About This Series

In February 2010, the George Washington University School of Public Health and Health Services, Department of Health Policy released *Changing pO$_2$licy: The Elements for Improving Childhood Asthma Outcomes*. The report provided a comprehensive look at childhood asthma prevalence, risk factors and disparities; described best practices for clinical care and disease management; and outlined evidence-based policy recommendations to improve the prevention, diagnosis, treatment, and long-term management of childhood asthma.

The report identified five essential elements for improving asthma outcomes in children:

(1) Stable and continuous health insurance
(2) High-quality clinical care, case management and asthma education available for all children
(3) The ability to continuously exchange information and monitor progress, using health information technology
(4) Reducing asthma triggers in homes and communities
(5) Learning what works and increasing knowledge

Following the release of these recommendations, Congress passed the *Affordable Care Act* (ACA), emphasizing expanding access to private health insurance and Medicaid and reforming the healthcare delivery system to improve quality. The ACA includes provisions to eliminate health care disparities, strengthen public health programs and access to preventive services, invest in expanding and improving the health care workforce, and encourage care coordination and disease management.

Many ACA provisions correspond to recommendations in the *Changing pO$_2$licy* report and have the potential to profoundly impact the prevention and treatment of childhood asthma.

This paper focuses on one of the five essential elements for improving asthma outcomes in children: ***high-quality clinical care, case management and asthma education***. The accompanying chart describes ACA provisions and implementation activities that could be activated to help millions of children most at risk for asthma.

Leveraging Affordable Care Act Opportunities to Improve Childhood Asthma Outcomes

How advocacy organizations can mobilize around ACA provisions to improve health outcomes for millions of children most at risk for asthma

MAKING HIGH-QUALITY CLINICAL CARE, CASE MANAGEMENT AND ASTHMA EDUCATION AVAILABLE TO ALL CHILDREN

The 2010 *Changing pO$_2$licy* report describes several essential elements that are critical to ensuring that comprehensive asthma treatment and management reach children in need. Specifically, the report identifies the need to improve quality of care for children with asthma. According to the report, this means having a regular source of medical care that offers a medical home to children and their families, access to specialty care, preventive and prompt treatment for acute episodes, ongoing case management and health education, and linkages to home-based services.

The following chart describes several *Affordable Care Act* (ACA) provisions and implementation activities that target quality improvement of clinical care, case management and education for children with asthma. Regardless of whether a provision has been fully implemented or is still in progress, each presents a unique opportunity for policy and advocacy efforts to improve access to health insurance for children with asthma.

This review includes descriptions and implementation timelines of several ACA programs and initiatives, including:

- ***Enrolling Medicaid beneficiaries with chronic conditions into a health home***
- ***Medication management services for persons with chronic disease***
- ***Educational tools to aid in patient decision-making and patient navigators to assist with linkages to community care***
- ***Funding to support community and clinical prevention and wellness strategies to reduce chronic disease***
- ***Upgrades to school-based health centers***

Following descriptions of each ACA provision and related implementation activities, the chart describes potential areas for asthma stakeholder engagement, policy research and development, and advocacy action at the national, state and local levels.

