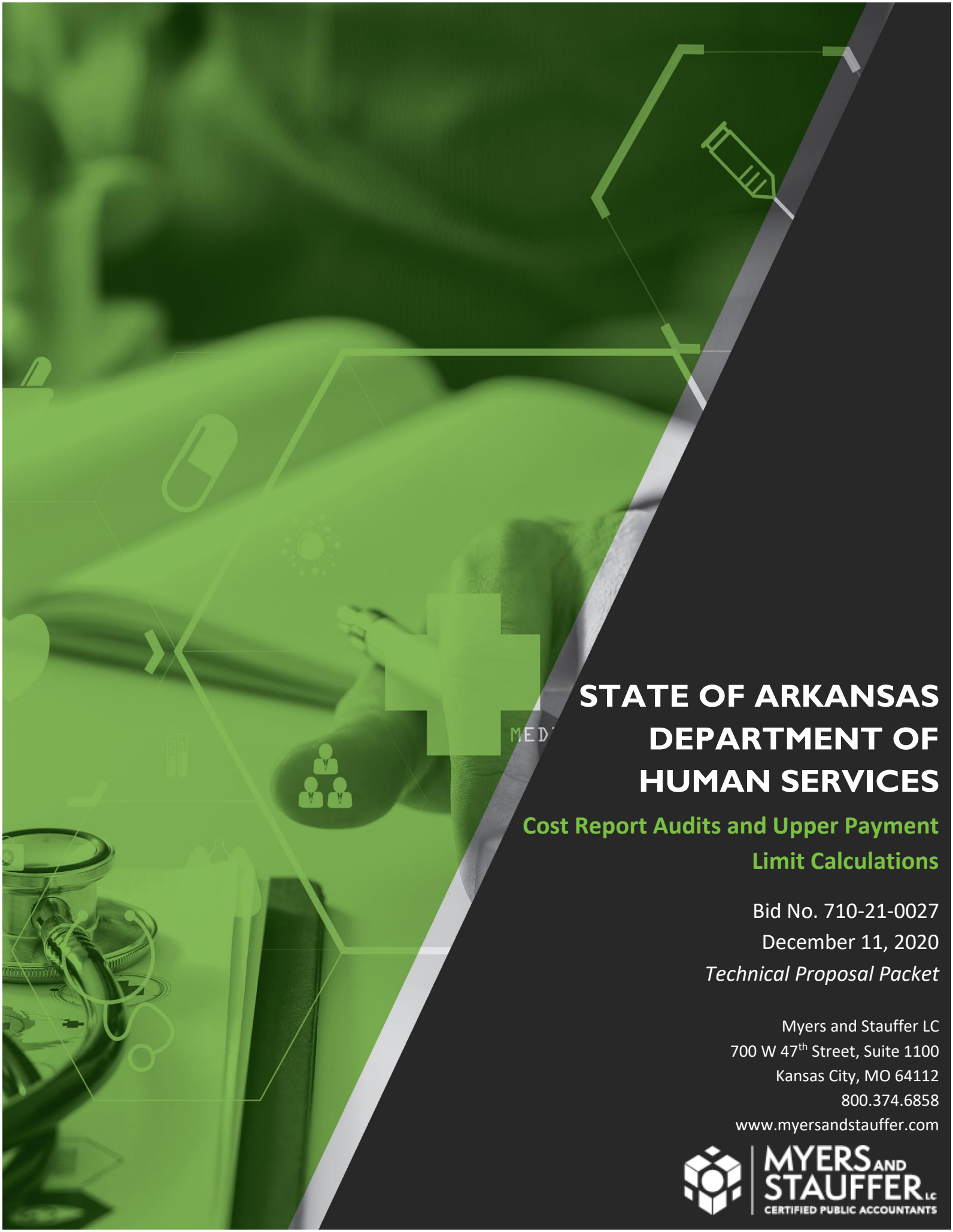


STATE OF ARKANSAS DEPARTMENT OF HUMAN SERVICES

Cost Report Audits and Upper Payment Limit Calculations

Bid No. 710-21-0027

December 11, 2020

Technical Proposal Packet

Myers and Stauffer LC
700 W 47th Street, Suite 1100
Kansas City, MO 64112
800.374.6858
www.myersandstauffer.com

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

Myers and Stauffer is wholly-owned and managed by its partners, and does not have parent or subsidiary companies. We have elected to operate our CPA firm under an alternative practice structure, as defined by the American Institute of Certified Public Accountants (AICPA). Under this structure, our staffing resources are obtained through a contract with the publicly-traded company Century Business Services, Inc. (CBIZ). All of the staff we obtain through this relationship work exclusively for Myers and Stauffer.

Specifically, in the fall of 1998, we entered into a transaction with CBIZ, which resulted in the creation of CBIZ M&S Consulting Services, LLC. CBIZ M&S Consulting Services, LLC is wholly-owned by CBIZ, Inc. As part of this business model, Myers and Stauffer acquires office space, personnel, and other business resources from CBIZ M&S Consulting Services, LLC. These resources, including personnel and consultants, are assigned exclusively to serve the clients of Myers and Stauffer. AICPA professional standards provide specific guidance regarding independence within alternative practice structure firms. These professional standards are published in the Independence, Integrity, and Objectivity section of the AICPA Code of Professional Conduct at ET Section. 1.220.020. We fully comply with this, and all other professional standards.

Forms

Proposal Signature Page

Technical Proposal Packet ***Bid No. 710-21-0027***

PROPOSAL SIGNATURE PAGE

Type or Print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION					
Company:	Myers and Stauffer LC				
Address:	700 W. 47th Street, Suite 1100				
City:	Kansas City	State:	MO	Zip Code:	64112
Business Designation:	☐ Individual ☐ Sole Proprietorship ☐ Public Service Corp ☐ Partnership ☒ Corporation ☐ Nonprofit				
Minority and Women-Owned Designation*:	☒ Not Applicable ☐ American Indian ☐ Asian American ☐ Service Disabled Veteran ☐ African American ☐ Hispanic American ☐ Pacific Islander American ☐ Women-Owned AR Certification #: N/A * See *Minority and Women-Owned Business Policy*				

PROSPECTIVE CONTRACTOR CONTACT INFORMATION *Provide contact information to be used for bid solicitation related matters.*			
Contact Person:	Amy Perry	Title:	Member
Phone:	(800) 374-6858	Alternate Phone:	(816) 945-5300
Email:	APerry@mslc.com		

CONFIRMATION OF REDACTED COPY

☐ YES, a redacted copy of submission documents is enclosed.
☒ NO, a redacted copy of submission documents is not enclosed. I understand a full copy of non-redacted submission documents will be released if requested.

Note: If a redacted copy of the submission documents is not provided with Prospective Contractor's response packet, and neither box is checked, a copy of the non-redacted documents, with the exception of financial data (other than pricing), will be released in response to any request made under the Arkansas Freedom of Information Act (FOIA). See Bid Solicitation for additional information.

ILLEGAL IMMIGRANT CONFIRMATION

By signing and submitting a response to this *Bid Solicitation*, a Prospective Contractor agrees and certifies that they do not employ or contract with illegal immigrants. If selected, the Prospective Contractor certifies that they will not employ or contract with illegal immigrants during the aggregate term of a contract.

ISRAEL BOYCOTT RESTRICTION CONFIRMATION

By checking the box below, a Prospective Contractor agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract.

☐ Prospective Contractor does not and will not boycott Israel.

An official authorized to bind the Prospective Contractor to a resultant contract shall sign below.

The signature below signifies agreement that any exception that conflicts with a Requirement of this *Bid Solicitation* **will cause the Prospective Contractor's proposal to be disqualified.**

Authorized Signature: Amy Perry *Use Ink Only.* **Title:** Member

Printed/Typed Name: Amy Perry **Date:** 12/08/2020

Agreement and Compliance Pages

Technical Proposal Packet ***Bid No. 710-21-0027***

SECTION 1 - VENDOR AGREEMENT AND COMPLIANCE

- *Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.*
- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

Authorized Signature: Amy Perry
Use Ink Only.

Printed/Typed Name: Amy Perry **Date:** 12/08/2020

Technical Proposal Packet ***Bid No. 710-21-0027***

SECTION 2 - VENDOR AGREEMENT AND COMPLIANCE

- *Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.*
- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

Authorized Signature: Amy Perry
Use Ink Only.

Printed/Typed Name: Amy Perry **Date:** 12/08/2020

Technical Proposal Packet ***Bid No. 710-21-0027***

SECTIONS 3, 4, 5 - VENDOR AGREEMENT AND COMPLIANCE

- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section(s) of the bid solicitation.

Authorized Signature: Amy Perry
Use Ink Only.

Printed/Typed Name: Amy Perry **Date:** 12/08/2020

Proposed Subcontractors Form

Technical Proposal Packet ***Bid No. 710-21-0027***

PROPOSED SUBCONTRACTORS FORM

- ***Do not*** *include additional information relating to subcontractors on this form or as an attachment to this form.*

PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.
Type or Print the following information

Subcontractor's Company Name	Street Address	City, State, ZIP

☒ **PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

Signed Addenda

State of Arkansas
DEPARTMENT OF HUMAN SERVICES
700 South Main Street
P.O. Box 1437 / Slot W345
Little Rock, AR 72203
501-320-6511

ADDENDUM 1

DATE: November 23, 2020
SUBJECT: 710-21-0027 Cost Report Audits and Upper Payment Limit Calculations

The following change(s) to the above referenced Invitation for Bid for DHS has been made as designated below:

Change of specification(s)
_____Additional specification(s)
__X__Change of bid opening date and time
_____Cancellation of bid
__X__Other

1. Change language in RFP section **2.3 (A) 5 Hospitals and Federally Qualified Health Centers (FQHC)** to:

Other provider types to be identified may include, without limitation (See Section 2.3.G Ad Hoc Projects):

- Home health
- Early intervention day treatment
- Adult developmental day treatment

2. Chang language in RFP section **2.3.E Revision of State Plan Amendments for All Supplemental Payments and Provider Fees** to:

Revision of State Plan Amendments for All Supplemental Payments and Provider Fees
Prospective Contractor must provide its approach to providing the services as required in this section (2.3.E) as part of its technical response (See *Technical Proposal Packet*).

With the State's approval, Contractor shall provide revisions to Arkansas State Plan amendments for all supplemental payments and provider fees (See Section 2.3.G Ad Hoc Projects). This revision **shall** include without limitation:

1. Revising the language in the state plan as needed to be submitted to CMS.
2. Calculating budget impact needed for submission to CMS, along with any other calculations that may be required by CMS to get approval of the revised State plan amendment for any of the UPLs.
3. Answering follow up questions from CMS to get the State Plan amendment approved by CMS.

The State **shall** be given copies of any document done for these revisions, which would be needed for submissions.

3. Change language in RFP section **2.4 (A) IMPLEMENTATION** to:

A. Contractor shall be fully operational and providing services as specified herein on May 1, 2021, unless mutually agreed to by the Contractor and DHS, at no additional cost to the State.

4. Change language in RFP section **2.4(C) IMPLEMENTATION** to:

C. Between contract start date and May 1, 2020, Contractor shall meet with the State,

according to a schedule agreed upon by Contractor and DHS, for the purposes of Project Plan development and approval. Contractor's final project plan must be approved by DHS no later than thirty (30) business days prior to May 1, 2020. At a minimum, the Managing Supervisor and Project Manager shall attend these meetings along with any additional staff necessary to implement the terms of the Contract, with DHS having final determination of the required attendees. Further details regarding these meetings shall be agreed upon by the Vendor and DHS during contract negotiations.

D. Update web link in RFP section **1.28 COMPLIANCE WITH THE STATE SHARED TECHNICAL ARCHITECTURE PROGRAM**

The Contractor's solution must comply with the State's shared Technical Architecture Program which is a set of policies and standards that can be viewed at: https://www.transform.ar.gov/information-systems/polices-standards/standards/. Only those standards which are fully promulgated or have been approved by the Governor's Office apply to this solution.

BID OPENING DATE AND TIME

Bid opening date and time is changed to Friday, December 11, 2020 at 2:00p.m.

Bid submission date and time is changed to Friday, December 11, 2020 at 1:00p.m.

BIDS WILL BE ACCEPTED UNTIL THE TIME AND DATE SPECIFIED. THE BID ENVELOPE MUST BE SEALED AND SHOULD BE PROPERLY MARKED WITH THE BID NUMBER, DATE AND HOUR OF BID OPENING AND BIDDER'S RETURN ADDRESS. IT IS NOT NECESSARY TO RETURN "NO BIDS" TO THE DEPARTMENT OF HUMAN SERVICES.

If you have questions, please contact the buyer at nawania.williams@dhs.arkansas.gov or 501-320-6511

Amy Perry
Vendor Signature

12/08/2020
Date

Myers and Stauffer LC
Company

Contract and Grant Disclosure and Certification Form

Contract Number 710-21-0027
Attachment Number
Action Number

CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM

Failure to complete all of the following information may result in a delay in obtaining a contract, lease, purchase agreement, or grant award with any Arkansas State Agency.

SUBCONTRACTOR: ☐ Yes ☑ No SUBCONTRACTOR NAME:

TAXPAYER ID NAME: Myers and Stauffer LC IS THIS FOR: Goods? ☐ Services? ☑ Both? ☐

YOUR LAST NAME: Perry FIRST NAME Amy M.I.: C.

ADDRESS: 700 W. 47th Street, Suite 1100

CITY: Kansas City STATE: Missouri ZIP CODE: 64112 COUNTRY: United States c

AS A CONDITION OF OBTAINING, EXTENDING, AMENDING, OR RENEWING A CONTRACT, LEASE, PURCHASE AGREEMENT, OR GRANT AWARD WITH ANY ARKANSAS STATE AGENCY, THE FOLLOWING INFORMATION MUST BE DISCLOSED:

FOR INDIVIDUALS*

Indicate below if: you, your spouse or the brother, sister, parent, or child of you or your spouse *is* a current or former: member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee:

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/ commission, data entry, etc.]	For How Long?		What is the person(s) name and how are they related to you? [i.e., Jane Q. Public, spouse, John Q. Public, Jr., child, etc.]	
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Relation
General Assembly							
Constitutional Officer							
State Board or Commission Member							
State Employee							

☑ None of the above applies

FOR AN ENTITY (BUSINESS)*

Indicate below if any of the following persons, current or former, hold any position of control or hold any ownership interest of 10% or greater in the entity: member of the General Assembly, Constitutional Officer, State Board or Commission Member, State Employee, or the spouse, brother, sister, parent, or child of a member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee. Position of control means the power to direct the purchasing policies or influence the management of the entity.

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/commission, data entry, etc.]	For How Long?		What is the person(s) name and what is his/her % of ownership interest and/or what is his/her position of control?		
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Ownership Interest (%)	Position of Control
General Assembly								
Constitutional Officer								
State Board or Commission Member								
State Employee								

☑ None of the above applies

DHS Revision 11/05/2014

Contract Number 710-21-0027
Attachment Number
Action Number

Contract and Grant Disclosure and Certification Form

Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.

As an additional condition of obtaining, extending, amending, or renewing a contract with a *state agency* I agree as follows:

1. Prior to entering into any agreement with any subcontractor, prior or subsequent to the contract date, I will require the subcontractor to complete a CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM. Subcontractor shall mean any person or entity with whom I enter an agreement whereby I assign or otherwise delegate to the person or entity, for consideration, all, or any part, of the performance required of me under the terms of my contract with the state agency.

2. I will include the following language as a part of any agreement with a subcontractor:

   Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this subcontract. The party who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the contractor.

3. No later than ten (10) days after entering into any agreement with a subcontractor, whether prior or subsequent to the contract date, I will mail a copy of the CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM completed by the subcontractor and a statement containing the dollar amount of the subcontract to the state agency.

I certify under penalty of perjury, to the best of my knowledge and belief, all of the above information is true and correct and that I agree to the subcontractor disclosure conditions stated herein.

Signature Amy Perry Title Member Date 12/08/2020

Vendor Contact Person Amy Perry Title Member Phone No. (800) 374-6858

Agency use only

Agency Number 0710 Agency Name Department of Human Services Agency Contact Person _____ Contact Phone No. _____ Contract or Grant No. _____

DHS Revision 11/05/2014

Equal Employment Opportunity Policy

Equal Employment Opportunity and Affirmative Action Policy

Myers and Stuffer Consulting Services, LLC (the Company) is a federal contractor subject to Section 4212 of the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended (VEVRAA) and Section 503 of the Rehabilitation Act of 1973, as amended (Section 503). The Company is committed to equal employment opportunity, and it is the Company's policy to take affirmative action to employ and advance in employment protected veterans (disabled veterans, recently separated veterans, Armed Forces service medal veterans, and/or active duty wartime or campaign badge veterans) and individuals with disabilities at all levels of employment, including the executive level. The Company also will provide reasonable accommodation to known physical or mental limitations of an otherwise qualified employee or applicant for employment, unless the accommodation would impose undue hardship on the operation of the Company's business.

The Company will recruit, hire, train, and promote individuals in all job titles, and will ensure that all other personnel actions are administered, without regard to an individual's disability or protected veteran status. All employment decisions will be based only on valid job requirements. In addition, employees and applicants shall not be subjected to harassment, intimidation, threats, coercion, or discrimination because they have engaged in or may engage in any of the following activities: (1) filing a complaint; (2) assisting or participating in an investigation, compliance evaluation, hearing, or any other activity related to the administration of any federal, state or local law requiring equal opportunity for protected veterans or individuals with disabilities; (3) opposing any act or practice made unlawful by VEVRAA, Section 503, their implementing regulations, or any other federal, state or local law requiring equal opportunity for protected veterans or individuals with disabilities; or (4) exercising any other right protected by VEVRAA, Section 503, or their implementing regulations.

The non-confidential portions of the affirmative action program for individuals with disabilities and protected veterans shall be available for inspection upon request by any employee or applicant for employment.

As the Company's Senior Managing Director, I fully support our affirmative action program and am committed to the implementation of the Company's equal opportunity and affirmative action policies.

Kevin Londeen
Senior Managing Director

December 8, 2020
Date

Overall responsibility for Myers and Stuffer Consulting Services, LLC equal opportunity and affirmative action policies has been delegated to Robin O'Connor (Director of Affirmative Action) and Kristy Bartnes (Affirmative Action Administrator). Questions or complaints should be directed to your local Human Resources Representative or Kristy Bartnes at kbartnes@cbiz.com or 816-945-5457.

Information for Evaluation

Vendor Background and Experience (E.1)

Myers and Stauffer LC (Myers and Stauffer) is a national certified public accounting (CPA) firm that specializes in providing auditing, analysis, consulting, data management, accounting, and other operational support services to state and federal government health care and social service agencies. Our purpose and vision are to deliver those services to our clients in an efficient, effective, and timely manner, and to do so according to the highest levels of integrity and accountability. We have a wealth of knowledge and experience that guides our engagements. Because we work exclusively with governmental agencies providing services similar to those requested in this solicitation, we are uniquely positioned to provide the Department of Human Services (DHS), Division of Medical Services (DMS) (herein referred to as DMS) with unrivaled expertise from our staff of dedicated professionals.

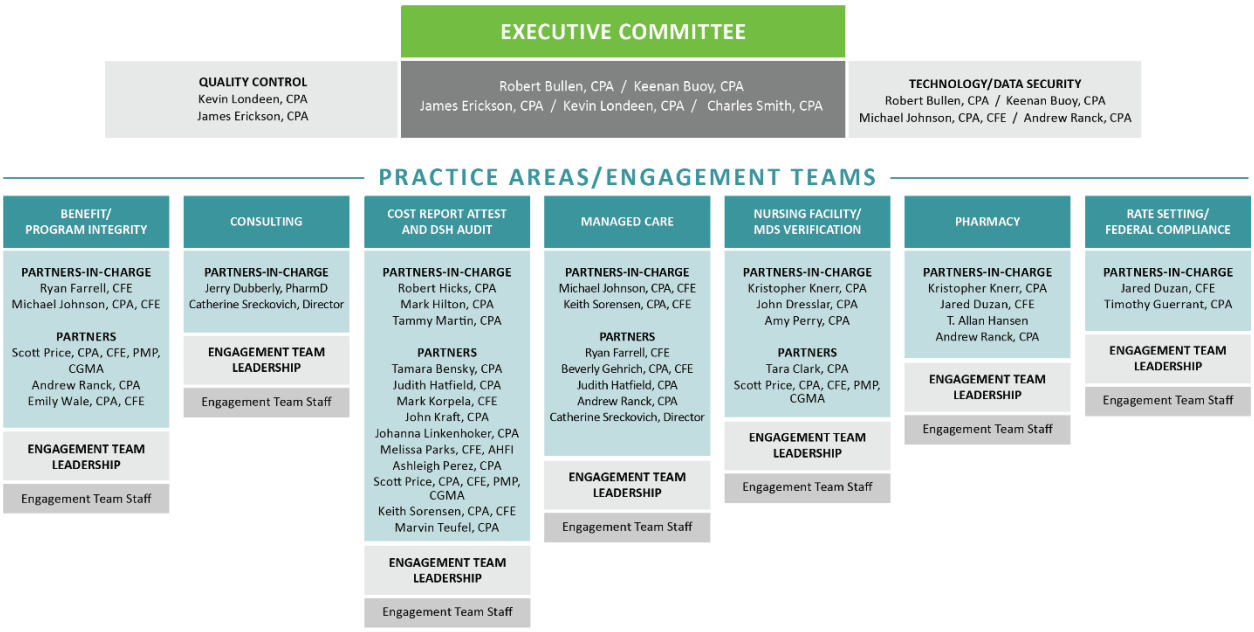
Myers and Stauffer: At a Glance

- More than 43 years as a national CPA firm providing services exclusively to state Medicaid agencies and the federal government.
- Unlike our competitors, we do not accept engagements with providers or other commercial entities, thereby eliminating any real or perceived conflicts of interest.
- Actively engaged in conducting Medicare and Medicaid audits for 42 states, the District of Columbia, and U.S. territories.
- Strong working relationship with the state of Arkansas dating back to 2009, including projects related to desk reviews for nursing facility cost reports, disproportionate share hospital (DSH) audit, nursing facility case mix services, and upper payment limit (UPL) demonstration.
- Multi-disciplinary staff of 900 professionals, across 20 offices, dedicated to assisting states with all aspects of Medicaid and Medicare policy, management, and financing.

Through these opportunities, we have prevented unnecessary program expenditures; identified and recovered hundreds of millions of dollars in inappropriate payments; assisted in the development of state reimbursement systems; performed eligibility audits and analysis; defended audit findings from providers' administrative and judicial challenges; and performed data management and analysis services to assist our clients in better managing their programs.

We were founded and continue to operate on the principles of extraordinary client service and an unwavering commitment to quality. Myers and Stauffer is highly regarded nationwide for our professional objectivity, innovation, quality people, and unparalleled service. Our success has been achieved by providing our clients with excellent service on a timely basis, including those times when clients have made urgent requests with minimal turnaround time. Our unparalleled service requires commitment, an understanding of the client's goals and objectives, and specialized industry knowledge to help our clients achieve success.

The organizational structure shown below depicts our firm's practice areas that facilitate the development of highly-specialized technical skills and coordinated delivery of services. As delineated in the chart below, our engagement teams address the full spectrum of Medicaid and Medicare services. These services include: consulting, benefit and program integrity, cost report attest and DSH audits, managed care, nursing facility/minimum data set (MDS) verification, pharmacy, and rate setting/federal compliance.



The chart above identifies the members and principals (collectively referred to as "partners") leading each engagement team. Below is a brief description of each engagement team.

- ***Benefit/Program Integrity.*** *This engagement team focuses on the integrity of various payment programs and operating systems. This includes activities focused on fraud, waste, and abuse; eligibility accuracy; regulatory compliance; risk assessments; payment accuracy; and systems security.*

- ***Consulting.*** *This engagement team works with state government agencies to address issues impacting the complexities of the program, evaluation of care required by program beneficiaries, integrating physical medicine with behavioral health treatment pathways, as well as the data and technical infrastructure that supports them. The consulting team provides innovative solutions that align with overarching health care and social service objectives to address quality improvement, care integration, data and health information technology (health IT), change management, alternative payment models (APMs), performance measurement, and evaluation while addressing social determinants of health and the unique needs of local patient populations.*
- ***Cost Report Attest and DSH Audit.*** *This engagement team provides attest services ensuring provider costs are properly reported in accordance with program policies, and they perform required audits of state Medicaid DSH payment programs.*
- ***Managed Care.*** *This engagement team focuses on contract compliance performance audits; encounter data validation and reconciliation; medical loss ratio (MLR) audits; policy and program development consulting, including readiness reviews, contracting best practices, APMs, and pass-through and supplemental payments.*
- ***Nursing Facility Rate Setting.*** *This engagement team focuses on the development, implementation, and maintenance of nursing facility payment systems, especially case mix systems. These systems may also include value-based purchasing (VBP) and pay-for-performance. In addition, the team performs MDS reviews to ensure pricing accuracy.*
- ***Pharmacy.*** *This engagement team focuses on various components of a pharmacy program, including rate setting for drug ingredients and dispensing fees; National Average Drug Acquisition Cost pricing benchmark; pharmacy benefit manager (PBM) audits; and other consulting services to address subjects such as specialty drugs, compound drugs, and 340B programs.*
- ***Rate Setting/Federal Compliance.*** *This engagement team develops rates and reimbursement systems, Medicaid financing, and payment ecosystems that support and promote program policies and health care objectives. They work with clients to address the need of reimbursement to address the rapidly evolving changes in health care as a result of the behavioral health crisis that states have been grappling with over the last decade or more. Services include Medicaid financing and supplemental payments (e.g., provider assessments, UPLs, and DSH payment calculations); reimbursement and rate setting for both systems and ambulatory services: acute care, ambulance, ambulatory payment classification (APC), behavioral health, clinics, dental, diagnosis-related group (DRG), durable medical equipment (DME), enhanced ambulatory patient groups, federally-qualified health center (FQHC), graduate medical education (GME), outpatient, physician and practitioner, transportation, and other fee schedules.*

The majority of our client engagements have continued for greater than 10 years, which is a clear indication of our clients' ongoing satisfaction. Our exemplary track record has led to the development of a dedicated team of professionals who are committed to providing the highest-quality service while staying up-to-date on regulatory changes and receiving training that exceeds professional requirements. We are licensed to do business in Arkansas and we have provided our certificate in *Appendix A: Certificate to Do Business in Arkansas*.

Why Choose Myers and Stauffer?

Myers and Stauffer has significant experience in performing the services requested in this solicitation for Medicaid agencies across the nation. We are proficient in the challenges faced by our state Medicaid clients in the administration of their Medicaid programs. The selection of Myers and Stauffer offers a number of distinct advantages to DMS, including:

- ***In-depth Knowledge of the Medicaid Industry.*** *Myers and Stauffer has been successfully working with local, state, and federal health care agencies for more than 43 years. We continually invest in our professional relationships with all of our state and federal clients. We have a national reputation for delivering high-quality services on time and in a manner that meets and often exceeds expectations.*
- ***In-depth Knowledge of National Health Care Environment.*** *We maintain dialogues with Centers for Medicare & Medicaid Services (CMS) executives, state Medicaid officials, and industry leaders across the nation in order to provide our clients with guidance and assistance in a manner that other firms simply cannot match. We also closely monitor the activities of the state and national health care regulatory environment for items that may be relevant to DMS.*
- ***Knowledge of DMS' Operations.*** *We have worked effectively with DMS on various projects, including many of the services contained in this request for proposal (RFP) and have established solid working relationships throughout the Department. Through our work, we have learned invaluable lessons that can only be gained through direct experience.*
- ***Unmatched Team of Professionals.*** *Our professionals include former CMS and state Medicaid program directors and staff, CPAs, policy experts, health information specialists, certified fraud examiners, pharmacists, medical doctors, registered nurses, and certified coders. Our team members dedicate their careers to health care improvement and compliance through continued engagement with a constantly growing knowledge base that best serves our state agency clients. This extensive and diversified background allows Myers and Stauffer to provide DMS with*

a comprehensive team of experienced professionals who truly understand the needs and objectives of DMS.

- ***Excellent Oversight and Proactive Leadership.*** *DMS will benefit from hands-on service by our team's senior professionals. We can provide this level of service because our partner-to-staff ratio is similar to smaller firms allowing our senior-level professionals to be involved and immediately available throughout the entire client service process. Our approach ensures all members of the engagement team will stay abreast of key issues at DMS and take an active role in addressing them.*
- ***Flexibility.*** *Myers and Stauffer is large enough to meet any client's needs, yet is structured in a manner that allows our professionals to have the flexibility to design customized solutions. In addition, our focus on quality, while also investing in technology solutions designed for efficiency, have proven to be a valuable combination for our clients. Because Myers and Stauffer has a 43-year history of producing quality work and maintaining a culture of integrity, we are able to balance the profitability of our firm with affordability for our clients.*
- ***Cost Effectiveness.*** *Because of our utilization of experienced professionals, we are capable of providing services efficiently without sacrificing quality. We will be competitively priced if awarded this contract, using staff assignments we believe to be the most efficient and effective based on our firsthand experience performing the services outlined in the solicitation.*
- ***Desk Reviews and Audits Focused on Medicaid Policy.*** *We find that it is typical for states to use a Medicare contractor to perform Medicaid audits and desk reviews because it is seen as a way to minimize duplication of work on the Medicaid side that Medicare auditors may have already completed. Prior to Medicare hospital prospective payment systems (PPS) and the federal move to lower budget contracts with Medicare Administrative Contractors (MACs), this resulted in a significant benefit for Medicaid programs since Medicare auditors did extensive cost audits and desk reviews that could be used for Medicaid rate setting and settlements. However, with the implementation of Medicare hospital PPS and the budget cuts that came with the MACs, Medicare audits and desk reviews are no longer as valuable to state Medicaid programs. With the exception of a limited number of critical access hospital (CAH) audits, most Medicare audits (including FQHCs) now focus only on Title XVIII reimbursement issues such as Medicare bad debts, Medicare (GME, and Medicare DSH. While these issues are important to Medicare, they rarely impact much on the Medicaid reimbursement side.*

  Myers and Stauffer has obtained hospital audit contracts from MACs in other states, which has proven to be very successful for the states and for Myers and Stauffer. One example is our audit work in Florida that we successfully procured in 2014 from the incumbent MAC that had been performing the work for more than 20 years. The MAC had been behind on delivering hospital audits for years and Myers and Stauffer was able to get the audits completely caught up within a few years after procuring the contract. In addition, the state awarded us with an additional

contract to help with a backlog of appeals/litigation resulting from the MAC audits previous to our audit contract. Myers and Stauffer found significant audit adjustments missed in previous years and helped resolve appeals/litigation related to incorrect audit adjustments. The state was pleased with the work and also hired Myers and Stauffer to assist with helping catch up the hospital per diem rates that had fallen behind partly due to the delay in the cost report audits. Within a six month period, Myers and Stauffer helped the state recalculate hundreds of hospital rates dating back seven plus years.

The integrity of our work product, the commitment of our staff, and our above-and-beyond approach have made us a well-known and appreciated service partner within the Medicaid program. We are confident when you see our expertise and level of commitment to the Arkansas Medicaid program, you will agree Myers and Stauffer is the firm that will best serve your needs.

Health Care Consulting, Auditing, and Cost Report Preparation (2.2.B)

Health Care Consulting

Myers and Stauffer is an industry expert in government-funded health care programs including Medicaid and the Children's Health Insurance Program (CHIP). Having spent more than 43 years working with public health care clients, we have an organizational commitment to help our clients address the toughest operational, fiscal, and policy opportunities. Using our multi-disciplinary approach, Myers and Stauffer assists our clients with administering and advancing their Medicaid programs in a manner that improves population health and individual health care, which results in smarter spending of public health care and social service funding.

We have been highly successful with navigating the complex policy and reimbursement environment across a number of service areas, including but not limited to: transportation providers, hospitals, long-term care (LTC) facilities, home health agencies (HHAs), FQHCs, rural health clinics (RHCs), transportation, pharmacies, physicians, dentists, and other practitioners. This experience includes policy analysis and enhancement; development of reimbursement systems; identifying and/evaluating APMs; establishing and defending rates; performing cost report audits; and providing a diverse mix of other reimbursement services.

Myers and Stauffer's team of Medicaid policy, legal, financial, and clinical experts are uniquely positioned to deliver consulting, research, and advisory services relating to Medicaid and rate setting, Medicaid payment limits, such as DSH UPL and Medicare UPLs, and provider tax programs. Our firm has spent more than 43 years in the Medicaid arena developing internal expertise and has an in-depth understanding of Medicaid policies and requirements.

As health care reimbursement, coverage, and financing issues continue to evolve, working with a firm that has a national practice dedicated to Medicaid programs will ensure you have a partner that remains current on developments with health care reform and changes resulting from tighter budgets or federal

oversight. Our firm has a wealth of experience helping states identify federal revenue enhancement opportunities and develop provider payment strategies, including approaches and methodologies for calculating and administering supplemental payments, and the funding mechanisms and compliance requirements that accompany such programs.

We have more than 25 years' experience in preparing UPL demonstration models for more than 30 state Medicaid agencies that support supplemental payments. We have demonstrated the technical knowledge and skill necessary to prepare these UPL demonstrations, ensured their compliance with federal regulations, and satisfied all CMS reporting requirements. We also bring to this project the knowledge we have amassed regarding other Medicaid programs' approaches to UPL calculation strategies, techniques for incorporating intergovernmental transfer (IGT) and certified public expenditure (CPE) into Medicaid payment systems, and mitigation techniques for common areas of CMS inquiry.

Exceptional Experience: Consulting

- **Experience:** Our proposed engagement team has a depth of experience that stands out amongst our competition.

  Our professionals include partners and senior staff members who have significant experience providing a range of accounting services to state Medicaid agencies on health care reimbursement issues; managing rate setting and federal compliance projects; and leading Medicare/ Medicaid accounting, auditing, rate setting, and consulting engagements.

- **Regulatory Analysis:** Myers and Stauffer constantly surveys the regulatory and legislative Medicaid environment and assists our clients with understanding the impact they have on their program.

  We understand both the functions and the timing required to memorialize all policy changes through the formal CMS approval and rule promulgation processes, and we are committed to always meeting, and when possible, exceeding performance and timeliness expectations.

Our work has encompassed preparing detailed analyses, developing alternative payment methodologies, and helping our clients address issues and/or questions raised by CMS. Representatives from CMS have reviewed UPL demonstrations we have prepared for our Medicaid agency clients for all provider types requiring UPL demonstrations. CMS has also reviewed our work related to state plan amendments (SPAs), CMS pre-prints (for managed care directed payment programs) and waiver documents related to these programs. As a result of our work with other states, we have developed a comprehensive understanding of Medicare reimbursement principles. We have also demonstrated our understanding of Medicare reimbursement through various UPL system development projects. With changes to CMS rules, we have more recently worked with state agency clients on directed payment programs. The table below highlights state agencies for which we have performed UPL services.

Relevant Client Overview: UPL									
	Inpatient and Outpatient Hospital Services	Nursing Facility Services	Clinic Services	Qualified Practitioner Services	Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Services	Institutions for Mental Disease (IMD) Services	Psychiatric Residential Treatment Facility (PRTF) Services	DME	Ambulance
Client									
Alabama Medicaid Agency	✓*	✓	✓			✓	✓		
Alaska Department of Health and Social Services		✓							
Arkansas Department of Human Services	✓	✓	✓		✓		✓	✓	
Colorado Department of Health Care Policy & Financing		✓**							
Georgia Department of Community Health	✓	✓							✓
Hawaii Department of Human Services	✓	✓			✓				
Idaho Department of Health and Welfare	✓	✓			✓	✓		✓	
Indiana Family and Social Services Administration	✓	✓	✓	✓	✓		✓	✓	✓
Iowa Department of Human Services	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kansas Department for Aging and Disability Services		✓			✓		✓		
Kentucky Cabinet for Health and Family Services	✓	✓	✓	✓	✓	✓	✓	✓	✓
Louisiana Department of Health	✓	✓	✓						
Maryland Department of Health	✓	✓	✓		✓	✓	✓		
Maine Department of Health and Human Services	✓	✓	✓	✓	✓			✓	
Mississippi Division of Medicaid	✓	✓	✓	✓	✓		✓	✓	
Missouri Department of Social Services	✓	✓	✓						✓
Montana Department of Public Health and Human Services		✓							
Nebraska Department of Health and Human Services				✓					
Nevada Department of Health and Human Services									✓
New Jersey Department of Human Services		✓							
New Mexico Human Services Department	✓	✓	✓	✓	✓		✓		
North Carolina Department of Health and Human Services	✓	✓							
North Dakota Department of Human Services	✓				✓	✓			
Oklahoma Health Care Authority		✓							
Pennsylvania Department of Public Welfare		✓							
South Dakota Department of Social Services	✓	✓	✓					✓	
Virginia Department of Medical Assistance Services	✓	✓			✓		✓		
West Virginia Department of Health and Human Services	✓	✓			✓		✓		

Relevant Client Overview: UPL										
	Inpatient and Outpatient Hospital Services	Nursing Facility Services	Clinic Services	Qualified Practitioner Services	Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Services	Institutions for Mental Disease (IMD) Services	Psychiatric Residential Treatment Facility (PRTF) Services	DME		
Client										**Ambulance**
Wyoming Department of Health		✓			✓					

*Provide support to the State to perform a technical review of calculations performed by others and also support in generating CMS-required templates.
**Provide all data analytics for State to compile and prepare the UPL documents and calculations.

Over the years, many states have implemented provider assessment programs to generate additional state share to fund UPL supplemental payments. Our federal funding consultants are well versed on Medicaid provider tax programs. Myers and Stauffer has assisted our state Medicaid agency clients with provider assessment projects since enactment of the provider assessment and donation regulations. We have assisted states in modeling and adopting provider tax programs. We have also assisted several states with developing the statistical models needed to demonstrate that a state's tax program meets the criteria to obtain a federal waiver of the broad-based and uniformity requirements of the provider assessment regulations. Our experience includes hospital assessment and other provider assessments for the following state clients:

- *Alabama Medicaid Agency.*
- *Arkansas Department of Human Services.*
- *Colorado Department of Health Care Policy and Financing.*
- *Georgia Department of Community Health.*
- *Idaho Department of Health and Welfare.*
- *Indiana Family and Social Services Administration.*
- *Iowa Department of Human Services.*
- *Kansas Department for Aging and Disability Services.*
- *Kentucky Cabinet for Health and Family Services.*

- *Louisiana Department of Health.*
- *Maryland Department of Health.*
- *Mississippi Division of Medicaid.*
- *Missouri Department of Social Services.*
- *Montana Department of Public Health and Human Services.*
- *New Jersey Department of Health.*
- *New Mexico Human Services Department.*
- *North Carolina Department of Health and Human Services.*
- *North Dakota Department of Human Services.*
- *Pennsylvania Department of Human Services.*
- *Virginia Department of Medical Assistance Services.*
- *West Virginia Public Employees Insurance Agency.*
- *Wyoming Department of Health.*

While our experience varies by state, we have been involved in nearly all aspects of the programs, from initial design and development to implementation and ongoing maintenance. Examples of our experience include:

- *Developing, implementing, and monitoring provider assessment programs.*
- *Reviewing a state's Medicaid funding structure for hospital payments and identifying the goals for the hospital assessment program, (e.g., shore up budget shortfalls, fund existing payments, provide increased payments, or support broader initiatives such as Medicaid expansion or quality improvement programs).*
- *Evaluating the feasibility of assessments across the permissible provider "classes" in federal regulations.*
- *Analyzing data requirements, data sources, and the availability of data for calculating the assessment.*
- *Preparing calculation models to help the state and stakeholders evaluate options for the structure of the assessment, including elements such as the assessed unit (beds, days, discharges, revenues), assessment rates, assessment tiers (differing tax rates), and included and exempted providers.*
- *Preparing financial analyses of the funding levels generated by the assessment.*

- *Calculating the impact to the state and to providers, including the net impact on individual providers in order to identify "winners and losers."*
- *Developing the statistical models needed to demonstrate the assessment program meets the criteria for obtaining a federal waiver of the broad-based and uniformity requirements and compliance with the safe harbor threshold.*
- *Providing support for CMS review of waivers.*
- *Assisting with other interrelated aspects of the program, including UPL demonstrations, fiscal impact estimates, SPAs, and administrative rules.*
- *Preparing draft legislation and presenting analyses to legislators.*
- *Participating in, or leading meetings and work group discussions with, state staff and various stakeholders such as providers and provider representatives.*
- *Developing operational procedures for levying and collecting the assessment, such as the frequency and method of collection, provider responsibilities for remitting payment, tracking payment compliance, penalties for non-compliance, and appeal rights.*
- *Assisting with maintaining assessment programs after implementation, including collecting data, updating or rebasing calculations, and communicating assessments to providers.*
- *Monitoring provider changes to ensure new providers are assessed and other provider changes are treated appropriately (closures, changes in ownership, etc.).*
- *Monitoring assessment collections and comparing to projections and funding needs.*
- *Assisting with modifications to the structure of the assessment program after implementation.*

We recognize the value our state Medicaid clients can realize from having a contractor who has a broad understanding of the different methods and standards used across the country in setting reimbursement rates and who is available to assist with policy revisions and special projects. Myers and Stauffer constantly surveys the regulatory and legislative Medicaid environment and assists our clients with understanding the impact they have on their program. We closely monitor the federal health care regulatory environment and maintain an ongoing dialogue with CMS executives, state Medicaid officials, and industry leaders across the nation to best support our clients. We also stay current on national trends and best practices by regularly attending national conferences, webinars, and training so our staff members are current and well diversified in their knowledge. In addition, many of our staff members are former state Medicaid and CMS employees with direct experience developing, implementing, and administering state and federal programs and policies.

