MDDCSAM - SB 638 FAV - Claims Enforcement MIA.pdf
Uploaded by: Adams, MD, Joseph
Position: FAV

Maryland-DC Society of Addiction Medicine

A Chapter of American Society of Addiction Medicine

MDDCSAM is the Maryland state chapter of the American Society of Addiction Medicine whose members are physicians and other health providers who treat people with substance use disorders.

SB 638 - Maryland Insurance Commissioner - Specialty Mental Health Services and Payment of Claims – Enforcement

Senate Finance Committee

February 24, 2021

SUPPORT

In July 2019, Optum Maryland, as the lowest bidder, was awarded Maryland's Administrative Service Organization (ASO) contract for the state's public behavioral health system. The system failed immediately when operations commenced in January 2020. Fundamental systems problems continue to the present with no end in sight.

Behavioral health providers across Maryland have been put under tremendous strain, spending countless unreimbursed hours of staff time to reconcile old claims, review reams of data, attempt to communicate with the ASO, and suffer from cash flow crises. At this point there is no expectation that the problems will ever be resolved by pursuing the current path.

The prospect of actual enforcement is needed in order for the ASO needs to make the necessary investment in making providers whole.

Ultimately it is the citizens of Maryland with mental and substance use challenges who suffer the consequences of the failure to enforce the ASO contract.

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CC - SB 638 - MIA - FAV.pdf
Uploaded by: Becker, Scott
Position: FAV

CATHOLIC CHARITIES | CHERISHING THE DIVINE WITHIN ALL

Senate Bill 638
Maryland Insurance Commissioner –
Specialty Mental Health Services and Payment of Claims – Enforcement

Senate Finance Committee
February 24, 2021

Favorable

Catholic Charities of Baltimore strongly supports Senate Bill 638, which would grant the Maryland Insurance Administration clear statutory authority to oversee the payment process for specialty behavioral health services administered by the administrative services organization.

Inspired by the gospel mandates to love, serve and teach, Catholic Charities provides care and services to improve the lives of Marylanders in need. We offer 80 different programs at over 300 sites, with services focused on poverty alleviation, behavioral health, developmental disabilities, long term care of low income seniors, and housing. As one of the largest private providers of behavioral health care in the state, we serve children, youth and families in our six clinics, 120 public schools, a residential treatment center, and now via telehealth.

Catholic Charities is accustomed to complying with the regulations, policies, billing practices, and other intricacies of our numerous local, state and federal funders. We thought we had seen it all, but never in the almost 100-year history of our organization have we experienced a complete failure of operations comparable to the Optum launch, which occurred on January 1, 2020.

All of our behavioral health encounters are billed through Optum. During the first seven months of operations, Optum was not able to properly process any claims -for us or for any other provider. Providers instead received estimated payments arbitrarily based on the prior year's volume. This is despite the fact that the pandemic forced us into a completely different model of service delivery. Payments we have received from Optum for claims billed since the late summer of 2020 are equally unidentifiable and unmatchable to the claims we have billed. At 11,000 claims per month, we are now approaching 150,000 total claims over more than 13 months equaling approximately $15 million in unmatched claims. We have no confidence in the work of the ASO that this will be resolved.

Optum has not been able to give providers the tools necessary to identify claims that have been paid or not paid, claims that were denied for legitimate reasons that need to be reprocessed, how much money we might owe the state, or how much the state may owe us. These are basic functions of any billing system, and functions past ASO's were able to deliver. Unfortunately, the failure of Optum has resulted in a 13-months long diversion of significant Catholic Charities' resources and created a significant lack of clarity in our financial records, the latter causing difficulties completing our annual external audit last year and now again for the current fiscal year. Furthermore, the magnitude of this situation has now become part of the regular conversation with our Board of Trustees, and our leadership is greatly concerned. Routine accounting processes should never have to rise to such a level of oversight within any organization.

It has been over a year since Optum took over as the ASO. Their systems are still not working and there is no resolution in sight. It is long past time for Optum to be held accountable. SB 638 would provide the Maryland Insurance Administration with the clear statutory authority to do so. **Catholic Charities of Baltimore appreciates your consideration, and urges the committee to issue a favorable report for Senate Bill 638.**

Submitted By: Scott Becker, Chief Financial Officer

SB 638 Maryland Insurance Commissioner Specialty
Uploaded by: Breidenstine, Adrienne
Position: FAV

Behavioral Health System Baltimore

February 24, 2021

Senate Finance Committee
TESTIMONY IN SUPPORT
SB 638 Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement

Behavioral Health System Baltimore (BHSB) is a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City. BHSB works to increase access to a full range of quality behavioral health (mental health and substance use) services and advocates for innovative approaches to prevention, early intervention, treatment and recovery for individuals, families, and communities. **Baltimore City represents nearly 35 percent of the public behavioral health system in Maryland, serving over 77,000 people with mental illness and substance use disorders (collectively referred to as "behavioral health") annually.**

Behavioral Health System Baltimore is pleased to support SB 638 Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement. This bill requires the Maryland Insurance Commissioner to enforce existing law of § 15-1005 of the Insurance Article (payment of "clean claims") to the Administrative Services Organization (ASO) of the Public Behavioral Health System (PBHS).

Maryland's fee-for-service PBHS is managed by an ASO through a statewide contract with the Maryland Department of Health (MDH). In 2020, the ASO transitioned from Beacon Health to Optum Maryland. Since this transition occurred, Optum Maryland has not met provisions and performance metrics within its contract with the Maryland Department of Health. This has resulted in an array of challenges for behavioral health providers in the PBHS, including but not limited to a largely inoperable provider portal for entering and managing provider claims, denied authorizations, incorrect claims payments to providers, inaccurate information for reconciliation of claims. Although Optum Maryland has made efforts to correct the many system failures, the challenges still exist today and Optum has not demonstrated a plan to resolve them.

Existing statute requires the ASO to comply with existing Insurance Articles enforced by the Maryland Insurance Commission. Current law requires Optum Maryland to do at least one of the following within 30 days:

1. Claims payment;
2. Notification of a dispute regarding reimbursement amount;
3. Notification that the claim is not "clean" and what action would need to be taken by the provider to fix it.

If none of those happen within 30 days, then interest penalties are applied. SB 638 would provide Maryland Insurance Commissioner the statutory authority to enforce Optum Maryland's compliance with these requirements. **As such, BHSB urges the Senate Finance Committee to pass SB 638.**

2021 SB 638 NAMI-FAV.pdf
Uploaded by: Cyphers, Moira
Position: FAV

February 24, 2021

Senate Bill 638 – Specialty Mental Health Services and Payment of Claims – Enforcement - SUPPORT

Chair Kelley, Vice Chair Feldman, and members of the Senate Finance Committee,

The National Alliance on Mental Illness, Maryland and our 11 local affiliates across the state represent a statewide network of more than 45,000 families, individuals, community-based organizations and service providers. NAMI Maryland is dedicated to providing education, support and advocacy for persons with mental illnesses, their families and the wider community.

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.

Optum runs the state's behavioral health ASO, which typically manages more than $1 billion in payments a year for more than 200,000 Marylanders with behavioral health issues. The extreme billing issues and service denials are putting access to services at risk – extraordinarily concerning in a year when more Marylanders are relying on Medicaid and our current pandemic is taking an incredible toll on the mental health of everyone.

We know you don't control the contract, but without immediate action, our public behavioral health system will start to crumble. Please pass this legislation accountable. This debacle couldn't have occurred during a worse year and it's been months and the issue is still not resolved. We cannot risk providers turning us and our loved ones away because the state won't pay.

For these reasons, NAMI Maryland asks for a favorable report on **SB 638.**

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Moira Cyphers
Compass Government Relations
MCyphers@compassadvocacy.com

MIA Letter 1.13.21.pdf
Uploaded by: Doyle, Lori
Position: FAV

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

KATHLEEN A. BIRRANE
Commissioner

JAY COON
Deputy Commissioner

DAVID COONEY
Associate Commissioner
Life and Health

Maryland
INSURANCE ADMINISTRATION
200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Phone: 410-468-2277 FAX: 410-468-2270
1-800-492-6116 TTY: 1-800-735-2258
www.insurance.maryland.gov

January 13, 2021

Ms. Shannon Hall
Executive Director
Community Behavioral Health Association of Maryland

RE: MIA File Number: MIA-2020-12-23-00123898
Company: United Behavioral Health (UBH)

Dear Ms. Hall:

I am writing in response to the complaint you submitted to the Maryland Insurance Administration (MIA) concerning the actions of Optum in its role as the administrative services organization for behavioral health claims under the Maryland Medical Assistance (Medicaid) program. For the reasons discussed below, the MIA has concluded, in consultation with the Office of the Attorney General, that the MIA does not have jurisdiction over the issues raised in your complaint. The MIA will forward your complaint to the Maryland Department of Health (MDH).

The role of the MIA is to enforce the provisions of the Insurance Article, Title 19, Subtitle 7 of the Health-General Article, and their associated regulations.

Optum is the trade name of United Behavioral Health. Optum is certified by the MIA to act as a private review agent, and is subject to enforcement action by the MIA when it is performing services under the jurisdiction of the MIA. However, Optum may act in other capacities that are not regulated by or subject to the jurisdiction of the MIA. That includes circumstances where, as here, Optimum is acting in an administrative role for a government program.

The Medicaid program is a separate State/federal program operated MDH. The statute that establishes the program is § 15-103 of the Health-General Article. For medical/surgical services, Medicaid has contracts with managed care organizations (MCOs). The MIA has limited jurisdiction over these entities, and the existence and extent of that jurisdiction is clearly and expressly specified in statute.

Section 15-103(b)(21) of the Health-General Article lays out the requirements for MDH to provide coverage of behavioral health services under Medicaid. Specialty behavioral health services are covered by Medicaid, through the Behavioral Health Administration within MDH, and are not provided by the MCOs. Section 15-103(b)(21)(vi) of the Health-General Article

states that the provisions of § 15-1005 of the Insurance Article apply to the delivery system for specialty mental health services administered by an administrative services organization. However, the law does not vest the MIA with enforcement authority with respect to compliance with those provisions by Optum when it is acting as the administrative services organization for MDH's system for delivering behavioral care services.

We will forward your complaint to the appropriate person at MDH. Please let me know if you have any questions.

Sincerely,

Paul R. Meyer, FLMI
Special Projects Analyst
Life and Health Unit
(410) 468-2241
paulr.meyer@maryland.gov

CC:
Leah Spence
Manager
Regulatory Affairs
UnitedHealthcare Insurance Company

SB 638 MIA AL FAV.pdf
Uploaded by: Doyle, Lori
Position: FAV

ARUNDEL LODGE behavioral health
hope re-imagined

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

POSITION: FAVORABLE

I am Michael Drummond, and I am Executive Director at Arundel Lodge. We provide behavioral health services in Anne Arundel County. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 2500 every year, and we employ 160 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 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 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.

Here are some examples:

1. A few weeks ago, we lost the ability to download information on our service authorizations for 2 weeks.
2. On the 12/31/20 check processing, "New Date Claims" were processed and were offset against our estimated payments for the period between January 2020 through July 2020. The following week, on the 1/7 check processing, Optum repaid these claims correctly but did not provide providers with electronic provider reports retracting the incorrect payment on 12/31. They have informed providers that Optum "voided" the incorrect payments in their system but providers will need to manually retract the incorrect payments in their EHR's. This is a very time consuming process and puts unnecessary additional work on providers without electronic payment files..

2600 Solomons Island Rd • Edgewater, MD 21037
main 443.433.5900 • fax 410.841.6045 • video ph 443.569.7132
www.ArundelLodge.org

3. Our Substance Use Disorder and Supported Employment Programs there is an issue of not receiving provider reports on our denied or pended claims. We are manually having to research these claims on Optum's system.

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.

Sincerely,

Michael J Drummond
Executive Director
Arundel Lodge
2600 Solomons Island Road
Edgewater, MD 21037

SB 638 MIA CBH FAV.pdf
Uploaded by: Doyle, Lori
Position: FAV

SB 638
Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement
Senate Finance Committee
February 24, 2021
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 95 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.

$60,590,238
TOTAL DOLLAR VALUE OF CLAIMS WAITING OVER 30 DAYS FOR OPTUM PAYMENT.

Optum took over as the administrative services organization (ASO) on Jan. 1, 2020. The main function of the ASO is to authorize services and pay claims. It became quickly evident that Optum's system was not functional in these two critical areas – to the point that the Maryland Department of Health (MDH) had to authorize advances, or estimated payments, to providers.

Almost eight months later – in August 2020 – the estimated payments ended and Optum's system once again began to pay claims. Unfortunately, many bugs that plagued Optum's system earlier continued after the go-live period. These issues were presented to the Finance Committee in a briefing in November last year.

These glitches in Optum's system have resulted in late payments and growing accounts receivable over 30 days, a violation of existing statute. This is true of large community providers and hospital systems as well as smaller niche providers. Our members report an average value of $1,836,068 in claims submitted more than 30 days ago that have no payer response. With 44 reporting providers, over $60 million is owed in total.

$1,836,068
AVERAGE DOLLAR VALUE PER PROVIDER OF CLAIMS SUBMITTED MORE THAN 30 DAYS AGO WITH NO PAYER RESPONSE

In addition, despite Optum's many promises, providers are still not receiving reports within 30 days that let them know if claims submitted have been accepted or rejected – and if rejected, why.

This lack of reporting hampers providers' ability to perform revenue cycle management, and it is also a violation of current statute. Receipts and reports are a critical payer function needed for providers to manage their claims. "Every tool we have to manage the business is gone," says one of our members' CFOs. "We can't forecast cash or run pivot tables on our claims because the data is so poor. Optum's processes are unreliable."

Health-General § 15-103 (b)(21)(vi) states that § 15-1005 of the Insurance Article applies to the delivery system for specialty mental health services administered by an administrative services organization (ASO). Section 15-1005 of the Insurance article states that entities subject to this subsection must do one of three things within 30 days:

1. Mail or otherwise transmit payment for the claim;

2. Send a notice of receipt and status of the claim specifying that the ASO refuses to reimburse all or part of the claim, the reason for the refusal, and what additional information is necessary to determine if all or part of the claim will be reimbursed; or
3. State that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.

The subsection includes the provision of interest penalties if the ASO violates these requirements and establishes fines and penalties for arbitrary and capricious violations as well as penalties for frequent violation.

