

**LEGISLATION REQUIRED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

Short Title: PPACA-required Fraud and Abuse Provisions.

(Public)

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Sponsors:

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Referred to:

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1 The General Assembly of North Carolina enacts:

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

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4 **“Chapter 108C: Medicaid and Health Choice Provider Requirements**

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6 **108C-1. Scope; applicability of this chapter.**

7 This chapter shall apply to health care providers enrolled in the North Carolina Medicaid  
8 program or the North Carolina Health Choice program.

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10 **108C-2. Definitions.**

11 (a) Department. – This term includes the North Carolina Department of Health and  
12 Human Services, its agents, contractors, or vendors who assess, authorize, manage, review, audit,  
13 monitor, or provide services pursuant to Title XIX or XXI of the Social Security Act, the North  
14 Carolina State Plan of Medical Assistance, the North Carolina State Plan of the Health Insurance  
15 Program for Children, or any waivers of the federal Medicaid Act granted by U.S. Department of  
16 Health and Human Services.

17 (b) Division. – This term means the Division of Medical Assistance of the North Carolina  
18 Department of Health and Human Services.

19 (c) Medicaid. – This term means the Medical Assistance program authorized by Section  
20 108A-54 of the General Statutes and as set forth in the North Carolina State Plan of Medical  
21 Assistance.

22 (d) Health Choice. – This term means the Health Insurance Program for Children  
23 authorized by Section 108A-70.25 of the General Statutes and as set forth in the North Carolina  
24 State Plan of the Health Insurance Program for Children.

25 (e) Provider. – This term means an individual, partnership, group, association,  
26 corporation, institution, or entity required to enroll in the North Carolina Medical Assistance  
27 Program or the North Carolina Health Insurance Program for Children to provides services,  
28 goods, supplies, or merchandise to a Medicaid or Health Choice recipient.

29 (f) Applicant. – This term means an individual, partnership, group, association,  
30 corporation, institution, or entity that applies to the Department for enrollment as a provider in  
31 the North Carolina Medical Assistance Program or the North Carolina Health Insurance Program  
32 for Children.

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

35 (h) Final overpayment, assessment, or fine. – This term means the amount the provider  
36 owes after all appeal rights have been exhausted and shall not include any agency decision that is  
37 being contested at the Department or the Office of Administrative Hearings or in Superior Court  
38 provided that the Superior Court has entered a stay pursuant to the provisions of G.S. § 150B-48.

1       (i) Payment suspension. – This term means any delay or withholding of payment to a  
2 provider by the Department.

3  
4 **108C-3. Medicaid and Health Choice provider screening.**

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

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

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

- 15           (1) Physician or nonphysician practitioners (including nurse practitioners,  
16 CRNAs, physician assistants, physician extenders, occupational therapists,  
17 speech/language pathologists, directly-enrolled outpatient behavioral health  
18 services providers, chiropractors and audiologists) and medical groups or  
19 clinics.
- 20           (2) Ambulatory surgical centers.
- 21           (3) End-stage renal disease facilities.
- 22           (4) Federally qualified health centers.
- 23           (5) Histocompatibility laboratories.
- 24           (6) Vision and Hearing Aid providers.
- 25           (7) Transplants and Transplant-Related Services.
- 26           (8) Hospitals, including critical access hospitals, Department of Veterans Affairs  
27 Hospitals, and other state or federally owned hospital facilities.
- 28           (9) Health programs operated by an Indian Health Program (as defined in section  
29 4(12) of the Indian Health Care Improvement Act) or an urban Indian  
30 organization (as defined in section 4(29) of the Indian Health Care  
31 Improvement Act) that receives funding from the Indian Health Service  
32 pursuant to Title V of the Indian Health Care Improvement Act.
- 33           (10) Mammography screening centers.
- 34           (11) Mass immunization roster billers.
- 35           (12) Organ procurement organizations.
- 36           (13) Radiation therapy centers.
- 37           (14) Rural health clinics.
- 38           (15) Nursing facilities, including Intermediate Care Facilities for the Mentally  
39 Retarded.
- 40           (16) Local Education Agencies.

