Exhibit F/3

1/16/15

Draft Fiscal Note
Hospital and Ambulatory Surgical Facilities
Transparency Rules

Fiscal Impact Analysis for
Permanent Rule Amendment and Adoptions with Substantial Economic Impact

Agency Proposing Rule Change

North Carolina Medical Care Commission

Contact Persons

Drexdal Pratt, Secretary, N.C. Medical Care Commission (DHSR Director)	(919) 855-3750
Azzie Conley, Chief, Acute & Home Care Licensure & Certification Section	(919) 855-4646
Nadine Pfeiffer, Rulemaking Coordinator, N.C. Medical Care Commission	(919) 855-3811
Charles Frock, Member, N.C. Medical Care Commission	(919) 855-3750

Impact Summary

State Government:	Yes
Local Government	Yes
Federal Government:	No
Substantial Economic Impact:	Yes

Statutory Authority

N.C.G.A. Session Law 2013-382 s. 10.1 *(Effective Date: October 1, 2013)*
N.C.G.A. Session Law 2014-100 s. 12G.2 *(Effective Date: August 7, 2014)*
Gen. Stat. 131E-91
Gen. Stat. 131E-214.4
Gen. Stat. 131E-147.1
Gen. Stat. 131E-147.13
Gen. Stat. 131E-149

Rule Citations:

10A NCAC 13B - Licensing of Hospitals

- Definitions 10A NCAC 13B .2101 (Adopt)
- Reporting Requirements 10A NCAC 13B .2102 (Adopt)

10A NCAC 13C - Licensing of Ambulatory Surgical Facilities

- Definitions 10A NCAC 13C .0103 (Amend)
- Reporting Requirements 10A NCAC 13C .0206 (Adopt)

Background

The proposed amendments and adoptions of rules in Chapters 10A NCAC 13B *Licensing of Hospitals* and 10A NCAC 13C *Licensing of Ambulatory Surgical Facilities* are in response to enactment of Session Law 2013-382, Part X. *Transparency in Health Care Costs*, which became effective on October 1, 2013, and Session Law 2014-100,

Part 12.G *Health Care Cost Reduction and Transparency Act Revisions*, which became effective on August 7, 2014. These acts require the N.C. Medical Care Commission (MCC) to adopt rules to ensure the provisions of the acts are properly implemented and the required data is submitted to the Department of Health and Human Services (DHHS) in a uniform manner.

In order for the MCC to comply with the statutory requirements to adopt rules, an ad hoc committee comprised of hospital and ambulatory surgical facility representatives, the public, DHHS staff, agency legal counsel, and chaired by a MCC member, met periodically from October 2013 through April 2014 to prepare these draft rules. Furthermore, since there were timelines embodied within the statute for implementation of rules, temporary rules were adopted effective December 31, 2014, and as required by Gen. Stat. 150B, permanent rulemaking is necessary to comply with these statutory directives.

Additionally, in order to ensure uniformity in data submission, the MCC has decided to utilize a certified statewide data processor to provide the format to be used by the affected facilities when submitting data pursuant to this statute.

Purpose and Benefits

Over the past decade states have attempted to reduce the overall costs of healthcare through various legislative initiatives. Studies have demonstrated that when the public is able to compare the costs of medical procedures between healthcare providers within their geographical area, the costs variances between the providers narrow and results in a lowering of overall procedural costs.[1,2] Through transparency in healthcare cost reporting, competition becomes a factor that provides incentives to the healthcare providers to align their charges to reflect the local market, rather than to remain isolated from view. It is also anticipated by the Department that ultimately these costs reductions will not only result in a significant reduction on a person's private or third-party healthcare expenses, but will also realize as a reduction to taxpayers being subsidized through federal, state and local governmental healthcare programs.

Rule Summaries and Anticipated Fiscal Impact

The statute addresses hospital in-patient, hospital out-patient imaging and surgical procedures, and ambulatory surgical facility out-patient imaging and surgical procedures. When practical, this fiscal note will combine the areas common to both facility types, and separate the facilities where the procedures performed differ.

10A NCAC 13B .2101 and **10A NCAC 13C .0103**

10A NCAC 13B .2101 and 10A NCAC 13C .0103 are definition rules. These rules are being adopted for hospitals and amended for ambulatory surgical facilities to provide clarity in language contained throughout the proposed revised rules for both hospitals and ambulatory surgical facilities.

