

August 15, 2022

Mr. David Cooney  
Associate Commissioner, Life and Health  
Maryland Insurance Administration  
200 St. Paul Place, Suite 2700  
Baltimore, Maryland 21202

Dear Associate Commissioner Cooney:

The UnitedHealthcare (“UHC”) carriers are providing this letter in response to the Maryland Insurance Administration (“MIA”) request for comments on the MIA Network Adequacy draft proposed regulation.

We believe that several of the data requirements being proposed are unduly burdensome due to the volume and different types of data required, the potential amount of resources needed to comply with these data requirements and associated costs, and other reasons included below. Also, some of the proposed sections and/or subsections require data that we do not have or that cannot be identified in and provided from the data that we have. Further, it is unclear how some of the proposed data requirements directly relate to measuring the adequacy of a carrier’s network. In summary, we oppose several sections and/or subsections of the draft proposed regulation (hereafter “regulation”).

Additional comments are included below, and some are provided in bullet point format. Applicable language from the regulation is also included below and is provided in *italic* format.

### **.03 Network Adequacy Standards**

*(A)(7) A carrier shall identify, by zip code, the number of participating providers for each provider type code and specialty code listed on the uniform credentialing form described in Insurance Article, § 15-112.1, Annotated Code of Maryland.*

- It is unclear why this is a proposed requirement. The travel distance standards are categorized by urban, suburban and rural areas, and there is no requirement to have a certain number and type of providers in each zip code.

### **.04 Filing and Content of Access Plans**

We oppose several subsections of (4)(C) in their entirety. The data requirements being proposed in (4)(C) are unduly burdensome due to the volume and different types of data required and the potential amount of resources needed to comply with these data requirements. We believe that some of the claims data being required can be obtained by

MIA through Maryland's All Payer Claims Database rather than having carriers provide that data again in access plans.

The proposed language in (4)(C)(3) is not provided herein due to its length, however, we would like to note that we oppose that language in its entirety. The data requirements being proposed are unduly burdensome. Also, based on the data requirements, it is unclear how MIA will take into consideration benefit plans that have out of network benefits. UHC has plans with out of network benefits and members in those plans have a choice if they would like to access out of network providers. Therefore, out of network benefit utilization should not receive negative treatment in MIA's access plan review.

Additional comments specific to subsections (4)(C) and (4)(D) are included below.

*C. Each annual access plan filed with the Commissioner shall include the following information in the standardized format described on the Maryland Insurance Administration's website:*

...

*(3) A description of out-of-network claims received by the carrier in the prior calendar year, which shall include:*

*(a) The percentage of total claims received that are out-of-network claims;*

*(b) The percentage of out-of-network claims received that are paid;*

- We cannot differentiate between member choice and other out of network claims.

*(c) The percentage of claims described in §C(3)(a) and (b) of this regulation that are for emergency services, on-call physicians, or hospital-based physicians;*

- There is no way to identify a claim received from an on-call provider.

*(d) The percentage of total claims received that are out-of-network claims for:*  
*(i) Subject to §F of this regulation, all enrollees with a residence in a zip code where less than 100% of enrollees have access to a provider within the applicable travel distance standard in Regulation .05 of this chapter for the provider type in the claim, listed by provider type for each of the rural, suburban, and urban areas;*  
*(ii) Subject to §F of this regulation, the ten provider types with the highest number of out-of-network claims for enrollees with a residence in each of the rural, suburban, and urban areas, listed by provider type and geographic area; and*  
*(iii) Subject to §F of this regulation, the ten provider types with the highest percentage of total claims that are out-of-network claims for enrollees with a residence in each of the rural, suburban, and urban areas, listed by provider type and geographic area;*

- Although previously referenced above, it is worth reiterating here that this subsection is unduly burdensome due to the volume and different types of data required and the potential amount of resources needed to comply with these data requirements.

*(e) For each provider type and geographic area described in §C(3)(d) of this regulation, (i) The total dollar amount paid by the carrier for out-of-network claims received in that category; and (ii) The total billed charges for out-of-network claims received in that category;*

- It is unclear how billed or paid charges directly relate to measuring the adequacy of a carrier's network. Like other sections and/or subsections, we oppose these proposed requirements.

