

GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2011

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SENATE BILL 496\*  
Health Care Committee Substitute Adopted 6/6/11  
PROPOSED HOUSE COMMITTEE SUBSTITUTE S496-PCS95107-TK-32

Short Title: Medicaid and Health Choice Provider Req. (Public)

Sponsors:

Referred to:

April 4, 2011

1 A BILL TO BE ENTITLED  
2 AN ACT RELATING TO REQUIREMENTS OF MEDICAID AND HEALTH CHOICE  
3 PROVIDERS.

4 The General Assembly of North Carolina enacts:

5 SECTION 1. The General Statutes are amended by adding a new Chapter to read:

6 "Chapter 108C.

7 "Medicaid and Health Choice Provider Requirements.

8 "§ 108C-1. Scope; applicability of this Chapter.

9 This Chapter applies to providers enrolled in Medicaid or Health Choice.

10 "§ 108C-2. Definitions.

11 The following definitions apply in this Chapter:

- 12 (1) Adverse determination. – A final decision by the Department to deny,  
13 terminate, suspend, reduce, or recoup a Medicaid payment or to deny,  
14 terminate, or suspend a provider's or applicant's participation in the Medical  
15 Assistance Program.
- 16 (2) Applicant. – An individual, partnership, group, association, corporation,  
17 institution, or entity that applies to the Department for enrollment as a  
18 provider in the North Carolina Medical Assistance Program or the North  
19 Carolina Health Insurance Program for Children.
- 20 (3) Department. – The North Carolina Department of Health and Human  
21 Services, its legally authorized agents, contractors, or vendors who acting  
22 within the scope of their authorized activities, assess, authorize, manage,  
23 review, audit, monitor, or provide services pursuant to Title XIX or XXI of  
24 the Social Security Act, the North Carolina State Plan of Medical  
25 Assistance, the North Carolina State Plan of the Health Insurance Program  
26 for Children, or any waivers of the federal Medicaid Act granted by the  
27 United States Department of Health and Human Services.
- 28 (4) Division. – The Division of Medical Assistance of the Department.
- 29 (5) Final overpayment, assessment, or fine. – The amount the provider owes  
30 after appeal rights have been exhausted, which shall not include any agency  
31 decision that is being contested at the Department or the Office of



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1 Administrative Hearings or in Superior Court, provided that the Superior  
2 Court has entered a stay pursuant to the provisions of G.S. 150B-48.

3 (6) Health Choice. – The Health Insurance Program for Children authorized by  
4 G.S. 108A-70.25 and as set forth in the North Carolina State Plan of the  
5 Health Insurance Program for Children.

6 (7) Managing employee. – As defined in 42 C.F.R. § 455.101.

7 (8) Medicaid. – The Medical Assistance program authorized by G.S. 108A-54  
8 and as set forth in the North Carolina State Plan of Medical Assistance.

9 (9) Owner and/or operator. – As defined in 42 C.F.R. § 455.101.

10 (10) Provider. – An individual, partnership, group, association, corporation,  
11 institution, or entity required to enroll in the North Carolina Medical  
12 Assistance Program or the North Carolina Health Insurance Program for  
13 Children to provide services, goods, supplies, or merchandise to a Medicaid  
14 or Health Choice recipient.

15 (11) Revalidation. – The reenrollment of a provider in the Medicaid or Health  
16 Choice programs as required under federal law.

17 **§ 108C-3. Medicaid and Health Choice provider screening.**

18 (a) Provider Screening. – The Department shall conduct provider screening of Medicaid  
19 and Health Choice providers in accordance with applicable State or federal law or regulation.

20 (b) Enrollment Screening. – The Department must screen all initial provider  
21 applications for enrollment in Medicaid and Health Choice, including applications for a new  
22 practice location, and all revalidation requests based on Department assessment of risk and  
23 assignment of the provider to a categorical risk level of "limited," "moderate," or "high." If a  
24 provider could fit within more than one risk level described in this section, the highest level of  
25 screening is applicable.

