EDI 835 ERA transaction data would include to calculate and encode the median, 10th and 90th percentile allowed amounts as well as the count of allowed amounts.



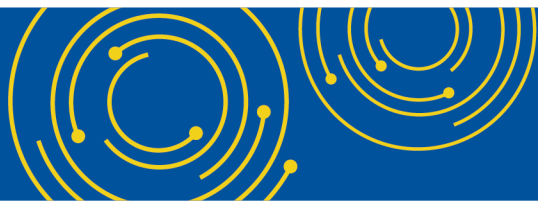
Lookback Period for Allowed Amounts: 45 CFR § 180.20

- Hospitals must use a lookback period of no less than 12 months and no longer than 15 months prior to posting the MRF for the median allowed amount, 10th and 90th percentile allowed amounts, and count of allowed amounts.
- We expect hospitals to use at least the most recent 12 months of data that are available to them.
 - In the case where hospitals need additional time to pull or prepare the data before posting the MRF, hospitals may use data from up to 15 months prior to the date the MRF is posted to help ensure they have adequate data to encode the allowed amounts.
 - Nothing precludes a hospital from using all 15 months of data to encode the “Median Allowed Amount,” “10th Percentile Allowed Amount,” and “90th Percentile Allowed Amount.”
- Hospitals should report data from both prior to and after a contract negotiation date to capture a full 12-month period regardless of when the contract negotiation takes place.
 - In the event that hospitals renegotiate a contract during the lookback period, hospitals should use data from both prior to and after the negotiation date.
 - Hospitals should encode one figure for each of the allowed amount data elements.
 - Regardless of how many times a contract was modified or the amount changed, the hospital should use all data available over a 12-month lookback period.



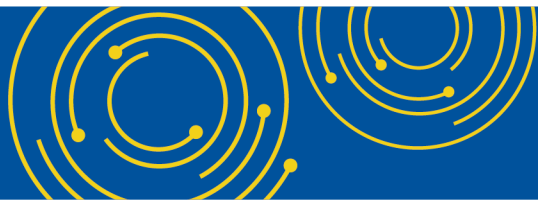
Calculating the Allowed Amounts: 45 CFR § 180.20

- How do I calculate the allowed amount if it is between two data points?
 - For the “Median Allowed Amount,” the “10th Percentile Allowed Amount,” and the “90th Percentile Allowed Amount,” should the calculated percentile fall between two observed allowed amounts, use the next highest observed value.



Examples: Encoding Allowed Amount Data Elements in the CSV Tall Format

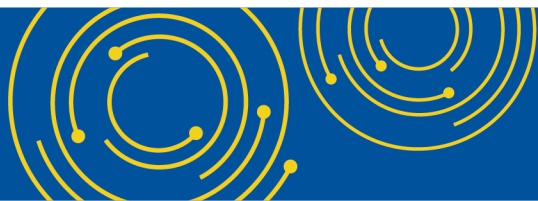
description	code 1	code 1 type	payer_name	plan_name	standard_charge negotiated_dollar	standard_charge negotiated_percentage	standard_charge negotiated_algorithm	median_amount	10th_percentile	90th_percentile	count	additional_generic_notes
Major hip and knee joint replacement or reattachment of lower extremity without mcc	470	MS-DRG	Platform Health Insurance	PPO		50		21345.12	18765.9	39627.88	23	
Major hip and knee joint replacement or reattachment of lower extremity without mcc	470	MS-DRG	Region Health Insurance	HMO	25678		If days in visit is less than or equal to 3, then the standard charge is \$25,678.00. Otherwise, the standard charge is \$25,678.00 plus 80% of billed charges on the days exceeding 3 days.	25678	25678	45964	43	
Heart transplant or implant of heart assist system without mcc	2	MS-DRG	Region Health Insurance	HMO		40	40% of billed charges up to billed charges of \$1 million, then 50% of billed charges in excess of \$1 million.	560043.22	256789.17	945001.98	1 through 10	
Heart transplant or implant of heart assist system without mcc	2	MS-DRG	Platform Health Insurance	PPO		45					0	No services performed during 15-month lookback period.



Summary of CY 2026 OPPS/ASC Final Rule Changes to HPT MRFs

- Type 2 NPI now required in general data elements.
- Attestation Statement replaces Affirmation Statement in general data elements.
- Attester name now required in general data elements.
- Estimated Allowed Amount removed and replaced with four allowed amount data elements:
 - Median Allowed Amount
 - 10th Percentile Allowed Amount
 - 90th Percentile Allowed Amount
 - Count of Allowed Amounts

New and updated requirements are effective January 1, 2026, but enforcement of new and updated requirements at § 180.50 will begin on April 1, 2026.



