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VIA E-MAIL

Maryland Department of Health

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Re: Retro-Eligibility and Recoupment: Concerns with Notice and Process Prompting the Need to Delay Recoupment of Overpayments

Dear Maryland Department of Health and Optum officials:

On behalf of our client, the Community Behavioral Health (CBH) Association of Maryland, and its 90 provider-members, we write to you to respectfully request that you delay the recoupment of potential overpayments made to providers through the Optum Behavioral Health Administrative Services Organization (Optum), a process that is scheduled to begin this week on December 1. While Optum's website states that the Maryland Department of Health (MDH) and Optum "have been working closely to establish an estimated payment recoupment process that is as fair and flexible as possible," many providers remain frustrated by (i) the lack of time to validate claims receipts; (ii) inadequate notice of the total dollar value to be retracted and the rationale for retraction; (iii) the absence of an itemized list of claims identified as overpayments; and (iv) an unfair process that has blocked providers' ability to dispute claims identified erroneously as overpayments and to secure claims corrections. These issues are explained in more detail below.

Because MDH has announced December 1, 2021 as the beginning of the recoupment period for providers that received purported overpayments

stemming from retroactive eligibility issues for the period of July 2019 to March 2021 (a portion of which overlaps with the estimated claims period of January 1 to August 3, 2020),<sup>1</sup> time is of the essence. CBH asks that we schedule a call with you as soon as possible (ideally this week) to explore whether the payment recoupment process can be stayed while these very relevant provider concerns are more sufficiently addressed.

## I. Background

In 2019, MDH began a transition to a new Administrative Services Organization (ASO) vendor and, in January 2020, Optum assumed the State's ASO contract. Even though Optum's authorization and payment systems were non-functioning and Optum's inoperability prevented providers from revising and resubmitting 2019 claims, the MDH urged providers to continue delivering services despite the lack of authorization and eligibility information. Optum's inoperability issues continued into 2020 but MDH explicitly urged behavioral health providers to continue to provide services, recognizing their services were even more critical in the midst of both the opioid and coronavirus pandemics.

During the period of January through July 2020, MDH directed Optum to make estimated payments to providers based on each provider's average monthly claims payments in 2019, due to the inoperability issues with processing and paying claims through Optum's platform. Recently, MDH announced it would embark on a three-phase reconciliation process. The first phase, beginning on December 1, would recoup any alleged overpayments, while subsequent phases would address reconciliation of estimated payments (taking into account these December recoupments). In sum, MDH intends to recover monies when estimated payments received by providers are believed to be greater than the claims submitted.

By way of background, the Maryland Department of Health published a Request for Proposals in November 29, 2018 for an administrative services organization (ASO) for the state's public behavioral health system, providing that, for claims processing: "Federal rules allow Medicaid coverage to be applied retroactively for up to three months prior to the month of application

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<sup>1</sup> Although the November 17 Provider Alert seemingly attempts to limit the number of providers from which payment will be recouped in December based on certain factors, the guidance remains unclear and remaining providers who received overpayments and do not fall under the December umbrella will face a spring 2022 recoupment period. Thus, CBH believes it is proper to broadly address all issues pertaining to retro-eligibility and recoupment now, at the start of MDH and Optum's process.

provided the individual would have been eligible for coverage during the retroactive period had s/he applied at that time.” See Section 2.3.9. The same section further stated that “if the ASO pays for services from the state-only bank account and later determines the individual is eligible for Medicaid, the ASO will process the claim through MMIS to draw down federal funds at which time the ASO would replenish the BHA State bank account.” The same section also instructed, as to claims proceeding, that the contractor shall complete a number of specific tasks, including “develop[ing] and maintain[ing] an accurate, efficient claims processing system to receive and adjudicate claims for medically necessary behavioral health services and submit Medicaid eligible claims to MDH for purposes of drawing down federal funds” and “reconcil[ing] payments between the Medicaid and State bank accounts from which providers are reimbursed . . .” See 2.3.9 (A) & (C). Optum (the state’s third-party contractor) must abide by this language as it assumed the state’s ASO contract in January 2020.

