SB 549_ASO- Requirements for Retraction, Repayment
Uploaded by: Adrienne Breidenstine
Position: FAV

Behavioral Health System Baltimore

February 16, 2022

Senate Finance Committee
TESTIMONY IN SUPPORT
SB 549 Administrative Services Organization—Requirements for Retraction, Repayment, or Mitigation Claims

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 78,000 people with mental illness and substance use disorders (collectively referred to as "behavioral health") annually.**

Behavioral Health System Baltimore supports SB 549 Administrative Services Organization—Requirements for Retraction, Repayment, or Mitigation Claims. This bill prohibits Maryland's Administrative Services Organization (ASO), Optum, from collecting payment from community-based behavioral health providers unless the ASO can provide accurate insurance encounter, claim, and payment information. To date, Optum has not provided timely or accurate information to behavioral health providers, which is needed to move forward with repayment reconciliation process.

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 local behavioral health authorities (LBHAs), including a largely inoperable provider portal system that provides very limited and often in accurate information to LBHAs, which inhibits their ability to provide proactive care coordination for people with complex behavioral health needs.

As the system manager for Baltimore City, BHSB is required to provide care coordination for people with behavioral health needs who are considered high utilizers of hospital services. However, the Optum provider portal system is unable to provide BHSB with the daily list of "high-utilizers." When provided this information, BHSB can intervene and help the hospital to implement a discharge plan for the individual by assisting that individual access services in the community that can support their health and wellness. Without these daily reports, BHSB is unable to assist individuals and as a result people end up staying longer than necessary in hospital EDs and inpatient psychiatric units.

The challenges with the Optum provider portal system are not limited to LBHAs. Behavioral health providers in the PBHS to have experienced ongoing challenges, 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. A functional provider portal system is key to ensuring providers can submit claims for payment. Because the provider portal system was not functional, in 2019 MDH began to provide estimate payments to behavioral health providers, allowing time for Optum Maryland to fix the provider portal system, however, to date, this system is still not providing accurate and timely information to providers.

SB 549 will ensure the behavioral health provider network remains stable at a time when it is most critical. Deaths from suicide have risen steadily over decades, with alarming trends showing a doubling of suicide deaths among Black Maryland residents in the years leading up to the COVID-19 pandemic. Overdose deaths have skyrocketed, increasing four-fold over the last decade to almost three thousand deaths per year. The COVID-19 pandemic has only made the mental health needs of Marylanders more urgent. If Maryland fails to ensure the provider network remains stable, people struggling with mental health and substance use needs will fall through the cracks.

SB 549 would put in place fair processes for reconciliation of payment from behavioral health providers and hold the ASO, Optum Maryland, accountable for providing accurate information before collecting repayment from behavioral health providers. **As such, BHSB urges the Senate Finance Committee to pass SB 549.**

MCF_Fav_SB 549.pdf
Uploaded by: Ann Geddes
Position: FAV

SB 549 – Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims

Committee: Finance
Date: February 16, 2022
POSITION: Support

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for a loved one with behavioral health needs. Using personal experience, our staff provide one-to-one peer support and navigation services to family members with a child, youth or adult with a mental health, substance use or gambling issue.

MCF strongly supports SB 549.

Ever since Optum took over as Maryland's Administrative Services Organization in January 2020, the providers who offer behavioral health services have been negatively impacted. Optum's system immediately failed, forcing the state to step in with estimated payments while giving Optum more time to develop a working system. Up to this day, there remain problems with Optum's technology – inappropriate denials that require a substantial amount of additional paperwork to correct and underpayments continue to plague the system.

Now, Optum is seeking to reclaim some $200 million dollars from the estimated payments that had to be made because of their faulty system. They are undertaking this effort without yet having a well-functioning system, without adequate documentation, and without accounting for the additional costs that its dysfunction has imposed on providers.

SB 549 would ensure that providers be protected from Optum recouping funds without adequate justification and documentation. In addition, it would ensure that the state not have to pick up the tab in an effort to correct Optum's many failures. To this day they have been held to little accountability.

Therefore we urge a favorable report on SB 549.

Contact: Ann Geddes
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SB549 Cornerstone Montgomery 02162022.pdf
Uploaded by: Cari Cho
Position: FAV

SB 549

Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims

Senate Finance Committee

February 16, 2022

POSITION: FAVORABLE

Good Afternoon Chairwoman Kelley, Vice Chair Feldman and members of the committee. My name is Cari Guthrie Cho and I am the President and CEO of Cornerstone Montgomery. We have been meeting the behavioral health needs of Montgomery County for over 50 years, and with a staff of 350 and the capacity to serve up to 3,000 individuals each year, Cornerstone Montgomery is the largest service provider in Montgomery County. We have remained committed to serving our community's mental health and substance use needs throughout the COVID19 pandemic and disastrous Optum rollout and we need your help to ensure that we are able to continue to do so.

Let me start by saying that Cornerstone Montgomery is not opposed to paying back money that was erroneously paid. However, we can not in good conscience and with fiscal responsibility pay something that we are unable to verify and ensure is accurate. We can not, and will not pay back any amount without accurate and reliable supporting documentation that ties claims to data. We do not have the resources to dedicate staff to reviewing reports and verifying data - we need to continue to work on agency operations that keep us financially afloat as well as provide the necessary services to our clients.

Optum is intent on steamrolling forward with recoupment when they have not accurately supported the overpayments and have demonstrated an irresponsible pattern of repeated errors and misstatements - errors and misstatements that CONTINUE and run the very real risk of clouding the claims status with even more new claims that are not properly vetted, further muddying the waters.

To give a recent example. In December 2021, Optum denied 2.2% of our claims - a number much higher than we ever experienced under the previous ASO. Specifics of these denials include a 76% denial rate for Residential Crisis Psychiatrist services, all of which we believe to be erroneous denials as they are being denied for "no authorization" when there is no authorization required for this service. We have repeatedly been told that this error has been fixed, however we continue to get denials. This is disruptive to our cash flow and takes additional time to follow and correct. Extended authorizations in our vocational programs were denied at a rate of 3.5% -most due to "other payor" when the client has private insurance, but

private insurance does not, and has never covered Vocational services so this denial should never happen, and our Outpatient Mental Health Clinic experienced a 10% denial rate, about 50% of which we believe are also erroneous. This equates to HUNDREDS of claims and thousands of dollars to research and follow up on - often requiring 2-3 calls with Optum to resolve each denied claim. It is extremely difficult to resolve any of these current denials and we are still sorting through denials and Optum errors from 2019 while maintaining our current operations with the same number of billing staff.

Cornerstone Montgomery has a small billing department that has already spent countless hours managing this fiasco. To quantify the amount of staff time to address this, it would be close to $75,000-100,000/per year for the last two years. This does not account for the cost of shifting staff time from regular operations in our billing department including managing other insurance payors, and managing our EHR which has a direct impact on all of our program staff. All of this during a global pandemic when many of our staff were stretched thin and wearing multiple hats to help navigate the complexities and uncertainties of COVID-19. It has had a tremendous negative impact on Cornerstone Montgomery and it is not unreasonable to expect some remedy for this.

This entire situation has crippled our ability to manage and project cash flow with any confidence which in turn inhibits our ability to ensure services are in place to meet the growing demand for mental health and substance use services. This results in lasting negative impacts on our state's most vulnerable citizens who rely on us for behavioral health services.

Also threatening service continuity is the fact that our FY20 audit received a qualified opinion because of this issue and we are currently looking at the same outcome for FY21. This could negatively affect our relationships with funders and impact our ability to successfully apply for grants that are critical to sustaining programs and expanding services.

Cornerstone Montgomery simply does not have the cash reserves to just pay back potentially over a million dollars on the say-so of a system that has been ineffective since its inception. I am confident that you would agree that these unpaid or erroneously denied claims should be deducted from any amount we are asked to repay, yet they are included in Optum's current recoupment plan.

SB 549 is aimed at giving providers like Cornerstone Montgomery the accuracy and transparency they need in order to check Optum's math and ensure that what we owe is accurate so that we can continue to provide services to some of the most vulnerable in our community. We urge you to give SB549 a favorable report.

SB 549 - Families First CLEAN.pdf
Uploaded by: Chandra Chester
Position: FAV

SB 549

Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims

Senate Finance Committee

February 16, 2022

POSITION: FAVORABLE

Senator Kelley and members of the Senate Finance Committee, thank you for taking the time to hear my testimony in support of Senate Bill 549.

I am Chandra Chester, Vice President at Families First Counseling and Psychiatry. We provide behavioral health services in Baltimore City, as well as Howard, Prince George's, and Montgomery counties. Our organization serves approximately 1,800 clients every year, and we employ103 individuals. Most of the patients we serve are publicly funded Medicaid patients.

Families First Counseling and Psychiatry has been severely impacted by the administrative service organization, Optum, which took over as the ASO as of January 1, 2020. Since Optum took over, it has been unable to correctly adjudicate claims for services that Families First has provided to its clients.

Due to the inaccuracy of the information received from Optum, Families First was forced to hire additional staff, pay overtime, and overwork our staff. As we have shouldered these additional expenses, we have had to restructure and cut positions. We have clients with mental health needs ranging from trauma to psychosis on a waitlist due to having to downsize and not having enough therapists to serve them. Referring clients out isn't an option in most cases because many clinics across Maryland are dealing with the same crisis.

In December 2021, Families First received a demand letter for the first phase of recoupment. Our figures are far lower than Optum's, but Optum provided no documentation to justify their amount and help us understand how they arrived at their figure. This month, we have received new information that the amount has gone up, but we have again received no support for the change. Before any amount is recouped we need all of our claims to be correctly adjudicated and accounted for. Passage of SB 549 will ensure that this basic step occurs, and provides a critical independent auditor to review disputes.

The combination of COVID and Optum has negatively impacted our workforce and the clients we serve. The Surgeon General recently issued a historic advisory describing the "devastating" impact that COVID has had on youth mental health. We need to meet our community's need for treatment, and for that reason I ask you to support SB 549 and debt relief for providers.

SB0549 ASO Claims Repayment Requirements w BHC Let

Uploaded by: Dan Martin

Position: FAV

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Senate Bill 549 Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims
Finance Committee
February 16, 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 549.

SB 549 is an emergency bill requiring Optum – the state's current administrative services organization (ASO) for public behavioral health services – to meet certain requirements before it can retract or require repayment for certain claims submitted by mental health and substance use providers. If Optum is unable to comply with these requirements they must retain an independent auditor to determine any amounts owed by providers. The bill also allows providers to request an independent auditor at Optum's expense to resolve differences regarding amounts owed, following reasonable efforts to reach resolution with Optum. Lastly, it requires the Maryland Department of Health (MDH) to report to the legislature on plans to forgive any provider balances that resulted from service disruptions due to COVID-19.

Over two years have passed since Optum took over as ASO for the state's public behavioral health system, and Maryland providers are still struggling to navigate the company's faulty claims payment system. The Maryland General Assembly passed legislation and enacted budget language in 2021 to increase accountability and oversight of Optum, but the challenges persist. In September, the Maryland Behavioral Health Coalition sent a letter to Governor Hogan detailing these challenges and pleading for a fix, yet not a single one of the enumerated system failures has been completely resolved. That letter, which was co-signed by over 120 organizations, is attached to this testimony.

Now, mental health and substance use providers face the prospect of paying back an unverified differential in estimated payments that were made for several months to keep the public behavioral health system afloat when Optum's IT system crashed immediately upon launching in January 2020. These recoupment plans are moving forward despite the lack of reliable data to reconcile historical payments and services.

This is a situation that would be untenable in normal times. However, it is particularly disconcerting at a time of skyrocketing demand. The need for mental health and substance use treatment is at an all-time high, yet our behavioral health providers are finding they must spend enormous time and resources attending to an administrative failure not of their making.

