From:	Sean
To:	solicitation.questions
Subject:	RFI
Date:	Sunday, June 5, 2022 11:50:09 PM
Attachments:	image001.gif image002.png image003.jpg RFI Response.docx RFI Response Redacted.docx

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Dear Mr. Massa,

Responses to the RFI were due Friday at 5pm. At that time and after Florida was experiencing the effects of a severe tropical wave that was inundating South Florida with rain and heavy lightening. Prior to and through the due date our company was working to communicate with our many Medicaid members to assure all were prepared the storm. This priority inhibited our ability to finish and forward our responses.

We ask you to take that into consideration and accept this tardy but important response to the RFI.

Thank you

Sean P. Schwinghammer

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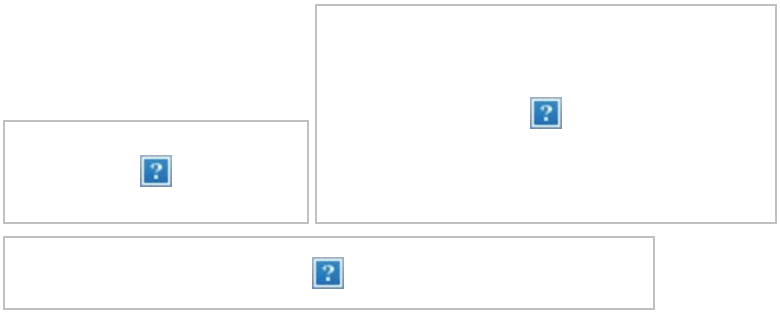

June 3rd, 2022

To: **Cody Massa**
Procurement Officer
solicitation.questions@ahca.myflorida.com

From: [redacted]

Re: **RFI Response**

Dear Mr. Massa,

Thank you for creating the current RFI for the upcoming procurement. Our companies have a keen interest in improving the Long-Term Care program along with the MMA program. We hope the below suggestions are understood. If there are any questions regarding our responses, we will be open to providing clarification.

Our responses are written below each of the Agency's written request for innovative ideas and best practices. The answers are Marked as being applicable to Durable Medical Equipment and Medical Supplies (DME) or Home Care Services (HCS). We hope that is easily understood.

• Leverage the managed care delivery system, either through expanded benefits or other mechanisms, to promote sustainable economic self-sufficiency among Medicaid recipients in the short and long term.

DME

Economic self-sufficiency requires personal self-sufficiency which can only be assured, especially regarding the Long-Term Care population, by keeping members in their homes. The managed care delivery system must facilitate ancillary services and foster robust home-based care and Medical Equipment and supply industries that do not are not held to low, random rates that quell quality and innovation, rather monies must to targeted to those industries to pay them well and equally so providers compete for work based on quality of services rather that MCOs relying on the provider willing to accept the least.

It was proven by CMS that when providers compete based on service, the quality of work, the responsiveness, and most importantly the member outcomes are improved.

• Improve birth outcomes for mothers and infants through and beyond 12-month postpartum coverage period.

DME

Florida recently passed laws to use DRG funds to pay for human Breast Milk for infants. Those laws can and should be expanded to include outpatient use of human breast milk. To do so there needs to be proper codes added to the fee schedule and licensure requirements implemented into the Florida Medicaid system.

Breast Milk is a nutrition product. Oral nutrition is made available in Medicaid through DME companies. Milk Banks cannot obtain a DME license without an exception to licensing criteria, we suggest such an exception be made. Access to Human breast milk is essential to foster infant care in the first months of life.

• Utilize value-based payment designs to simultaneously increase quality and reduce costs.

HCS

Value-based programs are of great value for some segments of the Medicaid continuum (such as skilled nursing wound care), but they are, undoubtedly, horrifically impractical and impossible in others. Personal Care Services cannot be value based i.e., a MCO's cannot pay a provider for a limited amount of bath visits and expect greater results. Personal care requires regularity. It is a maintenance and not an improvement program.

