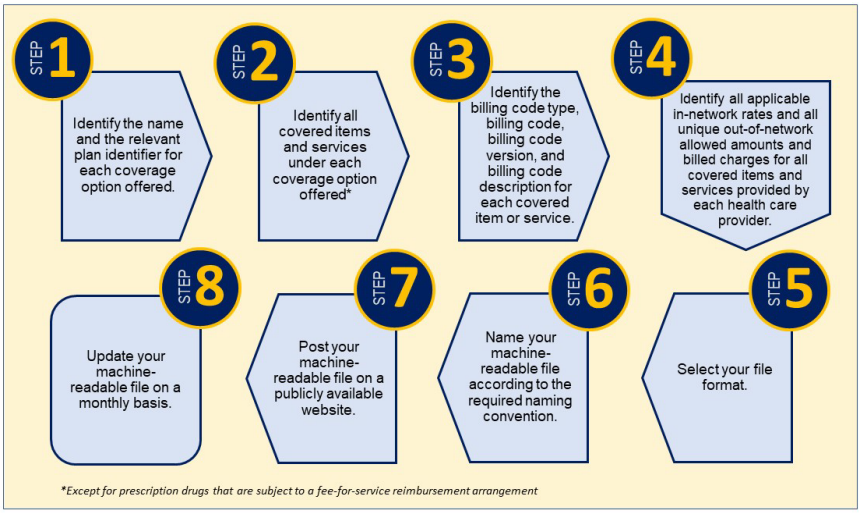
8 Steps to an In-Network Rate and an Out-of-Network Allowed Amount Machine-Readable File[1, 2, 3]

Starting July 1, 2022,[4] the Departments of Labor, Health and Human Services, and Treasury (the Departments) will begin enforcement of the requirement for non-grandfathered health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets to make available on an internet website machine-readable files providing information regarding: (1) in-network provider rates for covered items and services, and (2) out-of-network allowed amounts and billed charges for covered items and services.[5] The machine-readable files must meet the requirements set forth in the Transparency in Coverage Final Rules that appeared in the November 12, 2020 edition of the Federal Register, referred to in this document as the "TiC Final Rules."[6] These Rules implement section 1311(e)(3) of the Patient Protection and Affordable Care Act (Pub. L. 111-148) and section 2715A of the Public Health Service Act. Technical implementation guidance for each of the machine-readable files is available through GitHub—an online collaborative hosting platform for development and source code management.

Figure 1. 8 Steps to an In-Network Rate and an Out-of-Network Allowed Amount Machine-Readable File

This document lays out 8 steps (**Figure 1**) to meeting the requirements for the In-Network Rate and the Out-of-Network Allowed Amount machine-readable files.



[1] The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.
[2] This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.
[3] The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.
[4] Under the TiC Final Rules, the machine-readable file requirements are applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2022. However, as an exercise of enforcement discretion, enforcement of the TiC Final Rules' requirement to publish these machine-readable files was deferred until July 1, 2022. *See* FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49, Q2 (Aug. 20, 2021), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf.
[5] The Departments released guidance indicating that, as an exercise of enforcement discretion, enforcement of the TiC Final Rules' requirement that plans and issuers publish machine-readable files relating to prescription drug pricing will be deferred pending further rulemaking. *See* FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49, Q1 (Aug. 20, 2021), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf.
[6] 85 FR 72158 (Nov. 12, 2020).

STEP 1 Identify the name and the relevant plan identifier for each coverage option offered.

For both the In-Network Rate and Out-of-Network Allowed Amount machine-readable files, plans and issuers should start by identifying both the name and the plan identifier for each coverage option offered. The identifier must be one of the following:[7]

(1) If there is a 10-digit Health Insurance Oversight System (HIOS) identifier, this should be used.
(2) If there is no 10-digit identifier, use the 5-digit HIOS identifier.
(3) If there is no HIOS identifier, use the EIN.

STEP 2 Identify all covered items and services under each coverage option offered (except for prescription drugs that are subject to a fee-for-service reimbursement arrangement).

