Optum's Missing Functionality

Quarterly Report | October 1, 2021

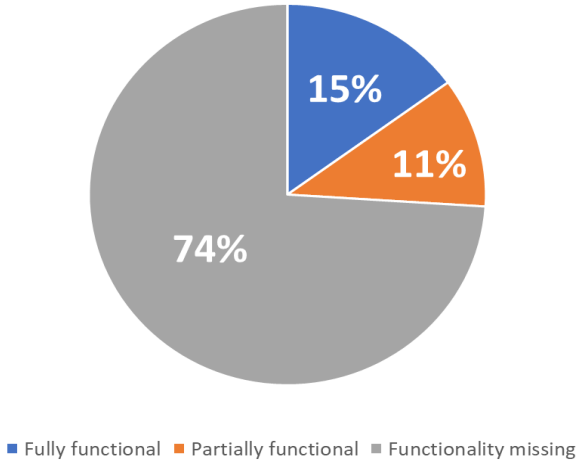
Optum was awarded a contract to manage Maryland's public behavioral health system on June 12, 2019. Optum launched its claims processing system on January 1, 2020, and relaunched it on August 3, 2020. Core functions needed to stabilize and support providers' revenue cycle management activities remain missing.

On May 12, 2021, CBH issued a report describing the minimum functions necessary for managing Maryland's public behavioral health system, and it identified 52 functions that were needed but missing in Optum's current system.

This quarterly update describes Optum's progress toward fully implementing the minimally necessary functions for an ASO vendor. Optum has moved 15% of measures to completion, compared to 6% in July.

843 days since contract award:

76% of the minimum necessary functions remain absent.



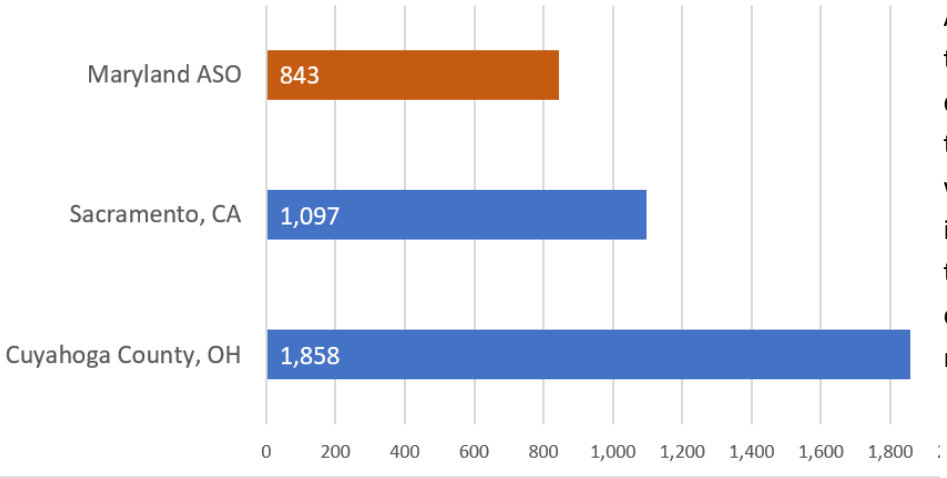
Claims processing Optum lacks 73% of needed system functionality.

Eligibility & authorization Optum lacks 80% of needed functionality.

Provider relations Optum lacks 100% of needed system functionality.

Security & privacy Optum lacks 67% of needed system functionality.

A history of contracts terminated for non-performance



According to media reports, Optum's technology subvendor for claims processing has had multiple city contracts terminated due to its failure to deliver working technology systems. Authorities in Ohio and California terminated contracts with InfoMC after multi-year efforts to secure adequate performance.

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Minimum necessary functionality standards for Maryland ASO

