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9.3 Medicaid Recovery Audit Contractor (RAC) Services

RFP Reference: 7.

In the following sections, we provide our cross-walk to the requirements from AHCCCS's scope of work (SOW) and our approach to providing industry-leading Medicaid Recovery Audit Contractor (RAC) Services.

> Section 6411 of the Affordable Care Act of 2010 established the Medicaid RAC program and 42 CFR Part 455 Subpart F, implements section 1902(a)(42)(B) of the Social Security Act. The federal rule requires Medicaid RACS to review fee-for-service claims for overpayments and underpayments.
>
> Within the contract term AHCCCS may request that the Contractor develop a methodology for a recovery audit of managed care claims.

In response **Section 9.0.10,** we provide our method of approach to meeting Medicaid RAC Services from AHCCCS's SOW.

9.3.1 Fee for Service Claim Responsibilities

RFP Reference: 7.1, 7.1.1

> All requirements as defined in 42 CFR 455.506 and 455.508, that include:

Our RAC solution for AHCCCS includes best practices to identify, review, validate, and recover improperly paid Medicaid claims, including Fee-For-Service (FFS) claims in accordance with 42 CFR 455.506 and 455.508.

Medical Professionals and Certified Coders

RFP Reference: 7.1.1.1

> Providing at all times trained medical professionals, to the satisfaction of AHCCCS, who are in good standing with the relevant State licensing authorities, where applicable, to review Medicaid claims. In addition, the Contractor must hire certified coders for effective review of claims.

AHCCCS can rely on the expertise of our proposed personnel for this engagement. These team members bring knowledge of the regulations, laws, and rules that govern Arizona's Medicaid and RAC programs. In addition, they have Payment Integrity (PI) expertise derived from working with Medicaid programs and other healthcare payers.

Our team members' complementary skills help us provide a strong, well-rounded team. This team can maximize recoveries for AHCCCS and fulfill the required SOW. It features the following benefits:

- **Qualified, experienced RAC service specialists.** Our team has expertise in the following areas:
  - Healthcare and public policy administration
  - Health insurance
  - Data processing

- Systems analysis and development
- Information management
- Claim processing and auditing
- Clinical review
- Provider and stakeholder education
- Supporting operations

- **Professional, licensed experts.** Our medical professionals are all properly licensed, certified, and credentialed and in good standing with licensing authorities. Licensure verification is documented below.
- **Experts in serving Arizona's Medicaid RAC service needs.** Our team members have an exceptional understanding of Arizona RAC and Medicaid programs, as we have been supporting AHCCCS for the past several years.
- **High-performing, engaged team already in place.** Since we began providing services to AHCCCS, we have ensured that only qualified personnel serve on the project team. The upcoming engagement will be no exception.
- **Committed support teams.** Our collaborative operations, quality assurance, and executive advisory teams will support our project management team. This backing will ensure that we deliver services that meet AHCCCS requirements in a timely manner.

Our staff include certified coders, registered nurses, physicians, behavioral health clinicians, pharmacists, statisticians, pharmacy technicians, data miners, data analysts, and a panel of more than 900 board-certified clinicians and other specialists who represent nearly every recognized specialty. Our entire organization will support our project team. If the need for additional personnel to support this engagement arises, we will efficiently realign our staffing resources to meet that need. Our project management team, with the support and guidance of our executive advisors, will deploy the most effective approaches to achieve AHCCCS's objectives. We commit to allocating the correct resources to this engagement.

LICENSURE VERIFICATION

HMS has established processes for reviewing and verifying the licensure of our claims reviewers:

- [redacted]
- [redacted]

[redacted]

An associate without a license, an associate whose licensure is in suspension, or an associate who is otherwise not in good standing will not perform any activities that require licensure as a healthcare professional.

Medical Director

RFP Reference: 7.1.1.2

Hiring 1.0 FTE Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant State licensing authorities and has relevant work and educational experiences.

