Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

February 16, 2022

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: SB 549 – Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims – Letter of Information

Dear Chair Kelley and Committee Members:

The Maryland Department of Health (MDH) respectfully submits this letter of information on Senate Bill (SB) 549 – Administrative Services Organizations – Requirements for Retraction, Repayment, or Mitigation of Claims.

SB 549 outlines the process by which an Administrative Services Organization (ASO) may conduct the billing and creation and maintenance of claims for behavioral health services rendered to Marylanders in 2019 and processed or reprocessed after January 1, 2020 or from January 1, 2020 to August 3, 2020, inclusively. The effective date of this bill is immediately upon its passing, and it requires MDH to immediately amend its contract with its ASO to conform to the contract requirements of the bill.

Since the inception of the contract in 2020, UnitedHealth Group (UHG)/Optum made significant progress to correct issues raised by MDH and providers. Between January 2020 and November 2021, UHG/Optum received nearly 17 million claims and successfully paid nearly $3.2 billion associated with those claims to over 2,600 providers who participate in the Public Behavioral Health System. UHG/Optum maintains a weekly average of $30 to $40 million in payments to providers.

SB 549 will violate two provisions of the Maryland Constitution. Specifically, Article III, s. 33 prohibits special laws applicable to only one person or entity. As written, SB 549 applies only to UHG/Optum which is a clear violation. Additionally, Section 8 of the Declaration of Rights prohibits legislation that violates the separation of powers. In this instance, this applies to the administration of contracts.

The fiscal impact of this bill is to create a $215 million general fund deficiency to the Maryland taxpayer for non-existent provider services. If a provider does not agree with the estimated payment owed to MDH, there is a mechanism to appeal. These are funds that are paid for services not provided to patients and would be ineligible for a federal funding match.

Additional information can be found in the most recent 2021 Joint Chairman's Quarterly Report on the Status of ASO Functionality (p. 101-102), published January 2022 and attached. If you have any questions, please contact Heather Shek, Director of Governmental Affairs, at heather.shek@maryland.gov or (443) 695-4218.

Sincerely,

Dennis R. Schrader
Secretary

Maryland
DEPARTMENT OF HEALTH

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

January 31, 2022

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 Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2021 Joint Chairmen's Report (p. 101-102) – Report on the Status of ASO Functionality

Dear Chairs Guzzone and McIntosh:

Pursuant to the 2021 Joint Chairmen's Report (p. 101-102) 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."*

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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2021 Joint Chairmen's Report

p. 101 - 102

Quarterly Report on the Status of ASO Functionality

January 2022

Table of Contents

Introduction

This report supplements the previously submitted reports on October 1 and July 1, 2021, on this subject.[1,2]

UHG/Optum has received nearly 17 million claims between January 2020 through November 2021 and successfully paid nearly $3.2 billion ($1.5 billion in 2020 and $1.7 as of November 2021) 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.

Current Core Operating Outcomes can be seen in the table below:

Core Operating Outcomes

Key Performance Metrics	Target	December Actual	Year-to-date Actual
Claims Processed in 14 Days (received and adjudicated)	100%	99.85%	99.78%
Claims Processed and paid within 14 Days (received, adjudicated and paid by Payspan)	N/A	98.0%	97.28%
Claims Denial Percentage	N/A	15.23%	15.5%
Optum CS Participant ASA 30 Second Service Level	90%	97.8%	86.2%
Optum CS Provider ASA 30 Second Service Level	90%	98.4%	83.8%
Authorizations Processed within TAT	100%	99.5%	99.4%
Auto Adjudication Rate	85%	91.72%	90.11%
Clinical Service Level	80%	82.1%	84.4%

MDH defines a fully functional Behavioral Health Administrative Services Organization (BHASO) as a BHASO that pays valid claims from providers accurately, consistently,

[1] July 1, 2021, 2021 Joint Chairmen's Report (p. 101-102) – Report on the Status of ASO Functionality http://dlslibrary.state.md.us/publications/JCR/2021/2021_101-102_2021(7).pdf

[2] October 1, 2021, 2021 Joint Chairmen's Report (p 90-91) – Report on BHASO Reconciliation Process 2021 Joint Chairmen's Report (p 101-102) – Status of ASO functionality http://dlslibrary.state.md.us/publications/JCR/2021/2021_90-91,101-102_2021(10).pdf

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 - Claims 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 claims 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 outlines the Operation Improvement Committee and provider discussions so far, as well as next steps for continuing engagement and addressing such gaps.

