TEMPORARY RULE-MAKING FINDINGS OF NEED

[Authority G.S. 150B-21.1]

OAH USE ONLY

VOLUME:

ISSUE:

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

2. Rule citation & name: 10A NCAC 13B .2102 REPORTING REQUIREMENTS

3. Action: ☐ **Adoption** ☒ **Amendment** ☐ **Repeal**

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

5. Provide dates for the following actions as applicable:

a. Proposed Temporary Rule submitted to OAH: 11/16/15

b. Proposed Temporary Rule published on the OAH website: 11/20/16

c. Public Hearing date: 12/18/15

d. Comment Period: 11/24/15 – 12/18/15

e. Notice pursuant to G.S. 150B-21.1(a3)(2): 11/16/15

f. Adoption by agency on: 02/12/16

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]: 02/26/16

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 2015-241 (House Bill 97)
Effective date: 09/18/15
☐ **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 amendment 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 2015-241, House Bill 97, “Current Operations and Capital Improvements and Appropriations Act of 2015” which became effective on September 18, 2015. In Section 12A.15.(a) of this law, revisions to the Health Care Cost Reduction and Transparency Act were made. G.S. 131E-214.13 was changed from requiring quarterly reporting of data to requiring annual reporting of data from hospitals beginning with the reporting period ending September 30, 2015. This law also 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 amendment protects 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 a change in the data reporting timeframe requirement for a hospital from quarterly data submission to annual data submission. The time frame for the annual reporting of the data has been mandated by the General Assembly in S.L. 2015-241. Annual data reporting will be used in the reporting of the statewide 100 most frequently reported DRGs, 20 most common outpatient imaging procedures and 20 most common surgical procedures to ensure that these practices are transparent, fair and reasonable to the health care consumer as intended by the General Assembly. A process was established for the data to be submitted to the statewide data processor and 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. The posting of quarterly data has been of some use to the public since posting of the data began; however, the General Assembly recognized the need for more data with each data report submission and amended the reporting timeframe requirement to an annual submission. This proposed rule addresses a change in the established process for health care pricing data submission. With the change to hospital annual data report submission, the larger volume of data submitted will lend itself to be transparent, consistent and accurate, thus ensuring that it 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**	**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.**
Agency contact, if any: Azzie Conley, Section Chief **Phone: 919-855-4646** **E-Mail: azzie.conley@dhhs.nc.gov**	**Typed Name: Dr. John A. Fagg, M.D.** **Title: Chair, N.C. Medical Care Commission** **E-Mail:**

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

SESSION LAW 2015-241
HOUSE BILL 97

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 2015."

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.

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's departments, institutions, and agencies and for other purposes as enumerated, are made for the fiscal biennium ending June 30, 2017, according to the following schedule:

Current Operations – General Fund	**FY 2015-2016**	**FY 2016-2017**
EDUCATION		
Community Colleges System Office	1,069,066,998	1,065,895,520
Department of Public Instruction	8,516,769,297	8,419,444,621
University of North Carolina – Board of Governors		
Appalachian State University	127,841,892	127,835,582
East Carolina University		
Academic Affairs	210,407,112	210,739,558
Health Affairs	73,527,686	73,527,686
Elizabeth City State University	33,759,228	33,759,228
Fayetteville State University	48,741,530	48,741,530
NC A&T State University	90,898,021	90,898,021
NC Central University	82,132,848	82,132,848
NC State University		
Academic Affairs	392,256,502	392,249,291
Agricultural Extension	38,595,927	38,595,927
Agricultural Research	53,099,332	53,099,332

SECTION 12A.12.(d) The Department of Health and Human Services shall submit a report to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Committee on Health and Human Services, and the Fiscal Research Division by June 1, 2016, on the progress of the pilot program and shall include an evaluation plan based on the U.S. Department of Health and Human Services, Health Resources and Services Administration Office of Rural Health Policy's Community Paramedicine Evaluation Tool published in March 2012.

SECTION 12A.12.(e) The Department of Health and Human Services shall submit a final report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2016. At a minimum, the final report shall include all of the following:

(1) An updated version of the evaluation plan required by subsection (d) of this section.
(2) An estimate of the cost to expand the program incrementally and statewide.
(3) An estimate of any potential savings of State funds associated with expansion of the program.
(4) If expansion of the program is recommended, a time line for expanding the program.

STUDY DESIGN AND IMPLEMENTATION OF CONTRACTING SPECIALIST AND CERTIFICATION PROGRAM

SECTION 12A.13. The Joint Legislative Oversight Committee on Health and Human Services shall study and make recommendations regarding the design of a contracting specialist training and certification program for management level personnel within the Department of Health and Human Services (DHHS) similar to the Certified Local Government Purchasing Officer program and local purchasing and contracts program of the University of North Carolina School of Government.

