1. **Type and number of mental health outpatient/office visits**
    a. **Diagnosis/position on claim**
        i. CF: "Recommend sticking with anxiety as a primary diagnosis on the claim versus second or third diagnosis."
        ii. KP: "Cost sharing based on diagnosis code will lead to a lot of member dissatisfaction and will drive appeals volume: A member could receive a diagnosis code that is not on the list for $0 cost sharing but has the chronic condition targeted by the design. A member could have multiple diagnoses and if the wrong one is placed in the primary position, a cost share will be applied. Differential cost sharing will drive diagnosis coding to primary position even if the diagnosis should be in the second or third position."

    b. **Categories/visit types**
        i. CF: "We would recommend combining evaluation & management and follow up visits into a single category with shared visit limits." "We support combining the visit types into a single service break."
        ii. KP: "We do not have the system capability to implement this design. The following CPT codes span 2 or 3 different buckets (initial screening/assessment/referral, evaluation and monitoring, follow-up), and there is no way to determine if the service was an initial visit, evaluation and management or a follow up visit: 99202,99203,99204,99205,90791,90792,90832,90834,90836,90837,90847,99213,99214,99215
        iii. KP: Follow-up medication management appointments on semi-annual basis: There is really no way to identify the visit as a medication check. Standard evaluation and management codes are used by all provider types for all diagnoses. From our benefits team: There is no CPT code for medication management, so we would have no way to know when to waive the cost share. For example, a primary care physician would bill one of the evaluation and management codes listed in the care scenario with a diagnosis of anxiety. Neither the CPT code nor the diagnosis would identify that this is a medication management visit. We can assume that a behavioral health/psychiatry provider is performing medication management when using the evaluation and management codes, but that doesn't apply to the other provider types listed.
        iv. KP: There is no diagnosis or CPT coding that would differentiate an initial or a follow-up screening. From our benefits team: For the new/assessment visit, the CPT codes provided in the care scenario are for a new patient exam. We see those codes every time a member sees a new provider. Is the intent that we would allow one of these CPT codes annually at no cost share, or would we allow one of these per provider if the diagnosis is anxiety?

    c. **Number of mental health therapy visits**
        i. Claire M: "Do as much as possible zero cost sharing within AV, not limit zero cost sharing based on current average/median visits or treatment guidelines. Medical necessity will reflect that already."
        ii. UHC: "we see average visits per patient at much less than 26 visits per year in our claims data"; need to get additional clinical input on "if "at-least" biweekly is an appropriate base assumption for standard of care." 26 visit limit feels

somewhat arbitrary. 8-16 constitutes a standard clinical "round" of therapy; 26 sessions is not common."

iii. CF: "With opening the benefits up to additional conditions, we would strongly support either reducing the number of visits available at $0, or going with a lower cost share for these conditions but not $0. We are concerned that expanding $0 cost sharing could impact other cost shares or premium, and need to ensure that our internal AV analysis remains in AV range."

2. **Diagnosis-specific comments**
   a. **Additional services for treatment of gender dysphoria**
      i. CF: "We have clinical concerns with covering labs, imaging and procedures at $0 for <18 members for gender dysphoria."
      ii. CF: "for the gender dysphoria drug classes listed (GnRH analogs, Sex hormones, Nonsteroidal anti-androgens, and 5-alpha reductase inhibitors), these are not mental health drugs, but hormonal interventions. These may be used as part of a patient's overall treatment plan, but they would NOT be prescribed by mental health providers. We do not support making these available at $0 cost share."

3. **Prescription drugs**
   a. UHC: "Many of these drugs are oftentimes used for other indications, not just for behavioral health conditions. Diabetes was a little more straightforward because those meds typically aren't used for other indications."
   b. CF: "At point of sale, cost sharing is based on drug/class, not linked to specific diagnosis codes/can't distinguish what the drug is being prescribed for. Can add in an age adjustment."
   c. UHC: Unlike diabetes drugs which are prescribed predominantly for diabetes, the drugs proposed to treat anxiety may be used for other conditions. Diagnosis information is not commonly available at the time a prescription is filled at the pharmacy, therefore different strategies to apply the $0 cost share would need to be considered. For UHC the following processes are available. **Cover all of the proposed drugs at $0 cost sharing regardless of the diagnosis. (**PRO – Simpler, easier operationally.CON - Other non-BH/anxiety conditions covered at $0 cost share and results in premium increase. **Stop the prescription at the point of sale to check diagnosis**. If someone is at the pharmacy, the pharmacist processes the prescription and the system prevents them issuing the drug until a physician clarifies diagnosis. Once the diagnosis is obtained, the appropriate cost share is determined. (PRO - More accurate. Supports the intent of the program. Only those with anxiety diagnoses get the drug at $0 cost sharing. Others with non-anxiety diagnoses get the drug for standard tier cost share. CON – HIGHLY disruptive to the constituent. They must wait until the prescriber provides the diagnostic information to determine the appropriate cost share. This option may delay filling the prescription.). **Process claim with plan's standard copay unless diagnostic information is provided.** The claim will process at the plan's standard copay. If the medication is being used for anxiety, the prescriber would need to contact UHC with the diagnosis and an authorization is placed to allow the drug to process for $0 for future fills. Reimbursements can be offered for initial fill if member paid standard copay. (PRO – Member would not be delayed in picking up their prescription. CON – If member or prescriber does not notify UHC of diagnosis to assess $0, then standard copay would apply.

d. UHC: "Concerned about benzodiazepines. These drugs are extremely effective in the short-term but can be counterproductive to long-term psychotherapy strategies."

e. CF: "CareFirst has concerns that several of these drugs are subject to abuse or are not FDA-approved/primarily used for the treatment of behavioral health disorders in pediatric patients. Similar to our suggestions for the Diabetes V-BID, we will recommend modeling the list off of the generic drugs that are part of the Healthy Blue generic (HBG) list today, subject to member age. This list is inclusive of the SSRIs, SNRIs, and cyclic antidepressants that are used as long-term treatments for behavioral health."

f. CF: On the prescription drug side, we support $0 cost sharing for generic drugs that are supported by evidence or clinical practice guidelines, which we have included on our HealthyBlue Generics list. We do not support therapies that are not recommended for these conditions or are subject to abuse, as previous feedback has elaborated on.

g. CF: The HealthyBlue Generics list does not include categories for stimulants or hormonal therapies or some of the individual call-outs. Implementation would require custom coding for the plan, and would not be able to distinguish the indication for the medication being used.