We have worked with several states that have conducted "modernization" projects, or that routinely conduct methodology and rate studies, as well as an assessment of methodologies including alternative strategies; significant impacts on systems or system resources; the impact on members and providers;

and the development of a strategy for prioritizing changes in methodologies and/or rate increases. Having reliable methodologies and processes to routinely assess reimbursement from a global perspective, including reports and other tools that may be readily available, can be extremely helpful in not only aligning reimbursement with DMS' overall objectives but also helping to respond quickly to requests for information from the Governor's office, the Legislature, and other interested stakeholders. If the report sets out priorities and action steps for implementing those, DMS may be better prepared to proactively address challenges, inquiries, questions, and requests from stakeholders.

Myers and Stauffer has provided executive support to public sector clients to develop strategic plans in the area of advancing health care delivery system transformation and payment reform. We have worked with state clients that are moving from a volume-driven reimbursement system to one that pays for quality and outcomes and assisted in the redesign of health care infrastructure, including new health IT, quality metric design, integration of behavioral health providers, and benefit design. We have also supported stakeholder engagement and training amongst state clients and their private sector stakeholders in order to ensure the success of these programs. Our rate setting and consulting services help states achieve their mission of aligning payment methodologies and policy to promote value, accountability, equity, and efficiency in reimbursement.

Auditing

Federal, state, and local government health agencies reimburse health care providers and health plans billions of dollars annually for providing health care services to their most fragile populations. The audits employed by these organizations assist them in ensuring that those dollars are being used economically and to reimburse providers and health plans for the allowable costs for providing those services. Providing independent attest services to our clients provides the assurance that their limited resources are being distributed appropriately while at the same time, providing the health care community with assurance they are being treated fairly in relation to their peers.

Our professionals are accountants and auditors who are highly trained and knowledgeable in the health care industry in areas including, but not limited to, claims, cost reports, state financial reports, application of federal and state regulations, valuations, and asset tracing.

Myers and Stauffer's breadth of experience in performing audits of cost, and other financial and clinical data, goes beyond traditional cost reporting and DSH examinations. Many state and federal agencies rely on our expertise in engagements that focus on specific elements of financial or clinical data, which is often supplemental to cost reports, and the verification of the completeness and accuracy of that data for use in reimbursement. Our financial component audit services include:

- *Program or process cost verification.*
- *VBP performance payment reviews.*
- *MDS assessment classification verification reviews.*

- *Pharmacy invoice compilation and review.*
- *Payroll-based journal audits.*

We also perform audit and attest services of managed care organizations (MCOs) on behalf of Medicare and state Medicaid programs. Our extensive federal and state experience places our firm in a unique position to ensure your programs are adhering to applicable guidance, criteria, and industry standards. These services include, but are not limited to:

- *MLR examinations.*
- *Administrative expense reviews.*
- *Encounter data reconciliation and validation.*
- *Readiness reviews.*
- *Contract compliance reviews.*
- *Access to care reviews.*
- *Performance audits.*
- *Compliance program effectiveness audits.*

Myers and Stauffer specializes in providing, risk assessment, error rate measurement, and specialized auditing services to support public health care and social service agencies. We are a client-focused, data-driven, value-oriented firm actively engaged in the environmental and regulatory challenges faced by our clients. Services include, but are not limited to:

- *System and organization control audits.*
- *Credit balance audits.*
- *Eligibility audits.*
- *Provider claims audits.*

Myers and Stauffer provides audit and consulting services to help states administer the Promoting Interoperability (PI) Program (formerly the Electronic Health Records (EHR) Incentive Program). We specialize in updating existing audit strategies by taking into account the state's unique operations and the on-going changes to program requirements. In 2012, CMS made our audit strategy/guide available in an online toolkit as a benchmark for states to follow. Since that time, Myers and Stauffer has expanded our role and now provides pre-payment and post-payment services for states and are helping our clients develop strategies for the program's 2021 sunset. As CMS looks to streamline multiple quality reporting programs into the new Merit-based Incentive Payment Systems and other APMs, we can help states explore options for the transition of the PI program in support of your state's health IT landscape. Our services include:

- *Conduct adopt, implement, upgrade and meaningful use post-payment desk and on-site reviews for both eligible providers (EPs) and eligible hospitals (EHs).*
- *Perform EH aggregate Medicaid incentive payment post-payment desk reviews.*
- *Review current program operations and make recommendations for appropriate audit coverage and/or audit strategy modifications.*
- *Perform a risk assessment to select post-payment audits.*
- *Perform pre-payment processing services for EPs and EHs, including security risk assessment reviews.*

Myers and Stauffer has been working with pharmacy data for more than 40 years. Our team of auditors and pharmacists has extensive experience auditing Medicaid, Medicare, and state health plan pharmacy benefits. Our pharmacy audits include:

- *PBM audits.*
- *340B consulting and auditing.*
- *Procedure-coded drug/National Drug Coded drug claim audits.*
- *MCO pharmacy benefit contract compliance audits.*
- *Medicaid drug rebate performance consulting and auditing.*

We have also provided Medicare audit, investigative, and consulting services to many federal agencies, including CMS, HHS, Office of Inspector General (OIG), Department of Justice (DOJ), and the Federal Bureau of Investigation (FBI). A sample of our federal projects include:

- *Providing audit services for CMS to include Cost Report Audit Risk Assessment Accuracy and Education.*
- *Performing eligibility compliance reviews as a part of CMS' national Eligibility Review Contractor team.*
- *Conducting program audits and financial examinations of Medicare Advantage Organization and Prescription Drug Plan sponsors.*
- *Partnering with prime contractors on key CMS program integrity initiatives, such as Unified Program Integrity Contractor and Medicare Drug Integrity Contractor.*

Cost Report Preparation

Myers and Stauffer intentionally restricts its practice to servicing government-sponsored health care programs, primarily state Medicaid agencies and does not perform work for, or solicit or accept engagements from, health care providers, commercial businesses, or individuals. We pride ourselves in avoiding any conflicts of interest and circumstances that could create any real or perceived conflict of

interest. Therefore, we do not prepare cost reports for health care providers. Our extensive experience in understanding cost reports comes from designing Medicaid cost reporting instruments and performing cost report audits. We have demonstrated our experience with cost reports in our response to RFP Section 2.2.D.

Prior Relevant Experience and Business Contacts

Myers and Stauffer has the reputation of being professional, knowledgeable, courteous, and timely with our projects. On the pages that follow, we have provided project profiles that contain narrative descriptions of work we have performed, along with a business point of contact. We encourage the evaluation committee to contact these references for more information about the project or more detail regarding their experience with Myers and Stauffer.

Idaho Department of Health and Welfare

Medicaid Attest & Consulting Services

Scope of Project

From 1992 to the present, Myers and Stauffer has performed examinations, desk reviews, rate calculations, and data management services for nursing homes, DSH providers, ICF/IDs, hospitals, FQHCs, RHCs, and (HHA providers. Our work involves audit and reimbursement issues, as well as performing approximately 140 annual examinations and/or desk reviews of Medicaid cost reports of health care providers. This project requires an understanding of various reimbursement systems, facility operations, health care issues, valuation of property, and other applicable regulations.

CONTACT

Angela Toomey

Principal Financial Specialist

3232 Elder Street
PO Box 83720
Boise, ID 83705

PH 208.364.1817

angela.toomey@dhw.idaho.gov

TERM OF CONTRACT

1992 – Present

Services Provided

- Verification of cost report accuracy and establishment of reimbursement rates.
- Processing and tracking of provider cost reports.
- Development and maintenance of a database of cost report information.
- Calculate quarterly case mix reimbursement rates for nursing facilities.
- Manage the MDS data and generate resident rosters used in calculating case mix indices (CMIs).
- Development of detailed cost estimates of proposed or pending reimbursement system modifications.
- Annual DSH survey of hospitals and calculate allowable DSH payment in accordance with state and federal regulations.
- Annual examinations of the DSH program.
- Field examinations and desk reviews on cost reports to determine allowable cost in accordance with federal and state reimbursement criteria.
- Calculation of UPLs and provider taxes for hospitals, nursing facilities, and ICF/IDs.
- Establishment of hospital per diem payments based on cost reports in accordance with state Medicaid limits.

- Calculation of a reimbursement settlement amount in accordance with the department's reimbursement criteria.
- Preparation and presentation of testimony at hearings in defense of our adjustments made to provider cost reports.
- Calculation of interim reimbursement rates and class ceiling limitations for department approval.
- Preparation of monthly status reports which track provider cost reports through the review process and the applicable settlement or final rate issuance process.

Results

Myers and Stauffer successfully assisted the state of Idaho in converting the nursing home reimbursement system from a cost-based and retrospective payment settlement system to a prospective rate reimbursement system utilizing case mix data which more accurately reimburses providers based on their resident acuity. Myers and Stauffer also successfully assisted the state of Idaho in converting the ICF/ID reimbursement system from a cost based and retrospective payment settlement system to a prospective rate reimbursement system that does not normally require settlements. This system has allowed this provider group of mostly smaller providers to no longer have to contend with large and unexpected settlements, which has been a great benefit to maintaining provider financial stability.

Indiana Family & Social Services Administration

Medicaid Rate Setting Services

Scope of Project

CONTACT

Kathleen Leonard

Director of Reimbursement and Actuary

402 W. Washington St., Rm W374
Indianapolis, IN 46204

PH 317.233.9282

Kathleen.Leonard@fssa.IN.gov

TERM OF CONTRACT

1982 – Present

Since 1982, Myers and Stauffer has provided reimbursement methodology consulting, compliance analysis, fiscal impact analysis, provider tax calculations, and monitoring services for long-term care facility provider tax programs. We also provide rate setting services for long-term care, home health, and hospice providers. The project involves calculating rates based on provider cost reports, regulatory, and other situational changes and audit findings for ID group homes, large private ICF/ID, state-operated facilities, and nursing facilities. From 1993 to 1994, the State undertook major reimbursement reform efforts throughout the Medicaid program to build in greater incentives for provider cost containment. Myers and Stauffer played a crucial role in developing, implementing, and defending the reimbursement reforms for ICF/ID, nursing facilities, and HHAs. These reforms save the state tens of millions of dollars each year.

The nursing facility case mix reimbursement functions were incorporated into this contract in 1998 in conjunction with the case mix system implementation. This was a hotly-debated implementation that involved complex negotiations, litigation, direct legislative oversight, extensive policy and fiscal modeling, and countless stakeholder meetings.

Services Provided

- Rate setting services for LTC, home health, and hospice providers.
- Calculate rates based on provider cost reports, regulatory and other situational changes, and audit findings for ID group homes, large private ICF/ID, state-operated facilities, and nursing facilities.
- Developed, implemented, and defended reimbursement reforms for ICF/ID, nursing facilities, and HHAs.
- Communicated with CMS regarding provider tax issues.
- Attended meetings with provider associations and other stakeholders.
- Research regulations regarding provider tax programs.

- Collected revenue and patient day data.
- Performed P1/P2 analysis for waiver of broad based requirement.
- Performed B1/B2 analysis for waiver of broad based and uniform requirement.
- Performed analysis of waiver compliance with hold harmless requirement.
- Performed fiscal impact analysis for reimbursement methodology changes that include the use of waiver funds.
- Calculate provider tax for individual Medicaid certified facilities.
- Communicate the provider tax to the fiscal intermediary for offsetting against Medicaid claims.
- Monitor the posting and collection of provider tax receivables and payments established and received by the fiscal intermediary.
- Calculate provider tax for non-Medicaid certified facilities.
- Send invoices of provider tax due to non-Medicaid certified providers.
- Send monthly statements of provider tax due plus any interest to non-Medicaid certified providers.
- Track accounts receivable and provider tax payments for non-Medicaid certified providers.
- Notify the State Budget Office of provider tax payments received from non-Medicaid certified providers.
- Provide accounts receivable reports to the Office of Medicaid Policy and Planning and the State Budget Office to track the non-Medicaid certified provider tax billed, owed, and collected.
- Provide litigation support for appeals regarding the provider tax.

Results

Myers and Stauffer has assisted the Indiana Medicaid Program in implementing numerous policy and rate setting reforms for long-term care, home health, and hospice services. Rate setting performance included development of sophisticated models and analyses, development of regulatory and SPA language, stakeholder training, communications with CMS, participation on technical guidance workgroups, and delivery of expert testimony. We actively partnered with the State to implement a case mix system of reimbursement that is resource-utilization groups (RUGs)-based and is bolstered by clear and user-friendly supportive documentation guidelines, and a rigorous program monitoring and reporting system. The reimbursement system is easily adaptable and sustainable, having undergone numerous enhancements over the years, including adoption of pay-for-performance incentives. Rate setting is highly accurate, responsive, and predictable, and is based on a transparent and reliable process that is further supported by a positive and productive relationship with its Medicaid providers.

Provider rate setting appeals and litigation are significantly lower than in previous years, and CMS has on numerous occasions looked to the Indiana Medicaid program for technical advice and best practices.

Iowa Department of Human Services

Provider Cost Audits and Rate Setting Services

Scope of Project

Myers and Stauffer is engaged to provide professional accounting and consulting services to the Iowa Medicaid Enterprise. The purpose of this engagement is to assist the state of Iowa in determining reasonable reimbursement rates and cost settlements for services as well as determining other calculations such as UPLs and supplemental payments.

CONTACT

Julie Lovelady
Iowa Medicaid Deputy Director

611 5th Avenue
Des Moines, IA 50309

PH 515.256.4644
jlovela@dhs.state.ia.us

TERM OF CONTRACT

2004 – Present

Services Provided

- Medicaid nursing facility case mix rate setting.
- Manage MDS database and perform quality review of quarterly resident rosters and CMI calculations.
- Rate setting, auditing and cost settlement for nursing facilities, ICF/IDs, residential care facilities, home and community based waiver providers, targeted case management, rehabilitation services, community mental health centers (CMHCs), FQHCs, home health, RHCs, psychiatric medical institutions for children (PMIC), CAHs, and general acute care hospitals.
- Medicaid fee schedule updates.
- Calculation of cost of dispensing fees and average actual acquisition cost (AAC) reimbursement.
- DSH, IGTs, and UPL calculations, and other revenue maximization.
- Hospital payment rate setting including outpatient and inpatient services.
- Consulting and litigation support services.
- Assistance with Iowa Administrative Code updates and SPAs.
- Calculation of the required annual UPL calculations.
- Provider tax calculations and collection.
- Budget analysis and consulting services related to Iowa's 1115 Medicaid demonstration.
- EHR incentive post payment audits.
- Assistance with implementation of comprehensive managed care.
- 340B audits of Medicaid fee-for-service and Medicaid managed care claims.

Results

Myers and Stauffer has successfully implemented and/or maintained:

- Inpatient and outpatient hospital rebasing.
- Provider assessment programs for nursing facilities, hospitals, and ICF/IIDs.
- Outpatient prospective payment system (OPPS) using the APC methodology.
- Supplemental payment methodology for state-owned physician clinics.
- Transition of Medicaid to managed care by assisting with reimbursement requirements and resolving ongoing issues with the transition.
- Transition to a new home health payment methodology for intermittent services using the Medicare Low Utilization Payment Adjustment (LUPA) rates.
- The cost of dispensing (COD) and the AAC for pharmaceutical ingredients for pharmacy reimbursement.

Kentucky Cabinet for Health and Family Services

Medicaid Rate Setting

Scope of Project

In 1998, Myers and Stauffer began performing rate setting and consulting services for the Commonwealth of Kentucky. Since the project inception, rate setting activities have grown to include many provider types such as nursing facilities; ICF/IID; IMDs; RHCs, and FQHCs; CMHCs; hospitals; freestanding psychiatric facilities; rehabilitation facilities; long-term acute care hospitals; Commission for Children with Special Health Care Needs; and hospice providers. We partner with the state to perform rate and settlement calculations; agreed-upon procedures (AUPs); DSH examinations and DSH payment calculations; annual UPL demonstrations for each federally-mandated provider type; ad-hoc analyses that include a variety of projects involving data modeling, reimbursement rate setting projections, rebasing analyses, and research; regulation and SPA reviews; and appeals support. We also conduct annual training on behalf of the state for nursing facility personnel on MDS topics and Resident Assessment Instrument requirements.

CONTACT

Jacob Wilson

Branch Manager

275 East Main Street, 6W-C
Frankfort, KY 40621

PH 502.564.8196

Jacob.wilson@ky.gov

TERM OF CONTRACT

1998 – Present

Services Provided

- LTC rate setting for both case mix providers under the standard price system and cost-based providers reimbursed through the intermediate care facilities for individuals with intellectual disabilities or developmental disabilities (ICF/IID/DD), IMD, pediatric nursing facilities (PNF) and veterans administration nursing facilities (VANF) regulations.
- Hospital cost-based and DRG rate setting, CPE and outpatient settlement reimbursement determinations, to include the following provider types: acute hospitals, CAH providers, freestanding psychiatric providers, rehabilitation providers, and LTAC providers, and DPU providers.
- Rate setting for primary care centers, FQHCs and RHCs, change in scope analyses and wrap payment calculations.
- Rate setting for ICF/IID/DD clinics, community mental health providers, hospice, Commission for Children with Special Health Care Needs, and PRTFs.
- Annual MDS training to the Kentucky OIG.

- Quarterly resident roster productions and distribution for long-term care providers in support of quarterly rate setting.
- Annual DSH examination as mandated by CMS.
- Analytical services and reporting for grants, cost report development, and ad-hoc services.
- Workman's compensation form completion for hospitals and ambulatory surgery centers.
- UPL demonstrations for long-term care, hospital, clinic, and PRTF providers.
- Appeals and litigation support services.
- Regulation and SPA review.
- Administrative services in support of documenting, distributing, safeguarding, monitoring and managing aspects related to contract requirements.

Results

Myers and Stauffer has assisted the Kentucky Cabinet for Health and Family Services with:

- Development and implementation of inpatient DRG rates based on Medicare payment principles.
- GME payment calculations based on Medicare payment methodology.
- Development of cost per diem rate setting for freestanding inpatient rehabilitation, long-term acute care, and mental health hospitals.
- Cost settlements for outpatient services based on Medicare cost reporting principles.
- DSH payments and DSH audits.
- UPL/fiscal impact preparation and SPA and state regulation writing.
- Stakeholder trainings and communications.
- Support for legislative requests.

Medicaid/Medicare Program Audits, Analyzing Cost Report Data, and Disproportionate Share Hospital Payment Calculations (2.2.D)

Medicaid/Medicare Program Audits

We have provided a comprehensive narrative of our auditing experience across Medicaid and Medicare programs in our response to RFP Section 2.2.B. The following narrative focuses on Myers and Stauffer's Medicaid cost report audit experience that spans more than four decades giving us the highest level of technical experience in providing the services requested in the solicitation. Our ability to audit, perform desk reviews and analyze cost report information on behalf of our Medicaid agency clients has long been a strength of Myers and Stauffer. Many of our staff have dedicated their careers to working with the Medicare cost report audit process. We have staff that worked directly for CMS, as well as numerous staff that previously worked for various MACs with decades of experience in this area.

Providing states with timely and accurate cost report examination services has historically been a significant portion of our business. During this time, we have performed limited- and full-scope examinations, limited- and full-scope desk reviews, and have set rates or calculated cost settlements for every provider type addressed in the RFP. We have assisted our Medicaid clients with defending provider appeals and class action lawsuits. When requested, we have provided testimony as either fact or expert witnesses. Our efforts have saved state agencies literally, millions of dollars, while at the same time, ensuring program policies are based upon accurate cost and statistical information.

Our work on 11,000-plus cost reports annually involve Medicare and Medicaid cost reporting principles. We have been accepting and auditing Medicaid and Medicare cost reports for more than 43 years and we are required to apply Medicare and Medicaid cost reporting principles as part of those services. We use CMS Publications 15-I and 15-II to apply cost reporting principles during our Medicaid cost report audits. We also have applied Medicare cost reporting principles for 10 years as part of our Medicaid DSH audits. Our knowledge of Medicare cost reports and cost reporting principles is a primary reason we were selected by CMS to assist in oversight of their MACs beginning in 2018.

To further illustrate the breadth of our cost report experience, we have included a table on the following page which details our approximate annual cost report responsibilities in each state. This table illustrates our approximate annual cost report responsibilities, but does not reflect the multiple functions, such as desk reviews, audits, and rate calculations, performed on an individual cost report.

Myers and Stauffer: Approximate Provider Cost Reports Processed Annually for State Medicaid Clients							
State Medicaid Agency	SNF/NF	ICFs/IID	Hospitals	FQHC/ RHC	HHA	Other	Total
Arkansas	212	50	-	-	-	-	262
Colorado	188	3	89	146	-	-	426
Connecticut	46	29	-	-	-	30	105
Florida	370	-	4	-	-	-	374
Georgia	322	-	168	-	-	-	490
Hawaii	31	3	27	4	-	-	65
Idaho	73	65	87	14	40	-	279
Indiana	525	500	170	25	215	-	1,435
Iowa	425	105	180	316	410	1,307	2,743
Kansas	370	40	145	-	-		555
Kentucky	312	15	116	20	12	110	585
Louisiana	263	521	-	-	-	32	816
Maryland	254	4	30	6	-	29	323
Mississippi	20	-	112	-	-	-	132
Missouri	500	-	143	-	-	-	643
Nevada	51	7	11	1	-	-	70
New Hampshire	-	-	29	-	-	-	29
New Jersey	-	-	86	-	-	-	86
New Mexico	80	41	48	24	40	-	233
North Carolina	60	10	84	6	-	8	168
North Dakota	-	16	36	-	-	-	52
Pennsylvania	660	-	-	-	-	-	660
South Carolina	-	-	63	-	-	-	63
Vermont	-	-	18	26	-	-	44
Virginia	512	55	110	152	-	15	844
Wyoming	36	2	-	-	-	-	38

Myers and Stauffer: Approximate Provider Cost Reports Processed Annually for State Medicaid Clients							
State Medicaid Agency	**SNF/NF**	**ICFs/IID**	**Hospitals**	**FQHC/ RHC**	**HHA**	**Other**	**Total**
Total	**5,310**	**1,466**	**1,756**	**740**	**717**	**1,531**	**11,520**

SNF: Skilled Nursing Facilities; NF: Nursing Facilities; ICFs/IID: Intermediate-care Facilities for Individuals with Intellectual Disabilities; FQHC: Federally Qualified Health Center; RHC: Rural Health Clinic; HHA: Home Health Agency

This data includes operating cost reports and FRV reports for SNFs.

Analyzing Cost Report Data

The Medicaid program is complex with diverse and potentially-competing objectives. Successful management of this multi-faceted program requires combining accurate and reliable information with a competent project team that is driven to meet program objectives. Myers and Stauffer understands that the ability to collect, analyze, and interpret cost report data is key to this success.

Through the years of rate setting and cost reporting auditing engagements, we have refined our ability to collect and analyze provider data. As part of these efforts, our firm has grown our data analytics teams and focused on developing data gathering and processing tools and procedures to help us to interface and work effectively with any state data source. Our firm has significant experience building cost report databases. The resulting databases, linked with our knowledge of the Medicaid and Medicare programs, often prove to be highly important to our clients. Our project team has extensive experience analyzing cost report data for purposes such as developing rates, evaluating trends in historical cost report data, identifying risk areas based on changes in cost, and calculating budget estimates.

We have developed cost report data extraction tools to quickly analyze and report on Medicaid and Medicare cost report data. These tools include the ability to quickly run reports from CMS' Healthcare Cost Report Information System (HCRIS) data. Our staff have a strong understanding of all Medicare cost report public use files to supplement any state Medicaid cost report data in providing analyses.

Our staff stay educated on federal cost report changes and the impact these changes have on states. One example would be the recent COVID-19 pandemic, which resulted in cost report changes at the Medicare level that may allow states some additional analysis of revenues related to the pandemic.

DSH Payment Calculations

Myers and Stauffer brings DMS unmatched DSH experience assisting states with developing DSH programs, including DSH eligibility and DSH payment calculations. We assist with DSH payment calculations on an annual basis for 14 state Medicaid programs. We added our first DSH audit client in 2006 and have grown to be a national leader in assisting states with their DSH programs. We are

currently engaged with 42 Medicaid programs to perform their DSH audits and assist with preparing the required DSH report.

In addition, we have supported our clients' analysis and evaluation of the programmatic impacts of the series of federal legislation over the years that has defined, refined, and limited states' use and implementation of the DSH provisions, including:

- *The Omnibus Budget Reconciliation Act (OBRA) of 1986, which stated that the Health Care Financing Administration (HCFA) had no authority to limit payment adjustments to DSH hospitals.*
- *The OBRA of 1987, that defined which hospitals, at a minimum, must be included.*
- *The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, which established the first upper bounds on DSH payments.*
- *The OBRA of 1993, which sought to better target DSH hospital payments and set limits on the amounts of DSH payments individual hospitals would be allowed to receive.*
- *The Medicare Prescription Drug Improvement and Modernization Act of 2003, which among other changes, included a requirement that states submit a detailed annual report and an independent certified audit on their DSH payments to hospitals.*
- *Patient Protection and Affordable Care Act (ACA).*

Exceptional Experience: DSH Program

Myers and Stauffer is a national leader in assisting states with their DSH programs. We are currently engaged with 42 Medicaid programs to perform their DSH audits. In addition, we assist with DSH payment calculations on an annual basis for 14 state Medicaid programs. Many of our DSH payment projects include consulting on eligibility issues and managing or revising DSH payment methodologies. We were instrumental in developing the initial approach and methodology designed to satisfy the DSH audit requirements established by CMS regulations in 2008, and our audit protocol has been reviewed and accepted by CMS. We have conducted this work longer than any other firm in the nation, as we were the first firm to be engaged by a state audit pursuant to the Draft Rule (August 2005) and the Final DSH Audit Rule (December 2008).

When the ACA first came out and the proposed reduction to DSH payments were confirmed, many states came to Myers and Stauffer seeking guidance on what they could do to minimize the impact these changes may have on them. We worked with the states to develop strategies to better protect themselves from the loss of federal funding. We sat with the states as they talked and negotiated with CMS regarding their DSH allotments and programs, acting more as a partner than a consultant during these times.

In addition to understanding the DSH guidance listed above, providing DSH consulting and advisory services requires our staff to understand various Medicaid regulations related to bona fide insurance, provider taxes, physician costs, bankruptcy, Medicare cost reports, delivery system reform incentive payment (DSRIP), health IT payments, prisoners, non-Title XIX programs, DSH allotment reductions, and certified/licensed hospital units.

We have assisted states with developing DSH payment methodologies and also with managing existing DSH reimbursement systems. After reviewing the State's methodology for estimating hospital DSH limits and DSH payment methodologies, our DSH experience will enable us to assist in refining those methodologies to help eliminate the possibility of adverse DSH audit outcomes, as the audit requires recoupment of DSH funds that were paid in excess of the hospital-specific DSH limits.

Our DSH assistance varies based on the individual state and methodology, and includes services such as sending and receiving survey information (or a state-specific alternative); developing and managing databases to calculate DSH eligibility and payment levels; performing desk and on-site reviews of reported uninsured services and payments received; and preparing preliminary DSH payment calculations for the State's review and acceptance. We have assisted in designing DSH payment methodologies, preparing SPAs, and communicating DSH methodologies to CMS on behalf of our state clients.

Our current state Medicaid DSH payment experience includes:

- *Alabama Medicaid Agency.*
- *Colorado Department of Health Care Policy & Financing.*
- *Georgia Department of Community Health.*
- *Idaho Division of Medicaid, Department of Health and Welfare.*
- *Indiana Family and Social Services Administration.*
- *Iowa Department of Human Services.*
- *Kansas Department of Health and Environment, Division of Health Care Finance.*
- *Kentucky Cabinet for Health and Family Services.*
- *Louisiana Department of Health.*
- *Mississippi Division of Medicaid.*
- *Missouri Department of Social Services, MO HealthNet Division.*
- *New Mexico Human Services Department.*
- *North Carolina Department of Health and Human Services.*

- *South Dakota Department of Social Services.*

DSH payment consulting services not only requires our knowledge and understanding of the federal DSH audit rules so to avoid overpayments, but it also requires that our staff have sound knowledge of all Medicaid financing options available to a state. This may include UPL payments, CPEs, IGTs, and managed care quality/utilization incentive payments. Most importantly, it is crucial that our staff understand the approved state plan so that the calculations are compliant, or so that necessary changes can be made. Our team's extensive experience with multiple state plans brings unmatched experience and expertise of to all our engagements.

Concurrent DSH Audits and Payment Calculations

Myers and Stauffer has assisted numerous states with consulting on their DSH payment calculations, while concurrently being engaged to perform their federally-mandated DSH audit. The main reason this does not impair independence is that the DSH payment calculations are a methodology to allocate available DSH funding to EHs based on their **estimated** uncompensated care based on historical cost reports. For example, to make 2021 DSH payments, many states would use 2019 or 2020 cost reports and claims data to calculate uncompensated care.

The purpose of the DSH audit is not to audit the calculation of DSH payments, but rather to address the six verifications in the final DSH audit rule. The primary verification subject to audit is that the hospitals that received a DSH payment had **actual** UCCs sufficient to warrant the payment received. In the example above, if 2019 and 2020 cost reports and claims data were used for the payment calculation, the audit would be looking at the actual cost reports and claims data that occurred during the DSH payment year and determining if the actual uncompensated care for DSH year 2021 was higher or lower than the DSH payment received. The DSH auditors are not opining on whether the DSH payment was calculated correctly, but whether the actual UCCs support the DSH payment received.

Shortly after the final rule was published in 2008, we contacted a member of the CMS Central Office who works on DSH issues to confirm that our interpretation of professional standards agreed with CMS' position. The contact agreed with our interpretation and verified that CMS does not believe that a conflict of interest (i.e., impairment of independence) exists when a CPA firm assists with DSH calculations and also performs the federally-required DSH audits. To gain additional comfort with our position, we engaged the law firm of Covington & Burling LLP, to evaluate the regulations and professional standards and provide their interpretation. They also agreed that DSH audit regulations and professional standards do not prohibit a CPA firm from providing services to a state Medicaid agency related to their DSH calculation and also performing the required DSH audit.

We currently work with DSH programs in 39 states, which gives us a unique and unmatched level of experience with the data necessary to calculate a DSH payment and meet the requirements of subsequent DSH audits.

Prior Relevant Experience and Business Contacts

Myers and Stauffer has the reputation of being professional, knowledgeable, courteous, and timely with our projects. Below, we have provided project profiles that contain a narrative of work we have completed or are completing, along with a business point of contact. We encourage the evaluation committee to contact these references for more information about the project or more detail regarding their experience with Myers and Stauffer.

Indiana Family & Social Services Administration

Medicaid Rate Setting Services

Scope of Project

Since 1982, Myers and Stauffer has provided reimbursement methodology consulting, compliance analysis, fiscal impact analysis, provider tax calculations, and monitoring services for long-term care facility provider tax programs. We also provide rate setting services for long-term care, home health, and hospice providers. The project involves calculating rates based on provider cost reports, regulatory, and other situational changes and audit findings for ID group homes, large private ICF/ID, state operated facilities, and nursing facilities. From 1993 to 1994, the State undertook major reimbursement reform efforts throughout the Medicaid program to build in greater incentives for provider cost containment. Myers and Stauffer played a crucial role in developing, implementing, and defending the reimbursement reforms for ICF/ID, nursing facilities and HHAs. These reforms save the state tens of millions of dollars each year.

CONTACT

Kathleen Leonard

Director of Reimbursement and Actuary

402 W. Washington St., Rm W374
Indianapolis, IN 46204

PH 317.233.9282

Kathleen.Leonard@fssa.IN.gov

TERM OF CONTRACT

1982 – Present

The nursing facility case mix reimbursement functions were incorporated into this contract in 1998 in conjunction with the case mix system implementation. This was a hotly-debated implementation that involved complex negotiations, litigation, direct legislative oversight, extensive policy and fiscal modeling, and countless stakeholder meetings.

Services Provided

- Rate setting services for LTC, home health, and hospice providers.
- Calculate rates based on provider cost reports, regulatory and other situational changes, and audit findings for ID group homes, large private ICF/ID, state operated facilities, and nursing facilities.
- Developed, implemented, and defended reimbursement reforms for ICF/ID, nursing facilities, and HHAs.
- Communicated with CMS regarding provider tax issues.
- Attended meetings with provider associations and other stakeholders.
- Research regulations regarding provider tax programs.

- Collected revenue and patient day data.
- Performed P1/P2 analysis for waiver of broad based requirement.
- Performed B1/B2 analysis for waiver of broad based and uniform requirement.
- Performed analysis of waiver compliance with hold harmless requirement.
- Performed fiscal impact analysis for reimbursement methodology changes that include the use of waiver funds.
- Calculate provider tax for individual Medicaid certified facilities.
- Communicate the provider tax to the fiscal intermediary for offsetting against Medicaid claims.
- Monitor the posting and collection of provider tax receivables and payments established and received by the fiscal intermediary.
- Calculate provider tax for non-Medicaid certified facilities.
- Send invoices of provider tax due to non-Medicaid certified providers.
- Send monthly statements of provider tax due plus any interest to non-Medicaid certified providers.
- Track accounts receivable and provider tax payments for non-Medicaid certified providers.
- Notify the State Budget Office of provider tax payments received from non-Medicaid certified providers.
- Provide accounts receivable reports to the Office of Medicaid Policy and Planning and the State Budget Office to track the non-Medicaid certified provider tax billed, owed, and collected.
- Provide litigation support for appeals regarding the provider tax.

Results

Myers and Stauffer has assisted the Indiana Medicaid Program in implementing numerous policy and rate setting reforms for long-term care, home health, and hospice services. Rate setting performance included development of sophisticated models and analyses, development of regulatory and SPA language, stakeholder training, communications with CMS, participation on technical guidance workgroups, and delivery of expert testimony. We actively partnered with the State to implement a case mix system of reimbursement that is RUGs-based and is bolstered by clear and user-friendly supportive documentation guidelines and a rigorous program monitoring and reporting system. The reimbursement system is easily adaptable and sustainable, having undergone numerous enhancements over the years, including adoption of pay-for-performance incentives. Rate setting is highly accurate, responsive, and predictable, and is based on a transparent and reliable process that is further supported by a positive and productive relationship with its Medicaid providers. Provider rate setting appeals and litigation are

significantly lower than in previous years, and CMS has on numerous occasions looked to the Indiana Medicaid program for technical advice and best practices.

Iowa Department of Human Services

Provider Cost Audits and Rate Setting Services

Scope of Project

Myers and Stauffer is engaged to provide professional accounting and consulting services to the Iowa Medicaid Enterprise. The purpose of this engagement is to assist the state of Iowa in determining reasonable reimbursement rates and cost settlements for services as well as determining other calculations such as UPLs and supplemental payments.

CONTACT

Julie Lovelady

Iowa Medicaid Deputy Director

611 5th Avenue
Des Moines, IA 50309

PH 515.256.4644

jlovela@dhs.state.ia.us

TERM OF CONTRACT

2004 – Present

Services Provided

- Medicaid nursing facility case mix rate setting.
- Manage MDS database and perform quality review of quarterly resident rosters and CMI calculations.
- Rate setting, auditing and cost settlement for NFs, ICF/ID, residential care facilities, home and community based waiver providers, targeted case management, rehabilitation services, CMHCs, FQHCs, home health, RHCs, PMIC, CAHs, and general acute care hospitals.
- Medicaid fee schedule updates.
- Calculation of cost of dispensing fees and AAC reimbursement.
- DSH, IGTs, UPL calculations, and other revenue maximization.
- Hospital payment rate setting including outpatient and inpatient services.
- Consulting and litigation support services.
- Assistance with Iowa Administrative Code updates and SPAs.
- Calculation of the required annual UPL calculations.
- Provider tax calculations and collection.
- Budget analysis and consulting services related to Iowa's 1115 Medicaid demonstration.
- EHR incentive post payment audits.
- Assistance with implementation of comprehensive managed care.
- 340B audits of Medicaid fee-for-service and Medicaid managed care claims.

Results

Myers and Stauffer has successfully implemented and/or maintained:

- Inpatient and outpatient hospital rebasing.
- Provider assessment programs for nursing facilities, hospitals, and ICF/IIDs.
- OPPS using the APC methodology.
- Supplemental payment methodology for state-owned physician clinics.
- Transition of Medicaid to managed care by assisting with reimbursement requirements and resolving ongoing issues with the transition.
- Transition to a new home health payment methodology for intermittent services using the Medicare LUPA rates.
- The COD and the AAC for pharmaceutical ingredients for pharmacy reimbursement.

Kentucky Cabinet for Health and Family Services

Medicaid Rate Setting

Scope of Project

In 1998, Myers and Stauffer began performing rate setting and consulting services for the Commonwealth of Kentucky. Since the project inception, rate setting activities have grown to include many provider types such as nursing facilities; ICF/IIDs; IMDs; RHCs, and FQHCs; CMHCs; hospitals; freestanding psychiatric facilities; rehabilitation facilities; long-term acute care hospitals; Commission for Children with Special Health Care Needs; and hospice providers. We partner with the state to perform rate and settlement calculations; AUPs; DSH examinations and DSH payment calculations; annual UPL demonstrations for each federally-mandated provider type; ad-hoc analyses that include a variety of projects involving data modeling, reimbursement rate setting projections, rebasing analyses, and research; regulation and SPA reviews; and appeals support. We also conduct annual training on behalf of the state for nursing facility personnel on MDS topics and Resident Assessment Instrument requirements.

CONTACT

Jacob Wilson

Branch Manager

275 East Main Street, 6W-C
Frankfort, KY 40621

PH 502.564.8196

Jacob.wilson@ky.gov

TERM OF CONTRACT

1998 – Present

Services Provided

- LTC rate setting for both case mix providers under the standard price system and cost-based providers reimbursed through the ICF/IID/DD, IMD, PNF, and VANF regulations.
- Hospital cost-based and DRG rate setting, certified public expenditures (CPE) and outpatient settlement reimbursement determinations, to include the following provider types: acute hospitals, CAH providers, freestanding psychiatric providers, rehabilitation providers, and LTAC providers, and distinct part unit (DPU) providers.
- Rate setting for primary care centers, FQHCs and RHCs, change-in-scope analyses and wrap payment calculations.
- Rate setting for ICF/IID/DD clinics, community mental health providers, hospice, Commission for Children with Special Health Care Needs, and PRTFs.
- Annual MDS training to the Kentucky OIG.
- Quarterly resident roster productions and distribution for long-term care providers in support of quarterly rate setting.
- Annual DSH examination as mandated by CMS.

- Analytical services and reporting for grants, cost report development, and ad-hoc services.
- Workman's compensation form completion for hospitals and ambulatory surgery centers.
- UPL demonstrations for long-term care, hospital, clinic, and PRTF providers.
- Appeals and litigation support services.
- Regulation and SPA review.
- Administrative services in support of documenting, distributing, safeguarding, monitoring, and managing aspects related to contract requirements.

Results

Myers and Stauffer has assisted the Kentucky Cabinet for Health and Family Services with the following:

- Development and implementation of inpatient DRG rates based on Medicare payment principles.
- GME payment calculations based on Medicare payment methodology.
- Development of cost per diem rate setting for freestanding inpatient rehabilitation, long-term acute care, and mental health hospitals.
- Cost settlements for outpatient services based on Medicare cost reporting principles.
- DSH payments and DSH audits.
- UPL/fiscal impact preparation and SPA and state regulation writing.
- Stakeholder trainings and communications.
- Support for legislative requests.

Missouri Department of Social Services

DSH Audits

Scope of Project

Myers and Stauffer collects the data for the annual DSH payment and performs analytics on the data. Missouri has an extremely rigid and short timeline to develop their DSH payment calculations and we have always delivered on time to meet their deadlines. Myers and Stauffer also performs federally-mandated independent certified audits of the state's DSH program which includes between 105 and 145 hospitals annually. We have always completed the audits in a timely manner so the State has been able to file their reports with CMS by December of each year. Throughout the DSH audit process, Myers and Stauffer has worked closely with State staff and the hospital association, as well as providing annual training to the hospitals. This is necessary given the complexities of Missouri's DSH program and provider tax pooling arrangements.

CONTACT

Christina Jenks

Director of Hospital Policy and Reimbursement

615 Howerton Court
Jefferson City, MO 65102

PH 573.526.4746

christina.jenks@dss.mo.gov

TERM OF CONTRACT

2010 – Present

Services Provided

- Development of DSH information tool to obtain required data elements to complete the audit.
- Extraction of information needed from Missouri Medicaid hospital cost reports and paid claims data.
- Participation in meetings with Missouri hospitals to inform and train on federal DSH requirements.
- Desk review procedures on data submitted by Missouri hospitals and assess risk of each hospital.
- Fieldwork on selected hospitals.
- Preparation of federally required audit reports.
- Consultation during meetings with the state on modifications to the DSH program to conform to federal requirements.
- Assistance with transitioning the state's DSH payment methodology to be consistent with the DSH audit methodology.
- Technical assistance during CMS audits of the DSH audit work performed.

- Research and explanation of the constantly changing DSH audit rules to state and hospital association staff.

Results

Over the course of our work with the state of Missouri, we have assisted with the reduction of statewide DSH overpayments by $225 million and have modified their DSH program to conform to federal requirements.

Disclosure (E.2)

Below, we have provided our signed disclosure attestation.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

December 11, 2020

Ms. Nawania Williams
Arkansas Department of Human Services
Office of Procurement
112 West 8th Street
Little Rock, AR 72201

Dear Ms. Williams and Members of the Evaluation Committee:

I, Amy Perry, CPA, member, attest that Myers and Stauffer has never had a contract terminated for default, convenience, non-performance, non-allocation of funds, or for any other reason. We have never been under a corrective action plan, or had sanctions imposed by a state or federal government in the 43 years that our firm has been in existence.