According to a letter from the Maryland Insurance Administration (MIA), the MIA does not have statutory authority to enforce compliance by the ASO with these prompt-pay provisions; that authority currently abides with MDH. Unfortunately, despite many months of provider complaints regarding Optum's failure to comply with statute, no interest penalties have been imposed, and fines have been minimal, at best. In fact, there has been no communication from MDH as to how providers can make a complaint under § 15-1005. SB 638 gives the MIA clear statutory authority to oversee Optum's compliance with § 15-1005. We believe the MIA is best positioned to perform this oversight function since they have years of experience enforcing the law with other payers.

The providers impacted by Optum's system failures are safety net providers in our communities. They continue to serve those in need in good faith and have also worked with Optum to try to fix the system's shortcomings. Many are historic providers who have operated under three prior ASOs – and have experienced nothing to this magnitude. In fact, this issue of prompt payment and adequate claims reports has never before been raised in the almost 25-year history of ASOs because prior ASOs tended to pay within 14 days of claims submission and routinely provided quick feedback on the acceptance or rejection of claims.

Optum states that they have been paying claims in a timely fashion and providing the necessary reports. If this is the case, then Optum has nothing to worry about with passage of SB 638.

Our safety net providers simply cannot continue to be underpaid and to divert scarce human resources to cleaning up behind Optum.

Passage of SB 638 is an action this committee and the General Assembly can take to hold Optum accountable to our providers and the individuals they serve.

I urge a favorable report on SB 638.

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

SB638 MIA Thrive FAV.pdf
Uploaded by: Doyle, Lori
Position: FAV

THRIVE BEHAVIORAL HEALTH
MEETING PEOPLE WHERE THEY ARE

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

POSITION: FAVORABLE

I am Elizabeth T. Hymel, CPA and I am the Chief Executive Officer at Thrive Behavioral Health, LLC. We provide outpatient behavioral health clinic services in Anne Arundel, Montgomery, Prince Georges, Cecil, Frederick, Harford, Howard, Baltimore City, Baltimore County Calvert County and Carroll counties. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization provided services to approximately 18,000 clients in 2020 with services in excess of 300,000 billable and nonbillable services. We employ 245 individuals. 99% of the patients we serve are publicly funded Medicaid patients.

Subsection 15-1005 of the Insurance Article requires the ASO to do one of the following within 30 days of a claim's submission:

1. Pay the claim
2. Provide notice that the amount of the claim is in dispute, or
3. Deny the claim as not being clean and tell the provider what must be done to make it clean.

Optum has failed to meet these provisions since it took over as the ASO on Jan. 1, 2020. It is costing Providers and the state so much time and money, I don't even know how to express the frustration.

I am a provider with more than 20 years' experience in the public mental health system and have been through at least 4 ASO transitions. I have never seen a change be handled so poorly in the past. It has been 14 months and things are still not running correctly. Never, under any other ASO tenure, have I had to deal with so many systemic errors, erroneously denied claims, and bungled solutions. It just seems unconscionable to let this continue to wreak havoc on community providers in the midst of an already challenging time that is driving high demand for our services. Our attention should be focused on getting and keeping people well, and instead we have had to re-direct staff resources to administrative functions in order to keep our business running.

I really do not want to burden the committee with tons of examples of how, as a mental health provider, we have suffered, so I will only highlight a couple of key examples.

1. Client care is suffering as a result of all the ongoing issues with Optum. Probably the most egregious example I can give is lack of response on some very serious requests. We recently were unable to get approval to provide care to a child for many months because the Optum system had incorrect insurance information—a widespread and still unresolved issue. We forwent payment and our clinical staff continued to provide the care regardless of this issue. Thank goodness they did because the child became suicidal and had we not been providing this care, who knows if a child would have taken their own life. We provide greater than 80% of our services to the black and brown communities and more than 60% of the population we serve are under the age of 18 in over 200 schools. This is not the time for any agency to have to worry that we cannot provide much needed services.

2. The reports remitted by Optum, if any are received at all, are almost always incorrect. This causes providers to have to resubmit information many times. In fact, 18% of our clean claims have been processed 2 or more times—one as many as 23 times. This alone has caused endless work for our staff, posting and reposting items, often manually because Optum's system does not enable you to export, research or run reports of claims. Can you imagine if you received an invoice for a bill and it always added up incorrectly? This is the level of errors we see daily.

    a. Most providers are not data analysts- Our reimbursement rates do not allow for profit margins to support the additional staff hours and FTEs required to manage Optum's chaotic billing system.

    b. We rely on our ASO to understand and implement the rules as set forth by BHA. However, every week there is an issue regarding the ASO not understanding how the Maryland public behavioral health system operates. Our staff have spent hours on the phone educating Optum's customer service on Maryland regulations and billing structures.

    c. Optum relies heavily on manual processes in the year 2021 - This is a huge issue for providers as the volume of processor errors at Optum is significant—many caused by Optum staff who operate outside the state Maryland and are unfamiliar with the complex rules of Maryland's system.

    d. Providers are unable to get the simplest reporting out of Optum. Providers generally would receive a report (277CA) when submitting an electronic batch daily. This is medical industry standard report and Optum cannot produce this report after 14 months. It remains "in testing."

    e. Often times, Optum staff are not aware of the errors in their own system- Providers are continually meeting with Optum in order to educate them on their own system issues within the Incedo Platform.

    f. Providers are told to call Customer service to report problems. Our agency submits greater than 1,000 claims a day. There is no way we can continually call Customer service for systemic issues.

Thrive billed approximately $18 million in 2019 via Beacon the prior ASO and were unable to collect $50,000 generally because of insurance changes that we were uninformed of by the client. During 2020, were it not for spending endless hours in Optum's system, resubmitting and reworking erroneously denied claims, our uncollectible claims would have been greater than $3,000,000. Currently that number it is approximately $150,000. This is still unacceptable, and the manhours required to get there is unsustainable.

An OMHC is the easiest type of Provider to bill an ASO. Our issues pale in comparison to other provider types, like Psychiatric Day Rehab, Psychiatric Residential, Supported Employment, Respite, Intensive Outpatient and Crisis care organizations--many of whom are still not getting paid for certain service lines at all. Even after 14 months.

I am asking for your support of SB 638 so we can move forward and hold the ASO accountable for providing a reliable claims payment system to Maryland's Behavioral health providers. If you have questions or need clarification on any points please contact me. I would be happy to have a virtual meeting if you would like.

Thank you,

Elizabeth T. Hymel, CPA
Chief Executive Officer
Bhymel@Thrivebh.com

SB638 MIA UBCSS FAV.pdf
Uploaded by: Doyle, Lori
Position: FAV

Upper Bay Counseling
& Support Services, Inc.

Suanne Blumberg, LCPC
Chief Executive Officer

Upper Bay Counseling & Support Services

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

POSITION: FAVORABLE

I am Suanne Blumberg, and I am the Chief Executive Officer at Upper Bay Counseling & support Services. We provide mental health and substance use services in both Cecil and Harford Counties. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 4700 clients every year, and we employ 180 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 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 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 will lose financial stability needed to continue provide the array of services to the clients we serve, and ensure access to those who will need our support in the future.

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments—all basic revenue cycle management functions-- are not available in Optum's system. Billing operations which used to be done electronically now require an enormous manual lift for our agency. We've been forced to hire additional billing staff to keep up. We are also at risk of losing our billing manager who has worked for UBCSS for 28 years due to burnout from the substantial workload required to manage Optum's system.

- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. 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 than their claims processing system. Just last week, our billing manager had to manually review and match 100 pages of claims to our submitted billing because of a coding error in Optum's file receipts. That was not the first time she had to do this for UBCSS to be able to balance our books, and it is unlikely to be the last.

  The financial impact on our organization has been astronomical. As of 1/31/21 we have **$911,411 AR over 30 days.** As of 1/31/21 our **AR at 121+ days was $796,512** or 53.9% of Medicaid receivables. For comparison, under the previous ASO, that number was 3-5%, and the issue causing that small percentage of unpaid claims was both easily identifiable and easily remedied. The performance of Optum is unacceptable and will kill our organization financially. It has already taken a brutal toll on our staff morale, as the workload is simply unsustainable. I live in fear of having to replace my billing manager and train a new person (likely several new people) to manage the constant stream of erroneously denied claims, unannounced process and policy changes, and wide-ranging errors caused by this ASO that have now become a part of the job description.

As the leader of an agency organized to support those who are most vulnerable in our community, we cannot afford to be so deeply vulnerable ourselves. We will remain so, however, unless Optum is held accountable for operating a working system. I am asking for your help to provide the oversight needed to help us regain a working billing system so we can keep our doors open and return to the business and getting and keeping people well. I urge you to act now to preserve Maryland's treatment capacity and vote a favorable report on SB 638.

SB638 MIA UMMC FAV.pdf
Uploaded by: Doyle, Lori
Position: FAV

University of Maryland Medical Center
Division of Community Psychiatry

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

POSITION: FAVORABLE

I am Maxine Klane, and I am the Division Administrator for the Community Psychiatry Division at the University of Maryland Medical Center (UMMC). We provide behavioral health services in Baltimore City, primarily on the West Side. I am submitting this written testimony on SB 638 to urge your support for this bill. The UMMC Community Psychiatry Division serves approximately 2,600 clients every year, and we employ 170 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 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 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 the ongoing squandering of staff resources, payment delays, and the potential loss of significant revenue for FY20 and FY21 if reconciliation is not resolved fairly and accurately.

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments—all basic revenue cycle management functions-- are not available in Optum's system. The Incedo system is set up to pay claims based on Tax ID numbers and lumps all programs together related to that Tax ID number. Since the Community Psychiatry Division is part of the larger University of Maryland Medical Center, this practice of paying claims to the Tax ID number has resulted in:

    - Community Psychiatry did not routinely receive estimated payments during the January through July 2020 time period as payments were sent to various lockboxes across the campus with no identifying information. This was especially detrimental financially to our rate-regulated clinic programs. Early in 2020, we requested that Optum provide an individual set-up for each clinic, so they are distinct from the rest of the UMMC programs. That has never happened.

- **Erroneous claims denials:** The limitations and errors in Optum's system mean claims are denied in error constantly. For instance:

    - Optum denies clinic services for using the NCCI (National Correct Coding Initiative) modifiers established by Medicare. Optum won't accept the modifiers, despite their industry standard nature, and UMMC Revenue and Integrity Department requires them. We requested coding from Optum to provide to the Revenue and Integrity Department to alter the modifiers directly in the UMMC system, but this was never received. Instead, we have had to re-bill them and then edit them in the Optum system which is triple work for our billing staff and totally unnecessary.

    - Optum continues to deny secondary treatment plans without a Medicare EOB. After contacting Optum many times, we were told that Optum processors would be educated appropriately so those denials would stop. The denials did not stop, and we now know that they are caused by a systemic issue with insurance indexing in their system.

    - Optum denies claims as duplicates when we re-bill claims that were Optum mistakes in the first place. Optum routinely requests providers to send them spreadsheet of erroneously denied claims for them to review and reprocess, but does not fix the root cause of the denials, so they occur again. *Optum needs to correct their own mistakes without our involvement.*

- **Customer Service**: Erroneous denials often do not have accurate or actionable denial reasons, requiring our staff to call to Optum customer service for each of these. Optum staff are poorly trained and consistently remit incorrect information, so each phone call lasts about 45-60 minutes and fixes only a handful of claims, if at all.

    - There have been numerous times when staff have had to explain rules, COMAR regulations, basic insurance information, or practices related to billing and/or authorizations to Optum staff. *Providers' billing staff should not have to educate Optum staff on how to process claims correctly*.

- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. 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.

    - The reports designed by Optum to "assist" providers with reconciling estimated payment amounts contain claims information for many areas of the University of Maryland Medical Center including psychiatric programs that are not part of Community Psychiatry, as well as clinical areas entirely outside of psychiatry. Our program now has the daunting and tedious task of weeding out our claims from this huge report. Reviewing this report manually line by line is the only way to accomplish this as *Optum says they are unable to remit a report that reflects claims for our program only. Needless to say, these reports also contain HIPAA protected information for patients that are not seen at UMMC Community Psychiatry programs.*

- We are very concerned about timely filing deadlines for claims that never seemed to make it into Optum's system despite successful submission. We should not be penalized for Optum's faulty system that continues to have problems after 14 months.

- The unresolved claims on our books from 2020 has impacted our recent financial audits and leaves us with incomplete financial information. It affects our ability to manage and plan for our programs during an already challenging time, the Covid-19 pandemic. Too much time has been wasted on Optum-related issues instead of focusing entirely on making sure our clients are safe, have access to PPE, food and medications. The flow of billing claims and receiving payments has never been this complicated and time consuming.

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.

SB638 MIA WIN FAV.pdf
Uploaded by: Doyle, Lori
Position: FAV

WIN Team LLC

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

POSITION: FAVORABLE

I am Alford Laws Jr and I am Chief Executive Officer and owner of WIN Team, LLC. We provide behavioral health services in Baltimore City, Baltimore, Cecil, Harford and Prince Georges Counties. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 900 youth and adults every year, and we employ 60 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 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 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. 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 certain financial catastrophe—we are owed more than a million dollars!***

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments—all basic revenue cycle management functions-- are not available in Optum's system. Billing operations which used to be done electronically now require an enormous manual lift for our agency. We've been forced to hire additional billing staff to keep up.
- **Erroneous claims denials:** The limitations and errors in Optum's system mean claims are denied in error constantly. For instance, Optum's system cannot accurately process multiple insurances or changes in client eligibility. All of these claims have denied since August.

- **Customer Service**: Erroneous denials often do not have accurate or actionable denial reasons, requiring our staff to call to Optum customer service for each of these. Optum staff are poorly trained and consistently remit incorrect information, so each phone call lasts about 45-60 minutes and fixes only a handful of claims, if at all. Optum's phone lines are also notorious for disconnecting calls, and not reliably giving issue #s to complaints so they can be tracked or escalated.
- **Reprocessed claims:** The substantial volume of erroneous claims denials, as well as a steady stream of claims paid at the wrong rate, mean that our agency has hundreds of thousands of claims reprocessed 1, 2. 3 and sometimes 10 times. What this means is that instead of managing the billing for an agency that submits 10,000 services in a month, our billing staff are managing a revenue cycle equivalent to an agency 5 times our size.
- **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 claims denials.
- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. 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. It is these gross errors in the estimated payment reconciliation that has Optum still owing WIN Team a million dollars.

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.

