GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 496*
Health Care Committee Substitute Adopted 6/6/11

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

Sponsors:

Referred to:

April 4, 2011

A BILL TO BE ENTITLED

AN ACT RELATING TO REQUIREMENTS OF MEDICAID AND HEALTH CHOICE PROVIDERS.

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.**

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

"**§ 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. – 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. Managing employee also includes the chief financial officer for the organization.

(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. – A person or corporation that has direct, indirect, or combined ownership interest in a health care provider greater than or equal to five percent (5%) or is a partner, officer, or director of a health care provider organized as a partnership, corporation, or limited liability company.

(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.

"**§ 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, and medical groups or clinics.

(13) Radiation therapy centers.
(14) Rural health clinics.
(15) Hearing aid dealers.

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

(1) Conduct database checks on a pre-enrollment and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.
(2) Conduct license verifications, including licensure verifications across state lines for physicians or nonphysician practitioners and providers and suppliers that obtain or maintain Medicare or Medicaid billing privileges as a result of state licensure, including state licensure in states other than North Carolina.
(3) Verify that a provider or supplier meets all applicable federal regulations and State requirements for the provider or supplier type prior to making an enrollment determination.

(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) Dentists and orthodontists.
(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, or home infusion.

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

(1) Conduct a pre-enrollment and post-enrollment site visit. The purpose of the site visit will be to verify that the information submitted to the Department is accurate and to determine compliance with federal and State enrollment requirements.
(2) Perform all of the "limited" screening requirements described in subsection (d) of this section.

(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) 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 or another state's Medicaid 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) High Screening Level: Screening Requirements. – When the Department designates a provider or supplier as a "high" categorical level of risk, the Department shall do all of the following:
(1) Conduct a fingerprint-based criminal history record check in accordance with G.S. 108C-4.
(2) Perform all of the "limited" and "moderate" screening requirements described in subsections (d) and (f) of this section.
(3) Require the submission of a set of fingerprints for a national background check from all individuals who maintain a five percent (5%) or greater direct or indirect ownership interest in the provider or supplier.

(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 Health Insurance Program for Children agencies of other states.

"**§ 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 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.

"**§ 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 credible allegation of fraud concerning the provider.

(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 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.

"**§ 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.

"**§ 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 or data analysis performed by the Department 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 no less than 20 calendar days prior to instituting prepayment claims review. The notice shall contain 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 contemporaneously with the claims that will be 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 submission by the provider. 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 receipt of such claim. 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. If the provider does not meet this standard 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 for an additional six-month period. The Department shall give adequate advance notice of any modification, suspension, or termination of the Medicaid Administrative Participation Agreement. In no instance shall prepayment claims review continue longer than 12 months.

(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 a provider on prepayment review.

"**§ 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.

"**§ 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 Employment Security Commission, 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.

(e) 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 requires compliance by the provider and the Department with the terms of the Medicaid administrative participation or enrollment agreement.

"**§ 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.

"**§ 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.

"**§ 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 Department shall have the burden of proof in appeals of Medicaid providers or applicants concerning an adverse determination."

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

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

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

"(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.~~

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

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