Standard	July 1, 2021	October 1, 2021	Notes
Standard 1: Claims Processing. ASO vendor's claims processing system includes all functionality necessary to support providers' revenue cycle management and is consistent with industry-standard practices.			
1A: If a claim is submitted with all required information, it will be timely and accurately paid by Optum without additional intervention by the provider. Performance includes:			
a. Optum will publish and maintain a companion guide as referenced by 42 CFR §§ 162.1203, 162.1403, and 162.1603 that includes required information such as payer testing, EDI contacts, payer-specific business rules and limits.	Partial	Partial	Companion guide does not accurately describe 999, 277, and 835 transaction limitations, omits process flows in Section 4.
b. Claims will be paid or denied within clearly defined contractual expectations, which has historically been 14 days from submission, but was re-interpreted under Optum to be 21 days from submission.	X	X	Because Incedo assigns a new claim number to every reprocessing, accurate performance on payments is not reported.
c. System will generate an accurate 835 that fully describes the status of every encounter, claim, and payment adjustment, and deliver it to provider at the same time as the claim payment, retraction, or payment adjustment.	X	X	835s on all claims, encounters and retractions due in October , 2021
d. If claims are not paid within 30 days, Optum will automatically include interest payment on such claims without provider demand, as required by Maryland law.	X	X	See 1Ab. Without accurate payment dates, accurate penalties cannot be calculated.
e. Upon an update in service fee schedules, Optum will pay claims at the updated rate within 30 days of the effective date of the rate change.	X	X	For fee changes known in advance, fee schedule updates should be timely & accurate.
f. MDH defines evidentiary requirements and reporting mechanism for providers to report non-compliance with deadlines by Optum to the Department.	X	X	Assignment of issue ID numbers not working. No reporting mechanism
1B: If a claim fails to process and/or pay in Optum's system, providers will receive timely automated reports at each step in the process that identify the reason for the failure and the information needed to correct the claim. Performance includes:			
a. System will generate accurate 999 reports for all claims batches that reject or fail to upload.	X	Partial	999 report corrected July 10, 2021. 999s only report rejections; failures must be supplemented with manual report. Not described in companion guide.
b. System will generate accurate 277 reports (claim response on front-door edits) that accurately identifies rejected claims and contains all necessary data required to submit a clean claim without requiring supplementary reports.	Partial	Partial	277CA incomplete without manual supplement on undetermined timeframe. Not described in companion guide.
c. System will generate an accurate 835 on every encounter, claim, and payment adjustment, and deliver it to provider at the same time as the claim payment, retraction, or payment adjustment.	X	X	Functionality missing. See 1Ac.
d. System will use industry standard denial codes and denial explanations. Each denial code will identify a singular and distinct denial reason and its correlating denial explanation will accurately and completely describes the reason for the claim denial and offer sufficient information for the provider to correct the claim.	X	X	Denial codes fail to give provider info needed to correct claim without calling Optum to know why claim denied.
e. If there are multiple reasons for a claim denial, the system will include each of the distinct denial reasons and their correlating industry standard explanations on the 835.	X	X	835s began including after system relaunch in August 2021. Earlier claim receipts may be incomplete.

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1C: If a claim is in any status other than full payment (including but not limited to fails, rejects, pends, remains "in process," underpayments, partial payments, zero payments, or denials) due to a failure or error in Optum's claims processing, Optum will identify, correct and pay the claim within 30 days of claim submission without additional provider intervention.			
a. Failures or errors in Optum's claims processing system include but are not limited to non-payment statuses arising from:			
i. Client naming convention errors;	X	Complete	No current reported problems. Historical claims not corrected..
ii. Insurance indexing errors (i.e. selecting incorrect primary insurance or displaying inactive insurance);	X	X	Problems continue to be reported.
iii. Secondary payer processing errors;	X	X	Problems continue to be reported.
iv.Denials of add-on codes when underlying code is appropriately authorized;	X	X	Problems continue to be reported.
v. Duplicate client records;	X	Partial	No current reported problems. Historical claims not corrected.
vi. Erroneous duplicate claims denials;	X	Complete	No current reported problems. Historic claims not corrected.
vii. Unfunded spans without end dates;	X	X	Problems continue to be reported.
viii. Service portal and data errors including incorrect NPI numbers;	X	X	Problems continue to be reported.
ix. Manual processing errors by Optum	X	X	Problems continue to be reported.
b. If a provider reports claims denied or underpaid due to Optum errors, Optum will correct and pay each claim within 30 days of original submission date.	X	X	Reprocessing incomplete; no process for clearing provider issue tickets.
c. If claims are not corrected and paid within 30 days, Optum will automatically include interest payment on such claims without provider demand, as required by Maryland law.	X	X	No compliance. No interest paid to providers as of Sept. 20, 2021
d. MDH offers mechanism for providers to report noncompliance to MDH; and upon validation, MDH applies requisite monetary penalty for contractual noncompliance	X	X	No process in place.
1D: Incedo will include necessary functionality to enable providers' revenue cycle management activities, including:			
a. Full export and download capacity for claims and authorizations (not max of 500);	Partial	Complete	Completed in August 2021
b. Void and resubmit capacity for individual and batch claims;	Complete	Complete	
c. Reporting and search capacity that meets basic industry standards and includes eligibility statuses; uninsured requests; claims data by processed dates, service dates, and claims status; search capability should identify the full array of client and/or claims data present in the system at any and all times;	X	Partial	Significant functionality still absent
d. Full and accurate reporting capacity on claims' processing history including dates of each reprocessing, check numbers and check dates associated with every reprocessing of a claim;	X	X	Functionality not present.
e. Capability to save draft/in progress authorizations; and	X	X	Functionality not present.
f. When applying retroactive funding switches for eligibility changes, the system will remit retraction and repayment info for a single claim simultaneously and on the same 835.	X	X	Functionality not present.