Sincerely,

Amy Perry

Amy Perry, CPA
Member

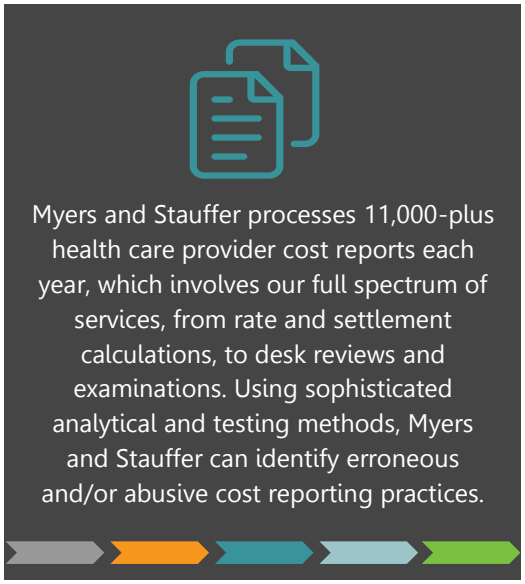
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

700 W 47th Street, Ste. 1100 | Kansas City, MO 64112
PH 816.945.5300 | PH 800.374.6858 | FX 816.945.5301
www.myersandstauffer.com

Cost Report Audits and Analysis: Hospitals and Federally Qualified Health Centers (E.3)

Audits (2.3.A.1.)

As a firm, Myers and Stauffer processes 11,000-plus health care provider cost reports each year, which involves our full spectrum of services, from rate and settlement calculations, to desk reviews and examinations. Our experience includes on-site examinations and desk reviews of hospitals, nursing facilities, FQHCs, RHCs, HHAs, home and community-based service (HCBS) waivers, and ICF/ID. Using sophisticated analytical and testing methods, Myers and Stauffer can identify erroneous and/or abusive cost reporting practices. We recognize that the first objective in developing audit protocols is to have a thorough understanding of Arkansas's Medicaid reimbursement system and using that knowledge to mold procedures around risks inherent to that system.



The Medicaid program is complex with diverse and potentially competing objectives. Successful management of this multi-faceted program requires combining accurate and reliable information with a competent project team that is driven to meet program objectives. Myers and Stauffer is committed to continuing to provide this high level of support to DMS. Our team of experts offers a unique combination of experience and knowledge within all facets of health care reimbursement, making us ideally suited to ensure an organic and cooperative relationship is developed with the provider community.

Unlike a firm that believes the sole goal of an audit report is the cost settlement, Myers and Stauffer knows it is merely the first step of many. It has dedicated its practice to the delivery of audit, rate setting, and consulting services for government health care programs. We understand the depth of our responsibility encompasses a deep understanding of the health care environment at a local and national level, providing competent advice, and interpreting the vast amount of data generated by the many participants in the health care reimbursement arena. Myers and Stauffer has the experience and knowledge to fulfill this need.

An important objective for our Medicaid agency clients is to direct as much of the available program funding toward the care of Medicaid clients. Since the services performed through these engagements directly impact Medicaid program expenditures, our project functions will be well-managed, disciplined, and contribute to the efficient operation of the Medicaid program.

Our desk reviews and full-scope audits will be designed to verify that cost reports adhere to Arkansas Medicaid policy and that our work products are delivered timely.

Our team's expertise across the spectrum of review and reimbursement issues is unparalleled, which allows us to focus our audit effort on issues relevant to provider reimbursement and program management. It also allows us to refine our efforts as the reimbursement systems continue to evolve. This, in turn, ensures that DMS' objectives for provider reimbursement continue to be realized in the complex and ever-changing health care environment.

We propose a project team that has the necessary experience to exceed the performance standards for the cost report audits and UPL calculation functions. We will complete all duties in an accurate, timely, and professional manner. We understand our reports will be used to distribute significant Medicaid program expenditures.

Specifications outlined in the RFP include audit or desk review, cost settlement, and rate determination responsibilities for hospitals, sexual offender programs, and FQHCs. We have provided a discussion of our general approach to completing desk reviews in Sections 2.3.A.7 and 2.3.A.8 of this proposal and anticipate following these procedures to accomplish the desk review and full-scope audit requirements.

Calculate Interim Reimbursement Rates and Medicaid Cost Settlements (2.3.A.2.)

Myers and Stauffer agrees to calculate interim Medicaid per diem reimbursement rates and Medicaid interim and final cost settlements in a manner consistent with the method used by the Medicare program and any other specific requirements identified in the Arkansas Medicaid State Plan.

Hospitals

In-state and out-of-state inpatient psychiatric and rehabilitative hospitals are reimbursed based on prospective per diem basis and no cost settlements will be completed for these hospitals except for residential treatment units and sexual offender program units located within an inpatient psychiatric hospital in which the unit will be cost settled. Any Arkansas state operated psychiatric hospital will also be paid based on a retrospective cost settlement.

Based on our understanding, Arkansas reimburses inpatient hospital services using an interim per diem methodology with a retrospective cost settlement subject to limits. The cost settlement amount is calculated as the lower of the following:

1. Allowable costs after application of the Tax Equity and Fiscal Responsibility Act (TEFRA) rate of increase limit. The TEFRA rate of increase limit is the hospital's TEFRA target rate multiplied by its total number of Medicaid discharges. The TEFRA rate of increase limit is not applied to Arkansas State Operated Teaching Hospitals effective for cost reporting periods after June 30, 2000.

2. The hospital's customary charges.

3. A maximum limit per Medicaid days. The maximum limit is the total number of Medicaid inpatient days per the cost reporting period multiplied by the $850.00 per diem cost limit. This limit does not apply to pediatric hospitals, border city university-affiliated pediatric teaching hospitals, Arkansas State operated teaching hospitals, rehabilitative hospitals, inpatient psychiatric hospitals, out-of-state hospitals, and CAHs. In addition, for recipients age 21 and older, no cost settlement is done for hospital days beyond 24 during the State Fiscal Year (SFY). Any days beyond 24 will be paid a prospective per diem rate of $400.00 (this does not apply to recipients age 21 or older who receive inpatient services in accordance with special diagnosis criteria identified in the State Plan).

There are certain costs and services that are excluded from the cost settlement calculation described above, such as malpractice insurance, GME costs, and transplant services.

Upon contract award, project team members will work with DMS staff to review and fully understand the current interim per diem rate setting and cost settlement processes, and underlying Medicaid reimbursement policy. We will also request that the state provide current and historical interim per diem rates and TEFRA target rates. Hospitals' TEFRA target rate (limit) will be updated on an annual basis using the CMS Market Basket Index or the Congressional Set Inflation Factor. We will also update, as necessary, interim per diem rates based on current Medicaid policy.

FQHCs

Arkansas reimburses FQHC providers who choose the alternative payment methodology at the greater of 100 percent of the provider-specific costs that are reasonable (based on the provider's cost report) and related to the cost of furnishing services or the provider-specific PPS rate. Interim payments are made based on a cost per visit subject to settlement after a cost report has been received. Both a tentative and final settlement will be completed by our project team.

Our project team will inflate the PPS rate annually to be effective as of the first day of the provider's fiscal period by the regional Medicare Economic Index for primary care services and will be used in the cost settlement determination. We will also update, as necessary, interim per visit rates based on current Medicaid policy.

FQHCs are also provided wraparound payments for services paid through MCOs. A wraparound payment is made to ensure the FQHC is provided reimbursement at the greater of 100 percent of the provider-specific cost per encounter (visit) or the provider-specific PPS rate, less any payments received from the MCOs. Wraparound payments are subject to settlement through the tentative and final settlement processes.

Upon contract award, our project team will work with DMS to review the current cost settlement process to ensure we fully understand Arkansas Medicaid policy and request current and historical interim per visit rates and PPS rates. While not included in the RFP scope of services, our project team has significant experience with FQHCs and are available to assist in reviewing and updating PPS rates based on a provider's request for a change in their PPS to account for increases or decreases in scope of services. We are also available to assist in establishing new PPS and interim per visit rates if a new provider should enter the Medicaid program.

We have provided further discussion on our approach to tentative and final cost settlement in our response to Section 2.3.A.7. Desk Reviews.

Obtaining Audited Cost Reports from Out-of-State Intermediary (2.3.A.3.)

Myers and Stauffer has worked with Medicare intermediaries during the performance of their contracts with other state Medicaid agencies. Our project staff members are experienced in building positive working relationships with Medicare intermediaries across the nation. Myers and Stauffer has acquired the software needed to import Medicare electronic cost report (ECR) files and have trained our staff in the use of these software products.

In addition, we are in the unique position of having access to quarterly cost report data published by CMS which allows us to access the final Medicare cost report data as soon as it becomes published. If the data is unavailable in a timely manner, we will accept responsibility for making arrangements with the Medicare intermediaries to obtain Form CMS 2552 or other relevant cost reports to ensure that the final Medicare cost data is reflected in the final Medicaid cost settlement, if applicable. Both a contact person and backup staff are designated to coordinate activities and communication with the Medicare intermediaries. Project staff will work with the fiscal intermediary to develop procedures for obtaining Medicare cost reports and related information. It is our experience that this process is vital to meet project deadlines.

Audited Reviewed Cost Report Information (2.3.A.4.)

Arkansas utilizes prospective payment rates to reimburse psychiatric and rehabilitative hospital services. Although the cost reports are not utilized to compute a cost settlement, we recognize it is critical the state has reliable audited data available to make informed reimbursement or budgeting decisions. We will develop audit protocols to ensure the timely completion of these cost report reviews while also mitigating, to the extent possible, the administrative burden audits place on these hospitals given the limited role the cost reports have in rate setting.

Deliverables (2.3.A.5.)

Myers and Stauffer will complete the following number of audits and cost settlements per contract year:

Deliverables						
Type of Provider Cost Report or Service	Desk Reviews					Full-Scope Audits
	Additional	Tentative	Final	Reopening	TEFRA	
In-state acute hospitals	25	127	80	15	100	3 - 9
Border-city acute hospitals		25	25			1
In-state and out-of-state Psychiatric hospitals and sexual offender programs		16	16			
In-state and out-of-state Pediatric hospitals		25	25			
FQHCs			56			2 - 3
Other provider types	Cost report form design and desk review					

Myers and Stauffer is aware that the total number of required audits and settlements may fluctuate due to unforeseen issues or circumstances such as hospital bankruptcies, closures, changes of ownership, or DMS needs in a specific rate setting period.

We have assisted our clients with developing cost surveys for adult developmental disabilities and HCBS' which includes various provider types and services. We have also completed cost report reviews and cost settlement calculations for adult day facilities. Our project team stand ready to assist with cost report for design and desk reviews for other provider types such as HHAs, early intervention day treatment, and adult developmental day treatment. Myers and Stauffer has provided various services pertaining to HHAs such as cost report verification, rate setting, and analysis of alternative reimbursement methodologies on behalf of our other state Medicaid agency clients. We have provided our approach to completing ad-hoc projects in our response to the Ad Hoc Projects (2.3.G) requirement.

Cost Report Requirements (2.3.A.6.)

Cost report data for each provider type will be collected throughout the year based on each provider's fiscal year end. DMS and each hospital, sexual offender program, and FQHC provider will be sent a letter 30 days prior to their respective fiscal year end detailing the Medicaid cost report due date and submission requirements. According to Medicare regulations and the Arkansas state plan, providers are required to submit their Medicaid cost report within five calendar months after the close of their cost reporting period. All documentation will be accepted through an easy-to-use, secure web portal utilized by thousands of providers in other states. Providers will upload documentation to the web portal, and communication or other documentation requests will be transmitted via the portal. We will work with DMS to require providers to submit the Medicare cost report (MCR) using the electronic MCR file format. This will allow the automatic upload of the Medicare cost report data to a database that will house all as-filed and audited cost report data. The database will be available to project staff and DMS for additional ad-hoc analysis.

The web portal communications can be customized to send reminder emails to providers and DMS prior to the due date as required by the contract. For example, we could have the web portal send providers a reminder email 10 days prior to the due date if the cost report has not been uploaded to the web portal by that time. Our applications provide customizable automation based on DMS requirements, allowing for accurate and traceable communication options. The portal has proven to be extremely useful by our other clients and providers have grown accustomed to the layout and efficiency it affords them during the submission and audit process. We have provided a more detailed description of our secure web portal in our response to the Paper Workflow (E.8) requirement.

Additionally, if a provider does not submit a cost report by the due date, an automatic email will be sent 14 business days after their cost report was due stating the cost report is delinquent, and every 30 days thereafter until the cost report is received. The submission items are tracked through the web portal and a summary report is available for the DMS showing if a provider was delinquent, what items were submitted, date they were submitted, and date Myers and Stauffer has accepted their submission. A submissions report is auto-generated through the web portal and is available for DMS to download at any time. We will also monitor delinquent submissions and promptly communicate delinquent providers and proposed solutions via telephone or direct email as needed.

It is our understanding that a request for an extension of the due date for filing a cost report should be submitted in writing to DMS at a minimum of fifteen calendar days before the cost report due date. Myers and Stauffer agrees to forward any extension request received to DMS for approval or denial.

Once a cost report submission is received by Myers and Stauffer, a para-professional is assigned to review all submitted documentation and verify no additional information is necessary and that the Medicaid report meets all Arkansas Medicaid requirements. The para-professionals assigned will utilize provider-specific checklists to verify that hospital, sexual offender, and FQHC providers submitted all required items needed for their specific audit steps. Once all documentation is received, Myers and Stauffer will accept the cost report and the provider will be notified. We understand that if a cost report is found to contain specific edit errors or missing required documentation, we will reject the cost report and notify the provider. If the report is received after the due date, it will be treated as a past-due cost report if an acceptable cost report is not submitted within fifteen calendar days of our notification. We will notify DMS of any past due cost reports and will immediately notify DMS as soon as a cost report has been received and accepted to allow DMS to discontinue any suspension of payments.

Desk Reviews (2.3.A.7.)

Limited scope procedures, referred to as desk reviews, will be performed on all hospital and FQHC cost reports at the conclusion of the cost report acceptance process. The desk reviews will be performed in accordance with Medicare scoping, along with completion of a Medicaid-specific supplemental pediatric and nursery service desk review program as currently required by DMS. It is our understanding that the

primary difference between a tentative and final settlement is the status of the cost report. The provider filed cost report with applied desk review procedures is used to perform the tentative settlement while the final settlement is calculated based on the Medicare intermediaries finalized/audited cost report.

In accordance with Provider Reimbursement Manual, Part I (PRM-I), § 2408.2, an initial/tentative ("initial") retroactive adjustment must be made as quickly as possible after receipt of a cost report from the provider. For purposes of a tentative settlement, costs are typically accepted as reported except for obvious errors or inconsistencies. While it is our experience that tentative settlement calculations are usually standard calculations, it is important that the contractor review overall cost report data for reasonableness. Additional procedures will include confirming the completeness and mathematical accuracy of the cost report and reconciliation of the cost report to the trial balance and financial statements.

Upon contract award, project staff will meet with DMS to review current tentative and final settlement procedures, discuss varying levels of verification and analysis that could be performed, and develop a desk review settlement program that meets DMS goals. This will include review of Medicare's Uniform Desk Review (UDR) tool and the varying levels of desk review programs based on specific thresholds. For FQHCs, the UDR prescribes that the hospital limited desk review be completed, which includes minimal review procedures such as testing the mathematical accuracy, ensuring appropriate FQHC rate per visit limits are applied, and testing and adjusting to actual Medicaid visits per paid claims. We will work with DMS to determine if the desk review completed for the tentative settlement is standard across all providers or if thresholds should be developed and applied to determine the level of desk review to be completed. In addition, we will evaluate whether or not additional procedures should be included beyond the Medicare UDR for both hospitals and FQHCs.

Myers and Stauffer will review the calculation for reasonableness and identify issues that may cause tentative settlements to be out of line with prior years. For example, there may be current errors in a recent version of the 2552 cost report form that have caused significant variances in cost calculations. We will need to be aware of such issues and report them to DMS to avoid potential overpayments or underpayments prior to final settlement. Our staff are required to monitor regulations that impact the cost report forms.

During the initial meetings with DMS, project staff will also work with DMS to develop a process for requesting and obtaining provider statistical and reimbursement (PS&R) reports (paid claims history) from the Medicaid Management Information System (MMIS) or data warehouse. We also find it necessary to obtain Medicaid managed care paid claims information in order to accurately review and prepare wraparound settlement payments. We will also work with DMS to determine the process for notifying providers of draft and final results of the review and settlement process.

The auditor will work through the desk review program identifying discrepancies and errors in the reported amounts. Error messages and cross-checks will be identified and corrected. During the process of reviewing the cost report and desk review program, the auditor will generate a list of additional questions for the provider. All issues noted will be reported on a "Summary of Issues/Exceptions" work paper and then cross-referenced to their resolutions. Throughout the desk review process, the auditor may elect not to review all steps based on thresholds contained in the program and risk that is assessed. However, the reasons for omitting steps will be documented in the work papers.

Upon receipt of the requested paid claims history and completion of the review, an accountant will calculate the tentative cost settlement. The settlement process includes identification of allowable Medicaid operating costs as derived from the Medicare cost report and any supplemental Medicaid schedules. Allowable costs are compared to the interim payments made to determine the settlement amount. A manager will review the tentative settlement calculation for accuracy and submit the draft tentative settlement to DMS, which demonstrates the amount due to the provider or DMS, along with supporting electronic cost report files, for approval within 60 calendar days after the cost report is accepted.

All final Medicaid Notice of Program Reimbursements will be prepared and submitted to DMS within 75 business days after receipt of the Medicare Notice of Program Reimbursement (NPR). As previously stated, the final settlement (NPR) is based upon the final/audited Medicare cost report which is used in reconciling Medicaid costs. We will accept responsibility for making arrangements with the Medicare intermediaries to obtain final Medicare cost reports and NPR.

As final Medicare cost reports are received, project staff will request paid claims history based on the AUPs. Upon receipt of the paid claims history, the final settlement will be calculated and final NPR prepared. Similar to the tentative settlement process, all final settlement calculations and NPRs will be reviewed by a manager before submitting to DMS.

During both the tentative and final settlement processes, project staff will be available to answer any questions that DMS may have during their review. We agree to return any corrected tentative or final Medicaid NPR to DMS within 10 business days after receiving any corrections noted and received by DMS. Provider notifications will be made in accordance with the agreed upon procedures with DMS.

We understand that providers may not always agree with the results of our reviews, and in those instances, we agree to work with the provider and DMS to resolve any item of dispute. Our senior-level staff have provided extensive Medicaid appeals/litigation support to our clients. This has included appeals filed by different provider types, including nursing facilities, hospitals, hospice, home health, residential treatment centers, psychiatric service providers, physicians, treatment foster care – case management, personal and respite care, private duty nursing, rehabilitation (inpatient and outpatient), intellectual disability waiver services, DME, and laboratories. The issues have included cost report audit

and settlement findings, personal fund account audit findings, EHR post-payment audit findings, and findings as a result of a post-payment review of claims. Additionally, we have testified in federal court in support of clients' prosecution of fraudulent health care providers.

At the informal level, audit disagreements with providers offer both parties the opportunity to present their position and genuinely hear the other point of view. Our experience helps us to understand the providers' concerns and clearly articulate the nature of any actions taken to reduce costs or to recover funds. The providers are afforded every opportunity within the regulations to express their concerns and present information to support their position. Relevant information offered by the providers clearing any deficiencies often results in the resolution of appeal issues. Our approach is a positive one that results in many disputes being concluded at the informal level, well before an official appeal or hearing is needed.

At the formal level, appeal discussions often take an adversarial tone, where an administrative law judge directs the proceedings and lawyers drive the discussions. Our professionals have the education, training, skill, and experience to offer testimony as experts in program policy and audit matters to successfully represent DMS.

We will meet every timeframe for which we are responsible, and we will provide timely information to others within the litigation/appeal process so they may meet their timeframes. Our professionals are experienced in applying and interpreting state-specific regulations, guidelines, and policies. Our interpretations are regularly adopted in both informal and final agency decisions. Our team approach results in a high rate of successful appeal decisions.

Full-Scope Audits (2.3.A.8.)

Myers and Stauffer agrees to conduct an annual field audit on the following, without limitation:

- *Arkansas Children's Hospital.*
- *Arkansas Children's Hospital Northwest.*
- *University of Arkansas for Medical Sciences (UAMS).*
- *Methodist University Hospital, Memphis.*
- *Up to an additional five percent of the in-state hospitals in consultation with DMS.*
- *At least 20 percent of FQHCs with all FQHCs being auditing at least once every five years.*

Results of the desk reviews will be used to determine the necessity of full-scope audits. The following risk factors can be used for full-scope selection:

- *Type of hospital (PPS or critical access) or type of FQHC (free-standing or hospital-based).*
- *Time elapsed since last full-scope audit.*

- *Dollar amount of cost reimbursement.*
- *Medicaid utilization within the state.*
- *Increase or decrease in operating outlier cost-to-charge ratio.*
- *Increase or decrease in operating routine per diem (hospital) or per visit cost (FQHC).*

The first step to developing criteria for selecting hospitals and FQHCs for full-scope audits is to evaluate Medicare's guidelines. From there, Myers and Stauffer can develop a risk assessment based on other criteria that we note during the acceptability and desk review. Since Medicare has different objectives, it may be of greater benefit for DMS to allow Myers and Stauffer to develop risk-based assessments based on the reimbursement methodologies being employed at the Medicaid level. We have extensive experience with rate setting and various Medicaid reimbursement methodologies which enables us to develop sophisticated risk assessments to help in determining which providers should receive greater scrutiny at and beyond the desk review level.

To prevent duplication of audit work, we can also modify the Medicaid full-scope audit based on the type of review already completed by the MACs. We can modify the audit programs based on the current status of the Medicare cost report with the MAC. The MAC will typically list the cost report status as one of the following:

- *As-submitted.*
- *Amended.*
- *Settled without audit.*
- *Settled with audit.*
- *Reopened.*

If the cost report is still determined to be as-submitted or amended, DMS may want us to wait until the cost report has been settled by the MAC before beginning the Medicaid audit. However, there may be times when DMS needs a review done immediately regardless of the MAC's audit status. Medicaid settlements, rate setting, and DSH cannot always wait on Medicare cost report settlement timelines. The MACs have had significant delays in cost report settlements over the years due to Medicare PS&R changes and Medicare DSH Supplemental Security Income ratios that have no impact on the Medicaid reimbursement. These delays can last for years and seem to come up every time new legislation is passed at the federal level; changes are made to Medicare systems; or significant policy changes are made by CMS due to Medicare appeals. A major advantage of using Myers and Stauffer as opposed to the MAC is that we are not tied to the Medicare cost report settlement timelines. If DMS needs a cost report desk review or audit done immediately, we can prioritize it without duplicating work later.

If the MAC lists the cost report status as settled, we will determine what work has been done and modify the desk review and audit appropriately to prevent duplicative audit work. If the status is "Settled without audit" it usually means the MAC only adjusted Medicare paid claims data which has little or no impact on the Medicaid desk review and audit. If the status is "Settled with audit" or "Reopened," the MAC most likely has done at least a limited desk review, meaning we will reduce the scope of the Medicare programs at the time of our Medicaid review. In all cases, we will perform the full Medicaid-specific program related to pediatrics and nursery services.

Myers and Stauffer staff have significant experience with the Medicare review programs since they are used by Medicare and other state Medicaid programs. We have successfully developed processes and automated systems to efficiently and effectively obtain the greatest benefit for our clients using a cost-effective, risk-based desk review approach. Project team members will work with DMS to develop a schedule for conducting the full-scope audits and will not perform any full-scope audits until DMS has approved.

Key sections of the typical Medicare/Medicaid audit programs, and the importance of the audit steps, are summarized below. The following discussion is more focused on a hospital audit; however, the FQHC audit program would include many of the same key sections, as Medicare FQHC review programs are based upon the Medicare hospital review programs. In all steps, we will first consider the scope of any desk review and audit already completed by the MAC so that we do not duplicate effort or place an unnecessary burden on providers.

1. Working Trial Balance

Expenses will be reviewed for proper classification of overhead, routine patient care, and ancillary services to ensure proper costing. For FQHCs, expenses will be reviewed for proper classification general and administrative costs, direct care costs, reimbursable pass through costs, other FQHC services, and non-reimbursable costs.

Revenues will be reviewed to determine that they are properly matched to expenses in the cost report. This will ensure the accuracy of cost-to-charge ratios that may be used to develop cost for ancillary services.

In this review, the auditor will look for non-reimbursable or misclassified expenses. This includes but is not limited to, the following:

- *Bad debts.*
- *Legal fees related to appeals in which the provider does not prevail on all claims/issues.*
- *Fines associated with revenue assessments.*
- *Costs not related to patient care.*

- *Related-party profit.*
- *Related-party interest expense.*
- *Luxury or extravagant motor vehicles.*
- *Employee personal use of facility property.*
- *Promotional advertising and fundraising expense.*
- *Expense related to non-hospital facilities or services.*
- *Home office costs directly assignable to other facilities.*
- *Unsupported or inadequately documented expense.*
- *Fines and penalties.*
- *Contributions or donations.*
- *Federal and state income taxes.*
- *Retail pharmacy (FQHC).*
- *Non-allowable GME costs (FQHC).*

2. Prior Year Adjustments and Notes

The auditors always review prior year audit adjustments, management letter items, and notes to future auditors to determine if the same issues exist in the current period. Using our electronic audit software, these items are readily available from year to year for the auditor to review. However, during the first year of transition, we will need to collect this data from the previous audit contractor or DMS, if possible.

Repeat adjustments and management letter items that indicate a hospital has refused to make necessary changes to be in compliance with CMS Publication 15-1 or Arkansas Statutes, will be discussed and referred to DMS on an annual basis. Based on those discussions, additional work will be done as needed, including potential fraud and abuse referrals.

3. Limits and Rates

The cost report will be reviewed and compared to published limits and rates as required under Arkansas Medicaid and CMS Publication 15-1. This would include adjusting the cost report for any applicable Reasonable Compensation Equivalents and skilled nursing facility (SNF) swing bed rates. Under the Medicare cost-based reimbursement methodology for FQHCs, there was a maximum rate per visit that was applied during the cost settlement process. Based on review of the state plan, it does not appear that Medicaid applies this maximum during the cost settlement process. During discussions with DMS, we will clarify our understanding and develop audit procedures accordingly.

4. Automated Desk Review (ADR)

At the beginning of the full-scope review, we will run the ADR, to identify risk areas that need to be addressed through examination procedures. This process can also be applied during the desk review. The ADR can be generated using the CMS cost report software and assists the auditors in determining risk based on comparisons to prior year as-filed or as-adjusted cost reports. The ADR will be reviewed for several issues including:

- *Bed changes.*
- *Expenses on Worksheet A.*
- *Expense reclassifications on Worksheet A-6 (Worksheet A-1 for FQHC).*
- *Expense adjustments on Worksheet A-8 (Worksheet A-2 for FQHC).*
- *Expense allocation statistics on Worksheet B-1.*
- *Charges on Worksheet C.*
- *Cost-to-charge ratios on Worksheet C.*
- *Routine per-diems on Worksheet D-1 (Cost per visit on Worksheet B Parts I & II for FQHC).*

All significant variances noted during the ADR process will be reviewed in other sections of the program or noted on the Summary of Issues/Exceptions. As part of this review, costs not related to patient care and miscellaneous revenues will be reviewed to determine if they were properly handled on the cost report.

5. Audited Financial Statements

If audited financial statements are available, they will be reviewed for consistency with the cost report and the working trial balance. The auditors will pay close attention to the type of opinion issued by the independent auditor and the notes included in the financial statements. As a CPA firm with CPAs on staff, we have a much better understanding of the audited financial statements and their notes than other non-CPA firm contractors. Our auditors can identify potential cost report issues from the audited financial statements without duplicating work that may have already been completed by the independent auditors. This saves DMS contract dollars that can be better spent on other parts of the Medicaid program.

6. Capital

The auditors will review capital expenses such as depreciation, interest, insurance, and property taxes. Assets may be reconciled to the hospital's asset listing (depreciation summary).

We will review major additions and improvements reported on the cost report to ensure that the provider has reported additions in accordance with the regulations. Groupings of capital costs, including

direct assignment as reported on Worksheet B Part II will be reviewed for evidence of manipulating cost-to-charge ratios in cost centers with greater Medicaid utilization.

7. Interest

Interest will be reviewed for significant changes and variances may be addressed through additional testing. Interest expense reviews can be complex due to the sophisticated financing employed by many hospitals and large chains. Our auditors have experience reviewing some of the largest hospitals and chains in the country so they understand issues such as bond defeasance, interest rate swaps, funded depreciation, and how to properly offset investment income.

8. Medical Education

As of December 31, 2013, GME costs are excluded from the interim rate and reimbursed using Medicare rules under separate quarterly payments made outside of the cost report. The only exception to the Medicare rules is the inclusion of nursery cost in the calculation of the cost per resident for Medicaid purposes. The reimbursement settlement for GME will be made at the time the cost settlements are proposed. The procedures will be modeled around Arkansas Medicaid reimbursement concepts to ensure the costs are appropriately carved out of the routine per diem calculations to avoid duplicate reimbursement. Based on review of the Arkansas State Plan, any allowable GME costs incurred by the FQHC would be included as reasonable cost and included in the cost settlement calculation. This will be clarified with DMS and audit procedures will be developed accordingly.

9. Organ Acquisition and Transplant Costs

Organ acquisition costs will be reviewed to determine if direct organ acquisition cost and indirect organ acquisition costs have been properly reported and segregated on the cost report. Arkansas reimburses costs of transplant services based on organ type, while organ acquisition appears to be reimbursed based on actual cost from the providing organization or reasonable cost as determined by the cost settlement process.

10. Home Office Costs

Home office costs will be adjusted to the home office cost statement. The home office cost statement will be desk reviewed or audited based on DMS' workload assignments.

Through our various other contracts, we have extensive interaction with many regional and nationwide home offices that service hospitals in Arkansas. Examples include Mercy Health System and Community Health Systems. Our working relationships with these chains, as well as others, allow for a smooth transition to this contract with the state of Arkansas.

If DMS requires the home office cost statement to be included in the full-scope audit procedures, we have staff capable of performing home office audits in accordance with CMS Publication 15-1. Since FQHCs within a chain organization are allowed to receive approval to file a consolidated cost report,

standard audit procedures will be included to test the home office cost statement and allocations for all full-scope audits. The home office cost statement will be examined to ensure compliance with state and federal regulations. Our experience in auditing numerous large-scale home offices provides us enhanced knowledge regarding their often times complex cost allocation schedules that present increased risk to the Medicaid program.

The step down of home office costs to the hospital will be scrutinized to ensure that any directly-assignable costs are not included in total pooled costs allocated amongst all facilities, as is required by Medicare regulations. We will ensure that statistics used to allocate home office costs to the facilities are appropriate, supported, and result in an equitable distribution of expenses to each provider. Additionally, we will review the home office trial balance to ensure that any expenses that are non-reimbursable at the facility level are excluded from the costs stepped down from the home office.

We will develop a set of working papers for each home office examination. We understand that only one set of home office working papers is necessary if a home office examination relates to more than one hospital. Proposed adjustments relating to the home office will be included in each individual hospital's schedule of adjustments.

11. Cost Allocation Statistics

The review of cost allocation statistics is particularly important with cost-based reimbursement systems and hospitals with significant non-hospital services. However, the risk in this area is very small for FQHCs, as there are minimal cost allocations within the cost report form. Some of the typical statistics used in the allocation of overhead to revenue-generating cost centers include square footage, gross salaries, gross revenue, accumulated cost, pounds of laundry, meals served, hours of service, full time employees, nursing hours, patient days, and costed requisitions. The overall percentage of overhead cost allocation to a cost center should not change significantly between cost reporting periods unless there was an operational change at the hospital. We will review statistics based on automated desk review comparisons to prior year. We will also review the financial statements with follow-up inquiry related to potential operational changes (such as new non-hospital units). The review of statistics is important and can be very complex when hospitals begin subscripting overhead cost centers and set up several non-reimbursable cost centers. We understand the complexity of cost-finding and review it in the entire context of the cost report considering sub-scripting, Worksheet A-8 offsets, Worksheet B Part II direct assignment of capital costs, non-hospital units, non-reimbursable cost centers, and where the charges are reported on Worksheet C.

12. Settlement Data

Prior to the start of the full-scope audit, project staff will request the PS&R report from DMS. This step involves the review and adjustment of Medicaid days/visits, charges, and payments to the paid claims summaries from DMS in order to accurately calculate the appropriate settlement amount.

13. Pediatrics and Nursery Services

The review of pediatrics and nursery services will be done based on Arkansas' Medicaid-specific program. Medicare does not adequately address these areas since they have so little Medicare cost. Cost, charges, and statistics need to be identified for nursery and pediatric units so that Medicaid can set appropriate reimbursement rates.

While the above list is not comprehensive, it does show the areas on Medicare's hospital UDR program that most frequently impact Medicaid. In addition to those areas, it is common for our state Medicaid programs to have us review other key areas at either the desk review or full-scope level such as related parties. If a contract is awarded to us, we will meet with DMS to compile all of the desk review and full-scope programs and procedures important to Arkansas' program.

14. Additional Cost Validation Procedures for FQHCs

Direct care practitioner salary expense is a significant percentage of the FQHC's total cost, therefore audit procedures may include a step to reconcile salaries reported on the cost report to supporting documentation. Salaries may also be compared to market data to test for reasonableness.

When the hospital or FQHC full-scope audit is complete, the auditor will prepare a summary of findings, including any cost report adjustments proposed. The adjustments will be recorded in the CMS cost report software, including authoritative sources and work paper references. The software will then generate an adjusted cost report. The entire file will be forwarded to senior management for the internal review process. This review will ensure that all steps were properly completed and documented, work papers were appropriately filed and signed, and that the conclusions reached were properly documented. Our procedures have been developed and are continually refined to provide a transparent audit process for the provider and DMS.

At this point, Myers and Stauffer usually sends the preliminary results to the provider for review. As previously stated, we will work with DMS to develop protocol for provider notification. All disputes between the hospital and Myers and Stauffer will be resolved prior to sending a final Medicaid NPR to DMS.

After provider disputes have been resolved, project staff will prepare the appropriate cost settlement calculations and NPRs. We will follow the same tentative and final settlement procedures outlined in the Desk Reviews (2.3.A.7.) section of our proposal and agree to provide all deliverables within the timeframes specified in the RFP.

Additional Audit Functions (2.3.A.9.)

Myers and Stauffer understands that we will incur the cost of common audit functions to the extent that such activity would normally be undertaken for the Title XVIII purposes. We also understand that the cost of audit work required by DMS for Title XIX purposes and not routinely undertaken for Title XVIII

purposes shall be charged by Myers and Stauffer to DMS. We have provided a discussion of our understanding and approach to performing desk reviews and full-scope audits in the Desk Reviews (2.3.A.7.) and Full-scope Audits (2.3.A.8) sections of this proposal. These discussions include approaches to minimize and/or eliminate non-duplicative work between functions undertaken for Title XVIII purposes. The RFP also includes a note to see section 2.3.G of the RFP. See the Ad-Hoc Projects (2.3.G.) section of this proposal for a discussion on our approach to completing ad-hoc projects.

Myers and Stauffer agrees to perform a reconciliation of the PS&R report for Title XIX data. This reconciliation is typically performed during both a desk review and a full-scope audit. However, project staff will be available to assist with additional reconciliations upon request from DMS.

Myers and Stauffer agrees to perform resolution of disputed cost report adjustments and that we will not charge DMS for audits performed to correct errors made by Myers and Stauffer, which results in the reopening of cost reports.

Myers and Stauffer agrees to perform other audit activity expressly related to the Title XIX programs as required by federal regulation or directives or as requested in writing by the Director of DMS or other DMS designee. Our project team has experience in performing various types of audit with respect to the Title XIX program and are accustomed to developing appropriate audit procedures that accomplish the goals and objectives of the audit. As other audit requests are made, our project team will meet with DMS to obtain an understanding of the needs of DMS.

Based on the information gathered, we will determine if the audit will be completed as an AUP or examination engagement. Once this has been determined, we develop draft procedures and submit to DMS for review. We will conduct a meeting to review the draft procedures with DMS and answer any questions. Final procedures will be developed based on feedback from DMS. We will work with DMS to develop an agreed-upon timeline for completing the work and will begin work as soon as official approval has been received by DMS. Once the review/audit has been completed we will prepare a document of our findings and a report, which will be reviewed by senior management prior to submitting to DMS.

Myers and Stauffer agrees to report any information discovered in the performance of the audit functions which impacts the Arkansas Medicaid Program to DMS designee. This notification will be sent electronically within five business days of discovery.

Myers and Stauffer agrees to respond to written inquiries at the administrative level in writing. We will notify DMS in writing if additional time is needed to prepare a response. Based on our understanding, this function is something typically performed by the MAC. Our project team will work with DMS to obtain a better understanding of this requirement and develop an agreed-upon process for responding to written inquiries at the administrative level in writing.

Myers and Stauffer understands that we will be liable for all adverse actions, losses, or damages resulting from any errors made by Myers and Stauffer staff.

Cost Report Audits and Analysis: Nursing Homes and Intermediate Care Facilities (E.4)

As the current subcontractor performing desk reviews and full scope audits of nursing homes and intermediate care facilities in Arkansas, we have a thorough understanding of the rate setting process and guiding cost reimbursement principles, as outlined in the Arkansas Long-Term Care Manual. We have cultivated a rapport with DMS and providers which has fostered a cooperative relationship built on a foundation of transparency, reliability, and accuracy. The organic nature of our relationships have resulted in the successful implementation of processes to ensure DMS deadlines are met and the rate setting process continues unimpeded. In addition, we continue to consult with DMS and bring to the forefront cost trends and risk areas identified through the completion of our analytics, which have a significant impact on Medicaid reimbursement throughout the state. We understand the importance of being more than an audit firm, and take seriously our role as experts in health care reimbursement to promote efficiencies in the Medicaid program.

Myers and Stauffer agrees to provide the following:

- *By the first week of December, complete desk reviews of all 12-month and short-period nursing home cost reports submitted in mid-September.*
- *Complete desk reviews of all new nursing homes within two months of their submission.*
- *Complete desk reviews of all state-operated Human Development Centers, Arkansas Health Center, and private large ICFs within six weeks of their bi-annual cost report submission.*
- *Complete desk reviews of all small private ICFs within six weeks of their submission.*
- *Following the rate setting of nursing homes in January, we shall, in collaboration with DMS, commence the planning, selection, and implementation of expanded reviews for eight to 10 current year nursing homes cost reports. These expanded reviews shall be completed by September.*

The requirements of the RFP contain various levels of desk reviews, cost-settlement activities, and on-site audits. Myers and Stauffer has assisted numerous states in developing cost report validation processes that maximize the benefits of those reviews, while minimizing unnecessary or unproductive steps that increase the costs of the services.

The initial step in developing an effective cost report validation process is to obtain a thorough understanding of the reimbursement system in place for the type of program subject to the review. This development begins with a detailed review of the State plan, administrative rules, cost reporting

process, rate setting/settlement process, DHS Medical Assistance Program Manual of Cost Reimbursement Rules for Long-Term Care Facilities, and discussions with the Medicaid officials leading these programs. Upon absorbing this information, we develop desk and field audit guides that are customized according to the risks inherent in the state's Medicaid rate setting methodology.

Our team recommends a streamlined approach that subjects cost reports first to a desk review. Then, if the desk review process reveals significant risk factors, an increased level of scrutiny through a full-scope audit is recommended. Experience shows a desk review is generally sufficient in situations where:

- *The provider has low Medicaid utilization.*
- *The ability to effect reimbursement for that provider through a cost report review, based on the reimbursement system in place, is limited.*
- *Historical experience with the provider has resulted in few, or minor adjustments.*
- *The existence of high-risk transactions appear to be limited.*
- *Analytical review of the provider's report does not identify any significant risk areas.*

The audit guide we develop will thoroughly outline the process for both desk and full-scope audits. We envision that this two-level audit process will include AUP review conducted for desk audits, and an examination process followed for full-scope audits. The audit guide will include programs, work papers, and standard report forms for both the desk and full-scope audits. The audit guide will then be communicated to DMS for review. Myers and Stauffer will incorporate DMS' feedback into the final version of the audit guide. Only after the procedures have been agreed to for the various program types does cost report review begin.

In order to ensure a high quality product that is delivered in a timely and cost-effective manner, these AUPs will be revisited on at least a yearly basis and revised as needed. Trends within the state, adjustments from the prior year, the value derived from procedures, as well as anticipated changes within the health care industry will all be considered when determining any necessary revisions. We propose to continually analyze trends in cost data which will allow us to take a proactive approach to our reviews as providers continue to search for avenues to maximize reimbursement.

While the procedures and levels of review will be determined and finalized only after a thorough evaluation of the programs and consultations with DMS staff, it is our team's experience that these types of engagements are most efficient and effective when they include both desk reviews, which are limited in their scope and audits, which offer a more comprehensive review.

Desk Reviews

As previously discussed, the specific procedures related to each type of program will vary based on the risk factors present within each program. Typically, a cost report desk review will contain at a minimum

the following types of procedures to further validate the cost report and assess whether a more intensive expanded review is warranted:

- *Medicaid cost report totals comparison to prior year.*
- *Reviewing past desk reviews or limited scope verifications to determine if prior period reporting errors appear to be present in the current period cost report.*
- *Patient day statistics comparison to prior year.*
- *Per diems comparison to prior year.*
- *Reconciling the cost report to supporting financial information (working trial balances [WTB] or audited financial statements), if available.*
- *Tracing revenues and cost from the WTB to the cost report and scanning for non-allowable or misclassified costs.*
- *Reviewing analytical profiles and investigating unusual relationships or large changes from prior periods.*
- *Checking for inconsistencies in the application of Generally-Accepted Accounting Principles, or Medicare and Medicaid regulations, policies, and procedures.*
- *Ascertaining the presence of any related-party transactions, management fees, or complex capital transactions.*
- *Determining if there has been a change of ownership or control of the facility.*
- *Preparing and reviewing preliminary rate or settlement worksheets to assess relationships to reimbursement limitation and Medicaid program dollars at risk.*
- *Discussing the results of the previous steps with a manager or supervisor and finalizing our review procedures.*
- *If necessary, recommending to DMS that the cost report undergo an increased level of review.*

The accountants assigned to this project are experts in Medicare and Medicaid allowable cost definitions, as well as the underlying reimbursement methodologies for the provider types they audit. Myers and Stauffer's review/audit process has migrated to a paperless environment where working papers are stored using electronic audit software. The software includes standard work paper filing procedures, tick mark legends, checklists, and other tools to promote consistency in our deliverables. We have developed processes which allow our staff to focus on the analyzation and scrutiny of data, as opposed to being burdened by overly-cumbersome administrative functions often associated with audit documentation and record retention.

