The Role of Medicaid and CHIP in Improving Asthma Control

Center for Medicaid and CHIP Services (CMCS)
Improving Asthma Control Learning Collaborative: Webinar #1

October 22, 2019

Deirdra Stockmann, Center for Medicaid and CHIP Services (CMCS)
Natasha Reese-McLaughlin, Mathematica
Joy Hsu, Centers for Disease Control and Prevention (CDC)
Housekeeping Instructions
Webinar Logistics

- Mute phone, unless speaking
- Q&A
- Chat
Agenda

• Welcome and Overview of CMCS’s Improving Asthma Control Learning Collaborative (CMCS)
• The Case for Improving Asthma Control (CDC)
• Medicaid’s Role in Improving Asthma (Mathematica)
• Q&A
Objectives

- Support state Medicaid agencies’ efforts to reduce the impact of asthma among Medicaid and CHIP beneficiaries
- Expand state Medicaid agencies’ knowledge of evidence-based asthma interventions
- Discuss the importance of using data-driven approaches to focus asthma improvement efforts
- Learn from states’ experiences implementing asthma interventions
Learning Collaborative Events and Opportunities

• Webinar #1: The Role of Medicaid in Improving Asthma Control – October 22, 2019

• Webinar #2: Using Data to Improve Asthma Control: Asthma Quality Measures – November 21, 2019

• Webinar #3: Choosing a Change Activity to Improve Asthma Control – December 2019

• Webinar #4: Improving Asthma Control Affinity Group Q&A – January 2020

• Affinity Group Expression of Interest Form posted – January 2020
The Case for Improving Asthma Control

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Asthma and Community Health Branch
Division of Environmental Health Science and Practice
National Center for Environmental Health
Centers for Disease Control and Prevention

The findings and conclusions in this report are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Setting the Stage: Why Asthma?

Asthma is common and disparities exist

U.S. Prevalence of Current Asthma by Selected Demographics (2017)

Source: www.cdc.gov/asthma/most_recent_national_asthma_data.htm and National Health Interview Survey
Notes: FPL= federal poverty level; NH=non-Hispanic
Why Asthma: High Cost Chronic Condition

Asthma places a significant economic burden on the US

- U.S. medical costs for asthma are >$50 billion per year
- Per-person medical cost of asthma is higher for people living below the poverty line compared to the overall population: $3,581 vs. $3,266 per year
- Medical costs from hospitalizations and emergency department (ED) visits for asthma can be reduced by improving asthma control

Source: www.cdc.gov/asthma/pdfs/EXHALE_technical_package-508.pdf
Why Asthma: Variation By State and Payer

Variation in asthma prevalence suggests there are opportunities for improvement


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<thead>
<tr>
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<th>Medicaid</th>
<th>Commercial</th>
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<tbody>
<tr>
<td>Overall asthma prevalence</td>
<td>6.0–9.6%</td>
<td>4.2–5.9%</td>
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<td>(range across 50 states)</td>
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<tr>
<td>Child asthma prevalence</td>
<td>5.2–10.4%</td>
<td>4.7–9.1%</td>
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<td>(range across 50 states)</td>
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Source: MEPS, Medical Expenditure Panel Survey
Setting the Stage: Why Now?

- Increased understanding of how various state agencies (Medicaid, public health, etc.) can improve asthma control
- Increased number of tools available to state agencies
- Aligned federal, state, and local public health activities

Examples from CDC:

www.cdc.gov/sixeighteen
Setting the Stage: What Can be Done?

