

## Method of Approach

- 2.1 Offeror shall provide a detailed method of approach (response) that pertains directly to satisfying the statement of work and other related documents within this Solicitation. Offeror shall limit its response to 10 pages or less. General marketing material (e.g., brochures) may not be substituted for response content but may be provided for reference only.

### Offeror Response

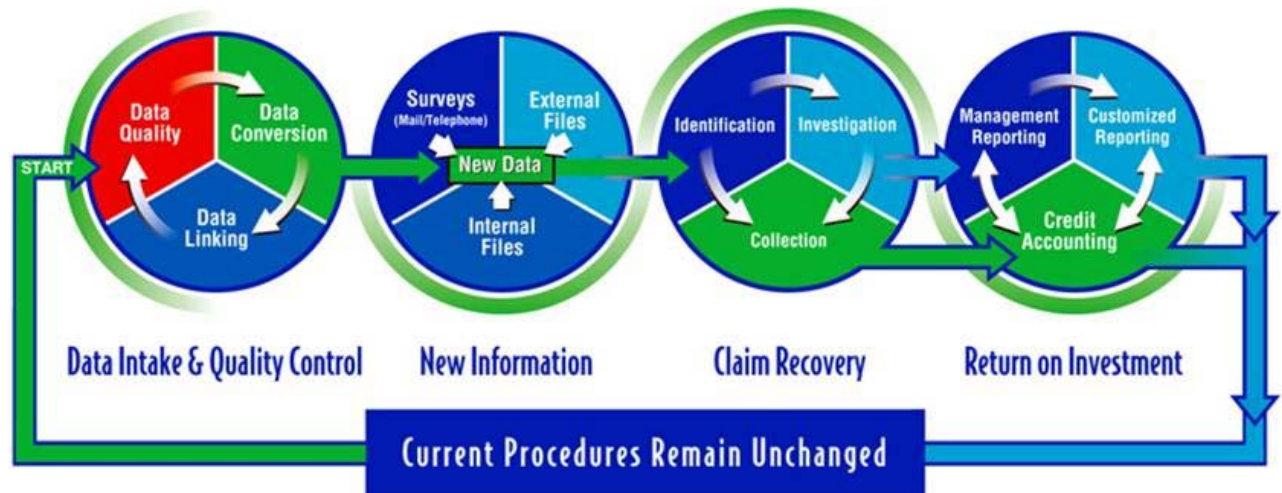
Recovery Audit Specialists, LLC (RAS) understands that it will work under the general oversight of the State Comptroller while performing its recovery audit services for the State of Arizona. Our services are performed with due diligence and with the intent of minimizing any administrative burden on Arizona State agencies throughout the process. Our goal is to recover the maximum amount of misspent taxpayer funds with minimum disruption to the State. Our findings and resultant feedback to the State will help management monitor performance progress of State agencies and identify financial management areas in need of attention to avoid future overpayments.

Our work processes and all forms of communications are conducted in strict compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191).

We will cover our costs to perform the services, including travel. A large portion of the work can be conducted electronically, but to the extent RAS needs to examine original documents, we will do it on site or make copies. We will not remove any original records from State agencies.

Recovery Audit Specialists, LLC will perform a comprehensive recovery audit for the State of Arizona. To accomplish this, RAS will be performing three simultaneous audit types for the State of Arizona: Pharmacy Benefits, Health Care Benefits and Accounts Payable. We have developed specific analytical tools and reporting mechanisms that enable us to perform efficient and effective recovery audits for the three audit types without disrupting the State's current procedures.

Each recovery audit type will proceed through the audit process steps outlined in the graphic below, which is discussed in detail later. However, some technical features to gather and process the data are unique to each audit type and we therefore, have outlined each type below.



Recovery Audit Specialists, LLC will analyze relevant documents and data to and identify duplicate payments, invoice errors, pricing errors, failure to apply discounts, rebates, or other allowances, failure to comply with a purchasing agreement or any other errors that result in erroneous payments. The improper payments will be approved by the State Comptroller before we begin the collection process. We will provide written reports on our findings on a schedule to be agreed upon, most likely monthly, and recommend corrective actions the State may take in our Best Practices recommendations developed jointly with the Authorized Purchaser and GAO.