2021 MCHS SB 638 Senate Side.pdf
Uploaded by: Elliott, Robyn
Position: FAV

Maryland Community Health System

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 638 – Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims - Enforcement**

Hearing Date: **February 24, 2021**

Position: **Support**

Maryland Community Health System (MCHS) supports *Senate Bill 638 – Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement*. The bill would provide for the Maryland Insurance Commissioner to enforce Insurance Article § 15-1005 in the review of any complaints related to administrative service organizations (ASOs) that administer mental health benefits.

MCHS is a network of federally qualified health centers, and we have been supporting our health centers in navigating the Department of Health's recent transition to a new ASO to provide coverage of mental health services. The transition has been enormously challenging, as the ASO is not paying providers in a timely manner, putting some providers at great financial risk. These payment problems have occurred when providers are already stretched to the limit by the COVID-19 pandemic.

We believe that the Maryland Insurance Commissioner could take steps to address problem of timely claims payments under existing law; and this legislation would ensure that such enforcement actions are a priority. If we can provide any additional information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

5850 Waterloo Road, Suite 140, Columbia, Maryland 21045
410-761-8100

2021 LCPCM SB 638 Senate Side.pdf
Uploaded by: Faulkner, Rachael
Position: FAV

LICENSED CLINICAL PROFESSIONAL COUNSELORS OF MARYLAND

Committee: **Senate Finance Committee**
Bill Number: **Senate Bill 638**
Title: **Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement**
Hearing Date: **February 24, 2021**
Position: **Support**

The Licensed Clinical Professional Counselors of Maryland (LCPCM) supports *Senate Bill 638 – Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement.* This bill would require the Maryland Insurance Commissioner to enforce compliance with reimbursement provisions under Maryland's Administrative Service Organization (ASO) for behavioral health services.

Since the transfer of Maryland's ASO from Beacon Health Options to Optum Maryland in early 2020, behavioral health providers, including licensed clinical professional counselors, have consistently experienced problems with Optum's claims system. We regularly hear from our members of the difficulties in managing claims and revenue.

While we are very concerned by the difficulties facing clinical professional counselors in managing the new ASO system, we are equally concerned that unless these issues are addressed, fewer behavioral health providers will choose to accept Medicaid payment. We already know anecdotally, that many providers choose not to accept Medicaid reimbursement in lieu of private insurance and self-pay. If we lose Medicaid providers, wait times for individuals who cannot self-pay when seeking behavioral health services will worsen. We are at a point in time, in part due to the current COVID crisis, where demand is increasing for behavioral health services. Providers need the help of the Maryland General Assembly to find solutions so that providers can serve Marylanders seeking care.

Thank you for your consideration of our testimony, and we urge a favorable vote. If we can provide any further information, please contact Rachael faulkner at rfaulkner@policypartners.net or 410-693-4000.

MCF_Fav_SB 638.pdf
Uploaded by: Geddes, Ann
Position: FAV

Senate Bill 638
Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims - Enforcement

Senate Finance Committee
February 24, 2021

POSITION: FAVORABLE

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for someone with behavioral health needs. Using personal experience as parents, caregivers and other loved ones, our staff provide one-to-one peer support and navigation services to parents and caregivers of young people with mental health issues and to any loved one who cares for someone with a substance use or gambling issue.

MCF strongly supports SB 638.

You are receiving testimony from a great number of behavioral health providers detailing all of the problems with Optum's performance since it became Maryland's Administrative Service Organization (ASO) in January 2020. I will not repeat all of this in my testimony. The debilitating problems with Optum's administration are obvious, the absence of any significant course correction is abundantly evident, and the negative impact on providers is overwhelming.

I want to talk about the impact Optum's failure has had on consumers of behavioral health services.

We know of two certified recovery residences for individuals with substance use disorders that were forced to shut down owing to prolonged delayed payment of claims. Certified recovery residences are already in short supply, and losing two has a profound negative impact. For the young men in these facilities, having to scramble to try to find a new living arrangement was a significant challenge. They were forced to move at some distance outside of their communities, and one young man therefore had to resign from his job, since his new recovery residence was at too great a distance and without public transportation to his previous place of employment. Such a disruption as this can put a new and precarious recovery at risk.

We know that as a result of the COVID pandemic, demand for behavioral health services is going to skyrocket. We already know that overdoses and suicides are up. In addition, a CDC report of October 2020 showed that emergency department usage for psychiatric crises between March and October 2020 had increased 31% in youth aged 12-17 over the same period in 2019 – and before COVID there was already a critical shortage of psychiatric services for children and adolescents. There are too many studies to cite – all indicating that the pandemic is having a profound negative impact on people's behavioral health. We must anticipate a huge demand, and an incompetent ASO will have a profound negative impact on Maryland consumers in the Public Behavioral Health System. SB 638 will put

measures in place to force Optum to improve their performance, thereby easing the burden on providers, and ultimately to the benefit of consumers.

Therefore we urge a favorable report.

Contact: Ann Geddes
Director of Public Policy
The Maryland Coalition of Families
10632 Little Patuxent Parkway, Suite 234
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ageddes@mdcoalition.org

Advantage Testimony SB 638.pdf
Uploaded by: Grimes, Lauren
Position: FAV

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

POSITION: FAVORABLE

I am Cindy Pixton, and I am the Chief Executive Officer at Advantage Psychiatric Services. We provide behavioral health services in Districts 8, 10, 34A, and 36. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 1200 adults and children every year, and we employ 75+ 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 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 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 is in jeopardy of not making current payroll.***

We have been struggling with underpayments, erroneous denials and inadequate customer service for over a year under the current ASO vendor. These problems with Optum's performance remain unresolved. My inability to get sufficient payment is jeopardizing my ability to meet my payroll obligations. My immediate concerns include:

- Over $20,000 in claims unpaid due to errors in Optum's system such as its inability to accurately process multiple insurances or changes in client eligibility. These unpaid claims have accumulated since August and are still waiting for systemic fixes.
- $4,000 in claims denied for children services for reasons that I can't identify and which multiple Optum staff have failed to clarify.

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.

Archway Station Testimony SB638.pdf
Uploaded by: Grimes, Lauren
Position: FAV

Archway Station, Inc.

Administrative Offices:
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Cumberland, MD 21502
301-777-1700

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

POSITION: FAVORABLE

Good afternoon and thank you for taking time to read my testimony which I have written to urge your support for SB638. My name is Jim Raley and I am the Executive Director of Archway Station, a psychiatric rehabilitation program (PRP) providing mental health services in Allegany County, Maryland. Our organization serves approximately 250 people, including adults, children, and veterans every year, and we employ 110 individuals. A majority of the patients we serve are publicly funded Medicaid patients or uninsured.

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 the 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 need higher than ever.

My staff will weather the snow/ice storm today to provide face to face contacts to our clients to ensure medication regiments are followed and to support those who struggle with daily functioning, many of whom live in the residential rehabilitation programs we operate. Our PRP (Psychiatric Rehabilitation Program) is second to none in this area. Our staff are dedicated to the provision of the everyday, unglamorous services and supports that help people retain independence and avoid costly hospitalizations, not only for psychiatric issues but also somatic health conditions. ***For 40 years we have proudly served the residents of Allegany County—never allowing snow or any other external force to hamper the essential work we perform—but the severe problems created by Optum Maryland have definitively impacted our work, our staff, and if allowed to continue, our clients.***

We have been working under the current ASO's 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 be remotely credible. Instead, 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 a dire financial and operational future.

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments—all basic revenue cycle management functions-- are not available in Optum's system. Billing operations which used to be done electronically now require an enormous manual lift for our agency. We spend countless staff hours—billing, clinical and leadership-- simply trying to get reimbursed for provided services so our business can stay afloat. Our billing department staff have been billing Medicaid for many, many years and they have never encountered the errors and problems seen with Optum with any previous ASOs.
- **Erroneous claims denials:** The limitations and errors in Optum's system mean claims are denied in error constantly. For instance, Optum's system cannot accurately process multiple insurances or changes in

client eligibility. All of these claims have denied since August. Our billing staff are demoralized and overworked to the point that we have had to stop re-billing for denials of clean claims, and hope that Optum fixes the systemic issues and manual processing errors causing these false claim denials. Like other providers, we face a campaign of Optum blaming providers for these errors. For Optum to allege this is deceitful, an insult to credible organizations such as Archway Station, and a grave disservice to the public mental health system in Maryland.

- **Customer Service**: Erroneous denials often do not have accurate or actionable denial reasons, requiring our staff to call to Optum customer service for each of these. Optum staff is poorly trained and consistently remit incorrect information, so each phone call lasts about 45-60 minutes and fixes only a handful of claims, if at all. Often times we spend hours with customer service attempting to correct a denial, only to have the resubmitted claim deny for the same reason. There seems to be "luck of the draw" in place with Optum where a claim is denied by one representative only to be authorized by another. This inconsistency makes it hard for us to correct situations that arise.
- **Reprocessed claims:** The substantial volume of erroneous claims denials, as well as a steady stream of claims paid at the wrong rate, mean that our agency has hundreds of thousands of claims reprocessed 1, 2. 3 times. What this means is that the volume of claims that must be managed by our staff is far beyond our normal billing, for which we need more staff just to keep up.
- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. Our staff is manually reconciling claims from reports remitted by Optum which do not match the receipts we have received which still yet display different information than their claims processing system. This has impacted our recent financial audits and forced our agency to have audit notations indicating an uncertainty in revenues due for the fiscal year ending June 30, 2020. This matter will inevitably be compounded by another fiscal year's worth of problems as we are only months away from closing out FY21.
- **Authorization Delays:** Optum's service authorization process has been fraught with processing errors and unannounced policy and operational changes leading to high denial rates. We continue to see authorizations denied citing absent information that is indeed present as well as process changes that were communicated to providers only after weeks of unexplained denials. The authorization process is a similarly circular effort to claims processing characterized by erroneous denials, constant resubmissions, and unresolved problems.

In closing, I ask on behalf of those who we serve, for you to preserve the integrity of a public system being damaged at the hands of a billion+ dollar insurance company provider with an unlimited ability to marshal the resources required to fix their system. 14 months into this contract, we find ourselves "beaten down" and wondering whether the State of Maryland will offer reprieve. It is unconscionable to allow this vendor to destroy quality programs destabilize public mental health and substance use services.

Thank you for your attention. I urge you to act now to preserve Maryland's treatment capacity and vote a favorable report on SB 638.

BTST Services LLC Testimony SB 638.pdf
Uploaded by: Grimes, Lauren
Position: FAV

BTST Services, LLC

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

POSITION: FAVORABLE

I am Desirae Williams, and I am Payroll and Billing Manager at BTST Services, LLC. We provide behavioral health services in Baltimore City, Baltimore County, Frederick County, Washington County and Prince George's County. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 5,000 clients every year, and we employ 200 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 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 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. 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 significant staffing and fiscal challenges. Our agency is struggling with staff morale and burnout due to the vastly increased workload caused by Optum's malfunctioning system and failure to implement processes for issues such as timely filing deadlines impacted by the 7 months that their system did not function. Our agency has seen an increase in HR complaints due to the stressors related to Optum, which are impacting both clinical and administrative staff. We have been forced to hire additional staff to handle the backlog of work while continuing to be underpaid by Optum, and if this continues, we will have to hire even more.

Most importantly, clients will be unable to receive care if these ongoing systemic problems are permitted to continue. The inability to confirm client eligibility causes an inability to obtain client authorizations, and ultimately eliminates our ability to bill for services and decreases our revenue. We are continuing to see clients despite all of this but will not be able to do so indefinitely.

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments—all basic revenue cycle management functions-- are not available in Optum's system. Billing operations which used to be done electronically now require an

enormous manual lift for our agency. We've been forced to hire 2 additional billing staff to keep up with this work.

- **Erroneous claims denials:** The limitations and errors in Optum's system mean claims are denied in error constantly. For instance, Optum's system cannot accurately process multiple insurances or changes in client eligibility. All of these claims have denied since August. Additionally, our psychiatric rehabilitation claims continue to deny or pay at lower rates because of manual processing errors in Optum's operations. Our months-long efforts to get Optum to reprocess and pay these claims has been largely unsuccessful.
- **Reprocessed claims:** The substantial volume of erroneous claims denials, as well as a steady stream of claims paid at the wrong rate, mean that our agency has hundreds of thousands of claims reprocessed 1, 2. 3 and sometimes 10 times. What this means is that instead of managing the billing for an agency that submits 10,000 services in a month, our billing staff are managing a revenue cycle equivalent to an agency 5 times our size.
- **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 claims denials.
- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. 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. This has impacted our recent financial audits and forced our agency to write off hundreds of thousands of dollars. It has also caused challenges with obtaining additional financing as our aging reports date back to the first quarter of 2020 with claims having outstanding balances.

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.

CCYSB Testimony SB638.pdf
Uploaded by: Grimes, Lauren
Position: FAV

CARROLL COUNTY YOUTH SERVICE BUREAU, INC.

59 KATE WAGNER ROAD – WESTMINSTER, MD 21157

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

POSITION: FAVORABLE

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

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

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

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

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

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

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

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

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

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

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

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

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

Cornerstone Montgomery Testimony SB 638.pdf
Uploaded by: Grimes, Lauren
Position: FAV

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

Position: FAVORABLE

I am Cari Guthrie Cho, and I am the President and CEO at Cornerstone Montgomery. We provide behavioral health services in Montgomery County. I am submitting this testimony on SB 638 to urge your support for this bill. Our organization serves approximately 2500 people a year and we employ 330 individuals. Most of the people we serve are publicly funded Medicaid patients.

SB 638 authorizes the Maryland Insurance Commission to enforce minimum performance standards for the Administrative Services Organization (ASO) that is responsible for managing care and paying claims in the Maryland public behavioral health system. This bill is urgent because immediate action is needed to stop the unprecedented incompetence and damage that has been happening for the last year. The current ASO vendor transition has been a disaster from day 1. The system is not stable nor operating at the level that is necessary for the behavioral health system to function. Fixes have not been delivered in the timeframes promised and critical functions remain absent. Without immediate enforcement, our agency faces major cash flow disruption which will lead to staff not getting paid, program closures and thousands of clients without support in the community.

The following are just some of the issues that we are still dealing with at Optum.

1. **Claims Denial** – Claims are being denied constantly. Our billing people are being told when they call about claims denied incorrectly by Optum, not provider error, that they have 14 days to reprocess from report. This is an issue because if it's a psychiatric rehabilitation program (PRP) that is affected, it could be 5 weeks to get payment on what was technically a clean claim. Outpatient mental health center (OMHC) claims, which usually pay in about a week, are delayed by at least 3 weeks. This is a huge issue in terms of administrative burden and cash flow.

