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

**Agency Proposing Rule Change**

North Carolina Medical Care Commission

**Contact Persons**

| | |
|---|---|
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**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)

(See proposed rule text in the Appendix.)

**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] A price transparency study conducted by AIM Specialty Health on elective advanced imaging procedures of patients demonstrated a significant decrease in imaging costs for MRI scans by 18.7% when patients were given informed choice about price differences and provider selection options. Since the study also revealed a decrease in the costs associated with CT Scans, it is conceivable to assume the transparency in costs model for medical services/procedures and providers' results in lowering costs.

The potential benefits from these proposed rules to the citizens of N.C. can be demonstrated using the following assumptions. The Health Care Cost Institute's 2013 Health Care Cost and Utilization Report cited a Radiology cost of $135/person covered by employer-sponsored insurance in 2013.[3] The Kaiser Family Foundation estimated that 48% of North Carolinians were covered by private insurance in the year 2013 (42% employer, 6% other private).[4] The AIM Specialty Health study demonstrated a reduction of 18.7% in cost for MRI procedures. If the proposed rules were to lead to a decrease in the radiology costs in N.C. similar to those demonstrated in the AIM Specialty Health study, applying this 18.7% reduction assumption to the projected July 2014 population of N.C. of 9,955,983,[5] multiplied by the percent of the population covered by private insurance (48%) and the cost of an MRI procedure ($135), would result in totals savings of over $120 million. Even if the cost reductions in N.C. would be lower than those of the AIM Specialty Health study, and if similar cost reductions would not

[1] Wu, Sze-jung, et al. "Price transparency for MRIS increased use of less costly providers and triggered provider competition." *Health Affairs* 33.8 (2014): 1391-1398.

[2] Christensen, Hans B., Eric Floyd, and Mark Maffett. "The Effects of Price Transparency Regulation on Prices in the Healthcare Industry." *Center for Health and the Social Sciences (CHeSS)* (2013).

[3] Health Care Cost Institute Inc. website. "2013 Health Care Cost and Utilization Report Appendix," Table A4: Expenditures Per Capita by Subservice Category (2011-2013). October 2014. Available at: http://www.healthcostinstitute.org/files/2013%20HCCUR%20Appendix%2010-28-14.pdf

[4] The Henry J. Kaiser Family Foundation website. Health Insurance Coverage of the Total Population. Available at: http://kff.org/other/state-indicator/total-population/

[5] North Carolina Office of State Budget and Management. Facts and Figures. Population Estimate and Projections. Annual County Population Totals, 2010-2019. Available at: http://www.osbm.state.nc.us/ncosbm/facts_and_figures/socioeconomic_data/population_estimates/demog/countytotals_2010_2019.html

occur outside of medical imaging procedures, it can be reasonably assumed that the costs would decrease by at least $10 million, therefore benefitting consumers.

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. DHHS staff also anticipate that these costs reductions will not only result in a significant reduction on private and third-party healthcare expenses but will also materialize as a reduction in costs to taxpayers through a reduction in subsidies to 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.

**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. The latest change to the proposed rules text also requires annual 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.

Truven’s current fee structure for ambulatory surgical facilities (AMSF), for both the initial set-up cost and recurring submission cost as 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.

There are currently 126 hospitals in North Carolina and 116 ambulatory surgical facilities. For the proposed of this fiscal note, and given the low fluctuation in facilities per year, these numbers are assumed constant for the next 10 years.

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[1]**

| 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.)[2] | Recurring quarterly FTE costs required for on-going submission (20 hrs. @ $30/hr.)[2] | Total 1st Year Cost[3] | Total Recurring Annual Cost (4 quarters submission and recurring Truven fee) |
|---|---|---|---|---|---|---|
| All Facilities | $500 | $250 | $1,200 | $600 | $3,500 | $2,700 |

[1] First year and recurring annual cost numbers are rounded to the nearest hundred.

[2] DHSR's estimate of the hourly cost in this Table is based on an actual cost DHHS paid to temporary staffing agencies for Human Service Evaluator/Planner IV temporary staff. The number of hours required for set-up and the first submission and for the on-going quarterly submissions were based on staff's best professional judgment.

[3] First-year total cost was calculated using initial set-up fee, plus FTE cost for set-up and first quarter submission, plus three remaining quarters for on-going submission for the first year.

