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9.0.10 Medicaid Recovery Audit Contractor (RAC) Services

RFP Reference: 7.

Medicaid Recovery Audit Contractor (RAC) Services Overview

[redacted]

Figure 9.0.10-1. [redacted]

[redacted]

Our solution includes a comprehensive set of analysis, audit, and recovery capabilities. These components maximize the identification and recovery of improper payments within AHCCCS Medicaid program.

Our focus on collaboration is essential to the value of our solution for AHCCCS—we work in partnership with our clients to identify and recover improper payments by integrating our processes to the extent possible and engaging our clients actively throughout the process. Our collaborative focus identifies program-improvement opportunities that can reduce future improper payments. We help clients avoid future improper payments through the identification of potential edit changes, process enhancements, and provider education initiatives. We have assisted both state Medicaid and commercial clients in avoiding millions of dollars in future costs through suggested/assisted process improvements.

Accurate Analytics Require Accurate, Well-Understood Data

At a recent industry conference, one attending vendor announced the finding of "hundreds of millions of dollars" in fraudulent, impossible-timed procedure billings (i.e., more hours billed in a day than were possible). We have since learned that the vendor did not realize that providers were billing more than one DOS on a line and had to revise the findings. Our experience has taught us that accurate data and an accurate understanding of that data are critical to delivering effective results to our clients. Besides providing experienced leadership and appropriate training to our Electronic Data Interchange (EDI) and Analyst teams, we use specific processes to validate our claim mapping and adjustment/void "netting" to ensure accurate data, and we fully test each algorithm and the results before release to the client.

Actionable Results Require Specific Program Understanding

[redacted]

We have learned that it is critical to understand both the published and unpublished policies of each program and to configure the analytics according to the policies. We thoroughly research regulations and policies around each service and configure our analytics around those policies. We test and validate all analytics and findings before releasing them to clients, and we continually monitor results and changes in those results to better align with each client's program.

Small Anomalies Can Lead to Big Issues

[redacted] We configured one of our algorithms to target the issue, and the client **recovered $17 million in overpayments from providers.** More importantly, the client was able to fix their system to prevent the errors from happening again. We have learned to identify, research, and resolve small inconsistencies, as extrapolating small issues in the claim universe can uncover much larger issues.

Application of National Best Practices

Our national perspective, gained from serving as the RAC to 16 Medicaid agencies as well as the Medicare program, supports our best-practice approach to post-payment recovery audits.

HMS uses processes from across our broad portfolio of national Payment Integrity (PI) projects in our development of predictive models and algorithms detecting wasteful and abusive behaviors. For example, our Federal Division recently participated as part of the team for the CMS Provider Enrollment Predictive Model (PEPM) project, which is a component of the 10-State Provider Enrollment Pilot project. This was initiated to determine if a subset of Transformed Medicaid Statistical Information System data could be used to **identify suspect medical providers prior to their admittance to the Medicaid program.**

We helped evaluate the model and discovered key attributes with predictive significance, including providers excluded in one state but practicing in another, providers excluded from Medicare but not Medicaid, and providers with professional sanctions.

Based on these results, a behavioral pattern emerged that could be replicated and employed by states through a predictive model identifying suspect Medicaid providers at the time of their enrollment or continued enrollment in the Medicaid program. We now use these indicators in our provider analysis models and scorecards for our clients.

Continuous Development and Testing of New Analytics Is Important

HMS has learned that we must continually develop new types of analytics, since those used to identify abusive or negligent providers several months ago may no longer produce the same results. Because of our ongoing research and identification of new improper payment schemes and development of tools to combat fraud in healthcare claim operations, we can successfully detect new forms of improper payments for our clients.

[redacted]

- We attend and participate in industry conferences and educational programs, such as NAMPI, National Health Care Anti-Fraud Association, and data analytics conferences across the nation.

Ongoing Code of Federal Regulations Compliance

[redacted]

- State Plans
- State Codes
- State Administrative Rules
- State Medicaid Provider Manuals
- State Medicaid Provider Bulletins
- State Medicaid Official Publications
- State Board of Pharmacy Rules and Regulations
- CFR 42
- Medicaid State Operations Manual
- HHS OIG Exclusion Database
- State Exclusion Databases (various)
- National Coding Determinations
- Federal Policy Guidance
- CMS Informational Bulletins

We base our overpayment identifications and determinations on valid regulatory-source authority/requirements as well as local standards of practice. We apply the rule in effect at the time the claim was made (unless regulatory authority explicitly declares that a retroactive rule applies) and cite the applicable regulatory authority in our communications with providers during the recovery process.