For these reasons, MHAMD supports Senate Bill 549 and urges a favorable report.

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

Maryland Behavioral Health Coalition

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September 28, 2021

The Honorable Larry Hogan
Governor of Maryland
100 State Circle
Annapolis, MD 21401

Dear Governor Hogan,

In the midst of the greatest health care crisis in the United States in a century, which has been accompanied by rising mental illness and addiction, alarming suicide rates, and increased opioid deaths, the basic functionality of Maryland's Public Behavioral Health System (PBHS) remains broken due to the selection in 2019 of a faulty IT vendor. As we approach two years of basic claims payment system failure, we are again writing with a desperate plea to you to take direct action to fix this solvable problem. Attached are copies of our prior correspondence, dating back to April 2020.

After 21 months:

- Claims receipts and payments remain missing
- Insurance coverage and Medicaid eligibility functions do not work and continue to cause erroneous claims denials
- Contractual turn-around times for authorization approvals are missed, delaying services to consumers
- Guardrails preventing multiple authorizations by different providers for the same service do not exist, so services are routinely rendered by authorized providers and not paid
- Plans for the recoupment of unverified overpayments continue to move forward despite the lack of reliable data to reconcile historical payments and services
- Manual interventions to address claims processing failures are plagued by insufficient staffing, resulting in missed deadlines and vendor failure to meet contractual system performance standards
- Optum continues to not be held accountable for contract deliverables

In short, this is a mess. It is clear the Incedo system will never be properly functional and needs to be discarded. And it is likely that reconciliation of estimated payments and claims may not be fully possible due to the extreme dysfunction of the Incedo system.

Failing to act now only increases the likelihood of increased negative impact on the public and the providers who serve them in this time of great need.

This is not the first time an IT vendor has delivered a product with disastrous results, an issue we all are familiar with in today's world, and it won't be the last. Times are hard and we have no interest in casting blame anywhere. We appreciate the impact of COVID 19 on the Health

Department's operations and are well aware that the state government workforce has been impaired in its wake. We appreciate your leadership, Secretary Schrader's leadership and the entire MDH team's responsiveness with respect to COVID 19.

What is heartbreaking about this unfortunate situation is that Maryland's PBHS is among the highest rated in the nation and was poised to move forward with a system transformation effort to advance value-based purchasing using best practice measurement-based care tools, ensuring results-based accountability and incentives promoting the most effective care for those in need. Instead, modernizing the system has been shelved, while our community providers continue to act heroically to serve their clients, amidst increasingly precarious circumstances.

Of utmost importance to us is a commitment that Optum be held financially accountable in any reconciliation effort and that consumers and providers be held harmless as the state moves forward with these plans.

On behalf of the 122 undersigned organizations, we are requesting a meeting with you at your earliest convenience. We wish to share our concerns, discuss solutions and offer our partnership to eliminate this problem.

Thank you for your attention to this issue and request.

Sincerely,

Acadia Healthcare Maryland Clinics
Advantage Psychiatric Services
Archway Station
Arrow Child and Family Ministries
Arundel Lodge
Aspire Wellness Center
Awakenings Recovery Center
Baltimore City Substance Abuse Directorate
Baltimore Crisis Response, Inc. (BCRI)
Baltimore Harm Reduction Coalition (BHRC)
Baymark
Bayside Recovery
Behavioral Health System Baltimore (BHSB)
Board of Child Care
Born Free Wellness Centers of America
Brain Injury Association of Maryland (BIAMD)
Brantwood Family Services
Carroll County Youth Service Bureau
Catholic Charities
Center for Children
Change Health Systems

Channel Marker
Charles County Freedom Landing
Chesapeake Voyagers
Children's Guild
Community Behavioral Health Association of Maryland (CBH)
Community Connections
Community Residences
Cornerstone Montgomery
Corsica River Mental Health Services
Crossroads Community
Eastern Shore Behavioral Health Coalition (ESBHC)
EveryMind
Families First Counseling and Psychiatry
Family Services Foundation
For All Seasons
Foundations Recovery Center
Frederick Institute
Fresh Start Recovery Center
Garrett County Lighthouse
Go-Getters
Goodwill Industries of the Chesapeake (STEP)
Greater Washington Society for Clinical Social Work (GWSCSW)
Harford Belair Community Mental Health Center
Head Injury Rehabilitation and Referral Services (HIRRS)
Hope Health Systems
Humanim
Hudson Behavioral Health
Institutes for Behavioral Resources (IBR)
James' Place
Jewish Social Services Agency
Key Point Health Services
La Clinica del Pueblo
Leading By Example
Legal Action Center (LAC)
Licensed Clinical Professional Counselors of Maryland (LCPCM)
Life Renewal Services
Lower Shore Clinic
Maryland Addiction Directors Council (MADC)
Maryland Association of Behavioral Health Authorities (MABHA)
Maryland Association for the Treatment of Opioid Dependence (MATOD)
Maryland Chapter, American Academy of Pediatrics (MDAAP)
Maryland Clinical Social Work Coalition (MCSWC)
Maryland Coalition of Families (MCF)
Maryland-DC Society of Addiction Medicine (MDDCSAM)
Maryland Hospital Association (MHA)

Maryland Psychiatric Society (MPS)
Maryland Psychological Association (MPA)
Maryland Public Health Association (MdPHA)
Maryland Rural Health Association (MRHA)
Mary T Maryland
Medmark Treatment
Mental Health Association of Maryland (MHAMD)
Mental Health Association of Frederick County
Mental Health Center of Western Maryland
Mid Shore Behavioral Health (MSBH)
Mindful Healing Works
Montgomery County Federation of Families for Children's Mental Health
Montgomery Recovery Services
MSA the Child and Adolescent Center
National Alliance on Mental Illness, Maryland Chapter (NAMI Maryland)
NAMI Metro Baltimore
NAMI Carroll County
NAMI Frederick County
NAMI Harford County
NAMI Howard County
NAMI Kent and Queen Anne's
NAMI Lower Shore
NAMI Montgomery County
NAMI Prince George's County
NAMI Southern Maryland
National Council on Alcoholism and Drug Dependence, Maryland Chapter (NCADD Maryland)
New Journey
On Our Own of Maryland (OOOMD)
Parker Psychiatric Services
Partnership Development Group (PDG) Rehabilitation Services
Pathways
People Encouraging People (PEP)
Phoenix Health Center
Pro Bono Counseling Project
Prologue
Psychotherapeutic Treatment Services
Reginald Lourie Center for Children's Social and Emotional Wellness
Rehabilitation Systems, Inc.
Serenity Health
Seventy Times Seven Wellness Mission
Sheppard Pratt
Silverman Treatment Solutions
Southern Maryland Community Network
Starting Point
Step by Step of Maryland

Thrive Behavioral Health
Transformation Health
Trauma Informed, Inc.
University of Maryland Medical Center (UMMS) Community Psychiatry Division
Upper Bay Counseling and Support Services
Vesta
Voices of Hope
Volunteers of America
Washington Pain Center
Wells House
WIN Family Services

cc: Boyd Rutherford, Lieutenant Governor
Dennis Schrader, Secretary, Maryland Department of Health
Aliya Jones, M.D., Deputy Secretary for Behavioral Health
Steve Schuh, Deputy Secretary for Health Care Financing and Medicaid

SB0549_FAV_MedChi, MACHC, MdCSWC_ASOs - Req. for R
Uploaded by: Danna Kauffman
Position: FAV

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

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Christine K. Krone

DATE: February 16, 2022

RE: **SUPPORT** – Senate Bill 549 – *Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims*

On behalf of the Maryland State Medical Society, the Mid-Atlantic Association of Community Health Centers, and the Maryland Clinical Social Work Coalition, we submit this letter of **support** for Senate Bill 549. Senate Bill 549 requires the State's administrative service organization to provide certain information to a health care provider that delivered specialty mental health services under the Medicaid program during specified dates prior to retracting, requiring repayment of, or seeking mitigation of a claim. The bill also provides a process for non-compliance by the administrative service organization.

Senate Bill 549 is a direct result of the inability of the State's administrative service organization (Optum) to process claims or pay health care providers for services rendered since inception on January 1, 2020. As a result, the Maryland Department of Health has had to resort to making advanced, but estimated payments, to health care providers based on historic 2019 billing data that did not account for the impacts of the COVID-19 pandemic. This has now placed health care providers in the precariuos position of having to pay back the difference between the estimated payments and the claims amount submitted. In a functioning system, this would be a complicated process; however, because Optum's system continues to malfunction, providers are at a disadvantage during a time when a greater number of individuals are seeking behavioral health services.

Therefore, Senate Bill 549 requires Optum to give health care providers the tools needed to substantiate the processing of claims. Health care providers should not be disadvantaged due to the failure of Optum (and the State) to employ a workable billing and claims processing system. Therefore, we urge the Committee to vote favorably on Senate Bill 549.

For more information call:
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SB0549Testimony.pdf
Uploaded by: elizabeth hymel
Position: FAV

THRIVE BEHAVIORAL HEALTH
MEETING PEOPLE WHERE THEY ARE

SB 549
Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims
Senate Finance Committee
February 16, 2022
POSITION: FAVORABLE

I am Elizabeth Hymel, CEO of Thrive Behavioral Health, which has offices in Catonsville, Millersville, Silver Spring and Rosedale. We service more than 5,000 active Medicaid participants at any point during a year.

More than two years after Optum assumed responsibility for claims processing in the public behavioral health system, Thrive continues to struggle with claim problems that disrupt our operations and distort reconciliation. I recently evaluated a sample of our claims to identify these problems. I found the issues widespread and spanning every month from January 2020 through December 31, 2021. While I was only trying to pull together a small sample to show the errors, I wanted to be sure I identified the ongoing issues with Optum. In reality, the actual total volume of these errors was much larger than even I could imagine:

- **Late Payments**. Maryland law requires Optum to pay claims within 30 days. My sample identified 42 claims paid an **average of 104 days after submission**.
- **Claims Denied, Reprocessed, and Paid Late**. I identified a sample 44 claims denied due to Optum errors and then reprocessed multiple times until finally arriving at payment. These claims **averaged 90 days from submission to payment**.
- **Retractions of Claims Never Paid**. We have identified multiple instances where Optum has retracted payment for which we never received a payment.
- **Claims Submitted and Never Paid**. My sample identified **12 claims submitted to Optum in 2020 and never processed or paid**. This is particularly disturbing as these are valid claims that have increased the amount of money that the State of Maryland will ultimately make Thrive payback as an overpayment. The payment of these claims should be reducing that overpayment balance.

It is clear, that there is a persistent pattern by Optum to not pay or acknowledge claims to Thrive within the 30-day state requirement after submission. The problem continues even today, more than two years after Optum became the ASO for the state of Maryland.

We need accountability for Optum and debt relief for providers. Please support SB 549/HB 715 and behavioral health debt relief.

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SB 549 - Administrative Services Organization - Le
Uploaded by: Erin Dorrien
Position: FAV

Maryland
Hospital Association

February 16, 2022

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

Re: Letter of Support – Senate Bill 549 – Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims

Dear Chair Kelley:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment in support of Senate Bill 549. 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.

Maryland's current system for providing behavioral health care to the Medicaid population is managed by an administrative services organization (ASO). MHA acknowledges and appreciates efforts of the Maryland Department of Health (MDH) and the General Assembly to resolve continuing issues with the current ASO, Optum Maryland (Optum). However, Maryland hospitals that deliver specialty behavioral health services continue to struggle with the Optum system. Hospital and community-based specialty service professionals face massive financial uncertainties and growing administrative burdens to manually review Optum accounts.

