**Data Request for Round 5 of the RAND Hospital Price Transparency Study**

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**List of Key Reminders**

Please **do not** send the following:

* Data for members that are eligible for any Medicare or Medicaid plan, even if they are enrolled in a commercially managed plan
* Social security numbers, patient names, or any personally identifiable information- we are required to immediately destroy data that comes to us with PII
* Data for years prior to 2018. Anything before 2018 will be discarded. For Round 5 of the study, we will focus on the three year time period 1/1/2020 through 12/31/2022 This is a new stipulation, but due to the volume of data we are processing, we can only process data for)

Data fields, **please include:**

* Plan type code or Medicare/Medicaid eligibility indicator
* Product type code
* Inpatient data that contains either:
  + Valid ICD procedure codes **or**
  + Valid DRG codes
* APCDs only: Please include a self-insured or fully-insured indicator
* All data must include variable names on the first line or specific column pointers and definitions - Please include data dictionary

File transfers:

* First time data contributors are strongly encouraged to use RAND’s Kiteworks platform to submit data
* Data should be compressed to a max file size of 1 GB (split into as many files as needed for smooth transfer)
* If submitting delimited files, we prefer pipe- or tab- over comma-delimited, unless strings are fully enclosed in quotation marks

**Attachment A:** **Summary of Required Variables**

In the full table (below), we list all the variables requested for this study. A subset of this list (the below bullets) arethe **absolutely essential** variables. In other words, if any of the following bulleted variables are missing, we cannot use the data at all.

* **Claim ID - A unique medical claim identifier assigned by claims processor**
* **Member ID or “PATIENT IDENTIFIER”, usually encrypted and assigned by claims processor. This identifier must be unique to each individual member, it must uniquely identify a member throughout the entire submission (i.e. across years). This field must not be an unencrypted social security number.**
* **Allowed Amount (or Paid + Deductible + Copay + Coinsurance) The contracted reimbursable amount for covered medical services or supplies or amount reflecting local methodology for non-contracted providers**
* **From and To date of service**
* **CPT – The 5 character code for the medical procedure a patient received from a health care provider. Current coding methods include: CPT-4 and HCFA Common Procedure Coding System Level II - (HCPCS-II).**
* **Place of Service (POS) - Identify the setting, using a place of service code, for each item used or service performed. Usually this is a 2 digit numeric code as described here:** [**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)

**This variable is sometimes named “CMS place of service” or “facility type”.**

* **Bill type – Field 4 of the UB-04 Type of Bill**
* **Diagnosis code(s) – Primary and other ICD-10 diagnosis codes**
* **Servicing NPI or TIN - The National Provider Identifier (NPI) assigned to the Rendering Provider. This is the lowest level of provider available (for example, if both individual and group are available, then the individual should be provided). Federal tax identification number (TIN) or employer identification number (EIN) of the provider may also be used. TIN may be omitted if the claim is a professional claim and the provider has indicated that the TIN is an SSN. We would prefer to have both the billing and servicing NPI, and both the billing and servicing TIN, but we must have at least 1.**
* **ICD procedure code(s) - Primary and other ICD-10 procedure codes**
* **Revenue code – The 4 character code used on the UB-92 (Form Locator 42) to identify a specific accommodation, ancillary service, or billing calculation related to the service being billed. The code can identify the cost center in the institution where inpatient care was provided, for example: physical therapy, surgery, room and board.**
* **The patient’s age or date of birth. Exact DOB not necessary, can be year of birth at a minimum.**
* **Patient sex**
* **Patient discharge status – The hospital discharge status code**
* **Both facility and professional claims**

**Billed Amount (aka Total Charges, Field 47 of UB-04, Item 24F of CMS-1500) is also extremely helpful (but not absolutely required).**

