

**MARKET CONDUCT EXAMINATION REPORT
OF
UNITED BEHAVIORAL HEALTH**

**2716 N. Tenaya Way, NV017-S500
Las Vegas, NV 89128**

Report No. MCLH-2-2021-E

Examination Period: January 1, 2020 – March 31, 2021



**STATE OF MARYLAND
MARYLAND INSURANCE ADMINISTRATION**

KATHLEEN A. BIRRANE, COMMISSIONER

JUNE 7, 2022

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June 7, 2022

The Honorable Kathleen A. Birrane
Commissioner of Insurance
State of Maryland
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Dear Commissioner Birrane:

Pursuant to your instructions and authorization, an Examination has been made of the market conduct affairs of:

UNITED BEHAVIORAL HEALTH

whose home office is located at 2716 N. Tenaya Way, NV017-S500, Las Vegas, Nevada 89128. The report of such Examination is being respectfully submitted.

Sincerely,

signature on file with original

Mary M. Kwei
Associate Commissioner
Market Regulation & Professional Licensing

I. EXECUTIVE SUMMARY

In June 2021, the Maryland Insurance Administration (the “Administration”) initiated a target Market Conduct Examination (the “**Examination**”) of United Behavioral Health, operating in Maryland under the trade name “Optum Maryland” (the “**Company**”). The purpose of the Examination was to evaluate whether the Company complied with the requirements of Md. Code Ann., Ins. § 15-1005 (2017 Repl. Vol.) when acting as an administrative services organization (“**ASO**”) for specialty mental health services established under Md. Code Ann., Health-Gen § 15-103(b)(21)(vi); specifically in connection with its administration of specialty mental health claims under its contract with the Maryland Department of Health (“**MDH**”) (MDH Control # OPASS-20-18319/M00B0600078; hereinafter, the “**Medicaid Contract**”).

While an entity acting as an ASO for Medicaid services has always been subject to the provisions of § 15-1005, the Administration was given authority to investigate and examine the compliance of such an ASO with § 15-1005 under emergency legislation enacted during the 2021 Regular Session of the Maryland General Assembly. *Laws of Maryland 2021*, Ch. 151 (“**HB 919**”). The law became effective on May 18, 2021. In light of the number of complaints from specialty mental health providers regarding the timing and completeness of payment for their services by the Company under the Medicaid Contract, the Administration initiated the Examination shortly thereafter.

Based on materials and information reviewed during the Examination, the Administration has concluded that the Company did not comply with § 15-1005 at any time during the Examination Period. Consequently, as discussed in greater detail herein, the Company has been directed to prepare and submit corrective action plans to identify, calculate, and make restitution to providers for interest that should have been paid on claims submitted during the Examination Period and any period thereafter. The Company also has been directed to develop and submit for approval by the Administration policies and procedures that demonstrate and ensure its future compliance with § 15-1005.

II. SCOPE OF EXAMINATION

The Examination was conducted pursuant to §§ 2-205, 2-207 and 2-209 of the Annotated Code of Maryland, Insurance Article and 31.04.20 of the Code of Maryland Regulations (“**COMAR**”). The Examination Period was January 1, 2020 through March 31, 2021.

The purpose of the targeted Examination was to determine whether the Company complied with the requirements of Md. Code Ann., Ins. § 15-1005 (2017 Repl. Vol.) when acting as the ASO for MDH under the Medicaid Contract.

Section 15-1005 requires that within thirty days of its initial receipt of a claim for reimbursement of certain services by certain providers, a payor subject to the section must either pay the claim or provide written notice as to the basis for non-payment. If a “clean claim” is not paid within thirty days, interest on the amount of the claim that remains unpaid thirty days after receipt of the initial clean claim must be paid in accordance with a statutory interest rate schedule.

At the Administration’s request, the Company provided the total population for each area listed in the chart below:

| AREA | POPULATION | SAMPLE SIZE |
|---------------------------------------|------------|-------------|
| Paid Claims - 1.1.2020 to 7.31.2020 | 3,306,052 | 200 |
| Paid Claims - 8.1.2020 to 3.31.2021 | 5,361,555 | 200 |
| Denied Claims - 1.1.2020 to 7.31.2020 | 1,096,183 | 125 |
| Denied Claims - 8.1.2020 to 3.31.2021 | 1,539,443 | 125 |
| Total: | | 650 |

The examination and testing methodologies used during the Examination followed standards established by the National Association of Insurance Commissioners and procedures developed by the Administration. All sample files were selected using a computer generated random sample program unless otherwise stated herein.

