December 6, 2023
Study packet contents

Obesity and Eating Disorders Prevention and Treatment

- Obesity report in brief
- Eating disorder report in brief
- Policy options
- Staff follow-up memo excerpt
- Public comments

Obesity and Eating Disorder Prevention and Treatment in Virginia

Obesity Policy Options and Findings

POLICY OPTIONS IN BRIEF

There are 6 policy options in the report for Member consideration. Below are highlighted options to address obesity services.

Option: Direct DMAS to develop a plan to incorporate the National Diabetes Prevention Program as a covered service within the Medicaid State Plan.
(Option 1, page 8)

Option: Request HIRC and BOI to define nutritional counseling in the EHB benchmark plan.
(Option 2, page 10)

Option: Request HIRC and BOI conduct assessments to include the following services in the Essential Health Benefits benchmark plan when medically necessary:

- Medical nutrition therapy
- Weight loss medication
- Bariatric surgery

(Options 3, 5, and 6; pages 10-16)

Option: Direct DMAS to remove service limits for medical nutrition therapy when treating qualifying or eligible medical conditions.
(Option 4, page 11)

FINDINGS IN BRIEF

Coverage of obesity prevention and early intervention services varies by insurer

Virginia Medicaid currently covers preventive services for children and adults, including physical exams and nutrition counseling. Two Medicaid MCOs piloted an evidence-based prevention program, the Diabetes Prevention Program, that successfully targets people who are at high risk for type 2 diabetes by promoting a change in lifestyle factors for modest weight loss. The program could benefit people with obesity; however, this program is not currently a covered Medicaid benefit. The Virginia EHB benchmark plan covers counseling services related to nutrition as a preventive health benefit but does not cover behavioral interventions for obesity. Some individual and small group plans also exclude medical nutrition therapy as a treatment for obesity.

Weight loss medications are not covered in the Virginia Essential Health Benefits benchmark plan and allowed under strict criteria for Medicaid

The Virginia EHB benchmark plan outlines services which must be covered by individual and small group plans. Also, the Virginia EHB benchmark plan specifically excludes coverage for weight loss drugs. Consequently, there are no individual or small group plans that cover these services. Medicaid requires prior authorization for weight loss drugs.

Weight loss surgery is not covered in the Virginia Essential Health Benefits benchmark plan and allowed under strict criteria for Medicaid

The Virginia EHB benchmark plan specifically excludes coverage for weight loss surgery, which is similar to most states. Twenty-three states cover bariatric surgery through their state EHB benchmark. Coverage is limited in the individual and small group market. Virginia Medicaid covers bariatric surgery when medically necessary.

Prepared by Estella Obi-Tabot, MSPH and
Emily Atkinson, MPH, CHES

Obesity and Eating Disorder Prevention and Treatment in Virginia

Eating Disorder Policy Options and Findings

POLICY OPTIONS IN BRIEF

There are 2 policy options in the report for Member consideration. Below are highlighted options to address eating disorder services.

Option: Direct DMAS to conduct a rate study to develop reimbursement rates for residential, partial hospitalization, and intensive outpatient services for eating disorder services for adults over 21.

(Option 7, page 27)

Option: Require all Medicaid MCOs and state-regulated health insurers to remove prior authorization for eating disorder services.

(Option 8, page 29)

FINDINGS IN BRIEF

Limited reimbursement and coverage of eating disorder services are major barriers to treatment

Eating disorder treatment providers reported unsustainably low reimbursement rates and difficult rate negotiations with commercial insurance companies. Medicaid does generally cover some eating disorder treatment, but there is not an established rate for eating disorder services. Providers can participate in single-case agreements with Medicaid to provide services, when possible.

Lack of alignment in prior and continued authorization requirements and medical necessity among insurers can create administrative barriers and delay care

Eating disorder treatment usually requires prior authorization based on an insurer's medical necessity criteria before services will be covered. Insurers can use discretion on what clinical guidelines they use to authorize services, resulting in differences in eating disorder treatment coverage across plans and carriers. Additionally, insurers often require continued stay authorization and can deny coverage if the patient no longer meets their medical necessity criteria. However, when the insurer fails to provide their definition of medical necessity, providers find it challenging to justify ongoing treatment.