Provider Engagement - Operations Improvement

Starting in December 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, 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 and is intended to allow for an involved discussion of issues affecting groups of providers. 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 a thorough 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, as well as a smaller, bi-weekly meeting of provider leadership to discuss issues regarding the reconciliation and recoupment process.

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.

Since the system went live in July 2020, providers noted a lack of reports needed to resolve claims in their own accounting systems. These are known in the insurance industry as 835 Health Care Claim Payment transactions for Electronic Data Interchange (EDI) claims. Missing 835s can be caused either by a technical issue between UHG/Optum and the provider, UHG/Optum and a clearing house, or a temporary transmission failure. The overall system functionality is a complex picture, thus starting from a single shared document is critical.

As of the end of October 2021, all missing 835 reports and Provider Remittance Advice (PRAs) have been delivered to providers by UHG/Optum to facilitate their record keeping and reconciliation of estimated payments made between January 1, 2020, and August 3, 2020. Providers who are still unable to locate a needed 835 can contact UHG/Optum to report it and request that one be provided. 835s are now automatically generated and provided on an ongoing basis for all claims.

UHG/Optum shares regular updates with the Operations Improvement Committee members for discussion in the twice-monthly meetings. The meeting also includes a product roadmap that 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; and
- Privacy and Security.

System Security Discussion

The network, systems, and data employed by UHG/Optum to provide Behavioral Health ASO services do not reside on the Maryland Health Department's system network and were therefore unaffected by the recent network outages. All of UHG/Optum's systems have remained in operation during this time and have been authorizing services and processing claims and payments to providers with no disruption of service.

However, a recent audit by the MDH Office of Internal Controls and Audit Compliance (IAC) found that some of UHG/Optum's systems are deficient and require stabilization. As a result, MDH required Optum to complete testing of all systems by December 31, 2021 and to provide test results by January 28, 2022, along with a plan of correction and all other risk assessments going forward.

MDH continues to track each procedure and process failing in separate Root Cause Analysis reports (RCAs) and Corrective Action Plans (CAPs). Subsequently, some RCA and CAP documents related to system issues have yet to be satisfactorily completed by Optum and accepted by MDH in the subsequent iterations. CMS is fully aware of the situation, and MDH is closely monitoring progress.

MDH carefully coordinates its findings and audits of the system with DoIT, CMS, and all other authorities as required and thoroughly investigates, reports, and creates remedy recommendations where needed as necessary. MDH is also consulting with internal compliance, privacy, security officers, and departmental and state legal counsel to determine the financial and legal responsibilities of all parties.

Contract Management Steps

As updated in our October 1, 2021, report, MDH initiated a new Request for Proposal (RFP) process in July 2021, with the goal to have a new contract signed no later than December 31, 2023 in order to allow for an entire year of development and implementation. RFP development continues and additional announcements will be made in accordance with state procurement statute and regulations.

MDH has four main contract management tools within the BHASO contract for damages/breach: service-level agreements (SLAs), liquidated damages, withholds, and termination.

SLAs 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 SLAs allows MDH to withhold a percentage of the total invoice based on the number of SLAs 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 have been met at this time is the requisite number of staffing. A total of $1,344.666.86 has been withheld under this authority through November, 2021.

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 an RCA/CAP allows 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 an RCA/CAP is delivered. UHG/Optum failed to deliver an acceptable CAP in a timely manner for the loss of claims images; MDH reserves all rights and remedies to ensure compliance by UHG/Optum.

Downtime occurrences are available if the system experiences an outage and is not available under certain conditions and allow for $1,000 per occurrence, with a $4,000 per-day maximum. MDH reserves all rights and remedies to ensure compliance by UHG/Optum.

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.

UHG/Optum has failed to deliver a comprehensive reporting system as defined in the contract. The current reports are limited in nature, and specific reports are only produced by request on an ad hoc basis. UHG/Optum is attempting to solve this issue with the creation of a Data Mart; MDH reserves all rights and remedies to ensure compliance by UHG/Optum.

State contracts also have two other penalty measures within their basic structures 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 would receive payment for that invoice. MDH has withheld one half of the implementation amount, retaining approximately $4 million for UHG/Optum's continued failure to deliver on critical claims-adjudication tools, including the 835 forms, consolidated claims history reports, other data 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's contract with UHG/Optum, as required by the State's procurement regulations, includes provisions for the termination of the contract for default and for convenience.

