# EXHIBIT B-2

*NEW Temporary Rules*

# Health Care Cost Reduction & Transparency Rules for Pricing & Data Reporting

10A NCAC 13B  Licensing of Hospitals

10A NCAC 13C  Licensing of Ambulatory Surgical Facilities

SB 744 - NEW TRANSPARENCY



FUNDS APPROPRIATED TO IMPLEMENT RECOMMENDATIONS OF THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES REGARDING BEHAVIORAL HEALTH CRISIS SERVICES

**SECTION 12F.5.(a)** The following definitions apply in this section:

(1) Facility-Based Crisis Center. – A 24-hour residential facility licensed under 10A NCAC 27G .5000 to provide facility-based crisis service as described in 10A NCAC 27G .5001.
(2) Secretary. – The Secretary of the North Carolina Department of Health and Human Services.
(3) Behavioral Health Urgent Care Center. – An outpatient facility that provides walk-in crisis assessment, referral, and treatment by licensed behavioral health professionals with prescriptive authority to individuals with an urgent or emergent need for mental health, intellectual or developmental disabilities, or substance abuse services.

**SECTION 12F.5.(b)** From funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for community services for the 2014-2015 fiscal year, the Division shall use two million two hundred thousand dollars ($2,200,000) in recurring funds to accomplish the following:

(1) To increase the number of co-located or operationally linked behavioral health urgent care centers and facility-based crisis centers.
(2) To increase the number of facility-based crisis centers designated by the Secretary as facilities for the custody and treatment of involuntary clients pursuant to G.S. 122C-252 and 10A NCAC 26C .0101. The Department 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.

**Rules for: Hospitals**
**Type of Rule: Temporary**
**MCC Action: Approve for Rule-making**

**EXHIBIT B-2**

1 10A NCAC 13B .2101 is proposed as a temporary rule as follows:

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3 **SECTION .2100 – TRANSPARENCY IN HEALTH CARE COSTS**

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6 **10A NCAC 13B .2101 DEFINITIONS**

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

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

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

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

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

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

20 (a) bad debt;

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

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

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

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

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

29 (8) "Health Insurer" means an entity that writes a health benefit plan as defined in G.S. 131E-
30 214.13(a)(3).

31 (9) "Hospital" means a medical care facility licensed under Article 5 of Chapter 131E or under Article
32 2 of Chapter 122C of the General Statutes.

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

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36 *History Note: Authority G.S. 131E-214.13; S.L. 2013-382(s.10.1); (s.13.1); S.L. 2014-100;*

1 *Temporary Adoption Eff. January 31, 2015.*

**Rules for: Hospitals**
**Type of Rule: Temporary**
**MCC Action: Approve for Rule-making**

**EXHIBIT B-2**

1 10A NCAC 13B .2102 is proposed as a temporary rule as follows:

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3 **10A NCAC 13B .2102 REPORTING REQUIREMENTS**

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

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

13 (c) In accordance with G.S. 131E-214.13 and quarterly per year all licensed hospitals shall report the data required in
14 Paragraph (d) of this Rule related to the statewide 20 most common outpatient imaging procedures and the statewide
15 20 most common outpatient surgical procedures to the certified statewide data processor in a format provided by the
16 certified statewide processor. This report shall include the related primary CPT and HCPCS codes. The data reported
17 shall be from the quarter ending three months previous to the date of reporting and includes all sites operated by the
18 licensed hospital.

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

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

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

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

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

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

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

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

1 (C) the average amount of payment shall be reported as the arithmetic average of each of the
2 five health insurers payment amounts;
3 (D) the highest amount of payment shall be reported as the highest payment from each of the
4 five insurers on the DRG or procedure; and
5 (E) the identity of the top five largest health insurers shall be redacted prior to submission.
6 (e) The data reported, as defined in Paragraphs (b) through (d) of this Rule, shall reflect the payments received from
7 patients and health insurers for all closed accounts. For the purpose of this Rule, closed accounts are patient accounts
8 with a zero balance at the end of the data reporting period.
9 (f) A minimum of three data elements shall be required for reporting under Paragraphs (b) and (c) of this Rule.
10 (g) The information submitted in the report shall be in compliance with the federal "Health Insurance Portability and
11 Accountability Act of 1996."
12 (h) The Department shall provide the location of each licensed hospital and all specific hospital data reported pursuant
13 to this Rule on its website. Hospitals shall be grouped by category on the website. On each quarterly report, hospitals
14 shall determine one category that most accurately describes the type of facility. The categories are:
15 (1) "Academic Medical Center Teaching Hospital," means a hospital as defined in Policy AC-
16 3 of the N.C. State Medical Facilities Plan. The N.C. State Medical Facilities Plan can be
17 accessed at the Division's website at: http://www.ncdhhs.gov/dhsr/ncsmfp.
18 (2) "Teaching Hospital," means a hospital that provides medical training to individuals
19 provided that such educational programs are accredited by the Accreditation Council for
20 Graduated Medical Education to receive graduate medical education funds from the
21 Centers for Medicare & Medicaid Services.
22 (3) "Community Hospital," means a general acute hospital that provides diagnostic and medical
23 treatment, either surgical or nonsurgical, to inpatients with a variety of medical conditions, and that
24 may provide outpatient services, anatomical pathology services, diagnostic imaging services,
25 clinical laboratory services, operating room services, and pharmacy services, that is not defined by
26 the categories listed in this Subparagraph and Subparagraphs (h)(1), (2), or (5) of this Rule.
27 (4) "Critical Access Hospital," means a hospital defined in the Centers for Medicare & Medicaid
28 Services' State Operations Manual, Chapter 2 – The Certification Process, 2254D – Requirements
29 for Critical Access Hospitals (Rev. 1, 05-21-04), including all subsequent updates and revisions.
30 The manual may be accessed at no cost at the internet website: http://www.cms.gov/Regulations-
31 and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf
32 (5) "Mental Health Hospital," means a hospital providing psychiatric services as defined in G.S.
33 131E-176(21).
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35 *History Note: Authority G.S.131E-214.4; 131E-214.13; S.L. 2013-382(s.10.1); S.L. 2014-100;*
36 *Temporary Adoption Eff. January 31, 2015.*