Work will commence on all audit types simultaneously. However, since the Pharmacy Benefits Audit is based on electronic records, that audit can be conducted in a shorter timeframe than the other two types and should reap the fastest return of recovered payments for the State of Arizona.

## Pharmacy Benefits Audit

We start by conducting a Contract Compliance Analysis, which examines 100 percent of the pharmacy claims for the audit years and compares each claim to the terms and conditions of your Pharmacy Benefit Manager (PBM) contract. Historically, we find that about half of the overcharges come from the individual claim review and the other half from violations of the terms and conditions of the PBM contract. Prices on prescription drugs change frequently. Our analytical tools are updated to reflect price changes on a daily basis, and we have the day-to-day prescription drugs costs programmed in our system for the past seven years.

Our Pharmacy Benefits analysis begins with a thorough review of the following documents:

- All Contracts and contract amendments
- Data File Layout NCPDP 2.0 or greater that identifies the location of data elements within the claim file
- The initial Plan set up documentation including Plan Coverage Detail
- Log of all plan changes since inception
- List of any drugs that have exceptions, limitations to the retail days supply limit
- Excluded and Specialty Drug List
- List of Pharmacy drugs and the pricing arrangement for each NDC
- All plan design Quantity Limits associated with this plan
- All plan design Step Therapies utilized for the plan
- MAC Generic Drug Lists defined by the contract between the State and PBM

We analyze the following data fields with respect to each prescription drug claim, including all current and historical claims pricing data (including all changes during the relevant time period):

- **Transaction Number:** a number assigned to identify individual claims for reference
- **Date of Service:** date that the drug was dispensed by pharmacy.
- **Paid Date:** date the processor processed the claim
- **Group ID Number:** Medicaid or Employer Identification Number
- **Contract ID Number:** large groups with Multiple Plan Designs have group and sub-group identification numbers
- **Member ID Number:** Medicaid or Employee ID number
- **Pharmacy NABP Number:** ID number of the dispensing pharmacy
- **Mail/Retail Indicator:** Determines if dispensed at a neighborhood Retail (or Network Pharmacy) or the PBM owned Mail Service Pharmacy
- **Rx Number:** unique number for prescriptions that is assigned by the dispensing pharmacy
- **Brand/Generic Indicator:** indicates the medication dispensed was brand or generic
- **Formulary Indicator:** drugs that are designated as preferred drugs by the PBM; assignment relates to cost effectiveness and/or contract arrangements
- **NDC—11:** National Drug Code identifies a specific drug manufacturer (5 digits), drug and strength (next 4 digits) and also bottle size (last 2 digits)
- **Drug Name and Strength:** name of medication and milligram strength dispensed
- **Dispensed Quantity:** the metric quantity dispensed amount
- **Days Supply:** calculated by the pharmacy or software program and submitted with the transmission to the PBM. Maximum allowable days a medication can be filled as defined in the plan design
- **AWP Unit Price or Claim AWP:** Average Wholesale Price is a standard value issued by national data sources First DataBank and Medispan. AWP is the one basic common denominator used for pharmacy contracting and pricing
- **Ingredient Cost:** contracted cost of the claim (calculated as AWP less the contracted discount of % off AWP)
- **Dispensing Fee:** amount added to the Ingredient Cost to get the Gross Cost of the claim and can be described as the pharmacy fee for dispensing the medication
- **Tax Amount:** tax paid on the transaction sale if applicable in the state
- **MAC Cost:** (Maximum Allowable Cost) is the highest price the PBM will reimburse a pharmacy for specified Generic drugs
- **Member Co-pay:** amount the employee has to pay at the pharmacy which maybe called Member Share