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1E: Optum will provide prompt and adequate notice to providers of planned and unplanned system outages, including:			
a. For unplanned outages: Within 30 minutes of a reported outage of authorization or claims processing functionality by more than two providers, Optum will release a notice to the provider community;	X	X	Aug 26 PaySpan error not subject to communications update..
b. For unplanned outages: Once the scale and duration of a system outage is reasonably identified, Optum will release an update to provider community;	X	X	
c. For unplanned outages: Within 30 minutes of an outage resolution, Optum will release an update to the provider community;	X	X	
d. For planned upgrades, Optum will provide 48-hour advance notice to provider community of planned upgrades that may result in system outages or reduced functionality, including date, duration and functions impacted.	X	Partial	Only 6 of last 10 outages announced via Provider Alert (Sept 7 Ops Imprvt)

Standard 2: Eligibility and Authorizations. Uninsured eligibility decisions and authorizations are accurately and timely processed.	July 1, 2021	October 1, 2021	Notes
2A: Timeframes and Workflows.			
a. Authorization requests for crisis services are approved accurately on first review and responded to within 24 hours of request;	X	X	Outpt crisis auth treated as routine instead of urgent.
b. Authorization requests for non-crisis services are approved accurately upon first review and within 14 days; If additional documentation is requested by Optum, approval is made within 3 calendar days of provider submission of requested documentation;	X	X	Optum data excludes "pended" auths and PRP auth delays for third time in contact not rept'd
c. if auth is pended for reasons other than routine approval (i.e. for overlapping date spans), provider should receive notification of the pended authorization within 5 days of submission as well as justification for the pend;	X	X	Cause of pended auth not ID'd; if due to internal auth span overlap
d. Requested uninsured eligibility spans are approved or renewed within 5 days of submission;	X	Complete	Monthly data shows compliance for July—Aug.
e. Requested unfunded spans are approved within 3 days; and	Insufficient	Insufficient	Insufficient info to evaluate status.
f. Split authorizations are appropriately identified and approved; conflicting authorizations are appropriately identified and prevented.	X	X	Functionality does not exist
2B: Transparency and Accountability.			
a. Optum will report monthly on the average time from request to decision for uninsured eligibility by provider type	X	Complete	Ensure ongoing reports.
b. Optum will report monthly on the average time from request to decision for authorization request by provider type	X	X	No reporting by provider type; see 2Ab.
c. Authorization process for every provider type matches the workflow and clinical requirements described in the provider manual; and	X	X	Auths for bed day hold (T2048) unresolved.
d. MDH clearly defines evidence necessary to document non-compliance with time standards and provides a mechanism to report it.	X	X	No process in place.

Standard 3: Provider relations. Performance standards for the ASO's provider relations are accurately defined, measured, and actionable.	July 1, 2021	October 1, 2021	Notes
A: Identify. Optum has effective process in place to log and individually track provider inquiries.	X	X	ID # not routine; workflow not clear
B. Respond. Optum responds to provider inquiries within one business day.	X	X	No.
C. Resolve. Optum resolves provider inquiries on claim problems and other open tickets with 5 business days.	X	X	No reporting.
D. Report. Optum reports unresolved provider inquiries to MDH.	X	X	No reporting.
E. Accountability. MDH offers mechanism for providers to report noncompliance to MDH	X	X	No reporting.

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Standard 4: ASO demonstrates the ability to identify and mediate security and privacy violations in a timely manner.	July 1, 2021	October 1, 2021	Notes
4A: The ASO issues payments only to providers who have billed the ASO for providing treatment to a patient.			
a. A clear avenue for providers to report misdirected payments is established and communicated to the provider community;	complete	complete	
b. Optum identifies a root cause for ongoing misdirected payments;	complete	complete	See 1Ca(ix) re manual processing errors.
c. Implementation of appropriate corrective action is reported; and	X	X	Insufficient information.
d. Efficacy of corrective actions is evaluated by MDH through monitoring of ongoing reports from provider community.	X	X	Ongoing misdirected payments as of Sept 2021. Adequacy of risk mitigation..
4B Security.			
a. Optum describes how individuals accessed PHI for 18 months through provider alerts.	X	X	New measure added due to privacy & security breaches revealed June 29, 2021
b. Optum describes how individuals accessing PHI were identified	X	X	

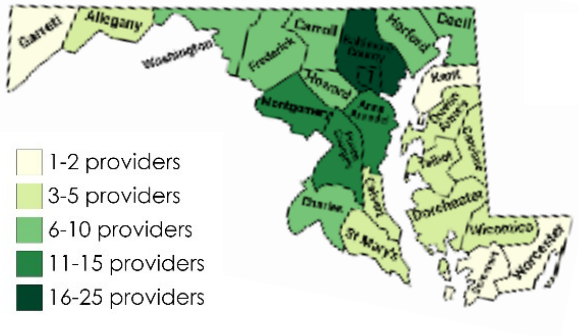
Join Us

Our peer-to-peer learning communities tackle measurement-based care, opening Maryland's commercial market to behavioral health providers, HR in a COVID world, and providers' needs in the face of a difficult ASO transition. Be part of the solution: http://mdcbh.org/join

About Us

The Community Behavioral Health Association of Maryland (CBH) seeks to improve the quality of behavioral health care and access to treatment.

We represent 90 organizations providing mental health and addiction treatment to Maryland residents. Our members encompass over 810 service sites, 180,000 individuals served and 13,000 employees.



learn more For details on CBH priorities, contact Shannon Hall at shannon@mdcbh.org.

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