*(f) For each provider type and geographic area described in §C(3)(d) of this regulation, the following information regarding requests to obtain a referral to an out-of-network provider in accordance with Insurance Article, § 15-830, Annotated Code of Maryland: (i) The number of referral requests received; (ii) The number of referral requests granted; (iii) The percentage of out-of-network claims received for which a referral was requested; (iv) The percentage of out-of-network claims received for which a referral was granted; (v) The number of single case agreements entered between the carrier and an out-of-network provider; and (vi) The percentage of out-of-network claims received for which a single case agreement was entered between the carrier and an out-of-network provider; . . .*

- Some of the referral and single case agreement data included in the proposed requirements cannot be identified, compiled and/or provided from the data that we have. Also, while previously noted above, it is worth reiterating here that UHC has plans with out of network benefits and members in those plans have a choice if they would like to access out of network providers. Members or providers may request a referral due to personal preference, continuity of care, or other reasons. Because of this, it is unclear how the number of out of network referrals and other referral data directly relates to measuring the adequacy of a carrier's network. It is also unclear how MIA will take into consideration referrals for out of network benefits. Out of network referrals and related benefit utilization should not receive negative treatment in MIA's access plan review. Lastly, if this proposed language is included in the finalized regulation, we will need additional guidance on how to handle and/or report referrals that have been partially granted.

...

*(4) A description of complaints received by the carrier in the prior calendar year relating to access to or availability of providers, which shall include: (a) The total number of complaints made by enrollees relating to the wait time or distance of participating providers; (b) The total number of complaints made by providers,*

*whether or not under contract, relating to the wait time or distance of participating providers; (c) The total number of complaints relating to the accuracy of the network directory; (d) The total number of complaints relating to the dollar amount of reimbursement for out-of-network claims, including balance billing; and (e) The percentage of complaints described in §C(4)(d) of this regulation that are for claims subject to the federal No Surprises Act.*

- This is unduly burdensome, and we oppose this section and/or these subsections. Complaints are not currently tracked to these specifications and/or separated into these categories. Also, it is unclear how some of the categories directly relate to measuring the adequacy of a carrier's network (e.g. subsection (d) regarding out-of-network reimbursement).

...

*(7) A description of whether the carrier's provider contracts require health care providers to engage in appointment management, including procedures related to: (a) No show policies; (b) Patient appointment confirmation; (c) Same day appointment slotting; (d) Patient portals; (e) Access to a provider performance dashboard to monitor appointment lag time, no show rate, bump rate (health care provider initiated cancelation of a scheduled appointment), and new patient appointments; and (f) Weekly polling programs of providers to check for appointment availability;*

- This is unduly burdensome, and we oppose this section and/or these subsections. Our understanding of the above language is that the referenced requirements would need to be included in provider contracts. We cannot require this and providers would likely not agree to this. Also, there is currently not a way to monitor this.

...

*(9) An indication of whether the carrier has a patient portal for enrollees to make health care appointments;*

- We oppose this section. Our understanding of the above language is that a carrier would be required to have a patient portal for enrollees to make health care appointments. A carrier should not be responsible for providing a patient portal whereby a member has access to all health care providers' appointment scheduling systems and/or electronic medical record ("EMR") databases. Additionally, the technology is not available to support this proposed requirement.

...

*D. The Commissioner may require a carrier to include in the annual access plan the number of participating providers by zip code for certain provider type codes and*

*specialty codes listed on the uniform credentialing form described in Insurance Article, § 15-112.1, Annotated Code of Maryland, if the Commissioner notifies the carrier in writing and identifies the particular provider type codes and specialty codes that shall be reported.*

- Clarification is needed as to how this would work along with the network adequacy standards referenced above and included in section (3)(A)(7) of the regulation. The language in that section and/or subsection states that a “carrier shall identify, by zip code, the number of participating providers for each provider type code and specialty code . . .”. However, section (4)(D) above references that the “Commissioner may require” such information. When reading both sections and/or subsections together, it is unclear whether the data requirement is mandatory or at the Commissioner’s discretion. It is also unclear how and/or when the Commissioner would notify a carrier in writing (e.g. whether the Commissioner will notify all carriers of this requirement prior to each year’s filing requirement or whether the notification will be in response to a carrier’s individual filing).

