Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

July 1, 2021

The Honorable Guy Guzzone
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Operations
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2021 Joint Chairmen's Report (p. 101-102) – Report on the Status of ASO Functionality

Dear Chairs Guzzone and McIntosh:

Pursuant to the 2021 Joint Chairmen's Report (p. 101-102), the Maryland Department of Health respectfully submits the attached report on the status of the ASO functionality. Specifically, the committees requested:

> *"Given the reports of ongoing struggles with the new BHASO over a year after the initial go-live date, the budget committees request ongoing status updates of its functionality. The budget committees are requesting a series of reports, the first of which, in consultation with the providers in the Public Behavioral Health System, identifies which reports and features are required for a fully functional ASO. Subsequent reports should identify progress made on each of these features, identify what is not fully functional, the steps needed to reach functionality, and the estimated completion date. The first report should be submitted by July 1, 2021, and subsequent reports shall be submitted quarterly through fiscal 2022, or until full functionality is achieved."*

If you have questions or need more information, please contact Heather Shek, Director, Office of Governmental Affairs at heather.shek@maryland.gov or 410-767-5282.

Sincerely,

Dennis R. Schrader
Secretary

cc: Steven R. Schuh, Deputy Secretary, Health Care Financing and Medicaid
Aliya Jones, M.D., MBA, Deputy Secretary, Behavioral Health Administration
Heather Shek, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

Table of Contents

Introduction

On January 1, 2020, the Maryland Department of Health (MDH) transitioned to Optum Maryland (Optum) for its Behavioral Health Administrative Services Organization (BHASO). At its initial launch, the Optum system had technical and system failures that impacted behavioral health providers. Despite those difficulties, Optum reported receiving over 14 million claims between January 2020 through June 2021and successfully paid $2.4 billion dollars associated with those claims to over 2,700 providers who participate in the Public Behavioral Health System.

While acknowledging deficiencies at the commencement of the contract, Optum has made significant progress to correct issues and began real-time processing of claims in July 2020. Optum and MDH continue to work together to improve the system and to deliver on the functionality that providers need to render services to Marylanders within the Public Behavioral Health System. Since real-time processing began in July 2020, Optum has maintained a weekly average of $30 to $40 million in payments to providers.

MDH and Optum continue to engage with providers to address system issues and functionality. As a starting point, a fully functional BHASO can be summarized as an BHASO that pays valid claims from providers accurately, consistently, efficiently, and transparently. Each of these four areas are defined below:

- Accurately - Claims are properly processed according to the rules of the system and the clinical judgments contained with medical necessity criteria.
- Consistently - Claims with the same characteristics process in the same manner such that providers can resolve issues within their claims submission.
- Efficiently - Claim processing occurs with minimal human intervention and without additional inputs beyond those needed to process the claims.
- Transparently - Providers are given visibility into the status and details of their claim relevant to processing in a timely manner.

Using this starting point, MDH and Optum consistently collaborate and communicate with providers through a standing Operations Improvement Meeting to discuss their needs and concerns about perceived functionality gaps with the BHASO. This Executive Summary, along with the presentation deck discussed with providers (Attachment A), outlines the Operation Improvement Committee and provider discussions so far, as well as next steps for continuing engagement and addressing functionality gaps.

Provider Engagement - Operations Improvement

Starting in December of 2019, as part of the transition to Optum as Maryland's BHASO, MDH organized a series of meetings with key providers and provider associations to submit direct input to Optum regarding user experience and administrative issues. Since their inception, these meetings have become the core of the Operations Improvement Committee in which MDH, Optum, and provider staff regularly interact about feature implementation and issue resolution. Community participants in this meeting include:

- Community Behavioral Health Association of Maryland
- Maryland Association for the Treatment of Opioid Disorders
- Maryland Addictions Directors Council
- Maryland Hospital Association, and
- A broad array of active providers ranging from large to midsize programs throughout the State.

The Operations Improvement Committee meets regularly on the first and third Tuesday of each month. Presentations from Optum often include information about customer service, upcoming operational fixes, feedback regarding recent changes or issues encountered, and other concerns affecting the provider community. The Operations Improvement Committee meeting is intended to allow for an involved discussion of issues affecting groups of providers generally. This meeting is in addition to the monthly Provider Council meeting where MDH and Optum provide routine updates to over 200 attendees each session.

System Functionality Report Discussion

Through the Operations Improvement Committee meetings, MDH and Optum have engaged the providers and provider associations on issues of system functionality, efficiency, and efficacy. Beginning with documents submitted by the provider associations (Attachments B and C), Optum combined identified items, current status of efforts for those items, and any additional notes or explanations into Attachment A. The level of specificity in Attachment A is necessary due to the breadth of provider types and sizes in the Public Behavioral Health System. Issues may impact some providers differently than others while having no impact on other providers.

For example, some providers noted a lack of reports needed to resolve claims in their accounting systems. On further discussion with providers, they were specifically referring to the 835 Health Care Claim Payment transaction for Electronic Data Interchange (EDI) claims. While providers who use EDI represent a small number of providers, they are often large entities responsible for the majority of services rendered in Maryland. As such, a missing 835 could be caused by a technical issue between Optum and the provider, Optum and a clearing house, or a temporary

transmission failure. This complexity can create a different picture of the system functionality, thus starting from a single shared document is critical.

Once composed, Optum shared Attachment A with Operations Improvement Committee members for discussion in the May and June meetings. During the meetings, Optum walked through the document to obtain clarification on the specific issue and whether Optum's answer addressed it accurately, efficiently, and transparently. The meeting also included a product roadmap (Attachment D) which has been integrated into Optum's website so providers can readily access it. Functional areas covered in the document are wide-ranging and include:

- Claims processing
- Reporting claim status for claims payment/provider interaction
- Additional functionality related to claims export, download, and history (revenue cycle management)
- System Status Notifications and Outage Report
- Authorization and Eligibility Processing
- Responsiveness and Timeliness of Communications and Provider Relations
- Privacy and Security

Out of those initial discussions, the participants requested more clarity on the status of raised concerns. Rather than a yes or no response to the issue, the participants requested a more concise measure of progress and/or agreed upon metrics that would reflect the performance on that issue. Future iterations of the slide deck will incorporate more of those measures as the terminology and issues are further refined. Blanks in Attachment A indicate that further clarification was needed to respond. For example, items that listed what evidence of non-compliance providers should submit to MDH will require a clear definition of the issue to make sure the submission is useful.