[redacted]

Additionally, we have personnel and processes in place to monitor new and changing laws and regulations as they relate to the ACA and the Health Care and Education Reconciliation Act interpretations guidance. Legal mandates regarding these new laws frequently change, and we continuously gather information to help our clients prepare for the future.

As part of our RAC program for AHCCCS, HMS will perform a thorough analysis of Arizona Medicaid laws, rules, and policies to generate positive outcomes for the State. Our team actively reviews Agency websites and tracks the changes noted in the monthly Medicaid updates. We base all recovery efforts on existing laws and regulations to support clear, defensible evidence of overpayment and to help avoid appeals and provider abrasion. We know it is not enough just to identify payment errors and that research of the related laws, regulations, and policies must support actual funds recovery.

RECOVERY OF IMPROPER MEDICAID PAYMENTS

As an experienced recovery contractor, we are acutely aware of the impact our activities has on providers. Because of this, we work with our clients to minimize provider abrasion by communicating audit results clearly and providing support during the recovery process. Our Provider Services team is knowledgeable and educated on AHCCCS-specific processes and team members are equipped to answer any RAC-related questions from the provider community.

We use a provider-sensitive approach to recovering provider overpayments. We make the process easy to understand and offer support through our dedicated Provider Services team. Arizona providers know and trust HMS.

[redacted]

[redacted]

APPROACH TO CONTINGENCY PREPARATION AND CONTROLS

HMS does not offer incentive payments in the form of increased salaries, bonuses, or other forms of remuneration to certified coders, RNs, auditors, or other review personnel based on or associated with the dollars identified as being in error and/or recovered from providers. This could potentially create a risk of bias for the purpose of personal gain and we strongly believe that it should not be available.

We pride ourselves on our more than 30 years of success and the high quality of our audits. Through our established audit management protocols, we are careful to assign audits to reviewers in such a way that we do not sacrifice quality, unlike other audit and recovery companies that set audit production goals too high. When goals are unrealistically high, auditors tend to skim through records and make rash decisions just to meet certain quotas. While this tactic may yield high recoveries during a start-up phase, it will cause unnecessary complications as the contract progresses. We use industry standards to guide our determination of how many high-quality reviews we can reasonably expect to complete each day, and we monitor our reviewers' compliance.

Our robust Personnel Monitoring program ensures that all areas of operations—not just claim and Medical Record reviews—are free of assessment bias. Our Project Management, Data Analysis, Clinical, Coding, Provider Outreach, Customer Service, and other Audit team members must meet our standards of practice. We periodically evaluate their work. In all cases, a supervisor or the Quality Control (QC) Manager immediately and clearly provides feedback concerning quality. The feedback is either verbal or in writing, depending on the issue, required response, and whether the issue (such as assessment bias) is a repeat of a prior issue. This multifaceted approach prevents the development of a culture of inappropriate assessment bias.

[redacted]

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QUALITY ASSURANCE AND PROJECT CONTROLS

Effective QA and QC processes are critical to any high-performing RAC program. HMS maintains an [redacted]

ACCURACY

[redacted]

TIMELINESS

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MEASUREMENT

[redacted]

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QUALITY ASSURANCE FOR RAC

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HMS MEDICAID RECOVERY AUDIT CONTRACTOR (RAC) SUCCESSES

[redacted] Our key capabilities related to recovery audit services include:

- In-depth AHCCCS program and policy expertise
- Established and successful TPL Commercial Direct billing and recovery processes
- Sophisticated data-mining and data analysis capabilities
- Extensive clinical expertise

- Thorough review and audit proficiencies
- Complete tracking, reporting, and process-improvement capabilities

As the nation's leading RAC for both Medicare and Medicaid, we offer AHCCCS unprecedented experience and capabilities. We have built on this experience to develop the personnel expertise, clinical expertise, RAC infrastructure, and overpayment-recovery abilities described in this proposal. Not only has our experience exposed us to a wide variety of overpayment scenarios across nearly every Medicaid service type, we continue to apply innovative methodology and processes to build on our successes. As part of our RAC offering to AHCCCS, HMS will be leveraging the assets of our Las Vegas, Nevada, office to both identify and recover overpayments. That office also currently provides services for our Medicare RAC program. We have applied this successful Operations team expertise to our key Medicaid RAC projects. We will establish processes, clinical resources, data analytics, and operational infrastructure to support all recovery operations for a new contract term. Please refer to **Section 8.0** for additional information on HMS's experience and expertise in Medicaid Recovery Audit Contractor (RAC) Services.

