

SPWG Minutes, Meeting 4, October 4, 2022

Attendance:

Ku	Leighton	Chair
Kwarciany	Jodi	Vice Chair
Baker	Kellan	Whitman-Walker
Barlow	Yuolondra	CareFirst
Blake	Nikki	CareFirst
Blecher	Keith	UHC
Bream	Cory	CareFirst
Chandrasekaran	Dave	Voter Empowerment
Chuang	Stephen	KP
Davis	Janice	Living Capital
Dobrasevic	Stevan	Aetna
Feleke-Eshete	Lienna	Whitman-Walker
Kinlow	Tonya	Children's National
Le	Ky	KP
Liebers	Howard	DISB
Lucado	Dwayne	CareFirst
Mangiaracino	Allison	KP
McAndrew	Claire	Waxman Strategies
Neimiller	Jason	CareFirst
O'Brien	Alexandra	CareFirst
Ongwen	Sam	KP
Parcham	Cheryl	Families USA
Scharl	Peter	Oliver Wyman
Speidell	Paul	Aetna
Storm	Jennifer	CareFirst
Willing	Laura	Children's National
Kempf	Purvee	HBX
Libster	Jenny	HBX
O'Brien	Ellen	HBX

Jodi: vice chair of the working group. Welcome back this is our 4th meeting. We have a full agenda today. We will not do a full roll call but if we have any one new, please introduce yourself.

(silence)

Some housekeeping first. Thank you to everyone for sending comments. Its helpful to get your thoughts and we will continue to work through those on the next few meetings. We will send the notes from the last meeting around this week. Please review and send any corrections you have.

The goal of getting to the Executive Board in November we are doing to ask staff to schedule one more meeting on November 1, in case we need it.

On our agenda today: First, Tonya Kinlow from Children's National Hospital. They are providing information on pediatric conditions based on race and ethnicity. Next, we will hear from Dr. Baker on their development of their clinical scenarios. Last, we will hear from Peter on AV.

Tonya Kinlow: Serving as VP I lead our child health advocacy work. I have been engaged in health care policy for a long time and appreciate the work that this committing is doing to define and refine benefit that are available to your consumers and patients that are seen at children's and elsewhere in the DC

I want to set the stage for what you will hear from Dr. Laura Willing and Alana Aronin.

Sharing with you our experience seeing patients in the District dealing with MH conditions. Since meeting with HBX we were told this would be fast paced, but we had no idea how fast passed this would be! It's a snapshot of what we experience but we think this will be informative for your work.

Alana Aronin: we took some time to look at our data. We looked at FY 2022 for non-Medicaid in total and then by race/ethnicity. Looking at patient count, not visit count. Specifically, this includes patients seen in integrated health, and MH providers. In the chart, you are seeing total cases by condition, clustered so looking at categories. Then also pulling out % by race and ethnicity. This captures a moment in time. Also seeing that if access was equitable, we would expect that the patient numbers would be more reflective of the DC population. It does not look balanced from our numbers.

Dr. Willing: Top DX categories: for non-Medicaid patients in DC are: Anxiety and adjustment disorders, ADHD, Depression, Autism, Gender dysphoria, Disruptive behavioral disorders. The infant disorders are really outside your scope, but we left it in only because of how prevalent it is.

Draw attention to trauma related disorders – if we just talk about PTSD, the numbers are much lower. But still really important, and this does impact black and brown kids -- a lot of ACES in DC. It can be hard to meet all the diagnostic criteria for PTSD, so that is where another trauma related disorder might be diagnosed.

We have evidence-based treatments for these diagnoses. While there is no FDA approved medication for PTSD, we do have evidence-based medications and therapies. If we can provide care when they are young, this can help reduce the amount of care they need.

Alana: this slide shows variances in prevalence across race and ethnicity. Also shows that there is not an equivalency to expected diagnoses and what we see in terms of people getting care. This shows that black kids may be more likely to have a condition but may be less likely to seek care.

This one is a little surprising. From our community health needs assessment. On the left we are looking at another explanation that we are seeing a high % of patients that are black and brown relative to what we are seeing in care. [See Community Health Needs assessment slide]

Dr. Willing – we were also asked whether cost sharing was really a barrier to care and with addressing, We think yes. Increased cost sharing has reduced the care families are seeking. Also impacts medication accessed. Especially when talking about counseling. Recommended treatment is frequently weekly. And monitoring and evaluation is 1-3 months. So much more frequent than some other care and cost can become a barrier. Changing the cost sharing does have an impact.

Risk if suicide is higher for patients of color than for white patients.

Seeing that cost is disproportionately impacting communities of color.

None of our data was specific to transgendered youth.

Leighton: can you hear me now.

[yes]

Thank you for the helpful information from Children's and thank you for Jodi for getting the meeting going.

Leighton: one of the things that is significant from Children's is the scope of what we are talking about is broader. Now we are talking about a broader set from just anxiety and PTSD. There are pros and cons to broadening this out. Now we are hearing more about the prevalence. The cost of this will get more expensive as we broaden out conditions.

Allison: on slide 4, seeing that autism is 4th or 5th on the list of prevalence. Is this now included?

Leighton: that is now part of the discussion. This is a question for the group to discuss. I think a fair question is do we want to have it meet this whole set. Basically, all MH conditions or are there some that we want to think about separately.

Dr. Willing: I would recommend including autism. It is common and there are barriers to care.

Leighton: are we ready for Whitman Walker now?

Dr. Baker: Hi everyone.

Slide one is the list of the DX codes that we included in the scenario we are going to present today.