Next Steps

As the first of four quarterly reports, the initial focus was on making sure that Optum and MDH understood the information presented by providers. Future reports will focus on actionable improvements to BHASO operations. Optum and MDH will continue the discussions with providers through the Operations Improvement Committee meeting to further refine the issues and to present solutions or explanations for how the BHASO does and should function. Additionally, Optum and MDH continue to incorporate all provider feedback to ensure that the quarterly reports are comprehensive and accurate.

Attachment A:
Operations Improvement
System Functionality Report

OPTUM®

Standard 1A: Claims Processing

Includes all functionality necessary to support providers' revenue cycle management and is consistent with industry- standard practices.

Reported Item	Performance	Optum Response	Action
a) Optum will publish and maintain a companion guide	a) See Optum esponse	a) Industry standard companion guides are available on www.maryland.optum.com which have been modified any applicable information related to the Maryland ASO Additionally, Optum Maryland has created FAQ and QRG to support provider questions related to the 277CA file Optum Maryland has conducted training webinars and Post Go live drop in webinars to support implementation of 277CA transaction file	a) Optum will continue to provide educational opportunities in response to inquiries regarding this transaction
a) 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;	b) Yes	b) The BHASO contract requirements is for Optum to process electronic claims within 14 calendar days of receipt, Optum is reporting this metric at 99.7% . Our data further shows that on average checks are released for payment within 8 calendar days.	b) Optum has reporting in place to monitor this measure and will continue to take actions to ensure we are meeting TAT. A copy of this report is provided next slide.
b) 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;	c) See actions	c) 835 files are being generated for all activity going through a check write on a weekly basis. Including payments, encounters , and payment adjustments. The industry standard file contains information necessary for a provider to understand the actions applied to a claim during the adjudication process.	c) No Action required.

Performance: Claims Insights for Providers – Month of May

Definitions

- Claims – the new day volume of claims each week
- First pass rate - ratio of first pass claim lines (or claims) to the total claim of claim lines (or claims) adjudicated/processed/touched within the week of reporting
- First Pass < 14 day % - Percentage of claim lines/claim adjudicated/touched in less than 14 days to the total of First Pass claims (denials included, pended excluded)

Adjustment Rate and Volume, these show claims reprocessed based on defect fixes or provider resubmissions

Month	Week ending date	Claims	First Pass	First Pass Rate	First Pass < 14 day %	Adjusted	Adjusted Rate
May-2021	05/09/2021	262,066	215,220	82.1%	99.98%	30,512	11.64%
May-2021	05/16/2021	232,216	187,309	80.7%	99.93%	28,815	12.41%
May-2021	05/23/2021	224,534	178,792	79.6%	99.97%	35,288	15.72%
May-2021	05/30/2021	210,158	170,503	81.1%	99.46%	27,068	12.88%
May 2021 total		**928,974**	**751,824**	**80.9%**	**99.84%**	**121,683**	**13.10%**

OPTUM®

Standard 1A: Claims Processing continued

includes all functionality necessary to support providers' revenue cycle management and is consistent with industry- standard practices.

Reported Item	Performance	Optum Response	Action
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;	d) TBD	d) Optum Maryland is working to operationalize the interest payment requirement in accordance with MIA requirements	d) TBD
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;	e) Yes	e) Optum can not update rates until the Department approves the update, and that is not always notified by MDH and CMS within 30 days of the effective date. We can initiate claims processing within 7 days but claims reprocessing may take 30 to 60 days based on the volume of claims impacted	e) No further action
f) MDH defines evidentiary requirements and reporting mechanism for providers to report non- compliance with deadlines by Optum to the Department.		f) MDH	

Standard 1B: Claims Processing

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.

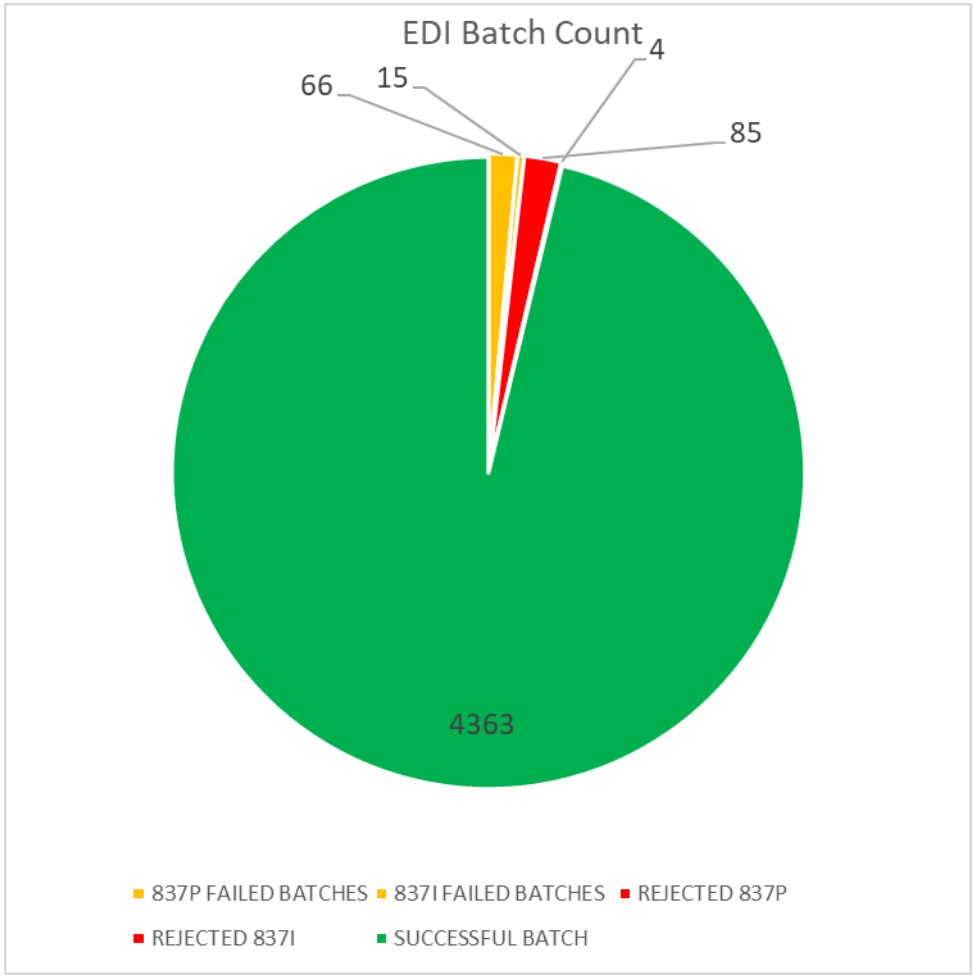
Reported Item	Performance	Optum Response	Action
a. System will generate accurate 999 reports for all claims batches that fail to upload;	a. See action	a. 999 was in place at go-live, however an enhancement was made to provide 999's for rejected batches, this was implemented in December 2020.	a) An additional enhancement to correct the HC code. This item is included in release version 6.5.
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;	b. See action	b. 277CA file exchange was implemented on Monday 4/12/2021. Additional modification to the file exchange was made on April 25, 2021 allowing 8 additional provider to utilize the information. Currently a total of 70 providers have requested this report, however it is available to ALL providers who request it. On 5/13/2021 Optum published the 277CA Edits Spreadsheet that facilitates a comprehensive understanding of your claims and their processing lifecycle	b) Periodic reject report is still needed to communicate the claims that have ultimately been rejected. This item is currently being prioritized
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;	c. See action	c. PRA reporting for historical and current H2016 was completed as of May 2021	c) IT is sizing a change in the Incedo programming to produce 835 on retractions and claims held in recoupment. Specifically, to address the H2016 issues.

