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

POSITION: FAVORABLE

I am Dr. Todd Christiansen, and I am the CEO/Medical Director at Families First Counseling and Psychiatry. We provide behavioral health services in Montgomery County, Prince George's County, Howard County, Baltimore City and Baltimore County. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 4,900 patients every year, and we employ 117 individuals. A majority of the patients we serve are publicly funded Medicaid patients.

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

We have been working under the current ASO vendor for over a year. Fixes have not been delivered in the timeframes promised, and critical functions remain absent. The system is not stable and not functioning at the level needed to. Optum's current dysfunction is reducing our revenue and increasing our costs. We have already been forced to redirect resources away from treatment because of Optum. ***Without immediate enforcement, our agency faces decisions as follows: lower or eliminate company contributions to offset medical/dental premium costs for staff, eliminate coverage of necessary continuing education training and other staff benefits, eliminate entire staff positions, cut patient services in accordance with the elimination of staff, and ultimately the inability to pay rent.***

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

- **Basic business revenue tools don't exist**: Optum's system is unable to provide basic business revenue tools. Our agency is unable to run necessary reports, research claims and reconcile payments which are all basic revenue cycle management functions. Billing operations which our agency was able to do electronically now require an enormous amount of work that must be done manually. Since Optum became the ASO, our agency has been forced to hire a full-time billing manager and several additional staff. These additional staff

were hired at a significant cost to our agency in order to attempt to obtain/reconcile/research the information necessary to keep our business running.

- **Erroneous claims denials:** The limitations and errors in Optum's system mean claims constantly deny in error. Optum's system cannot accurately process multiple insurances or changes in client eligibility, so claims deny erroneously when a client has dental insurance from another payer, for instance. Optum's manual claims processing is a "hit and miss" game. Optum will deny claims for a patient who they say did not have active coverage at the time of service, but will pay a claim the next day for the same patient within the same date range. Whether your claim gets paid seems to depend on who processes it, rather than an automated system that processes all clean claims. All of these erroneous denials are not singular, but have continued to occur regularly since Optum's system went live in August.

- **Customer Service**: Erroneous denials often do not have accurate or actionable denial reasons, requiring our staff to call to Optum customer service for an explanation. Optum staff are poorly trained and consistently remit incorrect information. The length of an average phone call to Optum lasts a minimum of 45-60 minutes and fixes only a handful of claims. We also often get different answers each time we call. For example, our billing manager called inquiring about the process for adding more units to an authorization, and received 3 different answers from 3 different representatives. In another instance, we had a customer service rep who didn't know how to look up a patient's eligibility history in their own system. We had to walk her through it via Webex. In a third instance, while working with a customer service rep who was trying to assist us in locating missing payments, we were sent HIPAA-protected information for a client in another practice.

- **Reprocessed claims:** The substantial volume of erroneous claims denials, as well as a steady stream of claims paid at the wrong rate, means that our agency has hundreds of thousands of claims reprocessed 1, 2, 3 and sometimes 10 times. When these claims are reprocessed, the remittance advice that we receive is inadequate, inaccurate and/or unclear. Retractions, denials and adjustments are similarly coded on the receipts so our electronic health record cannot read and post them, and we must process them manually.

- **Broken functions:** Optum's claims system is constantly malfunctioning. A few weeks ago, we lost the ability to download information on our service authorizations for 2 weeks. Our entire workflow stalled and backed up. Another example is the search function in Optum's system has been broken since early November, inhibiting our ability to access the entirety of client and claims information we need--causing duplicate records, which in turn, causes more claim denials. These are the latest of a consistent bevy of issues we have faced since Optum took over as ASO. Their system lacks basic functions such as the ability for providers to review eligibility and validate insurance coverage. We are unable to view detailed adjudication information in their system for claims processed numerous times, rendering us unable to reconcile our billing without substantial cross-referencing and manual intervention.
- **Reconciliation:** The absence of basic revenue cycle management tools as detailed above has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. Our staff are manually reconciling claims from reports remitted by Optum which do not match the receipts we have received which still yet display different information that their claims processing system.

Our agency bills an average of 7,500 claims each month. Over the 7 months of estimated payments, that is approximately 53,000 claims that need to be reconciled, for which we lack the automated tools and research functions to do so. Further, during an ASO transition like the one that occurred when Optum took over in January 2020, a process of transferring claims submitted to the prior ASO during the final few months of its tenure, occurs. When Optum took over, these claims were not transferred properly and remain unpaid to this day.

All of the above details how the ASO switch to Optum has impacted our Families First's overall financial stability and forced our agency to incur additional unbudgeted expenses in the form of additional employees as well as overtime pay for our current staff to get their regular work done. This situation is unsustainable, both financially and, for our overworked staff, mentally and emotionally.

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

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