HEADLINES

CMS Changes Course on Sleeve NCD

On June 27, 2012, the Centers for Medicare & Medicaid Services (CMS) finalized a Medicare National Coverage Decision regarding Laparoscopic Sleeve Gastrectomy (LSG).

While CMS has issued a “National” Coverage Decision on LSG, the agency has basically punted the decision to cover LSG to the local level by stating that “Medicare Administrative Contractors acting within their respective jurisdictions may determine coverage of stand-alone laparoscopic sleeve gastrectomy for the treatment of co-morbid conditions related to obesity.”

Though this decision will mean additional work at the regional level to secure coverage for LSG, it represents a vast improvement over Medicare proposed “coverage with evidence development” process which would have severely limited access to a critical surgical intervention for those affected by obesity – especially given that many major private health plans already provide coverage for laparoscopic sleeve gastrectomy.
ASMBS is very pleased and gratified that CMS has recognized the true value and compelling need for coverage of this procedure. ASMBS will immediately initiate the formal pathway for coverage with each regional CMS intermediary by reiterating the arguments for coverage as expressed in the ASMBS April 2012 appeal letter written by John Morton (Access to Care Committee Chair and Secretary/Treasurer) and Matt Brengeman (Insurance Committee Chair).

ASMBS and the State Chapters will need to reach out to the Medical Policy Divisions in each Medicare Administrative Contractor (MAC) jurisdiction. MACs are new entities created by CMS to integrate the administration of Medicare Parts A and B from the former fiscal intermediaries and carriers.

Initially, CMS created 15 A/B MAC jurisdictions that served as the primary A/B MAC procurements. However, CMS decided to consolidate the A/B MAC jurisdictions from 15 to 10. The 15-Jurisdiction primary procurement grouping may be viewed by the color-blocked areas in the map below, while the 10-Jurisdiction consolidated procurement is denoted by CMS with a lettering system, which has been overlaid on the color-blocked map below.

**Medicare Administrative Contractor Jurisdictions**
MAC JURISDICTION/MAC CONTRACTOR

Above MAC Jurisdiction Map courtesy of Johnson & Johnson

**MAC Jurisdiction E:** California, Hawaii, and Nevada
Palmetto GBA (Palmetto)

**MAC Jurisdiction F:** Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming
Noridian Administrative Services, LLC (NAS)

**MAC Jurisdiction G:** Iowa, Kansas, Missouri, and Nebraska
Wisconsin Physicians Service Health Insurance Corporation (WPS)
**MAC Jurisdiction G:** Illinois, Minnesota, and Wisconsin
National Government Services, Inc. (NGS)

**MAC Jurisdiction H:** Colorado, New Mexico, Oklahoma, and Texas
TrailBlazer Health Enterprises, LLC (Trailblazer)

**MAC Jurisdiction I:** Indiana and Michigan
Wisconsin Physician Services Health Insurance Corporation (WPS)
**MAC Jurisdiction I:** Kentucky and Ohio
CGS Administrators, LLC (formerly CIGNA Government Services)

**MAC Jurisdiction J:** Alabama, Georgia, and Tennessee
Cahaba GBA, LLC (Cahaba)

**MAC Jurisdiction K:** Connecticut, and New York
National Government Services (NGS)
**MAC Jurisdiction K:** Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
National Heritage Insurance Corporation (NHIC)

**MAC Jurisdiction L:** Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania
Novitas Solutions, Inc. (formerly Highmark Medicare Services, Inc.)