Reconciliation and Recoupment 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 check write 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. For example, 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 check write 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 $223,498,383 as of December 2, 2021. Figure 1 below shows the Estimated Payment Balance reduction over time, with Medicaid accounting for $193,621,166.90 of the current outstanding balance, and state-only programs accounting for the rest.

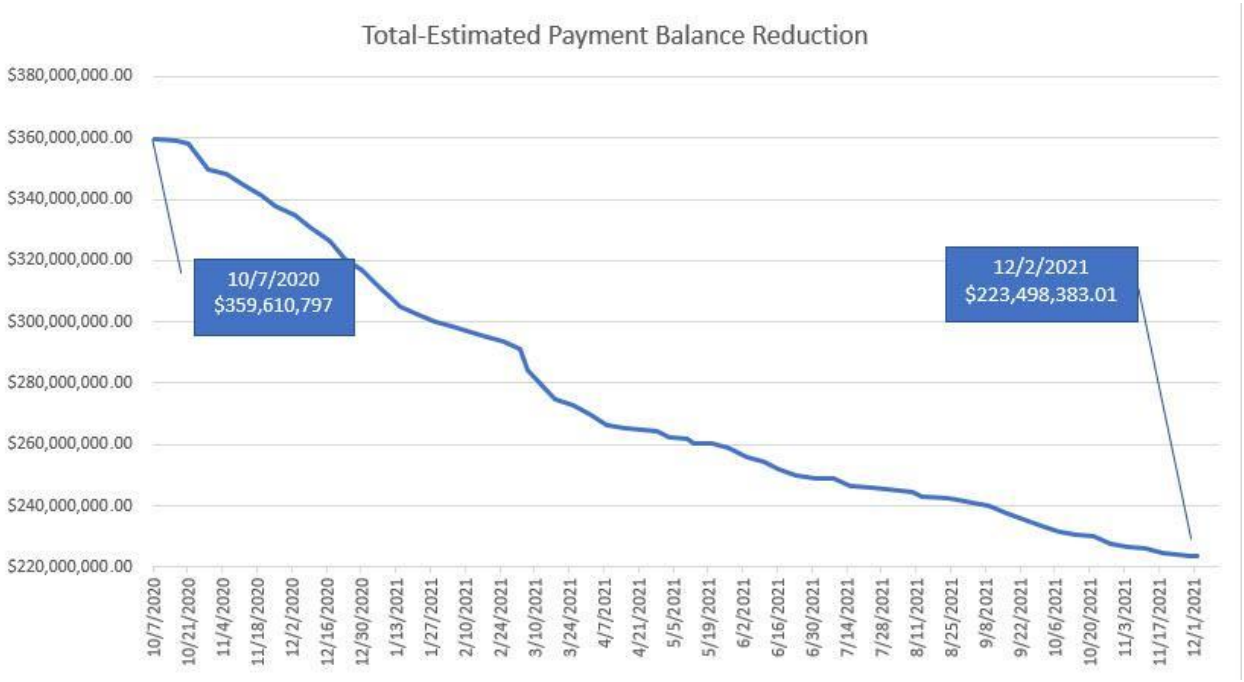

Figure 1: Estimated payment balance over time

The outstanding balances are highly concentrated among a few providers. Forty (40) providers account for approximately $63.5 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 its 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 2,107 providers who have outstanding estimated payment balances, 895 (42.5%) 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 November 29, 2021

Provider Outstanding Balance	Provider Count	Total Outstanding
Providers Owing < $10K	895	$3,513,735.69
Providers Owing $10K < $50K	601	$14,095,512.89
Providers Owing $50K < $100K	164	$11,658,744.64
Providers Owing $100K < $500K	347	$80,264,365.24
Providers Owing $500K < $1M	57	$38,049,854.36
Providers Owing $1M < $4M	40	$63,508,792.77
Providers Owing Over $4M	3	$12,423,484.94
Totals	2,107	$223,519,490.53

It is worth noting the progress made since the last report MDH submitted in October 2021. **Since the last quarterly report, estimated payment balances have decreased by nearly $17.4 million, and the number of providers with outstanding balances has decreased by 38. Of the more than $1.06 billion paid out in estimated payments, 80% of those payments have now been fully offset with paid claims or repayments from providers.**

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 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.

Of the total 2,107 providers with balances remaining, 338 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 balances represent providers who closed locations, retired, moved out of state, stopped providing Medicaid services, etc. These are detailed in Table 2 on the following page.