Once you have identified all coverage options (plans and products) offered, identify all items and services covered by those coverage options (except for prescription drugs that are subject to a fee-for-service reimbursement arrangement).[8] "Covered items and services" means those items and services the costs for which are payable, in whole or in part, under the terms of a group health plan or health insurance coverage.[9] "Items and services" are defined as all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees), provided or assessed in connection with the provision of health care.[10]

Next, for each covered item and service, including each bundled payment arrangement,[11] identify the billing code used by the plan (including the billing code type and version, if applicable) as well as a plain language description for each billing code. The TiC Final Rules require that plans and issuers associate each amount required to be reported with a billing code.[12]

STEP 3 Identify the billing code type, billing code, billing code version, and billing code description for each covered item or service.

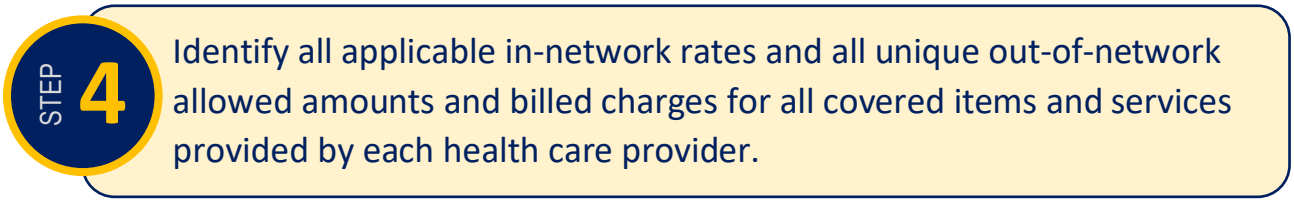
[7] 26 CFR 54.9815-2715A3(b)(1)(ii)(A) and (iii)(A); 29 CFR 2590.715-2715A3(b)(1)(ii)(A) and (iii)(A); 45 CFR 147.212(b)(1)(ii)(A) and (iii)(A). *See* also supporting documentation for the information collection approved under OMB Control Number 0938-1372 (CMS-10715, Transparency in Coverage Appendix), available at: https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10715.
[8] 26 CFR 54.9815-2715A3(b)(1)(i); 29 CFR 2590.715-2715A3(b)(1)(i); 45 CFR 147.212(b)(1)(i).
[9] 26 CFR 54.9815-2715A1(a)(2)(ix); 29 CFR 2590.715-2715A1(a)(2)(viii); 45 CFR 147.210(a)(2)(viii).
[10] 26 CFR 54.9815-2715A1(a)(2)(xiii); 29 CFR 2590.715-2715A1(a)(2)(xii); 45 CFR 147.210(a)(2)(xiii).
[11] 85 FR 72158; 72227. Under bundled payment arrangements, plans and issuers may reimburse a provider for multiple items and services under a single billing code.
[12] 26 CFR 54.9815-2715A3(b)(1)(i)(B); 29 CFR 2590.715-2715A3(b)(1)(i)(B); 45 CFR 147.212(b)(1)(i)(B).

The billing code is the code used by the plan or issuer to identify an item or service for the purposes of billing, adjudicating, and paying claims for a covered item or service.[13] Plans and issuers may use a mixture of billing code types to identify covered items and services so long as the billing codes included in the files are consistent with the billing codes plans and issuers use in their operations for the purposes of billing, adjudicating, and paying claims.[14]

A "billing code" could include the CPT code, HCPCS code, DRG code, NDC (note that for prescription drugs, the billing code must be an NDC[15]), *"or other common payer identifier."*[16] When a covered item or service does not have a corresponding code, a plan or issuer is permitted to choose its own indicator or other method to communicate to the public that there is no corresponding code.[17]

To facilitate identification of the billing code type, there is an indicator in the file schemas that allows plans and issuers to select the appropriate type of billing code for each item or service from a list of possible allowed values. The current list of possible allowed values for the billing code type is set forth in the table here. For billing code types that are not in this table, you may open a discussion on GitHub to suggest a new standard for the table. Information and updates regarding the inclusion of billing codes and billing code types in the file schemas can be found at this GitHub discussion on documenting different types of billing codes for negotiated rates.

Plans and issuers are also required to include a plain language description for each billing code reported. "Plain language" means written and presented in a manner calculated to be understood by the average participant, beneficiary, or enrollee.[18] In the case of items and services that are associated with common billing codes (such as HCPCS codes), plans and issuers are permitted to use the codes' associated short text description.