**Table 2. Per Facility Hospital Implementation Costs[1]**

| Hospital Category | Initial Fee charged by Truven | Recurring Annual Fee charged by Truven | Set-up cost plus 1st quarter submission (80 hrs. @ $75/hr.)[2] | Recurring quarterly submission costs (40 hrs. @ $75/hr.)[2] | Total 1st Year Cost[3] | Total Recurring Annual Cost |
|---|---|---|---|---|---|---|
| Tier 1 | $200 | $100 | $6,000 | $3,000 | $15,200 | $12,100 |
| Tier 2 | $400 | $200 | $6,000 | $3,000 | $15,400 | $12,200 |
| Tier 3 | $600 | $300 | $6,000 | $3,000 | $15,600 | $12,300 |
| Tier 4 | $800 | $400 | $6,000 | $3,000 | $15,800 | $12,400 |
| Tier 5 | $1,000 | $500 | $6,000 | $3,000 | $16,000 | $12,500 |

[1] First year and recurring annual cost numbers are rounded to the nearest hundred.

[2] The opportunity costs associated with the per hour FTE cost is based on information submitted by the N.C. Hospital Association representing the estimated salary, including costs and benefits, at $75/hour and using existing hospital staff. The number of hours required for set-up and the first submission and for the on-going quarterly submissions were based on staff's best professional judgment.

[3] First-year total cost was calculated using initial set-up fee, plus first-quarter FTE costs for set-up, plus three remaining quarters for on-going submission for the first year.

*Impact – Federal Government*

No fiscal impact associated with the adoption of these rules.

*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*

The proposed change would affect state-owned hospitals, as they too would be required to submit information, and Table 3 below presents that impact.

**Table 3. Total Data Reporting Costs for State-Owned Hospitals[1]**

| 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[2] | Total Recurring Annual Cost |
|---|---|---|---|---|---|---|---|
| Tier 3 | 2 | $1,200 | $600 | $12,000 | $6,000 | $31,000 | $25,000 |
| Tier 5 | 1 | $1,000 | $500 | $6,000 | $3,000 | $16,000 | $13,000 |
| **TOTAL** | **3** | | | | | **$47,000** | **$38,000** |

[1] First year and recurring annual cost numbers are rounded to the nearest thousand.

[2] First-year total cost was calculated using initial set-up fee, plus first-quarter FTE costs for set-up and submission, plus three remaining quarters for on-going submission for the first year. (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 (Table 4 through Table 5) reflect the costs to DHHS for developing and maintaining the website, including quarterly updating of data received from Truven.

**Table 4. First Year Website Development and On-Going Quarterly Website Data Posting ***

| 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 First Year Cost | Total Recurring Annual Cost |
|---|---|---|---|---|---|---|
| Business and Technology Application Specialist | $62 | $0 | $2,500 | $0 | $2,500 | $0 |
| Technology Support Analyst | $41 | $3,300 | $1,600 | $300 | $5,200 | $300 |
| **TOTAL** | **N/A** | **$3,300** | **$4,100** | **$300** | **$7,700** | **$300** |

*The opportunity costs for staff time devoted to IT development includes salary and benefits using the cost for salaries and benefits identified in Tables 4a and 4b below. The estimates for hours per FTE are based on actual time expenditures incurred for implementation of the quarterly reporting process for development of the database, the website, and posting of the quarterly report. Numbers are rounded to the nearest hundred.

*Table 4a. N.C. State Employee Salary Data*

| Position Type | Min. | Average | Max. |
|---|---|---|---|
| Business & Technology/ Application Specialist | $57,000 | $88,000 | $119,019 |
| Tech Support Analyst | $32,473 | $57,000 | $81,000 |
| Business Officer* | $38,748 | $70,000 | $101,602 |

*Source:* N.C. Office of State Human Resources. "State of North Carolina Salary Plan." Revised October 1, 2014. Available at: http://www.oshr.nc.gov/Guide/CompWebSite/2014%20Salary%20Plan%20Book.pdf

* This information will be used in calculations described in the Alternatives section.