- SSRIs – support
- SNRIs – support
- Hydroxyzine – do not support
- Prazosin – support
- Benzodiazepines – do not support
- Buspirone – support
- Alpha agonists – support, used in ADHD
- Beta blockers – do not support
- Anticonvulsants – do not support
- Anti-manic agents – support
- Stimulants – support, used in ADHD
- Anti-psychotics – support
- As for the gender dysphoria classes listed (GnRH analogs, Sex hormones, Nonsteroidal anti-androgens, and 5-alpha reductase inhibitors), these are not mental health drugs, but hormonal interventions. These may be used as part of a patient's overall treatment plan, but they would NOT be prescribed by mental health providers. We do not support making these available at $0 cost share.

Additional comments from CareFirst on Rx:

DC Exchange proposed list:

- SSRIs – support, part of HBG list
- SNRIs – support, part of HBG list
- Cyclic antidepressants – support, part of HBG list
- Anticonvulsants (e.g., gabapentin, Klonopin) – do NOT support; we would not be able to distinguish within pharmacy claims the indication of these drugs, to separate their use for seizure disorders. In addition, gabapentin is not FDA-approved for behavioral health indications (off-label) and subject to abuse; Klonopin is a brand-name controlled substance (benzodiazepine), subject to abuse.
    - Mood stabilization can also be achieved with the use of antipsychotics, which are included on the HBG list, but were not called out specifically by the DC Exchange.

- Anxiolytics (e.g., benzodiazepines, beta blockers) – do NOT support; benzodiazepines are controlled substances, subject to abuse, and are not intended to be used as primary therapy for behavioral health; beta-blockers are not FDA-approved for behavioral health indications (off-label) and we would not be able to distinguish within pharmacy claims the indication of these drugs, to separate their use for hypertension / tachycardia
- Hydroxyzine – do NOT support; we would not be able to distinguish within pharmacy claims the indication, to separate use for allergic conditions (pruritis, urticaria); although indicated for anxiety, the data for using this drug in pediatrics is sparse – expert recommendations for pediatric patients do not consider hydroxyzine a therapeutic option for the management of anxiety disorders

Anticonvulsants –

  - As a drug class, anti-epileptic drugs (AEDs) are increasingly used off-label for conditions other than epilepsy. In a population-based study (1998-2013) using administrative health databases in Manitoba, the prevalence of use in epilepsy is higher than not, at 813.9 vs. 21.1 per 1,000, however due to the larger population of individuals without epilepsy, the prescription volume is higher. Off-label utilization outside of epilepsy with literature support includes neuropathic pain, migraine prophylaxis, restless legs syndrome, and fibromyalgia. In 2012/2013, 69.9% of AED users without epilepsy were also taking a concurrent antidepressant. (ref: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4782115/pdf/NEUROLOGY2015668475.pdf)
  - Currently available randomized controlled trials do not support the efficacy of anticonvulsants as mood stabilizers in children. There is some preliminary evidence from small RCTs of the efficacy of some anticonvulsants in the control of aggression and behavioral dyscontrol in conduct disorder, autism, and intellectual disability (ref: https://www.frontiersin.org/articles/10.3389/fpsyt.2018.00270/full)
  - In pediatric patients, there is likely a higher prevalence of epilepsy compared to behavioral health diagnoses compared to adults, therefore assume that there is more utilization of AEDs for epilepsy in this population. Of note, this drug class is not included in the following review article for pharmacological treatment of anxiety in children and adolescents (ref: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803020/pdf/tp-07-01-23.pdf)
- Anxiolytics –
  - Benzodiazepines – for pediatrics, more commonly used for procedure related anxiety. BZDs are controlled substances and subject to abuse. They should be used sparingly, as adjunct/short-term treatment for anxiety disorders, such as when starting the longer-acting SSRIs and waiting for them to take effect. The evidence is insufficient to support the use of BDZs in the treatment of anxiety disorders in children and adolescents. (ref: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803020/pdf/tp-07-01-23.pdf)
  - Beta blockers – for pediatrics, most likely being used for cardiovascular indications; evidence is insufficient to support the use of propranolol in the treatment of anxiety disorders in children and adolescents (ref: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803020/pdf/tp-07-01-23.pdf)
- Hydroxyzine
  - Most likely being used for allergic conditions in pediatrics; hydroxyzine is not recommended for use in the treatment of anxiety disorders in children and adolescents (ref: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803020/pdf/tp-07-01-23.pdf)

4. **VBID and low/no value**
    a. CF: “There was a presentation in the prior session on no value care. We would be interested in opportunities to increase cost share for areas of low value/no value care to help offset premium impact of lowering cost share for pediatric mental health benefits.”
    b. CF: “Recommend applying the V-BID to the non-HSA DC Standard plans, similar to the approach taken for 1/1/23 with Type 2 diabetes.”