

Chapter 108C.

Medicaid and Health Choice Provider Requirements.

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

This Chapter applies to providers enrolled in Medicaid or Health Choice. (2011-399, s. 1.)

§ 108C-2. Definitions.

The following definitions apply in this Chapter:

- (1) Adverse determination. – A final decision by the Department to deny, terminate, suspend, reduce, or recoup a Medicaid payment or to deny, terminate, or suspend a provider's or applicant's participation in the Medical Assistance Program.
- (2) Applicant. – An individual, partnership, group, association, corporation, institution, or entity that applies to the Department for enrollment as a provider in the North Carolina Medical Assistance Program or the North Carolina Health Insurance Program for Children.
- (3) Department. – The North Carolina Department of Health and Human Services, its legally authorized agents, contractors, or vendors who acting within the scope of their authorized activities, assess, authorize, manage, review, audit, monitor, or provide services pursuant to Title XIX or XXI of the Social Security Act, the North Carolina State Plan of Medical Assistance, the North Carolina State Plan of the Health Insurance Program for Children, or any waivers of the federal Medicaid Act granted by the United States Department of Health and Human Services.
- (4) Division. – The Division of Medical Assistance of the Department.
- (5) Final overpayment, assessment, or fine. – The amount the provider owes after appeal rights have been exhausted, which shall not include any agency decision that is being contested at the Department or the Office of Administrative Hearings or in Superior Court, provided that the Superior Court has entered a stay pursuant to the provisions of G.S. 150B-48.
- (6) Health Choice. – The Health Insurance Program for Children authorized by G.S. 108A-70.25 and as set forth in the North Carolina State Plan of the Health Insurance Program for Children.
- (7) Managing employee. – As defined in 42 C.F.R. § 455.101.
- (8) Medicaid. – The Medical Assistance program authorized by G.S. 108A-54 and as set forth in the North Carolina State Plan of Medical Assistance.
- (9) Owner and/or operator. – As defined in 42 C.F.R. § 455.101.
- (10) Provider. – An individual, partnership, group, association, corporation, institution, or entity required to enroll in the North Carolina Medical Assistance Program or the North Carolina Health Insurance Program for Children to provide services, goods, supplies, or merchandise to a Medicaid or Health Choice recipient.
- (11) Revalidation. – The reenrollment of a provider in the Medicaid or Health Choice programs as required under federal law. (2011-399, s. 1.)

§ 108C-2.1. Provider application and recredentialing fee.

(a) Each provider that submits an application to enroll in the Medicaid program shall submit an application fee. The application fee shall be the sum of the amount federally required and one hundred dollars (\$100.00).

(b) The fee required under subsection (a) of this section shall be charged to all providers at recertifying every five years. (2017-57, s. 11H.3.)

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

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

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

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

- (1) Ambulatory surgical centers.
- (2) End-stage renal disease facilities.
- (3) Federally qualified health centers.
- (4) 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.
- (5) Histocompatibility laboratories.
- (6) Hospitals, including critical access hospitals, Department of Veterans Affairs Hospitals, and other State or federally owned hospital facilities.
- (7) Local Education Agencies.
- (8) Mammography screening centers.
- (9) Mass immunization roster billers.
- (10) Nursing facilities, including Intermediate Care Facilities for the Mentally Retarded.
- (11) Organ procurement organizations.
- (12) Physician or nonphysician practitioners (including nurse practitioners, CRNAs, physician assistants, physician extenders, occupational therapists, speech/language pathologists, chiropractors, and audiologists), optometrists, dentists and orthodontists, and medical groups or clinics.
- (13) Radiation therapy centers.
- (14) Rural health clinics.
- (15) Hearing aid dealers.
- (16) Portable X-ray suppliers.
- (17) Religious nonmedical health care institutions.
- (18) Registered dietitians.
- (19) Clearinghouses, billing agents, and alternate payees.
- (20) Local health departments.

