Maryland
DEPARTMENT OF HEALTH

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

October 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
2021 Joint Chairmen's Report (p. 90-91) Report on BHASO Reconciliation Process

Dear Chairs Guzzone and McIntosh:

Pursuant to the 2021 Joint Chairmen's Report (p. 101-102), and the 2021 Joint Chairmen's Report (p. 90-91) Report on BHASO Reconciliation Process, the Maryland Department of Health respectfully submits the attached report.

Specifically, the committees requested the following for ASO functionality:

> *"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."*

The committees also requested that we address steps made by MDH during the reconciliation process, including:

1. *Affirming that MDH and the BHASO have provided behavioral health providers with a comprehensive claims history in an up loadable 835 format. These reports to providers shall comply with Health Insurance Portability and Accountability Act (HIPAA) standards and include HIPAA-standardized denial codes. The 835 reports shall also include the original submission date of each claim, as well as reprocessing and denials.*

The claims history report shall also include corresponding check number and accurate check date for the full or partial amount paid on the claim;

2. *Providing detail on a neutral, independent third-party reconciliation mediator used during the process. This reconciliation mediator shall be selected in consultation with behavioral health providers and shall provide oversight and mediation in disputes of the reconciliation amounts between MDH and individual providers; and*

3. *Outlining contract management steps employed by MDH in response to challenges with the ASO. This shall include any liquidated damages and other fees and fines against the current BHASO under the ASO contract, including the totality of damages, fees, and fines that could be levied against BHASO as outlined under the contract as well as the total amount that has actually been imposed by the department, and, if applicable, why MDH did not impose the maximum amount."*

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
Webster Ye, Assistant Secretary, Health Policy
Heather Shek, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

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Introduction

On January 1, 2020, the Maryland Department of Health (MDH) transitioned to United Health Group/Optum Maryland (UHG/Optum) for its Behavioral Health Administrative Services Organization (BHASO). At its initial launch, the UHG/Optum system had technical and system failures that impacted behavioral health providers. As a result, MDH directed UHG/Optum to make weekly estimated payments to behavioral health providers beginning on January 23, 2020 and continuing through August 3, 2020. During the estimated payment period, UHG/Optum made weekly estimated payments to providers of approximately $35 million, for a total of $1.06 billion.

Despite those initial difficulties, UHG/Optum has received nearly 17 million claims between January 2020 through August 2021 and successfully paid nearly $2.9 billion associated with those claims to over 2,600 providers who participate in the Public Behavioral Health System.

While acknowledging deficiencies at the commencement of the contract, UHG/Optum has made significant progress to correct issues and began real-time processing of claims in July 2020. UHG/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, UHG/Optum has maintained a weekly average of $30 to $40 million in payments to providers.

MDH and UHG/Optum continue to engage with providers to address system issues and functionality. As a starting point, a fully functional BHASO can be summarized as a 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.

MDH and UHG/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 report, 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 UHG/Optum as Maryland's BHASO, MDH organized a series of meetings with key providers and provider associations to submit direct input to UHG/Optum regarding user experience and administrative issues. Since their inception, these meetings have become the core of the Operations Improvement Committee in which MDH, UHG/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 UHG/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 UHG/Optum provide routine updates to over 200 attendees each session.

System Functionality Report Discussion

Through the Operations Improvement Committee meetings, MDH and UHG/Optum have engaged the providers and provider associations on issues of system functionality, efficiency, and efficacy. UHG/Optum has 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, several providers noted a lack of reports needed to resolve claims in their accounting systems. These are known as 835 Health Care Claim Payment transactions 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 UHG/Optum and the provider, UHG/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.

UHG/Optum shares regular updates with the Operations Improvement Committee members for discussion in the twice monthly meetings. During the meetings, UHG/Optum walks through a presentation to obtain clarification on specific issues and whether UHG/Optum has addressed it accurately, efficiently, and transparently. The meeting also includes a product roadmap which has been integrated into UHG/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 these ongoing discussions, the providers have requested more clarity on the status of raised concerns. Rather than a yes or no response to the issue, the providers requested a more concise measure of progress and/or agreed upon metrics that would reflect the performance on that issue. As a result, Attachment A incorporates 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.

Reconciliation Process

As discussed in the introduction, due to the inability of UHG/Optum to pay claims when the system launched on January 1, 2020, MDH instituted estimated payments for providers based on their calendar year 2019 average weekly claims. Providers were informed at the time that the estimated payments would have to be reconciled against processed claims after the system went live. For the estimated payment period, UHG/Optum received $1.6 billion worth of claims that have since been processed against the estimated payment total. In October 2020, UHG/Optum instituted a dual checkwrite cycle, in which claims for dates of service during the estimated payment period are used to "offset" a provider's estimated payment balance, while claims for dates of service after the estimated payment period are processed normally. Providers generally have a year to submit claims from the date of service, and a service rendered in June 2020, during the estimated payment period, may be submitted in January 2021. In this example, the payment for that claim would be used to "offset" the provider's outstanding estimated payment

balance. The "offset" would also apply if there was reprocessing of a June 2020 claim in October 2020 as part of a retroactive rate increase or special project.