III. COMPANY INTRODUCTION

Pursuant to the Medicaid Contract, the Company assumed the administration of specialty mental health benefits for Maryland Medicaid participants with respect to mental health services provided on or after January 1, 2020. The Company's responsibilities under the Medicaid Contract included administering and paying claims.

The Company has acknowledged that, as a result of what it characterizes as "functionality issues" with its claim platform (the "**Platform**"), it was unable to process or to pay provider claims from January 1 through August 3, 2020. In an effort to mitigate the impact of this, and to assure a consistent flow of provider payments until the Platform was functional, MDH directed the Company to advance estimated monthly payments to Medicaid providers ("**Providers**"), subject to the Company's obligation to reconcile Provider accounts when the Platform became functional. Advance estimated payments were calculated by MDH and supplied to the Company based on prior claim payment data. Advance estimated payments were made from January 23, 2020 through August 3, 2020 (the "**Estimated Claim Payment Period**"). On August 4, 2020, the Company's began using the Platform for claim administration and payment processing of new claims (the "**Standard Processing Period**"). MDH allowed Providers additional time to submit claims for services provided during the Estimated Claim Payment Period. On July 27, 2020, the Company began reconciling claims received during the Estimated Claim Payment Period with the estimated payments made to Providers. MDH directed the Company to begin making claim payments on reconciled claims from the Estimated Claim Payment Period on August 13, 2020.

IV. VIOLATIONS

Issue 1 - Violation of Section 15-1005(c)

The Company failed to pay claims or send notice of receipt and status of claims within 30 days of their receipt for reimbursement.

Section 15-1005(c) provides in pertinent part:

(c) Except as provided in § 15-1315 of this title and subsection (i) of this section, within 30 days after receipt of a claim for reimbursement from a person entitled to reimbursement under § 15-701(a) of this title or from a hospital or related institution, as those terms are defined in § 19-301 of the Health - General Article, an insurer, nonprofit health service plan, or health maintenance organization shall:

(1) mail or otherwise transmit payment for the claim in accordance with this section; or

(2) send a notice of receipt and status of the claim that states:

(i) that the insurer, nonprofit health service plan, or health maintenance organization refuses to reimburse all or part of the claim and the reason for the refusal;

(ii) that, in accordance with § 15-1003(d)(1)(ii) of this subtitle, the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or

(iii) that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.

FINDING 1

The samples reviewed by the Administration confirmed that, regardless of the advance estimated payments, there were instances when the Company failed to pay claims or send notice of receipt and status of claims within 30 days of its receipt of a claim for reimbursement. Likewise, after its standard claims handling processes were deployed, the Administration identified instances when the Company failed to either pay the claim or send notice of receipt and status of the claim within 30 days of its receipt of the claim for reimbursement. The Company is in violation of Section 15-1005(c).

| AREA REVIEWED | POPULATION | SAMPLE SIZE | VIOLATIONS | % OF ERROR | EXHIBIT |
|-------------------------------------|------------|-------------|------------|------------|---------|
| Paid Claims 1.1.2020 to 7.31.2020 | 3,306,052 | 200 | 94 | 47 | A |
| Paid Claims 8.1.2020 to 3.31.2021 | 5,361,555 | 200 | 13 | 7 | B |
| Denied Claims 1.1.2020 to 7.31.2020 | 1,096,183 | 125 | 79 | 63 | C |
| Denied Claims 8.1.2020 to 3.31.2021 | 1,539,443 | 125 | 10 | 8 | D |

Issue 2 - Violation of Section 15-1005(g)(1)
The Company failed to pay interest on claims in accordance with Maryland law.

