ARIZONA PSYCHIATRIC SOCIETY

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March 3, 2022

Arizona Department of Insurance and Financial Institutions (DIFI)
100 North 15th Avenue, Suite 261
Phoenix, AZ 85007-2630

Attention: Mary Boatright, JD, CHC, Manager, Life & Health Oversight
public_comments@difi.az.gov

Re: Comments to Proposed MHPAEA Rulemaking

Dear Department of Insurance and Financial Institutions,

On behalf of the Arizona Psychiatric Society (APS), which represents over 500 psychiatrist members in the state that serve as advocates for the mentally ill, we thank you for considering our comments in response to proposed rules promulgated by the Department of Insurance and Financial Institutions (DIFI), as required by Arizona Senate Bill SB1523 and ARS § 20-3502 to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). We have restricted the scope of our comments to commentary on Exhibit A, Medical Necessity Criteria and Nonquantitative Treatment Limitation (NQTL) Reports, as we found the text regarding definitions, quantitative treatment limitations (QTLs), and financial requirements (FRs) to be completely appropriate and in need of no revision.

In submitting these comments to the proposed rules, we are resubmitting significant portions of our commentary to the draft rules. The focus of those previous comments were threefold:

1. Explain in careful detail how the draft rules were compatible with and did not exceed the comparative analysis requirements of MHPAEA.

2. Request that the terms process, strategy, evidentiary standard, and other factor be pluralized as they are in the MHPAEA statute and final rules.

3. Request that the draft rules explicitly require that the comparative analyses must define every factor, as is required by the MHPAEA statute comparative analysis requirements.

We feel it is important to restate the first item in full for the sake of putting it on the record. While some stakeholders may think that the proposed rules go beyond what is required by MHPAEA, they do not, and we feel it is necessary to point this out and explain how.

We also feel it is important to restate the second item and expound on it to demonstrate why it is important that the terms be pluralized as they are in the MHPAEA statute and final rules.
We have no need to restate the third item as the Department adopted our suggestion that Exhibit A explicitly require that every factor be defined. We thank the Department for adopting this suggestion and also appreciate how it is currently worded in the proposed rules.

Exhibit A

Before we provide any commentary on Exhibit A of the proposed draft rules, we think it is necessary to highlight the amendments made to MHPAEA in 2020 within Section 203 of Division BB of the Consolidated Appropriations Act (CAA), which President Trump signed into law on December 27, 2020. We know that DIFI and other stakeholders are well aware of these amendments, but we think it is appropriate to bring attention to them again because our commentary on Exhibit A flows from the new MHPAEA obligations for health insurance issuers (issuers).

The most relevant of the amendments made was the addition of a new subsection (a)(8)(A) to 42 U.S.C. 300gg-26, which is the MHPAEA statute that DIFI (and other state insurance departments) can enforce. This new subsection established NQTL compliance requirements for state-regulated health insurance issuers. The text is as follows (***emphasis added***):

(8) Compliance requirements

(A) Nonquantitative treatment limitation (NQTL) requirements

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits and that imposes nonquantitative treatment limitations (referred to in this section as "NQTLs") on mental health or substance use disorder benefits, such plan or issuer shall perform and document comparative analyses of the design and application of NQTLs and, ***beginning 45 days after December 27, 2020***, make available to the ***applicable State authority*** (or, as applicable, to the Secretary of Labor or the Secretary of Health and Human Services), upon request, the comparative analyses and the following information:

(i) The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.

(ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

> (iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.
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> (v) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.

The most obvious matter the text reveals is that issuers in Arizona have been obligated under federal law to perform NQTL analyses since February 10 of 2021 (45 days after December 27, 2020). And, they must make these analyses available to the applicable state authority upon request, which in Arizona is DIFI. Therefore, the main question at hand is whether the stipulated reporting format in Exhibit A is inconsistent with or exceeds the requirements of 42 U.S.C. 300gg-26(a)(8)(A). The answer is no. First, it is necessary to explain how the format of Exhibit A does not exceed the requirements of 42 U.S.C. 300gg-26(a)(8)(A). And, this is necessary because some commenters may note that within each classification of benefits there appear to be more comparative analysis steps involved than what is in 42 U.S.C. 300gg-26(a)(8)(A). Exhibit A requires a distinct as written comparative analysis requirement for each process, each strategy, each evidentiary standard, and each factor along with a distinct in operation comparative analysis requirement for each process, each strategy, each evidentiary standard, and each factor. However, this is exactly what is required under clause (iv) of 42 U.S.C. 300gg-26(a)(8)(A), even if it may not appear to be salient. Again, here is clause (iv) (***emphasis added***):
(iv) The comparative ***analyses*** demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, ***as written and in operation***, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

