HB1272 - MIA - Support -FINAL.pdf
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Commissioner

TAMMY R. J. LONGAN
Acting Deputy Commissioner

Maryland
INSURANCE ADMINISTRATION

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2353 Fax: 410-468-2020
1-800-492-6116 TTY: 1-800-735-2258
www.insurance.maryland.gov

Date: **March 15, 2023**

Bill # / Title: **House Bill 1272 - Maryland Insurance Commissioner Enforcement - Specialty Mental Health Services and Payment of Claims - Sunset Extension**

Committee: **House Health and Government Operations Committee**

Position: **Support**

The Maryland Insurance Administration (MIA) appreciates the opportunity to share its support for House Bill 1272 (HB 1072).

House Bill 1272 amends Chapters 151[1] (HB0919) and 152[2] (SB0638) of the Acts of the General Assembly of 2021 to extend by two years the sunset date on this emergency legislation, which provided the Insurance Commissioner with the authority to examine an ASO that administers mental health benefits for the Maryland Department of Health (MDH) for compliance with Maryland's prompt pay statutes and required the MIA to submit the final report resulting from any such examination to the legislature. MIA was provided with this limited authority over an ASO, because the MIA enforces prompt pay laws with respect to commercial health insurers and, thus, had the staffing, infrastructure, and personnel necessary to conduct this examination.

Immediately following the 2021 enactment, the MIA initiated a market conduct exam of the entity currently serving as the ASO for the administration of mental health for MDH. The final market conduct report, which was submitted to this Committee, found significant violations and directed the ASO, among other things, to develop and implement corrective action plans as approved by the MIA. The ASO's agreement to do so is reflected in a consent order dated June 7, 2022 (the "Consent Order"), which was also provided to the Committee.

While the ASO has fully implemented many provisions of the Consent Order, it has not completed the automation of its system to automatically pay interest if a clean claim is not paid within 30 days of its receipt. Given that, under the Consent Order, the ASO is currently on a monthly reporting schedule to the MIA which enables the MIA to track the ASO's manual process for assuring payment of interest where required. The ASO has now estimated that its system will be updated by June 2023 and, assuming that occurs, time will be required to validate the accuracy of the system.

This extension will enable the MIA to continue to monitor the ASO for compliance with the Consent Order and with prompt pay laws for the duration of its current contract with MDH. For this reason, the MIA supports the extension of the sunset provision in order to assure that it retains the authority to conduct additional investigations or examinations, if warranted and to avoid any contention that the MIA would, by virtue of the sunset, lose the authority to continue to enforce the Consent Order.

[1] https://mgaleg.maryland.gov/2021RS/chapters_noln/Ch_151_hb0919T.pdf
[2] https://mgaleg.maryland.gov/2021RS/chapters_noln/Ch_152_sb0638E.pdf

Thank you for the opportunity to provide this written letter of support for House Bill 1272. The MIA is available to provide any additional information that might be helpful to the sponsor or the Committee.

2022 Joint Chairmens Report (p. 90) Report on reco

Uploaded by: Heather Bagnall

Position: FAV

Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

September 13, 2022

The Honorable Guy Guzzone, Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Ben Barnes, Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2022 Joint Chairmen's Report (p. 90) Report on recoupment, forgiveness, and identification of amounts to be recouped

Dear Chairmen Guzzone and Barnes:

Pursuant to the 2021 Joint Chairmen's Report (p. 90), the Maryland Department of Health (MDH) respectfully submits this report with an update on the Behavioral Health Administrative Services Organization's efforts on recoupment, forgiveness, and identification of amounts to be recouped.

MDH is pleased to report the following progress:

- **Estimated Payments:** Since the beginning of this calendar year, the total estimated payments balance has decreased by over $73.5 million (from $223.5 to $146 million after forgiveness). The number of providers with outstanding balances has decreased by 1,383 (2,107 to 712).
    - Of the more than $1.06 billion originally paid out in estimated payments, nearly 86% of those payments have now been fully offset with paid claims, direct repayments from providers, or forgiveness.
- **Forgiveness:** In July 2022, forgiveness amounts of $25,000 were offered and applied to providers with balances owed of $25,000 or less.
    - In total, 1,235 providers were forgiven debts of up to $25,000, totaling $11,666,279. This amount was within the budgeted amount of $13 million provided in the FY24 budget.
    - 61% of providers (1,589 of 2,606) who owed money to the State have now fully paid their debt and have no more responsibility for this debt.
- **Recoupment:** 712 providers owe the remaining balance of $146 million and will have 12 months interest free to repay these amounts through payment plans beginning in October.

- We are working on payment plans, which should be completed by late September. We anticipate completing recoupment by the end of CY24.
- 251 accounts have been sent to the Central Collections Unit for collections of a little over $4 million. These balances primarily represent providers who may have closed locations, retired, moved out of state, stopped providing Medicaid services, etc.

- Negative balances caused by duplicate payments and other issues such as fee schedule changes, retro-eligibility and other causes have also decreased $41.6 million (49%) since the end of calendar year 2021.

MDH requests that the withheld funds, pending the submission of this report, be released. If you have questions or need more information, please contact Megan Peters, Acting Director, Office of Governmental Affairs at megan.peters@maryland.gov or 410-844-2318.

Sincerely,

Dennis R. Schrader
Secretary

cc: Steven R. Schuh, Deputy Secretary, Health Care Financing and Medicaid
Lisa Burgess, M.D., MBA, Acting Deputy Secretary, Behavioral Health Administration
Webster Ye, Assistant Secretary, Health Policy
Megan Peters, Acting Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

2022 Joint Chairmen's Report (p. 90)

Report on recoupment, forgiveness, and identification of amounts to be recouped

September 2022

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Executive Summary

On January 1, 2020, the Maryland Department of Health (MDH) transitioned to United Health Group/Optum Maryland (UHG/Optum) as its Behavioral Health Administrative Services Organization (BHASO). At its initial launch, the UHG/Optum system had technical and system failures that impacted behavioral health providers. While acknowledging deficiencies at the commencement of the contract, UHG/Optum has made significant progress to correct issues.

For the estimated payment period, UHG/Optum paid out $1.06 billion in estimated payments to providers between January 1, 2020, and August 3, 2020. The outstanding balance of these overpayments by October 2020 was approximately $359,610,797 across both federal Medicaid and state-only programs. That balance was down to $162,352,061 as of August 4, 2022 (before forgiveness is applied), representing a reduction of nearly 55% since the first overpayment amounts were calculated in October of 2020 and a nearly 86% completion rate for reconciliation and recoupment of the original estimated payments of $1.06 billion.

In July, providers who had either paid down or had remaining balances of less than or equal to $25,000 were forgiven the balance of that debt. Some 1,235 providers have therefore received forgiveness amounting to $11,666,279. As a result, 61% of all providers (1,589) have been notified that their debt to the State is fully paid.

The remaining 712 providers with estimated payment balances due are highly concentrated among a few providers. Twenty four (24) providers have balances over $1 million and account for approximately $44.2 million of the outstanding balance of $146 million after forgiveness is applied. All are actively engaged with Optum to reconcile their accounts and repay these amounts.

Finally, there has been a significant reduction in negative balances owed to the State due to issues related to duplicate payments made to providers caused by issues resulting from retro-eligibility, fee schedule changes, and other related causes. Recoupment has been under way for these overpayments since early 2022, and significant progress has been made. The total amount of overpayments due is currently $43.3 million as of 8/01/22. This represents a decrease of $41.6 million (49%) since the end of calendar year 2021.

Reconciliation and Recoupment Process

UHG/Optum has received nearly 24.5 million claims between January 2020 through June 2022 and successfully paid nearly $4.6 billion ($755.6 million in 2020, and $2.3 billion in 2021, and $1.6 billion through June 2022) associated with those claims to over 2,600 providers who participate in the Public Behavioral Health System.

UHG/Optum and MDH continue to work together to improve the system and to deliver on the functionality that providers need to render services to Marylanders within the Public Behavioral Health System. Since real-time processing of claims began in August 2020, UHG/Optum has maintained a weekly average of $30 to $40 million in payments to providers.

Key to reconciling provider billing accounts, the Electronic Remittance Advice (ERA), or 835 report, is an electronic transaction that provides claim payment information, and a PRA is a statement explaining what services are being paid on each claim. These files are used by practices, facilities, and billing companies to auto-post claim payments into their systems. As of the end of October 2021, all 835 reports and Provider Remittance Advice (PRAs) had been delivered to providers by UHG/Optum to facilitate provider record keeping and reconciliation of estimated payments made between January 1, 2020 and August 3, 2020. 835s are now automatically generated and provided on an ongoing basis for all claims.

In addition to 835 reports and PRAs, Optum, with the direct input of the provider community, developed a "Claims Lifecycle History Report" for every provider that makes it possible for providers to track the life of an individual claim through the system from beginning to end. Those reports are available to any provider on a monthly basis.

MDH and UHG/Optum consistently collaborate and communicate with providers through a twice-monthly Operations Improvement Meeting to discuss provider needs and concerns about overpayment and the recoupment and reconciliation processes to repay them. The meeting also includes a product roadmap that has been integrated into UHG/Optum's website so providers can readily access it. Functional areas covered in the document are wide-ranging and include:

- Claims processing
- Reporting claim status for claims payment/provider interaction
- Additional functionality related to claims export, download, and history (revenue-cycle management)
- System Status Notifications and Outage Report
- Authorization and eligibility processing
- Responsiveness and timeliness of communications and provider relations

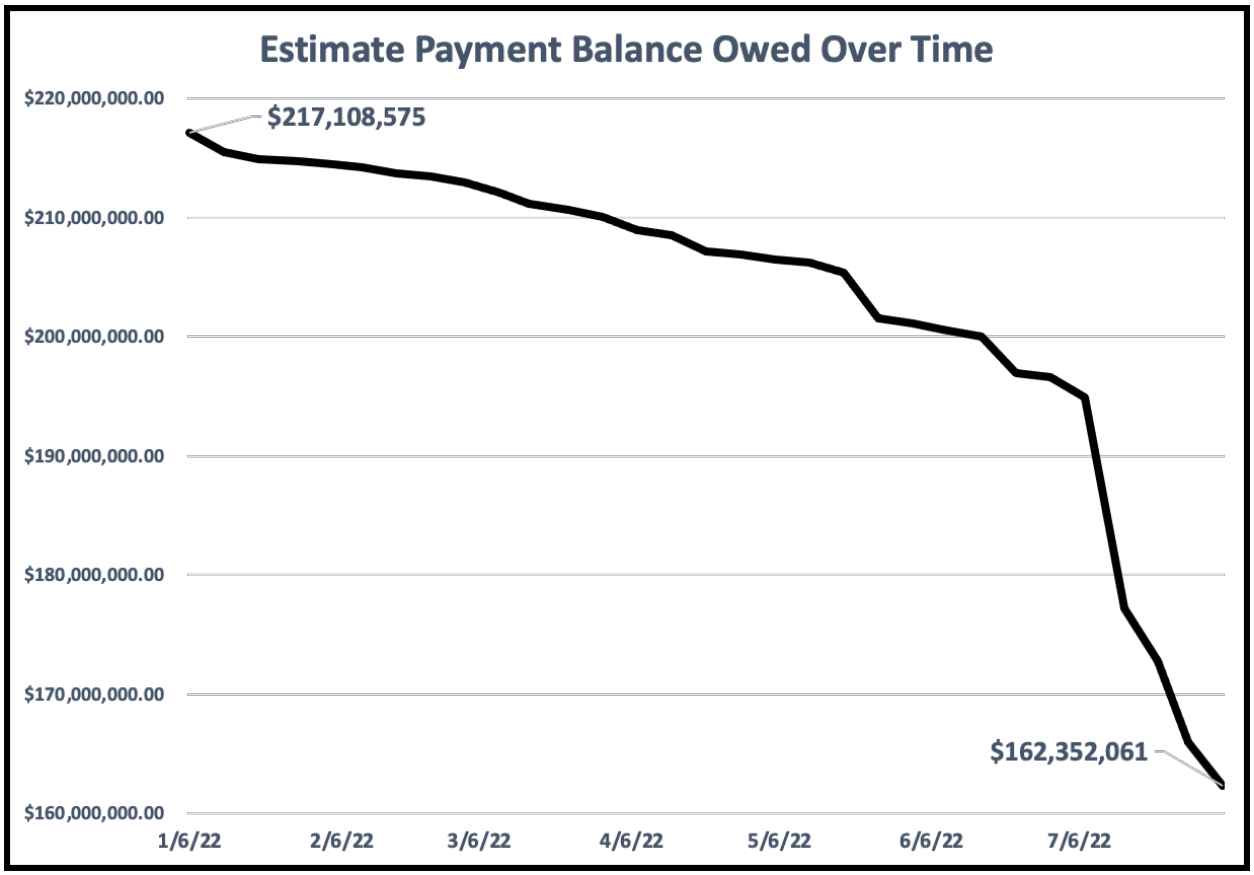
In addition to this meeting, there is a monthly Provider Council meeting with all providers, and every other week, there is an Executive Leadership meeting for the leaders of the large behavioral health associations, MCOs, hospitals, and other leaders who represent large institutions or groups of providers.

Due to the inability of UHG/Optum to pay claims when the system launched on January 1, 2020, MDH instituted estimated payments for providers based on their calendar year 2019 average weekly claims. Providers were informed at the time that the estimated payments would have to be reconciled against actual processed claims for service on those dates after the system went live. For the estimated payment period, UHG/Optum paid out $1.06 billion in estimated payments to providers between January 1, 2020, and August 3, 2020. In October 2020, UHG/Optum instituted a dual checkwrite cycle in which claims for dates of service during the estimated payment period were used to "offset" a provider's estimated payment balance, while claims for dates of service after the estimated payment period were processed normally. Providers generally have a year to submit claims from the date of service. For example, a service

rendered in June 2020 (during the estimated payment period) may be submitted in January 2021. In this example, the payment for that claim would be used to offset the provider's outstanding estimated payment balance. The offset would also apply if there was reprocessing of a June 2020 claim in October 2020 as part of a retroactive rate increase or special project.

Payments made prior to the establishment of the dual checkwrite for claims were not applied to the outstanding balance, as providers would essentially receive double "payment" for the same claim. With that in mind, the outstanding balance of overpayments in October 2020 was approximately $359,610,797 across both federal Medicaid and state-only programs. That balance was down to $162,352,061 as of August 4, 2022 (before forgiveness is applied), representing a reduction of nearly 55% since the first overpayment amounts were calculated in October of 2020 and a nearly 85% completion rate for reconciliation and recoupment of the original estimated payments of $1.06 billion. Figure 1 below shows the Estimated Payment Balance reduction over time.

Figure 1: Estimated payment balance over time as of August 4, 2022



Forgiveness Program

On June 13, 2022, MDH announced an expanded forgiveness program for providers to forgive their outstanding paid and unpaid balances of $25,000 or less. In addition, providers were given until July 15, 2022 to pay down any outstanding balances to $25,000 and receive forgiveness on the remaining balance. This incentive was aimed to provide relief to small providers and provided an incentive for all providers to reconcile their accounts quickly by benefiting from a significant reduction in debt.

A subset of providers are not eligible for forgiveness: hospitals, labs, out-of-state providers, and somatic non-behavioral health practitioners. In addition, 251 providers never submitted claims to offset the estimated payments received (i.e., "No-Offset Providers") during the initial period of January-August, 2020, and have thus far not responded to any communication attempts to collect these overpayments. These balances primarily represent providers who may have closed locations, retired, moved out of state, stopped providing Medicaid services, etc. These accounts have been forwarded to Central Collections to be worked through individually and pursued. This process has just begun.

Table 1: Provider Forgiveness as of 8/04/22.

Providers with Balance Due	712	$146,033,957
Providers <$25,000 forgiven	1,045	$10,124,429
Providers Sent to Collections	251	$4,082,793
Providers Who Paid Due Refund	192	$1,541,850
County Health Depts.	10	$569,032
Providers with No Payment Due	395	$0
Total Providers	**2,606**	**$162,352,061**

The remaining 712 providers with balances due are highly concentrated among a few providers. Twenty-four (24) providers have balances over $1 million and account for approximately $44.2 million of the outstanding balance. These providers are typically large entities, such as hospitals, large community substance use disorder providers, and large community-health providers. UHG/Optum has focused its reconciliation efforts on these larger providers and is engaged with 100% of the providers who have an outstanding balance of $1 million or more.

Table 2: Distribution of Provider Outstanding Payments as of 8/04/22

Provider Outstanding Balance	Provider Count	Total Outstanding
Providers Owing < $50K	279	$6,870,497
Providers Owing $50K < $100K	117	$8,809,879
Providers Owing $100K < $500K	258	$61,814,590
Providers Owing $500K < $1M	34	$24,366,554
Providers Owing $1M < $4M	23	$40,040,302
Providers Owing Over $4M	1	$4,132,135
Total	**712**	**$146,033,957**

A total of 1,237 (47%) of providers were either eligible for forgiveness because they had balances of $25,000 or less, paid their balance down to $25,000 to qualify for forgiveness, or paid in full by cash and have no negative balance due and are owed a refund. A majority of these balances are held by individual practitioners, such as licensed social workers and professional drug counselors, precisely the group for which relief was intended.

It is worth noting the progress made since the last JCR report MDH submitted in late January 2022.[1] **Since then, total estimated payment balances have decreased by over $73.5 million (from $223.5 to $150 million including collections), and the number of providers with outstanding balances has decreased by 1,383 (2,107 to 712). Of the more than $1.06 billion originally paid out in estimated payments, nearly 86% of those payments have now been fully offset with paid claims, direct repayments from providers, or forgiveness.**

Estimated payments are not the only claims that need to be recouped. A separate subset of claims, known as "negative balances," have occurred for a variety of reasons. Negative balances occur naturally in any insurance claims cycle. For example, retro-eligibility claims arise when Medicaid patients are billed initially as uninsured and later found to be eligible; such claims are reprocessed and approved. As a result, there is always some level of negative balance. These increased balances built up and accrued over time, primarily due to duplicate or overpayments

[1] 2021 Joint Chairmen's Report (p. 101-102) - Report on Status of ASO Functionality. January 2022. http://dlslibrary.state.md.us/publications/JCR/2021/2021_101-102_2022(1).pdf

that occurred when UHG/Optum was unable to properly transfer funds between the State and Medicaid accounts and, as a result, duplicate payments were made. Recoupment has been under way for these overpayments since early 2022, and significant progress has been made. **The total amount of overpayments due is currently $43.3 million as of 8/01/22. This represents a decrease of $41.6 million (49%) since the end of calendar year 2021.** The vast majority of these overpayments are small (< $5,000) but affect a large segment of providers. **These are true overpayments to providers and will not be discounted or forgiven.**

Table 3: Distribution of Negative Balances as of August 1, 2022

Provider Outstanding Balance	**Provider Count**
Providers Owing < $5K	1,825
Providers Owing >$5K and <$50K	361
Providers Owing >$50K	44
Providers Owing >$100K	55
Providers Owing >$500K	8
Providers Owing >$1M	5
Totals	**2,298**

Reconciliation and Recoupment Actions

UHG/Optum has added specific reconciliation resources to assist providers by hiring Reconciliation Managers. The Reconciliation Managers serve as the central points of contact for providers regarding estimated payment balances and reconciliation. Providers can send their questions to maryland.provpymt@UHG/UHG/Optum.com or request a Reconciliation Manager through that email address. This is in addition to the normal route of contacting customer service or UHG/Optum Provider Relations. The Reconciliation Manager then establishes contact with the provider to better understand their questions and to schedule a follow up meeting with the appropriate UHG/Optum resources to resolve the issue. The UHG/Optum Reconciliation Team consists of 11 Reconciliation Managers who service an average of 69 providers each and receive an average of 300 to 400 emails a week.

Although all the Assisted Reconciliation Reports are currently available to providers, UHG/Optum and MDH are continuing the Assisted Reconciliation process to allow providers time to review the denied claims and to submit any follow-up information. As such, MDH provided for certain flexibility to continue during the Assisted Reconciliation process. First, timely filing requirements for claims with dates of service within the estimated-payment period were waived so that providers would receive credit for those claims. Second, MDH waived the

reconsideration and appeal timelines that would normally apply to claims, recognizing that the estimated-payments period created significant information challenges for providers.

Recoupment Plans and Process

1. **February 2022 - Current:** Providers who owe negative balances (Table 3) are required to pay those balances in full. Recoupment efforts have been underway with discrete provider groups (based on the specific cause of their negative balance) and will increase in scope over time until all dollars are recouped.

2. **June 13 - July 15, 2022**: Forgiveness plan is announced, and providers are given 30 days to pay down their balance due and receive $25,000 forgiveness.

3. **July 15 - July 31**: Analysis, reconciliation of forgiveness amounts and calculations of final estimated payment amounts made.

4. **August 1:** Any claim denials remaining from the estimated-payment period that are adjudicated in the provider's favor will be paid in cash from this date forward. Up until this date, those funds were being automatically applied to a provider's estimated-payment balance.

5. **August 1 - August 12:** Individualized letters were mailed to providers on August 12 indicating final estimated-payment balances due as of 7/31/22, minus any forgiveness amount, and directing providers to a short survey to indicate how they would like to repay their balances owed. Letters were sent via USPS certified mail, placed in the provider's online billing folder, and emailed. Providers have one of four options for repayment:

    a. Payment in full by check or wire transfer
    b. Reduction of weekly claims amounts by 20%, 40%, 60% or 80% to pay the balance in 12 months at no interest
    c. Monthly ACH withdrawals of a set amount
    d. A combination of b and c.

6. **August 12 - August 26**: Providers had 10 business days to complete the survey.

7. **Early September:** Providers will receive individual confirmation of their survey choices, with an estimate of any balloon payment due at the end of the 12 months.

8. **Late September:** Recoupment begins.

Denials

Throughout this process, one of providers biggest concerns was that UHG/Optum still had a large volume of incorrect denials for claims submitted during the estimated-payment period that artificially inflated the estimated payment balances due.

At the beginning of the year, denials for the estimated-payment period amounted to $81 million in billed charges for the $223.5 million in total estimated payments remaining at that time, or roughly 36%. This number has now decreased to $51.8 million in *billed* denials. (Providers routinely bill at a much higher rate than the Medicaid fee schedule, which is generally the floor rate for providers.) The current billed claims to paid claims ratio is less than 60%. Therefore, that represents only about $32.3 million in actual dollars that *could* be paid out in the highly unlikely eventuality that 100% of all denials were overturned and paid. Current denials represent a 5.3% overall denial rate in billed claims and are close to, or within, industry standards. Even if another 10% of the billed claims were determined to be payable, that is only worth an estimated $3.2 million, which would be paid to providers in cash as the denials are adjudicated.

Another large area of concern among providers are the outstanding claims submitted for payment that were denied for third party liability and long term care codes. Both of these groups are in the process of being reprocessed and adjudicated and should be completed before recoupment begins. This amount will be reflected in the overall denial amount for this period and could amount to as much as an additional $13 million in reductions to denied claims.

