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Youth Insured By Medicaid With Restrictive Eating Disorders— Underrecognized and Underresourced

Erin C. Accurso, PhD¹, Sara M. Buckelew, MD, MPH², Lonnie R. Snowden, PhD³

¹Department of Psychiatry and Behavioral Sciences, Weill Institute for Neurosciences, University of California, San Francisco

²Department of Pediatrics, University of California, San Francisco

³School of Public Health, University of California, Berkeley

Paloma, a fictional yet realistic exemplar, is a 16-year-old Latinx girl hospitalized for bradycardia and hypotension due to malnutrition. Family-based treatment (FBT) for anorexia nervosa (AN) was recommended but not provided by her county given an absence of trained providers. Instead, she received supportive individual therapy. Paloma required repeated hospitalizations over 18 months, each time requiring longer stays due to greater medical acuity. Her parents felt less and less empowered to manage her symptoms upon discharge. After six hospitalizations, the county behavioral health plan agreed to contract with residential and partial hospitalization programs. Upon discharge to outpatient care, she precipitously lost weight and was re-admitted to the hospital. Paloma represents one of countless Medicaid-insured patients denied access to evidence-based care, with devastating consequences.

The number of individuals requiring eating disorders (EDs) treatment has increased dramatically since the onset of Covid-19,¹ with a near 80% increase in calls to the National Eating Disorders Association helpline.² EDs are severe but treatable psychiatric disorders that are under-identified and undertreated in low-income youth, with tragic consequences. Elevated suicide risk and serious medical consequences lead to 77,000 hospitalizations and emergency room visits and 10,000 deaths yearly, with annual costs of \$65B in healthcare expenditures, informal care, and lost productivity and efficiency.³ This viewpoint focuses on AN and atypical AN (AAN) as EDs with more severe medical complications.

Anorexia nervosa and AAN typically develop in adolescence or young adulthood and affect 4% of the U.S. population.⁴ Lay media and entertainment perpetuate the misperception that AN/AAN are conditions of White cisgender adolescent girls that somehow do not affect racially/ethnically and socioeconomically diverse individuals, despite the fact that AN

Correspondence: Erin C. Accurso, PhD, University of California, San Francisco, Department of Psychiatry and Behavioral Sciences, 401 Parnassus Avenue, Box F-0984, San Francisco, CA 94143-0984 (phone: (415) 476-5139, erin.accurso@ucsf.edu).

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and extreme dieting prevalence does not differ by race/ethnicity⁵ or socioeconomic status,⁶ respectively. Nevertheless, screening for EDs in public mental health systems is poor, with some systems deliberately minimizing or excluding screening questions from standardized assessments to absolve them of the legal obligation to provide treatment for a disorder in which their providers typically lack expertise. Screening is also low in primary care, schools, and other non-mental health sectors. Even when identified, EDs are undertreated. Although medical and behavioral health interventions for EDs in inpatient and outpatient settings are covered by Medicaid, terms of coverage and administrative practice often favor intensive medical interventions, while denying coverage for intensive behavioral health interventions.

Early intervention is critical to capitalize on higher recovery rates for adolescents than adults and minimize impacts on physical health and functioning.⁷ FBT is the most effective treatment for adolescents with AN/AAN,⁷ but access is limited. Of the 64 clinicians in the US certified in FBT by the Training Institute for Child and Adolescent Eating Disorders,⁸ only 3 are contracted with Medicaid, based on the first author (E.C.A.)'s review of insurance contracts and payments accepted by every listed clinician/program. Two-thirds accepted self-payment only, so FBT is delivered to the privileged few who can pay out-of-pocket costs. The gap in access to evidence-based care disproportionately impacts youth with public insurance, leaving them overly reliant on medical care, especially vulnerable to hospitalization, and at risk for developing a chronic AN/AAN requiring ongoing, expensive treatment.

