

Letters

RESEARCH LETTER

Assessment of Compliance With Centers for Medicare & Medicaid Services Price Transparency Final Rule

In November 2021, the Centers for Medicare & Medicaid Services (CMS) issued a new final ruling on price transparency, updating the prior rule to disclose a comprehensive machine-readable file with payer-negotiated rates for shoppable services, as well as to display shoppable services in a patient-friendly format. The revised ruling most notably raised the annual maximum penalty fee for nondisclosure from \$109 500 to \$2 000 000 to address patient complaints and demonstrate the importance of compliance.

Before the announcement of the increased penalty, studies indicated substantial variation in both negotiated prices and price disclosures. Prior work revealed that 65% of the 63 National Cancer Institute–Designated Cancer Centers (NCI-CCs) had a patient-friendly online cost estimator and only 38% had an at least partially complete machine-readable file with payer-negotiated prices (last assessed June 1, 2021).¹ Other research has shown that negotiated oncology prices could vary from 70 to more than 1000 times higher across centers.^{2,3}

Methods | In this cross-sectional study, we conducted an updated analysis of disclosure of commercial payer-negotiated rates in compliance with the CMS ruling effective January 1, 2022. Machine-readable files for hospital systems associated with NCI-CCs were searched for using the terms *payer negotiated prices*, *price transparency*, and *price transparency machine readable file*. We also searched for patient-friendly estimator tools with the terms *online cost estimator* and *shoppable services estimate*. Finally, we searched for hospital chargemasters with searches for *hospital standard charges* and *hospital chargemaster*. Data collection was completed in March 2022 to account for possible variation in time to implementation of the CMS ruling. The institutional review board of Memorial Sloan Kettering Cancer Center deemed this study exempt from review and waived the requirement for informed consent, consistent with its policy on nonhuman participant research that uses publicly available data.

Results | On reassessment, there was a decrease in price disclosure among 63 NCI-CCs. A total of 32 NCI-CCs (48%) had a patient-friendly online estimator (down from 65% in 2021). A total of 14 (21%) had at least partially complete machine-readable files with payer-negotiated prices (down from 38% in 2021). Furthermore, 25 centers (38%) had a chargemaster, and 11 centers (17%) stated inaccurately on their websites that linked chargemaster lists were in accordance with the most recent CMS ruling regarding price transparency. Only 12 NCI-CCs (19%) were in full compliance with the most recent ruling, having both a patient-friendly online estimator and a complete ma-

chine-readable file. On repeated assessment, 6 centers that had previously published machine-readable files no longer had any functional price transparency tools.

Discussion | Increasing the maximum penalty fee to \$2 000 000 was not associated with increased compliance with price transparency among the nation's top health systems' affiliated cancer centers on repeated analysis 3 months after penalty increase. Although our findings were limited by restricting the analysis to NCI-CCs, they were nonetheless distressing. Despite the passing of 2 years since the initiation of mandates intended to empower patients with accessible pricing information, price transparency has not substantially increased. To create a culture where patients and physicians make informed decisions and understand full risks and benefits, costs of treatment should be discussed.⁴

Research has shown that price transparency can lead to lower and more uniform prices,⁵ which can ultimately improve affordability for patients. Although CMS did not explicitly require cancer treatment to be included, prior research has shown that health systems associated with NCI-CCs compliant with the transparency rule listed cancer-related services, allowing for price comparisons.¹⁻³ To improve transparency, policy makers could consider implementing more stringent penalties, up to and including disallowment of Medicare payments, regular audits, frequent communication with transparency monitoring agencies, additional technical assistance, and public reporting of price transparency to improve compliance.⁶ Additionally, initiatives aimed at improving transparency at the individual patient level, such as increasing access to financial navigators, may empower patient choice and mitigate financial toxicity.

Angelin Tresa Mathew, BS
Bhav Jain, BS
Edward Christopher Dee, MD
Jordan Johnson, BSRT, MSHA
Fumiko Chino, MD

Author Affiliations: Yale University, New Haven, Connecticut (Mathew); Massachusetts Institute of Technology, Cambridge (Jain); Department of Radiation Oncology, Affordability Working Group, Memorial Sloan Kettering Cancer Center, New York, New York (Dee, Chino); Oncospark, Ashland, Kentucky (Johnson).

Accepted for Publication: April 7, 2022.

Published Online: June 9, 2022. doi:10.1001/jamaoncol.2022.1783

Corresponding Author: Fumiko Chino, MD, Department of Radiation Oncology, Affordability Working Group, Memorial Sloan Kettering Cancer Center, 1275 York Ave, Box 33, New York, NY 10065 (chinof@mskcc.org).

Author Contributions: Ms Mathew and Mr Jain had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Jain, Dee, Johnson, Chino.

Acquisition, analysis, or interpretation of data: Mathew, Jain, Dee.

Drafting of the manuscript: All authors.

Critical revision of the manuscript for important intellectual content: Mathew, Jain, Dee, Chino.

Statistical analysis: Mathew, Jain, Johnson.

Supervision: Jain, Dee, Chino.

Other - data gathering: Johnson.

Conflict of Interest Disclosures: Mr Johnson reported being chief innovation officer of Oncospark, an oncology value-based care and technology company, and leader of Price Transparency, an arm of Oncospark that allows for price comparison. No other disclosures were reported.

Funding/Support: Drs Dee and Chino are funded in part through the Cancer Center Support Grant from the National Cancer Institute (P30 CA008748).

Role of the Funder/Sponsor: The funder had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

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