April 18, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard Baltimore, MD 21244

Dear Administrator Brooks-LaSure:

On behalf of the Asthma and Allergy Foundation of America (AAFA), thank you for the opportunity to respond to the RFI, Access to Coverage and Care in Medicaid and CHIP. AAFA is the leading patient organization advocating for people with asthma and allergies, and the oldest asthma and allergy patient group in the world.

We appreciate CMS' efforts to help ensure equitable access to health care for people enrolled in the Medicaid and CHIP programs. Asthma affects 25 million children and adults in the United States, and the burden is highly disproportionately experienced by people of color. Meanwhile, Medicaid has long been a crucial source of coverage for Americans with asthma, and after passage of the Affordable Care Act (ACA), the program has become even more important in covering asthma care. We would like to share the following information to help inform efforts to expand equitable access to both Medicaid and the CHIP program.

Objective 1, Question 3:

3. In what ways can CMS support states in addressing barriers to enrollment and retention of eligible individuals among different groups, which include, but are not limited to: people living in urban or rural regions; people who are experiencing homelessness; people who are from communities of color; people whose primary language is not English; people who identify as lesbian, gay, bisexual, transgender, queer, or those who have other sexual orientations or gender identities (LGBTQ+); people with disabilities; and people with mental health or substance use disorders? Which activities would you prioritize first?

Barriers to enrollment and retention for all these populations is vitally important. At AAFA, our recent work has focused on racial and ethnic disparities in asthma, and therefore our comments reflect the importance of addressing barriers to enrollment and retention among communities of color.

As we detailed in our 2020 report, "Asthma Disparities in America: A Roadmap to Reducing Burden on Racial and Ethnic Minorities," people of color, particularly Blacks and Puerto Ricans, bear a disproportionately high burden of asthma in the United States. While fortunately the disparities have been narrowing in recent years, disparities remain. For example, in 2018, the lifetime prevalence of asthma was 12.9% for white, 15.6% for Blacks, and 23% for Puerto

Ricans.[1] Black Americans are almost three times as likely as whites to die of asthma,[2] and are almost five times as likely to experience an ER visit for asthma.[3]

As you know, passage of the ACA made significant impacts on disparities in access to health insurance. Between 2010 and 2018, the Medicaid enrollment rate for white Americans increased from 12% to 15%, whereas the enrollment rate for Black and Hispanic Americans increased from 30% to 34% and 27% to 32% respectively during the same period.[4] Declines in the number of people without insurance are more evident in states with expanded Medicaid coverage than those without it. A comparison of people without insurance in expansion and non-expansion states shows increased coverage rates across racial and ethnic groups. Although expansion states began with lower uninsured rates prior to the ACA, states that implemented Medicaid expansion had more significant coverage gains for white, Hispanic, and Black populations than states that have not expanded Medicaid.[5]

Continuing to identify ways to reduce racial and ethnic barriers to care in Medicaid and CHIP is crucial for the health of people with asthma. In a study of children with asthma using data from 2012-2014, children on Medicaid or CHIP faced out-of-pocket cost barriers to seeing a physician more often than privately insured children.[6] Researchers cite less expendable family income combined with Medicaid or CHIP premiums, enrollment fees, and/or mandated cost-sharing as potential causes. Also, insured Black children were more likely to face cost barriers than insured white children while seeing a physician of any kind.[7]

Medicaid reimbursement rates, which have been historically lower than Medicare or private insurance rates, have been implicated as another potential driver of lower asthma standards of care for the publicly insured in certain medical practice settings. Some studies documented difficulties for the Medicaid-insured in accessing outpatient physician care and then filling a prescription at a pharmacy, which creates an incentive for low-income families with insurance to rely instead on emergency rooms and/or hospitalization for their asthma care.[8,9,10] Patients with

