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

Re: Letter Dated 05/26/22

Date: July 6, 2022

Thank you for your letter dated May 26, 2022, on behalf of your clients, Counsel for the Community Behavioral Health Association of Maryland (CBH).

We will attempt to address each issue in order:

CBH: "...we are disappointed that MDH has elected not to respond to all of the concerns outlined in our May 2, 2022 letter and instead has directed Optum to supply a separate response at some undetermined date, focusing on certain issues that were identified as areas that Optum should "specifically address.""

MDH: See attached revised letter dated June 3, 2022, which contains all of Optum's responses in full.

CBH: "Optum's practice of assigning multiple claim identification numbers to a single claim and the overall problems with its Incedo system mean that the negative balance calculations continue to be difficult to verify. We remain concerned that there is insufficient due process for providers related to the anticipated Medicaid negative balance recoupment. Within the Medicaid negative balance, providers do not know which claims are being recouped, nor for what reason.1 Without this knowledge, providers are unable to validate whether any recoupment in the first place, is correct (sic). Thus, the "lesser of" and claims clipping of any "tail" excess balance outlined in your May 20 letter, while helpful, do not address CBH's fundamental concerns about the validity of Optum's calculations.

In the absence of a response that allows the providers to validate Optum's math, we ask that you deem the Medicaid negative balance as presumptively disputed in whole for any current

member of the Community Behavioral Health Association of Maryland, unless a member provider explicitly waives this provision in writing to Optum/MDH.

1 While MDH has named nine categories included in the Medicaid negative balance, it hasn't described them or itemized the impacted claims. For example, the "retro rate decrease" has not identified what rates are being decreased, why, or which claims are included in a provider's Medicaid negative balance for this reason. "

MDH:

1. Please refer to previous letter for Optum's response to claim identification numbers:

   > "Optum generates a new claim identification number whenever 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."

2. Optum has previously provided a complete list of Medicaid negative balance definitions.

3. As of June 1, MDH had not yet begun recoupment on a single subset of the Medicaid negative balance claims, other than PT54 providers and IMD providers, which are well defined. This aspect of recoupment began over six months ago. Therefore, before the entirety of legitimate Medicaid negative balances are "disputed" en masse, we will provide additional information in detail as requested for each type and amount of denial as indicated. We would remind CBH once again that the majority of these issues do not affect CBH providers.

CBH: Clarifications of Dispute Resolution Process

1. *The title of the dispute resolution procedure suggests that the procedure is limited to negative balances. Will this procedure apply to disputes of the estimated payment balance as well?*

MDH: The existing dispute resolution process for DENIALS has not changed, other than to allow more time for providers to seek resolution. The process applies to all DENIALS regardless of whether they occur during the estimated payment period or the negative balance period. It also applies specifically to claims that Optum indicates were paid twice or in duplicate, but for which the provider can find no record of a duplicate payment having been made for a specific claim or set of claims.

2. Although the title of the dispute resolution procedure suggests that the procedure applies to both state and Medicaid negative balances, Step 3 ("this is the FINAL level of review for payments/claims involving non Medicaid recipients") and Step 4 (OAH Appeal) suggest that an OAH appeal is limited only to Medicaid. Is it MDH's intention to exclude state negative balance disputes from administrative appeal to OAH? Why?

MDH: The process applies to all State and Medicaid Negative Balances and their denials. It does NOT apply to non-Medicaid recipients or the uninsured.

3. What is the "final decision letter" that Optum will produce in Step 1? Is that the same as the demand letter that providers received for state negative balance on May 13? Or is a separate decision letter expected from Optum?

MDH: No, it is not the same as the 5/13/22 demand letter at all. This is a letter that will be issued by Optum at the conclusion of Step 1 of the dispute process for very specific claim(s) identified in detail by the provider and cannot be resolved between Optum and the provider, or that Optum deems a final denial. Such claims are then eligible to be sent to Step 2. Providers have to be formally engaged in Step 1 of the dispute process, after the claim(s) have been identified and entered, and time would only start from that point forward. This renders question 4 moot.

