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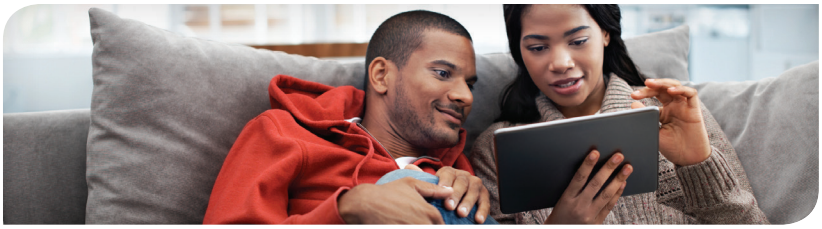

How to Find Asthma Care Coverage Information for a Medicaid Plan

Through the Asthma Guidelines-Based Care Coverage Project, the American Lung Association tracks Medicaid coverage of guidelines-based asthma care and related barriers to care in all 50 states, the District of Columbia, and Puerto Rico. Each state structures its Medicaid program differently. Some states only have a fee-for-service (FFS) program, where the state contracts directly with healthcare providers to pay for services that Medicaid enrollees use. However, many states also contract with managed care organizations (MCOs), private health insurance companies that often receive a per-member per-month fee to manage the healthcare needs and expenses of Medicaid enrollees.

In states with multiple Medicaid managed care plans, the Lung Association aggregates coverage information from all plans in the state when it releases its annual coverage data. There may be cases where stakeholders also want to find information about a specific FFS program's or MCO's coverage of guidelines-based asthma care. This document serves as a guide to finding asthma care coverage information for an individual Medicaid plan.

Identifying Medicaid Managed Care Plans in the State

The Kaiser Family Foundation provides a Medicaid Managed Care Market Tracker to help determine (1) if a state has a managed care program and (2) the number of Medicaid MCOs operating in that state. State Medicaid websites also provide a list of managed care organizations in the program with links to their individual websites, and this list can usually be found with a quick Google search of "[State] Medicaid Managed Care Plans." When examining managed care plans, make sure to look at the health plan's Medicaid plan information, not its commercial plans, as the health insurance company may offer many different plans in a state that offer different benefit packages.

Finding Quick Relief and Controller Medication Coverage

FFS programs and MCOs usually provide handbooks for their members, which can typically be found on the program or plan websites. These can serve as starting points to obtain a description of the overall prescription drug benefit, as well as information on any copays that may be charged for medications.

Health plans often list out covered drugs in a formulary or preferred drug list (PDL), which can also be found on the plan's website. In addition, these lists may also have information about barriers like step therapy and quantity limits that plans may impose to encourage patients and providers to select certain brand or generic medications over others (see box on barriers to care). As medications enter or leave the market, new formulations become available, and pharmaceutical manufacturers negotiate new contracts with health plans, plans update their formularies or PDLs and coverage of asthma care for Medicaid beneficiaries can change. Formularies and PDLs may be updated yearly, quarterly, or more or less frequently.

Some health plans may also provide a drug lookup tool on their website that allows physicians and patients to type in a specific asthma medication and verify coverage. These tools often include information about barriers to care as well. Some tools also include entries for non-formulary or non-preferred drugs that may not be listed on a PDL but will be covered if certain requirements such as prior authorization, step therapy or medical necessity are met.

Finally, plans may have prior authorization forms available for specific asthma medications that contain more detail about eligibility criteria, step therapy and other requirements that patients must meet as part of the prior authorization process. These forms are usually found on a prior authorization page on the plan's website or are linked through the plan's drug lookup tool.

Barriers to Care

The Lung Association looks for nine barriers when collecting information for a state Medicaid program or managed care plan. Here's a list of barriers to look out for when evaluating asthma care coverage.

