



Medicaid Cessation Coverage Roundtable Report April, 2014

How can we most effectively maximize the impact of the Affordable Care Act on access to, and coverage of, tobacco cessation for Medicaid enrollees?

BACKGROUND

The Affordable Care Act and Tobacco Cessation

The U.S. healthcare environment is undergoing many changes as a result of the Patient Protection and Affordable Care Act (ACA). The ACA has a lofty goal of ensuring all Americans have health insurance that covers *Essential Health Benefits* such as preventive services, wellness services and chronic disease management. Under the ACA, tobacco cessation is included as a required preventive service. The new law places the financial responsibility for providing tobacco cessation treatment on the insurer/health plan.

The most relevant requirements of the ACA¹ are:

- **Preventive Services:** The ACA requires health insurance plans to cover preventive services such as tobacco cessation at no cost to the patient, beginning in 2014. This applies to all plans created since March 2010. The Department of Health and Human Services (HHS) has not defined which medications and types of counseling should be included in the requirement.
- **Essential Health Benefits:** The ACA requires all individual and small group plans to cover an Essential Health Benefit (including preventive services, wellness services, and chronic disease management). Each state must choose a benchmark plan to serve as its Essential Health Benefit.
- **Medicaid:** The ACA provides Medicaid recipients who smoke and are pregnant with comprehensive tobacco cessation services without cost-sharing. As of January 1, 2014, Medicaid programs are no longer able to exclude tobacco cessation medications from their prescription drug coverage.
- **Medicare:** The ACA adds a free annual wellness visit that may include tobacco cessation counseling and a prescription for a tobacco cessation medication. All Medicare enrollees will have access to expanded cessation counseling and more affordable medications.

- State Health Insurance Exchanges: The unemployed, self-employed and those without employer-sponsored insurance in 2014 will be covered by the Exchanges. The ACA requires all plans in the Exchanges to cover the Essential Health Benefit (which includes an undefined tobacco cessation benefit).
- Employer-sponsored Insurance: The ACA requires coverage of all preventive services given an 'A' or 'B' rating by the U.S. Preventive Services Task Force, including tobacco cessation.
- Outcomes-based wellness programs: The ACA allows employers to charge 50% of the total cost of an employee's health care coverage (i.e., a surcharge) if the employee is a smoker and does not participate in a "reasonable alternative" cessation program.

As implementation of the ACA moves forward, the lack of a defined tobacco cessation benefit creates significant uncertainty about the availability and quality of tobacco cessation services for tobacco users seeking help in quitting. Tobacco cessation experts have recommended using the Federal Employees Health Benefit (FEHB) plan as a model for the *Essential Health Benefit* on tobacco cessation. This recommendation was made to HHS Secretary Sebelius in a February 19, 2014 letter signed by 30 national organizations.² The FEHB plan is based on the clinical guideline and covers:

- Four tobacco cessation counseling sessions of at least 30 minutes. This includes proactive telephone counseling, group counseling and individual counseling.
- All 7 tobacco cessation medications approved by the Food and Drug Administration (FDA).
- Coverage for two quit attempts per year.
- The benefits must be provided with no copayments or coinsurance and not subject to deductibles, annual or life time dollar limits.

To date, HHS has not responded to the recommendation. Considering Secretary Sebelius' resignation from HHS on April 10, 2014, tobacco control and cessation professionals will need to educate the new leadership about the importance of issuing specific guidance in this area.

WHY MEDICAID?

Approximately 37 percent of Medicaid enrollees smoke, compared to 21 percent of the total adult population and smoking-related medical costs make up 11% of Medicaid expenditures.³ The ACA clearly expands coverage of tobacco cessation in several significant ways, for both publicly- and privately-insured tobacco users, and also presents the tobacco control field with numerous opportunities to bolster access to

evidence-based cessation treatment among this critical and often hard to reach population of smokers. However, according to a recent Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR) that assessed state Medicaid coverage of individual counseling, group counseling, and the seven FDA-approved cessation medications, as of 2014 all 50 states and the District of Columbia cover *some* cessation treatments for at least *some* Medicaid enrollees, but only seven states cover all nine treatments for all enrollees.⁴ Common barriers in 2014 include duration limits (40 states for at least some populations or plans), annual limits (37 states), prior authorization requirements (36 states), and copayments (35 states).⁴

Healthy People 2020 Objective TU-8 encourages partnership across systems to increase comprehensive Medicaid insurance coverage of evidence-based treatment for nicotine dependency.

