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VIA E-MAIL

May 2, 2022

Maryland Department of Health
Ms. Linda Rittelmann, linda.rittelmann@maryland.gov
Ms. Rebecca Frechard, rebecca.frechard@maryland.gov
Mr. Steve Schuh, steve.schuh@maryland.gov
Mr. Spencer Gear, spencer.gear@maryland.gov

Optum Behavioral Health
Mr. Karl Steinkraus, karl.steinkraus@optum.com
Mr. Chad Burkholder, chad.burkholder@optum.com

Re: Retro-Eligibility and Recoupment

Dear Maryland Department of Health and Optum officials:

On behalf of our client, the Community Behavioral Health (CBH) Association of Maryland, and its 105 provider-members, we write to request written clarification from you as to the intended next steps in the recoupment process. As Optum attempts to recoup certain denied claims in the near future, our members would appreciate concrete answers from you relating to various areas of your planned approach, including well-defined notice, correction of erroneous claims reprocessing, and a clear claims history report, among other issues.

We would appreciate if you could respond to our questions set forth in this letter in writing within 14 business days from the date of this letter, so that communication between MDH, Optum and CBH (on behalf of its provider-members) is not misconstrued.

Our outstanding questions are detailed as follows.

1. State Negative Balance: Amount, Timing, and Process

Providers have reported that the amounts owed on their negative balances change weekly as Optum continues to correct and reprocess claims, and these changes are reflected in the monthly claims history reports that providers are now receiving. The changing amount owed raises questions about the adequacy of notice

that will allow providers to validate the math and make appropriate financial plans. Specifically:

- To reduce administrative burden and improve the transparency and accountability of Optum's recoupment, we urge MDH to begin recoupment only once Optum has completed correcting TPL and insurance-related denials and claim reprocessing. How can recoupment begin in May 2022, prior to Optum's completion of its work on correcting the TPL and other insurance-related claim denials? If May 20, 2022 is no longer the expected recoupment date (which would be understandable given the problems we've outlined here), please let us know.
- Providers received notice in December 2021 of the amount the state intended to recoup for the state negative balance. MDH has orally communicated that providers will only be responsible for repayment of this amount, even if their total state negative balance has since grown, but this has not been communicated in writing. Providers require written communication of their exact repayment responsibilities prior to May 20. Additionally, since, in many cases, the claims and dollars included in total state negative balances are now greater than the amount owed on May 20, how and when will providers receive claims itemization for the funds repaid to MDH on May 20?
- In a few instances, the state negative balance amount to be recouped has *decreased* since the December 2021 demand letters. How will providers receive notice of the current amount to be recouped? Again, MDH has orally communicated that, in these cases, providers will only be responsible for the decreased amount, but no written communication has been delivered confirming this policy. How and when will providers receive claims itemization for the funds repaid to MDH on May 20?
- The state negative balance lists claims to be recouped, even if the claim was not paid twice. It is our understanding, based on communications with CBH's members and Optum, that the negative balance tab lists a claim for recoupment if the claim was processed twice – once on the state account and once on the Medicaid account. In some instances, the claim's second processing on a different account resulted in a denial. This occurred systemically, for instance, on some claims impacted by the known TPL errors. Thus, the negative balance seeks to recoup claim payments as overpayments even when the claim was only paid once. Recoupment should be sought only on claims *paid* twice, *not claims processed twice where the second processing resulted in a denial and the provider received only a single payment.* Can you please address how MDH intends to handle recoupment of claims where the provider was only paid once?
- Providers have had limited success in using the claims history report to validate the accuracy of the proposed state negative balance recoupment. Each time Optum processes a claim, it assigns a new claim identification number, making it difficult to track the final status of a claim. Individual reprocessing

transactions of a claim – under a new identification number – may appear in multiple tabs of the report. This makes it difficult to track a single claim's status through the multiple phases of recoupment. Please advise in writing how providers should proceed in repaying funds to MDH on May 20 if providers cannot sufficiently track claim status through using a claims history report. Also, please advise if MDH is amenable to directing Optum to discontinue its practice of assigning a new identification number each time Optum processes its claim or, if MDH is not amenable, please explain why as Optum's practice makes it difficult for both providers *and MDH* to have access to verifiable and traceable claims data.