Upon award, our Chief Medical Officer will work with the State and account management to identify an Arizona-licensed Contract Medical Director who will be responsible for the oversight of all clinical review activities. Clinical review activities include physician reviews, assisting certified coders and registered nurses as needed, ensuring the integrity and consistency of audit protocols and the Quality Assurance (QA) program, and participating in appeals/hearings as needed. In our experience, RAC contracts are better supported by a panel of physicians spanning multiple specialties rather than by one Medical Director. As such, HMS recommends the State consider our request for an exception from CMS so that Arizona can rely on a physician panel, versus the federally-mandated licensed Medical Director. Our experience supporting other state RAC programs with physician panels has demonstrated the benefit of access to multiple specialties. We can obtain the most relevant physician review and decision, better access for appeals support and where needed, and physician peer-to-peer comparisons on a medical record review. HMS will fully comply with this requirement and state direction. We appreciate the opportunity to discuss best practices and bring additional value to AHCCCS.

Education and Outreach Program

RFP Reference: 7.1.1.3

Working collaboratively with AHCCCS to develop an education and outreach program which includes notification to providers of audit policies and protocols.

HMS works closely with our clients to ensure that all of the components of our Education and Outreach program accomplish the objectives set forth by CMS and each client. When our Provider Education and Outreach plan is approved by AHCCCS, we will reach out to provider associations and individual providers to schedule initial meetings and will provide ongoing education and outreach through webinars, newsletters, emails, bulletins, special sessions, and a website with a link to AHCCCS website.

HMS's Medicaid RAC services work plan for AHCCCS includes outreach efforts that will educate providers regarding our services and how they benefit the Medicaid program. HMS has been working with the Arizona provider community for many years on AHCCCS's behalf.

Our ability to provide education about the RAC 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 enables provider stakeholder understanding and prevents abrasion that can result when providers have little or no notice of the reviews.

HMS understands that direct interaction with providers enhances overall understanding and cooperation for achieving Arizona's program goals. We know from experience that, with communication and education, providers will support Medicaid policies, communicate regularly with our team, and promote evidence-based interventions.

HMS will initially reach out to Arizona provider associations and other stakeholders to introduce HMS, explain the purpose and requirements of the RAC program, and describe the RAC process. **Table 9.3-1** gives an overview of the methods that we use to provide effective outreach to the provider and stakeholder community.

Table 9.3-1. HMS RAC Provider Outreach and Education Activities

Outreach Activity	Information
Meetings of Introduction	HMS will schedule meetings to introduce our company and discuss the purpose of the RAC and its process.

Outreach Activity	Information
Provider Webinars	HMS will reach out to providers and other stakeholders and offer webinars for introduction prior to any audit activity.
Email	HMS will provide a specific email address for providers and other stakeholders to submit questions or comments and for an avenue to present additional information to individuals. This email will be continuously monitored and answered by HMS Provider Relations staff.
Website	HMS will have a public website for all RAC stakeholders, including educational materials, Frequently Asked Questions (FAQs), and a link to AHCCCS's website.
Toll-Free Telephone Number	HMS will provide a specific toll-free telephone number directly to our Provider Relations staff to assist all providers and answer any appropriate questions; all policy-specific questions will be referred to AHCCCS.
Special Sessions	HMS will hold special meetings or educational forums on an as-needed basis and will invite all providers/stakeholders; these sessions can be scheduled regionally.
Provider Portal	The HMS Provider Portal allows providers to access status/recovery information.

[redacted]

[redacted]

[redacted]

HMS Customer Service

RFP Reference: 7.1.1.4

Providing customer service measures such as a toll free customer number; compiling and maintaining provided addresses and points of contact; mandatory acceptance of electronic medical records.

We will enable providers to access information directly throughout the audit recovery process using our Provider Portal—a proprietary, web-based tool that provides an interface between HMS's Provider Relations team members, our Claims Database, and providers. The Provider Portal serves as an interface between the ReSults case management platform and the provider community. As we initiate an audit from

ReSults, our Provider Portal facilitates communication by giving authorized providers secure, direct access to communications regarding the status or stage of the review process for each claim and the ability to view any Notification Letter sent as a result of the audit.

The Provider Portal's rich functionality facilitates timely recoveries for AHCCCS. In addition, it enhances security and privacy for the protected health information that we receive from providers.