2. **Authorizations** – The Incedo authorization system has operated sporadically, at best. It is unable to process authorizations for the uninsured or to differentiate among various payers (such a Medicare). Incedo's limitations have created an enormous burden on providers who must submit and resubmit auth requests. And of course payment is withheld or delayed until the authorization problems are fixed. Although Incedo's malfunction is at fault, providers take the hit.

   I could detail many more shortcomings of Optum's system but they are beyond the scope of this bill. Suffice it to say that the issues with Optum are current and ongoing, and that their processes are extremely unreliable. As a result we can't forecast our cash receipts and we can't create electronic claims status reports because Optum's data is so poor that it requires manual review. In short, we don't have the tools needed to run our business, and Optum seems oblivious to the burden and financial risk their system has placed on providers.

This is an administrative and financial nightmare. Our organization – like many other community behavioral health providers - lives check to check - we can't afford to have late payments or no payments without jeopardizing payroll and ultimately access to services for people in need. Where will those people go? Homeless shelters, hospitals, and jails are already overburdened.

We have operated under four other ASOs that have NEVER been this bad. We have never experienced the level of mistakes, lack of communication, and incompetence that we have over the last year and a half. The thought of four more years of Optum's dysfunction is unconscionable.

Please urge you to support SB 638 so that Optum can be held accountable to its statutory requirements.

Respectfully submitted, Cari Guthrie Cho, CEO and LCSW-C

Corsica River Testimony SB 638.pdf
Uploaded by: Grimes, Lauren
Position: FAV

Corsica River Mental Health Services, Inc.

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

POSITION: FAVORABLE

I am John Plaskon, the Executive Director at Corsica River Mental Health Services, Inc. We provide mental health and substance use services in Queen Anne's, Talbot, Caroline and Dorchester Counties. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 900 adults and youth every year, and we employ 33 individuals. A majority of the people 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. Immediate action is needed to prevent continued harm that reduces our capacity to treat Maryland residents at a time when the pandemic is driving 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. Optum's current dysfunction is reducing our revenue and increasing our costs. We have already been forced to redirect resources away from treatment due to Optum. Without immediate enforcement, our agency faces continuing administrative burden and revenue losses.

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments - all basic revenue cycle management functions - are not available in Optum's system. Billing operations which used to be done electronically now require an enormous manual lift for our agency. We've been forced to significantly increase billing staff hours to try to keep up.
- **Erroneous claims denials:** The limitations and errors in Optum's system means claims are denied in error constantly. For instance, Optum's system cannot accurately process multiple insurances (Medicaid as secondary payer) or changes in client eligibility. All of these claims have denied since August when Optum's system went live after many months of not functioning at all. Additionally, the process to submit corrected claims is STILL not set up properly in Optum's system. These claims do not pay, and continue to deny. We are endlessly chasing our tail.
- **Customer Service**: Erroneous denials often do not have accurate or actionable denial reasons, requiring our staff to call to Optum customer service for each of these. Optum staff are poorly trained, resulting in our billing staff consistently having to educate *their* staff. Their customer service representatives consistently remit incorrect information, so each phone call lasts about 45-60 minutes and fixes only a handful of claims, if any. Optum's

phone lines are also notorious for disconnecting calls, and not reliably giving issue #s to complaints so they can be tracked or escalated. This often results in multiple attempts to contact customer service with no results, and at times, no successful contact at all.

- **Reprocessed claims:** The substantial volume of erroneous claims denials, as well as a steady stream of claims paid at the wrong rate, mean that our agency has hundreds of thousands of claims reprocessed 1, 2, 3 and sometimes TEN times. This means that instead of managing the billing for an agency that submits 1,800 services in a month, our billing staff are managing a revenue cycle equivalent to an agency 3 - 5 times our size.
- **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 that 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 claims denials.
- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. Our staff are manually reconciling claims from reports remitted by Optum, on top of doing their already full-time job. These reports do not match the receipts we have received or the billings we have submitted. Each report also does not match what is able to be pulled up inside their INCEDO system. This cumbersome process impacted our recent 6/30/2020 financial audits, delaying it for months (finalized 12/15/2020) which is first time a delay has happened in the 10 years Corsica River Mental Health Services, Inc. has been in business.

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. Thank you.

CRi Testimony SB 638.pdf
Uploaded by: Grimes, Lauren
Position: FAV

Choice. Respect. independence.
Arthur M. Ginsberg, President & CEO

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

POSITION: FAVORABLE

I am writing on behalf of Community Residences, Inc. (Cri) in my capacity as President and CEO. CRi is a non-profit human service agency supporting individuals with mental health, substance use and intellectual/developmental disabilities. We provide services in Baltimore, Anne Arundel and Montgomery counties to over 1,000 individuals every year, and we employ 650 staff members. All individuals we support in Maryland are publicly funded by Medicaid. I am submitting this written testimony on SB 638 to urge your support for this bill.

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 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 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.

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments—all basic revenue cycle management functions-- are not available in Optum's system. Billing operations which used to be done electronically now require an enormous manual lift for our agency.
- **Customer Service**: Erroneous denials often do not have accurate or actionable denial reasons, requiring our staff to call to Optum customer service for each of these. Optum staff are poorly trained and consistently remit incorrect information, so each phone call lasts about 45-60 minutes and fixes only a handful of claims, if any. Optum's phone lines are also notorious for disconnecting calls, and not reliably giving issue #s to complaints so they can be tracked or escalated.

- **Reprocessed claims:** The substantial volume of erroneous claims denials, as well as a steady stream of claims paid at the wrong rate, mean that our agency has hundreds of claims reprocessed 1, 2, 3 and sometimes 10 times.
- **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 claims denials.
- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. 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.

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.

Crossroads Community Testimony SB638.pdf
Uploaded by: Grimes, Lauren
Position: FAV

Crossroads Community, Inc.

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

POSITION: FAVORABLE

I am John Plaskon, the Executive Director at Crossroads Community, Inc. We provide behavioral health services in Queen Anne's, Kent, Talbot, Caroline and Dorchester Counties. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 225 adults and youth every year, and we employ 68 individuals. A majority of the people 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. Immediate action is needed to prevent continued harm to our organization that reduces our capacity to treat Maryland residents at a time when the pandemic is driving 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. Optum's current dysfunction is reducing our revenue and increasing our costs. We have already been forced to redirect resources away from treatment due to Optum. Without immediate enforcement, our agency faces significant loss in revenue and continued increases in administrative burden.

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments - all basic revenue cycle management functions - are not available in Optum's system. Billing operations which used to be done electronically now require an enormous manual lift for our agency. We've been forced to add billing staff to keep up with the increased workload due to the inability of Optum's system to accurately and timely post claims data. For our psychiatric rehabilitation services, we are forced to manually count the encounter data inside INCEDO to ensure they have properly approved them before billing the case rate because Optum often processes them out of order, causing them to deny or pay at a lower rate. This delays our ability to submit case rate billings by at least two weeks, and thus delays payment by at least that long—often longer, as other errors occur once claims enter their system that we have not been able to find ways to avoid.
- **Erroneous claims denials:** The limitations and errors in Optum's system means claims are denied in error constantly. For instance, Optum's system cannot accurately process changes in client eligibility resulting in claims denials. Additionally, the billing correction process for certain service lines including respite care are STILL not set up properly in Optum's system, resulting in further claims denials. We are endlessly chasing our tail.

- **Customer Service**: Erroneous denials often do not have accurate or actionable denial reasons, requiring our staff to call to Optum customer service for each of these. Optum staff are poorly trained and consistently remit incorrect information. Each phone call lasts about 45-60 minutes often requiring our billing staff to educate Optum's customer service associates, while only a handful of claims, if any, get corrected. Optum's customer support does not routinely provide issue #'s and often does not respond when messages are left, requiring billing staff to make multiple calls to get something resolved. The same is true for emails sent to Optum's Provider Relations department-- many go unanswered and issues remain unresolved.
- **Reprocessed claims:** The substantial volume of erroneous claims denials, as well as a steady stream of claims paid at the wrong rate, mean that our agency has hundreds of thousands of claims reprocessed 1, 2, 3 and sometimes TEN times. What this means is that instead of managing the billing for an agency that submits 8,000 services in a month, our billing staff are managing a revenue cycle equivalent to an agency 3 - 5 times our size!
- **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 claims denials.
- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. Our staff are manually reconciling claims from reports remitted by Optum, which do not match the receipts we have received or the billings we have submitted. Each report also does not match what is able to be pulled up inside their INCEDO system. This cumbersome process impacted our recent 6/30/2020 financial audits, delaying it for months (finalized 12/15/2020) which the first time a delay has happened for our agency since any ASO has been in place in the state of Maryland.

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. Thank you.

Families First Testimony SB 638.pdf
Uploaded by: Grimes, Lauren
Position: FAV

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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Family Service Foundation Testimony SB638.pdf
Uploaded by: Grimes, Lauren
Position: FAV

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

POSITION: FAVORABLE

I am Donald Webster, and I am Chief Financial Officer at Family Service Foundation. We provide behavioral health services in Prince George's County and Frederick County. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 350 clients every year, and we employ 29 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 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 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 ensure claims are paid accurately and on time. 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 significant cash flow shortages.***

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

- **Basic business revenue tools don't exist:** The ability to run reports, reconcile payments, and research claims, are not available in Optum's Incedo system. Incedo also displays insufficient claims data. For instance, the system identifies one level of denial, where more denial reasons could exist, which often leads to resubmissions that deny a second time. Incedo also does not include check numbers in claims data, creating significant additional work on providers to link the claim to their remittance advice.

- **Erroneous claims denials:** The limitations and errors in Optum's system cause denied claims for diverse and unresolved reasons. For instance, our agency's claims for clients with multiple insurances deny incorrectly because their system cannot index multiple insurances. This is a known and unresolved issue. Incedo is also unable to retroactively apply client eligibility so all claims deny despite our clients having had active coverage for the dates of service for which we billed.

Additionally, claims consistently pay at the wrong rate. Optum often applies prior fee schedules rather than current rates and claims take weeks or months to reprocess at the correct rate.

- **Customer Service**: Our agency recently found out that our Landover location's billing was submitted with an incorrect NPI# back in March 2020. Optum provided us no notification of this, and all of our claims from March through August 2020 denied without us understanding why. This required the resubmission of thousands of claims in short order as we had not been being paid for the vast majority of our 2020 billing.

  Optum customer service responses are slow, if they come at all. Customer service reps also often provide incorrect answers that cost agencies significant staff time and resources. Typically, an ASO will identify problems communicated to them with an issue ID, but Optum rarely offers them even when asked. Even when they do, the representative we speak to when we follow up on an inquiry can rarely locate the issue ID. Optum reps have told our staff that they are "unable to tell you how to bill," despite the fact that their errors and poor and untimely communication have left agencies confused and uncertain how to proceed. Billing for the public behavioral health system should be a partnership between providers, the ASO, and the State of Maryland. This has been far from the case under Optum's tenure.

- **Reconciliation:** Optum has delivered numerous versions of reports intended to guide providers through the reconciliation process, but all of these have incomplete information. Reconciling claims requires a laborious cross-referencing process between remittance advice, reconciliation reports, the Incedo portal and Payspan.

This ASO has created an untenable situation that puts the stability of the public behavioral health system at risk. 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.

Sheppard Pratt written testimony SB6388HB919 MD In
Uploaded by: Grossi, Jeffrey
Position: FAV

Sheppard Pratt

Written Testimony
Senate Finance Committee
House Health and Government Operations Committee
SB638 / HB919 Maryland Insurance Commissioner –
Specialty Mental Health Services and Payment of Claims – Enforcement

February 17, 2021

Position: Support

Sheppard Pratt thanks the Maryland General Assembly for your longstanding leadership and support of mental and behavioral health providers in Maryland. This testimony outlines the Sheppard Pratt **support for SB638/HB919 Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement.** It is our hope that the Maryland General Assembly vote a favorable report on this legislation.

Sheppard Pratt does acknowledge and appreciate the efforts of the Maryland Department of Health and especially the leadership at the Department who have tried to make the Administrative Service Organization (ASO) transition seamless through estimated payments and participation in meetings. We also commend the Maryland General Assembly for the continued oversight and debate of the legislation before you today.

However, challenges continue to persist with a transition that is over a year long process. Given the size and scope of the services Sheppard Pratt provides throughout the State, this ASO transition is an extraordinary challenge especially as we also try to keep our doors open during a pandemic. The legislation before you is necessary to ensure that the transition comes to a successful conclusion. It authorizes the Maryland Insurance Commissioner to enforce minimum performance standards for the ASO that is responsible for managing care and paying claims for the Maryland public behavioral health system. This immediate action is needed to prevent continued harm that reduces our capacity to treat Maryland residents at a time when the pandemic is driving need higher than ever.

The Sheppard Pratt mission is to improve the quality of life of individuals and families by compassionately serving their mental health, addiction, special education, and community support needs. This mission is severely compromised by our experience with Optum and is illustrated by the examples below:

Authorization Issues

From the very start of a long, tumultuous year, we have had and continue to have issues with routine authorizations, including the following:

- No explanation for authorization denials.
- Inconsistency with authorizations.
- Time to enter authorizations and follow-up have increased.

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Sheppard Pratt

- System was set up by provider type which creates challenges moving authorizations for a single patient between provider types.

Claims Processing Issues

We continue to experience claims processing errors, including:

- Insufficient plan outlined for reconciliation process for estimated payment period claims which represents bulk of claims (all claims though August 2nd), requiring additional workforce.
- Overpayments (duplicate payments for new day claims, secondary payments processing as primary).
- Inpatient and residential claims not paying for the discharge date.
- Services paid at incorrect rate (universal, inpatient, outpatient, residential treatment).
- Insurance issues creating large percentage of denials.
- Payments being made out to clinicians.
- Patients that were not billed are being paid.
- Receiving patient claims data from other organizations.

Audit and Reporting Issues

Lack of accurate reporting resulting in the following:

- Current payment summary report for all corporations within Sheppard Pratt are off by millions in billed charges verses internal records.
- Lack of valid reports coupled with the reprocessing of claims multiple times as well as high rate of denials and authorization issues means that management believes balance sheet accounts are not reliable.

Call Center

Staff at the call center have not been adequately trained on Maryland Medicaid and Behavioral Health programs and billing. This results in inconsistent messaging from call center staff. While issues are escalated, they remain unresolved.