26 (c) Limited Categorical Risk Provider Types. – The following provider types are hereby  
27 designated as "limited" categorical risk:

28 (1) Ambulatory surgical centers.

29 (2) End-stage renal disease facilities.

30 (3) Federally qualified health centers.

31 (4) Health programs operated by an Indian Health Program (as defined in  
32 section 4(12) of the Indian Health Care Improvement Act) or an urban  
33 Indian organization (as defined in section 4(29) of the Indian Health Care  
34 Improvement Act) that receives funding from the Indian Health Service  
35 pursuant to Title V of the Indian Health Care Improvement Act.

36 (5) Histocompatibility laboratories.

37 (6) Hospitals, including critical access hospitals, Department of Veterans Affairs  
38 Hospitals, and other State or federally owned hospital facilities.

39 (7) Local Education Agencies.

40 (8) Mammography screening centers.

41 (9) Mass immunization roster billers.

42 (10) Nursing facilities, including Intermediate Care Facilities for the Mentally  
43 Retarded.

44 (11) Organ procurement organizations.

45 (12) Physician or nonphysician practitioners (including nurse practitioners,  
46 CRNAs, physician assistants, physician extenders, occupational therapists,  
47 speech/language pathologists, chiropractors, and audiologists), optometrists,  
48 and medical groups or clinics.

49 (13) Radiation therapy centers.

50 (14) Rural health clinics.

51 (15) Hearing aid dealers.

1        (d) When the Department designates a provider as a "limited" categorical level of risk,  
2 the Department shall conduct such screening functions as required by federal law.

3        (e) Moderate Categorical Risk Provider Types. – The following provider types are  
4 hereby designated as "moderate" categorical risk:

5            (1) Ambulance services.

6            (2) Comprehensive outpatient rehabilitation facilities.

7            (3) Critical Access Behavioral Health Agencies.

8            (4) Dentists and orthodontists.

9            (5) Hospice organizations.

10           (6) Independent clinical laboratories.

11           (7) Independent diagnostic testing facilities.

12           (8) Pharmacy Services.

13           (9) Physical therapists enrolling as individuals or as group practices.

14           (10) Revalidating adult care homes delivering Medicaid-reimbursed services.

15           (11) Revalidating agencies providing durable medical equipment, including, but  
16 not limited to, orthotics and prosthetics.

17           (12) Revalidating agencies providing home or community-based services  
18 pursuant to waivers authorized by the federal Centers for Medicare and  
19 Medicaid Services under 42 U.S.C. § 1396n(c).

20           (13) Revalidating agencies providing private duty nursing, home health, personal  
21 care services or in-home care services, or home infusion.

22        (f) When the Department designates a provider as a "moderate" categorical level of  
23 risk, the Department shall conduct such screening functions as required by federal law and  
24 regulation.

25        (g) High Categorical Risk Provider Types. – The following provider types are hereby  
26 designated as "high" categorical risk:

27           (1) Prospective (newly enrolling) adult care homes delivering  
28 Medicaid-reimbursed services.

29           (2) Agencies providing behavioral health services, excluding Critical Access  
30 Behavioral Health Agencies.

31           (3) Directly enrolled outpatient behavioral health services providers.

32           (4) Prospective (newly enrolling) agencies providing durable medical  
33 equipment, including, but not limited to, orthotics and prosthetics.

34           (5) Agencies providing HIV case management.

35           (6) Prospective (newly enrolling) agencies providing home or community-based  
36 services pursuant to waivers authorized by the federal Centers for Medicare  
37 and Medicaid Services under 42 U.S.C. § 1396n(c).

38           (7) Prospective (newly enrolling) agencies providing personal care services or  
39 in-home care services.

40           (8) Prospective (newly enrolling) agencies providing private duty nursing, home  
41 health, or home infusion.

42           (9) Providers against whom the Department has imposed a payment suspension  
43 based upon a credible allegation of fraud in accordance with 42 C.F.R. §  
44 455.23 within the previous 12-month period. The Department shall return  
45 the provider to its original risk category not later than 12 months after the  
46 cessation of the payment suspension.