OPTUM®

Standard 1B: Claims Processing – Transaction reconciliation

EDI KPI 5/11/21 thru 6/11/21

EDI 837 BATCH CATEGORIES	Count	%
837P FAILED BATCHES	66	
837I FAILED BATCHES	15	1.8
REJECTED 837P	85	
REJECTED 837I	4	2
SUCCESSFUL BATCH	4363	96
TOTAL	**4533**	
number of claims 755996		
* 837P FAILED BATCHES ON WEEKENDS	6	
* 837I FAILED BATCHES ON WEEKENDS	1	



Rejected batches generate 999s with reject status codes. Also followed up with a manual email from EDI Support.

Failed batches may or may not generate a 999 with accepted status. Failed batches are followed up on by the EDI Support team to determine corrective action.

A ticket has been submitted to address the failed batches mentioned above

999 (and 277CA if requested) are generated for ALL successful and failed batches

Standard 1B: Claims Processing continued

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.

Reported Item	Performance	Optum Response	Actions
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	d. Yes	d. Incedo platform does currently use industry standard CARC codes however there is not a unique CARC code that can crosswalk to each Incedo denial reason. Optum has supplied providers with a Denial reason cross walk is posted on the web site	d. Optum will update the crosswalk on a monthly basis with the next update occurring in June
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.	e. See action	e. Optum is in the process of aligning the denials codes so the same codes would appear on both PRA and 835 (1:1)	e. This work is being prioritized.

Standard 1C: Claim statuses impacting claim payment

Reported Item	Performance	Optum Response	Action
i. Client naming convention errors (A.Smith vs A.Smyth);	i. Yes	i. Optum uses the information supplied by the State of Maryland on the MMIS files to validate participant information. Optum has edits in place that result in review of claims that are received with different naming conventions on claims vs. what MMIS has provided Incedo.	i. No further action
ii Insurance indexing errors (i.e., selecting incorrect primary insurance or displaying inactive insurance);	ii. Yes	ii. See item iii. Below	ii. No further action
iii. Secondary payer processing errors;	iii. See Optum response	iii. Optum acknowledges the secondary processing errors for Supported Employment and PRP claims. .	iii. Incorrectly denied claims have been reprocessed. Secondary payer processing Standard Operating Procedure (SOPs) were updated to not deny these claims. Item 2: Supplemental TPL file was received from MDH and fully loaded as of 4/23. We will continue to monitor and resolve TPL file issues if the occur
iv. Denials of add-on codes when underlying code is appropriately authorized	iv. Yes	iv. The Incedo platform was updated as of May 1, 2021 to support this requirement	iv. Optum is going back to review old claims to verify this issue has not occurred on those claims
v. Duplicate client records	v. See actions	v. All activities related to merging Beacon eligibility records has been completed.	v. Any Beacon historical claims that were denied due to member eligibility caused by duplication will be reprocessed.
vi. Erroneous duplicate claims denials;	vi. See Optum response	vi. Optum does have duplicate claim criteria coded in Incedo. The logic is working today as expected. In February we performed an audit to identify incorrect denials (i.e., if denied as a duplication in error). The identified claims were re-processed and we enhanced the duplicate logic to prevent this from happening in the future.	vi Optum will continue to monitor duplicate denial rates

Standard 1C: Claim statuses impacting claim payment continued

Reported Item	Performance	Optum Response	Action
vii. Unfunded spans without end dates;	vii. See Action	vii. The unfunded spans without end dates is being addressed.	vii. Targeted for release version 6.6
viii. Service portal and data errors including incorrect NPI numbers;	viii. N/A	viii. Optum is not aware of this issues and would require additional information to respond. Manual processing and selection of provider record	
ix. All errors caused by manual processing by Optum	ix. See Optum response	ix. Optum has a quality control program in place that pulls a statistically valid sample of random audits for both auto adjudicated and manually processed claims. Furthermore, Optum continuously reviews manual processing policy and procedures to increase clean processing of claims. As defects are identified additional system enhancements are reviewed and/or implemented. All identified defects have a root cause analysis completed to improve the overall health of claims processing.	Ix continued adherence to quality control program

Standard 1D: System functionality to enable revenue cycle management

Reported Item	Performance	Optum Response	Action
a. Full export and download capacity for claims and authorizations (not max of 500);	a. See action for claims, Yes authorizations	a. Providers are currently able to export authorization information beyond 500 records. Very large providers may need to split into smaller timeframes (e.g., each month) due to extremely large volume. Optum is expanding functionality to support the Full export and download capacity for claims.	a Export claims will be delivered in release version 6.5
b. Void and resubmit capacity for individual and batch claims;	b. yes	b. Optum supports standard EDI processing and practices which includes the ability to VOID or REPLACE a previously accepted claim. An entire batch can be voided by submitting all claims in a particular batch as a void transaction	b No action
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;	c. See Actions	c. On April 2, there was an Incedo release that included the ability to view eligibility statuses Following the system update, the “Status” field in the “Eligibility” screen in IPP will reflect one of three status values: ● Active: The provider’s request has been approved ● Pending: The provider’s request is pending processing by Optum ● Denied: The provider’s request has been denied Eligibility statuses, uninsured requests	c System functionality has been requested to supply a census type view uninsured eligibility requests. This would allow a provider to view all of their uninsured eligibility requests to learn status, as well as to view Individuals requiring a renewal. No release date targeted yet Optum has also requested expanded functionality for the claim status search that will be included in release version 6.5

Standard 1D: System functionality to enable revenue cycle management

Reported Item	Performance	Optum Response	Action
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	d. See action	d. Claims Status are visible in Incedo Portal, other functionality is not	d. Expanded functionality will be delivered in release version 6.5
e. Capability to save draft/in progress authorizations	e. N/A	e. Capability to save draft/in progress authorizations is not supported on our platform and was intentional in design. If a form was saved as draft, it could be submitted with an authorization request without being updated, possibly resulting in an admin denial. We believe it causes more administrative burden for providers if they do not complete the clinical information in a timely manner	e. No further action
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.	f. See action	f. There are situations where retractions will not appear on an 835 until the outstanding receivable is off set	f. Optum to scoping/sizing the system enhancement to allow the retractions to appear on the PRA . Update available in next report.