Optum's contract began Jan. 1, 2020 and almost immediately was plagued by issues, including a system failure within weeks of its launch. Estimated provider payments were distributed to keep behavioral health providers afloat from February to August 2020. Attempts to reconcile the difference between estimated payments and claims submitted by providers during that period began in late 2020. Yet, providers are still waiting on forms and reports identified in SB 549 to appropriately settle their finances for that period. Providers need this information to determine whether Optum and MDH's recoupment estimates are appropriate and/or accurate.

We thank the sponsor for introducing this bill to add a level of accountability to the ASO when recoupment payments are necessary. We look forward to continuing our work with legislators, Optum, MDH, and community behavioral health professionals to address these ongoing operational issues.

For these reasons, we urge a ***favorable*** report on SB 549.

For more information, please contact:
Erin Dorrien, Vice President, Policy
Edorrien@mhaonline.org

SB 549 - Collins testimony Final.pdf
Uploaded by: Heather Collins
Position: FAV

J. DAVID COLLINS & ASSOCIATES LLC
Addictions & Mental Health

SB 549
Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims
Senate Finance Committee
February 14, 2022

Position: Favorable

I am Heather Collins, Executive Director of J. David Collins & Associates LLC, which has offices in Salisbury, Cambridge, and Princess Anne. Our team of 22 employees serves more than 300 Medicaid participants at any point during the year. As you well know, the transition to Optum as the ASO for the Public Mental Health System in January of 2020 has been an ongoing debacle. Optum was not prepared to assume the responsibility and did not have the systems nor personnel in place to operate as the ASO. We have worked diligently over the past two years to operate within their broken system and processes. The system continues to be cumbersome, delay authorizations and incorrectly deny claims for services provided.

These failures lead directly to the problems with reconciliation.

The reports that Optum has provided to date are incomplete and inaccurate. Optum has the expectation that we, as the providers, will review their incorrect denials and communicate the necessary information to refute their denials. The estimated time to review the current reports exceeds 200 work hours. Prior to 2020, we had fewer than 20 denials at a time. We currently have more than 1,800 denials of which Optum has denied payment.

We have provided these services in good faith, and the payments should be approved. The responsibility should not be on the provider to defend our claims against the broken Optum system, it is not possible for us to do this and continue to manage our regular job requirements.
We had hired an outside contractor to assist us at the beginning of the reconciliation process, but after paying them $6,500 and being no closer to being reconciled, we ceased utilizing their services.

Our organization has had 3 reconciliation specialists in the past 18 months. Each time a new specialist is assigned by Optum, we start the entire process over. We are required to explain all the open issues and re-state all the questions that we have been asking.

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As an example, we have been asking specific questions about our incorrectly denied Nurse Practitioner claims for 14 months. We have received no answers, and just last month, we were asked to explain our obvious questions and challenges for a 4th time to our 3rd reconciliation specialist.

When we send an email to our reconciliation specialist, the only acceptable mode of communication, we receive an automated response that their reply will come in 3 to 5 days due to the high workload they are facing. The reconciliation process as it is structured will never work, and it has taken my focus off leading my business for over a year. Every minute I spend defending our claims and challenging the incorrect information received is a minute that I am not supporting my team, supervising the quality of our current services and developing new programming. I do not have an extra 30 hours per week to focus on the reconciliation process that will never bring us to an accurate reconciliation.

Optum is telling us that we owe them $305,000. This is wrong. We have been overpaid less than $50,000. If they begin to take back the incorrect amount by retracting current payments, we will be forced to close one of our three locations, limit services in our other two locations and decrease staffing. I will personally have to liquidate personal assets to make payroll. It is not unrealistic to believe that we could cease to operate in all three counties that we serve.

In addition to the incorrect overpayment calculation, we estimate that we have spent $70,575 in hourly costs managing the Optum debacle. These are also hours that are not spent providing support to our clinical teams and our clients.

Optum must be held accountable for their inability to perform and there must be debt relief for the providers who have had to navigate this lack of performance. Please support SB 549/HB 715 and behavioral health debt relief.

Sheppard Pratt written testimony SB549 HB715 ASO –
Uploaded by: Jeffrey Grossi
Position: FAV

Sheppard Pratt

Written Testimony

Senate Finance Committee
House Health and Government Operations Committee

SB549 / HB715 Administrative Services Organizations –
Requirements for Retraction, Repayment, or Mitigation of Claims

February 9, 2022

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 SB549 / HB715 Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims.** It is our hope that the Maryland General Assembly vote a favorable report on this legislation.

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

However, challenges continue to persist with a transition that has become a two year plus 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 that continues to persist. 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.

This legislation is about bringing accuracy and transparency to a process caused entirely by Optum's dysfunction. On January 1, 2020, Optum's authorization and claims payment system went live. It was unable to perform critical functions, and the Maryland Department of Health (MDH) was forced to make advance – or estimated – payments to providers to keep them afloat. These estimated payments were based on historic 2019 billing data and did not anticipate the impacts of COVID on service delivery and utilization. Providers were urged to keep serving individuals in need and to submit claims for services, even though estimated payments would replace fee-for-service reimbursement until such time as Optum's system was functional enough to go live again.

Now, Sheppard Pratt and all providers face the prospect of paying back the difference between estimated payments and the amount of claims submitted during the estimated payment period. This process is complicated not only due to the downturn in service volumes caused by COVID but also because Optum's

Sheppard Pratt

system continued to malfunction. Individual claims were reprocessed multiple times, many were erroneously denied, some were lost in Optum's system, and others still sit unprocessed after all this time.

With that said, there is no way for Sheppard Pratt to check Optum's math in terms of what they owe unless all claims submitted during the estimated payment period are correctly processed and Optum provides a report detailing each claims' full history of processing and reprocessing.

This bill requires Optum to meet industry standards for processing claims and providing transparency before they can recoup money from providers. If Optum is unable to meet these standards they are required to hire – at their own expense and without using State funds – an independent auditor to determine actual amounts owed. The bill also allows providers to request an independent auditor – paid for by Optum – if they can't reach agreement with Optum on the amount owed, after reasonable efforts to do so.

The final provision of the bill is a requirement that MDH report back to the policy and budget committees on the amounts providers owe back due to the impact of COVID, and any plans to forgive that debt. Unlike other human service providers that received retainer payments to shield them from the financial impact of COVID, behavioral health providers received no such assistance. Through no fault of our own we now face repayment of significant amounts of money at a time when demand for services is at an unprecedented high.

Sheppard Pratt stresses to the Committees that this legislation is about keeping doors to providers open when the State is looking at an upward trajectory of need for mental and behavioral health services.

Sheppard Pratt urges you to act now to preserve Maryland's treatment capacity and vote a favorable report on **SB549 / HB715 Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims**.

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.

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

Directorate Support letter SB549(HB715).pdf
Uploaded by: Joan Sperlein
Position: FAV

BALTIMORE CITY
SUBSTANCE ABUSE DIRECTORATE

February 16, 2022

Senate Bill 549/House Bill 715 Support

The Baltimore City Substance Abuse Director (BSCAD) is an advocacy and provider organization comprised of 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.

As such, BCSAD strongly supports SB549/HB715.

Since December of 2019 providers have been faced with multiple issues with functionality and transparency with Optum and the Incedo System. Often the problems with in the system were brought to Optum's attention by the providers themselves. Fixes often created other problems and information on how to deal with these was not forthcoming from Optum. Providers have spent a good portion of the last two years discussing these amongst ourselves, asking Optum for clarity and resolutions, only to receive partial responses and a lack of detail required for providers to confidently understand process and movement toward resolution.

Provider representatives have been fully engaged and they have brought information back to specific groups including the BCSAD. Some issues have been resolved, but many have not, and there are no statutory protections for providers for those concerns that linger.

Providers need these protections and Optum needs to be held responsible for the product that they are supposed to be providing the Maryland Behavioral Health Community. Providers need the guardrails that SB549/HB715 outline in order to continue to provide high quality behavioral health services for the citizens of Maryland.

The cost of the failed ASO, a sloppy transition during the height of a global pandemic, a lack of response and transparency have been great for providers. Protections need to be afforded to the provider community to ensure that the ASO is: acting responsibly, communicating effectively their intentions, providing ALL the data providers need to reconcile in a usable format, and providing an avenue to address disagreements that is through a third party.

It is also doubly important to emphasize the need for forgiveness of money owed. Not only were providers forced through the COViD-19 pandemic to spend additional money to serve the mental health and substance abuse needs of our communities in a completely different modality (telehealth) - but we were also forced to do so with an ASO that was not working and unreliable.

Protection for providers in this process is essential and we therefor ask for a favorable reading of this bill. But for this to be made right, forgiveness of the burden providers have had to carry these last two years must also be considered.

c/o REACH Health Services
2104 Maryland Avenue
Baltimore, Maryland 21218
(410) 752-6080

MD Addiction Directors Council - SB 549 - FAV - Op
Uploaded by: Kim Wireman
Position: FAV

Maryland Addiction Directors Council

February 14, 2022

Senate Finance Committee

Testimony in Support of

SB 549 – Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims (Accountability for Optum)

Maryland Addictions Directors Council (MADC) represents outpatient and residential substance use disorder (SUD) and dual recovery treatment across Maryland. Our members provide over 1,000 residential treatment beds across the state. MADC strongly supports accountability for Optum and debt relief for the mental health and addiction providers who have struggled over the last two years to manage the Optum failure to launch then endless other problems with the Optum system. MADC providers are at the forefront of the Opioid Epidemic as well as managing the Covid pandemic during this same 2-year period.

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

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

For the past 2 years Optum has been unable to accurately report on claims and payments resulting from the failure to launch in January 2020. Providers have

(over)

been handed spreadsheets with tens of thousands to hundreds of thousands of lines of claims from Optum's system that providers have had to struggle to sort through by hand. This was due to the public behavioral health vendor for claims payment not functioning properly. None of these issues existed with any of the previous ASOs, of which there had been several.

Now Optum is initiating a process to recoup over $200 million from providers, without getting claims paid correctly, without adequate documentation, and without accounting for the additional costs its dysfunction has imposed on providers. MADC therefore strongly supports:

- Accountability for Optum and debt relief for providers by supporting SB549/HB715. After 2 years, providers should be able to receive claims information and documentation basic to a functioning system that documents proposed recoupment.

- Debt relief to offset the financial impact on providers of Optum's dysfunction on top of COVID. This one-time budget allocation will allow providers to preserve treatment capacity to address Maryland's Opioid Epidemic and rising mental health crisis.

In closing, thank you for the opportunity to offer written testimony. Maryland Addictions Directors Council strongly supports SB 549/HB715.

Sincerely,

Craig Lippens

Craig Lippens
President, MADC

SB549 Written Testimony WIN Family.pdf
Uploaded by: Lauren Grimes
Position: FAV

SB 549

Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims

Senate Finance Committee

February 16, 2022

POSITION: FAVORABLE

My name is Al Laws, CEO of WIN Family Health. Since 1992, WIN has provided behavioral health services in Baltimore City, Baltimore, Cecil and Prince Georges Counties. WIN currently employees over 70 full time staff, 60 contractors, 70 foster parents, and serves over a thousand clients each year. We are members of Maryland's Community Behavioral Health (CBH).

I am writing to implore you to pass this bill which would require OPTUM to provide standard documentation required for providers to accurately reconcile payments, and identify and pay for an independent auditor to ensure fair outcomes in a 2+ circular process fraught uncorrected errors. We also ask that the legislature provide debt relief to the provider community as the cost of correcting and surviving Optum's never-ending claims-processing errors cannot be understated, and this burden has been layered on providers in the midst of COVID and an unprecedented workforce crisis.

Base claims processing is a complex process to understand, below is the best analogy I can offer to give a picture of the utter incompetence that Optum has demonstrated and the chaos they have created for the provider community to untangle.