- **Member Coinsurance:** term for Member Co-pay if the benefit design calculates a percentage amount of the claim cost
- **Deductible:** amount the Member has to pay out of pocket before the plan design of normal claim co-pay starts
- **Paid Amount:** amount charged to the State. (Calculated as Gross Claim amounts less Member Co-pays)
- **DAW Code:** Dispense as Written Code is submitted by the pharmacist after the review of the prescription
- **Ancillary Charge:** a financial penalty charged to the Member when a DAW rule is applied to the claim.
- **GPI—14:** Medispan's Generic Product Identifier is a 14 digit number that defines the specific drug – without a designation of brand or generic (e.g., Tylenol and Acetaminophen have the same number). The program uses this number for drug exclusions and clinical issues
- **Physician ID:** doctor's identification number
- **Base of Cost:** a numerical or abbreviated designation code that is specific to each PBM. The code relates to the method the PBM used in processing the claim.
- **Prior Authorization (PA):** a number assigned to a claim that has failed normal edits (rules of coverage) but with the PA, has been passed for processing

As we perform the audit, our software checks the processing accuracy of each claim and compares those results to what the State actually paid. Discrepancies are totaled and reported with a "Reason Code" for PBM confirmation.

### **PBM Examination**

Pharmacy Benefits are all electronically managed by PBM's (Pharmacy Benefit Managers) in a large part because they must deal in real-time with thousands of pharmacies around the country. This enabled the establishment of data standards, specifically we use the NCPDP 2.0 or greater data format that all PBMs use.

### **Authorization and Definitions**

First, we request the pharmacy data from the State if it is warehoused within their system. If the State does not, or can not access the data we need, then we sign documents of authority with the relevant State agency in order to work on their behalf in communicating with the PBM and others, as may be required for the audit. We also sign letters of HIPAA compliance; although in most cases we do not request patient information where this would be required. We outline the scope of the examination in consultation with the State. This stage of the process may take less than a week to complete.

### **Data Requests**

On the behalf of the State agency we request data in the NCPDP 2.0 or greater data format for the period of the examination covering the lives to be examined. RAS requests copies of the contracts and setup sheets that explain all the exclusions and special inclusions of their pharmaceutical and supply agreement. We request additional documents such as MAC (Maximum Allowable Charge) lists that may have been included in the agreement, as well as all interim changes that may have been requested by the State agency. Finally, we request a copy of the same documentation that the State agency may have. This stage can take from two weeks to a month, depending on the State's system or the PBM.

### **Contract Review and System Setup**

Upon receipt of both the contracts and data from the PBM, we compare the source documents and create a duplicate adjudication system as that of the PBM. Frequently, we discover differences in information from the two sources and they are resolved at this point. The data is thoroughly checked for completeness and integrity. This process requires from one to three weeks, depending on the completeness, accuracy and format of the data.

### **Data Audit**

The Pharmacy claims are then 100 percent re-adjudicated by our system and discrepancies with the PBM claim data are identified and examined. Our system processes over 500,000 transactions per hour. Our system recently examined almost 500 million claims. Because our specialized system can handle multiple terabytes of data and run non-stop, the actual data audit run may be completed in as little as a day.

### **Results Review and Presentation**

Our program is an extremely detailed forensic examination of 100 percent of claims and how those claims are processed, relating to the terms and conditions of the contract between the State and its PBM. The output from the audit is listed by individual claim that we found in non-compliance with the contractual agreements. Each claim contains the reason code(s) and an explanation of why that individual claim was found to be non-compliant. Summaries allow for the examination of global errors or significant trends in the data. Frequently, we will find reasons to return to the Contract Review and Setup phase and re-run the data. This phase is a process of meetings with the client to understand the results and hone the output before we deliver our final results presentation for collection from the PBM. This stage can take one to three weeks, depending on challenges with the source data.

### **Reports and Approval of Results**

We submit weekly reports that are consistent with those required by the State or Federal agencies for the approval by the State before collection. These reports contain summaries of what type of errors were observed as well as averages and percentages to describe the data. Since this is an audit of a single contractor, the PBM, there is no need to approve collections from individuals, recipients or multiple vendors, but we do get approval from the State on types, amounts and methods of recoveries from the PBM.

