

GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2011

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SENATE BILL 496\*  
PROPOSED COMMITTEE SUBSTITUTE S496-PCS15170-SQ-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  
24 of 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  
32 Administrative Hearings or in Superior Court, provided that the Superior  
33 Court has entered a stay pursuant to the provisions of G.S. 150B-48.



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- 1           (6)    Health Choice. – The Health Insurance Program for Children authorized by  
2           G.S. 108A-70.25 and as set forth in the North Carolina State Plan of the  
3           Health Insurance Program for Children.
- 4           (7)    Managing employee. – A general manager, business manager, administrator,  
5           director, or other individual who exercises operational or managerial control  
6           over, or who directly or indirectly conducts the day-to-day operation of, an  
7           institution, organization, or agency. Managing employee also includes the  
8           chief financial officer for the organization.
- 9           (8)    Medicaid. – The Medical Assistance program authorized by G.S. 108A-54  
10          and as set forth in the North Carolina State Plan of Medical Assistance.
- 11          (9)    Owner and/or operator. – A person or corporation that has direct, indirect, or  
12          combined ownership interest in a health care provider greater than or equal  
13          to five percent (5%) or is a partner, officer, or director of a health care  
14          provider organized as a partnership, corporation, or limited liability  
15          company.
- 16          (10) Provider. – An individual, partnership, group, association, corporation,  
17          institution, or entity required to enroll in the North Carolina Medical  
18          Assistance Program or the North Carolina Health Insurance Program for  
19          Children to provide services, goods, supplies, or merchandise to a Medicaid  
20          or Health Choice recipient.
- 21          (11) Revalidation. – The reenrollment of a provider in the Medicaid or Health  
22          Choice programs as required under federal law.

23 **§ 108C-3. Medicaid and Health Choice provider screening.**

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

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

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

- 34           (1)    Ambulatory surgical centers.
- 35           (2)    End-stage renal disease facilities.
- 36           (3)    Federally qualified health centers.
- 37           (4)    Health programs operated by an Indian Health Program (as defined in  
38           section 4(12) of the Indian Health Care Improvement Act) or an urban  
39           Indian organization (as defined in section 4(29) of the Indian Health Care  
40           Improvement Act) that receives funding from the Indian Health Service  
41           pursuant to Title V of the Indian Health Care Improvement Act.
- 42           (5)    Histocompatibility laboratories.
- 43           (6)    Hospitals, including critical access hospitals, Department of Veterans Affairs  
44           Hospitals, and other State or federally owned hospital facilities.
- 45           (7)    Local Education Agencies.
- 46           (8)    Mammography screening centers.
- 47           (9)    Mass immunization roster billers.
- 48           (10) Nursing facilities, including Intermediate Care Facilities for the Mentally  
49           Retarded.
- 50           (11) Organ procurement organizations.

1           (12) Physician or nonphysician practitioners (including nurse practitioners,  
2           CRNAs, physician assistants, physician extenders, occupational therapists,  
3           speech/language pathologists, chiropractors, and audiologists), optometrists,  
4           and medical groups or clinics.

5           (13) Radiation therapy centers.

6           (14) Rural health clinics.

7           (15) Hearing aid dealers.

8           (d) Limited Screening Level: Screening Requirements. – When the Department  
9           designates a provider or supplier as a "limited" categorical level of risk, the Department shall do  
10           all of the following:

11           (1) Conduct database checks on a pre-enrollment and post-enrollment basis to  
12           ensure that providers and suppliers continue to meet the enrollment criteria  
13           for their provider/supplier type.

14           (2) Conduct license verifications, including licensure verifications across state  
15           lines for physicians or nonphysician practitioners and providers and  
16           suppliers that obtain or maintain Medicare or Medicaid billing privileges as  
17           a result of state licensure, including state licensure in states other than North  
18           Carolina.

