Provenant — Cross-Hospital Rate Dispersion in Surgical Oncology

Independently verifiable negotiated-rate analytics built on CMS-mandated hospital machine-readable files (MRFs).

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The Finding

One national commercial payer (UnitedHealthcare), four leading cancer centers, one procedural code. For CPT 19101 — an open surgical breast biopsy, high-volume in oncology — UnitedHealthcare's negotiated rate is $22,041.00 at Stanford, $14,341.63 at Cedars-Sinai, $10,824.00 at MSK, and $1,155.70 at MD Anderson: a 19.07× spread, max over min, same payer, same code. Every figure reconstructs from independently signed source packs. Three are litigation-grade (Stanford, Cedars-Sinai, MSK); MD Anderson's is analytics-tier — a CSV source where the CMS validator is not yet wired — so the roll-up carries `tier_metadata: analytics` and the verifier surfaces it. No aggregation step is taken on trust. Each hospital's contribution is the median of its preserved rates for this tuple — a deterministic, reproducible selection rule documented in the accompanying methodology; the source pack retains every disclosed rate as a separate provenance-bearing row.

Why This Matters

CPT 19101 is one of five 19xxx surgical-oncology codes showing the same structure across these hospitals (CPT 19000, 53.08×; 19081, 13.56×; 19105, 18.88×; 19296, 5.6×). These are not anomalies. They are the visible distribution of how a single national payer prices identical procedural codes across four cancer centers. The pattern is consistent with hospital-pricing variation documented in the RAND Hospital Price Transparency Study (Round 5.1, 2020-2022 data, published December 2024), which reports commercial insurance prices averaging 254% of Medicare across all hospital inpatient and outpatient services in 2022, with substantial hospital-level variation. RAND Round 5.1's drug-specific finding is more directly comparable to the analytics here: commercial insurance prices for physician-administered drugs in a hospital setting averaged 281% of ASP, versus 106% of ASP paid by Medicare for the same drugs. Across the broader corpus, 340B-eligible institutions appear at the high end of negotiated-rate distributions for these codes. Provenant draws no causal inference from that. Whether dispersion reflects market power, case mix, or program incentives is the question an expert is retained to investigate.

The 340B-Drug Illustration

On the same source data, Provenant surfaces modeled 340B markup analytics. For J0881 (darbepoetin alfa, an erythropoiesis-stimulating agent used for chemotherapy-induced anemia and a supportive-care drug commonly acquired under 340B), MSK's within-hospital commercial rates reach $7,083.45 against a modeled 340B floor of $2.36 — Medicare ASP × the 0.769 statutory brand-discount factor — a modeled markup of 2,998× the modeled floor. **This figure carries the asp_unit_caveat: MSK's source MRF does not disclose drug_unit.** It is the ratio of the MRF's published rate to Medicare's published per-unit ASP; a reader reconciling unit basis would compute a different number. Provenant's discipline is to surface that question, not to assert a ratio it cannot independently verify — the figure ships with its caveat, never without. For external context, the Community Oncology Alliance's September 2022 analysis of 340B DSH hospitals reported a median commercial markup of 4.9× the assumed 340B acquisition cost, up to 11.3× for fulvestrant; that denominator is an assumed acquisition cost, not the statutory ceiling-price floor modeled here, so the figures are not directly comparable. ASCO's May 2026 updated 340B policy statement recommends that documentation of how program savings are reinvested

be made mandatory and publicly available. Provenant publishes no 340B ceiling prices, which are confidential under 42 CFR Part 10.

What Provenant Enables

- Per-row provenance to a signed, CMS-mandated public MRF (SHA-256 hash-pinned source).
- Cross-hospital rate aggregation under normalized canonical payer entities.
- Modeled 340B markup proxies gated on recomputable §340B eligibility — DSH adjustment via HCRIS Worksheet E Pt A line 4.03, or PPS-exempt cancer-hospital status under 42 CFR 412.23(d). Gated on eligibility, never on enrollment.
- Composable per-row methodology caveats (asp_unit_basis, modeled_340b_markup, brand-default assumption); no claim exceeds what its source data supports.
- Recursive cryptographic verification across the aggregation chain — every claim reproducible from a clean checkout in one command.

Limitations

The corpus is seven hospitals deep: cross-hospital roll-up density is 41 rows at four-hospital depth and 71 rows at three-hospital depth out of 278 total aggregated (canonical_payer, code) rows as of May 2026. Payer-side Transparency-in-Coverage rate ingestion is on the roadmap; payer ToC files are bot-gated and structurally blocked on a payer-access layer. Provenant does not ingest claims data, does not publish actual 340B ceiling prices, and does not infer NDC class from J-code — a brand-default assumption applies until FDA NDC-class refinement lands (roadmap, ADR 0036). The product surfaces dispersion; it does not adjudicate its cause.

How to Verify

```
oncorate-verify-pack --pubkey signing_public_key.pem <pack-directory>
```

- The public signing key ships with every pack.
- 10/10 PASS expected, including `manifest_signature`, `tier_metadata`, and `source_packs` (recursive re-verification of every contributing source pack through the aggregation chain).