Archway Station, Inc.

Administrative Offices:
45 Queen St.
Cumberland, MD 21502
301-777-1700

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