Section 15-1005 provides in pertinent part:

(g) (1) If an insurer, nonprofit health service plan, or health maintenance organization, or administrative services organization that administers the delivery system for specialty mental health services established under § 15-103(b)(21) of the Health - General Article fails to pay a clean claim for reimbursement or otherwise violates any provision of this section, the insurer, nonprofit health service plan, or health maintenance organization shall pay interest on the amount of the claim that remains unpaid 30 days after receipt of the initial clean claim for reimbursement at the monthly rate of:

- (i) 1.5% from the 31st day through the 60th day;
- (ii) 2% from the 61st day through the 120th day; and
- (iii) 2.5% after the 120th day.

FINDING 2

The Company failed to pay interest on the amount of the claim that remained unpaid 30 days after initial receipt of a clean claim for reimbursement. The Company is in violation of Section 15-1005(g)(1).

| AREA REVIEWED | POPULATION | SAMPLE SIZE | VIOLATIONS | % OF ERROR | EXHIBIT |
|-----------------------------------|------------|-------------|------------|------------|---------|
| Paid Claims 1.1.2020 to 7.31.2020 | 3,306,052 | 200 | 94 | 47 | A |
| Paid Claims 8.1.2020 to 3.31.2021 | 5,361,555 | 200 | 13 | 7 | B |

Issue 3 - Violation of Section 15-1005(c)(2)

The Company failed to send a notice of receipt and status of claim that stated the reason for refusal.

Section 15-1005 provides in pertinent part:

(c) Except as provided in § 15-1315 of this title and subsection (i) of this section, within 30 days after receipt of a claim for reimbursement from a person entitled to reimbursement under § 15-701(a) of this title or from a hospital or related institution, as those terms are defined in § 19-301 of the Health - General Article, an insurer, nonprofit health service plan, or health maintenance organization shall:

(2) send a notice of receipt and status of the claim that states:

(i) that the insurer, nonprofit health service plan, or health maintenance organization refuses to reimburse all or part of the claim and the reason for the refusal;

FINDING 3

The Company failed to send a notice of receipt and status of a denied claim that states the reason for refusal. The Company is in violation of Section 15-1005(c)(2).

| AREA REVIEWED | POPULATION | SAMPLE SIZE | VIOLATION | % OF ERROR | EXHIBIT |
|-------------------------------------|------------|-------------|-----------|------------|---------|
| Denied Claims 1.1.2020 to 7.31.2020 | 1,096,183 | 125 | 1 | 1 | E |
| Denied Claims 8.1.2020 to 3.31.2021 | 1,539,443 | 125 | 5 | 4 | E |

Issue 4 - Violation of COMAR 31.10.11.07

The Company failed to fully reimburse clean claims in accordance with Maryland laws.

COMAR 31.10.11 provides in pertinent part:

.07 General Provisions.

- A. A third-party payor shall accept a clean claim which is submitted in compliance with these regulations for the processing of the third-party payor's claims.
- B. A third-party payor is subject to the provisions of Insurance Article, §15-1005, Annotated Code of Maryland.

FINDING 4

The Company failed to fully reimburse claims that contained all of the required elements of a clean claim. The Company is in violation of COMAR 31.10.11.07.

| AREA REVIEWED | POPULATION | SAMPLE SIZE | VIOLATIONS | % OF ERROR | EXHIBIT |
|-------------------------------------|------------|-------------|------------|------------|---------|
| Paid Claims 8.1.2020 to 3.31.2021 | 5,361,555 | 200 | 1 | <1 | F |
| Denied Claims 1.1.2020 to 7.31.2020 | 1,096,183 | 125 | 2 | 2 | F |

V. CONCLUSIONS AND DIRECTIVES

In an effort to quantify the extent of violations resulting from the Company's lack of compliance procedures, a sampling of 650 randomly selected files were reviewed. Of the selected files, a total of 312 violations occurred during the Examination Period. Those violations included failure to pay claims or send notice of receipt and status of claims within 30 days, failure to pay applicable interest, failure to send a notice of which includes the reason for denial, and failure to reimburse clean claims.

In light of its findings, the Administration directs the Company as follows:

A. Timely Claim Payments and Notices

The Company will provide to the Administration a corrective action plan that includes a detailed description of the processes it has implemented for assuring compliance with those provisions of § 15-1005 that require the timely processing of claims and either payment or notice of the basis for non-payment under § 15-1005(c) within 30 days of claim submission. The Company shall demonstrate that it has updated its current systems and procedures to assure that clean claims are timely paid and that all statutory notices are timely issued. The Company shall provide its corrective action plan and verification of its implementation in writing to the Administration on or before February 28, 2022.