Paying for outpatient FBT can be cost-effective for health systems. FBT reduces the need for inpatient admission by >50%, saving \$9,000 per patient in treatment charges, compared to another specialized outpatient treatment.⁷ This likely underestimates real-world savings of FBT compared to non-specialized outpatient mental health care, particularly over the long-run because inpatient charges are much greater than outpatient charges. Just preventing one hospitalization saves \$57,168 on average,⁹ which would cover charges for 637 Medicaid-reimbursed family therapy sessions or 190 private-pay sessions (if FBT were only available out-of-network at the upper end of private practice rates), sufficient for 7 to 25 unique patients.

A Call to Action for Health Equity

Training.

Community-based clinicians report low ED competence. Training and consultation is needed to increase awareness of EDs in Medicaid-insured populations and to improve screening, diagnostic assessment, and treatment in medical and mental health settings. Training should be inclusive of binge eating, which is more prevalent among racial/ethnic minorities⁵ and lower-income individuals.⁶

Screening.

While AN is more readily recognized due to low weight, medical providers are in a unique position to identify AAN as well since weight change in youth—regardless of weight status

—is concerning for an ED. Standardized mental health assessments should also include ED screening questions.

Implementation.

Implementation efforts for common presenting concerns (e.g., mood/anxiety, disruptive behavior) have improved the quality of publicly-funded care for most treatment-seeking youth; we must similarly strive to improve publicly-funded care for youth with EDs—less common yet deadly and costly disorders. Implementation strategies for lower base-rate disorders will need to tackle unique challenges. Accessible, cost-effective training methods (e.g., online) are needed for scalability and sustainability given high clinician turnover rates in community-based settings.

Models of care.

Telehealth has the potential to improve treatment access, particularly for patients in rural and under-resourced communities, but also presents challenges for Medicaid-insured populations, who may not have reliable internet or appropriately private spaces for therapy due to crowded/shared living. Innovative solutions might include the development of centers of excellence for EDs that could provide specialized behavioral and medical telehealth to multiple counties, supported by local providers. Wraparound services that support youth and families in their home and school environments could augment traditional services. Online interventions (e.g., self-help treatment, chatbots) may also offer relatively inexpensive alternatives that would significantly improve access given reduced dependence on clinicians.

Adaptation.

Dissemination efforts require sensitivity to culturally appropriate adaptations to meet the needs of the low-income, ethnically, racially, and linguistically diverse patients served by public health systems because they have been grossly underrepresented in treatment research. Treatments may need to be tailored for patients insured by Medicaid and their families.

Policy.

As with other psychiatric disorders requiring interdisciplinary care (e.g., substance use disorders), the bifurcation of medical and mental health care in EDs is problematic. Health plan administrators report spending time confused about which plan pays for what. Medicaid authorizes inpatient medical care if hospitalization criteria are met, but psychiatric authorization for a higher level of care is influenced by the limited availability of mental health funds. The division between medical and mental health plans doesn't facilitate cost savings, leading to recent efforts in some California counties to share medical and mental health care ED costs. Finally, policy changes are needed to leverage technology to increase access, such as the financing of newer, cost-effective online screening, prevention, and treatment models since these treatments are not covered by most health plans, including Medicaid.

Mental health services research.

Medicaid pays for most mental health treatment in the U.S., and their claims data offer a path toward understanding service utilization patterns and costs. Evidence can inform plan administrators on coordination, administration, and payment for publicly-funded services, across levels of care, to maximize efficiency and effectiveness. Full-fledged cost-benefit and cost-effectiveness studies are especially promising since hospitalization savings might offset other treatment costs.

Conclusions

The disparity in care between those with public insurance and those with private insurance and resources is alarming and unethical. Specialized, evidence-based ED treatment should be available to all young people, regardless of insurance status. When not available within the public health care system, we urge administrators to close the gap in care by committing to cover out-of-network treatment. These efforts could have a big impact on long-term health and significantly reduce the likelihood of a chronic course of disorder and death.

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