### **Collection from the PBM**

The PBM was notified of the Audit process back in the Data Request stage and is therefore expecting our results. Usually we hold a meeting for the presentation of the results with representatives of the State agency and the PBM in attendance. We then send the PBM the line-by-line, claim-by-claim results we discovered. Most PBM contracts have a period where the PBM may review the data before payment. Collection is easiest when the PBM is an existing contractor with the State.

Using the method approved above, we can institute credit memos against current invoices, lump sum requests or other methods consistent with recovering the full value of the overpayment.

### **Post Recovery Reporting and Billing**

After payment (in the form of cash, credits, refunds, discounts, etc.) is received from the PBM and confirmed by the State, RAS will submit several documents to the State. We will also produce reports required by the Federal government showing the funds that will be returned to them (if required). We will submit reports to the State outlining the recoveries and submit the invoice for our services.

After the audit is completed, we provide the State a list of all drugs that were out of compliance along with the reason codes of what is wrong with the claim via our encrypted FTP site or external hard drive. The State or our team, if required, will contact the PBM for their response. We will also provide the State a management report that will show the claims buckets where the improper claims came from, our opinion of what needs to be changed by either the State's process or its PBM contract. We also will present tools that will save the State money moving forward and assist it in negotiating a new contract or PBM. We can also provide, on mutually agreeable terms, a prospective audit program that will audit the pharmacy claims before the State pays the PBM, minimizing or eliminating future improper payments by the State.

### **Health Care Benefits Recovery Audit**

Recovery Audit Specialists, LLC Medical Claim Recovery and Administrative Overpayment Audit combines innovative technology and proprietary software with expert review to identify claims that were improper. The audits are comprehensive and screen 100 percent of paid claims.

Our team has conducted Administrative Overpayment Audits since 1989, which makes us one of the most experienced health claim audit firms in the nation. Our audit service goes beyond the industry standard by having the most sophisticated query logic and case detection software in the industry. In brief, our custom software tools:

- Accept the State's data in any format
- Review 100 percent of claims – no sampling
- Verify eligibility on all claims before moving on to expert review
- Expertly manage the collections phase
- Follow through on claim recovery findings to ensure future savings
- Respect existing procedures – reduce costs without changing coverage
- Capture 100 percent of paid claims (with associated enrollment and administrative data)
- Validate and combine these data to create a new data asset
- Add to this asset new information from a variety of sources

- Analyze all data to identify claims warranting recovery follow-up
- Support that follow-up via secure, HIPAA-compliant communications
- Follow all potential recoveries (from any internal or external source) until resolved; and
- Provide a full range of routine and custom reports.

Work on the Arizona Medicaid and State employee health care benefits audit will proceed in the following five phases:

#### **Planning and Customization**

- RAS reviews any contracted recovery efforts currently underway to assure that we do not duplicate reviews with existing efforts
- We review State efforts involved with direct payment administration of Medicaid and State employee claims with specific emphasis on post-payment review programs
- RAS confirms the number and type of Medicaid and State employee payment arrangements with contracted plans and any special benefit, administrative and/or contracting terms
- We confirm the scope of excluded benefits and other payment edits to be enforced
- RAS will seek direction from the State as to potential recovery areas it may want to incorporate and determine their feasibility

#### **Data Intake**

- RAS works with all identified data sources to inventory available data files for inclusion in the audit. Specific attention will focus on:
  - Arizona Health Care Cost Containment System (AHCCCS) accounting systems
  - Databases maintained by the State Medicaid and State employee program administration
  - Databases from Medicaid and State employee managed care or other contracted plans
- Data requests encompass all available claim, enrollment and related administrative files
- Data file downloads are defined by each source and provided in the form and format of their choosing; no special programming is expected or required
- All files will be accompanied by current documentation that will permit the interpretation of files, records, fields and field content codes
- Conference calls with IT personnel at each data source will be conducted to explain data expectations and answer any questions related to data submittal. This call will usually last an hour or less
- Files received will have control counts verified and be run through a series of quality checks
- A follow-up conference call will be conducted with IT personnel at each data source to address data quality issues identified and confirm the data are suitable for use or if any follow-up is warranted. Specific attention will focus on replicating claim adjustment calculations to eliminate existing recoveries and document subsequent recoveries. This call will usually last an hour or less