OPTUM®

Standard 1E: System outage reporting

Optum will provide prompt and adequate notice to providers of planned and unplanned system outages

Reported Item	Performance	Optum Response	Action
a. For unplanned outages:	a. Yes	a. Optum provides notice to provider of planned an unplanned systems outages via posted notification on the Incedo Provider Portal and provider portal. Provider alerts. As Optum researches and resolves any unplanned outages periodic updates are supplied as outlined above. MDH contract Monitors are fully informed through the outage	a. Investigate additional ways to notify Providers of unplanned outages. Continue using current methods of communication but more consistently
b. 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;	b. See Action	b. Optum recognizes a provider needs to be informed regarding system availability and will do its best efforts to notify as soon as possible	b) Optum will share monthly performance report
c. Planned outages: 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	c. See action	c. Optum will ensure providers receive notification 48 hours prior to system upgrades	c) Optum will share monthly performance report

Standard 1E: System outage reporting for Feb - June

- Planned system outage reporting (48-hour advanced notice)

Planned System Outage Report				
Scheduled Outage Date	Notification to providers	Impacted Systems	Reason	48- hr TAT
6/12/21	6/10/21	Incedo Provider and Web Portals	System Maintenance	Y
6/5/21	6/4/2021	Incedo Provider and Web Portals	System Maintenance	N
5/29/21	5/26/21	Incedo Provider and Web Portals	System Maintenance	Y

- Unplanned system outage reporting

Unplanned Outages						
Title	Impacted System/Componen	Who was impacted	Problem Description	Date/Time Identified	Resolution Date	Resolution Notes
Call Center Down	Call Center	Anyone calling Optum Maryland	internal telecom move from Protocall to Optum, resulted in 1-800# being unavailable to callers. Added a temporary line until fixed, alerted providers notice on Incedo Portal and alert	2/26/2021 [7:30:00 AM]	2/26/2021 [12:00pm]	**Resolution:** Added a temporary line until fixed, alerted providers notice on Incedo Portal and alert, Resolution: completed internal telecom move
Incedo Web and IPC down	IPC - Incedo Web - couldn't login	Providers and Internal Optum Staff	Provider and Staff received error when logging in, could not continue	4/9/2021 [10:50 am – 11:40 am]	4/9/2021 [12:02pm]	**Resolution:** ran out of disc spaced/added more disc space
Error Message when entering authorizations	IPP - Authorization Entry	Providers	Providers may have received an error message when attempting to enter an authorization request	4/30/2021 [12:30:00 PM]	4/30/2021 [3:45pm]	**Resolution:** The statistics on the index of a table for loading with provider sites was reset.

Standard 2: Authorizations accurately and timely processed

Reported Item	Performance	Optum Response	Action
a. Authorization requests for crisis services are approved accurately on first review and responded to within 24 hours of request;	a. Yes	a. All authorization requests for urgent LOC are authorized within 24 hours of receipt of request. Previously crisis OP sessions were considered under the 14-day time period as those requests were received after the service had taken place. In response to concern regarding this delay, they are now processed within 24 hours.	a. Optum will continue to perform Daily monitoring / analysis of our turn around times to ensure we meeting requirements. If we are missing turn around times, we will investigate the root cause and implement an appropriate control.
b. Authorization requests for non-crisis services are approved accurately upon first review and within14 days; If additional documentation is requested by Optum, approval is made within 3 calendar days of provider submission of requested documentation;	b. Yes, see clarification in Optum response	b. Routine requests are turned around within 14 days of request in over 99% of cases. If documentation is missing from a request and is provided prior to a determination being made, then the request will still be completed within the 14 days TAT. If the missing documentation is provided after a determination has been made, then that is considered to be a new request and will be turned around within the 14-day time frame. Due to back dating grace period ending a backlog was created but we are now compliant with the 14 days.	b. Optum will continue to perform Daily monitoring / analysis of our turn around times to ensure we meeting requirements. If we are missing turn around times, we will investigate the root cause and implement an appropriate control.

OPTUM®

Performance: Authorization: Insights for Providers

Definitions

- Category/Measure
  - Emergent is if the participant is in the ER when the request is being made for one of those LOC
  - Urgent: IMD 4.0, ASAM 3.7, ASAM 3.7WM, Inpatient MH, Inpatient SUD, Inpatient Detox and RCS
  - Routine is everything else that requires auth

TAT for All Authorizations

Auth Month	Category/Measure	MET % of Auths	NOT MET % of Auths
May	EMERGENT/60 MINUTES	100.00%	0.00%
	URGENT/24 HOURS	97.01%	2.99%
	ROUTINE/14 DAYS	98.29%	1.71%
May Total		98.17%	1.83%

TAT for Clinically Reviewed Authorizations

		MET % of Auths	NOT MET % of Auths
May	EMERGENT/60 MINUTES	100.00%	0.00%
	URGENT/24 HOURS	97.75%	2.25%
	ROUTINE/14 DAYS	97.07%	2.93%
May Total		97.38%	2.62%

OPTUM®

Standard 2: Authorizations accurately and timely processed continued

Reported Item	Performance	Optum Response	Action
c. If authorization is pended for reasons other than routine approval (i.e. for overlapping dates spans), provider should receive notification of the pended authorization within 5 days of submission as well as justification for the pend;	c. Yes	c. Authorizations for participants who have active coverage will only pend when an authorization request overlaps with an approved auth for the same participant, provider and code for at least one date of service. Providers are able to see that an authorization is pended for overlap as soon as they hit submit and the auth is processed. See example below. Instructions regarding this situation are found in the August 11, 2020 alert	c. No further action
f. Split authorizations are appropriately identified and approved; conflicting authorizations are appropriately identified and prevented.	f. Yes, see Optum clarification in response	f. No authorizations have been split since the relaunch on July 1, 2020. Whenever a request is being entered for an authorization that overlaps with an approved authorization already on file for another provider, a message is displayed to the user. When providers see the message, they should speak with their clients to ensure that they are not in overlapping services. There was a period of time during which this message was not displaying. This along with the allowance for auths to be backdated back to July 1, 2020 through April 30, 2021 contributed to some overlapping auths being approved but we should not see that occurring going forward. See additional note below	f. Investigate examples of conflicting authorizations submitted by providers