Once you have identified all covered items and services (Step 2) and related billing code information (Step 3), identify all applicable in-network rates and out-of-network allowed amounts and billed charges to be included in each file.

[13] 26 CFR 54.9815-2715A1(a)(2)(iv); 29 CFR 2590.715-2715A1(a)(2)(iii); 45 CFR 147.210(a)(2)(iii).
[14] 85 FR 72158, 72241.
[15] 26 CFR 54.9815-2715A3(b)(1)(i)(B); 29 CFR 2590.715-2715A3(b)(1)(i)(B); 45 CFR 147.212(b)(1)(i)(B), (b)(1)(ii)(B); 85 FR 72158, 72222. Prescription drug products must be included in the In-Network Rate File to the extent a plan or issuer uses an alternative payment arrangement, such as a bundled payment arrangement, that includes prescription drugs.
[16] 26 CFR 54.9815-2715A1(a)(2)(iv); 29 CFR 2590.715-2715A1(a)(2)(iii); 45 CFR § 147.210(a)(2)(iii).
[17] 85 FR 72158, 72223.
[18] 26 CFR 54.9815-2715A1(a)(2)(xx); 29 CFR 2590.715-2715A1(a)(2)(xix); 45 CFR 147.210(a)(2)(xx).

In-Network Rate File	Out-of-Network Allowed Amount File
Plans and issuers must disclose all applicable rates[19] for covered items and services provided by in-network providers.[20] To do this, plans and issuers should start by gathering information from their **provider contracts, rate sheets, or other files regarding their applicable rates** with in-network providers for covered items and services (see discussion below regarding the types of applicable rates).	Plans and issuers must disclose unique out-of-network allowed amounts and associated billed charges for covered items or services furnished by out-of-network providers[21] during the 90-day time period that begins 180 days prior to the publication date of the Allowed Amount file.[22] To obtain these amounts, plans and issuers will need to **access historical claims** for items and services furnished by out-of-network providers during the period referenced above. "Out-of-network allowed amount" means the maximum amount a plan or issuer will pay for a covered item or service furnished by an out-of-network provider.[23] "Billed charge" means the total charges for an item or service billed to a plan or issuer by a provider.[24]

Next, for each amount specified above (that is, each in-network rate and each out-of-network allowed amount and billed charge), you will need to identify the relevant provider and location where the item or service was provided. To do this, each in-network rate and each out-of-network allowed amount and billed charge must be associated with the following three data elements:[25]

1. National Provider Identifier (NPI),
2. Taxpayer Identification Number (TIN), and
3. Place of Service (POS) Code for a particular provider where the reported rates or allowed amounts are based on professional claims.

***Note** that POS Codes are required to be reported on professional health care claims. If the rate or allowed amount reported for an item or service is not based on a professional claim, but instead on a facility claim, the POS Code is optional and should only be included when the rate or allowed amount is dependent on the place of service.*[26]

[19] 26 CFR 54.9815-2715A3(b)(1)(i)(C); 29 CFR 2590.715-2715A3(b)(1)(i)(C); 45 CFR 147.212(b)(1)(i)(C).
[20] 26 CFR 54.9815-2715A1(a)(2)(xii); 29 CFR 2590.715-2715A1(a)(2)(xi); 45 CFR 147.210(a)(2)(xii). "In-network provider" means any provider of any item or service with which a group health plan or health insurance issuer, or a third party for the plan or issuer, has a contract setting forth the terms and conditions on which a relevant item or service is provided to a participant, beneficiary, or enrollee.
[21] 26 CFR 54.9815-2715A1(a)(2)(xviii); 29 CFR 2590.715-2715A1(a)(2)(xvii); 45 CFR 147.210(a)(2)(xviii). "Out-of-network provider" means a provider of any item or service that does not have a contract under a participant's, beneficiary's, or enrollee's group health plan or health insurance coverage to provide items or services.
[22] 26 CFR 54.9815-2715A3(b)(1)(ii)(C); 29 CFR 2590.715-2715A3(b)(1)(ii)(C); 45 CFR 147.212(b)(1)(ii)(C).
[23] 26 CFR 54.9815-2715A1(a)(2)(xvii); 29 CFR 2590.715-2715A1(a)(2)(xvi); 45 CFR 147.210(a)(2)(xvii).
[24] 26 CFR 54.9815-2715A1(a)(2)(iii); 29 CFR 2590.715-2715A1(a)(2)(ii); 45 CFR 147.210(a)(2)(ii).
[25] 26 CFR 54.9815-2715A3(b)(1)(i)(C)(*2*) and (b)(1)(ii)(C)(*2*); 29 CFR 2590.715-2715A3(b)(1)(i)(C)(*2*) and (b)(1)(ii)(C)(*2*); 45 CFR 147.212(b)(1)(i)(C)(*2*) and (b)(1)(ii)(C)(*2*).
[26] The schema field "service_code" is defined as "the CMS-maintained two-digit code that is placed on a professional claim to indicate the setting in which a service was provided. When attribute of billing_class has the value of "professional", service_code is required." *See* Negotiated Price Object documentation, available at https://github.com/CMSgov/price-transparency-guide/tree/master/schemas/in-network-rates#negotiated-price-object.