Sheppard Pratt Financial Exposure with Optum

The continued problems with Optum and the Incedo system coupled with sustained losses resulting from COVID-19 leaves Sheppard Pratt exposed to (1) cash on hand issues; (2) loss of margin; (3) continued audit issues and (4) resource constraints. The impact to Sheppard Pratt continues to be in the range of tens of millions of dollars.

- Based on Optum documents, for billed charges for one corporation, 23 percent of claims were denied, and an additional 12 percent were disallowed resulting in millions in underpayment. Prior denial rates were below 10 percent.

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- Based on Optum documents, 99.94 percent of claims were adjudicated and paid within 14 days
    - This is because Optum paid, retracted, and then denied claims
- Overpayments and resulting liability to Optum from duplicate payments and Optum not recognizing primary insurance is currently unknown.
- Auditors are unable to test and confirm balances and rely on Optum reports.
- Workforce issues include:
    - Additional time to process authorizations;
    - Claims management time and effort have dramatically increased; and
    - The expense and impact beyond time and workforce stress is not known.

Sheppard Pratt urges you to act now to preserve Maryland's treatment capacity and vote a favorable report on **SB638/HB919 Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement**.

About Sheppard Pratt

Sheppard Pratt is the nation's largest private, nonprofit provider of mental health, substance use, developmental disability, special education, and social services in the country. A nationwide resource, Sheppard Pratt provides services across a comprehensive continuum of care, spanning both hospital- and community-based resources. Since its founding in 1853, Sheppard Pratt has been innovating the field through research, best practice implementation, and a focus on improving the quality of mental health care on a global level. Sheppard Pratt has been consistently ranked as a top national psychiatric hospital by *U.S. News & World Report* for nearly 30 years.

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Humanim Testimony SB638.pdf
Uploaded by: Hall, Shannon
Position: FAV

HUMANIM INC.

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

POSITION: FAVORABLE

My name is Karen Booth and I am the Vice President of Behavioral Health Services at Humanim, Inc. Humanim provides behavioral health services in Howard County and Anne Arundel County. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves over 300 individuals annually in our behavioral health division and has approximately 100 staff. A majority of the individuals 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 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 need higher than ever.

We have been working under the current ASO vendor for over a year. We have met with the ASO leadership and, with their assistance, were able to fix some of our aging claims. Our concern moving forward is that system 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 that is needed. Optum's current dysfunction is reducing our revenue and increasing our costs. We have already been forced to re-direct resources away from treatment because additional staff time has been needed for administrative tasks caused by Optum's system issues.

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

- **Erroneous claims denials:** The limitations and errors in Optum's system mean claims are denied in error with high frequency. Optum's system (Incedo) also will skip charges in a monthly sequence and deny random claims with no explanation.

- **Reprocessed claims:** The substantial volume of claims denials, as well as a steady stream of claims paid at the wrong rate, mean that our agency has hundreds of claims reprocessed multiple times which has substantially increased the volume of work for our billing staff.

- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. Our staff are manually reconciling claims from reports remitted by Optum which do not match the receipts we have received which still display different information than their claims processing system.

- **Customer Service**: The denials often do not have accurate or actionable denial reasons, requiring our staff to call to Optum customer service for each of these. Optum customer service staff lack the necessary training and consistently remit incorrect information, so each phone call lasts about 45-60 minutes and fixes only a handful of claims, if at all. Optum's phone lines also frequently disconnect calls and issue #s are not reliably provided to complaints so that they can be tracked or escalated. Staff often have to call about one authorization multiple times or submit multiple re-authorizations for clients. Authorizations, in addition to claims, are denied at a high rate for unknown reasons. Delayed authorizations mean delayed services at a time when people are often in need of immediate support.

- **Broken functions:** The search function in Optum's system has been broken since early November which has inhibited our ability to access the entirety of client and claims information we need--causing duplicate records, which in turn, causes more claims denials.

- **Authorizations:** For the first half of 2020, there was significant difficulty in submitting authorizations due to a system that was only partially functional. When the system started working in July 2020, albeit unreliably, all providers were forced to scramble to initiate authorization start dates of 7/1/20 which created a huge administrative burden on staff. As authorizations for services are required to be renewed every 6 months, these 7/1 authorizations had to all be re-authorized as of 1/1/21. These compressed time periods for submitting ALL authorizations rather than the staggered workflow our agency had previously– even with a grace period put in place by Optum due to the systems issues – meant that quality hours that should have been spent providing services to clients were diverted to administrative work. Communication of documentation requirements has also been poor, leading to frequent denials and re-submissions.

- **Insurance/Eligibility system issue:** Optum's system cannot accurately process multiple insurances or changes in client eligibility. The feature that enables eligibility to be retroactively processed does not, and has never worked, so Incedo can only display a client's most current entitlement information. This causes claims denials for services rendered before the client's most recent insurance change.

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.

JSSA Testimony SB638.pdf
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Position: FAV

Jewish Social Service Agency

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

POSITION: FAVORABLE

I am Caroline Appleby, Chief Financial Officer at Jewish Social Service Agency. We provide behavioral health services in Montgomery County. I am submitting this written testimony on SB 638 to urge your support for this bill. The behavioral health department of our organization serves approximately 1,900 individuals every year, and we employ 50 behavioral health clinicians. Approximately 9% of the patients we serve are publicly funded Medicaid patients, with anticipated growth to 25% over the next three to six months as both Medicaid enrollment and mental health needs continue to grow as a result of the pandemic.

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 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 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 increasing our costs and administrative burden. Without immediate enforcement, our agency faces greater expenses against services with little or no profit margin.

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

- **Basic business revenue tools do not exist:** The ability to run reports, research claims, and reconcile payments—all basic revenue cycle management functions-- are not available in Optum's system. Billing operations which used to be done electronically now require an enormous manual lift for our agency. We are no longer able to import electronic EOBs (billing receipts) to reconcile to payments. Instead, we must manually enter EOBs and manually manage their reconciliation to claims submitted while Optum's system was non-functional for 7 months. We have needed to increase billing staff by 1 FTE in order to keep up, and will need to add additional staff if these issues persist.

- **Customer Service**: Optum's claims processing system, called INCEDO, is their online portal where providers are expected to register agency information, including their provider type, as authorizations and claims are processed by provider type. This system, after not functioning at all for 7 months, caused challenges for many providers including JSSA in setting up their

payments portals. Optum's initial guidance was poor, and their attempts to resolve this issue were subsequently bungled, leaving us finally to work directly with Medicaid's customer support, and leaving us without access to claims information for months. Because of this set-up delay, many of our patient authorizations were attached to the wrong provider type, and caused claims denials. Optum agreed to review their system for a solution, however, after repeated requests for status updates, we received no response. Left to rectify the problems ourselves, we were forced to manually seek new authorizations to avoid timely filing issues, a fix that also took many weeks to resolve.

- **Communications:** Optum's communication is both slow and poorly timed. Optum will often alert providers of an upcoming deadline only to change the deadline at the last minute because a systems issue they expected to be fixed, was not ready. When this happens, we have had to drop other tasks to meet this deadline only to be told after completion of the task that the deadline was extended an additional three months.

- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. 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.

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.

Leading by Example Testimony SB 638.pdf
Uploaded by: Hall, Shannon
Position: FAV

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

POSITION: FAVORABLE

I am Johnnie Fielding, and I am the Program Director and Co-Founder at Leading By Example. We provide behavioral health services in Baltimore County, Baltimore City, and Harford County. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 600 individuals and families every year, and we employ 65 individuals. The 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. This bill is urgent 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 needs higher than ever.

We have been working under Incedo; the current ASO's vendor for over a year. The Incedo platform fixes have not been delivered in the timeframes promised, and critical functions remain absent. Incedo is not stable and not functioning at the level needed. 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 significant financial losses that threaten our ability to service the most vulnerable communities.

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

- **Customer Service**: Customer service is consistently unreliable and time consuming. Calls for authorization issues often take 45 minutes, yield no immediate resolution to an inquiry, and result in escalation of the issue to higher Optum staff, delaying a response for days or weeks. Recently, we have been unable to set up new staff to access Optum's claims processing portal as a part of their basic job function, and Optum has been consistently unresponsive in resolving this matter that is imperative to our functioning.
- **Reprocessed claims:** In March 2020, Optum released a new fee schedule which included new rates for Therapeutic Behavioral Services (TBS) effective 1/1/2020. Optum supported our billing team in reprocessing claims from the prior months to retroactively pay the services delivered between January and March at the new rate. However, in July 2020,

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Optum informed us that they made an error on the March 2020 fee schedule and that they believe they overpaid us for services provided during that time period. Consequently, they intend to retract and recoup any overage of funds that was paid to us during that time period. This recoupment could be catastrophic for our organization, and Optum has not responded to our efforts to resolve this error with any consideration of the significant impact their error in releasing incorrect rates to the public, will cause our organization. This issue is demonstrative of the consistent ineffectiveness of Optum, as well as the continued failure to resolve issues.

- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. 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. This has impacted our recent financial audits and forced our agency to pay taxes on funds that they intend to recoup.

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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Life Renewal Services Testimony SB638.pdf
Uploaded by: Hall, Shannon
Position: FAV

OUTPATIENT BEHAVIORAL CENTER
PSYCHIATRIC REHABILITATION PROGRAM

Life Renewal Services

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

POSITION: FAVORABLE

I am Karen Byrd, and I am CEO at Life Renewal Services, Inc. We provide behavioral health services in Carroll and Howard Counties, and in the Baltimore Metropolitan area. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 1,090 clients every year, and we currently employ 79 individuals. A majority of the clients we serve are publicly funded Medicaid clients.

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. We consider this this bill to be 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 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 eventual layoffs which will inevitably lead to a decrease in client services.***

The bullets listed below illustrate our experiences working with Optum:

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payment and all basic revenue cycle management functions are simply not available in Optum's system. Billing operations which used to be done electronically now require an enormous manual lift for our organization. We use Optum's Incedo system as our direct entry portal for claims submission, and the system has not been maintaining all of our data entry for claims. We have had many batches of claims disappear over the past 14 months, and we are constantly having to check Incedo to confirm the system has captured all of our submitted claims. As a direct result of this additional workload, we had to hire an additional billing staff member.

- **Erroneous claims denials:** The limitations and errors in Optum's system mean claims are denied in error constantly. For instance, Optum's system cannot accurately process multiple insurances or changes in client eligibility. All of these claims have denied since August. Additionally, our clinic service line billing

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configuration is STILL not set up properly in Optum's system. We request payment for the correct amount and often get paid a lower rate.

- **Customer Service**: Erroneous denials often do not have accurate or actionable denial reasons, requiring our staff to call to Optum customer service for each of these. It's been our experience that Optum staff are poorly trained and consistently remit incorrect information, so each phone call often lasts approximately an hour and typically fixes made only translate to a handful of claims, if any. Our billing team members have contacted customer services and emailed designated supervisors and still no responses are received. Optum's phone lines are also notorious for disconnecting calls, and not reliably giving reference #s to complaints so they can be tracked or escalated.

- **Authorizations**: There have been several occasions when authorization requests for services have received denials because an Optum representative missed a piece of documentation that was present or could not open an attached word document. After contacting customer service, the Optum representative receiving the call was miraculously able to open the attached document, however, due to the denial already being rendered, staff members still had to resubmit the authorization request. These types of errors inevitably lead to which wasted staff time and weeks-long delays in service authorizations.

- **Reprocessed claims:** The substantial volume of erroneous claims denials, as well as a steady stream of claims paid at the wrong rate, mean that our organization has hundreds of thousands of claims reprocessed 1, 2, 3, and occasionally up to 10 times. What this means is that instead of managing the billing for an agency that submits 10,000 services in a month, our billing staff are managing a revenue cycle equivalent to an agency 5 times our size.

  In addition to reprocessed claims, we also have claims that are more than 30 days old for which we have received neither payment nor remittance advice (denial or receipt). We are at a loss to determine how to get these claims paid despite repeated contacts with Optum. We also have claims that have sat in the Incedo system for months in "approved" status but have never paid. We have also not been successful, after many contacts with Optum, in determining why these have not paid.

- **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 claims denials.

OUTPATIENT BEHAVIORAL CENTER
PSYCHIATRIC REHABILITATION PROGRAM

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- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. 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. This has impacted our recent financial audits and forced our agency to pay taxes on money that we will have to return. If recoupment of funds from the estimated payment period precede our agency being paid for our outstanding unpaid claims reconciliation issues, it may force us to apply for lines of credit to cover the deficit.

In summary, significant problems with Optum continue to hamstring our operations, tie up significant amounts of staff time, and threaten our financial well-being. 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.

Karen Byrd, LCPC
CEO
Life Renewal Services, Inc.

MFR Testimony SB 638.pdf
Uploaded by: Hall, Shannon
Position: FAV

MARYLAND FAMILY RESOURCE, INC.

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

POSITION: FAVORABLE

I am Michael Mills, and I am the President and CFO at Maryland Family Resource, Inc. We provide behavioral health services in Prince George's County and the surrounding area. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 1,000 consumers every year. A majority of the consumers 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 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 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. 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 severe financial hardship and operational constraints limiting our ability to serve the needs of our consumers.

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments—all basic revenue cycle management functions-- are not available or are not functioning properly in Optum's system. Our billing and reconciliation operations,which used to be done electronically, now require an enormous amount of manual processing for our agency.
- **Customer Service**: Responsiveness to emails and calls has been substandard and unreliable. Denials often do not have accurate or actionable denial reasons, requiring undue burden on our staff to repeatedly call Optum's customer service to inquire about each claim. Optum's customer service representatives consistently remit incorrect information, so a phone call lasts approximately 45 minutes or longer and may only fix only a handful of problems, if any. Since we are regularly given incorrect information, our staff feel obligated to follow-up with multiple representatives at Optum to verify if we've received the correct information in order to avoid further errors and problems.
- **Training Webinars:** Optum offers basic training webinars with minimal frequency that do not effectively prepare staff to perform the billing and authorization processes that they

encounter via the online interface. These trainings also often deliver incorrect or outdated information.

- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. Under Optum, reconciliation has been an arduous process. Our billing staff is manually reconciling claims from reports remitted by Optum, which do not match the billing statements we have received, which still yet display different information than their claims processing system. This has impacted our recent financial reports and audits, and has forced our agency to pay out on claims we have yet to fully adjudicate or resolve. In addition, we have contacted Optum numerous times in the past six months requesting assistance with reconciliation questions, and have received multiple auto-generated responses, which provide no help to our specific inquiries.