In response to V.A. of the draft market conduct report, the Company advised of the following corrective actions:

“Optum claims operational leadership reviews a daily inventory report to identify claim volumes and aging to ensure timely processing of claims. If a claim is identified to be at risk of non-compliance, leadership works with the claim processor to enable the claim to be processed timely.”

In Q4 of 2021, Optum completed a project to analyze if any 835s/Provider Remittance Advices (PRAs) for claims processed by the Incedo platform that were not sent to providers. The analysis was completed in conjunction with the MDH. The project determined denied claim lines (\$0) that were previously not sent in the form of a PRA/3835 were regenerated and sent to providers by the end of December. Optum has implemented controls to mitigate future risk. The controls include validation processes that review the provider, dollar values to include \$0, claim counts, Incedo Check register, and Check run tables against files sent to PaySpan.

Additionally, Optum has developed a policy that outlines § 15-1005 and COMAR 31.10.11.08 and 31.10.11.09 requirements and expectations.”

B. Timely Interest Payments

The Company has agreed to develop an automated process to identify claims that, notwithstanding the procedures implemented in accordance with V.A., are not timely

processed in accordance with § 15-1005(c). The Company asserts that the automated process will include the identification of any clean claims that were not paid within 30 days and will include the ability to calculate the correct interest rate in compliance with § 15-1005(g). The Company asserts that its automated process will be tested and reviewed by the Company and MDH in Q3 2022, with the expectation that the automated process will be implemented into the claims system for completion at the end of Q4 2022.

The Company is directed to report to the Administration on its progress in the development and implementation of the automated process at the end of each quarter, beginning on March 31, 2022. If the automated process has not been implemented by December 31, 2022, the Company is directed to report such progress at the end of each calendar month until the automated process is fully implemented.

In addition, pending the development and implementation of the automated process, the Administration directs the Company to employ the process described below in V.C.

In response to V.B. of the draft market conduct report, the Company advised of the following:

“Optum agrees with the statements referenced in V.B paragraph one. Optum agrees to provide a status of the implementation of the automated process to the Administration not later than requested, March 31, 2022. If the automated process has not been implemented by December 31, 2022, Optum will provide the Administration with a status of the progress at the end of each calendar month until the automated process is fully implemented.”

C. Payment of Unpaid Interest on Clean Claims During the Standard Processing Period

During the Examination, the Administration noted that the Company had no procedures in place to pay interest on clean claims not paid within 30 days. Consequently, the Administration directed the Company to:

1) Develop and provide a corrective action plan to identify all claims on which interest was required to be paid from August 4, 2020 through the present and (i) to pay such interest to any provider or (ii) deduct such interest from any amounts due to any Provider whose Estimated Claim Payments exceeded the amounts due to that Provider (after the application of the methodology ultimately approved by the Administration for the consideration of interest as part of the reconciliation of provider accounts).

In response to V.C.1) of the draft market conduct report, the Company advised of the following corrective actions:

“Optum has developed a process to resolve unpaid interest on claims in two phases (see item #2, below, for phase 2). Optum has developed a report to identify the claims that were processed and for which an interest payment

was due to the provider between August 4, 2020 - November 30, 2021. The report identified, by provider, the claims that were processed in excess of 30 days during this period, the amounts, and the interest amounts owed related to those claims. ”

- 2) Develop and provide a corrective action plan to ensure that interest is paid on all claims remaining unpaid 30 days after receipt of a clean claim for reimbursement in compliance with § 15-1005 (g) and COMAR 31.10.11.08 and 31.10.11.09.

In response to V.C.2) of the draft market conduct report, the Company advised of the following corrective actions:

“Beginning with claims paid in December 2021, Optum will use the report described in item #1 above to identify claims and to pay providers interest, as applicable and required by Maryland law. The claims report will be reviewed on a quarterly basis to identify any claims that require an interest payment. Interest will be paid by Optum and not via accounts funded by the State of Maryland. Interest payments will be paid quarterly.