To increase quality in this space, rates need to be able to accommodate increased wages that can draw quality Direct Care Workers. Monies can be saves if Florida's fee schedule moves from a Minute based approach to care to a Pay Per Task approach.

While a bath visit is often paid for in 15-minute intervals up to 3 intervals and light cleaning for an hour, etc, if all the tasks are paid for their execution, not for their time in the home, Direct Care Aides are then incentivized to get more done in a shorter period of time and assume more tasks from other clients, thus getting more done with one person. This will reduce costs over all and decrease some of the workforce needs.

DME

Medical Supplies cannot be value-based as they are regularly required items as is all medical equipment. Efforts to create value-based designs for reoccurring maintenance services and supplies reduce quality and often then increases costs. While Medicare plans often use Third Party Administrators to manage and serve their populations at capitated rates, those populations are very specific, being 65 and older with generalized aging needs and not nearly as diverse and expansive as the entire Medicaid populations which includes all ages and every health type. The vastness of the demographic populations makes it an impossible capitate.

Possible designs that can work in DME include but are not limited to Per Member Per Month agreements, in which providers benefit from volume guarantees and pass on savings to the MCO. In a PMPM arrangement a MCO collects 6 months to a years-worth of data and, based on their usage, agree to a per member per month payment arrangement with a DME company for

all services. Savings are generated by volume purchases, reduced oversight of large networks, claims efficiencies and members benefit from faster service. Still choice would be provided for members.

Additional allowing MCOs to have limited regional providers would achieve many of the same results.

The biggest issues at hand today in DME is the Fee Schedule's archaic codes and pricing. MCOs' 'Single Rates' which mean a single discounted percentage off of the entire fee schedule is incongruent with the reality of pricing. While certain items can be provided under a low discounted rates, other items cannot. This has led to massive CHERRY PICKING in which companies contract at rates that will accommodate certain times they wish to carry but chose not to service many or most others. The result is providers who attempt to supply the items other will not are told they must adhere to the low rates "because other providers accept that rate", when in truth other providers do not actually provide said items.

The only solution is to assure MCOs' contract rates are based on product categories, not single discounts. AHCA defined and approved separate product categories in DME nearly 4 years ago, (Respiratory, Bent Metal, Incontinence, Wound care/Ostomy/Urological, Custom Mobility, prosthetics). MCOs must be required to negotiate rates based on categories that have homogeneity, because the current schedule is to obtuse for single rates.

• **Maximize home and community-based placement and services through proactive aging-in-place strategies**.

HCS

Aging-in-Place is the desired circumstance for all sick and elderly, who want to remain at home and in their comfortable environments. HCBS is the mechanism to assure the above while it also saves money by keeping people out of institutional care and reaps the benefits of loving and supportive family member involved with the care and treatment of members. The entities that foster HCBS, though, have traditionally been undervalued. Low rates in personal care services and higher expenses in the form of technology and liability insurance, etc. have been destructive to the very needed direct care work force. To maximize HBCS there must be investment in the field. It must always pay beyond the minimum wage because in truth, the work involves intimate practices that family members will not undertake. There is no motivation to perform intimate tasks for less than the going rate of a cashier in a store. This fact must be recognized by AHCA and MOCs.

Nurse Registries are a vital part of the Medicaid program. Registries work with 1099 contracted Direct Care Workers to help them find work and negotiate rates while they protect beneficiaries by background checking all workers and guarantees services can be rendered by working with a stable of Aides. There has been some question regarding the future of registries in Medicaid. It must be understood that many if not most HHA working in Medicaid Personal Care use 1099 workers. The aide pool is exactly the same, btu MCOs work with Registries because the aides often make more money while the MCOs pay a lesser rate, this is a benefit to the over-all Medicaid program. To maximize Home and Community Based Services, Nurse Registries must

have their positions secured and be treated on par with HHA when it comes to Personal Care Services.

