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

To: Kathy S. Ghiladi, Partner, Feldesman Tucker Leifer Fidell LLP
Mindy B. Pava, Partner, Feldesman Tucker Leifer Fidell LLP

From: Steve R. Schuh, Deputy Secretary of Health Care Financing and Medicaid
Linda Rittelmann, Medicaid Behavioral Health ASO Lead

Re: Letter Dated 05/02/22

Date: June 3, 2022

Thank you for your letter dated May 02, 2022, on behalf of your clients, Counsel for the Community Behavioral Health Association of Maryland (CBH).

We delayed this letter by a week or more while we addressed most of the issues in it. We appreciate your patience in this regard. Below are the responses to the list of items your client specifically requested in your letter:

1. **State Negative Balance: Amount, Timing, and Process**

Letters were sent to providers on May 13th, 2022, via their Incedo download portal, email and by USPS. These letters contained the specific amounts due on 5/20/22 for each provider as well as instructions for remittance (sample letter attached).

Calculation of Negative Balances

Provider negative balances are calculated as the lesser of:

a. The amount currently due on May 20, 2022 (with consideration given to reductions in the balance or repayments by the provider) or
b. The amount specified in the demand letter originally issued on or around December 21, 2021.

If the amount currently due has increased since issuance of the original demand letter, this "tail" excess balance will be handled through clipping of future claims.
Example: A provider owes $100,000 based upon the demand letter, and $120,000 on current balance due in the claim history reports. The provider must repay the lesser

amount ($100,000) by May 20, and the $20,000 difference will be considered a "tail" amount to be repaid through claims clipping or another payment arrangement approved by the Maryland Department of Health (MDH).

Dispute Process

All retro-eligibility claim disputes will follow the normal dispute resolution process (see attached).

TPL Amounts

The TPL issue is scheduled to be completed by the end of June. They do not amount to a large sum spread out over nearly 1,300 providers with retro-eligible claims. If those specific claims are in dispute, they may be withheld and paid after the TPL issue has been resolved on a case-by-case basis.

Optum completed reprocessing of claims that were denied for "No Authorization" when no authorization is required for secondary claims.

Claims processed not taking OPA (Other Paid Amount) submitted with the claim began reprocessing the week of 5/30/2022. Optum anticipates completing this work in the near future and will provide further updates on timing. For 2020 TPL/COB claims that were paid as primary and then down adjusted following receipt of a TPL record, Optum is collaborating with MDH to determine the approach to resolve those claims. An estimated timeline regarding this process will be provided at a later date.

Claims processed twice where the second processing resulted in a denial and the provider received only a single payment.

These retro-eligibility claims should be addressed specifically on an individual basis with the provider's Reconciliation Manager for final resolution.

Each time Optum processes a claim, it assigns a new claim identification number, making it difficult to track the final status of a claim.

Optum response: Optum generates a new claim identification number when the provider submits a new claim. When the provider submits a corrected or otherwise updated claim, Optum generates an extension to the existing claim identification number, which allows the provider to clearly identify the claim associated with the resubmittal and tie it to the original claim submission. These are all listed on the Life Cycle Claims History Report.

2. **Notice of the Medicaid Negative Balance Amount, Timing, and Process**

As has been discussed in multiple meetings over the last few months, there are various causes to the different sources of the Medicaid negative balances. The largest cause resulted in amounts which affected just 6 large IMD providers. MDH and Optum have been working with those providers for many months now and their balances were also due on 5/20/22.

Many of the other causes affect only 4-7 providers each and are for smaller amounts. We will be working with each group individually to determine the most efficient and reasonable way to recoup those dollars going forward, taking into account that this process may overlap with Estimated Payment recoupment. MDH is committed to working with providers in a way that minimizes disruption and provides adequate advance notice, but each situation may differ in timing and collection. It is important that we address the recoupment so that Medicaid balances do not continue to accrue over time.

Claims on the Medicaid negative balance tab of the claim history report aren't identified by category.

We are taking this issue under advisement for further review. It is our goal to provide as much complete information as possible for each specific category of claims.

Recoupment should be sought only on Medicaid claims paid twice.

As stated above - there are a variety of reasons that resulted in a Medicaid negative balance. Many of them were not due to claims being paid twice. Some were due to fee schedules and or rate changes, and some were due to State-only claims paid as Medicaid. We will strive to be as specific as possible in the identification of these claims when notice is provided.