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

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

- (1) Ambulance services.
- (2) Comprehensive outpatient rehabilitation facilities.
- (3) Critical Access Behavioral Health Agencies.
- (4) Repealed by Session Laws 2013-378, s. 6, effective October 1, 2013.
- (5) Hospice organizations.
- (6) Independent clinical laboratories.
- (7) Independent diagnostic testing facilities.
- (8) Pharmacy Services.
- (9) Physical therapists enrolling as individuals or as group practices.
- (10) Revalidating adult care homes delivering Medicaid-reimbursed services.
- (11) Revalidating agencies providing durable medical equipment, including, but not limited to, orthotics and prosthetics.
- (12) 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).
- (13) Revalidating agencies providing private duty nursing, home health, personal care services or in-home care services, or home infusion.
- (14) Nonemergency medical transportation.

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

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

- (1) Prospective (newly enrolling) adult care homes delivering Medicaid-reimbursed services.
- (2) Agencies providing behavioral health services, excluding Critical Access Behavioral Health Agencies.
- (3) Directly enrolled outpatient behavioral health services providers.
- (4) Prospective (newly enrolling) agencies providing durable medical equipment, including, but not limited to, orthotics and prosthetics.
- (5) Agencies providing HIV case management.
- (6) 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).
- (7) Prospective (newly enrolling) agencies providing personal care services or in-home care services.
- (8) Prospective (newly enrolling) agencies providing private duty nursing, home health, or home infusion.
- (9) Providers against whom the Department has imposed a payment suspension based upon a credible allegation of fraud in accordance with 42 C.F.R. § 455.23 within the previous 12-month period. The Department shall return the provider to its original risk category not later than 12 months after the cessation of the payment suspension.

- (10) Providers that were excluded, or whose owners, operators, or managing employees were excluded, by the U.S. Department of Health and Human Services Office of Inspector General, the Medicare program, or another state's Medicaid or Children's Health Insurance Program within the previous 10 years.
- (11) Providers who have incurred a Medicaid or Health Choice final overpayment, assessment, or fine to the Department in excess of twenty percent (20%) of the provider's payments received from Medicaid and Health Choice in the previous 12-month period. The Department shall return the provider to its original risk category not later than 12 months after the completion of the provider's repayment of the final overpayment, assessment, or fine.
- (12) Providers whose owners, operators, or managing employees were convicted of a disqualifying offense pursuant to G.S. 108C-4 but were granted an exemption by the Department within the previous 10 years.

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

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

(j) For out-of-state providers, the Department may rely on the results of the provider screening performed by the Medicaid agencies or Children's Health Insurance Program agencies of other states. (2011-399, s. 1; 2013-378, s. 6; 2016-94, s. 12H.3(a).)

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

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

(b) The Division shall deny enrollment or terminate the enrollment of a provider where any person with a five percent (5%) or greater direct or indirect ownership interest in the provider has been convicted of a 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 Medicaid and the State Medicaid agency documents that determination in writing. The Department shall honor civil and criminal settlement agreements entered into with a provider or any person with a five percent (5%) or greater direct or indirect ownership interest in the provider within 10 years of the effective date of this act.

(c) The Division may deny enrollment or terminate the enrollment of a provider subject to G.S. 108C-3(g) for any of the following offenses of the provider, an owner and/or operator, or employee 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 Medicaid or Health Choice 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, Legislative, and Court Officers; Article 6, Homicide; Article 7B, 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. (2011-399, s. 1; 2015-181, s. 47; 2015-181, s. 47.)

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

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

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

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

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

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

(f) 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 final overpayment, assessment, or fine. The Department shall give 30 days advance written notice to all providers which share the same IRS Employee Identification Number or corporate parent as the provider or provider site location of the intention of the Department to implement a payment suspension.

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

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

(i) Prior to extrapolating the results of any audits, the Department shall demonstrate and inform the provider that (i) the provider failed to substantially comply with the requirements of State or federal law or regulation or (ii) the Department has a credible allegation of fraud concerning the provider. Nothing in the subsection shall be construed to prohibit the Department from identifying the extrapolated overpayment amount in the same notice that meets the requirements of this subsection.

