JOINT COMMISSION ON HEALTH CARE

OBESITY AND EATING DISORDERS PREVENTION AND TREATMENT IN VIRGINIA

REPORT TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT #667

COMMONWEALTH OF VIRGINIA
RICHMOND
2023

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Obesity and Eating Disorder Prevention and Treatment in Virginia

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Obesity and Eating Disorders Prevention and Treatment in Virginia

Key terms and definitions

ACA – Affordable Care Act

AN – Anorexia Nervosa

ARFID – Avoidant Restrictive Food Intake Disorder

ARTS – Addiction Recovery Treatment Services

BED – Binge Eating Disorder

BMI – Body Mass Index

BN – Bulimia Nervosa

BOI – Bureau of Insurance

CMS – Centers for Medicare and Medicaid

DBHDS – Department of Behavioral Health and Developmental Services

DMAS – Department of Medical Assistance Services

ED – Eating Disorder

EDE – Eating Disorders Examination

EHB – Essential Health Benefits

EPSDT – Early and Periodic Screening, Diagnostic and Treatment

GLP-1 – Glucagon-like Peptide 1

HIRC – Health Insurance Reform Commission

IOP – Intensive Outpatient Treatment

JLARC – Joint Legislative Audit and Review Commission

LGBTQ+ – Lesbian, Gay, Bi-Sexual, Transgender, Queer, Plus

MCO – Managed Care Organization

MNT – Medical Nutrition Therapy

NQTL – Non-Quantitative Treatment Limitations

OSFED – Other Specified Feeding and Eating Disorder

PCP – Primary Care Providers

PHP – Partial Hospitalization Program

Project BRAVO – Behavioral Health Redesign for Access, Value, and Outcomes

SISP – Specialized Instructional Support Personnel

SOLs – Standards of Learning

USPSTF – United States Preventive Services Task Force

VMAP – Virginia Mental Health Access Program

VDH – Virginia Department of Health

VDOE – Virginia Department of Education

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.

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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.

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Obesity and Eating Disorder Prevention and Treatment in Virginia

The Joint Commission on Health Care directed staff to study prevention and treatment strategies for obesity and eating disorders. The study resolution (Appendix 1) specifically directs staff to:

- identify prevalence of obesity and eating disorders in Virginia;
- identify available prevention and early identification strategies for obesity and eating disorders in the education and primary care setting;
- identify evidence-based strategies for the treatment of obesity and eating disorders;
- analyze the extent to which Medicaid and state-regulated health plans cover the costs of prevention, early identification, and treatment of obesity and eating disorders; and
- assess barriers to care for eating disorder treatment in Virginia.

While obesity and eating disorders fall along a spectrum of weight-related problems, obesity is not considered an eating disorder. Obesity and eating disorders are independent medical conditions that each come with severe physical and mental health consequences. As such, this report focuses on each condition separately.

Obesity is defined as excessive fat accumulation that presents a risk to health. Obesity is often associated with health complications such as diabetes, hypertension, heart disease, and stroke. Rates of obesity have continued to increase in recent years. In 2021, about 68 percent of Virginia adults were overweight or obese, and 38 percent of Virginia children between 10-17 were overweight or obese. Many factors can contribute to excess weight gain including behavior, genetics, or taking certain medications. Additionally, certain social and environmental factors can influence obesity including access to healthy food, physical activity, and stress. Policy options related to broad social and environmental factors are beyond the scope of this study.

Eating disorders are a group of complex mental health conditions identified by a persistent disturbance in eating behavior which can impair physical and mental health. There are several types of eating disorders recognized in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (Appendix 2). Each disorder has its own set of symptoms and characteristics, and the most common eating disorders are anorexia, bulimia, and binge-eating disorder. It is estimated that 9 percent of Virginians (749,797 people) will have an eating disorder in their lifetime. Eating disorder

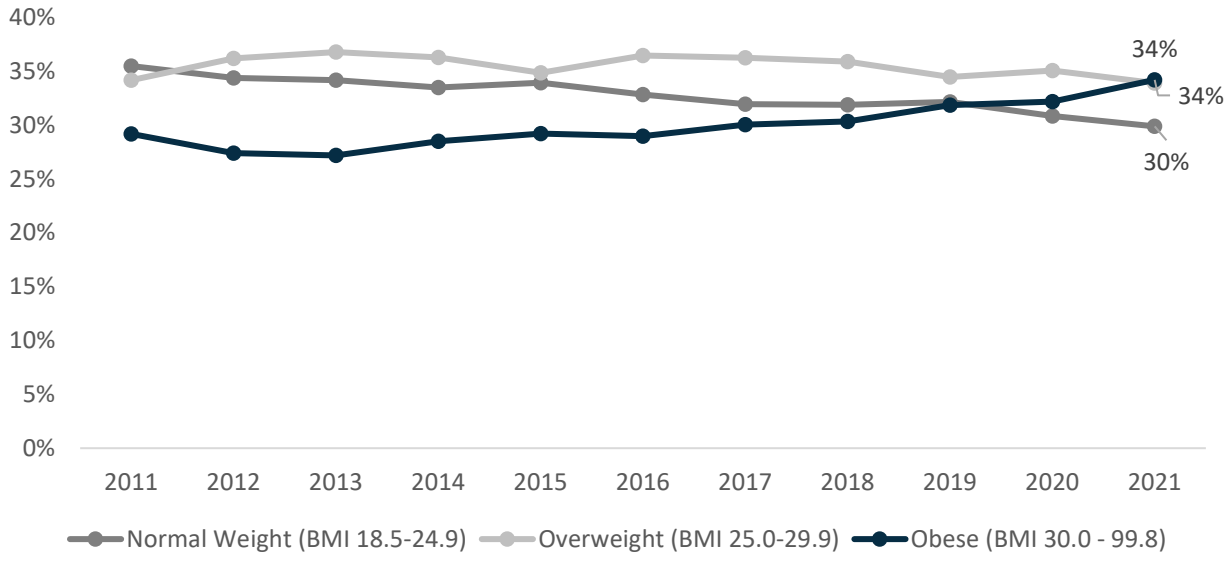
treatment is not widely available and individuals have reported challenges with receiving coverage from their insurance companies. Eating disorders have the second highest mortality of all mental illnesses with over 10,000 deaths nationally each year, second only to drug overdose caused by opioid addiction.

Obesity Prevention and Treatment

Obesity prevalence in Virginia has steadily increased in the last decade

The number of individuals living with obesity in Virginia has steadily increased since 2011, while the number of individuals who are overweight has remained relatively consistent (FIGURE 1). In 2021, 34 percent of Virginians were obese. Individuals with lower income are more likely to be obese, while individuals with higher income are more likely to be overweight (Appendix 3, FIGURE 7). Obesity disproportionately affects certain racial and ethnic groups. About 47 percent of Black individuals were obese in 2021, despite accounting for 18 percent of the population in Virginia (Appendix 3, FIGURE 8). In the same year, about 30 percent of Hispanic individuals were obese even though this group is about 10 percent of Virginia's population (Appendix 3, FIGURE 8).

FIGURE 1: The population of individuals living with obesity in Virginia has increased since 2011.

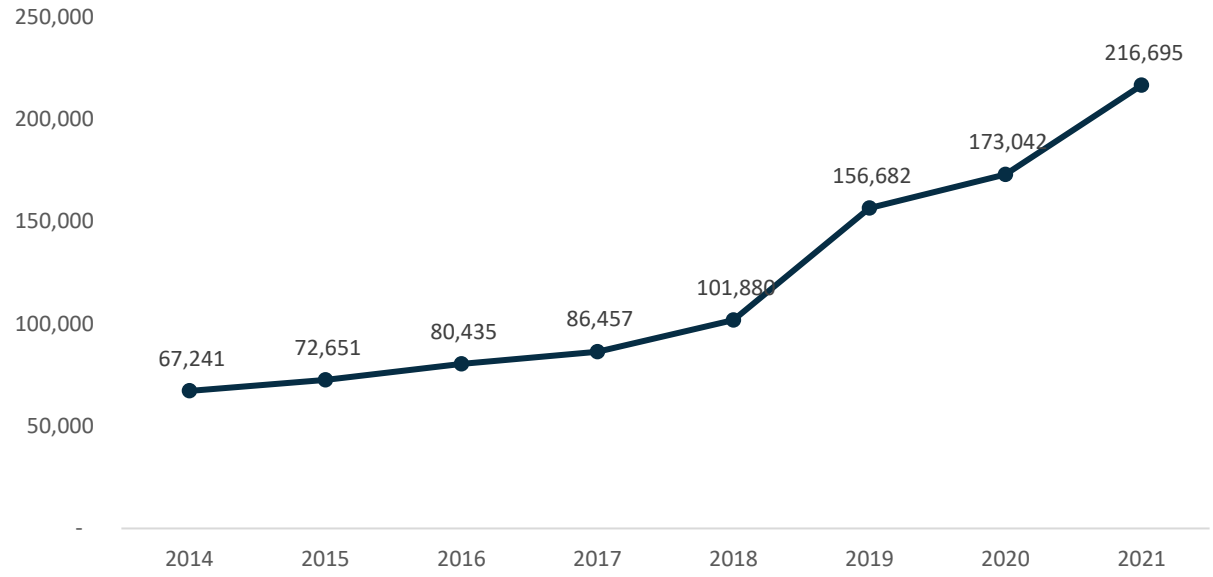


SOURCE: JCHC analysis of Behavioral Risk Factor Surveillance System (BRFSS) data from 2011 to 2021.

Medicaid members have seen a greater increase in obesity compared to the general population

The number of Medicaid members with an obesity diagnosis has increased 222 percent between 2014 and 2021 (FIGURE 2). By 2021, about 12 percent of Medicaid members in Virginia were diagnosed as obese. Medicaid members between the ages of 30 and 64 are the most likely to be obese and account for the fastest growing group of individuals who are obese across the Medicaid population (Appendix 3, FIGURE 9). The Central and Eastern Virginia regions have the highest proportion of Medicaid individuals who are obese (Appendix 3, FIGURE 10). There are persistent racial and ethnic disparities across the Medicaid population. White individuals comprise about 54 percent of the entire Medicaid population and account for51 percent of obesity diagnoses. Conversely, Black individuals comprise roughly 35 percent of the Medicaid population, yet represent 41 percent of obesity diagnoses. Hispanic individuals accounted for about 4 percent of the entire Medicaid population, yet account for nearly 11 percent of obesity diagnoses

FIGURE 2: The population of Medicaid members diagnosed with obesity has increased 222% between 2014 and 2021



SOURCE: JCHC analysis of Department of Medical Assistance Services data of individuals with a primary or secondary diagnosis of obesity, 2023.

Best practices to promote prevention and early identification of obesity aim to increase healthy behaviors

Public schools and primary care providers are uniquely positioned to educate children and young adults on ways to support healthy behavior choices and address unhealthy weight gain before it poses a risk to health.

Local implementation of evidence-based prevention standards for obesity in Virginia K-12 curriculum varies

The Virginia **Standards of Learning (SOLs)** establish minimum expectations for what students should know by the end of each grade in various subjects.

JCHC staff found evidence-based prevention principles were adequately incorporated into the public school curriculum after comparing the content of Virginia's health, physical education, and family life standards of learning (SOLs; see sidebar) with evidence-based prevention and early identification principles cited in peer-reviewed literature.

Evidence-based prevention principles identified in the literature include the importance of engaging in healthy lifestyle factors such as meeting recommended physical activity guidelines, adequate food and vegetable intake, limiting screen time and sedentary activity, and promoting adequate sleep. Virginia students learn as early as kindergarten and first grade about food groups, the importance of physical activity, and how behaviors impact health and wellness. By 5th grade, Virginia students should distinguish between reliable and unreliable information and resources, practice healthy behaviors, and analyze the influences of media on personal and community well-being. By the 9th and 10th grade, Virginia students should demonstrate comprehensive wellness knowledge and know how to create a healthy lifestyle for themselves, their family, and their community. There is also an emphasis on the importance of energy balance, and the nutritional needs of the body to maintain health and prevent chronic disease.

Virginia Department of Education (VDOE) staff cited that health and physical education SOLs are a lower priority compared to subjects with a state assessment. Unlike mathematics or reading, students are not required to take an annual state assessment in health and physical education.

Primary care providers assess multiple factors to identify those at risk for obesity

A primary care provider is usually an individual's first entry point to the health care system and can identify signs of weight gain that could pose a risk to individual health. Primary care providers routinely screen for obesity, and they are often part of a care team when less intense interventions are needed for those who are beginning to address excess weight or those who have not yet reached clinical obesity.

Body mass index (BMI) is widely used as the clinical guideline to assess the level of fat accumulation in the body (see sidebar), though it has limitations. For example, BMI may overestimate body fat among individuals with more muscle, or underestimate fat in older adults who have lost muscle over their lifespan. Abdominal obesity is independently associated with increased cardiovascular risk and is measured by waist circumference. Clinical practice guidelines more commonly use waist circumference in conjunction with BMI to assess cardiometabolic risk. Clinicians may also use other clinical parameters to gain a comprehensive understanding of individual fat distribution. However, BMI and waist circumference are generally the most cost efficient and accessible indicators for obesity. In rare cases, genetic testing may be recommended for children with extreme early onset obesity before the age of five.

Body Mass Index (BMI) is calculated as weight in kilograms divided by height in meters squared (kg/m^2). It is a clinical measure that can indicate fat in the body, but it does not diagnose the health of an individual. Higher BMI categories are defined as overweight and obese with the corresponding BMI ranges below.