*Table 4b. Calculation of Hourly FTE Cost*

| Positions | Average Salaries | Retirement (15.21%)[1] | FICA (7.65%)[2] | Health Ins. ($5,378) [1] | Paid Leave (16.93%)[2] | Total | Hourly Rate (rounded)[3] |
|---|---|---|---|---|---|---|---|
| Business & Tech./App. Spec. | $88,000 | $13,385 | $6,732 | $5,378 | $14,898 | $128,393 | $62 |
| Tech. Support Analyst | $57,000 | $8,670 | $4,361 | $5,378 | $9,650 | $85,058 | $41 |
| Business Officer[4] | $70,000 | $10,647 | $5,355 | $5,378 | $11,851 | $103,231 | $50 |

[1] *Source:* Session Law 2014-100 (Current Operations and Capital Improvements Appropriations Act of 2014), sec. 35.13. Available at: http://www.ncleg.net/Sessions/2013/Bills/Senate/PDF/S744v9.pdf

[2] *Source:* N.C. Office of State Human Resources. "State of North Carolina 2014 Compensation & Benefits Report." May 2014. Available at: http://www.oshr.nc.gov/Guide/CompWebSite/2014%20compensation%20&%20benefits%20report.pdf

[3] Assumes a total of 2,080 possible work hours.

[4] This information will be used in calculations described in the Alternatives section.

*Fiscal Impact – Local Government*

The proposed change would affect local government-owned hospitals, as they too would be required to submit cost information, and Table 5 below presents that impact.

**Table 5. Total Data Reporting Costs for County-Owned Hospitals[1]**

| 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[2] | Total Recurring Annual Cost |
|---|---|---|---|---|---|---|---|
| Tier 3 | 5 | $3,000 | $1,500 | $30,000 | $15,000 | $78,000 | $62,000 |
| **TOTAL** | **5** | | | | | **$78,000** | **$62,000** |

[1] First year and recurring annual cost numbers are rounded to the nearest thousand.

[2] First-year cost was calculated using initial set-up fee, plus first-quarter FTE costs for set-up and submission, plus three remaining quarters for on-going submission for the first year. (Refer to Table 2 for base cost figures.)

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

The tables below present the cost to private hospitals and ambulatory surgical units, by facility type.

*Private Licensed Hospitals*

**Table 6. Total Statewide Private Hospital Data Reporting Costs[1]**

| 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[2] | Total Recurring Annual Cost |
|---|---|---|---|---|---|---|---|
| Tier 1 | 30 | $6,000 | $3,000 | $180,000 | $90,000 | $456,000 | $363,000 |
| Tier 2 | 18 | $7,200 | $3,600 | $108,000 | $54,000 | $277,000 | $220,000 |
| Tier 3 | 50 | $30,000 | $15,000 | $300,000 | $150,000 | $780,000 | $615,000 |
| Tier 4 | 10 | $8,000 | $4,000 | $60,000 | $30,000 | $158,000 | $124,000 |
| Tier 5 | 10 | $10,000 | $5,000 | $60,000 | $30,000 | $160,000 | $125,000 |
| **TOTAL** | **118** | | | | | **$1,831,000** | **$1,447,000** |

[1] First year and recurring annual cost numbers are rounded to the nearest thousand.

[2] First-year cost was calculated using initial set-up fee, plus first-quarter FTE costs for set-up and submission, plus three remaining quarters for on-going submission for the first year. (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[1]**

| 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[2] | Total Recurring Annual Cost |
|---|---|---|---|---|---|---|---|
| AMSF | 116 | $58,000 | $29,000 | $139,200 | $69,600 | $406,000 | $307,000 |
| **TOTAL** | **116** | | | | | **$406,000** | **$307,000** |

[1] First year and recurring annual cost numbers are rounded to the nearest thousand.

[2] First-year cost was calculated using initial set-up fee, plus first-quarter FTE costs for set-up and submission, plus three remaining quarters for on-going submission for the first year. (Refer to Table 2 for base cost figures.)

**Alternatives**

*Alternative 1*

One alternative that the MCC considered was for DHSR to develop a request for proposal (RFP) to identify another external data-services provider that could 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, DHSR does not believe any potential cost savings or quality improvements to

reporting would be likely to result from identifying another external data collection and reporting provider. The MCC considers this alternative to be the least viable among the three alternatives it considered to comply with the statutory healthcare-cost reporting mandate.

*Alternative 2*

Another alternative that the MCC considered was for the hospitals and ambulatory surgical facilities to directly report the data quarterly to DHHS through DHSR. The MCC rejected this alternative due to various factors including 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 modify the main DHHS website to accommodate the new online reporting tool to make it user friendly for the public. As seen in Tables 8 and 9 below, individuals with varied skill sets would be needed for this endeavor. Due to the job responsibilities of these individuals and the tasks charged for the project, there would be varied costs associated for implementation. The Business Officer (Advanced Banded position), Table 8, would develop the spreadsheet for the providers to enter the quarterly data submissions and submit to the agency, of which the Temporary Analyst, Table 10, would use for reviewing the data and entering the data into the database. In Table 9, the Technology Support Analyst (Journey Banded position) would be responsible for developing the database to house the data submissions and for developing the initial website for posting the data, while the Business and Technology Application Specialist (Advanced Banded position) would be responsible for refining the website into a more user friendly look and functionality.