DME

This situation is replicated for Medical Equipment providers. Fostering Aging in Place requires 24-hour responsiveness, extra equipment at the ready, a layer support staff of professionals, trucks, supplies, and more. The current economic climate had shrunk the availability of each of the items mentioned above, which are essential to support HCBS. AHCA and MCOs need to have a true understanding of the services and VALUE them, which means monetarily but also, valuing them enough to prioritize non-monetary issues including updating the fee schedules to incorporate new codes and service levels, to change unit counts, to eliminate problematic miscellaneous codes. Assuring middlemen, known as Third Part Administrators, do not self-refer business and do not have profit margins that cut into the rates of providers, that TPA administration costs be counted in MCO Medical Loss Ratios. Also valuing means proper oversight that MCOS pay their bills properly and timely and if not the penalties for inadequate billing are substantial and include paying for losses incurred by providers.

Provider's should not and cannot afford to carry losses due to MCO incompetence when it comes to paying bills. MCOs that have internal claims issues should pay 5% to 10% per month in penalties to providers they cannot pay and should also pay fines to AHCA until their claims issues are resolved. This must also apply to MCO regarding TPAs they hire.

- **Improve integration of dental and primary care services for children and adolescents.**

- **Align quality metrics and outcomes with the Florida State Health Improvement Plan.**

The FSHIP has clear goals and strategies, below is a list of such to which in home DME and Home Health Services apply.

Goal HE 1: *Establish shared understanding across all sectors (including, but not limited to, state and local agencies and other organizations) concerning information and issues surrounding health equity (HE), cultural competency/sensitivity and how social determinants of health (SDOH)influence the health of Florida's residents anticommunities. Enhance specialty health plans services to improve outcomes for recipients. Increase the number of plans to address target populations with specific health conditions or needs.*

DME

Enhancing specialty health plans' services is important to keeping people at home, which establishes health equity and fosters sensitivity to cultures. DME providers help MCOs adhere to this goal by keeping people in their communities. Problems arise when MCOs do not understand DME, its poor codes, its low rates, the limitations that come from large bureaucratic systems. This is why it is essential that AHCA require each MCO to have on staff a certified DME specialist that has worked in the sector for at least 5 years. Such a person would be responsible for authorizations and timeliness. They would have the perspective necessary to attend to DME issues as they arise. This is or particular importance regarding Long Term Care. The needs of LTC members are vast and individualized, requiring many customized items and order, the type of

which do not easily or at all accommodate MOC payment systems, causing denials, audits and countless claims projects. This is true of every health plan. Hence why a DME specialist is vitally important. This will improve responsiveness and outcomes.

HCS

As has been mentioned is other section of this RFI, improved outcomes for recipients in Long Term Care requires services be render-able. Without proper or enough Direct Care Workers, the model on which LTC Managed Medicaid laid its foundation, to keep members home where the cost savings is greatest and where members want to be, will be completely broken. For that reasons rates that can accommodate a better than Minimum wage are essential.

To enhance the program, it should be modernized, below are some suggestions:

- Paying for services based on service type and not minutes
    - Using advanced technology including incorporating more communication devices into GPS systems so Direct Care Workers can be used as resources of information regarding a patient condition
    - Allowing Aides certification to perform currently prohibited tasks such as changing band-aides, giving medicine, checking temperature, etc.

Other states have modernized home care, while Florida has not. At least allow MCOs the ability to pilot various ideas and incentivize them to do so.

Goal HE *2: Strengthen the capacity of state and local agencies and other organizations to work collaboratively with communities to reduce disparities in SDOH and advance HE.*

DME

DME providers are the deliverers of services that reduce deficits in health equity and respond to problems with social determinant of health. They provide equity of care between all races and backgrounds by offering the same services that all classes receive, but reduced rates from MCOs have a deleterious affect on providers ability to produce timely care and quality products.

Commercial health coverage and exchange programs can and due pass on increased cost to their beneficiaries which are used to keep service levels consistent. Medicaid providers cannot pass on costs to member and when MCO refuse to adjust rates despite PHEs and inflation, there is a a trickle-down affect contrary to the FSHIP. To assure services are comparable to other delivery bodies of medical coverage, rates must be similar if not exceed those other bodies, as the needs in Medicaid are much greater.