For situations in which a provider uses their Social Security Number (SSN) as their TIN for both negotiated rates and claims adjudication, the provider's NPI should be reported as the TIN in place of the SSN.[27] Plans and issuers may obtain the NPI, TIN, and POS Code from rate sheets and contracts maintained with in-network providers or from submitted claims. For example, the POS Code must be included on professional medical claims. *In addition, we note that there are several internet-based NPI lookup tools available online, including CMS's National Plan & Provider Enumeration System (NPPES) NPI registry*.

An example of reporting the NPI, TIN, and POS code can be found here on GitHub.

In-Network Rate File

For the **In-Network Rate file**, plans and issuers are required to include all applicable rates for all covered individual items and services, as well as items and services included in bundled payment arrangements, that are furnished by an in-network provider (as identified by NPI, TIN, and POS Code). This requirement applies to all plans and issuers regardless of the reimbursement model(s) they use—that is, plans and issuers that reimburse providers on a basis that is different from a standard fee-for-service model are still required to report applicable rates for all covered items and services furnished by in-network providers.[28] Plans and issuers must report one or more of the following rates, as applicable, in the file for each covered item or service (or bundle of items and services) furnished by an in-network provider:[29]

- **Negotiated rates**: A "negotiated rate" is the amount a plan or issuer has contractually agreed to pay an in-network provider for covered items and services, whether directly or indirectly (including through a third-party administrator or pharmacy benefit manager).[30] This requirement includes negotiated rates for individual items or services and for bundles of items and services. Negotiated rates must also be reported for alternative payment arrangements, as applicable.[31] Information on how to display alternative payment arrangements can be found on GitHub, including percentage-of-billed charges arrangements[32]and per diem arrangements.
- **Derived amounts**: In some instances, negotiated rates are not used for provider reimbursement. For example, this may be the case where a plan or issuer uses a capitated reimbursement arrangement where a specific negotiated rate is not available for a particular item or service (for instance, a sole capitation arrangement, such as a staff model Health Maintenance Organization (HMO) under which services are provided by in-network salaried providers). If a plan or issuer does not use a negotiated rate for provider reimbursement, it should report any derived amounts it has assigned to the items or

[27] Technical Clarification Questions and Answers, Question #13, available at https://www.cms.gov/healthplan-price-transparency/resources/technical-clarification.
[28] 85 FR 72158, 72226.
[29] 26 CFR 54.9815-2715A3(b)(1)(i)(C); 29 CFR 2590.715-2715A3(b)(1)(i)(C); 45 CFR 147.212(b)(1)(i)(C).
[30] 26 CFR 54.9815-2715A1(a)(2)(xvi); 29 CFR 2590.715-2715A1(a)(2)(xv); 45 CFR 147.210(a)(2)(xvi).
[31] 85 FR 72158, 72227.
[32] The Departments are providing an enforcement safe harbor for satisfying the reporting requirements for plans and issuers that use alternative reimbursement arrangements that do not permit the plans and issuers to derive with accuracy specific dollar amounts contracted for covered items and services in advance of the provision of that item or service, or that otherwise cannot disclose specific dollar amounts according to the schema. *See* FAQS About Affordable Care Act Implementation, Part 53 (April 19, 2022), available at https://www.cms.gov/files/document/faqs-part-53.pdf and https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-53

services.[33] A "derived amount" is 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).[34] These prices, or derived amounts, should be disclosed in the In-Network Rate file in lieu of negotiated rates if these amounts are already calculated in the normal course of business.