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.

MSA Testimony SB638.pdf
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Position: FAV

MSA The Child & Adolescent Center

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

POSITION: FAVORABLE

I am Martin Slutsky, and I am the President at MSA The Child & Adolescent Center. We provide behavioral health services to children in Howard County. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 4000 patients every year, and we employ 30 individuals.

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 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 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 may be forced to stop treating children insured by Medicaid.***

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments—all basic revenue cycle management functions-- are not available in Optum's system. Billing operations which used to be done electronically now require an enormous manual lift for our agency. We've been forced to hire 2 additional billing staff to keep up.
- **Erroneous claims denials and inaccurate payment:** The limitations and errors in Optum's system mean claims are denied in error constantly and the payments that are made are at incorrect rates. Optum is unable to correctly process billing we submit on behalf of psychiatrists. Our psychiatrists are paid as a percentage of collections, and none of them want to accept MA patients any longer because the payments are almost always incorrect.
- **Customer Service**: Erroneous denials often do not have accurate or actionable denial reasons, requiring our staff to call to Optum customer service for each of these. Optum staff are poorly trained and consistently remit incorrect information, so each phone call lasts about 45-60 minutes and fixes only a handful of claims, if at all. Optum's phone lines are also notorious for disconnecting calls, and not reliably giving issue #s to complaints so they can be tracked or escalated. We just do not have the staff time available to be placed on hold constantly only to receive wrong information.

- **Reprocessed claims:** The substantial volume of erroneous claims denials, as well as a steady stream of claims paid at the wrong rate, mean that our agency has hundreds of thousands of claims reprocessed 1, 2, 3 and sometimes 10 times. What this means is that instead of managing the billing for an agency that submits 1000 services in a month, our billing staff are managing a revenue cycle equivalent to an agency 5 times our size.
- **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 claims denials.
- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. 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. We received contact from Optum representatives who are supposed to guide us through the reconciliation process, but they have remitted no clear information on how that process would work nor have they given us the tools to access the information that would enable us to begin the process.

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.

Pathways Testimony SB638.pdf
Uploaded by: Hall, Shannon
Position: FAV

Pathways, Inc.

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

POSITION: FAVORABLE

I am Gerard McGloin, and I am the Executive Director at Pathways, Inc. We provide mental health and substance use services in Calvert, Charles, Prince Georges, and St. Mary's counties. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 2,000 persons every year, and we employ 125 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's 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 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. Optum's current dysfunction is reducing our revenue and increasing our costs. We have already been forced to redirect resources away from treatment in response to persistent problems with Optum. Without immediate enforcement, our agency faces continued inefficiencies in the use of already tight resources primarily due to significant wasted time spent by personnel in our multiple programs needlessly attempting to respond to and counter Optum's incompetent efforts to provide service authorizations and pay valid claims. I have first-hand experience with all 4 of the ASOs that have preceded Optum – this has, by far, been an unprecedented terrible experience.

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments—all basic revenue cycle management functions-- are not available in Optum's system. Billing operations which used to be done electronically now require an enormous manual lift for our agency. This burden of manual reconciliation has resulted in 227 hours of overtime for billing staff to keep up.
- **Erroneous claims denials:** The limitations and errors in Optum's system mean claims are denied in error constantly. For instance, Optum's system cannot accurately process multiple insurances or changes in client eligibility. All of these claims have denied since August. Additionally, the Supported Employment billing configuration is STILL not set up properly in Optum's system. Most of these claims do not pay.
- **Customer Service**: Erroneous denials often do not have accurate or actionable denial reasons, requiring our staff to call to Optum customer service for each of these. Optum staff

are poorly trained and consistently remit incorrect information, so each phone call lasts about 45-60 minutes and fixes only a handful of claims, if any. Optum's phone lines are also notorious for disconnecting calls, and not reliably giving issue #s to complaints so they can be tracked or escalated. Claims are not reviewed in a timely manner after 14 business days from the initial call. Also, our staff is not receiving 835s Claims Payment Advice on denied claims in Optum's Incedo system. In spite of continuous attempts by our billing staff to educate Optum regarding the erroneous denial responses we receive, we still experience frequent inconsistency in responses from Optum staff during attempts to resolve a problem. In addition to Optum's apparent inadequate staff training, their internal communications are terribly inadequate.

- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. 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. This has impacted our current financial audit, and we've been forced to spend an excessive amount of time manually tracking cashflow due to an inability to run an accurate balance sheet since Optum had to issue estimated payments over a number of months to compensate for their inability to adequately process claims.

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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Position: FAV

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SB 638

Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement

Senate Finance Committee

February 24, 2021

POSITION: FAVORABLE

I am Sondra Tranen, Executive Vice President at Partnership Development Group, Inc. (PDG). We provide behavioral health services in Anne Arundel, Baltimore City, Howard, Montgomery, Prince George's, and Baltimore Counties. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 1,200 people every year, and we employ 55 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 the 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 demand 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. 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 the continuation of unspeakable burdens on existing staff, deteriorating employee morale stemming from systemic Optum issues beyond their control, and the inevitable need to hire additional staff in order to mitigate the mental and emotional toll on our current employees. **Additional staff hours has cost PDG over $77,000 so far, and I estimate our company stands to lose approximately $305,000 in earned program income due to the ineptitude of Optum as the Maryland ASO**. This number represents approximately 10% of total Optum claims submitted, and will ultimately affect the company's ability to meet cash flow requirements.

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments—all basic revenue cycle management functions--are not available in Optum's system. Billing operations which used to be done electronically now require an enormous manual lift for our agency. We estimate that 24% of our billing and management staff time is spent troubleshooting Optum's deficit system.
- **Erroneous claims denials:** The limitations and errors in Optum's system mean claims are denied in error constantly. For instance, Optum's system cannot accurately process multiple insurances or changes in client eligibility. All of these claims have been denied since August. This represents $153,000 in lost revenue just for the period of August through December 2020.
- **Reprocessed claims:** The substantial volume of erroneous claims denials, as well as a steady stream of claims paid at the wrong rate, mean that our agency has hundreds of claims reprocessed 1, 2, 3 and sometimes 10 times. What this means is that instead of managing the billing for an agency that submits 1,320 services in a month, our billing staff are managing a revenue cycle equivalent to an agency 5 times our size.
- **Estimated payment reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. 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 than that in their claims processing system. In addition, Optum has launched three different reconciliation process attempts, none of which have provided the tools and data needed by providers to complete reconciliation. This has caused our agency, alongside hundreds of others, to pivot to the latest and greatest, at Optum's whim. Suffice to say, our staff are carrying the burden of a painstaking, mostly manual reconciliation process, whose outcome may not serve our company in the face of Optum's inaccurate data. In other words, we have significant trepidation regarding Optum holding the key to final reconciliation outcomes given their year+ long track record of instability and inaccuracy. A fair and accurate outcome to reconciliation seems unlikely, and we are trying to prepare for this probability. Further, we have spoken to an auditor and CPA about the incomplete details associated with the receipt of Optum's 2020 estimated payments and the potential tax repercussions. There is no question—this too, will present problems as we move into tax and audit season.

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 for a favorable report on SB 638.

Prologue Testimony SB638.pdf
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Position: FAV

Prologue, Inc.

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

POSITION: FAVORABLE

I am Sendy Rommel and I am President and CEO at Prologue, Inc. We provide mental health and substance use, and housing and homeless services in Baltimore, Carroll and Harford Counties. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 1,000 individuals and/or families every year and we employ 100 + individuals. A majority of the persons we serve are publicly funded Medicaid recipients.

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 emergency because immediate action is needed to prevent continued harm that reduces our capacity to provide services to Maryland residents at a time when the pandemic is driving 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. Optum's current dysfunction is reducing our verifiable revenue and increasing our costs. Without immediate enforcement our agency faces ongoing financial limbo caused by continued delays in obtaining the necessary tools to complete the reconciliation process. ***In the last 24 years, our agency has worked through many ASO transitions with several different vendors and have never experienced anything remotely comparable to this level of dysfunction and system inadequacy.***

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments—all basic revenue cycle management functions-- are not available in Optum's system. Billing operations which used to be done electronically now require an enormous manual lift for our agency. The Incedo portal does not display check numbers matched with claims information, an especially essential tool given the volume of reprocessed and partially paid claims. Each claim therefore requires extra staff time and manual effort to verify and cross-reference.
- **Erroneous claims denials:** The limitations and errors in Optum's system mean claims are denied in error constantly. For instance, Optum's system cannot accurately process multiple insurances or changes in client eligibility. All of these claims have denied since August. These claims do not pay and are near impossible to track; leading to the need to re-bill multiple times.
- **Customer Service**: Erroneous denials often do not have accurate or actionable denial reasons, requiring our staff to call Optum customer service for each of these. Optum staff is poorly trained and consistently convey incorrect information. Just this week, one of our

Program Directors spent three hours on the phone with customer service to correct 15 of 28 pending issues. Based on past experience, we expect only 8 of these to be resolved correctly, requiring our staff to make another lengthy follow-up call. The time spent resolving these issues takes away from time providing essential services to individuals in need.

- **Broken functions:** Optum's claims system is constantly malfunctioning. Some recent malfunctions include foundational operations such as downloading authorizations and searching the Incedo system for claim information. When they are broken, we can't do our jobs. Every week it is something new that they are "going to fix" or "getting ready to relaunch."
- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. Our staff is manually reconciling claims from reports remitted by Optum which do not match the receipts we have nor do they match the information in Optum's claims processing system. This has impacted our fiscal year-end financial audit. ***This is the first time in decades our financial audit has not been completed within three months of the fiscal year end. It has impacted our ability to move forward with several pending projects requiring bank level approvals that require a current audit.***

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.

SB 638 - Keypoint.pdf
Uploaded by: Hall, Shannon
Position: FAV

OUTPATIENT MENTAL HEALTH PROGRAMS

RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

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

POSITION: FAVORABLE

I am Russ Weber, and I am the CEO at Key Point Health Services, Inc. We provide behavioral health services in Harford County, Cecil County, Baltimore County and Baltimore City. I am submitting this written testimony on SB 638 to urge your support for this bill. Our organization serves approximately 3000 clients every year, and we employ 270 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 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 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 required for our agency to operate effectively. Optum's current dysfunction is reducing our revenue and increasing our costs. We have already been forced to redirect resources away from treatment and toward billing and administrative functions in order to keep our organization afloat due to Optum's systemic dysfunction. Without immediate enforcement, our agency faces the possibility of having to hire additional staff to meet the added workload Optum continues to place on providers of essential community behavioral health services. Payments remain so inconsistent that it is very difficult to forecast and budget for the future.

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

- **Basic business revenue tools don't exist:** The ability to run reports, research claims, and reconcile payments—all basic revenue cycle management functions-- are not available in Optum's system. Billing operations which used to be done electronically now require an enormous manual lift for our agency. We need to be able to run reports through Optum's portal to retrieve data integral to managing our business operations and finances. The inability to do this places significant and tedious burden on our billing department to individually track authorizations, eligibility and claims that have been reprocessed dozens of

times. We are managing without the most basic ability to export and analyze bulk data as Optum's system only allows a provider to see a max of 500 claims per inquiry, and Key Point bills thousands of claims weekly.

- **Erroneous claims denials:** The limitations and errors in Optum's system mean claims are denied in error constantly. For instance, Optum's system cannot accurately process multiple insurances or changes in client eligibility. Key Point currently has hundreds of claims which have denied as "duplicate claims," which were submitted only once. We also have a substantial volume of "black hole" claims which never made it into Optum's claims portal despite receiving a receipt stating our batches of claims have been accepted.
- **Customer Service**: Erroneous denials often do not have accurate or actionable denial reasons, requiring our staff to call to Optum customer service for each of these. Optum staff are poorly trained and consistently remit incorrect information, so each phone call lasts about 45-60 minutes and fixes only a handful of claims, if at all. Optum's phone lines are also notorious for disconnecting calls, and not reliably giving issue #s to complaints so they can be tracked or escalated. The dates on Optum's checks are often incorrect and do not reflect that date claims were actually paid. Optum's customer service is unable to provide us this information, and refer us to various other departments where we receive no further clarity on such questions. This is illustrative of our experience overall, where Optum online portal doesn't provide us key information and our attempts to obtain it through their customer service and provider relations departments yield no further information.
- **Reprocessed claims:** The substantial volume of erroneous claims denials, as well as a steady stream of claims paid at the wrong rate, mean that our agency has hundreds of thousands of claims reprocessed 1, 2, 3 and sometimes 10 times. What this means is that instead of managing the billing for an agency that submits 10,000 services in a month, our billing staff are managing a revenue cycle equivalent to an agency much larger than ours.
- **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 claims denials.

- **Reconciliation:** The absence of basic revenue cycle management tools has rendered the reconciliation of 7 months of estimated payments (from the period when Optum's claims system was entirely non-functional) nearly impossible. 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. ***This has impacted our recent financial audits and forced our agency to increase our line of credit to protect our payroll and operating expenses.*** Key Point is still waiting on Optum to provide us with over 100 missing electronic payment files so we can begin to work on our reconciliation process. This request was made in October 2020.

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.

SB0638_FAV_MdCSWC_Ins. Commisioner - Specialty MH

Uploaded by: Kasemeyer, Pam

Position: FAV

MdCSWC **The Maryland Clinical Social Work Coalition**

The MdCSWC, sponsored by the Greater Washington Society for Clinical Social Work, represents the interests of more than 9,500 licensed clinical social workers in Maryland.

TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Malcolm Augustine

FROM: Judith Gallant, LCSW-C, Chair, Maryland Clinical Social Work Coalition

DATE: February 24, 2021

RE: **SUPPORT** – Senate Bill 638 – *Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement*

The Maryland Clinical Social Work Coalition (MdCSWC), sponsored by the Greater Washington Society for Clinical Social Work, represents the interests of more than 9,500 licensed clinical social workers in Maryland. On behalf of MdCSWC, we **support** Senate Bill 638.

Senate Bill 638 authorizes the Maryland Insurance Commissioner to enforce the existing law of § 15-1005 of the Insurance Article with respect to the Administrative Services Organization (ASO) of the Public Behavioral Health System (PBHS). Maryland's fee-for-service PBHS is managed by an ASO through a statewide contract with the Maryland Department of Health (MDH). In 2020, the ASO transitioned from Beacon Health to Optum Maryland. Since this transition occurred, there have been significant and unaddressed challenges for behavioral health providers in the PBHS, including, but not limited to, a largely inoperable provider portal for entering and managing provider claims, denied authorizations, incorrect claims payments to providers, and inaccurate information for reconciliation of claims. Although, Optum Maryland has made efforts to correct the many system failures, the challenges still exist today and Optum has not demonstrated a plan to resolve them.