Note: Auth's for other providers will not pend, a warning is generated only, and they can proceed if they believe the overlap is not genuine

c: example

Standard 2: Eligibility accurately and timely processed

Reported Item	Performance	Optum Response	Action
d. Requested uninsured spans are approved or renewed within 5 days of submission;	d. See action	d. Eligibility requests that meet criteria for the first and second request are automatically approved by Incedo. The 3rd request must go through the exception process. Individuals meeting special criteria are handled via Optum and for new requests we are achieving five-day turnaround. If further research is required than it has taken longer.	d. Optum will be aligning their system functionality to the new uninsured submission policy. This alignment is to automate the approval of all requests that meet criteria defined in the new submission policy. Targeting completion third quarter 2021.
e. Requested unfunded spans are approved within 3 days	e. Yes	e. Functionality exists today for providers to add an unfunded span when they are adding a new member to the system, these updates are approved in real time. If it's an existing member, the Provider contacts the Call Center and we enter the update in real time.	e. No further action

2B: Transparency and Accountability

Reported Item	Performance	Optum Response	Action
a. Monthly report on the average time from request to decision for authorization requests (by Provider type)	a. See action	a. Optum uses a daily report to monitor turn around times by level of care.	a. Refer to the turn around time report shared on slide 16 where we show % of authorization meeting TAT and those that are not. We can provide reason for not meeting
b. Monthly on the average time from request to decision for uninsured eligibility	b. See action	b. Optum uses a daily report to identify outstanding requests and processes them each day. Acknowledging prior delays in processing, our current turn around time on the requests that are not auto approved is 1-2 days.	b. Although we plan to more fully automate the approval process, we develop report to show uninsured requests that fall outside of the turn around time, targeting completion by the end of the third quarter
g. Authorization process for every provider type matches the workflow and clinical requirements described in the provider manual;	g. See action	g. Optum reviews the Provider manual on an annual basis	e. The annual update is targeted for completion by the end of the third quarter
h. MDH clearly defines evidence necessary to document non-compliance with time standards and provides a mechanism to report it			

OPTUM®

Standard 3: Response to Provider inquiries, Timeliness

Reported Item	Performance	Optum Response	Action
a. Respond to provider inquiries within one business day	a. Yes, see clarification in Optum response	a. Optum acknowledges receipt of inquiries within one business day. Resolution times vary based upon the type and complexity of the issue. A reduction in the time it takes to resolve Provider inquiries is our goal.	a. Optum will ensure that staff is trained on Incedo/MDH Programs so that they can respond to inquiries more efficiently, and aware of current system issues and or problems so that they respond with status or resolution
b. Resolve claims problems and open tickets within same week, or report to Contract Monitor	b. See clarification in Optum response	b. Although every effort is made to resolve problems and open tickets within the same week, there are contributing factors that delay this such as complexity of the issue.	b. Optum will review and monitor problems that remain open on our aging reports assess reason for delay and implement solutions for more timeliness
c. Optum will track timeframe for provider problem resolution and share with MDH	c. See Optum response	c. Optum does employ several tools to track inquiries and problems received from Providers. Inquiries received via the Call Center are logged into Incedo and assigned a unique reference number for tracking. The Call Center triages the inquiry and sends it via Incedo tasking to the responsible department for resolution. Depending upon the nature or complexity of the issue, it may involve review by multiple departments. Each handoff to other departments is also tracked. We have existing reports to show the aging of issues, and have reoccurring meetings with MDH to discuss any reported issue trends or escalated issues with MDH on our recurring meetings	c. Optum plans to review the Provider issue intake process and develop a comprehensive guide for providers that includes instructions on the process as well as turn around times with an escalation path. The goal is to make this information available on our Website
d. MDH will have a reporting mechanism for providers to submit evidence to MDH of Optum's noncompliance with the contractual performance standards in terms of timeframes and/or issue resolution; and	d. MDH		
e. MDH will report this data to the provider community monthly.	e. MDH		

Standard 4: Ability to identify and mediate *privacy* violations in a timely manner

Reported Item	Performance	Optum Response	Action
The ASO issues payments only to those providers who have billed the ASO for providing treatment to a patient.	See Optum Response	Today there are current system edits that require human intervention to adjudicate claims and that may lead to errors.	To avoid errors in processing, Optum has developed additional staff training and controls to prevent incorrect disclosures. For example, a recent system modification provides the Claims Examiner with a prompt that they are attempting to link a claim to an incorrect provider

Standard 4: Ability to identify and mediate *privacy* violations in a timely manner , continued

Reported Item	Performance	Optum Response	Action
ASO demonstrates the ability to identify and mediate privacy violations in a timely manner	See Action	All Optum Employees are trained on an annual basis on how to identify what constitutes a breach or inappropriate disclosure of PHI or PII. They are also trained on the process for reporting potential disclosures to the Optum Privacy Office. Optum MD has a local Privacy lead to which employees can report BH ASO specific potential privacy incidents to. The local Privacy Lead works in concert with the Optum Privacy office Optum follows established processes designed in concert with MDH that informs the reporting of potential inappropriate disclosures. Optum investigates each reported item and explores the root cause of each disclosure. The root causes and remediations are documented and communicated. Privacy incidents maybe reported from external partners 24/7 to privacy@optum.com; During business hours external partners and internal Optum parties may report privacy incidents to OMD Local Privacy Lead tamisha.smith@optum.com or privacy@optum.com. If a security event is identified by Optum Privacy or reported externally, a call to Optum Security Response at 1-888-255-2554 or email SIR@optum.com	Optum to continue with annual Employee trainings as well as adhoc trainings as needed and continue with current process of identifying and mediating violations.

Standard 4: Ability to identify and mediate *security* violations in a timely manner, continued

Reported Item	Performance	Optum Response	Action
ASO demonstrates the ability to identify and mediate security violations in a timely manner	See Action	All Optum Employees are trained on an annual basis on security and privacy. They are trained on the process for reporting potential data breaches to Optum Leadership, Security Officer/Security Incident response team and/or the Optum Privacy Office. Optum process for notification and responding to security events is consistent with contractual, State and Federal regulations Privacy/Security incidents may be reported from external partners 24/7 to privacy@optum.com; During business hours external partners and internal Optum parties may report privacy incidents to OMD Local Privacy Lead tamisha.smith@optum.com or privacy@optum.com. If a security event is identified by Optum Privacy or reported externally, a call to Optum Security Response at 1-888-255-2554 or email SIR@optum.com	Optum is enhancing their security response process in the event of a security incident that impacts the MD Public Behavior Health System

Attachment B: CBH Systemic Issue Log

Billing & Operations Committee

Known Incedo Systemic Errors | January 13, 2021

From January 1 to August 2, 2020, Optum paid providers estimated payments while processing claims in the background in order to correct its claims processing system. From August 3 to present, Optum has paid "new day" claims submitted through Incedo, while work occurs concurrently to address known system errors and dysfunctions. Since February, providers have requested transparency of the known system errors in order to improve their own and Optum's efficiency.

