February 21, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-2334-P; Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; Proposed Rule

Dear Administrator Tavenner:

On behalf of the Childhood Asthma Leadership Coalition, we are pleased to submit the following comments on the proposed Medicaid rule referenced above. The *Childhood Asthma Leadership Coalition* (CALC) convened in June of 2012 with a primary purpose of engaging diverse stakeholders to advance policy proposals that will improve childhood asthma management and symptom prevention. Relying on a strong foundation of evidence-based policy analysis to inform its work, one of CALC's primary goals is to increase patient access to the multi-component interventions that make up effective asthma control, including clinical-and community-based services.

We are particularly concerned about access to these services under Medicaid, as Medicaideligible populations are more likely to have asthma: very low-income people living below 100% of the federal poverty line (FPL) have an asthma prevalence of 11.2%, compared to 7.3% among persons above 200% FPL.¹ In some states, more than half of all children with asthma rely on Medicaid for their health coverage.² The burden of asthma in the Medicaid population is also

¹ Kaiser Commission on Medicaid and the Uninsured. The Role of Medicaid for People with Respiratory Disease. *Kaiser Family Foundation*. November 2012. Available at: http://www.kff.org/medicaid/upload/8383_RD.pdf. Accessed: January 15, 2013; Akinbami, L., Mooreman, J., Bailey, C., Zahran, H., King, M., Johnson, C., & Liu, X. Centers for Disease Control and Prevention, National Center for Health Statistics. (2012). Trends in asthma prevalence, health care use, and mortality in the United States, 2001-2010. Retrieved from http://www.cdc.gov/nchs/data/databriefs/db94.pdf

² Medicaid's Impact in Mississippi: Helping People with Serious Health Care Needs. Families USA. September 2011. Available at: http://www.lung.org/assets/documents/publications/medicaid/mississippi.pdf; Medicaid's Impact in Arkansas: Helping People with Serious Health Care Needs. Families USA. September 2011. Available at: http://www.lung.org/assets/documents/publications/medicaid/arkansas-medicaid.pdf.

more acute: lower-income populations are less likely to have well-controlled asthma and are more likely to use an emergency department for crisis-oriented asthma treatment.³

We appreciate this opportunity to comment on the implementation of the Medicaid expansion provisions of the Affordable Care Act. While we are supportive of approaches to improving care for children overall – including streamlining Medicaid enrollment, and insuring adequate premium assistance for low-income children – we limit our comments to the preventive services provisions of the proposed rule. If implemented with the modifications recommended herein, these provisions can play a significant role in bringing effective asthma treatment to low-income and medically underserved populations.

Our comments are detailed below.

I. EPSDT

We thank CMS for clarifying that the Early Periodic Screening, Diagnostic and Testing (EPSDT) benefit applies to the Medicaid expansion, so that any pediatric services limitation applicable to base benchmark plans in the individual or small group market does not apply to Medicaid alternative benefit plans. The EPSDT benefit ensures that Medicaid- and CHIP-eligible children have access to a complete range of medically necessary services, especially important for children with chronic conditions, such as asthma. We are very pleased to see confirmation that these benefits will reach children enrolled in Medicaid expansion plans.

II. Preventive Services: ACA Section 2713

Because preventive services are required under EPSDT, Medicaid expansion plans will support many interventions important to asthma treatment and care. If modified as we recommend, one proposed provision of this NPRM could greatly improve access to certain preventive services of importance to asthma treatment and control. The preamble states that all preventive services required under Section 2713 of the Affordable Care Act (ACA) should be included in Medicaid alternative benefit plans. Section 2713 of the law requires that all group and health insurance issuers offering group or individual health insurance to provide, <u>without cost-sharing</u>, a minimum level of preventive health services, including:

(1) Evidence-based items and services that have a rating of 'A' or 'B' in the current recommendations of the United States Preventive Service Task Force (USPSTF);

_

³ Finkelstein JA, Barton MB, Donahue JG, et al. Comparing Asthma Care for Medicaid and Non-Medicaid Children in a Health Maintenance Organization. *Archives of Pediatric & Adolescent Medicine*. 2000;154:563-568; Gold LS, Smith N, Allen-Ramey FC, et al. Associations of patient outcomes with level of asthma control. Ann *Allergy Asthma Immunol*. 2012; 109:260-265; Hanania NA, David-Wang A, Kesten S, Chapman KR. Factors associated with emergency department dependence of patients with asthma. *Chest* 1997; 111:290-295.

- (2) Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP);
- (3) Evidence-informed preventive care and screenings for infants, children, adolescents as presented in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- (4) With respect to women, additional preventive care and screenings as provided for in comprehensive quidelines supported by HRSA.