OBTAINING RECOVERIES FOR AHCCCS

HMS will gain a thorough understanding of how the recoupment/recovery process works in Arizona. Our system accommodates the required flexibility, supporting the processing of refund checks as well as offsets applied towards future payments.

[redacted]

PROCESSING CHECKS

[redacted]

[redacted]

RECOUPMENT PROCESS

[redacted]

OUR APPROACH FACILITATES POSITIVE PROVIDER RELATIONSHIPS

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HMS Findings-Reconsideration Process

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[redacted]

The following pages detail our approach to identifying improper-payment scenarios and data analysis.

Figure 9.0.10-2. [redacted]

[redacted]

Figure 9.0.10-2. [redacted]

[redacted]

Figure 9.0.10-3. [redacted]

[redacted]

MEDICAID RECOVERY AUDIT CONTRACTOR (RAC) SERVICES PROCESS

PROJECT START-UP

As the incumbent, we understand Arizona Medicaid's data and program requirements, which we believe are crucial in implementing an effective RAC solution for AHCCCS. Our process includes all tasks and activities involved in performing Medicaid Overpayment Recovery Audit Project services, hardware, software, and telecommunications lines as well as preparing and gaining approval for Project Plans and strategy documents. With the new contract term, HMS will work in conjunction with AHCCCS to meet the requirements and objectives laid out by AHCCCS during the project kickoff.

Because we have implemented our Medicaid Recovery Audit solution in various states across the country, HMS is prepared to implement the Recovery Audit Contract with AHCCCS engagement.

PROJECT START-UP APPROACH

We undertake a thorough start-up process for all new and reprocured contracts to ensure that we continue to innovate and deliver services that meet both client and HMS expectations. Our Implementation Services team will work with AHCCCS and HMS operational teams to review current processes, identify and document all project business requirements, and manage every aspects of the implementation. At this time, we will work with AHCCCS to develop all necessary Project Plans and Strategy documents, identify key project stakeholders, and formalize the approval process.

[redacted]

[redacted]

The Kickoff meeting will also finalize project activity timelines. Decisions made at this meeting will allow us to create a project roadmap that HMS project managers will maintain and document all requirements and processes agreed too during the implementation process. Please review our activities documented in the implementation plan for this procurement for the Medicaid RAC.

Acquiring and Validating Project Data

[redacted]

DATA INTAKE AND TRANSFORMATION

[redacted]

[redacted]

We understand AHCCCS's Medicaid program data. We have closely worked with the State to identify data needs and obtain the data necessary to implement an effective Recovery Audit solution.

[redacted]

[redacted]

SUPPORT OF MULTIPLE TELECOMMUNICATIONS PROTOCOLS

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- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

Our Data Validation Supports Review Accuracy

[redacted]

Requirements Analysis

Our project Start-up activities include meeting with AHCCCS and other key stakeholders to review project requirements and discuss how our solution will address each of AHCCCS's needs. We will record these sessions by transcribing thorough minutes and using a tracking log to document all requirements and milestones.

[redacted]

Requirements Analysis Process

To ensure the RAC program's implementation is timely and efficient, we will establish and follow a Project Plan for all project requirements, including key phase gates, milestones, tasks, dependencies, anticipated deliverables, and estimated durations.

We have extensive experience in implementing and maintaining ongoing operations for our Medicaid agency clients across the nation, including AHCCCS. This experience enables us to accurately forecast our required time and resource requirements. We use manpower- and time-estimating methods based on the federal government–accepted standard for project estimating, the Program Evaluation and Review Technique (PERT).

The PERT method measures and analyzes the scheduled tasks needed to complete a project—specifically, the time required to complete each task—and calculates the minimum amount of time needed to complete the total project. Developed to simplify the planning and scheduling of large and complex projects, we use PERT to identify the essential services (and their dependencies) necessary for the successful completion of a project. We then set the critical path of the project lifecycle and determine the total number of resources needed and estimate the time required time. Our Project Management team has flexibility in assigning additional corporate resources at any phase of the project if we identify risks of project slippage in critical deadlines or deliverables.