19           (3) Verify that a provider or supplier meets all applicable federal regulations and  
20           State requirements for the provider or supplier type prior to making an  
21           enrollment determination.

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

24           (1) Ambulance services.

25           (2) Comprehensive outpatient rehabilitation facilities.

26           (3) Critical Access Behavioral Health Agencies.

27           (4) Dentists and orthodontists.

28           (5) Hospice organizations.

29           (6) Independent clinical laboratories.

30           (7) Independent diagnostic testing facilities.

31           (8) Pharmacy Services.

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

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

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

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

39           (13) Revalidating agencies providing private duty nursing, home health, or home  
40           infusion.

41           (f) Moderate Screening Level: Screening Requirements. – When the Department  
42           designates a provider or supplier as a "moderate" categorical level of risk, the Department shall  
43           do all of the following:

44           (1) Conduct a pre-enrollment and post-enrollment site visit. The purpose of the  
45           site visit will be to verify that the information submitted to the Department is  
46           accurate and to determine compliance with federal and State enrollment  
47           requirements.

48           (2) Perform all of the "limited" screening requirements described in subsection  
49           (d) of this section.

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

- 1           (1) Prospective (newly enrolling) adult care homes delivering  
2           Medicaid-reimbursed services.
- 3           (2) Agencies providing behavioral health services, excluding Critical Access  
4           Behavioral Health Agencies.
- 5           (3) Directly enrolled outpatient behavioral health services providers.
- 6           (4) Prospective (newly enrolling) agencies providing durable medical  
7           equipment, including, but not limited to, orthotics and prosthetics.
- 8           (5) Agencies providing HIV case management.
- 9           (6) Prospective (newly enrolling) agencies providing home or community-based  
10           services pursuant to waivers authorized by the federal Centers for Medicare  
11           and Medicaid Services under 42 U.S.C. § 1396n(c).
- 12           (7) Agencies providing personal care services or in-home care services.
- 13           (8) Prospective (newly enrolling) agencies providing private duty nursing, home  
14           health, or home infusion.
- 15           (9) Providers against whom the Department has imposed a payment suspension  
16           based upon a credible allegation of fraud in accordance with 42 C.F.R. §  
17           455.23 within the previous 12-month period. The Department shall return  
18           the provider to its original risk category not later than 12 months after the  
19           cessation of the payment suspension.
- 20           (10) Providers that were excluded, or whose owners, operators, or managing  
21           employees were excluded, by the U.S. Department of Health and Human  
22           Services Office of Inspector General or another state's Medicaid program  
23           within the previous 10 years.
- 24           (11) Providers who have incurred a Medicaid or Health Choice final  
25           overpayment, assessment, or fine to the Department in excess of twenty  
26           percent (20%) of the provider's payments received from Medicaid and  
27           Health Choice in the previous 12-month period. The Department shall return  
28           the provider to its original risk category not later than 12 months after the  
29           completion of the provider's repayment of the final overpayment,  
30           assessment, or fine.
- 31           (12) Providers whose owners, operators, or managing employees were convicted  
32           of a disqualifying offense pursuant to G.S. 108C-4 but were granted an  
33           exemption by the Department within the previous 10 years.
- 34           (h) High Screening Level: Screening Requirements. – When the Department designates  
35           a provider or supplier as a "high" categorical level of risk, the Department shall do all of the  
36           following:
  - 37           (1) Conduct a fingerprint-based criminal history record check in accordance  
38           with G.S. 108C-4.
  - 39           (2) Perform all of the "limited" and "moderate" screening requirements  
40           described in subsections (d) and (f) of this section.
  - 41           (3) Require the submission of a set of fingerprints for a national background  
42           check from all individuals who maintain a five percent (5%) or greater direct  
43           or indirect ownership interest in the provider or supplier.
- 44           (i) For providers dually enrolled in the federal Medicare program and Medicaid, the  
45           Department may rely on the results of the provider screening performed by Medicare  
46           contractors.
- 47           (j) For out-of-state providers, the Department may rely on the results of the provider  
48           screening performed by the Medicaid agencies or Health Insurance Program for Children  
49           agencies of other states.