- Overweight – BMI 25-29 kg/m^2
- Obese – BMI ≥ 30 kg/m^2

Obesity is further categorized into 3 categories:

- Obesity Class 1 – BMI 30.0-34.9 kg/m^2
- Obesity Class 2 – BMI 35.0 – 39.9 kg/m^2
- Obesity Class 3 – BMI ≥ 40 kg/m^2

Obesity treatment primarily consists of behavioral interventions, pharmacotherapy, and bariatric surgery

The goals of obesity treatment are to achieve and maintain weight loss as well as reduce risk of comorbid conditions that are exacerbated by obesity. Obesity treatment falls into three categories from least aggressive to most aggressive: behavioral interventions, pharmacotherapy, and bariatric surgery (TABLE 1). These treatments take a multidisciplinary approach that focuses first on improving lifestyle factors such as diet and physical activity before engaging in more aggressive treatment. Individuals usually need to meet strict inclusion criteria before pharmacotherapy or bariatric surgery is deemed medically necessary. Gastric bypass, one type of bariatric surgery, costs an average of $23,000 nationally without insurance. Notably, bariatric surgery is widely considered to be outside the scope of primary care, but it can be effective for those who have tried a behavioral intervention and were unsuccessful.

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.

Behavioral interventions are recommended for most people with or at risk for obesity, and coverage varies by insurer

All non-grandfathered, fully insured individual and small group health insurance plans in Virginia are required to provide **essential health benefits (EHB)**, which include items and services in 10 broad categories, including preventative services, required by the Affordable Care Act (ACA). The ACA also requires state Medicaid plans to cover EHB for Medicaid beneficiaries enrolled under ACA's Medicaid expansion.

All non-grandfathered fully insured individual and small group plans and Medicaid beneficiaries enrolled under Medicaid expansion are required to cover obesity screening and counseling as a preventative service (see sidebar). Preventive services are defined as the evidence-based recommendations with an "A" or "B" rating by the United States Preventive Services Task Force (USPSTF) (see sidebar).

USPSTF recommends clinicians screen children and adolescents 6 years and older for obesity When BMI falls within the threshold for obesity, USPSTF recommends clinicians offer or refer individuals to comprehensive, intensive behavioral interventions to promote improvements in weight status. Peer-reviewed literature suggests that interventions with at least 26 total contact hours over a period of two to 12 months result in significant weight loss. However, behavioral interventions greater than 52 hours are more effective at improving other cardiovascular risk factors than shorter interventions. These interventions typically include education about healthy eating, weight self-monitoring, and engage the parent separately or with their child.

The **United States Preventative Services Task Force (USPSTF)** is an independent, volunteer-led panel of national experts in disease prevention and evidence-based medicine. The Task Force makes evidence-based recommendations about clinical preventive services by assigning each recommendation a letter (an A, B, C, or D grade or an I statement) based on: the strength of the evidence, the balance of benefits, and the harms of a preventive service.

For adults 18 years or older, USPSTF recommends clinicians offer or refer individuals with a BMI of 30 kg/m^2 to intensive, multicomponent behavioral interventions that include weight self-monitoring and other tools that support weight loss such as scales, fitness equipment, and wearable fitness trackers. These behavioral interventions are designed to achieve or maintain clinically significant weight loss of 5 percent or greater. Interventions usually last 1-2 years and use an interdisciplinary care team including psychologists, registered dietitians, exercise physiologists, and lifestyle coaches.

Behavioral interventions aimed to promote healthy diet or increase physical activity may be combined for initial weight loss or to sustain weight loss over time. Most interventions engage with patients through counseling sessions or some other lifestyle support. The clinician or care team also tailors interventions based on a patients' social, environmental, and individual factors.

Virginia Medicaid covers preventive services for children and adults through a comprehensive health benefit

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is designed to deliver medically necessary, comprehensive pediatric health care services for Medicaid-enrolled children and persons under 21 years of age, even if the services are not usually covered by Medicaid. Examples of relevant covered screening services include physical exams, behavioral interventions to reduce the risk of obesity, nutrition counseling, prescription drugs that promote weight loss, and bariatric surgery when deemed medically necessary.

Virginia covers adult preventive services through an optional state benefit

States are required to cover preventive services without cost sharing to adults newly enrolled in Medicaid as a requirement of Medicaid expansion. In addition, Virginia opted to expand coverage for preventive services for all adults enrolled in Medicaid. These services could include BMI screening, a wellness exam, and nutritional counseling for obesity.

Virginia's managed care programs may offer behavioral interventions as an enhanced benefit not covered under Medicaid

Enhanced benefits are services offered by a managed care organization (MCO) in addition to services offered by the managed care program. For example, Aetna offers a weight management program that consists of six counseling visits with a certified nutritionist over twelve weeks. UnitedHealthcare members age 10 years and above can request free "Weight Watchers" meeting vouchers, and members over age 18 can access free gym memberships and virtual fitness options by contacting their representative. Anthem HealthKeepers Plus offers a six-month program to their members designed to help families live a healthy lifestyle. Optima offers an online weight management program to help members improve current habits related to diet and physical activity.

Virginia Medicaid has piloted an evidence-based prevention program that could benefit people with obesity

The Department of Medical Assistance Services (DMAS) and Virginia Department of Health (VDH) partnered to test a value-based payment strategy for the National Diabetes Prevention Program - Lifestyle Change Program for managed care organization (MCO) enrollees on Optima and Anthem. This evidence-based program targets people who are at high risk for type 2 diabetes by promoting a change in lifestyle factors for modest weight loss to ultimately delay onset or prevent disease. Obesity is a primary risk factor for type 2 diabetes, and individual risk of type 2 diabetes increases with body weight. USPSTF recommends screening for prediabetes and type 2 diabetes in asymptomatic adults aged 35 to 70 years who are overweight or obese. Compared to adults within normal BMI range, adults who are obese can be three to seven times more likely to have type 2 diabetes.

The Lifestyle Change Program lasted three years and had demonstrated success after its first year, was cost-effective after three years, and could potentially prevent 1,443 cases of type 2 diabetes in the Virginia Medicaid population. However, this program is not currently a Medicaid benefit. There are 10 states that already provide coverage for this program within their state Medicaid program.

➔ **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.

The Virginia Essential Health Benefits (EHB) benchmark plan, individual, and small group plans do not specify coverage for behavioral interventions for weight management

Behavioral interventions are recommended for nearly all children and adults as a first line treatment for obesity. However, it is important to note, there is not a single evidence-based behavioral intervention that is more effective than another. USPSTF refers to behavioral interventions as a range of programs that are designed to achieve clinically significant weight loss through a combination of dietary changes and increased physical activity, therefore insurance carriers can interpret what constitutes a behavioral intervention and whether it is covered. A health care provider may recommend behavioral interventions for weight management, but since these programs can be broad in nature, insurers may not cover what a provider recommends, or it is not covered to the extent needed for long-term behavior change. The Virginia Essential Health Benefits (EHB) benchmark plan (see sidebar) specifically excludes coverage of weight loss programs, which could fall under behavioral intervention. As such, individual and small group plans that are required to cover services in the EHB benchmark plan also do not cover weight loss programs. Additionally, there are no individual or small group plan carriers on or off the health insurance exchange that cover health club memberships and fitness services that may be used as part of a behavioral intervention. The new EHB benchmark plan effective beginning calendar year 2025 also excludes coverage in these areas.

The essential health benefits (EHB), Benchmark Plan is a set of benefits that comprehensive individual and small group health insurance coverage must provide. Each state determines the EHB Benchmark Plan within guardrails set by federal law. A state may change its EHB Benchmark Plan. See Appendix 4 and 5 for additional details.

Individuals with obesity may have difficulty accessing nutrition services

The Affordable Care Act (ACA) requires coverage of nutrition services as a preventative health benefit when there is risk for chronic disease. The Virginia EHB benchmark plan covers "counseling services related to nutrition" as a preventive health benefit without a quantitative limit on the service. This can include nutritional counseling depending on the insurer and the expertise of the clinician providing services. However, when nutritional counseling is used as a treatment for obesity, there may be a copayment, or it may not be covered at all by the insurer. The new EHB benchmark plan effective beginning calendar year 2025 covers nutrition counseling, but it does not provide a definition of the services in plan documents to ensure it is consistent across individual and small group plans that are required to comply with the EHB benchmark plan. Since obesity is a chronic disease that can lead to other costly comorbidities such as diabetes and cardiovascular disease, increasing access to nutrition counseling to support a healthy diet could potentially lead to reduced morbidity and cost savings.

➔ **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 (HIRC) and the Bureau of Insurance (BOI) to define nutritional counseling in the EHB benchmark plan.

Some individual and small group plans exclude medical nutrition therapy for obesity treatment

Medical Nutrition Therapy (MNT) is a nutrition-based treatment provided by a registered dietitian nutritionist. MNT can be used to treat several chronic conditions such as diabetes, obesity, heart disease, kidney disease, and cancers.

Virginia offers medical nutrition therapy (MNT) as a state-mandated benefit exclusively for people with diabetes. MNT, a form of nutritional counseling, can also benefit individuals managing excess weight and obesity (see sidebar). JCHC staff found only two individual and small group plans cover medical nutrition therapy when used as treatment for obesity. Increasingly, clinical guidelines recommend MNT for people who are overweight or obese. For those who do not have diabetes, an insurer may impose yearly limits for these services. It is possible to require plans to cover services as a state-mandated benefit through Virginia's mandated benefit review process (Appendix 4). If a state-mandated benefit is approved through this process, it would take at least two years to submit a new EHB benchmark plan for federal approval (Appendix 5).

➔ **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 (HIRC) and the Bureau of Insurance (BOI) conduct an assessment to include medical nutrition therapy when treating a qualifying or eligible medical condition in the essential health benefits (EHB) benchmark plan.

Coverage for nutrition services varies within Medicaid MCOs

Virginia Medicaid covers medical nutrition therapy and nutritional counseling for all adults with obesity or chronic medical diseases including type 1 and type 2 diabetes, and members with metabolic disorders. A member would need a physician to certify and document medical necessity for these services before they are approved. JCHC staff reviewed plan documents for the five Medicaid managed care organizations in the state and found differences in nutrition services that are offered. Aetna, Anthem, Molina Health Care, and United HealthCare cover nutritional counseling if the member is diagnosed with obesity or other chronic medical diseases. Optima Health mentions coverage of nutritional counseling when there is a diagnosis of obesity or other chronic medical condition; however, one provider-directed document states that Optima Health covers nutritional counseling only when there is a diagnosis of diabetes.

While Virginia MCOs cover these services, they also impose annual limits (TABLE 2). There is not a body of evidence to suggest more sessions receiving nutritional

counseling would lead to better outcomes. However, it is possible that removing a quantitative limit on a lower cost service such as nutritional counseling or medical nutrition therapy could ensure that individuals are maximizing their opportunity to use a lower level of care before seeking a more aggressive treatment option.

TABLE 2: Virginia Medicaid imposes annual limits on MNT services

Description	DMAS Limit
Medical nutrition therapy; initial assessment and intervention, face-to-face with the patient, each 15 minutes.	12 units per calendar year
Medical nutrition therapy; reassessment and intervention, face-to-face with the patient, each 15 minutes.	12 units per calendar year
Medical nutrition therapy, group two or more individual(s), each 30 minutes.	4 units per calendar year
Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes.	8 units per calendar year
Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group two or more individuals, each 30 minutes.	4 units per calendar year
Nutritional counseling, dietitian visit.	8 units per calendar year

SOURCE: JCHC analysis of Medicaid MCO provider guidelines, 2023

➔ **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.

Weight loss medications are typically only recommended after an unsuccessful behavioral intervention

Weight loss medications do not replace physical activity and healthy eating habits for weight loss. Though medications are typically only considered after a behavioral

intervention alone does not yield positive results, a number of studies found weight management medications work best when they are combined with a behavioral intervention program.

Glucagon-Like Petide-1 Receptor Agonists (GLP-1) are a class of medications used in the treatment of type 2 diabetes and obesity. Two GLP-1 drugs, liraglutide and semaglutide, are the only GLP-1 drugs that are FDA-approved to treat obesity and type 2 diabetes.

There are six medications that are approved for weight loss by the U.S. Food and Drug Administrations (FDA) for children 12 years and older and adults (TABLE 3). Weight loss medications that are categorized as GLP-1, and also approved to treat type 2 diabetes, are more expensive than non-GLP-1 medications (see sidebar). Generally, weight loss medications can help an individual feel less hungry, increase satiety, or make it harder for the body to absorb fat from food. The duration an individual may take these medications will vary based on effectiveness, other concurrent medications, lifestyle factors, and balancing side effects with potential benefits. If weight loss medications are ineffective, an individual may be referred to a bariatric surgeon to consider a surgical intervention for obesity.

TABLE 3: There are 6 FDA-approved weight loss medications

Weight Management Medication (Common brand name)	Population	GLP-1 Drug
Bupropion-Naltrexone (Contrave)	Adults only	No
Orlistat (Xenical)	Adults and children 12 years and older	No
Liraglutide (Saxenda)	Adults and children 12 years and older	Yes
Phentermine-topiramate (Qsymia)	Adults and children 12 years and older	No
Semaglutide (Wegovy)(Ozempic)(Rybelsus)	Adults and children 12 years and older	Yes
Setmelanotide (IMCIVREE)*	Adults and children 6 years and older	No

SOURCE: National Institute of Diabetes and Digestive and Kidney Diseases

*NOTE: FDA-approved exclusively for children ages 6 years and older who have one of the three specific rare genetic disorders contributing to obesity.