47           (10) Providers that were excluded, or whose owners, operators, or managing  
48 employees were excluded, by the U.S. Department of Health and Human  
49 Services Office of Inspector General or another state's Medicaid program  
50 within the previous 10 years.

1           (11) Providers who have incurred a Medicaid or Health Choice final  
2 overpayment, assessment, or fine to the Department in excess of twenty  
3 percent (20%) of the provider's payments received from Medicaid and  
4 Health Choice in the previous 12-month period. The Department shall return  
5 the provider to its original risk category not later than 12 months after the  
6 completion of the provider's repayment of the final overpayment,  
7 assessment, or fine.

8           (12) Providers whose owners, operators, or managing employees were convicted  
9 of a disqualifying offense pursuant to G.S. 108C-4 but were granted an  
10 exemption by the Department within the previous 10 years.

11       (h) When the Department designates a provider as a "high" categorical level of risk, the  
12 Department shall conduct such screening functions as required by federal law and regulation.

13       (i) For providers dually enrolled in the federal Medicare program and Medicaid, the  
14 Department may rely on the results of the provider screening performed by Medicare  
15 contractors.

16       (j) For out-of-state providers, the Department may rely on the results of the provider  
17 screening performed by the Medicaid agencies or Health Insurance Program for Children  
18 agencies of other states.

19 **"§ 108C-4. Criminal history record checks for certain providers.**

20       (a) The Department shall conduct criminal history records checks of provider applicants  
21 and enrolled providers in accordance with federal law and regulation.

22       (b) The Division shall deny enrollment or terminate the enrollment of a provider where  
23 any person with a five percent (5%) or greater direct or indirect ownership interest in the  
24 provider has been convicted of a criminal offense related to that person's involvement with the  
25 Medicare, Medicaid, or Health Choice program in the last 10 years, unless the Division  
26 determines that denial or termination of enrollment is not in the best interests of Medicaid and  
27 the State Medicaid agency documents that determination in writing. The Department shall  
28 honor civil and criminal settlement agreements entered into with a provider or any person with  
29 a five percent (5%) or greater direct or indirect ownership interest in the provider within 10  
30 years of the effective date of this act.

31       (c) The Division may deny enrollment or terminate the enrollment of a provider subject  
32 to G.S. 108C-3(g) for any of the following offenses of the provider, an owner and/or operator,  
33 or employee if, after review of the seriousness, age, and other circumstances involving the  
34 offense, the Division determines it is in the best interest of the integrity of Medicaid or Health  
35 Choice to do so: any criminal offenses as set forth in any of the following Articles of Chapter  
36 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article  
37 5A, Endangering Executive, Legislative, and Court Officers; Article 6, Homicide; Article 7A,  
38 Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction;  
39 Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material;  
40 Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article  
41 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and  
42 Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit  
43 Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20,  
44 Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article  
45 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery;  
46 Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article  
47 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the  
48 Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes  
49 also include possession or sale of drugs in violation of the North Carolina Controlled  
50 Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses

1 such as sale to underage persons in violation of G.S. 18B-302, or driving while impaired in  
2 violation of G.S. 20-138.1 through G.S. 20-138.5.

3 **"§ 108C-5. Payment suspension and audits utilizing extrapolation.**

4 (a) The Department may suspend payments to a provider in accordance with the  
5 requirements and procedures set forth in 42 C.F.R. § 455.23.

6 (b) In addition to the procedures for suspending payment set forth at 42 C.F.R. §  
7 455.23, the Department may also suspend payment to any provider that (i) owes a final  
8 overpayment, assessment, or fine to the Department and has not entered into an approved  
9 payment plan with the Department or (ii) has had its participation in the Medicaid or Health  
10 Choice programs suspended or terminated by the Department. For purposes of this section, a  
11 suspension or termination of participation does not become final until all administrative appeal  
12 rights have been exhausted and shall not include any agency decision that is being contested at  
13 the Department or the Office of Administrative Hearings or in Superior Court provided that the  
14 Superior Court has entered a stay pursuant to the provisions of G.S. 150B-48.

