TEMPORARY RULE-MAKING FINDINGS OF NEED

[Authority G.S. 150B-21.1]

OAH USE ONLY
VOLUME:
ISSUE:

11/17/14

ORIGINAL

1. Rule-Making Agency: N.C. Medical Care Commission

2. Rule citation & name: 10A NCAC 13B .2101 Definitions

3. Action: ☒ Adoption ☐ Amendment ☐ Repeal

4. Was this an Emergency Rule: ☐ Yes ☒ No Effective date:

FILED
2014 NOV 17 PM 2:33
OFFICE OF ADMIN HEARINGS

5. Provide dates for the following actions as applicable:

   a. Proposed Temporary Rule submitted to OAH: 9/17/14

   b. Proposed Temporary Rule published on the OAH website: 9/23/14

   c. Public Hearing date: 10/15/14

   d. Comment Period: 9/25/14 – 10/17/14

   e. Notice pursuant to G.S. 150B-21.1(a3)(2): 9/22/14

   f. Adoption by agency on: 11/14/14

   g. Proposed effective date of temporary rule [if other than effective date established by G.S. 150B- 21.1(b) and G.S. 150B-21.3]: 12/31/14

   h. Rule approved by RRC as a permanent rule [See G.S. 150B-21.3(b2)]: n/a

6. Reason for Temporary Action. Attach a copy of any cited law, regulation, or document necessary for the review.

   ☐ A serious and unforeseen threat to the public health, safety or welfare.
   ☒ The effective date of a recent act of the General Assembly or of the U.S. Congress.
   Cite: N.C.G.A. Session Law 2014-100 (Senate Bill 744) "Appropriations Act of 2014"
   Effective date: 8/7/14
   ☐ A recent change in federal or state budgetary policy.
   Effective date of change:
   ☐ A recent federal regulation.
   Cite:
   Effective date:
   ☐ A recent court order.
   Cite order:
   ☐ State Medical Facilities Plan.
   ☐ Other:

Explain: The proposed temporary adoption to the rule in Chapter 10A NCAC 13B *Licensing of Hospitals* is in response to a recent act of the General Assembly, specifically Session Law 2014-100, Senate Bill 744, "Appropriations Act of 2014" which became effective on August 7, 2014. In this law, revisions to the Health Care Cost Reduction and Transparency Act from Session Law 2013-328, Part X were made to clarify some components within the original law to improve transparency in the cost of health care provided by hospitals and ambulatory surgical facilities, to provide for the establishment of quality measures and to exempt certain rules from G.S. 150B-21.3. Section 12.G.2 of this Act requires the N.C. Medical Care Commission to adopt rules to ensure that the provisions of the law are properly implemented.

7. Why is adherence to notice and hearing requirements contrary to the public interest and the immediate adoption of the rule is required?

The availability of information related to health care pricing and transparency of that information is of significant importance to the citizens of North Carolina. The rule will protect patients' rights to be fully informed of charges they have incurred or may incur, and will also empower patients to make informed health care decisions. The proposed temporary rule addresses the definitions that will be used in the quarterly reporting of billing and collections practices for hospitals to ensure that these practices are transparent, fair and reasonable to the health care consumer as intended by the General Assembly. The time frame for the quarterly reporting of the data has been mandated by the General Assembly in S.L. 2014-100 and a process has been developed for the information to be provided to the public following data submission and receipt by the Department.

Transparency in health care pricing and billing is important to North Carolinians. This proposed rule is the first step to achieving it in a manner that is meaningful and useful to the public.

8. Rule establishes or increases a fee? (See G.S. 12-3.1)

☐ **Yes**
Agency submitted request for consultation on:
Consultation not required. Cite authority:

☒ **No**

9. Rule-making Coordinator: Nadine Pfeiffer

Phone: 919-855-3811

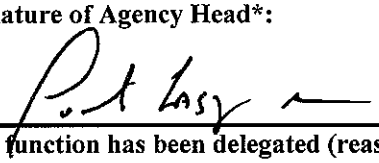
E-Mail: Nadine.pfeiffer@dhhs.nc.gov

Agency contact, if any: Azzie Conley, Section Chief

Phone: 919-855-4646

E-Mail: azzie.conley@dhhs.nc.gov

10. Signature of Agency Head*:



*** If this function has been delegated (reassigned) pursuant to G.S. 143B-10(a), submit a copy of the delegation with this form.**

Typed Name: Dr. John A. Fagg, M.D.

Title: Chair, N.C. Medical Care Commission

E-Mail: jafmd@aol.com

RULES REVIEW COMMISSION USE ONLY	
Action taken: ☐ Date returned to agency:	Submitted for RRC Review:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

SESSION LAW 2014-100
SENATE BILL 744

AN ACT TO MAKE BASE BUDGET APPROPRIATIONS FOR CURRENT OPERATIONS OF STATE DEPARTMENTS, INSTITUTIONS, AND AGENCIES, AND FOR OTHER PURPOSES.