**MAC Jurisdiction M:** North Carolina, South Carolina, Virginia, and West Virginia
Palmetto GBA, LLC (Palmetto)

**MAC Jurisdiction N:** Florida*
First Coast Service Options, Inc. (FCSO)
At press time, the ASMBS Access to Care and Insurance Committees were finalizing a list of contacts in the medical policy divisions for each of the above regional MACs. Should you have any close contacts within your regional MAC or wish to engage them to initiate Medicare’s Local Coverage Determination (LCD) process, please contact ASMBS Access to Care Committee Chair John Morton at morton@stanford.edu

Supreme Court Upholds Affordable Care Act

On June 31, 2012, the United States Supreme Court upheld virtually all of the provisions of the Affordable Care Act (ACA), including the controversial Individual Mandate. This long awaited ruling by the Court will now spur States to move forward toward setting up their healthcare exchanges for individuals and small employers.

While many of the provisions of the law surrounding disease prevention will benefit those affected by obesity, real questions remain as to whether states will opt to include comprehensive obesity treatment services in their essential benefit package. For example, in evaluating possible state benchmark plans highlighted in guidance documents issued earlier this year by the US Department of Health & Human Services (HHS), coverage for bariatric surgery and weight loss programs would be specifically excluded in 38 and 46 states, respectively. (see March 2012 Potomac Current for additional information)

It will be critical for leaders in the obesity community to closely monitor development of healthcare exchanges at the state and regional level. Should you be interested in finding out how you can influence this process, please contact Chris Gallagher at chris@potomaccurrents.com who will provide you with the latest information regarding advocacy opportunities within your state.

FDA Approves Obesity Drug

On June 27, 2012, the Food & Drug Administration (FDA) approved the first new drug to treat obesity in 13 years when the agency gave a positive nod to BELVIQ (Lorcaserin HCl), which was developed by Arena Pharmaceuticals. In a June 27 press release, members of the Obesity Care Continuum (OCC) applauded FDA for providing a new treatment tool for those affected by obesity.

The FDA has recommended that BELVIQ be classified by the U.S. Drug Enforcement Administration (DEA) as a scheduled drug. The DEA will review the FDA's recommendation and determine the final scheduling designation.
Once the DEA has provided the final scheduling designation, Eisai will announce when BELVIQ will be available to patients and physicians in the United States.

**USPSTF Finalizes Obesity Screening & Treatment Recommendations**

On June 25, 2012, the United States Preventive Services Task Force (USPSTF) reinforced the necessity for the health care system to treat obesity seriously by recommending that clinicians not only screen adults for obesity but offer or refer patients with a body mass index (BMI) of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions for 12-26 sessions in a year.

Members of the OCC applauded the Task Force for recognizing the importance of addressing obesity in clinical settings. For example, in a June 25 press release, the two groups praised the USPSTF for “recognizing that most clinicians in private practice will not have the time nor the expertise to offer a comprehensive, intensive behavioral program... and the next step will be to provide referral mechanisms to assure for effective and efficient delivery of the needed care.”

**STATE FOCUS**

**Wolfe Works to Preserve Bariatric Surgery Benefit during Oregon State Exchange Debate**

During June, ASMBS Past President and TOS Advocacy Committee member Dr. Bruce Wolfe alerted the Obesity Action Coalition (OAC) about recent activities of the State of Oregon’s Essential Health Benefit (EHB) Workgroup – specifically regarding the Workgroup’s choice of a PacificSource health plan as the basis for the state’s essential health benefit package.

Dr. Wolfe has been closely monitoring the EHB Workgroup and has also testified and provided a slide presentation before this advisory body regarding the importance of ensuring patient access to comprehensive obesity treatment services. Unfortunately, like so many other HHS-suggested state benchmark plans, PacificSource does not cover obesity treatment services such as bariatric surgery, obesity drugs or weight loss programs.

In response to a formal request for public comments by the Workgroup regarding the choice of PacificSource, the OAC submitted a June 15, 2012
letter highlighting the obesity community’s concerns over the Workgroup’s proposed selection. In closing, OAC President Joe Nadglowski urged “the Workgroup to use its wide discretionary powers in defining the benefit package to ensure that those who struggle with obesity have access to the full continuum of care – consistent with diagnosis and treatment coverage policy for other chronic diseases.”