ROUNDTABLE RATIONALE AND PURPOSE

The North American Quitline Consortium (NAQC) Medicaid Cessation Coverage Roundtable is a result of over two years of

dialogue, technical assistance and resource development aimed at tobacco control programs working to secure cost-sharing partnerships with their state Medicaid agencies. The impetus of this early work was the June 2011 letter from the Centers for Medicare & Medicaid Services Director (CMS), Cindy Mann, to State Medicaid Directors announcing tobacco cessation telephone quitlines as allowable Medicaid administrative activities and thus, eligible for the 50 percent Federal Medicaid matching rate.⁵

After nearly three years of providing support to state quitlines on securing the Federal Medicaid matching rate for quitline services, it has become clear to NAQC that, in addition to technical support to states working to take advantage of the CMS guideline on quitlines and the ACA, there is **a need to elevate many of the structural, operational and policy barriers** that hinder implementation of comprehensive cessation coverage to Medicaid enrollees to those who are most able to influence change. In order to openly discuss specific topics, identify barriers and make targeted recommendations for addressing them, NAQC determined that a roundtable of leaders from state tobacco control, state Medicaid, CDC's Office on Smoking and Health, and national advocacy organizations who work to ensure access to comprehensive cessation coverage among those who are publicly ensured would be extremely useful. The specific aims of the Roundtable are:

- To work across systems to **improve understanding** of the Medicaid cessation policy landscape in light of the Affordable Care Act (ACA), as well as general changes to Medicaid, that may impact on partnership-building efforts focused on tobacco cessation-related cost sharing and benefit design;
- To clearly articulate to the tobacco control community how specific aspects of the Medicaid policy landscape **impact positively and negatively on efforts** to improve coverage for cessation;
- To **develop targeted recommendations** to decision-makers within HHS and CMS for addressing identified structural, operational and policy barriers to successful implementation of comprehensive cessation coverage for Medicaid enrollees; and
- To provide a **forum for strategizing and sharing information** on both national and state Medicaid cessation policy priorities.

Lessons Learned So Far

There have been many Medicaid-related lessons learned by state tobacco control programs since June 2011 that serve as the groundwork for future efforts. A few of these lessons include:

Policy-related lessons

- Drawing down federal matching funds for quitline administrative services does not always impact positively on quitline sustainability. In some states, federal matching funds are required by state statute to go directly into the state's general fund and in some states matching funds are placed back into the larger tobacco control program budget.
- There are both federal and state-level barriers to accessing over-the-counter cessation medications that seem nearly impossible to "fix" and the variability among states is immense. These barriers also make it nearly impossible to offer cessation medications to Medicaid enrollees via the quitline.

Structural-related lessons

- Building the relationship between the state tobacco control program and the state Medicaid agency is hard work and takes time, good data, strategy and leadership from both sides. It appears that relationship-building is less time-intensive when the Medicaid program and the state public health program operate within the same state agency. For example, in Maryland, Medical Assistance (Medicaid) and Prevention and Health Promotion Administration (includes tobacco) are both housed within the Department of Health and Mental Hygiene.
- Building the infrastructure needed to support drawing down federal matching funds for quitline services (e.g., memorandum of understanding, cost allocation

methodology) also takes a great deal of time, energy and expertise. In some states, the process can require a legislatively-approved transfer of spending authority from the state Medicaid agency to the tobacco control program. There have also been examples of a regional CMS office giving advice to the state Medicaid agency that is in conflict with advice and guidance given to tobacco control program staff by federal CMS staff.