The General Assembly of North Carolina enacts:

PART I. INTRODUCTION AND TITLE OF ACT

TITLE OF ACT

SECTION 1.1. This act shall be known as "The Current Operations and Capital Improvements Appropriations Act of 2014."

INTRODUCTION

SECTION 1.2. The appropriations made in this act are for maximum amounts necessary to provide the services and accomplish the purposes described in the budget. Savings shall be effected where the total amounts appropriated are not required to perform these services and accomplish these purposes and, except as allowed by the State Budget Act, or this act, the savings shall revert to the appropriate fund at the end of each fiscal year as provided in G.S. 143C-1-2(b).

PART II. CURRENT OPERATIONS AND EXPANSION GENERAL FUND

CURRENT OPERATIONS AND EXPANSION/GENERAL FUND

SECTION 2.1. Appropriations from the General Fund of the State for the maintenance of the State departments, institutions, and agencies, and for other purposes as enumerated, are adjusted for the fiscal year ending June 30, 2015, according to the schedule that follows. Amounts set out in parentheses are reductions from General Fund appropriations for the 2014-2015 fiscal year.

Current Operations – General Fund	**2014-2015**
EDUCATION	
Community Colleges System Office	$ 24,423,804
Department of Public Instruction	58,874,986
University of North Carolina – Board of Governors	
Appalachian State University	
East Carolina University	
Academic Affairs	(620,650)
Health Affairs	
Elizabeth City State University	
Fayetteville State University	
North Carolina Agricultural and Technical State University	
North Carolina Central University	

shall give priority to areas of the State experiencing a shortage of these types of facilities.

(3) To provide reimbursement for services provided by facility-based crisis centers.

(4) To establish facility-based crisis centers for children and adolescents.

SUBPART XII-G. DIVISION OF HEALTH SERVICE REGULATION

TECHNICAL CORRECTION TO CERTIFICATE OF NEED EXEMPTION FOR REPLACEMENT OF PREVIOUSLY APPROVED EQUIPMENT

SECTION 12G.1.(a) G.S. 131E-184(f) reads as rewritten:

"(f) The Department shall exempt from certificate of need review the purchase of any replacement equipment that exceeds the two million dollar ($2,000,000) threshold set forth in ~~G.S. 131E-176(22)~~ G.S. 131E-176(22a) if all of the following conditions are met:

(1) The equipment being replaced is located on the main campus.

(2) The Department has previously issued a certificate of need for the equipment being replaced. This subdivision does not apply if a certificate of need was not required at the time the equipment being replaced was initially purchased by the licensed health service facility.

(3) The licensed health service facility proposing to purchase the replacement equipment shall provide prior written notice to the Department, along with supporting documentation to demonstrate that it meets the exemption criteria of this subsection."

SECTION 12G.1.(b) This section is effective when it becomes law.

HEALTH CARE COST REDUCTION AND TRANSPARENCY ACT REVISIONS

SECTION 12G.2. G.S. 131E-214.13 reads as rewritten:

"**§ 131E-214.13. Disclosure of prices for most frequently reported DRGs, CPTs, and HCPCSs.**

(a) The following definitions apply in this Article:

(1) Ambulatory surgical facility. – A facility licensed under Part 4 of Article 6 of this Chapter.

(2) Commission. – The North Carolina Medical Care Commission.

(3) Health insurer. – ~~As defined in G.S. 108A-55.4, provided that "health insurer" shall not include self-insured plans and group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974.~~An entity that writes a health benefit plan and is one of the following:

a. An insurance company under Article 3 of Chapter 58 of the General Statutes.

b. A service corporation under Article 65 of Chapter 58 of the General Statutes.

c. A health maintenance organization under Article 67 of Chapter 58 of the General Statutes.

d. A third-party administrator of one or more group health plans, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1167(1)).

(4) Hospital. – A medical care facility licensed under Article 5 of this Chapter or under Article 2 of Chapter 122C of the General Statutes.

(5) Public or private third party. – Includes the State, the federal government, employers, health insurers, third-party administrators, and managed care organizations.

(b) Beginning with the quarter ending June 30, 2014, and quarterly thereafter, each hospital shall provide to the Department of Health and Human Services, utilizing electronic health records software, the following information about the 100 most frequently reported admissions by DRG for inpatients as established by the ~~Commission:~~Department:

(1) The amount that will be charged to a patient for each DRG if all charges are paid in full without a public or private third party paying for any portion of the charges.

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection.
(3) The amount of Medicaid reimbursement for each DRG, including claims and pro rata supplemental payments.
(4) The amount of Medicare reimbursement for each DRG.
(5) For each of the five largest health insurers providing payment to the hospital on behalf of insureds and teachers and State employees, the range and the average of the amount of payment made for each DRG. Prior to providing this information to the Department, each hospital shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.