Benefits of the HMS Provider Portal

Our Provider Portal offers the following features that benefit our PI projects:

- **Increased accuracy.** A higher claim accuracy rate means fewer subsequent claim adjustments and less need for State personnel intervention.
- **Decreased provider abrasion.** The convenience and speed of taking action and the ability to view the action taken by HMS regarding documentation submitted or claims refuted minimizes provider abrasion.
- **Real-time review.** Clients can access information by provider to review the status of the claim listing by provider at any time.
- **Accelerated recoveries.** Closure of Recovery cycles can more rapidly occur, accelerating recoveries
for clients.
- **Provider self-disclosure.** Providers have a web-based tool to report improper payments, reducing their administrative burden.

To support the new contract, we will continue to provide AHCCCS and Arizona providers with access to our Provider Portal for the RAC project. The portal is a secure, web-based, password-protected system that facilitates the RAC audit/review and recovery process and enables providers to engage in the process with minimal burden. It supports almost every aspect of interaction among HMS, AHCCCS, and providers.

Through the Provider Portal, providers can:

- **Update contact information** (e.g., name, telephone number, email address, address) to ensure that notifications and determinations go to the appropriate place within the provider's organization
- **Receive notifications of overpayment identifications and record requests;** the portal reflects notifications sent to providers, and providers can configure the portal to receive emails upon initiation of new projects (providers also get letters)
- **Confirm receipt of notifications**
- **Obtain additional information and education about Recovery projects;** providers can find additional information related to scenarios and cycles via the portal
- **Track status of review and recovery activities;** the portal reflects the status of each claim as we determine, review, and respond to overpayments

- **Respond to notifications and determinations, initiate questions, and request informal reconsiderations;** providers can directly respond within the portal and send messages to our Provider Relations team related to questions and requests for reconsideration based on new information
- **Directly generate summary and detail Claim Status Reports from the portal** via a drop-down menu that lets providers filter and directly generate a series of summary and detail reports related to their Recovery projects; these reports assist providers in working through outstanding claims and report internally on activity

Easy-to-Use Portal Fully Supported by the Provider Relations Team

Our Provider Portal is easy and intuitive for providers to use, but we do provide web-based training as well as an online manual to train providers on how to use the portal. Providers can also call our toll-free Provider Relations Line for assistance.

Registered providers use a secure password to log in, and they can access the Provider Portal via a menu option. Once logged into the Provider Portal system, users land on their PROVIDER HOME page and have a variety of options.

Our Provider Relations team fully supports the Provider Portal, and the portal creates a "virtual community" that allows our representatives and healthcare providers to work collaboratively and efficiently to complete review tasks. We use this tool to facilitate communication with providers, expedite their involvement in recoveries, and provide ongoing guidance and support throughout the review cycle.

Provider Home Page

For each provider, HMS establishes a HOME page within the Provider Portal that serves as a central point of operations, guiding individual providers to all applications available to them within the portal **(Figure 9.3-1).** After accessing the portal by entering a valid user ID and password, providers are immediately directed to their HOME page, from which they can access individual screens to update their demographic data (e.g., address and contact information). Each HOME page also identifies and provides access to any projects that are currently open for that provider's response online.

[redacted]

PROVIDER CONTACT DATA

Having valid contact information is essential to prompt interactions with providers. HMS ensures that our Provider Outreach and Customer Service team has the most-accurate information by prompting regularly providers to update their information and by matching provider data in the Provider Portal against data files provided by the Fiscal Intermediary (FI). We have learned the limited utility of traditional methods for obtaining change-of-address and other contact information from providers.

Providers can take care of this basic housekeeping task whenever they log in to the portal. In addition, the Provider Portal prompts users to review and update demographic data every six months if there has been no activity on their HOME pages.

The PROVIDER INFORMATION page **(Figure 9.3-2)** captures basic information about the provider, including:

- Formal organization name
- Enrollment status in various healthcare programs or associations (e.g., Medicaid, Medicare Part A, National Supplier Clearinghouse, National Association of Boards of Pharmacy) and associated IDs
- Space for provider and HMS comments
- Summary of provider address information currently available in the portal (read only; provider must access a separate page to edit address information)
- Summary of provider contact information currently available in the portal (read only; provider must access a separate page to edit contact information)

[redacted]

[redacted]

TRACK PROVIDER NOTIFICATIONS LETTERS

As we identify improperly paid claims and receive approval for recovery, HMS generates Provider Notification Letters, which the Provider Portal automatically reflects. If providers have turned on the **Email Alert function,** the system generates an email directly sent to that contact (providers also always receive a hardcopy letter). Providers can directly go to the Provider Portal to view the Notification Letter as well as detail listings and claims.