Methods to ensure compliance with federal and state mental health parity laws continue to evolve

Non-quantitative treatment limitations (e.g., prior authorization requirements) may not indicate a mental health parity violation, but current state processes for oversight and enforcement of parity may not effectively identify and reduce barriers to mental health treatment. Some states have updated their mental health parity laws to increase transparency and ensure behavioral health services are covered to the same extent as medical surgical benefits.

Prepared by Estella Obi-Tabot, MSPH and
Emily Atkinson, MPH, CHES

Policy Options

Joint Commission on Health Care
Obesity and Eating Disorders Prevention and Treatment in Virginia

OPTION 1
JCHC could direct DMAS to develop a plan to incorporate the Diabetes Prevention Program as a covered service within the Medicaid State Plan.

OPTION 2
JCHC could write a letter to the Chair of House Commerce and Energy or Senate Commerce and Labor requesting Health Insurance Reform Commission and the Bureau of Insurance to define nutritional counseling in the EHB benchmark plan.

OPTION 3
JCHC could write a letter to the Chair of House Commerce and Energy or Senate Commerce and Labor requesting Health Insurance Reform Commission and the Bureau of Insurance conduct an assessment to include medical nutrition therapy when treating a qualifying or eligible medical condition in the essential health benefits benchmark plan.

OPTION 4
JCHC could direct DMAS to remove service limits for medical nutrition therapy when treating qualifying or eligible medical conditions. DMAS should work with stakeholders to identify the most appropriate medical conditions that could be treated with MNT.

OPTION 5
JCHC could write a letter to the Chair of House Commerce and Energy or Senate Commerce and Labor requesting the Health Insurance Reform Commission and the Bureau of Insurance conduct an assessment to include obesity medication when medically necessary in the essential health benefits benchmark plan.

OPTION 6
JCHC could write a letter to the Chair of House Commerce and Energy or Senate Commerce and Labor requesting the Health Insurance Reform Commission and the Bureau of Insurance to conduct an assessment to include bariatric surgery coverage when medically necessary in the essential health benefits benchmark plan.

OPTION 7
JCHC could direct DMAS to conduct a rate study to develop reimbursement rates for residential, partial hospitalization, and intensive outpatient services for eating disorder services for adults over 21 years of age.

OPTION 8
JCHC can submit legislation requiring all Medicaid managed care organizations and state-regulated health insurers to remove prior authorization for eating disorder treatment services.

Obesity Prevention and Treatment

Delegate Adams asked about the source of data for the obesity rate for the general population compared to the Medicaid population. Additional clarification was requested to understand potential reasons why the obesity rate we reported was lower within the Medicaid population (12%) compared to the general population (34%).

We collected data from two different sources for Medicaid and the general population. The obesity rate for the general population was collected from the Behavior Risk Factor Surveillance System, a national dataset that calculates body mass index based on self-reported height and weight.

Within the Medicaid population, we defined obesity as an individual who had a primary or secondary diagnosis of obesity in any medical claim. Therefore, it is possible that individuals who meet a clinical threshold for obesity based on their height and weight are underrepresented in this report if their medical record did not have an obesity diagnosis. Also, if an individual did not generate a claim during the plan year, they would not be captured in our counts. We used this data because we wanted to understand the population who may be actively receiving treatment for obesity. At the time of our study, all-payer claims data that would reflect obesity diagnoses for the general population were not available. One study found about 70% of Medicaid adults are overweight or obese when analyzing national health interview survey data in 2015.[1]

[1] Ku, L., Paradise, J., & Thompson, V. (2017). Data Note: Medicaid's Role in Providing Access to Preventive Care for Adults. *Kaiser Family Foundation*.

Delegate Orrock asked if there is a percentage of success associated with each recommended treatment strategy to understand where best to focus state efforts.

JCHC staff categorized three types of evidence-based treatments for obesity in the following categories: behavioral interventions, pharmacotherapy, and bariatric surgery. Table 1 cites when the following treatments are recommended. This table is also located on page 6 of the report.