HEALTH CARE COST REDUCTION AND TRANSPARENCY ACT REVISIONS

SECTION 12A.15.(a) 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. – 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,~~ reporting period ending September 30, 2015, and ~~quarterly~~ annually 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 Department:

4

(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 ~~January 1, 2015,~~ March 1, 2016, 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,~~ reporting period ending September 30, 2015, and ~~quarterly~~ annually 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 ~~January 1, 2015,~~ March 1, 2016, 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 method by which the Department shall determine the 20 most common surgical procedures and the 20 most common imaging procedures for which the hospitals and ambulatory surgical facilities must provide the data set out in subsection (d) of this section.

(e1) The Commission shall adopt rules to establish and define no fewer than 10 quality measures ~~identical to those established by the Joint Commission for each of the following:~~ for licensed hospitals and licensed ambulatory surgical facilities.

~~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 Rules Review Commission."

SECTION 12A.15.(b) G.S. 131E-214.14 reads as rewritten:

"**§ 131E-214.14. Disclosure of charity care policy and costs.**

(a) Requirements. – A hospital or ambulatory surgical facility required to file Schedule H, federal form 990, under the Code must provide the public access to its financial assistance policy and its annual financial assistance costs reported on its Schedule H, federal form 990. The information must be submitted annually to the Department in the time, manner, and format required by the Department. The Department must post all of the information submitted pursuant to this subsection on its internet Web ~~site.~~site in one location and in a manner that is searchable. The posting requirement shall not be satisfied by posting links to internet Web sites. The information must also be displayed in a conspicuous place in the organization's place of business.

…."

RENAMING OF OFFICE OF RURAL HEALTH AND COMMUNITY CARE

SECTION 12A.16.(a) The Office of Rural Health and Community Care within the Department of Health and Human Services, Division of Central Management and Support, is hereby renamed the Office of Rural Health.

SECTION 12A.16.(b) Consistent with subsection (a) of this section, the Revisor of Statutes may conform names and titles changed by this section and may correct statutory references as required by this section throughout the General Statutes. In making the changes authorized by this section, the Revisor may also adjust subject and verb agreement and the placement of conjunctions.

FUNDS FOR DEVELOPMENT OF HEALTH ANALYTICS PILOT PROGRAM

SECTION 12A.17.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, the sum of seven hundred fifty thousand dollars ($750,000) in nonrecurring funds for the 2015-2016 fiscal year and the sum of two hundred fifty thousand dollars ($250,000) in recurring funds for the 2015-2016 fiscal year and the 2016-2017 fiscal year shall be used for the development and implementation of a pilot program for Medicaid claims analytics and population health management.

SECTION 12A.17.(b) The Department shall coordinate with the Government Data Analytics Center (GDAC) to develop the pilot program and to provide access to needed data sources, including Medicaid claims data, for the pilot program. The pilot program shall utilize the subject matter expertise and technology available through existing GDAC public-private partnerships in order to apply analytics in a manner that would maximize health care savings and efficiencies to the State and optimize positive impacts on health outcomes.

SECTION 12A.17.(c) By November 30, 2015, the Department shall execute all contractual agreements and interagency data-sharing agreements necessary for development and implementation of the pilot program authorized by this section.

SECTION 12A.17.(d) By January 15, 2016, the Department and GDAC shall provide a progress report on the pilot program authorized by this section to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Committee on Health and Human Services, and the Fiscal Research Division. By May 31, 2016, the Department and GDAC shall make a final report of their findings and recommendations on the pilot program authorized by this section to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Information Technology, and the Fiscal Research Division.

SECTION 33.3. The Fiscal Research Division shall issue a report on budget actions taken by the 2015 Regular Session of the General Assembly. The report shall be in the form of a revision of the Committee Report adopted for House Bill 97 pursuant to G.S. 143C-5-5. The Director of the Fiscal Research Division shall send a copy of the report issued pursuant to this section to the Director of the Budget. The report shall be published on the General Assembly's Internet Web site for public access.

ADJUSTMENT OF ALLOCATIONS TO GIVE EFFECT TO THIS ACT FROM JULY 1, 2015

SECTION 33.3A.(a) The appropriations and authorizations to allocate and spend funds set out in S.L. 2015-133, S.L. 2015-184, and S.L. 2015-233 expire when this act becomes law. At such time, this act governs appropriations and expenditures.

When this act becomes law, the Director of the Budget shall adjust allocations to give effect to this act from July 1, 2015.