Normally when you interact with a bank, the bank processes your payments to creditor, manages your deposits, tracks loan repayments, and provides documented verification of these transactions with detailed balance reporting on a monthly basis. This allows you to verify or dispute any information, clarify your financial standing, and close out your monthly activities by balancing your monthly statements.

Now imagine that the banker informs you that their electronic banking system is not operating and all of the deposits, transactions and payments done during the first quarter of the year cannot be processed according to standard processes. The bank gives you a loan to cover you until the system issues are fixed.

Later, the bank indicates their system is working, your loan payments cease, and you expect to be able to return to banking as normal. Instead, what you find is that payments that the bank indicates were paid are not, other are double paid, and deposits are verified as received but then go missing.

The bank begins to credit and debit funds from your various accounts multiple times over without a paper trail, so you can't determine if the transactions history is correct, or in what account each transaction occurred. All inquiries and error corrections must be resolved through their hotline; the representatives are not properly trained, put you hold for lengthy times, drop calls, and do not return calls.

Amidst this dysfunction, the bank now demands repayment of the loan, which was required through no fault of your own. The bank offers various accounting reports that group and display transactions in formats that are foreign to the standard banking practices. There is no appeals process transaction errors.

I hope this analogy helps to paint a picture of the provider experience and the failure of the ASO over the past 2 years. We want nothing more than to continue to serve the people that come to us for support, but the ongoing challenges with Optum and the imminent recoupment of unverified money puts us and those that we serve in harm's way.

I ask for a favorable report on SB549. Thank you so much.

SB549-CBH-FAV.pdf
Uploaded by: Lori Doyle
Position: FAV

Testimony on SB 549
Administrative Services Organization – Requirements for Retraction, Repayment, or Mitigation of Claims
Senate Finance Committee
February 16, 2022
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.

SB 549 is about bringing accuracy and transparency to a process caused entirely by Optum's dysfunction. On January 1 of 2020, Optum's authorization and claims payment system went live. It was unable to perform these critical functions, and the Maryland Department of Health (MDH) was forced to make advance – or estimated – payments to providers to keep them afloat through August 3, 2020. These estimated payments were based on historic 2019 billing data and did not anticipate the impacts of COVID on service delivery and utilization. Providers were urged to keep serving individuals in need and to submit claims for services, even though estimated payments would replace fee-for-service reimbursement until such time as Optum's system was functional enough to go live again.

Now - two years later – providers face the prospect of paying back the difference between estimated payments and the amount of claims submitted during the estimated payment period. This process is complicated not only due to the downturn in service volumes caused by COVID but also because Optum's system continued to malfunction. Individual claims were reprocessed multiple times, many were erroneously denied, some were lost in Optum's system, and others still sit unprocessed after all this time. There is no way for providers to check Optum's math in terms of what they owe unless all claims submitted during the estimated payment period are correctly processed and Optum provides a report detailing each claims' full history of processing and reprocessing.

This bill requires Optum to meet industry standards for processing claims and providing transparency before they can recoup monies from providers. If Optum is unable to meet these standards they are required to hire – at their own expense and without using State funds – an independent auditor to determine actual amounts owed. The bill also allows providers to request an independent auditor - paid for by Optum - if they can't reach agreement with Optum on the amount owed, after reasonable efforts to do so.

The final provision of the bill is a requirement that MDH report back to the policy and budget committees on the amounts providers owe back due to the impact of COVID, and any plans to forgive that debt. Unlike other human service providers that received retainer payments to shield them from the financial impact of COVID, behavioral health providers received no such assistance. Through no fault of our own we now face repayment of significant amounts of money at a time when demand for services is at an unprecedented high.

We urge your support for the behavioral health safety net and a favorable report for SB 549.

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

SB 549 - Arundel Lodge.pdf
Uploaded by: Michael Drummond
Position: FAV

SB 549
Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims
Senate Finance Committee
February 16, 2022

POSITION: FAVORABLE

My name is Mike Drummond, and I am the Executive Director at Arundel Lodge, which serves the City of Annapolis, Anne Arundel County and beyond. Arundel Lodge provided mental health and substance use services to over 3000 individuals, ages 3 to older adults, in 2021. We provide outpatient treatment services at our main location on Solomons Island Road, on Bay Ridge Avenue in the City of Annapolis, and at our new Urgent Care Clinic in the Sajak Pavilion on the Luminis AAMC campus. We also operate programs for residential housing, psychiatric rehabilitation, supported employment, and specialized services for transitional-aged youth.

I am submitting this testimony in support of SB549 because Optum Maryland continues to wreak havoc on public behavioral health providers due to its inability to reliably process authorization requests and claim payments. Optum continues to incorrectly deny claims and pay them at the wrong amount. We are continually reprocessing claims multiple times because of their errors, which diverts our attention and vital resources away from client care.

Amidst this ongoing dysfunction, in December, Optum and MDH attempted to begin the recoupment process for a bucket of duplicate payments they issued even though they were incapable of providing the specific claims paid twice. Make no mistake – Arundel Lodge did not bill the claims twice and will return all of the duplicate payments made because of Optum's incompetence. However, Optum has, to date, not provided any documentation showing which claims constitute the duplicate payments, and the volume of claims reprocessed again and again makes it incredibly challenging for providers to identify these claims. Additionally, the volume of erroneous claims retractions we have seen occur without explanation makes it unconscionable to expect repayment without itemization of the specific claims paid

twice. We are now told that an itemized report will be available by February 15th, but it remains to be seen whether this report will deliver the information required. Still looming is the much larger issue of reconciling the first 7 months of the contract when estimated payments were paid to providers because Optum's system failed outright and was incapable of providing any authorizations or payment for claims.

Arundel Lodge needs your help. The passage of SB549 can ensure protections for providers in the reconciliation and recoupment process, and will seek debt relief for providers hit simultaneously by Optum chaos, COVID, and an unprecedented workforce crisis. I ask for a favorable report on SB549.

Thank you for your consideration.

2600 Solomons Island Rd · Edgewater, MD 21037
main 443-433-5900 · fax 410-841-6045 · video ph 443-569-7132
www.ArundelLodge.org

MATOD - SB 549 FAV - Optum Accountability.pdf
Uploaded by: Michael Oliver
Position: FAV

c/o IBR/REACH Health Services
2104 Maryland Avenue
Baltimore, MD 21218

(410) 752-6080

www.matod.org

House Health and Government Operations Committee
February 16, 2022

House Bill 549
Support

Good afternoon – my name is Michael Oliver, and I am here as a representative of MATOD, but also as a treatment provider who has been working with the ASO (Optum) and the Maryland Department of Health (MDH) since December 2019 to ensure the protection and service of the public behavioral health system. From the day of the initial transition to today, there have been litany of systemic issues with the ASO. We have engaged in good faith to identify and help rectify these issues as they arise - from claims processing, authorization issues, claim receipts, poor functionality in Incedo, poor communication, and many others.

There has been one consistent, however, and that is the lack of statutory protection for the providers from a failing ASO.

As the ASO begins to function more regularly, we are now faced with the reconciliation of the errors they made in the initial roll out. Providers are concerned about the accuracy, fairness, and ability of the ASO to conduct this process in a way that will not be to the detriment of the providers who serve their communities.

This concern is not unfounded. Providers have made continuous asks for transparency and data from the ASO to support their work. Over the past two years there have been countless roll outs of initiatives to help this aim that have been: later than the announced date, not fully inclusive of the information requested, miscommunicated, conflicting information to what providers already have, and damaging to the provider community.

Our concern is deepened by the ASO's inability to: identify problems themselves - relying on providers to identify them, not fixing issues that are systemic - rather simply for the providers who raised the issue, and continuously claiming issues are fixed that the provider can clearly prove are not.

The ASO has already initiated a retraction process starting with the failed implementation of retro eligibility. This is one of many examples in which a poorly functioning ASO implemented a process that was not ready, causing over payments, problems, and confusion to the provider community. This retraction is happening as we speak, while the ASO is fully aware of issues regarding these claims that providers have been raising for months. It is important to highlight just a few of the issues that the ASO is aware of but continuing anyway to pull back money: not all 835s (claims receipts) have been given to providers, claims inappropriately denied due to third party liability, and changing totals of amounts owed - which has yet to be communicated to the provider community at large.

Protections need to be afforded to the provider community to ensure that the ASO is: acting responsibly, communicating effectively their intentions, providing ALL the data providers need to reconcile in a usable format, and providing an avenue to address disagreements that is through a third party.

It is also doubly important to emphasize the need for forgiveness of money owed. Not only were providers forced through the COVID-19 pandemic to spend additional money to serve the mental health and substance use needs of our communities in a completely different modality (telehealth) - but we were also forced to do so with an ASO that was not working and unreliable.

The failed ASO roll out and now looming reconciliation were not caused by the provider community. We are being forced to clean up the mistakes of the ASO at our own expense. Even in the scenario where a provider successfully works with the ASO to agree upon a balance owed - providers are still suffering from this whole process. Not only will they have to pay back every penny that they may owe, but there is currently zero compensation for the tens or even hundreds of thousands of dollars providers spent on working to find the amount through hours diverted from normal operations, increased hours of current staff, and the hiring of new staff.

Protection for providers in this process is essential and we therefore ask for a favorable report on this bill. But for this to be made right, forgiveness of the burden providers have had to carry these last two years must also be carried out.

MATOD - SB 549 FAV - Optum Accountability.pdf
Uploaded by: Nancy Rosen-Cohen
Position: FAV

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2104 Maryland Avenue
Baltimore, MD 21218

(410) 752-6080

www.matod.org

House Health and Government Operations Committee
February 16, 2022

House Bill 549
Support

Good afternoon – my name is Michael Oliver, and I am here as a representative of MATOD, but also as a treatment provider who has been working with the ASO (Optum) and the Maryland Department of Health (MDH) since December 2019 to ensure the protection and service of the public behavioral health system. From the day of the initial transition to today, there have been litany of systemic issues with the ASO. We have engaged in good faith to identify and help rectify these issues as they arise - from claims processing, authorization issues, claim receipts, poor functionality in Incedo, poor communication, and many others.

There has been one consistent, however, and that is the lack of statutory protection for the providers from a failing ASO.

As the ASO begins to function more regularly, we are now faced with the reconciliation of the errors they made in the initial roll out. Providers are concerned about the accuracy, fairness, and ability of the ASO to conduct this process in a way that will not be to the detriment of the providers who serve their communities.

This concern is not unfounded. Providers have made continuous asks for transparency and data from the ASO to support their work. Over the past two years there have been countless roll outs of initiatives to help this aim that have been: later than the announced date, not fully inclusive of the information requested, miscommunicated, conflicting information to what providers already have, and damaging to the provider community.

Our concern is deepened by the ASO's inability to: identify problems themselves - relying on providers to identify them, not fixing issues that are systemic - rather simply for the providers who raised the issue, and continuously claiming issues are fixed that the provider can clearly prove are not.

The ASO has already initiated a retraction process starting with the failed implementation of retro eligibility. This is one of many examples in which a poorly functioning ASO implemented a process that was not ready, causing over payments, problems, and confusion to the provider community. This retraction is happening as we speak, while the ASO is fully aware of issues regarding these claims that providers have been raising for months. It is important to highlight just a few of the issues that the ASO is aware of but continuing anyway to pull back money: not all 835s (claims receipts) have been given to providers, claims inappropriately denied due to third party liability, and changing totals of amounts owed - which has yet to be communicated to the provider community at large.

Protections need to be afforded to the provider community to ensure that the ASO is: acting responsibly, communicating effectively their intentions, providing ALL the data providers need to reconcile in a usable format, and providing an avenue to address disagreements that is through a third party.

It is also doubly important to emphasize the need for forgiveness of money owed. Not only were providers forced through the COVID-19 pandemic to spend additional money to serve the mental health and substance use needs of our communities in a completely different modality (telehealth) - but we were also forced to do so with an ASO that was not working and unreliable.