HCS

Home Health providers and their Direct Care workers do not treat any patient differently based on the payer. Medicaid, and especially the Nursing Home Diversion program that became the

Long-Term Care program has been monumental in reducing disparities in SDOC and advancing HE.

Now people who would not previously have been able to stay at home when ill and they age, can do so. It is so important this continue. Unfortunately, while commercial plans, long term care insurance policies and private pay has been able to increase rates to pay the wage increases, Medicaid MCOs have not done so enough or not at all. We are already seeing an inability to maintain these services for the Medicaid population, thus we are on the precipice of going backward in health equity as lower income and older Medicaid members will not have access to these services. Rates must rise to fund this needed work.

<u>Goal HE 3:</u> Strengthen the capacity of state and local agencies and other organizations to work collaboratively with communities and each other to support the specific needs of Florida's most vulnerable populations.

DME

For decades AHCA had an official policy, to used State funds to assure a 'robust' health care industry that could meet and exceed the needs of the entire population. AHCA wanted to assure this was true of Medicaid providers and to that end AHCA pushed for innovation, including new technology and processes, all in an effort to be advanced and be the best state in the union when managing vulnerable populations. Since the SMMC program all of that has changed. DME providers have been reduced by more than half, rates have been stagnant or reduced for 10 years as real cost have skyrocket. There are no new codes to accommodate innovation and not enough money or effort to foster innovation.

To strengthen the industry there must be

- sustainable rates
- contracts with Cost-of-living increases
- Payment for providers when they work during and after Public Health Emergencies and natural disasters
- Updated codes and modifiers

<u>Goal MCH3:</u> Increase the proportion of children with special healthcare needs under the age of 21 who receive their care in a patient-centered medical home.

DME

This important goal can only be achieved by saving money and assuring access. The SMMC program can and does save money as does Health Kids which is administered by the MCOs.

Patient Centered Medical Homes require a true coordination of services. Medical equipment Custom Mobility providers must be part of that coordination because many with special health care needs rely on custom mobility products to move in and outside of their homes. Medical experts want to coordinate care, but find provider hindered by the lack of proper codes, units and understanding of Mobility. Mobility is fundamental, yet the Custom Mobility DME fee

Schedule is sparce so orders for repairs, new chairs and alike are slowed and denied. The DME fee schedule must be expanded to include all relevant codes that will allow providers to ability to create accurate custom mobility plans and bill appropriately. This would also generate proper encounter data.

<u>Goal ISV1:</u> Prevent and reduce intentional and unintentional injuries and deaths in Florida. Strategy ISV1.3Reduce injuries related to senior falls through implementation of evidence-based fall prevention programs.

DME

Falls are the number one cause of hospitalizations for the elderly and most occur in their own bathrooms. Making a safe bathroom and home environment is required to achieve the goal. Prior to the SMMC program all DME providers were allowed to install bath safety equipment such as grab bars, raised toilet seats, handheld shower heads and more. Also, Providers could install ramps into and out of homes and bars at entrances, etc. All of that was included in the purchase rates for the equipment or at a small install fee.

After the SMMC program, regulations changed. The new regulations required that only General Contractors were allowed to install all of the above items. That increased the cost geometrically. A $50 installation rose to over $300 and also delayed and, in some areas, stopped the installation of these vital fall prevention tools.

Altering the requirement from having General Contractors install these items to once again allowing insured DME providers to do so will save money and assist in timely installation which will prevent falls.

HCS

The most common injuries that occur are falls. Elderly and the sick try to preform many tasks without assistance, while health and aging limit what may have been previous abilities. The best way to combat falls is to provide Direct Care Workers in the home to assist in everything from bathing to changing, cleaning, etc. As mentioned in other area, the wage crisis in Florida has harmed Home Care because the low rates paid by MCOs to providers is not enough to pay the need desired/ required wage.