The Maryland Insurance Administration (MIA) has indicated that without the passage of this legislation, it does not have statutory authority to enforce compliance by the ASO with the prompt pay and interest penalty provisions of § 15-1005 of the Insurance Article, that authority currently abides with MDH. § 15-1005 provides that entities subject to this subsection must do one of three things within 30 days:

1. Mail or otherwise transmit payment for the claim;
2. Send a notice of receipt and status of the claim specifying that the ASO refuses to reimburse all or part of the claim, the reason for the refusal, and what additional information is necessary to determine if all or part of the claim will be reimbursed; or
3. State that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.

The subsection also includes the provision of interest penalties if the ASO violates these requirements and establishes fines and penalties for arbitrary and capricious violations as well as penalties for frequent violation.

Greater Washington Society for Clinical Social Work: www.gwscsw.org
Contacts: Coalition Chair: Judy Gallant, LCSW-C; email: jg708@columbia.edu; mobile (301) 717-1004
Legislative Consultant: Pamela Metz Kasemeyer, Schwartz, Metz & Wise PA, 20 West Street, Annapolis, MD 21401
Email: pmetz@smwpa.com; mobile (410) 746-9003

The providers impacted by Optum's system failures are safety net providers who serve those in need. While they have continued to work with Optum to try to fix the system's shortcomings, these providers cannot continue to be underpaid and divert scarce human resources to address the malfunction of Optum with respect to claims administration. Passage of Senate Bill 638 will ensure that Optum will be held accountable to the providers and the individuals they serve. A favorable report is requested.

For more information call:
Pamela Metz Kasemeyer
Danna L. Kauffman
410-244-7000

SB0638 MIA ASO Enforcement - MHAMD FAV.pdf
Uploaded by: Martin, Dan
Position: FAV

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

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Senate Bill 638 Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims - Enforcement
Finance Committee
February 24, 2021
Position: SUPPORT

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health and substance use disorders (collectively referred to as behavioral health). **We appreciate the opportunity to provide this testimony in support of Senate Bill 638.**

SB 638 authorizes the Maryland Insurance Commissioner to **enforce minimum performance standards** for the Administrative Services Organization (ASO) that is responsible for managing the delivery of public mental health and substance use disorder services.

In January 2020, the Maryland Department of Health transitioned administrative management of the public behavioral health system to a new vendor – Optum Maryland. To say the transition has been a challenge would be an understatement. Optum's IT system failed immediately, and over a year of chaos and uncertainty have followed.

The Optum system is unable to perform even the most basic claims processing functions. Mental health and substance use treatment providers do not have the information they need to determine their financial position or their ability to make payroll. Optum has not provided clear and consistent communication or basic technical assistance support, leaving behavioral health providers mired in a system that requires duplication of effort and diversion of their attention away from clinical care.

This is a situation that would be untenable in normal times. It is particularly disconcerting at a time of skyrocketing demand for treatment. Maryland has managed many of these vendor transitions over the past 20 years. Never before has the process been so dysfunctional and disruptive.

As the pandemic wanes and the need for mental health and substance use treatment continues to rise, these services will be more important than ever. But if this situation continues unabated many community providers will find it difficult to carry on, and access to critical public behavioral health services will decrease even further

The additional enforcement mechanism provided by Senate Bill 638 is a critical component in our efforts to ensure Marylanders with mental health and substance use disorders are able to access care during this time of increasing demand. For this reason, **MHAMD supports this bill and urges a favorable report.**

For more information, please contact Dan Martin at (410) 978-8865

Sheppard Pratt written testimony SB6388HB919 MD In

Uploaded by: Richardson, Jeffrey

Position: FAV

Sheppard Pratt

Written Testimony
Senate Finance Committee
House Health and Government Operations Committee
SB638 / HB919 Maryland Insurance Commissioner –
Specialty Mental Health Services and Payment of Claims – Enforcement

February 17, 2021

Position: Support

Sheppard Pratt thanks the Maryland General Assembly for your longstanding leadership and support of mental and behavioral health providers in Maryland. This testimony outlines the Sheppard Pratt **support for SB638/HB919 Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement.** It is our hope that the Maryland General Assembly vote a favorable report on this legislation.

Sheppard Pratt does acknowledge and appreciate the efforts of the Maryland Department of Health and especially the leadership at the Department who have tried to make the Administrative Service Organization (ASO) transition seamless through estimated payments and participation in meetings. We also commend the Maryland General Assembly for the continued oversight and debate of the legislation before you today.

However, challenges continue to persist with a transition that is over a year long process. Given the size and scope of the services Sheppard Pratt provides throughout the State, this ASO transition is an extraordinary challenge especially as we also try to keep our doors open during a pandemic. The legislation before you is necessary to ensure that the transition comes to a successful conclusion. It authorizes the Maryland Insurance Commissioner to enforce minimum performance standards for the ASO that is responsible for managing care and paying claims for the Maryland public behavioral health system. This immediate action is needed to prevent continued harm that reduces our capacity to treat Maryland residents at a time when the pandemic is driving need higher than ever.

The Sheppard Pratt mission is to improve the quality of life of individuals and families by compassionately serving their mental health, addiction, special education, and community support needs. This mission is severely compromised by our experience with Optum and is illustrated by the examples below:

Authorization Issues

From the very start of a long, tumultuous year, we have had and continue to have issues with routine authorizations, including the following:

- No explanation for authorization denials.
- Inconsistency with authorizations.
- Time to enter authorizations and follow-up have increased.

Jeffrey Grossi, JD, Chief of Government Relations | jgrossi@sheppardpratt.org | 410.938.3181

Sheppard Pratt

- System was set up by provider type which creates challenges moving authorizations for a single patient between provider types.

Claims Processing Issues

We continue to experience claims processing errors, including:

- Insufficient plan outlined for reconciliation process for estimated payment period claims which represents bulk of claims (all claims though August 2nd), requiring additional workforce.
- Overpayments (duplicate payments for new day claims, secondary payments processing as primary).
- Inpatient and residential claims not paying for the discharge date.
- Services paid at incorrect rate (universal, inpatient, outpatient, residential treatment).
- Insurance issues creating large percentage of denials.
- Payments being made out to clinicians.
- Patients that were not billed are being paid.
- Receiving patient claims data from other organizations.

Audit and Reporting Issues

Lack of accurate reporting resulting in the following:

- Current payment summary report for all corporations within Sheppard Pratt are off by millions in billed charges verses internal records.
- Lack of valid reports coupled with the reprocessing of claims multiple times as well as high rate of denials and authorization issues means that management believes balance sheet accounts are not reliable.

Call Center

Staff at the call center have not been adequately trained on Maryland Medicaid and Behavioral Health programs and billing. This results in inconsistent messaging from call center staff. While issues are escalated, they remain unresolved.

Sheppard Pratt Financial Exposure with Optum

The continued problems with Optum and the Incedo system coupled with sustained losses resulting from COVID-19 leaves Sheppard Pratt exposed to (1) cash on hand issues; (2) loss of margin; (3) continued audit issues and (4) resource constraints. The impact to Sheppard Pratt continues to be in the range of tens of millions of dollars.

- Based on Optum documents, for billed charges for one corporation, 23 percent of claims were denied, and an additional 12 percent were disallowed resulting in millions in underpayment. Prior denial rates were below 10 percent.

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- Based on Optum documents, 99.94 percent of claims were adjudicated and paid within 14 days
    - This is because Optum paid, retracted, and then denied claims
- Overpayments and resulting liability to Optum from duplicate payments and Optum not recognizing primary insurance is currently unknown.
- Auditors are unable to test and confirm balances and rely on Optum reports.
- Workforce issues include:
    - Additional time to process authorizations;
    - Claims management time and effort have dramatically increased; and
    - The expense and impact beyond time and workforce stress is not known.

Sheppard Pratt urges you to act now to preserve Maryland's treatment capacity and vote a favorable report on **SB638/HB919 Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement**.

About Sheppard Pratt

Sheppard Pratt is the nation's largest private, nonprofit provider of mental health, substance use, developmental disability, special education, and social services in the country. A nationwide resource, Sheppard Pratt provides services across a comprehensive continuum of care, spanning both hospital- and community-based resources. Since its founding in 1853, Sheppard Pratt has been innovating the field through research, best practice implementation, and a focus on improving the quality of mental health care on a global level. Sheppard Pratt has been consistently ranked as a top national psychiatric hospital by *U.S. News & World Report* for nearly 30 years.

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NCADD-MD - SB 638 FAV - Behavioral Health Payment
Uploaded by: Rosen-Cohen, Nancy
Position: FAV

Senate Finance Committee
February 24, 2021

Senate Bill 638
Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement
Support

NCADD-Maryland supports Senate Bill 638 – Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement.

Since January 1, 2020, Maryland's public behavioral health system's new administrative services organization (ASO) has failed to accomplish the basic functions it was contracted to do. After more than a year, it has become evident that additional oversight is needed to enforce provisions in State law that require appropriate and timely responses to claims submitted by providers.

As the Maryland Insurance Administration (MIA) does not have statutory authority to enforce compliance by the ASO with prompt payment provisions in law, Senate Bill 638 seeks to change that. Currently, the Maryland Department of Health (MDH) holds that authority, but despite more than a year of provider complaints regarding Optum's failure to comply with statute, MDH has not held Optum accountable. We are only recently aware that minimal fines have been charged for a few months. We believe the MIA is in a better position to perform this oversight function since they have years of experience enforcing the law with other payers.

The failure of Optum led to significant additional administrative burdens on providers. Difficulties were then compounded with the impact of the COVID-19 pandemic. Dealing with these operational challenges amid growing mental health and substance use problems in the community has created an untenable situation. This bill will not magically fix all that is wrong, but will demonstrate how serious the State is about ensuring a well-functioning system.

We urge a favorable report on Senate Bill 638.

The Maryland Affiliate of the National Council on Alcoholism and Drug Dependence (NCADD-Maryland) is a statewide organization that works to influence public and private policies on addiction, treatment, and recovery, reduce the stigma associated with the disease, and improve the understanding of addictions and the recovery process. We advocate for and with individuals and families who are affected by alcoholism and drug addiction.

National Council on Alcoholism & Drug Dependence – Maryland Chapter
28 E. Ostend Street, Suite 303, Baltimore, MD 21230 · 410-625-6482 · fax 410-625-6484
www.ncaddmaryland.org

Directorate Support letter SB638 MIA Enforcement.p
Uploaded by: Sperlein, Joan
Position: FAV

BALTIMORE CITY
SUBSTANCE ABUSE DIRECTORATE

February 22, 2021

Testimony on SB 638
Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims - Enforcement
Senate Finance Committee
February 24, 2021
POSITION: SUPPORT

The Baltimore City Substance Abuse Director (BSCAD) is an advocacy and provider organization comprised of 30 Baltimore City substance use disorders treatment providers representing all levels of care from prevention to residential treatment. Our mission is the promotion of high-quality, best-practice and effective substance use disorders treatment for the citizens of Baltimore City. We are also involved in and support legislation that ensures our citizens get the best possible care through active consideration of legislation as it relates to the health and well-being of our consumer population.

In July 2019, Optum Maryland, as the lowest bidder, was awarded Maryland's Administrative Service Organization (ASO) contract for the state's public behavioral health system. The system failed immediately when operations commenced in January 2020. Fundamental systems problems continue to the present with no end in sight. Substance Use Disorder providers across Baltimore City have been put under tremendous strain, spending countless unreimbursed hours of staff time to reconcile old claims, review reams of data, attempt to communicate with the ASO, and suffer from cash flow crises. At this point there is no expectation that the problems will ever be resolved by pursuing the current path.

Ultimately it is the citizens of Baltimore City with mental and substance use challenges who suffer the consequences of the failure to enforce the ASO contract. Passage of SB 638 is an action this committee and the General Assembly can take to hold Optum accountable to our providers and the individuals they serve.

As such, the BCSAD urges a favorable report on SB 638.

Joan Sperlein, LCPC, CAC-AD
President, BCSAD

c/o REACH Health Services
2104 Maryland Avenue
Baltimore, Maryland 21218
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SB 638 - Support - MPS WPS.pdf
Uploaded by: Tompsett, Thomas
Position: FAV

February 22, 2021

The Honorable Delores G. Kelley
3 East - Miller Senate Office Building
Annapolis, Maryland 21401

RE: Support with Amendments – SB 638: Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement

Dear Chairman Kelley and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strives through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS and WPS support Senate Bill 638: Maryland Insurance Commissioner – Specialty Mental Health Services and Payment of Claims – Enforcement (SB 638) as it would require enforcement of the insurance law that requires prompt payment of claims to be paid by insurers to all mental health providers caring for Medicaid patients under the 1115 Health Choice waiver. Maintaining the viability of services to Maryland's poor mental health population is particularly important during the added stress of a pandemic. Mental health centers, and clinicians who provide care to Medicaid patients, are the backbone of Maryland's public mental health system.

MPS and WPS asks the committee for a favorable report of SB 286. If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Joint Legislative Action Committee

MATOD - SB 638 FAV - MIA Enforcement - Specialty M

Uploaded by: Walters, Vickie

Position: FAV

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Finance Committee
Specialty Mental Health Services and Payment of Claims – Enforcement
February 24, 2021
Support of Senate Bill 638

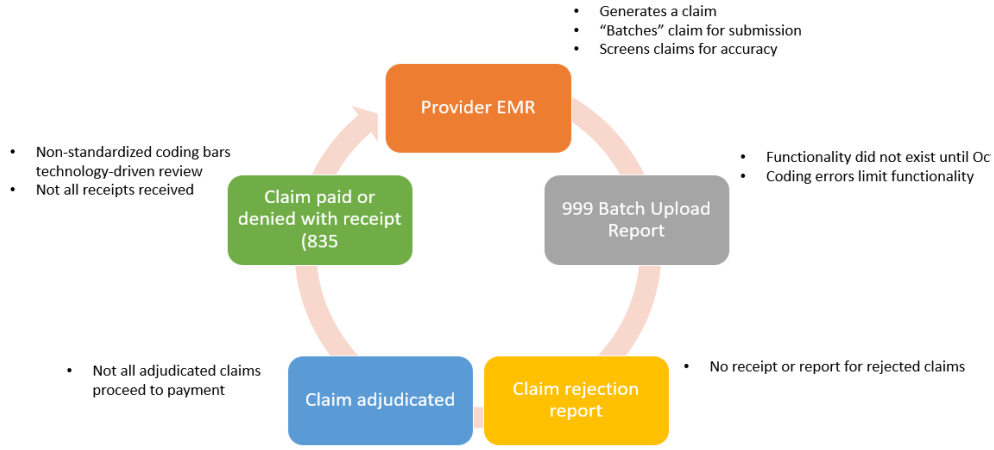
MATOD is a provider and advocacy association comprised of the majority of the state's 95 opioid treatment programs (OTPs). Maryland OTPs currently provide comprehensive medication assisted treatment for over 40,000 Marylanders with opioid use disorder (OUD).