50           "§ 108C-4. Criminal history record checks for certain providers.

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

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

12       (c)     The Division may deny enrollment or terminate the enrollment of a provider subject  
13 to G.S. 108C-3(g) for any of the following offenses of the provider, an owner and/or operator,  
14 or employee if, after review of the seriousness, age, and other circumstances involving the  
15 offense, the Division determines it is in the best interest of the integrity of Medicaid or Health  
16 Choice to do so: any criminal offenses as set forth in any of the following Articles of Chapter  
17 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article  
18 5A, Endangering Executive, Legislative, and Court Officers; Article 6, Homicide; Article 7A,  
19 Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction;  
20 Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material;  
21 Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article  
22 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and  
23 Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit  
24 Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20,  
25 Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article  
26 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery;  
27 Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article  
28 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the  
29 Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes  
30 also include possession or sale of drugs in violation of the North Carolina Controlled  
31 Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses  
32 such as sale to underage persons in violation of G.S. 18B-302, or driving while impaired in  
33 violation of G.S. 20-138.1 through G.S. 20-138.5.

34 **"§ 108C-5. Payment suspension and audits utilizing extrapolation.**

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

37       (b)     In addition to the procedures for suspending payment set forth at 42 C.F.R. §  
38 455.23, the Department may also suspend payment to any provider that (i) owes a final  
39 overpayment, assessment, or fine to the Department and has not entered into an approved  
40 payment plan with the Department or (ii) has had its participation in the Medicaid or Health  
41 Choice programs suspended or terminated by the Department. For purposes of this section, a  
42 suspension or termination of participation does not become final until all administrative appeal  
43 rights have been exhausted and shall not include any agency decision that is being contested at  
44 the Department or the Office of Administrative Hearings or in Superior Court provided that the  
45 Superior Court has entered a stay pursuant to the provisions of G.S. 150B-48.

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

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

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

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

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

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

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

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

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

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

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

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

50        (1) The provider shall notify the Department within 15 days of receipt of the  
51 tentative audit results of the provider's challenge of the Department's results

1 under this subsection. The provider's notification shall select the means of  
2 challenging the error rate found by the Department.

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

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

10 b. Conducting a second audit upon a sample identified and produced by  
11 the Department utilizing the same statistical and sampling  
12 methodology to produce a sample twice the size of the original  
13 sample to review those matters and time periods identified in  
14 subsection (k) of this section. The Department shall provide a new  
15 sample to the provider within 30 days from the date of receipt of a  
16 provider's request. The provider shall have 60 days from receipt of  
17 the new sample to conduct the audit and provide the results to the  
18 Department.

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

24 (4) Nothing in this subsection shall limit a provider from challenging the  
25 statistical methodology of the Department's original sample or the  
26 credentials of the individuals who performed and reviewed the audit.

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

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

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

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

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

40 **"§ 108C-6. Agents, clearinghouses, and alternate payees; registration required.**

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

49 **"§ 108C-7. Prepayment claims review.**

50 (a) In order to ensure that claims presented by a provider for payment by the  
51 Department meet the requirements of federal and State laws and regulations and medical

1 necessity criteria, a provider may be required to undergo prepayment claims review by the  
2 Department. Grounds for being placed on prepayment claims review shall include, but shall not  
3 be limited to, receipt by the Department of credible allegations of fraud, identification of  
4 aberrant billing practices as a result of investigations or data analysis performed by the  
5 Department or other grounds as defined by the Department in rule.