On February 28, 2021—424 days after it received the ASO contract—Optum activated the retro-eligibility functionality described in the RFP. On March 5, 2021, Optum issued a specific provider alert where it announced it was activating this functionality and stated that claims with dates of service from July 1, 2019 to March 31, 2021, a period of 609 days, would be reprocessed if there was an eligibility change or denial due to an eligibility reason. Providers were informed that reprocessed claims would undergo “standard adjudication edits” and outcomes would be reflected in the PRA.

The next provider alert from Optum, dated April 13, 2021, acknowledged that the large volume of claims reprocessed created issues for some providers, including that some claims did not generate 835s (standardized electronic claims receipts) or PRAs (provider remittance advices—the paper version of 835s) until the negative balance was completely resolved. Optum stated that it was researching and considering solutions to resolve the negative balances that were a “natural outcome of this reprocessing project.” While different solutions were considered, Optum suppressed retro-eligibility 835s as a “temporary measure” to ensure that claims flowed normally.

On October 24, 2021, these suppressed retro-eligibility 835s (covering claims from the 609-day period described above) were released to providers. These detailed 835s, often covering thousands of claims per each provider, lacked standardized formatting and required manual reconciliation in many cases. Providers were tasked with validating claims’ status and payment, but the lack of standardized formatting and inability to link multiple reprocessing instances of the same claim have turned this project into an extremely

burdensome workload. Optum's "Estimated Payment Frequently Asked Questions" document, revised on October 5, 2021, stated that providers would have a minimum of 30 days to review these 835s before agreeing to their repayment amount and entering into a payment agreement, despite the COMAR regulation expressly requiring 60 days for providers to review and resubmit corrected claims following receipt of an 835. See COMAR 10.09.36.06.

Optum's final provider alert, dated November 17, 2021, announced that providers falling into certain categories would be required to repay their retro-eligibility balance "on or before" December 1, 2021, but no later than December 31, 2021. Optum's FAQ guidance also advised that if a provider, "after completing the reconciliation resolution process" disputes the final determination on their repayment amount, the provider can request third party mediation through the Maryland Office of Administrative Hearings, but that a case will not be accepted for mediation until it has been adjudicated through a "reconciliation management" process. However, given the plans to auto-deduct these funds in full between December 1 and December 31, recoupment of these funds would precede any mediation process.

## **II. Providers' Outstanding Concerns**

Numerous providers have raised significant concerns with the proposed recoupment process, and these pressing issues form the impetus behind CBH's request in this letter. These issues include, but are not limited to, (i) timing, (ii) notice, (iii) transparency, and (iv) appeals process.

### **A. Timing**

To the extent recoupment is based on the 835s sent to providers on October 24, 2021, providers have not had enough time to validate the status of those claims. COMAR requires 60 days for provider review and resubmission of corrected claims, and this is based upon an assumption of standardized, electronic reconciliation. See COMAR 10.09.36.06. The manual processes required by Optum's non-standardized system require more time. CBH therefore requests 120 days from October 24, 2021 for providers to analyze the claims and requests that the recoupment process be delayed from the December 1 anticipated start.

The November 17, 2021 provider alert attempts to limit the December recoupment of overpayments to a very limited subset of providers (only those that submitted no claims; adult residential SUD providers receiving duplicate payments; providers that received an additional Medicaid payment for claims

submitted between January 1, 2020 and March 31, 2020 due to retroactive eligibility determinations; and hospitals and institutions receiving overpayments). Providers assert that the December recoupment plan is broader than what has been described by MDH and Optum, as retro-eligibility reprocessing includes reprocessing to correct funding sources originally paid incorrectly by Optum, not only eligibility changes. Moreover, known errors in third-party liability data mean that Optum is applying retro-eligibility to some claims with invalid or expired insurance information, resulting in claims retractions that were paid correctly or that were never paid at all.<sup>2</sup> In other words, recoupment based on these denials may over-collect what MDH is owed.