## 2. Notice of the Medicaid Negative Balance Amount, Timing and Process

In January 2022, CBH and providers learned that a Medicaid negative balance – distinct from the state negative balance – would be recouped at a future date. We respectfully request additional information about the notice, substance, and timing of this phase of recoupment, including:

- MDH has orally indicated that letters will be sent to providers impacted by each of the nine recoupment categories within Medicaid negative balances. How far in advance of the anticipated recoupment will providers receive notice that allows them to validate Optum's math and make appropriate financial plans?
- How and when will providers receive an itemization of the claims making up each category of the Medicaid negative balance? Claims on the Medicaid negative balance tab of the claims history report aren't identified by category, reducing providers' ability to validate the accuracy of Optum's planned recoupment. Additionally, providers who have received letters about a category recoupment report that detail about total funds to be recouped, claims itemization, and the start date for recoupment was not included in the letter. When and how will this be communicated to providers?
- How will MDH verify that Optum's global TPL reprocessing slated to be complete in June has captured the universe of TPL errors before recoupment begins?
- As with the state negative balance, the Medicaid negative balance lists claims to recouped, even if the claim was not paid twice. It is our understanding, based on communications with CBH members and Optum, that the negative balance tab lists a claim for recoupment if the claim was processed twice – once on the state account and once on the Medicaid account. In some instances, the claim's second processing on a different account resulted in a denial. This occurred systemically, for instance, on some claims impacted by the known TPL errors. Thus, the negative balance seeks to recoup claim payments as overpayments even when the claim was only paid once. Recoupment should be sought only on claims paid twice, not claims processed twice where the second processing resulted in a denial and the provider received only a single payment. Please

address how MDH intends to handle recoupment of claims where the provider was only paid once?

- As with the state negative balance, Optum's practice of assigning a new claim identification number each time it processes a claim makes it virtually impossible for providers to use the claims history report to validate the accuracy of the proposed Medicaid negative balance recoupment. Optum's practice is utterly outside the standard norm and makes it difficult to track a single claim's status through the multiple phases of recoupment. Please advise in writing how providers should proceed in repaying funds if providers cannot sufficiently track claim status through using a claims history report.

## 3. Optum's Errors in Re-Processing Claims

After Optum re-launched its claims processing system in August 2020, providers reported erroneous disposition of many claims. Since November 2020, Optum has worked with CBH and its members to identify systemic errors in claim dispositions and correct them. As a result, since November 2020, Optum has reprocessed denials associated with at least 14 of its 32 denial codes. However, correction of denied claims has been impeded for many reasons, including the fact that providers did not receive the full set of claim receipts (835s) until March 2022, Optum's corrections were often incomplete (resulting in providers having outstanding denials for eligibility errors, TPL errors, and other mistakes stemming from Optum's manual processing), and providers could not identify various causes for claims denials because Optum's 835s only consisted of a single denial code until summer 2021.

The major errors are summarized as follows:

a. As Optum made systemic corrections to denied claims, providers concurrently reported that Optum's corrections had not always captured the full universe of claims needing correction. Thus providers have outstanding denials for eligibility errors, TPL errors, Beacon data migration errors, cascaded PRP rates due to skipped encounters, and various errors stemming from Optum's manual processing. Providers are unable to correct the denied status of these claims on their end;
b. According to Optum, providers did not receive the full set of claim receipts (or 835s) until March 2022, preventing providers from timely identification of the full universe of claims impacted by faulty denials;
c. Optum's system was not set up to deliver claim receipts on PRP encounters until late 2020. Once this functionality was launched, Optum made the decision not to release historic claim receipts for PRP encounters, preventing providers from identifying missed encounters that led to denials of PRP encounters;
d. Until Summer 2021, Optum's 835s only contained a single denial code for a claim. If a claim denied for multiple reasons, the additional reasons were masked to the provider. While Optum could see all the denial reasons, 835s were delivered to providers with only a single denial code, raising an absolute

bar to providers' ability to from identify the full universe of claims impacted by denial code corrections. Additionally, until Fall 2021, CO45 (payment adjustment) codes were displaying in error on many 835s masking all correct denial codes for claims, further complicating providers' ability to identify causes for claims denials and flag erroneous denials; and

e. Various errors resulting from authorization processing malfunctions have caused authorization-related denials which cannot be corrected by the provider.