**Attachment A: Complete List of Requested Data Fields**

| **COLUMN NAME** | ***Column Description*** | ***Notes*** | ***Considered PHI? (blank = no) (if yes, this field will be processed and removed in first step in processing)*** | ***UB-04 field (if applicable)*** | ***CMS-1500 item (if applicable)*** |
| --- | --- | --- | --- | --- | --- |
| Claim ID | *A unique medical claim identifier.* | *Assigned by claims processor* |  |  |  |
| Type of claim | *Indicator for facility claim or professional claim. Facility claims are submitted using the UB-04 layout, professional claims are submitted using the CMS-1500 layout.* | *Assigned by claims processor* |  |  |  |
| Servicing Provider Name | *Either the concatenated Individual Provider First and Last Name of the servicing provider (for professional claims) or the Provider Organization Full Name of the servicing provider (for facility claims)* |  |  | *Field 1* | *Item 32* |
| Servicing Provider Street Address | *Street address of the servicing provider* |  |  | *Field 1* | *Item 32* |
| Servicing Provider City | *City of the servicing provider* |  |  | *Field 1* | *Item 32* |
| Servicing Provider State | *State of the servicing provider (2-character postal abbreviation)* |  |  | *Field 1* | *Item 32* |
| Servicing Provider Zip | *Zip code of the servicing provider* |  |  | *Field 1* | *Item 32* |
| Billing Provider Name | *Either the concatenated Individual Provider First and Last Name of the billing provider (for professional claims) or the Provider Organization Full Name of the billing provider (for facility claims)* |  |  | *Field 2* | *Item 33* |
| Billing Provider Address | *Street address of the billing provider* |  |  | *Field 2* | *Item 33* |
| Billing Provider City | *City of the billing provider* |  |  | *Field 2* | *Item 33* |
| Billing Provider State | *State of the billing provider (2-character postal abbreviation)* |  |  | *Field 2* | *Item 33* |
| Billing Provider Zip | *Zip code of the billing provider* |  |  | *Field 2* | *Item 33* |
| UB04 Type of bill | *Only available for facility claims. TYPE OF BILL CODE is a four-digit alphanumeric code that gives three specific pieces of information after a leading zero. CMS will ignore the leading zero. CMS will continue to process three specific pieces of information. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.* |  |  | *Field 4* |  |
| TIN | *Federal tax identification number (TIN)/employer identification number (EIN) of provider* | *Omit if the claim is a professional claim and the provider has indicated that the TIN is an SSN* |  | *Field 5* | *Item 25* |
| Statement covers period from date | *CLAIM STATEMENT FROM DATE represents the earliest date of service of the claim.* |  | *yes* | *Field 6* |  |
| Statement covers period through date | *CLAIM STATEMENT TO DATE represents the last date of service of the claim* |  | *yes* | *Field 6* |  |
| Pay-to ID | *PROVIDER IDENTIFIER assigned by claims processor* | *If claims processor has a billing provider ID (other than NPI or TIN), then please include here.* |  |  |  |
| Patient identifier (encrypted) | *PATIENT IDENTIFIER assigned by claims processor* |  |  |  |  |
| Medicare Eligibility Indicator | *Indicates if the member was eligible for Medicare at the time of service* | *Assigned by claims processor* |  |  |  |
| Patient birth date | *SOURCE MEMBER BIRTH DATE is the date the Member was born, as it exists in the system of record.* |  | *yes* | *Field 10* | *Item 3* |
| Patient sex | *SOURCE MEMBER GENDER CODE is a code which defines the gender / sex of an individual, as it exists in the System of Record.* |  |  | *Field 11* | *Item 3* |
| Admission date | *ADMIT DATE is the date the member was admitted to an inpatient facility.* |  | *yes* | *Field 12* |  |
| Discharge date | *DISCHARGE DATE is the date the member was released from an inpatient facility.* |  | *yes* |  |  |
| Start date of related hospitalization | *From date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.* |  | *yes* |  | *Item 18* |
| End date of related hospitalization | *To date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.* |  | *yes* |  | *Item 18* |
| Type of admission/visit | *ADMISSION TYPE CODE represents the priority of the admission, such as, emergency, urgent, elective or newborn.* |  |  | *Field 14* |  |
| Source of admission | *ADMISSION SOURCE CODE represents the point of patient origin for this admission or visit.* |  |  | *Field 15* |  |