Several of these preventive services are important to asthma. For example, ACIP recommends yearly influenza immunizations for all children over 6 months, and pneumococcal vaccines for all children under 5 years. These vaccinations are important means of controlling asthma in children, because respiratory infections can exacerbate asthma and because children with asthma are at increased risk for complications from influenza and pneumococcus. USPSTF-recommended obesity screening and counseling for children is also significant for asthma, as studies suggest that overweight children with asthma are less likely to have their symptoms well-controlled. While the preventive services supported by these recommendations would be covered under EPSDT requirements (and therefore, already part of Medicaid expansion plans) we note that other Section 2713 preventive services significant for controlling childhood asthma are recommended for adults, and, consequently, are not covered under EPSDT. These include:

- USPSTF-recommended tobacco counseling and tobacco cessation for adults (children
 who are exposed to secondhand smoke are at a greater risk for developing asthma,
 and if they already have asthma, they are more likely to experience increases in the
 severity of their symptoms);
- USPSTF-recommended tobacco counseling for pregnant women (exposure to tobacco *in utero* increases the likelihood that a child will develop asthma); and
- HRSA-supported guidelines for annual well-woman visits that may include tobacco cessation counseling.

We strongly support the proposed requirement that these services be included in Medicaid alternative benefit plans. However, we are extremely concerned that the cost-sharing requirements of the proposed rule may prevent children and families enrolled in Medicaid expansion plans from accessing these important services. The preamble proposes that premium and cost-sharing provisions under Title XIX would apply to these preventive services within the Medicaid expansion. This would mean that children and families accessing coverage through the Medicaid expansion would be responsible for copayments and other cost-sharing for preventive services, while higher-income children and families eligible for private coverage would be assured these benefits without facing any additional costs.

This element of the proposed rule is utterly unfair for low-income families who may have difficulty accessing preventive services if cost-sharing is attached. The "no cost-sharing"

⁴ Department of Health and Human Services, Centers for Medicare and Medicaid Services, Proposed Rule RIN 0938–AR04 78 Federal Register 14 at 4631 (Jan. 22, 2013).

requirement of Section 2713 reflects Congress' findings that increasing uptake of preventive services depends, in part, on the elimination of financial barriers. Even where a preventive service is included under EPSDT, children in low-income families will have more difficulty accessing that service if they must pay for a portion of the cost. It would be inconsistent with Congressional intent for CMS to expect children and families under 138% of the federal poverty line to cover the cost of preventive services, where higher-income families are exempt. We strongly urge the Department to codify a no-cost-sharing requirement for Section 2713 preventive services in the final rule.

III. Provision of Preventive Benefits under Medicaid -- §440.130(c)

We strongly support the proposed revisions to §440.130(c), to provide for Medicaid coverage of preventive services "recommended by a physician or other licensed practitioner." This change will align Medicaid regulations with the underlying statute, which allows reimbursement for preventive services when "<u>recommended by</u> a physician or other licensed practitioner of the healing arts within the scope of their practice under State law..." (emphasis added).⁵

Current Medicaid regulations have limited the scope of allowable coverage of preventive services to those that are actually "provided by a physician or other licensed practitioner..." (emphasis added). As a result, most state Medicaid programs have limited coverage of preventive services (both inside and outside EPSDT) to those furnished by a physician. These regulations have significantly limited the available care and treatment for Medicaid- and CHIP-enrolled children with asthma. Children and their families must be taught to use prescribed asthma-control medicines and equipment correctly, and to identify and mitigate asthma triggers so that they can proactively manage asthma symptoms throughout their daily routine. While children and their caregivers receive initial instruction in clinical settings by physicians, National Asthma Education Prevention Program (NAEPP) guidelines call for repeated sessions of demonstration and practice in homes and community settings to reinforce treatment recommendations.

Often, physicians and nurses in clinical settings do not have the capacity to take on the extensive community-based educational role envisioned by NAEPP guidelines – in 2008, less than half of patients with asthma received adequate information to control their disease. Certified asthma educators or other appropriately trained community health workers are necessary to fill this gap. This proposed regulatory change would mean that state Medicaid programs can reimburse for the preventive services provided by asthma educators and

⁵ Social Security Act §1905(a)(13); § 42 USC 1396d(a)(13).

⁶ 42 CFR §440.130.

⁷ U.S. Department of Health and Human Services, National Heart, Lung and Blood Institute, National Asthma Education and Prevention Program. Expert Panel Report 3: *Guidelines for the Diagnosis and Management of Asthma* 2007

⁸ Vital Signs: Asthma in the US. Centers for Disease Control and Prevention. May 2011. Available at: http://www.cdc.gov/vitalsigns/asthma/. Accessed: January 6, 2012.

community health workers – or other professionals that may fall outside of a state's clinical licensure system – so long as the services have been initially *recommended by* a physician or licensed practitioner. Not only is this regulatory change consistent with the underlying law, it will greatly increase access to evidence-based asthma services in homes, schools and other community locations, supplementing and reinforcing clinical treatment by reaching children where they live, learn and play. *We urge CMS to preserve this important provision in the final rule.*

Thank you for the opportunity to provide these comments. We appreciate your careful consideration of our recommendations and look forward to working with you to further community-based approaches to asthma management under Medicaid. If you have any questions or would like to contact the Childhood Asthma Leadership Coalition, please contact Mary-Beth Harty at mbharty@gwu.edu.

Sincerely,

Childhood Asthma Leadership Coalition
Association of Asthma Educators
Asthma and Allergy Foundation of America
First Focus
Inner City Asthma Alliance
Merck Childhood Asthma Network
Not One More Life
Trust for America's Health