In addition, since data would be submitted to DHSR throughout the quarter, as seen in Table 11 below, 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. The type of staff needed for these activities would be comparable to a Human Service Planner/Evaluator IV, pay grade 74, which would require someone that would be able to review, track and analyze 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:

**Table 8. Staff Cost for DHHS Implementation of Alternative 2**

| Position Type | FTE per Hour Cost[1] | Develop Spreadsheet (24hrs/FTE)[2] | Develop Database[3] | Develop Website[3] | Quarterly Website Data Posting[3] | Reporting Oversight (1.5 FTE)[4] | Total First Year Cost | Total Recurring Cost |
|---|---|---|---|---|---|---|---|---|
| Business and Technology Application Specialist | $62 | $0 | $0 | $2,500 | $0 | $0 | $2,500 | $0 |
| Technology Support Analyst | $41 | $0 | $3,300 | $1,600 | $300 | $0 | $5,200 | $300 |
| Business Officer | $50 | $1,200 | $0 | $0 | $0 | $0 | $1,200 | $0 |
| Temporary Staff Analyst[4] | $30[4] | $0 | $0 | $0 | $0 | $94,000 | $94,000 | $94,000 |
| **TOTAL** | | | | | | | **$102,900** | **$94,300** |

[1] See Tables 4a and 4b for the derivation of these costs.

[2] Spreadsheet development time was estimated as an average, based on best professional judgment. The actual time may be less, or more than estimated.

[3] The assumptions for the number of FTE hours are the same as those used to compute Table 4.

[4] This position would oversee quarterly reporting process and the agency estimated it would require 1.5 FTE hours per quarter. The hourly cost in this Table is based on an actual cost DHHS paid to temporary staffing agencies for Human Service Evaluator/Planner IV temporary staff.

Even with using the state agency as the conduit for data submission, the hospitals and ambulatory surgical facilities will still incur the same 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 and as documented in the analysis above:

**Table 9. Total Statewide Hospital and Ambulatory Surgical Facilities Data Reporting Costs**

| Facility Type | FTE Cost of Set-up per facility[1] | FTE Cost for Quarterly Reporting per facility[2] | Total 1st Year Cost per facility | Total Recurring Costs per facility | Aggregate Total 1st Year Cost[3] | Aggregate Recurring Costs[3] |
|---|---|---|---|---|---|---|
| Hospital | $6,000 | $3,000 | $16,000 | $12,500 | $1,956,000 | $1,547,000 |
| Ambulatory Surgical Facility | $1,200 | $600 | $3,500 | $2,700 | $406,000 | $307,000 |
| Total | | | | | **$2,362,000** | **$1,854,000** |

[1] Based on 80 FTE hours for hospitals at $75/hour and 40 FTE hours per AMSF at $30/hour.

[2] Based on 40 FTE hours for hospitals at $75/hour and 20 FTE hours per AMSF at $30/hour.

[3] Based on 126 hospitals and 116 AMSFs; these numbers are assumed to stay constant over the next few years.

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

**Table 10. Summary of Impacts from Alternative 2***

| Entity | Total 1st Year Cost | Total Recurring Cost |
|---|---|---|
| DHHS/DHSR | $100,000 | $100,000 |
| All Hospitals | $2,000,000 | $1,500,000 |
| All Ambulatory Surgical Centers | $400,000 | $300,000 |
| **Total** | **$2,500,000** | **$1,900,000** |

* Numbers are rounded to the nearest hundred thousand.

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. The estimates were based on what providers submitted as the cost for quarterly submission of quarterly data that the initial proposed rules required. However, the latest revision to the proposed rules requires quarterly submission of annual data. The agency received some information on there being no additional cost for this change to the proposed rule; nonetheless, it remains unclear whether this change would actually result in any additional costs.

