NCHA represents hospitals in North Carolina and appreciates the opportunity to provide comments pertaining to the reporting section of Health Care Cost Reduction and Transparency Act Revisions as published on the OAH website at http://www.ncoah.com/rules/10A%20NCAC%2013B,C%20proposed%20temporary%20rules.pdf

10A NCAC 13B .2102 REPORTING REQUIREMENTS
(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.

- The rule requires each hospital to report the statewide 100 most common DRGs to the certified statewide data processor. Certain hospitals including critical access hospitals and acute rehabilitation hospitals do not operate under the DRG based CMS inpatient payment system. Therefore they do not have specific DRG values that can be compared with those values reported by hospitals that are on the DRG payment system. We recommend modifications to the rule to reflect those differences, or in the situation of a hospital that does not provide inpatient medical surgical services, that it be considered for exemption from the inpatient reporting requirement.

- NCHA hospitals have estimated significant compliance costs for reporting the very specific information required by this law and regulation. NCHA recommends that the Division of Health Service Regulation and the Medical Care Commission work to establish a reporting process that enables hospitals to submit data directly and that does not require additional fees to be paid by the provider for data 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.

- The Transparency law requires quarterly collection of data, which is interpreted in the ensuing regulation to require only reporting accounts that were paid in full (zero balance) during that specific quarter, regardless of when care was provided. This, however, is resulting in the comparison of claims that may be years old and based on different charge levels, as it doesn't account for the date care was actually provided. It also lowers the volume of reported events used in the report, which could bring the case count to below 3 in some hospitals. Further, only the largest hospitals with the more sophisticated information technology systems are able to automatically extract episodes of care strictly on the dates that claims were paid in full. Others will have to manually extract each claim for each DRG and for each of the top 20 surgery and imaging procedures in order to include them into the report, an extremely time consuming procedure for those hospitals.

We recommend that the reporting process be extended to a longer period of time that is inclusive of the care episode, billings and collected payments.

(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.

Both hospitals and ambulatory surgery centers will likely face challenges in compiling the charges and payments related to specific procedures on the *statewide 20 most common outpatient surgical procedures list.*

Hospital payments are based on a number of coded services that are bundled to reflect the total payment for the procedure. If multiple procedures are provided during an episode of care, there is currently not a way to accurately extract only those codes and values that pertain to the "top 20" procedure.

Similarly, Ambulatory Surgery Centers may be reimbursed by some insurers that use a global payment system. Those payments may be inclusive of anesthesia, professional and other fees, which also cannot currently be accurately adjusted in a reported payment.

NCHA appreciates that the Division of Health Service Regulation and the Medical Care Commission continues to work with the workgroup of stakeholders in an effort to resolve these issues and thereby improve the data and the reports to be displayed on the Department website.

Please let me know if you have questions, and thank you for the opportunity to comment on these proposed temporary regulations.

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