

November 2019

Reporting under North Carolina's HealthCare Transparency Law and Regulations

HB 834 and its subsequent revisions and regulations include specific reporting requirements for licensed hospitals and ambulatory surgical centers. The "Transparency in Health Care Costs" rule was published in the July 1, 2014 issue of the *NC Register* and amended in August 2014 through changes in the Senate Budget Act (SB744). Technical updates to the regulation have been approved since that time.

2015 Section 12A.15(a) of House Bill 97 modified the reporting requirement to an annual basis, beginning with the report period ending September 30, 2015 for submission in January of 2016. Additional changes pertaining to the *Disclosure of charity care policy and costs* require the DHR to post providers' financial assistance policies and annual financial assistance costs (from Schedule H, federal form 990) directly to its website instead of using provider's weblinks. The DHR is now collecting that information on the annual *hospital license renewal application* form.

Regulations & Implementation

The Transparency in Health Care Cost regulation can be found in SECTION .2100 of the Administrative Code on the *Division of Health Service Regulation* website. The DHR collects these data with assistance from the statewide data processor, IBM (formerly Truven Health) Analytics. IBM has developed an electronic common format to use in reporting data, which will be displayed on the DHR webpage at <https://www2.ncdhhs.gov/dhr/ahc/hb834/index.html> along with the current DRG and procedure lists, reports, rules and related information.

Guidance for Reporting

The following is intended as guidance for completing IBM's financial data file in accordance with 10A NCAC 13B .2102 and 13C .0206, and was updated with the assistance of the Hospital Transparency Workgroup (through meetings with the State's DHR and Medical Care Commission), NCHA's MRI/GAP workgroup, and hospital and freestanding ambulatory surgery providers. This document will continually be updated to reflect regulatory and other changes.

Commencing with the data period ending September 30, 2015, an annual data report shall be submitted that includes all sites operated by the licensed hospital or ambulatory surgery center. *(Previously a quarterly report included data from a rolling four quarters)* This includes both the inpatient 100 DRG's and the 20 most common outpatient surgical procedures and the 20 most common outpatient imaging procedures. Therefore, each January 1 submission will include 12 months' DRG and outpatient procedure data for the period ending the previous September 30.

Each of (e)(1) through (e)(5) below is required to be completed using the 100 most frequently reported Diagnostic Related Groups and the 20 most common outpatient imaging and 20 most common outpatient surgical procedures included in the IBM File User Guide. Note that Medicare and Medicaid data should be reported using the templates found on the Transparency Reporting Resource section of NCHA's website at <https://www.ncha.org/transparency/????>. Also, the Transparency rule establishes that only those DRGs, CPT code or procedures where three or more cases exist per reporting period shall be reported under each of the following categories, so



hospitals should not report DRGs, CPT code or procedures in any of the payment categories where fewer than three cases exist. Hospitals should also not include the names of any insurers in their data transmissions to IBM. Please use the following as guidance in completing and submitting your data to IBM by the January 1 deadline.

Guidance for 10A NCAC 13B .2102 (e) Reporting Requirements

*(e)(1) the **average gross charge** for each DRG, CPT code or procedure without a public or private third party payer source.*

- On the form provided by IBM, record the average gross charge per the Chargemaster for each DRG, CPT code or procedure provided to patients without public or private insurance for the year of the data collection period. Record full charges before application of any discount, adjustment or write-off.

*(e)(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.*

- On the form provided by IBM, record the average total collection on the amount charged for each DRG, CPT code or procedure for (e)(1) above. Hospitals should calculate this using the average amount collected from self-pay patients, including those eligible for the facility's financial assistance policy. Include both formulaic and additional negotiated discounts, as well as any payments from Medicaid Pending patients.

*(e)(3) the amount of **Medicaid reimbursement** for each DRG, CPT code, or procedure, including all supplemental payments to and from the hospital;*

- On the form provided by IBM, record the average amount of North Carolina Medicaid reimbursement for each DRG, CPT code or procedure including all *supplemental payments* to and from the hospital. Begin with your Base Medicaid Rate as adjusted for each DRG, CPT code or procedures case weight. Critical Access Hospitals should estimate their inpatient reimbursement by taking the Medicaid amount for each DRG, CPT code or procedure and applying to it the Medicaid cost to charge ratio.
- *Supplemental Payments:* Hospitals are required to add the Medicaid supplemental payment amount to each DRG, CPT code or procedure. NCHA strongly suggests using the “**RCC Transparency Template**,” which was developed by NCHA’s MRI/GAP Workgroup specifically for this purpose. Supplemental payment calculations determined by this process will ensure that hospital reimbursements posted on the DHSR website are accurate and comparable.

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

- On the form provided by IBM, record the average amount of Medicare reimbursement for each DRG using data from the “**Medicare Payment Rate**” spreadsheet on NCHA’s website. The data in the table were derived from publicly available files from the 2019 final rule on the CMS website.

- Critical Access Hospitals can estimate their Medicare DRG reimbursement by applying their overall cost to charge ratio to the average charge for each of the posted 100 DRG’s where 3 or more cases were recorded during the reporting period.

*(e)(5) on behalf of patients who are covered by a **Department of Insurance licensed third-party (including Medicare Advantage) 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 (or ambulatory surgery center’s) top five largest health insurers.*

- (e)(5)(A) each hospital (or ambulatory surgery center) shall determine its five largest health insurers based on the dollar volume of all payments received from those insurers.*
- (e)(5)(B) the lowest amount of payment shall be reported as the lowest payment from each of the five insurers on the DRG (hospitals), CPT code, or procedure.*
- (e)(5)(C) the average of amount of payment shall be reported as the arithmetic average of each of the five health insurers payment amounts;*
- (e)(5)(D) the highest amount of payment shall be reported as the highest payment from each of the five insurers on the DRG (hospitals), CPT code, or procedure; and*
- (e)(5)(E) The identity of the top five largest health insurers shall be redacted prior to submission.*

- Reimbursement amounts to be listed in .2102 (e)(5) of the regulation should be based on each of the 5 largest health insurers (as measured by dollar volume of all payments received).
- The amount reported from an insurer should include all of that insurer’s plans if multiple plans or products are offered.
- For each of the top five insurers, three data elements; the lowest, the highest and the average amount, should be recorded for each DRG, CPT code or procedure for the reporting period
- The average amount of payment should be based on the paid claims for each of the five insurers during the reporting period.
- Report all payments including the patient portion.

*(f) 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 annual data-reporting period.*

- Count all reimbursements received from claims that went to a zero balance in active accounts receivable (*regardless of when care was provided*) during the data-reporting period. Include in

your report those accounts that your facility considers closed and has written off, regardless of post write-off collection activity.

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

- The rule establishes that only those DRG's, CPT codes or procedures where three or more cases exist per data reporting period shall be reported under each of the five reporting categories.

*(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.*