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VIA E-MAIL

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Maryland Department of Health
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Re: Retro-Eligibility and Recoupment: Concerns with Optum's Pilot Claims History Report

Dear Maryland Department of Health and Optum officials:

On behalf of our client, the Community Behavioral Health (CBH) Association of Maryland, we write to you to detail our concerns relating to the insufficient claims data provided in Optum's pilot claims history report and how this information will impact providers' repayment obligations.

During our December 7, 2021 meeting with you, we discussed Optum's plan to provide more details to providers who had questions about their estimated overpayment totals. We were informed that providers identified by Optum to "test" the claims history reports would receive these reports from Optum on December 20, 2021. If the information provided in the reports helped providers understand the calculations of their repayment obligations, the same methodology would then be rolled out in January to additional providers who request a full claims history report. As a reminder, CBH remitted the following feedback verbally to Optum and MDH during the initial report review on November 15, 2021 and again in writing on December 7, 2021. These details are essential to ensuring a more robust claims history report:

1. A full claims history for all claims processed or reprocessed by Optum *that links each/every reprocessing to the original claim* and includes:
    a. Accurate dates of *each/every* reprocessing

   b. Accurate check numbers associated with *every* reprocessing of a claim
   c. Accurate check dates associated with *every* reprocessing of a claim;
2. Identification of any and all individual claims applied to a negative balance and tracked to the total balance. This must include the status of the applied claim (withheld and in process vs. paid and to be retracted)
3. Identification of any and all claims applied to estimated payment balance tracked to the balance remaining
4. Identification of all denials for DOS under estimated payments updated and accessible to providers on a weekly basis

The CBH members who were selected to "test" the report have now analyzed the information provided by Optum in the pilot reports. While we are pleased that providers can view the list of claims that Optum is using to offset their alleged estimated payment balance and that the reports have facilitated the providers' ability to see their alleged negative balance totals and estimated payment balance totals in the aggregate, significant issues in the pilot reports must be rectified before the same system is used for the majority of providers.

We hope that MDH and Optum can work to address the following list of items from the pilot report before this system is unveiled globally to all providers:

- Providers still have not been given a full claims history for all claims processed by Optum that links each and every reprocessing to the original claim[1];

- Although providers have received alleged negative balance totals, those totals have failed to include any claims detail whatsoever; thus there has been no reconciliation of overlap between negative balance and estimated payment balance;

[1] This full claims history is critical due to Optum's practice of assigning a new claims number to a single claim each time a claim is reprocessed, contrary to both sound practice and its contractual requirements. If Optum were to discontinue this practice at least prospectively it would go a long way to obviating future claims reconciliation challenges.

- Although providers have received a list of all denials occurring under the estimated payments category, this extensive list of denials is not actionable, as it does not exclude corrected denials. Providers are thus unable to effectively parse out their outstanding denials to allow them to continue to negotiate their outstanding claims with their reconciliation manager. Moreover, denial codes are not standardized and are only Incedo-based, which poses additional barriers to being able to consistently work through claims;

- Providers have not been given the breakdown and exchanges between Medicaid and State funding sources, for reconciliation of estimated payment checks; and

- Testing providers have identified numerous inaccuracies in the report, including claims that should have been used to offset estimated payment balances but were not, as well as errors in Optum's own data, including discrepancies between the check summary and the corresponding claims detail in other tabs.

We appreciate Optum's work in developing these pilot reports, but the end result of the product, as it stands now, is disappointing in that it fails to accomplish the intended purpose of giving providers sufficient information to verify the basis for the negative balances asserted by MDH[2] and to work outstanding denials during the estimated payment period. We are eager to discuss whether fixes to these concerns are feasible, and we know that Optum plans to meet with pilot program providers this week to receive feedback. As part of that ongoing process, we wanted to express our view that (i) the pilot reports (as they currently stand) contain critical errors and (ii) there appears to be no sufficient way to track what was paid, in the instances where providers

[2] We are also concerned that the survey attached to the negative balance demand letters that has been recently issued requires providers to certify that they agree with the outstanding balance amount they have received simply in order to request a full claims history report. While this allows providers who agree with the amount to also request a full claims history report , it does not allow providers to go on record as disputing (or even as asking questions relating to) the negative balance amount first. As you know, a certification denotes serious consequences and implications and to require providers to certify as to their agreement with the outstanding amount when they historically have not been receiving reliable claims information also raises significant due process concerns. MDH has admitted to long-standing defects in the claims reconciliation process, and it is illogical and virtually coercive to require provider certification when so many questions remain unaddressed.

assert discrepancies between the negative balance demand letters from MDH and their own records.

These inaccuracies lead us to conclude that the amounts listed in the negative balance demand letters likely are incorrect in many instances, and that MDH and Optum have no precise means of providing a thorough accounting to providers who seek more information. Given these real concerns, and as a matter of due process for providers, we ask that you pause the payment recoupment process until these issues are more sufficiently addressed. As the Medicaid single state agency, we believe the MDH should have the same interest as CBH's membership in making sure its recoupment efforts are supportable and accurate.

Sincerely,

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