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# NC Medicaid Program Integrity Contract Highlights

***Who is Public Consulting Group?***

Public Consulting Group, or PCG, is a national management consulting firm that has maintained a regional headquarters in North Carolina since 1994. We assist and advise North Carolina with Medicaid, Human Services, Public Health, Behavioral Health, State Operated Facilities, and K-12 Education. PCG is a part of the North Carolina economic fabric, currently employing more than 100 North Carolinians throughout our three offices in Raleigh, Charlotte and Asheville.

***What is PCG's relationship to NC DHHS and the State of North Carolina?***

PCG has partnered with the state of North Carolina to implement revenue, cost containment, and operational efficiency projects; ensure compliance with program rules and regulations; perform policy and operations consulting, and, most recently, help North Carolina find its own health care reform path, consistent with North Carolina values and priorities. The State has realized significant value from the partnership. Since 1994, PCG's efforts have resulted in over $1 billion in additional revenue and cost containment to the State. In the last six years alone, PCG has implemented more than 25 projects, increasing efficiency, improving compliance, and realizing more than $325 million in revenue enhancements and cost containment.

***What is PCG's role in combating Medicaid fraud, waste, and abuse in North Carolina?***

PCG looks at Medicaid services after the fact to ensure that taxpayers are getting what they paid for. PCG's work, called Medicaid Post Payment Review, includes the investigation of leads *when either (1) a formal complaint is lodged toward a specific provider or (2) clinically suspect behaviors or administrative billing patterns indicate potentially abusive or fraudulent activities*. PCG supplies the clinical and administrative resources necessary to follow-up on these leads. The benefits of the project are threefold: (1) removal of non-compliant providers from the Medicaid program, (2) recovery of inappropriate payments via provider offset, and (3) ongoing and progressive cost savings by reducing non-compliant claims submitted to Medicaid.

***Was PCG's contract competitively procured?***

Yes. NC DHHS Division of Medical Assistance (DMA) issued a public Request for Proposal (RFP No. 30-DMA-256-10) on May 5, 2010. PCG submitted a proposal which DHHS/DMA awarded the highest technical score with the lowest cost. The contract was executed on June 29, 2010.

***What has been the focus of PCG's fraud, waste, and abuse activities?***

To date, PCG has focused on high-risk providers including Behavioral Health (BH) and Personal Care Service (PCS) providers. Historically and nationwide, monitoring these Home and Community Based

Service (HCBS) providers has proven more complex than the traditional monitoring of physicians and hospitals. As such, these service types have largely gone unchecked. In fact, North Carolina is one of the first states to take on HCBS reviews, and have uncovered significant issues. The investigation of suspicions and complaints about providers is required to meet federal compliance guidelines and provide in-state investigative teams that, as instructed by the NC General Assembly, replace and supplement reductions-in-force in Medicaid Program Integrity resources.

***How does the PCG audit process work?***

PCG's process includes selecting and auditing a statistically valid sample of claims and using federally-approved statistical software to extrapolate on these findings. This statistical process is based on federal procedures and has been developed, reviewed and validated by a team of expert statisticians, including Dr. Dennis Boos, Associate Department Head at North Carolina State University and one of the leading sampling experts in the country. For each case, PCG examines a list of issues related to Medicaid billing compliance, pursuant to protocols defined by the Department of Health and Human Services and included in our contract with DHHS. Even if some findings are eventually dismissed by Hearings Officers, all the results provide a roadmap for strengthening payment compliance and avoiding the inappropriate disbursement of funds in the future, thus avoiding costs rather than trying to "pay-and-chase" these dollars after the fact.

***How does PCG ensure consistency in its approach to Medicaid fraud, waste, and abuse work?***

PCG follows a standardized and consistent protocol in line with the policies and procedures of the state. Leads are generated through phone calls received within the DMA Program Integrity Office regarding potentially abusive billing practices or through other claims-based analysis. Once these leads are generated, a thorough follow-up investigation is necessary to adjudicate the complaint and ensure the Medicaid program has not overpaid for services rendered. Providers are afforded opportunities to respond to findings and can also request a hearing. (Remarkably, many providers do not provide contrary evidence to refute findings until the hearing stage.) Please see the answer to the next question for more detail about provider rights.