Selected evidence-based strategies to control asthma

- Education on asthma self-management
- X-tinguishing smoking and secondhand smoke
- Home visits for trigger reduction and asthma self-management education
- Achievement of guidelines-based medical management
- Linkages and coordination of care across settings
- Environmental policies or best practices to reduce asthma triggers from indoor, outdoor, and occupational sources

Source: www.cdc.gov/asthma/pdfs/EXHALE_technical_package-508.pdf

Notes: Environmental policies and best practices might be less relevant to state Medicaid activities. Partnerships can support or enhance an agency’s EXHALE-related activities.
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Each strategy has shown asthma-related outcomes:
- ↓ hospitalizations
- ↓ ED visits
- ↑ return on investment
- ↑ medication adherence*

*Environmental policies or best practices not linked to medication adherence

Source: [www.cdc.gov/asthma/pdfs/EXHALE_technical_package-508.pdf](http://www.cdc.gov/asthma/pdfs/EXHALE_technical_package-508.pdf)

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Setting the Stage: What Can Be Done?

Every individual with asthma does not necessarily need every strategy in EXHALE

More resource-intensive EXHALE-related activities can be focused on individuals at higher risk of asthma attacks

Family Health Partners: Stratified Interventions

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<tr>
<th>Stratum</th>
<th>Asthma Intervention Resources</th>
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<tbody>
<tr>
<td>Stratum 1: All members</td>
<td>• Initial screening questionnaire</td>
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<td>• Database search by claims</td>
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<tr>
<td>Stratum 2: Members with asthma</td>
<td>• Asthma education by PCP</td>
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<td>• Asthma Action Plan with Action Card™</td>
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<td>• Payment for education</td>
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<td>Stratum 3: Persistent Asthma</td>
<td>• Controller medications prescribed and filled</td>
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<td></td>
<td>• Case management for moderate and severe persistent asthma</td>
</tr>
<tr>
<td>Stratum 4: Frequent Fliers (80 per case mgr)</td>
<td>• Disease-specific case management</td>
</tr>
<tr>
<td>Stratum 5: Ultra frequent fliers</td>
<td>• Environmental assessment and counseling as indicated</td>
</tr>
</tbody>
</table>

Net savings: $1.57 per member per month

Home Asthma Response Program: Return on Investment

- ≥1 ED visit or hospitalization for asthma: $1.33 per $1 invested
- ≥2 ED visits for asthma: $2.26 per $1 invested

Partners include Hasbro Children’s Hospital, Saint Joseph’s Health Center, and Thundermist Health Center

Introduction to Asthma and Asthma Control Resources


• CDC’s National Asthma Control Program — State Contacts and Programs, www.cdc.gov/asthma/contacts/default.htm

• CDC’s 6│18 Initiative State Medicaid Agency Activities, www.cdc.gov/sixeighteen/medicaid/index.html

• Implementing CDC’s 6│18 Initiative: A Resource Center — Control Asthma, www.618resources.chcs.org/priority-conditions/control-asthma/

• Improving Asthma Care for Children: Best Practices in Medicaid Managed Care, www.chcs.org/media/IACC_Toolkit.pdf

Medicaid’s Role in Asthma Control

Natasha Reese-McLaughlin, MPP
Health Researcher
Mathematica
Potential Aims:
Reduce the impact of asthma
Reduce asthma-related ED visits
Improve asthma medication ratio (AMR-CH) measure

Notes: Primary drivers are the “Factors that contribute to Asthma” as defined by the CDC and “Asthma triggers and management” identified by the American Academy of Allergy, Asthma & Immunology.
Selected Change Activities

**Air pollution**
- Reduce vehicle exhaust pollutants
- Improve asthma self-management
- Promote guideline-based clinical care

**Asthma management**
- Increase adherence to asthma medications and devices
- Promote guideline-based clinical care
- Reduce co-pays or prior authorization for asthma medications

**Asthma triggers**
- Mitigate exposure to outdoor environmental triggers
- Reduce exposure to home and school-based triggers (such as mold, dust mites, rodents, cockroaches, etc.)
- Encourage partners to advance policies/practices to reduce environmental asthma triggers
- Provide home assessments for asthma trigger reduction and allergen elimination services

**Occupational irritants**
- Decrease exposure to asthma triggers in the workplace
- Prevent exposure to irritants with protective equipment (masks, gloves, ventilation systems)
- Create integrated hub-and-spoke asthma network to connect community and clinical partners