Payments made prior to the establishment of the dual checkwrite for claims were not applied to the outstanding balance as providers would essentially receive double "payment" for the same claim. With that in mind, the outstanding balance in October 2020 was approximately $359,610,797 across both Medicaid and State Only programs. That balance is currently down to $240,875,346.04 as of September 2, 2021. Figure 1 below shows the Estimated Payment Balance reduction over time, with Medicaid accounting for $206,389,720.66 of the current outstanding balance, and State Only programs accounting for the rest.

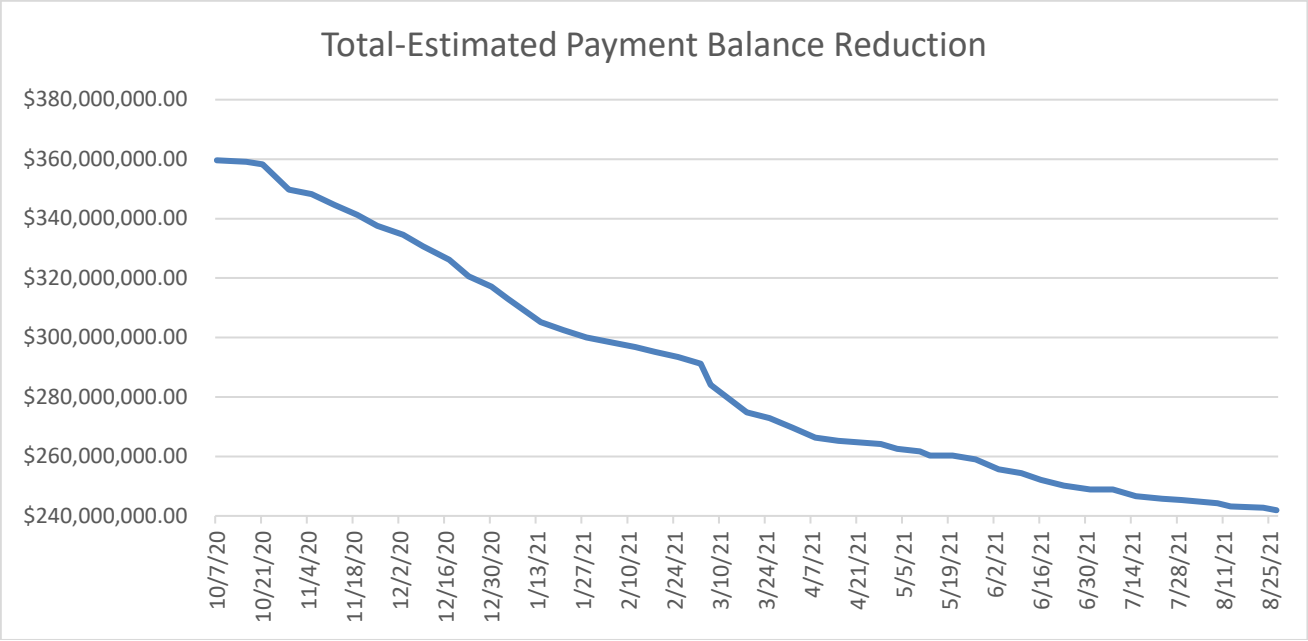

Figure 1: Estimated payment balance over time

The distribution of outstanding balances is highly concentrated among a few providers. Forty-four (44) providers account for approximately $83 million of the outstanding balance. These providers are typically large entities, such as hospitals, large community substance use disorder providers, and large community health providers. UHG/Optum has focused their reconciliation efforts on these larger providers and is engaged with 100% of the providers who have an outstanding balance of more than $1 million. Of the 2,149 providers who have outstanding balances, 907 have balances below $10,000. These smaller balances are generally held by individual practitioners, such as licensed social workers and professional drug counselors. Additional information regarding the distribution of the outstanding balances and providers is in Table 1 below.

Table 1: Distribution of Provider Outstanding Payments as of September 9, 2021

Provider Outstanding Balance	Provider Count	Total Outstanding
Providers Owing < $10K	907	$3,530,634,34
Providers Owing $10K < $50K	609	$14,380,896.44
Providers Owing $50K < $100K	173	$12,316,019.86
Providers Owing $100K < $500K	351	$81,156,975.60
Providers Owing $500K < $1M	65	$44,756,621.18
Providers Owing $1M < $4M	40	$70,292,041.34
Providers Owing Over $4M	4	$13,443,631.04
Totals	2,149	$240,875,346.04

Providers currently have the option of reconciling their balances either by remitting all or part of the amount of the outstanding balance or by submitting claims with dates of service during the estimated payment period. In addition to automatically applying those claims to the outstanding balance as processed, UHG/Optum has conducted significant outreach to providers with outstanding balances, with a focus on those providers who have an outstanding balance of $1 million or more. 100% of providers owing $1 million or more are currently engaged in the reconciliation process.