A hospital shall not be required to report the information required by this subsection for any of the 100 most frequently reported admissions where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

(c) The Commission shall adopt rules on or before ~~March 1, 2014,~~January 1, 2015, to ensure that subsection (b) of this section is properly implemented and that hospitals report this information to the Department in a uniform manner. The rules shall include all of the following:

(1) The method by which the Department shall determine the 100 most frequently reported DRGs for inpatients for which hospitals must provide the data set out in subsection (b) of this section.
(2) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the Department's Internet Web site.

(d) Beginning with the quarter ending September 30, 2014, and quarterly thereafter, each hospital and ambulatory surgical facility shall provide to the Department, utilizing electronic health records software, information on the total costs for the 20 most common surgical procedures and the 20 most common imaging procedures, by volume, performed in hospital outpatient settings or in ambulatory surgical facilities, along with the related CPT and HCPCS codes. Hospitals and ambulatory surgical facilities shall report this information in the same manner as required by subdivisions (b)(1) through (5) of this section, provided that hospitals and ambulatory surgical facilities shall not be required to report the information required by this subsection where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

(e) The Commission shall adopt rules on or before ~~June 1, 2014,~~January 1, 2015, to ensure that subsection (d) of this section is properly implemented and that hospitals and ambulatory surgical facilities report this information to the Department in a uniform manner. The rules shall include the ~~list of~~ method by which the Department shall determine the 20 most common surgical procedures and the 20 most common imaging ~~procedures, by volume, performed in a hospital outpatient setting and those performed in an ambulatory surgical facility, along with the related CPT and HCPCS codes.~~procedures for which the hospitals must provide the data set out in subsection (d) of this section.

(e1) The Commission shall adopt rules to establish quality measures identical to those established by the Joint Commission for each of the following:

a. Primary cesarean section rate, uncomplicated (TJC PC-02)
b. Early elective delivery rate (TJC PC-01)
c. C. difficile infection SIR (NHSN)
d. Multidrug resistant organisms (NHSN)
e. Surgical site infection SRI for colon surgeries (NSHN)
f. Post op sepsis rate (PSI13)
g. Thrombolytic therapy for acute ischemic stroke patients (STK-4)
h. Stroke education (STK-8)
i. Venous thrombolism prophylaxis (VTE-1)
j. Venous thrombolism discharge instructions (VTE-5)

(f) Upon request of a patient for a particular DRG, imaging procedure, or surgery procedure reported in this section, a hospital or ambulatory surgical facility shall provide the

information required by subsection (b) or subsection (d) of this section to the patient in writing, either electronically or by mail, within three business days after receiving the request.

(g) G.S. 150B-21.3 does not apply to rules adopted under subsections (c) and (e) of this section. A rule adopted under subsections (c) and (e) of this section becomes effective on the last day of the month following the month in which the rule is approved by the Commission."

STUDY CONCERNING EXPANSION OF HEALTH CARE COST REDUCTION AND TRANSPARENCY ACT TO ADDITIONAL HEALTH CARE PROVIDERS

SECTION 12G.3. By December 1, 2014, the Department of Health and Human Services shall study and submit a written report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division summarizing its recommendations for extending North Carolina's Health Care Cost Reduction and Transparency Act of 2013 (the Act) to additional health care providers. The report shall identify all of the following:

(1) Recommended categories of additional health care providers that should be subject to the requirements of the Act.
(2) Recommended data to be collected for the purpose of transparency from each category of identified health care providers.
(3) Recommended exemptions, if any, from certain requirements of the Act for each category of identified health care providers.
(4) Recommended effective dates for the applicability of the Act to each category of identified health care providers.

MORATORIUM ON HOME CARE AGENCY LICENSES FOR IN-HOME AIDE SERVICES

SECTION 12G.4.(a) For the period commencing on the effective date of this section, and ending June 30, 2016, and notwithstanding the provisions of the Home Care Agency Licensure Act set forth in Part 3 of Article 6 of Chapter 131E of the General Statutes or any rules adopted pursuant to that Part, the Department of Health and Human Services shall not issue any licenses for home care agencies as defined in G.S. 131E-136(2) that intend to offer in-home aide services. This prohibition does not apply to companion and sitter services and shall not restrict the Department from doing any of the following:

(1) Issuing a license to a certified home health agency as defined in G.S. 131E-176(12) that intends to offer in-home aide services.
(2) Issuing a license to an agency that needs a new license for an existing home care agency being acquired.
(3) Issuing a license for a new home care agency in any area of the State upon a determination by the Secretary of the Department of Health and Human Services that increased access to care is necessary in that area.

SECTION 12G.4.(b) This section is effective when it becomes law.

