Critical Questions State Medicaid Agencies Should Be Asking About Their Managed Care Organizations

IS YOUR STATE DOING ENOUGH TO MONITOR ITS MCOs?
7 Questions You Should Ask Yourself About Your Managed Care Program

As more and more states move their Medicaid populations into managed care, it is more important than ever that states monitor their managed care organizations (MCOs). Structures must be in place to ensure that MCOs are adhering to contractual arrangements and delivering high quality services. Lawmakers, oversight agencies and taxpayers are demanding predictable health care outcomes based on the cost effective delivery of services. The oversight and monitoring plan must include activities to monitor MCO performance and ability to control costs over time, as well as activities that can quickly identify and resolve current problems, and quantify and prevent inappropriate payments.

Using our considerable experience and expertise with managed care, Myers and Stauffer developed these seven questions to help state Medicaid programs ensure they are fulfilling their fiduciary duties to program stakeholders. Our scope of comprehensive services will help ensure that MCOs are on track to achieve intended performance goals. Let Myers and Stauffer give you peace of mind by helping ensure your managed care program is performing as it should and as you intended.
1. ARE YOU PREPARED TO IMPLEMENT OR RENEW YOUR MANAGED CARE CONTRACTS?

Poor implementation of managed care can result in a myriad of significant issues and, ultimately, may have a negative impact on the health of the very members the program is designed to protect. An effective implementation plan/management strategy should include considerations for plan benefits, robust managed care contracts, targeted stakeholder outreach plans, health plan implementation readiness reviews, health plan audit strategies, and other program-specific considerations (e.g., consideration of foster children inclusion within managed care).

Myers and Stauffer can make sure your managed care implementation goes smoothly. We can help you identify program risks, determine the resources necessary to manage the programs, and figure out the when/where/why/how to deploy those resources in order to maximize the efficiency and value of the program.

**Myers and Stauffer’s Implementation Assessment**
- Program benefit design consulting services (carve in/carve out).
- Implementation process/timeline management.
- Resource support, including subject matter expertise.
- Health plan contract development.
- Health plan and health plan system readiness reviews.
- Stakeholder outreach planning and implementation, including liaison to provider associations, legislative advocacy groups or other outreach, as appropriate.
- Program risk assessment and evaluation.
- Assistance with development of reporting requirements and other program management tools.
- MMIS readiness testing.

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**Spotlight on Managed Care Organization (MCO) Performance Audits**

- Is the state achieving the results it sought by outsourcing with the MCO?
- Is the MCO accurately self-reporting its performance according to the terms of its contract?
- Is the complex organizational structure and myriad of related party contracts used by many MCOs governed by effective management controls and compliance with federal cost principles to ensure the most cost effective operations to the state?

Through our successful work conducting MCO performance and contract compliance audits for other state Medicaid programs, Myers and Stauffer has gained considerable experience and expertise with managed care. We can help government health care leaders ensure that MCOs deliver all agreed-upon services to the populations that rely on such critical health care services. We offer:

**Enhanced Accountability.** Your MCOs may be overpaying for medical expenses, which costs the state money by driving up capitated rate payments. If your MCO is not in compliance with your contract requirements, it is possible that they are also not identifying any fraud, waste and abuse practices. Performance reports submitted by your MCO containing only self-reported data may be inaccurate, thereby indicating compliance with contract performance targets, when in reality performance is below contract requirements. Claims may be processed late or inaccurately due to non-compliant IT system applications and systems’ edits.

**Enhanced Patient Services and System Security.** Eligible patients may not have access to care due to provider network lists that may be inaccurate and out-of-date. Provider inquiries and prior authorizations may not be handled in a timely manner, thereby delaying or denying treatment to eligible enrollees. Complaint and appeal processes and Call Center operations may be inadequate and non-compliant with contract requirements. MCO IT systems may not be compliant with HIPAA regulations and therefore could expose personal health information (PHI) to unauthorized access.

Our team of managed care specialists and IT assurance professionals offers a range of comprehensive services to ensure that MCOs are on track to achieve intended performance goals.
2. DO YOU HAVE A SYSTEM IN PLACE TO MAKE SURE YOUR HEALTH PLANS ARE PAID CORRECTLY?