After our accountant completes the desk review, the file undergoes a two-step management review. The first step consists of a detailed review of each work paper to confirm the desk review program steps were properly performed and that internal quality control procedures were followed. Any exceptions detected during this review are noted and discussed in detail with the accountant during a review meeting. Exceptions are addressed by the accountant, and the desk review proceeds to the final review.

The second step confirms that the initial review was thorough and properly documented. Upon completion of the review procedures for a cost report, a draft report is prepared. These reports shall include a cover letter describing the engagement and cost report under review; adjustment report covering the findings of the desk review; detailed support for each adjustment; as well as a summary of impact the adjustments have on Form 6 Schedule of Expenses.

Throughout the process of completing desk reviews for existing nursing homes, Myers and Stauffer will provide weekly updates to DMS. These updates will detail the facilities under review, the progress of each review, any additional information requests, and any major issues that merit the attention of DMS.

Full-Scope Audit

After the rates are set on January 1, Myers and Stauffer will work with DMS to begin selecting a sample of 12-month cost reports for expanded review. The expanded reviews will further test cost report compliance with cost reimbursement principles and will be selected considering both professional judgement and quantified metrics. Issues that are unable to be resolved during the desk review, but noted as a basis for possible expanded testing, will also be considered in this section. We have successfully developed processes and automated systems to efficiently and effectively obtain the greatest benefit for our clients using a cost-effective full-scope audit approach. This approach recognizes the nuances specific to the Medicaid program and focuses resources towards identified areas of risk.

While the specific metrics used will be determined in collaboration with DMS, our experience shows the following metrics may be useful:

- ***Medicaid spending impact.*** *This metric combines Medicaid utilization and the facility rate to determine the amount Medicaid will pay out to the facility during the year.*
- ***Direct care ceiling impact.*** *This metric measures the facility's impact on the direct care ceiling. As this ceiling can impact multiple facilities, identifying the facilities that have the largest impact helps verify the accuracy of the ceiling and helps control Medicaid spending.*
- ***Indirect care median impact.*** *This metric identifies facilities that are below the indirect care median in the prior year and above it in the current year. Verifying the accuracy of reporting for these facilities helps ensure the class rate is set accurately and helps control Medicaid spending.*

- ***Direct care per diem increase.*** *The direct care rate is an area of high risk, as it is reimbursed at cost. Facilities with large increases in the direct care rate may need to be selected for expanded review to ensure the added costs comply with cost reimbursement principles.*
- ***Low quality to high direct care impact.*** *Higher direct care spending should lead to an increase in resident quality of care. Using publicly available nursing home compare data, we are able to identify facilities that have low quality ratings and match that with facilities that also have high direct care cost. Better understanding the circumstances surrounding these facilities helps ensure that DMS is directing Medicaid funds where they will be best utilized.*

All of the metrics identified above also serve to identify trends occurring within the Medicaid program, giving DMS an opportunity to implement new policies as necessary. Myers and Stauffer will perform more analysis on an ad-hoc basis as requested by DMS in order to ensure all trends and issues are identified in a timely manner.

Myers and Stauffer's audits begin with development of an overall strategy to determine the scope of the review. Audit planning activities help to form a preliminary assessment of the nature, timing, and extent of auditing procedures considered necessary to formulate an opinion on the fair presentation of the cost report (in accordance with GAAP and the appropriate regulatory authorities, including federal and state guidelines).

Given the unique circumstances surrounding the novel COVID-19 pandemic, we acknowledge that fieldwork or on-site visits may not always be prudent. Before any field visit is initiated, we will thoroughly evaluate the current operational environment and consult with the provider and DMS. Full-scope audits begin with a determination of whether provider representations on the cost report are in agreement with provider records. Preliminary procedures assist in obtaining an understanding of the provider's control environment, accounting system, and control procedures. An assessment of control risk helps determine the nature, timing, and extent of testing to be performed.

An audit selection process that maximizes benefits realized from the full-scope audits is most beneficial. Like the desk review process, audits are performed using risk analysis, issue investigation, report preparation, and review. The primary difference between desk reviews and audits is the amount and level of evidence examined, as well as the documentation needed to support cost report amounts.

Myers and Stauffer's cost report examinations accomplish two primary functions:

- *Examine each identified risk area so the risk of cost report misstatements is reduced to an acceptable level.*
- *Develop sufficient appropriate audit evidence to provide a basis for an auditor's opinion on the Medicaid cost report in accordance with the rules governing the Arkansas Medicaid program.*

Beginning in January each year, Myers and Stauffer will work closely with DMS to develop the full-scope audit program, questionnaire, and standard work papers required for the audit. We will also develop a separate program for each of the provider types to address differences in risk areas and cost reporting requirements.

Myers and Stauffer's programs are developed in accordance with a risk-based approach to auditing and the procedures will be reviewed with DMS before continuing with the expanded review. The program will contain "Inquiry and Standard Testing" and "Additional Testing" for each audit area. The inquiry and standard testing steps have been developed to assist the auditor in quickly assessing the reasonableness (material correctness) of the provider's cost report. Although this testing is generally performed using only the information provided with the cost report or produced as part of a standard accounting package, it allows assessment of the risk that the cost report could be materially incorrect in each audit area.

If the results of the standard testing indicate that material cost report misstatements may be present, additional testing occurs so these risk areas are thoroughly examined. The additional testing steps provide the auditor with guidance for this examination. When necessary, the auditor will request additional information from the providers to resolve material issues. Myers and Staffer emphasizes its goal of limiting additional information requests to those cases that are truly justified.

By following this risk-based cost report review process, state Medicaid agency customers receive a high level of confidence that material cost reporting errors have been detected and corrected, while minimizing interruptions and information requests to the health care providers.

Our discussion of the processes we will use in completing each full-scope audit engagement is organized into three components:

- *Pre-field (audit planning) activities.*
- *Field site visit activities.*
- *Post-field/report preparation activities.*

Pre-Field "Audit Planning" Activities

Immediately on receipt of an audit assignment, Myers and Stauffer contacts the provider and establishes dates for the site visit. We have a standard scheduling letter used to inform the facility of records and personnel that need to be available at the time of the visit. Concurrently with the audit scheduling, the project manager will assign an in-charge auditor and an appropriate number of additional senior and staff auditors, matching audit assignments with staff expertise to properly perform the engagement.

Before the site visit, the audit team assigned to the engagement will obtain and familiarize themselves with relevant documents, which include the following:

- *Medicaid financial and statistical report.*
- *Medicare cost report.*
- *Provider's or Accountant's cost report preparation work papers.*
- *Prior year cost report and cost report audit reports.*
- *Provider's WTB used to prepare the cost report.*
- *Independent audit report, if applicable.*

Having access to these documents helps the audit team become familiar with the provider and identify risk areas that will require additional audit analysis during the site visit.

As discussed in the previous section, desk reviews are performed on cost reports before being scoped for a full-scope visit. Many of the pre-field procedures will be performed during the desk review process and the audit team will review the results of the desk review and complete any additional pre-field/planning steps. The pre-field/planning section of our audit includes the following procedures:

- ***Reviewing the desk review program and work papers.***
- ***Reconciling revenues and expenses to the WTB and performing analytical review procedures.*** *This procedure assists in identifying cost report issues that need to be further analyzed during the field audit.*
- ***Reviewing analytical profiles to assist our staff in identifying deviations in the cost report from industry norms and past cost report filings for the provider.*** *The auditors typically produce profiles that assist in identifying deviations in provider reporting for each cost report line item. They also look at the following expense account groupings as part of our analytical review procedures; salaries and wages, depreciation and interest, other expenses, patient days and revenue, and allocation statistics.*

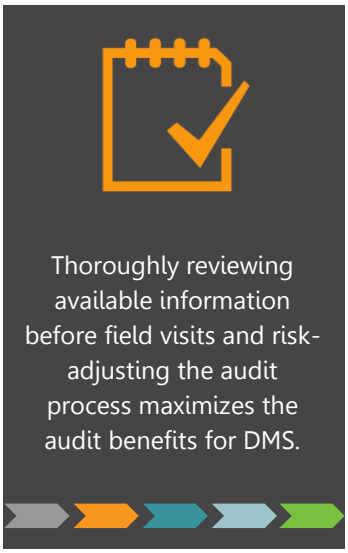
The accountants will then note in a planning memo the items or risk areas they have identified during the performance of each of these audit steps.

An in-depth, expert level of understanding of the reimbursement system and rate development is critical to properly performing audit planning. Team development protocols include intensive training on reimbursement systems and properly assessing the risk of cost report misstatements and misclassifications on the reimbursement rates generated from our audited cost data.

For example, reported per diem costs must be compared to screens or limits to determine where the provider's costs are being limited. This allows the auditor to assess the potential benefits of misclassifying reported costs to shift them into an area that is not limited by the screen.

The accountant in charge and assigned staff meet with the project manager to verify that pre-field activities were properly performed and that risk was accurately assessed. These meetings allow more senior personnel to develop appropriate audit strategies for complicated and often technical reimbursement issues.

To thoroughly examine risk areas identified, the audit processes are tailored to each specific audit issue. Myers and Stauffer frequently adds questions to its entrance interview questionnaire to obtain additional representation from facility management.



Myers and Stauffer may also change its standard audit program to perform additional or expanded testing to examine unique audit risk issues.

Full-Scope Audit (Site Visit) Activities

Full-scope audit (site visit) activities are designed to provide the audit team with a consistent approach to auditing the cost report. Specific procedures have been developed for each segment of the audit. The following discussion addresses typical site visit audit activities. Specific site visit steps will be contained in the audit program approved by DMS. As previously stated, these procedures will be conducted remotely until approval from DMS is provided to enter into nursing facility and/or home office buildings. The effectiveness of the full-scope audit is not reduced due to the remote nature.

To assist in evaluating the audit process, we have provided brief discussions of the typical full-scope audit (site visit) activities for the following:

- *Entrance interviews.*
- *General ledger/trial balance testing.*
- *Census and revenue testing.*
- *Allocation statistic testing.*
- *Home office/related organization testing.*
- *Payroll (salary and wage) testing.*
- *Non-salary expenses.*

- *Exit conference.*

Entrance Interview

At the start of each field visit, auditors will conduct an entrance interview. This allows them to accomplish the following:

- *Gain additional familiarity with the provider's operation, records, and internal control environment.*
- *Confirm the availability of records requested in the scheduling letter.*
- *Inquire about the issues (risk areas) identified during the pre-field procedures.*

For other Medicaid cost report audit projects, Myers and Stauffer uses interview questionnaire forms designed for each provider type. We propose to use similar questionnaires for DMS audits. Additional questions will be added to the questionnaire based on the risk areas identified during the pre-field review.

At the beginning of the site visit, the auditor typically requests a tour of the entity, which helps us identify areas of the facility not used for health care activities (for example, to determine if a nursing facility also provides adult day care). If evidence of adult day care is observed during the tour, they will then verify that this business activity has been properly reflected in the Medicaid cost report. They also look for evidence of new construction, additions/deletions of assets, and when appropriate, if allocation statistics using square footage reasonably agree with the actual facility layout.

The tour also provides an opportunity for the auditors to raise additional questions to further their understanding of the facility being audited. For instance, if a nursing facility provider has a distinct room for physical therapy, the auditor might ask if facility staff provide this service or if the facility contracts with a physical therapy company. The knowledge gained from the tour is then used to further refine the subsequent audit steps.

General Ledger/Trial Balance Testing

After the questionnaire is completed, testing begins. This testing centers on verifying that the pre-field information agrees with the facility's general ledger and other subsidiary ledgers. Auditors trace the WTB amounts to supporting general ledger information and determine that records requested in the scheduling letter have been produced. Any exceptions detected during this portion of the audit are discussed with the provider.

Unit and Revenue Testing

Auditors typically combine their testing of routine revenues and patient days, visits, or units because the volume of routine services provided is directly related to the revenue generated. By combining the testing in these two areas, auditors take advantage of the audit effort from this direct relationship. The

following figure, a standard audit worksheet, shows how this works. Computerized worksheets assist staff members in performing testing procedures, foster consistent application of the audit, and promote mathematical correctness.

By recording residents per month by payer type and the rates charged to each group, the auditor can quickly recalculate routine revenues and total census days. This worksheet helps staff identify issues such as discounting to non-Medicaid customers, non-routine revenue being improperly recorded as routine, and incorrect reporting of Medicaid or total patient days or units.

In this section of the audit, the auditor also will perform the following:

- *Review non-routine revenues and confirm that revenues have been used to reduce allowable cost when required by regulations.*
- *Look for revenues associated with non-health care services and then verify that the cost report properly reflects these services. For example, an examination of revenues will help detect if the facility's dietary department is preparing meals for another entity, and if so, whether the associated costs have been removed.*
- *Review and test patient census records to confirm that only allowable days of care are recorded and reported on the cost report, as shown in the figure on the following page.*

As potentially non-allowable costs or other adjustments are identified during the performance of audit testing, we will discuss these items with the provider. This gives the provider an opportunity to investigate the issue and be prepared to further discuss the issue at the exit conference.

Report of Patient Census Records

MYERS & STAUFFER

W/P INDEX 600.4

PREPARED BY TGM
REVIEWED BY
W/P DATE 12/15/11
RUN DATE 01/16/12
NAME OF W/P RSDY

PROVIDER NUMBER N/A
PROVIDER NAME XYZ, Inc.
PERIOD ENDED 06/30/11
SOURCE OR ACCOUNT

Resident Days

MM/YY	Census Days	Adj.	Adj. Days	Private Days	Medicaid Days	Other Days	(a) Private Rate	Medicaid Rate	(a) Other Rate	Private Revenue	Medicaid Revenue	Other Revenue	Total Revenue
Jan-98	1,643		1,643	282	1,094	267	102.00	95.14	203.00	28,764	104,083	54,201	187,048
Feb-98	1,548		1,548	268	1,051	229	102.00	95.14	203.00	27,336	99,992	46,487	173,815
Mar-98	1,675		1,675	249	1,250	176	102.00	95.14	203.00	25,398	118,925	35,728	180,051
Apr-98	1,524		1,524	187	1,125	212	115.00	95.14	203.00	21,505	107,033	43,036	171,574
May-98	1,569		1,569	126	1,279	164	115.00	95.14	203.00	14,490	121,684	33,292	169,466
Jun-98	1,641		1,641	100	1,423	118	115.00	95.14	212.00	11,500	135,384	25,016	171,900
Total			9,600	1,212	7,222	1,166				128,993	687,101	237,760	1,053,854
Per Cost Report			9,600	1,170	7,264	1,166							
Difference			0	42	-42	0							
% of Cost Report			0.00%	3.59%	-0.58%	0.00%							

Reconciling Items to Revenue:

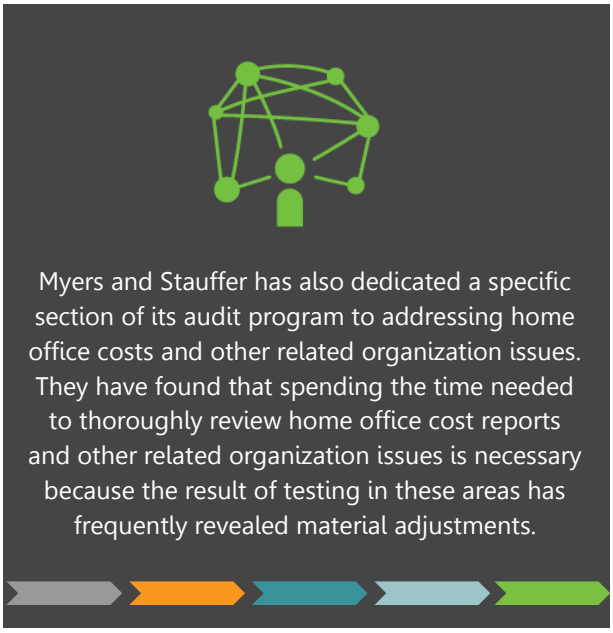
	0	0	0	0
	0	0	0	0
	0	0	0	0
	0	0	0	0
	0	0	0	0
Adjusted Routine Revenue	128,993	687,101	237,760	1,053,854
Total Routine Revenue per Cost Report	129,768	688,952	236,956	1,055,676
Difference	(775)	(1,851)	804	(1,822)
% of Cost Report	-0.60%	-0.27%	0.34%	-0.17%

Comments:

(a) See AR Room Rate Master PBP in expandable

Home Office/Related Organization Testing

Myers and Stauffer's process for reviewing home office cost reports replicates the testing procedures discussed in this portion of our proposal (Employee/Owner's Compensation, Property, and so on). Its audit processes are designed to confirm that costs reported on the home office cost report are allowable, and that allocation of these costs to each facility is appropriate.



Home offices often include non-reimbursable costs at the home-office level and attempt to allocate this cost to their facilities as allowable facility-level cost. Another area of concern relates to expenses, such as interest. Auditors need to verify that the provider is not including facility-related mortgage interest expenses in the home office cost and also reporting them as administrative and general home office-related cost on the facility's cost report. Obviously, this reporting scheme will circumvent the Medicaid capital asset reimbursement process.

Payroll (Salary and Wage) Testing

Auditors typically combine their testing of employee payroll expenses with owner's compensation. Myers and Stauffer has developed standard worksheets to assist its staff in performing the audit testing in these areas. They test total payroll using the worksheet shown in the following figure.

Payroll Worksheet

MYERS AND STAUFFER — WORKPAPER INDEX 900.2

		PREPARED BY	JMB
PROVIDER NUMBER	N/A	REVIEWED BY	
PROVIDER NAME	XYZ, Inc.	WORKPAPER DATE	12/15/2011
PERIOD ENDED	6/30/2011	RUN DATE	01/15/12
SOURCE OR ACCOUNT	941's	NAME OF WORKPAPER	RCPR

Payroll Reconciliation

Quarter MM/YY	Gross Payroll	Percent of Period	Current Period Payroll Amount	FICA 7.65% Percent	FUTA 0.80% Percent	SUTA 1.50% Percent	Total Payroll Tax
Mar-99	345,275	100.00%	345,275	26,414	2,762	5,179	34,355
Jun-99	366,050	100.00%	366,050	28,003	2,928	5,491	36,422
Sep-99	362,572	100.00%	362,572	27,737	2,901	5,439	36,076
Dec-99	368,278	100.00%	368,278	28,173	2,946	5,524	36,644
			0	0	0	0	0
			0	0	0	0	0
SUBTOTAL	1,442,175		1,442,175	110,326	11,537	21,633	143,496
RECONCILING ITEMS							
Less Beg. Accruals:			(69,725)	(7,112)	(725)	(1,350)	(9,187)
Plus End. Accruals:			92,674	7,268	760	1,390	9,418
Other: (401K, etc.)							
		Total	1,445,124	110,482	11,572	21,673	143,727
		Per C/R	1,443,694	110,850	11,683	21,234	143,767
		Diff.	1,430	-368	-111	439	-40
		% Diff	0.10%	-0.33%	-0.95%	2.07%	-0.03%

Comments:

Differences appear reasonable. No further testing necessary.

Besides performing the testing addressed in this worksheet, Myers and Stauffer typically performs the following for employee compensation and owner's compensation:

- *Trace payroll cost for a sample of pay periods from the payroll register to the general ledger, verifying that there has been no cost shifting between payroll departments and that rates of pay and deduction to net pay are reasonable.*
- *Scan W-2s and the payroll registers looking for owner and owner-related party compensation.*
- *Verify that hours worked according to the payroll documents agree with amounts reported on the cost report.*

Non-Salary Expenses

During the pre-field planning processes and other audit verification procedures, auditors identify the expense accounts that require additional audit emphasis. They focus their review in this segment of the audit on the examination of these accounts to determine the source of their concerns and then to ultimately determine if the costs are allowable and properly reported within the Medicaid cost report.

By focusing their examination on these risk areas, they increase the quality and value of the audit effort. These focused examinations are typically performed using judgmental sampling techniques. Besides the risk-adjusted focused sampling, they typically also conduct some random sampling of accounts and expenses. This random sampling of provider cost is performed to confirm their understanding of the control environment and to generate sufficient competent evidential matter for expressing their opinion on the cost report.

Exit Conference

Before leaving the field, the audit team conducts a final meeting with the provider to discuss the findings and questionable costs identified during the field visit. This step in the audit process is extremely effective in reducing the frequency of challenged findings and appeals. The audit staff is instructed to allow sufficient time at the end of the field visit to thoroughly discuss the proposed adjustment areas before leaving.

The audit team then returns the provider's records and a detailed listing of any additional information needed to complete the audit. The results of the meeting are documented in the work papers.

Post Field/Report Preparation Activities

On return from the field visit, team members meet to discuss any audit issues with the project manager to confirm that the audit was conducted in accordance with the firm's quality control policies and that audit areas and risk issues were properly addressed and documented. The meeting also is a planning session for completing the audit process.

Following the post-field meeting, the audit team completes the audit and prepares the draft report, which is guided by standard work paper filing procedures, tick mark legends, checklists and other tools to verify consistency between audits and across time.

After the audit is completed, the team performs a two-step management review. The first review includes an initial detailed review of each work paper to confirm that the audit program steps were properly performed and that internal quality control procedures were followed. Any exceptions detected during this step are marked for correction and then addressed by the audit team before proceeding to the final review.

The purpose of the final review is to verify that the initial review was thorough and properly documented in the file. On completion of the review procedures, the appropriate accountants report is

issued. Myers and Stauffer will work with DMS to develop the appropriate reporting mechanisms for each type of provider under review.

On completion of the expanded review procedures for a cost report, a draft report is prepared. These reports shall include a cover letter describing the engagement and cost report under review; adjustment report covering the findings of the expanded review; detailed support for each adjustment; as well as a summary of the impact adjustments have on Form 6 Schedule of Expenses.

Appeals

Myers and Stauffer provides timely and accurate audit, desk review, Medicaid reimbursement rate, and settlement information. Occasionally, providers take exception to Myers and Stauffer's findings and file an appeal. The nature of provider's exceptions may include disagreements regarding the allowability of costs, the classification of costs, or the treatment of statistical or other rate or settlement variables.

Project staff members assigned to the DMS engagement have expert-level understanding of Medicaid reimbursement processes and requirements and knowledge of the issues under dispute. They are available to assist in the resolution of each provider appeal.

Their assistance includes preparing additional analyses, performing additional research of reimbursement criteria, and preparing pro forma reports to evaluate the issue(s) under appeal. When the appeal cannot be resolved in an informal setting, Myers and Stauffer staff will be available to consult with DMS staff and legal representatives. Staff will be available to provide testimony at administrative or judicial hearings. Project managers have experience providing expert testimony at appeal hearings.

Besides providing professional services such as cost report audits, rate setting and settlement appeals, Myers and Stauffer is frequently engaged by Medicaid agencies to assist in large class action appeals. When necessary, Myers and Stauffer will draw on the full resources of the firm to assist DMS in responding to these actions.

Cost Report Data Analysis

Project team members will be available to assist DMS in preparing nursing home cost report data analysis on an ad-hoc basis to identify trends and issues impacting the State Plan. One example is the current regulation that classifies the expense for cable television in a resident's room as non-allowable. Given the significant impact of COVID-19 on nursing facility residents and the social distancing requirements, DMS may want to evaluate this regulation. Project staff could prepare an analysis of current cable television expenses reported on Form 6, Line 5-13 and the impact of changing the regulation to recognize this as an allowable expense.

State Medicaid Disproportionate Share Hospital Payment Calculations (E.5)

The calculation of DSH eligibility and payments requires an in-depth knowledge and understanding of the applicable state and federal laws, regulations, policies, and procedures. We currently calculate DSH payments on an annual basis for 14 state Medicaid programs. We are also currently engaged by 42 Medicaid programs to perform the DSH audits as required in the December 19, 2008, Federal Register. We understand that DSH is only one financing mechanism states use to help fund Medicaid and uninsured. Our experience with looking at all areas of state Medicaid financing allows us to consider the "big picture" when discussing potential changes or modifications to DSH. Our experience in assisting states beyond DSH includes CPE programs, IGT programs, UPL calculations, and provider taxes. We are committed to increasing our knowledge, understanding, and expertise related to DSH and other state financing matters. In addition, the Patient Protection and Affordable Care Act (PPACA) DSH reductions slated to begin in December 2020, will need to be considered in future DSH payment methodology changes. It will be important that Arkansas ranks higher than other states in targeting DSH payments to Medicaid and uninsured to limit their exposure to reductions in the DSH allotments.

Myers and Stauffer will determine the DSH eligibility and calculate the payments in accordance with the Arkansas Medicaid state plan and applicable federal regulations. We will accomplish the project tasks by using experienced DSH staff, computer software and hardware applications, and maintaining ongoing and constant monitoring of DSH-related issues utilizing a number of sources.

Data Collection

The first step in developing the DSH eligibility and payment models for a state usually involves meeting with the state and reviewing the state plan to determine the data sources to be used in the annual DSH models. In Arkansas, we anticipate utilizing the current DSH questionnaire included with the annual cost report and the statistical and reimbursement data reports from DMS as data sources for the DSH eligibility and payment calculations. We will continue to use the cost report ending in the prior SFY for the current DSH payment calculations year as required in the state plan. On an annual basis, we will submit a list of hospitals to DMS by March 1 to obtain the necessary statistical and reimbursement data reports to be used in the DSH payment calculations.

Should the State decides to change data sources in the future, Myers and Stauffer can assist with best practices, including the potential use of a single survey for the DSH examination and the DSH payment calculation, as is done in several states. Using a single survey can streamline the process and reduce the burden of data collection on hospitals and the state. The greatest benefit of a single survey is the ability to control or limit DSH overpayments since the same data sources are being used in the audit and payment processes.

After all data is collected, our staff will begin importing the data into the DSH eligibility and payment models to be delivered to Arkansas. Based on the RFP, there will be at least the following four models developed:

- *In-state acute hospitals.*
- *Border city acute hospitals.*
- *In-state psychiatric hospitals.*
- *In-state pediatric hospitals.*

When importing data into the DSH eligibility and payment models, Myers and Stauffer will utilize our internally developed data extraction software tools and the cost report software application, Health Financial Systems (HFS), if possible. This process also allows us to minimize the number of steps and staff time involved in extracting cost report data and eliminates error-prone manual processes. There may still be some manual data extraction depending on the format of all data received.

During the data extraction/import processes, analytic procedures will be applied to various key fields such as Medicaid-eligible days to determine whether any of the data being reported is inconsistent with key parameters or prior years, if possible. Any data irregularities will be flagged and follow-up with the providers or DMS will be completed to validate the data.

Apply Federal Regulations

After importing all key data sources into the DSH eligibility and payment models, our staff will apply all applicable federal regulations against each hospital's eligibility and DSH payment calculations as part of each model.

The DSH adjustment was established by Congress in 1981 as a provision of the Boren Amendment. It was intended to provide protection for hospitals, specifically hospitals with large caseloads of low income and uninsured individuals. Over the years, there has been a series of legislation that have defined, refined, and limited states' use and implementation of the DSH provisions, including:

- *The OBRA of 1986, which stated that the Health Care Finance Administration (now CMS) had no authority to limit payment adjustments to DSH hospitals.*
- *The OBRA of 1987, which defined which hospitals, at a minimum, must be included.*
- *The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, which established the first upper bounds on DSH payments.*
- *The OBRA of 1993, which sought to better target DSH hospital payments and set limits on the amounts of DSH payments individual hospitals would be allowed to receive.*

- *The Medicare Prescription Drug Improvement and Modernization Act of 2003, which among other changes included a requirement that states submit a detailed annual report and an independent certified audit on their DSH payments to hospitals.*

While efforts at the federal level have been made to control total DSH expenditures, states still have considerable flexibility in designing their reimbursement systems and determining how available funds are distributed. Current federal DSH program requirements can be summarized into three general categories:

- *Federal DSH Eligibility.*
- *Federal Facility-Specific Payment Limitations.*
- *Aggregate State DSH Payment Limitations.*

Federal DSH Eligibility

Federal DSH eligibility requirements establish mandatory coverage groups and set minimum requirements standards below which a state cannot designate a hospital as a DSH facility. Federal DSH eligibility requirements are located in Section 1923(b) and (d) of the Social Security Act (SSA). Hospitals that must be designated "deemed" as a DSH facility are required to meet or exceed one of two eligibility standards, the Medicaid inpatient utilization rate (MIUR) or the low-income utilization rate (LIUR) eligibility requirement. Hospitals that qualify for DSH under either test must receive a DSH payment adjustment. The requirements for DSH payment adjustments are contained in Section 1923(c) of the SSA.

In addition to these minimum DSH eligibility requirements, Congress also created restrictions on the maximum number of hospitals states could deem as DSH facilities. State Medicaid agencies are allowed to expand the number of hospitals that qualify for DSH, but are not allowed to deem a hospital as a DSH facility unless its MIUR is equal to or greater than one percent. The hospital must also have two or more obstetricians (OB) with staff privileges who have agreed to provide OB service to individuals eligible under the state plan. The latter requirement is waived for children's hospitals and for hospitals not offering non-emergency OB services in 1987.

All of the MIUR, LIUR, and OB federal eligibility requirements will be verified as part of the DSH models. While Arkansas has their own unique eligibility criteria in the state plan, the models still must ensure none of the hospitals violate the above-noted federal requirements.

Federal Facility-Specific Payment Limitations

A hospital cannot receive DSH in excess of their calculated DSH payment limitation in accordance with Section 1923(g) of the SSA. The payment limitation is referred to as the hospital's UCCs and includes Medicaid-eligible cost, less all sources of payment and uninsured costs, less patient payments. The DSH models will always include a check of the final calculated DSH payment against the DSH payment

limitation to make sure no hospital exceeds their limit. This federal limitation is consistent with the DSH payment limit established in the Arkansas state plan.

Aggregate State DSH Payment Limitations

Each Medicaid agency must also comply with aggregate DSH payment limits. This limitation is referred to as the state's DSH allotment. Section 1923(f) addresses the DSH allotments for each state. This section of the SSA identifies the maximum amount of federal funds available for each state to use in their DSH program. Congress put additional restrictions on the DSH allotment in Section 1923(h) limiting the amount of the state's DSH allotment that can be directed to IMD to no more than 33 percent of their annual DSH allotment. In the case of Arkansas, the IMD allotment is further limited to the 1995 IMD and mental health DSH expenditures. Per the RFP, the Arkansas DSH models will limit the DSH expenditures to the previous SFY's Medicaid DSH total allotment and any adjustments from CMS. The IMD DSH payments will also be verified against the total available IMD DSH allotment.

Apply Arkansas State Plan Criteria

We will prepare preliminary DSH eligibility and payment calculations in accordance with the Arkansas state plan criteria for the State's review and approval. The payment calculation models will include a statewide mean Medicaid utilization rate (MUR) calculated based on the Arkansas state plan. Rural and urban hospitals' DSH qualification will be verified against the MIUR and LIUR criteria, as required by the Arkansas state plan. OB requirements, as discussed previously, will be verified.

Arkansas has specific DSH payment calculation criteria based on the hospital pool and, in some cases, how the hospitals qualify (MIUR or LIUR). Those criteria will be built into each DSH payment model so that it is transparent to DMS how all DSH payments were calculated.

Myers and Stauffer will calculate the hospital-specific limit for all hospitals determined to be qualified for a DSH payment. We will compare the calculated payment to the hospital-specific limit and ensure any payment in excess of the limit will be reduced according to the state plan criteria. The total DSH payments will be compared to the DSH allotment and the DSH caps in the Arkansas state plan. The excess payments will be reduced proportionately across all providers.

We understand our DSH eligibility and payment calculations will have to distinguish between different criteria for rural and urban hospitals and other classes including acute, psychiatric, rehabilitative, teaching, and border hospitals. For Arkansas, we will prepare the following four separate eligibility and DSH payment models noted in the RFP annually.

- *In-state acute hospitals.*
- *Border city acute hospitals.*
- *In-state psychiatric hospitals.*

- *In-state pediatric hospitals.*

Review Data

All data used in the DSH eligibility and payment calculations, and the actual calculations themselves, will be subjected to review based on AUP programs. The programs for each hospital pool will be agreed upon with DMS prior to being implemented. The review procedures typically include, but are not limited to, analytic procedures such as the following:

- *Reviewing payment-to-charge ratios.*
- *Reviewing missing obstetrician names.*
- *Reviewing eligibility status changes.*
- *Reviewing changes in LIUR and MIUR.*
- *Reviewing changes in UCCs and hospital cost.*
- *Reviewing changes in DSH payments.*

We will review DSH payment calculations and methodologies for compliance with the approved state plan. Once the DSH calculations have been completed by project staff, the spreadsheets will be reviewed by the Project Managers. Managers will check the accuracy of the file, evaluate the reasonableness of the data, and ensure the state plan/regulations have been applied correctly. Before the spreadsheet is delivered to the DMS, management not involved in the preparation will perform the final review.

For most states, Myers and Stauffer sends out a DSH payment notification letter to each hospital after the DSH eligibility and payment review is complete so that they can review the final DSH payment determination and submit additional documentation if needed. If requested by DMS, Myers and Stauffer will prepare a notification letter for each eligible DSH hospital that will be in the format approved by DMS. We will forward the letters to DMS for review and distribution 90 days prior to the final submission. Myers and Stauffer will make revisions to the letters as requested by DMS. Hospitals are normally provided a short amount of time to review the results and respond with any additional documentation. Myers and Stauffer would then use the additional documentation, if any, to make the necessary changes to the DSH payment models.

Final Deliverables

Myers and Stauffer will complete and submit a final DSH eligibility and payment model to DMS for each hospital pool as follows:

- *In-state acute hospitals.*
- *Border city acute hospitals.*

- *In-state psychiatric hospitals.*
- *In-state pediatric hospitals.*

The DSH eligibility and payment calculations will be completed and submitted to DMS by May 31 annually.

Myers and Stauffer's DSH payment models will clearly document why providers were qualified for DSH and how the payments were calculated, as well as the source documentation. Myers and Stauffer will provide this documentation to DMS and any authorized contractors, including their DSH auditors.

Myers and Stauffer will assist DMS with any appeals that are filed as a result of the annual DSH eligibility process and will revise calculations, as necessary, as a result of successful appeals. Myers and Stauffer will be available to assist DMS with its review of the federal DSH reporting and auditing requirements. We will work with DMS to help ensure Arkansas' DSH program continues to comply with federal requirements. Our extensive experience with designing and implementing DSH payment methodologies with other state programs also allows us to suggest some of the best practices we have seen in other Medicaid programs.

Demonstration Payment Limit Calculations (E.6)

Myers and Stauffer has more than 25 years of experience in preparing UPL demonstration models for nearly 30 state Medicaid agencies. We have demonstrated the technical knowledge and skill necessary to prepare these UPL demonstrations, ensured their compliance with federal regulations, and satisfied all CMS reporting requirements. We also bring to this project the knowledge we have amassed regarding other Medicaid programs' approaches to UPL calculation strategies and mitigation techniques for common areas of CMS inquiry. We also assist clients with preparing UPL analyses included in SPA submissions, as well as writing those SPAs and preparing the related fiscal impact analyses. We provide support to those clients throughout the SPA approval process, including assisting in responding to CMS questions related to the SPA and UPL demonstration.

Our team also has decades of experience with relevant Medicaid financing techniques, including IGT and CPE programs and health care provider taxes (or assessments). We have assisted many states in identifying federal revenue enhancement opportunities and developing provider payment strategies, including approaches and methodologies for calculating and administering supplemental payments, and the funding mechanisms and compliance requirements that accompany such programs. We have assisted our state Medicaid agency clients with hospital, nursing facility, and other provider assessment projects since enactment of the provider assessment and donation regulations. We have assisted numerous states with their pursuit of waivers of the broad-based and uniformity requirements of the provider assessment regulations.

This experience has allowed us to become familiar with numerous approaches to developing UPL analyses and provider assessment models. It has also allowed us to become familiar with approaches acceptable to CMS. We have assisted clients for many years with these financing programs, several of which have successfully undergone considerable scrutiny and audit by CMS and the OIG. We anticipate providing DMS with consulting, analysis, and support for the operation of these programs. Our proposed services include maintaining an understanding of Medicare payment principles (including evolving interpretations by CMS and OIG), developing reasonable and defensible methodologies to facilitate the application of Medicare principles to Medicaid payments, calculating the UPL amounts for applicable provider categories to support program objectives and required federal assurances, and calculating the assessment amounts associated with the state's hospital funding program.

At this time, states continue to have considerable flexibility in developing their UPL analysis. Currently, UPL analyses can be cost-based, follow Medicare PPS methodologies, payment to charge, or various other methods. In any case, the Medicaid program must prepare analyses showing the estimated amount the state would have paid for the covered service using Medicare payment principles. States should be aware that if they elect the inpatient PPS system, they can also include Medicare DSH payments in the UPL calculations. We regularly assist our clients in selecting the methodology most appropriate to support their specific objectives. Our goal for previous engagements has been to develop a defendable UPL calculation that is consistent with the Medicaid state plan, maximizes the Medicare and Medicaid rate differential, and supports federal leveraging opportunities.

Despite the historical flexibility afforded to states, the proposed Medicaid Fiscal Accountability Regulation would have established in regulation detailed specifications relating to data sources, data time periods, and calculation methodologies for demonstrating compliance with UPL requirements. These changes would have codified in regulation the approaches and methodologies already deployed by many states, such as cost-based and payment-based methods. However, the regulation did not appear to accommodate other reasonable methodologies some states have used that may not conform to the prescribed methodologies, but yet generate a reasonable estimate of Medicare payment.

On September 14, 2020, CMS Administrator, Seema Verna, announced the decision to rescind the proposed regulation. Despite the withdrawal of the regulation and the pending change in national leadership following the 2020 elections, states will continue to face the potential for regulatory changes that affect UPL demonstrations. A critical function of our work is to monitor developments that may impact our clients. Whether it is regulatory changes, the differing policies of a new administration, or the impact of other factors, such as the on-going COVID-19 pandemic, we will constantly monitor developments that impact our work and stand ready to provide our clients with timely and effective guidance.

Overview of Upper Payment Limit Demonstrations and Assessment Fees

DMS is seeking a contractor to assist the state in the annual calculation of UPL demonstrations for purposes of determining hospital access payments and emergency medical transportation access payments and for compliance with CMS UPL requirements. The contractor will also assist the state in calculating the annual assessment fees for privately owned and operated hospitals.

UPL Demonstrations

Based on our extensive experience preparing UPL demonstrations and our in-depth knowledge of Medicare reimbursement policy, Myers and Stauffer is able to develop UPL models using a variety of methodologies for all the provider types required by CMS. The following provides a summary of the various UPL methodologies we have utilized for our existing clients.

Inpatient Hospital Services

- ***Medicare discharge.*** *In this option, Medicaid utilization data and hospital financial data would be used to complete the analysis. Medicare and Medicaid payments and discharges are aggregated by hospitals to compute a Medicare and Medicaid payment per discharge. Medicaid utilization is classified into Medicare DRGs using the Medicare grouper in order to assign Medicare relative weights and calculate the Medicare CMI for Medicaid services. Medicare and Medicaid CMI values are used to case mix-adjust the per-discharge amounts.*
- ***Medicare PPS.*** *Under this methodology, the estimated Medicare payment is computed using Medicare PPS payment policies. Beyond the PPS DRG payments, the comparison can also include capital payments, medical education payments, outlier payments, Medicare DSH payments, and any other additional reimbursement subject to the UPL determination.*
- ***Inpatient costs.*** *A third UPL approach uses total allowable Medicaid costs. Medicaid costs are identified using information contained in facility cost reports. The estimated UPL will be computed using Medicare cost principles, including capital and medical education costs. The UPL is limited to the lower of the cost of the service or the usual and customary charge. This model may also permit the following costs for tertiary services owned by the hospital: home health/hospice services, nursing facility services, medical school costs, physician costs, and transportation costs.*
- ***Medicare payment to charge/cost.*** *Another approach to determining a reasonable estimate of the Medicare UPL is to calculate the ratio of Medicare payments to either Medicare billed charges or costs. The ratio is then applied to the corresponding Medicaid billed charges or cost to determine the UPL.*
- ***TEFRA targets.*** *The computation of the Medicare UPL can be based on the Medicare payment methodology known as TEFRA, which specifies the computation of hospital-specific target rates and rates-of-increase. TEFRA was used by Medicare as a reimbursement methodology for all*

hospitals during the transition from retrospective cost reimbursement to the PPS. Medicare continues to use TEFRA principles to reimburse hospitals and units exempt from the PPS.

