**North Carolina Department of Health and Human Services**
**Division of Health Service Regulation**
**Office of the Director**

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Drexdal Pratt
Division Director

September 22, 2014

**MEMORANDUM**

**TO:** Interested Parties

**FROM:** Megan Lamphere, Rule-making Coordinator

**RE:** Proposed Temporary Rules for Hospitals and Ambulatory Surgical Facilities

GS 150B-21.1 requires a rule-making body to notify certain individuals of its intent to publish a temporary rule on the Office of Administrative Hearings website. It also requires notification of the date, time and location of the public hearing on the rules.

The N.C. Medical Care Commission has submitted form OAH 0700 to the Codifier of Rules, Office of Administrative Hearings, indicating its intent to propose the following temporary rules:

Hospital Rules: 10A NCAC 13B .2101, .2102
Ambulatory Surgical Facility Rules: 10A NCAC 13C .0103, .0206

The public hearing is scheduled for October 15, 2014 at 10:00 a.m. in Room 104, Brown Building, 801 Biggs Drive, Raleigh, NC 27603. The building is located on the Dorothea Dix Hospital campus. The Commission is accepting public comments on these rules from September 25, 2014 – October 17, 2014. Written comments can also be sent via electronic mail to DHSR.RulesCoordinator@dhhs.nc.gov. The proposed effective date of these rules is January 31, 2015.

A copy of the proposed rules are attached and can also be found at the Division of Health Service Regulation web site (www.ncdhhs.gov/dhsr/ruleactions.html). If you have questions related to the proposed rules please contact the Acute & Home Care Licensure & Certification Section at (919) 855-4620.

Should you have any questions regarding this memorandum please feel free to contact me at 919-855-3974.

cc: Drexdal Pratt, Division Director
Azzie Conley, Chief, Acute & Home Care Licensure & Certification

10A NCAC 13B .2101 is proposed for temporary adoption 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. January 31, 2015.*

10A NCAC 13B .2102 is proposed for temporary adoption 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. January 31, 2015.*

10A NCAC 13C .0103 is proposed for temporary amendment 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. January 31, 2015.*

10A NCAC 13C .0206 is proposed for temporary adoption 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. January 31, 2015.*