February 21, 2012

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


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 Medicaid-eligible 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

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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, without cost-sharing, 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);

(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 guidelines 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.4 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”

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 “recommended by 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).6 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.7

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.8 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

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5 Social Security Act §1905(a)(13); § 42 USC 1396d(a)(13).
6 42 CFR §440.130.
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