15 (c) For providers who owe a final overpayment, assessment, or fine to the Department,  
16 the payment suspension shall begin the thirty-first day after the overpayment, assessment, or  
17 fine becomes final. The payment suspension shall not exceed the amount owed to the  
18 Department, including any applicable penalty and interest charges.

19 (d) Providers whose participation in the Medicaid or Health Choice programs has been  
20 suspended or terminated shall have all payments suspended beginning on the thirty-first day  
21 after the suspension or termination becomes final.

22 (e) The Department shall consult with the N.C. Departments of Treasury and Revenue  
23 and other State departments and agencies to determine if a provider owes debts or fines to the  
24 State. The Department may collect any of these debts owed to the State subsequent to  
25 consideration by the Department of the financial impact upon the provider and the impact upon  
26 access to the services provided by the provider.

27 (f) When issuing payment suspensions in accordance with this Chapter, the Department  
28 may suspend payment to all providers which share the same IRS Employee Identification  
29 Number or corporate parent as the provider or provider site location which owes the final  
30 overpayment, assessment, or fine. The Department shall give 30 days advance written notice to  
31 all providers which share the same IRS Employee Identification Number or corporate parent as  
32 the provider or provider site location of the intention of the Department to implement a  
33 payment suspension.

34 (g) The Department is authorized to approve a payment plan for a provider to pay a  
35 final overpayment, assessment, or fine including interest and any penalty. The payment plan  
36 can include a term of up to 24 months. The Department shall establish in rule the conditions of  
37 such provider payment plans. Nothing in this subsection shall prevent the provider and the  
38 Department from mutually agreeing to modifications of a payment plan.

39 (h) All payments suspended in accordance with this Chapter shall be applied toward  
40 any final overpayment, assessment, or fine owed to the Department.

41 (i) Prior to extrapolating the results of any audits, the Department shall demonstrate  
42 and inform the provider that (i) the provider failed to substantially comply with the  
43 requirements of State or federal law or regulation or (ii) the Department has credible allegation  
44 of fraud concerning the provider.

45 (j) Audits that result in the extrapolation of results must be performed and reviewed by  
46 individuals who shall be credentialed by the Department, as applicable, in the matters to be  
47 audited, including, but not limited to, coding or specific clinical issues.

48 (k) The Department, prior to conducting audits that result in the extrapolation of results  
49 shall identify to the provider the matters to be reviewed and specifically list the clinical,  
50 including, but not limited to, assessment of medical necessity, coding, authorization, or other  
51 matters reviewed and the time periods reviewed.

1       (l) For those matters and time periods identified in subsection (k) of this section, the  
2 provider shall not be subject to further audits by the Department, unless the Department  
3 receives a credible allegation of fraud concerning the same time period or the federal  
4 government initiates action based on allegations of fraud or other illegal activity for the same  
5 time period.

6       (m) The Department may specify in rules the means by which a provider may conduct  
7 voluntary self-audits upon matters subject to audit by the Department. The Department has the  
8 authority to review the self-audit for compliance with requirements of State or federal law and  
9 regulation and may reject any self-audit conducted by a provider found not in compliance.  
10 Upon the provider's payment or payment agreement for any final overpayment, assessment, or  
11 fine arising from the provider's self-audit, the provider shall not be subject to further audits by  
12 the Department of the matters and time periods subject to the provider's self-audit, except  
13 where the Department has received a credible allegation of fraud or the federal government  
14 initiates action based on allegations of fraud or other illegal activity for the same time period.

15       (n) The results of audits that result in the extrapolation of results may be challenged by  
16 a provider within the limited or moderate risk categories, pursuant to G.S. 108C-3.

17           (1) The provider shall notify the Department within 15 days of receipt of the  
18 tentative audit results of the provider's challenge of the Department's results  
19 under this subsection. The provider's notification shall select the means of  
20 challenging the error rate found by the Department.

21           (2) The provider may challenge the error rate found by the Department by doing  
22 one of the following:

23           a. Conducting a one hundred percent (100%) file review of those  
24 matters and time periods identified in subsection (k) of this section  
25 and providing the results to the Department within 60 days from the  
26 date of the receipt of the Department's notice of tentative audit  
27 results.