Percentage of success varies and is based on individual adherence to each treatment strategy. One systematic review found behavioral interventions yielded an average weight loss of 8-15% of body weight; however, there are many people that do not benefit from this type of intervention. Pharmacotherapy with or without an accompanying behavioral intervention showed a greater weight loss and less weight regain over a 12 to18-month period. Depending on the type of medication used, patients saw an average weight loss ranging from 5.7 to 12.8 pounds. The available literature suggests bariatric surgery promotes the greatest amount of weight loss. Individuals three years post-surgery had an average weight loss of 11.7% to 18.8% of body weight. Among types of bariatric surgery, gastric bypass showed the greatest amount of weight loss at 3-year and 7-year follow-up.[2]

TABLE 1: Evidence-based obesity treatment falls into 3 categories grouped by intensity

Intervention Type	Description	Recommended
Behavioral Interventions	Range of weight loss programs that promote healthy diet and increased physical activity	Recommended to most children and adults.
Pharmacotherapy	FDA-approved weight management medications	Generally only recommended after a failed behavioral intervention, and if a patient has a BMI above 30 kg/m or a BMI of 27-29.9 kg/m with a weight-related comorbidity.
Bariatric Surgery	Surgical weight loss intervention	Generally only recommended in conjunction with a behavioral intervention and reserved for those who are at greater risk of developing obesity related complications.

SOURCE: JCHC analysis of peer-reviewed literature, 2023.

[2] Bray, G., & Ryan, D. (2021). Evidence-based weight loss interventions: Invidividualized treatment options to maximize patient outcomes. *Diabetes Obes Metab, Suppl. 1*(23), 50-62. doi:https://doi.org/10.1111/dom.14200

Senator Hashmi asked if there was any analysis available to justify the cost of weight loss medications compared to the overall costs associated with obesity-related comorbidities that can arise when left untreated.

JCHC staff reviewed peer-reviewed literature for cost-effective analysis of FDA-approved weight loss drugs and found weight loss medications can be more cost-effective than the overall costs associated with obesity-related comorbidities in some cases. Staff also found that glucagon-like peptide-1(GLP-1) drugs were more effective at treating obesity[3]; however, the higher costs associated with this class of drugs can make these options less cost-effective overall.[4] For adolescents, one weight loss medication had an estimated cost benefit after five years[5][6] but research was insufficient to suggest sustained benefits into adulthood.

One study compared the cost-effectiveness of treating obesity with weight loss medications compared to treating daytime sleepiness, smoking cessation, migraines, and fibromyalgia and found weight loss medications had the greatest direct medical cost savings of $2,586.00 in per patient per year.[7]

Delegate Orrock asked if recent changes to Medicaid's prior authorization requirements for weight loss medications follow the private insurance market.

Medicaid has recently updated prior authorization for weight loss medications to align with clinical evidence, FDA guidelines, other state Medicaid agencies, and industry experts. The guidelines can be found here.

The private insurance market includes individual, small group, and large group plans. Our study found that individual and small group plans do not provide coverage for weight loss drugs.

Large group plans and the state employee health plan were outside the scope of our study, but some of these plans do cover weight loss drugs. We contacted the Virginia Association on Health Plans to ask generally how prior authorization is approved in the large group market. Generally, for five major commercial insurers in Virginia, a patient must have a BMI at or above 27 and have other comorbidities before prior authorization for weight loss medication is approved. This aligns with Medicaid's criteria, as Medicaid allows for prior authorization when BMI is at or above 30 without comorbidities.

[3] Hu Y, Zheng SL, Ye XL, Shi JN, Zheng XW, Pan HS, Zhang YW, Yang XL, Huang P. (2022). Cost-effectiveness analysis of 4 GLP-1RAs in the treatment of obesity in a US setting. Ann Transl Med. 10(3):152. https://doi.org/10.1002/osp4.390
[4] Lee, M., Lauren, B. N., Zhan, T., Choi, J., Klebanoff, M., Abu Dayyeh, B., Taveras, E. M., Corey, K., Kaplan, L., & Hur, C. (2020). The cost-effectiveness of pharmacotherapy and lifestyle intervention in the treatment of obesity. Obesity Science & Practice, 6(2), 162–170. https://doi.org/10.1002/osp4.390
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Senator Dunnavant requested cost estimates of weight loss drugs to the Medicaid program. Senator Favola also wanted to know if there are any perceived savings for weight loss drugs in the Medicaid program.

DMAS reports Medicaid expenditures for diabetic and weight loss drugs each quarter, and the report breaks out expenditures by drug. This information will be shared with Members as soon as it is available. Medicaid FFS and MCOs have seen an increase in expenditure for weight loss therapy, particularly for newer GLP-1 medications. General information about perceived savings is included in Senator Hashmi's question on page 3.

Delegate Adams asked if it is possible to cover specific types of bariatric surgery in Virginia's EHB benchmark plan to focus on treatments that are more effective.