**Rules for: Ambulatory Surgical Facilities**
**Type of Rule: Temporary**
**MCC Action: Approve for Rule-making**

**EXHIBIT B-2**

10A NCAC 13C .0103 is proposed as a temporary rule 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;

1 (b) uncollectable charges that the organization recorded as revenue but wrote off due
2 to a patient's failure to pay;
3 (c) the cost of providing such care to such patients;
4 (d) the difference between the cost of care provided under Medicare or other
5 government programs, and the revenue derived therefrom.
6 ~~(12)~~(15) "Governing authority" means the individual, agency or group or corporation appointed, elected or
7 otherwise designated, in which the ultimate responsibility and authority for the conduct of the
8 ambulatory surgical facility is vested.
9 (16) "Health Insurer" means an entity that writes a health benefit plan as defined in G.S. 131E-214.13.
10 (17) "Healthcare Common Procedure Coding System (HCPCS)" means a three tiered medical code set
11 consisting of Level I, II and III services and contains the CPT code set in Level I.
12 ~~(13)~~(18) "JCAHO" or "Joint Commission" means Joint Commission on Accreditation of Healthcare
13 Organizations.
14 ~~(14)~~(19) "Licensing agency" means the Department of Health and Human Services, Division of Health
15 Service Regulation.
16 ~~(15)~~(20) "Licensed practical nurse" (L.P.N.) means any person licensed as such under the provisions of G.S.
17 90-171.
18 ~~(16)~~(21) "Nursing personnel" means registered nurses, licensed practical nurses and ancillary nursing
19 personnel.
20 ~~(17)~~(22) "Operating room" means a room in which surgical procedures are performed.
21 ~~(18)~~(23) "Patient" means a person admitted to and receiving care in a facility.
22 ~~(19)~~(24) "Person" means an individual, a trust or estate, a partnership or corporation, including associations,
23 joint stock companies and insurance companies; the state, or a political subdivision or
24 instrumentality of the state.
25 ~~(20)~~(25) "Pharmacist" means a person who holds a valid license issued by the North Carolina Board of
26 Pharmacy to practice pharmacy in accordance with G.S. 90-85.
27 ~~(21)~~(26) "Physician" means a person who holds a valid license issued by the North Carolina Medical Board
28 to practice medicine. For the purpose of carrying out these Rules, a "physician" may also mean a
29 person holding a valid license issued by the North Carolina Board of Podiatry Examiners to practice
30 podiatry.
31 (27) "Public or Private Third Party" means the State, federal government employers, health insurers,
32 third-party administrators and managed care organizations.
33 ~~(22)~~(28) "Qualified person" when used in connection with an occupation or position means a person:
34 (a) who has demonstrated through relevant experience the ability to perform the required
35 functions; or
36 (b) who has certification, registration or other professional recognition.

1 ~~(23)~~(29) "Recovery area" means a room used for the post anesthesia recovery of surgical patients.
2 ~~(24)~~(30) "Registered nurse" means a person who holds a valid license issued by the North Carolina Board of
3 Nursing to practice nursing as defined in G.S. 90-171.
4 ~~(25)~~(31) "Surgical suite" means an area which includes one or more operating rooms and one or more
5 recovery rooms.
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7 *History Note:* *Authority G.S. 131E-149; 131E-214.13; S.L. 2013-382(s.10.1),(s.13.1);S.L. 2014-100;*
8 *Eff. October 14, 1978;*
9 *Amended Eff. April 1, 2003; ~~November 1, 1989.~~ November 1, 1989;*
10 *Temporary Amendment Eff. January 31, 2015.*

**Rules for: Ambulatory Surgical Facilities**
**Type of Rule: Temporary**
**MCC Action: Approve for Rule-making**

**EXHIBIT B-2**

1 10A NCAC 13C .0206 is proposed as a temporary rule as follows:

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3 **10A NCAC 13C .0206 REPORTING REQUIREMENTS**

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

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

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

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

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

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

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

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

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

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

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

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

1 (E) the identity of the top five largest health insurers shall be redacted prior to submission.
2 (e) The data reported, as defined in Paragraphs (b) through (c) of this Rule, shall reflect the payments received from
3 patients and health insurers for all closed accounts. For the purpose of this Rule, closed accounts are patient accounts
4 with a zero balance at the end of the data reporting period.
5 (f) A minimum of three data elements shall be required for reporting under Paragraph (b) of this Rule.
6 (g) The information submitted in the report shall be in compliance with the federal "Health Insurance Portability and
7 Accountability Act of 1996."
8 (h) The Department shall provide all specific ambulatory surgical facility data reported pursuant to this Rule on its
9 website.
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11 *History Note:* *Authority G.S.131E-214.4; 131E-214.13; S.L. 2013-382(s.10.1); S.L. 2014-100;*
12 *Temporary Adoption Eff. January 31, 2015.*