- **Underlying Fee Schedule Rate**: Under some reimbursement models, one set of negotiated rates is used for provider reimbursement (or comparable derived amounts are used for internal accounting purposes in lieu of negotiated rates), and another set of rates is used for determining cost-sharing (which is referred to here as the underlying fee schedule rate). An "underlying fee schedule rate" is the rate for a covered item or service from a particular in-network provider that a plan or 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 or derived amount*.[35] If the plan or issuer uses underlying fee schedule rates for calculating cost-sharing, then the plan or issuer should include the underlying fee schedule rate in the file *in addition to* the negotiated rate or derived amount. So, if a plan or issuer has a negotiated rate or a derived amount but does not also use that applicable rate to determine consumer cost-sharing liability, then the plan or issuer must publicly disclose both the **negotiated rate or derived amount and the underlying fee schedule rate** used to determine cost-sharing liability.[36]

Further information regarding how these applicable rates should be reflected in the In-Network Rate file can be found on GitHub here.

For **bundled payment arrangements**, plans and issuers should provide a negotiated rate (or comparable derived amount) for the single billing code associated with the bundled arrangement and list the items and services that are included in the bundle. If a negotiated rate (or comparable derived amount) exists for each item or service in the bundle, the file should include both the rate for the total bundle and the respective negotiated rates (or derived amounts) for all covered items and services included in the bundle.[37]

In addition, each applicable rate (whether it is a negotiated rate, derived amount, or underlying fee schedule rate) must be:[38]

- **Reflected in the file as a dollar amount** with respect to each covered item or service that is furnished by an in-network provider (except as provided below). If the negotiated rate is subject to change based upon certain patient characteristics (such as age, gender, or co-morbidities) or other factors (such as quality or value-based weighting factors) the dollar amount should be reflected as the **base negotiated rate** for an item or service prior to adjustments for such factors.[39] If the negotiated rate is **based on a percentage of billed charges** as discussed above, the negotiated percentage should be entered into the Negotiated Price Object and reflected as a whole number (for example, 35.7% would be reported as 35.7, not .357). If the negotiated rate is **based on a formula that otherwise**

[33] 26 CFR 54.9815-2715A3(b)(1)(i)(C); 29 CFR 2590.715-2715A3(b)(1)(i)(C); 45 CFR 147.212(b)(1)(i)(C); 85 FR 72158, 72226-72228.
[34] 26 CFR 54.9815-2715A1(a)(2)(x); 29 CFR 2590.715-2715A1(a)(2)(ix); 45 CFR 147.210(a)(2)(ix). *See also* 45 CFR 153.710(c), which sets forth a process through which capitated plans that do not generate individual enrollee claims in the normal course of business must submit data for the purpose of the HHS-operated risk adjustment program.
[35] 26 CFR 54.9815-2715A1(a)(2)(xxii); 29 CFR 2590.715-2715A1(a)(2)(xxi); 45 CFR 147.210(a)(2)(xxii).
[36] 26 CFR 54.9815-2715A3(b)(1)(i)(C); 29 CFR 2590.715-2715A39(b)(1)(i)(C); 45 CFR 147.212(b)(1)(i)(C); 85 FR 72158, 72227.
[37] 85 FR 72158, 72227-72228.
[38] 26 CFR 54.9815-2715A3(b)(1)(i)(C); 29 CFR 2590.715-2715A3(b)(1)(i)(C); 45 CFR 147.212(b)(1)(i)(C).
[39] 26 CFR 54.9815-2715A3(b)(1)(i)(C); 29 CFR 2590.715-2715A3(b)(1)(i)(C); 45 CFR 147.212(b)(1)(i)(C); 85 FR 72158, 72228. Note that it is a best practice to include a disclaimer noting that the rate could change subject to patient-specific characteristics or other factors.

does not generate a base rate or other set dollar amount that can be reflected in the file, an open text field is provided in the Negotiated Price Object "additional information" to describe the alternative payment arrangement or provide additional contextual information describing the negotiated arrangement. GitHub has further guidance.

