VIA E-MAIL

May 24, 2022

Maryland Department of Health
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Ms. Rebecca Frechard, rebecca.frechard@maryland.gov
Mr. Steve Schuh, steve.schuh@maryland.gov
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Optum Behavioral Health
Mr. Karl Steinkraus, karl.steinkraus@optum.com
Mr. Chad Burkholder, chad.burkholder@optum.com

Re: Retro-Eligibility and Recoupment

Dear Mr. Schuh:

On behalf of the Community Behavioral Health Association of Maryland ("CBH") we would like to respond to your letter of May 20, 2022 (sent to us on May 23, 2022). We appreciate the response but continue to have significant concerns as further set forth below.

As a preliminary matter, 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." As your letter indicated, MDH delayed its response "by a week or more" to be able to respond more thoroughly, and a single coordinated response with input from Optum would foster better communication amongst and between the parties. Apart from the communication challenges this creates, MDH's willingness to defer to Optum - - MDH's contractor and agent - - poses a greater barrier to being able to problem-solve with CBH. For example, in response to CBH's concerns stemming from Optum's unusual and confusing practice of assigning a new claim identification number each time it processes a claim, your letter indicates that MDH is amenable to working with Optum to alter this practice "if it is feasible to do so." This is not the first time that CBH has raised concerns over Optum's disruptive practice of assigning a new claim number and we are surprised that MDH has not yet inquired of Optum whether Optum considers it feasible.

In any event, Optum's opinion as to feasibility should not be the last word on the matter. If CBH is advising that the practice is unworkable and a significant source of problems, MDH has the ability to form its own conclusions and direct Optum to discontinue this practice pursuant to the ASO contract. What concerns us about MDH's response is the failure to recognize that at the end of the day, irrespective of whether MDH has elected to delegate aspects of its program

to Optum as the ASO, MDH is ultimately responsible for ensuring that it is administering a sound program consistent with applicable requirements, standards, and practices. We respectfully request that future correspondence relating to these issues comes jointly from MDH and Optum so that all pertinent concerns can be addressed at once and to ensure that there is no effort to pass off responsibility between MDH and Optum – leading to a troubling situation where some of CBH's concerns are overlooked.

Specific Concerns

With this letter, we cover three topics: (1) our concern about basic due process for recoupment of Medicaid negative balances, (2) our urgent questions about the dispute resolution process recently published on May 20, the very day that state negative balances were purported to be due; and (3) our formal request and supporting evidence that six denial codes be treated as presumptively and categorically disputed for any CBH member.

Topic 1: Due Process for Medicaid Negative Balance

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. Thus, the "lesser of" and claims clipping of any "tail" excess balance outlined in your May 20 letter, while helpful, does 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.

Topic 2: Clarifications of Dispute Resolution Process

We seek urgent clarification of the "Procedure for Resolving Disputes over Negative Balances," published via Optum Bulletin on May 20, 2022. This procedure modifies a draft procedure initially shared with CBH and other associations on May 17, 2022. We note with concern that the procedure was published to providers on May 20, the very day that state negative balance were purported to be due.

[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 a provider's Medicaid negative balance for this reason.

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?

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) suggests 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?

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?

4. If the "final decision letter" described in Step 1 is the letter that was delivered to providers on May 13, then one-third of the 20-day window to review the demand and prepare a list of disputed claims had already elapsed before MDH communicated this appeals process. We request that the 20-day window be extended to 27 days, if the "final decision letter" is the May 13 letter.

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.

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 remain 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 (ie CO170, CO150/Incedo code 118), Optum's 835s (CO45) and TPL/eligibility (ie CO22, CO26, CO27, CO96). How is an individual provider expected to submit evidence of systemic error in their claim denials?

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?

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?

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?

Topic 3: Six Categorically Disputed Denial Codes

For the past two years, Optum's claims processing system has lacked consistent, functioning reports (999, 277, 835), and CBH submitted documentation to MDH that Optum's claim transactions failed HIPAA compliance testing in May 2021 and May 2022.

Against this backdrop, Optum's claims processing system produced denials at rates far exceeding historic performance. Evidence indicates that the largest dollars remain tied up in the very denial codes that have already been established to operate in error during the estimated payment period. For these reasons, we ask MDH to deem any claim with the following denial codes as presumptively and categorically in dispute for any current member of the Community Behavioral Health Association, unless a member provider waives this provision in writing to Optum/MDH, {CO22, CO26, CO27, CO96, CO170/Incedo Code 170, CO150/Incedo Code 118, CO45} and to exclude denials with these codes from the balances on demand letters slated to be released in July, until these known global errors are fully corrected for all CBH members. Our reasoning for this request is detailed below:

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 3 specific TPL and eligibility-related denial reasons, and given that Optum has indicated that their 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 their 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)
c. "Non-covered Charge" or "DOS not covered/authorized" (CO96)

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 was caused 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, please accept [refer to Billing minutes Nov 2020 – Jan 2021].

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.

   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. As evidence, please accept [refer to Billing minutes Nov 2020 – Jan 2021].

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 after Optum has delivered a root cause analysis for every denial.** As evidence, please accept [refer to Billing minutes September 2021 – November 2021].

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.[2] Despite the existence of this authority, MDH has been unable or unwilling to hold Optum accountable for its functional deficiencies. CBH's proposal to categorically and presumptively carve out the denial codes from any recoupment is a relatively modest and reasonable solution until these known and admitted systemic issues can be resolved.

Conclusion

We appreciate your willingness to review the concerns we have previously raised and hope we can continue to work to resolve those issues as well as the issues we've identified here.

We reiterate our request that any recoupment be stayed pending the parties' efforts to ensure that there can be sufficient confidence in the amounts to be recouped. In the alternative, we ask that the denial codes listed above be treated as categorically and presumptively disputed by CBH's provider members unless explicitly waived in writing.

Finally, we look forward to Optum's forthcoming response and the opportunity to comment on it, but re-emphasize our request that all future correspondence on behalf of MDH and Optum be consolidated into one cohesive response.

[perhaps suggest a meeting once all the issues have been identified]

[2] Those liquidated damages could be held for the benefit and distributed to CBH's members to remedy any unsupported recoupment.