**Respiratory infections**
- Reduce respiratory infections
- Increase access to influenza and pneumococcal vaccinations among asthma patients

**Smoking and secondhand smoke**
- Reduce tobacco smoking
- Reduce exposure to secondhand smoke
- Participate in learning collaborative on tobacco
- Provide tobacco cessation counseling or medications to parents of children with asthma
Encourage partners to advance policies/practices to reduce environmental asthma triggers

Participate in learning collaborative on tobacco

Reduce co-pays or prior authorization for asthma medications

Provide AS-ME to patients with frequent refills, ED visits, or hospitalizations for asthma

Identify asthma medications that do not align with guidelines and notify providers

Encourage partners to advance policies/practices to reduce environmental asthma triggers

Provide home assessments for asthma trigger reduction and allergen elimination services

Prevent exposure to irritants with protective equipment (masks, gloves, ventilation systems)

Create integrated hub-and-spoke asthma network to connect community and clinical partners

Increase access to influenza and pneumococcal vaccinations among asthma patients

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Provide tobacco cessation counseling or medications to parents of children with asthma

Selected Change Activities

Alignment with EXHALE

Education on asthma self-management

X-tinguishing smoking and secondhand smoke

Home visits for trigger reduction and asthma self-management education

Achievement of guidelines-based medical management

Linkages and coordination of care across settings

Environmental policies or best practices to reduce asthma triggers from indoor, outdoor, and occupational sources
Example Data Uses for QI Initiatives

Selected Change Activities

- Provide AS-ME to patients with frequent refills, ED visits, or hospitalizations for asthma
- Reduce co-pays or prior authorization for asthma medications
- Identify asthma medications that do not align with guidelines and notify providers
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- Identify number of asthma patients referred for home assessments
- Analyze claims data to identify patients with frequent medication refills, ED visits, or asthma-related hospitalizations
- Analyze claims data to identify asthma-related hospitalizations at 12 months (e.g. PQI05-AD; PQI15-AD)
- Analyze claims data to identify asthma medication purchases that aren’t guideline-based
- Analyze claims data to identify prescriptions for tobacco cessation medications
- Analyze claims data to identify patients with asthma-related hospitalizations at 12 months (e.g. PQI05-AD; PQI15-AD)
Primary Drivers that Medicaid Agencies Can Address

Aim: Reduce the impact of asthma

- Air pollution
  - Reduce vehicle exhaust pollutants
  - Improve asthma self-management

- Asthma management
  - Increase adherence to asthma medications and devices
  - Promote guideline-based clinical care

- Asthma triggers
  - Reduce exposure to home and school-based triggers (such as mold, dust mites, rodents, cockroaches, pet dander)
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- Occupational irritants
  - Decrease exposure to asthma triggers in the workplace
  - Facilitate cross-sector collaborations

- Respiratory infections
  - Reduce respiratory infections

- Smoking and secondhand smoke
  - Reduce tobacco smoking
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Secondary Drivers Most Relevant to Medicaid Agencies

Aim: Reduce the impact of asthma

- **Air pollution**
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Aim: Reduce the impact of asthma

Focus of the Asthma Learning Collaborative

- Air pollution
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  - Improve asthma self-management

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Live Poll

Which secondary driver is your state most interested in learning about? Select all that apply.

a) Improve asthma self-management

b) Increase adherence to asthma medications and devices

c) Promote guidelines-based care

d) Reduce exposure to home and school-based triggers

e) Facilitate cross-sector collaborations
Q&A

• To submit a written comment, click on the “Q&A” pod and submit your question in the text box provided. Please select All Panelists in the “Ask:” field when submitting your question or comment.

  – Please note, your comments can only be seen by our presentation team and are not viewable by other attendees.
Contact for Improving Asthma Control Learning Collaborative

For questions related to the “Improving Asthma Control” Learning Collaborative, please submit your questions to the TA mailbox at:

MACQualityImprovement@mathematica-mpr.com
Wrap Up
Thank you for participating in the webinar.

Please complete the evaluation as you exit the webinar.