United Healthcare

November 17, 2021

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 request by Maryland Insurance Commissioner Kathleen Birrane for comments by stakeholders on the MIA proposed Data Supplement templates, including on any increased compliance costs expected to result from use of the proposed templates and whether the data supplements should be submitted at the same time as the carrier's report demonstrating compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) required by § 15-144 of the Maryland Insurance Article. UHC provides health benefits plans nationwide and is already incurring significant organizational costs of compliance resulting from the federal MHPAEA reporting requirements of 42 U.S.C. § 300gg-26(a)(8), and use of the Self-Compliance Tool and appendices issued by the Department of Labor.

UHC has estimated the Maryland specific costs of compliance in terms of the effort to pull and produce the data requested in the proposed templates. The time required for the efforts are important given the consideration being provided to the idea that carriers should submit these data supplements along with the first company report on March 1,2022. The actual dollar costs are difficult to estimate because the work itself requires effort by employees at different levels of employment. In addition, any effort to satisfy a new reporting requirement or requirements from new data pulls will have unanticipated challenges.

In addition to the estimates below UHC has made a few suggestions which it believes can lessen the anticipated and unanticipated administrative burdens and streamline the data reporting.

I. Data Supplement 1 (Utilization Review) & Data Supplement 2 (Formulary Exceptions)

Costs

a. UHC estimates that to producing the needed data for Supplements 1 and 2 will require work from approximately 35 employees and total 700 man hours. This includes work from employees in Director, Associate Director, Sr. Analyst, and Consultant level positions.

b. The company does not currently have a designated or specific data field to indicate that a peer-to-peer review has taken place. Peer-to-peer specifics are currently only captured in a more general notes section of the member record. Since the requested information is not currently captured in a reportable form, the company will need to perform significant IT work to be able to report the

number of actual peer-to-peer reviews as well as other specific requests for utilization management in the current templates.

Suggestions for simplification

a. Remove the current age groups and ranges for reporting. Doing so reduces the time needed to pull and review the data and eliminates the creation of what appears to be an impermissible subclassification under final federal MHPAEA regulations. (See 45 C.F.R. § 146.136(c)(2)(ii))
b. There are no concurrent or retrospective reviews for Rx; the data will be "0" so that field could be removed.

II. Data Supplement 3 (Provider Credentialing)

Costs

Credentialing and provider network contracting are separate and distinct functions conducted by different areas within the company. Information for each function is housed on a separate IT system. These UHC source systems do not house all the requested information on one seamless database and will require collection from multiple sources to compile the requested information. A reporting requirement that covers both the credentialing and contracting timeframes will require IT enhancements. This will include establishing searching capability by the "later of" logic to capture the relevant later date of either contract execution or the contract effective date. A conservative estimate to generate a first version of this supplement is at least 6 weeks from the date of finalization of the templates. However, as previously noted this estimate cannot account for all unforeseen technical issues which may arise during the establishment of a new process.

Suggestions for simplification

a. The reporting could be streamlined by the removal of the requirement to provide a percentage of providers that submitted an initial application, but later withdrew or failed to complete the credentialing process by not responding. Providers may fail to pursue an application for participation for many reasons, including some that have nothing to do with the carrier. Accordingly, any percentage may not have the appropriate foundation or context for this to be a useful data point.

b. The carrier does not have any control over the time that it takes a provider to complete their application. We suggest that we be able to report two separate turn-around-timeframes:
    1) the timeframe of when the provider requests to be part of the network to the receipt of a completed application; and
    2) the receipt of a completed/clean application to the decision timeframe.

III. Data Supplement 4 (Reimbursement Rates)

Suggestions for simplification

a. The proposed templates require carriers to report data that may not be used in the creation of the carrier's reimbursement methodology. For example, the Maryland report uses Weighted Average in-Network Allowed amounts. Averages can be easily skewed by only a few number highly specialized/ high volume providers with inflated reimbursement rates when compared to the overall provider network. We suggest that "median" is a better representation of a true market rate. UHC can produce the requested averages as part of its comparative analysis, however for the reasons described below it is inconsistent with our current methodology.

b. To illustrate the lack of comparability we offer the following examples:
    1. 99214 is not a commonly used code with MD MH/SUD providers. We suggest utilizing the 90792 CPT code, which is an initial evaluation and used by almost all MD MH/SUD providers.
    2. For non-MD's MH/SUD, the Maryland report utilizes CPT codes 90834 & 90837
        i. 99213 and 90834 are different types of services. 99213 is an evaluation code and 90834 is a therapy code. We suggest 90791, which is more of an evaluation code and more comparable to 99213.
        ii. 99214 and 90837 are also different types of services for the same reasons above.

IV. The Data Worksheet

Suggestions for simplification

The Maryland report combines MH and SUD on all other reports except this report. UHC believes that all medical/Surgical benefits should be compared to all MH/SUD services.

Regarding timing, UHC believes that due to the time and resources needed to produce the requested information that the Data Supplements should not be required to be submitted with a carrier's report on March 1, 2022. Rather, carriers should be allowed additional time to be produce the Data Supplements with the templates the MIA adopts.

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

Regards,

Robert D. Morrow Jr.
Sr. Associate General Counsel – Employer & Individual
Director of Regulatory Affairs – D.C., MD, and NJ