**SPWG – Minutes – Meeting 2, September 20, 2022**

## Attendance:

| Ku | Leighton | Chair |
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| **Kwarciany** | **Jodi** | **Vice Chair** |
| Barlow | Yuolondra | CareFirst |
| Bishop | Chelsea | Aetna |
| Blake | Nikki | CareFirst |
| Blecher | Keith | UHC |
| Bream | Cory | CareFirst |
| Chandrasekaran | Dave | Center for Voter Empowerment |
| Chuang | Stephen | KP |
| Davis | Janice | Living Capital |
| Dobrasevic | Stevan | Aetna |
| Feleke-Eshete | Lienna | Whitman-Walker |
| Hathaway | Kris | AHIP |
| Hoffman | Sarah | Children's National |
| Kinlow | Tonya | Children's National |
| Le | Ky | KP |
| Liebers | Howard | DISB |
| Lipphardt | Sarah | CareFirst |
| 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 |
| Stoddart | Robert | KP |
| Storm | Jennifer | CareFirst |
| Tomczyk | Tammy | Oliver Wyman |
| Vo | Tina | UHC |
| Weber | Joni | Aetna |
| Willing | Laura | Children's National |
| Young | Theresa | KP |
| Kempf | Purvee | HBX |
| Libster | Jenny | HBX |
| O'Brien | Ellen | HBX |

Leighton Ku: Welcome back – it's our second meeting. Today this group will be discussing comments on the proposed scenario for $0 cost sharing for the treatment of anxiety in children and adolescents.

Jodi Kwarciany of the National Alliance for Mental Illness (NAMI) has agreed to be our Vice Chair in the Work Group. Jodi is a member of the HBX Standing Advisory Board and has served on other HBX working groups.

Leighton: for those who were already here last week, we know your affiliation. But if you were not on last week, or you are on a phone, could you introduce yourself?

> Paul Speidel: I'm calling in. Claire: I'm Claire McAndrews working at Waxman strategies and on the SAB. Really glad to be here today and thrilled to hear Jodi is the vice chair. Howard Leibers: I'm with the Department of Insurance. Lienna Feleke-Eshete – from Whitman-Walker on behalf of Kellan who was not able to be on today. Sarah Lipphardt: I am joining from CF. I'm a pharmacist.

Leighton Ku: As a brief recap, for those that were not here last week: we are working on an initiative to improve equity with DCHBX benefits. Started last year to modify cost sharing for insulin and then care for type 2 diabetes more broadly. This year, we are look at pediatric mental health. Starting with 3 conditions recommended by Children's National: Anxiety, PTSD, and Gender Dysphoria. Last week, Kellan Baker of the Whitman-Walker Institute presented a typical treatment scenario for anxiety. My hope for this is that we will get input on this proposal to modify the standard plans benefit design to reduce cost sharing for pediatric mental health.

We shared the minutes from last week's meeting. Ellen or Purvee do you want to recap the minutes from last week?

Ellen: I am happy to share the scenario.

Leighton: We will have our actuaries (from Oliver Wyman) weigh in on the AV impacts of these proposals. Then, later in this process we will get much more specific on these recommendations. Right now, we are looking at the three pediatric conditions. There may be changes as we move along. Bur for now we want to have a discussion about the general issues, and then get more specific about how to modify the standard plans.

Ellen, it would be helpful if you can talk about the scenario and then talk about the comments we got from the working from.

Ellen: (Showing the draft scenario and comments). Starting with the ICD 10 codes, then have the list of items and services below.

Purvee: we are having a hard time to hear you.

Ellen: We received comments from carriers and others. [These are summarized in the comments document that we will circulate after this call]. We got responses our question about whether copays for telehealth needed to be addressed in the scenario, as well as individual, group and family therapy. (2) We received several comments on the diagnoses and on the number and type of visits. (3) many of the comments received related to the prescription medicines proposed in the scenario for $0 cost sharing, with some suggesting that the list was appropriate and others raising concerns about the some of the inclusions. A concern was raised about these medicines being prescribed for conditions other than anxiety.

What we are looking for is more specific comments on the scenario and thoughts from your clinical team.

Leighton: please roll back to the first and second page. First this has to do with the CPT code and the specific services for treatment. WW was saying they think these are important treatments for this condition. One of the issue that came up is how many visits. WW recommended 20 visits be covered at $0 cost sharing and also medications.

Purvee: This is a reminder that WW is working with us to develop the clinical care scenario. They issued a combination of their data, clinical guidelines, and provider interviews.

Leighton: they are doing this using their own data, so possible that others would have other data.

Purvee: lets start with the specific comment around diagnosis.

Would anxiety be the primary dx or would this also include secondary or tertiary codes?

[Silence}

Leighton: if we limit to the primary diagnosis, that would limit this a little bit more. These are fair questions about how far we want to go. Someone could go in for a sprained ankle and also have anxiety.

Cheryl: How consistent are providers on how they report diagnostic codes? I Would lean towards a more inclusive approach.

Leighton: I think that generally this is a provider question and not something determined by the carriers.

Lienna: at WW the providers have noticed that anxiety is frequently diagnosed concurrently with depression, so it would be hard to determine which one would be the primary diagnosis in those cases.

