

LEGISLATION REQUIRED BY THE AFFORDABLE CARE ACT AND TO REDUCE FRAUD AND ABUSE IN THE MEDICAID AND HEALTH CHOICE PROGRAMS

Short Title: ACA-required Fraud and Abuse Provisions. (Public)

Sponsors:

Referred to:

The General Assembly of North Carolina enacts:

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

“Chapter 108C: Medicaid and Health Choice Provider Requirements

108C-1. Scope; applicability of this chapter.

- (a) This chapter shall apply to health care providers as that term is defined in G.S. 108C-2(e).
- (b) Nothing in the North Carolina General Statutes or the North Carolina Administrative Code shall be construed to give rise to any property or liberty right in initial or continued participation as a provider in the North Carolina Medicaid or Health Choice programs.
- (c) Entering into a Medicaid or Health Choice administrative participation or enrollment agreement with the Department does not give rise to any property or liberty right in continued participation as a provider in the North Carolina Medicaid or Health Choice programs.
- (d) The approval or acceptance of a Medicaid administrative participation or enrollment agreement by the Department that grants Medicaid billing privileges or allows a provider to furnish services under the North Carolina State Plan for Medical Assistance in accordance with 42 C.F.R. 431.107 shall not be construed to waive the Department’s sovereign immunity.

(Codifies existing provision contained in Section 10.73A.(b) of Session Law 2009-451; consistent with federal court interpretation of Medicaid provider rights. See, e.g. Kelly Kare, Ltd. v. O’Rourke, 930 F. 2d 170 (2d Cir. 1991); Geriatrics, Inc. v. Harris, 640 F.2d 262 (10th Cir. 1981); Silver v. Baggiano, 804 F.2d 1211 (11th Cir. 1986); Green v. Cashman, 605 F. 2d 945 (6th Cir. 1979); Pers. Care Prods. v. Hawkins, 2011 U.S. App. LEXIS 4144 (5th Cir. 2011))

108C-2. Definitions.

- (a) Department. – The North Carolina Department of Health and Human Services .
- (b) Division. – The Division of Medical Assistance of the North Carolina Department of Health and Human Services.
- (c) Medicaid. – The Medical Assistance program authorized by Section 108A-54 of the General Statutes and as set forth in the North Carolina State Plan for Medical Assistance.
- (d) Health Choice. – The Health Insurance Program for Children authorized by Section 108A-70.25 of the General Statutes and as set forth in the North Carolina State Plan for the Health Insurance Program for Children.
- (e) Health care provider or Provider. – An individual, partnership, group, association, corporation, institution, or entity enrolled or seeking to enroll in the North Carolina Medicaid program or the North Carolina Health Insurance Program for Children, or who provides State-funded behavioral health services or any other services reimbursed from any Federal Block Grant Funds.
- (f) Program Integrity. – This term means all activities undertaken by the Department, its Divisions, contractors, vendors and authorized agents, to prevent fraud, waste and abuse in, and ensure the integrity of, the NC Medicaid and Health Choice programs.

(g) Revalidation. – This term means the re-enrollment of a provider in the Medicaid or Health Choice programs as required under state or federal law.

Definitions necessary for statutory construction; not required by ACA.

108C-3. Medicaid and Health Choice provider screening.

(a) The Department shall conduct provider screening of Medicaid and Health Choice providers in accordance with the Affordable Care Act and implementing regulations and this Chapter.

(b) The Department must screen all initial and revalidation applications for enrollment in Medicaid and Health Choice, including applications for a new practice location, based on Department assessment of risk and assignment to a categorical risk level of “limited,” “moderate,” or “high.” If a provider could fit within more than one risk level, the highest level of screening is applicable.

(c) Limited categorical risk provider categories. The following provider types are hereby designated as “limited” categorical risk:

- (1) Physician or nonphysician practitioners (including nurse practitioners, CRNAs, physician assistants, physician extenders, occupational therapists, speech/language pathologists, chiropractors, optometrists and audiologists) and medical groups or clinics.
- (2) Ambulatory surgical centers.
- (3) End-stage renal disease facilities.
- (4) Federally qualified health centers.
- (5) Histocompatibility laboratories.
- (6) Vision and Hearing Aid providers.
- (7) Transplant and Transplant-Related Service providers.
- (8) Hospitals, including critical access hospitals, Department of Veterans Affairs Hospitals, and other state or federally owned hospital facilities.
- (9) Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act.
- (10) Mammography screening centers.
- (11) Mass immunization roster billers.
- (12) Organ procurement organizations.
- (13) Radiation therapy centers.
- (14) Rural health clinics.
- (15) Nursing facilities, including Intermediate Care Facilities for the Mentally Retarded.
- (16) Local Education Agencies.

