CARROLL COUNTY YOUTH SERVICE BUREAU, INC.

59 KATE WAGNER ROAD – WESTMINSTER, MD 21157

410.848.2500 – 1.888.588.8441 – FAX 410.876.3016

SB 638
Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement
Senate Finance Committee
February 24, 2021

POSITION: FAVORABLE

I am Lynn Davis, the executive director at Carroll County Youth Service Bureau. We provide mental health and substance use services in Carroll County. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 2,500 people every year. Over 65% of the people we provide services for are publicly funded Medicaid patients. Our agency employs over 65 staff members.

SB 638 authorizes the Maryland Insurance Commissioner to enforce minimum performance standards for the Administrative Service Organization (ASO) responsible for managing care and paying claims for Maryland public behavioral health system. The bill is an emergency. Immediate action is needed to prevent continued harm that reduces our capacity to treat Maryland residents when the pandemic is driving the need higher than ever.

We have been working under the current ASO vendor since January 1, 2020. Fixes have not been delivered in the timeframes promised, and critical functions remain absent. The system is not stable and not functioning at the level it needs to. I have never witnessed this level of dysfunction in any of the prior four ASOs in Maryland. Optum's current operations are reducing our revenue, increasing our costs, and placing undue burden on our staff members and patients. We had hoped that more than a year after a failed launch, we would be at a better place. However, we are still working through the same claims many times over, continuing to deal with unresolved "fixes" to an endless stream of systemic problems, and grappling with the frustrations of a hard-working, diligent staff.

Our experience with Optum to date is illustrated by the examples below:

Basic business revenue tools don't exist: The ability to run reports, reconcile payments, and research claims in Incedo (there is no actual payment information that shows), are not available in Optum's system. These are all basic revenue cycle management tools. Billing operations which used to be performed electronically now require an enormous manual lift for our agency. We employ two people in our billing/claims department. One is an exempt employee, working far over her normal weekly schedule and consistently placing many other tasks on hold to deal with Optum issues; the second is a non-exempt employee whom we have paid for hundreds of extra work hours over the course of this last year. We have recently added another staff member and additional hours, all due to the extra, repetitive work caused by Optum.

Erroneous claims denials: The limitations and errors in Optum's system cause denied claims for diverse and unresolved reasons.

1) Some of the insurance policy spans did not transfer correctly from the previous ASO, which caused claims to deny for several months at the beginning of 2020—these claims have still not paid.
2) At least 23 Assertive Community Treatment claims ($30,000) were denied due to Optum's inability to process patient changes in insurance and eligibility. These have still not paid.
3) Medicare/Medical Assistance QMB client policies did not transfer over from the state's system to Optum MD correctly and are currently causing our claims to deny. This is not yet fixed.
4) There is no way for providers to track rejected claims in the Incedo system. We do not receive remittance advice (835s) for these.
5) Many claims are denied for reasons that make no sense. Denials reasons such as "Not payable to this provider type" are caused by manual processing errors by Optum representatives.

Customer Service: Erroneous denials often do not have accurate or actionable denial reasons, requiring our staff to call Optum customer service for each of them. Optum often implements substantive changes to policy/procedure without any formal communication to providers. Sometimes it is weeks/months before providers receive written notification from Optum of process changes, by which time they have received a huge volume of claims and authorizations denials because these were submitted using last known instructions. It is only by word of mouth or from fellow providers that we learn about major changes.

Optum customer service also remits incorrect information regularly. *Example:* When claims were denying due to insurance issues for one of our ACT clients back in October 2020, we were told by Customer Service that the client would need to contact Medicare and Medical Assistance and correct her insurance information with them. Our staff assisted this client in making these calls (a lot of time spent), but both agencies indicated that client's eligibility was correct. The client, who struggles with a serious and persistent mental illness, became very upset and agitated, fearing that her services would be discontinued. Many weeks later, we discovered that an error in Optum's system leading to inaccurate insurance information was causing claims to deny for thousands of Medicaid recipients. This is still not fixed.

Reprocessed claims: The substantial volume of erroneous claims denials, as well as a steady stream of claims paid at the wrong rate, mean that our agency has hundreds of thousands of claims reprocessed 1, 2. 3 and sometimes ten times. Third-Party Liability (Private Insurance primary w/ MA secondary) claims have not processed correctly for over a year now. These claims continue to be paid at the full MA amount without taking the primary payment into account. This has caused overpayments, and more work hours for staff to track incorrect payments without adequate tools to do so.

Reconciliation: The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. Due to the numerous delays from Optum concerning the reconciliation of estimated payments to services rendered, we had no choice but

to delay our annual audit for our year ending June 30, 2020. The delayed audit has created an issue with the refinancing of our building loan because these statements are a bank requirement. The current loan matures at the end of March and our agency is now scrambling to make sure we can close the loan prior to going into a default status. If we had audited statements back in the fall as usual, the loan process would have been able to begin sooner as well as allowed us to shop for the best option. Instead, this has become yet another ripple effect caused by the failure of the ASO.

As a provider on the front lines of behavioral health care in Maryland, we urge you to act now to preserve Maryland's treatment capacity and vote a favorable report on SB 638.