However, the level of engagement declines as the outstanding balance becomes lower, with only 42% of providers with an outstanding balance of $10,000 or less engaging with UHG/Optum on reconciliation. The drop-off in engagement is not unexpected, as the providers with lower outstanding balances either already submitted claims for the relevant period, have a low volume of or intermittent claims, or view the value of their claims to be less than the administrative cost to recover.

Of the total 2,149 providers, 363 of them have not submitted any claims to offset the estimated payments received (i.e., “No-Offset Providers”) during the initial period of January–August 2020. These are detailed in Table 2.

Table 2: Distribution of No-Offset Providers as of September 2, 2021

Provider Outstanding Balance	Provider Count	Total Outstanding
Providers Owing < $10K	229	$679,505.05
Providers Owing $10K < $50K	101	$2,355,714.42
Providers Owing $50K < $100K	14	$1,006,148.89
Providers Owing $100K < $500K	17	$3,359,307.71
Providers Owing $500K < $1M	1	$869,633.00
Providers Owing $1M < $5M	1	$1,599,542.33
Totals	363	$9,869,851.40

Of these 363 No-Offset Providers, 240 of them have NOT been engaged, and of these non-engaged providers, 86 have balances over $10,000 for a total outstanding balance of $4,471,402 for the period of January 1, 2020–August 3, 2020. It is likely that these provider accounts will have to be worked through individually and pursued through collections.

UHG/Optum (via their vendor Incedo / InfoMC) has been unable from the outset to generate a "clean" 835 for many providers, and at one point had to re-issue missing 835's for hundreds of providers, further compounding the issues. Until this issue is resolved, most providers do not yet have the information they need to perform basic reconciliation and to verify the overpayment amounts being requested. As a result, many payers will be unlikely to settle their balances willingly.

UHG/Optum had targeted 9/01/21 as the date that 835's would be in production. This date was not met, and currently the targeted production date is now 10/24/21. Once the providers have 30 days to review and reconcile their records, this will trigger official notification of negative balance letters to be sent to providers requesting payments.

Reconciliation Actions

Recognizing that reconciling estimated payments against claims was too much for providers to handle all at once, MDH and UHG/Optum established the Assisted Reconciliation process to reduce the effort on providers and to offer them additional support. Previous efforts consolidated all claims into a single document that was not easily digestible in an electronic format. The Assisted Reconciliation process divided the effort into six separate reports. UHG/Optum also

provided an additional report, requested by providers, regarding rejected claims that were not able to be processed. The reports were uploaded to the provider's Downloads folder in the Incedo Provider Portal so that providers could download, and review as needed.

Phase 1 of the Assisted Reconciliation process was focused on ensuring that providers' claims were in the system, as well as the Rejection Report. UHG/Optum instructed providers to review the report for the relevant period for any missing claims, regardless of the claim status and/or timely filing deadlines to ensure that UHG/Optum had their claims. Missing claims can still be submitted and will be processed against the outstanding estimated payment balance through the dual checkwrite cycle "offset".

Phase 2 of the Assisted Reconciliation process shifted the focus to resubmission and correction of claims that were denied with a date of service during the estimated payment. Phase 2 is still underway, and there are an estimated $17 million of outstanding claims that can still be processed for correction and payment.

In addition to making the electronic reports more manageable by reducing the scope of each report, UHG/Optum added specific reconciliation resources to assist providers by hiring Reconciliation Managers. The Reconciliation Managers serve as the central points of contact for providers regarding estimated payment balances and reconciliation. Providers can send their questions to maryland.provpymt@UHG/UHG/Optum.com or request a Reconciliation Manager through that email address. This is in addition to the normal route of contacting customer service or UHG/Optum Provider Relations. The Reconciliation Manager then establishes contact with the provider to better understand their questions and to schedule a follow up meeting with the appropriate UHG/Optum resources to resolve the issue. The Reconciliation Team consists of 60 providers per Reconciliation Manager and receives an average of 400 to 450 emails a week which includes those issues that are resolved via email.

Although all the Assisted Reconciliation Reports are currently available to providers, UHG/Optum and MDH are continuing the Assisted Reconciliation process to allow providers time to review the denied claims and submit any follow up information. As such, MDH provided for certain flexibility to continue during the Assisted Reconciliation process. The first is that timely filing for claims with dates of service within the Estimated Payment period is waived so that providers receive credit for those claims. Second, MDH continues to waive the reconsideration and appeal timelines that would normally apply to claims, recognizing that the estimated payments period created significant information challenges for providers.

Recoupment Plans and Process

The reconciliation process through the BHASO is time consuming for everyone involved. To provide equity where the reconciliation process may be onerous for providers, MDH will be exempting *de minimis* outstanding balances from the reconciliation process.

After carefully evaluating a variety of options developed, the recommended option allows eligible providers to participate in the process and provides some level of relief. The providers impacted and the cost to MDH can be calculated using the data currently available.