(d) Moderate categorical risk provider categories. The following provider types are hereby designated as “moderate” categorical risk:

- (1) Directly-enrolled outpatient behavioral health services providers.
- (2) Comprehensive outpatient rehabilitation facilities.
- (3) Revalidating Critical Access Behavioral Health Agencies.
- (4) Hospice organizations.
- (5) Independent clinical laboratories.
- (6) Independent diagnostic testing facilities.
- (7) Physical therapists enrolling as individuals or as group practices.
- (8) Pharmacy Services.
- (9) Dentists and Orthodontists.

(10) Revalidating Agencies providing Private Duty Nursing, Home Health, or Home Infusion Services.

(11) Revalidating Agencies providing Home- or Community-Based Services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under 42 U.S.C. §1396n(c).

(e) High categorical risk provider categories. The following provider types are hereby designated as “high” categorical risk:

(1) Agencies providing Personal Care Services or In-Home Care Services.

(2) Adult Care Homes delivering Medicaid reimbursed services.

(3) Agencies providing Durable Medical Equipment, including but not limited to Orthotics and Prosthetics.

(4) Agencies providing Behavioral Health Services, excluding revalidating Critical Access Behavioral Health Agencies and all directly-enrolled outpatient behavioral health services providers.

(5) Prospective (newly enrolling) Critical Access Behavioral Health Agencies.

(6) Prospective (newly enrolling) Agencies providing Private Duty Nursing, Home Health, or Home Infusion Services.

(7) Prospective (newly enrolling) Agencies providing Home or Community Based Services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under 42 U.S.C. §1396n(c).

(8) Agencies providing HIV Case Management.

(9) Ambulance services.

(10) Providers who have incurred a Medicaid or Health Choice overpayment to the Department in excess of ten percent of the provider’s payments received from Medicaid and Health Choice in the previous twelve (12) month period.

(11) Providers against whom the Department have imposed a payment suspension in accordance with 42 C.F.R. § 455.23 or G.S. 108C-4 within the previous twelve (12) month period.

(12) Providers whose owners, operators, or managing employees were convicted of a disqualifying offense pursuant to G.S. 108C-3A but were granted an exemption by the Department within the previous ten (10) years.

(13) Providers that were excluded, or whose owners, operators, or managing employees were excluded by the OIG or another State’s Medicaid program within the previous ten (10) years.

(f) Adjustment of risk level. The Department may adjust the categorical risk level for any individual provider or provider type from “limited” or “moderate” to “high” when any of the conditions described in 42 C.F.R. 455.450(c)(3) or any of the following conditions occur:

(1) The Department places a provider on prepayment review.

(2) The provider has an outstanding overpayment owed to the Department.

(3) The Department or any licensing board institutes a licensure action against a provider.

The Department shall establish a procedure for a provider who has had its risk level adjusted to the “moderate” or “high” category to be adjusted back to the previous risk level after the above condition(s) are resolved to the satisfaction of the Department.

(g) For providers dually-enrolled in the federal Medicare program and the NC Medicaid program, the Department may rely on the results of the provider screening performed by Medicare contractors.

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

Required by Section 6401 of the Affordable Care Act and implementing federal regulations.

108C-3A. Criminal background checks for certain providers.

(a) The Division shall conduct a criminal background check of and require the submission of fingerprints from a provider subject to G.S. 108C-3(e) (a high categorical risk provider), an owner and/or operator of that provider, and its managing employees, unless it is relying upon the results of screenings pursuant to G.S. 108C-3(g) or (h). The Division may also require a criminal background check of employees involved in direct patient care on behalf of the high categorical risk provider. For purposes of this section:

(1) A “managing employee” means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency, including the chief financial officer for the organization.