5. The procedure does not describe how Optum will record disputed claims identified by the provider in Steps 1-2. CBH has consistently expressed concerns over the last three months that reconciliation managers are not accurately itemizing or resolving claims that providers are submitting for correction. Without an accurate system to ticket disputed claims, we are concerned that the dispute resolution process outlined here will be futile and that steps 1-2 will lead to frustration and a waste of time and resources. Please identify how Optum will record claims identified by the provider as disputed, and how MDH will track Optum's response to the disputes to ensure that Optum's reconciliation managers are doing their jobs and moving the process forward.

MDH: Optum currently carefully tracks denials and reprocessing status of all claims in weekly reports.

6. Please identify examples of supporting documentation required in Step 2 where known errors in Optum's claim denials are already established. The largest volume of denials remains concentrated in the denial codes which have already been demonstrated to be applied in error. Often the provider is unable to independently validate the error. For example, claim denials exist because of errors in Optum's claims processing (i.e. CO170, CO150/Incedo code 118), Optum's 835s (CO45), and TPL/eligibility (i.e. CO22, CO26,

CO27, CO96). How is an individual provider expected to submit evidence of systemic error in their claim denials?

MDH: MDH regularly audits these claims and reviews them in weekly or more frequent intervals with Optum. We direct them to reprocess systemic denials routinely where appropriate. It is an iterative process, and consumes a great deal of staff and analysis.

7. *Please describe how Optum will "render a decision" on the disputed claims as described in Step 2. Will Optum's decision be in writing and will the decision respond to each individual disputed claim submitted by a provider?*

MDH: Yes. Decisions will be in writing for each individual claim or a list of claims.

8. *To the extent that Optum's decision is in favor of the provider, what steps will MDH take to ensure that Optum timely reprocesses and pays all impacted claims and associated interest penalties for late payment? What expected timeframe will Optum be held accountable for?*

MDH: Optum reprocesses identified charges in an ongoing iterative process. There are multiple reprocessing projects occurring all the time. We have weekly meetings to review reprocessing efforts on groups of claims with a focus on the Top 20 denials reasons on both a dollar amount and claim lines amount.

9. *Has MDH issued instructions or guidance to Optum with respect to the appeals process? If so, can CBH receive a copy of those instructions to distribute to its membership and be afforded an opportunity to provide comment on those instructions?*

MDH: This same dispute process has been in place with previous ASO contracts throughout MDH and has not changed, other than to allow more time for the provider to dispute and reconcile their claims.

CBH: Categorically Disputed Denial Codes

1. MDH has launched recoupment despite the fact that Optum has not completed its work in correcting TPL and a variety of other insurance related denials. Without Optum's completion of the correction of these known global TPL errors, providers cannot know whether the erroneous TPL and eligibility denials inflating their estimated payments balances will be corrected by this work on not. Given that 33%—$27 million worth of denials under the estimated payment period -- are for three specific TPL and eligibility-related denial reasons, and given that Optum has indicated that its TPL reprocessing projects comprise only 2% of estimated payment denials, CBH members fully expect there to be denials of this kind which remain uncorrected. Thus, on behalf of CBH members, we request that all claims denied for the reasons listed below be categorically excluded from recoupment and deemed as disputed until 60 days after Optum has completed the TPL reprocessing projects.

a. "Member's Coverage Not in Effect on Date of Service" (CO26, CO27);
b. "Service Payable by Another Primary Carrier" or "Please submit Primary Carrier's EOB for Service" (CO22); and
c. "Non-covered Charge" or "DOS not covered/authorized" (CO96).

MDH: We lifted the authorization requirement for an additional month and processed/paid those claims. We are also currently analyzing and considering various TPL and LTC claims for exclusion from the Recoupment process if we think they are likely to be paid in the provider's favor. A decision will be shared as soon as it is reached. Once a final determination of Estimated Payment liability is made, all remaining denials in process will be adjudicated and paid in cash as a "live" claim.