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

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

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

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

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

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

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

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

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

- (3) The results of an audit conducted by the provider pursuant to this subsection shall be binding upon the provider. The Department has the authority to review the provider's audit for compliance with the requirements of State and federal law and regulation and may reject any audit conducted by a provider pursuant to this subsection found not in compliance.
- (4) Nothing in this subsection shall limit a provider from challenging the accuracy of the Department's audit, the statistical methodology of the Department's original sample, or the credentials of the individuals who performed and reviewed the audit.

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

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

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

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

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

(t) Nothing in this Chapter shall be construed to prohibit the Department from utilizing a contractor to send notices to providers on behalf of the Department. (2011-399, s. 1; 2014-100, ss. 12H.26(a), (b).)

§ 108C-5.1. Post-payment review and recovery audit contracts.

The Department shall not pay contingent fees pursuant to any contract with an entity conducting Medicaid post-payment reviews or Recovery Audit Contractor (RAC) audits before all appeal rights have been exhausted. Any contingent fee for Medicaid post-payment reviews or RAC audits shall be calculated as a percentage of the amount of the final overpayment, as defined in G.S. 108C-2(5). The State share of the contingent fee paid for Medicaid post-payment reviews or RAC audits shall not exceed the State share of the amount actually recovered by the Department and applied to the final overpayment. (2013-360, s. 12H.16(b).)

§ 108C-6. 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 providers and to charge a fee to recover the costs of maintaining the registry in accordance with 42 U.S.C. § 1396a(a)(79) and implementing regulations. All billing agents, clearinghouses, or alternate payees shall register with the Department before submitting claims on behalf of providers or within six months of enactment of this Chapter, whichever is later. Any billing agent, clearinghouse, or alternate payee that fails to register with the Department prior to submitting claims on behalf of providers shall be excluded from the registry for a period not to exceed one year. (2011-399, s. 1.)

§ 108C-7. Prepayment claims review.

(a) In order to ensure that claims presented by a provider for payment by the Department meet the requirements of federal and State laws and regulations and medical necessity criteria, a provider may be required to undergo prepayment claims review by the Department. Grounds for being placed on prepayment claims review shall include, but shall not be limited to, receipt by the Department of credible allegations of fraud, identification of aberrant billing practices as a result of investigations, data analysis performed by the Department, the failure of the provider to timely respond to a request for documentation made by the Department or one of its authorized representatives, or other grounds as defined by the Department in rule.

(b) Providers shall not be entitled to payment prior to claims review by the Department. The Department shall notify the provider in writing of the decision and the process for submitting claims for prepayment claims review. The written notice shall be deposited, first-class postage prepaid, in the United States mail and addressed to the most recent address given by the provider to the Department. The prepayment claims review shall be instituted no less than 20 calendar days from the date of the mailing of written notification. The notice shall contain all of the following:

- (1) An explanation of the Department's decision to place the provider on prepayment claims review.
- (2) A description of the review process and claims processing times.
- (3) A description of the claims subject to prepayment claims review.
- (4) A specific list of all supporting documentation that the provider will need to submit to the prepayment review vendor for all claims that are subject to the prepayment claims review.
- (5) The process for submitting claims and supporting documentation.
- (6) The standard of evaluation used by the Department to determine when a provider's claims will no longer be subject to prepayment claims review.

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

(d) The Department shall process all clean claims submitted for prepayment review within 20 calendar days of receipt of the supporting documentation for each claim by the prepayment review vendor. To be considered by the Department, the documentation submitted must be complete, legible, and clearly identify the provider to which the documentation applies. If the provider failed to provide any of the specifically requested supporting documentation necessary to process a claim pursuant to this section, the Department shall send to the provider written notification of the lacking or deficient documentation within 15 calendar days of the due date of requested supporting documentation. The Department shall have an additional 20 days to process a claim upon receipt of the documentation.