Virginia Medicaid is in the process of updating criteria for FDA-approved weight-loss drugs

Under 2023 Special Session I Amendments to the 2023 Appropriation Act, Virginia Medicaid proposed revisions to prior authorization requirements for weight loss drugs (see sidebar; TABLE 4). Notably, an individual now must demonstrate trial and failure of weight loss using a non-GLP-1 drug in the previous six months before beginning a GLP-1 drug. These revisions are subject to review and approval during a special session of the Virginia Medicaid Pharmacy and Therapeutics Committee on October 18, 2023. It is too early to estimate how these changes may impact access to weight loss drugs. Since GLP-1 drugs are more expensive than non-GLP-1 drugs, this change may result in a potential cost savings for the Medicaid program. However, future cost benefit analyses could help illustrate the long-term impacts of this change to prior authorization.

Prior authorization is a pre-approval that insurance carriers may require before a patient can have a certain drug, treatment, or service covered. This may be to coordinate services or ensure the correct payment is provided. As part of prior authorization, an insurer may require the provider to demonstrate why the care is needed so that the insurer can evaluate whether care is medically necessary under their guidelines. A carrier may not pay for care if the patient's condition does not meet certain standards.

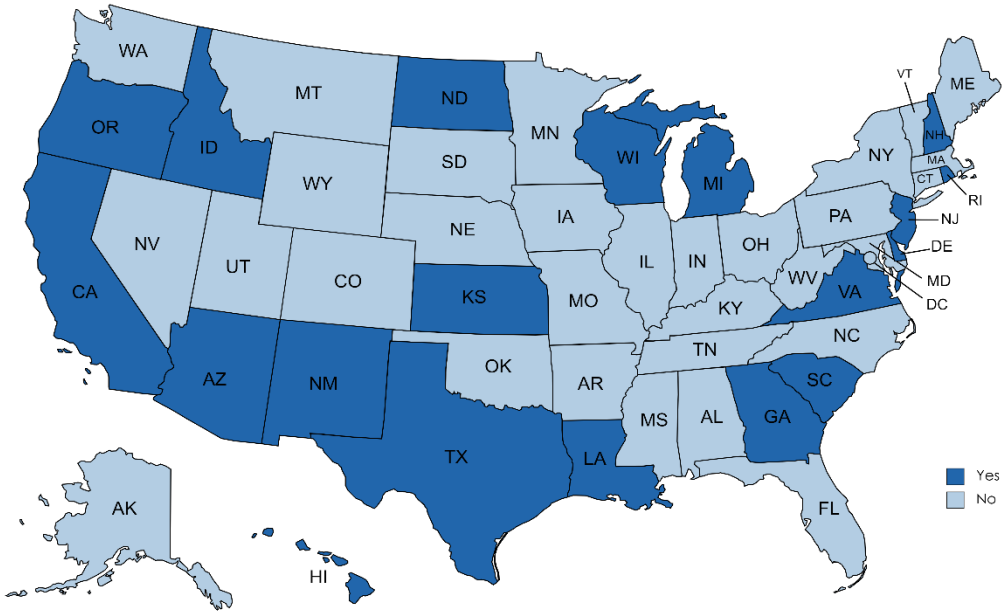
TABLE 4. Virginia Medicaid requires five criteria to be met before providing coverage for preferred weight loss drugs

1.	Patient has demonstrated trial of and failure of a comprehensive lifestyle intervention for weight loss
2.	Provider can verify the patient's obesity is a disability and potentially life-threatening (e.g. puts the patient at risk for high morbidity conditions)
3.	Patient has demonstrated trial and failure of weight loss using a non-GLP-1 weight loss drug in the previous 6 months
4.	Patient has a BMI of at least 40 kg/m^2, or a BMI of at least 35 kg/m^2 and two or more chronic conditions
5.	Expectations around submission of documentation supporting patients' completion of service authorization requirements

SOURCE: Department of Medical Assistance Services June 23, 2023, memo to all providers and managed care organizations participating in Virginia Medicaid and FAMIS programs.

Prior to the proposed criteria, there were fewer prior authorization requirements for FDA-approved weight loss drugs. An individual would need to meet federal Social Security Administration disability standards, meet DMAS' medical necessity requirements, and the condition would need to be certified as life threatening by the treating physician. Virginia is one of 19 states that provides coverage for pharmacotherapy for weight loss within its managed care program (FIGURE 3).

FIGURE 3: Virginia is one of 19 states that covers weight loss drugs through its state Medicaid program.



SOURCE: JCHC analysis of STOP Obesity Alliance 2016-2017 data.

The Virginia EHB benchmark plan does not provide coverage for weight loss drugs

The current Virginia EHB benchmark plan specifically excludes coverage for weight loss drugs. Consequently, there are no individual or small group plans that cover weight loss drugs. The new Virginia EHB benchmark plan effective January 1, 2025, also excludes coverage of weight loss drugs within their pharmacy benefit, which is consistent with most states. New Mexico and North Carolina are the only two states that cover weight loss drugs within their state benchmark plan.

However, as more evidence becomes available for the effectiveness of these treatments, health insurance carriers and other stakeholders will need to reevaluate how weight loss medications will be covered to balance the use of weight loss medications in an

appropriate context. Since this provision would be subject to Virginia's mandated benefit review process (Appendix 4) to be considered in Virginia's EHB benchmark plan, it is possible to revisit the evidence available for weight loss drugs before a new EHB benchmark plan is submitted. If a state-mandated benefit is approved through this process, it would take at least two years to submit a new EHB benchmark plan for federal approval before the plan could go into effect (Appendix 5).

➔ **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 (EHB) benchmark plan.

Patients eligible for surgical interventions to treat obesity must meet highly exclusive criteria

Individuals who have not yet achieved weight loss through behavioral intervention and/or pharmacotherapy may be referred to a health care provider for bariatric surgery. For adults, bariatric surgery is recommended after a behavioral intervention or pharmacotherapy intervention was deemed ineffective. A pre-operative psychological assessment is required to identify factors that may impact post-operative weight loss such as substance use, major depression, and binge eating disorder.

Bariatric surgery recommendations for children are mixed. Several professional clinical guidelines have not supported bariatric surgery for pre-adolescent children, adolescents, or anyone that has not mastered the principles of healthy diet and physical activity. However, the American Academy of Pediatrics' latest clinical guidelines support bariatric surgery for children with severe obesity.

Virginia Medicaid covers bariatric surgery when deemed medically necessary

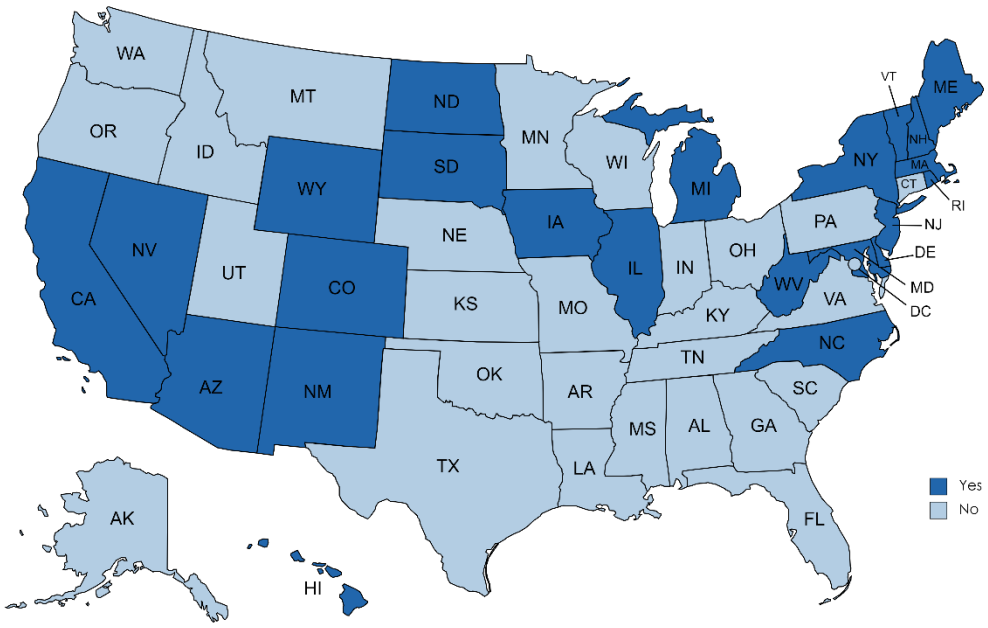
Virginia has strict medical necessity criteria before prior authorization for bariatric surgery is approved. All states excluding Montana and Mississippi cover bariatric surgery within their state's Medicaid managed care program.

Less than half of individual and small group plans in Virginia cover bariatric surgery, even when deemed medically necessary

The Virginia EHB benchmark plan does not cover bariatric surgery. JCHC staff analysis found 16 percent of individual plans in Virginia cover bariatric surgery. One carrier covered weight loss surgery exclusively for their off exchange plans. About 43 percent of small group plans covered weight loss surgery when medically necessary. The new EHB benchmark plan effective calendar year 2025 excludes coverage for bariatric surgery. Currently, there are 23 states that cover bariatric surgery through their state benchmark plan (FIGURE 4). A 2022 BOI report cited that 4 of the 7 Virginia's

neighboring states cover bariatric surgery including Delaware, Maryland, North Carolina, and West Virginia at least when medically necessary. If a state-mandated benefit is approved through this process, it would take at least two years to submit a new EHB benchmark plan for federal approval before the plan could go into effect.

FIGURE 4: Twenty-three states cover bariatric surgery through their state EHB benchmark plan



SOURCE: JCHC analysis of STOP Obesity Alliance 2016-2017 data.

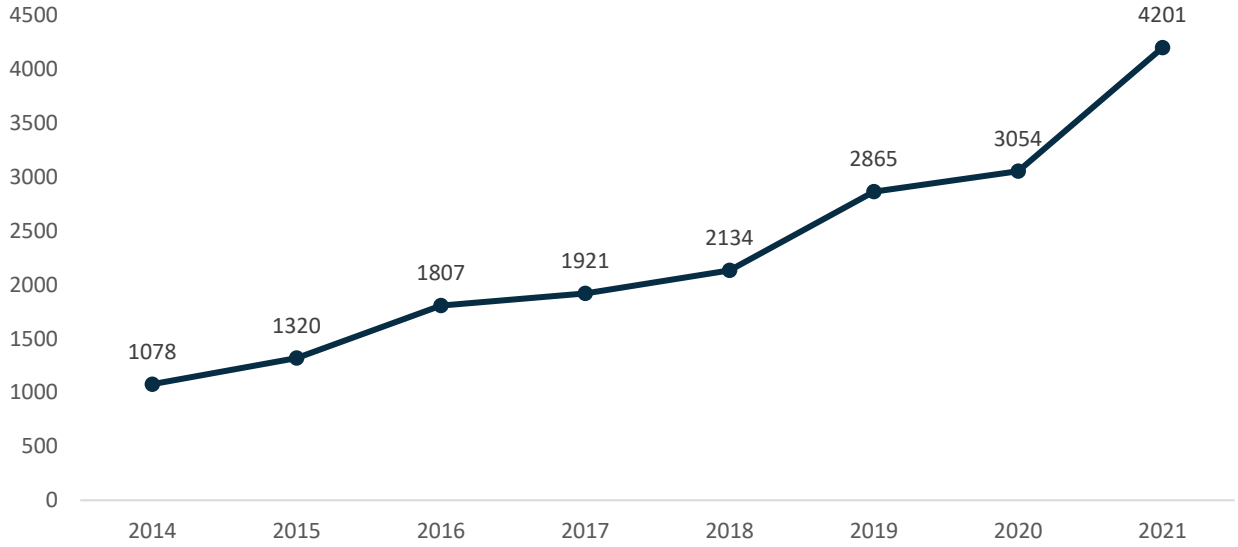
➔ **Option 6:** JCHC could write a letter to the Chair of House Commerce and Energy or Senate Commerce and Labor requesting the Health Insurance Reform Commission and the Bureau of Insurance to conduct an assessment to include bariatric surgery coverage when medically necessary in the essential health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

Eating Disorders

There was a spike of eating disorder cases among Medicaid population during the COVID-19 pandemic

The total number of individuals with an eating disorder has tripled since 2014 within the Medicaid population, with a notable spike during the beginning of the COVID-19 pandemic (FIGURE 5). Medicaid adults between the ages of 19 and 29 saw the largest increase in eating disorder diagnosis since 2020. Adolescents between ages 10 and 18, and adults between ages 30 and 64 years have the highest rates of eating disorder diagnosis. Women and white individuals were most likely to have an eating disorder. However, American Indian and Alaskan Native individuals were disproportionately affected by higher rates of eating disorders.

FIGURE 5: Medicaid members diagnosed with an eating disorder increased 290% between 2014 and 2021



SOURCE: JCHC analysis of Department of Medical Assistance Services data of individuals with a primary or secondary diagnosis of obesity, 2023.

Best practices to promote prevention and early identification of eating disorders target at-risk individuals

Evidence-based eating disorder prevention strategies aim to avoid a one-size fits all approach. The most effective eating disorder prevention strategies target at-risk individuals rather than universal prevention strategies. Eating disorder prevention strategies are usually classroom-based, though self-guided programs available online may be more accessible. Effectiveness of prevention programs within schools can vary depending on the participants' ages. Research shows that current programs tend to be significantly more effective for older adolescents, above the age of 15, and young adults, which is around the time when eating disorders are likely to emerge. Some studies have found that with younger participants, increased eating disorder knowledge was associated with increased disordered eating behaviors at follow-up.