The failed ASO roll out and now looming reconciliation were not caused by the provider community. We are being forced to clean up the mistakes of the ASO at our own expense. Even in the scenario where a provider successfully works with the ASO to agree upon a balance owed - providers are still suffering from this whole process. Not only will they have to pay back every penny that they may owe, but there is currently zero compensation for the tens or even hundreds of thousands of dollars providers spent on working to find the amount through hours diverted from normal operations, increased hours of current staff, and the hiring of new staff.

Protection for providers in this process is essential and we therefore ask for a favorable report on this bill. But for this to be made right, forgiveness of the burden providers have had to carry these last two years must also be carried out.

MPA Testimony 2022 -Support - SB549 - Administrati
Uploaded by: Paul Berman
Position: FAV

MARYLAND
PSYCHOLOGICAL ASSOCIATION

10480 Little Patuxent Parkway, Ste 910, Columbia, MD 21044. Office 410-992-4258. Fax: 410-992-7732. www.marylandpsychology.org

February 16, 2022

Senator Delores G. Kelley, Chair
Senate Finance Committee, 3 East
Miller Senate Office Building
Annapolis, MD 21401

RE: SB 549 - SUPPORT

Dear Chair, Vice-Chair, and Members of the Committee:

The Maryland Psychological Association, (MPA), which represents over 1,000 doctoral level psychologists throughout the state, asks the **Senate Finance Committee to favorably report on SB 549.**

The following are a few examples of the many problems one large mental health practice on the Eastern Shore has experienced because of the numerous administrative problems which started with the award of the ASO contract to Optum. The mental health practice had to significantly reduce its services (by over 50%) since Optum took over as ASO of the Medical Assistance program. They have had to do this despite the ongoing need for behavioral health services. The downsizing was necessary in part due to the pandemic, and in part due to Optum's software, policies, provider relations, and billing problems.

1. Optum launched its claims processing system on August 3, 2020. Core functions needed to process claims for providers to be fully compensated for their work are still not fully functioning. This has resulted in a reduction in staff, reduction in services to clients, and a reduction in capacity to see clients.
2. Psychiatric Rehabilitation (PRP) is a cost-effective way to provide skill building services to Maryland's chronically and severely mentally ill. The practice has 3 PRP programs. Initial billings were completed based on instructions from Optum. They then received additional instructions over the next 4 months from Optum support staff regarding billing for PRP services. Each time PRP claims were submitted, however, the majority of claims were denied, reportedly due to not filling in the claims properly, even though all instructions were followed. Many PRP claims are still being wrongly denied. Because of the difficulty in determining what has and not been paid, the practice still does not have an adequate picture of claims paid.
3. The mental health practice has experienced ongoing problems with claims retractions in error but still not paid and claims denied in error. These problems have required significant staff administrative time to attempt to obtain payments, to try to correct errors in payments, and to determine what has and has not been properly reimbursed.
4. Optum has not yet delivered an accurate accounting of what monies the practice allegedly owes and even what has and has not been properly billed and paid.

For these reasons, and many others, the **MPA urges the Senate Finance Committee to issue a favorable report on SB 549.**

Please feel free to contact MPA's Executive Director Stefanie Reeves at exec@marylandpsychology.org if we can be of assistance.

Sincerely,

Linda McGhee
Linda McGhee, Psy.D., JD
President

R. Patrick Savage, Jr.
R. Patrick Savage, Jr., Ph.D.
Chair, MPA Legislative Committee

cc: Richard Bloch, Esq., Counsel for Maryland Psychological Association
Barbara Brocato & Dan Shattuck, MPA Government Affairs

SB549_CC_Becker_FAV.pdf
Uploaded by: Scott Becker
Position: FAV

CATHOLIC CHARITIES | CHERISHING THE DIVINE WITHIN ALL

Senate Bill 549
Administrative Services Organizations –
Requirements for Retraction, Repayment, or Mitigation of Claims
Finance Committee
February 16, 2022

Favorable

Catholic Charities of Baltimore strongly supports Senate Bill 549, which would require the Administrative Service Organization to provide basic documentation establishing an overpayment before recouping funds or adjusting/denying claims for services provided

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 began 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. In addition to the estimated payments, Optum sent us a live check for $1.4 million in claims billed during that same period; in essence a duplicate payment. They have been unresponsive to our request to return the $1.4 million to the State.

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 26-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 for the past two years 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.

Catholic Charities is prepared to return any overpayments. However, our calculated overpayment amount is different from Optum's calculation. Optum cannot back up their calculation with documentation, so we are left in a stalemate.

It has been over two years since Optum took over as the ASO. Optum should be accountable for providing the appropriate documentation for overpaid claims. SB 549 would require Optum to provide that documentation before recouping and purported overpayments. **Catholic Charities of Baltimore appreciates your consideration and urges the committee to issue a favorable report for Senate Bill 529.**

Submitted By: Scott Becker, former Chief Financial Officer (retired February 2022)

SB549 - Collins.pdf
Uploaded by: Shannon Hall
Position: FAV

J. DAVID COLLINS & ASSOCIATES LLC
Addictions & Mental Health

SB 549
Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims
Senate Finance Committee
February 14, 2022

Position: Favorable

I am Heather Collins, Executive Director of J. David Collins & Associates LLC, which has offices in Salisbury, Cambridge, and Princess Anne. Our team of 22 employees serves more than 300 Medicaid participants at any point during the year. As you well know, the transition to Optum as the ASO for the Public Mental Health System in January of 2020 has been an ongoing debacle. Optum was not prepared to assume the responsibility and did not have the systems nor personnel in place to operate as the ASO. We have worked diligently over the past two years to operate within their broken system and processes. The system continues to be cumbersome, delay authorizations and incorrectly deny claims for services provided.

These failures lead directly to the problems with reconciliation.

The reports that Optum has provided to date are incomplete and inaccurate. Optum has the expectation that we, as the providers, will review their incorrect denials and communicate the necessary information to refute their denials. The estimated time to review the current reports exceeds 200 work hours. Prior to 2020, we had fewer than 20 denials at a time. We currently have more than 1,800 denials of which Optum has denied payment.

We have provided these services in good faith, and the payments should be approved. The responsibility should not be on the provider to defend our claims against the broken Optum system, it is not possible for us to do this and continue to manage our regular job requirements.
We had hired an outside contractor to assist us at the beginning of the reconciliation process, but after paying them $6,500 and being no closer to being reconciled, we ceased utilizing their services.

Our organization has had 3 reconciliation specialists in the past 18 months. Each time a new specialist is assigned by Optum, we start the entire process over. We are required to explain all the open issues and re-state all the questions that we have been asking.

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Princess Anne, MD 21853

As an example, we have been asking specific questions about our incorrectly denied Nurse Practitioner claims for 14 months. We have received no answers, and just last month, we were asked to explain our obvious questions and challenges for a 4th time to our 3rd reconciliation specialist.

When we send an email to our reconciliation specialist, the only acceptable mode of communication, we receive an automated response that their reply will come in 3 to 5 days due to the high workload they are facing. The reconciliation process as it is structured will never work, and it has taken my focus off leading my business for over a year. Every minute I spend defending our claims and challenging the incorrect information received is a minute that I am not supporting my team, supervising the quality of our current services and developing new programming. I do not have an extra 30 hours per week to focus on the reconciliation process that will never bring us to an accurate reconciliation.

Optum is telling us that we owe them $305,000. This is wrong. We have been overpaid less than $50,000. If they begin to take back the incorrect amount by retracting current payments, we will be forced to close one of our three locations, limit services in our other two locations and decrease staffing. I will personally have to liquidate personal assets to make payroll. It is not unrealistic to believe that we could cease to operate in all three counties that we serve.

In addition to the incorrect overpayment calculation, we estimate that we have spent $70,575 in hourly costs managing the Optum debacle. These are also hours that are not spent providing support to our clinical teams and our clients.

Optum must be held accountable for their inability to perform and there must be debt relief for the providers who have had to navigate this lack of performance. Please support SB 549/HB 715 and behavioral health debt relief.

SB549 - Thrive.pdf
Uploaded by: Shannon Hall
Position: FAV

THRIVE BEHAVIORAL HEALTH
MEETING PEOPLE WHERE THEY ARE

SB 549
Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims
Senate Finance Committee
February 16, 2022

POSITION: FAVORABLE

I am Elizabeth Hymel, CEO of Thrive Behavioral Health, which has offices in Catonsville, Millersville, Silver Spring and Rosedale. We service more than 5,000 active Medicaid participants at any point during a year.

More than two years after Optum assumed responsibility for claims processing in the public behavioral health system, Thrive continues to struggle with claim problems that disrupt our operations and distort reconciliation. I recently evaluated a sample of our claims to identify these problems. I found the issues widespread and spanning every month from January 2020 through December 31, 2021. While I was only trying to pull together a small sample to show the errors, I wanted to be sure I identified the ongoing issues with Optum. In reality, the actual total volume of these errors was much larger than even I could imagine:

- **Late Payments**. Maryland law requires Optum to pay claims within 30 days. My sample identified 42 claims paid an **average of 104 days after submission**.
- **Claims Denied, Reprocessed, and Paid Late**. I identified a sample 44 claims denied due to Optum errors and then reprocessed multiple times until finally arriving at payment. These claims **averaged 90 days from submission to payment**.
- **Retractions of Claims Never Paid**. We have identified multiple instances where Optum has retracted payment for which we never received a payment.
- **Claims Submitted and Never Paid**. My sample identified **12 claims submitted to Optum in 2020 and never processed or paid**. This is particularly disturbing as these are valid claims that have increased the amount of money that the State of Maryland will ultimately make Thrive payback as an overpayment. The payment of these claims should be reducing that overpayment balance.

It is clear, that there is a persistent pattern by Optum to not pay or acknowledge claims to Thrive within the 30-day state requirement after submission. The problem continues even today, more than two years after Optum became the ASO for the state of Maryland.

We need accountability for Optum and debt relief for providers. Please support SB 549/HB 715 and behavioral health debt relief.

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5720 Executive Dr. #100-105
Catonsville, MD 21228
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SB549 Testimony PDG Updated 2-10-22 (2).pdf
Uploaded by: Sondra Tranen
Position: FAV

SB 549

Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims

Senate Finance Committee

February 16, 2022

POSITION: FAVORABLE

I'm the Executive Vice President of Partnership Development Group (PDG), a community based behavioral health provider in your jurisdiction for over 21 years. Our staff of 65 currently serve 420 of your constituents who have serious mental health issues.

As you are aware, Optum has been operating as the ASO for the Public Mental Health System since January 2020. From the start of their contract, we have experienced a myriad of problems in all aspects of authorizations for services, claims processing, and claims payments. While some issues have been corrected, we are still dealing with major system inadequacies. The authorization process continues to be problematic with some authorizations being denied for not having complete information when, in fact, the information is present. Some authorizations are approved for the incorrect date spans which causes claims to subsequently deny, and others are not approved within the required time period causing service delays for clients. Additionally, some claims are still processed manually by Optum, leading to a consistent volume of human errors and lengthens the time from claim submission to payment.

Finally, providers cannot run any reports on the claims data in Optum's system to verify that claims were denied or paid correctly. The result is that providers have no way of knowing if the reconciliation reports generated by Optum (showing what providers owe back to Optum for estimated payments made or what Optum owes the providers for underpayments during the period of estimated payments) are accurate. We need transparency in this process. We have been asking for this information for two years.