MORATORIUM ON SPECIAL CARE UNIT LICENSES

SECTION 12G.5. Section 12G.1(a) of S.L. 2013-360 reads as rewritten:

"**SECTION 12G.1.(a)** For the period beginning July 31, 2013, and ending ~~July 1, 2016,~~June 30, 2016, the Department of Health and Human Services, Division of Health Service Regulation (Department), shall not issue any licenses for special care units as defined in G.S. 131D-4.6 and G.S. 131E-114. This prohibition shall not restrict the Department from doing any of the following:

(1) Issuing a license to a facility that is acquiring an existing special care unit.
(2) Issuing a license for a special care unit in any area of the State upon a determination by the Secretary of the Department of Health and Human Services that increased access to this type of care is necessary in that area during the ~~three-year~~ moratorium imposed by this section.
(3) Processing all completed applications for special care unit licenses received by the Division of Health Service Regulation along with the applicable license fee prior to June 1, 2013.
(4) Issuing a license to a facility that was in possession of a certificate of need as of July 31, 2013, that included authorization to operate special care unit beds."

TEMPORARY RULES
REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13B .2101

DEADLINE FOR RECEIPT: Wednesday, November 19, 2014

***NOTE WELL:* This request when viewed on computer extends several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

On line 6, please capitalize "Section."

Items 1, 8, 9 and 10 are defined in G.S. 131E-214.13. Why not just state "In addition to the terms defined in G.S. 131E-214.13, the following terms…"

Why is "Commission" defined in Item (1)? It is in the statute and not used in the rest of the Section.

In (3), line 11, what is a "grouper program"?

In (5), why is "Financial Assistance" in caps? And note the same for all others, such as "Governing Body," "Public or Private Third Party."

On line 15, change the comma after "facilities" to a period.

In Sub-Item (5)(a), does your regulated public know what "bad debt" is?

In (5)(c), who do you mean by "such" patients? The patients in Sub-Item (5)(b)? If so, state that.

On line 22, add an "or" at the end of the line, assuming that is what you mean.

In Sub-Item (5)(d), you are saying this is the difference between the rate and the amount paid, correct? So, it's actually a loss?

Item (6) is not used again in .2100. Is this definition to address the earlier transparency rules? Even if it does, what is the use of the term since it simply restates the statute?

Amanda J. Reeder
Commission Counsel
Date submitted to agency: November 17, 2014

Item (7) - I take it your regulated public knows what this means? What does it mean?

Item (8), I know that "health benefit plan" is from statute, but does your regulated public know what it means? Also, why are you only partially reciting the statute here?

Item (10), insert a comma after "administrators" on line 33.

In the History Note, please state what section of the 2014 Session law you are referring to. 2014-100 is a very long law. Please include this in every History Note.

When citing to multiple parts of the Session Law, state "S.L. 2013-382(s.10.1); S.L. 2013-382(s13.1);"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: November 17, 2014

10A NCAC 13B .2101 is adopted under temporary procedures as follows:

SECTION .2100 – TRANSPARENCY IN HEALTH CARE COSTS

10A NCAC 13B .2101 DEFINITIONS

The following definitions shall apply throughout this section, unless text otherwise indicates to the contrary:

(1) "Commission" means the North Carolina Medical Care Commission.

(2) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association.

(3) "Diagnostic Related Group (DRG)" means a system to classify hospital cases assigned by a grouper program based on ICD (International Classification of Diseases) diagnoses, procedures, patient's age, sex, discharge status, and the presence of complications or co-morbidities.

(4) "Department" means the North Carolina Department of Health and Human Services.

(5) "Financial Assistance" means a policy, including charity care, describing how the organization will provide assistance at its hospital(s) and any other facilities, Financial assistance includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services. Financial assistance does not include:

(a) bad debt;

(b) uncollectable charges that the organization recorded as revenue but wrote off due to a patient's failure to pay;

(c) the cost of providing such care to such patients;

(d) the difference between the cost of care provided under Medicare or other government programs, and the revenue derived therefrom.

(6) "Governing Body" means the authority as defined in G.S. 131E-76.

(7) "Healthcare Common Procedure Coding System (HCPCS)" means a three tiered medical code set consisting of Level I, II and III services and contains the CPT code set in Level I.

(8) "Health Insurer" means an entity that writes a health benefit plan as defined in G.S. 131E-214.13(a)(3).

(9) "Hospital" means a medical care facility licensed under Article 5 of Chapter 131E or under Article 2 of Chapter 122C of the General Statutes.

(10) "Public or Private Third Party" means the State, federal government, employers, health insurers, third-party administrators and managed care organizations.

History Note: *Authority G.S. 131E-214.13; S.L. 2013-382(s.10.1); (s.13.1); S.L. 2014-100; Temporary Adoption Eff. December 31, 2014.*

TEMPORARY RULES
REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13B .2102

DEADLINE FOR RECEIPT: Wednesday, November 19, 2014

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

As I read S.L. 2014-100, Section 12G.2, the Medical Care Commission was told to go through rulemaking for four standards regarding hospitals:

1) *The methodology by which the Department will determine the 100 most frequently reported DRGs for inpatients in hospitals;*
2) *The methodology by which the Department will determine the 20 most common imaging procedures for hospitals;*
3) *The methodology by which the Department will determine the 20 most common surgical procedures for hospitals; and*
4) *The specific categories of hospitals for the purposes of reporting.*

I see the fourth prong is addressed by Paragraph (h). Where are the methodologies required by the law in the 13B rules?