Providers can directly acknowledge receipt of the Notification Letter within the portal. **Figure 9.3-3** shows an example of this functionality. This saves time and avoids a telephone call from our Provider Relations team.

[redacted]

[redacted]

REVIEW DETAIL LISTINGS, RECIPIENT, AND CLAIM INFORMATION

From the Notification Letter supplied in the portal, providers can drill down to see detail listings, recipient, and claim information associated with the identified overpayments or record requests. **Figure 9.3-4** shows a sample DETAILED OVERPAYMENT LISTING screen.

[redacted]

[redacted]

As illustrated in **Figure 9.3-5,** HMS's Provider Portal enables providers to view relevant Medicaid recipient and claim data. The system also enables providers to search for claims, update claim status, and confirm the accuracy of the information entered in the portal.

[redacted]

[redacted]

Track Recovery Cycle Activity/Status and Generate Reports

Providers can use the Provider Portal to track activity and status of each Recovery cycle, each claim within a Recovery cycle, and overall summary status, as shown in **Figure 9.3-6**.

[redacted]

Electronic Record Submission

We have developed our record request and intake processes through decades of experience in requesting Medical Records and other documentation for coding, COB, and clinical case review/audit.

We understand the potential for this process to cause provider abrasion due to the cost and time requirements imposed on providers. Therefore, we strive to minimize such disruption through tailoring letters to request items specific to the claims under review. We are also flexible regarding requests for extensions (if permitted by program policy) and provide multiple options for submitting records (i.e., mail, fax, and electronic transmission). We encourage providers to submit records stored on a password-protect CD/DVD or secure flash drive. If the provider has an electronic Medical Record system, our IT Department directly works with the provider to set up a secure process for the transfer of Medical Records. We have successfully established this process with a number of providers on behalf of our state agency clients.

Reviewing Aged Claims

RFP Reference: 7.1.1.5

Refraining from reviewing claims that are older than six (6) years from the date of the service. Eliminate claims from review that have been settled or negotiated through the State Fair Hearing Process or through AHCCCS.

As part of our implementation process, HMS will work with AHCCCS to identify all of the services that it wishes to exclude from review, such as:

- Date of service (i.e., claims that are older than six years from the date of service) or date of remittance limitations. Prior to submitting a selection file to AHCCCS for approval, HMS will exclude, through our Master Exclusion process, all claims that exceed 6 years from the date of service. HMS utilizes exclusion criteria, approved by AHCCCS, to validate that only claims eligible for review are included in the selection file and provider request process.
- Claims that have been settled or negotiated through the State Fair Hearing process or through AHCCCS
- Claims in process of being audited by another entity
- Types of service that AHCCCS would like to exclude from review

Please refer to **Section 9.3.2** for a description of how our Results system tracks claims exclusions and aged dates, as well as settled claims.

Auditing Claims

RFP Reference: 7.1.1.6

Refraining from auditing claims that are in process of being audited by another entity.

HMS works closely with our clients to ensure that the audits that we undertake do not duplicate or disrupt work being conducted by other entities, including State and federal agencies and their contractors. We meet regularly with our clients and other entities to apprise them of our activities and to understand the audits that they are undertaking. [redacted]

Notification of Overpayment Findings

RFP Reference: 7.1.1.7

Notifying providers of overpayment findings within sixty (60) calendar days of findings.

Our proprietary case management system, ReSults, ensures that provider notification of overpayments occur within the 60-day window. [redacted]. This dedicated functionality ensures that providers receive notification of overpayments well within the 60-day limit.

All alerts triggered by the status and aging of a claim are monitored and worked in our Alert Task Management (ATM) dashboard. ATM provides a holistic view of all claims currently in the workflow and ensures that claims are worked timely within each stage of RAC delivery. Each alert is assigned to the appropriate group for resolution based on the type of task aged. **Figure 9.3-7** shows our ATM dashboard used to monitor the status of each claim and drill down into alerts by claim.

[redacted]

[redacted]

Referring Suspected Cases of Fraud/Abuse to AHCCCS

RFP Reference: 7.1.1.8

Referring suspected cases of fraud/abuse to AHCCCS.