Many of the cases have been processed through the DHHS Office of Adminstrative Hearings and Appeals, and provider offsets are now being established to intercept future payments to the providers where justified. Many providers have ceased billing the Medicaid program, thus the use of provider offsets has significantly limited DHHS' ability to recover the overpayments but no additional wasteful or fraudulent claims are being processed for these providers either. As such, PCG's efforts are still contributing to the State's efforts to combat abusive billing practices especially among the high-risk provider groups whether dollars are collected or not.

***What opportunity do providers have to appeal PCG's audit findings?***

Providers are afforded *extensive due process*. PCG audits follow the Due Process Hearings and Appeals standards and protocols as set forth by 10A NCAC 22F .0402 and G.S. 150B-23(a) which include a DHHS Reconsideration Hearing, Mediation with OAH to try to reach settlement and an OAH Courtroom Hearing in front of an Administrative Law Judge.

- **392 cases are currently in the appeal process with a total case value of $37M**. As of August 2012, the state cannot yet collect on nearly 400 completed cases because the provider has already

appealed (215) or are still within the timeframe whereby they can appeal (177). These appeals include both DHHS and OAH appeals. Typically, it may take 6-12 months to complete the appeal process. Payments are not suspended nor do collections occur until after the appeals are exhausted.

- **20% of PCG's initial findings are amended after providers turn in sufficient documentation to support their claims.** PCG's audit methodology clearly communicates documentation requirements and offers providers multiple opportunities to submit the requested documents. Every PCG documentation request includes a document inventory and is supported by a call center to address provider inquiries. In addition, the current appeal process allows providers to submit more documentation during the reconsideration. Following initial PCG findings, providers bring forth sufficient documentation to improve their compliance 20 percent on average. Audits have the residual educational benefit of helping providers to prepare and submit compliant claims over time.
- **92% of findings are upheld following the reconsideration process.** As of August 2012, PCG has participated in 261 DHHS reconsiderations. PCG findings have been upheld 92% of the time and, when not, are overturned when policy infractions are deemed "educational" and not "recoupable." Educational findings are less severe: the provider is notified that the activity is not in line with policy, but no payback is required. Recoupable findings are findings that are more severe and require the provider to pay back the money for the services rendered during the time period of the audit.

***What are PCG's audit findings to date?***

As of August 2012, PCG has identified and accomplished the following:

- **47% compliance rate across all providers audited.** PCG has identified significant compliance issues related to non-credentialed staff, inconsistencies between plans of care, health assessment and the services delivered and inadequate documentation to support the time billed. To date, the overall compliance rate among the providers is 47% as compared to required DMA policies and standards.
- **28 onsite Behavioral Health reviews completed.** PCG has completed 28 onsite Behavioral Health reviews to date and issued 12 Tentative Notices of Overpayment (TNOs) totaling $3.1M, with 15 referrals to the Medicaid Investigations Division (MID) and an additional 5 in the final stages of QA. Further, PCG has been assigned an additional 40 onsite providers with significant fraud and abuse potential.
- **75 Behavioral Health providers identified with claims paid after loss of Local Management Entity (LME) billing endorsement.** PCG is issuing notices to 75 BH providers paid by Medicaid after losing their LME billing endorsement. Based on initial results, DMA/PCG expects 40-50 verified and validated recoupments valued at $100,000 per case.
- **200+ cases with a total case value of $20M are currently under review**. PCG has initiated reviews of 200 additional providers including PCS, BH, Community Alternatives Program for Chilidren / Disabled Adults (CAP C/DA), Dental, Ambulance and Durable Medical Equipment (DME) with total case value of $20M.