Contract Management Steps

MDH initiated a Request for Proposal (RFP) process in August 2021, with the goal to have a new contract signed for the next Behavioral Health Administrative Services Organization by early 2023 in order to allow for up to two years of development and implementation. One of the key findings from the current contract issues is that not enough time (four months) was allowed for proper development and testing of UHG/Optum's system prior to launch. MDH continues work on the RFP process and any updates will be posted on eMaryland Marketplace (emma.maryland.gov).

MDH has four main contract management tools within the BHASO contract for damages/breach: service-level agreements (SLAs), liquidated damages, withholds, and termination.

SLAs are contract terms that require UHG/Optum to meet certain requirements, such as customer-service response times, system availability, staffing, and claims processing. Failing to meet SLAs allows MDH to withhold a percentage of the total invoice based on the number of SLAs not met. Since the contract started, MDH has withheld a total of 4% ($2,411,387.63) from UHG/Optum invoices for failing to meet 11 of the 12 service levels.

Liquidated damages are additional authorities to withhold and keep funds and are available only for specific reasons. The four reasons allowed in the contract are:

- Minority Business Enterprise (MBE) requirements

- late delivery of a Root Cause Analysis or Corrective Action Plan
- downtime occurrences, and
- failure to deliver a working system.

As UHG/Optum has maintained their MBE requirements, MBE damages are not applicable. Late delivery of an RCA/CAP allows for liquidated damages of $200 to $500 per day for failure to deliver the associated analysis or plan. However, these damages are not available if an RCA/CAP is delivered. UHG/Optum failed to deliver an acceptable CAP in a timely manner for the loss of claims images; MDH reserves all rights and remedies to ensure compliance by UHG/Optum.

Downtime occurrences are available if the system experiences an outage and is not available under certain conditions and allow for $1,000 per occurrence, with a $4,000 per-day maximum. MDH reserves all rights and remedies to ensure compliance by UHG/Optum.

The final form of liquidated damages is for failure to deliver a working system; damages of up to $25,000 per day may be assessed under this section. While the January 1, 2020, delivery did not go well, MDH determined that there had not been enough implementation time and permitted estimated payments for providers while system configuration continued. As UHG/Optum did deliver a system that paid claims starting in August 2020, the decision was made to focus on UHG/Optum deploying additional resources rather than assessing damages that would not provide a direct benefit to providers.

State contracts also have two other penalty measures within their basic structures that are also in the BHASO contract: withholding of payments and termination of the contract. Payment of an invoice can be withheld if the vendor fails to provide a required deliverable, typically associated with the invoice itself. MDH began withholding $150,000 per invoice beginning in March 2022 due to ongoing system issues and to Optum's inability to resolve certain operating processing in a timely manner. This withhold will continue until the processes are resolved and deadlines are met. MDH reserves the right to withhold more dollars or the entire payment of an invoice, but once the requested deliverable is provided, UHG/Optum would receive payment for those invoice withholds. MDH has also withheld one half of the implementation amount, retaining approximately $4 million for UHG/Optum's continued failure to deliver on critical claims-adjudication tools, other data as referenced above, and other necessary configurations to support BHASO operation of the Public Behavioral Health System.

The final contract-management measure would be termination of the contract with UHG/Optum. This is not a viable solution as it requires a replacement solution.

2022-10-28 Legis Audit - BHA and Optum.pdf
Uploaded by: Heather Bagnall
Position: FAV

Audit Report

Maryland Department of Health
Behavioral Health Administration and Medical Care Programs Administration
Administrative Service Organization for Behavioral Health Services

October 2022

Public Notice

In compliance with the requirements of the State Government Article Section 2-1224(i), of the Annotated Code of Maryland, the Office of Legislative Audits has redacted a cybersecurity finding and related auditee response from this public report.

OFFICE OF LEGISLATIVE AUDITS
DEPARTMENT OF LEGISLATIVE SERVICES
MARYLAND GENERAL ASSEMBLY

To Obtain Further Information

Office of Legislative Audits
The Warehouse at Camden Yards
351 West Camden Street, Suite 400
Baltimore, Maryland 21201
Phone: 410-946-5900
Maryland Relay: 711
TTY: 410-946-5401 · 301-970-5401
E-mail: OLAWebmaster@ola.state.md.us
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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

Victoria L. Gruber
Executive Director

Gregory A. Hook, CPA
Legislative Auditor

October 25, 2022

Senator Clarence K. Lam, M.D., Senate Chair, Joint Audit and Evaluation Committee
Delegate Mark S. Chang, House Chair, Joint Audit and Evaluation Committee
Members of Joint Audit and Evaluation Committee
Annapolis, Maryland

Ladies and Gentlemen:

We have conducted a fiscal compliance audit of the Maryland Department of Health (MDH) – Behavioral Health Administration (BHA) for the period beginning November 13, 2017 and ending June 30, 2021 and the Medical Care Programs Administration (MCPA) Administrative Service Organization (ASO) for Behavioral Health Services for the period beginning January 1, 2019 and ending June 30, 2021.

BHA is responsible for operating the Public Behavioral Health System to provide mental health and substance-related disorder services to the citizens of Maryland. Community-based services are financed through a combination of grants and contracts with vendors and direct reimbursements. MCPA is responsible for overseeing the ASO. The ASO pays provider claims through its fee-for-service system, determines behavioral health recipient eligibility, authorizes recipient services, and performs oversight of providers to ensure the propriety and accuracy of claims and related services.

In our previous audit cycle, we issued separate audit reports for MDH BHA and MCPA ASO. To promote audit efficiency and considering that both entities provide services to overlapping populations we have consolidated our review of the entities into one audit, with our recommendations being made to MDH.

Our audit disclosed numerous issues with MCPA's procurement and monitoring of its new ASO. MCPA contracted with the ASO for the five-year period from

January 1, 2020, to December 31, 2024, with one additional two-year option and a cumulative value of approximately $198.2 million. According to the State's records, during fiscal year 2021 behavioral health claims disbursements made by the ASO totaled $1.8 billion.

Our review found that MCPA's evaluation of the ASO technical proposals did not include an independent comprehensive review of the subcontractor that was responsible for the most critical aspect of the contract, the claims processing system. We noted that prior to MCPA evaluating the ASO's technical proposal, three other localities had experienced performance issues with the subcontractor related to the development and implementation of the claims processing systems. In addition, MCPA did not ensure that the ASO's claims processing system functioned prior to launch. Ultimately, deficiencies with the claims processing system required the ASO to make $1.06 billion in estimated payments to providers, of which approximately $223.5 million had not been supported or recovered. Moreover, the claims processing system was unable to evaluate whether services provided to patients were medically necessary, improperly denied valid claims, and could not provide critical claim payment information to providers to perform reconciliations.

MDH did not conduct audits to ensure the ASO authorized services that were medically necessary. While MDH management advised us that an annual audit was performed, our review disclosed that the most recent audit covered calendar years 2017 through the first two quarters of 2019 and the audit had not been finalized. Moreover, MCPA and BHA did not ensure that the ASO performed a sufficient number of provider audits. The purpose of provider audits is to ensure patient medical records agree to paid claims, to identify and resolve overpayments, to identify potential fraud or abuse by providers, and to monitor providers who have filed claims with insufficient supporting documentation.

In accordance with the State Government Article, Section 2-1224(i) of the Annotated Code of Maryland, we have redacted a cybersecurity-related finding related to the services provided by the ASO from this audit report. Specifically, State law requires the Office of Legislative Audits to redact cybersecurity-related findings in a manner consistent with auditing best practices before the report is made available to the public. The term "cybersecurity" is defined in the State Finance and Procurement Article, Section 3A-301(b), and using our professional judgment we have determined that the redacted finding falls under the referenced definition. The specifics of the cybersecurity finding were previously communicated to BHA and MCPA as well as those parties responsible for acting on our recommendations.

We also noted that MCPA did not ensure the ASO complied with contractual operational requirements to implement certain federal best practices that ultimately resulted in the inability of MDH to recover enhanced federal funding, which we estimated could total $28.8 million over the life of the ASO contract. Further, MCPA did not timely investigate and resolve claims paid by the ASO for which federal reimbursement was denied or approved for a different amount. Although MCPA worked with the ASO to investigate denied and discrepant claims, as of September 10, 2021, according to MDH's records, there were approximately 292,000 unresolved denied claims requiring investigation totaling approximately $106.7 million.

MDH did not assess up to $20.5 million in liquidated damages permitted by the ASO contract despite the vendor's ongoing failure to provide an operational system or comply with specific requirements. MDH executive management advised that it had not assessed additional liquidated damages because it was concerned that such actions would discourage the ASO from resolving noted defects and may lead to litigation with an uncertain outcome. The State of Maryland *Procurement Manual* states that liquidated damages allow for compensation upon a specific breach of contract when actual damages may be difficult to ascertain.

MDH circumvented State procurement regulations by obtaining information technology (IT) consulting services totaling approximately $19.8 million from one vendor without seeking competition. Specifically, MDH obtained the services of a single IT vendor using a combination of procurement methods, such as, sole source contracts and grant agreements, which did not include competition.

Our audit included a review to determine the status of five non-cybersecurity-related findings contained in certain preceding audit reports. Specifically, our audit included a review to determine the status of three of the four findings contained in our preceding audit report of BHA dated July 9, 2019 and two findings contained in our preceding audit report of MCPA ASO dated January 13, 2020. We determined that three of these five findings were satisfactorily addressed. The remaining two findings are repeated in this report.

We determined that MDH's accountability and compliance level was unsatisfactory in accordance with the rating system we established in conformity with State law. The primary factors contributing to the unsatisfactory rating were the financial significance and repeat nature of many of the findings. In addition, although not specifically quantifiable, several identified deficiencies potentially impacted the effective and efficient delivery of health care to a vulnerable and needy population.

MDH's response to this audit, on behalf of BHA and MCPA, is included as an appendix to this report. In accordance with State law, we have reviewed this response and, while MDH agrees with the majority of our findings and recommendations, we found the responses to several findings indicate that MDH does not intend on implementing the recommendations until the current ASO contract expires on December 31, 2024. Furthermore, despite agreeing with certain findings related to the long-standing ASO performance issues, MDH disagrees with finding 8 and the related recommendation regarding the assessment of liquidated damages based on ASO performance; contending that liquidated damages would increase the risk of litigation and an adversarial relationship, along with the potential of furthering minimum performance by the contractor. In accordance with generally accepted government auditing standards, we have included an "auditor's comment" within MDH's response to explain our position. Based on the issues identified with the ASO in this report, we stand by our finding and recommendation. Finally, while there are other aspects of MDH's response which will require further clarification, we do not anticipate that these will require the Joint Audit and Evaluation Committee's attention to resolve.

We wish to acknowledge the cooperation extended to us during the audit by BHA and MCPA.

Respectfully submitted,

Gregory A. Hook, CPA
Legislative Auditor

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Background Information

Agency Responsibilities and Audit Scope

The Behavioral Health Administration (BHA) of the Maryland Department of Health (MDH) operates the Public Behavioral Health System (PBHS) to provide mental health and substance-related disorder (including drug, alcohol, and gambling addictions) services to the citizens of Maryland. These services are delivered through private for-profit and non-profit community-based providers, local health department clinics, and State operated facilities. Community-based services are financed through a combination of grants and contracts with vendors and direct reimbursements through a fee-for-service system operated by an Administrative Service Organization (ASO). The ASO is monitored by MDH's Medical Care Programs Administration (MCPA).

The scope of this audit includes BHA's responsibilities in overseeing the PBHS and MCPA's monitoring of the ASO contract deliverables, claims processing (including denied claims), provider audits, and information systems security. During the prior audit cycle, MCPA's monitoring of the ASO was audited separately. To promote consistency and a more comprehensive reporting of audit issues related to BHA activities, we have modified our audit approach and consolidated our review of MCPA's ASO monitoring into this audit's scope.

Separate audits are conducted of MCPA's primary functions (such as recipient eligibility, long-term care, and hospital services), MCPA's monitoring of Managed Care Organizations, and the MCPA pharmacy programs. The administration of the behavioral health facilities was transferred from BHA to the Office of the Deputy Secretary for Operations effective May 2019 and, as such, was not included in the scope of this audit.

According to the State's records, BHA's expenditures, which were primarily for mental health and substance-related disorder programs and services, totaled approximately $356.6 million during fiscal year 2021 (primarily funded by State and federal funds). For the same fiscal year, behavioral health claims disbursements made by the ASO from two State-funded bank accounts totaled $1.8 billion. The vast majority of these claims were eligible for federal fund participation (reimbursement), which is normally at least 50 percent of the amount paid.

Ransomware Security Incident

In December 2021, MDH experienced a broad security incident which resulted from a ransomware attack.[1] This incident affected the entire MDH computer network and disrupted information technology (IT) operations for all MDH servers and end user computers resulting in substantial impact on all MDH business operations including BHA. MDH notified the Department of Information Technology's (DoIT) Office of Security Management, which initiated incident response measures. The aforementioned incident and related controls will be subject to review as part of our next audit of the MDH Office of the Secretary and Other Units.

The incident did not significantly impact our audit and we were able to obtain information needed to satisfy our audit objectives and related conclusions.

Status of Findings from Preceding Audit Reports

Based on our current assessment of significance and risk relative to our audit objectives, our audit included a review to determine the status of three of the four findings contained in our preceding audit report of BHA dated July 9, 2019; and three findings contained in our preceding audit report of MCPA ASO dated January 13, 2020.

As disclosed in Figure 1, for the non-cybersecurity-related findings we determined three of these five findings were satisfactorily addressed. The remaining two findings are repeated in this report. The status of the remaining finding from the BHA report was previously determined during our separate audit of Prevention and Health Promotion Administration, Office of Population Health Improvement, Office of Preparedness and Response, and Office of Provider Engagement and Regulation, and reported upon in the resultant audit report dated February 23, 2021.

[1] As defined by the Federal Department of Homeland Security Cybersecurity and Infrastructure Security Agency, ransomware is an ever-evolving form of malware designed to encrypt files on a device, rendering any files and the systems that rely on them unusable. Malicious actors then demand ransom in exchange for decryption.

Figure 1
Status of Preceding Findings

Preceding Finding	Finding Description	Implementation Status
Behavioral Health Administration		
Finding 1	BHA did not adequately monitor the Core Service Agencies, Local Addiction Authorities, and Local Behavioral Health Authorities to verify actual performance as required by the grant agreements. In addition, BHA's monitoring of the grantees did not ensure that the required mental health and substance use disorder services were provided to clients.	Not repeated
Finding 2	BHA did not adequately monitor a State university administering a problem gambling program on behalf of BHA to ensure the required public awareness services were provided.	Not repeated
Finding 3	BHA did not monitor the State vendor responsible for providing care management services to children with intensive needs and did not ensure payments to the vendor were proper.	Not repeated
Medical Care Programs Administration Administrative Services Organization for Behavioral Health Services		
Finding 1	MCPA did not ensure that the ASO properly authorized behavioral health services and that the bases for the authorizations were adequately documented.	**Repeated** (Current Finding 3)
Finding 2	MCPA did not direct the ASO to recover certain provider overpayments identified during audits, did not ensure the ASO recovered overpayments once directed to do so, and did not ensure that deficiencies identified by provider audits were corrected.	**Repeated** (Current Finding 4)
Finding 3	MCPA did not have a process to verify that adjustments to provider payments processed by the ASO were proper.	Not repeated (Not followed up on)
Finding 4	Intrusion detection prevention system coverage did not exist for encrypted traffic, and sensitive personally identifiable information was stored without adequate safeguards.	Status Redacted[2]

[2] Specific information on the current status of this cybersecurity-related finding has been redacted from this publicly available audit report in accordance with State Government Article, Section 2-1224(i) of the Annotated Code of Maryland.

Findings and Recommendations

Administrative Service Organization (ASO)

Background

The ASO is responsible for determining behavioral health recipient eligibility, authorizing recipient services, paying provider claims, and performing oversight of providers to ensure the propriety and accuracy of claims and related services.

In November 2018, the Medical Care Programs Administration (MCPA) solicited proposals for a new ASO contract. Responses were received from two vendors, including the incumbent ASO. In accordance with the terms of the request for proposal, bidder submissions were evaluated by a three-member evaluation committee, under an evaluative process established by Maryland Department of Health (MDH) that weighted the technical proposal higher than the financial proposal. Technical proposals were evaluated on four primary criteria, in order of importance:

1. Statement/Understanding of scope of work to perform as an ASO for managing behavioral health integrated services in Maryland,
2. Experience and qualifications of proposed staff,
3. Offeror and subcontractor qualifications and capabilities, and
4. Economic benefit to the State.

These criteria were broken down into 36 sub-criteria where bidders were rated "poor", "satisfactory", "good", "very good", and "excellent" by each member of the evaluation committee. This served as the basis for the technical ranking of the proposals evaluated.

MDH ultimately awarded the contract to the non-incumbent bidder whose proposal was rated "excellent" while the incumbent ASO's proposal was rated "very good." On June 12, 2019, the Behavioral Health Administration (BHA) contracted with the winning bidder to provide ASO services for the five-year period from January 1, 2020 to December 31, 2024, with one additional two-year option and a cumulative value of approximately $198.2 million, including the option years. The contract included a monthly administrative fee for each recipient eligible to receive behavioral health services and a fixed fee for other services provided by the vendor. According to State accounting records, as of August 2021 administrative fees paid to the ASO totaled $39.8 million.

The new ASO uses the services of seven subcontractors to meet various contract requirements, as detailed in Figure 2.

Figure 2
ASO Service Subcontractor Schedule

Subcontractor	Description of Service(s)
1	Provides the ASO with provider training initiatives.
2	Provides specialty telephonic behavioral health services and call center services for the ASO.
3	Provides and maintains the claims processing system used by the ASO and providers.
4	Provides medical staffing services to enable the ASO to fulfill the scope of work.
5	Provides staffing services to enable the ASO to fulfill the scope of work.
6	Performs market research and assists the ASO with the participant and provider survey and associated reporting.
7	Disburses payments to behavioral health providers for processed claims.

Source: ASO proposal and MDH management

Maryland Insurance Administration Report on ASO

Subsequent to the completion of our fieldwork, the Maryland Insurance Administration issued a report on the ASO dated June 7, 2022 which identified issues with the timeliness of paying provider claims. Specifically, the report noted that the ASO did not pay certain claims within 30 days and the ASO did not pay providers the related interest as required by State law. In response, per the report, the ASO paid providers interest totaling $3.1 million and owed the providers an additional $631,933 in interest.

Provider Impact, Concerns, and Complaints

Maryland's provider advocacy groups have publicly expressed concerns to MDH and the Maryland General Assembly regarding the lack of functionality of the new ASO's system since the start of the contract. The concerns included the ASO's inability to generate claim payment information using the healthcare industry standard reporting format, referred to as an "835 form" (discussed in finding 2) which is needed to post payments for services rendered and reconcile the estimated payments authorized by MDH (discussed further below). In addition there were continuing data integrity problems highlighted, with providers receiving payments or portal access for patients not associated with their specific practice. As a result, the providers claimed their staff has had to devote time and energy to address the issues attributed to the ASO. Ultimately, the provider groups have requested that the ASO replace the claims processing system currently in use due to its failure to resolve ongoing issues.

Finding 1
The MCPA evaluation of the ASO technical proposals was not sufficiently comprehensive or documented.

Analysis
The MCPA evaluation of the ASO technical proposals was not sufficiently comprehensive and documented. We reviewed MCPA procedures for evaluating the technical proposals for the vendors bidding for the ASO contract. Each of the vendors submitted a technical proposal that included extensive use of subcontractors.

MCPA Did Not Evaluate Subcontractors' Past Experience and Qualifications
MCPA did not perform an independent comprehensive review of the past experience and qualifications of subcontractors responsible for performing critical work under the contract. Rather, MCPA relied upon a summary of qualifications of the proposed subcontractors submitted by each vendor bidding on the contract, which generally consisted of a few sentences. According to MCPA management, they did not obtain references or contact the proposed subcontractors – including the subcontractor identified as being responsible for the claims processing system. As a result, there was no independent attempt to obtain information or confirmation of the subcontractors' ability to perform the required services.

It is our belief that the sole reliance on bidder representations was a practice of questionable value in this circumstance given the significance of certain subcontractors' responsibilities. Specifically, we were advised by the winning ASO bidder that it had only used the aforementioned claims processing subcontractor's system at one locality with limited functionality compared to the extensive services being provided to Maryland. In addition, based on provider complaints we received during the audit, apparently three other localities had experienced performance issues with this subcontractor related to the development and implementation of claims processing systems (Figure 3).

Figure 3
Summary of Prior Work Experience (Subcontractor 3)

Date	Description
November 2018	A locality participated in a contract with the subcontractor in October 2013 to develop a healthcare management information system. Despite numerous attempts to fix many issues with the system, the locality withdrew from the contract in November 2018 because the subcontractor failed to provide a working system.
December 2007	The subcontractor provided a claims processing system for a local Department of Mental Health. An audit found the system did not meet the needs of the department and that programming and file format issues affected the department's ability to conduct business.
October 2006	A locality entered into a contract with the subcontractor to develop a claims system for mental health services. The locality paid the subcontractor $4.6 million before terminating the contract in October 2006 without implementing the new system.

Sources: November 14, 2018 Ohio's Alcohol, Drug Addiction and Mental Health Board of Cuyahoga County *Resolution 18-11-01*, December 2017 District of Columbia Office of the Inspector General *Audit of the District of Columbia Department of Mental Health's Program Management and Administration of Provider Reimbursements*, February 19, 2009 California Healthline Daily Edition article *Database Project for Medi-Cal Claims a Bust in Sacramento County*

Evaluations of ASO Bidders' Experience Were Not Sufficiently Comprehensive

Our review of the evaluations of the vendor awarded the ASO contract for past experience (considered under the "Offeror and subcontractor qualifications and capabilities" criterion) did not consider the nature of the past experience and were limited to the entities identified by the vendor in its bid documents.

- MDH did not formally document that it considered the nature of the vendor's past experience in relation to the services to be provided as Maryland's ASO. Specifically, three of the four references provided by the winning bidder were from states and localities where the vendor operated as a Managed Care Organization (MCO) and was paid on a capitated[3] payment basis. According to the references provided, only one locality received ASO services from this vendor totaling $21.2 million. In contrast, the incumbent ASO in its bid documents listed three states and localities where it operated as an ASO, with contracts ranging in value from $16.2 million to $87 million.

[3] A Managed Care Organization (MCO) is compensated for services through recurring capitation fees, such as monthly fees, paid for each member covered.

- MDH did not document in its technical specification analysis that it considered concerns noted by one state government that had a $149 million contract with the winning bidder. Specifically, this state was included as a reference in the winning vendor's bid documents, and responded to an individual conducting reference checks that the vendor struggled to manage detailed patient claim data and recommended that any agreement include the ability to assess daily penalties for missed deadlines. Furthermore, although these concerns were noted by the individual who contacted this reference, there was no documentation these concerns were considered when evaluating the bids by the ASO evaluation committee.

Evaluation Forms Were Not Sufficiently Documented or Were Not Supported

Based on our review of the three evaluation forms (one for each evaluator) we noted instances where the evaluation either was not clearly documented or did not support the rating.