Childhood Asthma Leadership Coalition

DESCRIPTION OF PROVISION	RECENT IMPLEMENTATION ACTIVITIES	OPPORTUNITIES FOR CHILDHOOD ASTHMA POLICY/ADVOCACY
PAYMENT ADJUSTMENT OF HEALTH CARE-ACQUIRED CONDITIONS (SECTION 2702)		
Requires the HHS Secretary to develop regulations that prohibit Medicaid from paying states for any amounts expended for providing medical assistance for certain health care-acquired conditions (HCACs). In developing the regulations, the HHS Secretary must identify current state practices that prohibit payments to providers for HCACs, and incorporate elements of such practices, as appropriate, into a regulation to apply to the Medicaid program as a whole. Medicaid beneficiaries may not lose access to care or services as a result of these regulations.	• June 6, 2011: CMS published a final rule prohibiting federal Medicaid payments to states for health care-acquired infections. • July 1, 2011: The payment adjustment of health care-acquired conditions became effective.	Asthma-related admissions account for 13.5% of pediatric hospitalizations, and children with asthma may be susceptible to respiratory infections and other HCACs. • ***Potential Policy Action: The Medicaid payment adjustment has the potential to improve quality of care for hospitalized children with asthma. Advocacy may be important here to push for new HCAC-related non-payment policies.***
STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS (SECTION 2703)		
• Beginning January 1, 2011, states now have the option to amend the state Medicaid benefit to enroll certain Medicaid beneficiaries with chronic conditions into a health home. Eligible Medicaid beneficiaries include beneficiaries with asthma. • Health Home Services: A health home may consist of either an individual provider (such as a community health center or comprehensive primary care clinic) or a health team. The health home would be responsible for all patient care, as well as a specific set of "health home" services, including: comprehensive care management; care coordination and health promotion; comprehensive transitional care; patient and family support; referral to community and social support services; and use of health	• November 16, 2010: CMS issued guidance to State Medicaid Directors regarding health homes for Medicaid enrollees. Under this guidance, states can choose which health home provider arrangement or arrangements to offer, and, if more than one option is available, beneficiaries may choose among them. States also have flexibility in designing the payment model that would be used for health home services (e.g. fee-for-service or capitated payments). • October, 2011: CMS released a Frequently Asked Questions document addressing key areas for health home design, including providers, enrollment and eligibility; delivery models; quality measurement; reporting; HIT; funding and payment; and	The Medical Home model, with its emphasis on holistic patient-centered care, care in community settings and comprehensive chronic disease management, has the potential to greatly improve the quality of childhood asthma treatment in the Medicaid population. • ***Potential Policy Action: There may be a need to advocate for states to take advantage of the health home option under Medicaid for improving the quality of health care for children with asthma.*** As of May 2012, CMS has approved six state plan amendments to offer health homes under Medicaid: Missouri (2), New York, Oregon, and Rhode Island (2). At least three state plan amendments are under official CMS review (Alabama, Iowa, and North Carolina); at least seven states have draft proposals under CMS review; and fifteen states have received CMS approval for planning activities such as feasibility studies. Six states, (Rhode Island, Iowa, Missouri, North Carolina, Oregon and New York) have elected to offer health home services to individuals with asthma. However, regulations grant states much flexibility to design their health homes. • ***Potential Policy Action: As asthma health homes develop under State Medicaid programs, advocacy may be important to ensure comprehensive care management, care coordination and other health home services meet evidence-based standards of care for children with asthma. Advocates may also wish to engage with provider groups working to establish health homes to ensure that these delivery systems incorporate patient preferences.*** Per ACA requirements, by January 1, 2014, the HHS Secretary must survey participating states and report to

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information technology to link services. • Federal Match: During the first 8 fiscal year quarters that the state plan amendment is in effect, the federal match applicable to these health home services will be 90 percent.	SPA/waiver authorities. CMS has issued no further guidance, and reportedly is refraining from writing regulations on this provision in order to learn from early adaptor states. Until regulations are issued, CMS will rely on the November 2010 guidance.	Congress on the ability of health homes to improve hospital admission rates, improve chronic disease management, coordinate care for individuals with chronic conditions, and produce cost savings. • ***Potential Policy Action: Asthma advocates could consider conducting supportive research on Medicaid health homes to support continuation or expansion of the health home provision.***
NATIONAL QUALITY STRATEGY (SECTION 3011)		
Requires the HHS Secretary to develop and update annually a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Priorities must (among other things): address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques; enhance the use of health care data to improve quality, efficiency, transparency, and outcomes; and improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and HAIs.	• March 21, 2011: HHS released a report to Congress outlining the priorities set by the National Quality Strategy, which include: (i) making care safer; (ii) ensuring person- and family-centered care; (iii) promoting effective communication and coordination of care; (iv) promoting the most effective prevention and treatment of the leading causes of mortality; (v) working with communities to promote wide use of best practices to enable healthy living; (vi) making quality care more affordable. • April 30, 2012: HHS released the 2012 Annual Progress Report to Congress on the National Quality Strategy. The report details the implementation of the National Quality Strategy over the past year and establishes key measures and goals that will be used to measure national progress in improving quality.	The *Changing pO2licy* report recommends developing a HHS-led, cross-agency strategy that comprehensively addresses childhood asthma. The continuing work of the National Quality Strategy could provide a vehicle for this work. • ***Potential Policy Action: Advocates could consider encouraging HHS to develop an asthma strategy under the National Quality Strategy, or work to ensure that the measurements used to assess national progress in improving quality include measurements of importance to the asthma community.***
MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASE (SECTION 3503)		
• Establishes a grant program that aids pharmacists in implementing medication management services for the treatment of	• Due to a lack of appropriations for this provision, the Agency for Health Care Research and Quality (AHRQ) has not yet	• ***Potential Policy Action: Pharmacist-delivered medication management programs that provide patient education and treatment in a community setting have the potential to improve patient adherence to medication and management of their condition. Studies suggest that pharmacist-managed asthma***