A comprehensive monitoring program is vital to ensuring the vast amount of data generated and used by your managed care program is accurate, the costs reported are allowable, the profits are accurate and reasonable and that operations are meeting contract performance standards. The most successful states create online reporting systems for MCOs to report data; thereby allowing the state to conduct further data analysis on the information provided. A successful monitoring program provides an incentive for MCOs to perform at a high standard.

Myers and Stauffer has extensive experience creating clear criteria for performance in MCO contracts and monitoring the following areas:

**Myers and Stauffer’s Contract Performance and Monitoring Criteria**

- Clear definition of cost principles.
- Treatment of third party recoveries, reinsurance recoveries and pharmacy rebates.
- Provisions for retention and submission of data.
- Provisions for state’s right to audit.
- Provisions for addressing non-compliance.
- Provisions for addressing overpayments and excess profits.
- Capitation payment testing.
- Data analysis and encounter testing.

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**Spotlight on Pharmacy**

- Are you confident that your MCO is administering your state’s pharmacy benefit as it was intended?
- Does the thought of going through the details of the contract and comparing it to the actual processes in place seem overwhelming?

Through our successful work over the past four years performing Medicare Advantage and Part D prescription drug plan program audits with the Centers for Medicare & Medicaid Services (CMS), Myers and Stauffer has gained valuable insight into monitoring pharmacy benefit administration and contract compliance with an MCO. We can help you feel confident in your program by monitoring your MCOs’ performance while ensuring their compliance with the delivery of prescription drug services. We offer the following reviews, which often uncover limitations in access to medications:

**Formulary and Benefit Administration.** Your MCO may be rejecting claims for formulary medications as non-formulary or applying unapproved prior authorization criteria. They could also be applying unapproved utilization management edits.

**Coverage Determination and Appeals.** Your MCO could be using insufficient provider outreach to obtain its supporting clinical information or failing to process requests and/or notify recipients within the prescribed timeframes. There is also the possibility of misclassification of coverage determination requests as a grievance or general inquiry.

We have an experienced team of pharmacists and other medical professionals who are ready to assist you with pharmacy contract compliance.
3. DO YOU HAVE PROCESSES IN PLACE TO ENSURE YOUR HEALTH PLANS ARE PAYING PROVIDERS APPROPRIATELY?

The most successful states audit cost and recovery data to determine any under or overpayment issues that could land them in hot water. Annual, quarterly, bi-monthly, or even monthly audits can give a state peace of mind by identifying missing encounters, duplicates and other common errors in encounter data. These audits can provide a real and substantial benefit to a state’s Medicaid agency by ensuring already limited funds aren’t being distributed improperly.

Myers and Stauffer can help states reconcile submitted encounters to financial documents, audit medical and administrative costs and recover overpayments. At the same time, we can help you review your member enrollment data for accuracy. Additionally, an actuarial review that coincides with any rate adjustments can help states remain compliant with contractual provisions.

*Are you paying too much?*

If the proper processes aren’t in place to verify that payments to providers are accurate, how can you be sure your capitation rate isn’t overstated and your state’s badly needed Medicaid funds aren’t being misspent? After auditing one state’s managed care organization program, Myers and Stauffer found potential overpayments of $17.5 million by two managed care organizations to providers, that inflated the capitation rate resulting in more than $22.5 million of potential overpaid capitation payments to the state’s MCOs for the year. The state is currently implementing Myers and Stauffer’s suggested process changes, including tightening contracts and monitoring their MCOs to make sure claims are properly coded, documented and reported.

**Spotlight on Program Integrity**

- Is your program integrity group struggling with how to define return on investment (ROI) within managed care?
- Are you confident that your MCOs are doing their part to identify and recover overpayments associated with fraud, waste and abuse (FWA)?

While many states have struggled with determining the appropriate ways to approach FWA under managed care, Myers and Stauffer has helped states and CMS identify overpayments and determine the impact on Medicaid and Medicare payments over the past five years. We can help you determine the best approach to overseeing program integrity within your managed care program. We offer:

**Claims Analysis.** Your MCOs may be improperly paying for services that should not be covered by Medicaid. We can review the MCOs’ medical and pharmacy claims data and perform testing to identify improper payments. We can help you determine how those improper payments impact government payments.

**Assessment of FWA Detection Program.** Your MCOs may not have an effective program for preventing, detecting and correcting FWA. We can help assess the effectiveness of your MCOs’ FWA detection program in order to determine whether valuable program dollars are being appropriately used.