(e) The provider shall remain subject to the prepayment claims review process until the provider achieves three consecutive months with a minimum seventy percent (70%) clean claims rate, provided that the number of claims submitted per month is no less than fifty percent (50%) of the provider's average monthly submission of Medicaid claims for the three-month period prior to the provider's placement on prepayment review. If a provider does not submit any claims following placement on prepayment review in any given month, then the claims accuracy rating shall be zero percent (0%) for each month in which no claims were submitted. If the provider does not meet the seventy percent (70%) clean claims rate minimum requirement for three consecutive months within six 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. The Department shall give

adequate advance notice of any modification, suspension, or termination of the Medicaid Administrative Participation Agreement.

Prepayment claims review shall not continue longer than 24 consecutive months unless the Department has initiated the termination or other sanction of the provider and the provider has appealed that termination or sanction. If the Department has initiated the termination or other sanction of the provider and the provider has appealed that termination or sanction, then the provider shall remain on prepayment review until the final disposition of the Department's termination or other sanction of the provider.

(e1) Failure of a provider to meet the seventy percent (70%) clean claims rate minimum requirement may result in a termination action. A termination action taken shall reflect the failure of the provider to meet the seventy percent (70%) clean claims rate minimum requirement and shall result in exclusion of the provider from future participation in the Medicaid program. If a provider fails to meet the seventy percent (70%) clean claims rate minimum requirement and subsequently requests a voluntary termination, the termination shall reflect the provider's failure to successfully complete prepayment claims review and shall result in exclusion of the provider from future participation in the Medicaid program.

(e2) A provider shall not withhold claims to avoid the claims review process. Any claims for services provided during the period of prepayment review may still be subject to review prior to payment regardless of the date the claims are submitted and regardless of whether the provider has been taken off of prepayment review for any reason, including attaining a minimum of seventy percent (70%) clean claims rate for three consecutive months, the expiration of the 24-month time limit, or the termination of the provider.

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

(g) If a provider elects to appeal the Department's decision to impose sanctions on the provider as a result of the prepayment review process to the Office of Administrative Hearings, then the provider shall have 45 days from the date that the appeal is filed to submit any documentation or records that address or challenge the findings of the prepayment review. The Department shall not review, and the administrative law judge shall not admit into evidence, any documentation or records submitted by the provider after the 45-day deadline. In order for a provider to meet its burden of proof under G.S. 108C-12(d) that a prior claim denial should be overturned, the provider must prove that (i) all required documentation was provided at the time the claim was submitted and was available for review by the prepayment review vendor and (ii) the claim should not have been denied at the time of the vendor's initial review. (2011-399, s. 1; 2017-57, s. 11H.19(a).)

§ 108C-8. 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 one hundred fifty dollars (\$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. (2011-399, s. 1.)

§ 108C-9. Provider enrollment criteria.

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

(b) The applicant's attestation shall contain a statement that the applicant's organization has met 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 North Carolina Departments of Revenue or Labor or the Division of Employment Security (DES) of the Department of Commerce, does not owe any final overpayment, assessment, or fine to the North Carolina Medicaid or North Carolina 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. The Department shall set forth by rule the minimum business requirements necessary to comply with all federal and State requirements governing the Medicaid and Children's Health Insurance Program.

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

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

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

(d) Making any materially false or misleading statement in an attestation or enrollment application shall be grounds for denial, termination of, or permanent exclusion from enrollment in the North Carolina Medicaid or North Carolina Health Choice programs. (2011-399, s. 1; 2011-401, s. 5.1.)

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

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

- (1) 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.
- (2) In the case of a Limited Liability Company (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.
- (3) In the case of an unincorporated sole proprietorship, the transfer of title and property of the provider that constitute the provider's business of providing services, goods, supplies, or merchandise to a Medicaid or Health Choice recipient to another party.
- (4) 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. Transfer of corporate stock or the merger of another corporation into the provider corporation shall not constitute change of ownership. Merger of related provider corporations shall not constitute a change in ownership.

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

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

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

- (1) Any existing plan of correction.
- (2) Payment of any outstanding final overpayments, assessments, or fines owed to the Department.