Fiscal Impact – Statewide
No fiscal impact associated with the adoption or amendment of these rules.

[1] Aw-jung Wu, Gosia Sylwestrzak, CHristaine Shah and Andrea DeVries *"Price Transparency for MRIs Increased Use of Less Costly Providers and Triggered Provider Competition."*

[2] Hans B. Christensen, Eric Floyd and Mark Maffett *"The Effects of Price Transparency Regulation on Prices in the Healthcare Industry."*

10A NCAC 13B .2102 and 10A NCAC 13C .0206

10A NCAC 13B .2102 and 10A NCAC 13C .0206 define the reporting requirements of the Diagnostic Related Groups (DRGs), Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS) codes for hospital in-patient, hospital out-patient imaging and surgical procedures, and ambulatory surgical facility out-patient imaging and surgical procedures. These rules also require the data to be submitted quarterly to the certified statewide data processor in a format provided by the certified statewide data processor.

The certified statewide data processor currently capturing hospital and ambulatory surgical center data pursuant to G.S 131E-214.4 for submission to the Division of Health Service Regulation is Truven Health Analytics. This data, in turn, will be submitted by Truven Health Analytics to the DHHS for placement on its website. Since G.S. 131E-214.4 requires the statewide data processor to provide healthcare data to the Division of Health Service Regulation (DHSR) "at no cost", Truven Heath Analytics is compensated for this service through a contractual agreement with each licensed hospital and ambulatory surgical center. Truven has implemented a fee schedule of the initial set-up cost and recurring submission charge (billed quarterly) for both facility types. The expansion of data required under S.L. 2013-382 will result in Truven amending the current contracts with hospitals and ambulatory surgical centers to address the increased costs associated with statutory compliance.

Using Truven's current fee schedule, the fee structure for ambulatory surgical facilities, for both the initial set-up cost and recurring submission cost reflected in Table 1, will be applied uniformly to all licensed facilities. The fee structure for hospitals reflected in Table 2 is established based upon patient discharges and consists of five tiers with *Tier 1* being utilized for hospitals with the lowest annual patient discharge rate and *Tier 5* being utilized for hospitals with the highest annual patient discharge rate.

The number of hospitals reflected for each tier in Tables 3, 5 and 6 was identified following response by selected hospitals to an inquiry by DHSR comparing the number of licensed beds for each hospital with the number of annual patient discharges. The cost figures reflected in the following tables for data submission were obtained from Truven Health Analytics and survey data provided by the North Carolina Hospital Association. The figures reflected in the table for website development and ongoing maintenance was provided by DHHS.

Table 1. Per Facility Ambulatory Surgical Facility Implementation Costs

AMSF Category	Initial Fee charged by Truven	Recurring Annual Fee charged by Truven	FTE costs required for set-up and 1st quarter submission (40 hrs. @ $30/hr.)	Recurring quarterly FTE costs required for on-going submission (20 hrs. @ $30/hr.)	Total 1st Year Cost*	Total Recurring Annual Cost (4 quarters submission and recurring Truven fee)
All Facilities	$500	$250	$1,200	$600	$3,500	$2,650

* first-year total calculated using initial set-up fee, plus first-quarter FTE costs for set-up, plus three remaining quarters for on-going submission for total 1st year cost. Per hour FTE cost is based on the current rate for hiring a temp employee (Technology Support Analyst) at @ $30.00 / hour.

Table 2. Per Facility Hospital Implementation Costs

Hospital Category	Initial Fee charged by Truven	Recurring Annual Fee charged by Truven	Set-up cost plus 1st quarter submission (80 hrs. @ $75.00/hr.)	Recurring quarterly submission costs (40 hrs. @ $75.00/hr.)	Total 1st Year Cost*	Total Recurring Annual Cost
Tier 1	$200	$100	$16,032	$6,972	$37,148	$27,988
Tier 2	$400	$200	$16,032	$6,972	$37,348	$28,088
Tier 3	$600	$300	$16,032	$6,972	$37,548	$28,188
Tier 4	$800	$400	$16,032	$6,972	$37,748	$28,288
Tier 5	$1,000	$500	$16,032	$6,972	$37,948	$28,388

* First-year total calculated using initial set-up fee, plus first-quarter FTE costs for set-up, plus three remaining quarters for on-going submission for total 1st year cost. The opportunity costs associated with the per hour FTE cost is based on information submitted by the NC Hospital Association representing the estimated salary including costs and benefits @ $75.00 / hour and using existing hospital staff. Since obtaining an actual figure for all 126 licensed hospitals was not possible, the Department assumes the $75.00 / hour estimate represents a figure that may be on the high end of the salary scale.