Outpatient Hospital Services

- ***APC.*** *The APC model is based on Medicaid utilization data and hospital financial data. Using a version of the 3M APC grouper, Medicaid utilization is classified into Medicare APCs. The estimated Medicare payment is computed using Medicare APC payment policies. Similar to the inpatient PPS model, it may be permissible to include the Medicare shortfall (the difference between APC reimbursement and costs) to the APC reimbursement, essentially using all allowable outpatient costs as the Medicare payment amount.*
- ***Outpatient costs.*** *A second model may be developed using total allowable Medicaid costs. Medicaid costs would be identified using information contained in facility cost reports. The estimated Medicare payment will be computed using Medicare cost principles to calculate allowable Medicaid cost. Current provider opinions suggest that Medicare APC payments are a reduction from previous cost settlements. Therefore, a cost-based model is likely to be a more financially-beneficial model and an easier comparison to complete.*
- ***Medicare payment to charge/cost.*** *Another approach to determine a reasonable estimate of the Medicare UPL is to calculate the ratio of Medicare payments to either Medicare billed charges or costs. The ratio is then applied to corresponding Medicaid billed charges or cost to determine the UPL.*

ICF/IID Services

- ***ICF/IID costs.*** *This model is developed using total allowable Medicaid costs. Medicaid costs would be identified using information contained in the facility cost reports. The estimated Medicare payment will be computed using Medicare cost principles to calculate allowable Medicaid cost. It has been well established that ICF/IID cost UPLs use a factor of 112 percent of cost to determine the limit.*

Nursing Facility Services

- ***RUG-IV-based Medicare PPS.*** *Medicare's PPS is an acuity-based, pricing system with a specific rate paid for each resident based on the resident assessment classification and the facility's urban/rural designation. Under the PPS option, MDS assessment data is used to determine the appropriate RUG classification and Medicare PPS rate for each Medicaid resident. Myers and Stauffer has all available grouper software necessary to determine the appropriate RUG-IV classification for each assessment. Individual resident PPS rates are aggregated to determine a facility average estimated Medicare PPS rate. Because the PPS rate is all-inclusive, an analysis to determine coverage differences between Medicare and Arkansas Medicaid will need to be completed. These coverage differences typically include services such as pharmacy, laboratory,*

and radiology. The average per diem Medicaid payment will be adjusted upward to account for services covered and reimbursed by Medicare through the PPS rate, but not within the nursing facility per diem rates. It may also be necessary to make an adjustment for Medicaid leave days, as Medicare does not pay for leave days.

- ***Patient-Driven Payment Model (PDPM) Medicare PPS.*** *In July 2018, CMS released the fiscal year 2019 Skilled Nursing Facility PPS final rule, which required the use of PDPM for payment of Part A Medicare stays in nursing facilities effective October 1, 2019. PDPM has replaced the RUG classification model that has been used for decades. PDPM is a paradigm shift in how Medicare determines reimbursement for residents. The data needed by states to classify Medicaid patients into PDPM groups is not currently available to states on OBRA assessments and will not be so until October 2020. CMS has allowed states to continue to use RUGs-based UPL demonstrations until the time that Medicaid can fully transition to the PDPM system. Myers and Stauffer developed a method of using data presented in the final SNF rule to inflate RUG rates to the current UPL year. We used these updated RUG rates to assist clients in preparing RUG-based UPL demonstrations due to CMS in June 2020. This same method can be used to allow Arkansas to continue its RUGs-based UPL calculations. Once data is available, we will assist the State in transitioning to a PDPM UPL demonstration if the State determines this approach best meets your objectives.*
- ***Cost-based and other alternative calculations.*** *There are occasions when a PPS UPL methodology fails to produce a favorable demonstration. In these cases, we explore alternative methodologies such as cost-based or payment-based calculations to produce the most favorable demonstration available for our clients. Our considerable experience working with nursing home UPL demonstrations enables us to create the best available alternatives to address the needs of our clients.*

Qualified Practitioner Services

- ***Average commercial rate.*** *Because a cost-based UPL is not feasible, Medicare allows the physician UPL to be based on applicable commercial rates. Medicaid claims data, usually limited to state owned or operated facilities, is re-priced using average commercial rates by Current Procedural Terminology/Health Care Common Procedure Coding System (CPT/HCPCS) code. Dental services can be included in this calculation.*
- ***The Medicare equivalent of the average commercial rate.*** *Medicaid claims data is re-priced using the Medicare Physician Fee Schedule by CPT/HCPCS codes. Then a ratio of average commercial payments to Medicare payments is used to calculate the upper limit of the supplemental payment. This ratio is multiplied by the Medicare payment for all CPT/HCPCS codes eligible for the supplemental payment.*

Clinic Services

- ***Ambulatory Surgical Centers (ASCs).*** *Comparison of the Medicaid ASC payment rate by HCPCS code to the Medicare ASC fee schedule. For HCPCS codes that are not on the Medicare ASC fee schedule, other Medicare fee schedules can be used, such as the Medicare Physician Fee Schedule non-facility rate, Medicare DME, Prosthetics, Orthotics, & Supplies (DMEPOS) fee schedule, or Medicare average sales price (ASP) fee schedule.*
- ***Renal disease providers.*** *Comparison of the Medicaid dialysis payment per treatment to the average Medicare payment per treatment for the state. The Medicare payment per treatment is published in the Medicare provider level impact file associated with the annual Medicare end stage renal disease final rule.*
- ***Other clinic providers.*** *Comparison of the Medicare payment rate by HCPCS code to Medicare fee schedules (Medicare Physician Fee Schedule and other fee schedules, as applicable). In addition, states often cover and reimburse clinic services that are not covered by Medicare and thus not present in any Medicare fee schedules. For these services, CMS permits states to identify a reasonably-equivalent Medicare code for purposes of the UPL demonstration comparison.*

Psychiatric Residential Treatment Facility Services

- ***Provider customary charge.*** *Under this model, Medicaid payments are compared to providers' usual and customary charges, which are the UPL. Unlike other UPL demonstrations, the PRTF UPL is a comparison on a facility-specific basis, rather than by ownership type (privately owned and operated, non-state government owned and operated, or state-owned and operated).*

Ambulance Services

- ***Ambulance cost.*** *This model is developed using total allowable Medicaid costs. Medicaid costs would be identified using information contained in the ambulance provider cost reports. The estimated Medicare payment will be computed using Medicare cost principles to calculate allowable Medicaid cost. A typical approach is to apply the allowable cost per trip to Medicaid trips.*
- ***Average commercial rate (or Medicare equivalent).*** *This approach utilizes the applicable commercial rates for ambulance services. Medicaid claims data is re-priced using the Medicare fee schedule by CPT/HCPCS codes. Under the Medicare Equivalent option, a ratio of average commercial payments to Medicare payments is used to calculate the upper limit of the supplemental payment. This ratio is multiplied by the Medicare payment for all CPT/HCPCS codes eligible for the supplemental payment.*

Durable Medical Equipment

- ***State payment rate to Medicare rate comparison****. This UPL methodology is a payment-based approach in which Medicaid DME rates are compared to Medicare rates from the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies fee schedule or Medicare competitive bidding single payment amounts. The comparison is done through a side-by-side comparison by HCPCS code of the Medicaid payment to the Medicare payment, taking into account modifiers impacting payment, such as purchase and rental modifiers. Depending on the state's methodology, the analysis may also incorporate the geographic location of the service in order to apply the Medicare rural rate, non-rural rate, or competitive bidding amount.*

Hospital Assessment Fees

Federal regulations permit states to impose health care-related taxes (assessments) on health care providers and services and utilize the funds generated from the assessment to finance the non-federal share of Medicaid program expenditures. Medicaid programs utilize funding generated from provider assessments for a variety of purposes, including reimbursement rate increases, supplemental payments, quality incentive payments, Medicaid expansion costs, budget shortfalls, or to fund other aspects of the Medicaid program. While federal regulations permit health-care-related assessments on a range of providers and services, the most frequently assessed entities nationally are those that provide the highest volume of Medicaid services, including hospitals (inpatient and outpatient), nursing facilities, ICF/IID, and MCOs.

Through our experience with hospital assessment programs nationally, we have been involved with all aspects of the programs, from initial design and development to implementation and ongoing maintenance. We assist our state Medicaid clients with all aspects of hospital assessment programs, including:

- *Reviewing the state's Medicaid funding structure for hospital payments and identifying the state's goals for the hospital assessment program, e.g., shore up budget shortfalls, fund existing payments, provide increased payments, or support broader initiatives such as Medicaid expansion or quality improvement programs.*
- *Evaluating the feasibility of assessments across the permissible provider "classes" in federal regulations.*
- *Analyzing data requirements, data sources, and the availability of data for calculating the assessment.*
- *Preparing calculation models to help the state and stakeholders evaluate options for the structure of the assessment, including elements such as the assessed unit (beds, days, discharges, revenues), assessment rates, assessment tiers (differing tax rates), and included and exempted providers.*

- *Preparing financial analyses of the funding levels generated by the assessment and calculating the impact to the State and to providers.*
- *Developing the statistical models needed to demonstrate that the assessment program meets the criteria for obtaining a federal waiver of the broad-based and uniformity requirements and compliance with the safe harbor threshold.*
- *Providing support for CMS review of waivers.*
- *Participating in, or leading meetings and work group discussions with, State staff and various stakeholders, such as providers and provider representatives.*
- *Developing operational procedures for levying and collecting the assessment, such as the frequency and method of collection, provider responsibilities for remitting payment, tracking payment compliance, penalties for non-compliance, and appeal rights.*
- *Assisting with maintaining assessment programs after implementation, including collecting data, updating or rebasing calculations, and communicating assessments to providers.*
- *Monitoring assessment collections and comparing to projections and funding needs.*
- *Assisting with modifications to the structure of the assessment program after implementation.*

Methodologies for hospital assessment programs vary depending on the state's programmatic and budgetary needs and objectives, input from hospitals, legislators and other stakeholders, and provider reimbursement and assessment collection considerations. Hospital assessment programs often impose the assessment on hospital revenues, such as a percentage of gross revenues or net patient revenues. Other methodologies levy the assessment on a non-revenue basis, such as on the number of beds, number of discharges, or the number of patient days.

Proceeds from hospital assessments are typically used for providing increased reimbursement to hospitals or to replace existing supplemental payment mechanisms. Hospital assessments are also used to generate funding for expanding Medicaid coverage. Some states retain a portion of the assessment funds to be used for other state Medicaid expenditures.

Approach to Upper Payment Limit Demonstrations and Assessment Fees

Our approach to assisting our clients with UPL demonstrations, supplemental payment calculations, and provider assessment fees is as follows:

- ***Gather necessary data.*** *To perform the annual UPL, supplemental payment, and assessment calculations, we will need to collect various data elements from the state, from providers, from the paperless workflow system, and from Medicare rate files. We will obtain MMIS claims data (for payment and utilization statistics) from DMS or its data warehouse contractor and provider listings from DMS. For providers that file cost reports with the Medicaid program, we will obtain*

their cost report data from the paperless workflow system. Medicare CMI data and fee schedule rates will be obtained from the Federal Register, Medicare public use files, and Medicare fee schedules. For private ambulance providers, average commercial rate data will be obtained through access payment data collection forms. Throughout all provider categories, ownership information (privately owned and operated, non-state government owned and operated, or state-owned and operated) data will also be required.

- ***Prepare UPL, supplemental payment, and assessment calculations.*** *Based on the various data sources, we will calculate the UPL demonstrations across all required provider categories, including the access payments for inpatient and outpatient hospital services and ambulance services. We will also prepare the annual hospital assessment calculation based on net patient revenue.*

  We anticipate preparing the UPL demonstrations, access payment calculations, and hospital assessment model based on the state's current methodologies, and if applicable, Medicaid state plan requirements. For example, we will ensure the private hospital access payment calculations follow the methodology described in the state plan and include eligible hospitals only. The hospital assessment model will be prepared following the state's current net patient revenue method. If requested, Myers and Stauffer will review options with DMS and develop analyses for your evaluation to determine if alternative UPL, access payment, and assessment model approaches would benefit the state. Once final methodologies have been agreed upon, project staff will prepare the UPL demonstrations and submit to DMS.

- ***Prepare materials for UPL submission to CMS.*** *Myers and Stauffer will assist DMS in preparing all material required for submission by CMS. Currently, CMS requires (or may require) the following items prior to UPL demonstration approval:*

  - *Submission of a UPL guidance document. The guidance document (or narrative document) provides substantial details relating to the underlying methodology and calculation of the UPL demonstration. It identifies the data source, the base rate, and payment information periods used in the calculation, as well as information pertaining to state funding resources.*
  - *Supporting rate documentation. CMS may require states to submit additional detailed rate or payment calculation support prior to UPL demonstration approval.*
  - *CMS-required UPL demonstration templates and notation. CMS is requiring states to complete a UPL demonstration template for each required UPL demonstration. These standard templates require additional notation to identify how current UPL demonstrations are cross-walked to required template fields.*

- ***Assist with correspondence with CMS.*** *The Department may receive questions or requests for additional information from CMS following the submission of your UPL demonstrations. We will*

assist in addressing these issues and drafting replies to CMS. Our services and commitment to a state do not end when the final UPL demonstration is delivered. We take pride in working with our state clients through the CMS acceptance process. We will leverage our years of experience communicating and defending UPL demonstrations to CMS, and will provide our guidance and professional expertise in order to ensure the process is as smooth as possible.

- ***Keep DMS abreast of UPL issues raised by CMS.*** *Our project team members prepare UPL demonstrations for multiple states and are continuously responding to questions raised by CMS. As new issues are raised by CMS, project staff will identify any possible concerns in the state's UPL methodology that may raise questions from CMS. All concerns will be communicated to DMS, along with alternative methodologies and/or strategies to address our concerns.*
- ***Keep DMS updated on changes in Medicare reimbursement policy and CMS requirements for UPL demonstrations and provider assessments that may affect future UPL demonstration and assessment models.*** *Health care, and in particular, health care provider reimbursement, is a dynamic field that will continue to evolve significantly over time. Assigned key project staff are members of firm-wide practice area leadership groups that, in part, research proposed and finalized changes in Medicare reimbursement and UPL requirements. Key project staff will leverage this expertise and communicate the potential impact of any proposed or finalized changes to DMS. We will work with DMS to mitigate the impact of identified changes through the implementation of acceptable demonstration modifications or the proposal of alternative calculation methodologies.*

We will apply the above approach and methodology in developing the annual UPL demonstrations, access payment calculations, and assessment models. For Arkansas, we will prepare the following calculations annually as noted in the RFP:

- *In-state acute hospitals.*
- *Border-city acute hospitals as identified in the Arkansas Medicaid State Plan.*
- *In-state psychiatric hospital residential treatment units and sexual offender programs.*
- *In-state pediatric hospitals.*
- *In-state teaching hospital.*
- *ICF-IID.*
- *Nursing homes – private, state-operated, non-state operated.*
- *Qualified practitioner services.*
- *Clinic services.*
- *PRTF.*

- *Private ambulance.*
- *DME.*

We understand the access payment and supplemental payment calculations must be completed by September 30 to allow sufficient time for DMS to review, plan for, and begin making quarterly access payment calculations. Any requests for modifications to the calculations will be completed within 14 days of the request from DMS. We recognize the timeframes for initial calculation of the access payments are dependent on the receipt of complete and accurate claims data from DMS' data warehouse contractor.

For purposes of compliance with CMS UPL submission requirements, we will provide DMS with final draft UPL demonstrations by April 30 of each year. We will provide to DMS the final UPL demonstration files, including required UPL guidance and templates, by June 1. The DME UPL operates on a different timeframe, with the initial UPL demonstration due March 1, and the final UPL demonstration due to DMS March 15.

The state's current UPL methodology for inpatient hospital services for privately owned and operated and non-state government owned and operated hospitals requires a calculation of the CMI of Medicaid services under the Medicare Severity Diagnosis Related Groups (MS-DRG) system. Myers and Stauffer has extensive experience with DRG grouping software, including the MS-DRG grouper. We are a working partner with 3M Health Information Systems (a common supplier of inpatient and outpatient grouping software). We maintain all forms of DRG grouper systems and supporting data and are able to generate the required CMI calculations.

Arkansas State Plan Amendment Revisions: Supplemental Payments and Provider Fees (E.7)

Myers and Stauffer will assist DMS with revisions to the Arkansas Medicaid state plan as needed for changes to the state's supplemental payment programs. Myers and Stauffer is accustomed to developing SPAs, fiscal impacts of proposed changes, and other documentation needed to support DMS reimbursement program changes and obtain CMS approval. Myers and Stauffer understands both the functions and the timing required to memorialize all policy changes through the formal CMS approval, and we are committed to always meeting, and when possible, exceeding performance and timeliness expectations.

Our team's understanding of CMS expectations and deep knowledge of CMS preprints and templates will ensure SPAs we support are properly developed, tracked, and submitted in accordance with state and federal requirements. Examples of support we anticipate providing DMS may include:

- *Collect information throughout our research to inform planning, such as identifying similar requests made by other states to confirm the SPA is the correct federal authority, or to identify pending regulatory changes that may impact the requested amendment. We will consider and raise required federal authorities throughout the design process so that DMS is aware of how certain decisions may drive need for specific approvals (e.g., SPA versus waiver).*
- *Facilitate planning meetings with DMS' team to gain consensus on the amendment being requested, finalize the policy approach, and follow up on next steps.*
- *Plan for meetings with CMS to discuss the amendment, including preparing talking points or other materials, attending the meeting, and helping to facilitate the discussion.*
- *When applicable, prepare Medicare UPL demonstration analysis to ensure the state continues to comply with federal requirements and not jeopardize federal funding.*
- *Conduct a fiscal impact analysis for the CMS-179 form.*
- *Support drafting of public notices, facilitating public hearings, and compiling public comments.*
- *Finalize the SPA for submission to CMS, and respond to CMS inquiries and negotiations.*

There are numerous issues that CMS can raise during its review of SPAs. The state must be prepared to address CMS' questions in order to obtain approval of the plan amendment. Myers and Stauffer has worked closely with states and CMS on various state initiatives. We have participated in meetings, discussions and negotiations with CMS on a variety of subjects, including reimbursement rate changes, supplemental payments, UPL tests, provider assessment programs, SPAs, DSH policies, federal funding policies, and new grant initiatives. We have an in-depth understanding of the relationship between states and CMS. We have assisted many state Medicaid agencies in compliance with federal regulations and CMS policies and obtaining approval of state plan authorities.

Paperless Workflow (E.8)

Myers and Stauffer fully supports the goal of DMS to provide a shared paperless workflow system to exchange information in a secure environment. With new technologies and the evolving demands of effective program management, there is a greater emphasis placed on IT and the development of centralized, comprehensive databases in order to operationalize reimbursement methodologies and provide necessary financial analyses for state policy makers. As such, we employ an extensive in-house software development and data analysis team that creates and maintains our internal and external-facing software solutions that reduce overhead, automate work flows, standardize processes, and ensure optimal efficiency.

Our proposed solution will allow upload and electronic storage of documents, which includes at a minimum, cost reports, work papers, provider correspondence, provider supplemental documents, and

other document types. To accomplish a shared paperless workflow, our system will utilize our in-house developed secure web-portal and CCH ProSystem fx Engagement an off-the shelf software.

Myers and Stauffer has extensive experience designing and developing secure web-based technical solutions to meet our clients' complex and ever-changing needs. Our team of developers have built customized tools that allow for effective project management, timely data analyses, program monitoring, and regular and ad-hoc reporting. We host many secure web-based data collection and storage portals on behalf of states to ensure robust tracking and communication mechanisms are in place to effectively manage project deliverables and provide relevant data and reporting. These solutions support our clients across a variety of long-term and acute care projects. Our firm regularly interfaces with the Medicare cost reporting forms and relevant state-specific Medicaid cost reporting forms and schedules in both a rate setting and audit/review capacity. As such, we understand the importance of appropriate tracking and communication functionality, data storage and retrieval/extraction capabilities, and system security and control to protect state and provider information. These systems have been developed to specifically facilitate these efforts and allow for secure, real-time interaction between state-authorized users, providers, and other related external entities.

Upon receipt of cost reports and supporting documentation through the secure web-portal, our engagement team will utilize CCH ProSystem fx Engagement for electronic work paper completion and storage. This platform allows all work papers included in the desk reviews and full-scope audits to be maintained in multiple file types, organized in a logical and efficient manner, stored for whatever period of time is required by our clients, and easily transferred to our proposed Arkansas web portal or other web-based transfer tools preferred by DMS. This will allow us to tailor the delivery of a complete set of work papers at the end of each examination to DMS' specifications. Our project team currently uses CCH ProSystem fx Engagement to complete our current nursing home and ICF desk review contractual requirements for DMS.

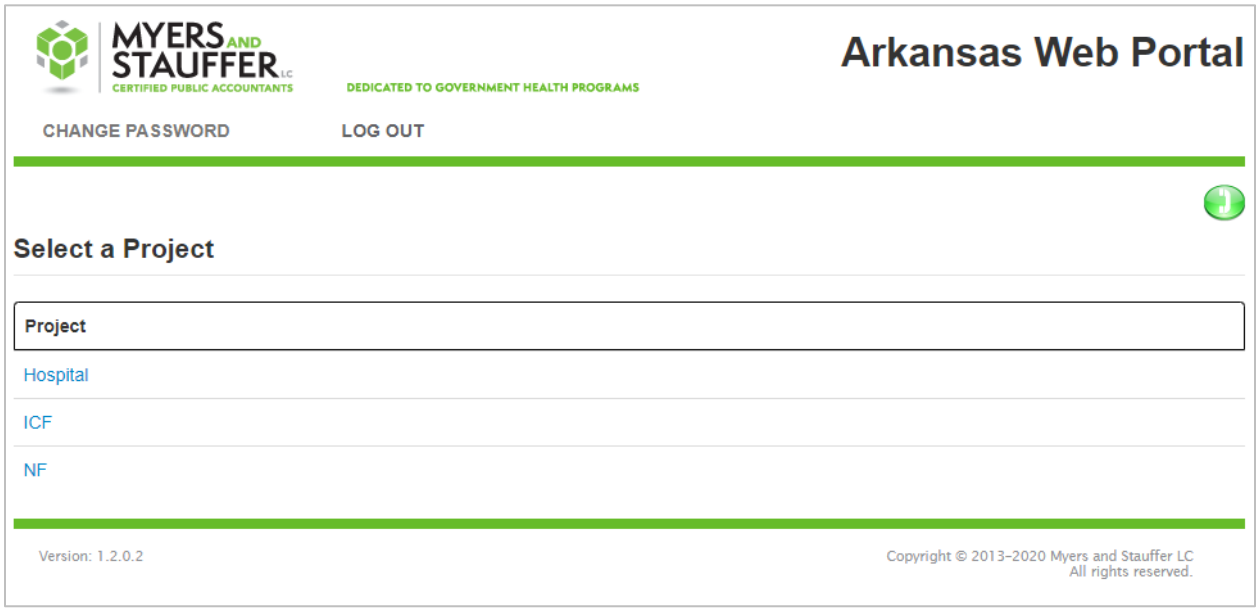
Within the first three months of the contract, we will implement a web-based submission process through a dedicated web portal interface. This interface will allow for a two-way exchange of data between us and providers, and between us and State users. If needed, we can also include a function to allow for a two-way exchange between the State and providers. The web portal will also allow for uploads, downloads, and long term electronic storage of documents. All cost reports, correspondence, supplemental documents, and any other necessary documentation can be transferred and stored on the web portal.

Our web portal also offers the capacity to generate pre-defined and ad-hoc live reports; auto-generated email notifications based on changes of status; the ability to attach files containing protected health information (PHI) and non-PHI; and the ability for the authorized state user and/or provider to review and monitor online submissions. Documents posted online indicate the first and last date retrieved.

Documents are retrievable by a simple click of a button and may be saved to the user's computer. Any file type – Microsoft Excel, Microsoft Word, Adobe PDF, encrypted password-protected zip file, etc. – may be posted to, and retrieved from, the web portal.

User access to the proposed web portal and appropriate credentialing and other security features can interface with other fiscal intermediary and provider-maintenance modules if needed; however, the proposed web portal itself will independently validate and authenticate users and their roles based on an established permission framework within the developed technology. These permissions will allow only certain known users to have read/write capabilities for selected tables within the software, further securing the protocols and processes established. Given an environment where state-authorized users and other authorized users may have system access, establishing appropriate permissions for read/write capabilities is important to ensure the integrity of the system and its results.

Below, we have included a screenshot of what the user will see once they have accessed the portal. Since this interface will be used for multiple provider types, there will be a provider type listing for which the user is authorized to access. Users, both a provider and state-authorized user, can be granted access to more than one provider type.



Once the user chooses the appropriate provider type, they will be presented with a dropdown list of providers they have been given permission to access. Each provider will be linked with the appropriate login ID ensuring the limited access to information. In addition, from the main menu, the user can search for a provider, change a password, and access reports. This functionality is slightly different if the user is a state-authorized user in which they will see a list of all providers based on the provider type chosen at entry. Once a provider has been chosen, they can choose the appropriate fiscal year end date. The

dropdown also displays the engagement type of that year end, which is customizable to meet client-defined designations. Once a cost report has been closed out, the provider and state can continue to access the history of events, also referred to as stat log, for prior cost report fiscal year ends. If there is a change of ownership, our system can be configured to either allow past fiscal year ends to be available to the new owners or start fresh with a new history depending on DMS' needs.

Project staff will work with DMS to identify a standard list of events that will be tracked per engagement type for each cost report submission. This can be customized by provider type. In addition, there is functionality to configure a list of additional events that can be selected and added by certain user groups. Events can also be configured to only show certain roles, such as provider or state-authorized user, to hide unnecessary history. We will work with DMS to obtain approval of these permission protocols. On the following page is a screenshot of a sample provider view. The sample shows Provider B using a December 31, 2019 fiscal year-end that is under a desk review engagement type.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS
DEDICATED TO GOVERNMENT HEALTH PROGRAMS

Arkansas Web Portal

MAIN | SEARCH PROVIDER | CHANGE PASSWORD | REPORTS | LOG OUT

Select Cost Report Period

Provider	Fiscal Year Begin Date	Fiscal Year End Date
09991234 - B - Test Provider	4/1/2019	3/31/2020 - Desk Review

History

Legend

Refresh	Upload	Download	Download PHI	Can't Download PHI	Review is Ok	Review is Not Ok	Needs Review	Comparison	Show File Information	Mark as Not Applicable	Not Applicable

Event Date	Event	Due Date	Response Date	User ID	Action
3/31/2020	Medicare 2552-10 Cost Report (ECR)	8/31/2020		JGAMIS	
3/31/2020	Medicare 2552-10 Cost Report (MCRx)	8/31/2020		JGAMIS	
3/31/2020	Medicare 2552-10 Cost Report (PDF)	8/31/2020		JGAMIS	
5/7/2020	Upload - Medicare 2552-10 Cost Report (PDF)		5/7/2020	Provider User	
3/31/2020	Working Trial Balance (Facility)	8/31/2020		JGAMIS	
3/31/2020	Working Trial Balance (Home Office)	8/31/2020		JGAMIS	
3/31/2020	Depreciation Expense Schedule (Facility)	8/31/2020		JGAMIS	
3/31/2020	Depreciation Expense Schedule (Home Office)	8/31/2020		JGAMIS	
3/31/2020	Grouping Schedule (Facility)	8/31/2020		JGAMIS	

In addition to the tracking of provider submissions, the web portal is capable of tracking desk review, full scope review, and AUP status. Events can be defined to track necessary steps in the desk review/full scope/AUP process, and those dates will be filled in upon completion of the step. Typical steps to track

the status of review work include review start and review complete. Events to track when draft results and final results are sent to providers will be created, and the associated results deliverables will be attached for providers and State users to download and review. Status log reports will be available for on-demand download by State users to allow DMS to easily monitor contract compliance.

We are able to support importation of Medicare cost report data through the use of a third-party product, HFS. The software is a CMS-approved vendor for the creation and submission of validated Medicare cost reports, and licensing allows us to handle all Medicare forms. Instead of rolling out custom modules to platforms, this processing is done via a web service that wraps their application programming interface to bring a consistent methodology for all solutions. HFS provides regular updates to their software to support CMS changes so we are able to handle prior and future versions. The web service is able to extract all data rather than small subsets of data to be a complete picture of the cost report. How we store and version the data is expanded upon later in this section.

Due to the length of time it can take to get a Medicaid cost report form or other Excel cost report form mapped and validated, the following feature would not be available in the first three months of the contract, but would be implemented within the first 12 months. Medicaid cost report forms, including all supplemental forms are “mapped” using a proprietary technology that is highly adaptable to any future changes to the forms. These mappings allow data to be stored in an agnostic structure while offering business rules to be executed with accuracy and efficiency. This allows us to embrace changes to the data collection process as it changes over time. Mappings are versioned in a manner that can either be cosmetic or a change in the data points collected.

We have worked with many clients to showcase our technology and how it reduces risk of managing online cost report systems. There is a high cost to maintaining versions of online entry forms and results in a poor experience, as it forces more provider access accounts to enter the data online and eliminates IT efficiencies at the provider level. Many competitors try to mimic what Excel already does by creating an online medium that ends up producing a report that lacks the transparency and validation that exists inherently within Excel. This means they have to support programming the form interface and reporting services with every change, no matter how small.

In our experience, Excel is the best medium to exchange data in a reliable and efficient manner. Providers can work with Excel offline and exchange forms with other individuals responsible for supplying data. Another advantage is that it supports visual cues/data validation which helps with data quality. We are able to offload the IT development time of changes as non-IT staff can manage the versions without programming. Our mapped Excel forms allow for IT-savvy providers to create processes to auto-fill information in an efficient manner. As versions change, the downstream impact can be very minimal for those that automate.

Most Excel forms support an interface we can expose that would allow users to edit their Excel files in the browser and save progress along the way without having access to Excel. Saved edits are versioned and can be used to download existing entered data. After filling out data offline, users can upload another version and continue editing online if they choose to do so before submitting their final version.

Regardless of the form's data source (Medicare or Medicaid), our database design never has to be altered to handle changes, nor will it ever lose data points when removed from future mappings. A byproduct of this innovative architecture is that we never lose support of importing older versions and data logic to aid in appeals or other reopening events of a completed review.

There is a high degree of flexibility on how data is consumed within the database. All sources support unlimited importing and tracking multiple versions of the data. We will work with DMS to define the import tracking, acceptance criteria, and reporting requirements of each form. A typical example would be how to process an as-submitted cost report. It can be set up in such a manner that the provider can upload as many as-submitted cost reports as needed until DMS reviews and accepts one. After acceptance, the provider can no longer upload other as-submitted files and the database import process can run. During the import process, a series of data checks can occur to ensure it passes all DMS-defined rules. This process can be set up to track as many different types of submissions DMS would like, such as as-submitted, adjusted, and final versions of forms.

Data extraction and reporting is a key component of any system. Within the first 12 months of the contract, we will work with DMS to determine the level of ad-hoc data extraction that is necessary or desired for the project. Depending on the complexity of the State's data extraction needs, Excel-based tools or certain database extraction engines can be created. We understand that quick access to accurate information is necessary for effective program management and policy making, and we have successfully delivered these services to states across the nation.

Ad-Hoc Projects (2.3.G.)

Myers and Stauffer agrees to be available to complete ad-hoc projects that are related to the scope of work for this contract. We have a team of experienced professionals with expertise that covers the health care fields of operation. We combine our expertise in the field with our enhanced knowledge of project management to give you access to a team of professionals who are ready to support you.

Prior to initiating any ad-hoc project, we will work with DMS to obtain an understanding of the goals and objectives of the project and assist in developing a scope of work document. Based on the scope of work document and understanding of the project, Myers and Stauffer will develop a draft work plan and associated fee to complete the project and discuss with DMS. The work plan will identify the activities and milestones for the project including deliverables and due dates. Any necessary revisions will be made to ensure we meet the objectives and timeline of DMS.

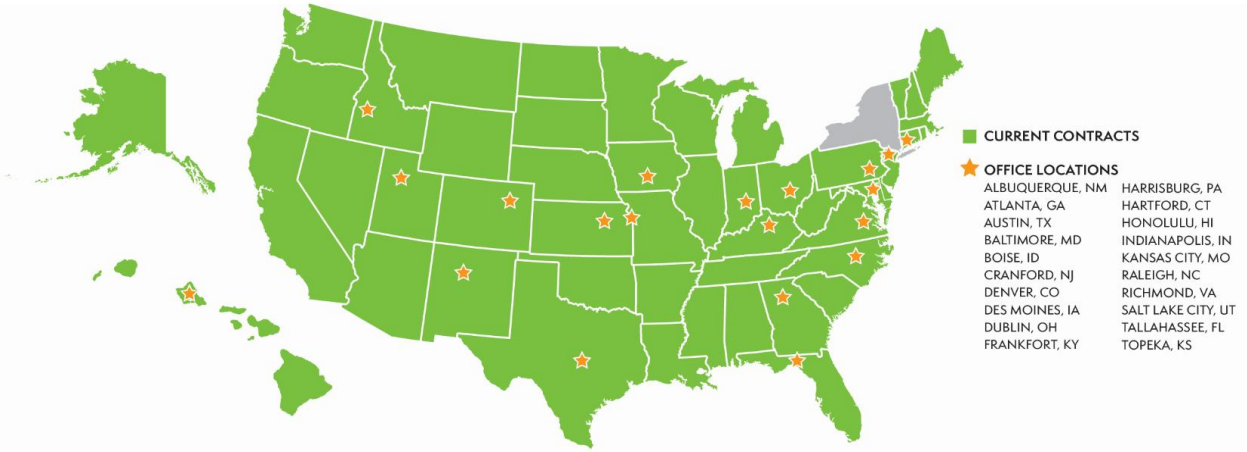
Once the work plan and associated fee has been approved by DMS, project team members will begin work on the project. We will provide written status reports to DMS based on the agreed-upon schedule. Throughout the project, staff will monitor the work plan and timeline and notify DMS staff if concerns or delays should occur. Our work plan will be flexible to meet project requirement changes and to address delays if they should occur. We understand and agree that we must receive approval from DMS whenever the scope, schedule, or budget must be modified.

As tasks are completed, deliverables will be drafted, quality reviewed, and provided to DMS for review. If requested, staff will prepare additional work papers to clarify points addressed in reports and/or deliverables. Comments and/or revisions are then incorporated before final release.

Other Contract Requirements (E.9)

Contract Administrator's Office (2.3.H.1.)

Myers and Stauffer has 20 offices located throughout the United States. Our headquarters, and where this contact would be administered from, is located at 700 W 47th Street, Suite 1100, Kansas City, MO 64112. This contract will be primarily administered from our Kansas City, Missouri office. The map below shows our nationwide presence and states where we are currently contracted.



Software (2.3.H.2.)

Myers and Stauffer does not use other manufacturers' equipment or software to perform the services required in this RFP. We certify that all equipment and software, installation, maintenance, support, personnel, etc. to fulfill the requirements of this RFP and the resulting contract will be provided at no additional cost above the proposal price.

Proposed Progress Report (2.3.H.3.)

Myers and Stauffer will prepare monthly progress reports and submit to the DMS Reimbursement Manager or designee by the 10th of every month, or more frequently if requested. Progress reports will be developed in the format prescribed by DMS and will include the following information, at a minimum:

- *Progress for the prior month.*
  - *Number of cost reports received and processed during the preceding month.*
  - *Field audit activity.*
- *Encountered problems, if any.*
- *Anticipated activities to be completed during the coming month.*
- *Anticipated problems and approaches to those and any support actions or information requested of DMS.*
- *Additional comments, such as reasons for any project deviations from the project schedule.*
- *Summary of activities to date.*

We have provided an example monthly project report on the following page that can be customized to meet the needs of DMS.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Arkansas Cost Report Audits and Upper Payment Limit Calcultaions
Monthly Project Progress Report: (insert month)
Submission Date:

Overall Project Status as of (insert date)

Monthly Progress:

1. Number of cost reports received and processed
2. Field audit activity

Upcoming Activities for (insert month)

1. Week of (insert):

2. Week of (insert):

Key Project Dates (insert month)

No.	Deliverable/Milestone	Due Date	Status	Comments
1.		Insert	Ongoing	
2.		Insert	Ongoing	
3.		Ongoing	Ongoing	

Issues/Concerns/Risks

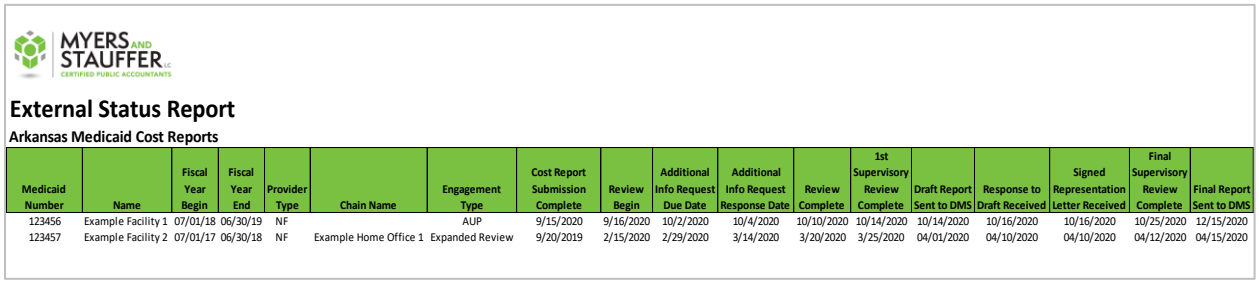
No.	Issue Description and Planned Action	Priority	Resolution Date
1.	***Issue:*** ***Action:***	Medium	Ongoing reporting

To ensure deadlines are tracked and met, status logs that meet the requirements set forth in this RFP will be immediately developed. These status logs will accompany the Monthly Progress Report. Should DMS wish to receive status updates more frequently, DMS personnel will have access to our status log via the secure web-based application, which will enable DMS personnel to see the status of each review in real time.

The status log will be developed in the format prescribed by DMS and will include the following information, at a minimum:

- *Provider number.*
- *Provider name.*
- *Fiscal year-end under review.*
- *Chain affiliation, if applicable.*
- *Review status.*
- *Appeal number, if applicable.*

The status log can also be expanded to include additional information, such as the date the review is assigned, identification of team members assigned to the work, dates of scheduled site visits and exit conferences, and expected dates of receipt of outstanding information from the providers. We understand DMS reserves the right to request additional information and clarification of status reports or timeline information, as needed. DMS may also request that we add other reports or other web-based solutions to accommodate their needs.



MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

External Status Report

Arkansas Medicaid Cost Reports

Medicaid Number	Name	Fiscal Year Begin	Fiscal Year End	Provider Type	Chain Name	Engagement Type	Cost Report Submission Complete	Review Begin	Additional Info Request Due Date	Additional Info Request Response Date	Review Complete	1st Supervisory Review Complete	Draft Report Sent to DMS	Response to Draft Received	Signed Representation Letter Received	Final Supervisory Review Complete	Final Report Sent to DMS
123456	Example Facility 1	07/01/18	06/30/19	NF		AUP	9/15/2020	9/16/2020	10/2/2020	10/4/2020	10/10/2020	10/14/2020	10/14/2020	10/16/2020	10/16/2020	10/25/2020	12/15/2020
123457	Example Facility 2	07/01/17	06/30/18	NF	Example Home Office 1	Expanded Review	9/20/2019	2/15/2020	2/29/2020	3/14/2020	3/20/2020	3/25/2020	04/01/2020	04/10/2020	04/10/2020	04/12/2020	04/15/2020

Approach to Meetings with the State (2.3.H.4.)

Our success is based on providing clients with excellent service on a timely basis. Myers and Stauffer understands that effective, ongoing communication is critical to providing superior client service and believes that communication and planning are essential to a project's success. We offer unfettered communication between our engagement team and DMS leadership throughout the contract period and will promptly respond to calls and correspondence, and participate in meetings as needed with

DMS. Team members will respond to all questions and requests on the same day the request is made, whenever possible.

Our team will facilitate both open formal and informal communications to discuss program status, opportunities, and challenges with a focus on solution building. We prioritize our team's access and availability to Department staff, and offer a full menu of communication options that include telephone, video-conferencing, email, and fax. In addition, we are committed to being accessible to our clients regardless of location; therefore, we will not hesitate to travel to face-to-face meetings with DMS. We understand the need to carefully manage DMS' time and resources and will schedule meeting content and substance accordingly. We will make every effort to properly prioritize and effectively present issues and status according to a specified, approved agenda. Depending on the status of COVID-19 at the time of contract award, our project leadership team will be willing to schedule travel to Little Rock within 30 to 60 days of contract initiation.

We take the time to get to know our clients and understand how they measure success. We believe that face-to-face meetings are essential for effective client relationships and are still the most effective means to gain insight into our clients' operations; however, with recent concerns surrounding the COVID-19 pandemic, we are committed to being flexible with our approach to meet your needs. No matter your preferred method for communication, we are dedicated to a hands-on approach that is proven to build trusting relationships, which is paramount when it comes to financial matters.

Early in the project, we will work with DMS to develop a communication plan that clearly articulates the frequency of recurring project meetings, preferred mechanisms for communicating with DMS, expectations regarding issue escalation, etc. Our practice with new projects is to schedule regular meetings and calls during the project start-up phase. During this phase, meetings usually center on discussing data sources, how to transmit data, provider communications, roadblocks, and other issues that may arise. These meetings or calls are usually held weekly for the initial phase; however, once the project is up and running, the status calls will likely be conducted less frequently, such as bi-weekly or monthly, where an overview of the status of all activities will be provided to DMS. Individual reviews may have separate meeting streams that include more detailed discussions, as needed; however, we believe the periodic engagement status meeting will give DMS an executive view into critical action items and any risks or issues identified, data needs to discuss, approaches to various tasks, and problem-solving options.

Approach to Executing Health Insurance Portability and Accountability-Compliant Data Transfers (2.3.H.5.)

Myers and Stauffer agrees to provide all proprietary data collected and/or created during the life of the contract to DMS and within 30 calendar days of request.

As a vendor that has served governmental agencies exclusively for more than 43 years, we have committed to, invested in, and built an IT system framework that supports performance of services that meet the requirements of our clients and the privacy and security standards to which we are bound as both a government vendor and a Business Associate under HIPAA. Establishing connectivity between DMS, Myers and Stauffer, and providers will develop a basis for sustaining all work performed under this contract. It is important that connectivity is reliable and that we have the necessary features to safeguard our IT platforms and data at all times – whether at rest, in use, or in motion.

Myers and Stauffer has built and maintains its systems according to industry standards and best practices, and we have in place robust HIPAA privacy and security policies, procedures, and controls that address among other things: access; awareness and training; audit and accountability; information system inventory and categorization; monitoring; security assessments; configuration management; contingency planning; identification and authentication; incident response; maintenance; media protection; physical and environmental protection; planning; personnel security; risk assessment; systems and services acquisition; system and communications protection; and system and information integrity.

