GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S **1**

SENATE BILL 496*

Short Title:	PPACA/Required Fraud and Abuse Provisions.	(Public)
Sponsors:	Senator Pate.	
Referred to:	Health Care.	

April 4, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FRAUD AND ABUSE PROVISIONS REQUIRED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

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) Affordable Care Act. – The Patient Protection and Affordable Care Act, Public Law 111-148.

(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 agents, contractors, or vendors who 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 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 all 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) Medicaid. – The Medical Assistance program authorized by G.S. 108A-54 and as set forth in the North Carolina State Plan of Medical Assistance.

(8) Payment suspension. – Any delay or withholding of payment to a provider by the Department.

(9) 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 that provides services, goods, supplies, or merchandise to a Medicaid or Health Choice recipient.

(10) 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 the Affordable Care Act, implementing regulations and this section.

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

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

(1) 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, directly enrolled outpatient behavioral health services providers, chiropractors, and audiologists) and medical groups or clinics.

(13) Radiation therapy centers.

(14) Rural health clinics.

(15) Transplants and Transplant-Related Services.

(16) Vision and Hearing Aid providers.

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

(1) Conducts database checks on a preenrollment and postenrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.

(2) Conducts 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) Verifies 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 Categories. – 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 Behavioral Health Services, excluding Critical Access Behavioral Health Agencies and directly enrolled outpatient behavioral health services providers.

(12) Revalidating Agencies Providing Durable Medical Equipment, including, but not limited to, Orthotics and Prosthetics.

(13) Revalidating Agencies Providing HIV Case Management.

(14) 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).

(15) Revalidating Agencies Providing Private Duty Nursing, Home Health, Home Infusion, Personal Care Services, or In-Home Care Services.

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

(1) Conducts a preenrollment and postenrollment 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) Performs the "limited" screening requirements described in subsection (d) of this section.

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

(1) Prospective (newly enrolling) Adult Care Homes delivering Medicaid-reimbursed services.

(2) Prospective (newly enrolling) Agencies Providing Behavioral Health Services, excluding Critical Access Behavioral Health Agencies and directly enrolled outpatient behavioral health services providers.

(3) Prospective (newly enrolling) Agencies Providing Durable Medical Equipment, including, but not limited to, Orthotics and Prosthetics.
(4) Prospective (newly enrolling) Agencies Providing HIV Case Management.
(5) 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).
(6) Prospective (newly enrolling) Agencies Providing Private Duty Nursing, Home Health, Home Infusion, Personal Care Services, or In-Home Care Services,
(7) 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.
(8) Providers that were excluded, or whose owners, operators, or managing employees were excluded, by the OIG or another state's Medicaid program within the previous 10 years.
(9) Providers who have incurred a Medicaid or Health Choice final overpayment 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.
(10) 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 does all of the following:
(1) Conducts a fingerprint-based criminal history record check in accordance with G.S. 108C-4.
(2) Performs the "limited" and "moderate" screening requirements described in subsections (d) and (f) of this section.
(3) Requires 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.

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

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

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

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

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

(a) For purposes of this section the following definitions apply:
(1) A "managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or

managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency. Managing employee also includes the chief financial officer for the organization.

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

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

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

c. Has an ownership interest totaling five percent (5%) or more in a health care provider;

d. Is a partner in a health care provider that is organized as a partnership; or

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

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

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

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

(d) The Division shall deny enrollment or terminate the enrollment of a provider where any person with a 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.

(e) 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 and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13,

Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302, or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

"**§ 108C-5. Payment suspension.**

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

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

The Division shall require any agent, clearinghouse, or alternate payee that submits claims to Medicaid or Health Choice on behalf of health care providers to register with the State pursuant to section 6503 of the Affordable Care Act and implementing federal regulations. The Division shall require no additional obligation or information from any agent, clearinghouse, or alternate payee than is necessary to comply with federal law."

SECTION 2. The Division of Medical Assistance of the Department of Health and Human Services, in consultation with stakeholder groups and the North Carolina Department of Justice, may study the status of criminal history record and other employment background checks among all providers and health care licensing boards and may make recommendations to the General Assembly when it reconvenes its 2011 Regular Session in 2012 concerning the use of background checks with respect to participation in the Medicaid and Health Choice programs.

SECTION 3. This act is effective when it becomes law.