As a result, MDH plans to forgive a *de minimis* amount of $10,000 from providers who owe <$10,000 with the exception of:

1. Hospitals
2. Laboratories
3. Out of State Providers
4. Somatic Non-BH Providers

Although an exact figure will not be available until the recoupment process begins, it is estimated that based on current outstanding balances and amounts already paid, this will cost on the order of $3.5 million, and that more than 42% of all providers who currently have an outstanding balance (>900) will have their balances cleared.

For providers with outstanding or fully paid balances of between $10,001 and $50,000, we will engage the provider community and will evaluate providing additional relief.

Reconciliation Mediator

To meet the third-party mediator requirement, MDH has engaged the Office of Administrative Hearings (OAH) to provide third-party mediation for the reconciliation process. Engaging any other third-party mediator would have required a lengthy state procurement process and added months of delays to the reconciliation efforts. Providers will be required to work with an UHG/Optum Reconciliation Manager to resolve any disputed claims and/or denials prior to engaging with OAH.

Contract Management Steps

Based on our current experience and issues endured under the current contract with UHG/Optum, to correct deficiencies in the current contract to meet responsible fiscal and IT development timelines, and to ensure compliance with all state procurement requirements in a timely fashion, MDH initiated a new Request for Proposal process in July, with the goal to have a new contract signed no later than 12/31/23, to allow for an entire year of development and implementation. The key finding from the failure of the current system, was the lack of time required to design, develop, and implement the UHG/Optum system thoroughly. MDH will use the lessons learned from the current contract, input from the behavioral health community, and the need to include an evaluation of past performance in similar contracts, to construct a robust RFP and procurement process that results in a superior product than we currently have.

In addition to the new RFP, MDH has four main authorities within the BHASO contract for damages/breach: service-level agreements, liquidated damages, withholds, and termination.

Service-level agreements are contract terms that require UHG/Optum to meet certain requirements, such as customer-service response times, system availability, staffing, and claims processing. Failing to meet service-level agreements allows MDH to withhold a percentage of the total invoice based on the number of service level agreements not met. Since the contract started, MDH has withheld a total of 4% from UHG/Optum invoices for failing to meet 11 of the

12 service levels. The only service level agreement determined to be met at this time is the requisite number of staffing. A total of $907,401.28 has been withheld under this authority.

Liquidated damages are additional authorities to withhold and keep funds and are available only for specific reasons. The four reasons allowed in the contract are:

- Minority Business Enterprise (MBE) requirements,
- late delivery of a Root Cause Analysis or Corrective Action Plan,
- downtime occurrences, and
- failure to deliver a working system.

As UHG/Optum has maintained their MBE requirements, MBE damages are not applicable. Late delivery of a Root Cause Analysis and Corrective Action Plans allow for liquidated damages of $200 to $500 per day for failure to deliver the associated analysis or plan. However, these damages are not available if a Root Cause Analysis or Corrective Action Plan is delivered. UHG/Optum has in fact delivered Corrective Action Plans. Accordingly, no liquidated damages under this section have been exercised. Downtime occurrences are available if the system experiences an outage and is not available under certain conditions and allows for $1,000 per occurrence with a $4,000 per day maximum. Although there has been only a very small number (fewer than five) of downtime occurrences, to date, MDH has not assessed the liquidated damages under this section. The final form of liquidated damages is for failure to deliver a working system; damages of up to $25,000 per day may be assessed under this section. While the January 1, 2020, delivery did not go well, MDH determined that there had not been enough implementation time and permitted estimated payments for providers while the system configuration continued. As UHG/Optum did deliver a system that paid claims starting in August 2020, the decision was made to focus on UHG/Optum deploying additional resources rather than assessing damages that would not provide a direct benefit to providers.

State contracts also have two other penalty measures within their basic structure that are also in the BHASO contract: withholding of payments and termination of the contract. Payment of an invoice can be withheld if the vendor fails to provide a required deliverable, typically associated with the invoice itself. MDH reserves the right to withhold payment of an invoice, but once the requested deliverable is provided, UHG/Optum BH would receive payment for that invoice. MDH has withheld one half of the implementation amount, retaining approximately $4 million for UHG/Optum's failure to deliver on critical claims adjudication tools, including the 835 forms as referenced above, and other necessary configurations to support BHASO operation of the Public Behavioral Health System.

The final contract management measure would be termination of the contract with UHG/Optum. MDH, as required by the State Finance and Procurement Articles, reserves the right to terminate a contract for convenience. However, MDH would still be required to make payments to the vendor associated with costs incurred due to the terminated contract. Furthermore, MDH would have to make alternate arrangements to continue the services the current vendor provides. Terminating the contract with UHG/Optum would also require an emergency contract with an unidentified vendor, subject providers and participants to another difficult transition, and potentially create lengthy litigation that may not provide relief to the providers impacting their service delivery.