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

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

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

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

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

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

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

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

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

28 (e) The provider shall remain subject to the prepayment claims review process until the  
29 provider achieves three consecutive months with a minimum seventy percent (70%) clean  
30 claims rate. If the provider does not meet this standard within six months of being placed on  
31 prepayment claims review, the Department may implement sanctions, including termination of  
32 the applicable Medicaid Administrative Participation Agreement, or continuation of  
33 prepayment review for an additional six-month period. The Department shall give adequate  
34 advance notice of any modification, suspension, or termination of the Medicaid Administrative  
35 Participation Agreement. In no instance shall prepayment claims review continue longer than  
36 12 months.

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

41 **"§ 108C-8. Threshold recovery amount.**

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

47 **"§ 108C-9. Provider enrollment criteria.**

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



1       **(b)**    The applicant's attestation shall contain a statement that the applicant's organization  
2 has met the minimum business requirements necessary to comply with all federal and State  
3 requirements governing the Medicaid and Children's Health Insurance programs, does not owe  
4 any outstanding taxes or fines to the U.S. or North Carolina Departments of Revenue or Labor  
5 or the Employment Security Commission, does not owe any final overpayment, assessment, or  
6 fine to the North Carolina Medicaid or North Carolina Health Choice programs or any other  
7 State Medicaid or Children's Health Insurance program, and has implemented a corporate  
8 compliance program as required under federal law. The Department shall set forth by rule the  
9 minimum business requirements necessary to comply with all federal and State requirements  
10 governing the Medicaid and Children's Health Insurance Program.

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

- 14           **(1)**    The Basic Medicaid Billing Guide, common billing errors, and how to avoid  
15 them.
- 16           **(2)**    Audit procedures, including explanation of the process by which the  
17 Department extrapolates audit results.
- 18           **(3)**    How to identify Medicaid recipient fraud.
- 19           **(4)**    How to report suspected fraud or abuse.
- 20           **(5)**    Medicaid recipient due process and appeal rights.

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

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

26       **(e)**    The approval or acceptance of a Medicaid administrative participation or enrollment  
27 agreement by the Department that grants Medicaid billing privileges or allows a provider to  
28 furnish services under the North Carolina State Plan for Medical Assistance in accordance with  
29 42 C.F.R. § 431.107 requires compliance by the provider and the Department with the terms of  
30 the Medicaid administrative participation or enrollment agreement.

31       **"§ 108C-10. Change of ownership and successor liability.**

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

- 34           **(1)**    In the case of a partnership, the removal, addition, or substitution of a  
35 partner, unless the partners expressly agree otherwise, as permitted by  
36 Chapter 59 of the General Statutes.
- 37           **(2)**    In the case of a Limited Liability Company (LLC), the withdrawal or  
38 removal of a member, or when a person acquires a membership interest from  
39 the LLC or when a business entity converts or merges into the LLC pursuant  
40 to Chapter 57A of the General Statutes.
- 41           **(3)**    In the case of an unincorporated sole proprietorship, the transfer of title and  
42 property of the provider that constitute the provider's business of providing  
43 services, goods, supplies, or merchandise to a Medicaid or Health Choice  
44 recipient to another party.
- 45           **(4)**    The merger of the provider corporation into another corporation, or the  
46 consolidation of two or more corporations, resulting in the creation of a new  
47 corporation. Transfer of corporate stock or the merger of another corporation  
48 into the provider corporation shall not constitute change of ownership.  
49 Merger of related provider corporations shall not constitute a change in  
50 ownership.

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

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

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

10           (1)   Any existing plan of correction.

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

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

16    **"§ 108C-11. Cooperation with investigations and audits.**

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

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

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

30    **"§ 108C-12. Appeals by Medicaid providers and applicants.**

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

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

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

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

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

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

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

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

51            ...

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

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

10           **SECTION 4.** G.S. 108C-5 as enacted by Section 1 of this act is effective when this  
11           act becomes law and applies to audits instituted on or after that date and to final overpayments,  
12           assessments, or fines due on or after that date. G.S. 108C-6 as enacted by Section 1 of this act  
13           becomes effective January 1, 2012. The remainder of this act is effective when it becomes law.