HMS has extensive experience in identifying fraud through our Medicaid audit contracts, our CMS Audit Medicaid Integrity Contractor contract, and our Medicare and Medicaid Unified Program Integrity Contractor (UPIC) work. Identification of potential fraud, waste, and abuse (FWA) can arise during any component of the improper payment–identification, audit, validation, and recovery services that we offer to AHCCCS. HMS trains our analysts and reviewers to look for these patterns and, if identified, to refer the case immediately to their supervisor and our Program and Account Manager, who will inform in writing of any suspected fraud with support documentation to AHCCCS or to other agencies as directed.

For one state client, HMS identified and referred a provider to MFCU due to unqualified personnel, duplicated assessments, duplicated progress notes, and excessive utilization. The provider billed over $9.5 million from 2006 to 2009, with error/overpayment found in an audit of 35 client records resulting in $731,955. As a result of another extensive investigation, we discovered that one of our client's providers was issuing an average of six prescriptions per patient seen in his office, even if another provider saw the

recipient. Of these prescriptions, the pharmacy located in his office issued 99%. The consequent investigation resulted in a multimillion-dollar fraud settlement.

LIMITING NUMBER AND FREQUENCY OF MEDICAL RECORD REVIEW

RFP Reference: 7.1.1.9

Collaborating with AHCCCS to set limits on the number and frequency of medical records to be reviewed.

HMS has developed our record request and intake processes through decades of experience in requesting medical records and other documentation for coding, COB, and clinical case review/audit. We will work with AHCCCS to set limits on the number and frequency of medical records to be reviewed, taking into consideration the provider size for determining number of records requested at one time, and the frequency of record requests. **Table 9.3-2** represents a record limitation that was set for another state RAC contract, based on Provider spend. Using the State's claim data, HMS split the providers into four different tiers based on annual Medicaid Spend. This approach limits provider abrasions while also maximizing recovery audit efforts.

9.3.2 AUDIT/REVIEW/COORDINATION

RFP Reference: 7.1.2

HMS will initiate the proper review (i.e., automated, semiautomated, or complex) and leverage our ReSults platform to manage all aspects of the review process.

In the following paragraphs, we describe the components of our ReSults platform that acts as our case management and Provider Portal systems, which allow us to perform the following tasks:

- Track all case activity
- Track anticipated recoveries, overpayments adjusted, and final recoveries in an accounts receivable (A/R) application
- Make entries associated with each case
- Track overpayments/underpayments identified and communicated to the PI Unit
- Document case-related communications
- Generate case-related review tools, letters, and attachments
- Provide standard and ad hoc reports
- Obtain electronic records from providers

HMS'S COMPREHENSIVE CASE MANAGEMENT TOOL

We will manage cases and track audit and review findings through our ReSults solution. AHCCCS will have access to ReSults data and reports so that it can review our efforts and results. **Figure 9.3-8** illustrates the functionality of ReSults, which we describe below.

[redacted]

[redacted]

[redacted]

[redacted]

TRANSPARENT REVIEW

[redacted]

ReSults Integrates with the Latest Image Technology

[redacted]

[redacted]

COORDINATION OF AUDIT AND RECOVERY EFFORTS

RFP Reference: 7.1.2.1

Coordinate all audit and recovery efforts with AHCCCS, other contractors and entities, including but not limited to the efforts of the AHCCCS Office of Inspector General, federal and state law enforcement, the Federal Department of Justice, the Federal Bureau of Investigations, the Federal Office of Inspector General, and the Arizona State Medicaid Fraud Control Unit to ensure activities proposed are not duplicative of other program integrity activities or operations.

[redacted]

[redacted]

[redacted]

[redacted]

ReSults Case Workflow Enables Tracking for Full Case Lifecycle

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

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

[redacted]

ReSults Facilitates Clear Provider Communication

[redacted]

HMS understands the value of clear, comprehensive communications with project stakeholders. ReSults provides easy access to the RAC-related data required by Arizona providers.

AHCCCS Personnel Will Have Access to ReSults Data

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

ReSults Is Fully Secure

[redacted]

Recommendations of Providers and Claims for Review/Audit

RFP Reference: 7.1.2.2

Provide information on types of providers and claims recommended for review/audit; provide the reason for selecting the type; and define the scope of the review/audit (time frame, type of claim and services reviewed/audited).