Conclusion

MDH and UHG/Optum remain focused on ensuring that the BHASO system is improved so that behavioral health providers can successfully continue their participation in the Public Behavioral Health System serving the behavioral health needs of vulnerable Marylanders. Reconciliation of estimated payments is a critical part of this effort so that providers can close their books accurately, Maryland receives its share of federal match for appropriate claims, and claims data is as complete as possible. Such data is essential to enabling Maryland to capture the impact of COVID-19 through data and to perform accurate budget analysis that can be used to plan for future needs in the Public Behavioral Health System. MDH and UHG/Optum recognize that, despite the amount of effort on all sides, there is still more work to be done before reconciliation is complete and all funds owed can be recouped. MDH and UHG/Optum will continue to work with all stakeholders and will provide updates on the process as issues are resolved.

Next Steps

MDH continues to make sure that UHG/Optum and MDH understand and meet the needs presented by providers. This report will focus on actionable improvements to BHASO operations, as well as steps taken and progress made to resolve all outstanding balances owed to, and from, providers. UHG/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.

Attachment A: System Functionality

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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 response	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. *There have been no requests for further training on this topic since the last report*
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;	b) See Optum response	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) Progress in first reporting period:* Optum is now sharing performance on contractual requirements with Providers on a monthly basis. Refer to claim performance metric report next slide
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;	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) Steps to reach functionality:* refer to 835 Issue resolution slide in this report

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835 Issue Resolution Summary – New for this reporting period

Item	Item Description	Action Plan
Negative Balance	Inability to see negative balance transaction on the PRA Pilot with a few providers	1. The change in the 835 to show negative transactions was delivered in the Incedo 6.6 Release on 8/28 with functionality turned off 2. Testing with pilot providers to begin week of 9/13 3. As transactions occur the 835 will reflect the negative balance
Review of CARC Codes	Expired CARC Codes and provide replacement codes	1. Testing and validation complete 2. Provider communication in final stages of review 3. Production delivery dependent on final communication approval (in progress)
CARC vs. Incedo Reason Codes	To correctly identify CARC vs. Incedo codes on 835 and PRA	1. Testing and validation complete 2. Provider communication in final stages of review 3. Production delivery dependent on final communication approval (in progress)
Missing 835	To ensure providers receive denials on 835 and PRA to be able to reconcile their A/R	1. Root cause analysis completed 2. Quality audit underway 3. Regeneration of missing 835s to parallel completed audit segments. Targeted completion is end of September
CAS Reason code for Reversals	Reversal claim lines do not provide the reason codes.	1. Updates to correct this issue will be placed in production along with Negative Balance changes.
RSA Information on PRA (impacting minimal# of providers)	A column for RSA information will be added to the PRA	1. Production delivery of this PRA , 9/6/21 2. Provider alert posted

Performance: Claims Insights for Providers – Month of August

New for Second Quarterly Report

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

As of 9.7.21

Month	Week ending date	Claim Lines	First Pass	First Pass Rate	First Pass < 14 day %	Adjusted
May-2021	05/09/2021	420,257	356,891	84.9%	99.98%	43,823
May-2021	05/16/2021	365,007	303,130	83.0%	99.94%	40,204
May-2021	05/23/2021	338,478	278,161	82.2%	99.97%	46,798
May-2021	05/30/2021	346,776	292,912	84.5%	99.50%	37,856
May 2021 total		**1,470,518**	**1,231,094**	**83.7%**	**99.85%**	**168,681**
Jun-2021	06/06/2021	372,995	290,392	77.9%	99.44%	54,542
Jun-2021	06/13/2021	395,053	328,917	83.3%	98.97%	45,878
Jun-2021	06/20/2021	334,636	270,907	81.0%	99.49%	36,948
Jun-2021	06/27/2021	307,441	250,667	81.5%	99.89%	40,454
Jun-2021	07/04/2021	376,985	311,012	82.5%	99.91%	46,379
Jun 2021 total		**1,787,110**	**1,451,895**	**81.2%**	**99.52%**	**224,201**
Jul-2021	07/11/2021	385,216	320,397	83.2%	99.85%	38,560
Jul-2021	07/18/2021	349,137	280,825	80.4%	99.93%	49,824
Jul-2021	07/25/2021	325,899	256,543	78.7%	99.96%	42,646
Jul-2021	08/01/2021	351,037	290,238	82.7%	99.96%	42,669
Jul 2021 total		**1,411,289**	**1,148,003**	**81.3%**	**99.92%**	**173,699**
Aug-2021	08/08/2021	395,639	325,927	82.4%	99.98%	43,884
Aug-2021	08/15/2021	430,944	353,078	81.9%	99.81%	53,968
Aug-2021	08/22/2021	347,717	290,300	83.5%	99.96%	42,778
Aug-2021	08/29/2021	324,909	262,518	80.8%	99.93%	44,267
Aug 2021 total		**1,499,209**	**1,231,823**	**82.2%**	**99.91%**	**184,897**