In (a), line 4, you refer to "most frequently reported" but in line 10, it's "most common." Please be consistent. I note the statute says "most frequently reported"

On line 5, I know the terms "outpatient imaging" and "outpatient surgical" come from statute, but what does it mean? Does your regulated public know?

On line 7, state "based upon"

Also on line 7, who is the "certified data processor"? How does one know this? Do you feel G.S. 131E-214.4 provides sufficient guidance for this?

In (b), line 9, do you mean "four times per year" or "quarterly throughout the year"? Insert a comma after "year" Note the same for (c), line 13.

On line 12, replace "previous" with "prior." Note the same on line 17.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: November 17, 2014

I note that (d), you are mostly reciting 131E-214.13(b)(1) through (5). You are making some changes to that language, so I do not believe the language is "unnecessary." However, I want to confirm you believe you need the language.

(d)(2), line 24, it's Subparagraph (d)(1) of this Rule.

On line 25, replace "is to" with "shall"

What are you saying in (d)(3)? What supplemental payments will hospitals make to themselves? And should "to" be "by" on line 28?

(d)(5), lines 30-31, is "licensed third-party and teachers and State employees" not "public or private third party" as defined in .2101(10)? Or are you relying upon statute (131E-214.13(b)(5)) for this terminology?

Also in (d)(5), line 31, I don't think you need "report" since the language in (d) says, "The reports… shall include:" Thus, the use of "report" here is redundant.

In (e), Page 2, line 7, "closed accounts" should be in quotation marks since it is being defined.

In (f), line 9, what are "data elements"?

In (g), please provide the citation for the Act. You probably don't need the name of the Act in quotation marks.

Since you reference the website in (a) and (h), have you considered creating another Paragraph (probably (b)) to simply state "All information required by this Rule shall be posted on the Department's website: … and may be accessed at no cost." and in (a) and (h) state "on its website."? (If you do not wish to make the change now, you may wish to consider it for permanent rulemaking.)

In (h)(1), line 17, please state that the facilities plan "may be accessed at http:.. at no charge." Additionally, don't say "Division" unless you plan to state which Division, as that is not defined.

In (h)(2), line 18, insert a comma after "individuals."

In (h)(4), line 30, delete "internet" before "website." And if you prefer the language here, "may be accessed at no cost" before the web address rather than putting it afterwards, that's fine. Please just be consistent.

In (h)(5), line 32, I note that "psychiatric services" is not defined in 131-176(21) – psychiatric facility is. So, replace "as defined in" with "pursuant to." However, if you meant for the definition to be, "psychiatric services for the diagnosis and treatment of mentally ill persons.", then you may wish to state "providing psychiatric services for the diagnosis and treatment of mentally ill persons as defined in…"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: November 17, 2014

10A NCAC 13B .2102 is adopted under temporary procedures as follows:

10A NCAC 13B .2102 REPORTING REQUIREMENTS

(a) The Department shall establish the lists of the statewide 100 most frequently reported DRGs, 20 most common outpatient imaging procedures, and 20 most common outpatient surgical procedures performed in the hospital setting to be used for reporting the data required in Paragraphs (b) through (d) of this Rule. The lists shall be determined based on data provided by the certified statewide data processor. The Department shall make the lists available on its website at: http://www.ncdhhs.gov/dhsr/ahc.

(b) In accordance with G.S. 131E-214.13 and quarterly per year all licensed hospitals shall report the data required in Paragraph (d) of this Rule related to the statewide 100 most common DRGs to the certified statewide data processor in a format provided by the certified statewide processor. The data reported shall be from the quarter ending three months previous to the date of reporting and includes all sites operated by the licensed hospital.

(c) In accordance with G.S. 131E-214.13 and quarterly per year all licensed hospitals shall report the data required in Paragraph (d) of this Rule related to the statewide 20 most common outpatient imaging procedures and the statewide 20 most common outpatient surgical procedures to the certified statewide data processor in a format provided by the certified statewide processor. This report shall include the related primary CPT and HCPCS codes. The data reported shall be from the quarter ending three months previous to the date of reporting and includes all sites operated by the licensed hospital.

(d) The reports as described in Paragraphs (b) and (c) of this Rule shall be specific to each reporting hospital and shall include:

(1) the average gross charge for each DRG or procedure if all charges are paid in full without any portion paid by a public or private third party;

(2) the average negotiated settlement on the amount that will be charged for each DRG or procedure as required for patients defined in Paragraph (d)(1) of this Rule. The average negotiated settlement is to be calculated using the average amount charged all patients eligible for the hospital's financial assistance policy, including self-pay patients;

(3) the amount of Medicaid reimbursement for each DRG or procedure, including all supplemental payments to and from the hospital;

(4) the amount of Medicare reimbursement for each DRG or procedure; and

(5) on behalf of patients who are covered by a Department of Insurance licensed third-party and teachers and State employees, report the lowest, average, and highest amount of payments made for each DRG or procedure by each of the hospital's top five largest health insurers.