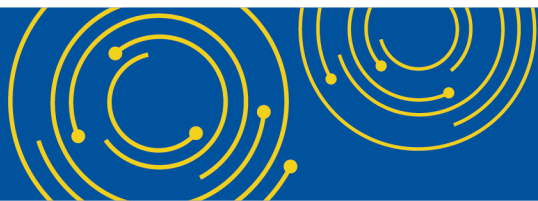
Regulatory Change to Compliance Waiver of Hearing, Automatic Reduction of Penalty Amount: 45 CFR §180.90(c)(4)

- To encourage faster resolution and payment of Civil Monetary Penalties (CMPs), CMS will reduce the amount of a CMP by 35 percent when a hospital waives its right to an ALJ hearing (with certain exceptions).
- A hospital would need to submit to CMS a written notice waiving its right to a hearing under § 180.100 within 30 calendar days of the date of the notice of imposition of the CMP.
- If a hospital elects to waive the right to a hearing, it would still be required to achieve compliance to avoid the potential imposition of additional CMPs.
 - Hospitals can continue to receive additional CMPs for the same violations if they remain out of compliance, but they will not be eligible to receive a 35 percent reduction in subsequent CMPs for the same instance(s) of noncompliance (that is, continuing violations) and waive their right to appeal subsequent CMPs for continuing violations.

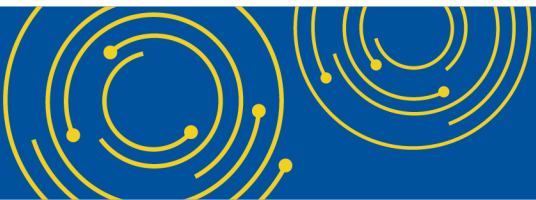
Waiver of Hearing, Automatic Reduction of Penalty Amount: 45 CFR §180.90(c)(4)(ii)

- CMS will decline to make this option available to hospitals if CMS imposed the CMP because the hospital failed to make public either:
 - an MRF or
 - a consumer-friendly list of standard charges (either in the form of a shoppable services file or an internet price estimator tool).

Effective January 1, 2026



Additional CMS Hospital Price Transparency Data Dictionary GitHub Repository Updates



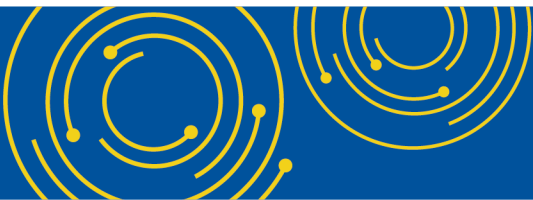
GitHub Overview Reminder

The CMS GitHub Repository:

- Is a website used by CMS to store CMS templates and data dictionary technical instructions that your hospital must use to create its MRF.
- Provides assistance for technical questions you may have.

HPT GitHub Resources:

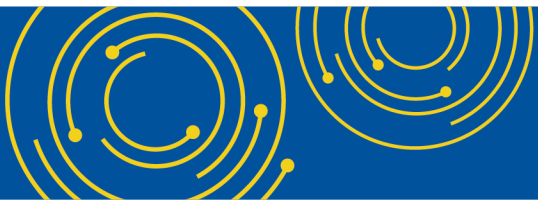
- The CMS Hospital Price Transparency – Data Dictionary GitHub Repository: <https://github.com/CMSgov/hospital-price-transparency>
- The Navigating GitHub and the HPT Data Dictionary Guide: <https://github.com/CMSgov/hospital-price-transparency/blob/master/resources/Navigating%20GitHub%20and%20the%20HPT%20Data%20Dictionary%20Guide.pdf>
- CMS Hospital Price Transparency Tools: <https://cmsgov.github.io/hpt-tool/>
- CMS HPT Online Validator Demonstration: <https://www.youtube.com/watch?v=e6b9kN9B11c>



Data Dictionary Updates

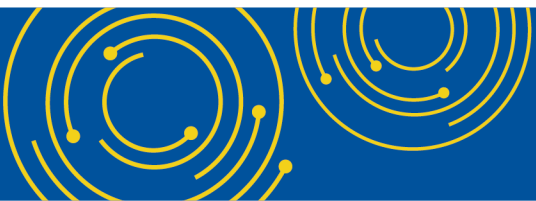
Review the Update Guide, the CSV and JSON Data Dictionary, and Examples on the **CMS Hospital Price Transparency Data Dictionary GitHub Repository**:

<https://github.com/CMSgov/hospital-price-transparency/tree/master>



Additional Data Dictionary Updates for CSV and JSON Formats

- Hospital location element name change:
 - “hospital_location” general data element is now named “location_name”.
- New allowed values for code type:
 - ‘CMG’
 - ‘MS-LTC-DRG’
- Payer-specific negotiated charge requirement:
 - When an item or service is encoded with a payer name and plan name, there must also be at least one payer-specific negotiated charge encoded.

