SPWG Notes, Meeting 3, September 27, 2022

Attendance:

Ku	Leighton	Chair
Kwarciany	Jodi	Vice Chair
Barlow	Yuolondra	CareFirst
Beaudin-Seiler	Beth	Altarum
Blake	Nikki	CareFirst
Blecher	Keith	UHC
Bream	Cory	CareFirst
Chandrasekaran	Dave	Voter Empowerment
Chuang	Stephen	KP
Dobrasevic	Stevan	Aetna
Feleke-Eshete	Lienna	Whitman-Walker
Hoffman	Sarah	Children's National
Le	Ky	KP
Liebers	Howard	DISB
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
Weber	Joni	Aetna
Willing	Laura	Children's National
Young	Theresa	KP
Kempf	Purvee	HBX
Libster	Jenny	HBX
O'Brien	Ellen	HBX

Welcome back – it's our third meeting. I am Leighton Ku, Chair of the SPWG. If you were not here last week, I just want to note Jodi Kwaciarny, a member of the HBX SAB, has agreed to serve as Vice Chair of this working group.

Ellen, do we have sufficient number/representation of working group members to proceed?

To recap very briefly, we are focusing on pediatric mental health benefits and we are trying to get recommendations by the end of these 7 meetings. Those will go to the executive board. Changes would go into effect for 2024. Joining me is Jodi Kwaciarny, my vice Chair. Senior manager for MH benefits at NAMI. Also joining me are staff members from HBX: Purvee, Ellen and Jenny.

Since we have had 2 meetings already, I will only ask you to introduce yourself if you are new today.

In our first year implementing the Social Justice recommendations, we considered changes related to type 2 diabetes. The work in DC is attracting attention from others in the country. So we may be setting a new path.

In our second year, we are focusing on pediatric mental health. Starting off we are looking at 3 conditions – anxiety, PTDS, and gender dysphoria. Last week we talked some more about the Whitman-Walker Institute care scenario for anxiety disorder. We got a number of comments from you, and we were happy to get more comments.

We did get recommendations around the types of and numbers of services proposed. Also some workgroup members raised some issues about the types of medications that would be covered under the waived cost sharing. In some cases, commenters noted that the medications for anxiety are used for other, non-mental health conditions. Carriers do not know, at the point of service, the reason the medication has been prescribed. This is an important issue.

Another thing that came up. Concerns raised bout the ability of DC residents to access MH services. Barriers may include cost sharing and also provider shortages. We cannot directly address provider access issues in standards plans, but we might have some thoughts that how to address that issue.
So we talked about other operational issues as well.

After that meeting, HBX went back and made minor changes to the care scenario. We are not going to go through the new comments we got today but we will focus on some new issues today. We are going to start off with discussion on value-based insurance design. Are the changes we could make to help offset the changes we are working on to help meet AV standards. Under federal law there are limits on how much plans are covering and how much consumers cover under the metal level plans. That is the difficult issues around AV standards. These are creating real problems. After that discussion, we will hear more from Whitman Walker about their care scenario on PTSD. After that we will hear from OW on their AV calculations. We will try to get this all done in the coming hour. IF you have questions, please add them to the chat or unmute yourself.

First up. We are asking Dr. Beth Beaudlin-Selier to talk about her work on VBID and no-value care.

[see presentation slides]

Leighton: anyone have any questions? [Silence]

I have one question, since we are talking about pediatric MH, are there any benefits include in NO value under that category:

Beth: No

Leighton: We will turn to WW to talk about PTSD scenario.

Lienna: Hi everyone. We are glad to be here to talk about PTSD. The methodology we used is similar to what we did for anxiety. First, we looked at publicly available data. National and locally.
[see presentation slides]

There is not a lot of data on PTSD in children, so we relied on trauma related data. We note the rate of ACES among children in DC. DX for PTSD in children of color and LBGTQ children is more likely to be missed. Trauma is more likely to be overlooked.

Next we reviewed clinical guidelines, including AACAP guidelines. Which lists female gender as a risk factor, but did not mention RE/SO or GI. Gap in data reflect larger trend in mental health

Based on this data and research, we created the treatment scenario.

Looking at our EMR data, we see that the most utilized medications for children and adolescents with trauma are antihistamines, SSRIs, and beta blockers.

Unique visit types - you will see a range in the median visits

Interviews with health care providers – spoke with 5 behavioral health providers to learn from their experience. DX process for PTSD- there are disparities in the DX process. Can depend on patients understanding of trauma. Where people are in communities where trauma is normalized, that can hinder access to care.

Unlike with anxiety, where providers are able to see early signs of anxiety. With PTSD, comorbidities might show up first. Most patients need several visits to get diagnosis. Providers are frequently seeing patients presenting with complex PTSD, based on experience of repeated trauma rather than one traumatic event.