The new $15 wage requirement, which MCO are not reacting too and for which they have not responsibility to pay a commensurate increase rate that will accommodate the new wage, is not enough. Before the state minimum wage of $15 is achieved, the $15 Direct Care Worker wage will be obsolete because if a person is not paid much more than minimum wage as an incentive to perform what president Obama described as “God’s Work”, Direct worker will do what they have been doing which is leave the industry for easily work.

Consideration must be made now to expect MCOs to pay rates that accommodate wages well above what even is the current minimum wage.

<u>Goal HW1</u>: Improve the food environment and nutrition habits across the life span to increase healthy weight.

DME

DME providers are the main supplies of oral nutrition to the Long-Term Care vulnerable populations. The products desired are currently on back ordered and their prices have skyrocket due to inflation and the baby formula crisis. It is incumbent upon AHCA to assure that the fee schedules and MCOs adjust their rates to respond to these types of crises which cause price hikes.

To assure proper ordering of oral nutrition, AHCA should include modifiers in the nutrition code that will differentiate calorie counts and product.

Goal HW2: Improve access to and participation in physical activity opportunities across the life span to increase healthy weight.

DME

Medical equipment providers are a main source of Aides for Daily living to Medicaid populations which include exercise bands, wraps and other items which help with exercise or are the exercise equipment. Recognizing that physical activity is a public good due to its health benefits, this area should be expanded upon, and Medical Equipment Providers should be the source for such equipment within the Medicaid program in order to assure clinical needs are met properly and services are properly coordinated by the MCO and executed properly.

Goal ID3: Demonstrate readiness for existing and emerging infectious disease threats.

DME

Readiness for infectious disease include who to protect the most vulnerable populations. During the recent pandemic it was DME providers who maintained the sick and elderly in their homes, especially Respiratory Therapist who had to enter the homes of oxygen patients to set up devices and monitor and maintain devices and Home Care Technicians who had to enter homes to drain the hospitals, prior to any vaccination, while honoring all safety protocols but still putting themselves in harms way. The entire way medical supplies and services are rendered was altered, yet the regulations and payment methods surrounding such were not.

To prepare for future threats, rates and codes should be establish that allow for reimbursement for providers going into harms way, for changes in rates when regulations are changed by direction of the governor or legislature, to fund cost increases associated with infection related inflation, etc. There can and should be a Nature Disaster Code that providers can use to bill for the extra services that need to be provided during a pandemic, before an after a hurricane, etc.

HCS

It cannot be understated the incredible work that Personal Care Aides rendered to home bound sick and elderly during the pandemic. Many left the industry, but most stayed out fo care for their members, going above and beyond and working without pay (above their slated hours) to

care for people in need in their home. For many their sacrificed was not worth it because their extra effort and hours were not funded, and they did not receive any increased rates while every other industry raised theirs. Direct Care Workers have soured on the hope of being rewarded.

To prepare for future threats there should be incentives available and increase rates suck as hazard pay, available to encourage people to do the hardest work in difficult and unsettled times such as pandemics.

Goal CD1: *Increase cross-sector collaboration for the prevention, early detection, treatment and management of chronic diseases and conditions to improve health equity.*

Strategy CD1.2 Promote policy and systems change to healthcare providers to increase team-based care and care coordination approaches for chronic disease treatment and management to ensure optimal and equitable care for all segments of the population.

HCS

For decades Direct Care Workers have been surveyed regarding the work they do and what they want from what is essentially a dead-end job. According to the authoritative book "Who Will Care For Us", Direct Care workers want to be more integrated into the health care team. This is a wise approach, Aides spend more time with patients/members than anyone else on the health care team, they know them and their habits and are the first to seem changes in health, awareness and ability. This information could be vital to the treatment of chronic diseases and ensuring health maintenance.