(2) An “owner and/or operator” means a person or corporation that:

a. Has an ownership interest totaling 5 percent or more in a health care provider;

b. Has an indirect ownership interest equal to 5 percent or more in a health care provider;

c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a health care provider;

d. Is an officer or director of a health care provider that is organized as a corporation or limited liability company; or

e. Is a partner in a health care provider that is organized as a partnership.

(b) Upon request by the Division, the North Carolina Department of Justice shall provide to the Division a national criminal history for a provider or other person subject to this section. The Division shall provide to the Department of Justice the fingerprints of the covered person to be checked, any additional information required by the Department of Justice, and a form signed by the person to be checked consenting to the check of the criminal record and to the use of fingerprints and other identifying information required by the State or National Repositories. The fingerprints of the individual shall be forwarded to the State Bureau of Investigation for a search of the State criminal history record file and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The Division shall keep all information pursuant to this section confidential. The Department of Justice shall charge a reasonable fee for conducting the checks of the criminal history records authorized by this section. A provider or applicant shall reimburse the Department for the cost of capturing fingerprints pursuant to this Chapter.

(c) All releases of criminal history information under this section shall be subject to, and in compliance with, rules governing the dissemination of criminal history record checks as adopted by the North Carolina Division of Criminal Information. All of the information received through the checking of the criminal history is privileged information and for the exclusive use of the Division.

(d) The Division shall deny enrollment or terminate the enrollment of a provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of any criminal offense related to that person’s involvement with the Medicare, Medicaid, or Health Choice program in the last 10 years, unless the Division determines that denial or termination of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.

(e) The Division may deny enrollment or terminate the enrollment of a provider subject to G.S. 108C-3(e) if it is determined that the applicant, provider, or owner, operator, or employee of the

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

Required by Section 6401 of the Affordable Care Act and implementing federal regulations. Subparagraph (d) mandates the permissive requirements set forth in 42 C.F.R. 455.106. This provision was proposed by the provider associations.

108C-4. Payment suspension.

(a) In addition to the procedures for suspending payment set forth at 42 C.F.R. 455.23, the Department shall also suspend payment to any NC Medicaid or NC Health Choice provider which: (1) owes an outstanding overpayment, assessment, fine or other accounts receivable to the Department; or (2) has had its participation in the NC Medicaid or NC Health Choice programs suspended or terminated by the Division of Medical Assistance.

(b) For providers who owe an outstanding overpayment, assessment, or other accounts receivable to the Department, the suspension of payment shall not exceed the amount owed to the Department, including any applicable penalty and interest charges, and shall continue during the pendency of any appeal filed at the Office of Administrative Hearings or state or federal courts.

(c) Providers whose participation in the NC Medicaid or NC Health Choice programs has been suspended or terminated shall have all payments suspended beginning on the thirty-first day after the notice of suspension or termination is mailed by the Department to the provider's last known address on file with the Division, and the suspension of payment shall continue during the pendency of any appeal filed at the Office of Administrative Hearings or state or federal courts. The notice to the provider of the overpayment, assessment, other accounts receivable, suspension or termination shall include notice of the potential payment suspension. The Department is not required to send a separate notice of the payment suspension.

(d) If the final agency decision is in favor of the provider, or if the provider appeals the final agency decision and the final court decision is in favor of the provider, the Department shall reimburse the provider for payments for all clean claims suspended during the period of appeal.

(e) The Department shall not make any payment to a NC Medicaid or NC Health Choice provider unless and until all outstanding recoupments, assessments, fines or overpayments have been repaid in full to the Department, together with any applicable penalty and interest charges, or unless and until the provider has entered into a payment plan approved by the Department not to exceed twenty-four (24) months. The Department has the sole discretion whether to allow a provider to enter into a payment plan and to set terms and conditions for such plans.

(f) A recoupment, assessment, fine or overpayment owed to the Department becomes outstanding on the thirty-first day after the final notice of such recoupment, assessment, fine or overpayment is mailed by the Department to the provider's last known address on file with the Division. For purposes of this Chapter, "outstanding" means thirty-one days after the provider receives notification that the Department has identified an overpayment, fine or assessment or other accounts receivable owed to the Department, or upon the thirty-first day after the recoupment, assessment, fine or overpayment is upheld, in full or in part, by a Department hearing officer following an informal hearing or reconsideration review, regardless of whether the provider has appealed such notification or determination to the Office of Administrative Hearings or any state or federal courts.