- Each of the three evaluations did not consider whether the ASO had sufficient controls over its information systems which was required by the request for proposals (RFP). In this regard, we noted the incumbent ASO provided a comprehensive response to the independent control review requirement while the winning vendor that received an overall higher rating only responded with "noted and agreed." The RFP specified that limited responses to requirements such as "concur" or "will comply" will receive a lower ranking than those proposals that demonstrate an understanding and include plans to meet or exceed them.

- The winning vendor's ASO transition plan included in the proposal was rated "very good" despite indicating an eight-month transition period, even though the RFP provided for a shorter transition period of up to six months.

Ultimately, the Board of Public Works questioned the winning vendor's experience as an ASO, and its ability to perform satisfactorily considering the financial proposal submitted was $72.1 million lower than the incumbent ASO's proposal. MDH responded that it had done "a lot of due diligence" in selecting the ASO. Subsequent events may have justified the Board's questioning, as it is possible that the value of the anticipated savings resulting from awarding this contract to the current ASO ultimately may have been negated by various deficiencies (such as overpayments made to providers and lost federal income) identified in findings 2 and 6 of this report.

Recommendation 1
We recommend that for future procurements, MDH

a. perform a comprehensive review of subcontractors performing critical services and vendor prior experience and ensure that the results are documented; and

b. ensure that evaluations encompass all critical contract requirements, are clearly documented, and are supported by the vendor's technical proposal.

Finding 2
MCPA did not ensure that the ASO's claim processing system was functioning prior to launch, resulting in numerous system deficiencies that ultimately required the ASO to make $1.06 billion in estimated payments to providers, of which approximately $223.5 million has not been supported or recovered.

Analysis
MCPA did not ensure that the ASO's claim processing system was functioning prior to its January 2020 launch, resulting in numerous system deficiencies that ultimately required the ASO to make $1.06 billion in estimated payments to providers, of which approximately $223.5 million has not been supported or recovered as of December 2021.

MCPA Did Not Ensure the ASO System Was Functional Prior to Launch
MCPA authorized the launch of the ASO claims processing system in January 2020, even though critical system testing had not been completed. As a result, the system was launched without having previously identifed the system's ability to perform critical functions, including the following:

- The system could not process provider service authorization requests which ensure services provided to patients were medically necessary, met quality standards, and were provided in a cost effective manner. One of the main functions of the ASO was to review claims to determine whether they met the criteria for authorization. According to MCPA records, system defects related to service authorizations included, but were not limited to, providers being unable to upload supporting documentation, authorization requests being automatically denied improperly, and providers being unable to perform data entry to submit authorization requests. Although providers were required to maintain documentation to support the medical necessity of services, the ASO has not reviewed the claims to this provider documentation, therefore there was a lack of assurance that the claims were proper.

- The system improperly denied valid claims (unrelated to medical necessity) submitted by providers. MCPA was unable to document the number and amount of claims that were improperly denied. However, we noted that paid claims in January 2020 (the ASO's first month of the contract) totaled $65.8 million compared to $103.5 million in January 2021. We were advised by MCPA management that the difference in claims paid was due to the improperly denied claims.

- The system was unable to generate accurate claim payment information using the healthcare industry standard reporting form (referred to as an "835 form") used by providers to perform basic reconciliations. Specifically, the 835 form used by the ASO did not reflect provider negative balances or accurate denial reason codes when claims were denied. We were advised by MCPA and ASO management that as of October 28, 2021, an accurate 835 form was being issued to providers. However, in December 2021 (two years into the new contract period), we were advised by a behavioral health provider advocacy group that certain providers had not received accurate 835 forms and that other providers received 835 forms with missing critical information, such as patient identifiers.

- The ASO's claims processing system was unable to properly process retroactive claims. Certain claims are processed pending approval of the recipient's eligibilty using State general funds, and must be submitted for retroactive federal reimbursement once eligibility is approved. MCPA's contract with the ASO required the system to account for federal rules allowing Medicaid coverage to be applied retroactively for up to three months. However, the ASO's automated system did not have the capability to process these retroactive claims until February 2021, 13 months after the start of the contract.

  Furthermore, once the system was corrected, the ASO erroneously made another payment to the providers for these previously paid retroactive claims instead of submitting the original claims for federal reimbursement. MCPA could not readily quantify these duplicate payments, but identified provider credit balances (payments that exceeded reported expenditures), which as of August 2021 totaled approximately $102 million. MCPA management advised that a majority of these credit balances were caused by the duplicate payments. As of February 2022, MDH had only recovered $1.5 million of the duplicate payments and advised us that it directed the ASO not to recover the remaining payments due to other unspecified system payment processing issues. We were further advised by MCPA management personnel that the

ASO corrected the claims processing system, but MCPA could not support this assertion.

MDH Directed the ASO to Make $1.06 Billion in Estimated Payments

Due to the aforementioned system deficiencies, during the period from Janurary 23, 2020 through August 3, 2020 MDH directed the ASO to bypass the authorization process and make estimated payments to providers based on the prior year's activity. According to MDH's records the estimated payments totaled $1.06 billion. The providers have been subsequently providing claim data supporting actual claims. However, as of December 2, 2021 (16 months after estimated payments were made), MDH reported that support or recoupment had still not been received for $223.5 million of the estimated payments made to 2,107 providers.

MDH management initially planned on waiving $3.5 million relating to unsupported payments of less than $25,000. Subsequently, MDH obtained deficiency appropriations of approximately $13 million to fund the forgiveness of unsupported payments of less than $25,000. We were further advised that MDH is working with providers to recoup the remaining unsupported estimated payments. This condition was also disclosed in our report on the *Statewide Review of Budget Closeout Transactions for Fiscal Year 2021.*

Recommendation 2

We recommend that MDH ensure the ASO

a. corrects system deficiencies, including those noted above;

b. reviews all claims processed during the period that authorization requirements were lifted to ensure services were medically necessary and properly documented; and

c. recovers any improper payments due to retroactive claims processing problems and the remaining estimated payments that have not been supported.

Finding 3

MDH did not conduct audits to ensure that the ASO properly authorized behavioral health services.

Analysis

MDH did not conduct audits to ensure that the ASO properly authorized behavioral health services. According to MDH written procedures, BHA personnel are to conduct annual audits of the ASO to verify the propriety of ASO behavioral health services authorizations. Our review disclosed that BHA only

performed one audit that covered calendar years 2017 and 2018, and the first two quarters of calendar year 2019.

However, as of September 2021 this audit had not been finalized, and therefore no corrective action had been initiated to address deficiencies identified in the audit. MDH management advised us that since it transitioned to a different ASO in January 2020, the results were considered irrelevant and not communicated to either vendor. No audits were performed of calendar year 2020 and 2021 claims activity and MDH did not plan on starting these audits until 2022. MDH management advised that the delay in these audits was due to complications encountered with the new ASO.

The lack of timely audits is significant because the aforementioned audit (which had not been finalized) identified certain authorized services for which the medical necessity of services and the clients' diagnoses were not documented. We could not readily determine whether these conditions resulted in improper payments to providers. Similar conditions were noted in our prior audit report of the MCPA ASO for behavioral health services.

Recommendation 3
We recommend that MDH ensure that the ASO properly authorized behavioral health services and that the bases for the authorizations were adequately documented. Specifically, we recommend that MDH ensure that

a. BHA personnel conduct audits of the ASO at least annually (repeat), and
b. appropriate corrective action is taken to address deficiencies identified by these audits (repeat).

Finding 4
MCPA and BHA did not ensure that the ASO performed a sufficient number of provider audits, that the audits included financially material and current transactions, and that any overpayments and deficiencies identified were corrected.

Analysis
MCPA and BHA did not ensure that the ASO performed a sufficient number of provider audits, that the audits included financially material and current transactions, and that any overpayments were recovered and deficiencies identified were corrected. Under the contract terms, the ASO is to audit clinical and financial records of providers to ensure patient medical records agree to paid claims, to identify and resolve overpayments, identify potential fraud or abuse by

providers, and monitor providers who have filed claims with insufficient supporting documentation.

- MCPA and BHA did not ensure the ASO completed 370 provider audits annually as required by the contract. In this regard, the ASO did not begin performing audits until September 2020, 9 months after the contract commenced, and MCPA allowed the ASO to conduct the required 1,110 audits for a collective 3 year period ending December 2022, rather than the required number of audits for annual periods (that is, 370 audits each calendar year). However, per a listing of audits conducted that was provided to us by the ASO as of November 2021, we determined that only 211 audits (or 19 percent) of the 1,110 audits had been completed. In addition, the audits conducted were of less material providers. Specifically, our review of the 193 providers associated with the aforementioned 211 audits for the period of January 1, 2020 through March 31, 2021, disclosed that these providers only accounted for approximately 6 percent of the total claims paid. MCPA and BHA did not have a plan in place to ensure the remaining 889 audits would be conducted in the next 13 months. As a result of the condition described in the next bullet, the value of the audit process is greatly diminished by not requiring timely audits of current or recent provider activity.

- MCPA did not require the ASO to audit current transactions. Specifically, as of November 2021, the ASO had been allowed to exclusively audit older transactions that occurred prior to January 1, 2020 under the prior ASO. We were advised by MCPA management that due to the complications experienced during the transition and implementation of the new ASO, it was determined that claims data for calendar year 2020 and 2021 related to the current ASO could not be relied upon for audit purposes.

- MCPA did not direct the ASO to recover outstanding overpayments identified during provider audits, including amounts identified during audits performed by the prior ASO. Specifically, we were advised by MCPA management that due to issues with the ASO transition, the current ASO had not been directed to recover such overpayments. Based on agency records, as of February 2022 outstanding overpayments identified during provider audits totaled $2.1 million, including $1.2 million identified by the prior ASO.

- BHA did not verify that deficiencies (such as, failure to maintain client records in accordance with State regulations) identified during provider audits were resolved. Providers were required to submit a Program Improvement Plan (PIP) to the ASO identifying processes to reduce the likelihood of the deficiency. BHA did not establish a documented process for monitoring

provider compliance with PIPs and instead relied on the Local Behavioral Health Authorities[4] to monitor provider compliance. Since BHA did not monitor the local authorities' completion of this process, there was a lack of assurance that the deficiencies were properly resolved.

Similar conditions regarding the failure to ensure provider overpayments were recovered were commented upon in our preceding audit report of MCPA ASO. In addition, similar conditions regarding the failure to ensure corrective actions were taken were commented upon in our preceding two audit reports of MCPA ASO.

Recommendation 4
We recommend that MDH

a. ensure the ASO develops a realistic plan so that provider audit requirements are completed within the timeframe provided and annually thereafter,
b. ensure that the provider audits include claims processed by the current ASO and the materiality of payments is considered in provider selection,
c. timely direct the ASO to recover overpayments identified during audits (repeat), and
d. develop and implement a process to monitor provider PIPs to ensure noted deficiencies are properly addressed (repeat).

We determined that Finding 5 related to "cybersecurity", as defined by the State Finance and Procurement Article, Section 3A-301(b) of the Annotated Code of Maryland, and therefore is subject to redaction from the publicly available audit report in accordance with the State Government Article 2-1224(i). Consequently, the specifics of the following finding, including the analysis, related recommendation(s), along with MDH's responses, have been redacted from this report copy**.**

Finding 5
Redacted cybersecurity-related finding.

[4] Local Behavioral Health Authorities are local health departments or private contractors that are responsible for planning, managing, and monitoring certain publicly funded mental health and addiction services.

Finding 6 (Policy Issue)
A lack of ASO vendor compliance with a certain contract requirement prevented MCPA from obtaining enhanced federal funding.

Analysis

The ASO vendor's failure to comply with a certain contract requirement prevented MCPA from obtaining enhanced federal funding. The contract required the ASO to implement certain operational best practices prescribed by the federal government, which would enable the State to obtain federal reimbursement of significant costs. Specifically, the contract required the vendor to complete an information technology related implementation plan to meet the specified best practices by the ASO's launch date of January 1, 2020. Although, the ASO provided an implementation schedule, as of January 2022 it had failed to fully implement the plan.

Compliance with these practices would allow MDH to pursue federal approval of its ASO process, making MDH eligible for reimbursement at 75 percent of maintenance and operation costs instead of the regular 50 percent federal fund reimbursement rate. Based on our calculations, this would result in an additional $28.8 million in federal funding over the course of the contract.

In January 2022, MCPA decided that it would no longer pursue federal approval due to the ASO's ongoing inability to comply with the practices and therefore would forego the enhanced federal funding. This decision will also require the return of prior federal reimbursed funding. Our review disclosed that MDH had erroneously requested reimbursement for 75 percent of these costs, resulting in $5.8 million in federal funding that needs to be reverted to the federal government and may need to be funded with State general funds. Finally, MDH had previously withheld $4.4 million from the ASO related to the implementation plan issue, however this would not compensate MDH for the full loss of the enhanced federal funds.

Recommendation 6

We recommend that MDH reevaluate its decision to not pursue completion of the ASO implementation plan and pursue federal approval with its enhanced federal funding.

Finding 7
MCPA did not timely investigate and resolve claims paid by the ASO for which federal reimbursement was denied or approved for a different amount than the amount paid.

Analysis
MCPA has not established a process to timely investigate claims paid by the current ASO that were denied or approved for a different amount (discrepant) by the federally certified Medicaid Management Information System (MMIS II).[5] Further, reports generated by the ASO to investigate these claims were not always reliable, contributing to a lack of assurance that federal reimbursement was maximized and proper. The ASO is responsible for initially receiving and processing provider claims through its claim processing system. Once a claim has been processed and paid by the ASO, it is submitted to MMIS II and subject to the claim processing edits that are intended to ensure only eligible claims are submitted for federal reimbursement.

Although MCPA has worked with the ASO to investigate denied and discrepant claims, according to MDH's records, as of September 10, 2021 there were approximately 292,000 unresolved denied claims requiring investigation totaling approximately $106.7 million (including $1.5 million and $36.1 million from the first and second quarters in calendar year 2020, respectively). In addition, there were 388,000 discrepant claims, including claims paid by the ASO that exceeded the Medicaid rate totaling more than $13.8 million and approximately 31,000 claims totaling more than $4.0 million where the amount paid by the ASO was lower than the Medicaid rate.

MCPA management advised it relied on reports generated by the ASO to identify and resolve denied and discrepant claims. However, we found, and MCPA management acknowledged, that these ASO generated reports were not always reliable and sometimes included incorrect data. Timely pursuit of a resolution to these claims is critical, since federal regulations only provide two years from the calendar quarter a claim was paid by the State to request federal reimbursement. Federal reimbursement for eligible claims is normally at least 50 percent of the amount paid. We were advised by MDH management that resolving the denied and discrepant claims was not a priority because they were focused on more significant issues, such as, recouping provider overpayments.

[5] MDH uses MMIS II to process paid claims for federal reimbursement. In addition, although provider payments for behavioral health services are issued by the ASO, MMIS II is used to pay providers for other Medicaid programs that operate on a fee-for-service basis.

Recommendation 7
We recommend that MDH

a. take immediate action to ensure denied and discrepant claims are timely investigated, resolved, and federal reimbursement recovered; and

b. ensure the ASO generates accurate reports of denied and discrepant claims.

Finding 8
MDH had not developed a formal policy on the assessing of liquidated damages and did not assess up to $20.5 million in liquidated damages permitted by the ASO contract despite the vendor's ongoing failure to provide an operational system or comply with certain requirements.

MDH had not developed a formal policy on the assessing of liquidated damages and did not assess up to $20.5 million in liquidated damages that were permitted by the terms of the ASO contract, despite the vendor's ongoing failure to provide an operational system or comply with certain requirements.

- The ASO contract permitted MDH to assess liquidated damages of $25,000 a day for the ASO's failure to be operational to the point of service[6] at the January 1, 2020 launch date. In December 2020, MDH informed the ASO that it had still not provided MDH a functional system because it was unable to generate accurate 835 forms. As noted in Finding 2, deficiencies with the 835 forms were ultimately not rectified until October 2021. Therefore, based on our calculations, MDH could have assessed the ASO liquidated damages totaling up to $16.7 million for not providing a functional system.

- The contract authorized MDH to assess liquidated damages of $5,000 a day if the ASO failed to follow the approved implementation plan for compliance with specified requirements. As of January 2022, we were advised by MDH management that the ASO had not met these requirements since commencement of the contract. Therefore, based on our calculations, as of January 2022, MDH could have assessed the ASO liquidated damages totaling approximately $3.8 million.

MDH did not assess these liquidated damages as of the time of our review, nor had it established a formal policy on the assessment of liquidated damages to aid in determining the appropriateness of assessing such damages (such as conditions

[6] The ASO contract defines operational to the point of service as "where 835 forms, eligibility files, and provider files are accepted for operations and claims payment, priority reports, bank and financial reports are available."

requiring damages and how to determine the amount of damages to be pursued). Rather, MDH had assessed certain charges for the ASO's failure to meet specified performance measures. MDH executive management advised that it has not assessed liquidated damages because it was concerned that such actions would discourage the ASO from resolving noted defects. We were further advised that MDH was concerned that the ASO may not pay the damages without litigation which may have an uncertain outcome. The State of Maryland *Procurement Manual* states that liquidated damages allow for compensation upon a specific breach of contract when actual damages may be difficult to ascertain.

Recommendation 8
We recommend that MDH develop a formal policy on the assessment of liquidated damages, including criteria for conditions warranting damages and the determination of the amount to be assessed. Further, MDH should assess liquidated damages as provided for in the ASO contract in accordance with that policy for long-standing periods of non-compliant performance, including those identified above.

Procurement

Finding 9
MDH circumvented State procurement regulations to obtain information technology (IT) consulting services totaling approximately $19.8 million from one vendor.

Analysis
MDH circumvented State procurement regulations to obtain several, sometimes related, IT consulting services totaling approximately $19.8 million from one vendor. We concluded that MDH obtained these services by improperly using a combination of interagency agreements (IA) with Core Service Agencies (CSA),[7] grant agreements, sole source contracts, and a Department of Information Technology (DoIT) master contract (See Figure 4).

[7] Core Service Agencies are designated county or multi-county authorities, such as a local health department or a private contractor, responsible for planning, managing, and monitoring certain publicly funded mental health services.

Figure 4
IT Consulting Services Vendor
Contracts and Agreements
Fiscal Years 2018 – 2026

	Agreement Type	Term	Agreement Total	Total Paid as of 10/28/21
1	IA with CSA	7/1/17-6/30/18	$634,200	$634,200
2	IA with CSA	7/1/17-6/30/18	873,600	873,600
3	IA with CSA	7/1/18-6/30/19	655,200	655,200
4	IA with CSA	7/1/18-6/30/19	873,600	873,600
5	Grant Agreement	7/1/19-6/30/21	836,854	831,230
6	Grant Agreement	7/1/19-6/30/21	776,498	761,481
7	Sole Source Procurement	7/1/19-6/30/21	2,279,039	2,265,922
8	DoIT Master Contract	7/1/20-6/30/21	312,000	312,000
9	DoIT Master Contract	7/1/21-2/28/26	12,600,000	675,000
		Total	**$19,840,991**	**$7,882,233**

Source: MDH agreements, grants, contracts, and State accounting records

- MDH used four IA's with two CSAs to obtain IT consulting services from the same vendor, circumventing State procurement regulations and the competitive procurement process. Specifically, MDH directed the CSAs to procure services on behalf of MDH, which included creating the groundwork for the development of a business intelligence dashboard and various data analysis and programming activities. According to agency records, MDH paid the two CSAs $3 million in fiscal years 2018 and 2019 for services performed by the vendor.

- MDH paid the vendor approximately $1.6 million in fiscal years 2020 and 2021 without competitively procuring the services. The services were procured using funds from a federal grant with BHA to develop business intelligence dashboards for MDH's mental health and substance use disorder services. Rather than competitively procuring the contract, MDH issued a grant to the vendor because it did not believe that a competitive procurement was necessary since the vendor was specifically identified in the federal grant. However, the federal grant application submitted by BHA did not specify that the services from this vendor were not competitively procured.

  State procurement laws and regulations do not exempt procurements made using grant funds from State procurement regulations. However, we acknowledge that while comprehensive laws and regulations are in place for

all aspects of contract procurement and administration, similar laws and regulations are not in place for grants to help safeguard the State's interests.

- MDH awarded a two-year sole source contract for $2.3 million to the vendor to provide technical and operational support to assist with ASO implementation, ongoing day-to-day functions, and support for the Medicaid program's oversight of the ASO. Although MDH prepared a sole source justification, it did not document that no other vendors were available to provide these services as required by State procurement regulations. Rather, the justification stated the vendor was selected because it had essential subject matter expertise and experience and that the vendor's pricing was below market rates based on a comparison of labor rates from a State Consulting and Technical Services Task Order Request for Proposal. This award was approved by the State Board of Public Works on June 19, 2019.

- MDH directed a contractor under a DoIT master contract to use the vendor for IT services on behalf of MDH. The use of the statewide contract in this manner circumvented State procurement regulations and resulted in MDH paying administrative fees to the statewide contractor. If all options of the work orders are exercised, administrative fees will total $2.8 million for the two work orders totaling $15.7 million.

- In addition, by using the aforementioned IA's with CSA and grant agreements, MDH circumvented State procurement regulations requiring approval by the Board of Public Works. Furthermore, MDH did not obtain Board of Public Works approval for the aforementioned work orders related to the DoIT master contract, as required.

State procurement regulations generally require a formal written competitive procurement for procurements exceeding $15,000, and control agency approval such as by the Board of Public Works, for larger procurements. Without competitive procurement, there is no assurance that the services provided represent the best value to the State.

Recommendation 9
We recommend that MDH comply with State procurement regulations by adequately documenting the justification for sole source procurements, publicly soliciting competitive proposals, publishing contract awards, executing written contracts, and obtaining control agency approval for procurements, where applicable.

Audit Scope, Objectives, and Methodology

We have conducted a fiscal compliance audit of the following units of the Maryland Department of Health (MDH) for the periods indicated:

- Behavioral Health Administration (BHA) for the period beginning November 13, 2017 and ending June 30, 2021.
- Medical Care Program Administration (MCPA) Administrative Service Organization (ASO) for Behavioral Health Services for the period beginning January 1, 2019 and ending June 30, 2021.

The audit was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

As prescribed by the State Government Article, Section 2-1221 of the Annotated Code of Maryland, the objectives of this audit were to examine the respective MDH units' financial transactions, records and internal control, and to evaluate its compliance with applicable State laws, rules, and regulations.

In planning and conducting our audit, we focused on the major financial-related areas of operations based on assessments of significance and risk. The areas addressed by the audit included procurement, the monitoring of ASO contract deliverables, claims processing (including denied claims), provider audits, and monitoring of grant and contract provisions. We also determined the status of three findings included in our preceding audit report of BHA and three findings included in our preceding audit report of MCPA ASO.

Our audit did not include certain support services provided by MDH's Office of the Secretary. These support services (such as payroll, maintenance of accounting records, and related fiscal functions) are included within the scope of our audit of the MDH - Office of the Secretary and Other Units. In addition, a separate audit of the State's behavioral health hospital centers is performed by our office. Therefore, the activities of these hospitals were not included in the scope of our audit.