Based on information from its members, CBH believes that there is considerable overlap in claims in both the alleged “overpayment” and estimated payment categories and MDH is mischaracterizing the nature of these “overpayments.” If a claim identified as a retro-eligibility overpayment had a DOS during estimated payments, the “double payment” was not paid with a live check. It is theoretical money that was subtracted from the estimated payment balance. As of the November 17 communication, Optum has simply sectioned off a subset of that estimated payment balance—that theoretical money that providers haven’t actually been paid—and added it to the negative balance bucket, now requiring providers to pay it back *in the course of only one month and without a payment plan*. The only legitimate “double paid” claims due to retro-eligibility, which remitted real money to providers, are for DOS *after* estimated payments. These were actually paid twice.

One of the collateral issues resulting from this “sectioning off” is that the balances identified and communicated by Optum to each provider have not included this subset of claims. Therefore, Optum has led providers to believe that they owe a lesser amount than they actually do. For example, a reconciliation manager could meet with a provider and inform the provider that it owes \$400,000, but the reconciliation manager would not count an additional \$50,000 worth of negative balance funds as part of this analysis.

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<sup>2</sup> Given the unreliability of Optum’s claims processing data, the formatting of the 835s, and overall process, we have to question how MDH meets its obligations under federal law to “provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program.” 42 U.S.C. § 1396a(a)(37)(B). Federal regulations likewise require state Medicaid agencies to “[m]aintain . . . supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements.” 42 C.F.R. § 433.32.

For these reasons, providers assert that starting recoupment in December, after only sending the 835s listing the overpaid claims on October 24, and amongst thousands of other previously missing 835s, places a considerable burden on providers. A 120-day period to validate receipts, raise concerns about incorrect claims, and itemize claims identified as overpayments would serve as a necessary improvement.

## B. Notice

Optum's guidance (prior to the November 17 notice) states that "providers . . . will be required to pay their outstanding balances on or before December 1<sup>st</sup> but not later than December 31<sup>st</sup>." This statement leaves providers with a series of unanswered questions, such as:

- Will the recoupment process start as soon as December 3? Also, will recoupments for December 3, 10, 17, 24 and 31 be retracted in equal amounts over those 5 weeks?
- How will claims already held in process against providers' negative balances be applied?
- Will providers receive 835s for the claims used to offset their negative balance?
- Will providers have the ability to make one lump sum payment if desired?
- How will receipt of payment be delivered?

These questions were left unresolved by the October 24 835s and the November 17 communication. Those 835s covered claims from a 609-day period and required manual reconciliation. Thus, they failed to include easily discernable information such as the total dollar value to be retracted. To rectify these unanswered questions, CBH is interested in proposing a more cohesive notice process, whereby providers would be informed of the total dollar value to be retracted, given a rationale for each retraction, receive an itemization by claim of all claims identified as overpayments and be provided a description of how retractions will be applied (when and in what amounts each time) if not paid in a lump sum.

After providers receive the clear notice as detailed above, providers should have a period of no less than 30 days prior to any recoupment occurring.

During that 30-day period, providers could iron out any questions or differences with reconciliation managers.

### C. Process for Appealing Disputed Claims

Optum's FAQ Guidance to providers instructs that if a provider does not agree to the final determination on its repayment amount after completing the reconciliation resolution process, the provider can request third party mediation through the Office of Administrative Hearings. See FAQ Guidance, Paragraph 7. However, a case will not be accepted for mediation until it has first been adjudicated through the reconciliation management process. There is no definition with respect to what is meant by "adjudication," what it entails, or its scope. Both the adjudication and mediation processes referenced in the FAQ are novel and are not in alignment with state law and regulations.

The dispute resolution framework proposed by MDH and Optum poses a series of questions relating to providers' ability to dispute claims erroneously identified as overpayments and to secure claim corrections. First, CBH has learned that many providers have requested assistance from Optum's reconciliation managers relating to claims identified in the 835s. While some reconciliation managers have been helpful, others have only responded once with vague guidance and/or have failed to offer sufficient answers to providers' questions. Because a case cannot be accepted for mediation until it has first been "adjudicated" through the reconciliation management process—yet the reconciliation management process has failed to provide concrete answers in many instances—providers are at a loss for when they can request mediation.