No.	Topic	Problem Summary	Fix Should Address Identified Problems	Correction Status
1	**Retro eligibility**	Incedo cannot process insurance retroactively. When a client has a change in insurance, the insurance fields on the claim and auth don't match, resulting in a denied claim.	*Applicable denial codes*: • Member coverage not in effect on date of service (CO27) • Not a covered service (CO 96) *Impact:* (1) All claims deny for any client with a previous unfunded span; (2) claims deny for all clients with change in insurance during active authorization span	*Status*: No payment rendered on impacted claims since Aug 3, 2020. ***Requested Interim Mechanism***: 1) End date unfunded spans 2) Remove insurance from auth *Targeted Fix Date*: none.
2	**Insurance indexing**	Incedo cannot correctly identify the primary insurance of a client with more than one type of coverage, and denies claims for all clients with multiple insurance payers.	*Applicable denial codes*: • Service payable by another carrier (CO 16) • Service Payable by other Primary Carrier (CO 22) *Impact:* (1) Claims may deny for clients with multiple active insurances if Incedo selects dental, secondary Medicare, etc. as primary; (2) Claims for clients who have a change in insurance midway through an active authorization period.	*Status*: No payment rendered on impacted claims since Aug 3, 2020. *Targeted Fix Date*: none.
3	**TPL processing**	Incedo denies a claim for services only covered by Medicaid – such as PRP or SE – due to failure to first bill primary insurer. There is no primary insurer that covers PRP and SE.	*Applicable denial codes*: • Service payable by another carrier (CO 16) • Service Payable by other Primary Carrier (CO 22) *Impact:* claims payable by Medicaid are denied.	*Targeted Fix Date*: none.
4	**Search capacity**	Incedo search function fails to identify all relevant claims under specified search criteria. Providers cannot research claims with accuracy, causing claims denials and duplication of effort.	*Applicable denial codes*: • No auth on file (CO 138) *Resulting claims impact includes denials for:* Claims that are attached to an authorization with one client Incedo ID versus another deny for "no auth on file."	*Status*: CBH reported functionality broken as of Nov 4, 2020. *Targeted Fix Date*: none.
5	**Duplicate record merge**	1) The inability of providers to identify all claims under a search criteria has subsequently led providers to have to input client info that already exists in Incedo. This has inadvertently	*Applicable denial codes*: • No auth on file (CO 138)	*Status*: Optum has instructed providers to identify duplicate records via claims denials and call Customer Service to ask for records

		caused duplicate records that the provider has no ability to merge. 2) Before Beacon claims were transferred, providers were instructed (in early 2020) to obtain new uninsured spans in Incedo so claims would pay. Once uninsured spans transferred from Beacon, they were assigned a different client Incedo ID resulting in duplicates.	*Resulting claims impact:* Claims that are attached to an authorization with one client Incedo ID versus another deny for "no auth on file."	to be merged. Duplicates are a result of 2 known issues with Incedo/Optum, and duplicates will recur until search function is fixed and duplication of Beacon and Incedo IDs are corrected. ***Requested Interim Mechanism:*** Optum should ID duplicate records and copy auth for identified clients to pertinent records until search function fixed and duplication of Beacon and Incedo IDs are corrected. *Targeted Fix Date*: none.
6	**NPI data mismatch**	Optum/Incedo implementation required a new provider configuration with NPIs at the service line and facility level in order to bill. Claims that cannot be identified by NPI often "disappear" because an Optum rep ties them to a bogus provider (per Gwen) and subsequently deny.	*Applicable denial codes*: • Unable to match treatment provider • Member does not have treatment for specified provider • Service not payable when billed by this provider type" (CO170). *Resulting claims impact:* • Auths cross portals • Claims cross portals	*Status*: Providers continue to go unpaid due to NPI set-up issues not yet resolved by MDH. *Targeted Fix Date*: None ***Requested Interim Fix***: Until the state creates a clear plan to validate NPI #s and communicates instructions to providers on how to obtain separate NPIs for each service/facility without disrupting the current billing workflow, Optum should not be permitted to tie claims to a bogus provider. When claims are not identifiable, they should be required to reach out to the provider, validate NPI numbers and reprocess/resubmit.
7	**Accurate 277CA**	277 reports are one of the industry-standard data exchange files between a payer and a provider. If present, when a batch of claims is uploaded by a provider, they receive an itemized receipt (277) that indicates that the batch made it into system, and it would identify which claims within the batch failed and why.	The absence of a 277 report results in a greater manual lift by providers in order to do their basic revenue cycle management, and requires more frequent direct communication with Optum's customer service in order to obtain claims level detail that should be remitted electronically.	*Targeted Fix Date*: none.

8	**Claim rejections**	Providers' data indicates claim rejection rates above industry-standard. Some rejections produce no corresponding 835, and others produce an 835 with a denial code present that it different than the rejected status in Incedo.	*Rejection reasons listed in Incedo*: • Unable to match treatment provider • Member does not have treatment for specified provider • Service not payable when billed by this provider type" (CO170). *Impact:* rejected claims are not paid, cannot be reprocessed, and must be resubmitted by provider.	*Status*: No instructions to providers have been given pertaining to how to reprocess these. *Targeted Fix Date*: none
9	**835s for all encounters**	Incedo does not generate 835s for encounters. Formerly, an 835 with a "no-pay" code was remitted for accepted encounters, which enabled providers to track the scaffolding of their paid case rates and complete their basic revenue cycle management. Currently, no providers receive 835s for accepted or rejected encounters, and some do not receive 835s for denied encounters.	*Resulting claims impact*: Providers are unable to reconcile encounters to case rates.	*Targeted Fix Date*: none.
10	**Assigning encounters to PRP case rates**	Encounters for the same case rate submitted together will yield some accepted and some denied with no clear reasoning. Encounters continue to be tied to bogus providers due to NPI # issues. (See #6) Encounters reject rather than deny for no clear reason. This eliminates the possibility of being reprocessed. These claims must be resubmitted.	*Resulting claims impact:* • PRP case rates cascade incorrectly and pay at a lower rate. • Providers cannot identify missing encounters because they do not receive 835s (See Systemic Issue #9)	*Status*: Optum has announced that they are performing monthly audits of cascaded case rates, however providers are reporting many case rates, denied incorrectly, and not captured by these audits. *Targeted Fix Date*: None
11	**Residential crisis services billing**	The residential crisis billing set-ups for providers are not functional and result in widespread claims denials. The three identified barriers are:		
		• RCS clinic service claims are denying for no authorization. Formerly, an authorization was not required, and instead the modifier -HE was applied. This means that clients receiving outpatient services at a different clinic than where they are referred for temporary residential crisis services will be denied authorization for having an active and open auth elsewhere.	*Applicable denial codes*: • "No authorization on file" (CO 138) • "Not a covered service" (CO96)	*Status*: No payment rendered on impacted claims since Aug 3, 2020. *Targeted Fix Date*: none.