(A) each hospital shall determine its five largest health insurers based on the dollar volume of payments received from those insurers;

(B) the lowest amount of payment shall be reported as the lowest payment from each of the five insurers on the DRG or procedure;

(C) the average amount of payment shall be reported as the arithmetic average of each of the five health insurers payment amounts;

(D) the highest amount of payment shall be reported as the highest payment from each of the five insurers on the DRG or procedure; and

(E) the identity of the top five largest health insurers shall be redacted prior to submission.

(e) The data reported, as defined in Paragraphs (b) through (d) of this Rule, shall reflect the payments received from patients and health insurers for all closed accounts. For the purpose of this Rule, closed accounts are patient accounts with a zero balance at the end of the data reporting period.

(f) A minimum of three data elements shall be required for reporting under Paragraphs (b) and (c) of this Rule.

(g) The information submitted in the report shall be in compliance with the federal "Health Insurance Portability and Accountability Act of 1996."

(h) The Department shall provide the location of each licensed hospital and all specific hospital data reported pursuant to this Rule on its website. Hospitals shall be grouped by category on the website. On each quarterly report, hospitals shall determine one category that most accurately describes the type of facility. The categories are:

(1) "Academic Medical Center Teaching Hospital," means a hospital as defined in Policy AC-3 of the N.C. State Medical Facilities Plan. The N.C. State Medical Facilities Plan can be accessed at the Division's website at: http://www.ncdhhs.gov/dhsr/ncsmfp.

(2) "Teaching Hospital," means a hospital that provides medical training to individuals provided that such educational programs are accredited by the Accreditation Council for Graduated Medical Education to receive graduate medical education funds from the Centers for Medicare & Medicaid Services.

(3) "Community Hospital," means a general acute hospital that provides diagnostic and medical treatment, either surgical or nonsurgical, to inpatients with a variety of medical conditions, and that may provide outpatient services, anatomical pathology services, diagnostic imaging services, clinical laboratory services, operating room services, and pharmacy services, that is not defined by the categories listed in this Subparagraph and Subparagraphs (h)(1), (2), or (5) of this Rule.

(4) "Critical Access Hospital," means a hospital defined in the Centers for Medicare & Medicaid Services' State Operations Manual, Chapter 2 – The Certification Process, 2254D – Requirements for Critical Access Hospitals (Rev. 1, 05-21-04), including all subsequent updates and revisions. The manual may be accessed at no cost at the internet website: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

(5) "Mental Health Hospital," means a hospital providing psychiatric services as defined in G.S. 131E-176(21).

History Note: *Authority G.S.131E-214.4; 131E-214.13; S.L. 2013-382(s.10.1); S.L. 2014-100; Temporary Adoption Eff. December 31, 2014.*

TEMPORARY RULES
REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13C .0103

DEADLINE FOR RECEIPT: Wednesday, November 19, 2014

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

In Item (1), do you feel you need to retain "at least" on line 6? Generally, rules set the minimum standard, so the use of "at least" or "at a minimum" is discouraged, but if it is needed for clarity, please retain it.

On lines 7-8, what are "contemporary professional standards of practice" and how do people know that?

In (5), line 15, do you mean "this Subchapter"? Please insert a comma after "Rules" or "Subchapter"

In (6), line 16, you refer to "as defined in Item 26 of this Rule." However, that only defines physician, but the language of the rule seems to say that dentist is defined by (26). Do you mean "a physician as defined in Item (26) of this Rule, or dentist as defined in Item (11) of this Rule"? Please note the same question for line 17. Or are you trying to reference Item (28) in (6)?

Why is Item (7) in all capital letters? I ask because in (13), "Director of nursing" is not.

In (13), you refer to the "CEO" on line 29. Should it say "chief executive officer or administrator" to be consistent with (8)?

In (14), line 33, replace the comma after "facility" with a period.

In Sub-Item (14)(a), does your regulated public know what "bad debt" is?

On Page 2, in (14)(c), who do you mean by "such" patients? The patients in Sub-Item (14)(b)? If so, state that.

On line 3, add an "or" at the end of the line, assuming that is what you mean.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: November 17, 2014

In Sub-Item (14)(d), you are saying this is the difference between the rate and the amount paid, correct? So, it's actually a loss?

In (16), I think the term should read "Health insurer" (with "insurer" beginning with lowercase letters.)

Item (20), "(L.P.N)" should be inside the quotation marks; see (17).

In Item (20), the statute cited on line 17 was recodified. Please give the proper citation.