Meeting with Other Project Stakeholders

During the implementation of the new contract to provide recovery audit services, we will perform outreach to the provider community and other stakeholders to introduce them to HMS and explain both HMS's and the providers' role in the recovery process.

Our ability to provide education about the program helps providers gain a better understanding of State rules and regulations, identifies common ground for improvement, strengthens our credibility, and enables us to cultivate an environment of mutual trust and respect. This outreach also prevents the abrasion that can result when providers have little or no notice of the reviews.

Through our prior contracts with Arizona, we have established relationships with key project stakeholders, such as Arizona provider associations, healthcare payers, and large hospital groups.

Direct interaction with providers enhances overall understanding and cooperation for achieving AHCCCS's program goals. With communication and education, providers will support Medicaid policies, regularly communicate with our team, and promote evidence-based interventions. Communication with hospitals, physicians, nursing facilities, community service providers, other provider associations, and Medicaid contractors is critical to building good provider relationships and minimizing abrasion. Once effective working relationships have been established, a multifaceted program can educate and update providers on the process for each audit.

[redacted]

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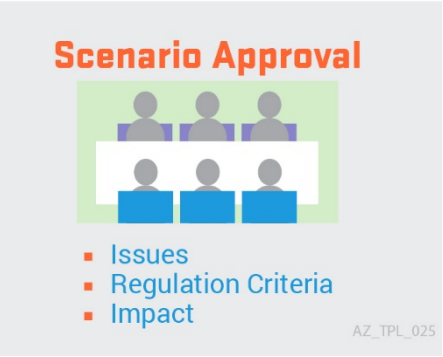
SCENARIO DESIGN

[redacted]

[redacted]

[redacted]

[redacted]



[redacted]

Using Data Analysis to Identify Overpayments

In the RAC work we do around the nation, we identify improper payments primarily through analysis and data mining of Medicaid claim data. For this project, we will configure and apply a wide set of overpayment algorithms that we have developed to identify improper payments in state Medicaid programs. Not all of the existing algorithms in our library are applicable for Arizona because they result from claim-billing codes and/or reimbursement methodologies that vary by state. Some of our algorithms might not produce results because PMMIS or State efforts have previously identified the billing issue and made system edits to correct the payment error. We research the policy and data requirements related to each algorithm and test each algorithm prior to presenting and recommending the scenario to the State.

[redacted]

We will work with AHCCCS to identify Arizona-specific payment issues and develop customized analyses that accurately target claims for recovery.

[redacted]

[redacted]

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[redacted]

Data Quality and Understanding

Accurate data mining begins with accurate data. Arizona's Medicaid program—and its reimbursement methodologies—is complex, and the data reflects that complexity. A vendor unfamiliar with these complexities could spend months or even years gaining the understanding necessary to avoid false positives and identify overpayments accurately. Because we have extensively worked Arizona Medicaid data, we are aware of its complexities and, in some cases, its limitations. We will develop customized analyses to net rate adjustments and historical void transactions accurately. In addition, our analytics include algorithms that continuously validate the quality of the data.

[redacted]

Table 9.0.10-1. [redacted]

[redacted]

[redacted]	[redacted]	[redacted]	[redacted]
Ambulance/ [redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

DEVELOPMENT OF NEW SCENARIOS

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[redacted]

[redacted]

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[redacted]

[redacted]

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[redacted]

[redacted]

[redacted]

[redacted]

SPECIALIZED PROVIDER–REVIEW METHODS TO IDENTIFY OVERPAYMENTS

In addition to data mining for the identification of improperly paid claims, we have developed specialized identification and review methods for managed care claims (encounter data) and capitation claims. These methods are a result of HMS's expertise working with these specific claim and overpayment types, efficiently targeting and validating overpayments to providers or MCOs for recovery.

MEDICAID MANAGED CARE OVERPAYMENTS

[redacted]

[redacted]

HMS has unmatched capability and experience in working with Medicaid MCO encounter data as well as demonstrated success in identifying and recovering inappropriate payments made to MCOs and their provider networks.

[redacted]

[redacted]

[redacted]

CONFIGURATION

To address the complexities of Recovery Audit scenario development and review, we have developed multiple layers of analytics that evaluate claims, providers, and members from different perspectives, incorporating both state and external data. We develop guided analytics that address specific payment integrity issues for each provider type based on our experience in clinical review, provider audit, and fraud detection. Our PI personnel are continuously developing new ideas on how to identify overpayments and testing those ideas through our Audit, RAC, and Data Analysis contracts by working with clients that include state Medicaid agencies, Medicaid MCOs, and CMS.