Optum is also developing an automated process to identify claims that remain unprocessed greater than 30 days from the submission of a clean claim. The automated process will identify claims that fail to process within 30 days, apply the correct interest rate, and then pay the interest from a non-State of Maryland bank account.

The automated process will be tested and reviewed by both internal Optum subject matter experts and MDH leadership in Q3 2022. Upon completion, the automated process will be implemented and integrated into the claims platform. The automated process will be implemented into the claims system and is targeted for completion at the end of Q4 2022.”

In response, the Company proposed corrective actions, which the Administration has accepted, as amended by the Administration, as follows:

- 1) The Company will prepare a detailed master claims report identifying all clean claims that were processed between August 4, 2020 and November 30, 2021 with respect to which interest was due under § 15-1005. The master claims report will identify, by Provider, the claims that were paid in excess of 30 days, the amount of the late-paid claim, and the interest calculated as payable on the late-paid claim.

On or before February 15, 2022, the Company will notify all Providers to whom interest is due that they will be receiving an interest payment/check in the amount mandated by § 15-1005(g). The Company will make the interest payments to the Providers in the amounts calculated in the master claims report. A provider specific report with claim information will be made available to each Provider via the Provider’s folder within the Company’s claims portal (consistent with the manner in

which Providers currently access Provider Remittance Advices (“PRAs”). All such interest payments will be made on or before March 31, 2022 and the interest paid will reflect interest due through the actual payment date.

The Company is directed to submit its initial master claims report to the Administration on or before February 4, 2022. In addition, on or before April 30, 2022, the Company is directed to provide the Administration with the final master claims report, together with a summary confirming that all of interest payments were made by March 31, 2022. The summary report shall identify each Provider, the date and amount of the original claim payments, and the date and amount of the interest payment.

In response to V.C.1) amended, of the draft market conduct report, the Company advised of the following corrective actions:

“Optum has submitted a detailed master claims report identifying all clean claims that were processed between August 4, 2020 and November 30, 2021 with respect to which interest was due under § 15-1005.

Optum confirms that a letter was sent to all impacted providers by February 15, 2022 communicating that they will be receiving an interest payment for claims processed greater than 30 days between the period August 4, 2020 - November 30, 2021.¹

Additionally, Optum confirms that a report containing the claim details for each impacted provider was uploaded to the Provider Folder in the Incedo claims platform by March 31, 2022. Please note this is a different provider folder than initially stated to the Administration, however this folder provides providers the accessibility they require.

Lastly, Optum agrees to submit a final master report to the Administration no later than April 30, 2022, together with a summary confirming that 97% of the interest payments were made by March 31, 2022 (the remaining 3% are awaiting provider W9s and pending vendor ID). The total amount of interest paid is \$3,124,044. The summary report will identify each Provider, the date and amount of the original claim payments, and the date and amount of the interest payment.”

2) The Company will develop and implement the automated interest calculation process described in V.B, above. Until implementation is complete, the Company will create a reporting tool that includes the information identified in subparagraph (a) that can be generated in real time to identify the following elements: (i) all claims initially received on or after December 1, 2021 that (notwithstanding the Company’s corrective actions to assure timely payment of claims as set forth in V.A) were not

¹ According to the company, provider letters were resent on March 25, 2022 because the provider letters that were sent on February 15, 2022 contained certain address errors.

paid within the statutory 30 day period, (ii) the late-paid claim amount, (iii) the payment date, (iii) the interest due on the late- paid claim amount, and (if applicable) (iv) that date the interest was paid. This reporting tool will be reviewed by a senior member of management on at least a quarterly basis to identify and direct the immediate payment on interest due. The first such review shall occur on March 31, 2022.

The Company is directed to identify the senior member of management receiving the report and to submit a copy of each quarterly report to the Administration, together with proof that interest has been paid, within 10 business days after the close of the quarter, until the automated process has been implemented.

In response to V.C.2) amended, of the draft market conduct report, the Company advised of the following corrective actions:

“Optum confirms that a reporting tool was created to identify in real time (i) all claims initially received on or after December 1, 2021 that (notwithstanding the Company’s corrective actions to assure timely payment of claims as set forth in V.A) were not paid within the statutory 30 day period, (ii) the late-paid claim amount, (iii) the payment date, (iii) the interest due on the late-paid claim amount, and (if applicable), (iv) that date the interest was paid.