(g) All payments suspended in accordance with this Chapter shall be applied toward any outstanding recoupment, assessment, fine or overpayment owed to the Department unless the Department is required to remit such payments to the United States Internal Revenue Service in accordance with federal law.

(h) When issuing payment suspensions in accordance with this Chapter, the Department may suspend payment to all providers which share the same IRS Employee Identification Number or corporate parent as the provider or provider site location which owes the recoupment, fine, assessment, or overpayment.

(i) If the Office of Administrative Hearings issues a stay of the agency action giving rise to the payment suspension described herein in accordance with G.S. §1A-1, Rule 65, a bond equal to the outstanding amount owed to the Department, or one month of the provider's average annual billing, shall be required, the case shall be placed on an expedited hearing docket and such stay shall only be in effect for a maximum of thirty days from issuance.

(j) The Office of Administrative Hearings is prohibited from issuing a stay of a payment suspension implemented in accordance with 42 C.F.R. 455.23.

Authorized by Section 6402 of the Affordable Care Act, 42 C.F.R. 455.23 and guidance from CMS stating that the federal rules governing payment suspension constitute a "floor, not a ceiling, for the protection of Medicaid funds." Codifies existing payment suspension language contained at Section 10.73A. of Session Law 2009-451.

108C-5. Agents, clearinghouses, and alternate payees; registration required.

The Department is authorized to establish a registry of billing agents, clearinghouses and/or alternate payees that submit claims on behalf of health care providers and to charge a reasonable fee to cover the costs of creating the registry in accordance with the Affordable Care Act and implementing regulations. All billing agents, clearinghouses, or alternate payees shall register with the Department within six months of the enactment of this Chapter before submitting claims on behalf of health care providers. Any billing agent, clearinghouse or alternate payee that fails to register with the Department prior to submitting claims on behalf of health care providers shall be excluded from the registry for a period not to exceed one (1) year.

Required by Section 6503 of the Affordable Care Act.

108C-6. Prepayment Claims Review

- (a) In order to ensure that all claims presented by a provider for payment by the Department meet the Department's medical necessity criteria and all other Medicaid, Health Choice, or other federal or state documentation requirements, a provider may be required to undergo prepayment claims review by the Department. Grounds for being placed on prepayment claims review include, but shall not be limited to, receipt by the Department of allegations of fraud, waste or abuse and identification of aberrant billing practices as a result of investigations or data analysis performed by the Division, its contractors and agents.
- (b) Providers are not entitled to payment prior to claims review by the Department. The Department or its applicable contractor is required to notify the provider in writing of the decision and the process for submitting claims for prepayment claims review within no less than fourteen (14) calendar days prior to instituting prepayment claims review, and the notice shall contain the following:
- (1) An of the Department's decision to place the provider on prepayment medical review;
 - (2) A description of the review process and timelines;
 - (3) A list of all supporting documentation that the provider will need to submit contemporaneously with the claims that will be subject to the prepayment claims review;
and
 - (4) The process for submitting claims and supporting documentation.
- (c) The Department or its applicable contractor is required to process all claims submitted for prepayment review within thirty (30) calendar days of submission by the provider. If the Department or its applicable contractor need additional information to process a claim pursuant to this section, a request for additional information must be sent to the provider in writing within fifteen (15) calendar days of receipt of such claim, and the provider shall have fifteen (15) calendar days to provide additional information. The Department or its applicable contractor shall have an additional thirty (30) days to process a claim after receipt of additional information. If the provider fails to submit additional information for review, the claim may be denied.
- (d) The provider's claims shall remain subject to the prepayment claims review process until the provider achieves three consecutive months with a minimum 70% clean claims rate. A provider shall not withhold claims to avoid the claims review process. If the provider does not meet this standard within six (6) months of being placed on prepayment claims review, the Department may implement sanctions, including termination of the applicable Medicaid Administrative Participation Agreement, or continuation of prepayment review for an additional six (6) month period. In no instance shall prepayment claims review continue longer than twelve (12) months.
- (e) The decision to place a provider on prepayment review does not give rise to a contested case appealable under Chapter 150B of the General Statutes. A provider may not appeal or otherwise contest a decision of the Department to place a provider on prepayment review. A determination by the Department that the provider did not satisfy the threshold set forth in subsection (d) above is an adverse determination, and the provider is entitled to appeal such a determination. The provider maintains its right to appeal the denial of any claims subject to prepayment claims review by the Department in accordance with procedures set forth by the Department and its fiscal agent.
- (f) Nothing in this Section shall prevent the Department from engaging in random prepayment claims review or otherwise reviewing or auditing providers' claims before payment.
- (g) The Office of Administrative Hearings is prohibited from issuing a stay of the Department's decision to place a provider on prepayment review.