Our audit did not include an evaluation of internal controls over compliance with federal laws and regulations for federal financial assistance programs and an assessment of compliance with those laws and regulations by MDH and its units

because the State of Maryland engages an independent accounting firm to annually audit such programs administered by State agencies.

Our assessment of internal controls was based on agency procedures and controls in place at the time of our fieldwork. Our tests of transactions and other auditing procedures were generally focused on the transactions occurring during our audit period, as detailed above for the units audited, but may include transactions before or after this period as we considered necessary to achieve our audit objectives.

To accomplish our audit objectives, our audit procedures included inquiries of appropriate personnel (including certain ASO employees), inspection of documents and records, tests of transactions, and to the extent practicable, observations of BHA and MCPA operations. Generally, transactions were selected for testing based on auditor judgement, which primarily considers risk, the timing or dollar amount of the transaction, or the significance of the transaction to the area of operation reviewed. As a matter of course, we do not normally use sampling in our tests, so unless otherwise specifically indicated, neither statistical nor non-statistical audit sampling was used to select the transactions tested. Therefore, unless sampling is specifically indicated in a finding, the results from any tests conducted or disclosed by us cannot be used to project those results to the entire population from which the test items were selected.

We also performed various data extracts of pertinent information from the State's Financial Management Information System (such as revenue and expenditure data). The extracts are performed as part of ongoing internal processes established by the Office of Legislative Audits and were subject to various tests to determine data reliability. We determined that the data extracted from these sources were sufficiently reliable for the purposes the data were used during the audit. We also extracted data from MDH's ASO system for the purpose of testing compliance with the ASO contract provisions. We performed various tests of the relevant data and determined that the data were sufficiently reliable for the purposes the data were used during the audit. Finally, we performed other auditing procedures that we considered necessary to achieve our objectives. The reliability of data used in this report for background or informational purposes was not assessed.

MDH's management at the respective units is responsible for establishing and maintaining effective internal control. Internal control is a process designed to provide reasonable assurance that objectives pertaining to the reliability of financial records; effectiveness and efficiency of operations, including safeguarding of assets; and compliance with applicable laws, rules, and

regulations are achieved. As provided in *Government Auditing Standards*, there are five components of internal control: control environment, risk assessment, control activities, information and communication, and monitoring. Each of the five components, when significant to the audit objectives, and as applicable to the respective MDH units, were considered by us during the course of this audit.

Because of inherent limitations in internal control, errors or fraud may nevertheless occur and not be detected. Also, projections of any evaluation of internal control to future periods are subject to the risk that conditions may change or compliance with policies and procedures may deteriorate.

Our reports are designed to assist the Maryland General Assembly in exercising its legislative oversight function and to provide constructive recommendations for improving State operations. As a result, our reports generally do not address activities we reviewed that are functioning properly.

This report includes findings relating to conditions that we consider to be significant deficiencies in the design or operation of internal control that could adversely affect the respective MDH units' ability to maintain reliable financial records, operate effectively and efficiently, and/or comply with applicable laws, rules, and regulations. Our report also includes findings regarding a significant instance of noncompliance with applicable laws, rules, or regulations. Other less significant findings were communicated to the respective MDH units that did not warrant inclusion in this report.

State Government Article Section 2-1224(i) requires that we redact in a manner consistent with auditing best practices any cybersecurity findings before a report is made available to the public. This results in the issuance of two different versions of an audit report that contains cybersecurity findings – a redacted version for the public and an unredacted version for government officials responsible for acting on our audit recommendations.

The State Finance and Procurement Article, Section 3A-301(b), states that cybersecurity is defined as "processes or capabilities wherein systems, communications, and information are protected and defended against damage, unauthorized use or modification, and exploitation". Based on that definition, and in our professional judgment, we concluded that certain findings in this report fall under that definition. Consequently, for the publicly available audit report all specifics as to the nature of cybersecurity findings and required corrective actions have been redacted. We have determined that such aforementioned practices, and government auditing standards, support the redaction of this information from the public audit report. The specifics of these cybersecurity findings have been

communicated to MDH and those parties responsible for acting on our recommendations in an unredacted audit report.

As a result of our audit, we determined that MDH's accountability and compliance level was unsatisfactory. The primary factors contributing to the unsatisfactory rating were the number and significance of our audit findings, including the number of findings repeated from our preceding audit report. Our rating conclusion has been made solely pursuant to the aforementioned law and rating guidelines approved by the Joint Audit Committee. The rating process is not a practice prescribed by professional auditing standards.

The response from MDH, on behalf of BHA and MCPA, to our findings and recommendations, is included as an appendix to this report. Depending on the version of the audit report, responses to any cybersecurity findings may be redacted in accordance with State law. As prescribed in the State Government Article, Section 2-1224 of the Annotated Code of Maryland, we will advise MDH regarding our review of its response.

APPENDIX

Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

October 20, 2022

Mr. Gregory A. Hook, CPA
Legislative Auditor
Office of Legislative Audits
The Warehouse at Camden Yards
351 West Camden Street, Suite 400
Baltimore, MD 21201

Dear Mr. Hook:

Enclosed, please find the Maryland Department of Health's responses and attachments to the draft audit report on the Maryland Department of Health –Behavioral Health Administration – Medical Care Program Administration – Administrative Service Organization Audit for the period beginning January 1, 2019 and ending June 30, 2021.

If you have any questions, please contact Frederick D. Doggett at 410-767-0885 or email at frederick.doggett@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

Enclosure

cc: Frederick D. Doggett, Director, Ofc. of Internal Controls, Audit Compliance & Security,
Steven R. Schuh, Deputy Secretary, Health Care Financing Admin & Medicaid Director
Lisa Burgess, M.D., Acting Deputy Secretary, Behavioral Health Administration
Jake Whitaker, Chief of Staff, Behavioral Health Administration
Tricia Roddy, Deputy Medicaid Director
Warren Waters, Jr., Chief of Staff, Health Care Financing Administration & Medicaid

Maryland Department of Health

Behavioral Health Administration and Medical Care Programs Administration
Administrative Service Organization for
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Administrative Service Organization (ASO)

Finding 1
The MCPA evaluation of the ASO technical proposals was not sufficiently comprehensive or documented.

We recommend that for future procurements, MDH

a. perform a comprehensive review of subcontractors performing critical services and vendor prior experience and ensure that the results are documented; and

b. ensure that evaluations encompass all critical contract requirements, are clearly documented, and are supported by the vendor's technical proposal.

Agency Response			
Analysis			
Please provide additional comments as deemed necessary.			
Recommendation 1a	Agree	**Estimated Completion Date:**	12/31/2024
Please provide details of corrective action or explain disagreement.	Since the BHASO contract was awarded in 2019, MDH has made significant changes that will enhance all future procurements and will ensure better and more rigorous pre-award review, especially of contractor-proposed technology. Chief among these changes is the creation of the Office of Contract Management and Procurement (OCMP), which has an enhanced role in the review and approval of contract bids. MDH implemented a new IT project and fiscal management policy in August 2022. The MDH Office of the Secretary will confer and coordinate with the Department of General Services (DGS) and its Office of State Procurement on developing and implementing a contract administration/management process as well as any attendant interim departmental policies by December 31, 2022. As part of any policies or procedures, we will include a section on the topic of liquidated damages. We will continue to work to improve service level agreements requirements and other contract management mechanisms in forthcoming requests for procurement that are in process. In addition, we will research contract administration and management national best		

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	practices to include in these policies and procedures. We will solicit and consult with the Office of Legislative Auditors and the Office of State Procurement for assistance in this process. As described in our Joint Chairmen's Report on this subject (submitted September 13, 2022 to the Department of Legislative Services), we intend to have a new contract for the next Behavioral Health Administrative Services Organization approved by the Board of Public Works by the first half of 2023. The current contract ends on December 31, 2024. The next BHASO RFP will include a greater number of graduated penalties for contractor performance to ensure they effectively manage their subcontractors as well as a drastically expanded set of service level agreements (SLAs) to ensure a greater flexibility of contract administration and management.		
Recommendation 1b	Agree	**Estimated Completion Date:**	12/31/2024
Please provide details of corrective action or explain disagreement.	Please see the MDH response to Recommendation 1a, above.		

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Finding 2
MCPA did not ensure that the ASO's claim processing system was functioning prior to launch, resulting in numerous system deficiencies that ultimately required the ASO to make $1.06 billion in estimated payments to providers, of which approximately $223.5 million has not been supported or recovered.

We recommend that MDH ensure the ASO

a. corrects system deficiencies, including those noted above;
b. reviews all claims processed during the period that authorization requirements were lifted to ensure services were medically necessary and properly documented; and
c. recovers any improper payments due to retroactive claims processing problems and the remaining estimated payments that have not been supported.

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.	Update as of June 1, 2022, $201.5 million has not been reconciled or recovered, although reconciliation is still occurring daily, along with reprocessing and review of all denials for the estimated payment period. Please see the Joint Chairmen's Report submission with the most recent updated number, where the total estimated payments has decreased to $146 million (as of September 13, 2022). This amount is expected to further decrease in Fall-Winter 2022. Any remaining amounts still owed by 12/31/2023 will be sent to CCU for collections.		
Recommendation 2a	Agree	**Estimated Completion Date:**	12/31/2024
Please provide details of corrective action or explain disagreement.	As noted in the response to Finding 1, MDH has made significant changes that will apply to all future procurements and contracts administration & management. MDH is using all available resources to work with the current vendor to address system deficiencies. Meetings both with and about the contractor occur daily, and subject-matter experts are engaged in all oversight activities to move the Contractor to correct their system deficiencies.		

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Recommendation 2b	Agree	**Estimated Completion Date:**	12/31/2023
Please provide details of corrective action or explain disagreement.	Services that were rendered solely during that time period that did not precede or have an authorization repeated after that six month period will be reviewed for medical necessity in future audits, but no later than 12/31/2023, presuming all reconciliation has occurred.		
Recommendation 2c	Agree	**Estimated Completion Date:**	12/31/2023
Please provide details of corrective action or explain disagreement.	MDH's approach to obtaining the recoveries involves: 1) reconciliation of any outstanding denials for the estimated payment period; 2) recoupment of all overpayments from both the estimated payment period; and 3) recoupment of duplicate payments or other payments made in error that resulted in the accumulation of a negative balance; 4) referral to central collections (CCU) for those providers not accounted for in 1 through 3. MDH expects to complete these efforts by 12/31/2023.		

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Finding 3
MDH did not conduct audits to ensure that the ASO properly authorized behavioral health services.

We recommend that MDH ensure that the ASO properly authorized behavioral health services and that the bases for the authorizations were adequately documented. Specifically, we recommend that MDH ensure that

a. BHA personnel conduct audits of the ASO at least annually (repeat), and

b. appropriate corrective action is taken to address deficiencies identified by these audits (repeat).

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.			
Recommendation 3a	Agree	**Estimated Completion Date:**	12/31/2022
Please provide details of corrective action or explain disagreement.	The first medical necessity criteria audit of the current BHASO has been completed and findings were shared on July 11, 2022. The overall scores for 2020 and 2021 were "meet standards" and "exceed standards" respectively. All appropriate action will be taken to address any deficiencies identified in the audits. Hereafter, annual audits will be scheduled for February and will include review of the previous calendar year. In addition, for ongoing quality assurance prior to the next BHA audit, in 2023, the BHASO medical director on a quarterly basis will oversee a random audit of at least 100 authorizations. It is noted that an audit of service authorizations by the BHASO for the first half of 2020 did not occur because services were not reviewed and authorized by the BHASO but had to initially be auto-authorized because of the problems with their launch.		
Recommendation 3b	Agree	**Estimated Completion Date:**	12/31/2022
Please provide details of corrective action or explain disagreement.	MDH will document a corrective action plan for all findings noted in the audit completed in July 2022. A follow-up by BHA and Medicaid will be scheduled with BHA/ASO immediately thereafter, with corrective actions implemented by 12/31/2022. The RFP for the next BHASO will be revised to avoid the scenarios that contributed to the issues that led to		

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	this finding, such as an extension of the go-live testing period, more robust transitions between ASOs, and a requirement for completion of audits by an outgoing ASO.

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Finding 4
MCPA and BHA did not ensure that the ASO performed a sufficient number of provider audits, that the audits included financially material and current transactions, and that any overpayments and deficiencies identified were corrected.

We recommend that MDH

a. ensure the ASO develops a realistic plan so that provider audit requirements are completed within the timeframe provided and annually thereafter,
b. ensure that the provider audits include claims processed by the current ASO and the materiality of payments is considered in provider selection,
c. timely direct the ASO to recover overpayments identified during audits (repeat), and
d. develop and implement a process to monitor provider PIPs to ensure noted deficiencies are properly addressed (repeat).

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.			
Recommendation 4a	Agree	**Estimated Completion Date:**	12/31/2023
Please provide details of corrective action or explain disagreement.	Due to delays in the implementation of the ASO's audit process, Medicaid and BHA approved a plan for the ASO to conduct the total minimum audit requirements for calendar years 2020 through 2022 across the three calendar years instead of the amount required each calendar year. The ASO projected that it would complete a total of 1,050 audits for mental health and substance use disorder providers, 60 audits for ABA providers, and 45 audits for Health Homes by the end of CY 2022. MDH will seek best practices and consultation for assessing additional penalties for failure to meet the contract deliverables -by the end of the full contract. MDH believes that this plan to complete audits through the end of CY 2023 is achievable if the ASO allocates appropriate resources, but also MDH will review progress at quarterly intervals and report in the subsequent QSRs if the deadline is not met. Even if the time frame is not met, the primary goal is that the ASO meets the volume of audits with factual and accurate data.		

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Recommendation 4b	Agree	**Estimated Completion Date:**	12/31/2023
Please provide details of corrective action or explain disagreement.	MDH has requested several audits to include claims processed by the BHASO. Because the BHASO is not yet able to produce reliably validated claims from their reporting system, this approach will have to rely, at least initially, on selection of audit samples from provider caseloads and subsequent validation of claims. This approach will initially be taken with providers who have generated some reason for concern. The BHASO will also be required to increase the proportion of audits of licensed programs, rather than individual providers.		
Recommendation 4c	Agree	**Estimated Completion Date:**	12/31/2023
Please provide details of corrective action or explain disagreement.	The recovery of overpayments based on audits will be fully reinstated once the recoupment of overpayments process has concluded, at least by the beginning of 2023. When the retraction process is reinstated, MDH will direct the ASO to complete retractions each month. MDH will request payment records for five randomly selected audits each month to confirm recovery of overpayments.		
Recommendation 4d	Agree	**Estimated Completion Date:**	12/31/2023
Please provide details of corrective action or explain disagreement.	MDH developed a process to monitor Performance Improvement Plans (PIPs) prior to the pandemic, but the resulting work changes, followed by the State's security incident, which affected the computing systems of most of the LBHAs, led to its interruption. A revised process is now being established that will require LBHAs to report on the progress of PIPs to the BHA Licensing and Compliance unit on at least a quarterly basis.		

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The Office of Legislative Audits (OLA) has determined that Finding 5 related to "cybersecurity" as defined by the State Finance and Procurement Article, Section 3A-301(b) of the Annotated Code of Maryland, and therefore is subject to redaction from the publicly available audit report in accordance with State Government Article 2-1224(i). Although the specifics of the finding, including the analysis, related recommendation(s), along with MDH's responses, have been redacted from this report copy, MDH's response indicated agreement with the finding and related recommendation(s).

Finding 5
Redacted cybersecurity-related finding.

Agency Response has been redacted by OLA.

Maryland Department of Health
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Finding 6 (Policy Issue)
A lack of ASO vendor compliance with a certain contract requirement prevented MCPA from obtaining enhanced federal funding.

We recommend that MDH reevaluate its decision to not pursue completion of the ASO implementation plan and pursue federal approval with its enhanced federal funding.

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.			
Recommendation 6	Agree	**Estimated Completion Date:**	
Please provide details of corrective action or explain disagreement.	While MDH agrees to continue to pursue the requirements traceability matrix and the support that could lead toward CMS certification, there is no evidence that leads us to believe that the current ASO vendor can attain CMS certification. We agree that it is a worthwhile goal, but achievement may not be within reach given the ongoing system issues with the current contractor during the life of the current contract.		

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Finding 7
MCPA did not timely investigate and resolve claims paid by the ASO for which federal reimbursement was denied or approved for a different amount than the amount paid.

We recommend that MDH

a. take immediate action to ensure denied and discrepant claims are timely investigated, resolved, and federal reimbursement recovered; and

b. ensure the ASO generates accurate reports of denied and discrepant claims.

Agency Response			
Analysis			
Please provide additional comments as deemed necessary.			
Recommendation 7a	Agree	**Estimated Completion Date:**	12/31/2024
Please provide details of corrective action or explain disagreement.	Using claims analysis and findings produced by the MDH BHASO Oversight contractor, MDH has continuously directed the ASO to review and resolve denied and discrepant claims in a timely manner and federal reimbursement recovered.. This is an ongoing, daily, weekly, monthly effort that has required extensive effort to review. We plan to have a fully reconciled system prior to the end of the BHA/ASO base year period that includes all corrections to MMIS submissions.		
Recommendation 7b	Agree	**Estimated Completion Date:**	12/31/2024
Please provide details of corrective action or explain disagreement.	The MDH BHASO Oversight contractor is performing continuous review and corrections of BHA/ASO's historical and current claims and authorizations. This is an ongoing, daily, weekly, monthly effort that has required extensive effort to review. Final reports of claims are reviewed in aggregate and compared against historical data, and each identified problem area is further investigated by the resources employed by the BHASO oversight contractor.		

Maryland Department of Health
Behavioral Health Administration and Medical Care Programs Administration
Administrative Service Organization for
Behavioral Health Services

Agency Response Form

Finding 8
MDH had not developed a formal policy on the assessing of liquidated damages and did not assess up to $20.5 million in liquidated damages permitted by the ASO contract despite the vendor's ongoing failure to provide an operational system or comply with certain requirements.

We recommend that MDH develop a formal policy on the assessment of liquidated damages, including criteria for conditions warranting damages and the determination of the amount to be assessed. Further, MDH should assess liquidated damages as provided for in the ASO contract in accordance with that policy for long-standing periods of non-compliant performance, including those identified above.

Agency Response			
Analysis			
Please provide additional comments as deemed necessary.			
Recommendation 8	Disagree	**Estimated Completion Date:**	12/31/2024
Please provide details of corrective action or explain disagreement.	Liquidated damages in a contract are not an effective way at ensuring the state receives a working product for a mission critical healthcare services system. In this instance, imposing liquidated damages on this vendor would have maximized the chances of litigation, adversarial working relationship, and further minimum performance by the vendor. The MDH Office of the Secretary will confer and coordinate with the Department of General Services (DGS) and its Office of State Procurement on developing and implementing a contract administration/management process as well as any attendant interim departmental policies by December 31, 2022. As part of any policies or procedures, we will include a section on the topic of liquidated damages. We will continue to work to improve service level agreements requirements and other contract management mechanisms in forthcoming requests for procurement that are in process. In addition, we will research contract administration and management national best practices to include in these policies and procedures. We will solicit and consult with the Office of Legislative Auditors and the Office of State Procurement for assistance in this process.		

Agency Response Form

	MDH has decided not to assess the $25,000 per day and $5,000 per day penalties at this time. Instead, other penalties have been applied, as follows: (i) MDH has withheld over $4 million in implementation funds in addition to SLAs which have resulted in $1,778,118 withheld to date. (ii) Recently, MDH penalized the BHASO for Security issues and has a $150K monthly penalty starting with the March invoice, with additional penalties pending until the Security issues are resolved. We remain committed to working with the current BHASO during this contract period to improve the system deficiencies. All appropriate penalties will continue to be applied for the duration of the contract.

Auditor's Comment: Despite agreeing with our findings related to the longstanding ASO performance issues, MDH refuses to assess liquidated damages in accordance with the contract based on several cited factors. In our opinion, MDH's position is contrary to the intent of State law (State Finance and Procurement § 13-218) that requires a provision for liquidated damages, as appropriate, in procurement contracts, which implies that damages are subject to assessment. In addition, MDH did not specifically agree to establish a formal policy on the assessment of liquidated damages, including criteria for conditions warranting damages and the determination of the amount to be assessed. Based on the issues identified with ASO contractual performance in this report and the lack of documented support for MDH's justification for not assessing the liquidated damages, we stand by our finding and recommendation.

Agency Response Form

Procurement

Finding 9
MDH circumvented State procurement regulations to obtain information technology (IT) consulting services totaling approximately $19.8 million from one vendor.

We recommend that MDH comply with State procurement regulations by adequately documenting the justification for sole source procurements, publicly soliciting competitive proposals, publishing contract awards, executing written contracts, and obtaining control agency approval for procurements, where applicable.

Agency Response			
Analysis	**Factually Accurate**		
Please provide additional comments as deemed necessary.			
Recommendation 9	Agree	**Estimated Completion Date:**	Need date
Please provide details of corrective action or explain disagreement.	MDH agrees, please see our previous responses to Findings 1 and 8 (repeated in relevant part below). We are taking further corrective steps, which are currently in the procurement review process with the relevant state agency partners. Any additional public actions will be posted on eMaryland Marketplace Advantage (emma.maryland.gov). (Finding 1) Since the BHASO contract was awarded in 2019, MDH has made significant changes that will enhance all future procurements and will ensure better and more rigorous pre-award review, especially of contractor-proposed technology. Chief among these changes is the creation of the Office of Contract Management and Procurement (OCMP), which has an enhanced role in the review and approval of contract bids. MDH implemented a new IT project review policy in August 2022. The MDH Office of the Secretary will confer and coordinate with the Department of General Services (DGS) and its Office of State Procurement on developing and implementing a contract administration/management process as well as any attendant interim		

Agency Response Form

	departmental policies by December 31, 2022. As part of any policies or procedures, we will include a section on the topic of liquidated damages. We will continue to work to improve service level agreements requirements and other contract management mechanisms in forthcoming requests for procurement that are in process. In addition, we will research contract administration and management national best practices to include in these policies and procedures. We will solicit and consult with the Office of Legislative Auditors and the Office of State Procurement for assistance in this process. As described in our Joint Chairmen's Report on this subject (submitted September 13, 2022 to the Department of Legislative Services), we intend to have a new contract for the next Behavioral Health Administrative Services Organization approved by the Board of Public Works by the first half of 2023. The current contract ends on December 31, 2024.

AUDIT TEAM

Catherine M. Clarke, CPA, CIA, CFE
Audit Manager

James J. Podhorniak, CPA, CFE
Senior Auditor

Malik A. Farooq
Paul A. McGrew
Stacey D. Streett
Staff Auditors

Gaudenzia 2022-10-26 Letter to Schuh.pdf
Uploaded by: Heather Bagnall
Position: FAV

JOSEPH GREENWALD & LAAKE, PA
ATTORNEYS AT LAW

Timothy F. Maloney
Attorney at Law
Office in Greenbelt, MD
Direct Dial: (240) 553-1107
Direct Fax: (240) 553-1737
Email: tmaloney@jgllaw.com

October 26, 2022

By Federal Express and Electronic Mail:
Steve.schuch@maryland.gov
Steven R. Schuh
Deputy Secretary, Health Care Financing
and Medicaid Director
Maryland Department of Health
Herbert R. O'Conor State Office Building,
201 West Preston Street
Baltimore, Maryland 21201

Re: United Health Group/Optum Maryland

Dear Secretary Schuh:

We represent Gaudenzia with the ongoing Medicaid and other state program payment and billing issues with United Health Group/Optum Maryland.