- Associated with the NPI, TIN, and POS Code for each in-network provider (see additional discussion above);
- Associated with the last date of the contract term or expiration date for each provider-specific applicable rate that applies to each covered item or service; and
- Accompanied by a notation where a reimbursement arrangement other than a standard fee-for-service model applies (such as capitation or a bundled payment arrangement). Further information regarding how to note this in the file is set forth in the documentation found on GitHub here with an example here.

Out-of-Network Allowed Amount File

The **Allowed Amount file** must include each unique out-of-network allowed amount and associated billed charge for each covered item or service furnished by a particular out-of-network provider (identified by NPI, TIN, and POS Code) during a defined historical period—specifically, during the 90-day time period that begins 180 days prior to the publication date of the machine-readable file.[40] Plans and issuers will need to pull allowed amounts and billed charges from claims for items and services furnished during the period referenced above. *Note that a plan or issuer is only required to include this information in the file if it has adjudicated the claim and determined that it will pay the allowed amount for the items or services furnished by the out-of-network provider.*[41]

After you identify each unique out-of-network allowed amount and associated billed charges for the relevant historical period as described above, to address privacy concerns, you must then omit data related to a particular item or service (identified by billing code, as discussed in Step 3) when there are fewer than 20 different claims for payment associated with such item or service's billing code under a single plan or coverage.[42] Note that if a claim includes a billing code modifier, the 20-claim threshold should be applied at the base billing code level, without taking into account the modifier.[43]

Each unique allowed amount included in the file must be:[44]

- reflected as a dollar amount, and
- associated with the NPI, TIN, and potential POS Code for each out-of-network provider.

Thus, the unique allowed amount (and associated billed charges) reported in the file must be a dollar amount associated with the particular covered item or service (identified by billing code) and the

STEP 5 Select your file format.

[40] 26 CFR 54.9815-2715A3(b)(1)(ii)(C); 29 CFR 2590.715-2715A3(b)(1)(ii)(C); 45 CFR 147.212(b)(1)(ii)(C).
[41] 85 FR 72158, 72232.
[42] 26 CFR 54.9815-2715A3(b)(1)(ii)(C); 29 CFR 2590.715-2715A3(b)(1)(ii)(C); 45 CFR 147.212(b)(1)(ii)(C).
[43] Technical Clarification Questions and Answers, Question #23, available at https://www.cms.gov/healthplan-price-transparency/resources/technical-clarification.
[44] 26 CFR 54.9815-2715A3(b)(1)(ii)(C)(*1*) and (*2*); 29 CFR 2590.715-2715A3(b)(1)(ii)(C)(*1*) and (*2*); 45 CFR 147.212(b)(1)(ii)(C)(*1*) and (*2*).

particular out-of-network provider that furnished the item or service (identified by NPI, TIN, and POS Code).

The machine-readable files must conform to a non-proprietary, open-standards format that is platform independent and made available to the public without restrictions that would impede the re-use of the information.[45]

"Machine-readable file" is defined by the TiC Final Rules as a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost.[46]

The required file schema and implementation examples for both machine-readable files can be found on GitHub. Currently, the schemas on GitHub are XML and JSON files, which are acceptable file formats. Microsoft Word, Microsoft Excel, and PDF files are proprietary and are not acceptable. If a format other than JSON or XML is selected, that format must still adhere to the defined schema on GitHub. The JSON schema can be used as a reference. Producers of the machine-readable files should consider the strengths and weaknesses of different file formats that meet the TiC requirements and select the appropriate one for their organization. A downloadable Validator Tool has been developed for file producers to assess whether their JSON files are compliant with the schema. The tool does not validate the accuracy of the data *itself*, just that it is expressed in the proper format.

Schema version 1.0 was finalized on March 1, 2022. Your files must comply with version 1.0 as of July 1, 2022. Further schema issues raised on GitHub post March 1, 2022 may be considered to allow for the continuation of development. Therefore, there is the possibility for the schema to have a version 1.1, 1.2, etc. These updates would be the latest iterations developers can use to produce files, **but files conforming to schema 1.0 on July 1, 2022 will be considered compliant.**

File schema specifications can be found here: https://github.com/CMSgov/price-transparency-guide/tree/master/schemas. You can click on either the allowed-amounts or in-network-rates to view the file's schema.