2. Optum has previously informed CBH and its members that over 80% of the denials for "Payment is denied/performed when billed by this provider type" (CO170) and "Claim detail lines cannot span dates" (Incedo Code 170) are not caused by provider error and cannot be fixed by the provider. The cause of the denial is not visible to the provider. A primary known cause of 170 denials occurred when Optum's manual processing moved a claim across portals. No further information was disclosed by Optum about potential causes. On behalf of CBH member organizations, we request that all claims with a CO170 or Incedo Code 170 denial be categorically excluded from recoupment and deemed as disputed until 30 days after Optum has delivered a root cause analysis to each CBH member on the causes of its 170 denials, including an analysis of the claims denied due to errors in Optum's manual processing. As evidence, we refer MDH to the minutes from our weekly billing calls, denial drilldown meetings, and systemic issue logs.[2]

MDH: As previously stated, denials will continue to be reprocessed and adjudicated throughout the recoupment process and paid as cash when found to be valid. There has been significant progress with the CO170 denials and we expect to continue to make progress in adjudication them all with provider input and cooperation.

3. Optum did not produce 835s for PRP encounters until about December 2020. Additionally, three errors were known to cause missing encounters and erroneous cascading of case rates during the estimated payment period:

a. Optum's manual processing of encounters was known to lag behind the processing of case rates causing case rates to incorrectly cascade;
b. Optum's manual processing of encounters resulted in the placement of encounters in incorrect service portals preventing them from attaching to the case rate and resulting in incorrect cascades; and
c. Errors in the migration of Beacon data caused encounters to transfer incorrectly or not at all into the Incedo system, causing erroneous cascades of case rates.

MDH: We are hoping to implement the following shortly:

1. Reprocess those reversals where Optum reversed a Beacon paid H2018 once Optum

updates the impact analysis, i.e. total claims reversed, providers, dollars involved.

2. Discontinue reconciling PRP claims where Beacon paid the H2018, even when Optum cannot determine if the correct number of supporting H2016s were submitted. At this point, 2.5 years after the services were rendered, it is too late to recover unsupported PRP payments at least through this method.

3. Identify providers who have not received payment for H2018s. The correction of the historical Beacon data load should be completed very shortly.

We are hoping that applying the above will move providers further into being able to reconcile their claims history.

CBH: On behalf of CBH member organizations, we request that all PRP claims with denial code CO150/Incedo Code 118 "Did not meet minimum case rate unit requirement" be categorically excluded from recoupment and deemed as disputed until 30 days after Optum has delivered a root cause analysis for each denial and an 835 for each supporting PRP encounter prior to December 31, 2020.

MDH: Once again, these claims will continue to be worked in an interactive, ongoing process and adjudicated in due course. Payments will be made as those claims are adjudicated.

4. 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 from identify the full universe of claims impacted by denial code corrections. Until Fall 2021, CO45 "Charge Exceeds Allowed Amount for this Service" codes were displaying in error on many 835s masking correct denial codes for claims, further complicating providers' ability to identify causes for claims denials and flag erroneous denials. On behalf of CBH member organizations, we request that all claims with denial code CO45 be categorically excludes from recoupment and deemed as disputed until 30 days after Optum has delivered a root cause analysis for every denial.

MDH: This claim fails to recognize that full denial codes have been issued and have been in place for review for nearly a year now.

CBH: As a reminder, we highlight that under the ASO RFP, MDH retains the authority to withhold payment to Optum as a consequence of non compliance with the terms of its contract and to consider imposing liquidated damages on Optum due to the significant disruption of the

state's behavioral health system. RFP 3.3.4 and 3.4.[3] *Despite the existence of this authority, MDH has been unable or unwilling to hold Optum accountable for its functional deficiencies.*

MDH: MDH is currently, and has been from the start of the contract, withholding dollars from monthly invoices regarding SLAs as well as failure to meet contractual obligations. These monies are being withheld in escrow and will be returned to Optum if and when they meet their contractual obligations. Additional, significant, penalties were levied in March and escalated in May.

Please do not hesitate to contact me or Optum Maryland with any further questions or concerns.

Sincerely,

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

CC: Linda Rittelmann
Monica McNeil
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