**Program Integrity Contract Provision Consulting.** Do the contracts that you have with your MCOs include the provisions necessary to support oversight of FWA? We can share best practices of contract provisions and regulations that allow you to adequately address FWA in managed care.

We have an experienced team of managed care experts who are ready to assist you with program integrity.
4. ARE YOU CONFIDENT YOUR HEALTH PLANS ARE COMPLYING WITH CONTRACTUAL REQUIREMENTS?

Can you be certain your MCO is following your contract requirements to the letter and providing your enrollees with the services expected? If your state relies on the MCO or Medicaid Fiscal Intermediary to regularly monitor and address contract non-compliance and poor performance, you’re taking a huge risk with your state’s most at risk population and your program’s reputation.

**Myers and Stauffer’s Contract Compliance Monitoring**

- Performance audits to test for compliance with contract performance provisions.
  - Follow-up audits to validate correction of issues.
- HIPAA compliance reviews and SSAE 16 audits to test for compliance with HIPAA laws and security of IT systems.
- Benefit administration reviews.

**Spotlight on Encounter Data Validation and Reconciliation**

- Do you know the quality and completeness of the encounter data submitted by your plans?
- Do you have good encounter data from your MCOs?
- Is your actuary utilizing this information to establish rate cells?
- Can program staff use the encounter data to provide program oversight?
- Can Program Integrity rely on the information for post-payment review?
- Are you confident in the data you are transmitting for T-MSIS?

If you are like many other states, often the answer to many of these questions is either “no” or “I don’t know.” Myers and Stauffer can assist the state with this initiative. We offer:

**Encounter Data Reconciliation.** We will review the encounter data submitted and reconcile the encounters against the plan financials to identify the percentage of plan paid encounters submitted. We will provide detailed information not only on the plan but also on delegated vendors as well. We will provide feedback to the State, the MMIS vendor and the plans on issues identified including companion guide problems and plan submission errors accepted by the MMIS vendor. Our feedback helps the MCOs resolve known and unknown issues to increase the volume of encounter claims submitted to within state requirements.

**Encounter Data Validation.** Once you have complete data, it is important to know if it is accurate. We test the data as adjudicated by the health plans to ensure the information submitted on the encounter is consistent with the adjudicated claim. We can perform all requirements established under EQR Protocol 4. Any issues identified can be addressed by the state and a corrective action plan can be established. Specifically we will:

- Review state requirements.
- Review the MCOs capability.
- Analyze the encounter data and compare findings to state standards.
- Review medical records.
- Submit a report detailing all findings.

We have an experienced team of managed care experts who are ready to assist you with your encounter data. Then you can say, “Yes, I can use my encounter data!”
5. DO YOU HAVE A SYSTEM TO HELP YOU EVALUATE THE EFFECTIVENESS OF YOUR MANAGED CARE PROGRAM (E.G., QUALITY OF CARE, ACCESS TO SERVICES, COST EFFECTIVENESS)?

One of the most visible ways for a managed care plan to land on the front page or the evening news is by not providing adequate services and resources to a state’s Medicaid population. Your MCO is obligated to provide services to beneficiaries and it is in the state’s best interest to ensure it’s happening as it should. Failure to effectively provide benefits can lead to beneficiary safety and access-to-care concerns. The state should be regularly reviewing denied claims and beneficiary appeals for services, as well as provider and member complaints.

Myers and Stauffer performs audits and analyses that go beyond the scope of external quality reviews (EQR) to ensure MCOs are providing beneficiaries with access to the services to which they are entitled. The audits focus on services that are denied by MCOs and ensuring beneficiaries are given the appropriate rights to obtain service. Auditors review samples of targeted cases to identify instances of non-compliance. We also offer clinician reviews to assist with evaluating the effectiveness of health plan quality improvement and member education initiatives.

**Myers and Stauffer’s Care Compliance Audits have identified:**
- Denial of pre-authorization for medically necessary care.
- Denial of emergency services.
- Improperly limiting the quantity of medication supplied to beneficiaries.
- Denial of coverage for protected class medications.

**Spotlight on Medical Loss Ratio (MLR) Audits**

- Are you ready for the additional audit responsibilities necessary to ensure compliance with MLR regulations?
- Have you developed reporting templates to conform to your state’s unique requirements?
- Have you developed adequate guidance for the managed care organizations (MCOs) to ensure their reporting is accurate, complete, and consistent?