Myers and Stauffer regularly deals with the transmission of electronic PHI and other sensitive information over electronic communication networks. Our transmission procedures include the establishment of secure file transfer protocol (SFTP) sites to achieve secure transfer of sensitive data. Data is encrypted during transmission using Transport Layer Security (TLS). PHI and other sensitive data may only be transmitted when expressly authorized, and transmission must occur through our SFTP site, which is FIPS 140-2 compliant, or through fully encrypted, restricted access secure web portals. In very limited circumstances and only for small files, transmission may be authorized through our secure email system. All connections to Myers and Stauffer internal networks must be made either while directly connected to the network (by Myers and Stauffer-issued computers only) or through a secure virtual private network (VPN) that encrypts all traffic.

We anticipate utilizing our SFTP site and secure web portals to transfer data to DMS. At stated above, Myers and Stauffer employs the following security measures to support our secure web portals: FIPS 140-2 ciphers with Secure Socket Layer (SSL)/TLS, internet protocol (IP) whitelisting at the user level, audit logging of all external logins and transactions, error logging and notification to our IT team, weekly performance of internal penetration testing, independent, annual penetration testing performed by a

leading third-party security firm, server-level encryption, and web servers hosted in a third-party data center within a private cloud.

Within the secure web portal, we employ the following programmed security measures: 1) PHI and other sensitive information is time-gated, which ensures data is only available to download for a pre-defined time period; 2) each project is segregated, eliminating comingling of data; 3) the application maintains separate roles for provider, state, and Myers and Stauffer users; 4) CAPTCHA technology is used for "change password" and "failed login attempts required" features; 5) web portal employs a session time out; and 6) web portal offers a self-service change password process.

Myers and Stauffer agrees to return to DMS all proprietary data collected and/or created during the life of the contract at contract termination and/or within 30 calendar days of request.

Transition (2.3.H.6.)

Myers and Stauffer understands the importance of a seamless transition of any contract from an incumbent vendor to a new one, or to the State at the end of the contract, and particularly one of this magnitude. We will develop and execute a detailed plan to complete a full transition within 90 calendar days of the contract end date. This plan will include the transfer of all proprietary data collected and/or created during the life of the contract to DMS within 30 calendar days prior to the end of the contract. Any further data collected after this final 30-day time period will be delivered to DMS no later than 15 calendar days following the contract end date. Our team's transition plan will utilize existing institutional knowledge, along with our project management expertise, to make the transition seamless with little to no disruption of DMS services or program activities. We understand that the transition plan will not be implemented until written approval has been received. We will keep DMS up to date by providing consistent and effective communication.

Training (2.3.H.7.)

Myers and Stauffer is ready to provide education and training to DMS staff and others as requested by DMS. We will consult with DMS to determine whether training for DMS staff shall be provided each contract year, along with developing a comprehensive list of the various training topics that project staff can provide. Since many of the issues typically encountered during a Medicaid engagement are not taught in a classroom, nor are they discussed in periodicals, it takes substantial exposure to the health care reimbursement field to provide the depth of understanding necessary to arrive at supportable conclusions.

Myers and Stauffer provides training development activities for our clients to assist them in remaining current on emerging issues within Medicaid reimbursement and health care initiatives nationwide.

Training modules will be developed based upon input and discussion with DMS staff. Once training areas are identified, the task of developing the training session will be assigned to one of the individuals on

our project team who is considered an expert in the field. Development of the training module will begin with an outline of the topic and focus on specific areas of interest. This outline will be shared with DMS staff who are in need of the training to ensure the topics included in the outline fully address their issues and concerns.

Upon approval of the outline, the assigned trainer will begin gathering and developing the relevant training materials. These materials will include any relevant authoritative guidance on the topic (i.e., statutes, rules, professional standards), examples of work product currently generated for the topic (i.e., work papers, compliance review reports), and presentation materials such as PowerPoint slides. When completed, the training materials will be forwarded to DMS staff for approval, and will be available for distribution to the trainees no later than seven days prior to the training.

Myers and Stauffer's project team will be available to provide training to all levels of staff, from DMS management to policy, program, and other technical staff. Training content will be customized to the specific interests of the audience and delivered within the same training session, or separately. Typically, one of the separate sessions, or the first part of the combined training, will focus on an overview of the topic and can be attended by both management and staff level. The second session, or second part of the combined session, will focus more on the detailed application of the particular topic that may be particularly relevant to certain staff. For each training session, we will work closely with DMS to identify the appropriate scope of topic and audience.

Recent topics have included:

- *DSH Regulation and Auditing Updates.*
- *Medicare Cost Reporting 101.*
- *Upper Payment Limit Demonstration Requirements and Approved Methodologies.*
- *State Staff and Provider Web Portal Training.*
- *DSH Training to Hospitals.*
- *PDPM.*
- *Case Mix Reimbursement.*
- *Quality Measures and Five-Star Data.*

Also, prior to beginning review/audit activities, we believe it is important that our staff and DMS staff are all in agreement as to the review/audit activities that will be performed. We want our clients educated as to the process and scope of our work. If interested, our first pre-audit activity is to provide a training session for the DMS staff for each provider type. Our training can be provided in-person at a location agreed upon by the State agency, or it can be provided via webinar. If provided via webinar, the training can be recorded and made available on our Myers and Stauffer website or web portal for

providers to view. We are also certified to provide our trainings as certified professional education in Arkansas.

Deliverable Acceptance Process (2.3.H.8.)

Myers and Stauffer understands and agrees that if DMS rejects a deliverable, we will receive a written description of the changes that must be made to the deliverable. We will repeat the cycle of submission, review, rejection, revision, and resubmission until DMS accepts the deliverable. We will be liable for all costs associated with additional work related to deliverables being rejected by DMS.

We agree to provide all requested services, support, and deliverables according to established timelines and in a manner that meets or exceeds your requirements. We are known nationwide for our superior auditing, consulting, analytical and pricing solutions, and for our impeccable delivery of services. We will meet the goals of this contract by applying proven methodologies and subject matter expertise to each core task.

Myers and Stauffer prides itself on our commitment to the quality of our work and the satisfaction of our clients. The firm's quality control process ensures all deliverables, documents, and calculations are complete, accurate, easy to understand, and of high quality. Quality control procedures will be implemented throughout the life of the contract, beginning at contract execution and concluding with contract close out.

Our extensive internal quality control plan meets applicable professional standards and customer expectations. Our system includes detailed policies for each of the elements of quality control over our practice, as well as policies and procedures for engagement performance and management to provide reasonable assurance that the conduct and supervision of the work at all organization levels are adequately planned and supervised, and meet both the professional standards and the firm's high standard of quality.

Implementation (E.10)

Myers and Stauffer affirms that we will work with DMS to provide support for supplemental payments, including cost report audits and related settlements, and UPL calculations for a variety of providers, including without limitation, hospitals, nursing homes, ICFs, FQHCs, physicians, and any emerging provider groups. We also agree to perform DSH payment calculations. Our general proposed approach and methodology for this engagement represents a logical approach to fulfilling the requirements of the RFP. We will customize our approach based on our post-award conversations with DMS to ensure our services meet your expectations, are flexible and adaptable, and help achieve desired outcomes. Our proposed methods/approach for implementation can be summarized into four general areas:

- ***Develop an understanding of project objectives.*** *To fulfill our duties on this project, it is imperative that we fully understand the State's objectives for each assigned task. Upon the State's notice of award and approval of a task work, a meeting will be scheduled to further our understanding of the project and DMS' objectives. Beyond general discussion, we will want to review background and contextual materials, relevant information technology capabilities, and coordinate data requirements for the project.*
- ***Plan and complete work assignments.*** *Project staff will also meet with DMS staff to discuss our initial work plan. Any necessary revisions will be made to ensure we meet the needs of the Arkansas Medicaid program. Once appropriate outcomes for each project are identified, we will proceed with project planning activities and completing our work assignments. We will develop revised written work plans to communicate our understanding of the work assignments, which will be provided to you for your review and input. Throughout the project, staff will monitor the work plan and timeline and notify DMS staff if concerns or delays should occur. Our work plans will be flexible to meet program requirement changes and to address delays if they should occur.*
- ***Perform quality control reviews.*** *It is the policy of Myers and Stauffer that all deliverables receive a second review by management staff who did not participate in the preparation. Additionally, when critical or sensitive issues are involved, our quality assurance partner will perform further consultation and review. This partner is not associated with the engagement directly, but is available to the project team as needed to ensure all products and services are of the highest quality and meet or exceed your expectations.*
- ***Communicate work products to our clients (and other stakeholders).*** *As work assignments are completed, deliverables will be drafted, quality reviewed, and provided to DMS for review. If requested, staff will prepare additional work papers to clarify our work. Comments and/or revisions are then incorporated into the reports before final release.*

Our solution is to properly plan, perform, supervise, review, document, and communicate engagements in accordance with professional standards, regulatory authorities, and project requirements. We have provided a more detailed discussion on our approach to completing the specific objectives of this RFP in the Project Work Plan section of this proposal.

Myers and Stauffer agrees to establish a secure mechanism to electronically collect, maintain, and transfer cost report information, etc. within the agreed upon timeframe. Our solution will provide the following:

- *Allow secure transference of information electronically between the contractor, DMS, and the providers.*
- *Be a secure system capable of storing large amounts of data for the services provided under the contract.*

- *Be compliant with the data transfer requirements state at Section 2.3.H.5 of the RFP.*
- *Collect and maintain cost report information (audited and unaudited) in a readily accessible format agreeable to DMS, from which ad-hoc reports may be produced the either the Contractor or state agency staff. Myers and Stauffer will make the information available to DMS on a timely basis, as mutually agreed upon with DMS.*
- *Allow DMS flexibility in obtaining data to implement and develop reimbursement methodologies.*
- *Have the ability to collect and maintain historical cost report information deemed appropriate by DMS.*

Staffing (E.11)

Myers and Stauffer is pleased to offer DMS a highly qualified and experienced team of professionals who have performed similar services for other state Medicaid agencies. We staff each project to exceed our clients' expectations, including meeting all required deadlines and are committed to integrating this contract into our existing Arkansas and firm obligations. Myers and Stauffer has all professional resources trained and ready to begin work immediately upon contract award. It will not be necessary to build capacity or spend contract hours training individuals.

We understand the complexities of operating a state's Medicaid agency. We also understand that in order to provide exceptional client service, it requires a team of dedicated and skilled professionals that can respond timely to client needs. Our staffing plan provides:

- *A team that is dedicated to providing timely responses to your inquiries.*
- *Access to technical expertise to address the complex challenges of rate and reimbursement systems.*
- *A resource that can bring a broad base of knowledge gained from experience working with other states and CMS to help share lessons learned and to incorporate best practices.*
- *An advisor who can stay on the cutting edge of advancements and new methodologies in Medicaid payment reforms.*
- *A team that understands the health care environment and can take over existing work streams without disruption to DMS, providers, or stakeholders.*

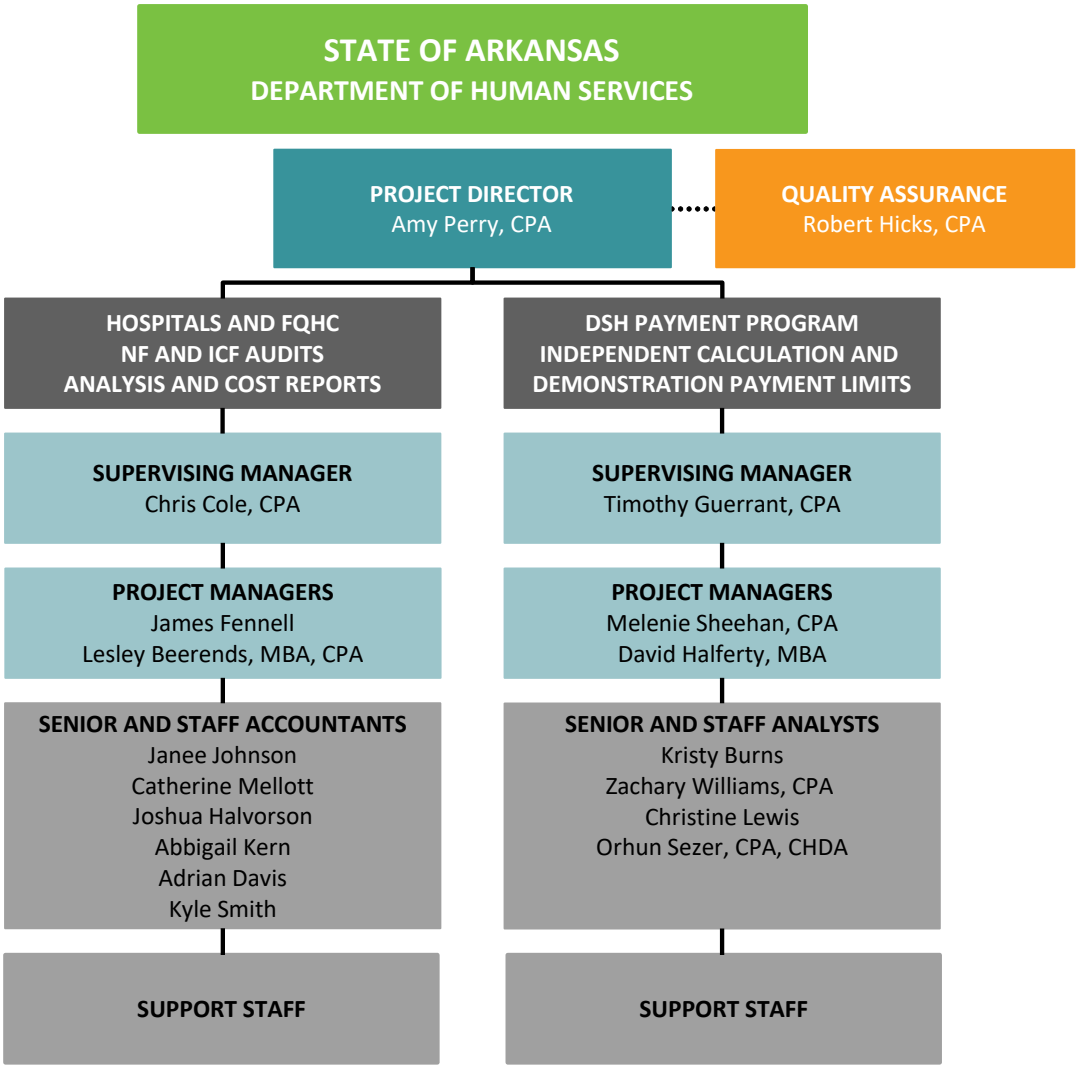
Myers and Stauffer is committed to performing this work within the desired time periods and has available the resources to efficiently manage this project. Our practice is well-rounded in terms of relevant experience and scope of services provided, and therefore, we do not experience the workload compression that other firms might experience during particularly busy seasons. This means better client service and closer, personal attention for DMS.

The size of our staff and our multi-state experience enables us to allocate the required resources to address Arkansas' needs. Selecting Myers and Stauffer as the Cost Report Audits and Upper Payment Limit Calculations vendor results in numerous benefits to the State, including:

- ***Reliability.*** *As documented by our references and client retention statistics, we offer the State reliability in meeting deadlines and providing quality staff who specialize in these types of engagements.*
- ***Experts.*** *Myers and Stauffer staff provide consulting, audit, and attest services specific to the Medicaid program. Through continuing education, our staff not only stay abreast of current professional accounting standards, but also spend a significant amount of time on research and education related to the health care field. We are not a CPA firm that chose health care as a small part of our specialty practice, rather, we are a CPA firm that made health care our only practice.*
- ***Specialized.*** *By limiting our clients to the entities managing government-sponsored health care programs, we offer a unique perspective to states, not only in providing the audit services requested, but also in providing states with a valuable resource to share information relevant to many areas of their program.*
- ***Free of conflicts.*** *As noted above, we limit our clients to government-sponsored health care programs and do not accept any engagements directly with providers. Therefore, we minimize the need for addressing conflicts of interest.*
- ***Appeals process.*** *With specialized experience in providing audit services to Medicaid agencies, we understand the importance of well-documented files. We have experience in providing states with necessary litigation support to defend the results of our examinations.*

Each of the proposed team members work full time and are available to perform the work. All of these individuals offer value-added insight, deliver creative solutions, and ensure regulatory compliance. Once an engagement is established, it is the policy of the firm to consistently maintain the same staff on engagements to ensure continuity to the client. This allows us to maximize quality and efficiency, and helps us avoid the learning curve often observed when new engagement teams are frequently cycled on a project.

Below, we have provided our organizational chart depicting proposed staff for this project. This chart outlines all lines of authority and establishes key personnel responsible for client contact, communications, and ensuring that project status updates and deliverables are provided on time with the highest quality.



Myers and Stauffer staffs each project to exceed our clients' expectations, including meeting all required deadlines. Our staff is required to obtain extensive continuing education and is given frequent internal health care specific training to keep up with the ever-changing field of health care and other government sectors. This institutional experience and knowledge is invaluable to DMS. Below, we have highlighted our proposed key team members.

Myers and Stauffer: Proposed Team Leadership				
Name	**Health Care Consulting, Auditing, and Cost Report Preparation Experience**	**Medicare/ Medicaid Program Audits, Analyzing Provider Cost Report Data, DSH Payment Calculations**	**Supervising Five or More Staff**	**Qualifications**
Project Director				
Amy Perry, CPA *Member (Partner)* *Licensed CPA:* ✓	29 Years	29 Years	16 Years	• 29 years of experience providing consulting and public accounting services to state Medicaid agencies regarding health care reimbursement issues. • Co-leads the firm's Nursing Facility Rate Setting and Minimum Data Set Verification engagement team and participates on the firm's Rate Setting and Federal Compliance engagement team. • Assists state Medicaid agencies in the development, implementation, and maintenance of nursing facility rate setting systems, including case mix and fair rental value, inpatient hospital PPS based on DRGs, and outpatient hospital PPS based on ambulatory payment classifications/ambulatory patient groups. • Performs desk reviews and rate setting engagements in accordance with Medicaid reimbursement regulations, and applies Medicare reimbursement regulations that are contained in the Medicare Provider Reimbursement Manual (HIM-15). • Serves as Project Director for the preparation of Medicare UPL determinations and ensuring states comply with federal requirements for several of the firm's state Medicaid agency clients. • Supervises project staff plans and organizes day-to-day project operations.
Quality Assurance				
Robert Hicks, CPA *Member (Partner)* *Licensed CPA:* ✓	25 Years	16 Years	20 Years	• 25 years of health care experience. • Partner in charge of the firm's Cost Report Attest and DSH audit engagement team. • Provides consulting and public accounting services to state Medicaid agencies addressing health care reimbursement issues. • Leads various Medicare/Medicaid accounting, auditing, rate setting, and consulting engagements. • Extensive experience with hospital and nursing facility cost report auditing, waiver programs, DSH

Myers and Stauffer: Proposed Team Leadership				
Name	**Health Care Consulting, Auditing, and Cost Report Preparation Experience**	**Medicare/ Medicaid Program Audits, Analyzing Provider Cost Report Data, DSH Payment Calculations**	**Supervising Five or More Staff**	**Qualifications**
				payments, financing, reimbursement litigation, creation of analytical reports, and fiscal models.
Supervising Managers				
Timothy Guerrant, CPA *Member (Partner)* *Licensed CPA:* ✓	21 Years	19 Years	12 Years	• 21 years of health care experience. • Partner in charge of the firm's Rate Setting and Federal Compliance engagement team. • Experience providing rate setting, reimbursement system design, and consulting services for government health care agencies. • Extensive experience in Medicaid rate setting across a wide spectrum of health care services, including hospitals, physicians, FQHCs, RHCs, DME and medical supplies, dental, transportation, waiver services, and behavioral health services. • Expert in Medicaid financing and compliance issues, including UPL demonstrations, health care provider taxes, IGTs, and CPEs. • Experience includes the development of cost reports and other data collection instruments, provider and stakeholder training, deployment of data collection tools, and data-driven rate setting and analysis. • Experienced in reimbursement and policy research, and preparation of analytical studies and reports, including fiscal impact modeling and reimbursement rate analysis. • Provides consulting services related to Medicaid SPAs, Medicare and Medicaid legislation and policy issues, and Medicaid financing and compliance issues.
Chris Cole, CPA *Senior Manager* *Licensed CPA:* ✓	12 Years	12 Years	5 Years	• 12 years of public accounting and auditing experience specifically focusing on state Medicaid agencies and the application of cost reimbursement principles promulgated in CMS publication 15-1. • Performs LTC Medicaid examinations, hospital Medicaid examinations, DSH examinations, and Medicaid managed care examinations in multiple states.

Myers and Stauffer: Proposed Team Leadership				
Name	**Health Care Consulting, Auditing, and Cost Report Preparation Experience**	**Medicare/ Medicaid Program Audits, Analyzing Provider Cost Report Data, DSH Payment Calculations**	**Supervising Five or More Staff**	**Qualifications**
				• Implements staff development, evaluation, and training programs; work paper development; examination program development, and quality supervisory reviews relating to LTC and hospital cost reports.

Myers and Stauffer: Proposed Project Managers		
Name	**Medicare/Medicaid Health Care Audit Work**	**Qualifications**
Project Managers		
Melenie Sheehan, CPA *Senior Manager*	20 Years	• 20 years of health care experience. • Manages the annual DSH audit for three state Medicaid agencies, and UPL consulting contracts for two state Medicaid agencies. • Responsibilities include review and analysis of federal and state legislative initiatives; review and analysis of the calculation of each state's DSH UCC; and participation in policy discussions related to IGTs, DSH, and UPL. • Reviews and analyzes hospital-specific limits, computes hospital eligibility for supplemental payments, and coordinates with the fiscal agent contractor and Office of Financial Management (OFM) for the release of supplemental payments. • Assists the OFM and state budget agency in monitoring account balances for the indigent care trust fund; attends and monitors fund distributions; and coordinates and meets with the hospital association. • Assists states with defending the examination results in hospital appeals. • Actively involved in other hospital reimbursement projects including policy and procedure analysis, survey research, data collection, data and financial analysis, reimbursement and medical policy consulting, and cost report reviews and audits.
David Halferty, MBA *Senior Manager*	21 Years	• 21 years of health care experience.

Myers and Stauffer: Proposed Project Managers		
Name	**Medicare/Medicaid Health Care Audit Work**	**Qualifications**
		• Provides rate setting and consulting services to state Medicaid agencies addressing health care reimbursement issues; worked on Medicaid rate setting and consulting projects related to HCBS providers, nursing facilities, the Program of All-Inclusive Care for the Elderly (PACE), and other provider groups. • Experience with rate methodology development, case mix system analysis, value-based payment methodology development, UPL demonstrations, provider tax analysis, and market feasibility analysis. • Experienced with EHR incentive payment compliance reviews, Medicare compliance audits, Medicaid managed care contract reviews and MLR analysis. • Monitors project requirements, communicates with clients, and ensures project deliverables are produced timely and accurately. • Serves as a member of the Myers and Stauffer Nursing Facility Engagement Team leadership group. • Recently worked on an internal taskforce committee researching the PDPM.
Lesley Beerends, CPA, MBA *Senior Manager*	24 Years	• More than 24 years of experience in health care reimbursement. • Assists state officials with designing reimbursement methodology and cost reporting procedures for new Medicaid programs, including market research and relevant rate and fiscal impact analysis. This includes ongoing policy and procedure analysis for current Medicaid services, updating the SPA, and drafting administrative rules. • Extensive knowledge of Medicaid cost reports and rate setting for HCBS, targeted case management, habilitation, CMHCs, hospitals, FQHCs, and RHCs. • Provides technical assistance and cost report training for Medicaid providers. • Led the DRG and APC recalibration and rebasing project for the state of Iowa for the past 14 years. This includes determination of hospital rates and CMI factors, calculation of DRG relative weights and outlier thresholds, cost-to-charge-ratios, fiscal impact studies, management of databases, statistical analyses, and calculation of disproportionate share and GME payments for qualifying hospitals. • Provides analysis of Medicaid claims data for financial and policy support and assists providers with claims billing and payment issues.

Myers and Stauffer: Proposed Project Managers		
Name	**Medicare/Medicaid Health Care Audit Work**	**Qualifications**
James Fennell *Senior Accountant*	6 Years	• Six years of experience providing public accounting services to state Medicaid agencies and CMS addressing health care reimbursement issues. • Has worked on several projects for Arkansas, CMS, Florida, Georgia, Louisiana, Maine, Missouri, New Jersey, and North Carolina. • Oversees day-to-day work on the Arkansas Nursing Facility Rate Setting project, the CMS Payroll-Based Journals project, and reviews Medicaid DSH audits for multiple states.

Our team is comprised of professionals with considerable academic training and specialized experience. Many on our team possess experience gained from serving in leadership positions in more than 15 different Medicaid programs, CMS, Medicaid health plans, fiscal agent contractors, health information networks, and health care providers. These individuals offer value-added insight, provide creative solutions to our clients' problems, and assist in implementing and complying with state and federal regulations. The depth and breadth of our training and experience gives Myers and Stauffer a unique understanding and appreciation for the pressures and daily constraints of trying to do more with less that is so often a reality for public benefit programs. We staff each project to exceed our clients' expectations, including meeting all required deadlines.

Beginning on the following page, we have provided resumes for our Project Director, Supervising Managers, and Project Managers that would be assigned to this important project. CPA licensures for our primary leadership staff can be found in *Appendix B: CPA Licensure*.

Resumes

Amy Perry, CPA

Member

Summary

Ms. Perry provides consulting and public accounting services to state Medicaid agencies regarding health care reimbursement issues. She co-leads the firm's Nursing Facility Rate Setting and Minimum Data Set Verification engagement team and participates on the firm's Rate Setting and Federal Compliance engagement team. Her responsibilities include supervising project staff and planning and organizing day-to-day project operations. She is also responsible for keeping abreast of current statutes, rules, and regulations that govern the industry, and researching and evaluating the impact of state and federal legislation on provider reimbursement issues.

Over the three decades she has been with the firm, she has assisted state Medicaid agencies in the development, implementation, and maintenance of nursing facility rate setting systems, including case mix and fair rental value, inpatient hospital prospective payment systems based on diagnosis related groups, and outpatient hospital prospective payment system based on ambulatory payment classifications/ambulatory patient groups. Recently, she has worked with several states developing and implementing inpatient, outpatient, and physician-directed payment programs that have been approved by CMS. She also serves as Project Director for the preparation of Medicare upper payment limit determinations and ensuring states comply with federal requirements for several of the firm's state Medicaid agency clients.

In 2004, Ms. Perry established the firm's Iowa office and hired and trained 15 staff members, including certified public accountants and candidates, computer professionals, and accounting technicians. She continues to oversee work with the Iowa Medicaid Enterprise, which includes rate setting for various provider types and performing desk reviews of Medicaid cost reports for various provider types. As part of this contract, Ms. Perry assisted the state of Iowa with their disproportionate share hospital program through data collection, payment calculations, hospital-specific limit calculations and consulting services. She has prepared detailed reports to the Centers for Medicare & Medicaid Services officials demonstrating the state's compliance with federal disproportionate share hospital statutes and regulations.

She is currently assisting states with strategies to maintain resource utilization group-based reimbursement systems in light of changes at the federal level. She has prepared pro forma reimbursement models and financial and statistical analyses that allow states to define multiple reimbursement variables that can be changed interactively. This type of modeling provides states the ability to evaluate multiple options quickly and efficiently.

Ms. Perry's experience with nursing facility case mix development, implementation, and maintenance includes managing projects in Colorado, Hawaii, Iowa, Louisiana, Montana, New Jersey, and North Carolina.

Education

B.S., Accounting, Northeast Missouri State University, 1990

Experience

29 years of professional experience

Affiliations

American Institute of Certified Public Accountants
Kansas Society of Certified Public Accountants

Licenses/Certifications

Certified Public Accountant

Relevant Work Experience

Alaska Department of Health and Social Services (2019 – Present)
Diagnosis Related Group (DRG) Technical Assistance

Scope of Work:
Myers and Stauffer was engaged to provide technical assistance and support to the Department regarding the feasibility, development, and implementation of a diagnostic-related group (DRG) payment methodology for Alaska hospitals.

Responsibilities:

- Provide high-level strategic input to ensure project quality and successful completion.
- Provide quality assurance checks to promote adherence to contract compliance and other management policies.
- Oversee quality control reviews and processes, and review deliverables.

Alaska Department of Health and Social Services (2020 – Present)
Skilled Nursing Facility Case Mix Based Payment Methodology Technical Assistance

Scope of Work:
Myers and Stauffer provides technical assistance to the department in order to evaluate the feasibility of a transition from the current cost-based per diem payment methodology for skilled nursing facilities to a case mix reimbursement methodology.

Responsibilities:

- Provide high-level strategic input to ensure project quality and successful completion.
- Provide quality assurance checks to promote adherence to contract compliance and other management policies.
- Oversee quality control reviews and processes, and review deliverables.

Connecticut Department of Social Services (2013 – 2017)
Hospital Reimbursement

Scope of Work:
Connecticut Medicaid engaged Myers and Stauffer to implement prospective payment systems for their inpatient and outpatient hospital services.

Responsibilities:

- Consulted with the State on their development and transition from a target payment per discharge and cost settlement system for hospitals to an inpatient PPS based on DRG.
- Oversaw and provided quality assurance of the preparation of fiscal impact models based on DRG methodology.
- Consulted with the State on their development and transition from a mix of fixed fees and cost-to-charge ratio method for hospitals to an outpatient PPS based on APC and fee schedule methodology.

- Assisted in the review of current outpatient billing requirements in relation to the Medicare outpatient code editor and proposed changes to allow appropriate APC assignment.
- Oversaw and provided quality assurance of the preparation of fiscal impact models based on APCs.
- Presented at hospital association meetings explaining both the DRG and APC underlying methodologies, including the DRG base rate and APC conversion factor development process.
- Assisted with state plan review and draft language changes to implement the inpatient and outpatient PPS.

Connecticut Department of Social Services (2020 – Present)

Waiver Rate Study of Home and Community-Based Services

Scope of Work:

Myers and Stauffer is engaged to study the state's current methodology for developing payment rates for Home and Community Based Services provided through their 1915(c) waivers.

Responsibilities:

- Provides high-level strategic input to ensure project quality and successful completion.
- Provides quality assurance checks to promote adherence to contract compliance and other management policies.
- Oversees quality control reviews and processes, and reviews deliverables.

Georgia Department of Community Health (2012 – Present)

Hospital Reimbursement Technical Assistance

Scope of Work:

Myers and Stauffer assisted with the redesign and calculation of the Medicaid DSH reimbursement system and technical and accounting issues related to the preparation of Medicare UPL findings for inpatient and outpatient hospital programs.

Responsibilities:

- Perform quality review of all project deliverables.
- Currently consulting with the State on development of an outpatient PPS based on APC methodology.
- Drafted state plan language to reflect the APC methodology.

Illinois Department on Aging (2018 – Present)

HCBS - Community Care Program Care Coordination Unit Administrative Services Rate Study

Scope of Work:

Myers and Stauffer is conducting a rate study for the Care Coordination Unit (CCU) administrative services provided through the state's Community Care Program (CCP). The study includes an examination of eleven different services including initial assessment, Medicaid application assistance, person centered plan of care development, face to face visits, reassessment, nursing facility screening, intensive casework/monitoring, presumptive eligibility, person centered plan of care adjustment, case management, and deinstitutionalization. The CCP includes home and community based services (HCBS) waiver participants and state funded beneficiaries over age 60.

Responsibilities:

- Serves as the partner-in-charge of the project.
- Provide consulting and input to project manager, staff and client.

- Oversee and provide quality assurance of project deliverables.

Iowa Department of Human Services (2005 – Present)
Fiscal Consultant for Audit and Rate Setting

Scope of Work:
Myers and Stauffer provides professional accounting and consulting services with the Iowa Department of Human Services.

Responsibilities:

- Currently serves as the partner-in-charge of the fiscal consultant and rate setting project.
- Performed Purchase of Social Services (POSS) and Rehabilitative Treatment and Supportive Services (RTSS) reviews.
- Perform quality review of ad-hoc reports when requested by the Department. Typically these are reports that document staff findings of completed research.

Iowa Department of Human Services (2004 – Present)
Provider Cost Audits and Rate Setting Services

Scope of Work:
Myers and Stauffer provides professional accounting and consulting services as the Provider Cost Audit and Rate Setting Unit of the Iowa Medicaid Enterprise.

Responsibilities:

- Currently serves as the partner-in-charge of the provider cost audit and rate setting project.
- Served as Project Manager during the design, development, and implementation of the nursing facility case mix reimbursement system.
- Established the firm's Iowa office in 2004 and served as on-site account manager through August 2012.
- Serves as lead consultant on the inpatient and outpatient hospital reimbursement triennial weight setting and rebase projects.
- Served as lead consultant assisting Medicaid program officials and hospital industry representatives with evaluating and implementing an outpatient PPS based on APC methodology.
- Served as lead consultant on preparation of nursing facility, ICF/IID, inpatient hospital, and outpatient hospital UPL demonstrations.
- Served as lead consultant assisting Medicaid program officials implement IowaCare an 1115 Medicaid demonstration project that expanded eligibility for the Medicaid population.

Kentucky Cabinet for Health and Family Services (2013 – Present)
Hospital Reimbursement

Scope of Work:
Myers and Stauffer assists the Kentucky Cabinet for Health and Family Services with the ongoing development and implementation of reimbursement systems for hospital inpatient and outpatient services.

Responsibilities:

- Assists Medicaid program officials and hospital industry representatives evaluate an implement an update to the DRG system.
- Performs quality review of all project deliverables.
- Provides technical assistance in responding to hospital association questions.

- Provides technical assistance with hospital-directed payment programs.

Louisiana Department of Health (2001 – 2004)
Case Mix Reimbursement System

Scope of Work:
Myers and Stauffer is assisting in the development and operation of a case mix reimbursement system and MDS data management and reporting services for nursing facilities participating in the Louisiana Medicaid Program.

Responsibilities:

- Assisted Medicaid program officials and nursing facility industry representatives with evaluating and implementing a nursing facility case mix reimbursement rate setting system.
- Prepared fiscal impact models that demonstrated the change in reimbursement from the current system to the proposed nursing facility case mix rate setting system.
- Assisted in writing business and system requirements to develop and implement the Louisiana cost report and rate setting application.
- Completed quarterly and annual nursing facility case mix rate setting activities.

Mississippi Division of Medicaid (2019 – Present)
Cost Report Automation

Scope of Work:
Myers and Stauffer is engaged to perform cost settlement functions and for the development and maintenance of a cost report database and utilization statistics, including automation of the cost report submission process for all applicable provider types.

Responsibilities:

- Serves as project director, attends project meetings, directs activities of the project team, and provides consultation to DMA.
- Coordinates professional resources based on the work plan and needs of the project.
- Performs final review of all deliverables.

Mississippi Division of Medicaid (2014 – Present)
Upper Payment Limit and DSH Program Calculations

Scope of Work:
Myers and Stauffer has assisted the state of Mississippi's Medicaid program with UPL and DSH calculations since 2006.

Responsibilities:

- Oversee and provide quality assurance of the preparation of UPL demonstration calculations for the skilled nursing facility/nursing facility, ICF/IID, psychiatric residential treatment facilities (PRTF), clinic, and physician provider types.

Missouri Department of Social Services (2012 – Present)
Upper Payment Limit Calculations

Scope of Work:
Prepare and support state’s annual nursing facility UPL demonstration.

Responsibilities:

- Oversee and provide quality assurance of the preparation of UPL demonstration calculations for the nursing facility/nursing facility, outpatient hospital, and clinic provider types.

Montana Department of Public Health & Human Services (1997 – 2004)

Nursing Facility Priced-Based Reimbursement Services: Rate Setting, Case Mix, and Medicare Upper Limit

Scope of Work:

Myers and Stauffer was engaged to develop a new case mix reimbursement system based on the MDS and RUG classification system to replace Montana's current reimbursement system which utilized management minutes. Currently we provide the state of Montana with nursing facility priced-based reimbursement services including annual rate setting, quarterly case mix calculations, annual Medicare upper limit calculation, an annual report with calculations and comparisons, and state plan consultation and litigation support.

Responsibilities:

- Served as project manager during the design, development and implementation of the nursing facility case mix reimbursement system.
- Provided recommendations to Department work groups on various acuity options and validation methods.
- Modeled potential reimbursement methodologies for review by the Department and provider work groups.
- Assisted in the preparation of training materials on the new reimbursement methodology.
- Formulated state plan/rule language necessary to implement policy changes and assisted with drafting responses to questions from CMS.

New Mexico Human Services Department (2015 – Present)

Hospital Audit

Scope of Work:

Myers and Stauffer performs examinations and reviews of hospitals that participate in the New Mexico Medicaid program.

Responsibilities:

- Oversee and provide quality assurance of the preparation of UPL demonstration calculations for the skilled nursing facility/nursing facility, ICF/IID, accredited residential treatment center, clinic, inpatient and outpatient hospital, and physician provider types.

New Mexico Human Services Department (2015 – Present)

Nursing Facility Audit

Scope of Work:

Myers and Stauffer performs examinations and reviews of home health agencies and long-term care institutional facilities (nursing facilities and intermediate care facilities) that participate in the New Mexico Medicaid program.

Responsibilities:

- Oversee and provide quality assurance of the preparation of UPL demonstration calculations for the skilled nursing facility/nursing facility, ICF/IID, accredited residential treatment center, clinic, inpatient and outpatient hospital, and physician provider types.

North Carolina Department of Health and Human Services (2001 – 2004)

Nursing Facility Cost Report and Case Mix

Scope of Work:

Myers and Stauffer provides case mix rate setting support and consulting services to the state of North Carolina.

Responsibilities:

- Served as Project Manager during the design, development, and implementation of the nursing facility case mix reimbursement system.
- Assisted Medicaid program officials and nursing facility industry representatives with evaluating and implementing a nursing facility case mix reimbursement rate setting system.
- Prepared fiscal impact models that demonstrated the change in reimbursement from the current system to the proposed nursing facility case mix rate setting system.
- Assisted in the preparation of training materials on the new reimbursement methodology.
- Formulated state plan/rule language necessary to implement policy changes and assisted with drafting responses to questions from the Centers for Medicare & Medicaid Services.
- Developed the nursing facility rate setting spreadsheet still used today by the Department to establish rates.

Oklahoma Health Care Authority (2019 – Present)

Nursing Facilities Supplemental Payment Program

Scope of Work:

Myers and Stauffer provides state plan consultation, prepare Medicare RUG UPL calculations, determines nursing facility supplemental payments, and prepares materials for and assists with correspondence with CMS.

Responsibilities:

- Serves as project director, attends project meetings and directs activities of the project team.
- Coordinates professional resources based on the work plan and needs of the project.
- Performs final review of all deliverables.

South Dakota Department of Human Services (2019 – Present)

Nursing Home Rate Methodology Consultant

Scope of Work:

Myers and Stauffer was engaged to evaluate the current methodology, consider relevant variables and make recommendations for changes to the nursing home reimbursement methodology.

Responsibilities:

- Serves as project director, attends project meetings, directs activities of the project team and provides consultation DHS.
- Coordinates professional resources based on the work plan and needs of the project.
- Performs final review of all deliverables.

Virginia Department of Health (2016)
Reimbursement and Financing Study

Scope of Work:
Virginia Department of Health engaged SVC and Myers and Stauffer to evaluate opportunities for the diversification of funding sources for Virginia's Title V care coordination program for children with special healthcare needs.

Responsibilities:

- Performed a review of the Care Connection for Children (CCC) program, nationwide practices, federal regulations and current Medicaid programming provided by the Department of Medicaid Assistance.
- Researched and compiled reimbursement rates of surrounding states.
- Assisted with developing a series of potential options for new CCC funding streams and to maximize current funding.
- Assisted with final report.

West Virginia Department of Health & Human Resources (2016 – Present)
Upper Payment Limit Demonstration Calculations

Scope of Work:
Myers and Stauffer was contracted to perform UPL demonstration calculations.

Responsibilities:

- Oversee and provide quality assurance of the preparation of UPL demonstration calculations for the skilled nursing facility/nursing facility, ICF/IID, PRTF, inpatient and outpatient hospital, and physician provider types.

Presentations
"Louisiana Medicaid Nursing Facility Case Mix Reimbursement," Gulf States Association of Homes and Services for the Aging, 2003.

"RUG-III Case Mix Reimbursement System," North Carolina Medicaid, 2003.

"Current Trends in Nursing Facility Rate Setting," Myers and Stauffer Workshop, Indianapolis, Indiana, 2003.

Robert Hicks, CPA

Member

Summary

Mr. Hicks is a partner-in-charge of the firm's cost report attest and DSH audit engagement team. He provides consulting and public accounting services to state Medicaid agencies addressing health care reimbursement issues. He leads various Medicare/Medicaid accounting, auditing, rate setting, and consulting engagements. He is responsible for working with clients to set up various audit and consulting engagements. His duties include setting up the initial project requirements, communicating with the clients, ensuring adequate staffing, quality assurance, training, and supervisory reviews.

Mr. Hicks has extensive experience with hospital and nursing facility cost report auditing, waiver programs, DSH payments, financing, reimbursement litigation, creation of analytical reports, and fiscal models.

Education

B.S., Accounting, University of Missouri – Kansas City, 1994

Experience

25 years of professional experience

Affiliations

American Institute of Certified Public Accountants
Missouri Society of Certified Public Accountants

Licenses/Certifications

Certified Public Accountant

Relevant Work Experience

California Department of Health Care Services (2016 – 2017)
Disproportionate Share Hospital (DSH) Audit

Scope of Work:
Myers and Stauffer assists the Department in its compliance with the federal regulation that requires states to have an independent audit of their DSH programs and submit an annual report to the Centers for Medicare & Medicaid Services (CMS).

Responsibilities:

- Oversaw the completion of the DSH examination for 2013.
- Reviewed and built a data collection tool based on the California 1115 Waiver.
- Review of Medicaid and uninsured health care claims for all DSH hospitals.

California Department of Health Care Services (2005 – 2007 and 2012)
Health Care Reform and Litigation Support

Scope of Work:
Myers and Stauffer was engaged to develop a model to implement Governor Schwarzenegger's health care reform proposal and provide litigation support related to various health care provider rate and access to care cases.