As these reasons (and others) illustrate, the provider alone is unable to identify and correct many remaining denials. Ensuring the accurate identification and disposition of claims in a denial status requires the cooperation of the provider and Optum. Unfortunately, CBH members have reported limited progress and cooperation from Optum's reconciliation managers in identifying and reversing claims that are erroneously in a denial status. With over $81 million in denied claims from the estimated payment period, our members report denial rates for this period that are orders of magnitude larger than their historic performance. Thus, CBH seeks answers to the following outstanding questions:

- CBH is concerned that the state may be past the deadline for claiming federal match funds on claims in the estimated payment period, and that the ASO contract makes Optum potentially liable for any lost federal match. While this may be perceived as solely a contract compliance issue between the state and Optum, we are concerned that Optum's lack of progress in correcting claim denials may be an attempt to limit its liability at the expense of CBH's provider members. How is MDH overseeing Optum's continued progress in correcting denied claims in concert with providers and ensuring that Optum's claim denials are not an attempt to limit its liability?
- At what point will Optum's disposition of a claim be treated as final, triggering the timeframe for formally appealing the claim denials? Can you, in writing, identify the framework for appealing Optum's erroneous disposition of claims? To the extent that providers have submitted claims to Optum for correction and not received a substantive response, will providers need to appeal the disposition of these claims formally as well?

## 4. Estimated Payment Balance

CBH sought the claims history report at its members' request to assist providers in understanding and validating the accuracy of Optum's recoupment demands. This task is complex, requiring the matching of claims data from provider EMRs, payment data from PaySpan, and the claims history report. The complexity of this task increases because Optum's system assigns a new claim number to every

claim reprocessing, and many claims during the estimated payment period are being recouped through separate processes.

To secure our members' goals of being able to validate the match for recoupment, CBH asks MDH to validate that the following exclusions and limitations – including starting and end dates – have been applied correctly to a data analysis that will allow providers to validate Optum's math for the estimated payment recoupment period. CBH's validation is attached to this letter as Exhibit 1.

CBH is aware that MDH and Optum have worked proactively to address many of its members' concerns relating to the recoupment process, but CBH believes clear communication on these remaining points is key, especially as we move closer to the date when recoupment of the state negative balance will begin. Thus, CBH reiterates its request to receive responses to these issues in writing, so that it can continue to work collaboratively, with no surprises and meaningful notice, as this process commences.

We have included our email addresses below to facilitate making timely contact and so that you may send us your written responses.

Sincerely,

FELDESMAN TUCKER LEIFER FIDELL LLP

*/s/ Kathy S. Ghiladi*
Kathy S. Ghiladi (kGhiladi@FTLF.com)
Mindy B. Pava (mPava@FTLF.com)

*Counsel for Community Behavioral Health Association of Maryland*

Enclosure: Exhibit 1

EXHIBIT 1

Exclusions/Limitations Principles for Validation Efforts

a. *Estimated Payments Received.* Provider verifies that the amount of estimated payments received matches the amount on the claims history report.
b. *Claims Revenue with Estimated Payments DOS, Adjusted.* Provider extracts from their EMR a list of claims submitted to Optum with dates of services between January 1, 2020, and August 3, 2020; the dollar value of these claims is totaled. This claims data is matched to the claims history report as follows:
    i. *SORT claims history report to identify only final disposition of claims with dates of service (DOS) January 1 – August 3, 2020, and total dollar value;*
    ii. *SUBTRACT claims with DOS January 1 – August 3, 2020, that were paid with live checks in Aug-Oct (match claims history report to PaySpan data);*
    iii. *SUBTRACT claims with DOS January 1 – August 3, 2020, that are listed in the state negative balance tab;*
    iv. *SUBTRACT claims with DOS January 1 – August 3, 2020, that are listed in the Medicaid negative balance tab;*
    v. *SUBTRACT claims with DOS January 1 – August 3, 2020, that are in a denied status waiting on TPL/COB corrections by Optum (???);*
    vi. *SUBTRACT claims with DOS in 2019 or earlier (???);*
    vii. *SUBTRACT claims with DOS January 1 – August 3, 2020, that were reported to reconciliation manager for Optum correction & remaining in denied status (disputed claims);*
    viii. *SUBTRACT claims with DOS January 1 – August 3, 2020, that were submitted by provider with no payer response (missing claims)*
    ix. *SUBTRACT claims with DOS January 1 – August 3, 2020, that were submitted by provider with no payer response (misdirected claims)*
c. *NET (a) estimated payments received with (b) applied claim revenue to offset. Figure should match Optum's figure if there are not disputed, missing, or misdirected claims.*