Operational-related lessons

- Building the internal systems to support the Medicaid match for quitlines is state-specific, extremely detailed and required close collaboration with contracts, legal and budget offices within both agencies. It is true that each agency speaks its own “language” and certainly the various offices within each agency do as well.
- Each state tobacco control program uses state-specific strategies to make movement on Medicaid that takes into account the overarching cessation sustainability plan, the current funding and political landscape within which they are operating, the stated goals of their quitline, their historical relationship with Medicaid, and how they believe they can most effectively and efficiently make an impact on increasing quit rates and quit attempts for this population of smokers (e.g., if Medicaid is made up primarily of Managed Care rather than fee-for-service, it may make more strategic sense to spend time strengthening the cessation benefit offered by the Managed Care Entities, rather than on building the quitline match).

Medicaid enrollees accounted for 25% of tobacco users served by U.S. quitlines in FY2012.⁶ For state tobacco control programs, guaranteeing that smokers insured by Medicaid have access to a comprehensive cessation benefit that includes quitline counseling *and* receiving reimbursement for the evidence-based treatment that quitlines provide to Medicaid enrollees has become a cornerstone of their work. This report aims to bolster these important efforts by states by providing a summary of the NAQC Roundtable’s discussion of four questions and recommendations that NAQC believes will accelerate progress toward truly comprehensive cessation coverage, including quitline counseling, for all Medicaid enrollees. With opportunities such as the Affordable Care Act and Medicaid Expansion, tobacco users should have more support and options to quit and stay quit than ever before – the question for us is, *How can we most effectively maximize the impact of the Affordable Care Act on access to, and coverage of, tobacco cessation for Medicaid enrollees?*

THE ROUNDTABLE’S VIEW

In this final section of the report, the questions posed to the roundtable, highlights from the discussion and recommendations for accelerating progress are presented.

Is ACA viewed as a critical opportunity for improving cessation coverage among Medicaid enrollees? Why or why not?

According to NAQC Roundtable members, the ACA is certainly an opportunity for cessation but is also viewed as challenging due to the political landscape within which it is being implemented – both at the federal and state levels. The ACA provides, in a time-bound way, for the emergence of comprehensive cessation within Medicaid. However, with only 27 states (including the District of Columbia) implementing Medicaid Expansion in 2014, the ability to reach those who are most vulnerable and who we know smoke at rates nearly 50 times greater than the general population, with cessation remains limited.⁷

The ACA, though complicated, has also offered Medicaid agencies the opportunity to take a second look at current cessation benefits and barriers to accessing those benefits and ensure alignment with ACA requirements, as well as budgetary and coverage goals. This has been especially true for Roundtable members in relation to their state's Medicaid Managed Care Entities.

The ACA requires critical changes to the provision of both public and private health insurance and brings the topic of prevention in healthcare delivery to the forefront of implementation discussions. Therefore, allies in tobacco cessation view the ACA as an important leverage point for improving coverage for cessation.

ACCELERATING PROGRESS ON IMPROVING COVERAGE

1. State tobacco control programs should reach out to their state Medicaid agency to learn what cessation coverage exists for their fee-for-service population and/or their managed care population and compare/contrast these to the model Federal Employees Health Benefit (FEHB) plan. State tobacco control programs must clearly understand barriers to accessing the benefit, as well as how the benefit is promoted to enrollees, in order to strategically leverage ACA and the existing cessation infrastructure already in place (e.g., the state quitline).
2. State Medicaid agencies should seek guidance from state tobacco control programs in the defining, implementation, promotion and evaluation of a standard comprehensive cessation benefit for all Medicaid enrollees and consider cost-sharing or reimbursement for quitline services to enrollees.

What is proving challenging to implementation of ACA's Medicaid tobacco cessation provisions or to taking full advantage of the opportunities they present? What are the national-level decisions/guidance/support that would be most critical for moving forward?

NAQC Roundtable members identified four challenges to taking full advantage of the cessation opportunities presented by ACA.

Lack of Definition

As implementation of the ACA moves forward, the lack of a defined tobacco cessation benefit has created significant variability in the availability and quality of tobacco cessation services for tobacco users seeking help across the country. This lack of a defined comprehensive tobacco cessation benefit that includes all FDA-approved cessation medications and individual, group and phone counseling has resulted in less than adequate implementation of the law in private plans, state health insurance exchange plans and Medicaid expansion plans. Roundtable members noted that the lack of guidance has slowed progress, as insurers want to be in compliance with the law, but not go beyond the minimum requirements.