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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) no	d) Optum Maryland is working to operationalize the interest payment requirement in accordance with MIA requirements	d) Interest payment is not currently a system functionality built into Incedo. *Progress in first reporting period :* Optum is in the process of defining requirements for system functionality.
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. One outstanding modification to correct the HC code is in development.	*a)* *Progress in first reporting period* : On 7/10/21 the correction to the HC code was delivered into production. In addition, Optum has begun sharing performance with providers on generation of 999 reports for all claim batches. See next slide for report.
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)* *Steps to reach functionality:* complete reject messaging & reporting for specific (missing member/ provider NPI errors. To be completed in next reporting period
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. Deliver missing 835 CAS segment into production	c) *Progress in first reporting period : on* 8/16/21 the missing CAS segment was added to the 835 transaction and delivered into production. Please refer to 835 improvement table in this report for summary on efforts to improve the 835

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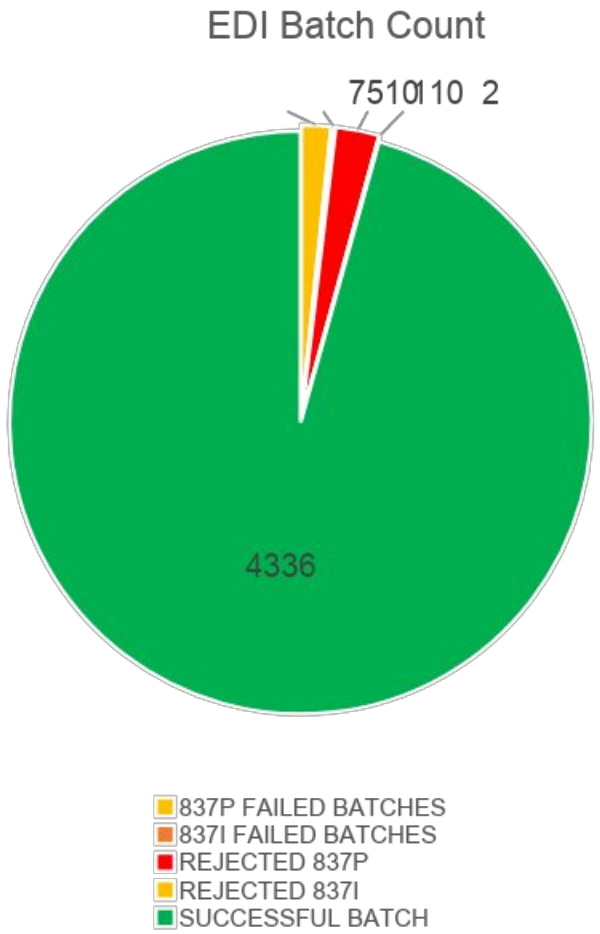
Standard 1B: Claims Processing – Transaction reconciliation

EDI KPI 8/1/21 thru 9/1/21

EDI 837 BATCH CATEGORIES	Count	%
837P FAILED BATCHES	75	
837I FAILED BATCHES	10	1.9
REJECTED 837P	110	
REJECTED 837I	2	2
SUCCESSFUL BATCH	4336	96
TOTAL	**4533**	
number of claims **772303**		



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

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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 cross walked to each Incedo denial reason. However, Optum has *not* supplied providers with a Denial reason cross walk as it is pending approval for publication.	d. *Progress in first reporting period :* To help with the distinction between industry standard CARC codes and Incedo codes, a two-letter indicator was added to the CARC codes so they can be identified. *Steps to reach functionality:* Obtain approval to publish Incedo to CARC code crosswalk with denial explanation. Targeting publication by 9/30
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). Today they multiple denial reasons are viewable in claim status.	e. *Progress in first reporting period:* Optum has been supplying multiple denial reasons for a claim denial and provides the Incedo denial description as well as the CARC code description on the 835 and PRA. On 9/12 Optum added a CO Prefix to the Incedo denial to further distinguish it from the industry standard CARC code.

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. No further action
iii. Secondary payer processing errors	iii. See Optum response	iii. Item 1: Optum acknowledges the secondary processing errors for Supported Employment and PRP claims, as well as secondary payer processing errors related to TPL file processing (item 2)	iii. Item 1: No further action. Item 2: *Progress in first reporting period.* As of 8/28 Optum is only loading one TPL file, so there is no longer a mismatch between primary coverage in MMIS/Incedo.
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. *Progress in first reporting period . In July and August,* Optum has completed an analysis of old claims. Minimal denials found that were associated with terminated sites A ticket was entered to correct these. Steps for functionality: complete ticket to correct denials
v. Duplicate client records	v. See actions	v. All activities related to merging Beacon eligibility records has been completed.	v. *Progress in first reporting period:* All Denied claims that were caused as a result of duplication will be processed at the end of September.
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 reprocessed and we enhanced the duplicate logic to prevent this from happening in the future.	vi Optum will continue to monitor duplicate denial rates. *No update since last report*