| Patient Discharge Status | *DISCHARGE STATUS CODE represents the hospital discharge status code.* |  |  | *Field 17* |  |
| Line number | *The line item number for a service in a claim* |  |  |  |  |
| From date of service | *Date of service, from date* |  | *yes* |  | *Item 24A* |
| To date of service | *Date of service, to date* |  | *yes* |  | *Item 24A* |
| Place of service | *Identify the setting, using a place of service code, for each item used or service performed.* |  |  |  | *Item 24B* |
| Revenue code | *Industry Standard - Code used on the UB-92 (Form Locator 42) to identify a specific accommodation, ancillary service, or billing calculation related to the service being billed. The code can identify the cost center in the institution where inpatient care was provided, for example: physical therapy, surgery, room and board.* | *Four characters* |  | *Field 42* |  |
| HCPCS/CPT code | *Industry Standard - Medical procedure a patient received from a health care provider. Current coding methods include: CPT-4 and HCFA Common Procedure Coding System Level II - (HCPCS-II).* | *Five characters* |  | *Field 44* | *Item 24D* |
| HCPCS/CPT modifier 1 | *Indicates special circumstances related to the performance of the service. For example, the 5 digit HCPCS base code if followed by 80 would indicate that an assistant surgeon delivered that service* | *Two characters* |  | *Field 44* | *Item 24D* |
| HCPCS/CPT modifier 2 | *Indicates special circumstances related to the performance of the service. For example, the 5 digit HCPCS base code if followed by 80 would indicate that an assistant surgeon delivered that service* | *Two characters* |  | *Field 44* | *Item 24D* |
| HCPCS/CPT modifier 3 | *Indicates special circumstances related to the performance of the service. For example, the 5 digit HCPCS base code if followed by 80 would indicate that an assistant surgeon delivered that service* | *Two characters* |  | *Field 44* | *Item 24D* |
| HCPCS/CPT modifier 4 | *Indicates special circumstances related to the performance of the service. For example, the 5 digit HCPCS base code if followed by 80 would indicate that an assistant surgeon delivered that service* | *Two characters* |  | *Field 44* | *Item 24D* |
| Billed Service units | *Service count, as billed. Generally, the entries in this column quantify services by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.* |  |  | *Field 46* |  |
| Paid Service units | *Service count, paid, generated by claims processor* |  |  |  |  |
| Days or units | *This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.* |  |  |  | *Item 24G* |
| Total charges | *Total charges* |  |  | *Field 47* | *Item 24F* |
| Noncovered charges | *The portion of the cost of this service that was deemed not eligible by the insurer because the service or member was not covered by the subscriber contract* |  |  | *Field 48* |  |
| Rendering NPI | *Industry Standard - The National Provider Identifier assigned to the Rendering Provider. This is the lowest level of provider available (for example, if both individual and group are available, then the individual should be provided).* |  |  | *Field 56* | *Item 24J* |
| Facility location NPI | *The NPI of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.* |  |  |  | *Item 32A* |
| Billing NPI | *Industry Standard - The National Provider Identifier assigned to the Billing Provider. This may represent a facility (for facility claims), a physician, a rendering provider, a group, or a billing entity.* |  |  |  | *Item 33A* |
| ICD version flag | *Flags ICD diagnoses and procedure codes as ICD-10* |  |  |  |  |
| Principal Diagnosis Code | *PRINCIPAL DIAGNOSIS CODE represents an ICD CM Diagnosis Code identifying a condition being treated. This was replicated to Claim Line for ease of reporting.* | *ICD-10* |  | *Field 67* | *Item 21.1* |
| Other Diagnosis 1 | *OTHER 1 EXTERNAL CAUSE OF INJURY CODE represents an ICD CM Diagnosis Code identifying the External Cause of Injury usually found with other Diagnosis Codes.* | *ICD-10* |  | *Field 67A* | *Item 21.2* |
| Other Diagnosis 2 | *OTHER 2 EXTERNAL CAUSE OF INJURY CODE represents an ICD CM Diagnosis Code identifying the External Cause of Injury usually found with other Diagnosis Codes.* | *ICD-10* |  | *Field 67B* | *Item 21.3* |
| Other Diagnosis 3 | *OTHER 3 EXTERNAL CAUSE OF INJURY CODE represents an ICD CM Diagnosis Code identifying the External Cause of Injury usually found with other Diagnosis Codes.* | *ICD-10* |  | *Field 67C* | *Item 21.4* |