Since the well-documented January, 2020 Optum system failure, its claims processing system has continued to be grossly dysfunctional. Nearly one year ago, on November 4, 2021, you accurately told the House Appropriations Committee that Optum could not give providers a complete claims history: "We have asked for that information, and the system is incapable of providing it." This remains true today.

Optum has conceded that it made duplicate payments and other overpayments to providers, but it has been unable to provide any meaningful or reliable reconciliation over those overpayments. Despite its nearly complete inability to give any significant accounting, Optum has now taken the extraordinary step of making arbitrary withdrawals from provider accounts. They have done so despite the lack of reliable accounting to support this withholding and clear evidence of massive errors on Optum's part.

There needs to be meaningful third-party supervision now. Gaudenzia requests a meeting with the State to discuss the following:

1. The installation of a third-party monitor to resolve issues with providers;

2. A suspension of the mandatory deduction and the development of a reasonable reconciliation and repayment process; and

3. Negotiate a fair settlement amount if Optum cannot provide adequate information to reconcile the claims submitted by Gaudenzia.

Gaudenzia has worked diligently through the catastrophic collapse of Optum's processing system. But unfortunately, it has been unable to resolve estimated payment issues with Optum despite Gaudenzia's extraordinary efforts to communicate and to remedy accounting issues, all of which were entirely due to Optum's failures.

The following background is essential:

1. **Duplicate Payment Reconciliation.** In 2021, Optum made $4.2 million in duplicate payments to Gaudenzia. These same payments were entirely the result of failures in the Optum system and through no fault of Gaudenzia. The charges were made between March and May 2021 and were interspersed with other regular payments. Duplicate payments were also made to other providers because of these Optum system failures.

   Guadenzia immediately undertook an extraordinary effort to reconcile duplicate reimbursements, confirming $4.2 million in the same payments. In June 2022, Gaudenzia paid Optum $4.2 million for the duplicate payments.

2. **Estimated Payments.** Because of the catastrophic failures in its processing system, Optum could not process reimbursements in early 2020 based on the actual claims submitted by providers. This resulted in a crisis in the reimbursement system and a significant challenge for the delivery of mental health and substance abuse services in the State. To address this emergency, the Health Department directed Optum to make weekly estimated payments to the State's 2,200 behavioral health providers from January 23, 2020, to August 3, 2020. The charges were based on the provider's 2019 historical payment average and included lump sum payments to make up for payment interruptions.

But then the unexpected happened. The onset of the pandemic in March 2020 resulted in the historic underutilization of provider services statewide, mirroring national trends. As a result, the estimated payments mandated by the Department exceeded the actual reimbursable value of services. The Department, relying on Optum's estimates, determined this amount to be approximately $230 million statewide. Still, this number turned out to be flawed because of the systemic flaws in Optum's claims processing.

As a result, Optum's claim for overpayment included claims marked paid but for which payments were never received, which Optum denied in error, and retracted claims from 2019, among others. In addition, a survey of behavioral health providers revealed that 40% of surveyed providers said their repayment numbers differ from Optum's by 60%.

In Gaudenzia's case, lump sum payments of $4 million were made in January and February 2020. Beginning on March 5, 2020, Optum paid Guadenzia the average weekly amount of $578,000. Then, amid Covid, Optum estimated that $3.2 million of its payments were overpayments.

These payments continued until August 6, 2020, when Optum began payment reimbursements purportedly based on actual claims submitted. Optum later estimated the repayments at $3.2 million. But much of this amount included valid Gaudenzia claims rejected by Optum. For example, during the estimated payment

period (3/5/20 – 8/6/20), Optum rejected 6,951 claims from Gaudenzia, totaling $3.5 million. All of these claims were eligible for resubmission.

Gaudenzia undertook an extensive review of the 6,951 rejected claims and, in December 2021, resubmitted $1.9 million in claims and continued its study of other rejected claims. This was significant because approval of these payments would reduce the estimated $3.2 million repayment amount.

In December 2021, Optum approved $1.2 million of those claims without notifying Gaudenzia. Instead, it inadvertently interspersed this amount as a new payment along with other new claims when it should have reduced the balance of overestimated payments. Gaudenzia discovered this in July 2022, and Optum confirmed that they inadvertently sent a new payment instead of lowering the outstanding $3.2 million balance.

Optum promised to send meaningful information to reconcile these payments and reduce the purported overpayments. But it later admitted that it could not do so, further adding to the confusion, and to the burden on Gaudenzia. Optum provided Gaudenzia with a data file of the 6,951 claims totaling $3.2 million, along with what it described as a "Life Cycle Report." This file had 673,000 rows of data in Excel format. It was challenging to manage, but Optum insisted on using this format of their raw data, which is unheard of in the claims processing industry.

Nevertheless, Gaudenzia attempted to comply with Optum's request. They assigned a highly experienced data claims management team with years of experience reading EOBs and managing extensive data sets. Even this team was not able to reconcile Optum's data for reasons which shortly became obvious.

Gaudenzia requested Optum to simplify the process: It requested that Optum take the 6,951 claims in the ARE Report 5 format and identify which claims have been paid (by claim and check #), pending, and rejected. This would make reconciliation significantly easier.

Optum's response was extraordinary. On August 30, 2022, Tracy Bunge conceded hat Optum's ARE Report "had become obsolete" and that "the reporting team is no longer able to generate this report." Despite the admitted obsolescence of its former report format, Optum still needs to identify with specificity which claims have been: (1) paid, 2) rejected, or 3) are still being processed.

This resubmission process is essential. Because 63% of the $1.9 million resubmitted claims were approved, this indicates that a large percentage of the balance of the claims are also highly likely to be supported, reducing any repayment obligation.

Meanwhile, on August 2, 2022, Optum sent a form letter to Gaudenzia stating that as of "July 31, 2022, your estimated repayment balance is $3,565,316.40. However, Optum has not explained why this amount has increased by over $350,000 or how this calculation was determined. Based on the recent experience with the Optum data systems, it is apparent that they are unable to do so.

Optum has an apparent conflict of interest here. The catastrophic failure of its data system prevented the accurate and timely processing of actual claim forms, created a crisis in behavioral healthcare financing. This necessitated the State mandate of estimated payments on the eve of the pandemic. These events has made

apparent Optum's obvious liability for its failure to comply with its contractual obligation to manage the behavior health reimbursement system. Presumably, the State will attempt to recover for the taxpayers Optum's failure to provide a functional claims processing system as their contract requires.

Now, Optum is charged with recouping excess estimated overpayments it necessitated. But it cannot effectively do so because of the continued deficiencies in its data management system. Because Optum operates without any real third-party supervision, it effectively has a license to undertake arbitrary and unsupported collection efforts to remedy a situation created by its own deficiencies – even though these collection efforts are not supported by any reasonable accounting or documentation.

This cannot continue. In Gaudenzia's case, Optum's undocumented demands, coupled with arbitrary withdrawals from its account, seriously impair the financial integrity of a well-run behavioral health program, the State's largest. It is creating substantial, immediate, and irreparable harm. It should be noted that Gaudenzia has never experienced anything remotely similar in any other state in which it operates.

The primary issue is Optum's undocumented request for $3.2 million in paybacks without any meaningful documentation corroborating this amount. It is profoundly unfair to claw back funds without straightforward reconciliation. Indeed, this is the standard operating procedure by MCOs throughout the country. Gaudenzia believes that it is reasonable in requesting a fair accounting. Like the State, we all share a responsibility to be good stewards of public money, and Optum's lack of accounting reflects extremely poor stewardship.

Gaudenzia has always been willing to make reasonable repayments based on proper accounting by Optum. Its repayment of $4.2 million in duplicate payments demonstrates its responsibility and accountability. In contrast, Optum has created this nightmare and cannot provide the accounting necessary to remedy it.

Optum has failed in its duty to communicate with providers. Its failure to communicate with Gaudenzia on the most fundamental issues is well documented. Optum failed to notify Gaudenzia of payments that were approved. It should have reduced repayment liability when it approved resubmitted claims adequately. And in one egregious example, it continues to insist that the Gaudenzia Foundation, the company's philanthropic and real estate arm, received $1.6 million when the Foundation has never offered services, submitted claims, or received payments.

Gaudenzia is committed to our shared mission, the behavioral health needs of the citizens of Maryland. We are also committed to a strong working relationship with the Department of Health. Unfortunately, the deeply flawed system of the State's vendor, Optum, is seriously interfering with this relationship and the delivery of behavioral health care.

The current $3.2 million takeback by Optum is unacceptable and needs to be resolved. Optum, the State's agent, cannot communicate in any meaningful way concerning these issues.

We request a meeting with you to address the issue outlined earlier in this letter:

1. The installation of a third-party monitor to resolve the problems with providers;

2. A suspension of the mandatory deduction and the development of a reasonable reconciliation and repayment process; and

3. Negotiation of a fair settlement amount if Optum is unable to provide adequate information to reconcile the claims submitted by Gaudenzia

We prefer to resolve these issues with the Department of Health. Still, if that becomes impossible, Gaudenzia will have no alternative but to seek emergency relief from the Circuit Court for Baltimore City.

Sincerely

JOSEPH, GREENWALD & LAAKE, P.A.

By: Timothy F. Maloney

TFM/kls

Letter to Schrader - Optum Billing Concerns.pdf
Uploaded by: Heather Bagnall
Position: FAV

MARYLAND ACEP CHAPTER
c/o National ACEP
4950 West Royal Lane
Irving, Texas 75063-2524
Direct: 410-727-2237
972-550-0911
www.mdacep.org

Maryland Chapter
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

July 18, 2022

Sent via email: dennis.schrader@maryland.gov

The Honorable Dennis Schrader
Secretary
Department of Health
201 West Preston Street
Baltimore, Maryland 21201

Re: *Physician Reimbursement in the Emergency Room for Treatment of Behavioral Health*

Dear Secretary Schrader:

On behalf of the Maryland Chapter of American College of Emergency Physicians (MDACEP), we are writing to express our continued concern with the billing practices that have been instituted by the Maryland Department of Health (MDH) through the State's Administrative Service Organization (Optum). Maryland's current policy of limiting reimbursement for behavioral health services performed in an emergency department to only those with the emergency physician certification is resulting in inappropriate denials of services to Maryland residents. Rather than continuing to focus billing based on the provider of services, MDH should allow billing based on the service provided as long as it is done within the provider's scope of practice.

ISSUE OVERVIEW

On August 5th, Optum issued an alert stating the behavioral health services received in an emergency department would only be reimbursed if provided by an individual with a psychiatric specialty, a psychologist, a certified nurse practitioner with a psychiatric mental health certification or a nurse psychotherapist. This policy denied reimbursement to ER physicians when they provided services to patients exhibiting mental health and substance use disorders.

On November 8th, after concerns were raised by MDACEP, the MDH reversed course and stated that, when services are rendered by an ER physician, those services should be reimbursed by the MCO regardless of the need for a somatic diagnosis. Likewise, when services are rendered by a specialty mental health provider those services should be reimbursed by Optum. However, due to concerns raised by the MCOs because of the behavioral health carveout, MDH released yet another transmittal on December 17th providing further changes to how these claims should be billed and reimbursed. Under the December 17th

transmittal, providers are again instructed to bill Optum, but the transmittal was changed to specify those with an "emergency medicine specialty" through recognition in ePrep of the appropriate licensing and certification when the primary diagnosis is a carved-out mental health diagnosis.[1]

PROBLEM

It goes without saying that emergency departments throughout the nation are the safety net for this population. Many patients covered by Medicaid are too often economically and socially marginalized. MDACEP leadership is committed to promoting health equity; however, the State's policy must ensure that this commitment can be achieved.

Unfortunately, there continues to be issues with the State's policy and the ability of providers in the ER to bill and receive reimbursement due to the requirement in the December 17th transmittal for "certification." Under this transmittal, physicians who are board-eligible are unable to bill for services through Optum. This is also true for pediatricians without an emergency board certification or other providers, such as a CRNP without a psychiatric mental health certification, both critical components in providing care to this population in the ER.

SOLUTION

MDACEP strongly urges the MDH to focus on the services being provided rather than the provider of services. As long as the services are within the ER and carried out under a provider's scope of practice, MDH should not be limiting reimbursement or who can provide the services. It is worth noting that the current policy could arguably violate Maryland's prudent layperson standard, which provides access to emergency care based on symptoms and not final diagnosis and does not limit provider type. When individuals are facing crisis, the ER is often their first stop in seeking care. With current workforce shortages and a growing demand for behavioral health services, the focus of the State should be on expanding access to ensure the availability of providers. As always, we are more than willing to engage in further dialogue with you or members of your team. Thank you for your attention to this critical matter.

Sincerely,

Michael A. Silverman, MD, FACEP

President
Maryland ACEP Chapter
Virginia Hospital Center

cc: Steve Schuh, Deputy Secretary, MDH
Webster Ye, Assistant Secretary, MDH
Tricia Roddy, Deputy Medicaid Director, MDH

[1] Physician fees for SUD diagnoses that are billed on the CMS 1500 for services rendered in the Emergency Room for non-specialty psychiatric services should be billed to the MCOs.

MADC Comments on Optum 11-01-2022.pdf
Uploaded by: Heather Bagnall
Position: FAV

Maryland Addictions Directors Council

House Health & Government Operations Committee
House Appropriations Health & Human Resources Subcommittee
November 1, 2022

Maryland Addictions Directors Council (MADC) represents outpatient and residential substance use disorder (SUD) and dual recovery treatment across the State of Maryland. Our members provide over 1,200 residential treatment beds throughout the state. MADC strongly supports accountability for Optum. Mental health and addiction treatment providers have struggled over the last three years to manage the Optum failure to launch and then endless other problems with the Optum system. MADC providers are at the forefront of the opioid overdose epidemic as well as managing the COVID pandemic during this same period.

In January 2020, Optum launched as the State vendor responsible for paying claims for publicly funded behavioral health services. Optum's system could not launch, leaving providers with no means to bill and receive payment from the public behavioral healthcare system. This forced the State to step in with estimated payments while giving Optum more time to deliver a working system.

In March 2020, the Covid pandemic hit Maryland causing disruption across behavioral healthcare. The opioid overdose epidemic, the COVID pandemic, and Optum's poor performance resulted in behavioral health providers struggling with underpayments and incurring additional costs as Optum's technology continued to fail.

For almost 3 years Optum has been unable to accurately report on claims and payments resulting from the failure to launch in January 2020. Providers have been handed spreadsheets with tens of thousands to hundreds of thousands of lines of claims from Optum's system that providers have had to sort through by hand. Many programs had to hire additional staff or reassign existing staff to this arduous task. This was due to the public behavioral health vendor for claims payment not

functioning properly. The vendor recently has improved its functionality but the lingering problems still pose a burden to many MADC providers.

None of these issues existed with any of the previous ASO's, of which there had been several.

In closing, thank you for the opportunity to offer written testimony.

Sincerely,

Craig Lippens

Craig Lippens
President, MADC

Optum Maryland Report-MCLH-2-2021-E-6.7.22 (1).pdf
Uploaded by: Heather Bagnall
Position: FAV

MARKET CONDUCT EXAMINATION REPORT
OF
UNITED BEHAVIORAL HEALTH

2716 N. Tenaya Way, NV017-S500
Las Vegas, NV 89128

Report No. MCLH-2-2021-E

Examination Period: January 1, 2020 – March 31, 2021

Maryland
INSURANCE ADMINISTRATION

STATE OF MARYLAND
MARYLAND INSURANCE ADMINISTRATION

KATHLEEN A. BIRRANE, COMMISSIONER

JUNE 7, 2022

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LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

KATHLEEN A. BIRRANE
Commissioner

GREGORY M. DERWART
Deputy Commissioner

MARY M. KWEI
Associate Commissioner
Market Regulation
& Professional Licensing

Maryland
INSURANCE ADMINISTRATION

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2113 Fax: 410-468-2245
Email: mary.kwei@maryland.gov
1-800-492-6116 TTY: 1-800-735-2258
www.insurance.maryland.gov

June 7, 2022

The Honorable Kathleen A. Birrane
Commissioner of Insurance
State of Maryland
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Dear Commissioner Birrane:

Pursuant to your instructions and authorization, an Examination has been made of the market conduct affairs of:

UNITED BEHAVIORAL HEALTH

whose home office is located at 2716 N. Tenaya Way, NV017-S500, Las Vegas, Nevada 89128. The report of such Examination is being respectfully submitted.

Sincerely,

Mary M. Kwei
Associate Commissioner
Market Regulation & Professional Licensing

I. EXECUTIVE SUMMARY

In June 2021, the Maryland Insurance Administration (the "Administration") initiated a target Market Conduct Examination (the "**Examination**") of United Behavioral Health, operating in Maryland under the trade name "Optum Maryland" (the "**Company**"). The purpose of the Examination was to evaluate whether the Company complied with the requirements of Md. Code Ann., Ins. § 15-1005 (2017 Repl. Vol.) when acting as an administrative services organization ("**ASO**") for specialty mental health services established under Md. Code Ann., Health-Gen § 15-103(b)(21)(vi); specifically in connection with its administration of specialty mental health claims under its contract with the Maryland Department of Health ("**MDH**") (MDH Control # OPASS-20-18319/ M00B0600078; hereinafter, the "**Medicaid Contract**").

While an entity acting as an ASO for Medicaid services has always been subject to the provisions of § 15-1005, the Administration was given authority to investigate and examine the compliance of such an ASO with § 15-1005 under emergency legislation enacted during the 2021 Regular Session of the Maryland General Assembly. *Laws of Maryland* 2021, Ch. 151 ("**HB 919**"). The law became effective on May 18, 2021. In light of the number of complaints from specialty mental health providers regarding the timing and completeness of payment for their services by the Company under the Medicaid Contract, the Administration initiated the Examination shortly thereafter.

Based on materials and information reviewed during the Examination, the Administration has concluded that the Company did not comply with § 15-1005 at any time during the Examination Period. Consequently, as discussed in greater detail herein, the Company has been directed to prepare and submit corrective action plans to identify, calculate, and make restitution to providers for interest that should have been paid on claims submitted during the Examination Period and any period thereafter. The Company also has been directed to develop and submit for approval by the Administration policies and procedures that demonstrate and ensure its future compliance with § 15-1005.

II. SCOPE OF EXAMINATION

The Examination was conducted pursuant to §§ 2-205, 2-207 and 2-209 of the Annotated Code of Maryland, Insurance Article and 31.04.20 of the Code of Maryland Regulations ("**COMAR**"). The Examination Period was January 1, 2020 through March 31, 2021.

The purpose of the targeted Examination was to determine whether the Company complied with the requirements of Md. Code Ann., Ins. § 15-1005 (2017 Repl. Vol.) when acting as the ASO for MDH under the Medicaid Contract.

Section 15-1005 requires that within thirty days of its initial receipt of a claim for reimbursement of certain services by certain providers, a payor subject to the section must either pay the claim or provide written notice as to the basis for non-payment. If a "clean claim" is not paid within thirty days, interest on the amount of the claim that remains unpaid thirty days after receipt of the initial clean claim must be paid in accordance with a statutory interest rate schedule.

At the Administration's request, the Company provided the total population for each area listed in the chart below:

AREA	POPULATION	SAMPLE SIZE
Paid Claims - 1.1.2020 to 7.31.2020	3,306,052	200
Paid Claims - 8.1.2020 to 3.31.2021	5,361,555	200
Denied Claims - 1.1.2020 to 7.31.2020	1,096,183	125
Denied Claims - 8.1.2020 to 3.31.2021	1,539,443	125
Total:		**650**

The examination and testing methodologies used during the Examination followed standards established by the National Association of Insurance Commissioners and procedures developed by the Administration. All sample files were selected using a computer generated random sample program unless otherwise stated herein.

III. COMPANY INTRODUCTION

Pursuant to the Medicaid Contract, the Company assumed the administration of specialty mental health benefits for Maryland Medicaid participants with respect to mental health services provided on or after January 1, 2020. The Company's responsibilities under the Medicaid Contract included administering and paying claims.

The Company has acknowledged that, as a result of what it characterizes as "functionality issues" with its claim platform (the "**Platform**"), it was unable to process or to pay provider claims from January 1 through August 3, 2020. In an effort to mitigate the impact of this, and to assure a consistent flow of provider payments until the Platform was functional, MDH directed the Company to advance estimated monthly payments to Medicaid providers ("**Providers**"), subject to the Company's obligation to reconcile Provider accounts when the Platform became functional. Advance estimated payments were calculated by MDH and supplied to the Company based on prior claim payment data. Advance estimated payments were made from January 23, 2020 through August 3, 2020 (the "**Estimated Claim Payment Period**"). On August 4, 2020, the Company's began using the Platform for claim administration and payment processing of new claims (the "**Standard Processing Period**"). MDH allowed Providers additional time to submit claims for services provided during the Estimated Claim Payment Period. On July 27, 2020, the Company began reconciling claims received during the Estimated Claim Payment Period with the estimated payments made to Providers. MDH directed the Company to begin making claim payments on reconciled claims from the Estimated Claim Payment Period on August 13, 2020.

IV. VIOLATIONS

Issue 1 - Violation of Section 15-1005(c)
The Company failed to pay claims or send notice of receipt and status of claims within 30 days of their receipt for reimbursement.

Section 15-1005(c) provides in pertinent part:

> (c) Except as provided in § 15-1315 of this title and subsection (i) of this section, within 30 days after receipt of a claim for reimbursement from a person entitled to reimbursement under § 15-701(a) of this title or from a hospital or related institution, as those terms are defined in § 19-301 of the Health - General Article, an insurer, nonprofit health service plan, or health maintenance organization shall:
> (1) mail or otherwise transmit payment for the claim in accordance with this section; or
> (2) send a notice of receipt and status of the claim that states:
> (i) that the insurer, nonprofit health service plan, or health maintenance organization refuses to reimburse all or part of the claim and the reason for the refusal;
> (ii) that, in accordance with § 15-1003(d)(1)(ii) of this subtitle, the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or
> (iii) that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.

FINDING 1

The samples reviewed by the Administration confirmed that, regardless of the advance estimated payments, there were instances when the Company failed to pay claims or send notice of receipt and status of claims within 30 days of its receipt of a claim for reimbursement. Likewise, after its standard claims handling processes were deployed, the Administration identified instances when the Company failed to either pay the claim or send notice of receipt and status of the claim within 30 days of its receipt of the claim for reimbursement. The Company is in violation of Section 15-1005(c).