A key advantage of our process is that we can fully configure our analytics with respect to AHCCCS's program, user feedback, and ongoing exposure to nationwide best practices. **This configuration process, bolstered by our experience with Arizona Medicaid data, understanding of PI opportunities, and clinical understanding, will enable the analytics to minimize false positives.**

[redacted]

[redacted] Our team includes healthcare experts with practical and specific knowledge of improper-payment identification, overpayment identification, regulatory research and compliance, and national healthcare PI best practices, including:

- Investigators with AHFI® or CFE certification
- Coding specialists with CPC certification
- Clinicians
- RNs
- Pharmacists/technicians
- Clinical/reimbursement experts

Defining Values for Data Elements

Improper-payment issues across states are often similar; however, policies with regard to coverage, billing, and reimbursement differ substantially from state to state. HMS's Arizona Medicaid experience and ability to research, understand, and apply fully all of Arizona's Medicaid program regulations, policies, provider guidance, and reimbursement methodologies governing coverage, coding, and payments for each service type is critical to the success of AHCCCS's Medicaid RAC program.

Our Scenario Development team includes CPC reviewers, RNs, and experienced Medicaid auditors who understand the nuances of program policy and coding issues and are adept at researching the specific regulations and polices related to each audit concept. This team researches the policies surrounding each audit concept so that our understanding is complete and our audit approach consistent with policy.

The claims identified for review in our improper-payment scenarios are based in targeted claim–centric data-mining analytics. We analyze historical claim data based on very specific parameters incorporating the Arizona Medicaid program's regulations, policies, and reimbursement methodologies to determine which claims to review. We will only move forward with an audit scenario once AHCCCS has reviewed, provided feedback, and granted final approval. We will clearly detail each audit scenario and present it to AHCCCS via a Scenario Development Request Form, shown in proposal **Section 9.3 Scenario Design.**

Configuration Experience

To help Arizona address the complexities of Medicaid and healthcare environments efficiently and effectively, AHCCCS needs a vendor with a thorough understanding of the healthcare and reimbursement issues behind the data.

To minimize provider abrasion, our RAC approach emphasizes accuracy.

[redacted]

[redacted]

[redacted]

Accurate Data Mining

Successful RACs must ensure that the data used to data mine for overpayments is current and well understood. Failure to understand claim data at a detailed level leads to inaccurate claim-selection decisions. HMS has seen this happen when Medicare RACs move to Medicaid. Medicaid MMIS claim data is different from Medicare claim data, and we have seen many vendors that are successful in the Medicare environment attempt to apply their analysis engines to the Medicaid program. Almost invariably, they struggle due to the variations and complexities in MMIS data, compounded by lack of documented clarity with regard to reimbursement policies and practices. We have over 25 years of experience working with Arizona Medicaid data. We designed our databases and analytical processes to allow multiple data structures and logic branches based on the "version" of the claim data. We built our team members and infrastructure around MMIS data acquisition and analysis to best implement our process quickly and accurately, eliminate provider-abrasion issues related to inaccurate understanding of claims, and optimize recoveries under the RAC Services contract.

Best Practices in Analytics Configuration

HMS targets providers and claims for review through extensive data analysis. In states where we have been able to integrate data analytics and review processes, we are able to increase the results from our review processes by analyzing the specific attributes of providers and claims where error, abuse, and overpayment was found. Through regression analysis of targeted claims vs. actual results, we are able to identify attributes that best predict error and abuse and build predictive analytics that enable our targeting analytics to improve over time. HMS has been developing data analytics to identify improper payments for over three decades, and we have documented best practices during that time.

System Testing

In the System Testing phase of our technical approach, we ensure that the results of our scenario configuration meet expectations and produce actionable results. Our testing process verifies all system functionality and configuration to ensure that we are identifying claims that satisfy each scenario definition accurately. In this section, we describe our scenario-testing approach, controls, resources, and timeframes for testing. We also provide examples of test scenarios and test cases used for the system test and our process for error correction.

TESTING ANALYTICS AND SCENARIOS

One of the main issues in data analysis identifying improper payments is the occurrence of false positives (i.e., data analysis results that look like errors but because of an exception in policy or practice turn out to be correct). We understand the negative impact that false positives can have on audit and recovery actions, which is why we take great care during configuration and implementation to avoid them.