Authorized for newly enrolled providers at Section 6401 of the Affordable Care Act; codifies existing DHHS prepayment review procedures which are allowed under existing federal regulations.

108C-6. Threshold Recovery Amount.

The Department shall not pursue recovery of Medicaid or Health Choice overpayments owed to the State for any total amount less than \$150.00 unless directed to do so by the Centers for Medicare and Medicaid Services or unless such recovery would be cost effective and in the best interest of the State of North Carolina and Medicaid recipients.

Not required by the Affordable Care Act; necessary to maximize cost efficiency. In the absence of this statute, the State Medicaid Agency is required by Part 433 of Title 42 of the U.S. Code of Federal Regulations to collect all improper overpayments regardless of amount. CMS has indicated that a State can establish a minimum cost effective threshold.

108C-7. Cooperation with investigations and audits.

(a) Providers must permit all announced and unannounced site visits, audits, investigations, post-payment reviews or other program integrity activities conducted by licensing agencies, regulatory boards, the Department, its Divisions, or its contractors, vendors, or authorized agents. Providers who fail to grant prompt and reasonable access or who fail to timely provide documentation to licensing agencies, regulatory boards, the Department, its Divisions, or its contractors, vendors, or authorized agents shall be subject to a \$500.00 per day fine and may be terminated from the NC Medicaid or NC Health Choice programs.

(b) The Department shall establish deadlines of no less than 24 hours for providers to submit documentation in response to announced and unannounced site visits, audits, investigations, post-payment reviews or other program integrity activities. Once the provider has been notified in writing of the findings, including but not limited to any overpayment determination, resulting from any announced or unannounced site visit, audit, investigation, post-payment review or other program integrity action, the provider shall have no more than thirty (30) business days in which to submit additional documentation to the Department or longer if the provider can show good cause. There shall be no additional opportunities in which to submit further documentation for review by the Department in relation to the specific audit, investigation or post-payment review findings. This Section does not apply to criminal investigations conducted by the Medicaid Investigations Unit of the Attorney General's Office.

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

This Section attempts to establish similar requirements at the State level that are now in place at the federal level pursuant to Section 6408 of the Affordable Care Act.

Note: 108C-8 through 108C-10 not required by the Affordable Care Act.

108C-8. Collaboration among agencies to ensure effective investigation, monitoring and prosecution of Medicaid fraud and abuse.

(a) All state regulatory agencies, licensing Boards and accrediting bodies that are involved in the monitoring, investigation, licensure, or prosecution of health care providers are

directed to meet on a regular basis, but no more often than quarterly, to facilitate early identification of payment error trends, review procedures for incident reporting and response and identify system challenges and inconsistencies with the goal of improving operational performance of the NC Medicaid and NC Health Choice programs at the state and provider level.

- (b) Meetings shall consist of a closed session and an open session:
- (1) Closed Session: Licensing boards, law enforcement and state regulatory agencies will share information, to the extent they are authorized or permitted under federal and state law, regarding actions taken against health care providers, and will develop strategies and procedures for responding to fraud, abuse, neglect, exploitation, and quality of care issues.
 - (2) Open Session: Stakeholders, provider representatives, and other health care professionals, including health insurers and pharmacy benefit managers will be invited to participate.
- (c) The Department shall establish and announce the meetings schedule, and meetings shall be chaired by the State Medicaid Director or his or her designee.