SECTION 33.3A.(b) Section 2.1 of S.L. 2015-214 is repealed.

MOST TEXT APPLIES TO THE 2015-2017 FISCAL BIENNIUM

SECTION 33.4. Except for statutory changes or other provisions that clearly indicate an intention to have effects beyond the 2015-2017 fiscal biennium, the textual provisions of this act apply only to funds appropriated for, and activities occurring during, the 2015-2017 fiscal biennium.

EFFECT OF HEADINGS

SECTION 33.5. The headings to the Parts, subparts, and sections of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act, except for effective dates referring to a Part or subpart.

SEVERABILITY

SECTION 33.6. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of this act as a whole or any part other than the part so declared to be unconstitutional or invalid.

EFFECTIVE DATE

SECTION 33.7. Except as otherwise provided, this act becomes effective July 1, 2015.

In the General Assembly read three times and ratified this the 18th day of September, 2015.

s/ Tom Apodaca
Presiding Officer of the Senate

s/ Tim Moore
Speaker of the House of Representatives

s/ Pat McCrory
Governor

Approved 9:35 a.m. this 18th day of September, 2015

REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13B .2102

DEADLINE FOR RECEIPT: Wednesday, February 17, 2016

***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:

Please confirm the Temporary Amended Effective date in light of G.S. 131-214.13(g).

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: February 15, 2016

10A NCAC 13B .2102 is amended 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 (c) through (e) of this Rule. The lists shall be determined annually based upon data provided by the certified statewide data processor. The Department shall make the lists available on its website. The methodology to be used by the certified statewide data processor for determining the lists shall be based on the data collected from all licensed facilities in the State in accordance with G.S. 131E-214.2 as follows:

(1) the 100 most frequently reported DRGs shall be based upon all hospital's discharge data that has been assigned a DRG based on the Centers for Medicare & Medicaid Services grouper for each patient record, then selecting the top 100 to be provided to the Department;

(2) the 20 most common imaging procedures shall be based upon all outpatient data for both hospitals and ambulatory surgical facilities and represent all occurrences of the diagnostic radiology imaging codes section of the CPT codes, then selecting the top 20 to be provided to the Department; and

(3) the 20 most common outpatient surgical procedures shall be based upon the primary procedure code from the ambulatory surgical facilities and represent all occurrences of the surgical codes section of the CPT codes, then selecting the top 20 to be provided to the Department.

(b) Information required or reported in Paragraphs (a), (c), (d), and (i) of this Rule shall be posted on the Department's website at: http://www.ncdhhs.gov/dhsr/ahc and may be accessed at no cost.

(c) In accordance with G.S. ~~131E-214.13 and quarterly per year,~~ 131E-214.13, all licensed hospitals shall report the data required in Paragraph (e) of this Rule related to the statewide 100 most frequently reported DRGs to the certified statewide data processor in a format provided by the certified statewide processor. Commencing with the reporting period ending September 30, 2015, ~~a rolling four quarters~~ an annual data report shall be submitted that includes all sites operated by the licensed hospital. Each annual report shall be ~~for the period ending three months prior to~~ submitted by the due date of ~~the report.~~ January 1.

(d) In accordance with G.S. ~~131E-214.13 and quarterly per year,~~ 131E-214.13, all licensed hospitals shall report the data required in Paragraph (e) 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. Commencing with the reporting period ending September 30, 2015, ~~a rolling four quarters~~ an annual data report shall be submitted that includes all sites operated by the licensed hospital. Each annual report shall be ~~for the period ending three months prior to~~ submitted by the due date of ~~the report.~~ January 1.