Through our successful work assisting several state Medicaid programs with the oversight and monitoring of their MCOs, Myers and Stauffer has gained considerable experience and expertise with managed care. We can help you build an effective MLR auditing program to ensure compliance with state and federal requirements and increase value for consumers. We offer:

**Quality Improvement Expenses.** Your MCOs may be inappropriately allocating expenditures to activities that do not improve health care quality. They may also be improperly classifying certain types of information technology and marketing expenses as health care quality expenses.

**Administrative Costs of Vendors or Subcontractors.** Your MCO may be including the entire cost of certain vendor or subcontractor expenses as medical when a portion of the contracted service relates to administrative responsibilities. We have an experienced team of managed care specialists who are ready to assist you with your MLR Audits.
6. DOES YOUR MEDICAID PROGRAM LEVERAGE INNOVATIVE FEDERAL FUNDING OPPORTUNITIES?

For many years, Myers and Stauffer assisted states with developing and supporting supplemental payment programs to leverage payments up to the Medicare upper payment limit (UPL) findings as a means to support safety-net hospitals and tertiary care facilities. With the added emphasis on managed care over the last several years, states have been able to slow, and in some cases, decrease benefit expenditures through effective utilization management. While Medicaid expenditures have been better controlled with managed care, contributions to supplemental payment programs have decreased since managed care utilization may not be considered in UPL findings.

Myers and Stauffer can assist states in evaluating alternative financial models based on patient and population health quality improvement (QI) programs (i.e., CMS’ TripleAims). Many QI programs are based on targeted improvement, interventions and incentive/pay-for-performance models that recognize the contributions made by safety-net facilities. Many states are now taking advantage of such opportunities through the CMS Innovation Center, which oversees innovative initiatives such as delivery system reform incentive payments (DSRIP), state innovation models (SIM) or other strategies available through an 1115 waiver. DSRIP, SIM and other forms of QI models typically include incentive-based payments to eligible providers that undertake intensive delivery system reform initiatives where payments are based on the achievement of quality measures. Myers and Stauffer is assisting several states with the development, operations and oversight of such incentive payment programs.

Spotlight on Provider Medicaid Cost Reporting

• Do you know how payment increases to MCOs correlate to hospital and other provider costs?
• Are you able to demonstrate to legislators and the media that managed care payment rates to your state’s providers are adequate?
• Is there still a need in your state to set pass-through or traditional fee-for-service rates, even within the managed care environment?

Many states struggle demonstrating that managed care payments are still adequate compared to actual provider costs. Myers and Stauffer can help you collect and analyze provider cost data for this purpose. We offer:

Cost Report Collection and Auditing. Myers and Stauffer can implement cost reporting, collect cost reports and audit cost reports for Medicaid providers that don’t typically file Medicare cost reports including home and community based service providers (HCBS) and others.

Adequacy of Managed Care Rates. Analyzing Medicare cost report data from the health care cost report information system (HCRIS) or filed Medicaid cost reports is important for determining if provider costs are tracking with increases in managed care rates. We can use our years of cost report auditing and rate-setting experience to determine reasonable cost at the provider level. We have tools to extract data from HCRIS and other data sources to report provider census and cost data to our clients. The census data can also be used to assist states in reconciling provider tax payments.

Provider Rate Setting. Some managed care contracts include pass-through managed care rates that require minimum rates. These may be found in long-term care or other areas of the managed care spectrum. States may also still need fee-for-service rates for those recipients excluded from managed care. Myers and Stauffer has experience in rate setting for all Medicaid provider types, whether the rates are based on cost reporting only or a combination of cost report data and other acuity factors.

We have an experienced team of cost report and rate setting experts who are ready to assist you with cost report and rate setting in a managed care environment.
7. HAS YOUR STATE DEVELOPED SYSTEMS TO PREVENT AND/OR DETECT FRAUD, WASTE OR PROGRAM ABUSE?

Your managed care program is designed to help your beneficiaries have access to the care they need without leaving a legacy of fraud, waste and abuse. Every state should have a strategy to identify, detect and prevent fraud, waste and abuse within managed care. Myers and Stauffer offers a comprehensive risk assessment of managed care programs that identifies vulnerabilities and helps states determine where to focus scarce program integrity resources.