		• Bed Day codes. Providers now have to get a separate authorization for bed days and daily RRP/RCS services. Formerly H0019 applied exclusively to RCS daily bed day and T2048 applied exclusively to RRP. Now that bed days require auth, use of Optum codes is resulting in authorization? denials for service exclusions.	*Applicable denial codes*: • No auth on file (CO 138)	*Status*: No payment rendered on impacted claims since Aug 3, 2020. *Targeted Fix Date*: none.
		• NPI #s. Formerly, most RCS providers billed using their PRP NPI #. No formal instructions have been given to RCS providers on how to begin using new NPI once obtained (a process complicated by how RCS client records will transfer.)	*Applicable denial codes*: • Service not valid when billed by this provider (Code 170) *Resulting claims impact:* all impacted claims deny.	*Status*: No payment rendered on impacted claims since Aug 3, 2020. *Targeted Fix Date*: none.
12	**SE referrals**	1) The process for DORS counselors to receive referrals launched in Optum as of Nov 16 but is not working. Optum created a standalone DORS application/referral to avoid the requirement for providers to have to submit a new auth for every DORS referral, but this form does not give you the option of which DORS counselor to send it to -- the DORS counselor does not receive notification and is unable to process the referral. 2) LBHAs are tasked with closing/changing dates on auths but because they cannot see if claims are pending before they close/change dates claims deny for no auth on file.	*Applicable denial codes*: • No auth on file (CO 138) *Resulting claims impact*: Clients/claims sit in process indefinitely or deny for no auth on file.	*Status*: Providers are not being paid for the vast majority of SE claims since August 3, 2020. *Targeted Fix Date*: none
13	**Uninsured span waivers**	In Summer 2020, the state applied a waiver for authorization requirements for services delivered in January-June 2020. This was a result of providers being unable to obtain authorization while Incedo was not working. Providers were also unable to obtain uninsured spans during this time for the same reason. The state applied no requisite waiver for uninsured spans, causing claims denials for this significant period of time.	*Applicable Denial Codes*: • "Member coverage not in effect" (CO27)	*Targeted Fix Date*: none.

14	**Secondary claims**	Optum's client COB data often does not update at the same rate as MMIS data, so Incedo does not reflect the current primary insurance for clients with recent insurance changes.	*Resulting claims impact:* Claims deny for no auth because Incedo does not recognize the claim as a secondary one. *Applicable denial codes:* • No auth on file (CO138)	*Status:* Instructions to providers has been to have client call to update their COB. *Target Fix Date*: None
15	**Incedo Filters**	Providers cannot effectively perform revenue cycle management without key claims research functions. Incedo is missing necessary: 1. Mechanism for filtering claims by *Completed*, *Denied*, *Pended* and *In Process* labels. 2. Mechanism for filtering claim by *Processed date* and *Service date* 3. Check Date and check numbers need to be displayed on the claim lines for any claim that has fully processed (paid or denied). 4. Ability to export claims out of the system just like the function Optum added for authorizations. (Ability to see more than 500 claims per day) 5. Ability to export all of the Encounter Data services or run a report for processed Encounter Data so agencies can internally audit what has been processed for case-rate services 6. Ability to run a report on clients whose eligibility is ending 7. A claim file number assigned when an 837 file is uploaded into Incedo so we can match them to the correlating 999 reports. 8. Ability to see the history of processing the claims in Incedo with PRA references.		*Status*: Current functionality limits providers' ability to perform industry-standard revenue cycle management functions. *Targeted Fix Date*: none.
17.	Incomplete denial/remark codes in Incedo	Incedo seems to be able to show only one remark/denial/adjustment code per claim line whereas presumably the claim processing system on the back end can have multiple.	*Resulting claims impact:* Providers cannot know actual reason for denial and thus cannot determine how to address it.	*Status:* Instructions to providers has been to check the PRA to see all denial reasons, but there is no way to identify which PRA to look at by looking at the claim in Incedo. *Target Fix Date*: None

18.	Eligibility applications in Incedo	For third and subsequent uninsured span requests, some clients are diverted to the LBHA who can approve a 30 day span and others can continue to receive 90 day spans indefinitely. The form in Incedo is not designed to accommodate service level options. For example, clients in Supported Employment (SE) can get 90 day spans indefinitely, but in most cases the logic of the form does not give you a place to indicate the client is in SE.	It is not clear to all providers which clients get 90 day spans indefinitely and which need to be sent to the LBHA for a 30 day span. *Resulting claims impact*: Clients entitled to indefinite 90 day spans do not get approved. Calling the call center is of no help as the staff there do not understand the issue and do not have access to correct/approve spans.	*Status*: In early December Anne Armstrong indicated that a form correction and corresponding alert were in process, but nothing has been forthcoming. *Target Fix Date*: None

Attachment C: CBH ASP Performance Standards

Achieving a Functional ASO

Necessary ASO Performance Standards | May 11, 2021

The Maryland Department of Health (MDH), in consultation with the providers in the Public Behavioral Health System, is required to identify the necessary reports and features required for a fully functional ASO. MDH's report should be filed with the Maryland General Assembly by July 1, 2021. Quarterly reports thereafter should identify progress made on each of these features, identify what is not fully functional, the steps needed to reach functionality, and the estimated completion date(s). This document seeks to define the core functionality necessary in an ASO vendor.

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; 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; 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; 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; 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; and f. MDH defines evidentiary requirements and reporting mechanism for providers to report non-compliance with deadlines by Optum to the Department.
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 fail to upload; 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; 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; 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; and 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.

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;
   ii. Insurance indexing errors (i.e. selecting incorrect primary insurance or displaying inactive insurance);
   iii. Secondary payer processing errors;
   iv. Denials of add-on codes when underlying code is appropriately authorized;
   v. Duplicate client records;
   vi. Erroneous duplicate claims denials;
   vii. Unfunded spans without end dates;
   viii. Service portal and data errors including incorrect NPI numbers;
   ix. All errors caused by manual processing by Optum;

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;

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; and

d. MDH offers mechanism for providers to report noncompliance to MDH; and upon validation, MDH applies requisite monetary penalty for contractual noncompliance.