AREA REVIEWED	POPULATION	SAMPLE SIZE	VIOLATIONS	% OF ERROR	EXHIBIT
Paid Claims 1.1.2020 to 7.31.2020	3,306,052	200	94	47	A
Paid Claims 8.1.2020 to 3.31.2021	5,361,555	200	13	7	B
Denied Claims 1.1.2020 to 7.31.2020	1,096,183	125	79	63	C
Denied Claims 8.1.2020 to 3.31.2021	1,539,443	125	10	8	D

Issue 2 - Violation of Section 15-1005(g)(1)
The Company failed to pay interest on claims in accordance with Maryland law.

Section 15-1005 provides in pertinent part:

> (g) (1) If an insurer, nonprofit health service plan, or health maintenance organization, or administrative services organization that administers the delivery system for specialty mental health services established under § 15-103(b)(21) of the Health - General Article fails to pay a clean claim for reimbursement or otherwise violates any provision of this section, the insurer, nonprofit health service plan, or health maintenance organization shall pay interest on the amount of the claim that remains unpaid 30 days after receipt of the initial clean claim for reimbursement at the monthly rate of:
>
> (i) 1.5% from the 31st day through the 60th day;
> (ii) 2% from the 61st day through the 120th day; and
> (iii) 2.5% after the 120th day.

FINDING 2

The Company failed to pay interest on the amount of the claim that remained unpaid 30 days after initial receipt of a clean claim for reimbursement. The Company is in violation of Section 15-1005(g)(1).

AREA REVIEWED	POPULATION	SAMPLE SIZE	VIOLATIONS	% OF ERROR	EXHIBIT
Paid Claims 1.1.2020 to 7.31.2020	3,306,052	200	94	47	A
Paid Claims 8.1.2020 to 3.31.2021	5,361,555	200	13	7	B

Issue 3 - Violation of Section 15-1005(c)(2)
The Company failed to send a notice of receipt and status of claim that stated the reason for refusal.

Section 15-1005 provides in pertinent part:

> (c) Except as provided in § 15-1315 of this title and subsection (i) of this section, within 30 days after receipt of a claim for reimbursement from a person entitled to reimbursement under § 15-701(a) of this title or from a hospital or related institution, as those terms are defined in § 19-301 of the Health - General Article, an insurer, nonprofit health service plan, or health maintenance organization shall:
> (2) send a notice of receipt and status of the claim that states:
> (i) that the insurer, nonprofit health service plan, or health maintenance organization refuses to reimburse all or part of the claim and the reason for the refusal;

FINDING 3

The Company failed to send a notice of receipt and status of a denied claim that states the reason for refusal. The Company is in violation of Section 15-1005(c)(2).

AREA REVIEWED	POPULATION	SAMPLE SIZE	VIOLATION	% OF ERROR	EXHIBIT
Denied Claims 1.1.2020 to 7.31.2020	1,096,183	125	1	1	E
Denied Claims 8.1.2020 to 3.31.2021	1,539,443	125	5	4	E

Issue 4 - Violation of COMAR 31.10.11.07
The Company failed to fully reimburse clean claims in accordance with Maryland laws.

COMAR 31.10.11 provides in pertinent part:

.07 General Provisions.

A. A third-party payor shall accept a clean claim which is submitted in compliance with these regulations for the processing of the third-party payor's claims.
B. A third-party payor is subject to the provisions of Insurance Article, §15-1005, Annotated Code of Maryland.

FINDING 4

The Company failed to fully reimburse claims that contained all of the required elements of a clean claim. The Company is in violation of COMAR 31.10.11.07.

AREA REVIEWED	POPULATION	SAMPLE SIZE	VIOLATIONS	% OF ERROR	EXHIBIT
Paid Claims 8.1.2020 to 3.31.2021	5,361,555	200	1	<1	F
Denied Claims 1.1.2020 to 7.31.2020	1,096,183	125	2	2	F

V. CONCLUSIONS AND DIRECTIVES

In an effort to quantify the extent of violations resulting from the Company's lack of compliance procedures, a sampling of 650 randomly selected files were reviewed. Of the selected files, a total of 312 violations occurred during the Examination Period. Those violations included failure to pay claims or send notice of receipt and status of claims within 30 days, failure to pay applicable interest, failure to send a notice of which includes the reason for denial, and failure to reimburse clean claims.

In light of its findings, the Administration directs the Company as follows:

A. Timely Claim Payments and Notices

The Company will provide to the Administration a corrective action plan that includes a detailed description of the processes it has implemented for assuring compliance with those provisions of § 15-1005 that require the timely processing of claims and either payment or notice of the basis for non-payment under § 15-1005(c) within 30 days of claim submission. The Company shall demonstrate that it has updated its current systems and procedures to assure that clean claims are timely paid and that all statutory notices are timely issued. The Company shall provide its corrective action plan and verification of its implementation in writing to the Administration on or before February 28, 2022.

In response to V.A. of the draft market conduct report, the Company advised of the following corrective actions:

> *"Optum claims operational leadership reviews a daily inventory report to identify claim volumes and aging to ensure timely processing of claims. If a claim is identified to be at risk of non-compliance, leadership works with the claim processor to enable the claim to be processed timely.*
>
> *In Q4 of 2021, Optum completed a project to analyze if any 835s/Provider Remittance Advices (PRAs) for claims processed by the Incedo platform that were not sent to providers. The analysis was completed in conjunction with the MDH. The project determined denied claim lines ($0) that were previously not sent in the form of a PRA/3835 were regenerated and sent to providers by the end of December. Optum has implemented controls to mitigate future risk. The controls include validation processes that review the provider, dollar values to include $0, claim counts, Incedo Check register, and Check run tables against files sent to PaySpan.*
>
> *Additionally, Optum has developed a policy that outlines § 15-1005 and COMAR 31.10.11.08 and 31.10.11.09 requirements and expectations."*

B. Timely Interest Payments

The Company has agreed to develop an automated process to identify claims that, notwithstanding the procedures implemented in accordance with V.A, are not timely

processed in accordance with § 15-1005(c). The Company asserts that the automated process will include the identification of any clean claims that were not paid within 30 days and will include the ability to calculate the correct interest rate in compliance with § 15-1005(g). The Company asserts that its automated process will be tested and reviewed by the Company and MDH in Q3 2022, with the expectation that the automated process will be implemented into the claims system for completion at the end of Q4 2022.

The Company is directed to report to the Administration on its progress in the development and implementation of the automated process at the end of each quarter, beginning on March 31, 2022. If the automated process has not been implemented by December 31, 2022, the Company is directed to report such progress at the end of each calendar month until the automated process is fully implemented.

In addition, pending the development and implementation of the automated process, the Administration directs the Company to employ the process described below in V.C.

In response to V.B. of the draft market conduct report, the Company advised of the following:

> *"Optum agrees with the statements referenced in V.B paragraph one. Optum agrees to provide a status of the implementation of the automated process to the Administration not later than requested, March 31, 2022. If the automated process has not been implemented by December 31, 2022, Optum will provide the Administration with a status of the progress at the end of each calendar month until the automated process is fully implemented."*

C. Payment of Unpaid Interest on Clean Claims During the Standard Processing Period

During the Examination, the Administration noted that the Company had no procedures in place to pay interest on clean claims not paid within 30 days. Consequently, the Administration directed the Company to:

1) Develop and provide a corrective action plan to identify all claims on which interest was required to be paid from August 4, 2020 through the present and (i) to pay such interest to any provider or (ii) deduct such interest from any amounts due to any Provider whose Estimated Claim Payments exceeded the amounts due to that Provider (after the application of the methodology ultimately approved by the Administration for the consideration of interest as part of the reconciliation of provider accounts).

In response to V.C.1) of the draft market conduct report, the Company advised of the following corrective actions:

> *"Optum has developed a process to resolve unpaid interest on claims in two phases (see item #2, below, for phase 2). Optum has developed a report to identify the claims that were processed and for which an interest payment*

was due to the provider between August 4, 2020 - November 30, 2021. The report identified, by provider, the claims that were processed in excess of 30 days during this period, the amounts, and the interest amounts owed related to those claims. "

2) Develop and provide a corrective action plan to ensure that interest is paid on all claims remaining unpaid 30 days after receipt of a clean claim for reimbursement in compliance with § 15-1005 (g) and COMAR 31.10.11.08 and 31.10.11.09.

In response to V.C.2) of the draft market conduct report, the Company advised of the following corrective actions:

"Beginning with claims paid in December 2021, Optum will use the report described in item #1 above to identify claims and to pay providers interest, as applicable and required by Maryland law. The claims report will be reviewed on a quarterly basis to identify any claims that require an interest payment. Interest will be paid by Optum and not via accounts funded by the State of Maryland. Interest payments will be paid quarterly.

Optum is also developing an automated process to identify claims that remain unprocessed greater than 30 days from the submission of a clean claim. The automated process will identify claims that fail to process within 30 days, apply the correct interest rate, and then pay the interest from a non-State of Maryland bank account.

The automated process will be tested and reviewed by both internal Optum subject matter experts and MDH leadership in Q3 2022. Upon completion, the automated process will be implemented and integrated into the claims platform. The automated process will be implemented into the claims system and is targeted for completion at the end of Q4 2022."

In response, the Company proposed corrective actions, which the Administration has accepted, as amended by the Administration, as follows:

1) The Company will prepare a detailed master claims report identifying all clean claims that were processed between August 4, 2020 and November 30, 2021 with respect to which interest was due under § 15-1005. The master claims report will identify, by Provider, the claims that were paid in excess of 30 days, the amount of the late-paid claim, and the interest calculated as payable on the late-paid claim.

On or before February 15, 2022, the Company will notify all Providers to whom interest is due that they will be receiving an interest payment/check in the amount mandated by § 15-1005(g). The Company will make the interest payments to the Providers in the amounts calculated in the master claims report. A provider specific report with claim information will be made available to each Provider via the Provider's folder within the Company's claims portal (consistent with the manner in

which Providers currently access Provider Remittance Advices ("PRAs")). All such interest payments will be made on or before March 31, 2022 and the interest paid will reflect interest due through the actual payment date.

The Company is directed to submit its initial master claims report to the Administration on or before February 4, 2022. In addition, on or before April 30, 2022, the Company is directed to provide the Administration with the final master claims report, together with a summary confirming that all of interest payments were made by March 31, 2022. The summary report shall identify each Provider, the date and amount of the original claim payments, and the date and amount of the interest payment.

In response to V.C.1) amended, of the draft market conduct report, the Company advised of the following corrective actions:

> *"Optum has submitted a detailed master claims report identifying all clean claims that were processed between August 4, 2020 and November 30, 2021 with respect to which interest was due under § 15-1005.*
>
> *Optum confirms that a letter was sent to all impacted providers by February 15, 2022 communicating that they will be receiving an interest payment for claims processed greater than 30 days between the period August 4, 2020 - November 30, 2021.*[1]
>
> *Additionally, Optum confirms that a report containing the claim details for each impacted provider was uploaded to the Provider Folder in the Incedo claims platform by March 31, 2022. Please note this is a different provider folder than initially stated to the Administration, however this folder provides providers the accessibility they require.*
>
> *Lastly, Optum agrees to submit a final master report to the Administration no later than April 30, 2022, together with a summary confirming that 97% of the interest payments were made by March 31, 2022 (the remaining 3% are awaiting provider W9s and pending vendor ID). The total amount of interest paid is $3,124,044. The summary report will identify each Provider, the date and amount of the original claim payments, and the date and amount of the interest payment."*

2) The Company will develop and implement the automated interest calculation process described in V.B, above. Until implementation is complete, the Company will create a reporting tool that includes the information identified in subparagraph (a) that can be generated in real time to identify the following elements: (i) all claims initially received on or after December 1, 2021 that (notwithstanding the Company's corrective actions to assure timely payment of claims as set forth in V.A) were not

[1] According to the company, provider letters were resent on March 25, 2022 because the provider letters that were sent on February 15, 2022 contained certain address errors.

paid within the statutory 30 day period, (ii) the late-paid claim amount, (iii) the payment date, (iii) the interest due on the late- paid claim amount, and (if applicable) (iv) that date the interest was paid. This reporting tool will be reviewed by a senior member of management on at least a quarterly basis to identify and direct the immediate payment on interest due. The first such review shall occur on March 31, 2022.

The Company is directed to identify the senior member of management receiving the report and to submit a copy of each quarterly report to the Administration, together with proof that interest has been paid, within 10 business days after the close of the quarter, until the automated process has been implemented.

In response to V.C.2) amended, of the draft market conduct report, the Company advised of the following corrective actions:

> *"Optum confirms that a reporting tool was created to identify in real time (i) all claims initially received on or after December 1, 2021 that (notwithstanding the Company's corrective actions to assure timely payment of claims as set forth in V.A) were not paid within the statutory 30 day period, (ii) the late-paid claim amount, (iii) the payment date, (iii) the interest due on the late-paid claim amount, and (if applicable), (iv) that date the interest was paid.*
>
> *The reporting tool was reviewed by a senior member of management by March 31, 2022. The reporting tool will be reviewed on at least a quarterly basis to identify and direct the immediate payment of interest due.*
>
> *The quarterly report and proof that interest was paid will be submitted to the Administration each quarter until the automated process has been implemented."*

3) The Company is directed to identify the method of calculating interest owed on claims noted in (a) and (b) on or before February 4, 2022,

In response to V.C.3) amended, of the draft market conduct report, the Company provided the method of calculating interest in (a) and (b).

D. Payment of Unpaid Interest on Clean Claims During the Estimated Claim Payment Period

The Company is responsible for the payment of interest to Providers for clean claims that were not timely paid during the Estimated Claim Payment Period.

The Company reports that it has completed its reconciliation of Provider accounts to determine whether, as to each Provider who submitted valid claims during the Estimated Claim Payment Period, the Provider was overpaid or underpaid. According to the Company, of the 2,605 Providers who received Estimated Claim Payments, 223 Providers were underpaid and 2,382 Providers were overpaid. The Company states that the amounts calculated by the Company as owed to the 223 underpaid Providers have been paid to those Providers.

With respect to unpaid interest, the Administration directed the Company to develop a fair and reasonable methodology to pay interest to Providers who were underpaid during the Estimated Claim Payment Period. The Company proposed that it would treat a claim as a clean claim 30 days after the later of August 3, 2020 or the date the claim was submitted. While this methodology is imperfect, the Administration accepts it as a fair and reasonable approach that is designed to make Providers whole.

Using this methodology, the amount of interest to be paid to Providers is $631,933. The Company is directed to make all such interest payments to Providers by May 31, 2022 and to provide a report to the Administration no later than June 15, 2022 confirming that all payments have been made. The summary report shall identify each Provider, the date and amount of the original claim payments, and the date and amount of the interest payment.

To the extent that any Provider disputes the amount paid, the Company is directed to review the alleged error and, if the dispute is not resolved, to report the dispute to the Administration within 30 days of the date that the Provider notifies the Company in writing of the dispute.

The Company's position with regard to compliance with § 15-1005 of the Insurance Article is spelled out in its letter to the MIA dated May 10, 2022, which is attached as Exhibit G. As stated in this Report, the Administration disagrees with the Company's position.

EXHIBITS

EXHIBIT A
Prompt Pay Penalty for Paid Claims 1.1.2020 to 7.31.2020
Violations of § 15-1005(c) and (g)

MIA #	Claim Type	Claim Line	Received Date	Paid Date	PRA Date	Number of Days	Total Days Out of Compliance	Amount Paid	Interest Due $
1	Paid Claims 1.1.20 to 7.31.20	99214 90836	2/27/2020	99214 5/16/2020 90836 3/5/2021	99214 5/16/2020 90836 3/5/2021	79 372	49 342	109.35 100.00	3.03 26.50
2	Paid Claims 1.1.20 to 7.31.20	90837	2/27/2020	Initial 7/9/2020 Reprocess 3/07/2021	Initial 7/9/2020 Reprocess 3/07/2021	374	344	103.39	27.57
3	Paid Claims 1.1.20 to 7.31.20	90834	2/27/2020	Initial 5/16/2020 Reprocess 3/07/2021	Initial 5/16/2020 Reprocess 3/07/2021	374	344	72.50	19.33
4	Paid Claims 1.1.20 to 7.31.20	90834	2/27/2020	6/06/2020	6/06/2020	100	70	103.39	4.31
5	Paid Claims 1.1.20 to 7.31.20	90834	2/27/2020	5/16/2020	5/16/2020	79	49	70.05	1.94
6	Paid Claims 1.1.20 to 7.31.20	90834	2/27/2020	5/16/2020	5/16/2020	79	49	70.05	1.94
7	Paid Claims 1.1.20 to 7.31.20	99213	2/27/2020	Initial 5/16/2020 Reprocess 3/07/2021	Initial 5/16/2020 Reprocess 3/07/2021	374	344	51.29	13.68
10	Paid Claims 1.1.20 to 7.31.20	90791	2/27/2020	6/21/2020	6/21/2020	115	85	216.25	11.17
12	Paid Claims 1.1.20 to 7.31.20	H0015 H0015 H0015 H0015	2/12/2020 2/12/2020 2/12/2020 2/12/2020	5/16/2020 5/16/2020 5/16/2020 5/16/2020	5/16/2020 5/16/2020 5/16/2020 5/16/2020	94 94 94 94	64 64 64 64	139.51 139.51 139.51 139.51	5.25 5.25 5.25 5.25
13	Paid Claims 1.1.20 to 7.31.20	90791	2/13/2020	5/16/2020	5/16/2020	93	63	193.62	7.16
14	Paid Claims 1.1.20 to 7.31.20	90853	2/14/2020	5/16/2020	5/16/2020	92	62	494.73	17.98
15	Paid Claims 1.1.20 to 7.31.20	80307 60481	2/27/2020	5/16/2020	5/16/2020	79	49	181.59	5.02

MIA #	Claim Type	Claim Line	Received Date	Paid Date	PRA Date	Number of Days	Total Days Out of Compliance	Amount Paid	Interest Due $
16	Paid Claims 1.1.20 to 7.31.20	H0020	2/14/2020	5/16/2020	5/16/2020	92	62	68.84	2.50
17	Paid Claims 1.1.20 to 7.31.20	H0020	2/10/2020	5/16/2020	5/16/2020	96	66	68.84	2.68
18	Paid Claims 1.1.20 to 7.31.20	W7370 RESRB W7370 RESRB W7370 RESRB W7370 RESRB W7370 RESRB W7370 RESRB	2/21/2020 2/21/2020 2/21/2020 2/21/2020 2/21/2020 2/21/2020	5/16/2020 5/16/2020 5/16/2020 5/16/2020 5/16/2020 5/16/2020	5/16/2020 5/16/2020 5/16/2020 5/16/2020 5/16/2020 5/16/2020	85 85 85 85 85 85	55 55 55 55 55 55	550.00 50.00 550.00 50.00 550.00 50.00 550.00 50.00 550.00 50.00 550.00 50.00	17.42 1.58 17.42 1.58 17.42 1.58 17.42 1.58 17.42 1.58 17.42 1.58
28	Paid Claims 1.1.20 to 7.31.20	99211	1/23/2020	5/02/2020	516/2020	114	84	54.16	2.76
29	Paid Claims 1.1.20 to 7.31.20	99214	2/07/2020	5/16/2020	5/16/2020	99	69	109.35	4.48
30	Paid Claims 1.1.20 to 7.31.20	90847 90834	2/08/2020	5/16/2020	5/16/2020	98	68	227.25	9.17
31	Paid Claims 1.1.20 to 7.31.20	90834	2/08/2020	5/16/2020	5/16/2020	98	68	103.39	4.17
32	Paid Claims 1.1.20 to 7.31.20	90834 90847	2/12/2020	5/16/2020	5/16/2020	94	64	211.05	7.95
33	Paid Claims 1.1.20 to 7.31.20	H0005	2/12/2020	6/14/2020	6/14/2020	123	93	43.47	2.50
34	Paid Claims 1.1.20 to 7.31.20	90834	2/25/2020	6/06/2020	6/06/2020	102	72	119.59	5.14
35	Paid Claims 1.1.20 to 7.31.20	H0005	2/26/2020	5/16/2020	5/16/2020	80	50	43.47	1.23
36	Paid Claims 1.1.20 to 7.31.20	90834	2/26/2020	5/16/2020	5/16/2020	80	50	119.59	3.39

MIA #	Claim Type	Claim Line	Received Date	Paid Date	PRA Date	Number of Days	Total Days Out of Compliance	Amount Paid	Interest Due $
37	Paid Claims 1.1.20 to 7.31.20	80307 G0481	2/27/2020	5/16/2020	5/16/2020	79	49	57.10	1.58
38	Paid Claims 1.1.20 to 7.31.20	80307 G0481	2/27/2020	5/16/2020	5/16/2020	79	49	124.49	3.44
39	Paid Claims 1.1.20 to 7.31.20	99222	2/27/2020	7/23/2020	7/30/2020	154	124	136.99	11.42
40	Paid Claims 1.1.20 to 7.31.20	90868	2/27/2020	6/14/2020	6/14/2020	108	78	151.44	7.12
41	Paid Claims 1.1.20 to 7.31.20	H0005	2/21/2020	5/16/2020	3/14/2021	387	357	43.47	12.06
42	Paid Claims 1.1.20 to 7.31.20	H0004	2/21/2020	5/16/2020	5/16/2020	85	55	44.58	1.41
43	Paid Claims 1.1.20 to 7.31.20	90834	2/14/2020	5/23/2020	5/23/2020	99	69	103.39	4.24
44	Paid Claims 1.1.20 to 7.31.20	T2048	2/25/2020	5/16/2020	5/16/2020	81	51	14.31	0.41
45	Paid Claims 1.1.20 to 7.31.20	90868	2/27/2020	6/14/2020	6/14/2020	108	78	151.44	7.12
46	Paid Claims 1.1.20 to 7.31.20	90868	2/27/2020	6/21/2020	6/21/2020	115	85	151.44	7.82
47	Paid Claims 1.1.20 to 7.31.20	T1015 90832	2/27/2020	Initial 6/14/2020 Reprocess 3/7/2021	Initial 6/14/2020 Reprocess 3/7/2021	374	344	183.22	48.86
48	Paid Claims 1.1.20 to 7.31.20	90834	2/27/2020	5/16/2020	5/16/2020	79	49	72.50	2.01
49	Paid Claims 1.1.20 to 7.31.20	T015	2/27/2020	5/16/2020	5/16/2020	79	49	183.22	5.07
50	Paid Claims 1.1.20 to 7.31.20	90937	2/27/2020	7/09/2020	7/9/2020	133	103	103.39	6.81
51	Paid Claims 1.1.20 to 7.31.20	99214	3/24/2020	5/23/2020	5/23/2020	60	30	108.50	1.63