This can be achieve through enhanced GPS tracking technology, through regular meeting, through reporting, etc. Increased certification areas for Direct Care Aides, to gain skills, can help to ready aides for enhanced work and help them be placed with the proper healthcare team.

- **Improve coordination of care for individuals enrolled in both the Medicare and Medicaid programs.**

DME

The Dual population contains the majority of long-term care members in the Medicaid LTC program and a significant percentage of the MMA populations, still Managed Care Organizations have yet to streamline the Dual populations when authorizing ancillary services. As Medicaid is the payer of last resort, Medicare plans and payment sources should be utilized first, prior to Medicaid sources. While Medicaid pays for services and supports that Medicare plans do not.

Providers request that Medicaid Managed Care Organizations not require providers to first bill and get rejected by Medicare plans for items Medicare does not cover. Additionally, regarding lost a stolen Medicare items (replacement of which is requested of providers by Medicaid plans) mechanisms should be in place to allow for payments to providers that will not trigger recoupment audits. Often MCO systems will read that an item was provided by Medicare, and they automatically deny recoup a Medicaid payment. This is an undue burden on Medicaid providers.

• Consider innovative delivery methods, including care bundling, which empower recipients in making more informed health care decisions.

DME

Recipients, especially those undergoing health crises or those with long term disabilities, have many concerns and questions about their care. Eliminating confusion and burdens is important. This is a main reason why, for recipients, it is important to only have one DME provider in a home. Far too often MCO will chose one provider for oxygen tanks, one for beds and one for canes, etc. Having multiple providers causes confusion for members especially when they have a problem with their equipment. Using one provider only helps to assure that all items ordered are coordinated and are clinically needed, for example an authorization that requests a walker and another that requests a wheelchair at the same time may make sense to a case manager ordering them, but will be rejected in claims systems.

One provider gives members a single authority and eliminates the home-based care "blame games" that harm member.

Care bundling is mentioned, we might also suggest order bundling, in which all items ordered for members should be from one provider. Bundling all items in a single order reduces the amount of delivers, assures all item arrive timely and gives ease of mind to members. As important, bundled deliveries reduce delivery costs, which are rising every day. Multiple delivers increase prices and during this time of rising costs, varied orders to the same address are wasteful.

AHCA can and should require bundled deliveries and single providers whenever possible.

HCS

The most innovative concept within the Direct Care Worker industry is to alter the payment of personal care services from a time-based format to a task based format. Currently services are paid using 15-minute increments, and most services as assumed to take one hour. If one or multiple tasks are finished faster than within their expected time frame, the aide must remain in the residence until all the time is expired. A more innovative way to preform such work is to pay based on task. Under this format an aide is paid per service, which is an incentivize to finish their tasks quickly in order to undertake more work for other members. Time is not wasted. An Aide can do more work and care for more members in less time that the current format allows. This will allow Aides to make more money by working more cases, it will reduce the growing need for direct care workers and it will be more accurate while assuring members receive exactly the services they are receiving today.

• Improve recipients' experience with the SMMC Program.

DME

Competition based on service always results in a better experience for the recipients and better outcomes. When providers of ancillary services are all paid at the same rate by a MCO within a Region, they do not compete for the business based on the lowest rate, for which they will do the minimum required, rather they compete based on the level of quality service, trying to do their very best for the members and for their long-term reputations in order to assure future business. This model has proven

successful nationally in home-based care. Currently due to low rates, varying rates per MCO, rates that are statewide when services are rendered in differing Regions, etc., some providers are forced to deal with below standard rates, to withhold or delay services, extend response times, turn down cases, etc.

Recipients' experiences will improve when providers are afforded the opportunity to compete based on service. AHCA can require all providers are paid at the same rate per service, per region.

HCS
Beneficiaries prefer to work with the same people and limit their exposure to too many different care providers. They want one aide, who can do more. This is why AHCA can and should Empower Aides to do more, such as change bandages, provide certain regular medication, etc. Additionally, recipient will appreciate when Aides can forward general information to the medical team, using expanded technology from their GPS tracking devices, which will speed the access to new needed services.

