

## APPENDIX 2:

### In-network Rate Machine-Readable File

#### Data Elements

The Departments of the Treasury, Labor, and Health and Human Services (the Departments) have issued the Transparency in Coverage final rules (85 FR 72158), which require non-grandfathered group health plans and health insurance issuers in the individual and group markets (plans and issuers) to disclose certain cost-sharing information. Under the final rules at 26 CFR 54.9815-2715A3(b), 29 CFR 2590.715-2715A3(b), and 45 CFR 147.212(b) a plan or issuer must disclose applicable rates for in-network providers through a machine-readable file posted on an internet website. Applicable rates may include negotiated rates, derived amounts, or underlying fee schedule rates, as defined by the final rules at 26 CFR 54.9815-2715A1, 29 CFR 2590.715-2715A1, 45 CFR 147.210. The table below identifies data elements that a plan or issuer is required to include in each machine-readable In-network Rate File.<sup>1</sup>

DATA ELEMENT	DESCRIPTION
<b>General Information</b>	
Name of Reporting Entity <sup>2</sup>	The legal name of the entity publishing the machine-readable file.
Type of Entity	The type of entity that is publishing the machine-readable file (a group health plan, health insurance issuer, or a third party with which the plan or issuer has contracted to provide the required information, such as a third-party administrator, a health care claims clearinghouse, or a health insurance issuer that has contracted with a group health plan sponsor).
Date of Last File Update	The date the machine-readable file was last updated.

<sup>1</sup> For more technical implementation guidance for this machine-readable file, please see the GitHub website space established by the Departments. GitHub is a website and cloud-based service that helps developers store and manage their code, as well as to track and control changes to their code. The GitHub space offers the Departments the opportunity to collaborate with industry, including regulated entities, and third-party developers to ensure the file format is adapted for reporting of the required public disclosure data for various plan and contracting models. The GitHub space is available at: <https://github.com/CMSgov/price-transparency-guide>.

<sup>2</sup> A plan or issuer may contract with a third party (such as a third-party administrator, a health care claims clearinghouse, or a health insurance issuer that has contracted with a group health plan sponsor) to satisfy the disclosure requirements, subject to the requirements in the final rules.

DATA ELEMENT	DESCRIPTION
<b>Identification of Plan or Coverage</b>	
Plan or Coverage Name	The plan name and name of plan sponsor and/or insurance company (for example, “Maximum Health Plan: Alpha Insurance Group”).
Plan Identifier	The 10-digit Health Insurance Oversight System (HIOS) identifier, or, if the 10-digit HIOS identifier is not available, the 5-digit HIOS identifier, or if no HIOS identifier is available, the Employer Identification Number (EIN) for each coverage option offered by a plan or issuer.
Type of Plan Identifier	EIN or HIOS ID, as applicable.
Type of Plan Market	The type of market in which the plan is offered (individual or group market coverage).
<b>Identification of Providers and Place of Service</b>	
Individual Provider Identifier	<i>The National Provider Identifier (NPI) Type 1<sup>3</sup></i> - The unique 10-digit identification number issued to a provider by the Centers for Medicare & Medicaid Services (CMS) to identify individual health care providers.
Provider Group Identifier <i>(Required if the in-network provider is a group organization)</i>	<i>The NPI Type 2<sup>4</sup></i> - The unique 10-digit identification number issued to a provider by CMS for an organization of health care providers, such as a medical group.

<sup>3</sup> <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPI-What-You-Need-To-Know.pdf> <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPI-What-You-Need-To-Know.pdf>.

<sup>4</sup> *Ibid.*

<b>DATA ELEMENT</b>	<b>DESCRIPTION</b>
Tax Identification Number (TIN)	The unique identification number issued either by the Social Security Administration or by the Internal Revenue Service (IRS).
Place of Service Code <sup>5</sup>	The CMS-maintained two-digit code that is placed on a professional claim to indicate the setting in which a service was provided.
<b>Applicable In-network Rates</b>	
Negotiated Rate for each Covered Item or Service	If applicable, the negotiated rate, reflected as a dollar amount, for each covered item or service under the plan or coverage that the plan or issuer has contractually agreed to pay an in-network provider, except for prescription drugs that are subject to a fee-for-service reimbursement arrangement, which must be reported in the prescription drug machine-readable file. If the negotiated rate is subject to change based upon participant, beneficiary, or enrollee-specific characteristics, these dollar amounts should be reflected as the base negotiated rate applicable to the item or service prior to adjustments for participant, beneficiary, or enrollee-specific characteristics.
Contract Term for Negotiated Rate for each Covered Item and Service	The last date of the contract term for each provider-specific negotiated rate that applies to each covered item or service, including rates for both individual items and services and items and services in a bundled payment arrangement.
Derived Amount for each Covered Item or Service	If applicable, the price that a plan or issuer assigns to an item or service for the purpose of internal accounting, reconciliation with providers or submitting data in accordance with the requirements of 45 CFR 153.710(c).

<sup>5</sup> “Place of Service Code Set.” CMS. Available at: [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set).

<b>DATA ELEMENT</b>	<b>DESCRIPTION</b>
Contract Term for Derived Amount for each Covered Item or Service	The last date of the contract term for each provider-specific derived amount rate that applies to each covered item or service, including rates for both individual items and services and items and services in a bundled payment arrangement.
Underlying Fee Schedule Rate for each Covered Item or Service	If applicable, the rate for a covered item or service from a particular in-network provider, or providers that a group health plan or health insurance issuer uses to determine a participant's, beneficiary's, or enrollee's cost-sharing liability for the item or service, when that rate is different from the negotiated rate.
Contract Term for Underlying Fee Schedule Rate for each Covered Item or Service	The last date of the contract term for each provider-specific underlying fee schedule rate that applies to each covered item or service, including rates for both individual items and services and items and services in a bundled payment arrangement.
<b>Identification of Items and Services</b>	
Billing Code	The code used by a plan or issuer or its in-network providers to identify health care items or services for purposes of billing, adjudicating, and paying claims for a covered item or service.
Type of Billing Code	The types of billing codes include the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis-Related Group (DRG) code, National Drug Code (NDC), or other common payer identifiers.
Billing Code Type Version	Any version designation associated with the billing code type. For example, Medicare is currently using the International Classification of Diseases (ICD) version 10.
Payment Arrangement Indicator	An indication as to whether a reimbursement arrangement other than a standard fee-for-service model (such as capitation or a bundled payment arrangement) applies.

<b>DATA ELEMENT</b>	<b>DESCRIPTION</b>
Covered Items and Services	The name of each item or service for which the costs are payable, in whole or in part, under the terms of the plan or coverage.
Plain Language Description	Brief description of the item or service. In the case of items and services that are associated with common billing codes (such as the HCPCS codes), the code's associated short text description may be provided. In the case of NDCs for prescription drugs, the plain language description must be the proprietary and nonproprietary names assigned to the NDC by the Food and Drug Administration (FDA).

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The Departments are seeking OMB approval for the model as part of the approval for a new OMB control number 0938-1372. The time required to complete this information collection is estimated to average of 3,199 hours per respondent, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.