MIA #	Claim Type	Claim Line	Received Date	Paid Date	PRA Date	Number of Days	Total Days Out of Compliance	Amount Paid	Interest Due $
52	Paid Claims 1.1.20 to 7.31.20	99232	3/24/2020	5/23/2020	5/23/2020	60	30	$72.84	1.09
53	Paid Claims 1.1.20 to 7.31.20	90834	2/27/2020	5/16/2020	5/16/2020	79	49	145.00	4.01
58	Paid Claims 1.1.20 to 7.31.20	90834	2/27/2020	5/16/2020	5/16/2020	79	49	72.50	2.01
59	Paid Claims 1.1.20 to 7.31.20	90832	2/27/2020	5/16/2020	5/16/2020	79	49	39.76	1.10
60	Paid Claims 1.1.20 to 7.31.20	H0020	3/27/2020	5/23/2020	5/23/2020	57	27	68.84	0.93
61	Paid Claims 1.1.20 to 7.31.20	W7350	3/28/2020	5/23/2020	5/23/2020	56	26	196.70	2.56
62	Paid Claims 1.1.20 to 7.31.20	H0020	3/30/2020	5/23/2020	5/23/2020	54	24	68.94	0.83
63	Paid Claims 1.1.20 to 7.31.20	T2048	3/31/2020	5/23/2020	5/23/2020	53	23	14.31	0.16
64	Paid Claims 1.1.20 to 7.31.20	H2018	4/1/2020	6/06/2020	6/06/2020	66	36	864.96	16.43
65	Paid Claims 1.1.20 to 7.31.20	H2018	4/05/2020	6/06/2020 11/29/2020	6/06/2020 11/29/2020	62 238	32 208	485.69 379.27	7.93 58.15
66	Paid Claims 1.1.20 to 7.31.20	H0015	4/06/2020	6/06/2020	6/06/2020	61	31	139.31	2.18
67	Paid Claims 1.1.20 to 7.31.20	90834	4/06/2020	6/06/2020	6/06/2020	61	31	103.39	1.62
68	Paid Claims 1.1.20 to 7.31.20	90834 H0032	4/07/2020	90834 8/9/2020 H0032 6/6/2020	8/9/2020 6/6/2020	124 60	94 30	119.59 94.21	6.98 1.41
69	Paid Claims 1.1.20 to 7.31.20	90834	2/27/2020	5/16/2020	5/16/2020	79	49	72.50	2.01
70	Paid Claims 1.1.20 to 7.31.20	80305 99214	2/27/2020	5/16/2020	5/16/2020	79	49	119.35	3.30
71	Paid Claims 1.1.20 to 7.31.20	80305 99214	2/27/2020	5/16/2020	5/16/2020	79	49	119.35	3.30
72	Paid Claims 1.1.20 to 7.31.20	90834	2/27/2020	5/16/2020	9/03/2020	189	159	72.50	8.16
73	Paid Claims 1.1.20 to 7.31.20	H0005	4/07/2020	6/06/2020	6/06/2020	60	30	43.47	0.65
74	Paid Claims 1.1.20 to 7.31.20	T2048	4/08/2020	6/06/2020	6/06/2020	59	29	14.31	0.21
75	Paid Claims 1.1.20 to 7.31.20	99215	2/27/2020	6/06/2020	6/06/2020	100	70	146.38	6.10
76	Paid Claims 1.1.20 to 7.31.20	90834	4/10/2020	7/12/2020	7/16/2020	97	67	103.39	4.10
77	Paid Claims 1.1.20 to 7.31.20	G0480 80307	4/10/2020	6/06/2020	6/06/2020	57	27	148.07	2.00
78	Paid Claims 1.1.20 to 7.31.20	H2018	4/12/2020	6/06/2020	6/06/2020	55	25	864.96	10.81
79	Paid Claims 1.1.20 to 7.31.20	90834	4/16/2020	6/06/2020	6/06/2020	51	21	103.39	1.09
80	Paid Claims 1.1.20 to 7.31.20	0451 0250 0258 0270 0305	4/17/2020	6/06/2020	6/06/2020	50	20	421.52	4.22
81	Paid Claims 1.1.20 to 7.31.20	99215	2/27/2020	6/06/2020	6/06/2020	100	70	146.38	6.10

MIA #	Claim Type	Claim Line	Received Date	Paid Date	PRA Date	Number of Days	Total Days Out of Compliance	Amount Paid	Interest Due $
82	Paid Claims 1.1.20 to 7.31.20	T1015 90832	4/17/2020	6/06/2020	6/06/2020	50	20	293.39	2.93
83	Paid Claims 1.1.20 to 7.31.20	H0004	4/17/2020	6/06/2020	6/06/2020	50	20	44.58	0.45
84	Paid Claims 1.1.20 to 7.31.20	H0004	4/17/2020	6/06/2020	6/06/2020	50	20	44.58	0.45
85	Paid Claims 1.1.20 to 7.31.20	H0020	4/21/2020	6/06/2020	6/06/2020	46	16	68.84	0.55
86	Paid Claims 1.1.20 to 7.31.20	90834	2/27/2020	7/09/2020	11/24/2020	271	241	72.50	13.11
87	Paid Claims 1.1.20 to 7.31.20	H0004	4/21/2020	6/06/2020	6/06/2020	46	16	44.58	.36
88	Paid Claims 1.1.20 to 7.31.20	H2018	4/21/2020	7/23/2020	7/23/2020	93	63	485.39	17.96
89	Paid Claims 1.1.20 to 7.31.20	99232	4/24/2020	6/06/2020	6/06/2020	43	13	72.84	0.47
90	Paid Claims 1.1.20 to 7.31.20	80307	4/27/2020	7/16/2020	7/16/2020	80	50	51.40	1.46
91	Paid Claims 1.1.20 to 7.31.20	T2048	4/30/2020	6/14/2020	6/14/2020	45	15	13.10	0.10
92	Paid Claims 1.1.20 to 7.31.20	T2048	5/01/2020	6/14/2020	6/14/2020	44	14	14.31	0.10
93	Paid Claims 1.1.20 to 7.31.20	99214	2/27/2020	5/16/2020	5/16/2020	79	49	109.35	3.03
94	Paid Claims 1.1.20 to 7.31.20	99214	2/27/2020	6/06/2020	6/06/2020	100	70	109.35	4.56
95	Paid Claims 1.1.20 to 7.31.20	99214	2/27/2020	6/06/2020	6/06/2020	100	70	109.35	4.56
96	Paid Claims 1.1.20 to 7.31.20	0450 0900	2/27/2020	5/16/2020	5/16/2020	79	49	899.00	24.87
97	Paid Claims 1.1.20 to 7.31.20	0250 0450	2/27/2020	5/16/2020	5/16/2020	79	49	270.50	7.48
98	Paid Claims 1.1.20 to 7.31.20	90834	2/27/2020	6/06/2020	10/19/2020	235	205	72.50	10.94
99	Paid Claims 1.1.20 to 7.31.20	90834	2/27/2020	5/16/2020	10/02/2020	218	188	72.50	9.91
100	Paid Claims 1.1.20 to 7.31.20	0124 0221 0301 0305 0306 0306 0324 0430 0434 0450	2/27/2020	5/16/2020	5/16/2020	79	49	$9,852	272.57
101	Paid Claims 1.1.20 to 7.31.20	T2048	5/04/2020	6/14/2020	6/14/2020	41	11	14.31	0.08
102	Paid Claims 1.1.20 to 7.31.20	H2018	5/04/2020	6/14/2020	6/14/2020	41	11	485.39	2.67
103	Paid Claims 1.1.20 to 7.31.20	T2048	5/05/2020	6/14/2020	6/14/2020	41	10	14.31	0.07
104	Paid Claims 1.1.20 to 7.31.20	H2018	5/06/2020	6/14/2020	6/14/2020	39	9	277.10	1.25

MIA #	Claim Type	Claim Line	Received Date	Paid Date	PRA Date	Number of Days	Total Days Out of Compliance	Amount Paid	Interest Due $
105	Paid Claims 1.1.20 to 7.31.20	H2018	5/08/2020	6/14/2020	6/14/2020	37	7	864.96	3.03
106	Paid Claims 1.1.20 to 7.31.20	90834	5/11/2020	6/14/2020	6/14/2020	34	4	93.56	0.19
107	Paid Claims 1.1.20 to 7.31.20	H0005	5/12/2020	6/14/2020	6/14/2020	33	3	43.47	0.07
108	Paid Claims 1.1.20 to 7.31.20	90832	5/06/2020	6/14/2020	6/14/2020	39	9	67.29	0.30
109	Paid Claims 1.1.20 to 7.31.20	90834	5/12/2020	6/14/2020 7/16/2020	6/14/2020 7/16/2020	33 65	3 35	93.56 9.83	014 0.18
110	Paid Claims 1.1.20 to 7.31.20	H0040	5/13/2020	6/14/2020	6/14/2020	32	2	954.28	0.95
Total: 94									

EXHIBIT B
Prompt Pay Penalty for Paid Claims 8.1.2020 to 3.31.2021
Violations of § 15-1005(c) and (g)

MIA #	Claim Type	Claim Line	Received Date	Paid Date	PRA Date	Number of Days	Days Out of Compliance	Amount Paid	Interest Due $
202	Paid Claims 8.1.20 to 3.31.21	90834	2/12/2020	5/16/2020	3/07/2021	389	359	70.05	19.56
203	Paid Claims 8.1.20 to 3.31.21	T2048	2/24/2020	10/04/2020	10/4/2020	223	193	14.31	2.02
206	Paid Claims 8.1.20 to 3.31.21	W7375 RESRB	6/05/2020	10/04/2020 10/11/2020	10/04/2020 10/11/2020	121 128	91 98	367.08 47.44	20.50 2.93
207	Paid Claims 8.1.20 to 3.31.21	H0005 H0005	3/30/2020 3/30/2020	3/07/2021 8/09/2020	3/07/2021 8/09/2020	342 132	312 102	43.47 43.47	10.43 2.83
208	Paid Claims 8.1.20 to 3.31.21	H0020	4/28/2020	3/07/2021	3/07/2021	313	283	68.84	14.86
209	Paid Claims 8.1.20 to 3.31.21	H0020 H0020 H0020 H0020	7/23/2020 7/23/2020 7/23/2020 7/23/2020	10/04/2020 10/04/2020 10/04/2020 10/04/2020	10/04/2021 10/04/2021 10/04/2021 10/04/2021	73 73 73 73	43 43 43 43	68.84 71.59 71.59 71.59	1.63 1.69 1.69 1.69
210	Paid Claims 8.1.20 to 3.31.21	W7370	7/23/2020	10/04/2020	10/04/2020	73	43	301.82	7.14
228	Paid Claims 8.1.20 to 3.31.21	80307 G0481	8/15/2020	3/28/2021	3/28/2021	225	195	175.89	25.06
252	Paid Claims 8.1.20 to 3.31.21	90834 90834	8/16/2020 8/16/2020	2/28/2021 2/28/2021	2/28/2021 2/28/2021	196 196	166 166	17.13 17.13	2.03 2.03
257	Paid Claims 8.1.20 to 3.31.21	H0015 H0015	8/15/2020 8/15/2020	10/04/2020 10/04/2020	10/04/2020 10/04/2020	50 50	20 20	144.88 144.88	1.45 1.45
283	Paid Claims 8.1.20 to 3.31.21	90834 90834	8/15/2020 8/15/2020	2/28/2021 2/28/2021	2/28/2021 2/28/2021	197 197	167 167	17.13 17.13	2.04 2.04
300	Paid Claims 8.1.20 to 3.31.21	H0020	12/08/2020	12/13/2020	3/21/2021	103	73	71.59	3.13

MIA #	Claim Type	Claim Line	Received Date	Paid Date	PRA Date	Number of Days	Days Out of Compliance	Amount Paid	Interest Due $
304	Paid Claims 8.1.20 to 3.31.21	W7350	2/10/2020	12/13/2020	3/21/2021	405	375	203.91	59.64
Total: 13									

EXHIBIT C
Prompt Pay Penalty for Denied Claims 1.1.2020 to 7.31.2020
Violations of § 15-1005(c)(2)

MIA #	Claim Type	Claim Line	Received Date	Denied Date	Available PRA Date	Number of Days	Days Out of Compliance
405	Denied Claims 1.1.20 to 7.31.20	80307 G0480	1/07/2020	2/19/2020	10/14/2020	281	251
407	Denied Claims 1.1.20 to 7.31.20	80305	1/14/2020	4/03/2020	4/03/2020	80	50
410	Denied Claims 1.1.20 to 7.31.20	90834	3/12/2020	6/22/2020	10/28/2020	230	200
415	Denied Claims 1.1.20 to 7.31.20	99281 99283 J2060	1/22/2020	5/16/2020	9/25/2020	247	217
416	Denied Claims 1.1.20 to 7.31.20	97156	2/24/2020	6/01/2020	9/04/2020	193	163
417	Denied Claims 1.1.20 to 7.31.20	97155	2/24/2020	6/01/2020	9/10/2020	199	169
424	Denied Claims 1.1.20 to 7.31.20	97156	2/24/2020	6/01/2020	9/10/2020	199	169
433	Denied Claims 1.1.20 to 7.31.20	90833	3/12/2020	6/02/2020	10/28/2021	595	565
435	Denied Claims 1.1.20 to 7.31.20	H2016	3/17/2020	5/09/2020	9/10/2020	177	147
443	Denied Claims 1.1.20 to 7.31.20	H2018	4/14/2020	5/27/2020	6/6/2020	53	23
448	Denied Claims 1.1.20 to 7.31.20	H2016	4/14/2020	5/28/2020	9/30/2021	534	504
450	Denied Claims 1.1.20 to 7.31.20	97156	2/24/2020	6/01/2020	9/10/2020	199	169
453	Denied Claims 1.1.20 to 7.31.20	H0020	2/08/2020	419/2020	9/04/2020	209	179
454	Denied Claims 1.1.20 to 7.31.20	H0020	2/08/2020	4/19/2020	10/14/2020	249	219
455	Denied Claims 1.1.20 to 7.31.20	90834	4/01/2020	6/26/2020	9/04/2020	156	126

MIA #	Claim Type	Claim Line	Received Date	Denied Date	Available PRA Date	Number of Days	Days Out of Compliance
456	Denied Claims 1.1.20 to 7.31.20	99214 90833	1/09/2020	4/23/2020	4/23/2020	105	75
458	Denied Claims 1.1.20 to 7.31.20	H2018	2/27/2020	6/17/2020	9/28/2020	214	184
459	Denied Claims 1.1.20 to 7.31.20	H2018 H2016	3/5/2020	6/30/2020	9/08/2021	552	522
463	Denied Claims 1.1.20 to 7.31.20	H2012 97155	2/24/2020	4/10/2020	9/04/2020	193	163
464	Denied Claims 1.1.20 to 7.31.20	H0005	7/09/2020	7/23/2020	9/28/2021	446	416
465	Denied Claims 1.1.20 to 7.31.20	90834	5/16/2020	5/17/2020	9/10/2020	117	87
466	Denied Claims 1.1.20 to 7.31.20	90834	5/18/2020	10/27/2020	9/28/2021	498	468
467	Denied Claims 1.1.20 to 7.31.20	99213	5/20/2020	6/10/2020	9/10/2020	113	83
468	Denied Claims 1.1.20 to 7.31.20	H2016	5/20/2020	5/21/2020	10/27/2020	160	130
469	Denied Claims 1.1.20 to 7.31.20	99214	5/21/2020	6/02/2020	9/10/2020	112	82
470	Denied Claims 1.1.20 to 7.31.20	90832	5/25/2020	5/25/2020	10/27/2020	155	125
472	Denied Claims 1.1.20 to 7.31.20	90834	5/27/2020	5/28/2020	9/10/2020	106	76
473	Denied Claims 1.1.20 to 7.31.20	0301 0450	5/27/2020	5/27/2020	10/27/2020	153	123
474	Denied Claims 1.1.20 to 7.31.20	0510	5/27/2020	5/28/2020	12/02/2020	189	159
475	Denied Claims 1.1.20 to 7.31.20	90853	5/27/2020	5/28/2020	10/27/2020	153	123
476	Denied Claims 1.1.20 to 7.31.20	90846	6/01/2020	6/02/2020	9/10/2020	101	71
477	Denied Claims 1.1.20 to 7.31.20	90834	6/03/2020	6/04/2020	9/10/2020	99	69
478	Denied Claims 1.1.20 to 7.31.20	90853	6/05/2020	6/06/2020	12/10/2020	188	158
479	Denied Claims 1.1.20 to 7.31.20	90846	6/08/2020	6/08/2020	10/28/2020	142	112
480	Denied Claims 1.1.20 to 7.31.20	0780	6/08/2020	6/8/2020	pended until 12/2021		

MIA #	Claim Type	Claim Line	Received Date	Denied Date	Available PRA Date	Number of Days	Days Out of Compliance
481	Denied Claims 1.1.20 to 7.31.20	H0020	6/11/2020	6/11/2020	10/28/2020	139	109
		H0020	6/11/2020	6/11/2020	10/28/2020	139	109
482	Denied Claims 1.1.20 to 7.31.20	H0020	6/11/2020	6/11/2020	8/26/2021	441	411
483	Denied Claims 1.1.20 to 7.31.20	90832	6/12/2020	6/13/2020	10/28/2020	138	108
484	Denied Claims 1.1.20 to 7.31.20	99281 99285 J1630 J7030 J7042	6/12/2020	6/19/2020	10/28/2020	138	108
485	Denied Claims 1.1.20 to 7.31.20	2016 H2016	6/12/2020	6/14/2020	5/21/2021	343	313
486	Denied Claims 1.1.20 to 7.31.20	80307	6/14/2020	6/16/2020	**pended until 12/2021**		
487	Denied Claims 1.1.20 to 7.31.20	H2016	6/15/2020	6/22/2020	9/11/2020	88	58
		H2016	6/15/2020	6/22/2020	9/11/2020	88	58
		H2016	6/15/2020	6/22/2020	9/11/2020	88	58
		H2016	6/15/2020	6/22/2020	9/11/2020	88	58
		H2016	6/15/2020	6/22/2020	9/11/2020	88	58
		H2016	6/15/2020	6/22/2020	9/11/2020	88	58
		H2016	6/15/2020	6/22/2020	9/11/2020	88	58
		H2016	6/15/2020	6/22/2020	9/11/2020	88	58
		H2016	6/15/2020	6/22/2020	9/11/2020	88	58
488	Denied Claims 1.1.20 to 7.31.20	H0015	6/16/2020	6/18/2020	12/08/2020	175	145
489	Denied Claims 1.1.20 to 7.31.20	H2016	6/17/2020	6/23/2020	10/28/2020	133	103
490	Denied Claims 1.1.20 to 7.31.20	99213	7/09/2020	7/23/2020	Pended until 12/21		
491	Denied Claims 1.1.20 to 7.31.20	99214	6/19/2020	6/20/2020	9/10/2020 9/22/2020	83 95	53 65
492	Denied Claims 1.1.20 to 7.31.20	G0482	6/26/2020	6/27/2020	Pended until 12/21		
493	Denied Claims 1.1.20 to 7.31.20	H2018	7/01/2020	7/13/2020	Pended Until 12/21		
494	Denied Claims 1.1.20 to 7.31.20	H0005	7/01/2020	7/11/2020	Pended Until 12/21		

MIA #	Claim Type	Claim Line	Received Date	Denied Date	Available PRA Date	Number of Days	Days Out of Compliance
495	Denied Claims 1.1.20 to 7.31.20	82075	7/02/2020	7/03/2020	Pended Until 12/21		
496	Denied Claims 1.1.20 to 7.31.20	H2016	7/02/2020	7/02/2020	10/28/2021		
497	Denied Claims 1.1.20 to 7.31.20	H018	7/03/2020	7/23/2020	**Pended until 12/21**		
498	Denied Claims 1.1.20 to 7.31.20	H0005	7/05/2020	7/05/2020	9/10/2020	67	37
499	Denied Claims 1.1.20 to 7.31.20	H0020	7/06/2020	7/18/2020	9/10/2020	66	36
500	Denied Claims 1.1.20 to 7.31.20	99212	7/08/2020	7/22/2020	**Pended Until 12/21**		
501	Denied Claims 1.1.20 to 7.31.20	0945	7/09/2020	7/11/2020	9/10/2020	63	33
502	Denied Claims 1.1.20 to 7.31.20	T2048	7/09/2020	7/10/2020	9/10/2020	63	33
503	Denied Claims 1.1.20 to 7.31.20	H2018	5/21/2020	5/27/2020	10/27/2020	159	129
504	Denied Claims 1.1.20 to 7.31.20	H0020	5/18/2020	5/19/2020	6/10/2021	388	358
505	Denied Claims 1.1.20 to 7.31.20	H0040	7/13/2020	7/15/2020	9/10/2020	59	29
506	Denied Claims 1.1.20 to 7.31.20	0510	7/14/2020	7/16/2020	9/10/2020	58	28
507	Denied Claims 1.1.20 to 7.31.20	99215	7/20/2020	7/21/2020	9/10/2020	52	22
508	Denied Claims 1.1.20 to 7.31.20	H0004	7/22/2020	7/23/2020	9/10/2020	50	20
509	Denied Claims 1.1.20 to 7.31.20	H0020	5/18/2020	6/08/2020	9/10/2020	115	85
510	Denied Claims 1.1.20 to 7.31.20	36415 80053	7/23/2020	7/24/2020	12/10/2020	140	110
512	Denied Claims 1.1.20 to 7.31.20	H2018	5/29/2020	6/02/2020	5/21/2021 9/08/2021	357 467	327 437
513	Denied Claims 1.1.20 to 7.31.20	W7375	5/19/2020	5/19/2020	9/10/2020	114	84
514	Denied Claims 1.1.20 to 7.31.20	W7310	7/23/2020	7/24/2020	9/10/2020	49	19
515	Denied Claims 1.1.20 to 7.31.20	90791 90834 90834	7/27/2020	7/28/2020	9/10/2020	45	15
516	Denied Claims 1.1.20 to 7.31.20	90834	7/09/2020	7/23/2020	9/10/2020	63	33

MIA #	Claim Type	Claim Line	Received Date	Denied Date	Available PRA Date	Number of Days	Days Out of Compliance
517	Denied Claims 1.1.20 to 7.31.20	RESERB	7/28/2020	7/28/2020	**Pended Until 12/21**		
518	Denied Claims 1.1.20 to 7.31.20	W7310	7/28/2020	7/29/2020	12/10/2020	135	105
519	Denied Claims 1.1.20 to 7.31.20	0780	7/03/2020	7/13/2020	**Pended Until 12/21**		
520	Denied Claims 1.1.20 to 7.31.20	99213	7/09/2020	7/23/2020	**Pended Until 12/21.**		
521	Denied Claims 1.1.20 to 7.31.20	W7530 RESRB	5/19/2020	5/19/2020	10/27/2020	161	131
		W7530 RESRB	5/19/2020	5/19/2020	10/27/2020	161	131
		W7530 RESRB	5/19/2020	5/19/2020	10/27/2020	161	131
		W7530 RESRB	5/19/2020	5/19/2020	10/27/2020	161	131
		W7530 RESRB	5/19/2020	5/19/2020	10/27/2020	161	131
		W7530 RESRB	5/19/2020	5/19/2020	10/27/2020	161	131
		W7530 RESRB	5/19/2020	5/19/2020	10/27/2020	161	131
		W7530 RESRB	5/19/2020	5/19/2020	10/27/2020	161	131
		W7530 RESRB	5/19/2020	5/19/2020	10/27/2020	161	131
		W7530 RESRB	5/19/2020	5/19/2020	10/27/2020	161	131
		W7530 RESRB	5/19/2020	5/19/2020	10/27/2020	161	131
		W7530 RESRB	5/19/2020	5/19/2020	10/27/2020	161	131
522	Denied Claims 1.1.20 to 7.31.20	90837	7/09/2020	7/23/2020	9/10/2020	63	33
523	Denied Claims 1.1.20 to 7.31.20	H2016	6/03/2020	6/04/2020	10/28/2020	147	117
		H2016	6/03/2020	6/04/2020	10/28/2020	147	117
524	Denied Claims 1.1.20 to 7.31.20	H2016	6/16/2020	8/17/2020	8/26/2021	436	406
525	Denied Claims 1.1.20 to 7.31.20	H0020	5/18/2020	5/19/2020	9/10/2020	115	85
Total 79							