Responsibilities:

- Participated in agency and industry calls weekly.
- Developed models to finance health care reform including restraints of no new state funds, increased federal participation, and minimizing negative impact to any provider's net Medicaid revenue.
- Included physician, hospital, managed care, and uninsured.
- Performed studies and technical analysis to support the state's defense.
- Surveyed various provider types for data collection.
- Included analysis and expert opinions related to home health rates and ambulance and non-emergency Medicaid transportation.
- Utilized cost report data and claims level data.

Florida Agency for Health Care Administration (2013 – Present)

Hospital Cost Report Audit and Disproportionate Share Hospital (DSH) Payment Reconciliation

Scope of Work:

Myers and Stauffer provides services to the Florida Agency for Health Care Administration (AHCA) for hospital cost report audits, federal DSH program payment reconciliation services, and for Medicaid Supplemental Schedule DSH Key Components Review (DSR).

Responsibilities:

- Oversee the annual completion of all Medicaid hospital cost report examinations for the Agency for Health Care Administration (AHCA).
- Assisted AHCA with various consulting analyses including waiver payments such as the Low Income Pool (LIP).
- Oversee the completion of the Florida DSH examination annually.
- Assist with Low Income Pool waiver development and renewal.
- Provide training to the hospital industry.
- Develop and maintain database of cost report data for use in developing hospital rates.
- Assisted Agency in issuing a backlog of hospital rate calculations.
- Quality reviews of all deliverables to the Agency.
- Review of Medicaid and uninsured health care claims for all DSH hospitals.

Florida Agency for Health Care Administration (2013 – Present)

Expert Witness Service

Scope of Work:

Myers and Stauffer provides expert witness and litigation support services to the Florida Agency for Health Care Administration (AHCA) in support of their hospital rate setting and cost reports.

Responsibilities:

- Assisted the Agency for Health Care Administration (AHCA) in settling litigation from hospitals related to rates and audits.
- Assisted AHCA in defending rate calculations as an expert witness (deposition) and in cross-examining opposing counsel expert witnesses.
- Assisted AHCA in writing their hospital state plan to clarify current rate setting methodologies and necessary changes.
- Research and analyze issues impacting various cases.

Florida Agency for Health Care Administration (2019 – Present)
Nursing Facility and Home Office Cost Report Examinations and Reporting

Scope of Work:
Myers and Stauffer performs compliance examinations and reviews of Medicaid nursing home and home office cost reports to provide assurance that Medicaid nursing home rates are based on allowable and supported costs.

Responsibilities:

- Oversee project development.
- Oversee audit staff and work with the client to find solutions to audit issues.

Kansas Department of Health and Environment (2008 – Present)
Disproportionate Share Hospital (DSH) Payments

Scope of Work:
Myers and Stauffer is engaged by Kansas Medicaid to assist with DSH eligibility determinations and payments.

Responsibilities:

- Oversee the state's annual DSH payment calculations.
- Recommend, evaluate, and assess different fiscal payment models for DSH payments.
- Assisted the state in state plan revisions and consulting related to DSH policy including attending meetings with the association and hospitals.

Louisiana Department of Health (2004 – Present)
Case Mix Reimbursement System

Scope of Work:
Myers and Stauffer assists with the operation of a case mix reimbursement system and MDS data management and reporting services for nursing facilities participating in the Louisiana Medicaid Program.

Responsibilities:

- Provide assistance to ensure all federal and state legislative mandates and other program requirements are met.
- Assist with feasibility studies, fiscal impacts, policy development, and new initiatives.
- Oversee the quarterly case mix rate setting for Louisiana nursing facilities for the Louisiana Department of Health and Hospitals (DHH).
- Assisted DHH in implementing state plan changes and nursing facility bed reduction initiatives.
- Oversee the annual nursing facility upper payment limit (UPL) calculations for DHH.
- Assisted with CPE claims for nursing home providers.
- Calculated annual provider tax.
- Assisted the DHH with implementing a home and community-based services cost collection tool.

Louisiana Department of Health (2010 – Present)
Disproportionate Share Hospital (DSH) Audit

Scope of Work:
Myers and Stauffer performs federally-mandated independent certified audits of the state's DSH program.

Responsibilities:

- Oversee the completion of the Disproportionate Share Hospital (DSH) examination annually for the Department of Health and Hospitals (DHH).

- Assisted DHH in DSH payment-related matters and train hospital personnel, as needed.
- Review of Medicaid and uninsured health care claims for all DSH hospitals.

Louisiana Department of Health (2018 – Present)
Disproportionate Share Hospital Payments

Scope of Work:
Myers and Stauffer was engaged to calculate annual disproportionate share hospital (DSH) payments for the Louisiana Department of Health and Hospitals.

Responsibilities:

- Assist the state with data collection and DSH payment calculations.

Louisiana Department of Health (2005 – Present)
Disproportionate Share Hospital Payment and Hospital Upper Payment Limit Calculations

Scope of Work:
Myers and Stauffer collects, analyzes and summarizes data for the state of Louisiana's Act 540 program.

Responsibilities:

- Assist with Louisiana ACT 540 data collection and uninsured calculations.
- Assist with Louisiana hospital UPL calculations.
- Assist with consulting related to financing (IGTs, CPEs, and taxes) and other legislative analysis.

Maine Department of Health and Human Services (2016 – Present)
Disproportionate Share Hospital (DSH) Audit

Scope of Work:
Myers and Stauffer performs federally mandated independent certified audits of the state of Maine’s DSH program.

Responsibilities:

- Oversee the completion of the DSH examination annually.
- Review of Medicaid and uninsured health care claims for all DSH hospitals.

Maine Department of Health and Human Services (2016 – 2017)
Ambulance Rate Study

Scope of Work:
Conduct a rate study of ambulance service providers in Maine.

Responsibilities:

- Review existing upper payment limit calculations and make recommendations to the Department on possible changes.

Michigan Department of Community Health (2017 – Present)
Annual Reports & Audits for Disproportionate Share Hospital Medicaid Program

Scope of Work:
Myers and Stauffer provides independent certified audits of DSH payments for the Michigan Department of Health and Human Services (MDHHS).

Responsibilities:

- Oversee the completion of the DSH examination annually.
- Review of Medicaid and uninsured health care claims for all DSH hospitals.

Missouri Department of Social Services (2019 – Present)
Ground Emergency Medical Transport (GEMT) Cost Reporting Services

Scope of Work:
Myers and Stauffer provides services to the Missouri HealthNet Division (MHD) for Medicaid GEMT cost report reviews.

Responsibilities:

- Oversee the annual collection and desk review of Medicaid GEMT cost reports for the Missouri Department of Social Services – MO HealthNet Division.
- Develop and maintain a GEMT cost database for GEMT payments and CPE calculations.
- Develop and maintain web portals for collection of GEMT data and monitoring of project status.

Missouri Department of Social Services (2018 – Present)
Cost Report Audit

Scope of Work:
Myers and Stauffer provides services to the Missouri HealthNet Division (MHD) for Medicaid cost report audits.

Responsibilities:

- Oversee the annual collection and desk review of Medicaid nursing facility cost reports for the Missouri Department of Social Services – MO HealthNet Division.
- Develop and maintain a nursing facility cost database.
- Develop and maintain web portals for collection of nursing facility data and monitoring of project status.
- Various analyses related to nursing facility rates and cost.

Missouri Department of Social Services (2016 – Present)
Disproportionate Share Hospital (DSH) Audits

Scope of Work:
Myers and Stauffer performs federally mandated independent certified audits of the state of Missouri's DSH program.

Responsibilities:

- Oversee the completion of the Disproportionate Share Hospital (DSH) examination annually.
- Assisted MO HealthNet transition to a new DSH payment model and oversee the group reviewing the data for use in their current DSH payment process.
- Assisted MO HealthNet and the hospital association in DSH-related matters, including litigation, and training for hospital personnel.
- Review of Medicaid and uninsured health care claims for all DSH hospitals.

Missouri Department of Social Services (2018 – 2019)

Hospital Cost Reporting Audit

Scope of Work:

Myers and Stauffer provides services to the Missouri HealthNet Division (MHD) for Medicaid hospital cost report audits.

Responsibilities:

- Oversee the annual collection and desk review of Medicaid hospital cost reports for the Missouri Department of Social Services – MO HealthNet Division.
- Develop and maintain a hospital cost database for hospital rate development.
- Develop and maintain web portals for collection of hospital data and monitoring of project status.

New Jersey Department of Human Services (2010 – Present)

Disproportionate Share Hospital Audit

Scope of Work:

Myers and Stauffer performs federally-mandated independent certified audits of the state's DSH program.

Responsibilities:

- Oversee the completion of the DSH examination annually.
- Review of Medicaid and uninsured health care claims for all DSH hospitals.

New Jersey Department of Health (2004 – 2015)

Nursing Facility Reimbursement System

Scope of Work:

Myers and Stauffer was engaged to assist in the development and implementation of a case mix reimbursement system for nursing facilities participating in the New Jersey Medicaid program.

Responsibilities:

- Performed annual audits of the Medicaid nursing facility cost reports for the Department of Human Services.
- Assisted the Department of Human Services in annual nursing facility upper payment limit (UPL) calculations and resulting CPE calculations.

North Carolina Department of Health and Human Services (2004 and 2011 – 2012)

DRG Reimbursement System Update and Review

Scope of Work:

Myers and Stauffer provides an update to the Medicare severity (MS)-DRG inpatient reimbursement system. New relative DRG weights are computed as well as inflation of hospital rates and adjustments to hospital add-on factors for indirect and direct medical education.

Responsibilities:

- Outpatient hospital cost report settlements.
- Supervisory reviews of Medicaid cost report audits and field work on large teaching facilities.

South Dakota Department of Social Services (2020 – Present)
DSH Analysis and Recommendations

Scope of Work:
Myers and Stauffer serves as a DSH consultant related to the state's current DSH payment methodology, audits previously conducted internally at the state and general DSH consulting related to eligibility, regulations, and judicial decisions.

Responsibilities:

- Review the entire DSH program and prepare a report with analysis and recommendations for DSH including changes to previous audits/payments and future methodology changes.

Presentations

"Hospital and Hospital Health Care Complex Cost Report Form CMS 2552-10," Louisiana Department of Health, Baton Rouge, Louisiana, 2018 & 2019.

"Government Health Care Financing," University of Missouri at Kansas City, Kansas City, Missouri, 2015.

"DSH Audit Update," HFMA, 2014.

"DSH Audits," Missouri, Florida, Louisiana, New Jersey and Kentucky Hospitals, Missouri, Florida, Louisiana, New Jersey and Kentucky, 2009 – 2014.

"DSH Update," Missouri Hospitals, Webinar, 2013.

"DSH Update," Louisiana Hospitals, Baton Rouge, Louisiana, 2013.

"2552-10 Medicare Cost Report," Myers and Stauffer Audit/AUP Training Workshop, Baltimore, Maryland, 2011.

"DSH Data Collection," Louisiana Rural Hospital Coalition, Baton Rouge, Louisiana, 2010.

"Louisiana Case Mix," Louisiana Nursing Facility Case Mix Training, Monroe and Baton Rouge, Louisiana, 2008.

"Medicare Cost Reports," Myers and Stauffer Audit/AUP Training Workshop, Kansas City, Missouri, 2006.

"Children's Hospitals Graduate Medical Education," HRSA Workshops, Chicago, San Francisco, Baltimore, 2004.

Timothy Guerrant, CPA

Member

Summary

Mr. Guerrant is a partner-in-charge of the firm's rate setting and federal compliance engagement team. He has experience providing rate setting, reimbursement system design, and consulting services for government health care agencies. He has extensive experience in Medicaid rate setting across a wide spectrum of health care services, including hospital, physician, federally qualified health center (FQHC), rural health clinic (RHC), durable medical equipment and medical supplies, dental, transportation, waiver services, and behavioral health services. He is an expert in Medicaid financing and compliance issues, including upper payment limit (UPL) demonstrations, health care provider taxes, intergovernmental transfers (IGTs), and certified public expenditures (CPEs).

Mr. Guerrant's experience includes the development of cost reports and other data collection instruments, provider and stakeholder training, deployment of data collection tools, and data-driven rate setting and analysis. His experience also includes reimbursement and policy research, and preparation of analytical studies and reports including fiscal impact modeling and reimbursement rate analysis. He provides consulting services related to Medicaid state plan amendments (SPAs), Medicare and Medicaid legislation and policy issues, and Medicaid financing and compliance issues.

Education

B.S., Accounting, Bob Jones University, 1999

Experience

21 years of professional experience

Affiliations

American Institute of Certified Public Accountants
Healthcare Financial Management Association
Indiana CPA Society

Licenses/Certifications

Certified Public Accountant

Relevant Work Experience

Arkansas Department of Human Services (2018 – Present)
Upper Payment Limit and Assessment Fee Calculations

Scope of Work:
Myers and Stauffer assists the Department with UPL demonstrations and assessment fee calculations.

Responsibilities:

- Oversee and provide project leadership and quality assurance for the preparation of UPL demonstration calculations for inpatient hospital, outpatient hospital, clinic, PRTF, and durable medical equipment providers and services. Myers and Stauffer assist the state in the preparation of assessment fee calculations for hospital providers.

Alabama Medicaid Agency (2017 – Present)

Accounting, Auditing, and Consulting Services

Scope of Work:

Myers and Stauffer performs consulting services relating to institutional and non-institutional reimbursement programs and federal reporting consulting services.

Responsibilities:

- Oversee and provide quality assurance for hospital UPL, funding model, state plan amendments, Medicaid financing issues and federal reporting (CMS-64).
- Provide project leadership for the preparation of the disproportionate share hospital (DSH) reporting for the annual audit of the state's DSH program.

Alaska Department of Health and Social Services (2019 – Present)

Diagnosis Related Group (DRG) Technical Assistance

Scope of Work:

Myers and Stauffer was engaged to provide technical assistance and support to the Department regarding the feasibility, development, and implementation of a diagnostic-related group (DRG) payment methodology for Alaska hospitals.

Responsibilities:

- Responsible for oversight of engagement and client satisfaction.
- Evaluate DRG payment methodology structure for Alaska Medicaid.
- DRG system design, rate setting, and payment modeling.
- Facilitate stakeholder engagement and communication.

Alaska Office of the Governor (2019 – 2019)

Health Care Provider Tax Feasibility Study

Scope of Work:

Myers and Stauffer conducted an updated feasibility study of implementing health care provider taxes in the state.

Responsibilities:

- Conducted an updated feasibility study of implementing health care provider taxes in Alaska across all applicable provider and service types.
- Developed recommendations for implementing a provider tax program.
- Assisted in the development of a report for the state containing the results of the study and recommendations for provider tax implementation.

Alaska Department of Health and Social Services (2015 – 2016)

Health Care Provider Tax Feasibility Study

Scope of Work:

Myers and Stauffer conducted a feasibility study of implementing health care provider taxes in the state.

Responsibilities:

- Conducted a feasibility study of implementing health care provider taxes in Alaska across all applicable provider and service types.
- Conducted provider outreach and training sessions.
- Developed recommendations for implementing a provider tax program.

- Assisted in the development of a report for the state containing the results of the study and recommendations for provider tax implementation.

Colorado Department of Health Care Policy and Financing (2017 – 2020)
Hospital Provider Fee, UPL, and Other Consulting

Scope of Work:
Myers and Stauffer provided Medicaid financing and reimbursement consulting services in conjunction with the Colorado's Medicaid reimbursement system for hospital and non-institutional services to eligible recipients of the Medicaid program.

Responsibilities:

- Oversee and provide quality assurance for hospital provider fee and upper payment limit (UPL) demonstration calculations.

Indiana Family & Social Services Administration (2001 – Present)
Medicaid Rate Setting Services

Scope of Work:
Myers and Stauffer provides reimbursement methodology consulting, compliance analysis, fiscal impact analysis, provider tax calculations, and monitoring services for long-term care facility provider tax programs.

Responsibilities:

- Leads the firm's non-LTC rate setting efforts, including inpatient (DRG) and outpatient hospital, FQHC, RHC, PRTF, behavioral health, waiver services, transportation, and other ambulatory providers and services.
- Reviews, evaluates, and designs Medicaid reimbursement methodologies and systems and assists with implementation.
- Calculates and updates reimbursement rates for a wide range of Medicaid-enrolled providers based on various data sources.
- Conducts various data analytics, including fiscal impact estimates of reimbursement changes, utilization analyses, and other ad-hoc analyses to support program objectives.
- Develops overall data gathering strategies on a variety of rate setting projects to include use of cost reports, surveys, data analysis and other data collection tools and mechanisms to include the Bureau of Labor Statistics and other published data.
- Supervises the reviews of provider cost reports.
- Assists the state in compliance with federal requirements, including upper payment limit demonstrations and state plan amendments.
- Develops federally-compliant provider tax programs and monitors provider assessments.
- Assists in the resolution of provider disputes and appeals.
- Responds to inquiries from program stakeholders, including providers, industry associations, and other advocates.
- Researches and evaluates Medicare and Medicaid legislation, regulations, and policy issues.

Indiana Family & Social Services Administration (2013 – Present)
Mental Health Claims Audit

Scope of Work:
Myers and Stauffer conducts an agreed-upon procedures engagement on mental health provider cost reports.

Responsibilities:

- Provide project direction for the collection of cost reports from providers and the performance of on-site review procedures on provider cost reports for the state's mental health funds recovery administrative claiming program.

Kentucky Cabinet for Health and Family Services (2020 – Present)
Medicaid Rate Setting

Scope of Work:
Myers and Stauffer provides Medicaid rate setting, reimbursement methodology consulting, compliance analysis, fiscal impact analysis, provider tax calculations, and monitoring services for long-term care facilities.

Responsibilities:

- Assisting Medicaid program officials evaluate an ambulance enhanced payment program, including fee-for-service supplemental payment and managed care directed payment programs.
- Review proposed program materials, including cost report, state plan amendment, and managed care directed payment pre-print.

Maine Department of Health and Human Services (2016 – 2017)
Ambulance Rate Study

Scope of Work:
Conduct a rate study of ambulance service providers in Maine.

Responsibilities:

- Directed the analysis of public payer reimbursement rates and provider cost of ambulance services in Maine.
- Computed the fiscal impact of changes in reimbursement rates.
- Oversaw the preparation of a final report to the legislature containing the results of the rate study.

Maine Department of Health and Human Services (2018 – Present)
Upper Payment Limit Calculations

Scope of Work:
Myers and Stauffer assists the state of Maine with UPL demonstration calculations.

Responsibilities:

- Oversee and provide quality assurance of the preparation of UPL demonstration calculations for inpatient hospital, outpatient hospital, clinic, and durable medical equipment providers and services.

Michigan Department of Community Health (2017 – Present)
Annual Reports & Audits for Disproportionate Share Hospital Medicaid Program

Scope of Work:
Myers and Stauffer provides independent certified audits of DSH payments for the Michigan Department of Health and Human Services (MDHHS).

Responsibilities:

- Provide project leadership and support to senior management in the performance of DSH audit services.

Missouri Department of Social Services (2019 – Present)
Ground Emergency Medical Transport (GEMT) Cost Reporting Services

Scope of Work:
Myers and Stauffer provides services to the Missouri HealthNet Division (MHD) for Medicaid GEMT cost report reviews.

Responsibilities:

- Provide technical assistance related to the review of GEMT provider cost report information for calculating Medicaid GEMT cost.

New Jersey, County of Essex (2020 – Present)
Hospital Assessment Fee Development and Implementation

Scope of Work:
Myers and Stauffer assists the County of Essex, New Jersey, with the development and implementation of a health care provider assessment for hospital services.

Responsibilities:

- Oversee and provide project leadership and quality assurance for the development and implementation of a hospital assessment fee program for the county under federal and state statutory and regulatory requirements.

New Mexico Human Services Department (2018 – Present)
CMS-64 Reconciliation Services

Scope of Work:
Myers and Stauffer assists the Department in the review of their Form CMS-64 reports for quarterly Federal reporting of Medicaid and CHIP expenditures.

Responsibilities:

- Oversee and provide project leadership and quality assurance for CMS-64 and CMS-21 reconciliation services and recommendations for federal reporting process improvements.

Virginia Department of Medical Assistance Services (2018 – Present)
DRG and UPL Services

Scope of Work:
Myers and Stauffer is contracted to perform an update of the state's existing DRG system and assist with UPL determinations.

Responsibilities:

- Provide project direction for the preparation of UPL demonstrations for hospital services.

West Virginia Children's Health Insurance Program (2010 – Present)
Federally Qualified Health Center and Rural Health Clinic Prospective Payment System

Scope of Work:
Myers and Stauffer was engaged by the West Virginia Children’s Health Insurance Program to implement and update a prospective payment system (PPS) for FQHC and RHC providers.

Responsibilities:

- Design and develop a PPS reimbursement methodology for the Children’s Health Insurance Program.

- Oversee all aspects of rate setting services for FQHC and RHC providers, including calculating rates for new providers and adjusting rates due to changes in scope of services.

West Virginia Public Employees Insurance Agency (2018 – Present)

Prospective Payment System/Resource-Based Relative Value System and UPL Demonstration Calculations

Scope of Work:

Myers and Stauffer is engaged by West Virginia Public Employees Insurance Agency and Department of Health & Human Resources to provide rate updates and consulting services related to their inpatient, outpatient, and physician reimbursement systems and perform UPL demonstration calculations.

Responsibilities:

- Oversee and provide quality assurance of rate setting and payment modeling for inpatient hospital, outpatient hospital, and physician services.
- Oversee and provide quality assurance of the preparation of upper payment limit demonstration calculations for inpatient and outpatient hospital services.

Presentations

"Medicaid Financing", Texas Health and Human Services, Austin, Texas, 2020.

"Inpatient Hospital Diagnosis Related Groups (DRG) Reimbursement Methodology", Alaska Department of Health and Social Services, Anchorage, Alaska, 2020.

"Hospital Assessment Fee," Indiana Family and Social Services Administration, Indianapolis, Indiana, 2018.

"Acute Care Reimbursement," Indiana Family and Social Services Administration, Indianapolis, Indiana, 2016.

"Health Care Provider Tax," Alaska Provider Tax Stakeholder Forum, Anchorage, Alaska, 2015.

Chris Cole, CPA

Senior Manager

Summary

Mr. Cole has over 12 years of public accounting auditing experience specifically focusing on state Medicaid agencies and the application of cost reimbursement principles promulgated in the Centers for Medicare and Medicaid Services (CMS) publication 15-1. His experience includes long-term care Medicaid examinations, hospital Medicaid examinations, disproportionate share hospital (DSH) examinations, and Medicaid managed care examinations in multiple states. His daily responsibilities include the implementation of staff development, evaluation and training programs, work paper development, examination program development, and quality supervisory reviews relating to long term care and hospital cost reports.

Education

B.A., Business Management and Accounting, University of Ottawa, 2011
M.B.A., Management, Emporia State University, 2016

Experience

12 years of professional experience

Affiliations

American Institute of Certified Public Accountants

Licenses/Certifications

Certified Public Accountant

Relevant Work Experience

Florida Agency for Health Care Administration (2014 – Present)
Hospital Cost Report Audit and Disproportionate Share Hospital (DSH) Payment Reconciliation

Scope of Work:
Myers and Stauffer provides services to the Florida Agency for Health Care Administration (AHCA) for hospital cost report audits, federal DSH program payment reconciliation services, and for Medicaid Supplemental Schedule DSH Key Components Review (DSR).

Responsibilities:

- Created standard work paper templates to increase the efficiency of the review process.
- Helped guide the state of Florida in catching up their hospital reviews through the year 2014 as the previous contractor was several years behind in their workload.
- Conducted set up and implementation of a statewide web portal, helping streamline the cost report submission process for 250 hospitals.
- Implemented a new internal stat log system to increase employee efficiency and progress tracking.

Florida Agency for Health Care Administration (2019 – Present)
Nursing Facility and Home Office Cost Report Examinations and Reporting

Scope of Work:
Myers and Stauffer performs compliance examinations and reviews of Medicaid nursing home and home office cost reports to provide assurance that Medicaid nursing home rates are based on allowable and supported costs.

Responsibilities:

- Perform the day-to-day project management functions required to ensure we remain in compliance with contractual deadlines.
- Created standard work paper templates to increase efficiency of the review process.
- Developed a risk assessment protocol modeled around the state's new PPS reimbursement methodology.
- Train staff members on the rate setting methodology and how to apply that knowledge in performing their reviews.
- Generated an entirely new limited scope review program to enhance the effectiveness of reviews according to the Florida rate setting methodology.

Louisiana Department of Health (2008 – 2011)

Case Mix Reimbursement System

Scope of Work:

Myers and Stauffer is assisting in the development and operation of a case mix reimbursement system and MDS data management and reporting services for nursing facilities participating in the Louisiana Medicaid Program.

Responsibilities:

- Helped develop and maintain a new Medicaid supplemental cost report for use by all institutions for mental diseases (IMDs) in the state.
- Trained providers on the use of the supplemental form and handled all troubleshooting issues with filing, alleviating this burden from the client.

Missouri Department of Social Services (2019 – Present)

Cost Report Audit

Scope of Work:

Myers and Stauffer provides services to the Missouri HealthNet Division (MHD) for Medicaid cost report audits.

Responsibilities:

- Perform supervisory quality reviews of hospital Medicaid cost reports to ensure compliance with Missouri Medicaid, Code of Federal Regulations and the Centers for Medicaid and Medicaid Services regulatory framework.
- Train staff on the completion of Agreed Upon Procedures, Desk Reviews and Examinations in conformity with Missouri Medicaid, Code of Federal Regulations and the Centers for Medicaid and Medicaid Services regulatory framework.
- Consult with project management on complex regulatory issues impacting Medicaid reimbursement.

New Jersey Department of Health (2010 – 2013)

Nursing Facility Audits

Scope of Work:

Myers and Stauffer provided nursing facility auditing services to ensure operating costs were reasonable, allocable, allowable, and in compliance with Medicaid and Medicare guidelines.

Responsibilities:

- Coordinated the review of nursing facility audits on a yearly basis to ensure quarterly and annual goals were met.

- Increased efficiency and quality of reviews by working with management to develop risk assessment procedures for each audit.

Melenie Sheehan, CPA

Senior Manager

Summary

Ms. Sheehan, a senior manager with Myers and Stauffer, is responsible for managing the annual disproportionate share hospital (DSH) and upper payment limit (UPL) consulting for four state contracts. Her responsibilities include review and analysis of federal and state legislative initiatives; review and analysis of the calculation of each state's DSH uncompensated care cost; and participation in policy discussions related to intergovernmental transfers (IGT), DSH, and UPL. She reviews and analyzes hospital-specific limits, computes hospital eligibility for supplemental payments, and coordinates with the fiscal agent contractor and Office of Financial Management (OFM) for the release of supplemental payments. She assists the OFM and state budget agency in monitoring account balances for the indigent care trust fund; attends and monitors fund distributions; and coordinates and meets with the hospital association.

In addition to conducting the exam, on-site review, and preparing the exam report and documentation, she assists the states with defending the exam results in hospital appeals. Ms. Sheehan has also been actively involved in other hospital reimbursement projects including policy and procedure analysis, survey research, data collection, data and financial analysis, reimbursement and medical policy consulting, and cost report reviews and audits. Her experience also includes preparing public notices, state plan amendments, regulatory changes, and responses to the Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG).

Education

B.A., Accounting, Ball State University, 1996

Experience

24 years of professional experience

Affiliations

American Institute of Certified Public Accountants
Healthcare Financial Management Association
Indiana CPA Society

Licenses/Certifications

Certified Public Accountant

Relevant Work Experience

Illinois Department of Healthcare and Family Services (2010 – Present)
Disproportionate Share Hospital (DSH) Examination

Scope of Work:
Myers and Stauffer performs federally mandated independent certified examinations of the Illinois DSH program.

Responsibilities:

- Assisted in developing the examination process.
- Review correspondence and reports.
- Provide consultation on technical issues.

Indiana Family & Social Services Administration (2000 – Present)

Medicaid Rate Setting Services

Scope of Work:

Myers and Stauffer provides reimbursement methodology consulting, compliance analysis, fiscal impact analysis, provider tax calculations, and monitoring services for long-term care facility provider tax programs.

Responsibilities:

- Oversee inpatient and outpatient hospital upper payment limit (UPL) calculations.
- Oversee physician UPL and supplemental payment calculations.
- Oversee nursing facility supplemental payment administration.
- Oversee disproportionate share hospital (DSH) eligibility determinations.
- Oversee determination of hospital DSH uncompensated cost of care or hospital-specific limits.
- Oversee calculation of DSH payments, Medicaid state plan amendments, and various ad-hoc assignments.
- Assist the client in working with the Centers for Medicare and Medicaid Services (CMS) and providers.
- Developed the examination process.
- Oversee communication to the client and providers.
- Oversee collection and compilation of data and create reports.

Mississippi Division of Medicaid (2014 – Present)

Disproportionate Share Hospital (DSH) Examinations

Scope of Work:

Myers and Stauffer performs federally mandated independent certified examinations of Mississippi's DSH program.

Responsibilities:

- Oversee the disproportionate share hospital (DSH) examination process.
- Review correspondence and reports.
- Conduct on-site reviews.
- Review work papers.
- Assist the client in provider appeals and communication with CMS.

Ohio Department of Medicaid (2010 – Present)

Disproportionate Share Hospital (DSH) Payment Examination Services

Scope of Work:

Myers and Stauffer performs federally-mandated independent certified examinations of the Ohio Department of Medicaid DSH program.

Responsibilities:

- Assisted in developing the examination process.
- Review correspondence and reports.
- Conduct on-site reviews.
- Provide consultation on technical issues.

Virginia Department of Medical Assistance Services (2020 – Present)
Hospital Upper Payment Limit Services

Scope of Work:
Myers and Stauffer performs calculates the annual inpatient and outpatient hospital upper payment limit calculations

Responsibilities:

- Oversee inpatient and outpatient hospital upper payment limit (UPL) calculations.
- Review correspondence and reports.
- Provide consultation on technical issues.

Presentations

"OMPP Training – Disproportionate Share Hospital (DSH) and Medicaid Supplemental Payments," Indiana Office of Medicaid Policy and Planning Staff, 2016.

"OMPP Training – Disproportionate Share Hospital (DSH) and Medicaid Supplemental Payments," Indiana Office of Medicaid Policy and Planning Staff, 2015.

"Mississippi Medicaid DSH Examination 2011," Mississippi Division of Medicaid, 2013.

"Disproportionate Share Hospital (DSH) Payment Audit," State of Illinois Department of Healthcare and Family Services, 2011 – 2013.

"Ohio Medicaid DSH Audits," Ohio Hospital Association, 2010 – 2013.

"OMPP Training – Disproportionate Share Hospital (DSH) and Medicaid Supplemental Payments," Indiana Office of Medicaid Policy and Planning Staff, 2010.

David Halferty, MBA

Senior Manager

Summary

Mr. Halferty is responsible for providing rate setting and consulting services to state Medicaid agencies addressing health care reimbursement issues. He has worked on Medicaid rate setting and consulting projects related to home and community based services providers (HCBS), nursing facilities, the Program of All-Inclusive Care for the Elderly (PACE), and other provider groups. Mr. Halferty's consulting experience includes rate methodology development, case mix system analysis, value based payment methodology development, upper payment limit (UPL) demonstrations, provider tax analysis, and market feasibility analysis. Mr. Halferty also has experience working with electronic health records (EHR) incentive payment compliance reviews, Medicare compliance audits, Medicaid managed care contract reviews, and medical loss ratio (MLR) analysis.

In his role as a senior manager, he is responsible for monitoring project requirements, communicating with clients, and ensuring project deliverables are produced timely and accurately. He also serves as a member of the Myers and Stauffer Nursing Facility Engagement Team leadership group. He recently worked on an internal taskforce committee researching the Patient-Driven Payment Model (PDPM). He has assisted with numerous client briefs and communications.

Education

M.B.A., Finance, Washburn University, 2014
M.S.E., Health, Sport & Exercise Science, University of Kansas, 2004
B.A., Mathematics, Simpson College, 1990

Experience

21 years of professional experience

Relevant Work Experience

Arkansas Department of Human Services (2014 – Present)
Nursing Facility UPL Demonstration

Scope of Work:
Myers and Stauffer prepares and supports the state's annual nursing facility UPL demonstration.

Responsibilities:

- Responsible for the data collection and assembly of the state's UPL demonstration for nursing facilities. This includes working with state staff to acquire the data needed to complete the demonstration, preparing a cost-based demonstration for the state-operated facilities, providing quality assurance oversight for the project, and assembling the UPL summary report.

Illinois Department on Aging (2018 – Present)
HCBS - Community Care Program Care Coordination Unit Administrative Services Rate Study

Scope of Work:
Myers and Stauffer is conducting a rate study for the CCU administrative services provided through the state's CCP. The study includes an examination of eleven different services including initial assessment, Medicaid application assistance, person-centered plan of care development, face-to-face visits, reassessment, nursing facility screening,

intensive casework/monitoring, presumptive eligibility, person-centered plan of care adjustment, case management, and deinstitutionalization. The CCP includes HCBS waiver participants and state-funded beneficiaries over age 60.

Responsibilities:

- Oversee cost data gathering, analysis, and reporting activities for CCUs.
- Coordinate stakeholder meetings and conduct provider cost survey training.
- Provide technical assistance as needed.
- Prepare and present rate study reports covering eleven different administrative services covered by the CCP.

Kansas Department for Aging and Disability Services (2015 – 2016)

HCBS-I/DD Rate Study - Consulting

Scope of Work:

Myers and Stauffer conducted a rate study for the state HCBS waiver for individuals with intellectual/developmental disabilities (I/DD).

Responsibilities:

- Oversaw cost data gathering, analysis, and reporting activities for Kansas HCBS-I/DD waiver.
- Coordinated stakeholder meetings and conducted provider cost survey training.
- Provided technical assistance as needed.
- Prepared and presented final rate study report covering nine different services covered by the HCBS-I/DD waiver including residential services.

Kansas Department for Aging and Disability Services (2014 – Present)

Rate Setting and MDS Data Management for Nursing Facilities and Mental Health Facilities

Scope of Work:

Myers and Stauffer provides rate setting services and state plan consultation for nursing facilities and nursing facilities for mental health.

Responsibilities:

- Act as the primary liaison to the agency.
- Oversee all rate setting activities for Kansas nursing facilities and nursing facilities for mental health. This includes processing cost report data, managing MDS/case mix data, preparing fiscal analysis for the State, and assisting the State with Medicaid state plan revisions.
- Make presentations to state staff, nursing facility trade associations, legislative committees, and other stakeholders as needed.
- Provide reimbursement consulting as needed and represent the State as a technical expert during litigation proceedings, public hearings, and other meetings.

Missouri Department of Social Services (2014 – Present)

Nursing Facility Reimbursement System Review

Scope of Work:

Conduct a review of the current nursing facility reimbursement methodology, analysis of case mix reimbursement options and options for implementing VBP provisions.

Responsibilities:

- Responsible for the data collection and assembly of the state's UPL demonstration for nursing facilities. This includes working with state staff to acquire the data needed to complete the demonstration, preparing a cost-based demonstration for the state-operated facilities, providing quality assurance oversight for the project, and assembling the UPL summary report.

Oklahoma Health Care Authority (2016 – Present)
Nursing Facilities Supplemental Payment Program

Scope of Work:

Myers and Stauffer provides state plan consultation, prepare Medicare RUG UPL calculations, determines nursing facility supplemental payments, and prepares materials for and assists with correspondence with CMS.

Responsibilities:

- Primary contact for this project and coordinate all communications, analysis, and consulting activities.
- Responsible for all data collection and calculation of UPL supplemental payment estimates, assisting the State with developing a SPA, working with the State to respond to inquiries from CMS, and coordinating and providing technical support to state program staff.

South Dakota Department of Human Services (2019 – Present)
Nursing Facility Reimbursement Methodology Review

Scope of Work:

Conduct a review of the current nursing facility reimbursement methodology and prepare a report to include recommendations for strengthening the system and incorporating VBP provisions.

Responsibilities:

- Act as the primary liaison to the Department.
- Responsible for all data collection, model development, data analysis, stakeholder engagement, meeting records, and report preparation.

Presentations

"Kansas Nursing Facility Rate Setting 101," Kansas Adult Care Executives Annual Convention, Wichita, Kansas, 2016 – 2020.

"VBP/P4P Trends in Managed Care for LTSS - Panel Moderator," Myers and Stauffer Value-Based Purchasing Forum, Atlanta, Georgia, 2019.

"Testimony to Long-Term Care Oversight Committee," Kansas Legislature, Topeka, Kansas, 2018.

"Managed LTC Panel Discussion Moderator," Long Term Care Payment Forum, Atlanta, Georgia, 2016.

"Medicaid Financing Alternatives," Myers and Stauffer Nursing Facility Rate Setting Training, Kansas City, Missouri, 2016.

"Managed LTC - The KanCare Experience," Long-Term Care Value-Based Purchasing Invitation Meeting, Atlanta, Georgia, 2015.

"Panel Discussion: Been There, Done That: A Conversation with States," Rebalancing for the Future - A Forum on Long Term Care in Indiana, Indianapolis, Indiana, 2015.

Lesley Beerends, MBA, CPA

Senior Manager

Summary

Ms. Beerends has more than 22 years of experience in health care reimbursement. She assists state officials with designing reimbursement methodology and cost reporting procedures for new Medicaid programs, including market research as well as relevant rate and fiscal impact analysis. This includes ongoing policy and procedure analysis for current Medicaid services and updating the SPA and drafting administrative rules. She also has extensive knowledge of Medicaid cost reports and rate setting for HCBS, targeted case management, habilitation, CMHCs, hospitals, FQHCs, and RHCs. Ms. Beerends provides technical assistance and cost report training for Medicaid providers. She is also a member of the firm's consulting engagement team.

For the past 14 years, she has led the DRG and APC recalibration and rebasing project for the state of Iowa. This includes determination of hospital rates and CMI factors, calculation of DRG relative weights and outlier thresholds, cost-to-charge-ratios, fiscal impact studies, management of databases, statistical analyses, calculation of disproportionate share and graduate medical education (GME) payments for qualifying hospitals, and upper payment limit (UPL) calculations. She provides analysis of Medicaid claims data for financial and policy support and to assist providers with claims billing and payment issues.

Education

B.A., Accounting, Simpson College, 1996
M.B.A., Northern Illinois University, 2005

Experience

24 years of professional experience

Affiliations

American Institute of Certified Public Accountants
Iowa Society of Certified Public Accountants

Licenses/Certifications

Certified Public Accountant

Relevant Work Experience

Arkansas Department of Human Services (2018 – Present)
Desk Reviews for Nursing Facility Cost Reports

Scope of Work:
Myers and Stauffer was engaged to perform AUP desk reviews for nursing facility cost reports and analysis of FQHC year-end settlement calculations.

Responsibilities:

- Develop the program and procedures necessary to thoroughly evaluate nursing facility cost reports before rates are set.
- Oversee and provide quality assurance of nursing facility AUP and desk reviews.

Iowa Department of Human Services (2005 – Present)

Provider Cost Audits and Rate Setting Services

Scope of Work:

Myers and Stauffer provides professional accounting and consulting services as the Provider Cost Audit and Rate Setting Unit of the Iowa Medicaid Enterprise.

Responsibilities:

- Managed, researched, designed, and implemented new reimbursement methodologies for hospitals, home and community based services, targeted case management, and community mental health centers.
- Oversaw annual rate setting activities for Iowa HCBS, case management, and CMHC providers. This included processing cost reports, calculating rates, preparing fiscal analysis for the State, and implementing legislative changes.
- Oversee and provide quality assurance of the preparation of Hospital DRG and APC recalibration and rebasing and upper payment limit calculations
- Complete Disproportionate Share (DSH) eligibility and calculation of DSH and GME payments.

Colorado Department of Health Care Policy and Financing (2018 – Present)

Examination Services for Medicaid Nursing Facilities

Scope of Work:

Myers and Stauffer provides accounting, rate setting, and reimbursement consulting services in conjunction with the Department's reimbursement system for nursing facility services to eligible providers (EPs) of the Medicaid program.

Responsibilities:

- Develop home and community based services agreed upon procedures.
- Perform the agreed upon procedures review and cost settlement.

Georgia Department of Community Health (2016 – 2019)

Hospital Reimbursement Technical Assistance

Scope of Work:

Myers and Stauffer assisted with the redesign and calculation of the Medicaid DSH reimbursement system and technical and accounting issues related to the preparation of Medicare UPL findings for inpatient and outpatient hospital programs.

Responsibilities:

- Consult with the State on development of an outpatient PPS based on APC methodology.
- Oversee outpatient reimbursement transition to APC.
- Perform hospital claims analysis and modeling with outpatient claims code editor review.

Connecticut Department of Social Services (2020 – Present)

Waiver Rate Study of Home and Community-Based Services

Scope of Work:

Myers and Stauffer is engaged to study the state’s current methodology for developing payment rates for Home and Community Based Services provided through their 1915(c) waivers. The study includes comparing the methodology to those used by other peer states, and making recommendations for change. Working with an advisory group of provider representatives to evaluate options.

Responsibilities:

- Project manager for a study of the state's current methodology for developing payment rates for HCBS, comparing the methodology to those used by other peer states, and making recommendations for change.
- Working with an advisory group of provider representatives to evaluate options.

Illinois Department on Aging (2018 – Present)

HCBS - Community Care Program Care Coordination Unit Administrative Services Rate Study

Scope of Work:

Myers and Stauffer is conducting a rate study for the Care Coordination Unit (CCU) administrative services provided through the state's Community Care Program (CCP). The study includes an examination of eleven different services including initial assessment, Medicaid application assistance, person centered plan of care development, face to face visits, reassessment, nursing facility screening, intensive casework/monitoring, presumptive eligibility, person centered plan of care adjustment, case management, and deinstitutionalization. The CCP includes home and community based services (HCBS) waiver participants and state funded beneficiaries over age 60.