108C-9. Provider Enrollment Criteria

- (a) Providers who submit an initial application for enrollment in NC Medicaid or NC Health Choice, including applications for a new practice or site location, shall be required to submit an attestation and complete required trainings prior to being enrolled. Currently enrolled providers shall be required to submit an attestation and complete required trainings within six months of the enactment of this Chapter.
- (b) The attestation shall contain a statement that the applicant has the minimum business requirements necessary to comply with all federal and state requirements governing the Medicaid and Children's Health Insurance programs, does not owe any outstanding taxes or fines to the U.S. or N.C. Departments of Revenue or Labor or the Employment Security Commission, does not owe any overpayment, assessment, or fine to the NC Medicaid or Health Choice programs or any other State Medicaid or Children's Health Insurance Program, and has implemented a corporate compliance program as required under federal law.
- (c) A provider representative shall be required to attend trainings on at least the following topics prior to the provider being enrolled in the NC Medicaid or Health Choice programs:
- (1) Basic Medicaid 101, including the Basic Medicaid Billing Guide, audit procedures, common billing errors and how to avoid them;
 - (2) How to identify Medicaid recipient fraud;
 - (3) How to report suspected fraud or abuse; and
 - (4) Medicaid recipient due process and appeal rights.

Online training shall be available for completion through the Department's website. The Department may charge a fee for such training as necessary to control costs.

- (d) Making any false or misleading statement in an attestation or enrollment application shall be grounds for denial or termination of, or permanent exclusion from, enrollment in the NC Medicaid or NC Health Choice programs.

108C-10. Change of Ownership and Successor Liability

- (a) For purposes of health care providers subject to this chapter, any of the following occurrences shall constitute a change of ownership:
- (1) Partnership. In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by Chapter 59 of the General Statutes, constitutes change of ownership.

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

(3) Unincorporated sole proprietorship. Transfer of title and property to another party constitutes change of ownership.

(4) Corporation. The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

(5) Leasing. The lease of all or part of a provider facility constitutes change of ownership of the leased portion. The provider agreement will be assigned to the lessee only to the extent of the leased portion of the facility.

(b) Notice to the Department. A provider must notify the Department at least thirty (30) days prior to the effective date of any change of ownership and provide a copy of the document(s) which the provider purports to constitute the sale or lease agreement between the parties.

(c) Assignment of agreement. When there is a change of ownership as specified in paragraph (a) of this section, the existing provider agreement will automatically be assigned to the new owner.

(d) Conditions that apply to assigned agreements. An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Compliance with applicable health and safety standards.

(3) Assumption of any liability associated with the agreement.

(4) Payment of any outstanding debts, recoupments, overpayments, assessments, taxes, or other accounts receivables owed to the Department or the State of North Carolina arising from the agreement.

(e) If the purchaser or lessee elects not to accept a transfer of the provider agreement, then the old agreement should be terminated, and the purchaser or lessee is considered a new applicant. The Department may deny the application based on any outstanding debts, recoupments, overpayments, assessments, taxes, or other accounts receivables owed to the Department or the State of North Carolina arising from the previous agreement.

SECTION 2. The Division, in consultation with stakeholder groups and the North Carolina Department of Justice, may study the status of criminal and other employment background checks among all providers and healthcare licensing boards and may make recommendations to the 2012 regular session of the General Assembly concerning the use of background checks with respect to participation in the Medicaid and Health Choice programs.

Section 2 is a recommendation from the NCIOM Fraud and Abuse Workgroup; not required by the Affordable Care Act.

SECTION 3. Chapter 108A is amended to read:

§ 108A-54.2. Procedures for ~~changing~~ medical or clinical coverage policy.

(a) The Department shall develop, amend, and adopt medical or clinical coverage policy in accordance with ~~the following~~; this section.

(b) Medical and clinical coverage policy is defined as those policies, definitions, or guidelines utilized to evaluate the health conditions of a recipient so as to determine eligibility.

authorization, or continued authorization for a covered procedure, product, or service and to establish requirements for how a covered procedure, product, or service shall be delivered by a provider, including but not limited to service records requirements.

(c) The Department shall:

- (1) During the development of new medical or clinical coverage policy or amendment to existing medical coverage policy, consult with and seek the advice of the Physician Advisory Group and other organizations the Secretary deems appropriate. The Secretary shall also consult with and seek the advice of officials of the professional societies or associations representing providers who are affected by the new medical or clinical coverage policy or amendments to existing medical or clinical coverage policy.
- (2) At least 45 days prior to the adoption of new or amended medical or clinical coverage policy, the Department shall:
 - a. Publish the proposed new or amended medical or clinical coverage policy on the Department's Web site;
 - b. Notify all Medicaid providers of the proposed, new, or amended policy; and
 - c. Upon request, provide persons copies of the proposed medical or clinical coverage policy.
- (3) During the 45-day period immediately following publication of the proposed new or amended medical or clinical coverage policy, accept oral and written comments on the proposed new or amended policy.
- (4) If, following the comment period, the proposed new or amended medical or clinical coverage policy is modified, then the Department shall, at least 15 days prior to its adoption:
 - a. Notify all Medicaid providers of the proposed policy;
 - b. Upon request, provide persons notice of amendments to the proposed policy; and
 - c. Accept additional oral or written comments during this 15-day period.