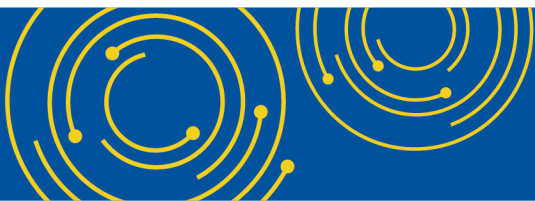


JSON Only - Additional Data Dictionary Updates

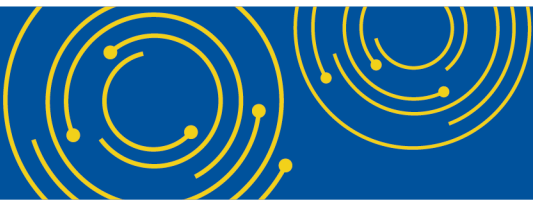
- New optional attribute in Modifier Information object:
 - A Modifier Information object may now contain a “setting” attribute. The allowed values for this attribute are the same as for the “setting” attribute in the Standard Charge object.
- New optional attribute in Standard Charge object:
 - A Standard Charge object may now contain a “modifier_code” attribute. This attribute is defined as an array of strings, each of which should be a modifier code present in a Modifier Information object.
- Drug unit of measurement data type change:
 - The “unit” attribute in the Drug Information object in the JSON schema is now a “number” type.



Check the updated definitions in the JSON Data Dictionary.



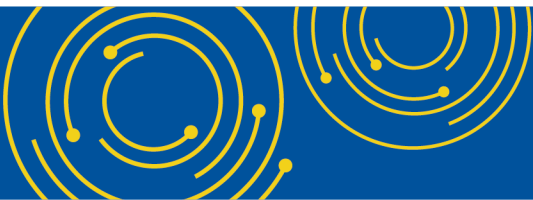
HPT MRF Validator Versioning



HPT Validator Tools

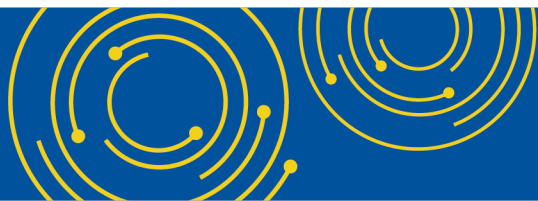
There are two software options for testing machine readable files against the required CMS template layouts and data specifications (45 CFR 180.50(c)(2)). Both run on the same core logic and will produce the same output:

- The **online validator** runs in a user's web browser, and it is recommended for nontechnical users.
- The **command-line interface (CLI) validator** is a downloaded tool that runs locally in the user's terminal, and it is recommended for technically proficient users validating multiple files simultaneously or integrating the validator into a software pipeline.

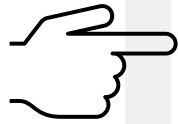


HPT Validator Versioning

- New capability introduced in November 2025.
- Allows the user to select which version of data dictionary to review their uploaded MRF against including past, current, and future requirements.
- The effective date of each data dictionary version is noted next to each option.
- The Online Validator defaults to the most recent data dictionary version.



HPT Online Validator Versioning



Select requirements version

- Requirements effective January 1, 2026 and enforced April 1, 2026 (Data Dictionary v3.0 [CSV JSON](#))
- Requirements effective January 1, 2025 (Archived Data Dictionary v2.2 [CSV JSON](#))
- Requirements effective July 1, 2024 (Archived Data Dictionary v2.1 [CSV JSON](#))

Upload file

Files must be in a required CMS template format (.json or .csv)

Drag file here or [choose from folder](#)

About This Tool

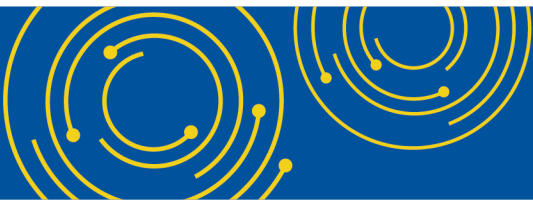
Please note: Leveraging the Validator helps ensure adherence to CMS form and manner requirements (45 CFR 180.50(c)(2)), but it does not certify that your MRF fully complies with all HPT requirements at 45 CFR 180.50.