#### **Audit Analyses**

- Once suitable data are confirmed, data files will be translated to a common, Microsoft compatible format and prepared for analysis
- 100% of all claims along with related enrollment and administrative data will be run through a series of audit algorithms to identify potential recoveries. A front-end edit will identify and separate from results all claims already identified as recoverable or under pursuit
- Audit tests will include but not be limited to
  - Ineligible enrollees, claimants, and claims
  - Claims incurred during lapses in coverage
  - Duplicate claims and enrollment

- Payments not passing federal correct coding standards
- Payments for excluded benefits
- Payments outside of contractual provisions

#### **Audit Reports and Validation**

- Audit results will be presented in HIPAA-compliant summary form for review and discussion with State officials regarding causes and possible remedial steps that may be warranted
- Detailed audit findings will be accessible to authorized users via a secure site. Audit results at a claim, claimant, provider or other relevant level may be viewed by State personnel for validation prior to the initiation of recovery pursuit. This validation review may be done on all or a sample of findings. Training in the use of validation software and procedures will be provided.
- Claims and other findings validated as recoverable by the State will be forwarded for collection.
- Claims and other findings pending or denied by the State will be documented and reviewed for audit process improvements

#### **Collection**

- All existing legal and regulatory authority available to the State will be applied to collection efforts
- Collection from contractors will be consistent with the terms and conditions of contracts
- Collection from providers will follow established procedures used by the State
- Collection from individuals is not proposed. Any monies due from individuals may be collected using available State authority.
- All collections will be accounted for as received, pending or closed with reasons for closure documented
- Collections received will be documented via payment of funds, credits, discounts, rebates or settlements received by the State
- Collection accounting and monitoring will utilize the same secure site used for collection validation, providing the State with a consistent basis for real-time monitoring of audit results from initial findings through final resolution. A series of reports and e-mail alert functions are also available to the State to assist with monitoring in a routine, non-disruptive fashion.

Audit recovery reviews may be continued on a monthly or quarterly basis depending on data availability from State sources. These subsequent analyses will also include credit tracking updates to confirm processing of recoveries received.

The data and information from our Clinical Claims Information Request for review and analysis does not include information that violates HIPAA (Health Insurance Portability and Accountability Act of 1996). The data we seek will not include personal identifiers of the recipients. The information will be used for the specific purpose of reviewing and evaluating medical claim costs and for no other purpose. Contract and Member ID can be encoded but must be a member identifiable number for the following documents:

- **Group Numbers:** including any associated plan numbers or suffixes used by the Carrier to identify enrollees (current Medicaid enrollees, employees/spouses/dependents as well as retirees and COBRA enrollees if applicable). We then use these group numbers in our data request to the Carrier.
- **Benefit Summary Plan Descriptions for Medicaid enrollees and State Employees:** These materials document key plan features to be tested (e.g., benefit exclusions and limits as well as eligibility, entitlement and enrollment rules).
- **COBRA Continuation Coverage Description and Rate Sheet:** We use this to estimate actuarially determined plan costs to confirm the nature of COBRA administration.
- **Administrative Service Agreement.** It is not uncommon to find that this agreement was signed years ago and a copy is not readily available. In that event, we request a description of the offered administrative services, the administrative fee arrangements, and any performance standards or expectations that have been established. These facts help set the context for claim processing review.