The reporting tool was reviewed by a senior member of management by March 31, 2022. The reporting tool will be reviewed on at least a quarterly basis to identify and direct the immediate payment of interest due.

The quarterly report and proof that interest was paid will be submitted to the Administration each quarter until the automated process has been implemented.”

3) The Company is directed to identify the method of calculating interest owed on claims noted in (a) and (b) on or before February 4, 2022,

In response to V.C.3) amended, of the draft market conduct report, the Company provided the method of calculating interest in (a) and (b).

D. Payment of Unpaid Interest on Clean Claims During the Estimated Claim Payment Period

The Company is responsible for the payment of interest to Providers for clean claims that were not timely paid during the Estimated Claim Payment Period.

The Company reports that it has completed its reconciliation of Provider accounts to determine whether, as to each Provider who submitted valid claims during the Estimated Claim Payment Period, the Provider was overpaid or underpaid. According to the Company, of the 2,605 Providers who received Estimated Claim Payments, 223 Providers were underpaid and 2,382 Providers were overpaid. The Company states that the amounts calculated by the Company as owed to the 223 underpaid Providers have been paid to those Providers.

With respect to unpaid interest, the Administration directed the Company to develop a fair and reasonable methodology to pay interest to Providers who were underpaid during the Estimated Claim Payment Period. The Company proposed that it would treat a claim as a clean claim 30 days after the later of August 3, 2020 or the date the claim was submitted. While this methodology is imperfect, the Administration accepts it as a fair and reasonable approach that is designed to make Providers whole.

Using this methodology, the amount of interest to be paid to Providers is \$631,933. The Company is directed to make all such interest payments to Providers by May 31, 2022 and to provide a report to the Administration no later than June 15, 2022 confirming that all payments have been made. The summary report shall identify each Provider, the date and amount of the original claim payments, and the date and amount of the interest payment.

To the extent that any Provider disputes the amount paid, the Company is directed to review the alleged error and, if the dispute is not resolved, to report the dispute to the Administration within 30 days of the date that the Provider notifies the Company in writing of the dispute.

The Company's position with regard to compliance with § 15-1005 of the Insurance Article is spelled out in its letter to the MIA dated May 10, 2022, which is attached as Exhibit G. As stated in this Report, the Administration disagrees with the Company's position.

EXHIBITS

MARYLAND INSURANCE ADMINISTRATION*
200 ST. PAUL PLACE, SUITE 2700
BALTIMORE, MARYLAND 21202

V.

UNITED BEHAVIORAL HEALTH
(t/a "Optum Maryland")
2716 N. TENAYA WAY, NV017-S500
LAS VEGAS, NV 89128

CASE NO.: MIA-2022-06-010

EXAMINATION NO.: MCLH-2-2021-E

* * * * *

CONSENT ORDER

This Consent Order is issued by the Maryland Insurance Administration ("Administration") against United Behavioral Health, t/a Optum Maryland ("Respondent"), with its consent, pursuant to Md. Code Ann., Ins. Art., §§ 2-204, 2-205 and 2-208 (2017 Repl. Vol. & Supp.) ("Insurance Article")¹.

Procedural History of Examination

1. At all times relevant to this Consent Order, Respondent has held, and currently holds, a certificate from the Administration to operate in the State as a private review agent.

2. Pursuant to §§ 2-205, 2-207, 2-208 and 2-209, in June 2021, the Administration called a targeted Market Conduct Examination ("Examination") of Respondent for the purpose of evaluating whether Respondent complied with the requirements of § 15-1005 when acting as an administrative services organization ("ASO") for specialty mental health services established under Md. Code Ann., Health-

¹ Unless otherwise indicated, all citations to statutes herein are to the Insurance Article.

Gen § 15-103(b)(21)(vi). The period covered by the Examination was January 1, 2020 through March 31, 2021 (the "Examination Period").