This scenario is intended to address all of these conditions. We reviewed guidelines, EMR and clinical guidelines for each condition. We also did interviews with providers.

One the basis of our earlier work, we found that many patients have multiple conditions and treatment is similar for a number of conditions. To reflect these recommendations in standard plan design, we created a unified scenario for all the conditions. We will go over each bucket of care for the scenario.

Initial assessment- up to 2 visit with PCP or referrals to behavioral health providers

Then there are frequent visits for evaluation and management – up to 4 per year

You will see some overlap in CPT codes here.

Then for follow up visits – these are conditions that require frequent follow up visits. E.g., anxiety recommendations range up to 20 per year.

We found a wide range of visits that people were using, noting that use is likely pushed down by cost sharing barriers. So, we combined out EMR data with published guidelines and recommend up to 20 follow up visits. This includes family, individual and/or group or a combination of those modalities

For gender dysphoria, in particular, there are some labs that are necessary. We did not include labs that are used to rule out other conditions, but guidelines do have recommendations for labs and screenings to ensure that medications are working as intended. Primarily hormone screening. Also, bone density screenings. Hormone injections, can do at home but can also do in a provider's office

Medications: the categories you are seeing are not exhaustive, many medications are use for several conditions. We think it's important to include medications in the class for anxiety. For PTSD we recommend some categories and also in some cases just a specific medication within a class. E.g., antihistamines, we recommend one specific medication and not the whole class.

GNRs are important for transgender youth seeking care.

We are working on more research related to cost sharing, but we echo that we find cost sharing to be a substantial barrier to care for our patients. We have had to get grants to make access for children in particular.

Happy to take any questions.

Purvee: can you talk about autism and why not in here.

Kellan: we did not include autism because of the significant differences in modalities of treatment. That is different from the other conditions, e.g., ABA services. To create a unified scenario, we focused on conditions that have significant overlap in care.

Purvee: Children's does have substantial experience in this area, and they will create a care scenario for the group to consider.

Dr. Willing: I was wondering about speech therapy. Is it included as an additional service in the treatment scenario for GD?

Kellan: we did not consider that. We would need to talk to our providers. Generally that is something that is needed after the onset of puberty. If you are delaying puberty, we do not think that would be heavily indicated for children

Cheryl: What about kids that fail on the medications initially provided?

Kellan: that is one of the reasons we recommended including categories of medications. Sometimes you need to move to another class of medication. The majority of these are offered as a generic.

Speech therapy – also I would note that this would not be provided by a MH provider, so this may fall outside of the scope of the work but we would defer to the hBX team on that question.

Leighton: in the interest of time. Can we have Peter discuss the AV estimates?

Peter: updates DX cost that were shared earlier today. Change to only include under \$0 when it's the primary dx. In prior estimates included if any diagnosis. RX list was updated to include all the cases provided by HBX. We ran several options for follow up visits. Ranging from 5-20 mental health therapy

visits with \$0 cost sharing. The results are similar to what we saw last week. The change re DX placement (limited to primary dx on the claim) and adding more DX codes basically offset each other out. The silver plan continues to be slightly outside the AV range, with other metal levels meeting AV with this scenario.

Leighton: is autism included in DX codes?

Peter: Let me check

Ellen: no autism or gender dysphoria.

Purvee: I think that ADHD was also excluded. We will ask Oliver Wyman to go back and run the current unified treatment scenario. This work is ongoing and continued into today, so there are some differences between the reports you are getting today.

Keith: You are just running against the existing plan? You are not modifying MOOP or anything like that?

Peter: Yes, that is correct. We are just running the proposed changes, not changing anything else

Keith: I don't know how many of you are familiar with AV analysis. Just calling out that the changes in AV may look small but could have a significant impact on cost of the plan.

Leighton: when we add on other conditions, that could make things a little more expensive.

I wonder if you could look at the impact of just reducing copayment down to \$10 would look like? I am concerned that people in the exchange are better off than medical patients. I have this concern that there are limits on MH providers so to the extent that we improve access for middle income patients, we squeeze lower income children.

Stephen from KP: did your analysis make changes equivalently across metal level or were there different adjustments made for each metal level.

Peter: This is based on AV calculator the 10% at \$0 will have a different impact at various metal levels. To the extent that there is more or less utilization, there will be a higher or lower changes. That is part of the logic in the AV calculator.

Stephen: I am surprised that bronze has the lowest impact of the metal level plans.

Peter: MH benefits are already at \$0 for some visits in the bronze plans which we had to do for parity

Dr. Willing: regarding the comments about eliminating cost sharing creating extra pressure on the systems. There are shortages everywhere, but there is movement at the system level, the care level and patient level. Hope is that there is not just pressure from one, but all system levels should be changing together.

Would this group be interested in publishing data on this work? So that others could use what we learn if it's shown to be effective?

Leighton: are Medicaid health plans charging any cost sharing for MH services?

Alana: I don't think there are co pays in DC but I would need to check.

Tonya Kinlow: we are working on other pieces of this work, including with DISB, to address other barriers to care. This is not just a one-off effort for Children's.

Allison: Thank you for presenting the slide of cost sharing as a barrier to care. We see this across the market and not just for kids. I want to think about the cut off for kids. We need some kind of rationale: why we would apply cost sharing at age 19? Especially for conditions like gender dysphoria where care may start later. What is the clinical and economic reason for this cut off?

Keith: still some legal and operational concerns about some of this. Especially around NBPP and the rules around benefit design based on age. Need to make sure that DISB is ok with these changes.

Purvee: we are at 1:00 pm. Next time we will have more time for discussion. Send any questions and comments you have any see you next week