- **Stop-Loss Agreements:** (if applicable) If the actual stop loss contract is not available, we request a description of any specific and/or aggregate terms that may apply. We will test the stop loss specific level with incurred and paid periods and aggregate attachment points, if any. We use these facts in our review of large cases and to confirm stop-loss enforcement.
- **Current Electronic Payroll and Medicaid Enrollee File:** This file should include information for all Medicaid enrollees, covered employees, spouses and dependents with 24 months of history. This information can be provided in any form and format but must be accompanied by documentation describing the record layout and field contents. In our experience, such client data are often more complete and up-to-date than external data. These data are also most useful as a source of verification and reconciliation.
- **Roster of COBRA enrollees.** This roster helps to resolve enrollment discrepancies and inconsistencies. If the State chooses to include this data in the payroll file, please include the employee status as coded in the States data dictionary. We accept this information via a CD or secure file, in the States secure transmission method of choice.

### **Post-Payment Recovery for Medicaid**

RAS has combined its 20 years of experience in post-payment recovery with recent audits by the Federal General Accounting Office (GAO) and the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) to identify fifteen areas where Medicaid programs can recover money that either should not have been paid or should have been paid by someone else. Our medical audit will address these areas. Eleven of the fifteen recovery areas can be pursued by individual Medicaid plans.

**1. State-to-State Overlap:** In areas where State border crossings are common, there will be the occurrence of persons enrolled in two (or more) Medicaid programs at the same time. This results in duplicated administrative expenses and possible double payments. Each State must agree to a comparison of enrollment rosters. This can be done using our “Anonymous Comparison” technique to assure any sharing does not violate individual confidentiality.

**2. Plan-to-Plan Overlap:** States with multiple Medicaid plans enrolling persons can experience persons enrolled in two (or more) Medicaid plans at the same time. This results in duplicated administrative expenses and possible double payments. The State Program must require each plan to share enrollment rosters that can be cross-referenced to the State’s records of eligibility and enrollment history.

**3. Plan-to-Plan Comparison:** State programs can use the following recovery areas not only as the basis for recoveries but also as the basis for comparative reviews that establish norms and gauge how well each plan is performing. The State program would need to follow normal rule making and evaluation protocols associated with their oversight role.

**4. Fraud Control Units:** Each State has a Medicaid Fraud Control Unit (MFCU) usually housed within the State Attorney General’s Office. Areas of fraud need to be documented by the MFCU and used as the basis for “data mining” programs that document further occurrences.

**5. Correct Coding:** Federal regulations require Medicaid programs only pay for physician services that meet Correct Coding criteria. Any payments not meeting these criteria can and should be denied.

**6. Medicare Coordination:** Dual eligible (persons enrolled in both Medicare and Medicaid) should exhaust all Medicare coverage before Medicaid payments occur. This coordination is particularly needed with Medicare HMOs (Medicare Part C) but also affects Part A and Part B claims as well. Even Part D prescription drug payments may be inadvertently paid by Medicaid plans.

**6. Medicare Coordination:** Dual eligible (persons enrolled in both Medicare and Medicaid) should exhaust all Medicare coverage before Medicaid payments occur. This coordination is particularly needed with Medicare HMOs (Medicare Part C) but also affects Part A and Part B claims as well. Even Part D prescription drug payments may be inadvertently paid by Medicaid plans. State programs need to define procedures for documenting Medicare effective dates and the type of Medicare coverage available.

**7. Private Coverage Coordination:** Persons enter and exit Medicaid coverage based on employment and access to private coverage. Delays in coordinating Medicaid coverage with private coverage result in unnecessary Medicaid payments and administrative expenses. Traditional forms of coordination enforcement

can be used. Or, the State or individual Medicaid plans can seek to perform enrollment comparisons using our “Anonymous Comparison” technique to assure individual confidentiality.

**8. Deceased Beneficiaries:** Persons have been identified as still receiving Medicaid benefits on dates that are after they have died. State death records would need to be accessed for comparison to Medicaid rosters.

**9. Incarcerated Patients:** Medicaid benefits are not available to persons in jail. Yet, instances of such payments are known to occur. Prisoner rosters (for both State prisons and county jails) with incarceration and release dates need to be accessed for comparison to Medicaid rosters.