Age limits	This barrier indicates that the treatment is only covered if a patient is under the age of x and applied only if it is more restrictive than FDA-approved guidelines.
Age restrictions	This barrier indicates that the treatment is only covered for patients over the age of x and applied only if it is more restrictive than FDA-approved guidelines.
Copayments	Payment that must be made to receive the treatment even when it is covered by the health plan (in this case Medicaid or Medicaid-managed care plans).
DME	A device is covered only as DME, which could result in having to pay full price for the device at a retail pharmacy.
Eligibility criteria	A plan will only provide the treatment after a patient has experienced an incident, such as numerous visits to the emergency department.
Prior authorization	This barrier requires the provider to get approval from the insurance company (in this case Medicaid or Medicaid-managed care plans) before the treatment will be covered.
Quantity limits	There is a limit on the number of treatments covered each month or under a certain amount of time.
Specialty visit limitations	This is when a plan only allows a patient to see a fixed number of specialists per year.
Stepped therapy	This means a plan requires a patient to try and fail on a different treatment before the insurance company (in this case Medicaid or Medicaid-managed care plans) will pay for the treatment that his/her provider prescribes.

Finding Medical Device Coverage

Some health plans list coverage of nebulizers, peak flow meters and valved-holding chambers in their PDL, formulary or drug lookup tool. These resources often include information about barriers that apply to the medical devices, such as prior authorization or quantity limits, as well.

If medical devices are not listed in these documents, the devices may be covered under the Durable Medical Equipment (DME) benefit. FFS programs and MCOs may provide a list of DME devices that they cover on their websites. Devices on a DME list would indicate coverage as well as the presence of the DME barrier.

Finally, information about medical device coverage can also be found in resources such as member handbooks and provider manuals. Look for headings like DME, medical devices, asthma care or chronic disease case management in these documents.

Finding Allergy Testing and Allergen Immunotherapy Coverage

A state Medicaid program typically has a fee schedule – a document which lists covered services by their Current Procedural Terminology (CPT) codes along with the fees that the state will pay providers for these services – on its website. The Lung Association has a list of CPT codes for allergy testing and allergen immunotherapy in the methodology document for the Asthma Guidelines-Based Care Coverage project, which can be used to search for allergy coverage information in a fee schedule.

For a managed care plan, allergy testing and allergen immunotherapy coverage information may be found in medical or clinical policy documents that outline coverage criteria and limitations. These documents are often found under the provider section of a health plan's website or in an online resource library specific to the health plan. Also, managed care plans may have prior authorization procedure search tools and precertification lookups on their websites where CPT codes can be entered to see if a procedure is covered and whether prior authorization is required. It is important to note that some search tools specify that finding the prior authorization requirements does not guarantee coverage and, in those cases, it is best to verify coverage with the Medicaid office.

Helpful Hint

If you're struggling to find coverage information in a given area, check out the Lung Association's Asthma Care Coverage Database and click on your state. At the end of each state page, there is a list of the publicly available sources used to collect information on the FFS program and managed care plans for the state. These can be a helpful starting point.

Finding Home Visit and Self-Management Education Coverage

While there is no standard place to look for information regarding coverage of home visits, health plans often include home visits and interventions for asthma in information about their asthma program if they have one. Look for information about an asthma program in a member handbook or on any pages about asthma on the plan's website. Home visits and interventions are not widely covered, and therefore detailed information on coverage and barriers is often not publicly available.

Coverage information for asthma self-management education is typically found in member handbooks and provider manuals, often under topics like case management and chronic disease management. However, the presence of a case

management or chronic disease management program does not necessarily mean that asthma self-management education is covered. Another possible way to find coverage information is to look up CPT codes for asthma self-management education in a process similar to that for allergy testing and allergen immunotherapy. Again, the Lung Association has a list of CPT codes that may be used for asthma self-management education in the methodology document for the Asthma Guidelines-Based Care Coverage project.

Final Tips

Remember that each Medicaid program and plan is different – so the place that you find coverage information for one plan might not work for others. This list of potential sources of coverage information is also not exhaustive – occasionally, coverage information also appears in state plan amendments, Medicaid managed care contracts, or other resources not discussed in detail here.

Finally, even if no information is found, a plan may still cover an asthma treatment or service. Contacting individual managed care plans or Medicaid offices directly can provide additional information that may not be publicly available.

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