| Other Diagnosis 4 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67D* | *Item 21.5* |
| Other Diagnosis 5 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67E* | *Item 21.6* |
| Other Diagnosis 6 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67F* | *Item 21.7* |
| Other Diagnosis 7 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67G* | *Item 21.8* |
| Other Diagnosis 8 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67H* | *Item 21.9* |
| Other Diagnosis 9 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67I* | *Item 21.10* |
| Other Diagnosis 10 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67J* | *Item 21.11* |
| Other Diagnosis 11 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67K* | *Item 21.12* |
| Other Diagnosis 12 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67L* |  |
| Other Diagnosis 13 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67M* |  |
| Other Diagnosis 14 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67N* |  |
| Other Diagnosis 15 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67O* |  |
| Other Diagnosis 16 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67P* |  |
| Other Diagnosis 17 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67Q* |  |
| Present on Admission Indicator, Principal Diagnosis | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67* |  |
| Present on Admission Indicator, Other Diagnosis 1 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67A* |  |
| Present on Admission Indicator, Other Diagnosis 2 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67B* |  |
| Present on Admission Indicator, Other Diagnosis 3 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67C* |  |
| Present on Admission Indicator, Other Diagnosis 4 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67D* |  |
| Present on Admission Indicator, Other Diagnosis 5 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67E* |  |
| Present on Admission Indicator, Other Diagnosis 6 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67F* |  |
| Present on Admission Indicator, Other Diagnosis 7 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67G* |  |
| Present on Admission Indicator, Other Diagnosis 8 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67H* |  |
| Present on Admission Indicator, Other Diagnosis 9 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67I* |  |
| Present on Admission Indicator, Other Diagnosis 10 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67J* |  |
| Present on Admission Indicator, Other Diagnosis 11 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67K* |  |
| Present on Admission Indicator, Other Diagnosis 12 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67L* |  |
| Present on Admission Indicator, Other Diagnosis 13 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67M* |  |
| Present on Admission Indicator, Other Diagnosis 14 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67N* |  |
| Present on Admission Indicator, Other Diagnosis 15 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67O* |  |
| Present on Admission Indicator, Other Diagnosis 16 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67P* |  |
| Present on Admission Indicator, Other Diagnosis 17 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67Q* |  |
| Admitting Diagnosis Code | *ADMITTING DIAGNOSIS CODE represents an International Classification of Diseases (ICD) Diagnosis Code identifying a condition being treated, upon admission.* | *ICD-10* |  | *Field 69* |  |
| Principal procedure code | *Industry Standard - Principal medical procedure a patient received during inpatient stay.* | *ICD-10* |  | *Field 74* |  |
| Principal procedure date | *Represents the date that the corresponding procedure was performed.* |  | *yes* | *Field 74* |  |
| Other procedure code 1 | *Industry Standard - Other medical procedure a patient received during inpatient stay.* | *ICD-10* |  | *Field 74A* |  |
| Other procedure date 1 | *Represents the date that the corresponding procedure was performed.* |  | *yes* | *Field 74A* |  |
| Other procedure code 2 | *Industry Standard - Other medical procedure a patient received during inpatient stay.* | *ICD-10* |  | *Field 74B* |  |
| Other procedure date 2 | *Represents the date that the corresponding procedure was performed.* |  | *yes* | *Field 74B* |  |
| Other procedure code 3 | *Industry Standard - Other medical procedure a patient received during inpatient stay.* | *ICD-10* |  | *Field 74C* |  |