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. *Progress in first reporting period:* Delivery of functionality did not occur as planned due to failure during testing. *Steps to reach functionality*: Deliver functionality in release targeted for 9/25/21
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.	viii. No action
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. *New update this reporting period:* • *Claim accuracy goal is 95%* • *for July Optum achieved 98.89% (approximately 4,700 claims audited)*

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. *Progress in first reporting period :* 7/31 delivered export functionality into production.
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 further 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	c item 1: System functionality has been requested to supply a census type view uninsured eligibility requests. *Progress in first reporting period none. Steps to reach functionality: In the next reporting period* Optum will ask for additional clarity on goals for this feature and this input will be used in the solution to reach this functionality c item 2: *Progress in first reporting period* : 7/31 Partial delivery of expanded claim search capability. 8/28 expanded claim search capability delivered. *Steps to reach functionality*: Providers have given Optum additional clarity on goals for this feature and this input will be used in the solution to reach this functionality

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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. *Progress in first reporting period.* 7/31 production delivery of feature to show most recent check number and check date on paid claims. *Steps to reach full functionality:* Providers have given Optum additional clarity on goals for this feature and this will be used in the solution to reach this functionality
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. *Step to reach functionality:* refer to 835 improvements slide in this report

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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. *Progress in first reporting period* . Optum is now sharing performance on this item to providers. Refer to next page
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) *Progress in first reporting period* . Optum is now reporting performance on this item to providers.
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) *Progress in first reporting period:* Optum is now reporting performance on this item to providers. *Step to reach functionality:* reviewing current processes to determine root cause for delays in notification and share this information with Providers.

Standard 1E: System outage reporting for

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

As of 9/12/21

Planned System Outage				
Scheduled Outage Date	Notification to Provider	Impacted Systems	Reason	GOAL: 48-hr TAT
9/11/2021	9/8/2021	Incedo Provider and Web Portal	System Maintenance	y
8/28/2021	8/27/2021	Incedo Provider and Web Portal	System Maintenance	N
8/14/2021	8/13/2021	Incedo Provider and Web Portal	System Maintenance	N
8/7/2021	8/6/2021	Incedo Provider and Web Portal	System Maintenance	N
7/30/2021	7/31/2021	Incedo Provider and Web Portal	System Maintenance	N
7/24/2021	7/25/2021	Payspan	System Maintenance	N
7/10/2021	7/9/2021	Incedo Provider and Web Portal	System Maintenance	N
6/25/2021	6/26/2021	Incedo Provider and Web Portal	System Maintenance	N
6/12/2021	6/10/2021	Incedo Provider and Web Portal	System Maintenance	N
6/5/2021	6/4/2021	Incedo Provider and Web Portal	System Maintenance	N
5/29/2021	5/26/2021	Incedo Provider and Web Portal	System Maintenance	Y

- Give notice via posting on Incedo Provider Dashboard, and via Provider Alerts
- Optum is currently reviewing Incedo release process, to ensure more consistency, timeliness and communication

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Standard 1E: System outage reporting

- Unplanned system outage reporting

As of 9/12/21

Title	Who was impacted	Problem Description	Date Identified	Resolution Dat	Resolution Notes
Error Message when entering authorizations	Providers and other users entering authorizations	504 gateway error when attempting to submit an authorization	3/5/2021	3/5/2021	After large loads and large processing, the statistics on an Incedo table needed to be reset, this occurred and the error messages were no longer returned.
Call Center Down	Anyone contacting the call center	internal telecom move from Protocall to Optum, resulted in 1-800# being unavailable to callers. Added a temporary line until fixed, alerted providers	3/4/2021	3/4/2021	Service Provider issue was corrected
Incedo Web and IPC down	Providers and Internal Optum Staff	Provider and Optum Staff received error when loggin in, could not continue	4/9/2021	4/9/2021	ran out of disc spaced/added more disc space
Payspan down	Providers and Optum Staff	could not access payspan	5/24/2021	5/25/2021	Hardware failure, Hardware replaced
No access to Incedo	Providers and Optum Staff	exception error logging in preventing access	6/9/2021	6/9/2021	Resource intenstive job that normally was complete by 8am did not, this was causing exception errors. More monitoring to take place to ensure job completes before business
CMS 1500 form Box 33	Providers	new NPI to Site Location check to ensure no mismatch and to prevent down stream claim denials. Information about the feature and new step needed for NPI/Site selection was not communicated in advance which caused Provider confusion during Incedo claim entry	8/30/2021		Leaving resolution open until posting of alert, however, instructions posted in Incedo dashboard for Provider visibility, Call Center/PR have information to instruct providers if needed

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. *Progress in first reporting period*– providers have visibility into Optum Performance on turn around times

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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 Mental Health, Inpatient Substance use disorder, Inpatient Detox and Residential Crisis Services
  - Routine is everything else that requires auth