28           b. Conducting a second audit upon a sample identified and produced by  
29 the Department utilizing the same statistical and sampling  
30 methodology to produce a sample twice the size of the original  
31 sample to review those matters and time periods identified in  
32 subsection (k) of this section. The Department shall provide a new  
33 sample to the provider within 30 days from the date of receipt of a  
34 provider's request. The provider shall have 60 days from receipt of  
35 the new sample to conduct the audit and provide the results to the  
36 Department.

37           (3) The results of an audit conducted by the provider pursuant to this subsection  
38 shall be binding upon the provider. The Department has the authority to  
39 review the provider's audit for compliance with the requirements of State  
40 and federal law and regulation and may reject any audit conducted by a  
41 provider pursuant to this subsection found not in compliance.

42           (4) Nothing in this subsection shall limit a provider from challenging the  
43 accuracy of the Department's audit, the statistical methodology of the  
44 Department's original sample, or the credentials of the individuals who  
45 performed and reviewed the audit.

46       (o) The Department shall permit limited correction of clerical, typographical,  
47 scrivener's, and computer errors by the provider prior to final determination of any audit.

48       (p) The provider shall have no less than 30 days from the date of the receipt of the  
49 Department's notice of tentative audit results to provide additional documentation not provided  
50 to the Department during any audit.

1       (q) Except as required by federal agency, law, or regulation, or instances of credible  
2 allegation of fraud, the provider shall be subject to audits which result in the extrapolation of  
3 results for a time period of up to 36 months from date of payment of a provider's claim.

4       (r) At least annually, the Department shall publish notice of the intention to use audits  
5 that result in the extrapolation of results upon its Web site. Such notice shall include the  
6 services, provider types, audit elements, and the time periods subject to audit.

7       (s) Nothing in this Chapter shall be construed to prevent the Department from  
8 conducting unannounced or targeted audits of providers.

9 **"§ 108C-6. Agents, clearinghouses, and alternate payees; registration required.**

10       The Department is authorized to establish a registry of billing agents, clearinghouses,  
11 and/or alternate payees that submit claims on behalf of providers and to charge a fee to recover  
12 the costs of maintaining the registry in accordance with 42 U.S.C. § 1396a(a)(79) and  
13 implementing regulations. All billing agents, clearinghouses, or alternate payees shall register  
14 with the Department before submitting claims on behalf of providers or within six months of  
15 enactment of this Chapter, whichever is later. Any billing agent, clearinghouse, or alternate  
16 payee that fails to register with the Department prior to submitting claims on behalf of  
17 providers shall be excluded from the registry for a period not to exceed one year.

18 **"§ 108C-7. Prepayment claims review.**

19       (a) In order to ensure that claims presented by a provider for payment by the  
20 Department meet the requirements of federal and State laws and regulations and medical  
21 necessity criteria, a provider may be required to undergo prepayment claims review by the  
22 Department. Grounds for being placed on prepayment claims review shall include, but shall not  
23 be limited to, receipt by the Department of credible allegations of fraud, identification of  
24 aberrant billing practices as a result of investigations or data analysis performed by the  
25 Department or other grounds as defined by the Department in rule.

26       (b) Providers shall not be entitled to payment prior to claims review by the Department.  
27 The Department shall notify the provider in writing of the decision and the process for  
28 submitting claims for prepayment claims review no less than 20 calendar days prior to  
29 instituting prepayment claims review. The notice shall contain the following:

30           (1) An explanation of the Department's decision to place the provider on  
31 prepayment claims review.

32           (2) A description of the review process and claims processing times.

33           (3) A description of the claims subject to prepayment claims review.

34           (4) A specific list of all supporting documentation that the provider will need to  
35 submit contemporaneously with the claims that will be subject to the  
36 prepayment claims review.

37           (5) The process for submitting claims and supporting documentation.

38           (6) The standard of evaluation used by the Department to determine when a  
39 provider's claims will no longer be subject to prepayment claims review.

40       (c) For any claims in which the Department has given prior authorization, prepayment  
41 review shall not include review of the medical necessity for the approved services.