Secondly, CBH asserts that the process for disputing claims identified as overpayments is unfair and lacking. To correct some of these problems, CBH is interested in discussing the following potential fixes to the process:

- To the extent the reprocessing of claims results in an erroneous denial, recoupment should be stayed until Optum corrects the wrongful denial;
- Providers should receive a separate 835 concurrently delivered for each claim retracted as an overpayment;
- Providers should receive itemization by claim for retracted payments with DOS in the estimated payment period to ensure the same claims are not retracted to offset the negative balance AND the estimated payment balances; and
- Providers should receive a total claims history (claims lifecycle) for each reprocessing of a claim.

These “fixes” would greatly assist providers in reviewing claims identified as overpayments and determining whether Optum’s analysis is accurate or whether the provider needs to invoke the reconciliation manager and potential mediation avenues. Moreover, CBH would like to discuss whether the recoupment process would charge interest penalties on claims not paid (or paid 31+ days after submission), as providers have received little to no guidance on the financial penalties for failing to pay (which is especially relevant if a provider disputes an overpayment and wants to invoke its right to appeal Optum’s overpayment determination).

Finally, providers remain concerned about their due process rights. Optum’s guidance makes third-party mediation through OAH seem like a provider’s last resort to challenge an erroneous overpayment designation. If a provider disagrees with the reconciliation manager’s overpayment amount or even with the mediator’s amount, the provider should be able to formally appeal and challenge the final payment decision before an OAH ALJ. See COMAR 10.09.36.09, which allows providers to appeal from a Medicaid program action to, among other things, withhold payment; such appeal procedures clearly apply to “specialty mental health services” described in COMAR 10.09.59. CBH and its member-providers are unable to locate a pertinent state regulation that permits MDH to rely on mediation as a final payment decision and bypass the traditional formal appeal procedures.<sup>3</sup>

### **III. Conclusion and Request**

Under the Medicaid Act, MDH has an overarching obligation to “ensure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” 42 U.S.C. § 1396a(30)(A).

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<sup>3</sup> See *also* the Maryland Medicaid State Plan, which defines the role of OAH relating to fair hearings. The Plan provides that “Maryland has established an Office of Administrative Hearings (OAH) to provide impartial hearing examiners to conduct contested case hearings for other state agencies, at the state agencies’ option and delegation.” Md. Code Ann., State Government Article (SG) § 10-205. OAH applies the procedural regulations adopted by the agency when, as for Medicaid fair hearings, it is required to do so by State or Federal law. SG § 10-206. The Department of Health has delegated final fact-finding, final conclusions of law, and final orders for all of its Medicaid fair hearings to OAH, but the Department of Health retains the ability to ensure its fair hearings are adhering to Medicaid requirements. The Department of Health has adopted procedural regulations consistent with federal Medicaid fair hearing requirements. COMAR 10.01.04. While these regulations offer “fair hearings” for providers, they do not seem to contemplate mediation as a final resort to disputed claims.

The payment challenges that CBH's members face as a result of MDH's and Optum's actions have had and will continue to have an adverse effect on the capacity of Maryland behavioral health providers to provide services to those most in need.

We have significant concerns stemming from MDH's and Optum's attempts to short circuit the due process rights of CBH's members. These behavioral health providers deliver critical services to Maryland residents, and jeopardizing their viability at a time when their services are needed more than ever in the face of the opioid and Covid-19 pandemics is short-sighted and unlawful. In order to avert any further negative consequences, we ask to schedule a call with you as soon as possible (ideally within the next week) to explore whether the payment recoupment process can be stayed while these very relevant provider concerns are more sufficiently addressed. On behalf of CBH and its member-providers, we also reserve all rights (and other claims) associated with the retro-eligibility and recoupment process.

We have included our email addresses below to facilitate making timely contact.

Sincerely,

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