| Other procedure date 3 | *Represents the date that the corresponding procedure was performed.* |  | *yes* | *Field 74C* |  |
| Other procedure code 4 | *Industry Standard - Other medical procedure a patient received during inpatient stay.* | *ICD-10* |  | *Field 74D* |  |
| Other procedure date 4 | *Represents the date that the corresponding procedure was performed.* |  | *yes* | *Field 74D* |  |
| Other procedure code 5 | *Industry Standard - Other medical procedure a patient received during inpatient stay.* | *ICD-10* |  | *Field 74E* |  |
| Other procedure date 5 | *Represents the date that the corresponding procedure was performed.* |  | *yes* | *Field 74E* |  |
| Claim status (paid as primary/paid as secondary/paid as tertiary/reversed/denied) | *CLAIM DISPOSITION CODE identifies the type of claim, whether an original, reversal, adjustment or void.* |  |  |  |  |
| In-network provider flag | *Flag for whether the health plan has a network contract with service provider* | *Yes/No* |  |  |  |
| In-network cost sharing flag | *Flag for whether the claim was paid applying in-network benefits to determine the patient's cost sharing* | *Yes/No* |  |  |  |
| MS-DRG code | *DIAGNOSIS RELATED GROUP CODE represents the specific 'Diagnosis Related Group' (DRG) associated with a Claim. A DRG is a national coding scheme which classifies an inpatient stay based on diagnosis, procedure, discharge status, age and sex.* |  |  |  |  |
| MS-DRG version | *DIAGNOSIS RELATED GROUP VERSION NUMBER represents the version of the vendor Diagnosis Related Group (DRG) table.* | *If available, please supply here the rate year corresponding to the MS-DRG code. If not available, ok to omit. If omitted, RAND will assume that MS-DRG codes are assigned applying appropriate MS-DRG grouper based on federal fiscal year of date of discharge.* |  |  |  |
| Allowed amount | *Measure - The contracted reimbursable amount for covered medical services or supplies or amount reflecting local methodology for non-contracted providers.* |  |  |  |  |
| Paid amount | *Measure - The amount sent to the payee from the health plan. This amount is to include withhold amounts (the portion of the claim that is deducted and withheld by the Plan from the provider's payment) and exclude any member cost sharing.* |  |  |  |  |
| Deductible amount | *Measure - The portion of this service that the member must pay which is applied to the total period deductible. Deductibles are usually applied over a specific time period, such as per calendar year, per benefit period, or per episode of illness. Amounts should include any sanction/penalty or deductible form of insured non-compliance such as lack of prior authorizations.* |  |  |  |  |
| Coinsurance amount | *Measure - The amount the insured individual pays, as a set percentage of the cost of covered medical services, as an out-of-pocket payment to the provider. Example: Insured pays 20% and the insurer pays 80%. This amount should include member sanctions/penalties for out of network or any coinsurance form of insured non-compliance such as lack of prior authorizations.* |  |  |  |  |
| Copay amount | *Measure - Amount an insured individual pays directly to a provider at the time the services or supplies are rendered. Usually, a copay will be a fixed amount per service, such as $15.00 per office visit. Amounts should include any sanction/penalty or copay form of insured non-compliance such as lack of prior authorizations.* |  |  |  |  |
| COB amount | *An amount paid through coordination of benefits* |  |  |  |  |
| Capitated payment flag (is this an information-only claim submitted by a provider who receives a capitated payment) | *CAPITATION GROUP INDICATOR CODE is a Yes / No code used to identify a paid claim for a group with a capitated arrangement* |  |  |  |  |
| Prepaid amount | *For capitated services, the fee for service equivalent amount.* |  |  |  |  |
| Plan type code | *Type of plan, including categories that identify Medicare Advantage or managed Medicaid plans* |  |  |  |  |
| Product type code | *Type of insurance coverage that a member is enrolled in* |  |  |  |  |
| Self-insured indicator or employer account number | *Account number uniquely identifies the account ID of the self-insured employer* | *Can be an indicator of a self-insured plan rather than an account number* |  |  |  |
| Fully insured indicator or line of business | *Insurance product type (large group, small group, individual market)* | *Can be an indicator of a fully insured plan rather than line of business* |  |  |  |