How is MDH overseeing Optum's continued progress in correcting denied claims in concert with providers and ensuring that Optum's claim denials are not an attempt to limit its liability?

CBH statement - a: As Optum made systemic corrections to denied claims, providers concurrently reported that Optum's corrections had not always captured the full universe of claims needing correction. Thus, providers have outstanding denials for eligibility errors, TPL errors, Beacon data migration errors, cascaded PRP rates due to skipped encounters, and various errors stemming from Optum's manual processing. Providers are

unable to correct the denied status of these claims on their end.

Optum response – a: When Optum completes claim projects, report(s) are immediately generated to assess the change impact of correction(s) to the claim universe in question. When processing finalizes for the initial universe identified or upon project completion, Optum continues to review post-processing reports to ensure no claims have been missed. However, because claims are being continuously resubmitted, corrected, and sometimes voided, the scope of the analysis necessarily changes when that occurs. Additionally, reprocessed claims can nonetheless result in denials on different grounds than the original denial reason based on the information contained in the resubmittals.

CBH statement – b: According to Optum, providers did not receive the full set of claim receipts (or 835s) until March 2022, preventing providers from timely identification of the full universe of claims impacted by faulty denials.

Optum response – b: The missed remit advice (835s) was specific to denials related to members with no eligibility. In March of 2021, a system correction was implemented to resolve this issue; however, the fix was not retrospective. In March 2022, a special project was implemented to generate missing remit advices (835s) to impacted providers, and these have been uploaded to Payspan.

CBH Statement- c: Optum's system was not set up to deliver claim receipts on PRP encounters until late 2020. Once this functionality was launched, Optum made the decision not to release historic claim receipts for PRP encounters, preventing providers from identifying missed encounters that led to denials of PRP encounters.

Optum response – c: Optum did not initially generate EDI 999 (Acknowledgement) for rejected EDI 837 files that failed EDI standard compliance validation; however, for successfully processed EDI 837 files, Optum returned 999 responses. Optum has updated EDI batch processing to also include sending 999 response files for instances where EDI 837 files fail to comply with EDI standards.

CBH statement – d: Until Summer 2021, Optum's 835s only contained a single denial code for a claim. If a claim denied for multiple reasons, the additional reasons were masked to the provider. While Optum could see all the denial reasons, 835s were delivered to providers with only a single denial code, raising an absolute bar to providers' ability to identify the full universe of claims impacted by denial code corrections. Additionally, until Fall 2021, CO45 (payment adjustment) codes were displaying in error on many 835s masking all correct denial codes for claims, further complicating providers' ability to identify causes for claims denials and flag erroneous denials.

Optum response – d: Initial code implementation limited the number of

explanation/remark codes and descriptions and as a result, providers did not receive every explanation/remark code available on remit advice (835). To address, Optum deployed a change to allow as many explanation/remark codes and descriptions available in Incedo for processed claims.

CBH Statement – e: Various errors resulting from authorization processing malfunctions have caused authorization-related denials which cannot be corrected by the provider.

Optum response - e: When authorizations could not be obtained through the provider portal, providers had the option to contact the Optum call center to obtain an authorization. As an example, due to issues with incorrect LTC eligibility, Optum instructed providers to submit backdated authorization exception requests which were automatically approved and directly entered by Optum staff. Once a retroactive authorization is approved, claims are automatically reprocessed without providers having to resubmit or take any further action.

MDH: We have been working closely with Optum to clean up the $81 million in denials and have a target date for completion of 5/20/22. We have weekly (or more often) progress meetings and progress reports are sent to Secretary Schrader weekly.

That said, MDH does not disagree that there are problems with the denial process AND the fact that denials are an entirely separate issue from estimated payments. While it would be convenient for all parties to have every denial reversed and credited against estimated claims balances, that is not a necessity to move this process forward. If a denied claim is ultimately found to be a good claim, it will be paid irrespective of whether it's paid in the normal course of affairs or credited against still outstanding estimated claims balances.

Furthermore, providers have a one-year repayment plan for the estimated claims, so as denials are reversed, they will be credited against those declining estimated claims balances over the next year.

Validation of Exhibit 1 attachment

MDH and Optum would be happy to review and discuss this process in greater detail.

Please do not hesitate to contact us, or Optum Maryland directly with any further questions or concerns.

Sincerely,

Steve R. Schuh
Deputy Secretary of Health Care Financing and Medicaid Director

CC: Linda Rittelmann
Monica McNeil
Lauren Grimes
Shannon Hall
Lori Doyle
Kathleen Ellis