Most prevention programs focus on addressing risk factors related to eating disorders, such as anxiety, depression, low self-esteem, and internalized ideas around an individual body. Shape and weight concerns are widely considered an important risk factor for eating disorders, therefore two main prevention strategies – dissonance-based programs and healthy weight programs – aim to promote body satisfaction and reduce body image concerns. Under dissonance-based prevention, participants with body image concerns engage in activities where they critique the thin-ideal, creating an uncomfortable cognitive dissonance. This strategy is more effective in reducing eating disorder risk factors and symptoms compared to other types of interventions. Healthy weight programs are another prevention strategy that aims to increase body satisfaction while endorsing a healthy diet and physical activity.

Eating disorder prevention principles are introduced at an age-appropriate stage in Virginia K-12 standards of learning

Virginia SOL standards introduce eating disorder education between 6th and 8th grades, when research suggests eating disorders are likely to begin (TABLE 5). To note, these standards do not address how to recognize risk factors in individual behavior.

TABLE 5: Summary of Virginia SOLs relating to eating disorder education

Grade Level	Virginia SOLs related to eating disorder education
6th grade	• Analyze the influence of media on issues related to body image
7th grade	• Get introduced to disordered eating • Learn about the different types of eating disorders • Understand warning signs, risk, and protective factors for eating disorders
8th grade	• Understand nutritional impact of disordered eating • Understand impact of society on eating habits and attitudes toward weight and body size • Evaluate the accuracy of claims for trending diets, supplements, and popular beverages • Identify and promote resources for help with disordered eating

SOURCE: JCHC staff analysis of Virginia Department of Education health education Standards of Learning, 2023.

Universal screening for eating disorders is not practiced and not feasible for most schools

While implementing universal eating disorder screenings in schools could lead to earlier identification of eating disorders, it is not feasible given other educational priorities. Virginia Department of Education (VDOE) stakeholders reported that an already strenuous school schedule leaves little time for activities such as universal screenings. Implementing these screenings may impact time dedicated to educational activities.

VDOE staff also cited concerns about eating disorder screenings because there is a lack of training specifically addresses eating disorders in schools. The VDOE Office of Specialized Student Services has developed a collection of resources and training for school mental health professionals. However, none of these resources provide education about recognizing and supporting a student who is at risk or has developed an eating disorder. Schools would have to do a considerable amount of training with staff on the screening, which may not be feasible for this strained workforce.

Virginia Code requires school boards to provide educational information regarding eating disorders to parents of students in grades 5 through 12 on an annual basis

The *Code of Virginia* § 22.1-273.2 requires VDOE to provide eating disorder information to school boards and parents (Appendix 6). The school boards have the autonomy to decide where, when, and how the information is disseminated to parents. This legislation resulted from a 2011 JCHC study on eating disorders. VDOE's current eating disorder information sheet was last updated in 2020. Local school boards can also decide the extent to which they want eating disorder policies (such as universal screening) implemented. There is no requirement for the type of screening tool a locality uses, should they opt-in to screening. Parents are notified when screenings are conducted in schools and can choose to opt-out for their child. The *Code of Virginia* § 22.1-273.2 does not require VDOE to collect or track data on eating disorders, therefore, VDOE does not have a way to identify localities that opt-in for screening.

Specialized instructional support personnel (SISP) in schools, such as school nurses, psychologists, social workers, and counselors do not have a process, a requirement, or training for early identification of eating disorders, however SISP can intervene if there is concern for a student's well-being. They will typically make a referral to a healthcare provider.

Eating disorders are underdiagnosed because they are difficult to identify and isolate

It can be difficult to recognize signs of an eating disorder, making diagnosis challenging. It is a common misunderstanding that those struggling with an eating disorder are severely underweight, but this is not the case for most individuals with an eating disorder. Less than 6 percent of people with eating disorders are medically diagnosed as underweight using the BMI scale. JCHC staff interviewed stakeholders who also reported that individuals in higher weight bodies are underdiagnosed due to the stereotypes surrounding eating disorders. Additionally, those with an eating disorder may present with other psychiatric comorbid conditions such as anxiety, depression, obsessive compulsive disorder, or substance use disorder. In a national survey of adolescents with anorexia nervosa, 55.2 percent of adolescents reported having another mental health condition in addition to an eating disorder. As a result, an individual may have a differential diagnosis of another mental health condition before getting the proper diagnosis needed to seek treatment for eating disorders. This process could take months or years.

Early identification of eating disorders in a clinical setting is based on recognizing signs that warrant screening

Unlike obesity screening, eating disorder screening is not required in primary care visits (see sidebar). Therefore, it is up to primary care providers to identify signs of disordered eating that could warrant further evaluation. Some patients may show signs of an eating disorder which include reported dieting, body image dissatisfaction, experiences of weight-based stigma, or changes in exercise or eating habits. However, these signs may be present for many individuals who do not have an eating disorder. Also, patients may not discuss their symptoms with their provider during a visit which results in a missed opportunity for further evaluation.

The **USPSTF** concluded there was insufficient evidence to assess the balance of benefits and harms of screening for eating disorders in adolescents and adults who do not have signs or symptoms of an eating disorder. Eating disorder screening, in comparison to other screenings and preventive services, is not covered by the ACA.

The Eating Disorders Examination (EDE) instrument is the gold standard for identifying eating disorders and warrants further evaluation

Several clinical guidelines emphasize the importance of screening all children and adolescent patients for eating disorders by first asking about eating patterns and body satisfaction. When there is a sign of an eating disorder present, the Eating Disorders Examination (EDE), a diagnostic interview designed to be administered by a clinician, is recommended. When clinician administration is not possible, there are additional variations of the EDE to be used in various settings, including a self-report version. Many other screening tools have been developed, but these tools have not been as widely adopted.

After a positive screening, a clinician should do complete a comprehensive evaluation to rule out other causes of symptoms. This evaluation should include laboratory tests in addition to a psychiatric and physical exam. Some clinical guidelines also recommended clinicians to assess a patient's nutritional history. Based on the results of the evaluation, a clinician could identify whether there are acute physical signs of an eating disorder or medical complications that would require treatment.

Most assessment tools for eating disorders are based on signs and symptoms of anorexia and bulimia in younger, white women. Early identification of eating disorders is important for ensuring patients can be referred to resources and intervention services as soon as possible. However, depending on the patient's characteristics, reliable screening within marginalized populations can be difficult. As a result, eating disorders are often underdiagnosed. Men are often underdiagnosed with eating disorders. It is estimated that 1 in 3 people struggling with an eating disorder is male despite a stereotype that eating disorders only occur in women. Individuals from

the LGBTQ+ community are also at an elevated risk of developing eating disorders; however, this population is also underdiagnosed. Beginning as early as age twelve, gay, lesbian, and bisexual teens may be at higher risk of binge-eating and purging than their heterosexual peers.

Primary care providers do not have robust training to identify eating disorders but can seek state-based resources for behavioral health conditions

Primary care providers (PCPs) are often the first line of defense for early identification of an eating disorder. JCHC staff interviewed stakeholders and found most PCPs do not have specific training in eating disorders, nor do they feel comfortable treating individuals struggling with an eating disorder. Lack of training and time constraints were commonly cited by stakeholders as barriers to performing adequate screening for eating disorders in primary care.

The Virginia Mental Health Access Program (VMAP) was created in 2018 to remove barriers between mental health care and primary care providers (see sidebar). VMAP provides educational opportunities to providers through pediatric mental health training and provides direct service education through their phone line. The VMAP line connects primary care providers to regional hubs that offer pediatric mental health consultation and care navigation to support patients age 21 and younger. Since the VMAP line opened in 2019, 6 percent (222 calls) of their total consult calls (3,479) reported a disordered eating concern for their patient.

The **Virginia Mental Health Access Program (VMAP)** is a statewide initiative to support primary care providers and increase mental health literacy through provider education and access to child psychiatrists, psychologists, social workers, and care navigators. As of July 2023, VMAP has approximately 1,200 registered primary care providers who are mostly physicians and nurse practitioners. VMAP is primarily funded through state general funds from the Department of Behavioral Health and Developmental Services (DBHDS), federal grants from the Health Resources and Services Administration, and state grants from VDH.

Evidence-based treatment intervention depends on the type of eating disorder and where services are provided

The goal for all eating disorder treatment is to ensure the individual is nourished back to a healthy weight, their eating patterns and behaviors are normalized, and the individual establishes a healthy relationship with food and their body. The treatment strategies a clinician may use depend on the severity of the patient's condition and the setting the patient is seeking for treatment.

Evidence-based eating disorder treatment targets mental and physical manifestations of each condition

JCHC staff conducted a literature review of evidence-based treatment strategies for eating disorders and found there were a core set of mental and physical health treatment strategies that clinicians use to treat eating disorders (TABLE 6). For example, mental health treatment strategies can include cognitive behavioral therapy and family-based therapy, and physical health treatment can include nutrition counseling and weight restoration treatment. Providers use a multidisciplinary care team to coordinate mental and physical health treatment strategies to ensure the best treatment outcomes.

TABLE 6. Eating Disorder treatment can use a combination of mental and physical health treatment strategies

Type of Strategy	Examples of Treatment
Mental Health Treatment Strategies	• Cognitive behavioral therapy • Intense-behavioral therapy • Family-based therapy • Parent-focused therapy • Group-based therapy • Individual therapy
Physical Health Treatment Strategies	• Weight Loss treatment • Nutritional restoration • Weight restoration treatment • Medication therapy • Physical therapy • Refeeding therapy

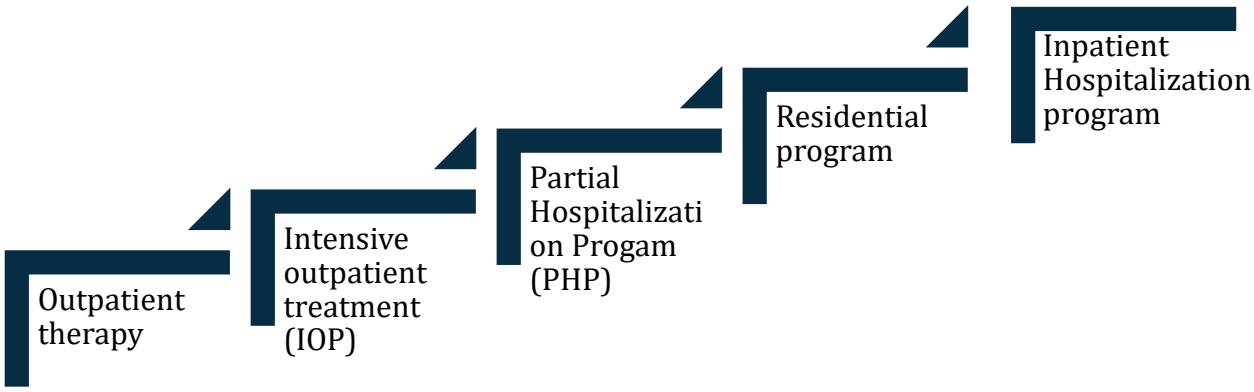
SOURCE: JCHC analysis of peer-reviewed literature of evidence-based eating disorder treatment, 2023.

Eating disorders can be treated in an outpatient setting with less evidence available for more intensive settings

A clinician can identify a treatment setting that is appropriate for a patient based on a variety of factors. Setting type ranges from outpatient care to inpatient hospitalization (FIGURE 6). Since these settings can be independently located, it is important to retain

continuity of care whenever a patient is making a step up or down in care. However, clinical practice guidelines do not indicate the level of care patients may need. Professional clinical practice guidelines specify outpatient care is appropriate for most patients who require eating disorder treatment, and this allows patients to stay within their community. However, there needs to be close monitoring of biological markers to ensure disordered eating behaviors do not progress.

FIGURE 6. Eating disorder treatment services can happen in a range of settings



SOURCE: JCHC analysis of evidence-based eating disorder treatment guidelines.
NOTE: Inpatient hospitalization programs can refer to any of the following: specialized pediatric/medical inpatient eating disorders program, general pediatric/medical inpatient program, specialized psychiatric inpatient eating disorder program or a general psychiatric inpatient program. Characteristics of each level of care are defined in more detail in Appendix 6.

Transitional outpatient programs provide a higher level of care than a traditional outpatient program. **Intensive Outpatient Programs** typically involve individuals attending therapy sessions or eating disorder programs 3-7 times a week for 3-4 hours per day while returning fully to home, work, and school. **Partial Hospitalization Programs** are typically a day program where patients come to a center five days a week and between 6-8 hours each day for services and return home each evening.

Some clinical guidelines suggest that more intensive treatment programs should only be considered when outpatient treatment programs are unavailable or unsuccessful. There is not enough evidence to suggest transitional outpatient treatment settings such as intensive outpatient programs and partial hospitalization programs are more effective than outpatient treatment, but they have been recognized as an important role in the continuum of care (see sidebar). The same is true for inpatient residential treatment programs (see sidebar). Additionally, there has not been research to balance the harms of separating a child or adolescent from their family with the benefits of treatment. However, these more intensive treatment programs can be considered when

there is no specialty outpatient treatment program available, it is the lowest level of care is used, the family is actively involved in treatment, and experienced staff are available.

Residential Treatment Programs includes 24-hour supervision in a home-like environment. Patients must be medically stable to participate in residential treatment programs because the centers are not equipped to handle hospital-level medical treatment.

There are several biomarkers that can show signs of medical instability that could warrant medical hospitalization or hospitalization in a specialized eating disorder unit (see Appendix 6). If someone has a significant medical need then they may require a higher level of care to ensure their safety and to get properly stabilized before progressing to lower levels of treatment. Inpatient treatment is the most restrictive treatment setting and is typically chosen when the patient requires intense medical monitoring because they are medically or psychiatrically unstable.