**ATTACHMENT B**

DATA USE INFORMATION AND AUTHORIZATION

**Institutional Review Board (IRB) review**.

☒ RAND will be reviewed through a formal IRB process.

☐ RAND has received approval through a formal IRB process.

☐ The IRB has approved waiver of individual authorization. If checked, see enclosed approval.

☐ IRB review not required. [*Add explanation.*]

**Access to Project Data by External Entities.**

No entities other than RAND will be given nor will have access to project data.

**Authorized Data Usage (Project)**.

PROJECT DESCRIPTION

Large employers typically offer health benefits to their employees through a “self-insured” plan, meaning the employer pays their employees’ claims and bears financial risk. Those employers are repeat buyers of health care services, which could put them in a strong position to demand increased value from the health care system. However, they rely on health plans and other intermediaries to negotiate contracts with providers and to process claims, and they generally lack useful information on the prices they are paying. The lack of transparency in contracting and negotiated prices undermines the ability of self-insured employers to demand value.

The Employers’ Forum of Indiana (EFI) is a multistakeholder, employer-led coalition whose mission is “to improve the value payers and patients receive for their health care expenditures.” EFI serves mainly in a convening role, and does not have the resources to fund significant research efforts on its own.

On November 8, 2016, RAND and EFI entered into a memorandum of understanding (MOU) describing a research project titled "Hospital Price Transparency Pilot" (the "pilot", or "round 1.0"). To conduct the pilot, RAND received funding from the Robert Wood Johnson Foundation (RWJF) and received hospital claims data from self-insured employer members of EFI. In September 2017, RAND published a research report titled "Hospital Prices in Indiana: Findings from an Employer-Led Transparency Initiative" ( <https://www.rand.org/pubs/research_reports/RR2106.html> ) that contained the results of the pilot. The pilot illustrated for employer members of EFI and for other employers and employer groups nationwide, a feasible and replicable approach to measuring and comparing hospital prices.

RAND and EFI continued to collaborate on follow-on projects titled "National Hospital Price Transparency Study” (Rounds 2, 3, and 4). The goals of rounds 2, 3, and 4 of the study were to prepare and disseminate broadly a public hospital price report based on claims data from three types of data contributors:

• Self-insured employers and coalitions of self-insured employers, including members of EFI as well as employers and coalitions based outside Indiana;

• fully insured health plans; and

• all-payer claims databases.

Round 2 covered 2014-2016 and results were published on May 9, 2018 at: <https://www.rand.org/pubs/research_reports/RR3033.html>

Round 3 covered 2016-2018 and results were published on September 17, 2020 at: <https://www.rand.org/pubs/research_reports/RR4394.html>

Round 4 covered 2018-2020 were published on May 17, 2022 at:

<https://www.rand.org/pubs/research_reports/RRA1144-1.html>

Round 5 will cover 2020-2022 and RAND plans to publish results during 2024.

One of the key goals of each successive Round has been to broaden the pool of data contributors to allow public reporting of prices for a broader set of hospitals, including hospitals outside Indiana. A second key goal was to shift the funding for the study to a more-sustainable model that includes foundation funding plus funding from self-insured employers. Each self-insured employer that contributes data and funding for the National Study receives a private employer-specific price report.

The key intended audiences for the reports are 1) large self-insured employers including members of EFI and other employer business coalition across the country, 2) intermediaries responsible for negotiating prices with hospitals, and 3) policy makers and researchers who are interested in price transparency. The Round 2 study focused on unit prices for hospital services because they have been identified in previous research as a key contributor to recent growth in spending per capita among the privately insured, and a key driver of geographic variation in spending among the privately insured. The public final report for Round 2 describes the project’s background and analytic methods, and includes measures of negotiated prices paid to specific, named facilities. That level of specificity will allow employers to assess whether negotiated prices for hospital care are in line with the quality and value of the services provided by those hospitals or health systems. Two measures of negotiated prices were calculated and reported publicly in the Round 2 report. The first price measure is relative prices (meaning allowed amounts) as a percent of the amount that Medicare would have paid to the same facilities for the same services. Medicare provides a useful price benchmark for three reasons. First, Medicare is the largest purchaser of health care services in the world and in many ways the standard setter in the U.S. health care system. Second, Medicare prices are set with the overarching goal of compensating providers fairly based on the costs of doing business and the services they provide. Third, Medicare makes detailed price data freely and publicly available. The second price measure is dollars per casemix-adjusted unit of service. For inpatient hospital stays casemix adjustment is based on Medicare Severity Diagnosis Related Groups (MS-DRGs), and for outpatient visits casemix adjustment is based on the Medicare Ambulatory Payment Classification (APC) system. The second price measure differs from the first in that it does not include Medicare's adjustments for local wages or hospital characteristics (e.g. teaching).