**10. Medical Care to Persons Ages 21-64 at Institutes for Mental Disease (IMD):** Medicaid benefits are not available to adults under 65 years old who are housed at an IMD. Yet, instances of such payment are known to occur. IMD resident rosters need to be accessed for comparison to Medicaid rosters. The Recovery Audit Specialists “Anonymous Comparison” technique can be used to assure individual confidentiality.

**11. Ineligibles:** Payments made for claims with incurred dates after a termination date should be recovered. Given the frequent changes in Medicaid eligibility status, such payments are known to occur. Paid claims file and Medicaid enrollment roster with effective and termination history.

**12. Duplicate Payments:** Multiple payments for the same service to the same provider or for the same service on the same day to multiple providers should be recovered.

**13. Excluded Benefits:** Payments for services not covered by Medicaid should be recovered. Paid claims file and roster of excluded benefits translated to applicable procedure codes.

**14. Subrogation:** Payments for claims associated with accidental injuries may have property and casualty coverage medical benefit payments due or may be subject to legal settlements including medical expenses. In either instance Medicaid may receive payment to offset claim payments made.

**15. Divorce Decree Enforcement:** Payments for children covered under a divorce decree with a Qualified Medical Child Support Order should not be made by Medicaid, yet such payments are known to occur.

### RAS Medical Claim Audit Tests Example

Standard Analyses	Custom Analyses	Confirmed Other Coverage	Facts to be Confirmed via Focused Survey
Ineligibles (after term, before effective, no member, no contract)	Excluded benefits	Coordination-of-Benefits (other payer primary verified)	Potential Coordination-of-Benefits (other coverage to be verified)
Duplicates (across claims, within claims)	Non-contractual payments	Medicare Primary (age, ESRD, disabled, COBRA)	Divorce Decree (court orders)
Physician Correct Coding (claims not meeting minimum federal standards)	Stop-loss cases	Double Provider Payment (credit balances)	Large Cases (fact verification and stop-loss enforcement)
Provider Overpayment (pay over charge, missed discounts)	Client custom requests	Worker’s Compensation	Subrogation (settlement lien for auto accident or liability coverage)

### Accounts Payable Recovery Audit

The AP audit begins with a review of relevant contracts, agreements and documents that reflect pricing, terms, allowances, rebate programs and other relevant factors. We analyze these documents to determine that all of the points offered in the agreement were received by the State as negotiated. We can perform certain audits, such as pricing, without the contracts. But in our experience, having the contract information solidifies our findings and increases recoveries.

We intend to make the data acquisition process as simple and easy for the State as possible. We can handle any method the State chooses for actual data transfer. RAS will examine the following data in the performance of the audit:

**Payment History Data:** Contain a listing of invoices paid and items deducted on checks issued. We will need a vendor number, invoice/deduction number, document date, amount paid/deducted, cash discount taken, date paid, check number, and other information – such as PO number – to identify and explain each transaction.

**Accounts Payable and Purchase Order Vendor Master Data:** Provides the name, address, payment terms, rebate details, freight terms, pick-up locations and other information about each vendor referenced in the other files we receive.

**Purchase Order/Receiver (Header/Detail) Data:** This database should contain item-level detail of purchase orders issued. In these files we need quantity ordered, quantity received, list price, allowances, up-charges, freight charges/allowances, and other information required to calculate the list price and dead net price you expected to pay for each item/shipment.

**Purchase Order/Receiver/Invoice Matching Data:** This database should provide item-level detail reflecting how each invoice was reconciled to your purchase order/receiver. This database might also contain the item-level detail for any system-generated charge-backs and internal adjustments that are required to complete the reconciliation.

**EDI Transmission Detail:** For this data, we would like to receive the original transmission file as received from your vendors. The EDI record types we can utilize are invoices, credits, remittance advises, promotional offers and advanced shipping notices. This data will provide details of documents that may not exist in hard copy form.

**Selected Accounts Receivable/Cash Receipts History Data:** This database should provide a listing of checks and funds due or received from your vendors, as opposed to any accounts receivable due from State customers.