41       (d) Limited screening level: Screening requirements. When the Department designates a  
42 provider or supplier as a “limited” categorical level of risk, the Department does all of the  
43 following:

- 44           (1) Verifies that a provider or supplier meets all applicable Federal regulations  
45 and State requirements for the provider or supplier type prior to making an  
46 enrollment determination.

- 1           (2)   Conducts license verifications, including licensure verifications across State  
2           lines for physicians or nonphysician practitioners and providers and suppliers  
3           that obtain or maintain Medicare or Medicaid billing privileges as a result of  
4           State licensure, including State licensure in States other than North Carolina  
5           (3)   Conducts database checks on a pre- and post-enrollment basis to ensure that  
6           providers and suppliers continue to meet the enrollment criteria for their  
7           provider/supplier type.

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

- 10          (1)   Ambulance services.  
11          (2)   Comprehensive outpatient rehabilitation facilities.  
12          (3)   Critical Access Behavioral Health Agencies  
13          (4)   Hospice organizations.  
14          (5)   Independent clinical laboratories.  
15          (6)   Independent diagnostic testing facilities.  
16          (7)   Physical therapists enrolling as individuals or as group practices.  
17          (8)   Pharmacy Services.  
18          (9)   Dentists and Orthodontists.  
19          (10) Revalidating Agencies Providing Private Duty Nursing, Home Health, Home  
20          Infusion, Personal Care Services, or In-Home Care Services.  
21          (11) Revalidating Adult Care Homes delivering Medicaid-reimbursed services.  
22          (12) Revalidating Agencies Providing Durable Medical Equipment, including but  
23          not limited to Orthotics and Prosthetics.  
24          (13) Revalidating Agencies Providing Behavioral Health Services, excluding  
25          Critical Access Behavioral Health Agencies and directly-enrolled outpatient  
26          behavioral health services providers.  
27          (14) Revalidating Agencies Providing Home- or Community-Based Services  
28          pursuant to waivers authorized by the federal Centers for Medicare and  
29          Medicaid Services under 42 U.S.C. §1396n(c).  
30          (15) Revalidating Agencies Providing HIV Case Management.

31          (f)   Moderate screening level: Screening requirements. When the Department designates  
32          a provider or supplier as a “moderate” categorical level of risk, the Department does all of the  
33          following:

- 34          (1)   Performs the “limited” screening requirements described in paragraph (d) of  
35          this section.  
36          (2)   Conducts a pre-enrollment and post-enrollment site visit. The purpose of the  
37          site visit will be to verify that the information submitted to the Department is  
38          accurate and to determine compliance with Federal and State enrollment  
39          requirements.

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

- 42          (1)   Prospective (newly enrolling) Agencies Providing Private Duty Nursing,  
43          Home Health, Home Infusion, Personal Care Services, or In-Home Care  
44          Services.  
45          (2)   Prospective (newly enrolling) Adult Care Homes delivering Medicaid-  
46          reimbursed services.

- 1           (3) Prospective (newly enrolling) Agencies Providing Durable Medical  
2 Equipment, including but not limited to Orthotics and Prosthetics.
- 3           (4) Prospective (newly enrolling) Agencies Providing Behavioral Health Services,  
4 excluding Critical Access Behavioral Health Agencies and directly-enrolled  
5 outpatient behavioral health services providers.
- 6           (5) Prospective (newly enrolling) Agencies Providing Home or Community  
7 Based Services pursuant to waivers authorized by the federal Centers for  
8 Medicare and Medicaid Services under 42 U.S.C. §1396n(c).
- 9           (6) Prospective (newly enrolling) Agencies Providing HIV Case Management.
- 10          (7) Providers who have incurred a Medicaid or Health Choice final overpayment  
11 to the Department in excess of twenty percent of the provider's payments  
12 received from Medicaid and Health Choice in the previous twelve (12) month  
13 period.
- 14          (8) Providers against whom the Department have imposed a payment suspension  
15 based upon a credible allegation of fraud in accordance with 42 C.F.R. §  
16 455.23 within the previous twelve (12) month period.
- 17          (9) Providers whose owners, operators, or managing employees were convicted of  
18 a disqualifying offense pursuant to Chapter 108C-3A but were granted an  
19 exemption by the Department within the previous ten (10) years.
- 20          (10) Providers that were excluded, or whose owners/ operators/ managing  
21 employees were excluded by the OIG or another State's Medicaid program  
22 within the previous ten (10) years.