3. At the completion of the Examination, the Administration forwarded to Respondent a proposed examination report as required by § 2-209(c). The proposed examination report included the Administration's conclusion that Respondent had violated § 15-1005 in its administration of mental health benefit claims. Respondent filed a timely request for a hearing on the proposed examination report.

4. Respondent denies committing any violation of the Insurance Article. However, in order to avoid further litigation, and without admitting any violation of the Insurance Article, Respondent consents to the entry of this Consent Order. In addition, and without admitting the accuracy of any of the findings contained in the Final Examination Report, Respondent further withdraws its request for a hearing on the proposed examination report and consents to the issuance of the Final Examination Report (including Respondent's Response to the Proposed Examination Report (Exhibit G) which is being issued at the same time as this Consent Order.

Examination Findings

5. The Final Examination Report (No. MCLH-2-2021-E (the "Report")) identifies violations of § 15-1005 by Respondent found by the Administration, including the following:

a. Respondent failed to pay claims or send notice or receipt and status of claims within 30 days of their receipt for reimbursement, in violation of § 15-1005(c) of the Insurance Article.

b. Respondent failed to send a notice of receipt and status of claim that stated the reason for refusal, in violation of § 15-1005(c)(2) of the Insurance Article.

c. Respondent failed to pay interest on the amount of the claim that remained unpaid 30 days after initial receipt of a clean claim for reimbursement, in violation of § 15-1005(g)(1) of the Insurance Article.

d. Respondent failed to fully reimburse claims that contained all of the required elements of a clean claim, in violation of COMAR 31.10.11.07.

6. Notwithstanding that it disputed the violations identified by the Administration in the Report, Respondent submitted and, with the agreement of the Administration, has begun to implement the following compliance plans to remediate the violations asserted by the Administration:

a. Respondent has developed and implemented a policy to ensure timely processing of claims and to ensure compliance with § 15-1005(c) of the Insurance Article.

b. Respondent is developing an automated process to identify clean claims that were not paid within 30 days and the calculation of the correct interest rates in compliance with § 15-1005(g) of the Insurance Article.

c. Respondent has developed a report to identify all clean claims that were processed and for which interest payment was due between August 4, 2020 to November 30, 2021. Beginning with claims paid in December 2021, Respondent is using the report to identify claims and to pay interest rates in compliance with § 15-1005(g) of the Insurance Article.

Respondent calculated the interest due to providers for the period August 4, 2020 to November 30, 2021 and has issued to checks to all such providers in the amounts calculated.

Conclusions of Law

7. The Report concluded that Respondent violated the following Maryland Laws and Regulations:

- Section 15-1005 (c) of the Insurance Article;
- Section 15-1005(g)(1) of the Insurance Article;
- Section 15-1005(c)(2) of the Insurance Article;
- Section 31.10.11.07 of the Code of Maryland Regulations.

8. The detailed legal and factual bases of these conclusions are set forth in the Report, which is incorporated by reference as if set forth in full herein.

9. Respondent and the Administration agree to the conditions of this Consent Order and the remedial measures set forth herein. Respondent executes this Consent Order knowingly and voluntarily. The parties acknowledge that this Consent Order is in the public interest and desire to resolve this matter without further proceedings.

Order

WHEREFORE, for the reasons set forth above, it is **ORDERED** by the Commissioner and consented to by Respondent, that:

A. Respondent shall accept the Report as final and waive any right to a hearing on the Report or for judicial review of the Report.

B. Respondent shall report to the Administration on its progress in the development and implementation of the automated process to identify clean claims that

were not paid within 30 days and the calculation of interest in compliance with § 15-1005(g) of the Insurance Article. The first report was submitted on March 31, 2022 and additional reports will be provided at the end of each quarter. If the automated process has not been implemented by December 31, 2022, Respondent shall report such progress at the end of each calendar month until the automated process is fully implemented.

C. Respondent has made the interest payments to the providers in the amounts calculated in the master claims report, with the exception of the interest payments due during the "Estimated Claim Payment Period" (January 23, 2020 through August 3, 2020). On March 31, 2022, a provider specific report with claim information was made available to each Provider via the Provider's folder within the Company's claims portal, which identifies each Provider, the date and amount of the original claim payments, and the amount of the interest payment.