**Chargeback/Billback Detail Data:** These databases should provide item-level data about the chargebacks/billbacks that the State has written against its vendors. If item-level detail is not available, any file that lists Chargebacks by vendor and total amount due will also be acceptable.

**General Ledger Distribution Detail:** This database should report the various amounts charged to each G/L Account Number for each invoice and deduction shown in your Payment History database.

**General Ledger Chart of Accounts:** This database should provide a listing of your general ledger account numbers and a description for each.

Our specialized software runs custom queries to interrogate the data and identify improper payments. It will detect all erroneous payments, both over and underpayments; we will report the full data to the State. To accomplish this we need access to relevant documents certain electronic information from the State. RAS realizes that all the data may not be available in electronic form and we will need to review some original documents. We will either conduct that review on State agency premises or make copies of necessary documents to conduct our analysis. Under no circumstances will RAS remove any original documents from State agency premises.

As we analyze and document the findings, RAS begins developing interim reports for the State. Documentation will be a continuous process throughout the audit. Periodic reports will continue to be refined to four objectives:

- List improper payments and trends apparent in them
- Develop approach for collection
- Describe control issues leading to improper payments
- Develop plan to alleviate control problems

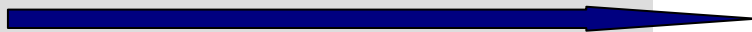
The RAS final management report will combine our intermediate reports, including specific recommendations to improve payment control issues in each of the three areas. Our recommendations will include next steps for the State to strengthen its systems, which may run from straight forward changes to procedures and responsibilities to more complex systemic modifications. Since RAS will share suggestions to strengthen Arizona's financial management of payments continuously throughout the auditing process, some of our suggestions may be implemented by the State earlier in real time.

Our goal is assist Arizona to move toward an environment in which improper payments are truly the exception by preventing improper payments, rather than discovering them after they've occurred.

### Client Roles and Time Commitment

	Enrollment Audit	Client Time	Claim Audit
<b>Planning and Customization</b>	<ul style="list-style-type: none"> <li>Supply plan description</li> <li>Review draft communications</li> <li>Participate in conference call to finalize communication plan</li> </ul>	2-3 hours	<ul style="list-style-type: none"> <li>Supply plan descriptions, administrator contract and stop-loss contract</li> <li>Describe custom analyses of interest</li> <li>Participate in conference call to finalize audit scope</li> </ul>
<b>Data Acquisition</b>	<ul style="list-style-type: none"> <li>Supply internal rosters (payroll, COBRA, etc.)</li> <li>Approve control counts produced by Health Decisions</li> </ul>	2-3 hours	<ul style="list-style-type: none"> <li>Supply internal rosters (payroll, COBRA, etc.)</li> <li>Execute data release agreement from administrator (if required) Approve control counts produced by Health Decisions</li> </ul>
<b>Audit Execution</b>	<ul style="list-style-type: none"> <li>Participate in progress status calls</li> <li>Review findings and recommendations</li> </ul>	2-3 hours	<ul style="list-style-type: none"> <li>Confirm dates of employment, termination, retirement, etc.</li> <li>Review findings and recommendations</li> </ul>
<b>Report of Findings</b>	<ul style="list-style-type: none"> <li>Participate in audit report presentation meeting.</li> <li>Authorize follow-up</li> </ul>	2-3 hours	<ul style="list-style-type: none"> <li>Participate in audit report presentation meeting.</li> <li>Authorize follow-up</li> </ul>
<b>Collection</b>	<ul style="list-style-type: none"> <li>Make necessary membership changes</li> </ul>	2-3 hours	<ul style="list-style-type: none"> <li>Make necessary membership changes</li> <li>Provide access to credit receipt documentation</li> </ul>

### Five Steps in the Audit Process

Audit Process Steps	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
<b>Planning &amp; Customization</b>						
<b>Data Acquisition</b>						
<b>Audit Execution</b>						
<b>Report Findings</b>						
<b>Collections</b> On-going until end of contract						
▪ <b>Credit</b>						
▪ <b>Check</b>						
▪ <b>Settlement</b>						