Obesity Groups Applaud Colorado HCPF Reconsideration of Medicaid Regulations Governing Coverage of Metabolic and Bariatric Surgery

March 28, 2025

On behalf of the American Society for Metabolic and Bariatric Surgery (ASMBS), the Colorado ASMBS State Chapter, the Obesity Action Coalition (OAC), the Obesity Medicine Association (OMA) and The Obesity Society, we are pleased to provide the following comments in response to recent stakeholder meetings held by the Colorado Department of Health Care Policy and Financing (HCPF) regarding potential updates to the state's Medicaid coverage regulations for metabolic and bariatric surgery.

We were pleased to have participated in each of the four stakeholder and public webinars throughout the last 7 months to learn more about the Department's thinking on possible options for ensuring that Medicaid beneficiaries have access to metabolic and bariatric surgical care based on the most recent clinical guidelines. Our groups applaud the HCPF staff for their willingness to include the vast majority of our suggested changes into the proposed regulation that will eventually be reviewed by the Medical Services Board.

Following are our responses to HCPF's specific questions about proposed revisions for the metabolic and bariatric surgery rule:

Section 1 (Slide 20). Staff maintained the same proposed language as in Meeting 1. Eligible Members include: all currently enrolled members age thirteen and older; and that EPSDT exceptions apply (10 CCR 2505-10 8.230). What do you think of this proposed revision?

RESPONSE: We support lowering the age threshold from 16 years to 13 and older. Children and adolescents with obesity carry the burden of the disease and its co-morbidities into adulthood, increasing the individual risk for premature mortality and complications from obesity co-morbidities. Metabolic and bariatric surgery is safe in the population younger than 18 years and produces durable weight loss and improvement in co-morbid conditions.

Section 2 (Slide 21). Staff maintained the proposal of keeping this section of the rule as it is currently. What do you think of this proposal?

RESPONSE: We are supportive of these changes

Section 3 (Slide 22). Staff proposed revising a sentence in this section so that all surgeries shall be performed at a Hospital, as defined at 8.300.1. What do you think of this proposed change? (Review the presentation and slide deck for details.)

RESPONSE: We are supportive of this approach.

Section 3 continued (Slide 23). During the presentation, staff asked, "Are there publicly available data on outcomes by facility?"

RESPONSE: While many facilities report their outcomes data to the American College of Surgeons Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) or National Surgical Quality Improvement Program (NSQIP), neither of these programs publish public outcomes data by facility.

Section 3 continued (Slide 23). During the presentation, staff asked, "Would it be beneficial to add a requirement that protocols are specific to the population being treated (age, comorbidities)?"

RESPONSE: We are supportive of ensuring that facilities are properly equipped to treat specific populations undergoing metabolic and bariatric surgery to ensure patient safety and quality outcomes.

Section 4 (Slide 24). Staff proposed condensing the language in this section 4.b in the rule to read: "b. Covered primary procedures are indicated by the Health First Colorado Fee Schedule." Review the slide deck and presentation for details. Do you agree with this proposal?

RESPONSE: We appreciated the robust discussion on this question during the March stakeholder meeting and again urge HCPF to utilize the Health First Colorado Fee Schedule in accordance with the metabolic and bariatric surgical procedures that are recognized and approved by the American Society for Metabolic and Bariatric Surgery.

Section 5.1 (Slide 25). Staff proposed maintaining existing BMI requirements for adults and updating the definitions of class 2 and 3 obesity for adolescents to the following:
Class 3 obesity is defined as BMI >140% of the 95th percentile
Class 2 obesity is defined as BMI >120% of the 95th percentile
(Review the presentation and slide deck for details.)
Share any thoughts on these proposals here.

RESPONSE: As highlighted during the March stakeholder meeting, ASMBS urges HCPF to adopt the BMI criteria as outlined in the 2022 American Society for Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO): Indications for Metabolic and Bariatric Surgery. While we understand HCPF's concern over budgetary impacts, we find that delaying patient access to surgery until their obesity has advanced to a higher acuity is tantamount to delaying chemotherapy or surgical intervention for a cancer patient until their cancer has reached stage 3 or 4. Treating obesity earlier will allow for better prevention of obesity related comorbidities such as diabetes and hypertension as well.

Section 5.2 (Slide 26). Staff proposed to 1) remove the requirement for qualifying BMI to be of two years duration, and 2) that contraindications must be ruled out through the pre-surgical evaluation in accordance with nationally recognized standards of care. Do you support these changes to the rule?

RESPONSE: We applaud HCPF for making this change as these types of prior authorization criteria, such as documented evidence of obesity are bias and discriminatory. No other chronic disease state forces patients to demonstrate that they have been affected by their condition for a specified period before treatment will be approved. In addition, we appreciate the comments from HCPF staff related to these pre-operative requirements that HCPF is being "…very careful to try to make sure that we're not requiring anything that's not covered."

Section 5.3 (Slides 27 and 28). Regarding pre-surgical preparation, staff proposed a requirement that members receive at least 3 visits with a qualified nutrition provider that includes education individualized for the member's health-related social needs, which identifies maladaptive eating behaviors and gives

recommendations, covers nutritional needs for postoperative success, and manages member's modifiable risk factors. Share any thoughts on this proposal here.

RESPONSE: We are supportive of this change.

Section 6 (Slides 31 and 32). Staff proposed that surgical revisions would be: 1) covered if the revision surgery is used to correct complications such as slippage of an adjustable gastric band, intestinal obstruction, or stricture, following a primary procedure, or is otherwise medically necessary; 2) that planned multi-stage procedures are not considered a revision and will be evaluated under the primary procedure criteria; and 3) unplanned multi-stage procedures are covered when the second stage is medically necessary. Do you agree with this rule change?

RESPONSE: We are supportive of this change.

Section 7 (Slide 33). Staff proposed that non-covered services would include: 1) Repeat/revision surgeries that are not medically necessary, and 2) Procedures performed for solely cosmetic purposes. Do you agree with this rule change?

RESPONSE: We are supportive of this change.

Missing topic or section? Is there something we've missed discussing or something that is not mentioned in the rule at all that attendees would like to bring up and discuss or highlight?

RESPONSE: We would also like to highlight that the Medicaid program and ACA regulated health plans should be providing patients with coverage for 12-26 intensive behavioral therapy visits a year (with no patient cost sharing as per the ACA and United States Preventive Services Task Force recommendations) to manage obesity. On October 23, 2015, the Departments of HHS, Labor and Treasury (Tri-Agencies) issued an FAQ advising against coverage exclusions for weight management services as part of the implementation of the ACA. As part of that FAQ, the Tri-Agencies highlighted how the 2012 USPSTF recommendation "specifies that intensive, multicomponent behavioral interventions include, for example, the following:

- Group and individual sessions of high intensity (12 to 26 sessions in a year),
- Behavioral management activities, such as weight-loss goals,
- Improving diet or nutrition and increasing physical activity,
- Addressing barriers to change,
- Self-monitoring, and
- Strategizing how to maintain lifestyle changes."

Many patients continue to request these services, but lack of coverage continues to be a real burden.