The Online Validator tool assists your hospital in developing a machine-readable file (MRF) to ensure it conforms to the required form and manner requirements (45 CFR 180.50(c)(2)). These form and manner requirements are described in the [CY 2024 OPPS/ASC Final Rule](#) and the [CY 2026 OPPS/ASC Final Rule](#). The detailed technical specifications can be found in the [Hospital Price Transparency Data Dictionary GitHub Repository](#).

The Online Validator includes a new capability, Version Validation, that allows the user to select which version of data dictionary to review your uploaded MRF against including past, current, and future requirements. The effective date of each data dictionary version is noted next to each option. The Online Validator defaults to the most recent data dictionary version.

HPT Online Validator Outputs

- The Validator will generate an output consisting of:
 - Errors
 - Alerts
 - Data Dictionary version
 - Validator run time
- ‘Errors’ are generated if your MRF does not conform to the form and manner requirements of the selected data dictionary version.
- ‘Alerts’ may be generated if your MRF meets technical specifications for form and manner but may not be compliant with all requirements.
 - Example: While “true” or “false” is accepted for the “Attestation Statement” data element from a form and manner perspective, if a value of “false” is encoded, the validator will produce an ‘alert’ as a value of “true” is required to meet the attestation regulatory requirement (45 CFR 180.50(a)(3)).



HPT Online Validator Output Example

Download the validator output by clicking this button

Validation results

Download results as spreadsheet

Errors

! Using hpt-validator version 2.1.2
Using requirements version: Requirements effective January 1, 2026 and enforced April 1, 2026 (Data Dictionary v3.0)
Validator run started at Tue Jan 13 2026 12:03:13 GMT-0500 (Eastern Standard Time)
Validator run completed at Tue Jan 13 2026 12:03:13 GMT-0500 (Eastern Standard Time)
There is 1 error found in the file: [V3.0.0_Tall_CSV_Webinar_Error_Example.csv](#)
See the [Hospital Price Transparency Data Dictionary GitHub Repository](#) for detailed technical specifications to understand and address these errors.

The data dictionary requirements version tested against, run time, and file name are found at the top of the results

Location of the error in the file

CSV cell	Error description
E4	A value is required for "code 2 type". You must encode the missing information.

Error description

Alerts

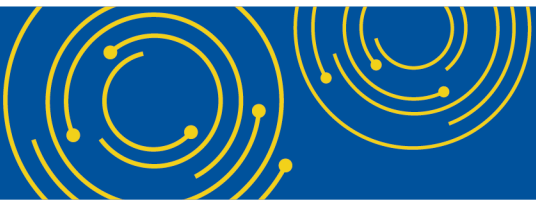
i There is 1 alert found in the file: [V3.0.0_Tall_CSV_Webinar_Error_Example.csv](#)
See the [CMS guidance](#) issued on May 22, 2025 to understand and address these alerts.

Location of the alert in the file

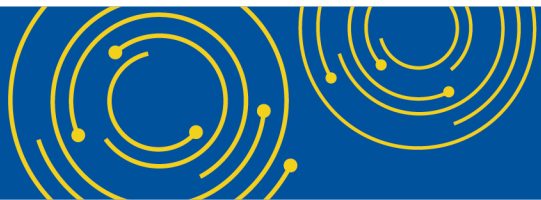
CSV cell	Alert description
H3	Attestation value is false.

Alert description

Poll



Questions & Answers



Hospital Price Transparency Resources



Visit the [CMS Hospital Price Transparency – Data Dictionary GitHub Repository](#) to access the CMS templates, technical specifications, and get technical support.

Visit the [HPT Website Resources Page](#) for:

- Slides and a recording of this webinar
- [CY 2026 OPPS/ASC Final Rule Fact Sheet](#)
- [Frequently Asked Questions](#)
- [Steps to a Machine-Readable File](#)
- [Steps to a Consumer-Friendly Display](#)
- [Hospital Price Transparency Tools](#)
- [Hospital Price Transparency Validator FAQs](#)
- Previous webinar recordings

For additional information, please contact:
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