(d) The Department shall not as a condition of enrollment require a provider to accept an assigned Medicaid administrative participation or enrollment agreement upon a change in ownership. (2011-399, s. 1.)

§ 108C-11. Cooperation with investigations and audits.

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

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

(c) Nothing in this Chapter shall be construed to limit the ability of the federal government, the Centers for Medicare and 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. (2011-399, s. 1.)

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

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

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

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

(d) Burden of Proof. – The petitioner shall have the burden of proof in appeals of Medicaid providers or applicants concerning an adverse determination. (2011-399, s. 1; 2014-100, s. 12H.27(a).)

§ 108C-13. Certain waivers of Medicaid and Health Choice co-payments prohibited.

(a) No provider that has obtained a permit pursuant to G.S. 90-85.21 or G.S. 90-85-21A shall waive the collection of co-payments owed by recipients of Medicaid and Health Choice, as required by the respective program, with the intent to induce recipients to purchase, lease, or order items or services from the permitted provider. For enforcement purposes, a permitted provider that waives a co-payment owed by a recipient of Medicaid or Health Choice is in violation of this subsection regardless of the monetary amount that is waived by the permitted provider. A permitted provider shall not be in violation of this subsection if the provider waives a co-payment owed by a recipient of Medicaid or Health Choice for any of the following reasons:

- (1) The waiver is authorized under the Medical Assistance Program or the North Carolina Health Insurance Program for Children.
- (2) The permitted provider determines on an individual basis that the collection of the co-payment amount would create a substantial financial hardship for the recipient, provided the waiver of co-payments is not a regular business practice of the provider. For the purposes of this subdivision, a provider shall be considered engaged in the regular business practice of waiving co-payments if the permitted provider holds himself or herself out to recipients as waiving required co-payments.
- (3) The permitted provider has made a good-faith effort to collect the co-payment amount, but the permitted provider's reasonable collection efforts fail.
- (4) The permitted provider is a health care facility regulated pursuant to Chapter 131E or Chapter 122C of the General Statutes or that is owned or operated by the State of North Carolina.

(b) A violation of this section shall result in suspension or termination by the Department of a permitted provider's participation in Medicaid and Health Choice in accordance with administrative sanctions and remedial measures established by the Department for violations of this section. (2013-145, s. 1.)

§ 108C-14. Provider performance bonds.

(a) Subject to the provisions of this section, the Department may require Medicaid-enrolled providers to purchase a performance bond in an amount not to exceed one hundred thousand dollars (\$100,000) naming as beneficiary the Department of Health and Human Services, Division of Medical Assistance, or provide to the Department a validly executed letter of credit or other financial instrument issued by a financial institution or agency honoring a demand for payment in an equivalent amount. The Department may require the purchase of a performance bond or the submission of an executed letter of credit or financial instrument as a condition of initial enrollment, reenrollment, recredentialing, or reinstatement if any of the following are true:

- (1) The provider fails to demonstrate financial viability.
- (2) The Department determines there is significant potential for fraud and abuse.
- (3) The Department otherwise finds it is in the best interest of the Medicaid program to do so.

The Department shall specify the circumstances under which a performance bond or executed letter of credit will be required.

(b) The Department may waive or limit the requirements of subsection (a) of this section for individual Medicaid-enrolled providers or for one or more classes of Medicaid-enrolled providers based on the following:

- (1) The provider's or provider class's dollar amount of monthly billings to Medicaid.
- (2) The length of time an individual provider has been licensed, endorsed, certified, or accredited in this State to provide services.
- (3) The length of time an individual provider has been enrolled to provide Medicaid services in this State.
- (4) The provider's demonstrated ability to ensure adequate record keeping, staffing, and services.
- (5) The need to ensure adequate access to care.

In waiving or limiting requirements of this section, the Department shall take into consideration the potential fiscal impact of the waiver or limitation on the State Medicaid Program. The Department shall provide to the affected provider written notice of the findings upon which its action is based and shall include the performance bond requirements and the conditions under which a waiver or limitation apply. (2013-360, s. 12H.17(a).)