*American Society of Addiction Medicine

Updated 9.13

TAT for All Authorizations

Auth Month	Category/Measure	MET % of Auths	NOT MET % of Auths
August	EMERGENT/60 MINUTES	100.00%	0.00%
	URGENT/24 HOURS	97.84%	2.16%
	ROUTINE/14 DAYS	97.76%	2.24%
		97.79%	**2.21%**
July	EMERGENT/60 MINUTES	100.00%	0.00%
	URGENT/24 HOURS	97.61%	2.39%
	ROUTINE/14 DAYS	98.91%	1.09%
		98.79%	**1.21%**
June	EMERGENT/60 MINUTES	100.00%	0.00%
	URGENT/24 HOURS	96.83%	3.17%
	ROUTINE/14 DAYS	99.27%	0.73%
		99.03%	**0.97%**

TAT for Clinically Reviewed Authorizations

Auth Month	Category/Measure	MET % of Auths	NOT MET % of Auths
August	EMERGENT/60 MINUTES	100.00%	0.00%
	URGENT/24 HOURS	99.12%	0.88%
	ROUTINE/14 DAYS	90.83%	9.17%
		93.54%	**6.46%**
July	EMERGENT/60 MINUTES	100.00%	0.00%
	URGENT/24 HOURS	99.04%	0.96%
	ROUTINE/14 DAYS	95.82%	4.18%
		96.93%	**3.07%**
June	EMERGENT/60 MINUTES	100.00%	0.00%
	URGENT/24 HOURS	98.73%	1.27%
	ROUTINE/14 DAYS	98.63%	1.37%
		98.71%	**1.29%**

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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. These have been resolved. 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. *Progress in first reporting period:* we are currently working to inform providers on the correct procedures for this.

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. *Progress in first reporting period :* Optum is reporting performance on this metric, refer to next slide. *Steps to reach functionality*: complete automation of uninsured eligibility approval, targeting completion in next reporting period.
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

Performance: Average Turn Around time Uninsured Eligibility

As of 9/12/21

Definitions (workstream)

- Approval of uninsured eligibility application – meets criteria
- Approval of uninsured exception – does not meet criteria
- Creation of uninsured eligibility line – after determination made

- Impacts to turn around time
  - Providers not completing uninsured exception forms, or was not needed
  - Uninsured exception requests remain open
  - County code discrepancies

- Opportunities for improvement
  - September Uninsured exception training for CSA/LBHAs
  - Monthly Uninsured training for providers

Month: June

Workstream	TAT Avg.	Volume
Approval of uninsured eligibility application	0.3	432
Approval of uninsured exception request	20.7	246
Creating approved uninsured eligibility line	0.4	149
Total	6.4	827

Month: July

Workstream	TAT Avg.	Volume
Approval of uninsured eligibility application	0.5	525
Approval of uninsured exception request	0.1	67
Creating approved uninsured eligibility line	2.5	150
Total	0.9	742

Month: August

Workstream	TAT Avg.	Volume
Approval of uninsured eligibility application	1.2	437
Approval of uninsured exception request	0.2	198
Creating approved uninsured eligibility line	9.3	268
Total	3.4	903

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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. Progress in this reporting period* – Optum is sharing performance with Providers on this item.
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. Progress in this reporting period*– Optum is sharing performance with Providers on this item.
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	*g. Progress in this reporting period – Optum has been working on completion of updates to the provider manual: Steps to reach functionality: Complete updates, targeting completion next reporting period*
h. MDH clearly defines evidence necessary to document non-compliance with time standards and provides a mechanism to report it			

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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. *Planned next reporting period:* Optum plans to share performance on this item with Providers, targeting October to begin reporting on this item
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. *Planned for next reporting period:* Optum plans to share performance on this item in October with Providers
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. *Progress in this reporting period* : Optum has been reviewing the provider issue intake and resolution flow from end to end to identify gaps and or inefficiencies. *In the next reporting period*, we will be reporting performance on provider issue resolution, and assist Providers by documenting the escalation process should issues remain unresolved
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 *New this reporting period: Reporting on incidents, timeliness of identification and mediation, refer to next page in this report*

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

Month	Total # of Privacy Incidents Reported	Notification to MDH within 24 hours of discovery	Initial Analysis within 15 days determining potential breach upon discovery	Average # of days to resolution
January	1	100%	100%	7
February	1	100%	100%	3
March	3	100%	100%	21
April	5	100%	100%	20
May	2	100%	100%	1.5
June	3	100%	100%	**Open-1 2 closed
July	3	100%	100%	35
August	2	100%	100%	10.5
**June presently averages 33 days due to 1 incident requiring more extensive research and date the incident was closed by MDH. Another incident was closed in 1 day.				
*To date 100% of the reported privacy incidents were determined not be reportable breaches under the HIPAA Notification Rule.				
* The remaining incidents are either pending formal closure by MDH or are still being investigated.				
There have been no further instances where claims have been processed to incorrect provider				

Increased times for resolution are impacted by the complexity of individual reports during a specific month.

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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. *No update in this reporting period*

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 *No update this reporting period*

Thank you.

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