If DHSR overestimated these assumptions and the number of hours to complete the steps necessary for data submission and the per hour costs associated with compliance, the overall initial and annual recurring costs could be reduced by as much as represented in the following table. The table assumes half the time used in analysis would be required, i.e. a hospital would need 40 and 20 FTE hours for set-up and quarterly reporting, respectively, and an ambulatory surgical facilities would need 20 and 10 FTE hours, respectively. Also, the table assumes that the FTE/hour cost for hospitals is $50 (instead of $75) and $20 (instead of $30) for ambulatory surgical facilities. As in the analysis above, this table assumes the number of hospitals and of AMSFs (126 and 116, respectively) would continue to stay relatively constant.

**Table 11. Sensitivity Analysis for Total Hospital and Ambulatory Surgical Facilities Data Reporting Costs**

| Facility Type | FTE's Required for Set-up per facility | FTE's Required for Quarterly Reporting per facility | Total 1st Year Cost per facility | Total Recurring Costs per facility | Aggregate Total 1st Year Cost | Aggregate Recurring Costs |
|---|---|---|---|---|---|---|
| Hospital | $2,000 | $1,000 | $6,000 | $4,500 | $696,000 | $1,000 |
| Ambulatory Surgical Facilities | $400 | $200 | $1,500 | $1,100 | $174,000 | $122,000 |
| Total | | | | | **$870,000** | **$123,000** |

An additional uncertainty in the estimates results from the assumption that the number of hospitals and ambulatory surgical facilities in the state would not change. This assumption was made based on the relatively low fluctuation in the number of facilities. If this assumption proves not to hold over the following 10 years, then the estimated provided in the summary table below would move in the same direction as the change in number of facilities.

**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 impact of these proposed permanent rules is reflected in the table below:

**Table 12. Summary of Estimated Impact**

| | 10-Year Present Value[1] | First-Year Impact | Ongoing Costs |
|---|---|---|---|
| **COSTS** | | | |
| Federal Government | N/A | - | - |
| State Government Cost | $10,000 | $7,700 | $300 |
| State Owned Hospitals | $300,000 | $47,000 | $38,000 |
| Local Owned Facilities | $500,000 | $78,000 | $62,000 |
| Private Owned Facilities | $11,300,000 | $1,831,000 | $1,447,000 |
| **TOTAL COSTS** | **$12.1 million** | **$2.0 million** | **$1.5 million** |
| **BENEFITS** | | | |
| Conservative Estimate of Healthcare Consumer Savings** | **$70.2 million** | **$5.0 million** | **$10.0 million** |
| **NET AND AGGREGATE IMPACTS** | | | |
| **Aggregate Impact** | **$82 million** | **$7 million** | **$12 million** |
| **Net Impact** | **+$40 million** | **$3 million** | **$8 million** |

* Present value calculated at a 7% discount rate, with ongoing costs and benefits estimated to continue for ten years. Numbers are rounded to the nearest hundred thousand, where possible.

** Estimates assume that consumer savings on radiology/medical imaging in North Carolina will equal roughly one-tenth of the transparency-related cost reductions for MRIs found in Wu et al. (2014) and will build gradually over the course of the first year of implementation.

**APPENDIX**

10A NCAC 13B .2101 is proposed for adoption as follows:

## SECTION .2100 – TRANSPARENCY IN HEALTH CARE COSTS

### 10A NCAC 13B .2101 DEFINITIONS

In addition to the terms defined in G.S. 131E-214.13, the following terms shall apply throughout this Section, unless text indicates to the contrary:

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

(2) "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.

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

(4) "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 the patients in Sub-Item (4)(b) of this Rule; or

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

(5) "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.

*History Note:* *Authority G.S. 131E-214.13; S.L. 2013-382, s.10.1; S.L. 2013-382, s.13.1; S.L. 2014-100, s. 12G.2; Temporary Adoption Eff. December 31, ~~2014.~~ 2014; Eff. September 1, 2015.*

10A NCAC 13B .2102 is proposed for 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 (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 and 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) All information required by Paragraphs (a), (c) and (d) 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, 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 September 30, 2015, a rolling four quarters data report shall be submitted that includes all sites operated by the licensed hospital. Each report shall be for the period ending three months prior to the due date of the report.

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

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

(1) the average gross charge for each DRG, CPT code, or procedure for all payer sources;

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

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

(E) the identity of the top five largest health insurers shall be redacted prior to submission.

(f) The data reported, as defined in Paragraphs (c) through (e) 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.

(g) A minimum of three data elements shall be required for reporting under Paragraphs (c) and (d) of this Rule.