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chronic diseases. • Under the program, medication management services will be targeted towards individuals who: (i) take four or more prescribed medications; (ii) take any "high risk" medications; (iii) have 2 or more chronic diseases as identified by the Secretary; or (iv) have undergone a transition of care, or exhibit other factors identified by the Secretary that are likely to create a high risk of medication-related problems.	provided grants under this authority; however, the Innovation Center is testing a number of new health care delivery models that include medication management services in the treatment of beneficiaries with targeted chronic diseases.	***management programs (with physician direction) reduce emergency department visits. The asthma community could consider advocating for funding for this grant program.***
PROGRAM TO FACILITATE SHARED DECISIONMAKING (SECTION 3506)		
• Establishes a program to develop, test, and disseminate educational tools to aid in patient and caregiver decision making. Decision aids are a technique to engage patients in decision making by encouraging patients to determine their own values with regard to health care. Using these decision aids as a tool, health care providers will be able to assist patients in weighing treatment options and can design medical plans that are better suited to a patient preferences. • Additionally, HHS will provide grants for the establishment and support of Shared Decision-Making Resource Centers to provide technical assistance to providers in adopting decision aides.	• Due to a lack of appropriations for this provision, AHRQ has not yet implemented this provision.	• ***<u>Potential Policy Action</u>: Shared decision making is associated with better adherence to asthma controller medications, better quality of asthma-related life, and better lung function. Shared decision making with children may improve their self-confidence and ability to manage their asthma. Advocates could consider advocating for funding for this important program.***
PATIENT NAVIGATOR SYSTEM (SECTION 3510)		
• Reauthorizes a demonstration program to provide patient navigator services (these programs would have expired on September	• HRSA issued approximately $4 million in grants under this program in 2011. No additional funds were appropriated for FY 2012. Demonstration grants are	Several of the grants issued under this program focus on asthma, among other chronic diseases. • ***<u>Potential Policy Action:</u> To the extent that this has not already happened, advocates may wish to engage with HRSA grantees, particularly to determine what support these entities may need when the***