In (24), on line 23, please make "State" capitalized.

In (25), the statute cited on line 26 was repealed. Please provide the correct citation.

In (27), line 32, insert a comma after "administrators"

In (28), line 34, define "relevant"

On Page 3, in (30), the reference on line 2 was recodified. Please give the proper citation.

In Item (31), please replace "which" with "that" on line 3.

In the History Note, when citing to multiple parts of the Session Law, state "S.L. 2013-382(s.10.1); S.L. 2013-382(s13.1);"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: November 17, 2014

10A NCAC 13C .0103 is amended under temporary procedures as follows:

10A NCAC 13C .0103 DEFINITIONS

As used in this Subchapter, unless the context clearly requires otherwise, the following terms have the meanings specified:

(1) "Adequate" means, when applied to various areas of services, that the services are at least satisfactory in meeting a referred to need when measured against contemporary professional standards of practice.

(2) "AAAASF" means American Association for Accreditation of Ambulatory Surgery Facilities.

(3) "AAAHC" means Accreditation Association for Ambulatory Health Care.

(4) "Ancillary nursing personnel" means persons employed to assist registered nurses or licensed practical nurses in the care of patients.

(5) "Anesthesiologist" means a physician whose specialized training and experience qualify him or her to administer anesthetic agents and to monitor the patient under the influence of these agents. For the purpose of these Rules the term "anesthesiologist" shall not include podiatrists.

(6) "Anesthetist" means a physician or dentist qualified, as defined in Item ~~(22)~~(26) of this Rule, to administer anesthetic agents or a registered nurse qualified, as defined in Item ~~(22)~~(26) of this Rule, to administer anesthesia.

(7) "Authority Having Jurisdiction" means the Division of Health Service Regulation.

(8) "Chief executive officer" or "administrator" means a qualified person appointed by the governing authority to act in its behalf in the overall management of the facility and whose office is located in the facility.

(9) "Commission" means the North Carolina Medical Care Commission.

(10) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association.

~~(9)~~ (11) "Dentist" means a person who holds a valid license issued by the North Carolina Board of Dental Examiners to practice dentistry.

~~(10)~~ (12) "Department" means the North Carolina Department of Health and Human Services.

~~(11)~~ (13) "Director of nursing" means a registered nurse who is responsible to the chief executive officer and has the authority and direct responsibility for all nursing services and nursing care for the entire facility at all times.

(14) "Financial Assistance" means a policy, including charity care, describing how the organization will provide assistance at its facility, Financial assistance includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services. Financial assistance does not include:

(a) bad debt;

(b) uncollectable charges that the organization recorded as revenue but wrote off due to a patient's failure to pay;

(c) the cost of providing such care to such patients;

(d) the difference between the cost of care provided under Medicare or other government programs, and the revenue derived therefrom.

~~(12)~~ (15) "Governing authority" means the individual, agency or group or corporation appointed, elected or otherwise designated, in which the ultimate responsibility and authority for the conduct of the ambulatory surgical facility is vested.

(16) "Health Insurer" means an entity that writes a health benefit plan as defined in G.S. 131E-214.13.

(17) "Healthcare Common Procedure Coding System (HCPCS)" means a three tiered medical code set consisting of Level I, II and III services and contains the CPT code set in Level I.

~~(13)~~ (18) "JCAHO" or "Joint Commission" means Joint Commission on Accreditation of Healthcare Organizations.

~~(14)~~ (19) "Licensing agency" means the Department of Health and Human Services, Division of Health Service Regulation.

~~(15)~~ (20) "Licensed practical nurse" (L.P.N.) means any person licensed as such under the provisions of G.S. 90-171.

~~(16)~~ (21) "Nursing personnel" means registered nurses, licensed practical nurses and ancillary nursing personnel.

~~(17)~~ (22) "Operating room" means a room in which surgical procedures are performed.

~~(18)~~ (23) "Patient" means a person admitted to and receiving care in a facility.

~~(19)~~ (24) "Person" means an individual, a trust or estate, a partnership or corporation, including associations, joint stock companies and insurance companies; the state, or a political subdivision or instrumentality of the state.

~~(20)~~ (25) "Pharmacist" means a person who holds a valid license issued by the North Carolina Board of Pharmacy to practice pharmacy in accordance with G.S. 90-85.

~~(21)~~ (26) "Physician" means a person who holds a valid license issued by the North Carolina Medical Board to practice medicine. For the purpose of carrying out these Rules, a "physician" may also mean a person holding a valid license issued by the North Carolina Board of Podiatry Examiners to practice podiatry.

(27) "Public or Private Third Party" means the State, federal government employers, health insurers, third-party administrators and managed care organizations.

~~(22)~~ (28) "Qualified person" when used in connection with an occupation or position means a person:

(a) who has demonstrated through relevant experience the ability to perform the required functions; or

(b) who has certification, registration or other professional recognition.