Yes, it would be possible to only cover specific types of bariatric surgery in Virginia's EHB benchmark plan.

Eating Disorder Prevention and Treatment

Senator Dunnavant wanted clarification about mental health conditions that are covered under some of Medicaid's mental health treatment services rates.

The generalized rates for mental health services under DMAS' Project Bravo program include eating disorder services for intensive outpatient, partial hospitalization, and residential treatment services. We heard from providers that the rates offered for these services were not enough to sustainably provide eating disorder treatment services. The policy option proposed was to develop a separate rate for eating disorder services. However, the recent budget includes increased rates generalized rates for mental health services, including eating disorder treatment services. JCHC staff will gather some initial feedback about how these increased rates may impact their ability to provide services.

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LEGISLATIVE MAIL

JCHC Public Comments <jchcpubliccomments@jchc.virginia.gov>

public comment on Medicaid coverage for eating disorder treatment

1 message

Gray, Susan H *HS <SMH5G@uvahealth.org> Fri, Nov 3, 2023 at 2:15 PM
To: "jchcpubliccomments@jchc.virginia.gov" <jchcpubliccomments@jchc.virginia.gov>

Dear Committee members:

Thank you so much for studying the issue of Medicaid coverage for eating disorder treatment.

As physicians, therapists, nutritionists, case managers, social workers, psychologists and nurses at UVA providing care for pediatric and adolescent patients with eating disorders, we write in strong support of Study Option 8, to require Medicaid managed care organizations and state-regulated health insurers to remove prior authorization requirements for eating disorder coverage. Lack of approval for specialized eating disorder care (IOP, PHP, and residential) continues to be a primary driver of the need for acute medical stabilization, long wait times to see outpatient providers, and differential access to appropriate care for patients with public health insurance. Additionally, the lack of transparency and consistency in criteria for PA approval/denial contributes to ongoing inequities in access and outcomes among pediatric and adolescent patients with eating disorders. Without appropriate (specialized, evidence based) care, eating disorders can become chronic, life-limiting and life-threatening, however, with treatment pediatric and adolescent patients have the best chance at achieving full remission/ recovery from their eating disorders. Our patients deserve access to treatment regardless of payor source.

We also support Study Option 7 directing DMAS to establish a rate for eating disorder treatment services. And, although not an official policy option, we believe the state should appropriate sufficient funds to support an adequate eating disorder treatment rate. We have repeatedly seen our Medicaid patients get turned down for medically indicated treatment due to inadequate reimbursement, and they deserve access to treatment just as much as patients with commercial insurance.

Please do not hesitate to contact me/our team if we can be of assistance to you and provide further information.

Sincerely,

University of Virginia Teen and Young Adult Health Center Eating Disorders Team
Susan Gray, MD
Serwa Ertl, MD
April Kimble, RN
Jennifer Louis-Jacques, MD
Eva Manthe, RD
Haley Stephens, PhD
Sara Stephens, LCSW, PhD
Isabel Sullivan, RN
Mary Sullivan, MEd
Julia Taylor, MD

University of Virginia inpatient pediatric hospitalist team
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November 3, 2023

Estella Obi-Tabot, MSPH
Joint Commission on Health Care
411 East Franklin Street, Suite 505
Richmond, Virginia 23219

Dear Ms. Obi-Tabot:

Thank you for the opportunity to provide comments regarding the Joint Commission's recent study regarding obesity and eating disorders prevention and treatment. The Virginia Association of Health Plans (VAHP) represents nine health plans that provide health insurance coverage to nearly 6 million Virginians; five of these plans operate managed care organizations (MCOs) that provide Medicaid to over 2 million residents. As health insurance providers, we are working to provide appropriate access to obesity and eating disorder treatments as the science and evidence-base for treatment continues to evolve.

The study presents options related to Medicaid coverage for obesity treatment and eating disorder services. Our five MCOs appreciate their ongoing partnership with the Department of Medical Assistance Services (DMAS) to evaluate obesity treatment options. VAHP supports Option 1 to incorporate the National Diabetes Prevention Program as a covered service. As noted, the program has shown strong results when implemented as a pilot in Virginia.