When Aides are empowered, Beneficiaries' experiences will improve.

- **Increase timely access to providers and services.**

HCS
This goal is again achieved through rate enhancement. Rates are so low currently that the ability to find Direct Care Aides who will work for the resulting wage is nearly impossible in some areas, hence timely access is hard to find. Also, as the wage is too low and rates will be too low for providers to accept work, there will be less Providers participating in Medicaid. Wages that comply with state law and rates that have at least a 30% margin, must be required by MCO to assure timely access.

DME

IN DME low rates have cause massive layoffs, More and more providers turn down orders due to staffing shortages or if the location of a recipient is to far to be included in daily routs. Most dangerous is the need for Respiratory Therapist who are needed to serve members 24 hours a day. RT wages have risen so sharply since the pandemic that DME providers cannot afford them, leading to less RTs and an inability to respond quickly to urgent request. The result for members becomes emergency hospital room visits which are very costly and often have negative consequences; much costlier to the SMMC program than a minor wage increase.

Certain attempts to increase timeliness have failed or have made work more difficult for Providers, such as when MCO email blast referrals to multiple providers who then need to respond quickly. Providers try repeatedly to accept the referrals, only to find out later those others beat them to it. Every provider who did not get the 'award' wasted minutes and sometimes hours trying to respond. Often the chosen provider may not be the right provider, they may have no history in an area, or do not have the ability to service the member but accepted the referral to prevent others from getting it so they could then take time to find someone to fulfill the order. Those types of systems, employed today, waste provider time and as a result, member time. Solutions could be to reduce the provider network, work on rotations, creating a simple program that work to chose providers based on service history and speed response, and a standard rotation of existing providers. etc. Paying accurately will increase timely service as will, as mentioned in an above section, assuring all providers are paid the same rate will create outcome-based competition.

• **Achieve cost savings throughout the SMMC Program.**

There are many ways to achieve cost savings in various aspects of the SMMC program, but throughout all at once is impossible.

Home Based Services is by far the best way to achieve over all savings to the Medicaid program and must be prioritized as it has not been for over 20 years. Keeping members at home and healthy saves money on institutional care and hospital visits. While there is great savings from Home Care, it has a cost, and those costs are increasing. Paying home based care providers appropriately to provide their cost saving services is important now and in the future.

DME

In DME the updating of codes will reduce miscellaneous codes that result in costly claims projects.

HCS

In Home Care increase the Direct Care Worker pool thought rate increases in order to expand home based care.

Best practices for maximizing communication and resources.

DME

Fundamentally, the Medicaid Managed Care authorization system is flawed because it is based on pre-Medicaid Managed Care arrangements, the parameters of which no longer apply and should be removed.

For historical understanding, Florida once paid Medicaid providers for services in a system that was completely paper-based. There were many different entities involved and many opportunities for confusion, and manipulation of the system. This is why when it comes to claims payment the rule is “AN AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. That was appropriate.

Today authorizations are rendered in a contained system.

- MCO approved clinicians or MOC case managers request authorizations
- MCO Utilization Management teams verify adherence to guidelines and authorize services
- Approved MOC network providers provide the services
- Claims are filed in an MCO system which confirms adherence to set regulations and protocols
- After claims are paid MCO auditors review claims and can recoup monies if needed

Even though all of this is in a contained system, the programs for which are owned and run by MCOs, MCO still claim that AUTHORIZATIONS ARE NOT A GUARANTEE OF PAYMENT.

When MCOs are in full control of the process they should not deny payment of claims for services that were authorized by them. There are many occasions when providers receive authorizations, verify the request, render the services and are not paid because the MCO was in error in their authorizations. That is simply wrong. MCO should be responsible for their authorizations and pay them. Providers render

services in good faith and expend money and time. To deny such based on an outdated regulation is fundamentally unfair.

In the ITN Authorization should be guarantees of payment unless the provider is proven to have committed fraud or failed to render services properly. Then monies can be recouped.