Section 3 was proposed by the Associations and amended by the Department; not required by the Affordable Care Act.

SECTION 4. Section 150B-1 of the General Statutes is amended to read:

(d) Exemptions from Rule Making. – Article 2A of this Chapter does not apply to the following:

* * *

- (9) The Department of Health and Human Services in adopting new or amending existing medical coverage policies under the State Medicaid Program pursuant to N.C. Gen. Stat. §108A-54.2.

* * *

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

* * *

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

Section 4 is necessary to correct an outdated legislative change from the 2008 budget bill (which expired July 2010).

SECTION 5. Section 150B-34 of the General Statutes is amended to read:

(a) Except as provided in G.S. 150B-36(c), and subsection (c) of this section, in each contested case the administrative law judge shall make a decision that contains findings of fact and conclusions of law and return the decision to the agency for a final decision in accordance with G.S. 150B-36. The administrative law judge shall decide the case based upon the preponderance of the evidence, giving due regard to the demonstrated knowledge and expertise of the agency with respect to facts and inferences within the specialized knowledge of the agency. All references in this Chapter to the administrative law judge's decision shall include orders entered pursuant to G.S. 150B-36(c).

(b) Repealed by Session Laws 1991, c. 35, s. 6.

(c1) Notwithstanding subsection (a) of this section, in cases arising under Article 9 of Chapter 131E of the General Statutes, the administrative law judge shall make a recommended decision or order that contains findings of fact and conclusions of law. A final decision shall be made by the agency in writing after review of the official record as defined in G.S. 150B-37(a) and shall include findings of fact and conclusions of law. The final agency decision shall recite and address all of the facts set forth in the recommended decision. For each finding of fact in the recommended decision not adopted by the agency, the agency shall state the specific reason, based on the evidence, for not adopting the findings of fact and the agency's findings shall be supported by substantial evidence admissible under G.S. 150B-29(a), 150B-30, or 150B-31. The provisions of G.S. 150B-36(b), (b1), (b2), (b3), and (d), and G.S. 150B-51 do not apply to cases decided under this subsection.

(c2) Notwithstanding subsection (a) of this section, in all cases arising from decisions made by the North Carolina Department of Health and Human Services in its capacity as the Medicaid single state agency as set forth in Subpart A of Part 431 of Title 42 of the Code of Federal Regulations, the administrative law judge shall make a recommended decision or order that contains findings of fact and conclusions of law. A final decision shall be made by the agency in writing after review of the official record as defined in G.S. 150B-37(a) and shall include findings of fact and conclusions of law. The provisions of G.S. 150B-36(b), (b1), (b2), (b3), and (d), and G.S. 150B-51(a), (b), (c), and (d) do not apply to cases decided under this subsection.

(d) Except for the exemptions contained in G.S. 150B-1(c) and (e), and subsection (c) of this section, the provisions of this section regarding the decision of the administrative law judge shall apply only to agencies subject to Article 3 of this Chapter, notwithstanding any other provisions to the contrary relating to recommended decisions by administrative law judges. (1973, c. 1331, s. 1; 1985, c. 746, s. 1; 1987, c. 878, ss. 5, 23; 1987 (Reg. Sess., 1988), c. 1111, s. 21; 1991, c. 35, s. 6; 2000-190, s. 6.)

SECTION 6. Section 150B-51 of the General Statutes is amended to add a new subsection (e) as follows:

(e) In reviewing a final decision in a contested case in which an administrative law judge made a recommended decision in accordance with 150B-34(c2), the Superior Court shall examine all the record evidence to determine whether there is substantial evidence to justify the final agency decision.

Sections 5 and 6 are necessary to bring DHHS into compliance with 42 C.F.R. 431.10(e).

SECTION 7. This act is effective when it becomes law.

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