[1] CDC, National Center for Health Statistics, National Health Interview Survey (2010-2018)
[2] CDC, National Center for Health Statistics, National Vital Statistics System: Mortality (2018)
[3] CDC, National Center for Health Statistics, National Ambulatory Medical Care Survey (2010-2017)
[4] Kaiser Family Foundation estimates based on the Census Bureau's American Community Survey (2010-2018).
[5] Kaiser Family Foundation estimates based on the Census Bureau's American Community Survey (2010-2018).
[6] Pate, C. A., Qin, X., Bailey, C. M., & Zahran, H. S. (2019). Cost barriers to asthma care by health insurance type among children with asthma. Journal of Asthma, 1–7. https://doi.org/10.1080/02770903.2019.1640730
[7] Pate, C. A., Qin, X., Bailey, C. M., & Zahran, H. S. (2019). Cost barriers to asthma care by health insurance type among children with asthma. Journal of Asthma, 1–7. https://doi.org/10.1080/02770903.2019.1640730
[8] Finkelstein, J. A., Barton, M. B., Donahue, J. G., Algatt-Bergstrom, P., Markson, L. E., & Platt, R. (2000). Comparing asthma care for Medicaid and Non-Medicaid children in a health maintenance organization. Archives of Pediatrics & Adolescent Medicine, 154(6), 563–568. https://doi.org/10.1001/ archpedi.154.6.563
[9] Piecoro, L. T., Potoski, M., Talbert, J. C., & Doherty, D. E. (2001). Asthma prevalence, cost, and adherence with expert guidelines on the utilization of health care services and costs in a state Medicaid population. Health Services Research, 36(2), 357–371. https://www.ncbi.nlm.nih.gov/pmc/articles/ PMC1089228/?page=12
[10] Ferris, T. G., Blumenthal, D., Woodruff, P. G., Clark, S., & Camargo, C. A. (2002). Insurance and quality of care for adults with acute asthma. Journal of General Internal Medicine, 17(12), 905–913. https://doi. org/10.1046/j.1525-1497.2002.20230.x

asthma who rely on the emergency room for asthma management may miss out on the long-term benefits of having a usual source of care.[11]

Objective 3, Question 5:

What are specific ways that CMS can support states to increase and diversify the pool of available providers for Medicaid and CHIP (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important?

Even with the insurance coverage gains of the ACA, many Americans still face geographic, financial, cultural, linguistic, or psychosocial barriers in primary care. One significant factor is the shortage of PCPs in the U.S. The Health Resources and Services Administration (HRSA) estimates that about 80 million Americans live in Health Professional Shortage Areas (HPSAs). This is particularly true in low-income urban and rural communities, which may face challenges in recruiting qualified medical professionals who are willing and trained to serve racially, ethnically, and culturally diverse Medicaid and CHIP beneficiaries and uninsured patients.

In addition to primary care providers, Medicaid and CHIP can help promote access to important providers including certified asthma educators and community health workers (CHWs). CMS has already supported work that points to ways to improve access to asthma and other care through Medicaid and CHIP. Pediatric asthma was one of the early targets of CMS Innovation Center funding provided to three projects in July 2012 as part of the first round of its Health Care Innovation Awards (HCIA) program.[12] All three interventions served primarily Black or Hispanic populations: 83% Black participants in Le Bonheur, 69% Black participants in Nemours, and 58% Hispanic participants in Health Resources in Action. Flexibility for sites to adapt the model as needed and good levels of communication between certified asthma educators and CHWs were judged to be driving factors for success across all project sites. Evidence from the program is being used to advance Medicaid reimbursement for CHW-led home-based interventions. However, costs were not yet measured in the interim evaluation due to difficulties in securing Medicaid claims data. In fact, working with state Medicaid agencies was highlighted as one of the more difficult challenges in project implementation.[13]

Objective 3, Question 3:

---

[11] Blewett, L. A., Johnson, P. J., Lee, B., & Scal, P. B. (2008). When a usual source of care and usual provider matter: adult prevention and screening services. Journal of General Internal Medicine, 23(9), 1354–1360. https://doi.org/10.1007/s11606-008-0659-0

[12] NORC at the University of Chicago (2016). HCIA disease-specific evaluation. https://downloads.cms.gov/files/cmmi/hcia-diseasespecific-thirdannualrpt.pdf

[13] NORC at the University of Chicago (2016). HCIA disease-specific evaluation: Health Resources in Action. https://downloads.cms.gov/files/cmmi/hcia-diseasespecific-thirdannualrpt.pdf

How could CMS consider the concepts of whole person care or care coordination across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?