D. On May 2, 2022, Respondent provided the Administration with an updated master claims report identifying all clean claims that were processed between August 4, 2020 and November 30, 2021, together with a summary confirming that all interest payments were made for all providers except for 26 providers. Respondent advised that a W-9 form was still awaiting for the 26 providers. The summary report identified each provider, the date and amount of the original claim payments, and the date and amount of the interest payment.

E. Respondent created a reporting tool to identify in real time (i) all claims initially received on or after December 1, 2021 that were not paid within the 30 days as mandated by § 15-1005(g) of the Insurance Article, (ii) the late-paid claim amount, (iii)

the payment date, and (iv) the date the interest was paid. The reporting tool was reviewed by a senior member of management by March 31, 2022, and will be reviewed on at least a quarterly basis to identify and direct the immediate payment of interest due. The quarterly report and proof that interest was paid will be submitted to the Administration each quarter until the automated process has been implemented.

F. Respondent has developed, and the Administration has agreed to, a fair and reasonable methodology to pay interest to providers for clean claims that were not timely paid during the Estimated Claim Payment Period (January 23, 2020 through August 3, 2020) and Respondent, as explained in the Report, shall pay interest to providers in accordance with that methodology by May 31, 2022, and Respondent, by June 15, 2022, shall provide a summary report to the Administration, consistent with the Report, confirming the payments were made. If any provider disputes the amount paid by Respondent, then Respondent will notify the Administration within thirty (30) days of receipt of a written or electronic notification from the provider.

Other Provisions

G. The executed Consent Order shall be sent to the attention of: Mary M. Kwei, Associate Commissioner, Market Regulation & Professional Licensing Unit, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202.

H. For the purposes of the Administration and for any subsequent administrative or civil proceedings concerning Respondent, whether related or unrelated to the foregoing paragraphs, and with regard to requests for information about Respondent made under the Maryland Public Information Act, or properly made by governmental agencies, this Consent Order will be kept and maintained in the regular

course of business by the Administration. For the purposes of the business of the Administration, the records and publications of the Administration will reflect this Consent Order.

I. The parties acknowledge that this Consent Order resolves all matters relating to the factual assertions and agreements contained herein and are to be used solely for the purposes of this proceeding brought by or on behalf of the Administration. Nothing herein shall be deemed a waiver of the Commissioner's right to proceed in an administrative action or civil action for violations not specifically identified in this Consent Order, including, but not limited to, specific consumer complaints received by the Administration, nor shall anything herein be deemed a waiver of the right of Respondent to contest other proceedings by the Administration. This Consent Order shall not be construed to resolve or preclude any potential or pending civil, administrative, or criminal action or prosecution by any other person, entity or governmental authority, including, but not limited to, the Insurance Fraud Division of the Administration, regarding any conduct by Respondent including the conduct that is the subject of this Consent Order.

J. Respondent has had the opportunity to have this Consent Order reviewed by legal counsel of its choosing, and is aware of the benefits gained and obligations incurred by the execution of the Consent Order. Respondent waives any and all rights to any hearing or judicial review of this Consent Order to which it would otherwise be entitled under the Insurance Article with respect to any of the determinations made or actions ordered by this Consent Order.

K. This Consent Order contains the entire agreement between the parties relating to the administrative actions addressed herein. This Consent Order supersedes any and all earlier agreements or negotiations, whether oral or written. All time frames set forth in this Consent Order may be amended or modified only by subsequent written agreement of the parties.

L. This Consent Order shall be effective upon signing by the Commissioner or her designee, and is a Final Order of the Commissioner under § 2-204 of the Insurance Article.

M. Failure to comply with the terms of this Consent Order may subject Respondent to further legal and/or administrative action.

KATHLEEN A. BIRRANE
Insurance Commissioner

signature on file with original

By: Mary M. Kwei
Associate Commissioner
Compliance & Enforcement

Date: June 7, 2022

RESPONDENT'S CONSENT

RESPONDENT hereby CONSENTS to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondent, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondent to the terms of this Consent Order resolving Report number MCLH-2-2021-E.

Name: Christopher Zaetta

signature on file with original

Signature: Christopher Zaetta (Jun 6, 2022 12:21 EDT)

Title: Chief Legal Officer

Date: 06/06/2022