Option 4 recommends *removing* service limits for medical nutrition therapy (MNT) in the Medicaid program. Page 11, Table 2 outlines the annual limits on MNT services as well as nutrition counseling. Table 2 indicates that if an individual accessed all the MNT available to them, they could obtain up to 12 hours per year of individual assessment, intervention, and/or group MNT. However, there are very prescriptive limits within each type of MNT. For example, 15-minute units for initial assessment and intervention with an individual patient are allowed up to 12 times per year, but only 2 hours total of group MNT is permitted per year. VAHP suggests Option 4 be amended to increase service limits when treating qualifying or eligible medical conditions or permit more flexible combinations of MNT services, but DMAS should maintain some service limits to ensure services are provided in the most effective clinical manner with treatment goals and outcomes clearly specified.

Option 8 seeks to remove all prior authorizations for eating disorder services in Medicaid MCOs as well as state-regulated health insurance plans. VAHP and its members disagree with this proposal. Eating disorders impact a relatively small proportion of the population (2.7% v. 22.8% for US adults with mental illness[1]). Consequently, there are a small number of providers that offer inpatient and/or partial hospitalization or intensive outpatient services for eating disorders. Most eating disorder providers operate on a cash-only basis and do not participate with health plans as in-network, contracted providers. In other words, the providers are considered out-of-network for MCOs and/or privately insured health plans and they are not subject to provider credentialing or vetting processes that would normally occur for in-network providers. Therefore, prior authorization serves an important role for these types of providers –it permits the plans to properly screen these providers to ensure they provide high quality, evidence-based care by credentialed professionals. Without this step, an individual can be placed in an inappropriate setting or not receive both the supportive physical health care and mental

[1] National Institute for Mental Health, health statistics: NIMH » Mental Illness (nih.gov).

health treatment required as part of eating disorder treatment. Finally, prior authorization in this instance ensures Medicaid MCOs and private health plans can negotiate appropriate payment rates for out of network care; this holds down costs in Medicaid and premiums in the private market.

There are several other options presented for state-regulated health insurance plans. As the Joint Commission notes on page 38, any changes to state-regulated health insurance plans will only impact 8 percent (610,000) of insured individuals in Virginia and 98,000 individuals covered by the state employee health plan. That means changes recommended by the Joint Commission will only impact a small portion –about 20 percent – of the health insurance market in Virginia.

Options 3, 5, and 6 encourage the Joint Commission to request the Health Insurance Reform Commission and Bureau of Insurance examine whether MNT, weight loss medication, and bariatric surgery should be included in the EHB Benchmark Plan. Despite the Joint Commission's findings on page 9, VAHP and its member plans do offer some or all of these services in the fully-insured state regulated market today as well as in the state employee health plan. Below are some of the factors that are currently considered as part of offering these services:

- **Medical Nutrition Therapy.** Medical Nutrition Therapy is delivered by a registered dietician while nutrition counseling can be delivered by registered dieticians as well as other clinicians or primary care providers. With limitations in the number of registered dieticians, nutritional counseling is an important alternative to support patients. Mandated MNT will not increase the number of registered dieticians. However, nutritional counseling is already included in the EHB Benchmark Plan.

- **Weight Lost Medications.** The state employee health plan and some fully-insured health plans do provide coverage for weight loss medications. Many of the newer generation GLP-1 medications approved for weight loss are expensive and patients stay on them for life once they begin. In addition, it is still unknown how these life-long medications will impact health outcomes (both positive and negative) for patients. Given these questions and the lack of low-cost generic or biosimilar options for the newer GLP-1 medications, health plans should not be mandated to cover these prescriptions. There are unintended costs with such a mandate, premiums will increase quickly. The Commission should use data from the state employee health plan as well as Medicaid to determine the potential increase in premium costs if a mandate was implemented. VAHP urges caution in including this mandate without further data and/or the introduction of lower cost alternative medications into the market.

- **Bariatric Surgery.** Bariatric surgeries are not for every patient seeking treatment for obesity. For some patients, the risk of complications can far outweigh the potential benefits. Mandating this service could impact premiums. The state employee health plan provides coverage for bariatric surgeries. The Commission should closely examine the impact these surgeries have had on costs as well as health outcomes.

We appreciate the opportunity to comment on these important health care conditions. VAHP and its members are committed to supporting high quality, cost-effective, and evidence-based health care for their 6 million insured members across the Commonwealth. We look forward to continuing to work with the Commission on this study as well as others. Please reach out with any questions.

Best regards,

Doug Gray
Executive Director