PTDS does not respond as well to medication only. Medication may help treat symptoms, such as sleep related issues. Therapy is necessary to treat PTSD to help a patient understand the root of the trigger. Co-pays for visits can be prohibitive for patients. Cost sharing for RX may also be barrier to care for patients. Recommend weekly therapy, more frequently than anxiety, and may need to be longer lasting

If child is experiencing trauma at home, family therapy may be crucial.
Medication classes – SSRI, propranolol; hydroxyzine HCL and prazosin

Visits: 3 new/assessment visits- would include PCP initial visit and then referral to a PMH providers. Follow up visits; minimum of 4/quarterly evaluation and management visits – including medication management. Therapy services: minimum of 20 follow up visits. Commonly this would be for therapy. Included family and group therapy and included a variety of modalities.

Any questions?

Cheryl: In thinking about the visits how many would be primary care vs therapy for follow up visits?

Lienna: most visits would be MH visits – usually the PCP would refer to a MH provider for ongoing treatment.

Kellan: I think we are looking at a version of the slides that merges to charts together. There are 4 medication visits and 20 therapy visits

Lienna: we can to 20 visits based on recommendations from providers and looking at treatment guidelines for trauma looking at up to 25 visits.

Leighton: looking at a relatively long period of treatment. Can you give us more information about why longer course is necessary here?

Lienna: Treatment guidelines recommend up to 25 therapy visits. We see a range in the utilization because some people cannot afford to continue care for 25 weeks. PTSD can also make it hard for patients to maintain care.

Leighton: How many people cut off care earlier?

Lienna: I don't have that information

Purvee/Kellan – go back to slide 7.

Kellan: related to a course of treatment – for anxiety and PTSD care specifically, these are intensive ongoing care. They are acute and intended to be intense regiments.

Cheryl: I am confused about 25.

Lienna: our providers recommended 25.

Claire: just to clarify we are not imposing any limits on care, just deciding how many should be included under this no cost sharing benefit.

Leighton: we have not seen any data or evidence about the impact of cost-sharing on getting care. Having that evidence would be helpful. Turning to the final part of this presentation. Peter from OW. Wait, I see a hand up. Allison?

Allison: in slide 8: talking about the progression of diagnoses. Curious about the early visits. Are you seeing early DX of depression or anxiety and then progressing to PTSD?

Lienna: sometimes. Some people might come in and be asked about potential traumas or may disclose that information. In that case the provider might hold off on a diagnosis. In other case they might get an early diagnose of depression or anxiety.

Allison: thank you, that was helpful.

Leighton: any other questions? Peter, are you on the line?

Peter: Yes. We took a similar approach as we took last year with diabetes. Looking at covering specific services for children with specific MH conditions at no cost sharing and determining the AV impact.
We have a nationwide data base that we narrow to DC area. We use the procedure and DX codes to determine what % of services in each AV category would have no cost sharing. For example, if we found that 10% of the services would be for children with the specified conditions, they would make that adjustment to the AV calculator. The changes have a different impact based on metal level. Changes have more of an impact on less rich plans (bronze and silver). There is a different distribution of services and cost in the different metal levels. Current metal AV is for PY 2023 plans. We ran the scenario provided to us including the 13 DX codes and the procedure codes in the clinical scenario.

The gold and platinum plans are still within the AV ranges. The silver plan is now slightly outside the AV range. This is using the 2023 plans and AV calculator. The 2024 calculator is not available, so the impact could be different when we see the new calculator.

Leighton: Thank you. Do you have anything else to add?

Peter: once there are decisions on the specific diagnoses, CPT codes, etc. we will work to incorporate those changes in the AV estimates.

Leighton: to recap, under federal requirements, we have 4 metal levels. There are CMS requirements about the value of these plans. There is some variation allowed, but Peter's information shows that the WW scenarios have limited impact and only seeing a problem in the silver level plan which is just slightly over the allowed AV. We talked about limiting the medications because we could not be sure what the reason for dx is for. I am assuming you are using the current list is that correct?

Peter: Yes.

Leighton: So if we were to put some limits on the list of medications at $0 cost sharing, that would potentially affect the AV estimates.

Peter: most of the impact is from the outpatient visits; medication impact was small.

Leighton: Anxiety is prevalent. Are we anticipating a change in demand in response to this proposal?

Peter: that is not anticipated in this calculation.

Leighton: any other questions?

Ellen: do you think there would be impact if we were to limit to just primary DX?

Peter: it would have some impact but I don't know to what extent that would impact the AV.

Leighton: you said that the cost driver is the outpatient visits. That gets to how many visits are covered with no cost sharing. A change there would have the most impact on AV is that correct?

Peter: yes.

Leighton: can you remind us what the copay is for the silver plan?

Peter, I think its $20. But let me check.

Purvee: I just want to note that we are past the 1:00 p.m. mark

Peter: it is $40.

Purvee: We should wrap up.

Please in response to what you heard today. Please send your thoughts including on VBID; PTDS scenario, and any questions on AV analysis for Peter. We will get answers to your question for next week.

Leighton: I assume next we will hear about PTSD AV impacts and then gender dysphoria. I assume that the AV impacts will be cumulative as we add conditions.

Thank you all of you today there were some great presentations and comments today. Please send comments and questions to Ellen O'Brien.

I think next week we will be hearing more about gender dysphoria and PTDS is that correct?

Ellen: we will get back you with an agenda