Examples for both the In-Network Rate and Out-of-Network Allowed Amount files can be found here: https://github.com/CMSgov/price-transparency-guide/tree/master/examples

Name your machine-readable file according to the required naming convention.

Plans and issuers must use the specified naming convention, which will help interested entities more easily locate and identify the machine-readable file. You have the option to build the In-Network Rate and Out-of-Network Allowed Amount files for a single plan or to group multiple plans together in the same file if they have the same negotiated rate data.[47] The naming convention is different for single plan files versus multiple plan files.

[45] 85 FR 72158, 72242.
[46] 26 CFR 54.9815-2715A1(a)(2)(xiv); 29 CFR 2590.715-2715A1(a)(2)(xiii); 45 CFR 147.210(a)(2)(xiv).
[47] File Naming Convention documentation, available at https://github.com/CMSgov/price-transparency-guide#file-naming-convention.

Single Plan Files

If a single plan is included in the machine-readable file, plans and issuers must use the following naming convention to name the file: <YYYY-MM-DD>_<payer or issuer name>_<plan name>_<file type name>.<file extension>.

- <YYY-MM-DD>: The date the file was produced
- <payer or issuer name>: Name of the payer or issuer
- <plan name>: Name of the plan
- <file type name>: Enter either "in-network-rates" or "allowed-amounts" to specify the file type, as applicable
- <file extension>: Your chosen file format (e.g., JSON)

For example, the following would be the required file name for a plan named "healthcare 100" with an issuer's name "issuer abc" producing a JSON file:

- 2022-07-05_issuer-abc_healthcare-100_in-network-rates.json
- 2022-07-05_issuer-abc_healthcare-100_allowed-amounts.json

For payer or issuer names that have spaces, those spaces should be replaced with dashes (–).
Only alphanumeric characters are allowed in the file name (no special characters such as ' are allowed).
Special characters are either to be removed completely or replaced with a dash (–).

Multiple Plan Files

You may report multiple plans together in a single file if the negotiated rates for all the items and services are exactly the same for all the providers across the different products. If you choose to report multiple plans in a single file, you must create a Table of Contents file (also known as an "index") that combines the plans and references the locations from which the appropriate files for the plans can be downloaded. The naming standard for the Table of Contents file is <YYYY-MM-DD>_<payer or issuer name>_index.<file extension>. For example, the following would be the required name for "issuer abc" building a JSON file that includes all its plans:

- 2022-07-05_issuer-abc_index.json

The individual In-Network Rate and Out-of-Network Allowed Amount files linked to the Table of Contents file need not follow a defined naming convention.

Again, for plan or issuer names that have spaces, those spaces should be replaced with dashes (–). Only alphanumeric characters are allowed in the file name (no special characters such as ' are allowed). Special characters are either to be removed completely or replaced with a dash (–).

Plans may also use the Table of Contents file to report aggregated allowed amount data in the Allowed Amount file across multiple plans. More information and an example of the aggregation reporting requirements can be found here.

More information regarding the Table of Contents file can be found here. Additional file naming documentation can be found here.

STEP 7 Post your machine-readable file on a publicly available website.

Each file must be posted on a publicly-available "https" website and accessible to any person free of charge and without conditions, such as the establishment of a user account, password, or other credentials, or submission of personally identifiable information, such as name, email address, or telephone number, to access the file.[48]

STEP 8 Update your machine-readable files on a monthly basis.

Plans and issuers are required to update the machine-readable files monthly and populate the attribute last_updated_on. The Departments consider "monthly" to refer to reasonably consistent periods of approximately 30 days, but are not specifying a particular day of the month.[49]

[48] 26 CFR 54.9815-2715A3(b)(2); 29 CFR 2590.715-2715A3(b)(2); 45 CFR 147.212(b)(2); 85 FR 72158, 72242.
[49] Timing Updates for Machine-readable Files, available at https://github.com/CMSgov/price-transparency-guide/blob/7c512ad2610990797bc6adc49563ab4a9d1b9b06/README.md#timing-updates-for-machine-readable-files.