

ASO Minimum Necessary Functionality

Debugging Talking Points | May 12, 2020



CBH's goal for the Debugging Committee meeting will be to clearly articulate the **minimum necessary functionality that Optum needs to demonstrate** before the state considers full relaunch/end of estimated payments.

1. **No Payment Reductions Due to Eligibility or Authorization Denials on Backlogged Claims.** Due to the failure of Optum's systems, providers have been unable to submit eligibility and authorizations with any expectation of consistency or accuracy. Despite that fact, MDH urged providers to continue serving people in need, which they did. Therefore, the lack of proper eligibility and authorization determinations cannot be used during the reconciliation process to deny claims or to accrue to the amount providers owe against their estimated payments. How was this known issued factored into reconciliation?
2. **Core Functionality Needed for Claims Processing.** Optum systems continue to fail to meet basic claims payment standards that allow providers to quickly and accurately know which submitted claims have been successfully processed and which will need to be resubmitted. How will the following functions be tested and confirmed to be acceptable functional prior to launch:
 - a. **Immediate Front-Door Claims Batch Acknowledgement.** There must be a consistently working "front door" function that provides timely feedback (within hours or, at most, days) that a claims batch has been received and identifies those claims – including the reject reasons – that will fail to make it to processing. This isn't a claims adjudication – just an acknowledgement that the claim has been received and will be adjudicated.
 - b. **Claim Feedback with Sufficient Information to Appeal or Rework.** Providers must receive sufficient feedback on claims to allow them to make timely decisions with accurate information. This includes detailed, actionable deniable codes (as may appear on an 835).
 - c. **Timeliness Ties to Receipt of Adequate, Accurate Notice.** Timelines for claims resubmission must start only when providers have received adequate and accurate information to determine which claims have been denied and why. The resubmission clock cannot begin to tick without timely access to adequate information. If Optum's denial codes or remittance advice is neither accurate nor adequate, the clock does not start.
3. **Modification of Deadlines.** The meltdown of the system has placed the onus on providers to research and resubmit hundreds of thousands of claims, many dating back to the Beacon contract prior to Optum's installment as the ASO. There is simply no way for providers to shoulder that burden within such a short timeframe, particularly now as they also face the challenges brought on by COVID-19.
 - a. **Timely Filing Waiver (12 months).**
 - i. CBH members with various claims that weren't paid due to various state delays (ePrep delays; retroactive EBP eligibility; Beacon's failure to manual rework RCS claims; inability to rework and submit Beacon denials from November onward). CBH sent questions seeking a transition plan for such claims to Provider Council and the ASO transition email on 8/5/2019, 10/3/2019, 11/4/2019, and 12/2/2019. CBH also communicated about individual provider situations with the Department and Beacon throughout the fall. No substantive response was received to these communications.
 - ii. CBH requests that MDH seek a timely filing waiver for claims that were previously identified to MDH and Beacon in 2019 as needing reprocessing and which failed to be reprocessed.
 - b. **Appeal Clock on Optum's Payment of Beacon Claims.** Optum's payment of Beacon claims in January 2019 resulted in mis-directed payment, incomplete EOBs, and no system or process in

- place to rework claims and appeal payments. CBH requests that the clock for the January Beacon claims begins only when providers have received sufficient and complete notice from Optum to initiate action.
- c. **Extension of Deadlines.** The reconciliation process includes deadlines for claims resubmission (60-days) and payment appeals (90 days). Due to the volume of claims needing reworking and appeal due to Optum’s system failures, the timelines must be extended beyond 60/90 days (assuming Optum has first met the conditions in item #2 above).
 - d. **Impartial Appeals.** Given the scope of Optum’s systems failures and the many permutations that failure may take, we believe that access to a fair and impartial appeals process must be included in the reconciliation process.
4. **Invoke FMAP Penalty.** We understand and appreciate the State’s desire to collect all federal matching dollars that it is due for Medicaid services rendered by our providers. Given that it is Optum’s failure that has placed the FMAP in jeopardy, the onus must fall on Optum – as allowed per the ASO RFP – to reimburse the State for lost FMAP resulting from their failed systems.