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30, 2010). • This program connects patients with "patient navigators" who coordinate health care services needed for the diagnosis and treatment of chronic disease. Patient navigators also facilitate the involvement of community organizations in assisting individuals who are at risk for or who have chronic diseases to receive better access to high-quality health care services (such as by creating partnerships with patient advocacy groups, charities, health care centers, community hospice centers, other health care providers, or other organizations in the targeted community).	scheduled to end in August 2012.	***demonstration program ends in August 2012.*** • ***<u>Potential Policy Action:</u> Advocacy may be required to ensure that HRSA appropriately evaluates the patient navigator program's impact on asthma treatment and prevention, and disseminates best practices.***
PREVENTION AND PUBLIC HEALTH FUND; COMMUNITY TRANSFORMATION GRANTS (SECTION 4002, 4201)		
Establishes a Prevention and Public Health Fund within HHS to provide for an expanded national investment in prevention and public health programs. The goal of the Prevention Fund is to create a stable, reliable funding source dedicated to public health and prevention. The Fund will provide resources to communities to invest in effective, proven prevention efforts, such as immunization programs and tobacco cessation. <u>Community Transformation Grants</u>: The Community Transformation Grant ("CTG") program is funded by the Prevention and Public Health Fund. The CTG program is a funding mechanism to support evidence- and practice-based community and clinical prevention and wellness strategies that address the leading causes of chronic disease, such as tobacco use,	• <u>February 11, 2011</u>: HHS announced $750 million in funds from the Prevention and Public Health Fund to help prevent tobacco use, obesity, heart disease, stroke and cancer; and to increase immunizations. • <u>September 27, 2011</u>: HHS provided $103 million in community transformation grants to 61 states and communities. None of the CTG programs state that they intend to specifically focus on asthma. • <u>February 22, 2012</u>: In February, President Obama signed the *Middle Class Tax Relief and* Job *Creation Act*, with the purpose of averting the impending cuts in physicians' payment under Medicare, extending jobless benefits to the unemployed and	The broad charge of the Prevention Fund and the CTG grants means that innovative programs for asthma treatment and prevention can fall under multiple initiatives funded by these ACA provisions. To date, none of the CTG grants have a specific asthma focus. However, grants are focused on obesity (which can increase the severity of asthma) and target other environmental triggers for asthma (including grants to promote tobacco-free living and healthy physical environments). • ***<u>Potential Policy Action</u>: Asthma advocates could consider assisting state/local partners in applying for CTG funding or other funding opportunities via the Prevention Fund. In addition, asthma advocates could consider teaming up with entities that have received Prevention Fund dollars to determine how asthma prevention can become part of these initiatives underway.*** Community prevention projects that target asthma may be awarded through the "CTG Small Communities Program" when funding is announced in September 2012. • ***<u>Potential Policy Action</u>: Asthma advocates could consider collaborating with entities awarded grants under this program to ensure that asthma prevention is appropriately included.*** As a result of the *Middle Class Tax Relief and* Job *Creation Act*, the Prevention Fund has lost a considerable amount of its previously allocated funding. From fiscal years 2012 through 2022, the ACA would have allocated $19.75 billion to the Prevention Fund, where the Middle Class Tax Relief and Job Creation Act only allocates

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obesity, and poor nutrition. The CTG program is focused on community-driven interventions that will lead to specific, measurable health outcomes to: • Reduce chronic diseases, including heart disease, cancer, stroke, asthma and diabetes; • Prevent the development of secondary conditions; • Address health disparities; and • Develop a stronger evidence base for community-level prevention programming.	extending payroll tax cuts. The law reduces $6.25 billion in funding previously allocated for the Prevention and Public Health Fund to partially offset costs related to these provisions. • CTG Small Communities Program: CDC expects to make 25 to 50 competitive grant awards under this program, with successful applicants announced in September 2012. Applicants must demonstrate how they can improve their communities through increasing the availability of healthy foods, improving access to safe places for physical activity, discouraging tobacco use, and encouraging smoke-free environments.	$13.5 billion, resulting in a net loss of $6.25 billion over the 10 year period. • ***Potential Policy Action: Advocates may wish to advocate for the protection of the Prevention Fund from efforts to cut this program in deficit-reduction legislation or to use it as an offset for other initiatives.***
SCHOOL-BASED HEALTH CENTERS (SECTION 4101)		
• Appropriates $200 million to establish school-based health centers. These grants enable school-based health centers to establish new sites or upgrade their current facilities, which will increase their ability to provide preventive and primary health care services, and help children improve their health and remain healthy. The law provides additional funding for the operation of school-based health centers (e.g. for equipment, training, management, operation, salaries, etc.).	• July 14, 2011: HHS announced awards of $95 million to 278 school-based health center programs. • December 8, 2011: HHS announced awards of $14 million to 45 school-based health centers. • May 9, 2012: HHS announced 150 awards totaling $75 million to school-based health centers.	School-based health centers are a key point of treatment for many children with asthma. Research shows that access to school-based health centers reduces the rate of hospitalization and increases the number of school days attended for children with asthma. • ***Potential Policy Action: Advocates could consider working with HRSA to ensure that school-based health centers receive program dollars to address asthma.***