Note that the term analyses is plural. That means that the comparative analysis requirement fundamentally requires multiple analyses. In other words, a single comparative analysis addressing all of the terms processes, strategies, evidentiary standards, and factors does not meet the requirements of clause (iv). Further, the text clearly separates the concepts of as written and in operation. And, even further, each term—processes, strategies, evidentiary standards, and factors—is listed in terms of applying to mental health or substance use disorder (MH/SUD) benefits and again in terms of applying to medical or surgical (M/S) benefits. That means that each as written process that applies to MH/SUD benefits must be compared and analyzed to its corresponding as written process that applies to M/S benefits. Each in operation process that applies to MH/SUD benefits must be compared and analyzed to its corresponding in operation process that applies to M/S benefits. This reality repeats itself for each of strategies, evidentiary standards, and factors, both as written and in operation. This is exactly the same as what is required under Exhibit A. Congress simply chose to be more parsimonious in its phrasing. Please note that we conferred with our colleagues at the American Psychiatric Association

(APA) and they confirmed that this interpretation is correct. The APA is a good authority on this matter as they supplied Congress with the legislative text that became codified in section 203 of Division BB of the CAA (including what is now 42 U.S.C. 300gg-26(a)(8)(A)).

However, we do believe that slight modification is necessary in order to fully match the requirements of 42 U.S.C. 300gg-26(a)(8)(A). First, for each classification of benefits the comparative analysis steps of Exhibit A list the terms as process, strategy, evidentiary standard, and factor. By framing the terms in the singular, instead of the plural as 42 U.S.C. 300gg-26(a)(8)(A) does, it creates the possibility that issuers will interpret the language as only requiring them to report on one process as written, one process in operation, one strategy as written, one strategy in operation and so on. For most NQTLs there are multiple as written processes and in operation processes, and multiples of all of the other terms as well.

To illustrate why this is important, we will examine the NQTL of concurrent review in the inpatient classification of benefits. When concurrent review is performed by an issuer, there will always be multiple processes, in operation, that are in play. The first in operation process is often called “first level review”, which is the initial review of clinical information provided by the facility to the issuer. This process happens 100 percent of the time during concurrent review. This first-level reviewer is not a physician and may be a social worker or a nurse practitioner, or other non-MD provider type. The first-level reviewer can approve a concurrent review request for a continued stay but cannot deny a request.

When the first-level reviewer comes across a request that he or she can’t approve as being medically necessary given the clinical information provided, the request for a continued stay—and all of the clinical information—is then sent to what is called a “second level review” or “physician review”. As the title implies, this reviewer is a physician and does have the authority to deny the request for a continued inpatient stay on the grounds of medical necessity. Sometimes the second-level reviewer approves the request, sometimes the second-level reviewer denies the request.

However, sometimes the second-level reviewer will initiate a third in-operation process before officially approving or denying the request: peer-to-peer review. During this in-operation process a physician working for the issuer will conduct a phone or other type of virtual meeting with the attending physician at the facility to discuss further before making a conclusion as to the medical necessity of the request for a continued stay. Usually, although not always, this physician is the same physician that acts as the second-level reviewer. The frequency with which peer-to-peer reviews take place and the way they transpire is significant in terms of determining MHPAEA compliance. It has been our members’ experience that these peer-to-peer reviews often occur more frequently for MH/SUD concurrent review requests and their clinical judgment is questioned in ways that their medical/surgical colleagues do not experience. This is also true for second-level review.

In fact, if an issuer’s reporting on the NQTL of concurrent review inpatient, in-network neglects to provide significant detail and comparative analysis regarding second-level review and peer-to-peer review between MH/SUD and medical/surgical, then it will have not supplied the Department with an

adequate comparative analysis. Every issuer conducts second-level and peer-to-peer review during concurrent review, broadly speaking (not for every single request), for both MH/SUD and medical/surgical. Failing to provide analyses of these two in-operation processes would be a willful withholding of very relevant information.

That is why it is so important that the Department pluralize the terms processes, strategies, evidentiary standards, and factors. If an issuer is presented with a format that seems to encourage merely reporting on one process as written, one process in operation, one strategy as written, etc., that is likely all they will report on.

We could provide real-world examples for as written processes, or as written and in operation examples for any of the other terms but we do not want to belabor the point. What is described above crystalizes our thoughts on this. With that in mind, we respectfully request that DIFI modify the language to pluralize each of the four terms.

Thank you for allowing APS to provide comment. We have been very encouraged by the good work DIFI has done so far in implementing MHPAEA and are impressed by the team at the Department. We look forward to working with you to further implement MHPAEA and Jake's Law and we are available to respond to any questions that you may have regarding these comments or related matters.

Respectfully yours,

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Don J. Fowls, MD
Government Affairs Committee Chair,
Past President, Arizona Psychiatric Society