***Has PCG's work produced positive results for North Carolina?***

The following are some of the key highlights to date resulting from PCG's Post Payment Reviews:

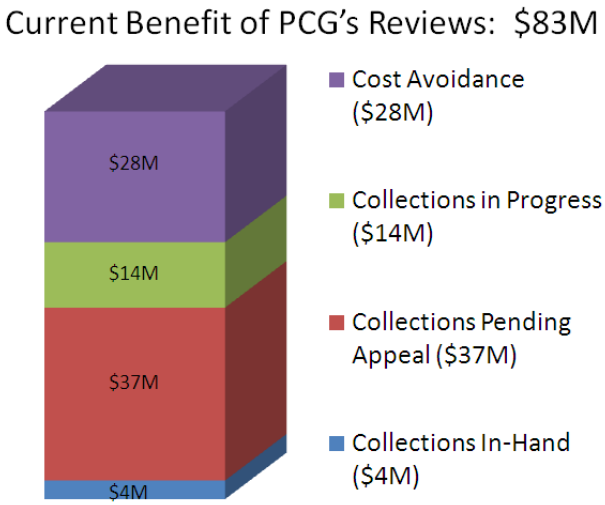
- **$125M in provider recoupments issued since FY10 through August 2012.** After PCG completes an investigation and identifies and verifies an overpayment, PCG sends a recoupment notice to the provider indicating how much the provider owes back to Medicaid. Since PCG began sending recoupment notices in July of 2010, PCG has completed 674 BH and PCS provider reviews, identifying more than $125M in in potentially abusive fraudulent or abusive billing activities.

- **213 audited providers ceased billing the Medicaid program in FY 2012 alone**. Following the audit, 213 providers have ceased billing the Medicaid program. The state has not been able to collect on all of the $125M in overpayments, but their closure has further reduce the overall number of inappropriate payments made to these providers.

- **$83M in Current Benefits of PCG's Reviews:** The value of PCG's Post Payment Reviews extends far beyond reoveries collected to date. Substantial additional recovery amounts are in the collection process, and cost avoidance is realized by audited providers decreasing biling or ceasing to bill altogether. Details are as follows:

  - **$28M generated in cost avoidance in FY 2012 alone.** In FY12, NC DMA achieved $28M in estimated cost avoidance via a 42% reduction in BH billing and 14% reduction in PCS billing for providers receiving initial audit notice.

  - **The State is actively in the process of collecting on $14M in overpayments.** PCG's reviews identified overpayments for NC DHHS and the Attorney General's Office to recover from providers that are currently billing Medicaid, and can thus offset future payments.




  - **$37M in overpayments are pending the appeal process.** Of the completed cases, an additonal $37M is currently under appeal with the State and cannot yet be collected. Recent legislation (S 496) has significantly delayed the collection period by preventing collection from occurring until after 60 days post-audit or until after the appeal is complete, which can take six months or more.

  - **NC DHHS has generated $4.1 M in recoveries relating to PCG's work since FY10 through August 2012.** PCG's contracted services do not include recoveries or collections. The NC DHHS Office of the Controller and the Office of the Attorney General's Office are responsbile for collecting on overpayments identified by PCG.

***What is PCG doing to prevent improper payments in the future?***

PCG has added an additional workstep to ensure non-compliant providers are removed from the system until all debts are paid:

- **PCG is assisting DHHS to prevent these providers from registering as a different business entity and obtaining new Medicaid provider numbers**. This practice has occurred previously, but can be eliminated or minimized with the step described above. PCG initiated a project to facilitate efficient communication between Program Integrity, Provider Services and the Controller's Office to ensure information is shared across all agencies. As a result, owners of providers found to have aberrant billing practices and who owe money to the State will not be able to obtain any additional Medicaid provider numbers until all outstanding issues are resolved to the satisfaction of DMA.

As lawmakers within the State try to determine means by which more effective rules can strengthen DMA's ability to contain costs as it relates to the abusive providers, the NC General Assembly might consider adopting legislation that would prevent providers who have an ownership stake in an entity which owes a debt to the State from obtaining another Medicaid ID through a separate Federal Tax ID that otherwise would allow him/her to avoid payment of this debt. PCG can provide supporting evidence including claim volumes related to this practice and assist in any other way if necessary.

For more information regarding this project or any other project that PCG is performing under contract with the State of North Carolina, please contact:

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