HMS will utilize the experience, expertise and understanding of both AHCCCS regulations and National regulations to identify providers and claims that will we recommend for review/audit. HMS will utilize our scenario approval form to provide the reason for selecting the providers and claims, which will include the regulation utilized to identify the overpayment or underpayment. HMS will include the lookback period for the specific audit type, claim type and overview of providers included in the review.

Our proven approach will assist AHCCCS by identifying and recovering overpayments while preventing future Medicaid overpayments. We recover Medicaid overpayments and identify underpayments through a variety of methods, including onsite and remote reviews of providers' patient accounts, Medicaid policy analysis, data mining, and reverse data analytics. Our approach covers a wide range of provider and claim types and enables us to maximize improper payment identification for the State. **Figure 9.3-10** illustrates our experience in working with all provider types.

Figure 9.3-10. HMS Brings the State of Arizona Recovery Audit Contractor Experience with All Provider Types

Provider Type Audit and Recovery Experience

- Adult Day Healthcare Providers
- Ambulatory Surgical Centers
- Ancillary Providers
- Assisted Living Facilities
- Behavioral Health Providers
- Clinic, Diagnostic, and Treatment Centers
- Dental Providers
- Durable Medical Equipment and Suppliers
- Freestanding Clinics
- Home Health Agencies
- Home Infusion Therapy Providers
- Hospice Providers
- Hospitals
- Laboratories
- Long Term Care Providers
- Managed Care Plans
- Nurse Practitioners
- Personal Care Agencies
- Pharmacies
- Physician/Professional Providers
- Radiology Providers
- Rural Health Clinics
- Surgery Centers
- Therapists (Physical, Occupational, and Speech
- Transportation Providers
- Waiver Providers

AZ TPL 012

Listing of Providers for On-Site Audits/Desk Reviews

RFP Reference: 7.1.2.3

Provide a list of criteria that is utilized to identify candidates for the provider on-site audits/ desk reviews.

[redacted]

PROVIDER MEDICAL RECORD REQUEST PROCESS

RFP Reference: 7.1.2.4

Establish provider medical record request process consistent with AHCCCS policy.

HMS generates an Audit Notification letter and Record Request Letter for providers in the audit/review cycle. The Audit Notification letter identifies HMS as a contractor to AHCCCS, discusses the authority under which we are requesting records, discusses the scope of the audit/review project, and outlines options for the provider to obtain additional information, including a toll-free telephone number.

The Record Request Letter identifies the specific medical record or other documentation required by HMS to review each claim for improper payment. Throughout the record request process, we will ensure that all affected parties (i.e., HMS and the providers) adhere to Arizona's regulations and policies concerning medical record requests. We will research and incorporate AHCCCS-approved requirements and letter formats into this process, customizing each letter to specify request details and response instructions.

HMS has developed our record request and intake processes through decades of experience in requesting medical records and other documentation for coding, COB, and clinical case review/audit. We will work with AHCCCS to set limits on the number and frequency of medical records to be reviewed.

HMS has intentionally designed our RAC processes to place the least amount of burden on providers while effectively asserting AHCCCS's right to recover improper payments.

[redacted]

HMS understands that there is a limit on the number of record requests that a provider can logistically process in a given period. We also understand that providers may receive requests from other vendors and State or federal agencies. With this in mind, we work with clients to structure projects so that we do not overburden providers. HMS will work with AHCCCS to develop and implement any necessary record request limits, and we will configure our case management system to flag any request in excess of a provider's predefined limits.

[redacted]

HMS requests only records that are necessary for review so we minimize the burden on providers. Each claim loaded to the case management system has an improper payment reason code that identifies why that claim was selected for review. For each reason code, we maintain a table of documentation components required to review that type of case.

HMS can configure record requests to specify the appropriate records required for the review (based on the type of issue being reviewed). This helps ensure that we request only necessary records. Upon receipt, we can quickly identify portions of the requested sections that may be missing.

Tracking Medical Record Requests

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Receipt and Scanning of Records

[redacted]

Additional Provider Documentation and Reconsideration

RFP Reference: 7.1.2.5

Allow providers the opportunity to present additional documentation and reconsideration consistent with AHCCCS policy.