We carefully review the results of each data analysis edit and algorithm and validate those results to ensure proof-of-concept for each issue. We use a multistage approach to ensure that results are targeting potential improperly paid claims with a high degree of accuracy, described as follows and illustrated in **Figure 9.0.10-4**.

Figure 9.0.10-4. [redacted]

[redacted]

The first step in validating the results of each scenario configuration is to run the test scenario and review the claims selected by the analysis. In this process, we look at the results or test cases on both an individual level and a "macro" level against Arizona data. Our analytics and edits have already undergone testing and validation to flag potential issues. This configuration determines if the analytics are accurately flagging AHCCCS's data and ensures that the results meet expectations. We confirm the proper configuration of the system controls when we obtain accurate results.

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After we test the scenario, we review the test results with AHCCCS's subject matter experts. We will only move to production after we are sure that the system is accurately flagging issues within AHCCCS's data and selecting the appropriate claims.

We employ Data Mining, Policy, and Scenario Development team members during the various testing stages of a scenario. They begin and end as scenarios and undergo development, testing, and review for approval. Testing timeframes and QA are ongoing activities for HMS. Data, programs, and provider behavior change over time. Healthcare practices constantly evolve, and our QA team continually monitors our systems to look for and proactively address any potential issues.

SCENARIO APPROVAL

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Figure 9.0.10-5. [redacted]

[redacted]

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[redacted]

IMPLEMENTATION AND OPERATIONS

In proposal **Attachment 4,** we provide a draft implementation plan identifying all the tasks and activities that need to be performed to implement tasks required in this RFP. As part of the Implementation phase of a new contract term, we will meet with AHCCCS to capture all project requirements, review past contract processes, diagnose performance gaps, and identify any new tasks and activities necessary to begin RAC operations.

POST-IMPLEMENTATION SUPPORT

Across all of our PI services, we understand the impact of each state's appeal process and the individual nuances that exist in managing it. Although we design our analytics and investigation/audit process to minimize appeals, we understand that they can occur, and we will continue to provide AHCCCS with full appeal support in the new contract.

We have been particularly successful in limiting the number of reconsideration and appeals requests through our experienced Clinical Review team members use of evidence-based criteria, nationally recognized criteria, along with ongoing communication and provider-education efforts. We leverage clear documentation and determinations based on approved criteria as well as clinical or subject matter expertise to prepare appeals packages that will support findings. For all of our Medicaid Recovery Audit clients, HMS strictly adheres to the specific appeals process laid out by each state Medicaid Agency.

[redacted]

[redacted]

PARTICIPATION IN HEARINGS

We will work with the State and its legal representatives to meet all requirements pertaining to our participation in the hearing process. HMS will promptly provide copies of the case file to assist in the pre-hearing process. HMS Review team members typically attend hearings via teleconference; we will discuss in-person participation requirements on a case-by-case basis. We are accustomed to contributing to pre-hearing conferences for our clients and providing witness testimony services. Members of our Audit team will be available to answer questions, explain the review process and rationale for the determination, and otherwise defend the determination that we made.

Our Physician Review Panel will review Medical Records for issues of medical necessity, resource utilization, standard of care, and overall quality. Our panel physicians provide reasoned opinions and responses to any specific questions posed. They will participate in hearings and other meetings as necessary to consult the Administration regarding the medical/clinical aspects of audits and audit findings. We also employ an Appeal Support team consisting of nurse reviewers, coders, and physicians

experienced in supporting Medicaid RAC appeals. These team members will review all appeal requests and additional documentation submitted from providers for pre-appeal review and determination. They will prepare all supporting documentation required for the appeal process and participate in pre-hearing conferences and hearings, as required.

HMS Maintains Comprehensive Documentation to Support our Findings

[redacted]

Reporting

The HMS team generates a variety of project-related reports, correspondence, files, and documentation that will enable AHCCCS to track our efforts and results. We extract documentation from secure systems that have a reliable audit trail and that represent deliverables that have been through multiple cycles of QA.

We will provide prompt, detailed reporting to enhance communication, and we will use a variety of reporting techniques, including oral progress reports, written Progress Reports, Case Summary Reports, and formal presentations to AHCCCS, to maintain meaningful dialogue. During the Kickoff meeting, we will present the reports for review and refinement, and, upon approval, we will implement use of revised project-related reports.

We have extensively worked with state government clients and have a clear understanding of the types of reporting that the Arizona Medicaid program needs to manage the process, participate in the process as desired, and comply with federal reporting requirements.