In the midst of this ongoing turmoil and uncertainty, Optum and MDH have sent letters demanding repayment for a specific set of claims they have identified as duplicate payments to providers. Optum has, to date, not provided any documentation showing which claims constituted these supposed duplicate payments, and the volume of claims reprocessed again and again makes it incredibly challenging for providers to identify these claims. Providers have been told that a report on the claims comprising the overpayment will be out sometime in February. Given Optum’s track record of never once hitting their own deadlines and remitting reports rife with errors, it is doubtful that such a report will be available in February, and it is likely that this report will again be a dense, illegible compilation of data in formats that require

substantial manual analysis by providers. It is unconscionable that we are being presented with a bill without itemization, and still worse, without a planned appeals process for claims flagged for recoupment in error!

In short, the administrative burden of continuing to stay on top of our current authorizations, claims, and payments compounded by our circular attempts to verify Optum's reconciliation math has not abated and, with the passage of time, grows exponentially. We estimate that the disruption from Optum's dysfunction has cost not only invaluable staff time and energy amidst a workforce crisis, but easily $100,000 in 2021, all of which could have been spent on direct care staff and outreach to consumers in need of mental health services.

I am asking you for a favorable report on SB549 in order to address the negative impact that Optum has had on our ability to provide services by supporting debt relief and legislation to require transparency and accountability in the recoupment process.

Thank you for your time and consideration.

SB 549 Testimony UBCSS 2 16 22.pdf
Uploaded by: Suanne Blumberg
Position: FAV

Upper Bay Counseling
& Support Services, Inc.

Suanne Blumberg, LCPC
Chief Executive Officer

Testimony on SB 549

Administrative Services Organization – Requirements for Retraction, Repayment, or Mitigation of claims

Senate Finance Committee

Hearing Date: February 16, 2022

POSITION: Favorable

Chairperson Delores Kelley, Vice Chairperson Brian Feldman, and members of the Senate Finance Committee, thank you for hearing testimony on SB 549. I am Suanne Blumberg, CEO at Upper Bay Counseling and Support Services. We serve over 4,000 consumers yearly, from early childhood to geriatric. We serve both Cecil County and Harford County providing an array of services including Outpatient Therapy, Residential Rehabilitation Program, Assertive Community Treatment, Psychiatric Rehabilitation Programs, Health Homes, and Substance Use Disorder Treatment to name just some of the services.

SB 549 requires Optum to produce industry-standard status reports for each claim, as well as a detailed claims history report to itemize the amounts it intends to recoup from providers. This is desperately needed. In December, we received a demand letter from Optum for the first phase of recoupment. It stated, without justification, that we owed $134,000. As of last week, Optum was telling us that this amount had dropped to a mere $769. Neither figure had any explanation or reason. Every week, the amounts that Optum says we owe across all phases of recoupment fluctuate as Optum continues to correct claims submitted over the past two years.

The absence of standardized reporting for Optum's claims processing has levied substantial costs on organizations like mine. We had to dedicate one staff person full-time to reviewing and tracking claims and payments. These tasks are largely automated in a system functioning to industry standards but require labor intensive manual reviews under Optum. Our billing manager has spent half of her time since January 2020 dealing with the Optum mess instead of supervising and training staff and fiscal operations.

The cost to our agency for staff time dedicated to Optum's inept roll out and two years of a broken system is about $206,105. This is money that could have gone to services and salary. On top of all of that our write-offs have increased 200% since Optum took over as the ASO. In one six-month period it was $30,000. This is due to Optum's lack of support and failure to provide authorizations in a timely manner, if at all for many services. Staff have spent countless hours on the phone with Optum trying to get these issues resolved to the point of just giving up out of complete frustration. Optum's claims processing and customer service systems do not work. It is damaging my organization's ability to deliver services, and it is destabilizing our financial future.

In addition to requiring Optum to deliver industry-standard claims reports like 835s and 277s, this bill also requires Optum to itemize the claims applied to recoupment phases. This report is the claims history report, which should allow providers to see the history of all claims processed or reprocessed. For the reprocessed claims, the original claim number and date is there so the claim can be tracked. Currently we do not have that information, which would be available on the report. This report is most important as we try to see if our math matches Optum's math. There is great concern that we will be overcharged since there is little data to support the recoupment amounts that have been presented to us, and many of our claims have not yet been correctly adjudicated.

All of this comes at a time when our services have never been more needed and, like most healthcare providers, we have a workforce shortage. We are having to re-scale our salaries without knowing how much our reimbursement will be week-to-week, given Optum's shortcomings. It has been an impossible task trying to run an organization when it is unknown the total amount that is owed. We have been unable to plan any new programming or expand any services with this looming recoupment hanging over our heads. It is unconscionable that is has continued, unchecked, for two years.

As a reminder, this is the ASO the MDH chose. Providers have been working very hard providing support to help resolve the issues. This broken ASO is hurting all providers and we need to know, and have confidence in, the recoupment amount we are being asked to repay. But please know, providers did not cause this problem. Yet it has cost all of us financially, loss of billing staff and an increase in staff frustration when they should be focusing on the people we serve.

I want to thank the committee for your consideration and I urge you to give SB 549 a favorable report.

SB 549 Admin Svcs Organization-Requirement for Ret

Uploaded by: Malcolm Augustine

Position: FWA

SB0549/163222/1

AMENDMENTS
PREPARED
BY THE
DEPT. OF LEGISLATIVE
SERVICES

03 FEB 22
16:26:31

BY: Senator Augustine
(To be offered in the Finance Committee)

AMENDMENT TO SENATE BILL 549
(First Reading File Bill)

On page 2, in line 7, strike "**TO**"; and in line 8, strike "**AN**" and substitute "**TO AN**".

On page 4, strike beginning with "**THE**" in line 9 down through "**(3)**" in line 13; after line 22, insert:

"**(F) THE SOLE PURPOSE OF AN INDEPENDENT AUDITOR RETAINED UNDER SUBSECTION (C) OR (D) OF THIS SECTION IS TO DETERMINE THE AMOUNTS OWED BY A HEALTH CARE PROVIDER, AND THE INDEPENDENT AUDITOR MAY NOT MAKE ANY ADDITIONAL FINDINGS.**";

and in line 23, strike "**(F)**" and substitute "**(G)**".

Optum Response to SB549.pdf
Uploaded by: Joseph Winn
Position: UNF

February 15, 2022

Maryland Senate Finance Committee
Annapolis, MD

Re: Comments Regarding Senate Bill 549

To the Members of the Maryland Senate Finance Committee:

Optum writes to oppose SB 549 as it is unnecessary and does not accurately reflect the operations of the Optum Maryland behavioral health administrative services organization (ASO) platform on behalf of the Maryland Medicaid and State behavioral health plans.

Since August 2020, the Optum authorization and claims platform has been performing well within industry standards. Paying out an average of $34.5 million a week to behavioral health care organizations based on important services provided to Marylanders. Approximately 99.4% of claims submissions are adjudicated in average of 14 days.

The bill before the committee today is about the January 2020 through August 2020 period when the Optum ASO platform was not available to process authorizations for care and adjudicate claims. During that time, Optum was directed by the Maryland Department of Health (MDH) to make weekly estimated payments to behavioral health providers based on the prior year's claims volume. Parties agreed that these estimated payments would eventually be reconciled with actual claims history when the Optum system was operational, and any estimated payments made in excess of actual claims volume would be returned to the state or be provided refunds if their claims experience was higher than their estimated payments.

Working together with our provider stakeholders and MDH, the process to reconcile estimated payments with provider organizations' actual claims history is ongoing and has made significant progress. Of the more than $1 billion in estimated payments made during the January to August 2020 period, more than $824 million of those estimated payments have been matched to actual claims and care delivered, and/or providers have voluntarily returned overpayments to the Maryland treasury since they have fully reconciled their books with the Optum ASO platform.

Provider organizations completing or nearly completing offsetting their balances represent both the largest and smallest provider groups, and those in between. For example, 12 of the 67 members of the Community Behavioral Health Association (CBH) that received estimated payments have completed 99% to 100% of their reconciliation efforts, representing nearly $70.5 million with most providers engaged with our teams. Outside of CBH, most of the largest health systems in the state have competed 99% to 100% of the process.

In addition, we believe this legislation is unnecessary because:

Full claims reports are being delivered for those who have requested the report: Over the last few months, we collaborated and piloted a full claims history report with providers. As of today, the first batch of these reports have been generated and delivered to providers for those requesting the report.

835s are being delivered in standard formats, with proper codes if relevant. Currently, providers are receiving 98% of all claims adjudicated and are making additional improvements that will result in 99.97% of all claims adjudicated in the next couple of weeks. Importantly, where data discrepancies may exist, the provider's reconciliation manager is able to research the issue to confirm the information.

Throughout this process, Optum has worked closely with MDH and provider community stakeholders to collaborate, identify and make process improvements. We offer one-on-one direct assistance to behavioral health organization in reconciling their books, including ensuring all authorizations and claims are properly submitted and both Optum and providers' claims systems are accurate. Additionally, we host Operations Improvement and Provider Council meetings on a recurring basis to keep the provider community abreast of operational status. This process is ongoing, and we will continue to engage with provider organizations.

For these and other reasons, we believe this legislation is unnecessary and does not reflect the significant progress made to date by many provider organizations that have fully reconciled their accounts and returning overpayments to Maryland. While we recognize there is still more to be done to assist providers, we remain committed to working closely with the state and the behavioral health provider community.

14 - SB 549 - FIN - MDH - LOI.pdf
Uploaded by: Heather Shek
Position: INFO

Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

February 16, 2022

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: SB 549 – Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims – Letter of Information

Dear Chair Kelley and Committee Members:

The Maryland Department of Health (MDH) respectfully submits this letter of information on Senate Bill (SB) 549 – Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims.

SB 549 outlines the process by which an Administrative Services Organization (ASO) may conduct the billing and creation and maintenance of claims for behavioral health services rendered to Marylanders in 2019 and processed or reprocessed after January 1, 2020 or from January 1, 2020 to August 3, 2020, inclusively. The effective date of this bill is immediately upon its passing, and it requires MDH to immediately amend its contract with its ASO to conform to the contract requirements of the bill.

Since the inception of the contract in 2020, UnitedHealth Group (UHG)/Optum made significant progress to correct issues raised by MDH and providers. Between January 2020 and November 2021, UHG/Optum received nearly 17 million claims and successfully paid nearly $3.2 billion associated with those claims to over 2,600 providers who participate in the Public Behavioral Health System. UHG/Optum maintains a weekly average of $30 to $40 million in payments to providers.

SB 549 will violate two provisions of the Maryland Constitution. Specifically, Article III, s. 33 prohibits special laws applicable to only one person or entity. As written, SB 549 applies only to UHG/Optum which is a clear violation. Additionally, Section 8 of the Declaration of Rights prohibits legislation that violates the separation of powers. In this instance, this applies to the administration of contracts.

The fiscal impact of this bill is to create a $215 million general fund deficiency to the Maryland taxpayer for non-existent provider services. If a provider does not agree with the estimated payment owed to MDH, there is a mechanism to appeal. These are funds that are paid for services not provided to patients and would be ineligible for a federal funding match.

Additional information can be found in the most recent 2021 Joint Chairman's Quarterly Report on the Status of ASO Functionality (p. 101-102), published January 2022 and attached. If you have any questions, please contact Heather Shek, Director of Governmental Affairs, at heather.shek@maryland.gov or (443) 695-4218.

Sincerely,

Dennis R. Schrader
Secretary

Maryland
DEPARTMENT OF HEALTH

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

January 31, 2022

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

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

Re: 2021 Joint Chairmen's Report (p. 101-102) – Report on the Status of ASO Functionality

Dear Chairs Guzzone and McIntosh:

Pursuant to the 2021 Joint Chairmen's Report (p. 101-102) the Maryland Department of Health respectfully submits the attached report.