Whole person care and care coordination across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs is critical for many patients, but especially for patients with asthma who may suffer severe anxiety and depression associated with their illness. Poor asthma control is often linked to treatment nonadherence and the presence of comorbidities as well as psychological disorders.[14] In fact, patients with asthma have demonstrated an elevated risk for anxiety and depression that may be twice that of the general population.[15] Many people with severe asthma find that the condition has an impact on almost every aspect of their lives. Managing and living with severe asthma can create a significant burden for people with severe asthma, often causing mental health issues such as anxiety and depression.

The Federal Parity Act mandates that health insurance plans' standards for substance use and mental health benefits be comparable to, and be no more restrictive than, the standards for other medical/surgical benefits. Yet individuals and families seeking care are often overwhelmed by the difficulty in finding accessible and affordable treatment for mental health issues through their insurer. AAFA believes in fair insurance coverage for mental health services and in robust enforcement of parity laws across the country. AAFA urges CMS to aggressively enforce parity compliance within Medicaid for the provision of behavioral health services.

On example of whole person care is seen in Washington, D.C.'s, Children's National Hospital's comprehensive pediatric asthma program, "Improving Pediatric Asthma Care (IMPACT DC)." This program aims to reduce asthma-related emergency room visits and hospitalizations through clinical care, care coordination and education. Enrollment in IMPACT's asthma clinic is triggered by recent emergency room visits and hospitalizations among children with poorly controlled asthma. The program offers individualized asthma education and facilitates care coordination among patients, primary care physicians, specialists, case managers, and school personnel. IMPACT also refers patients to home visiting programs, prescription assistance programs, financial counseling, Medicaid enrollment, legal services, tobacco cessation, mental health support systems and other social programs. The asthma clinic serves an average 40 to 50 new families each month. The program has been successful in increasing the use of controller medication, decreasing the number of subsequent emergency department visits, and improving

[14] Labor M, Labor S, Jurić I, Fijačko V, Popović Grle S, Plavec D. Mood disorders in adult asthma phenotypes. *J Asthma.* 2018;55:(1):57-65.
[15] Lehto K, Pedersen NL, Almqvist C, Lu Y, Brew BK. Asthma and affective traits in adults: a genetically informative study. *Eur Respir J*. 2019;53(6):1802142.

the quality of life for the children it serves. We urge CMS to study the success of this program and others like it to advance whole person care and to support and facilitate replication of the model of care.

Another opportunity to advance whole person care is through Medicaid health homes. Health homes offer person-centered, team-based care coordination with a strong focus on behavioral health care and social supports and services. To be eligible for health home services, an individual must be a Medicaid beneficiary diagnosed with the following according to state-defined criteria: (1) two chronic conditions; (2) one chronic condition and risk for a second; or (3) a serious mental illness. Chronic conditions include mental health conditions, substance use disorder, asthma, diabetes, heart disease, and overweight (body mass index over 25). States may propose other conditions to CMS for incorporation into their health home models.

As of March 2022, 19 states and the District of Columbia have approved state plan amendments (SPAs), with some states submitting multiple SPAs to target different populations or phase-in regional implementation.[16] AAFA strongly supports Medicaid health homes and believes this model promotes whole person care and improved care coordination. We urge CMS to continue expanding and facilitating this important innovation.

Thank you for the opportunity to provide feedback on this Request for Information. AAFA looks forward to working with CMS on this important work. If you have any questions, please contact Jenna Riemenschneider at Jennar@aafa.org.

[16] Medicaid Health Homes: An Overview, Centers for Medicare and Medicaid Services, March 2022 found at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf