

CMS-9882-F • FINALIZED OCTOBER 5, 2026

Transparency in Coverage Final Rule: What It Means for Oncology

A summary of the updated payer price-transparency requirements and their implications for physicians, hospitals, payers, and oncology service lines.

Executive Summary

On October 5, 2026, HHS (through CMS), Labor, and Treasury finalized amendments to the 2020 Transparency in Coverage (TiC) rules. The 2020 rules required health plans and insurers to publish massive monthly machine-readable files (MRFs) of negotiated rates and out-of-network allowed amounts. In practice those files were too large, too ambiguous, and too poorly aligned with hospital price-transparency data to use well.

The final rule fixes that. Files shrink and become **network-level**, implausible provider/service combinations are removed, new **Taxonomy** and **Utilization** files add context, out-of-network data expands, updates move to **quarterly**, and a named senior official must **attest** to accuracy.

Bottom line for oncology: payer rate data for infusion, oncology drugs, and radiation oncology is about to become cleaner, more comparable to hospital price files, and more credible. That benefits well-prepared negotiators and puts more pressure on high-cost sites of care. Expect payers, employers, and competitors to use it, so your service line should too. For radiation oncology, the data also makes it possible to build a payer-specific total cost of care model that goes well beyond Medicare-based ROCR case rates.

What Changed

Area	2020 Rules	Final Rule (CMS-9882-F)
In-network rate file level	One file per plan or policy	One file per provider network , aligned with how hospital price files are typically reported
Provider/rate combinations	Rates listed for every provider in a contracted organization, regardless of specialty	Combinations a provider would be unlikely to be paid for, given their specialty, are excluded using the payer's own claims-adjudication rules
New Taxonomy File	None	Payers publish the taxonomy mapping or rules used to filter each in-network file
New Utilization File	None	Lists every provider with at least one paid claim in the most recent plan year ending six months before posting
Out-of-network allowed amounts	Per plan; 20-claim minimum; data often sparse	Aggregated by market type (large group, small group, individual, self-insured); threshold lowered to 11 claims ; longer reporting period
Contextual data	Limited	Product type (HMO, PPO, etc.) plus common network name and network identifier
Update cadence	Monthly	Quarterly for in-network and out-of-network files
File format	Any non-proprietary open format	Single format; Departments intend to specify JSON in guidance

Area	2020 Rules	Final Rule (CMS-9882-F)
Findability	Varied by payer	A .txt file in the website root pointing to the files, plus a monitored contact email and a standardized footer link titled "Price Transparency" or "Transparency in Coverage"
Accountability	None	An accuracy attestation in each file, plus the name of the CEO, president, or designated senior official
Consumer cost-sharing tool	Online or paper	Also available by phone ; satisfies No Surprises Act section 114, including for grandfathered plans; notices updated for balance-billing protections

The prescription drug MRF remains under case-by-case enforcement following a 2023 FAQ and a June 2025 Request for Information. The rule extends the findability, contact, and senior-official requirements to it, but does not substantively resolve it.

Timeline

Milestone	Timing
Rule takes effect	60 days after Federal Register publication
In-network and out-of-network file amendments apply	5 months after publication
Taxonomy, Utilization, and .txt files apply	11 months after publication
Phone-based cost-sharing tool and updated notices	Plan or policy years beginning on or after January 1, 2027
Projected net payer savings	About \$174.5 million per year, starting in year two

Publication date not stated in the CMS fact sheet. If the rule publishes in mid-to-late October 2026, expect the new in-network and out-of-network files around **March 2027** and the contextual files around **September 2027**. Confirm against the Federal Register.

What It Means by Stakeholder

Physicians and Physician Groups

- **Your rates become easier to see and compare.** Smaller, network-level, specialty-filtered files make it practical for competitors, health systems, employers, and data vendors to benchmark your contracted rates.
- **The Taxonomy File shows how payers adjudicate claims.** It reveals the specialty-to-service rules a payer uses to decide what a provider type gets paid for. Revenue cycle teams can use it to explain and appeal specialty-based denials.
- **Check that your providers appear correctly.** If a payer's taxonomy rules filter out a service you actually provide, the public file will understate your network. Use the new contact email to report errors.
- **The Utilization File shows who is actually practicing in each network,** which is useful for recruitment, referral analysis, and competitive mapping.

Hospitals and Health Systems

- **Payer and hospital data become directly comparable.** Network-level reporting aligns TiC files with Hospital Price Transparency files, so hospital-outpatient versus physician-office price gaps will be easier to quantify.
- **Expect more site-neutral and site-of-care pressure.** Employers and payers will have cleaner evidence for steering, benefit design, and contract demands where the hospital-outpatient premium is large.