The transition of administrative services organizations (ASO) from Beacon Health Options to Optum Behavior Health has created immense difficulties for the Maryland public behavioral health system. OTPs have not been exempt from these problems.

In the first half of 2020, the claims system did not work. Providers had difficulties entering claims into Optum's claims processing system, and even more difficulty receiving payment for these claims. The Maryland Department of Health (MDH) allowed for estimated payments based on historic claims payments from the period of late January to August 3, 2020. The reprieve of estimated payments offered Optum an extra seven months to build and implement an effective claims system during this period.

A Dysfunctional System

When the "live" claims system came back online in early August, the system still demonstrated significant limitations and problems. Providers began receiving payment for claims submitted, but to this day, there is concern that the data is inaccurate. To explain why, a simple understanding of the claims processed must be understood (see flow chart below):



At virtually every step in Optum's claims processing system, there are limitations or missing report functions. Claims trapped in these gaps are difficult – if not impossible – to identify. Missing claims means reduced revenue for providers. We do not know what Optum has rejected, which leaves claims unpaid for weeks or months (or forever) without the providers knowing. Maryland law requires Optum, within 30 days of receiving a claim, to deliver payment or a detailed receipt identifying the information needed to pay the claim. Optum has not complied with these standards. Enforcement action is needed to ensure that providers can be paid for the services provided.

(over)

MATOD members include community and hospital based Opioid Treatment Programs, local Health Departments, local Addiction and Behavioral Health Authorities and Maryland organizations that support evidence-based Medication Assisted Treatment. MATOD members include thousands of highly trained and dedicated addiction counselors, clinical social workers, physicians, nurse practitioners, physician assistants, nurses, peer recovery specialists and dedicated staff who work every day to save and transform lives.

CURRENT FAILURES COMPOUNDED BY RECONCILIATION MESS

Optum's ongoing inability to process claims correctly is compounded by the reconciliation process in which Optum has begun to compare providers' estimated payments to what was billed and approved. This process cannot be accurately completed until all information and all claims submitted is received by providers - including the aforementioned rejections. Providers currently must work through roughly eight reports with hundreds of thousands of lines of data to crosscheck that the determinations Optum has made are correct.

This requires an immense amount of time and resources that the providers are being forced to utilize, even though the inefficient system that created the problem was Optum's responsibility. The time and resources are being diverted from daily claims processing (needed to maintain the stability of programs) all while revenues are down due to the inefficient Optum system.

The diversion of these resources and its effects on daily processing is happening in the shadow of impending recoupments that MDH is seeking for overpayments made during the estimated payment period - which is currently impossible for providers to verify the accuracy of the amount determined by MDH/Optum.

Moreover, this entire process is happening during a pandemic that required providers to completely re-design their workflows and impacts productivity.

These issues have been identified, raised, and discussed by the provider community since the initial transition to Optum on 01/1/2020. There are still systemic problems with the Optum system that need to be addressed outside of Optum and MDH to ensure providers are protected.

MATOD supports SB638/HB919 because it gives the Maryland Insurance Administration the authority to hold Optum accountable and provide financial support for errors made by Optum. This is a crucial missing piece in the public behavioral health system that will support providers and not allow Optum to create financial deficiencies and expect providers to clean up their mess.

SB638- Hopkins.Coble - LOI.pdf
Uploaded by: Coble, Annie
Position: INFO

JOHNS HOPKINS
UNIVERSITY & MEDICINE
Government and Community Affairs

SB 638
Letter of Information

TO: The Honorable Delores Kelley, Chair
Senate Finance Committee

FROM: Annie Coble
Assistant Director, State Affairs, Johns Hopkins University and Medicine

DATE: February 24, 2021

Johns Hopkins would like to provide information regarding **Senate Bill 638 Maryland Insurance Commissioner – Specialty mental Health Services and Payment of Claims – Enforcement.** This bill would grant the Maryland Insurance Administration authority to force the behavioral health administrative services organization (ASO), Optum Maryland, to pay claims. The need for this bill was provoked because of troubles during the transition of the behavioral health ASO from Beacon Health Options to Optum Maryland. Johns Hopkins is appreciative of the work done by the Maryland Department of Health to try and minimize the impact on providers and Medicaid recipients during the transition. As one of the largest providers of behavioral health services in the state of Maryland, Johns Hopkins has been uniquely impacted by the changes. This letter is to provide more detail to the challenges experienced by John Hopkins, which we believe are similar to those experienced by other providers.

Estimated Payments
When Optum Maryland began serving as the State's ASO on January 1, 2020, there were no claims payments made to providers for most of that month. At the end of January, estimated claims payments began based upon payments from the corresponding week in the previous year (2019).

This approach to payments, using 2019 payments as a guide, was originally scheduled to end in April 2020, but estimated payments continued through October 2020. This has been highly disruptive, as volumes of service for a provider or program do not necessarily track on past performance, especially during a global pandemic. Budgeting under these circumstances has been extremely challenging, and there has been the worry that an eventual reconciliation might necessitate payment back to the state if volumes had decreased. During that time, Johns Hopkins exceeded $50M in pending claims processing across its five hospitals. Throughout this time, Optum did not provide guidance or direction as to what the reconciliation process would be, making planning even more problematic.

Reports and Reconciliation
Reconciliation has been problematic throughout this process and remains a challenge to the present time. For a sustained period, Optum Maryland has not able to link payments with specific providers, making it extremely difficult for our health system

to determine appropriate payments for particular centers (e.g., Johns Hopkins Hospital versus Johns Hopkins Bayview Medical Center), let alone programs or individuals within those centers. This makes budget planning and individual provider feedback regarding performance impossible and has constrained targeted growth that might otherwise occur. This has been further confounded by delays in getting individual providers appropriately set up in the Optum system.

Additionally, reconciliation has also been delayed several times as the Optum Maryland system needed additional updates and reconciliation reports to be finalized. The first version of reconciliation reports provided by Optum lacked necessary information for Johns Hopkins to properly evaluate which submitted claims had been paid. Eventually Optum Maryland implemented a pilot reconciliation process in which Johns Hopkins was fortunate to participate. During the pilot there continued to be issues with the clarity and completeness of the reports. Additionally, Johns Hopkins continued to experience a lack of information that impeded progress. Unfortunately, the reconciliation meetings and resources to-date have failed to address concerns regarding missing information and some irreconcilable claims and payments received.

Authorizations

Johns Hopkins has had an issue with being able to get authorizations. There have been periodic episodes where many of our clinics do not have the option when getting an authorization to select a "service", which halts their capability to proceed in obtaining an authorization process. We have had several one on ones with Optum and our clinic representatives to resolve these issues when this happens, and it seems to work for a few months and then randomly the issue will return. This is in the process of being resolved again by Optum.

Customer Service

Although Optum Maryland's Customer Service representatives have consistently been cordial and accommodating, our experience has been that frequently representatives were unable to answer specific questions. Regular meetings with Johns Hopkins and Optum Maryland's customer service were established to try to resolve issues efficiently. But, the Optum representatives continued to be unable to answer questions, either because they did not know the answer or did not have the authority to respond on a certain issue. Having the proper Optum representation on the call would have allowed for quicker resolutions.

Johns Hopkins understands and appreciates all of the work and dedication the State has put forth to get Optum Maryland to this point. However, it is important for the Committee to have a full understanding of the issues around the Optum Maryland roll out. As you can imagine, such significant delay in reimbursement to providers, and the uncertainty as to whether payments are lower or higher than they should be, inhibits our ability to fully address the needs of our patients and to retain the providers who serve these vulnerable patients.

This delay of processing has resulted in unresolved system issues with Optum that were not exposed until August, when processing backlogged claims began. This processing, and these issues are still ongoing and need to be addressed. Additionally, patients are continuing to receive behavioral health care. These delays have resulted in Johns Hopkins Customer Service concerns over the status of the outcome of their insurance bills and authorized services.

Planning for expansion of services, critically needed during these stressful times, has

been extremely problematic and challenging. This has affected providers in the Hopkins system, and our financial projections. Of more significance, it has created an environment in which we are constrained in our operations and patient focus due to the distraction of Optum authorization and System issues. While we do not have a position on this legislation, we appreciate the General Assembly's attempt at addressing the concerns of the behavioral health providers impacted during this transition. Johns Hopkins and the State share the same goal of providing the highest quality of behavioral health care to Medicaid recipients. We felt as though this information was important when considering **SB638 Maryland Insurance Commissioner – Specialty mental Health Services and Payment of Claims – Enforcement**.

SB 638 Attachment- MHA Letter to MDH 11.20.2020.pd
Uploaded by: Frazee, Brian
Position: INFO

Maryland
Hospital Association

November 20, 2020

Dennis Schrader
Chief Operating Officer
Deputy Secretary, Health Care Financing
Maryland Department of Health
201 West Preston Street
Baltimore, MD 21201

Dr. Aliya Jones
Deputy Secretary, Behavioral Health
Maryland Department of Health
201 West Preston Street
Baltimore, MD 21201

Re: <u>Optum Administrative Service Organization (ASO) Impact on Hospitals</u>

Dear Mr. Schrader and Dr. Jones:

On behalf of the Maryland Hospital Association's (MHA) 61 member hospitals and health systems, we write to you regarding concerns with the public behavioral health system (PBHS) vendor, Optum Maryland. Maryland hospitals are on the front lines of the state's behavioral health challenges. Hospitals and their partners improved access to the most appropriate level of care for Marylanders overall, but for the one in five with a mental health or substance use disorder, the emergency department often remains the only door to access treatment. These challenges with Optum place immense resource constraints on the hospitals delivering those vital services. **We appreciate the opportunity to present our member hospitals' experience, which has been uniquely compounded by the ongoing fight against the COVID-19 pandemic.**

Through the Maryland Department of Health (MDH), MHA engaged Optum Maryland last fall after the vendor award was announced. We held a "meet and greet" between our hospital members and Optum representatives in our offices in November and maintained communications with the MDH transition team through the ramp-up period. When it became apparent in January that the transition from Beacon to Optum would require additional work, MHA was at the table to discuss alternatives and identify areas of targeted attention. Throughout this year—even during the spring peak of COVID-19 and during this latest surge—MHA engaged weekly with Optum via Operations Improvement Committee meetings. MHA appreciates the efforts Optum and MDH took to connect with advocacy groups. However, we remain concerned that despite consistent engagement, Maryland PBHS providers still experience significant challenges with Optum's performance. MDH authorized estimated provider payments quickly after it became clear Incedo was unable to perform as needed, yet our members remain unable to post a tremendous portion of payments because they lack the corresponding provider remittance advice (PRAs and 835s). **Some Maryland hospitals report they are unable to post tens of millions of dollars due to system inoperability. These aged accounts receivable date back nearly a year.** This is unsustainable for hospitals, which already face financial struggles due to the COVID-19 pandemic.

Optum missed multiple deadlines to release the much-needed PRAs and 835s, as well as critical reports to reconcile the estimated payment amounts against submitted claims. The final tranche of backlogged claims was due to be released in August. It is now mid-November and providers have no confirmation that all documentation has been delivered. Moreover, while MHA understands the need for flexibility in response to feedback, the constant revision of processes and timelines causes confusion and anxiety among PBHS providers. MHA regularly pushed to robustly test new processes—and participated in every testing opportunity offered to hospitals by Optum—but the resulting tests were often rushed with limited opportunity for direct feedback to and responses from Optum subject matter experts.

As it stands now, our members are devoting valuable resources on dual fronts to resolve issues with Optum and Incedo. Their finance and revenue cycle teams are attempting to reconcile estimated provider payments against the mismatched data that has been released—often resorting to time-consuming manual corrections while their billing teams still struggle with claims authorizations and submissions. Therefore, **MHA is asking for greater oversight and accountability for Optum's delivery of mission-critical items and to ensure that all processes for reconciliation and appeals appropriately account for the issues providers have faced during the prolonged transition period, as well as the enduring impacts of the COVID-19 pandemic.**

MHA looks forward to continuing its work within the PBHS for the benefit of our most vulnerable Marylanders. If you would like additional information about the issues experienced by Maryland hospitals, please let us know.

Sincerely,

Brian Frazee
Vice President, Government Affairs

SB 638- Specialty Mental Health Services and Payme

Uploaded by: Frazee, Brian

Position: INFO

Maryland
Hospital Association

February 24, 2021

To: The Honorable Delores G. Kelley, Chair, Senate Finance Committee

Re: Letter of Information- Senate Bill 638 – Specialty Mental Health Services and Payment of Claims – Enforcement

Dear Chair Kelley:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 638. Maryland hospitals are on the front lines of the state's behavioral health crisis. Hospitals and their partners improved access to the most appropriate level of care for Marylanders overall, but for the one in five living with a mental health or substance use disorder, the emergency department often remains the only door to access treatment.

Progress toward achieving a robust behavioral health delivery system, with several points of access to appropriate levels of care, requires seamless operation of the current provider infrastructure. For the most vulnerable populations on Medicaid with behavioral health diagnoses, this infrastructure is facilitated by the administrative services organization (ASO) of the public behavioral health system. MHA acknowledges and appreciates the efforts of the Maryland Department of Health (MDH) and the Maryland General Assembly to resolve continuing issues with the current ASO, Optum Maryland, which launched Jan. 1, 2020.

Maryland hospitals providing specialty behavioral health services continue to struggle with the Optum system. Specialty service professionals, hospital and community based alike, continue to strive for viability to ensure that they can serve individuals, while facing massive financial uncertainties. Last fall, MHA sent the attached letter documenting concerns to MDH. As of today, MHA continues to work with Optum, MDH, and community behavioral health professionals to address these operational issues.

For more information, please contact:
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