Specifically, the committees requested the following for ASO functionality:

> *"Given the reports of ongoing struggles with the new BHASO over a year after the initial go-live date, the budget committees request ongoing status updates of its functionality. The budget committees are requesting a series of reports, the first of which, in consultation with the providers in the Public Behavioral Health System, identifies which reports and features are required for a fully functional ASO. Subsequent reports should identify progress made on each of these features, identify what is not fully functional, the steps needed to reach functionality, and the estimated completion date. The first report should be submitted by July 1, 2021, and subsequent reports shall be submitted quarterly through fiscal 2022, or until full functionality is achieved."*

If you have questions or need more information, please contact Heather Shek, Director, Office of Governmental Affairs at heather.shek@maryland.gov or 410-767-5282.

Sincerely,

Dennis R. Schrader
Secretary

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

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2021 Joint Chairmen's Report

p. 101 - 102

Quarterly Report on the Status of ASO Functionality

January 2022

Table of Contents

Introduction

This report supplements the previously submitted reports on October 1 and July 1, 2021, on this subject.[1,2]

UHG/Optum has received nearly 17 million claims between January 2020 through November 2021 and successfully paid nearly $3.2 billion ($1.5 billion in 2020 and $1.7 as of November 2021) associated with those claims to over 2,600 providers who participate in the Public Behavioral Health System.

While acknowledging deficiencies at the commencement of the contract, UHG/Optum has made significant progress to correct issues and began real-time processing of claims in July 2020. UHG/Optum and MDH continue to work together to improve the system and to deliver on the functionality that providers need to render services to Marylanders within the Public Behavioral Health System. Since real-time processing began in July 2020, UHG/Optum has maintained a weekly average of $30 to $40 million in payments to providers.

Current Core Operating Outcomes can be seen in the table below:

Core Operating Outcomes

Key Performance Metrics	Target	December Actual	Year-to-date Actual
Claims Processed in 14 Days (received and adjudicated)	100%	99.85%	99.78%
Claims Processed and paid within 14 Days (received, adjudicated and paid by Payspan)	N/A	98.0%	97.28%
Claims Denial Percentage	N/A	15.23%	15.5%
Optum CS Participant ASA 30 Second Service Level	90%	97.8%	86.2%
Optum CS Provider ASA 30 Second Service Level	90%	98.4%	83.8%
Authorizations Processed within TAT	100%	99.5%	99.4%
Auto Adjudication Rate	85%	91.72%	90.11%
Clinical Service Level	80%	82.1%	84.4%

MDH defines a fully functional Behavioral Health Administrative Services Organization (BHASO) as a BHASO that pays valid claims from providers accurately, consistently,

[1] July 1, 2021, 2021 Joint Chairmen's Report (p. 101-102) – Report on the Status of ASO Functionality http://dlslibrary.state.md.us/publications/JCR/2021/2021_101-102_2021(7).pdf

[2] October 1, 2021, 2021 Joint Chairmen's Report (p 90-91) – Report on BHASO Reconciliation Process 2021 Joint Chairmen's Report (p 101-102) – Status of ASO functionality http://dlslibrary.state.md.us/publications/JCR/2021/2021_90-91,101-102_2021(10).pdf

efficiently, and transparently. Each of these four areas are defined below:

- Accurately - Claims are properly processed according to the rules of the system and the clinical judgments contained with medical necessity criteria.
- Consistently - Claims with the same characteristics process in the same manner such that providers can resolve issues within their claims submission.
- Efficiently - Claims processing occurs with minimal human intervention and without additional inputs beyond those needed to process the claims.
- Transparently - Providers are given visibility into the status and details of their claims relevant to processing in a timely manner.

MDH and UHG/Optum consistently collaborate and communicate with providers through a standing Operations Improvement Meeting to discuss their needs and concerns about perceived functionality gaps with the BHASO. This report outlines the Operation Improvement Committee and provider discussions so far, as well as next steps for continuing engagement and addressing such gaps.

Provider Engagement - Operations Improvement

Starting in December 2019, as part of the transition to UHG/Optum as Maryland's BHASO, MDH organized a series of meetings with key providers and provider associations to submit direct input to UHG/Optum regarding user experience, feature implementation, and issue resolution. Community participants in this meeting include:

- Community Behavioral Health Association of Maryland;
- Maryland Association for the Treatment of Opioid Disorders;
- Maryland Addictions Directors Council;
- Maryland Hospital Association; and
- A broad array of active providers ranging from large to midsize programs throughout the State.

The Operations Improvement Committee meets regularly on the first and third Tuesday of each month and is intended to allow for an involved discussion of issues affecting groups of providers. Presentations from UHG/Optum often include information about customer service, upcoming operational fixes, feedback regarding recent changes or issues encountered, and other concerns affecting the provider community. The Operations Improvement Committee meeting is intended to allow for a thorough discussion of issues affecting groups of providers generally. This meeting is in addition to the monthly Provider Council meeting where MDH and UHG/Optum provide routine updates to over 200 attendees each session, as well as a smaller, bi-weekly meeting of provider leadership to discuss issues regarding the reconciliation and recoupment process.

System Functionality Report Discussion

Through the Operations Improvement Committee meetings, MDH and UHG/Optum have engaged the providers and provider associations on issues of system functionality, efficiency, and efficacy.

Since the system went live in July 2020, providers noted a lack of reports needed to resolve claims in their own accounting systems. These are known in the insurance industry as 835 Health Care Claim Payment transactions for Electronic Data Interchange (EDI) claims. Missing 835s can be caused either by a technical issue between UHG/Optum and the provider, UHG/Optum and a clearing house, or a temporary transmission failure. The overall system functionality is a complex picture, thus starting from a single shared document is critical.

As of the end of October 2021, all missing 835 reports and Provider Remittance Advice (PRAs) have been delivered to providers by UHG/Optum to facilitate their record keeping and reconciliation of estimated payments made between January 1, 2020, and August 3, 2020. Providers who are still unable to locate a needed 835 can contact UHG/Optum to report it and request that one be provided. 835s are now automatically generated and provided on an ongoing basis for all claims.

UHG/Optum shares regular updates with the Operations Improvement Committee members for discussion in the twice-monthly meetings. The meeting also includes a product roadmap that has been integrated into UHG/Optum's website so providers can readily access it. Functional areas covered in the document are wide-ranging and include:

- Claims processing;
- Reporting claim status for claims payment/provider interaction;
- Additional functionality related to claims export, download, and history (revenue cycle management);
- System Status Notifications and Outage Report;
- Authorization and Eligibility Processing;
- Responsiveness and Timeliness of Communications and Provider Relations; and
- Privacy and Security.

System Security Discussion

The network, systems, and data employed by UHG/Optum to provide Behavioral Health ASO services do not reside on the Maryland Health Department's system network and were therefore unaffected by the recent network outages. All of UHG/Optum's systems have remained in operation during this time and have been authorizing services and processing claims and payments to providers with no disruption of service.

However, a recent audit by the MDH Office of Internal Controls and Audit Compliance (IAC) found that some of UHG/Optum's systems are deficient and require stabilization. As a result, MDH required Optum to complete testing of all systems by December 31, 2021 and to provide test results by January 28, 2022, along with a plan of correction and all other risk assessments going forward.

MDH continues to track each procedure and process failing in separate Root Cause Analysis reports (RCAs) and Corrective Action Plans (CAPs). Subsequently, some RCA and CAP documents related to system issues have yet to be satisfactorily completed by Optum and accepted by MDH in the subsequent iterations. CMS is fully aware of the situation, and MDH is closely monitoring progress.

MDH carefully coordinates its findings and audits of the system with DoIT, CMS, and all other authorities as required and thoroughly investigates, reports, and creates remedy recommendations where needed as necessary. MDH is also consulting with internal compliance, privacy, security officers, and departmental and state legal counsel to determine the financial and legal responsibilities of all parties.

Contract Management Steps

As updated in our October 1, 2021, report, MDH initiated a new Request for Proposal (RFP) process in July 2021, with the goal to have a new contract signed no later than December 31, 2023 in order to allow for an entire year of development and implementation. RFP development continues and additional announcements will be made in accordance with state procurement statute and regulations.

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

SLAs are contract terms that require UHG/Optum to meet certain requirements, such as customer-service response times, system availability, staffing, and claims processing. Failing to meet SLAs allows MDH to withhold a percentage of the total invoice based on the number of SLAs not met. Since the contract started, MDH has withheld a total of 4% from UHG/Optum invoices for failing to meet 11 of the 12 service levels. The only service-level agreement determined to have been met at this time is the requisite number of staffing. A total of $1,344.666.86 has been withheld under this authority through November, 2021.

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

- Minority Business Enterprise (MBE) requirements;
- late delivery of a Root Cause Analysis or Corrective Action Plan;
- downtime occurrences; and
- failure to deliver a working system.

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

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

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

UHG/Optum has failed to deliver a comprehensive reporting system as defined in the contract. The current reports are limited in nature, and specific reports are only produced by request on an ad hoc basis. UHG/Optum is attempting to solve this issue with the creation of a Data Mart; MDH reserves all rights and remedies to ensure compliance by UHG/Optum.

State contracts also have two other penalty measures within their basic structures that are also in the BHASO contract: withholding of payments, and termination of the contract. Payment of an invoice can be withheld if the vendor fails to provide a required deliverable, typically associated with the invoice itself. MDH reserves the right to withhold payment of an invoice, but once the requested deliverable is provided, UHG/Optum would receive payment for that invoice. MDH has withheld one half of the implementation amount, retaining approximately $4 million for UHG/Optum's continued failure to deliver on critical claims-adjudication tools, including the 835 forms, consolidated claims history reports, other data as referenced above, and other necessary configurations to support BHASO operation of the Public Behavioral Health System.

The final contract-management measure would be termination of the contract with UHG/Optum. MDH's contract with UHG/Optum, as required by the State's procurement regulations, includes provisions for the termination of the contract for default and for convenience.

Reconciliation and Recoupment Process

As discussed in the introduction, due to the inability of UHG/Optum to pay claims when the system launched on January 1, 2020, MDH instituted estimated payments for providers based on their calendar year 2019 average weekly claims. Providers were informed at the time that the estimated payments would have to be reconciled against processed claims after the system went live. For the estimated payment period, UHG/Optum received $1.6 billion worth of claims that have since been processed against the estimated payment total. In October 2020, UHG/Optum

instituted a dual check write cycle in which claims for dates of service during the estimated payment period are used to "offset" a provider's estimated payment balance, while claims for dates of service after the estimated payment period are processed normally. Providers generally have a year to submit claims from the date of service. For example, a service rendered in June 2020 (during the estimated payment period) may be submitted in January 2021. In this example, the payment for that claim would be used to offset the provider's outstanding estimated payment balance. The offset would also apply if there was reprocessing of a June 2020 claim in October 2020 as part of a retroactive rate increase or special project.

Payments made prior to the establishment of the dual check write for claims were not applied to the outstanding balance, as providers would essentially receive double "payment" for the same claim. With that in mind, the outstanding balance in October 2020 was approximately $359,610,797 across both Medicaid and state-only programs. That balance is currently down to $223,498,383 as of December 2, 2021. Figure 1 below shows the Estimated Payment Balance reduction over time, with Medicaid accounting for $193,621,166.90 of the current outstanding balance, and state-only programs accounting for the rest.