- **Out-of-network exposure becomes visible.** Market-level allowed amounts at an 11-claim threshold will publish data on what payers actually pay out of network, which affects negotiating leverage on both sides.
- **Patient access will improve, but estimates may vary.** Patients can now get payer cost-sharing estimates by phone. Financial counselors should expect patients to compare those estimates with the hospital's.

Payers and Self-Funded Employers

- **Lower ongoing cost, but heavier upfront work.** Quarterly cadence and smaller files cut hosting and maintenance costs. The Taxonomy, Utilization, and attestation requirements need new data governance.
- **A named executive is now accountable.** Each file must carry an accuracy attestation and the name of a senior official, which raises compliance stakes and the cost of sloppy data.
- **Self-funded employers gain a usable tool.** Plan sponsors, TPAs, and consultants can now analyze network pricing directly, which supports direct contracting, centers-of-excellence strategies, and vendor oversight.
- **The phone channel needs staffing.** Call centers must deliver the same cost-sharing information as online tools for plan years beginning January 1, 2027.

Implications for Oncology Service Lines

Oncology is especially exposed to this rule. Its spending is dominated by high-cost drugs, repeat infusion visits, and radiation courses with large price differences across sites of care. Each change in the rule affects the oncology service line in a specific way:

Rule Change	What It Means for Oncology
Specialty-filtered in-network files	Medical oncology, hematology, and radiation oncology rates for chemotherapy administration, oncology drugs, and radiation treatment become easier to isolate and benchmark against competitors. Risk: a multispecialty group, APP-led infusion, or hem/onc versus med onc taxonomy may be mis-mapped, so verify that your rates appear.
Taxonomy File	Shows which provider types each payer will reimburse for infusion, drug, and radiation codes. Use it to diagnose specialty-based denials, credentialing gaps, and billing-provider setup issues.
Alignment with hospital price files	Makes the hospital-outpatient versus physician-office price gap for infusion and drug margins easy to calculate. Expect more payer site-of-care programs, white- and brown-bagging, and home-infusion steering, along with employer pressure on hospital-based oncology pricing.
Out-of-network data at 11 claims, by market	Low-volume, high-cost services such as CAR-T, proton therapy, bispecifics, and rare-disease drugs are more likely to clear the threshold. This adds visibility for out-of-network and single-case agreement negotiations.
Utilization File	Reveals which oncologists and sites actually bill in each network. Useful for market-share analysis, referral leakage and outreach targeting, recruitment, and network-adequacy discussions with payers.
Quarterly updates	This lines up with quarterly ASP drug pricing updates, but mid-quarter contract changes will appear with a lag. Time your benchmarking runs accordingly.
Attestation and named official	Payer data becomes credible enough to cite in negotiations. Oncology contracting teams can also challenge visible errors through the required contact email.
Phone cost-sharing tool	Oncology patients face high, recurring cost-sharing. Financial navigators should use payer tools to reconcile estimates, flag deductible and out-of-pocket maximum timing, and connect patients to assistance programs early.

Rule Change	What It Means for Oncology
Drug MRF still unresolved	Pharmacy-benefit pricing for oral oncolytics remains largely opaque. Medical-benefit (buy-and-bill) drug rates in the in-network file are where the new transparency is concentrated.

Radiation Oncology: Building a Better Total Cost of Care Model Than ROCR

The Radiation Oncology Case Rate (ROCR) Act, ASTRO's proposed legislation, would move Medicare radiation oncology payment from per-fraction fee-for-service to a site-neutral, per-patient episode case rate across 15 disease sites. It builds on the methodology of CMS's 2020 Radiation Oncology Model. ROCR is a meaningful step for Medicare stability. But it is a Medicare payment policy built on historical Medicare claims, not a market-specific total cost of care model. The new TiC files supply the missing pieces.

Where ROCR-Style Modeling Falls Short

- **Medicare-only pricing.** Episode rates are derived from Medicare fee-for-service claims. They say nothing about commercial and Medicare Advantage rates, which vary widely by payer, network, and market.
- **Narrow scope.** A radiation case rate covers the radiation episode: planning, simulation, physics, delivery, and management. Total cost of care also includes concurrent systemic therapy, imaging, E/M visits, toxicity management, ED visits, and admissions.
- **Site neutrality hides the commercial gap.** A site-neutral Medicare rate cannot show how much more commercial payers pay hospital outpatient departments than freestanding centers, which is where most commercial savings lie.
- **National averages and lag.** Rates built on historical national data adjust slowly to local prices, fractionation trends, and code changes such as the 2026 treatment delivery revisions.