42       (d) The Department shall process all clean claims submitted for prepayment review  
43 within 20 calendar days of submission by the provider. If the provider failed to provide any of  
44 the specifically requested supporting documentation necessary to process a claim pursuant to  
45 this section, the Department shall send to the provider written notification of the lacking or  
46 deficient documentation within 15 calendar days of receipt of such claim. The Department shall  
47 have an additional 20 days to process a claim upon receipt of the documentation.

48       (e) The provider shall remain subject to the prepayment claims review process until the  
49 provider achieves three consecutive months with a minimum seventy percent (70%) clean  
50 claims rate. If the provider does not meet this standard within six months of being placed on  
51 prepayment claims review, the Department may implement sanctions, including termination of

1 the applicable Medicaid Administrative Participation Agreement, or continuation of  
2 prepayment review for an additional six-month period. The Department shall give adequate  
3 advance notice of any modification, suspension, or termination of the Medicaid Administrative  
4 Participation Agreement. In no instance shall prepayment claims review continue longer than  
5 12 months.

6 (f) The decision to place or maintain a provider on prepayment claims review does not  
7 constitute a contested case under Chapter 150B of the General Statutes. A provider may not  
8 appeal or otherwise contest a decision of the Department to place a provider on prepayment  
9 review.

10 **"§ 108C-8. Threshold recovery amount.**

11 The Department shall not pursue recovery of Medicaid or Health Choice overpayments  
12 owed to the State for any total amount less than one hundred fifty dollars (\$150.00) unless  
13 directed to do so by the Centers for Medicare and Medicaid Services or unless such recovery  
14 would be cost-effective and in the best interest of the State of North Carolina and Medicaid  
15 recipients.

16 **"§ 108C-9. Provider enrollment criteria.**

17 (a) Applicants who submit an initial application for enrollment in North Carolina  
18 Medicaid or North Carolina Health Choice shall be required to submit an attestation and  
19 complete trainings prior to being enrolled.

20 (b) The applicant's attestation shall contain a statement that the applicant's organization  
21 has met the minimum business requirements necessary to comply with all federal and State  
22 requirements governing the Medicaid and Children's Health Insurance programs, does not owe  
23 any outstanding taxes or fines to the U.S. or North Carolina Departments of Revenue or Labor  
24 or the Employment Security Commission, does not owe any final overpayment, assessment, or  
25 fine to the North Carolina Medicaid or North Carolina Health Choice programs or any other  
26 State Medicaid or Children's Health Insurance program, and has implemented a corporate  
27 compliance program as required under federal law. The Department shall set forth by rule  
28 the minimum business requirements necessary to comply with all federal and State requirements  
29 governing the Medicaid and Children's Health Insurance Program.

30 (c) Prior to being initially enrolled in the North Carolina Medicaid or Health Choice  
31 programs, an applicant's representative shall attend trainings as designated by the Department  
32 in rules, including, but not limited to, the following:

- 33 (1) The Basic Medicaid Billing Guide, common billing errors, and how to avoid  
34 them.
- 35 (2) Audit procedures, including explanation of the process by which the  
36 Department extrapolates audit results.
- 37 (3) How to identify Medicaid recipient fraud.
- 38 (4) How to report suspected fraud or abuse.
- 39 (5) Medicaid recipient due process and appeal rights.

40 Online training shall be available for completion through the Department's Web site. The  
41 Department may charge a fee to recover costs of such trainings.

42 (d) Making any materially false or misleading statement in an attestation or enrollment  
43 application shall be grounds for denial, termination of, or permanent exclusion from enrollment  
44 in the North Carolina Medicaid or North Carolina Health Choice programs.

45 **"§ 108C-10. Change of ownership and successor liability.**

46 (a) For providers subject to this Chapter, any of the following occurrences shall  
47 constitute a change of ownership:

- 48 (1) In the case of a partnership, the removal, addition, or substitution of a  
49 partner, unless the partners expressly agree otherwise, as permitted by  
50 Chapter 59 of the General Statutes.