Responsibilities:

- Perform cost data gathering, analysis, and reporting activities for CCUs.
- Provide technical assistance as needed.
- Prepare rate study reports covering eleven different administrative services covered by the CCP.

Washington Health Care Authority (2017 – Present)

Delivery System Reform Incentive Payment (DSRIP) Program - Independent Assessor

Scope of Work:

Myers and Stauffer is contracted to support the Washington Health Care Authority's (HCA) DSRIP program which is composed of nine Accountable Communities of Health (ACHs). Through this engagement, Myers and Stauffer's responsibilities include but are not limited to: receipt and evaluation of ACH project plans; provision of technical assistance regarding project plan improvement opportunities; conducting semi-annual assessments of ACH projects; performing a midpoint assessment of the DSRIP program; assessing value based purchasing (VBP) contracting by the MCOs; collaboration with other HCA contractors; and assisting with certain training and communication efforts.

Responsibilities:

- Serve as primary reviewer to assess projects within the ACHs' Project Plan portfolios.
- Support the development of the Project Plan assessment findings report.

Presentations

"Iowa Case Management Cost Report Training," Iowa State Association of Counties Case Management Provider Community, Des Moines, Iowa, April 2014.

"Iowa HCBS Projected Rate Setting," HCBS and Case Management Provider Community, Des Moines, Iowa, April 2014.

"Iowa HCBS Cost Report Training," Iowa Association for Community Providers, Des Moines, Iowa, August 2014.

"Iowa HCBS Cost Report Training," Iowa Association for Community Providers, Des Moines, Iowa, December 2013.

"Iowa Case Management Cost Report Training," Iowa State Association of Counties Case Management Provider Community, Des Moines, Iowa, July 2013.

"Iowa HCBS Projected Rate Setting," HCBS and Case Management Provider Community, Des Moines, Iowa, October 2013.

James Fennell

Senior Accountant

Summary

Mr. Fennell is responsible for providing public accounting services to state Medicaid agencies and CMS addressing health care reimbursement issues. Mr. Fennell has worked on several projects for Arkansas, CMS, Florida, Georgia, Louisiana, Missouri, Maine, North Carolina and New Jersey. Mr. Fennell's daily activities include overseeing day-to-day work on the Arkansas Nursing Facility Rate Setting project, overseeing day-to-day work on the CMS Payroll Based Journals and reviewing Medicaid DSH audits for multiple states.

Education

B.S., Accounting, University of Kansas, 2014

Experience

6 years of professional experience

Relevant Work Experience

Arkansas Department of Human Services (2018 – Present)
Desk Reviews for Nursing Facility Cost Reports and Federally Qualified Health Centers Claims

Scope of Work:
Myers and Stauffer was engaged to perform AUP desk reviews for nursing facility cost reports and analysis of FQHC year-end settlement calculations.

Responsibilities:

- Develop the program and procedures necessary to thoroughly evaluate nursing facility cost reports before rates are set.
- Oversee and provide quality assurance of nursing facility AUP and desk reviews.
- Provide rate setting consulting services, state plan amendment and administrative code regulation development services to the state for proposed changes to the nursing facility reimbursement methodology.

Florida Agency for Health Care Administration (2014 – Present)
Hospital Cost Report Audit and Disproportionate Share Hospital (DSH) Payment Reconciliation

Scope of Work:
Myers and Stauffer provides services to the Florida Agency for Health Care Administration (AHCA) for hospital cost report audits, federal DSH program payment reconciliation services, and for Medicaid Supplemental Schedule DSH Key Components Review (DSR).

Responsibilities:

- Developed and maintained testing procedures and work papers to aid in completion of DSH Examinations.
- Developed and maintained DSH Examination application.
- Provided quality assurance of facility desk reviews.
- Organized and led field work examinations of high risk facilities.

Florida Agency for Health Care Administration (2019 – Present)

Nursing Facility and Home Office Cost Report Examinations and Reporting

Scope of Work:

Myers and Stauffer performs compliance examinations and reviews of Medicaid nursing home and home office cost reports to provide assurance that Medicaid nursing home rates are based on allowable and supported costs.

Responsibilities:

- Created standard work paper templates to increase the efficiency of the review process.
- Train staff on the completion of Agreed Upon Procedures in conformity with Florida Medicaid, Code of Federal Regulations and the Centers for Medicaid and Medicaid Services regulatory framework.
- Completed Agreed Upon Procedures for Nursing Facilities and Home Office Cost Reports.
- Perform supervisory quality reviews of desk reviews to ensure compliance with Florida Medicaid, Code of Federal Regulations and the Centers for Medicaid and Medicaid Services regulatory framework.

Georgia Department of Community Health (2014 – 2018)

Independent Certified Audit of DSH Program

Scope of Work:

Myers and Stauffer assisted with the redesign and calculation of the Medicaid DSH reimbursement system and technical and accounting issues related to the preparation of Medicare UPL findings for both its nursing facility and inpatient and outpatient hospital programs.

Responsibilities:

- Developed and maintained testing procedures and work papers to aid in completion of DSH Examinations.
- Developed and maintained DSH Examination application.
- Provided quality assurance of facility desk reviews.
- Compiled and drafted DSH Examination Report.
- Organized and led field work examinations of high risk facilities.

Centers for Medicare & Medicaid Services (CMS) (2018 – Present)

Electronic Staffing Data Audit Specialist Payroll-Based Journal (PBJ) for Nursing Homes

Scope of Work:

As a subcontractor to Granite Dolphin Actuarial Services, Myers and Stauffer developed a pilot program which will lead to a permanent process to validate information submitted to the CMS PBJ system.

Responsibilities:

- Assist with the development of testing work papers.
- Perform validation of information submitted to the CMS PBJ System.
- Oversee and provide quality assurance of validation of information submitted to the CMS PBJ System.
- Perform supervisory quality reviews of desk reviews to ensure compliance with the CMS PBJ policy manual.
- Perform the day-to-day project management functions required to ensure we remain in compliance with contractual deadlines.

Louisiana Department of Health (2015 – 2016)
Case Mix Reimbursement System

Scope of Work:
Myers and Stauffer is assisting in the development and operation of a case mix reimbursement system and MDS data management and reporting services for nursing facilities participating in the Louisiana Medicaid Program.

Responsibilities:

- Performed provider cost analysis for home and community-based services provider types.
- Provided quality assurance of quarterly and annual nursing facility case mix rate setting activities and required nursing facility upper payment limit demonstrations.
- Provided quality assurance and maintenance of the internal Louisiana rate setting application.
- Provided rate setting consulting services, state plan amendment and administrative code regulation development services to the state for proposed changes to the nursing facility reimbursement methodology.
- Developed and maintained cost report instruments for the home and community-based services and nursing facility provider types for the state of Louisiana.

Louisiana Department of Health (2014 – 2018)
Disproportionate Share Hospital (DSH) Audit

Scope of Work:
Myers and Stauffer performs federally-mandated independent certified audits of the state's DSH program.

Responsibilities:

- Developed and maintained testing procedures and work papers to aid in completion of DSH Examinations.
- Developed and maintained DSH Examination application.
- Provided quality assurance of facility desk reviews.
- Organized and led fieldwork examinations of high-risk facilities.

Maine Department of Health and Human Services (2014 – 2018)
Disproportionate Share Hospital (DSH) Audit

Scope of Work:
Myers and Stauffer performs federally mandated independent certified audits of the state of Maine’s DSH program.

Responsibilities:

- Developed and maintained testing procedures and work papers to aid in completion of DSH Examinations.
- Developed and maintained DSH Examination application.
- Provided quality assurance of facility desk reviews.
- Organized and led field work examinations of high risk facilities.

Missouri Department of Social Services (2014 – 2018)
Disproportionate Share Hospital (DSH) Audits

Scope of Work:
Myers and Stauffer performs federally mandated independent certified audits of the state of Missouri's DSH program.

Responsibilities:

- Developed and maintained testing procedures and work papers to aid in completion of DSH Examinations.
- Developed and maintained DSH Examination application.
- Provided quality assurance of facility desk reviews.
- Organized and led field work examinations of high risk facilities.

New Jersey Department of Human Services (2014 – 2018)

Disproportionate Share Hospital Audit

Scope of Work:

Myers and Stauffer performs federally-mandated independent certified audits of the state's DSH program.

Responsibilities:

- Developed and maintained testing procedures and work papers to aid in completion of DSH Examinations.
- Developed and maintained DSH Examination application.
- Provided quality assurance of facility desk reviews.
- Organized and led field work examinations of high risk facilities.

North Carolina Department of Health and Human Services (2014 – 2018)

Disproportionate Share Hospital Examination

Scope of Work:

Myers and Stauffer performs federally mandated independent certified audits of North Carolina's DSH program.

Responsibilities:

- Developed and maintained testing procedures and work papers to aid in completion of DSH Examinations.
- Developed and maintained DSH Examination application.
- Provided quality assurance of facility desk reviews.

Tennessee Department of Finance and Administration (2015 – 2016)

Reimbursement Consulting and Technical Assistance

Scope of Work:

Myers and Stauffer provides reimbursement consulting and case mix technical assistance.

Responsibilities:

- Assisted the state in transitioning from a legacy nursing facility reimbursement system, to a case mix reimbursement system.
- Supported stakeholder engagement activities throughout the transition period.
- Developed and delivered training to State and provider community stakeholders.
- Assisted in the development and maintenance of internal rate setting applications.
- Performed nursing facility cost report collection and rate setting activities.

Appendix

- *Appendix A: Certificate to do Business in Arkansas.*
- *Appendix B: CPA Licensure.*

Appendix A: Certificate to do Business in Arkansas

Search Incorporations, Cooperatives, Banks and Insurance Companies

Printer Friendly Version

LLC Member information is now confidential per Act 865 of 2007

Use your browser's back button to return to the Search Results

Begin New Search

For service of process contact the Secretary of State's office.

Corporation Name	MYERS AND STAUFFER LC
Fictitious Names	
Filing #	100151578
Filing Type	Foreign Limited Liability Company
Filed under Act	Foreign LLC; 1003 of 1993
Status	Good Standing
Principal Address	700 WEST 47TH STREET SUITE 1100 KANSAS CITY, MO 64112
Reg. Agent	CORPORATION SERVICE COMPANY
Agent Address	300 SPRING BUILDING, SUITE 900 300 S. SPRING STREET LITTLE ROCK, AR 72201
Date Filed	10/02/1997
Officers	SEE FILE, Incorporator/Organizer
Foreign Name	N/A
Foreign Address	909 SW TOPEKA BOULEVARD TOPEKA, 72201
State of Origin	KS

Purchase a Certificate of Good Standing for this Entity

Pay Franchise Tax for this corporation

Appendix B: CPA Licensure

Amy Perry

11/23/20 14:04:17

CPAVerify Individual Report Results

NAME: **AMY C PERRY**
STATE OF LICENSE: **IA**
LAST UPDATED: **2020-11-17**

	Business	Mail
Address:	KANSAS CITY, MISS, US	KANSAS CITY, MO, UNITED STATES
License/Permit/Certificate Number:	R04651	
Registration Number:		
License/Permit/Certificate Status:	ACTIVE	
License/Certificate Status Details:	A certificate/license holder who is in good standing with the State of Iowa; has completed required continuing professional education and may use the designation and practice public accountancy.	
License Type:	CERTIFIED PUBLIC ACCOUNTANT	
Basis for License:	UNDEFINED	
Issue Date:	2004-03-29	
Expiration Date:	2021-06-30	
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board	
Other Information:		

Contact the Board for official verification of information.

State Board Contact Information:

IOWA ACCOUNTANCY EXAMINING BOARD
200 E. GRAND, STE. 350
DES MOINES, IOWA 50309

Phone: 515-281-7468
Fax: 515-725-9032
Email: ROBERT.LAMPE@IOWA.GOV
Website: https://plb.iowa.gov/?
Licensee Lookup: https://eservices.iowa.gov/licensediniowa/

NAME: **AMY PERRY**
STATE OF LICENSE: **KS**
LAST UPDATED: **2020-11-21**

	Mail
Address:	KANSAS CITY, KS,
License/Permit/Certificate Number:	1599
Registration Number:	
License/Permit/Certificate Status:	ACTIVE PERMIT
License/Certificate Status Details:	The permit or firm registration is in good standing.
License Type:	CPA
License Type Details:	CPA Permit. In Kansas, only those who have permits (also known as licenses) are allowed to hold out and provide or offer to provide services to the public as a CPA. If the permit status does not reflect Active, that person is not licensed to practice. If Permit Number shows N/A that means this person had a permit to practice at one point, but let it lapse. When the permit lapses in that case, so does the permit number.
Basis for License:	
Issue Date:	2018-07-01
Expiration Date:	2020-06-30
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board
Other Information:	IN KANSAS, A CERTIFICATE IS NOT A LICENSE. ONLY THOSE WHO HAVE PERMITS (ALSO KNOWN AS LICENSES) ARE ALLOWED TO HOLD OUT AND PROVIDE OR OFFER TO PROVIDE SERVICES TO THE PUBLIC AS A CPA. IF THE PERMIT STATUS DOES NOT REFLECT "ACTIVE", THAT INDIVIDUAL IS NOT LICENSED TO PRACTICE. CPAVERIFY INCLUDES ALL CERTIFICATE HOLDERS AND PERMIT HOLDERS. If an individual has a permit, their permit record and their certificate record will show. Only a certificate record will show for non-licensed certificate

1

11/23/20 14:04:17

holders.

If Permit Number shows N/A that means this person had a permit to practice at one point, but let it lapse. When the permit lapses in that case, so does the permit number. If permit shows Lapsed it means that this person once had a permit (license) to practice, but has since let them lapse. This individual is not licensed to practice as a CPA in Kansas.

Contact the Board for official verification of information.

License/Permit/Certificate Number:	4660
Registration Number:	
License/Permit/Certificate Status:	ACTIVE PERMIT
License/Certificate Status Details:	The permit or firm registration is in good standing.
License Type:	CPA
License Type Details:	CPA Permit. In Kansas, only those who have permits (also known as licenses) are allowed to hold out and provide or offer to provide services to the public as a CPA. If the permit status does not reflect Active, that person is not licensed to practice. If Permit Number shows N/A that means this person had a permit to practice at one point, but let it lapse. When the permit lapses in that case, so does the permit number.
Basis for License:	
Issue Date:	2020-07-01
Expiration Date:	2022-06-30
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board
Other Information:	IN KANSAS, A CERTIFICATE IS NOT A LICENSE. ONLY THOSE WHO HAVE PERMITS (ALSO KNOWN AS LICENSES) ARE ALLOWED TO HOLD OUT AND PROVIDE OR OFFER TO PROVIDE SERVICES TO THE PUBLIC AS A CPA. IF THE PERMIT STATUS DOES NOT REFLECT "ACTIVE", THAT INDIVIDUAL IS NOT LICENSED TO PRACTICE. CPAVERIFY INCLUDES ALL CERTIFICATE HOLDERS AND PERMIT HOLDERS. If an individual has a permit, their permit record and their certificate record will show. Only a certificate record will show for non-licensed certificate holders. If Permit Number shows N/A that means this person had a permit to practice at one point, but let it lapse. When the permit lapses in that case, so does the permit number. If permit shows Lapsed it means that this person once had a permit (license) to practice, but has since let them lapse. This individual is not licensed to practice as a CPA in Kansas.

Contact the Board for official verification of information.

License/Permit/Certificate Number:	7108
Registration Number:	
License/Permit/Certificate Status:	ACTIVE CERTIFICATE
License/Certificate Status Details:	The certificate is in good standing.
License Type:	CPA.
License Type Details:	CPA Certificate. In Kansas, a certificate is not a license so therefore, a certificate holder who does not also have an active permit may not hold out, perform or offer to perform services as a CPA. The person may use the title CPA in connection with their employment in industry.
Basis for License:	
Issue Date:	1993-10-19
Expiration Date:	
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board
Other Information:	IN KANSAS, A CERTIFICATE IS NOT A LICENSE. ONLY THOSE WHO HAVE PERMITS (ALSO KNOWN AS LICENSES) ARE ALLOWED TO HOLD OUT AND PROVIDE OR OFFER TO PROVIDE SERVICES TO THE PUBLIC AS A CPA. IF THE PERMIT STATUS DOES NOT REFLECT "ACTIVE", THAT INDIVIDUAL IS NOT LICENSED TO PRACTICE. CPAVERIFY INCLUDES ALL CERTIFICATE HOLDERS AND PERMIT HOLDERS. If an individual has a permit, their permit record and their certificate record will show. Only a certificate record will show for non-licensed certificate holders. If Permit Number shows N/A that means this person had a permit to practice at one point, but let it lapse. When the permit lapses in that case, so does the permit number. If permit shows Lapsed it means that this person once had a permit (license) to practice, but has since let them lapse. This individual is not

2

11/23/20 14:04:17

licensed to practice as a CPA in Kansas.

Contact the Board for official verification of information.

State Board Contact Information:

KANSAS BOARD OF ACCOUNTANCY
LANDON STATE OFFICE BUILDING
900 SW JACKSON, SUITE 556
TOPEKA, KS 66612-1239

Phone: 785-296-2162
Fax: 785-291-3501
Email: INFO@KSBOA.KS.GOV
Licensee Lookup: http://www.da.ks.gov/boa/searchforindividual.aspx

---

NAME: **AMY CAROL PERRY**
STATE OF LICENSE: **MO**
LAST UPDATED: **2020-11-23**

	Business
Address:	KANSAS CITY, MO,
License/Permit/Certificate Number:	2001028670
Registration Number:	
License/Permit/Certificate Status:	ACTIVE
License/Certificate Status Details:	The licensee is current and in good standing. The licensee can engage in the practice of public accountancy prior to the license expiration date.
License Type:	CPA-LICENSE HOLDER
License Type Details:	A license issued under section 326.280, or privilege to practice under section 326.283; or, in each case, an individual license or permit issued pursuant to corresponding provisions of prior law.
Basis for License:	
Issue Date:	2001-10-30
Expiration Date:	2021-09-30
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board
Other Information:	As of 2001, Certificates are no longer issued in the State of Missouri. Therefore, you may see some individuals with a Certificate only, or with a License only, or with both. Only individuals with a License or Certificate and License are Certified Public Accountants with unrestricted practice privileges. Individuals with only a Certificate may not practice public accounting; however, they may use the credential if they are in private industry, academia or retired and no longer practice public accounting.

Contact the Board for official verification of information.

State Board Contact Information:

MISSOURI STATE BOARD OF ACCOUNTANCY
P.O.BOX 613
JEFFERSON CITY, MO 65102-0613

Phone: 573-751-0012
Fax: 573-751-0890
Email: MOSBA@PR.MO.GOV
Website: http://pr.mo.gov/accountancy.asp
Licensee Lookup: https://renew.pr.mo.gov/licensee-search.asp

Details of Enforcement, Non-Compliance or Disciplinary Actions:

1. If "Contact State Board For Details" is displayed then the State Board has reported some type of enforcement, non-compliance or disciplinary action to this site and the State Board should be contacted for full details about the action reported.
2. If "None Reported To This Site By The Board" is displayed then the State Board provides enforcement, non-compliance and disciplinary action data to this site and none was indicated for this record.
3. If "State Does Not Provide This Type of Data At This Site" is displayed then CPAverify is not currently receiving enforcement, non-compliance or disciplinary action data for licensees in this state. Some states are limited to sharing this type of data with third party websites due to privacy laws or policies, but most State Boards offer this information on their official State Board websites.
4. Contact the State Board for official verification of all enforcement, non-compliance and disciplinary activity.

11/23/20 14:04:17

The results shown here include all data made available by participating states. Additional data about the individual or firm may exist and is not shown here for other states that are not yet participating in the CPAverify website. Please refer to the Participating States tab for more information about which states are currently sharing their licensing data for use with this website and for clarification about which states these results do not include. If the Board of interest is not participating, you may refer to the "Contact Boards" tab where a link to every Boards' website and therefore individual license lookup tool is available.

4

Robert Hicks

12/03/20 16:56:59

CPAVerify Individual Report Results

NAME: **ROBERT J. HICKS**
STATE OF LICENSE: **AR**
LAST UPDATED: **2020-12-03**

	Business	Mail
Address:	KANSAS CITY, MO,	KANSAS CITY, MO,
License/Permit/Certificate Number:	9450R	
Registration Number:		
License/Permit/Certificate Status:	ACTIVE	
License/Certificate Status Details:	Active license to practice.	
License Type:	CPA	
License Type Details:	Arkansas CPAs have no restrictions on scope of practice unless the Board has taken some action that limit their practice.	
Basis for License:	RECIPROCAL	
Basis for License Details:	Reciprocal License. An Applicant having a valid unrevoked license to practice as a CPA from any jurisdiction and who is planning to relocate to Arkansas must apply for a Reciprocal License.	
Issue Date:	2016-01-04	
Expiration Date:	2020-12-31	
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board	
Other Information:		

Contact the Board for official verification of information.

State Board Contact Information:

ARKANSAS STATE BOARD OF ACCOUNTANCY
101 E CAPITOL, SUITE 450
LITTLE ROCK, AR 72201

Phone: (501)682-1520
Fax: (501)682-5538
Email: ASBPA@ARKANSAS.GOV
Website: http://www.arkansas.gov/asbpa/
Licensee Lookup: https://www.ark.org/asbpa_olr/app/search.html

NAME: **ROBERT JOSEPH HICKS**
STATE OF LICENSE: **FL**
LAST UPDATED: **2020-12-03**

	Business	Mail
Address:	HICKS, ROBERT JOSEPH KANSAS CITY, MO, US	KANSAS CITY, MO, US
License/Permit/Certificate Number:	AC48082	
Registration Number:		
License/Permit/Certificate Status:	CURRENT, ACTIVE	
License/Certificate Status Details:	Holds a valid license to practice public accounting.	
License Type:	CERTIFIED PUBLIC ACCOUNTANT	
License Type Details:	Shall be deemed and construed to mean a person, who holds an active, inactive, delinquent, or temporary license issued under Chapter 473, F.S., or who is practicing public accounting in this state pursuant to the practice privilege granted in Section 473.3141, F.S.	
Basis for License:	RECIPROCAL	
Basis for License Details:	Reciprocal License. An Applicant having a valid unrevoked license to practice as a CPA from any jurisdiction and who is planning to relocate to Florida must apply for a Reciprocal License.	
Issue Date:	2014-12-15	
Expiration Date:	2021-12-31	
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board	
Other Information:		

Contact the Board for official verification of information.

1

12/03/20 16:56:59

State Board Contact Information:

FLORIDA DIVISION OF CERTIFIED PUBLIC ACCOUNTING
240 NW 76TH DRIVE, SUITE A
GAINESVILLE, FL 32607

Phone: (850) 487-1395
Website: http://www.myfloridalicense.com/DBPR/certified-public-accounting/
Licensee Lookup: https://www.myfloridalicense.com/wl11.asp?mode=0&SID=

NAME: **ROBERT HICKS**
STATE OF LICENSE: **KS**
LAST UPDATED: **2020-12-03**

Mail

Address:	LEE'S SUMMIT, MO,
License/Permit/Certificate Number:	2333
Registration Number:	
License/Permit/Certificate Status:	ACTIVE PERMIT
License/Certificate Status Details:	The permit or firm registration is in good standing.
License Type:	CPA
License Type Details:	CPA Permit. In Kansas, only those who have permits (also known as licenses) are allowed to hold out and provide or offer to provide services to the public as a CPA. If the permit status does not reflect Active, that person is not licensed to practice. If Permit Number shows N/A that means this person had a permit to practice at one point, but let it lapse. When the permit lapses in that case, so does the permit number.
Basis for License:	
Issue Date:	2019-07-01
Expiration Date:	2021-06-30
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board
Other Information:	IN KANSAS, A CERTIFICATE IS NOT A LICENSE. ONLY THOSE WHO HAVE PERMITS (ALSO KNOWN AS LICENSES) ARE ALLOWED TO HOLD OUT AND PROVIDE OR OFFER TO PROVIDE SERVICES TO THE PUBLIC AS A CPA. IF THE PERMIT STATUS DOES NOT REFLECT "ACTIVE", THAT INDIVIDUAL IS NOT LICENSED TO PRACTICE. CPAVERIFY INCLUDES ALL CERTIFICATE HOLDERS AND PERMIT HOLDERS. If an individual has a permit, their permit record and their certificate record will show. Only a certificate record will show for non-licensed certificate holders. If Permit Number shows N/A that means this person had a permit to practice at one point, but let it lapse. When the permit lapses in that case, so does the permit number. If permit shows Lapsed it means that this person once had a permit (license) to practice, but has since let them lapse. This individual is not licensed to practice as a CPA in Kansas.

Contact the Board for official verification of information.

License/Permit/Certificate Number:	9963
Registration Number:	
License/Permit/Certificate Status:	ACTIVE CERTIFICATE
License/Certificate Status Details:	The certificate is in good standing.
License Type:	CPA.
License Type Details:	CPA Certificate. In Kansas, a certificate is not a license so therefore, a certificate holder who does not also have an active permit may not hold out, perform or offer to perform services as a CPA. The person may use the title CPA in connection with their employment in industry.
Basis for License:	
Issue Date:	2004-06-17
Expiration Date:	
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board
Other Information:	IN KANSAS, A CERTIFICATE IS NOT A LICENSE. ONLY THOSE WHO HAVE PERMITS (ALSO KNOWN AS LICENSES) ARE ALLOWED TO HOLD OUT AND PROVIDE OR OFFER TO PROVIDE SERVICES TO THE PUBLIC AS A CPA. IF THE PERMIT STATUS DOES NOT REFLECT "ACTIVE", THAT INDIVIDUAL IS NOT LICENSED TO PRACTICE. CPAVERIFY INCLUDES ALL CERTIFICATE HOLDERS AND PERMIT

2

12/03/20 16:56:59

HOLDERS. If an individual has a permit, their permit record and their certificate record will show. Only a certificate record will show for non-licensed certificate holders.

If Permit Number shows N/A that means this person had a permit to practice at one point, but let it lapse. When the permit lapses in that case, so does the permit number. If permit shows Lapsed it means that this person once had a permit (license) to practice, but has since let them lapse. This individual is not licensed to practice as a CPA in Kansas.

Contact the Board for official verification of information.

State Board Contact Information:

KANSAS BOARD OF ACCOUNTANCY
LANDON STATE OFFICE BUILDING
900 SW JACKSON, SUITE 556
TOPEKA, KS 66612-1239

Phone: 785-296-2162
Fax: 785-291-3501
Email: INFO@KSBOA.KS.GOV
Licensee Lookup: http://www.da.ks.gov/boa/searchforindividual.aspx

---

NAME: **ROBERT J. HICKS**
STATE OF LICENSE: **LA**
LAST UPDATED: **2020-12-03**

	Business
Address:	ROBERT J. HICKS LEES SUMMIT, MO, US
License/Permit/Certificate Number:	CPA.0027908
Registration Number:	
License/Permit/Certificate Status:	REGISTERED
License/Certificate Status Details:	The individual license or firm permit, as applicable, is registered, current and in good standing for this renewal year.
License Type:	LICENSED / ACTIVE CERTIFICATE
License Type Details:	License to use the CPA title with personal name in LA. Continuing professional education is required to maintain the license. The license also provides the individual a right to obtain a LA CPA firm permit.
Basis for License:	RECIPROCAL
Basis for License Details:	Reciprocal License. An Applicant having a valid unrevoked license to practice as a CPA from any jurisdiction and who is planning to relocate to Louisiana must apply for a Reciprocal License.
Issue Date:	2015-10-10
Expiration Date:	2020-12-31
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board
Other Information:	

Contact the Board for official verification of information.

State Board Contact Information:

STATE BOARD OF CERTIFIED PUBLIC ACCOUNTANTS OF LOUISIANA
601 POYDRAS STREET, SUITE 1770
NEW ORLEANS, LA 70130

Phone: (504)566-1244
Fax: (504)566-1252
Email: SITEMASTER@CPABOARD.STATE.LA.US
Website: http://www.cpaboard.state.la.us/
Licensee Lookup: https://elicense.cpaboard.la.gov/Lookup/LicenseLookup.aspx

---

NAME: **ROBERT JOSEPH HICKS**
STATE OF LICENSE: **ME**
LAST UPDATED: **2020-12-03**

	Business	**Mail**
Address:		KANSAS CITY, MO, US

12/03/20 16:56:59

License/Permit/Certificate Number:	CP10895
Registration Number:	
License/Permit/Certificate Status:	ACTIVE
License/Certificate Status Details:	The license is current and in good standing. The licensee can engage in the practice of public accountancy prior to the license expiration date.
License Type:	CERTIFIED PUBLIC ACCOUNTANT
License Type Details:	Individual can issue a report on financial statements of a person, firm, organization or governmental unit or offering to render any attest or compilation service.
Basis for License:	RECIPROCITY
Basis for License Details:	Reciprocal License. An Applicant having a valid unrevoked license to practice as a CPA from any jurisdiction and who is planning to relocate to Maine must apply for a Reciprocal License.
Issue Date:	2020-11-10
Expiration Date:	2021-09-30
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board
Other Information:	NOTE: ANY PERIODS OF INACTIVITY FOR A LICENSE BETWEEN THE DATE THE LICENSE WAS ISSUED AND THE EXPIRATION DATE ARE NOT REFLECTED.

Contact the Board for official verification of information.

State Board Contact Information:

BOARD OF ACCOUNTANCY
35 STATE HOUSE STATION
AUGUSTA, ME 04333-0035

Phone: (207)624-8603
Fax: 207-624-8637
Email: ACCOUNTANCY.BOARD@MAINE.GOV
Website:
http://www.maine.gov/pfr/professionallicensing/professions/accountants/index.html
Licensee Lookup:
http://pfr.informe.org/almsonline/almsquery/welcome.aspx?board=4110

NAME: **ROBERT J HICKS**
STATE OF LICENSE: **NJ**
LAST UPDATED: **2020-12-03**

	Mail
Address:	KANSAS CITY, MO,
License/Permit/Certificate Number:	20CC03282600
Registration Number:	
License/Permit/Certificate Status:	ACTIVE
License/Certificate Status Details:	The Permit (license) is current and in good standing. The licensee can engage in the practice of public accountancy prior to the license expiration date.
License Type:	CERTIFIED PUBLIC ACCOUNTANT
License Type Details:	CPA Permit holders can use the designation CPA and have the unrestricted privilege of practicing as a CPA. CPA Certificate holders who do not have a Permit can only use CPA as a title but cannot practice as a CPA. Can issue a report on financial statements of a person, firm, organization or governmental unit or offering to render or rendering any attest or compilation service. Can also use other accounting skills, including the preparation of tax returns, management advisory services, and the preparation of financial statements without the issuance of reports. (No Limitations)
Basis for License:	ENDORSEMENT
Basis for License Details:	License by Endorsement-Transfer of Grades is available to applicants that have passed the CPA exam in another state or jurisdiction, but are not licensed in any jurisdiction.
Issue Date:	2006-12-20
Expiration Date:	2020-12-31
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board
CPA can practice public accounting?	Y
Other Information:	

Contact the Board for official verification of information.

12/03/20 16:56:59

State Board Contact Information:

NEW JERSEY STATE BOARD OF ACCOUNTANCY
P.O. BOX 45000
NEWARK, NJ 07101

Phone: (973)504-6380
Fax: (973)648-2855
Email: rossm@DCA.LPS.STATE.NJ.US
Website: http://www.njconsumeraffairs.gov/acc/Pages/default.aspx
Licensee Lookup: https://newjersey.mylicense.com/verification/

Details of Enforcement, Non-Compliance or Disciplinary Actions:

1. If "Contact State Board For Details" is displayed then the State Board has reported some type of enforcement, non-compliance or disciplinary action to this site and the State Board should be contacted for full details about the action reported.
2. If "None Reported To This Site By The Board" is displayed then the State Board provides enforcement, non-compliance and disciplinary action data to this site and none was indicated for this record.
3. If "State Does Not Provide This Type of Data At This Site" is displayed then CPAverify is not currently receiving enforcement, non-compliance or disciplinary action data for licensees in this state. Some states are limited to sharing this type of data with third party websites due to privacy laws or policies, but most State Boards offer this information on their official State Board websites.
4. Contact the State Board for official verification of all enforcement, non-compliance and disciplinary activity.

The results shown here include all data made available by participating states. Additional data about the individual or firm may exist and is not shown here for other states that are not yet participating in the CPAverify website. Please refer to the Participating States tab for more information about which states are currently sharing their licensing data for use with this website and for clarification about which states these results do not include. If the Board of interest is not participating, you may refer to the "Contact Boards" tab where a link to every Boards' website and therefore individual license lookup tool is available.

Timothy Guerrant

11/23/20 14:05:05

CPAVerify Individual Report Results

NAME: **TIMOTHY JOEL GUERRANT**
STATE OF LICENSE: **IN**
LAST UPDATED: **2020-11-23**

	Business
Address:	CARMEL, IN, UNITED STATES
License/Permit/Certificate Number:	CP10700349
Registration Number:	
License/Permit/Certificate Status:	ACTIVE
License/Certificate Status Details:	The license is current and in good standing. The licensee can engage in the practice of public accountancy prior to the license expiration date.
License Type:	CERTIFIED PUBLIC ACCOUNTANT
License Type Details:	Practice of accountancy means the performance or offering to perform a service by a licensee involving 1) use of accounting or auditing skills including the issuance of reports on financial statements; 2) management or financial advisory or consulting services; 3) preparation of tax returns or furnishing of advice on tax matters. The term does not include the performance or offering of the following services if the person performing or offering the services is not a licensee and no representation is made that the person performing or offering the service is a licensee: 1) selling and installing of data processing or bookkeeping equipment and forms; 2) preparation of tax returns; 3) the performance of bookkeeping.
Basis for License:	BOARD APPROVAL
Issue Date:	2007-12-06
Expiration Date:	2021-06-30
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board
Other Information:	

Contact the Board for official verification of information.

State Board Contact Information:

INDIANA BOARD OF ACCOUNTANCY
402 W WASHINGTON STREET ROOM W 072
INDIANAPOLIS, IN 46204

Phone: 317-234-8800
Fax: 317-233-4236
Email: PLA14@PLA.IN.GOV
Website: http://www.in.gov/pla/accountancy.htm
Licensee Lookup: https://mylicense.in.gov/everification/Search.aspx

Details of Enforcement, Non-Compliance or Disciplinary Actions:

1. If "Contact State Board For Details" is displayed then the State Board has reported some type of enforcement, non-compliance or disciplinary action to this site and the State Board should be contacted for full details about the action reported.
2. If "None Reported To This Site By The Board" is displayed then the State Board provides enforcement, non-compliance and disciplinary action data to this site and none was indicated for this record.
3. If "State Does Not Provide This Type of Data At This Site" is displayed then CPAverify is not currently receiving enforcement, non-compliance or disciplinary action data for licensees in this state. Some states are limited to sharing this type of data with third party websites due to privacy laws or policies, but most State Boards offer this information on their official State Board websites.
4. Contact the State Board for official verification of all enforcement, non-compliance and disciplinary activity.

The results shown here include all data made available by participating states. Additional data about the individual or firm may exist and is not shown here for other states that are not yet participating in the CPAverify website. Please refer to the Participating States tab for more information about which states are currently sharing their licensing data for use with this website and for clarification about which states these results do not include. If the Board of interest is not participating, you may refer to the "Contact Boards" tab where a link to every Boards' website and therefore individual license lookup tool is available.

1

Chris Cole

11/23/20 14:08:32

CPAVerify Individual Report Results

NAME: **CHRIS COLE**
STATE OF LICENSE: **KS**
LAST UPDATED: **2020-11-21**

	Mail
Address:	OVERLAND PARK, KS,
License/Permit/Certificate Number:	2361
Registration Number:	
License/Permit/Certificate Status:	ACTIVE PERMIT
License/Certificate Status Details:	The permit or firm registration is in good standing.
License Type:	CPA
License Type Details:	CPA Permit. In Kansas, only those who have permits (also known as licenses) are allowed to hold out and provide or offer to provide services to the public as a CPA. If the permit status does not reflect Active, that person is not licensed to practice. If Permit Number shows N/A that means this person had a permit to practice at one point, but let it lapse. When the permit lapses in that case, so does the permit number.
Basis for License:	
Issue Date:	2019-07-01
Expiration Date:	2021-06-30
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board
Other Information:	IN KANSAS, A CERTIFICATE IS NOT A LICENSE. ONLY THOSE WHO HAVE PERMITS (ALSO KNOWN AS LICENSES) ARE ALLOWED TO HOLD OUT AND PROVIDE OR OFFER TO PROVIDE SERVICES TO THE PUBLIC AS A CPA. IF THE PERMIT STATUS DOES NOT REFLECT "ACTIVE", THAT INDIVIDUAL IS NOT LICENSED TO PRACTICE. CPAVERIFY INCLUDES ALL CERTIFICATE HOLDERS AND PERMIT HOLDERS. If an individual has a permit, their permit record and their certificate record will show. Only a certificate record will show for non-licensed certificate holders. If Permit Number shows N/A that means this person had a permit to practice at one point, but let it lapse. When the permit lapses in that case, so does the permit number. If permit shows Lapsed it means that this person once had a permit (license) to practice, but has since let them lapse. This individual is not licensed to practice as a CPA in Kansas.

Contact the Board for official verification of information.

License/Permit/Certificate Number:	12053
Registration Number:	
License/Permit/Certificate Status:	ACTIVE CERTIFICATE
License/Certificate Status Details:	The certificate is in good standing.
License Type:	CPA.
License Type Details:	CPA Certificate. In Kansas, a certificate is not a license so therefore, a certificate holder who does not also have an active permit may not hold out, perform or offer to perform services as a CPA. The person may use the title CPA in connection with their employment in industry.
Basis for License:	
Issue Date:	2013-12-13
Expiration Date:	
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board
Other Information:	IN KANSAS, A CERTIFICATE IS NOT A LICENSE. ONLY THOSE WHO HAVE PERMITS (ALSO KNOWN AS LICENSES) ARE ALLOWED TO HOLD OUT AND PROVIDE OR OFFER TO PROVIDE SERVICES TO THE PUBLIC AS A CPA. IF THE PERMIT STATUS DOES NOT REFLECT "ACTIVE", THAT INDIVIDUAL IS NOT LICENSED TO PRACTICE. CPAVERIFY INCLUDES ALL CERTIFICATE HOLDERS AND PERMIT HOLDERS. If an individual has a permit, their permit record and their certificate record will show. Only a certificate record will show for non-licensed certificate holders. If Permit Number shows N/A that means this person had a permit to practice at

1

11/23/20 14:08:32

one point, but let it lapse. When the permit lapses in that case, so does the permit number. If permit shows Lapsed it means that this person once had a permit (license) to practice, but has since let them lapse. This individual is not licensed to practice as a CPA in Kansas.

Contact the Board for official verification of information.

State Board Contact Information:

KANSAS BOARD OF ACCOUNTANCY
LANDON STATE OFFICE BUILDING
900 SW JACKSON, SUITE 556
TOPEKA, KS 66612-1239

Phone: 785-296-2162
Fax: 785-291-3501
Email: INFO@KSBOA.KS.GOV
Licensee Lookup: http://www.da.ks.gov/boa/searchforindividual.aspx

---

NAME: **CHRISTIAN COLE**
STATE OF LICENSE: **MO**
LAST UPDATED: **2020-11-23**

	Business
Address:	KANSAS CITY, MO,
License/Permit/Certificate Number:	2015011903
Registration Number:	
License/Permit/Certificate Status:	ACTIVE
License/Certificate Status Details:	The licensee is current and in good standing. The licensee can engage in the practice of public accountancy prior to the license expiration date.
License Type:	CPA-LICENSE HOLDER
License Type Details:	A license issued under section 326.280, or privilege to practice under section 326.283; or, in each case, an individual license or permit issued pursuant to corresponding provisions of prior law.
Basis for License:	RECIPROCITY
Issue Date:	2015-04-17
Expiration Date:	2022-09-30
Enforcement, Non-Compliance or Disciplinary Actions:	None Reported To This Site By The Board
Other Information:	As of 2001, Certificates are no longer issued in the State of Missouri. Therefore, you may see some individuals with a Certificate only, or with a License only, or with both. Only individuals with a License or Certificate and License are Certified Public Accountants with unrestricted practice privileges. Individuals with only a Certificate may not practice public accounting; however, they may use the credential if they are in private industry, academia or retired and no longer practice public accounting.

Contact the Board for official verification of information.

State Board Contact Information:

MISSOURI STATE BOARD OF ACCOUNTANCY
P.O.BOX 613
JEFFERSON CITY, MO 65102-0613

Phone: 573-751-0012
Fax: 573-751-0890
Email: MOSBA@PR.MO.GOV
Website: http://pr.mo.gov/accountancy.asp
Licensee Lookup: https://renew.pr.mo.gov/licensee-search.asp

Details of Enforcement, Non-Compliance or Disciplinary Actions:

1. If "Contact State Board For Details" is displayed then the State Board has reported some type of enforcement, non-compliance or disciplinary action to this site and the State Board should be contacted for full details about the action reported.
2. If "None Reported To This Site By The Board" is displayed then the State Board provides enforcement, non-compliance and disciplinary action data to this site and none was indicated for this record.
3. If "State Does Not Provide This Type of Data At This Site" is displayed then CPAverify is not currently receiving enforcement, non-compliance or disciplinary action data for licensees in this state. Some states are limited to sharing this type of data with third party websites due to privacy laws or policies, but most State Boards offer this information on their official State Board websites.

2

4. Contact the State Board for official verification of all enforcement, non-compliance and disciplinary activity.

The results shown here include all data made available by participating states. Additional data about the individual or firm may exist and is not shown here for other states that are not yet participating in the CPAverify website. Please refer to the Participating States tab for more information about which states are currently sharing their licensing data for use with this website and for clarification about which states these results do not include. If the Board of interest is not participating, you may refer to the "Contact Boards" tab where a link to every Boards' website and therefore individual license lookup tool is available.