Myers and Stauffer is involved in managed care program integrity oversight within both Medicare and Medicaid. We identify outliers within medical and drug utilization, identify and recover overpayments made to providers in managed care, and identify overpayments made to health plans through capitation payment errors and/or administrative cost overpayments.

Myers and Stauffer’s Fraud, Waste and Abuse Analytics have identified:

- Improper payments made by MCOs to providers.
- Duplicate payments between benefit programs.
- Inappropriate payments to MCOs.
- Improper coding of data used to risk adjust payments.

WHY MYERS AND STAUFFER?

For more than 35 years, Myers and Stauffer has provided professional accounting, consulting, data management and analysis services to state and federal agencies managing government-sponsored health care programs. The firm’s health care practice has helped more than 45 state Medicaid programs address complex reimbursement issues for hospitals, long term care facilities, home health agencies, federally qualified health centers, rural health clinics, pharmacy providers, physicians and other practitioner providers. In addition, for more than a decade, we have provided Medicare and Medicaid audit, program integrity, managed care audit and consulting, investigative services and other delivery system consulting services to state Medicaid agencies, state Medicaid Fraud Control Units, federal health care agencies, including the Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS) Office of the Inspector General, and U.S. Department of Justice and the Federal Bureau of Investigation.
OUR MANAGED CARE LEADERSHIP TEAM

With a combined experience in Medicare and Medicaid of more than 160 years, our managed care leadership team brings the latest in audit, reimbursement, rate setting, consulting and program integrity to our clients. With unmatched experience in the government health care industry, our managed care partners can help you make sure your managed care program is as effective as you want it to be and that your state is getting the right value for your taxpayer’s money.

Bob Bullen
CPA, CFE, member and Partner-in-Charge of the Managed Care team

Bob has more than 30 years of experience relating exclusively to health care related audit and compliance services. Bob has worked with the Centers for Medicare & Medicaid Services (CMS) since 2005 overseeing various contracts to perform examinations of financial information submitted by Medicare Advantage Organizations and Prescription Drug Plans. This work included examination of base period data, prescription drug claims and medical claims, direct and indirect remuneration data (rebates), non-benefit expenses and solvency. He has also worked with the CMS to conduct performance and compliance audits of Medicare Advantage Organizations and Prescription Drug Plans.

Bob has also managed various financial and performance audits of managed care organizations for the States of Nevada, South Carolina, Maryland and the Commonwealth of Virginia. The performance audits covered encounter data validation, program integrity and fraud and abuse safeguards, the effectiveness of the compliance program, third party liability and stop loss. The administrative expense audits tested the accuracy and allowability of the reported administrative expenses. Bob also worked on nursing facility cost report audits for over 20 years.

Bob Hicks
CPA, member

With 18 years of experience, Bob is responsible for providing auditing, rate setting, consulting and public accounting services to state Medicaid agencies addressing health care reimbursement issues. He serves as the lead manager for several of the firm’s DSH audit contracts and has been involved with the Medicaid DSH audits from the beginning of the first audits for 2005.

Bob has worked on nursing facility cost report audits for 16 years. His experience includes approximately 8 years with the Medicare fiscal intermediary and 10 years with Myers and Stauffer performing Medicare/Medicaid cost report audits/desk reviews of nursing homes and hospitals among other various reimbursement projects.

Michael Johnson
CPA, CFE, member

Mike has 20 years of experience performing and managing agreed-upon procedures engagements, various program integrity engagements, and testifying as an expert witness for state and federal government agencies.

Mike has worked on a variety of engagements throughout his career. Some of his recent accomplishments include the development of a strategy to reconcile MCO encounter claims back to cash disbursement journals. With implementation of this strategy, the MCOs raised their completion rates from ~85% to ~99% and cleaned up erroneous encounters in the process. Recently, he worked with a State Medicaid Agency to evaluate the effectiveness of a National MCO’s fraud and abuse strategy. Several potential weaknesses had been identified by the OIG. The audit objective of this engagement was to evaluate the overall effectiveness of the program and provide “best practices” which can be implemented with the next MCO contract.
Beverly Kelly  
CPA, CFE, CFF, member  

Bev has more than 25 years experience with expertise in fraud and abuse detection, developing audit strategies, managed care compliance auditing, performing health plan operational assessments and other managed care operational issues. She recently completed a comprehensive examination of the Passport Health Plan for the Commonwealth of Kentucky, which included analysis of financial and utilization data, analyses of the health plan business model, fact finding interviews, on-site procedures, contract analyses, among other activities. She serves as the project manager for the managed care organization financial monitoring and encounter reconciliation engagement with the Louisiana Department of Health and Hospital’s Bayou Health program.