Access to eating disorder treatment can vary depending on carrier rules around provider reimbursement and broad compliance with parity laws

The two key challenges that limit access to eating disorder treatment are provider reimbursement and the coverage available for these services, regardless of treatment setting. JCHC staff found eating disorder treatment providers cited inconsistencies with how insurers can approve or deny treatment. Additionally, eating disorder treatment providers cited low reimbursement across carriers. All individual and small group plans that comply with benefits outlined in Virginia's EHB benchmark plan are required to offer behavioral health treatment including intensive outpatient, partial hospitalization, and residential treatment services without yearly or lifetime dollar limits for coverage.

Eating disorder treatment providers cite low reimbursement in the commercial market and can only access Medicaid in limited circumstances

Eating disorder treatment providers who conduct reimbursement rate negotiations with commercial insurance companies report the process is tenuous, and that they are being reimbursed at a rate that is not sustainable. One provider reported that they were losing money due to a lack of reimbursement and that costs to provide services had gone up, but reimbursement rates had not increased to accommodate for those increased costs. Without adequate resources, there is a risk of reduced patient care quality and access to services.

Project BRAVO (Behavioral Health Redesign for Access, Value, and Outcomes) is a collaborative initiative led by DMAS and DBHDS to provide a continuum of behavioral health services for children and adults.

Medicaid does not have an established rate for eating disorder services

Medicaid has focused on increasing behavioral health access through Project BRAVO (see sidebar) since 2021. Medicaid covers partial hospitalization and outpatient services as well; however, none of the eating disorder providers that offer partial hospitalization or intensive outpatient services in Virginia accept Medicaid.

Medicaid covers residential treatment services for persons under 21, but there is no coverage available for residential treatment for adults over the age 21. Residential services for youth are provided through fee-for-services (FFS) and are not included in managed care arrangements. Residential treatment centers interviewed reported participating in single case agreements (single case agreements are used to meet EPSDT requirements) with Medicaid when they could, but currently Medicaid does not have a specialty rate for residential treatment centers for eating disorder services. While outpatient, residential, and other services are technically a covered service under Medicaid and could be reimbursed for eating disorders, it is difficult for eating disorder treatment centers to predict what their reimbursement rate would be if they accept Medicaid clients. The reimbursement rates are not specialized to consider the specific components needed for evidence-based eating disorder treatment. Regardless, none of the eating disorder providers that offer residential treatment in Virginia accept Medicaid.

Virginia Medicaid does not provide eating disorder residential treatment for adults over the age of 21. Virginia only provides residential treatment for substance use disorders under 1115 waiver authority (waiving the federal exclusion of Institute of Mental Disease from federal match for adults.) Regarding non-residential treatment options, other states have set Medicaid reimbursement rate standards specifically for eating disorder treatment. For example, Maine's Medicaid program received approval for a state plan amendment to provide reimbursement for two levels of intensive outpatient program services. Participating providers can receive a per diem rate of up to $247.81 for Level I intensive outpatient services and $407.60 per diem for Level II intensive outpatient eating disorder services. As of April 2023, New York now provides a per diem rate for residential eating disorder treatment at a rate of $847.36 in downstate New York and $754.15 in upstate New York. It is worthwhile to note that an increase to the current intensive outpatient and partial hospitalization programs for mental health (IOP-MH, and PHP-MH) was recently included in the final budget for SFY 2024, which would align IOP-MH and PHP-MH rates with the addiction recovery treatment services (ARTS) IOP and PHP rates.

➔ **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.

Federal and state mental health parity laws are intended to reduce barriers to mental health treatment; methods to ensure compliance continue to evolve

Under Mental Health Parity and Addiction Equity Act (MHPAEA) (see sidebar), a plan cannot impose non-quantitative treatment limitations (NQTL; see sidebar) on mental health and substance benefits, unless there is appropriate justification and the NQTLs are not applied more stringently than medical surgical benefits within the same group of services. For example, a health insurance carrier may justify prior authorization for any service that is considered "high cost" and this practice would be permissible as long as "high cost" is defined consistently across medical benefits and substance use disorder benefits.

The federal **Mental Health Parity and Addiction Equity Act (MHPAEA)** originally passed in 2008, requires health plans to ensure access to mental health or substance use disorder benefits are applied no more stringent than medical or surgical benefits. Each state is responsible for complying with federal legislation.

Non-quantitative treatment limitations (NQTL) are non-numerical limits on the scope of duration of benefits for treatment. Examples of NQTLs are:

- Medical management standards limiting or excluding benefits based on medical necessity
- Prior authorization requirements
- Step therapy requirements
- Standards for provider admission to participate in a network, including reimbursement rates

A carrier that imposes NQTL may not indicate a parity violation. A carrier is required to document when NQTL are applied and demonstrate compliance with mental health parity through a comparative analysis. BOI reviews comparative analyses and publishes annual reports to compare differences in the rate of complaints, denials, and appeals across claims received for mental health services, substance use disorder services, and medical services. A 2020 Joint Legislative Audit and Review Commission (JLARC) report found this aggregate assessment is inadequate to draw conclusions about parity compliance by specific plans. The 2022 General Assembly amended the reporting requirements to include a summary of all comparative analyses prepared by a health insurance company to comply with Section 203 of the Consolidated Appropriations Act, 2021. Since the amendment was not effective until July 1, 2022, a summary will be included in BOI's 2023 report due on November 1, 2023.

Insurers prior and continued stay authorization requirement can create administrative barriers for eating disorder treatment and delay necessary care

Medical necessity criteria are standards a carrier may have in place to ensure care is reasonable, necessary, and/or appropriate based on clinical standards of care. Medical necessity criteria need to be met to gain **prior authorization** (see pg. 12) by the carrier and coverage of services. **Continued stay authorization** is the process in which a carrier may require additional documentation to ensure a patient still meets medical necessity criteria. An insurance company may not pay for care if the patient's condition does not meet certain medical necessity criteria for prior and continued stay authorization.

Eating disorder treatment in an intensive outpatient program, partial hospitalization program, or residential treatment program usually requires prior authorization before an insurer will cover the service based on insurer's medical necessity criteria (see sidebar). Carriers' criteria can vary substantially depending on how long prior authorization is initially approved. Medical necessity criteria are based on clinical practice guidelines. If additional care is needed past the allotted time approved in a prior authorization, a patient will need to meet other requirements including medical necessity criteria to receive continued stay authorization, where an insurer continues to cover services within the same episode of care (see sidebar).

Prior and continued stay authorization is monitored by BOI

JCHC staff reviewed all individual and small group health plan documentation available to identify variation in prior authorization policies. There are policy measures that can streamline prior authorization practices or set broad standards for prior authorization, but compliance in these areas is driven primarily by federal and state mental health parity requirements.

Continued stay authorization, which allows for a patient to continue treatment once prior authorization expires, is frequently needed for eating disorder treatment because treatment may only be approved for short periods of time. Providers have cited that treatment is usually approved for between 3-7 days, which varies by insurer. However, the average treatment time is expected to be 35-45 days. This can place a significant administrative burden on providers to seek continued stay authorization multiple times during treatment. Providers find it challenging to prove services are necessary and to justify ongoing treatment for their patients. If this lapse in coverage occurs, patients must convert to private pay if they wish to continue treatment.

Removing prior authorization would expand access to eating disorder treatment

Other states have removed prior authorization for all levels of care for eating disorder treatment to include inpatient, residential, partial hospitalization, and intensive

outpatient services. Vermont is the most recent state to do so. As of January 1, 2023, the Vermont Medicaid program no longer requires concurrent review of clinical documentation for admission to eating disorder treatment for any level of care. They also suggested that for parity purposes, these requirements should be considered by private insurers as well.

➔ **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.

Appendix 1: Study Resolution

Eating Disorders and Obesity Prevention and Treatment

Authorized by the Joint Commission on Healthcare on December 7, 2022

WHEREAS, obesity affects more than 30 percent of Virginians and eating disorders affect Virginians in smaller numbers but are often underdiagnosed;

WHEREAS, eating disorders and obesity are chronic conditions that are each associated with significant physical and mental health consequences; and

WHEREAS, evidence suggests effective strategies for prevention, early identification, and treatment of these chronic conditions can reduce morbidity, mortality, and societal costs; and

WHEREAS, matching federal funds are available to Virginia's Medicaid program to improve prevention services, including obesity prevention, but coverage of prevention services in the private market is unknown; and

WHEREAS, a previous Joint Commission on Health Care study highlighted multiple barriers to care for eating disorders, including patient costs and provider availability, and;

WHEREAS, House Bill 1098 from the 2022 Regular Session of the General Assembly requires the Joint Commission on Health Care to study the payment of medical assistance for obesity prevention and other obesity-related services; and

WHEREAS, Senate Joint Resolution 11 from the 2022 Regular Session of the General Assembly, directing a study of eating disorders in Virginia, was referred to the Joint Commission on Health Care, now, therefore be it

RESOLVED, by the Joint Commission on Health Care, that staff be directed to study the prevention and treatment of eating disorders and obesity in Virginia.

The study shall (i) document the prevalence and incidence of eating disorders and obesity among Virginians; (ii) identify evidence-based strategies for the prevention, early identification, and treatment of eating disorders and obesity; (iii) document the extent to which Virginia's Medicaid program and state-regulated private health plans cover the costs of these strategies; (iv) assess barriers to care for eating disorder treatment in Virginia; and (v) identify policy options to improve the prevention, early identification, and treatment of obesity and eating disorders in Virginia.

The Joint Commission on Health Care shall make recommendations as necessary and review other related issues as warranted.

In accordance with § 30-169.1 of the Code of Virginia, all agencies of the Commonwealth, including the Virginia Bureau of Insurance, the Virginia Department of Behavioral Health and Developmental Services, the Virginia Department of Education, the Virginia Department of Health, the Virginia Department of Health Professions, and

the Virginia Department of Medical Assistance Services, shall provide assistance, information, and data to the Joint Commission on Health Care for this study upon request.

Appendix 2: Definitions of eating disorders

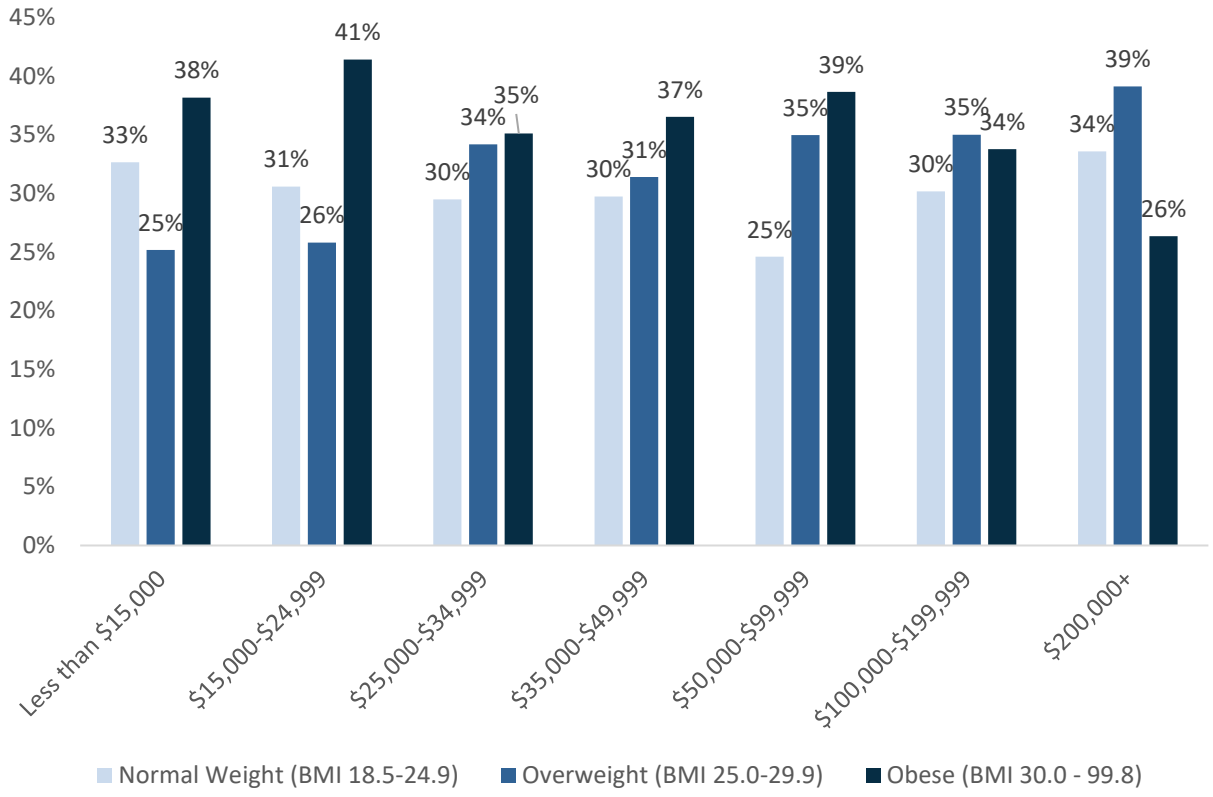
TABLE 7: Definition of eating disorders by the American Psychiatric Associations' Diagnostic and Statistical Manual

Eating Disorder Type	Definition
Anorexia Nervosa	Characterized by self-starvation and weight loss resulting in low weight for height and age.
Bulimia Nervosa	Characterized by binge eating followed by inappropriate compensatory behaviors designed to prevent weight gain.
Binge Eating Disorder (BED)	Characterized by binge or out of control eating accompanied by significant distress about eating.
Avoidant Restrictive Food Intake Disorder (ARFID)	Involves a disturbance in eating resulting in persistent failure to meet nutritional needs and extreme picky eating.
Other Specified Feeding and Eating Disorder (OSFED)	Characterized by eating disorder behaviors that do not meet diagnostic criteria for any other eating disorder.