Purvee: Proposing that we include both primary and secondary diagnosis. Folks can weigh in on this again after talking to their clinical teams.

Dave: there is a lot of similarity in treatment modalities for depression and anxiety.

Purvee: we think we will be getting more feedback on the depression diagnosis issues.

Leighton: I was surprised when I saw this list because I expected depression and ADHD to be included further on this list. So, this list may still be fluid.

Tonya: We want to close the loop on the final list of diagnosis. We will be prepared with more detailed recommendations for your next meeting. We will take these issues back and turn them around as quickly as possible.

Leighton: Thank you. We look forward to hearing more about that.

Leighton: What we can do in standard plans is around cost sharing, but others have raised questions around other barriers to care. I would like to see additional evidence that financial issues/cost sharing are important in limiting access or heightening disparities in anxiety/other pediatric mental health. What role does stigma play? Part of me thinks that modifying cost sharing may not have a substantial impact.

Purvee: We can look into that and provide additional research evidence on the effect of income and cost sharing.

Purvee: Back to the scenario itself: Children's National recommended adding 2 diagnoses: selective mutism and separation anxiety. Folks can submit comments on those 2 additional diagnoses should be added to the scenario. To the extent that you are proposing limiting visits, please provide details. We have suggestions that the initial visit be limited to 1. Others recommended that medication management follow ups be 2-3. Clinical guidelines recommend 12-20 follow up therapy visits. If you have other thoughts, please provide your recommendations on follow up visits with specifics.

In terms of CPT codes, we got an additional 6 CPT codes that Children's recommended, plus they recommended adding codes for behavioral assessment. Please review and provide feedback on the CPT codes. Some of this may require circling back to your clinical teams, but if you have comments now please share.

Claire: what is the connection between visits limits based on clinical guidelines and AV concerns?

Purvee: we are not actually setting visits limits, just discussing what services should be covered with no cost sharing. We are saying that for 1 assessment visit, 2 medical follow-up visits, and 20 therapy visits, there would no cost sharing. This does not change medical necessity or

anything else, it is just cost sharing. A person may get more or fewer services depending on their condition/needs. This would not impact covered services if clinically appropriate for someone. OW will be running AV analysis on this.

Claire: I understand this is based on clinical guidelines. I am not a clinician, but I have seen kids with this condition I have seen kids need care for multiple years. Especially if you experience adverse events. I would think more about what the AV limits are and how far we can go, rather than setting limits up front.

Leighton: Your point is well taken. I assume that when we change cost sharing we are not running up against mental health parity, is that right?

Claire M and Jennifer Storm: both clarifying that parity does apply to cost sharing as well as covered visits.

Leighton: it would be nice to have an actuary or someone else look at impact on parity.

Purvee: we generally think that eliminating cost sharing for MH benefits should not run afoul of parity

Cheryl: limiting the number of visits would run afoul of 1557.

Purvee: we are staying on top of 1557 standards and we assume our carriers are too.

Leighton: RX coverage. Generally, the DX code does not appear on RX when sent to fill. Can anyone confirm that?

Sarah Lipphardt: Yes, that is correct. There is no DX code on RX

Purvee: how do carriers determine that a medication is covered if no DX code?

Someone other than KP, as they have a different model.

Keith Blecher: this is something we will need to take back and follow up on.

Sarah Lipphardt: are you asking about prior authorization? CF uses CVS Caremark as our PBM, and they process the claims according to our formulary. The PBM system is separate from medical claims. PBM does not get medical claims information. Because of this, for diabetes, we covered all the specific medications. For these anxiety medications, it's more complex because these medications are used for other purposes.
Sarah Lipphardt: once a medication is approved, we could put an additional check for age to limit cost sharing to 18 and under.

Purvee: can we get more information from the carriers around what medications are primarily for anxiety, vs no mental health benefits.

Purvee: we got comments that were broader than the clinical scenario. If you have a proposal on what you would like to do beyond the proposal, please let us know. For example, if you have questions about age or nondiscrimination,

Allison M: this type of care sticks out as an area where reducing cost sharing will not effectively improve health outcomes and narrow disparities. This will also see a pricing impact over time, making the standard plans more expensive than other plans on the exchange over time.

We are also concerned about picking and choosing between conditions. What about someone who gets a diagnosis at 18 but still needs care as they get older?

The gold and platinum plans already have pretty low cost-sharing. Both bronze and silver plans have office visit copays at $45 dollars, so it's worth looking at reducing the cost of office visits rather than targeting conditions. A $45 copay does present a financial barrier to care.

With the alternative proposal, ee would not need to worry about aging out of this benefit or leaving out specific conditions. Want to think thought longer term impacts of these changes.

Purvee: are you taking about reducing cost sharing for office visit cost sharing overall, which would make care more affordable, including MH visits?

Leighton: this is a valid proposal. Noting that there are still other barriers to care such as limited providers.

Puree: network adequacy issues are broader than just the exchange. Howard is on and I know they are doing equity work as well.

Leighton: Next time will we be talking about anxiety or PTSD.

Purvee: I think PTSD will be ready for next time.