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.

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