(h) The information submitted in the report shall be in compliance with the federal Health Insurance Portability and Accountability Act of 1996, 45 CFR Part 164.

(i) 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 may be accessed at: http://www.ncdhhs.gov/dhsr/ncsmfp at no cost.

(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 (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. 2013-382, s.10.1; S.L. 2014-100, s. 12G.2; Temporary Adoption Eff. December 31, ~~2014.~~ 2014; Eff. September 1, 2015.*

10A NCAC 13C .0103 is proposed for amendment as follows:

**10A NCAC 13C .0103 DEFINITIONS**

In addition to the terms defined in G.S. 131E-214.13, the following terms shall apply throughout ~~As used in~~ this Subchapter, unless the context clearly requires ~~otherwise, the following terms have the meanings specified:~~ otherwise:

(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~~ this Subchapter, the term "anesthesiologist" shall not include podiatrists.

(6) "Anesthetist" means a physician or dentist qualified, as defined in ~~Item~~ Items (10) and ~~(22)~~ (24) of this Rule, to administer anesthetic agents or a registered nurse qualified, as defined in ~~Item~~ Items ~~(22)~~ (25) and (27) of this Rule, to administer anesthesia.

(7) "Authority ~~Having Jurisdiction"~~ 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) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association.

~~(9)~~ (10) "Dentist" means a person who holds a valid license issued by the North Carolina Board of Dental Examiners to practice dentistry.

~~(10)~~ (11) "Department" means the North Carolina Department of Health and Human Services.

~~(11)~~ (12) "Director of nursing" means a registered nurse who is responsible to the chief executive officer or administrator and has the authority and direct responsibility for all nursing services and nursing care for the entire facility at all times.

(13) "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 the patients in Sub-Item (13)(b); or

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

~~(12)~~ (14) "Governing authority" means the individual, ~~agency or group~~ agency, 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.

(15) "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)~~ (16) "JCAHO" or "Joint Commission" means Joint Commission on Accreditation of Healthcare Organizations.

~~(14)~~ (17) "Licensing agency" means the Department of Health and Human Services, Division of Health Service Regulation.

~~(15)~~ (18) "Licensed practical ~~nurse" (L.P.N.)~~ nurse (L.P.N.)" means any person licensed as such under the provisions of ~~G.S. 90-171.~~ G.S. 90-171.20(8).

~~(16)~~ (19) "Nursing personnel" means registered nurses, licensed practical ~~nurses~~ nurses, and ancillary nursing personnel.

~~(17)~~ (20) "Operating room" means a room in which surgical procedures are performed.

~~(18)~~ (21) "Patient" means a person admitted to and receiving care in a facility.

~~(19)~~ (22) "Person" means an individual, a trust or estate, a partnership or corporation, including associations, joint stock companies and insurance companies; the ~~state,~~ State, or a political subdivision or instrumentality of the state.

~~(20)~~ (23) "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.~~ G.S. 90-85.3A.

~~(21)~~ (24) "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.

~~(22)~~ (25) "Qualified ~~person"~~ person," when used in connection with an occupation or ~~position~~ position, means a person:

(a) who has demonstrated through ~~relevant~~ experience the ability to perform the required functions; or

(b) who has certification, ~~registration~~ registration, or other professional recognition.

~~(23)~~ (26) "Recovery area" means a room used for the ~~post-anesthesia~~ post-anesthesia recovery of surgical patients.

~~(24)~~ (27) "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.~~ G.S. 90-171.20(7).

~~(25)~~ (28) "Surgical suite" means an area ~~which~~ that 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.L. 2013-382, s.13.1; S.L. 2014-100, s. 12G.2;*
*Eff. October 14, 1978;*
*Amended Eff. April 1, 2003; November 1, 1989;*
*Temporary Amendment Eff. December 31, ~~2014.~~ 2014;*
*Eff.* September *1, 2015.*

10A NCAC 13C .0206 is proposed for 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 (c) and (d) of this Rule. The lists shall be determined annually based upon data provided by the certified statewide data processor. The lists shall be 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, 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 September 30, 2015, a rolling four quarters data report shall be submitted. Each report shall be for the period ending three months prior to the due date of the report.

(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 for all payer sources;

(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. 2013-382, s.10.1; S.L. 2014-100, s. 12G.2;*
*Temporary Adoption Eff. December 31, ~~2014.~~ 2014;*
*Eff. September 1, 2015.*