1           (2) In the case of a Limited Liability Company (LLC), the withdrawal or  
2 removal of a member, or when a person acquires a membership interest from  
3 the LLC or when a business entity converts or merges into the LLC pursuant  
4 to Chapter 57A of the General Statutes.

5           (3) In the case of an unincorporated sole proprietorship, the transfer of title and  
6 property of the provider that constitute the provider's business of providing  
7 services, goods, supplies, or merchandise to a Medicaid or Health Choice  
8 recipient to another party.

9           (4) The merger of the provider corporation into another corporation, or the  
10 consolidation of two or more corporations, resulting in the creation of a new  
11 corporation. Transfer of corporate stock or the merger of another corporation  
12 into the provider corporation shall not constitute change of ownership.  
13 Merger of related provider corporations shall not constitute a change in  
14 ownership.

15           (5) The lease of all or part of a provider's facility that will continue to be utilized  
16 for the provision of services, goods, supplies, or merchandise to a Medicaid  
17 or Health Choice recipient shall constitute a change of ownership of the  
18 leased portion.

19           (b) A provider must notify the Department at least 30 calendar days prior to the  
20 effective date of any change of ownership.

21           (c) An assigned Medicaid administrative participation or enrollment agreement shall be  
22 subject to all applicable statutes and regulations and to the terms and conditions under which it  
23 was originally issued including, but not limited to, both of the following:

24                   (1) Any existing plan of correction.

25                   (2) Payment of any outstanding final overpayments, assessments, or fines owed  
26 to the Department.

27           (d) The Department shall not as a condition of enrollment require a provider to accept  
28 an assigned Medicaid administrative participation or enrollment agreement upon a change in  
29 ownership.

30 **"§ 108C-11. Cooperation with investigations and audits.**

31           (a) Providers shall cooperate with all announced and unannounced site visits, audits,  
32 investigations, post-payment reviews, or other program integrity activities conducted by the  
33 Department. Providers who fail to grant prompt and reasonable access or who fail to timely  
34 provide specifically designated documentation to the Department may be terminated from the  
35 North Carolina Medicaid or North Carolina Health Choice programs.

36           (b) The Department shall make all attempts to examine documentation without  
37 interfering with the clinical activities of the provider while conducting activities on the  
38 provider's premises.

39           (c) Nothing in this Chapter shall be construed to limit the ability of the federal  
40 government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health  
41 and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the  
42 foregoing entities' contractors or agents, to enforce federal requirements for the submission of  
43 documentation in response to an audit or investigation.

44 **"§ 108C-12. Appeals by Medicaid providers and applicants.**

45           (a) General Rule. – Notwithstanding any provision of State law or rules to the contrary,  
46 this section shall govern the process used by a Medicaid provider or applicant to appeal an  
47 adverse determination made by the Department.

48           (b) Appeals. – Except as provided by this section, a request for a hearing to appeal an  
49 adverse determination of the Department under this section is a contested case subject to the  
50 provisions of Article 3 of Chapter 150B of the General Statutes.

1       (c) Final Decision. – The Office of Administrative Hearings shall make a final decision  
2 within 180 days of the date of filing of the appeal with the Office of Administrative Hearings.  
3 The time to make a final decision shall be extended in the event of delays caused or requested  
4 by the Department.

5       (d) Burden of Proof. – The Department shall have the burden of proof in appeals of  
6 Medicaid providers or applicants concerning an adverse determination."

7       **SECTION 2.** G.S. 150B-1(d)(9) reads as rewritten:

8       "(9) The Department of Health and Human Services in adopting new or  
9 amending existing medical coverage policies under the State Medicaid  
10 Program.~~Program~~ pursuant to G.S. 108A-54.2."

11       **SECTION 3.** G.S. 150B-1(e) reads as rewritten:

12       "(e) Exemptions From Contested Case Provisions. – The contested case provisions of  
13 this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter.  
14 The contested case provisions of this Chapter do not apply to the following:

15       ...