Fiscal Impact – Federal Government

No fiscal impact associated with the adoption of these rules.

Fiscal Impact – State Government

The impact of compliance with these rules affects State-owned licensed hospitals due to new reporting requirements and DHHS due to increased costs for website development and a requirement to post data received quarterly.

State-Owned Licensed Hospitals

Table 3. Total Data Reporting Costs for State-Owned Hospitals

Hospital Category	Number of Hospitals	Initial Fee charged by Truven	Recurring Annual Fee charged by Truven	Set-up cost plus 1st quarter submission	Recurring quarterly submission costs	Total 1st Year Cost*	Total Recurring Annual Cost
Tier 3	2	$1,200	$600	$32,064	$6,972	$75,096	$56,376
Tier 5	1	$1,000	$500	$16,032	$6,972	$37,948	$28,388
TOTAL	**3**					**$113,044**	**$84,764**

* First-year total calculated using initial set-up fee, plus first-quarter FTE costs for set-up, plus three remaining quarters for on-going submission for total 1st year cost. (Refer to Table 2 for base cost figures)

DHHS

In order to receive and post the data as required by statute, DHHS must develop a website that enables individuals to compare costs for each of the identified procedures. It also becomes necessary to update the website quarterly to reflect the data received for the current reporting period. The following tables reflect the costs to DHHS for developing and maintaining the website, including quarterly updating of data received from Truven.

Table 4. Website Development and On-Going Annual Maintenance *

Position Type	FTE per Hour Cost	Develop Database (80 hrs/FTE)	Develop Website (40 hrs/FTE)	Quarterly Website Data Posting (2 hrs/FTE x 4 quarters)	Total Cost
Business and Technology Application Specialist	$33.43	$0	$1,337.20	$0	$1,337.20
Technology Support Analyst	$26.51	$2,120.80	$1,060.40	$212.08	$3,393.28
TOTAL	**NA**	**$2,120.80**	**$2,397.60**	**$212.08**	**$4,730.48**

**The opportunity costs for staff time devoted to IT development includes salary and benefits using the midrange salaries and benefits costs identified in Tables 4a and 4b below.*

Table 4a.

Salaries	Min	Mid	Max
Business & Tech/App Spec	$43,590.00	$52,227.00	104,454.00
Tech Support Analyst	$32.473.00	$40,500.00	$81,000.00

Table 4b.

Positions	Mid-range salaries	Retirement 15.21	S.S. 7.65	Health Ins. $5,378	Total	Hrs/Yr	Hourly Rate
Business & Tech/App Spec	$52,227.00	$7,944.00	$2,757.60	$5,378.00	$69,544.00	2080	$33.43
Tech Support Analyst	$40,500.00	$6,160.00	$3,098.00	$5,378.00	$55,136.00	2080	$26.51

Fiscal Impact – Local Government

Table 5. Total Data Reporting Costs for County-Owned Hospitals

Hospital Category	Number of Hospitals	Initial Fee charged by Truven	Recurring Annual Fee charged by Truven	Set-up cost plus 1st quarter submission	Recurring quarterly submission costs	Total 1st Year Cost*	Total Recurring Annual Cost
Tier 3	5	$5,000	$2,500	$80,160	$34,860	$187,740	$140,940
TOTAL	**5**					**$187,740**	**$140,940**

* First-year total calculated using initial set-up fee, plus first-quarter FTE costs for set-up, plus three remaining quarters for on-going submission for total 1st year cost. (Refer to Table 2 for base cost figures)

Fiscal Impact – Licensed Facilities (Private Hospitals and Ambulatory Surgical Facilities)

Private Licensed Hospitals

Table 6. Total Statewide Private Hospital Data Reporting Costs

Hospital Category	Number of Hospitals	Initial Fee charged by Truven	Recurring Annual Fee charged by Truven	Set-up cost plus 1st quarter submission	Recurring quarterly submission costs	Total 1st Year Cost*	Total Recurring Annual Cost
Tier 1	30	$6,000	$3,000	$480,960	$209,160	$1,114,440	$839,640
Tier 1	18	$7,200	$3,600	$288,576	$125,496	$672,264	$505,584
Tier 3	50	$30,000	$15,000	$801,600	$348,600	$1,877,400	$1,409,400
Tier 4	10	$8,000	$4,000	$160,320	$69,720	$377,480	$282,880
Tier 5	10	$10,000	$5,000	$160,320	$69,720	$379,480	$283,880
TOTAL	**118**					**$4,421,064**	**$3,321,384**