[redacted]

AHCCCS Approved Provider Invoice

RFP Reference: 7.1.2.6

Invoice the provider using an AHCCCS approved format.

After cases pass the appeal response period, HMS generates the required deliverables (i.e., invoice) for recovery or recoupment, consistent with AHCCCS's approved methodology and recovery of the improper payments.

Maintaining Tracking and Reporting Processes

RFP Reference: 7.1.2.7

Maintain tracking and reporting processes as specified by the Agency.

HMS offers AHCCCS a powerful solution for tracking and managing the improper payment identification process and carefully and accurately documenting audit tasks and results throughout the contract term.

We have worked extensively 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. In addition to the menu of standardized and client-specific reports available on demand, HMS can create other reports in accordance with AHCCCS's needs on an ad hoc basis and run them when required or incorporate them into our standard reporting menu. We will maintain tracking and reporting processes as specified by AHCCCS.

As a data-driven company, we know how to develop the reports required to manage the improper payment and recovery process. We currently provide accurate, detailed, and timely reports to state, federal, and commercial clients across the nation. Our reporting capabilities are robust, meeting end-to-end requirements and reporting all case-related elements. Comprehensive sets of standard reports are part of each Audit Identification and Recovery program. Upon contract award, we will discuss reporting needs to meet AHCCCS's requirements. Reports can be generated at many different time intervals along with summary reports based on contract year or fiscal year time horizons.

HMS will deliver detailed transaction level reports on all recoveries and outstanding overpayments and on underpayments at the frequency and in the media required by AHCCCS. **Our experience in operating under contingency fee–based recovery contracts sets us apart from other vendors who may not have experience in processing and reporting collections from providers.** HMS understands the unique data requirements of Medicaid programs, how Medicaid recoveries are accounted for, and the types of information that may be needed for not only updating the PMMIS but also reporting to CMS and State accounting systems.

Our customizable reports capture all of the data elements needed to update claims in the MMIS and provide documentation for State and federal auditors. Itemized claim reports can be made available on demand through the HMS system or as a separate deliverable in a format specified by AHCCCS. Our client-driven recovery reports provide detailed and accurate payment and adjustment information on the

claim line level, and we can report the full history of payments and adjustments applied to claims in the data set received from AHCCCS. HMS status and results reporting is supported by our proprietary claims tracking and case management database. This system contains all claims identified by the project; for each claim, we maintain extensive data elements that enable tracking and reporting on status, results, event status and dates, and virtually all activity/information related to the identification, verification, and recovery process. **Table 9.3-6** contains a list of some of the data elements in the system that facilitate tracking and reporting.

[redacted]

In addition to reporting through our case management system, HMS can transmit electronic versions of each report to AHCCCS via secure email or other transmission protocol.

HMS will fully support AHCCCS in generating the information and reporting necessary to comply with CMS, Arizona legislative, and other regulatory requirements for recovery reporting. As CMS publishes guidelines on what information is required to demonstrate the effectiveness of its RAC program, HMS will support AHCCCS in any related requirements.

9.3.3 APPEALS

RFP Reference: 7.1.3

AHCCCS needs a RAC that supports its program from start to finish—HMS has the expertise and resources to be that partner. The goal of the appeals process is to allow an opportunity for reconsideration when a provider disagrees with the results of our overpayment analyses. Providers might appeal decisions that have an adverse financial impact on their businesses, especially when they believe that they comply with regulations. For this reason, closure of a case does not occur until either expiration of the time to appeal or finalization of the appeal. Throughout the review process, HMS will provide ongoing support to AHCCCS.

The Contractor shall provide all necessary documentation and support to defend the audit findings in the appeals process, if needed, as well as witness testimony, if required any administrative appeal or court proceeding resulting from a review/audit of a Medicaid provider by the Contractor.

AHCCCS will benefit from our focus on minimizing provider reconsiderations and appeals by identifying all discrepancies at the claim level. We make it easy for providers to review every claim for which we identify a recovery

Our team brings more than 30 years of experience in working with appeals for Medicaid agencies, MCOs, health plans, and other clients. Our services include assisting in and/or conducting pre-settlement and pre-appeal processes as well as attending or providing support through the various fair- and administrative-hearing processes.