~~(23)~~ (29) "Recovery area" means a room used for the post anesthesia recovery of surgical patients.

~~(24)~~ (30) "Registered nurse" means a person who holds a valid license issued by the North Carolina Board of Nursing to practice nursing as defined in G.S. 90-171.

~~(25)~~ (31) "Surgical suite" means an area which includes one or more operating rooms and one or more recovery rooms.

History Note: *Authority G.S. 131E-149; 131E-214.13; S.L. 2013-382(s.10.1),(s.13.1);S.L. 2014-100;*
Eff. October 14, 1978;
Amended Eff. April 1, 2003; ~~November 1, 1989.~~ November 1, 1989;
Temporary Amendment Eff. December 31, 2014.

TEMPORARY RULES
REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13C .0206

DEADLINE FOR RECEIPT: Wednesday, November 19, 2014

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

On line 6, replace "on" with "upon"

On line 7, who is the "certified data processor"? How does one know this? Do you feel G.S. 131E-214.4 provides sufficient guidance for this?

In (b), why not state "quarterly" or "four times per year"?

On line 13, replace "previous" with "prior"

In (c), line 15, state "Paragraph" (not "Paragraph<u>s</u>")

In (c)(2), line 20, it's "Subparagraph."

On line 21, replace "is to" with "shall"

In (c)(5), line 27, delete "report"

In (e), Page 2, line 1, state "Paragraphs (b) <u>and</u> (c) of this Rule"

On line 2, put "closed accounts" in quotation marks.

In (f), what are data elements? Also, rules generally set the minimum so saying "at a minimum" is generally not encouraged. But if you feel you need the language, retain it.

In (g), give a citation and please take the name of the law out of quotation marks.

Note my suggestion in .2102 for the website references.

Please cite 131E-147.1 in the History Note.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: November 17, 2014

10A NCAC 13C .0206 is adopted under temporary procedures as follows:

10A NCAC 13C .0206 REPORTING REQUIREMENTS

(a) The Department shall establish the lists of the statewide 20 most common outpatient imaging procedures and 20 most common outpatient surgical procedures performed in the ambulatory surgical facility setting to be used for reporting the data required in Paragraphs (b) through (c) of this Rule. The lists shall be based on data provided by the certified statewide data processor. The Department shall make the lists available on its website at: http://www.ncdhhs.gov/dhsr/ahc.

(b) In accordance with G.S. 131E-214.13 and quarterly per year all licensed ambulatory surgical facilities shall report the data required in Paragraph (c) of this Rule related to the statewide 20 most common outpatient imaging procedures and the statewide 20 most common outpatient surgical procedures to the certified statewide data processor in a format provided by the certified statewide processor. This report shall include the related primary CPT and HCPCS codes. The data reported shall be from the quarter ending three months previous to the date of reporting.

(c) The report as described in Paragraphs (b) of this Rule shall be specific to each reporting ambulatory surgical facility and shall include:

(1) the average gross charge for each DRG or procedure if all charges are paid in full without any portion paid by a public or private third party;

(2) the average negotiated settlement on the amount that will be charged for each DRG or procedure as required for patients defined in Paragraph (c)(1) of this Rule. The average negotiated settlement is to be calculated using the average amount charged all patients eligible for the facility's financial assistance policy, including self-pay patients;

(3) the amount of Medicaid reimbursement for each DRG or procedure, including all supplemental payments to and from the ambulatory surgical facility;

(4) the amount of Medicare reimbursement for each DRG or procedure; and

(5) on behalf of patients who are covered by a Department of Insurance licensed third-party and teachers and State employees, report the lowest, average, and highest amount of payments made for each DRG or procedure by each of the facility's top five largest health insurers.

(A) each ambulatory surgical facility shall determine its five largest health insurers based on the dollar volume of payments received from those insurers;

(B) the lowest amount of payment shall be reported as the lowest payment from each of the five insurers on the DRG or procedure;

(C) the average amount of payment shall be reported as the arithmetic average of each of the five health insurers payment amounts;

(D) the highest amount of payment shall be reported as the highest payment from each of the five insurers on the DRG or procedure; and

(E) the identity of the top five largest health insurers shall be redacted prior to submission.

(e) The data reported, as defined in Paragraphs (b) through (c) of this Rule, shall reflect the payments received from patients and health insurers for all closed accounts. For the purpose of this Rule, closed accounts are patient accounts with a zero balance at the end of the data reporting period.

(f) A minimum of three data elements shall be required for reporting under Paragraph (b) of this Rule.

(g) The information submitted in the report shall be in compliance with the federal "Health Insurance Portability and Accountability Act of 1996."

(h) The Department shall provide all specific ambulatory surgical facility data reported pursuant to this Rule on its website.

History Note: *Authority G.S.131E-214.4; 131E-214.13; S.L. 2013-382(s.10.1); S.L. 2014-100; Temporary Adoption Eff. December 31, 2014.*