* First-year total calculated using initial set-up fee, plus first-quarter FTE costs for set-up, plus three remaining quarters for on-going submission for total 1st year cost. (Refer to Table 2 for base cost figures)

Ambulatory Surgical Facilities

Table 7. Statewide Ambulatory Surgical Facility Implementation Costs per Truven Health Analytics Data Reporting Costs

AMSF Category	Number of AMSF	Initial Fee charged by Truven	Recurring Annual Fee charged by Truven	Set-up cost plus 1st quarter submission	Recurring quarterly submission costs	Total 1st Year Cost*	Total Recurring Annual Cost
AMSF	116	$58,000	$29,000	$139,200	$69,600	$406,000	$307,400
TOTAL	**116**					**$406,000**	**$307,400**

* First-year total calculated using initial set-up fee, plus first-quarter FTE costs for set-up, plus three remaining quarters for on-going submission for total 1st year cost. (Refer to Table 2 for base cost figures)

Alternatives

One alternative that the MCC considered was for the Department to develop a request for proposal (RFP) to identify another external data source that can provide the services consistent with the data collection process currently utilized by Truven Health Analytics. This seemed impractical because of several factors involved with the RFP process. Factoring the statutory implementation timelines against the steps in developing, posting, reviewing, awarding, and subsequent implementation of the process would far exceed the time needed by Truven Health Analytics to expand their current collection process to meet the needs of this reporting requirement. Additionally, there is no way to anticipate any potential cost savings or increases to reporting that may result in identifying another external data collection and reporting provider. This alternative is considered by the MCC to be the least viable alternative to the mechanism adopted to comply with the statutory healthcare cost reporting mandate.

Another alternative that the MCC considered was for the hospitals and ambulatory surgical facilities to directly report the data quarterly to DHHS through DHSR. This option was not favorable due to various factors which included cost, time constraints in meeting the statute's reporting deadline, and lack of consistency for the

providers in data reporting. For this alternative, DHSR would need to develop a reporting instrument, a database to store the data, and a website in order for the hospitals and ambulatory surgical facilities to report the data quarterly.

DHSR staff would need to spend time developing the reporting tool, developing the database and developing the website for implementation of the reported quarterly data from the database. DHHS staff would also need to spend time developing the overall website design for the public's interest. In addition, since data would be submitted to DHSR throughout the quarter, DHSR would require 1.5 FTEs of staff time to oversee the process of quarterly data reporting, which entails receiving and tracking reporting submissions by licensed facility type, maintaining the facility inventory, following up with facilities that did not submit, reviewing data submissions, entering data for all submissions, training providers on the use of the reporting tool, and analyzing data. Staffing for 1.5 FTEs for these tasks would be supplied through a temporary employment agency.

DHSR FTE costs for data reporting directly from hospitals and ambulatory surgical facilities would be:

Position Type	FTE per Hour Cost	Develop Spreadsheet (24hrs/FTE)	Total Cost
Business Officer	$39.47	$947.28	$947.28

Position Type	FTE per Hour Cost	Develop Database (80 hrs/FTE)	Develop Website (40 hrs/FTE)	Quarterly Website Data Posting (2 hrs/FTE x 4 quarters)	Total Cost
Business and Technology Application Specialist	$43.27	$0	$1730.80	$0	$1730.80
Technology Support Analyst	$28.96	$2316.80	$1158.40	$231.68	$3706.88

Position Type	FTE per Hour Cost	Oversee quarterly reporting process (1.5 FTE)	Total Annual Cost
Temporary Staffing agency - Analyst	$29	$90,480	$90,480

Even with using the state agency as the conduit for data submission, the hospitals and ambulatory surgical facilities will incur costs for the time it takes their staff to populate the data submission form, with initial set up and training and each subsequent quarterly reporting period as seen in the table below:

Facility Type	FTE's Required for Set-up ($75/hr) per facility	FTE's Required for Quarterly Reporting ($75/hr) per facility	Total 1st Year Cost per facility	Aggregate Total 1st Year Cost	Total Recurring Costs per facility	Aggregate Recurring Costs
Hospital	$6,000 (80 hrs)	$3,000 (40 hrs)	$18,000	$2,268,000 (126 facilities)	$12,000	$1,512,000 (126 facilities)
Ambulatory Surgical Center	$3,000 (40 hrs)	$1,500 (20 hrs)	$9,000	$1,044,000 (116 facilities)	$6,000	$696,000 (116 facilities)
Total	$9,000	$4,500	$27,000	$3,312,000	$18,000	$2,208,000

The total costs for the state agency to receive data submissions quarterly from hospitals and ambulatory surgical centers is seen in the table below:

Entity	Total 1st Year Cost	Total Recurring Cost
DHHS/DHSR	$96,613.48	$90,711.68
All Hospitals	$2,268,000	$1,512,000
All Ambulatory Surgical Centers	$1,044,000	$696,000
Total	$3,408,613.48	$2,298,711.68

DHSR would need time to develop a reporting tool for the hospitals and ambulatory surgical facilities to use in submitting the data as required by statute directly to the state agency. In addition, staff would need to be in place to provide education on the use of the reporting tool to these facilities. DHSR would also need time to develop a database to store the data submitted quarterly that had the ability to run reports and queries and load the database to the web server so the webpages can link to the database and post to the website for public to view. The statute requires June 30, 2014, to be the end date for the first quarter of data collection and all the facilities should be prepared to begin to submit data on July 1, 2014. In considering this alternative, the likelihood of the state agency's ability to receive data directly on July 1, 2014, was a concern due to the short time frame to accomplish these tasks.

The statewide data processor (Truven Health Analytics) has been collecting data on the 35 most-frequently-reported charges of hospitals and freestanding ambulatory surgical facilities in accordance with G.S. 131E-214.4. Data is submitted quarterly via a reporting tool with a large number of data elements. The facilities are currently familiar with this provider and the provider's reporting process.

Although a data reporting tool would need to be developed by the data processor for enactment of Session Law 2013-382, Part X, *Transparency in Health Care Costs*, to capture the statutory reporting requirements, the practice of data submission to this provider is consistent to the current process. The statewide data processor would be able to create a new data reporting tool by using pertinent data fields from their current reporting tool and add new data fields, thus making it feasible to meet the statute's established deadline for data reporting.

In addition, with providers currently submitting data quarterly to the data processor, as required in G.S. 131E-214.4, should providers submit data quarterly to another entity such as the state agency, this lack of consistency with a quarterly data reporting entity may cause confusion in submission deadline dates and could potentially result in inadvertent submissions of the incorrect data reporting tool to the wrong reporting entity. Consistency is key for accuracy in data collection and reporting for the process transparency in health care costs to be beneficial to the public.

In consideration of the factors stated above, the MCC rejected the alternative of having the hospitals and ambulatory surgical facilities directly report the data quarterly to DHHS through DHSR.

Risk Analysis

As DHSR staff attempted to determine the anticipated fiscal impact of implementing the proposed rules, throughout all areas where amounts were not firmly established, staff attempted to use conservatively high estimates for the per hour costs and the number of hours necessary to develop a data submission program and continue providing quarterly data as statutorily. If DHSR overestimated these per hour costs, the overall initial and annual recurring costs could be reduced by as much as up to 10% from the figures represented in the table below, although until a full year of data submission has been received, any attempt to calculate actual figures is not possible.

Fiscal Impact Summary

These rules are used by state and local governments, licensed hospitals, licensed ambulatory surgical facilities, the certified statewide data processor, and DHHS to comply with the transparency in healthcare costs mandates contained in S.L. 2013-382 and S.L. 2014-100. The aggregate financial impact of these proposed permanent rules is reflected in the following table using the net present value (NPV) rate figure of these rules at 1.07 and the NPV function.

	First Year Costs	Ongoing Costs			
NPV Cost Est.	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Federal Government	-	-	-	-	-
State Government	$118,500.00	$85,000.00	$41,062.80	$19,837.10	$9,583.14
Local Government	$187,740.00	$187,000.00	$68,115.94	$32,906.25	$15,896.74
Private Entities	$4,830,000.00	$3,629,000.00	$1,753,140.10	$846,927.58	$409,143.76
Aggravate Impact	**$5,136,240.00**	**$3,855,000.00**	**$1,862,318.84**	**$899,670.94**	**$434,623.64**