SOURCE: JCHC analysis of American Psychiatric Association's Diagnostic Statistical Manual, 5th edition, 2023.

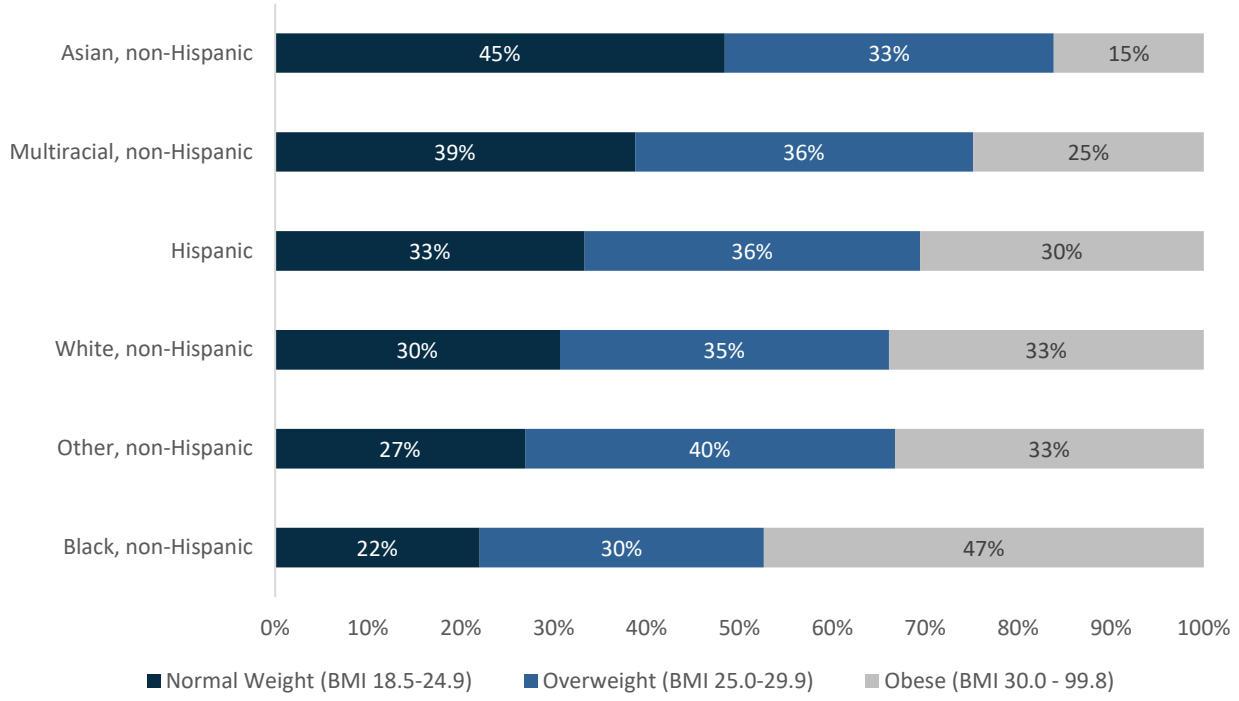
Appendix 3: Body Mass Index by Selected Demographic Variables

FIGURE 7: Body mass index by household income in Virginia, 2021.



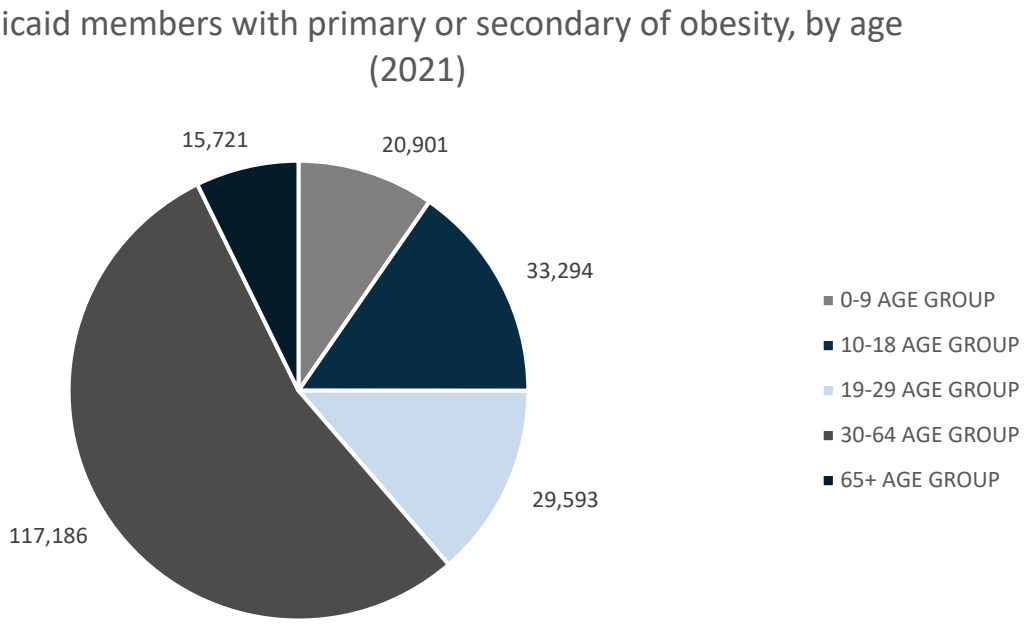
SOURCE: JCHC analysis of 2021 Behavioral Risk Factor Surveillance System (BRFSS) data.

FIGURE 8: Body Mass Index by Race and Ethnicity in Virginia, 2021.



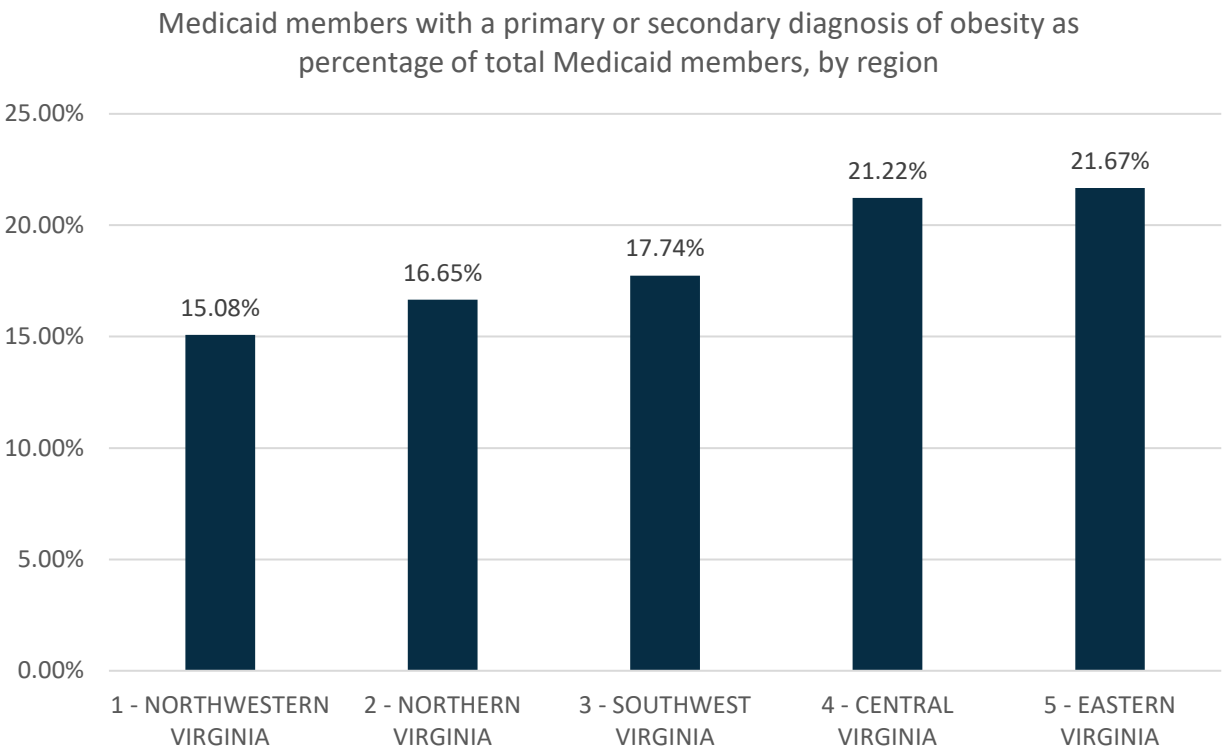
SOURCE: JCHC analysis of 2021 Behavioral Risk Factor Surveillance System (BRFSS) data.

FIGURE 9: In 2021, Medicaid members ages 30-64 years make up the largest group of people with obesity



SOURCE: JCHC analysis of Department of Medical Assistance Services data of individuals with a primary or secondary diagnosis of obesity, 2023.

FIGURE 10: Central and Eastern Virginia regions have the highest proportion of Medicaid individuals who are obese



SOURCE: JCHC analysis of Department of Medical Assistance Services data of individuals with a primary or secondary diagnosis of obesity, 2023.

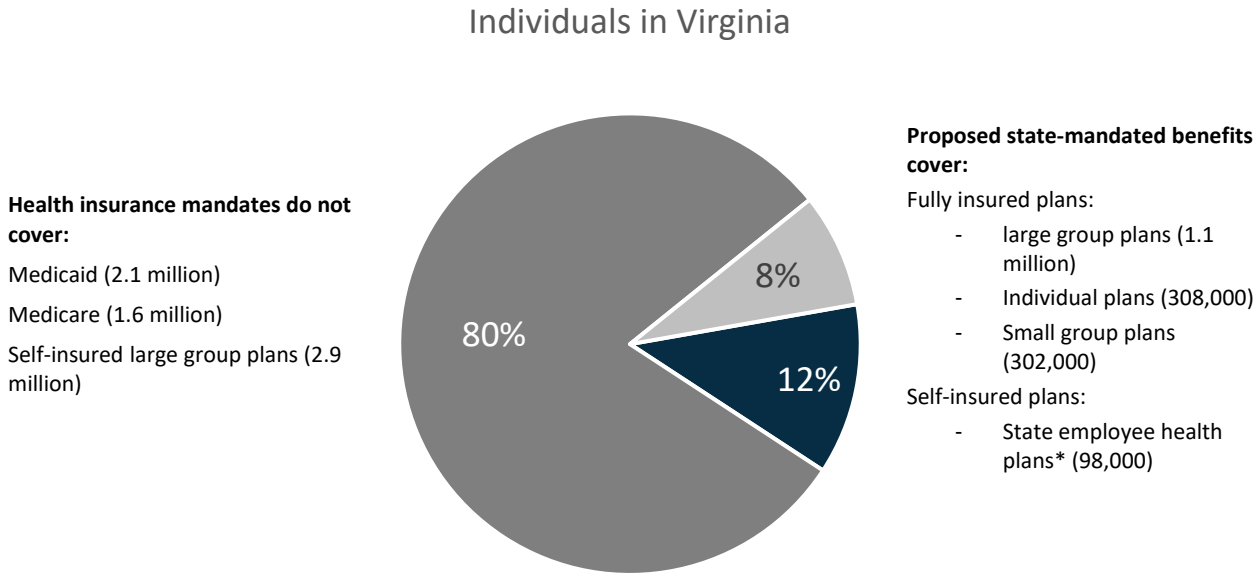
Appendix 4: Mandating health insurance benefits for different plan types in Virginia

All non-grandfathered individual and small group health plans in Virginia are required to provide essential health benefits (see sidebar) through the Affordable Care Act. Roughly 80 percent of Virginians (6.6 million people) have health insurance with plans that cannot be regulated by the state, including self-insured large group plans, Medicaid, and Medicare (FIGURE 11). The remaining 20 percent of Virginians (1.8 million) are covered through plans that can be regulated by the state-mandated benefit review process. This process applies to all fully insured large group plans (and five state employee health plans), individual, and small group plans. Newly proposed state mandated health benefits must go through Virginia's mandated benefit review process that went into effect March 2023, from bills HB 2198/SB 1399.

All non-grandfathered individual and small group health insurance plans in Virginia are required to provide **essential health benefits (EHB)**, which include items and services in 10 broad categories, including preventative services, required by the Affordable Care Act (ACA). The ACA also requires state Medicaid plans to cover EHB for Medicaid beneficiaries enrolled under ACA's Medicaid expansion.

Preventive services are defined by evidence levels from the United States Preventive Services Task Force (see sidebar pg. 6). This provision applies to all non-grandfathered individual and small group plans available after March 23, 2010.

FIGURE 11: Virginia's mandated benefit review process covers 20 percent of Virginians



SOURCE: JCHC analysis of individual and small group enrollment data provided, Medicaid enrollment, Medicare enrollment, Association of Health Insurance Plan large group plan enrollment, DHRM state employee health benefits enrollment, and population data from the United States Census Bureau.. *State-mandated health benefits would apply to state employee health insurance plans under § 2.2-2818.2 Code of Virginia.