HMS FINDINGS-RECONSIDERATION PROCESS

We support effective provider relationships through our findings-reconsideration process. Our approach allows providers to request reconsideration and provide additional documentation to support claims. Our Preliminary Findings Letter includes details on the rationale used to make an overpayment or underpayment finding. It also gives the provider instructions on submitting a request for reconsideration. If the provider disagrees with our preliminary findings and requests reconsideration, we log the request into our audit tracking system. We attach to the case record any additional documentation or information received.

Our audit team reviews the claim and supporting documentation. It then issues a final finding—either upholding or overturning the preliminary findings. If we uphold the decision, we issue a Final Notice of Recovery Letter. This letter includes the finding rationale, identifies the overpayment, and details the next steps that the provider can take to appeal the finding through the appeal process. If we overturn our preliminary findings, we issue a Finding Overturned Letter, close out the claim, and report the results as part of our monthly reporting process.

Formal Appeals Support

[redacted]

Participation in Hearings

We will work with AHCCCS and its legal representatives to meet all requirements pertaining to hearing-process participation. Typically, our audit team members participate in hearings as required via teleconference. We will discuss in-person participation requirements on a case-by-case basis. Our team members have experience in contributing to pre-hearing conferences and providing witness-testimony

services for our clients. Audit team members will be available to answer questions, explain the review process and finding rationale, and defend our determinations.

Maintenance of Comprehensive Documentation that Supports Our Findings

[redacted]

Our comprehensive approach to recovery audit and appeals support provides the information needed by AHCCCS, at the right time. Based upon HMS's experience, providers have appealed approximately 33% of all Medicaid RAC audits. We have actually seen providers appeal underpayment findings, too, in what appears to be an automatic appeal strategy leveraged by select providers across select states. Despite the high volume of appeals, actual experience across state, federal and health plan recovery audit clients indicates only seven percent of all findings have actually been overturned. Stated differently, **93% of Medicaid RAC findings are, in fact, accurate.** Provider appeal activity has clogged state appeals processes, hampered the roll-out of additional audits, and significantly increased administrative costs for both the state and the RAC contractor. We are confident in our findings and the ability to support the appeals for each of our states. We will need to collaborate with AHCCCS on how to approach the provider community in order to minimize the appeal volume.

9.3.4 OVERPAYMENT

RFP Reference:7.1.4

The recovery techniques utilized by the Contractor shall be legally supportable and follow the guidelines of all applicable AHCCCS policies, regulations and manuals as well as all federal laws and regulations. The Contractor shall not forward claims for adjustment if the claim is incorrectly coded but the coding error does not equate to a difference in the payment amount. For example, HCPCS code E0250 requires an RR modifier for payment. Payment with the modifier is $25.00 per service. Without the modifier payment is $25.00 per service. While the claim without the modifier is incorrect, there is no overpayment therefore the claim should not be forwarded for adjustment.

[redacted]

[redacted]

[redacted]

OBTAINING RECOVERIES FOR AHCCCS

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

9.3.5 UNDERPAYMENT

RFP Reference:7.1.5

The contingency fee for underpayments will be paid for underpayments of $250.00 or more on claims submitted on a UB04, and $100.00 or more on claims submitted on CMS 1500 and ADA forms. However the contractor shall still identify underpayments of any amount.

[redacted]

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

9.3.7 Right to Terminate RAC Recoveries

RFP Reference:7.1.6

If the Contractor demonstrates, with a reasonable degree of certainty, that the fees earned on RAC recoveries during any three (3) month period following the first twelve (12) month period of the start of this contract do not cover the direct costs of the recovery efforts during that same time period, the Contractor may exercise its right to terminate its contractual obligations under Section 7 of the Scope of Work ("MEDICAID RECOVERY AUDIT CONTRACTOR (RAC) SERVICES") after giving AHCCCS sixty (60) days written notice and obtaining agreement from AHCCCS regarding such termination. AHCCCS agrees not to unreasonably withhold such agreement from the Contractor. Further, efforts to exercise this Right to Terminate clause do not abrogate any other sections of this Scope of Work nor relieve either party from its obligations under the remainder of this agreement.

HMS understands and accepts this requirement.

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