#### **.05 Travel Distance Standards**

*(C)(1) Each provider panel of a carrier, that is not a group model HMO provider panel, shall include: (a)[at] At least 30 percent of the available essential community providers providing medical services in each of the urban, rural, and suburban areas[.]; (b) At least 30 percent of the available essential community providers providing mental health services in each of the urban, rural, and suburban areas; and (c) At least 30 percent of the available essential community providers providing substance use disorder services in each of the urban, rural, and suburban areas.*

- Clarification is needed on whether the correct percentage is 30% or 35%. As referenced above, the regulation notes 30%. However, weblinks from the MHBE website reference that 35% is required. See weblink provided herein. <https://docs.google.com/forms/d/e/1FAIpQLSczLpmlYEBrY50fmxwA8j85FMz37szGCQ3tLGS3X7aKJbJagw/viewform>

#### **.06 Appointment Waiting Time Standards**

Please see the bullet point below for related comments.

*(A)(2) On a semiannual basis, each carrier shall make available to its enrollees the median wait times to obtain the following in-person appointments with a participating provider as measured from the date of the initial request to the date of the earliest available in-person appointment:*

...

*(A)(3) To monitor availability of providers, a carrier shall: (a) Utilize a survey tool with enrollees; (b) Make direct contact with a random selection of provider offices qualified to provide the services for each of the appointment types listed in §A(2) of this regulation to ask for next available in-person appointments; . . .*

*. . .*

*(A)(4) The survey tool described in §A(3)(a) of this regulation shall: . . . (b) Ask enrollees to provide the time period from the date of the initial request for each appointment type listed in §A(2) of this regulation to the earliest date offered for an in-person appointment with a participating provider possessing the appropriate skill and expertise to treat the condition; . . .*

*. . .*

*(B)(1) On a semiannual basis, a carrier shall determine whether the provider panel meets the waiting time standards listed in §E of this regulation based on the enrollee surveys and the direct contacts with provider offices described in §A(3)(a)-(b) of this regulation.*

- Our understanding of the above referenced language is that carriers would now be required to survey providers twice a year (i.e. semiannually), as opposed to the current requirement to survey providers once a year (i.e. annually), and that carriers would also now be required to survey members twice a year (i.e. semiannually). These new and additional proposed survey requirements are unduly burdensome due to the potential amount of resources needed to comply with these requirements and associated costs. We also have concerns regarding the validity and/or reliability of a member survey on appointment wait times.

## **.08 Telehealth**

*(D)(1) A carrier seeking to apply the telehealth credit described in §B(1) or C(1) of the regulation shall submit the following documentation to demonstrate that it provides coverage for and access to clinically appropriate telehealth services as described in §§B(5) and C(3)(a) of this regulation: . . .*

*. . .*

*(c) Evidence that telehealth is clinically appropriate and available for the services performed by each provider type and for each appointment type to which the telehealth credit is being applied, which may include: . . .*

*. . .*

*(iv) Enrollee survey results indicating that enrollees have the willingness and ability to use telehealth services for the specific provider type or appointment type; . . .*

- This regulation language appears to address enrollees that have already received telehealth services. It is unclear why a carrier would need to survey an enrollee on their willingness and ability to use telehealth services in this instance. If the enrollee wasn't willing or able then they would not have already utilized telehealth services.

**.09 Network Adequacy Waiver Standards**

*(A)(7) An analysis of any trends in the reasons given by physicians, providers, or health care facilities for refusing to contract with the carrier, and a description of the carrier's proposals or attempts to address those reasons and improve future contracting efforts;*

- Such an analysis would be very unreliable. Providers may not give a reason for not contracting with a carrier. Also, any reason given by a provider may not be accurate or there may be several reasons given that cannot be adequately categorized for analysis purposes.

UHC appreciates the opportunity to provide comments on this regulation. Please let me know if you have any questions or need additional information.

Regards,

*Joseph Winn*

Joseph Winn  
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UnitedHealth Group