Any proposed state-mandated benefit would have to adhere to the Virginia mandated benefit review process

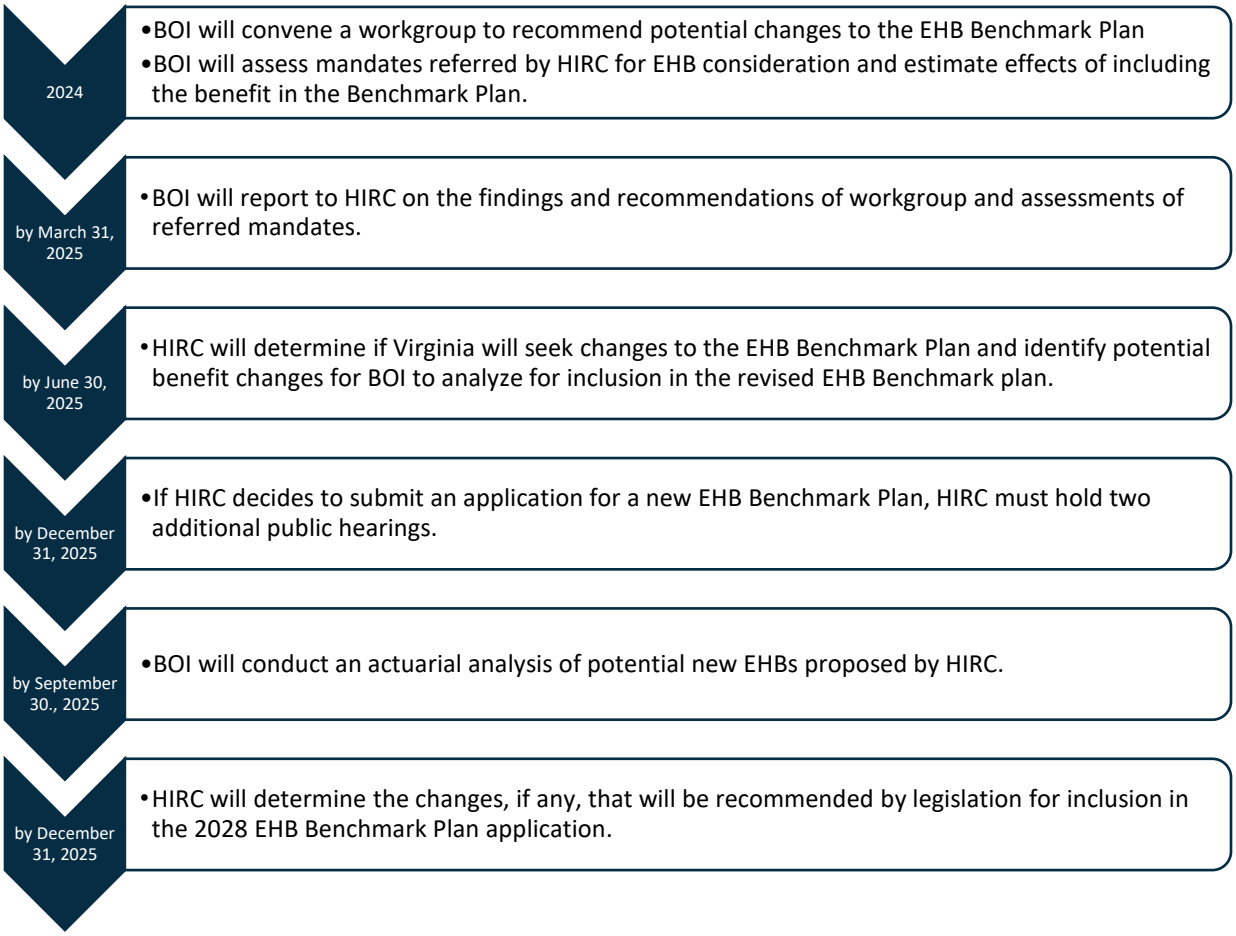
Fully insured individual and small group plans account for approximately 8 percent (610,000) of Virginians. The ACA requires each state to choose an essential health benefits (EHB) benchmark plan. Virginia's EHB benchmark plan determines the minimum scope of benefits individual and small group plans are required to provide. State mandates after December 31, 2011, cannot become part of the EHB unless removed as a mandate and added to EHB through this process. Updating the EHB benchmark plan is the only way a state can require new benefits as EHB.

States are required to defray the cost of the premium of any mandated benefits that exceed the coverage in the benchmark plan. This is because the federal government pays tax subsidies for EHB covered for plans in the individual and small group plans, and the federal government will not pay for the additional health benefits the state opts to add as a state-mandated health benefit.

Any approved state-mandated benefit for individual and small group plans would take at least 2 years to go into effect in the state benchmark plan

Virginia's current EHB benchmark plan is effective through calendar year 2024. Federal rules require states to submit applications to change the EHB benchmark plan two years before the plan would go into effect, and CMS recently approved Virginia's EHB benchmark application on August 28, 2023. The new EHB benchmark plan will go into effect beginning January 1, 2025. HIRC reviews the EHB benchmark plan periodically, and a timeline of the next review is outlined in FIGURE 12. If HIRC approves a proposed state-mandated benefit for the EHB benchmark plan, it would take at least two years to apply and receive federal approval from CMS. Based on HIRC and BOIs timeline, any new EHB benchmark plan could not go into effect until January 1, 2028. To note, states can choose not to update their EHB benchmark plan, and it is possible HIRC opts to maintain the EHB benchmark plan.

FIGURE 12: Timeline of Virginia's mandated benefit review process



SOURCE: State Corporation Commission Bureau of Insurance

NOTE: BOI = Bureau of Insurance; HIRC = Health Insurance Reform Commission; EHB = Essential Health Benefits

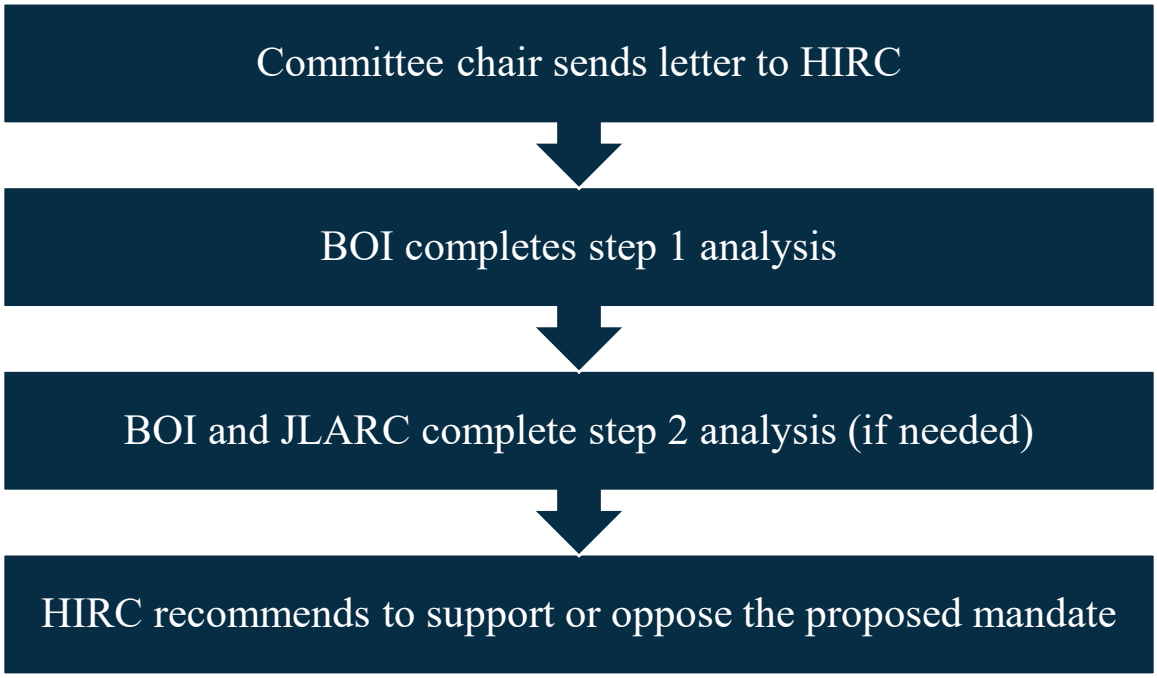
HIRC can propose a benefit to apply to fully insured large group plans and the state employee health plan

There are an estimated 1.2 million Virginians (12 percent) enrolled in fully insured large group plans or the state employee benefit plan. It is possible to propose a health insurance mandate that would apply to these plans, and this would be independent of the policy options mentioned in this study. HIRC may request an analysis to determine how the proposed benefit would impact state employee health benefit premiums. There is not a cost implication to the state for mandated benefits that apply to the fully insured large group market. Furthermore, a comprehensive assessment of obesity and eating disorder treatment coverage for fully insured large group plans or under the state employee health plan was beyond the scope of this study.

Appendix 5: Overview of Virginia mandated benefit review process

State-mandated health benefits are defined in § 38.2-3406.1 of the Code of Virginia. Policy options 3,5, and 6 refer to potential changes in state-mandated health benefits, which if considered, would be required to undergo the Virginia mandated benefited review process (FIGURE 13). This process is governed by the Health Insurance Reform Commission (HIRC) under § 30-343 of the Code of Virginia. This is required of any legislative measure with a proposed state-mandated benefit that is not identical or substantially similar to a legislative measure previously reviewed by the Health Insurance Reform Commission (HIRC) within the 3-year period immediately prior the proposal.

FIGURE 13: Overview of Virginia's mandated benefit review process



SOURCE: State Corporation Commission Bureau of Insurance.

The Chair of House Commerce and Energy or Senate Commerce and Labor sends a letter to the Health Insurance Reform Commission and to the Bureau of Insurance requesting an assessment of a proposed mandate. HIRC has 24 months to complete and submit its assessment.

The Bureau of Insurance prepares a Step 1 analysis upon receipt of request received from the Committee Chairs. Step 1 analysis refers to the extent to which the proposed

mandate falls within federal guidelines and if it is currently available through qualified health plans on the Exchange.

Any proposed mandate that exceeds EHB would have a fiscal impact to Virginia because the Affordable Care Act requires states to defray costs of benefits that exceed essential health benefits. In this situation, HIRC could request BOI and JLARC to assess the social and financial impact and medical efficacy of the proposed mandate in step 2 analysis.

HIRC may recommend to support or oppose the proposed mandate. HIRC determines if the proposed mandate should either: be included in part of EHB review, consider applying coverage only to fully insured large group plans, which removes state's responsibility to defray costs as we would for individual and small group plans, or another option that could apply. For example, it is also possible if carriers generally cover a service to remove cost sharing requirement for services. A report summarizing these findings is sent to the Governor and the Chairman of the standing committee that requested the assessment.

Appendix 6: Eating Disorders Parent Informational Sheet

Eating Disorders Awareness in the Public School Setting

Authorization

The *Code of Virginia* requires that each school board provide educational information regarding eating disorders to parents of students in grades 5 through 12 on an annual basis.

§ 22.1-273.2. Parent educational information regarding eating disorders.
Each school board shall annually provide parent educational information regarding eating disorders for pupils in grades five through 12. Such information shall be consistent with guidelines set forth by the Department of Education.

Overview

According to the National Eating Disorders Association (NEDA, 2020):

> "Eating disorders are serious but treatable mental and physical illnesses that can affect people of all genders, ages, races, religions, ethnicities, sexual orientations, body shapes, and weights. While no one knows for sure what causes eating disorders, a growing consensus suggests that it is a range of biological, psychological, and sociocultural factors. Eating disorders are not fads or phases, and can have serious consequences for health, productivity, and relationships.
>
> Eating disorders can develop or re-emerge at any age. Eating disorder specialists are reporting an increase in the diagnosis of children, some as young as five or six. Many eating disorder sufferers report that their' thoughts and behaviors started much earlier than anyone realized, sometimes even in early childhood. Although most people report the onset of their eating disorder in their teens and young adulthood, there is some evidence that people are being diagnosed at younger ages.
>
> It is not clear, whether individuals are actually developing eating disorders at younger ages or if an increased awareness of eating disorders in young children has led to improved recognition and diagnosis."

Hill, Reid, Morgan & Lacy (2010) further report, "Despite relatively low prevalence from a public health perspective, eating disorders have a high mortality and morbidity that can be drastically reduced with effective treatment."

A clinical report by the American Academy of Pediatrics (AAP, 2014) states that the number of children with eating disorders has increased steadily since the 1950's. The report further explains that, "the epidemiology of eating disorders has gradually changed; there is an increasing prevalence of eating disorders in males and minority populations in the United

States." It also reports that, "from 1999 to 2006, hospitalizations for eating disorders increased most sharply -119 percent- for children younger than 12 years."

According to the AAP website (2020), "males get eating disorders as well, with increasing prevalence now than in years past. They are actually more likely than females to get binge-eating disorder, and, by the latest estimates, they account for about 15 percent of cases of anorexia nervosa."

The purpose of this document is to provide best practice guidelines for developing a local policy for distributing educational information to parents/guardians regarding eating disorders.

Recommendations

In compliance with the *Code of Virginia* § 22.1-273.2, each school board shall adopt policies to provide parents educational information on eating disorders for students in grade 5 through 12 on an annual basis.

Early detection and treatment of eating disorders offer the best opportunity for positive outcomes and minimal long-term consequences. Educational materials should include, at a minimum, the following science-based information:

- A description of eating disorders and associated health consequences;
- A description of how eating disorders are identified (i.e., warning signs and symptoms);
- A statement describing why it is important to screen for eating disorders (early detection and treatment);
- A description of eating disorders screening;
- Information on referral for assessment, diagnosis, and treatment; and
- A description of prevention efforts and potential treatment.

Local policy should include the timeline for dissemination of information on an annual basis. There must be a clear delineation of such health information from other administrative documentation. Educational materials should be provided to parents/guardians using typical communication methods for the local school division. Examples include, but are not limited to:

- Information included in the student handbook;
- A letter home in the report card;
- Information posted to the school website;
- Information on school or division newsletter; and
- An email communication.