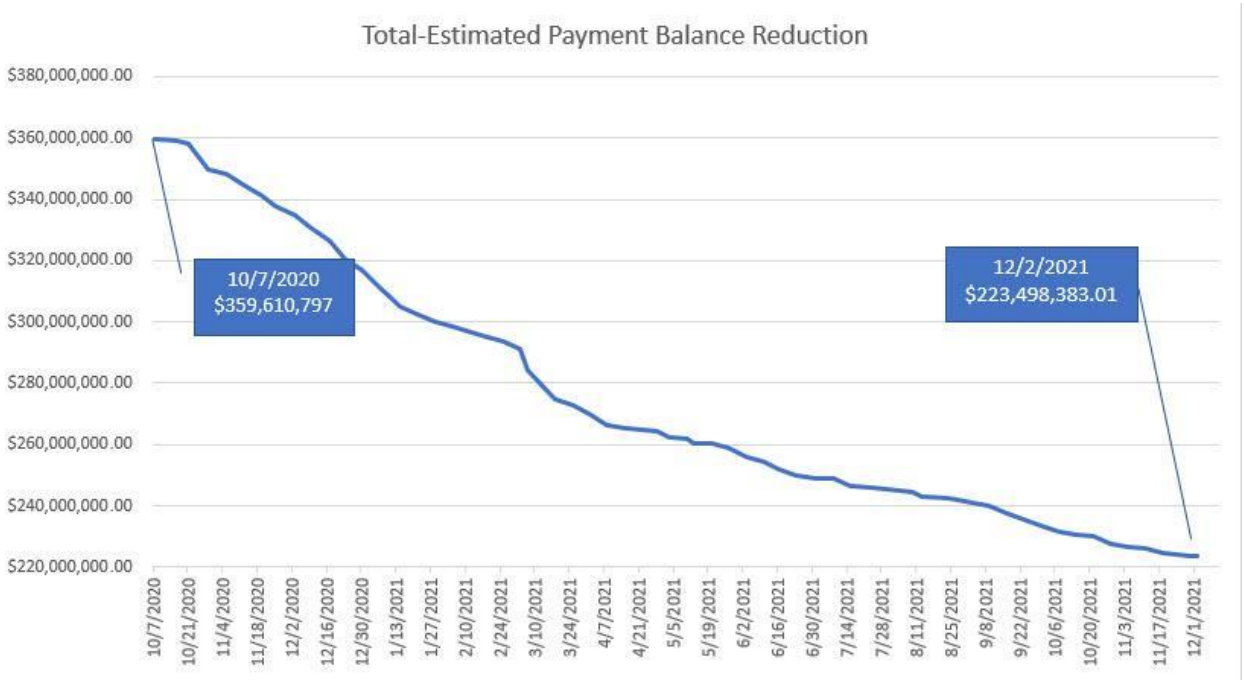

Figure 1: Estimated payment balance over time

The outstanding balances are highly concentrated among a few providers. Forty (40) providers account for approximately $63.5 million of the outstanding balance. These providers are typically large entities, such as hospitals, large community substance use disorder providers, and large community-health providers. UHG/Optum has focused its reconciliation efforts on these larger providers and is engaged with 100% of the providers who have an outstanding balance of more than $1 million. Of the 2,107 providers who have outstanding estimated payment balances, 895 (42.5%) have balances below $10,000. These smaller balances are generally held by individual practitioners, such as licensed social workers and professional drug counselors.

Additional information regarding the distribution of the outstanding balances and providers is in Table 1 below.

Table 1: Distribution of Provider Outstanding Payments as of November 29, 2021

Provider Outstanding Balance	Provider Count	Total Outstanding
Providers Owing < $10K	895	$3,513,735.69
Providers Owing $10K < $50K	601	$14,095,512.89
Providers Owing $50K < $100K	164	$11,658,744.64
Providers Owing $100K < $500K	347	$80,264,365.24
Providers Owing $500K < $1M	57	$38,049,854.36
Providers Owing $1M < $4M	40	$63,508,792.77
Providers Owing Over $4M	3	$12,423,484.94
Totals	2,107	$223,519,490.53

It is worth noting the progress made since the last report MDH submitted in October 2021. **Since the last quarterly report, estimated payment balances have decreased by nearly $17.4 million, and the number of providers with outstanding balances has decreased by 38. Of the more than $1.06 billion paid out in estimated payments, 80% of those payments have now been fully offset with paid claims or repayments from providers.**

Providers currently have the option of reconciling their balances either by remitting all or part of the amount of the outstanding balance or by submitting claims with dates of service during the estimated payment period. In addition to automatically applying those claims to the outstanding balance as processed, UHG/Optum has conducted significant outreach to providers who have an outstanding balance of $1 million or more. 100% of providers owing $1 million or more are currently engaged in the reconciliation process.

Of the total 2,107 providers with balances remaining, 338 of them have not submitted any claims to offset the estimated payments received (i.e., “No-Offset Providers”) during the initial period of January–August 2020. These balances represent providers who closed locations, retired, moved out of state, stopped providing Medicaid services, etc. These are detailed in Table 2 on the following page.

Table 2: Distribution of No-Offset Providers as of November 29, 2021

Provider Outstanding Balance	Provider Count	Total Outstanding
Providers Owing < $10K	210	$639,911.16
Providers Owing $10K < $50K	95	$2,196,051.81
Providers Owing $50K < $100K	14	$946,977.89
Providers Owing $100K < $500K	17	$3,237,044.35
Providers Owing $500K < $1M	1	$ 869,633.00
Providers Owing $1M < $5M	1	$1,599,542.33
Totals	338	$9,489,160.54

Of these 338 No-Offset Providers, 240 of them have not been engaged, and of these non-engaged providers, 86 have balances over $10,000 for a total outstanding balance of $4,471,402 for the period of January 1, 2020–August 3, 2020. These provider accounts have been forwarded to MDH to be worked through individually and pursued through collections. This process is proceeding currently.

Consolidated claims history reports are in the process of being created. A pilot of the report was made available on December 20, 2021, and UHG/Optum estimates report production by the end of January 2022.

Estimated payments are not the only monies that need to be recouped. A separate subset of claims, known as “negative balances,” have occurred for a variety of reasons since the checkwrite process went live in March 2021. The balances occur primarily due to duplicate or overpayments that occur when UHG/Optum was unable to properly transfer funds between the State and Medicaid accounts. The total amount of overpayments due is currently $67,892,166 as of 12/7/21. The balance is split between the State account ($41,166,608), with the remainder in Medicaid. The vast majority of these overpayments are small (< $5,000) but affect a large segment of providers. These are true overpayments to providers and will not be discounted or forgiven. The breakout of these amounts is shown in Table 3 below:

Table 3: Distribution of Negative Balances as of December 7, 2021

Provider Outstanding Balance	Provider Count
Providers Owing < $5K	1,838
Providers Owing >$5K - $50K	39
Providers Owing >$50K - $100K	67
Providers Owing >$500K - $1M	13
Providers Owing >$1M	14
Totals	2,381

Reconciliation Actions

Recognizing that reconciling estimated payments against claims was too much for providers to handle all at once, MDH and UHG/Optum established the Assisted Reconciliation process to reduce the effort on providers and to offer them additional support. Previous efforts consolidated all claims into a single document that was not easily digestible in an electronic format. The Assisted Reconciliation process divided the effort into six separate reports. UHG/Optum also provided an additional report, requested by providers, regarding rejected claims that were not able to be processed. The reports were uploaded to the provider's downloads folder in the Incedo Provider Portal so that providers could download, and review as needed.

Phase 1 of the Assisted Reconciliation process was focused on ensuring that providers' claims were in the system, as well as in the Rejection Report. UHG/Optum instructed providers to review the report for the relevant period for any missing claims, regardless of the claim status and/or timely filing deadlines to ensure that UHG/Optum had their claims. Missing claims were permitted to be submitted through 12/31/21 and will be processed against the outstanding estimated payment balance through the dual check write cycle offset.

Phase 2 of the Assisted Reconciliation process shifted the focus to resubmission and correction of claims that were denied with a date of service during the estimated-payment period. Phase 2 is still underway, and there are an estimated $12 million of outstanding claims that can still be processed for correction and payment.

In addition to making the electronic reports more manageable by reducing the scope of each report, UHG/Optum added specific reconciliation resources to assist providers by hiring Reconciliation Managers. The Reconciliation Managers serve as the central points of contact for providers regarding estimated payment balances and reconciliation. Providers can send their questions to maryland.provpymt@UHG/UHG/Optum.com or request a Reconciliation Manager through that email address. This is in addition to the normal route of contacting customer service

or UHG/Optum Provider Relations. The Reconciliation Manager then establishes contact with the provider to better understand their questions and to schedule a follow up meeting with the appropriate UHG/Optum resources to resolve the issue. The Reconciliation Team of some 40 Reconciliation Managers handle about 71 providers per Reconciliation Manager and receives an average of 400 to 450 emails a week.

In addition to the Assisted Reconciliation Reports which are currently available to providers, UHG/Optum and MDH are continuing the Assisted Reconciliation process to allow providers time to review any denied claims and to submit follow-up information. As such, MDH provided for certain flexibility to continue during the Assisted Reconciliation process. First, is that timely filing for claims with dates of service within the estimated-payment period is waived so that providers receive credit for those claims. Second, MDH waived the reconsideration and appeal timelines that would normally apply to claims, recognizing that the estimated-payments period created significant information challenges for providers.

Recoupment Plans and Process

Providers who owe negative balances will be required to pay those balances in full. For providers who owe negative balances, those recoupment efforts are currently underway with specific provider groups and will increase in scope once the complete claims history reports are available.

As previously announced, MDH plans to forgive 100 percent of amounts owed by providers who have outstanding or fully paid balances of $10,000 or less. Excluded from this forgiveness plan are hospitals, laboratories, out-of-state providers, somatic non-behavioral-health providers, and No-Offset Providers (see Table 2).

Reconciliation Mediator

To meet the third-party mediator requirement, MDH has engaged the Office of Administrative Hearings (OAH) to provide third-party mediation for the reconciliation process. Engaging any other third-party mediator would have required a lengthy state-procurement process and would have added months of delays to the reconciliation efforts. Providers will be required to work with an UHG/Optum Reconciliation Manager to resolve any disputed claims and/or denials prior to engaging with OAH, and OAH will only be available for mediation of amounts greater than $10,000.

Next Steps

MDH and UHG/Optum remain focused on ensuring that the BHASO system is improved so that behavioral health providers can successfully continue their participation in the Public Behavioral Health System serving the behavioral health needs of vulnerable Marylanders. Reconciliation of estimated payments is a critical part of this effort so that providers can close their books accurately, Maryland receives its share of federal match for appropriate claims, and claims data is as complete as possible.

Attachment A: Recoupment Process Infographic

As of 1/10/21

UHG / OPTUM OVERPAYMENTS PHASED COLLECTION PROCESS (a)

	Phase 1: December - March, 2021					April 2022	Phase 3: Late Spring 2022
Category	No-Offset Providers	PT54	Retro-Eligibility	IMD Funding Change	PRP (Psych Rehab Providers) Authorization	Non-Beacon Third Party Liability (TLP) Providers	Estimated Claims
Description	Providers who have not submitted claims to offset estimated payments.	SUD Residential Provider overpayments	Retroactive changes in obligated payer. State / Medicaid transfers	IMD was paid from wrong account. Essentially paid twice	Provider was not authorized to provide service.	Third-party-liability providers paid twice.	The amount owed to offset estimated claims paid between 1/01/20 and 8/03/20
Amount Owed	$9.5 million	$22 million	$30 million	$12 million	$1.4 million	$4 million	$223.5 million
Number of Providers	342	54	2,050 (1,838 owe < $5,000)	6	1	TBD	2,107 (includes only providers with outstanding balances)
Notice Given	Waiting for Collections Paperwork to be completed by Finance	Final letters sent 12/10/21	Provider Alert 12/13/21, 12/22/21, 1/7/22	YES	Waiting for complete claims Hx Reports	NO	Provider Alert 11/17/21

(a) Excludes:

(i) Providers on payhold (mostly under investigation) until matters are resolved

(ii) Beacon Carryover Claims (TPL, rate adjustment errors, failures to pay)

(iii) Claims under review and awaiting resolution