RAND and EFI’s Round 5 of the study differs from previous rounds in that the pool of data contributors will continue to expand to include additional self-insured employers, additional APCDs, and additional health plans in all 50 United States. The claims data includes both facility and professional claims, so that relative and standardized prices could be calculated for services that include a facility fee and a professional fee. The types of facilities included in the analysis have been expanded to include not just Medicare-certified short-stay hospitals but also other types of facilities, such as children's hospitals, cancer hospitals, and ambulatory surgical centers.

For each self-insured employer that contributed data and funding, RAND prepares an employer-specific price report that includes price measures based just on claims data from that employer. The employer-specific price reports allow employers to compare the negotiated prices paid by their health plan with the average prices paid by all health plans that contributed data to the study.

The ongoing Round 5 of this study will continue to expand data collection from all 50 United States. As more employers and TPAs contribute data, its value increases to all involved, including policymakers.

Especially during the COVID-19 pandemic, many self-insured employers are struggling with health care costs, and any additional information on prices could help them to manage their plans. Ultimately, the goal of Round 5 is to help those employers to become better informed, and to advocate more effectively on their employees’ behalf for increasing value in the health care system.

Project Technical Approach. The analysis will follow these steps:

(1) RAND will enter into appropriate Data Use Agreements (DUAs) with each of the data suppliers. These agreements, which are required by the Health Insurance Portability and Accountability Act (HIPAA) privacy rule, will establish appropriate safeguards so that RAND may receive protected health information in the form of a HIPAA Limited Data Set and guarantee that it will be maintained securely.

(2) Participating self-insured employers will instruct their claims administrator to provide RAND with facility and professional claims data. These claims data will span at least the period from January 1, 2020 through December 31, 2022. (Data contributors have the option to also submit claims as far back as 1/1/2018, but no earlier than that.) These claims data will identify the provider, the specific service provided (including Healthcare Common Procedure Coding System [HCPCS] codes, ICD-10 diagnoses and procedures, and charge data by cost center), submitted charges, and allowed amounts. (See Attachment A for a complete list of variables needed for the study.)

(3) RAND will attach Medicare provider numbers and health system identifiers to each claim. RAND will identify claims for services provided by Medicare-certified short-stay hospitals and other types of facilities, such as children's hospitals, cancer hospitals, and ambulatory surgical centers.

(4) RAND will use publicly available “grouper” software from the Centers for Medicare & Medicaid Services (e.g., https://downloads.cms.gov/files/MS-DRG-MCE-Software-2017.zip) to assign casemix classification codes to each claim. For inpatient stays, the Medicare Severity Diagnosis Related Grouper (MS-DRG) software will be used. For outpatient visits, the Ambulatory Payment Classification (APC) software will be used.

(5) RAND will compile the claims data and prepare a detailed price report that includes the two price measures, the first being the average allowed amount paid relative to a Medicare benchmark, and the second being allowed amounts per casemix-adjusted unit of service. In addition, relative price variation and price trends will be noted for large health systems. In order to guarantee enrollee confidentiality, this public price report will only include facilities with 11 or more claims.

(6) RAND will prepare a public final report that includes summary price measures for each hospital with 11 or more claims. This public report will describe the patterns observed in the price data, specify the analytic methods, and summarize the key takeaways for health plan administrators and policy makers.

(7) RAND will prepare a set of employer-specific price reports that include price measures from the public report plus price measures based just on claims data from each self-insured employer. RAND will **not** publish the employer-specific price reports, and will send each private report directly to the self-insured employer that contributed to funding this study.

(8) RAND and EFI, in consultation with self-insured employers who are participating in the study, will identify research topics of interest to those employers, and RAND will conduct and disseminate the results of that research. For example, in some areas of the country privately insured patients visiting an emergency department are at high risk of receiving a "surprise bill" from an out-of-network professional. One likely follow-on study would be an examination of the share of emergency department visits that include professional services provided by an out-of-network provider.

EFI will assist RAND with identifying and recruiting participants for Round 5, and EFI and RAND will communicate throughout the project. Data suppliers will communicate with RAND to establish DUAs and other agreements as needed.