23          (h) High screening level: Screening requirements. When the Department designates a  
24 provider or supplier as a "high" categorical level of risk, the Department does all of the  
25 following:

- 26           (1) Performs the "limited" and "moderate" screening requirements described in  
27 paragraphs (d) and (f) of this section.
- 28           (2) Requires the submission of a set of fingerprints for a national background  
29 check from all individuals who maintain a 5 percent or greater direct or  
30 indirect ownership interest in the provider or supplier; and
- 31           (3) Conducts a fingerprint-based criminal history record check in accordance with  
32 G.S. 108C-4A.

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

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

39          (k) The Department must verify that any provider purporting to be licensed in accordance  
40 with the laws of any State is licensed by such State.

41          (l) The Department must confirm that the provider's license has not expired and that  
42 there are no current limitations on the provider's license.

43          (m) The Department must revalidate the enrollment of all providers regardless of provider  
44 type at least every five years.

1        (n) Any enrolled provider must permit the Centers for Medicare & Medicaid Services  
2 (CMS), its agents, its designated contractors, or the Department to conduct unannounced on-site  
3 inspections of any and all provider locations.

4  
5 **108C-3A. Criminal background checks for certain providers.**

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

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

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

- 18            a. Has an ownership interest totaling 5 percent or more in a health care  
19 provider;  
20            b. Has an indirect ownership interest equal to 5 percent or more in a  
21 health care provider;  
22            c. Has a combination of direct and indirect ownership interests equal to 5  
23 percent or more in a health care provider;  
24            d. Is an officer or director of a health care provider that is organized as a  
25 corporation or limited liability company; or  
26            e. Is a partner in a health care provider that is organized as a partnership.

27        (b) Upon request by the Division, the North Carolina Department of Justice shall provide  
28 to the Division a national criminal history for a provider or other person subject to this section.  
29 The Division shall provide to the Department of Justice the fingerprints of the covered person to  
30 be checked, any additional information required by the Department of Justice, and a form signed  
31 by the person to be checked consenting to the check of the criminal record and to the use of  
32 fingerprints and other identifying information required by the State or National Repositories. The  
33 fingerprints of the individual shall be forwarded to the State Bureau of Investigation for a search  
34 of the State criminal history record file and the State Bureau of Investigation shall forward a set  
35 of fingerprints to the Federal Bureau of Investigation for a national criminal history record  
36 check. The Division shall keep all information pursuant to this section confidential. The  
37 Department of Justice shall charge a reasonable fee for conducting the checks of the criminal  
38 history records authorized by this section.

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

44        (d) The Division shall deny enrollment or terminate the enrollment of a provider where  
45 any person with a 5 percent or greater direct or indirect ownership interest in the provider has  
46 been convicted of a criminal offense related to that person’s involvement with the Medicare,

1 Medicaid, or Health Choice program in the last 10 years, unless the Division determines that  
2 denial or termination of enrollment is not in the best interests of the Medicaid program and the  
3 State Medicaid agency documents that determination in writing.

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

26  
27 **108C-4. Payment suspension.**

28 (a) The Department may suspend payments of a NC Medicaid provider in accordance with  
29 the requirements and procedures set forth in 42 C.F.R. § 455.23.

30  
31 **108C-5. Agents, clearinghouses, and alternate payees; registration required.**

32 The Division shall require any agent, clearinghouse or alternate payee that submits claims  
33 to Medicaid or Health Choice on behalf of health care providers to register with the State  
34 pursuant to Sec. 6503 of the Patient Protection and Affordable Care Act of 2010 and  
35 implementing federal regulations. The Division shall require no additional obligation or  
36 information from any agent, clearinghouse, or alternate payee than is necessary to comply with  
37 federal law.”

38  
39 **SECTION 2.** The Division, in consultation with stakeholder groups and the North Carolina  
40 Department of Justice, may study the status of criminal and other employment background  
41 checks among all providers and healthcare licensing boards and may make recommendations to  
42 the 2012 regular session of the General Assembly concerning the use of background checks with  
43 respect to participation in the Medicaid and Health Choice programs.

44  
45 **SECTION 3.** This act is effective when it becomes law.