Table 2: Distribution of No-Offset Providers as of November 29, 2021

Provider Outstanding Balance	Provider Count	Total Outstanding
Providers Owing < $10K	210	$639,911.16
Providers Owing $10K < $50K	95	$2,196,051.81
Providers Owing $50K < $100K	14	$946,977.89
Providers Owing $100K < $500K	17	$3,237,044.35
Providers Owing $500K < $1M	1	$ 869,633.00
Providers Owing $1M < $5M	1	$1,599,542.33
Totals	338	$9,489,160.54

Of these 338 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. These provider accounts have been forwarded to MDH to be worked through individually and pursued through collections. This process is proceeding currently.

Consolidated claims history reports are in the process of being created. A pilot of the report was made available on December 20, 2021, and UHG/Optum estimates report production by the end of January 2022.

Estimated payments are not the only monies that need to be recouped. A separate subset of claims, known as “negative balances,” have occurred for a variety of reasons since the checkwrite process went live in March 2021. The balances occur primarily due to duplicate or overpayments that occur when UHG/Optum was unable to properly transfer funds between the State and Medicaid accounts. The total amount of overpayments due is currently $67,892,166 as of 12/7/21. The balance is split between the State account ($41,166,608), with the remainder in Medicaid. The vast majority of these overpayments are small (< $5,000) but affect a large segment of providers. These are true overpayments to providers and will not be discounted or forgiven. The breakout of these amounts is shown in Table 3 below:

Table 3: Distribution of Negative Balances as of December 7, 2021

Provider Outstanding Balance	Provider Count
Providers Owing < $5K	1,838
Providers Owing >$5K - $50K	39
Providers Owing >$50K - $100K	67
Providers Owing >$500K - $1M	13
Providers Owing >$1M	14
Totals	2,381

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 in 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 were permitted to be submitted through 12/31/21 and will be processed against the outstanding estimated payment balance through the dual check write 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 period. Phase 2 is still underway, and there are an estimated $12 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 of some 40 Reconciliation Managers handle about 71 providers per Reconciliation Manager and receives an average of 400 to 450 emails a week.

In addition to the Assisted Reconciliation Reports which are currently available to providers, UHG/Optum and MDH are continuing the Assisted Reconciliation process to allow providers time to review any denied claims and to submit follow-up information. As such, MDH provided for certain flexibility to continue during the Assisted Reconciliation process. 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 waived 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

Providers who owe negative balances will be required to pay those balances in full. For providers who owe negative balances, those recoupment efforts are currently underway with specific provider groups and will increase in scope once the complete claims history reports are available.

As previously announced, MDH plans to forgive 100 percent of amounts owed by providers who have outstanding or fully paid balances of $10,000 or less. Excluded from this forgiveness plan are hospitals, laboratories, out-of-state providers, somatic non-behavioral-health providers, and No-Offset Providers (see Table 2).

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 would have 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, and OAH will only be available for mediation of amounts greater than $10,000.

Next Steps

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.

Attachment A: Recoupment Process Infographic

As of 1/10/21

UHG / OPTUM OVERPAYMENTS PHASED COLLECTION PROCESS (a)

	Phase 1: December - March, 2021					April 2022	Phase 3: Late Spring 2022
Category	No-Offset Providers	PT54	Retro-Eligibility	IMD Funding Change	PRP (Psych Rehab Providers) Authorization	Non-Beacon Third Party Liability (TLP) Providers	Estimated Claims
Description	Providers who have not submitted claims to offset estimated payments.	SUD Residential Provider overpayments	Retroactive changes in obligated payer. State / Medicaid transfers	IMD was paid from wrong account. Essentially paid twice	Provider was not authorized to provide service.	Third-party-liability providers paid twice.	The amount owed to offset estimated claims paid between 1/01/20 and 8/03/20
Amount Owed	$9.5 million	$22 million	$30 million	$12 million	$1.4 million	$4 million	$223.5 million
Number of Providers	342	54	2,050 (1,838 owe < $5,000)	6	1	TBD	2,107 (includes only providers with outstanding balances)
Notice Given	Waiting for Collections Paperwork to be completed by Finance	Final letters sent 12/10/21	Provider Alert 12/13/21, 12/22/21, 1/7/22	YES	Waiting for complete claims Hx Reports	NO	Provider Alert 11/17/21

(a) Excludes:

(i) Providers on payhold (mostly under investigation) until matters are resolved

(ii) Beacon Carryover Claims (TPL, rate adjustment errors, failures to pay)

(iii) Claims under review and awaiting resolution