Andrew Ranck  
CPA, member  

Andy has more than 18 years of experience with working with health care and government related compliance audit engagements. Specifically, he manages a significant number of the firm’s federal, state and local government clients, including ten years of experience performing managed care audits of state and federal Managed Care Organizations. Areas of expertise include Medicare Parts C and D, Program Integrity, Risk Assessments and Medicare/Medicaid Reimbursement.

He has managed contracts with CMS since 2004 on such projects as completion of examinations of Adjusted Community Rate Proposals prepared by Medicare Advantage Organizations (MAOs), examinations of Bid Pricing Tools prepared by MAOs Medicare Advantage Organizations and Prescription Drug Plans (PDPs), Agreed Upon Procedures Review of a disease management organization to validate operational procedures and expenditures relating to their participation in the BIPA Disease Management Demonstration, Compliance and Performance audits of MAOs and PDPs, Medicare Prescription Drug Integrity Contractor (MEDIC) and Agreed Upon Procedures financial reviews of MAOs and PDPs Medicare Part D Prescription Drug Plans.

Keith Sorensen  
CPA, CFE, member  

Keith has 15 years of health care audit experience, specializing in compliance auditing for health care programs with an emphasis on Medicare and Medicaid regulation compliance and reimbursement issues. Since 2009, Keith has managed audits overseeing the Medicare Parts C and D programs. His Parts C and D experience includes managing financial examinations of Medicare Advantage Organizations and Prescription Drug Plans (MA/PDPs), reviews under the MEDIC (Medicare Drug Integrity Contractor) program and compliance and performance audits of MA/PDPs. In addition, Keith managed a recent engagement with the Texas Health and Human Services Commission (HHSC) to assess MCOs’ [and their contracted pharmacy benefit managers’] compliance with regulatory and contractual requirements regarding the carve-in of pharmacy benefits into the State’s managed care program.
MYERS AND STAUFFER’S COMPREHENSIVE MANAGED CARE SERVICES

Managed Care Compliance Consulting
- Encounter reconciliation and validation.
- Contract compliance.
- Performance testing.
- Recommendations for process and contractual improvements.
- Monitoring activities.
- On-site audits.
- Benefit administration reviews.
- Quality of care reviews.
- Access to care reviews.
- HIPAA compliance reviews.
- Compliance plan effectiveness audits.
- Pharmacy benefit reviews.

Managed Care Fraud and Abuse Detection
- Field audits and investigations.
- Identification of mispayments.
- Litigation and statistical support.
- Recovery audit services.
- Eligibility audits.
- Chart audits.
- 100% claims reviews.
- FWA program effectiveness reviews.
- Benefit/program integrity contract provision consulting.
- ROI analyses.
- Predictive analytics.

Managed Care Financial Consulting
- Financial reconciliations.
- Development of policies and procedures.
- Review of internal controls.
- Specialized auditing.
- Medical loss ratio audits.
- Capitation payment testing.
- Administrative cost reviews.
- Related party transaction reviews.
- DSRIP development and oversight.

Frank Vito
CPA, CICA, member

Frank has more than 35 years of audit and financial management experience and is responsible for the management of operations in the Austin, Texas office. Prior to joining Myers and Stauffer, Mr. Vito served as the Director of Assurance Services for the Texas State Auditor’s Office. Frank has extensive experience in managing risk within state government operations. He has worked to develop the state’s risk assessment methodology used to develop the annual audit plan for the state of Texas. He has established and managed initiatives to enhance agency internal control structures and coverage of IT risks, to increase awareness of and detection of fraud, waste and abuse, and to increase efficiency and effectiveness of attestation and assurance engagements through data analytics, and strategy mapping techniques.

For the past 10 years, he has been the engagement partner on numerous Medicaid assurance, compliance and consulting engagements with specific expertise in the areas of Medicaid managed care and Disproportionate Share Hospital reimbursement programs. Frank’s clients include the states of Texas, Washington, Oklahoma, Alabama, Michigan, Arkansas, Colorado and Wisconsin.