How the New TiC Data Closes Those Gaps

TiC Data Element	Use in a Radiation Oncology TCOC Model
Network-level in-network rates	Price every component of a standard radiation episode (simulation, planning, dosimetry, devices, physics, delivery by modality, image guidance, and treatment management) for each payer network. The result is a commercial and Medicare Advantage episode price library rather than a single Medicare rate.
Alignment with Hospital Price Transparency	Join payer rates to hospital files to calculate freestanding versus hospital-outpatient episode cost by payer. This quantifies the site-of-care savings opportunity that a site-neutral Medicare rate cannot show.
Rates by code plus fractionation schedules	Price the same diagnosis under different fractionation schedules (for example, conventional, moderate hypofractionation, and SBRT/SRS) to show payers the savings from evidence-based short-course treatment, and to show the service line the revenue impact.
Systemic therapy, imaging, and E/M rates	Add the non-radiation components of the episode: concurrent chemotherapy drugs and administration, PET/CT/MRI, office visits, and supportive care. This turns a radiation case rate into a true total cost of care estimate.
Out-of-network allowed amounts (11 claims, by market)	Gives pricing visibility for low-volume, high-cost modalities such as proton therapy, brachytherapy, and SRS. Use it to set outlier pricing, stop-loss levels, and risk corridors.
Utilization File	Maps which radiation oncologists and facilities actually bill in each network. Use it for capacity and access-gap analysis, network-adequacy conversations, and assigning patients to providers in a model.

TiC Data Element	Use in a Radiation Oncology TCOC Model
Taxonomy File	Shows which provider types each payer pays for physics, dosimetry, and management codes. This clarifies how professional and technical components should be split and attributed within a bundle.
Product type, attestation, quarterly refresh	Segment the model by HMO, PPO, and market type. Present payer-attested data in negotiations. Refresh model inputs every quarter.

Recommended Model Structure

- Episode definition.** Start from ROCR-style disease-site episodes so results stay comparable to Medicare policy. Extend the episode window and scope to include systemic therapy, imaging, and acute care.
- Utilization layer.** Build care patterns from your own claims and EHR data, plus Medicare data where available. **TiC files supply prices, not patient volumes**, so this layer must come from clinical and claims data.
- Price layer.** Apply TiC rates by payer, network, and product, and Hospital Price Transparency rates by site of care. Use out-of-network allowed amounts for outlier and non-contracted services.
- Risk adjustment.** Adjust for disease site, stage, treatment intent, modality, fractionation, age, and comorbidity, so the case rate reflects clinical reality rather than a national average.
- Outputs.** Produce payer-specific and site-specific episode prices, a benchmark against Medicare and ROCR rates, and a quantified savings case for commercial payers and self-funded employers.

Why This Matters

ROCR, if enacted, would set the Medicare floor. But commercial and Medicare Advantage contracts will set the margin. A radiation oncology program that can price a full episode by payer, site, and fractionation schedule, using payer-attested data, can propose its own case rates and shared-savings arrangements. That puts it ahead of payers who would otherwise impose their own.

Recommended Actions for Oncology Leaders

Window	Actions
Now through Q4 2026	Inventory your top payer contracts and top oncology codes (infusion administration, top 25 drugs by spend, radiation treatment and IMRT/SBRT). Build a baseline from current TiC and hospital price files. Assign an owner for price-transparency analytics.
Around March 2027 (new in-network files)	Re-benchmark against competitors and hospital-outpatient rates by network. Model your exposure to site-of-care steering. Prepare negotiating positions backed by payer-attested data. Load rates into the radiation oncology total cost of care model and price episodes by payer, site, and fractionation schedule.
Around September 2027 (Taxonomy and Utilization files)	Audit taxonomy mappings for every oncology provider type. Reconcile against denials. Use utilization data for market-share, referral, and recruitment strategy.
Plan years beginning January 2027	Train financial navigators on payer phone and online tools. Align good-faith-estimate workflows. Track gaps between patient estimates and actual bills.



Bridge Oncology

Bridge Oncology helps practices, health systems, and payers turn regulatory change into oncology service line strategy, from payer contracting and site-of-care planning to price-transparency benchmarking. Contact us to build your oncology rate baseline before the new files arrive.

Source: CMS Fact Sheet, "Transparency in Coverage Final Rules (CMS 9882-F)," October 5, 2026; Federal Register public inspection document 2026-20447. ROCR description drawn from public ASTRO materials; ROCR is pending legislation and its terms may change. Rule provisions are summarized from the CMS fact sheet. Implications and recommendations are Bridge Oncology analysis. This brief is for informational purposes and is not legal advice. Confirm details against the final regulatory text.