Prevention Efforts

School communities are uniquely positioned to assist with eating disorder prevention efforts. School divisions are encouraged to educate teachers, staff, counselors, coaches, and administrators on strategies for reducing negative risk factors and increasing protective factors.
Topics such as body image, self-esteem, weight stigma, intuitive eating, and media literacy are valuable to all members of a school community. All adults should be encouraged to serve as positive role models and should resist the urge to comment on the physical appearance or weight of students.

Optional Screening Program

Research shows (Austin et al., 2008) that population screening for eating disorders in high schools may identify at-risk students who may benefit from early diagnosis and intervention. Screening for eating disorders may ensure that early cases are detected and referred for appropriate follow up. However, population screening may have possible harmful effects for the vulnerable students involved. If screening is conducted, it should be done with a validated measure that is appropriate for the target age group. Should the local school division decide to conduct eating disorders screening, the following guidance is provided.

Screening program. The tool used for screening should be evidence-based and age appropriate. Local policy should clearly indicate which grade levels are screened, and whether screening is conducted on an annual basis. As required by the *Code of Virginia* § 22.1-273.2, the division must provide educational information to parents/guardians of students in grades 5 through 12 regardless of whether or not optional screening is conducted.

Personnel and training. Training needs will be directly related to the screening tool selected. Training for school personnel should be conducted by qualified licensed practitioners. Training should be conducted before the initial screening and as needed in subsequent years. School staff most qualified to perform eating disorders screening include school psychologists, school social workers, school counselors, and school nurses. Confidentiality of student health information shall be included in the training session. Because of the sensitive nature of eating disorder screening, volunteers should not be utilized.

Written notice of screening. School divisions conducting optional eating disorders screening shall provide written notice to parents/guardians a minimum of ten (10) business days prior to screening. The written notice shall include:

- The purpose of screening;
- Information indicating when the screening will occur;
- The procedure for notifying parents/guardians of students who are identified as needing follow-up for further testing/screening; and
- The procedure for parents/guardians to opt-out of screening for their child.

Referral and Follow-Up. School divisions will determine the threshold for referral based upon the specific tool used for screening. Parents/guardians of all students who are identified as possibly “at risk” according to the screening tool will be notified by school personnel

conducting the screening. Parents/guardians should be encouraged to schedule a follow-up evaluation for their children with their health care provider and/or a qualified eating disorders specialist. School divisions may request a notice of receipt from the parent, indicating the receipt of the referral and plans for follow-up care.

Documentation. Documentation of screening and referral should be maintained in a confidential manner according to the *Family Educational Rights and Privacy Act*.

Resources

Eating Disorder Hope
Academy of Nutrition and Dietetics (AND)
American Academy of Pediatrics (AAP)
American Psychological Association (APA)
Families Empowered and Supporting Treatment of Eating Disorders (F.E.A.S.T.)
National Association of Anorexia Nervosa and Associated Disorders
National Association of School Nurses (NASN)
National Eating Disorders Association (NEDA)
National Institute of Mental Health

Educational Materials

Academy for Eating Disorders video library
EDucation and INsights on Eating Disorders (EDIN)
National Association of Social Workers (NASW)
NEDA Coach & Athletic Trainer Toolkit
NEDA Educators Toolkit
NEDA Parent Toolkit
NEDA School & Community

References

Austin, S.B., Ziyadeh, N.J., Forman, S., Keliher, A., and Jacobs, D. (2011). Eating Disorders Referral Rates Improved by Community-Led Nationwide Screening in U.S. High Schools. Children's Hospital, Boston, MA.

Austin SB, Ziyadeh NJ, Forman S, Prokop LA, Keliher A, Jacobs D. Screening high school studentsfor eating disorders: results of a national initiative. *Prev Chronic Dis*. 2008:5(4):A114.

Committee on Adolescence (2003). Identifying and Treating Eating Disorders. *Pediatrics* 111:1, 204-211.

Funair, M. (2013). Detecting symptoms, early intervention, and preventative education: eating disorders and the school age child. *NASN School Nurse,* 28, 163-166.

Hill, L.S., Reid, F., Morgan, J.F., and Lacey, J.H. (2010). SCOFF, the Development of an Eating Disorder Screening Questionnaire. *International Journal of Eating Disorders,* 43:4, 344-351.

Rosen, D. S. and Committee on Adolescence (2010). Identification and management of eating disorders in children and adolescents. *Pediatrics,* 126, 1240-12-53.

Appendix 7: Characteristics of eating disorder level of care

LEVEL OF CARE	**SPECIALIZED PEDIATRIC/ MEDICAL INPATIENT EATING DISORDERS PROGRAM**	**GENERAL PEDIATRIC/MEDICAL INPATIENT PROGRAM**	**SPECIALIZED PSYCHIATRIC INPATIENT EATING DISORDERS PROGRAM**	**GENERAL PSYCHIATRIC INPATIENT PROGRAM**
UNIT SECURITY	Unlocked	Unlocked	Typically locked	Typically locked
PATIENT LEGAL STATUS	Voluntary or involuntary	Voluntary	Voluntary or involuntary	Voluntary or involuntary
PHYSICIAN ON-SITE 24/7	On-site 24/7	On-site 24/7	On-call or on-site 24/7	On-call or on-site 24/7
NURSING ON-SITE 24/7	On-site 24/7	On-site 24/7	On-site 24/7	On-site 24/7
MEDICAL MONITORING	Frequent	Frequent	Frequent	Frequent
HOURS OF OPERATION	24/7	24/7	24/7	24/7
ABLE TO MAINTAIN WORK/SCHOOL	School, in some instances	School, in some instances	School, in some instances	School, in some instances
AVAILABLE INTERVENTIONS:				
OPTION FOR IV HYDRATION	Yes	Yes	On some units	On some units
OPTION FOR NASOGASTRIC TUBE FEEDINGS	Yes	Yes	On some units	On some units
OPTION FOR TREATMENT OVER OBJECTION	Yes	Yes	Yes	Yes
MEDICAL MANAGEMENT	Yes	Yes	Consultation	Consultation
PSYCHIATRIC MANAGEMENT	Yes	Consultation	Yes	Not eating disorder specific
PSYCHOLOGICAL MANAGEMENT	Yes	In some instances	Yes	On some units, not eating disorder specific
GROUP-BASED THERAPIES	Yes	No	Yes	Not eating disorder specific
INDIVIDUAL PSYCHOTHERAPIES	Yes	Generally not available	Yes	Not eating disorder specific
FAMILY PSYCHOTHERAPIES	Yes	Generally not available	On some units	Not eating disorder specific
MEAL SUPERVISION AND SUPPORT	All meals/day	In some instances	All meals/day	Not eating disorder specific
MILIEU THERAPY	Yes	No	Yes	Not eating disorder specific
NUTRITIONAL MANAGEMENT	Yes	Consultation	Yes	Consultation
MULTIDISCIPLINARY TEAM-BASED MANAGEMENT	Yes	In some instances, not eating disorder specific	Yes	Not eating disorder specific

LEVEL OF CARE	**Residential program**	**Partial hospitalization program**	**Intensive outpatient program**	**Outpatient**
UNIT SECURITY	Unlocked	Unlocked	Unlocked	Unlocked
PATIENT LEGAL STATUS	Voluntary	Voluntary	Voluntary	Voluntary
PHYSICIAN ON-SITE 24/7	On-call 24/7	Typically not on-site full-time	Not on-site full-time	No
NURSING ON-SITE 24/7	Typically on-site 24/7	Typically not on-site full-time	Typically not on-site full-time	No
MEDICAL MONITORING	Limited	Limited	Limited	As indicated
HOURS OF OPERATION	24/7	Variable hours per day (5–12 hours) and days per week (5–7)	3–4 hours per day, 3–7 days per week	1–2 psychotherapy sessions per week with additional visits with other clinicians as indicated
ABLE TO MAINTAIN WORK/SCHOOL	School, in some instances	School, in some instances	Often	Yes
AVAILABLE INTERVENTIONS				
OPTION FOR IV HYDRATION	No	No	No	No
OPTION FOR NASOGASTRIC TUBE FEEDINGS	Typically, not	No	No	No
OPTION FOR TREATMENT OVER OBJECTION	No	No	No	No
MEDICAL MANAGEMENT	Limited consultation	Limited consultation	No	Outpatient, as indicated
PSYCHIATRIC MANAGEMENT	Yes	Yes	Variable	As indicated
PSYCHOLOGICAL MANAGEMENT	Yes	Yes	Yes	Yes
GROUP-BASED THERAPIES	Yes	Yes	Yes	As indicated
INDIVIDUAL PSYCHOTHERAPIES	Yes	Yes	Yes	Yes
FAMILY PSYCHOTHERAPIES	Yes	Yes	Yes	Yes
MEAL SUPERVISION AND SUPPORT	All meals/day	2–3 meals/day	~1 meal/day	Provided by family or care partners
MILIEU THERAPY	Yes	Yes	Yes	No
NUTRITIONAL MANAGEMENT	Yes	Yes	Variable	As indicated
MULTIDISCIPLINARY TEAM-BASED MANAGEMENT	Yes	Yes	Yes	As indicated

SOURCE: American Psychiatric Association practice guideline of the treatment of patients with eating disorders, fourth edition.

Appendix 8: Methodology

Literature Review Methodology

JCHC staff conducted a literature review to identify evidence-based strategies for prevention and early identification of eating disorders and evidence-based strategies for prevention and early identification of obesity. Based on existing literature, staff identified common words and phrases associated with eating disorders and obesity. Then, a separate Boolean search phrase was created for each topic based upon key terms identified in the literature.

Eating Disorder Boolean Search Phrase:

> (Eating Disorder[Title/Abstract] OR Anorexia nervosa[Title/Abstract] OR bulimia nervosa[Title/Abstract] OR binge eating disorder[Title/Abstract]) AND (Early Detection[Title/Abstract] OR Risk Factors[Title/Abstract] OR Awareness[Title/Abstract] OR Health Maintenance[Title/Abstract] OR Monitoring[Title/Abstract] OR Checking[Title/Abstract]) AND (Screening[Title/Abstract] OR Detection[Title/Abstract] OR Testing[Title/Abstract] OR Assessment[Title/Abstract] OR Identification[Title/Abstract] OR Diagnostic[Title/Abstract] OR Examination[Title/Abstract] OR Treatment[Title/Abstract] OR Management[Title/Abstract] OR Intervention[Title/Abstract])

Obesity Boolean Search Phrase:

> (Obesity[Title/Abstract]) AND (Evidence-Based[Title/Abstract]) AND ((Early Detection[Title/Abstract] OR Risk Factors[Title/Abstract] OR Awareness[Title/Abstract] OR Health Maintenance[Title/Abstract] OR Monitoring[Title/Abstract] OR Checking[Title/Abstract]) AND ((Screening[Title/Abstract] OR Detection[Title/Abstract] OR Testing[Title/Abstract] OR Assessment[Title/Abstract] OR Identification[Title/Abstract]) OR (Diagnostic[Title/Abstract] OR Examination[Title/Abstract]) OR (Treatment[Title/Abstract] OR Management[Title/Abstract] OR Intervention[Title/Abstract]))

Once the phrases were created, JCHC staff conducted an advanced literature search for each topic using the predetermined Boolean phrases on one database, PubMed. Articles identified through PubMed were then populated into a reference management software, EndNote. Then, articles were examined for relevancy related to inclusion and exclusion criteria for each topic. Any articles that did not meet inclusion criteria were removed from analysis.

Inclusion criteria for eating disorders was that studies must: (1) be written in English, (2) be published between 2013 and 2023, (3) be peer-reviewed, and (4) have a primary diagnosis of an eating disorder. Exclusion criteria was that studies may not: (1) implicitly or

explicitly mention eating disorder as a comorbidity to another non-metabolic or non-cardiovascular disease or (2) be conference briefs and presentations.

Inclusion criteria for obesity was that studies must: (1) be written in English, (2) be published between 2013 and 2023, (3) implicitly or explicitly mention obesity as the primary diagnosis, and (4) implicitly or explicitly use behavioral modification as the primary intervention. Exclusion criteria was that studies may not: (1) implicitly or explicitly mention obesity as a symptom or comorbidity to another non-metabolic or non-cardiovascular disease, (2) have the primary intervention described as a fitness program, (3) be public health interventions, or (4) be conference briefs and presentations.

Once articles that were not relevant to the study were removed, staff analyzed remaining articles and sorted them into predetermined categories. JCHC staff then verified the other team member's articles and any discrepancies were discussed to determine a final set of articles for inclusion in the study. Staff then used content analysis within each category to identify key themes.

SERFF Analysis Methodology

Staff performed policy analysis to assess coverage of obesity and eating disorder services. Staff performed this analysis using the State Corporation Commission's Bureau of Insurance (BOI) System for Electronic Rate and Form Filings (SERFF) database, which has the Essential Health Benefits checklist for each plan. Staff reviewed EHB-checklists and full coverage policy for all (1) individual and (2) small group plans. Plans that were not reviewed due to lack of inclusion in the SERFF database included: large group self-insured plans, large group fully insured plans, and grandfathered plans.

Each included plan was analyzed for coverage of obesity-related services and eating disorder services. Plans were analyzed for coverage of the following obesity services: (1) weight loss programs, (2) weight loss surgery, (3) health club memberships and fitness services, and (4) weight loss drugs. Plans were analyzed for coverage of the following eating disorder services: (1) nutritional and dietary supplements and (2) residential treatment centers.

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