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

1 (1) the average gross charge for each DRG, CPT code, or procedure without a public or private third
2 party payer source;
3 (2) the average negotiated settlement on the amount that will be charged for each DRG, CPT code, or
4 procedure as required for patients defined in Subparagraph (e)(1) of this Rule. The average
5 negotiated settlement shall be calculated using the average amount charged all patients eligible for
6 the hospital's financial assistance policy, including self-pay patients;
7 (3) the amount of Medicaid reimbursement for each DRG, CPT code, or procedure, including all
8 supplemental payments to and from the hospital;
9 (4) the amount of Medicare reimbursement for each DRG, CPT code, or procedure; and
10 (5) on behalf of patients who are covered by a Department of Insurance licensed third-party and teachers
11 and State employees, the lowest, average, and highest amount of payments made for each DRG,
12 CPT code, or procedure by each of the hospital's top five largest health insurers.
13 (A) each hospital shall determine its five largest health insurers based on the dollar volume of
14 payments received from those insurers;
15 (B) the lowest amount of payment shall be reported as the lowest payment from each of the
16 five insurers on the DRG, CPT code, or procedure;
17 (C) the average amount of payment shall be reported as the arithmetic average of each of the
18 five health insurers payment amounts;
19 (D) the highest amount of payment shall be reported as the highest payment from each of the
20 five insurers on the DRG, CPT code, or procedure; and
21 (E) the identity of the top five largest health insurers shall be redacted prior to submission.
22 (f) The data reported, as defined in Paragraphs (c) through (e) of this Rule, shall reflect the payments received from
23 patients and health insurers for all closed accounts. For the purpose of this Rule, "closed accounts" are patient accounts
24 with a zero balance at the end of the data reporting period.
25 (g) A minimum of three data elements shall be required for reporting under Paragraphs (c) and (d) of this Rule.
26 (h) The information submitted in the report shall be in compliance with the federal Health Insurance Portability and
27 Accountability Act of 1996, 45 CFR Part 164.
28 (i) The Department shall provide the location of each licensed hospital and all specific hospital data reported pursuant
29 to this Rule on its website. Hospitals shall be grouped by category on the website. On each quarterly report, hospitals
30 shall determine one category that most accurately describes the type of facility. The categories are:
31 (1) "Academic Medical Center Teaching Hospital," means a hospital as defined in Policy AC-3 of the
32 N.C. State Medical Facilities Plan. The N.C. State Medical Facilities Plan may be accessed at:
33 http://www.ncdhhs.gov/dhsr/ncsmfp at no cost.
34 (2) "Teaching Hospital," means a hospital that provides medical training to individuals, provided that
35 such educational programs are accredited by the Accreditation Council for Graduated Medical
36 Education to receive graduate medical education funds from the Centers for Medicare & Medicaid
37 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 (i)(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 the website: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf at no cost.

(5) “Mental Health Hospital,” means a hospital providing psychiatric services pursuant to G.S. 131E-176(21).

History Note: *Authority G.S.131E-214.4; 131E-214.13; S.L. 2015-241, s. 12A.15.(a);*
Temporary Adoption Eff. December 31, 2014;
Eff. September 30, ~~2015.~~ 2015;
Temporary Amendment Eff. February 26, 2016.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13C .0206

DEADLINE FOR RECEIPT: Wednesday, February 17, 2016

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:

Please confirm the Temporary Amended Effective date in light of G.S. 131-214.13(g).

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: February 15, 2016

10A NCAC 13C .0206 is amended 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 (c) and (d) of this Rule. The lists shall be determined annually based upon data provided by the certified statewide data processor. The Department shall make the lists available on its website. The methodology to be used by the certified statewide data processor for determining the lists shall be based on the data collected from all licensed facilities in the State in accordance with G.S. 131E-214.2 as follows:

(1) the 20 most common imaging procedures shall be based upon all outpatient data for ambulatory surgical facilities and represent all occurrences of the diagnostic radiology imaging codes section of the CPT codes, then selecting the top 20 to be provided to the Department; and

(2) the 20 most common outpatient surgical procedures shall be based upon the primary procedure code from the ambulatory surgical facilities and represent all occurrences of the surgical codes section of the CPT codes, then selecting the top 20 to be provided to the Department.

(b) All information required by this Rule shall be posted on the Department's website at: http://www.ncdhhs.gov/dhsr/ahc and may be accessed at no cost.

(c) In accordance with G.S. ~~131E-214.13 and quarterly per year,~~ 131E-214.13, all licensed ambulatory surgical facilities 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. Commencing with the reporting period ending September 30, 2015, ~~a rolling four quarters~~ an annual data report shall be submitted. Each annual report shall be ~~for the period ending three months prior to~~ submitted by the due date of ~~the report.~~ January 1.

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

(1) the average gross charge for each CPT code or procedure without a public or private third party payer source;

(2) the average negotiated settlement on the amount that will be charged for each CPT code or procedure as required for patients defined in Subparagraph (d)(1) of this Rule. The average negotiated settlement shall 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 CPT code or procedure, including all supplemental payments to and from the ambulatory surgical facility;

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

(5) on behalf of patients who are covered by a Department of Insurance licensed third-party and teachers and State employees, the lowest, average, and highest amount of payments made for each CPT code 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 CPT code 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 CPT code 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 (c) and (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 Paragraph (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 45 CFR Part 164.

(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-147.1; 131E-214.4; 131E-214.13; S.L. 2015-241, s. 12A.15.(a);*
Temporary Adoption Eff. December 31, 2014;
Eff. September 30, ~~2015.~~ 2015;
Temporary Amendment Eff. February 26, 2016.