16       (16) ~~The Department of Health and Human Services with respect to contested~~  
17 ~~eases commenced by (i) Medicaid providers appealing a denial or reduction~~  
18 ~~in reimbursement for community support services, and (ii) community~~  
19 ~~support services providers appealing decisions by the LME to deny or~~  
20 ~~withdraw the provider's endorsement.~~

21       (17) The Department of Health and Human Services with respect to the review of  
22 North Carolina Health Choice Program determinations regarding delay,  
23 denial, reduction, suspension, or termination of health services, in whole or  
24 in part, including a determination about type or level of services."

25       **SECTION 4.** G.S. 108A-54.2 reads as rewritten:

26       "**§ 108A-54.2. Procedures for changing medical policy.**

27       (a) The Department shall adopt rules to develop, amend, and adopt medical coverage  
28 policy in accordance with the following: this section.

29       (b) Medical coverage policy is defined as those policies, definitions, or guidelines  
30 utilized to evaluate, treat, or support the health or developmental conditions of a recipient so as  
31 to determine eligibility, authorization or continued authorization, medical necessity, course of  
32 treatment and supports, clinical outcomes, and clinical supports treatment practices for a  
33 covered procedure, product, or service.

34       (1) During the development of new medical coverage policy or amendment to  
35 existing medical coverage policy, consult with and seek the advice of the  
36 Physician Advisory Group and other organizations the Secretary deems  
37 appropriate. The Secretary shall also consult with and seek the advice of  
38 officials of the professional societies or associations representing providers  
39 who are affected by the new medical coverage policy or amendments to  
40 existing medical coverage policy.

41       (2) At least 45 days prior to the adoption of new or amended medical coverage  
42 policy, the Department shall:

- 43       a. Publish the proposed new or amended medical coverage policy on  
44 the Department's Web site;
- 45       b. Notify all Medicaid providers of the proposed, new, or amended  
46 policy; and
- 47       c. Upon request, provide persons copies of the proposed medical  
48 coverage policy.

49       (3) During the 45-day period immediately following publication of the proposed  
50 new or amended medical coverage policy, accept oral and written comments  
51 on the proposed new or amended policy.

- 1 (4) If, following the comment period, the proposed new or amended medical  
2 coverage policy is modified, then the Department shall, at least 15 days prior  
3 to its adoption:  
4 a. Notify all Medicaid providers of the proposed policy;  
5 b. Upon request, provide persons notice of amendments to the proposed  
6 policy; and  
7 c. Accept additional oral or written comments during this 15-day  
8 period."

9 **SECTION 5.** G.S. 108A-54 reads as rewritten:

10 **"§ 108A-54. Authorization of Medical Assistance Program.**

11 (a) The Department is authorized to establish a Medicaid Program in accordance with  
12 Title XIX of the federal Social Security Act. The Department may adopt rules to implement the  
13 Program. The State is responsible for the nonfederal share of the costs of medical services  
14 provided under the Program. A county is responsible for the county's cost of administering the  
15 Program in that county.

16 (b) The Department is expressly authorized to adopt temporary and permanent rules to  
17 implement or define the federal laws and regulations, the North Carolina State Plan of Medical  
18 Assistance, and the North Carolina State Plan of the Health Insurance Program for Children,  
19 the terms and conditions of eligibility for applicants and recipients of the Medical Assistance  
20 Program and the Health Insurance Program for Children, audits and program integrity, the  
21 services, goods, supplies, or merchandise made available to recipients of the Medical  
22 Assistance Program and the Health Insurance Program for Children, and reimbursement for the  
23 services, goods, supplies, or merchandise made available to recipients of the Medical  
24 Assistance Program and the Health Insurance Program for Children."

25 **SECTION 6.** G.S. 108C-5 as enacted by Section 1 of this act is effective when this  
26 act becomes law and applies to audits instituted on or after that date and to final overpayments,  
27 assessments, or fines due on or after that date. G.S. 108C-6 as enacted by Section 1 of this act  
28 becomes effective January 1, 2012. Section 4 of this act is effective January 1, 2012, and  
29 applies to medical coverage policies entered into or amended on or after that date. The  
30 remainder of this act is effective when it becomes law.