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);
b) Void and resubmit capacity for individual and batch claims;
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;
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;
e) Capability to save draft/in progress authorizations; and
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.

1E: Optum will provide prompt and adequate notice to providers of planned and unplanned system outages, including:

- 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;
  - Once the scale and duration of a system outage is reasonably identified, Optum will release an update to provider community;
  - Within 30 minutes of an outage resolution, Optum will release an update to the provider community;

- 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.

Standard 2: Eligibility and Authorizations. Uninsured eligibility decisions and authorizations are accurately and timely processed.

2A: Timeframes and Workflows.

a. Authorization requests for crisis services are approved accurately on first review and responded to within 24 hours of request;
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;
c. if auth is pended for reasons other than routine approval (i.e. for overlapping dates spans), provider should receive notification of the pended authorization within 5 days of submission as well as justification for the pend;
d. Requested uninsured spans are approved or renewed within 5 days of submission;
e. Requested unfunded spans are approved within 3 days; and
f. Split authorizations are appropriately identified and approved; conflicting authorizations are appropriately identified and prevented.

2B: Transparency and Accountability. In consultation with the provider community, Optum will report monthly on the average time from request to decision for uninsured eligibility and authorization requests--by provider type-- to ensure that:

g. Authorization process for every provider type matches the workflow and clinical requirements described in the provider manual; and
h. MDH clearly defines evidence necessary to document non-compliance with time standards and provides a mechanism to report it.

Standard 3: Provider relations. Performance standards for the ASO's provider relations are accurately defined, measured, and actionable.

3A: The ASO RFP requires Optum to respond to provider inquiries within one business day (p. 16, 2.3.2.4.A), resolve claims problems and open tickets within same week, or report to Contract Monitor (p. 16, 2.3.2.4.A.5). Evaluating compliance with these requirements can ensure that MDH is able to hold Optum accountable for retaining sufficient staff to handle provider complaints and needs; and otherwise meeting contractual performance standards.

a. Optum will track timeframe for provider problem resolution and share with MDH;
b. MDH will have a reporting mechanism for providers to submit evidence to MDH of Optum's noncompliance with the contractual performance standards in terms of timeframes and/or issue resolution; and
c. MDH will report this data to the provider community monthly.

Standard 4: ASO demonstrates the ability to identify and mediate security and privacy violations in a timely manner.

4A: The ASO issues payments only to those providers who have billed the ASO for providing treatment to a patient.

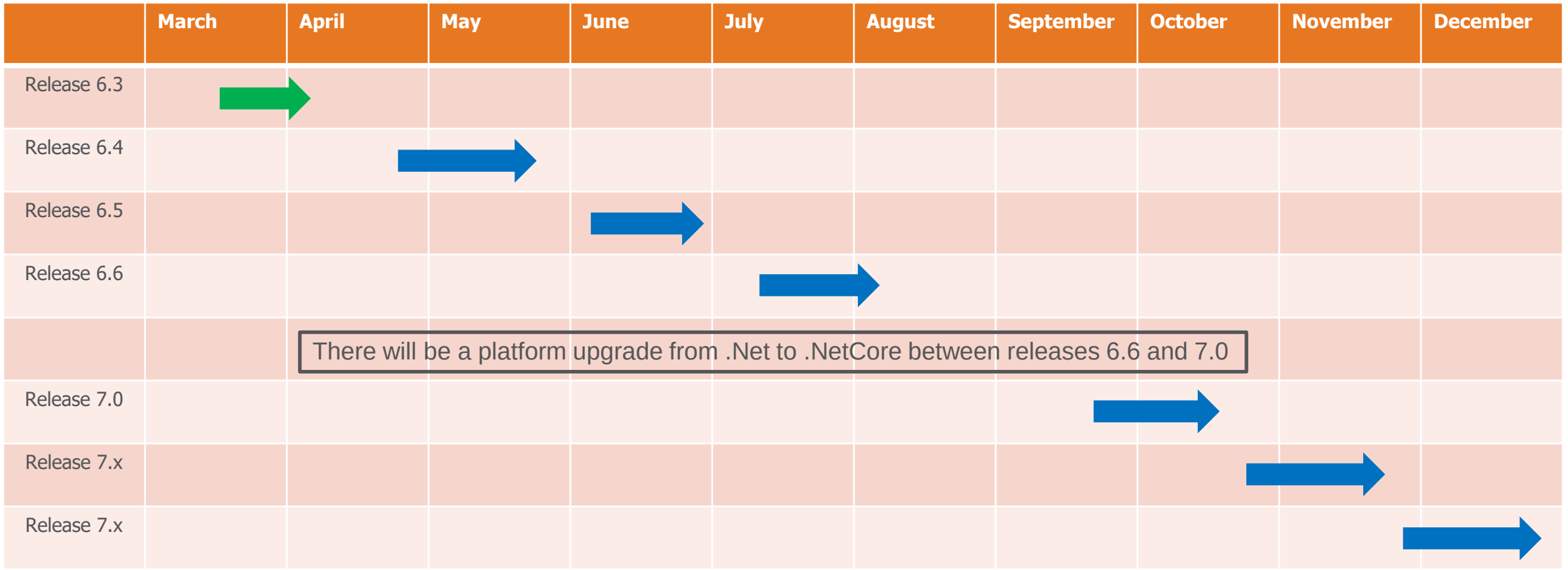
a. A clear avenue for providers to report misdirected payments is established and communicated to the provider community;
b. Optum identifies a root cause for ongoing misdirected payments;
c. Implementation of appropriate corrective action is reported; and
d. Efficacy of corrective actions is evaluated by MDH through monitoring of ongoing reports from provider community.

Attachment D

2021 Incedo Roadmap

OPTUM®

2021 Release Schedule



Release schedule is based on MDH prioritized items, level of effort and capacity for Incedo solution.

2021 Roadmap

Targeting monthly deployments.

Items are prioritized as they are raised. The upcoming releases are generated from the prioritized list of outstanding items, including consideration for level of effort and capacity.

April Deployment	May Deployment	June Deployment	July Deployment
✓ 277CA ✓ Clearing house issues ✓ Eligibility Status	❑ Claims Export ❑ Updates to Retro Eligibiltiy ❑ Authorization Auth Plan Selection updates	❑ SE Authorizations automatic enddating ❑ Alt+S to save the claim form update ❑ Ability to view ROI Designator in IPC ❑ Communication with Provider/User	❑ Multiple tickets related to accuracy and efficiency ❑ Update End Date for Unfunded span when participant gets Medicaid

OPTUM®