EXHIBIT D
Prompt Pay Penalty for Denied Claims 8.1.2020 to 3.31.2021
Violations of § 15-1005(c)(2)

MIA #	Claim Type	Claim Line	Received Date	Denied Date	Available PRA Date	Number of Days	Days Out of Compliance
534	Denied Claims 8.1.20 to 3.31.21	85025 80053 80061 84436 84479 80178	2/05/2020	10/02/2020	10/08/2020	246	216
537	Denied Claims 8.1.20 to 3.31.21	H2016	8/03/2020	8/13/2020	**pended until 12/2021**		
540	Denied Claims 8.1.20 to 3.31.21	99213	8/05/2020	9/09/2020	4/21/2021	259	229
566	Denied Claims 8.1.20 to 3.31.21	90792	2/08/2020	10/15/2020	**pended until 12/202**1		
572	Denied Claims 8.1.20 to 3.31.21	H0020	11/23/2020	1/01/2021	1/07/2021	45	15
585	Denied Claims 8.1.20 to 3.31.21	H0020 H0020	11/30/2020 11/30/2020	12/03/2020 12/03/2020	1/07/2021 1/07/2021	38 38	8 8
586	Denied Claims 8.1.20 to 3.31.21	H2016	10/16/2020	10/17/2020	1/01/2021	77	47
600	Denied Claims 8.1.20 to 3.31.21	H0005	11/30/2020	12/02/2020	8/05/2021	248	218
611	Denied Claims 8.1.20 to 3.31.21	H2016	2/22/2021	2/23/2021	**pended until 12/2021**		
647	Denied Claims 8.1.20 to 3.31.21	H0020	2/21/2020	2/22/2021	**pended until 12/2021**		
Total: 10							

EXHIBIT E
Failure to Send Status of Claim that States Reason for Refusal Violations of § 15-1005(c)(2)(i)

MIA #	Claim Type	Comments
435	Denied Claims 1.1.20 to 7.31.20	Company failed to send a notice of receipt and status of the claim that states the reason for the refusal. Specifically, the Provider Remittance Advice did not include the reason for refusal.
Total: 1		
529	Denied Claims 8.1.20 to 3.31.21	Company failed to send a notice of receipt and status of the claim that states the reason for the refusal. Specifically, the Provider Remittance Advice did not include the reason for refusal.
530	Denied Claims 8.1.20 to 3.31.21	Company failed to send a notice of receipt and status of the claim that states the reason for the refusal. Specifically, the Provider Remittance Advice did not include the reason for refusal.
549	Denied Claims 8.1.20 to 3.31.21	Company failed to send a notice of receipt and status of the claim that states the reason for the refusal. Specifically, the Provider Remittance Advice did not include the reason for refusal.
580	Denied Claims 8.1.20 to 3.31.21	Company failed to send a notice of receipt and status of the claim that states the reason for the refusal. Specifically, the Provider Remittance Advice did not include the reason for refusal.
581	Denied Claims 8.1.20 to 3.31.21	Company failed to send a notice of receipt and status of the claim that states the reason for the refusal. Specifically, the Provider Remittance Advice did not include the reason for refusal.
Total: 5		

EXHIBIT F
Failure to Reimburse Clean Claims
COMAR 31.10.11.07

MIA #	Claim Type	Comments
223	Paid Claims 1.1.20 to 3.31.21	Company denied claim initially in error. The Company stated that claim was denied in error and was later reprocessed and paid.
Total: 1		
423	Denied Claims 1.1.20 to 7.31.20	Company denied claim initially in error. The Company stated that claim was denied in error and was later reprocessed and paid.
524	Denied Claims 1.1.20 to 7.31.20	Company denied claim initially in error. The Company stated that claim was denied in error and was later reprocessed and paid.
Total: 2		

MARYLAND INSURANCE ADMINISTRATION *
200 ST. PAUL PLACE, SUITE 2700
BALTIMORE, MARYLAND 21202 *

V. *

UNITED BEHAVIORAL HEALTH * CASE NO.: MIA-2022-06-010
(t/a "Optum Maryland")
2716 N. TENAYA WAY, NV017-S500
LAS VEGAS, NV 89128 *

EXAMINATION NO.: MCLH-2-2021-E

*

* * * * * * * * * * * * * *

CONSENT ORDER

This Consent Order is issued by the Maryland Insurance Administration ("Administration") against United Behavioral Health, t/a Optum Maryland ("Respondent"), with its consent, pursuant to Md. Code Ann., Ins. Art., §§ 2-204, 2-205 and 2-208 (2017 Repl. Vol. & Supp.) ("Insurance Article")[1].

Procedural History of Examination

1. At all times relevant to this Consent Order, Respondent has held, and currently holds, a certificate from the Administration to operate in the State as a private review agent.

2. Pursuant to §§ 2-205, 2-207, 2-208 and 2-209, in June 2021, the Administration called a targeted Market Conduct Examination ("Examination") of Respondent for the purpose of evaluating whether Respondent complied with the requirements of § 15-1005 when acting as an administrative services organization ("ASO") for specialty mental health services established under Md. Code Ann., Health-

[1] Unless otherwise indicated, all citations to statutes herein are to the Insurance Article.

Gen § 15-103(b)(21)(vi). The period covered by the Examination was January 1, 2020 through March 31, 2021 (the "Examination Period").

3. At the completion of the Examination, the Administration forwarded to Respondent a proposed examination report as required by § 2-209(c). The proposed examination report included the Administration's conclusion that Respondent had violated § 15-1005 in its administration of mental health benefit claims. Respondent filed a timely request for a hearing on the proposed examination report.

4. Respondent denies committing any violation of the Insurance Article. However, in order to avoid further litigation, and without admitting any violation of the Insurance Article, Respondent consents to the entry of this Consent Order. In addition, and without admitting the accuracy of any of the findings contained in the Final Examination Report, Respondent further withdraws its request for a hearing on the proposed examination report and consents to the issuance of the Final Examination Report (including Respondent's Response to the Proposed Examination Report (Exhibit G) which is being issued at the same time as this Consent Order.

Examination Findings

5. The Final Examination Report (No. MCLH-2-2021-E (the "Report") identifies violations of § 15-1005 by Respondent found by the Administration, including the following:

a. Respondent failed to pay claims or send notice or receipt and status of claims within 30 days of their receipt for reimbursement, in violation of § 15-1005(c) of the Insurance Article.

b. Respondent failed to send a notice of receipt and status of claim that stated the reason for refusal, in violation of § 15-1005(c)(2) of the Insurance Article.

c. Respondent failed to pay interest on the amount of the claim that remained unpaid 30 days after initial receipt of a clean claim for reimbursement, in violation of § 15-1005(g)(1) of the Insurance Article.

d. Respondent failed to fully reimburse claims that contained all of the required elements of a clean claim, in violation of COMAR 31.10.11.07.

6. Notwithstanding that it disputed the violations identified by the Administration in the Report, Respondent submitted and, with the agreement of the Administration, has begun to implement the following compliance plans to remediate the violations asserted by the Administration:

a. Respondent has developed and implemented a policy to ensure timely processing of claims and to ensure compliance with § 15-1005(c) of the Insurance Article.

b. Respondent is developing an automated process to identify clean claims that were not paid within 30 days and the calculation of the correct interest rates in compliance with § 15-1005(g) of the Insurance Article.

c. Respondent has developed a report to identify all clean claims that were processed and for which interest payment was due between August 4, 2020 to November 30, 2021. Beginning with claims paid in December 2021, Respondent is using the report to identify claims and to pay interest rates in compliance with § 15-1005(g) of the Insurance Article.

Respondent calculated the interest due to providers for the period August 4, 2020 to November 30, 2021 and has issued to checks to all such providers in the amounts calculated.

Conclusions of Law

7. The Report concluded that Respondent violated the following Maryland Laws and Regulations:

- Section 15-1005 (c) of the Insurance Article;
- Section 15-1005(g)(1) of the Insurance Article;
- Section 15-1005(c)(2) of the Insurance Article;
- Section 31.10.11.07 of the Code of Maryland Regulations.

8. The detailed legal and factual bases of these conclusions are set forth in the Report, which is incorporated by reference as if set forth in full herein.

9. Respondent and the Administration agree to the conditions of this Consent Order and the remedial measures set forth herein. Respondent executes this Consent Order knowingly and voluntarily. The parties acknowledge that this Consent Order is in the public interest and desire to resolve this matter without further proceedings.

Order

WHEREFORE, for the reasons set forth above, it is **ORDERED** by the Commissioner and consented to by Respondent, that:

A. Respondent shall accept the Report as final and waive any right to a hearing on the Report or for judicial review of the Report.

B. Respondent shall report to the Administration on its progress in the development and implementation of the automated process to identify clean claims that

were not paid within 30 days and the calculation of interest in compliance with § 15-1005(g) of the Insurance Article. The first report was submitted on March 31, 2022 and additional reports will be provided at the end of each quarter. If the automated process has not been implemented by December 31, 2022, Respondent shall report such progress at the end of each calendar month until the automated process is fully implemented.

C. Respondent has made the interest payments to the providers in the amounts calculated in the master claims report, with the exception of the interest payments due during the "Estimated Claim Payment Period" (January 23, 2020 through August 3, 2020). On March 31, 2022, a provider specific report with claim information was made available to each Provider via the Provider's folder within the Company's claims portal, which identifies each Provider, the date and amount of the original claim payments, and the amount of the interest payment.

D. On May 2, 2022, Respondent provided the Administration with an updated master claims report identifying all clean claims that were processed between August 4, 2020 and November 30, 2021, together with a summary confirming that all interest payments were made for all providers except for 26 providers. Respondent advised that a W-9 form was still awaiting for the 26 providers. The summary report identified each provider, the date and amount of the original claim payments, and the date and amount of the interest payment.

E. Respondent created a reporting tool to identify in real time (i) all claims initially received on or after December 1, 2021 that were not paid within the 30 days as mandated by § 15-1005(g) of the Insurance Article, (ii) the late-paid claim amount, (iii)

the payment date, and (iv) the date the interest was paid. The reporting tool was reviewed by a senior member of management by March 31, 2022, and will be reviewed on at least a quarterly basis to identify and direct the immediate payment of interest due. The quarterly report and proof that interest was paid will be submitted to the Administration each quarter until the automated process has been implemented.

F. Respondent has developed, and the Administration has agreed to, a fair and reasonable methodology to pay interest to providers for clean claims that were not timely paid during the Estimated Claim Payment Period (January 23, 2020 through August 3, 2020) and Respondent, as explained in the Report, shall pay interest to providers in accordance with that methodology by May 31, 2022, and Respondent, by June 15, 2022, shall provide a summary report to the Administration, consistent with the Report, confirming the payments were made. If any provider disputes the amount paid by Respondent, then Respondent will notify the Administration within thirty (30) days of receipt of a written or electronic notification from the provider.

Other Provisions

G. The executed Consent Order shall be sent to the attention of: Mary M. Kwei, Associate Commissioner, Market Regulation & Professional Licensing Unit, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202.

H. For the purposes of the Administration and for any subsequent administrative or civil proceedings concerning Respondent, whether related or unrelated to the foregoing paragraphs, and with regard to requests for information about Respondent made under the Maryland Public Information Act, or properly made by governmental agencies, this Consent Order will be kept and maintained in the regular

course of business by the Administration. For the purposes of the business of the Administration, the records and publications of the Administration will reflect this Consent Order.

I. The parties acknowledge that this Consent Order resolves all matters relating to the factual assertions and agreements contained herein and are to be used solely for the purposes of this proceeding brought by or on behalf of the Administration. Nothing herein shall be deemed a waiver of the Commissioner's right to proceed in an administrative action or civil action for violations not specifically identified in this Consent Order, including, but not limited to, specific consumer complaints received by the Administration, nor shall anything herein be deemed a waiver of the right of Respondent to contest other proceedings by the Administration. This Consent Order shall not be construed to resolve or preclude any potential or pending civil, administrative, or criminal action or prosecution by any other person, entity or governmental authority, including, but not limited to, the Insurance Fraud Division of the Administration, regarding any conduct by Respondent including the conduct that is the subject of this Consent Order.

J. Respondent has had the opportunity to have this Consent Order reviewed by legal counsel of its choosing, and is aware of the benefits gained and obligations incurred by the execution of the Consent Order. Respondent waives any and all rights to any hearing or judicial review of this Consent Order to which it would otherwise be entitled under the Insurance Article with respect to any of the determinations made or actions ordered by this Consent Order.

K. This Consent Order contains the entire agreement between the parties relating to the administrative actions addressed herein. This Consent Order supersedes any and all earlier agreements or negotiations, whether oral or written. All time frames set forth in this Consent Order may be amended or modified only by subsequent written agreement of the parties.

L. This Consent Order shall be effective upon signing by the Commissioner or her designee, and is a Final Order of the Commissioner under § 2-204 of the Insurance Article.

M. Failure to comply with the terms of this Consent Order may subject Respondent to further legal and/or administrative action.

KATHLEEN A. BIRRANE
Insurance Commissioner

By: _____
Mary M. Kwei
Associate Commissioner
Compliance & Enforcement

Date: June 7, 2022

RESPONDENT'S CONSENT

RESPONDENT hereby CONSENTS to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondent, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondent to the terms of this Consent Order resolving Report number MCLH-2-2021-E.

Name: Christopher Zaetta

Signature: Christopher Zaetta
Christopher Zaetta (Jun 6, 2022 12:21 EDT)

Title: Chief Legal Officer

Date: 06/06/2022

PPT-CBH-MIA-MDH Briefing 11-1-22_.pdf
Uploaded by: Heather Bagnall
Position: FAV

House Appropriations HHS & House HGO Committees

Community Behavioral Health Association of Maryland

November 1, 2022

Optum | Where We Are Now

- MIA placed Optum on a corrective action plan to pay interest penalties – and to do so automatically
  - Automated interest is not yet in place. Quarterly penalties, calculated manually, were received for first time in April 2022 and twice (July, October) since then.
- Payment delays and problems continue.
  - As of October, Optum is still putting fixes in place to ensure subsets of claims process and pay correctly.
  - Meanwhile, another subset of claims submitted in June and caught up in a HIPAA breach have no estimated payment date.
  - Manual processes to get claims paid continue to break down.
- Recoupment of estimated payments has begun, resulting in significant payback from providers to state.

Optum | Broken Then, Broken Now

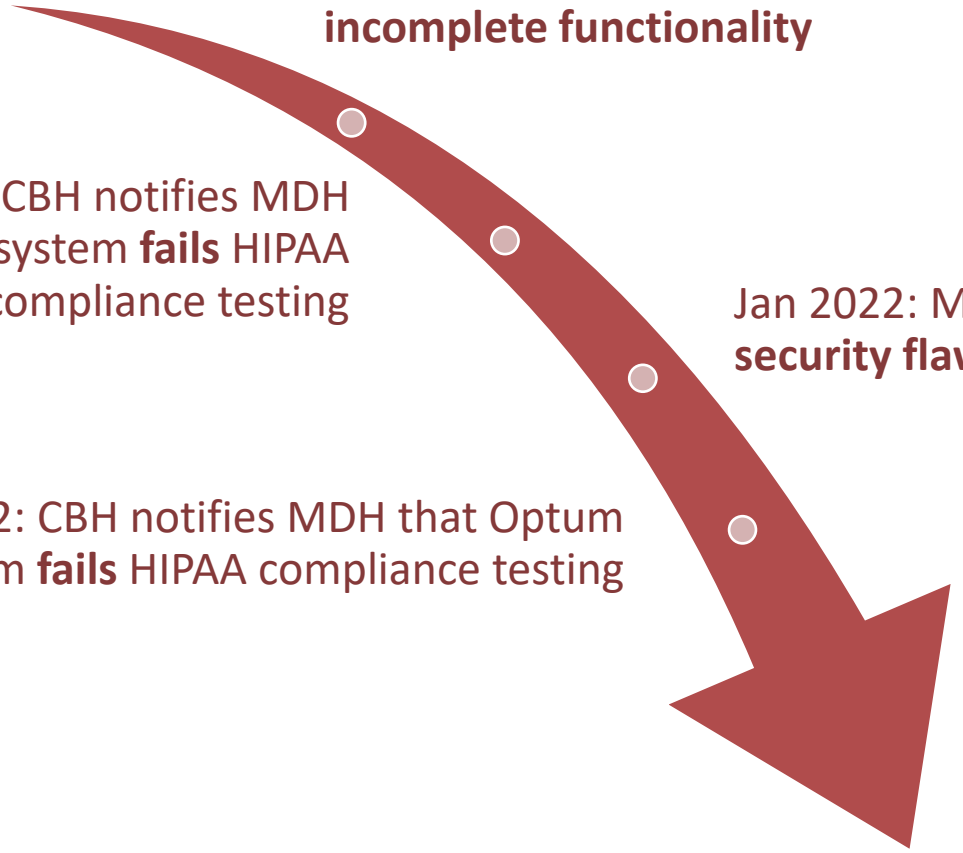
Jan 1, 2020: Optum launches – and **fails**

Aug 3, 2020: Optum relaunches with **incomplete functionality**

Apr 19, 2021: CBH notifies MDH that Optum system **fails** HIPAA compliance testing

Jan 2022: MDH identifies **security flaws** in Optum system

May 2, 2022: CBH notifies MDH that Optum system **fails** HIPAA compliance testing



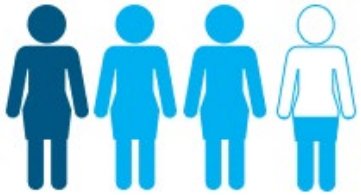
June 2022: **Optum experiences security breach**. For a subset of claims, records are deleted and pending claims must be resubmitted.

Optum | Eroding Maryland's Treatment Capacity

Pre-Optum

Post-Optum

Post-Optum
+ workforce crisis



3.5 fewer therapists...

=

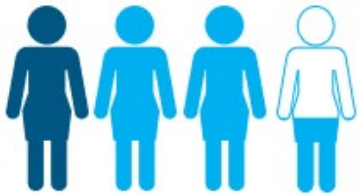
400 fewer Maryland residents in treatment annually

Optum | Triage for the Next Two Years

1. **Limit the Damage**. Legislators should support executive branch's timely and effective procurement process for new ASO vendor, so Optum's contract does not have to be extended.

2. **Staunch the Bleeding**. To minimize ongoing harms from two more years of Optum contract life, legislators should be prepared to support a new Administration's efforts to seek Optum's compliance with existing contract performance, even if litigation is required to do so.

3. **Heal the Wound**. Legislators can't step into MDH's shoes to enforce the contract, but you can mediate the harms through the funding measures in your control to **preserve treatment capacity** in the face of Maryland's mental health crisis and opioid epidemic.



3.5 fewer therapists...

=

400
fewer Maryland residents
able to receive needed
treatment annually

COMMUNITY BEHAVIORAL HEALTH
CBH
ASSOCIATION OF MARYLAND

Senate_HB1272_Bagnall_FAV.pdf
Uploaded by: Heather Bagnall
Position: FAV

HEATHER BAGNALL
Legislative District 33C
Anne Arundel County

Health and Government Operations Committee

Subcommittees

Health Occupations and Long-Term Care

Public Health and Minority Health Disparities

Annapolis Office
The Maryland House of Delegates
6 Bladen Street, Room 160
Annapolis, Maryland 21401
410-841-3406 · 301-858-3406
800-492-7122 *Ext.* 3406
Heather.Bagnall@house.state.md.us

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

March 23, 2023

HB1272 Maryland Insurance Commissioner Enforcement –
Specialty Mental Health Services and Payment of Claims - Sunset Extension

Madame Chair, Vice Chair, Members of the Senate Finance Committee,

In 2020 MDH started utilizing the services of Optum, an administrative service organization. The transition was tumultuous, resulting in delayed payments, wrongful claim denials, and multiple reconciliation issues. In 2021, an emergency bill was passed ensuring that the Maryland Insurance Commissioner will enforce a provision of code requiring administrative service organizations to pay claims on mental health services. This action was necessary after it was discovered that administrative service organizations were not paying out clean claims on mental health services, effectively preventing mental health organizations providing those services from operating. As this was a corrective measure, the 2021 bill was set to expire in two years. That bill expires this year; however, the situation concerning unpaid claims has not been resolved, and information presented at a recent briefing indicated that the need for corrective action remains. House Bill 1272 extends the sunset of the original act an extra two years, allowing the Maryland Insurance Commissioner to continue two years of work to ensure Maryland's mental health services are properly compensated for their work through the contract of the current administrative service organization.

The Maryland Department of Health and other agencies have reported concerns, which I have provided with my written testimony. Without this bill, mental health services are at risk of failing across the state as a result of unpaid claims. I respectfully ask for a favorable report on House Bill 1272.

HB 1272-CBH-FAV-Senate.pdf
Uploaded by: Lori Doyle
Position: FAV

Testimony on HB 1272
Maryland Insurance Commissioner Enforcement – Specialty Mental Health Services and Payment of Claims – Sunset Extension
Senate Finance Committee
March 23, 2023
POSITION: SUPPORT

The Community Behavioral Health Association of Maryland (CBH) is the leading voice for community-based providers serving the mental health and addiction needs of vulnerable Marylanders. Our 110 members serve the majority of those accessing care through the public behavioral health system. CBH members provide outpatient and residential treatment for mental health and addiction-related disorders, day programs, case management, Assertive Community Treatment (ACT), employment supports, and crisis intervention.

HB 1272 extends the sunset on the provision allowing the Maryland Insurance Administration (MIA) jurisdiction over enforcement of the prompt payment requirements for the public behavioral health system's administrative services organization (ASO). When the General Assembly passed HB 919 in the 2021 session, we had all hoped that Optum's dysfunctional system would undergo enough improvement that the MIA's oversight would no longer be necessary after two years from enactment of the legislation. Unfortunately, that improvement has not materialized. Providers continue to struggle with glitches in Optum's system that result in erroneous denials and late payment of claims.

Optum's contract does not expire until the end of CY 25. We don't know whether Optum's contract will be extended or if the new ASO will submit a lowball bid and subsequently be unable to perform the basic functions of authorizing services and paying claims. This bill would ensure that providers at least receive interest payments - as provided for in statute – for the next two years.

We urge a favorable report on HB 1272.

For more information contact Lori Doyle, Public Policy Director, at (410) 456-1127 or lori@mdcbh.org.