As of January 1, 2014, Medicaid programs are no longer able to exclude tobacco cessation medications from their prescription drug coverage. While this requirement has the potential to increase utilization of proven cessation medications among Medicaid enrollees, it lacks critical guidance from HHS on the specific medications that must be incorporated into Medicaid formularies and direction to state Medicaid agencies that the medication benefit must be extended to all Medicaid plans, fee-for-service and managed care.

Competing Priorities

Every state's Medicaid program is undergoing significant changes, from expanding coverage for adults, implementing insurance reforms, modernizing enrollment and renewal processes, to coordinating with state Health Insurance Marketplaces and defining their new role in the healthcare system. Attending to these and other overarching ACA-related priorities and deadlines within state Medicaid agencies can appear to be in conflict with state tobacco control program priorities to ensure comprehensive tobacco cessation coverage. Though, according to NAQC Roundtable members, it is possible to find the right people within a state Medicaid agency who *are* prioritizing defining benefit coverage, especially as it relates to ACA.

Increasing Utilization of Primary Care Services

A few Roundtable members noted that their states struggle with getting enrollees to use primary care services and this makes it difficult to get conversations about tobacco cessation started. In one state, new enrollees are encouraged to schedule a primary care appointment within 60 days of enrollment and their plan actually follows up with them to help get the appointment scheduled and a health risk assessment completed.

Promotion of the Benefit

Roundtable members expressed the need for periodic, repetitive, awareness-building of tobacco cessation benefits among enrollees and the healthcare providers who serve them. Promoting the benefit, while critical to ensuring utilization, is difficult. One Roundtable member noted that their state has a difficult time communicating with members about services and that reaching the fee-for-service is more challenging than reaching those served through managed care.

ACCELERATING PROGRESS ON EXISTING OPPORTUNITIES

1. Without further guidance and clarification by HHS to address the ambiguity of coverage required for “tobacco cessation services,” the ACA simply cannot guarantee the broadest access and availability of comprehensive tobacco cessation treatment to Medicaid enrollees. In the absence of HHS guidance, state Medicaid agencies should cover a comprehensive tobacco cessation benefit for all enrollees and require all managed care plans to cover the same. State tobacco control programs should work to ensure that the state quitline is viewed as a solution to the cessation-related challenges of ACA faced by Medicaid.
2. Restrictions and barriers to accessing cessation medications are plentiful and varied across states. State tobacco control programs should work to determine what these barriers are, if the restrictions are federally or state-imposed, and work with partners to address those that are within state control.
3. State tobacco control programs and state Medicaid agencies should work together to develop cessation benefit and quitline marketing/promotion strategies, taking full advantage of tobacco control programs’ existing provider referral networks and the CDC’s national tobacco education campaign, *Tips from Former Smokers*.

What should state Medicaid agencies know about state tobacco control program efforts to improve access to and coverage of tobacco cessation for Medicaid enrollees?

Roundtable members representing state tobacco control programs believe that it is important for state Medicaid agencies to understand that there is wide variation among states in the degree to which they are focused on cessation, states’ cessation objectives,

the goals of states' quitlines, as well as the ways in which states may be taking action on healthcare coverage with the public and private sectors to best leverage ACA. For instance, some states are focused on developing cost-sharing partnerships with private insurers and with state Medicaid agencies for quitline services. Others are playing a critical role in assisting health plans and employers to better understand the importance of evidence-based cessation services and in implementing eReferral systems within healthcare systems to improve access to quitlines. State tobacco control agencies are all working to ensure that the impact of CDC's Tips from Former Smokers is maximized.

According to Roundtable members, there is a lot on their plates, budgets are shrinking and many do not know where to begin in order to reap the biggest cessation reward. It is important to know that there can be quite a bit of turnover in state tobacco control programs as well, which can disrupt partnerships and collaborative efforts.

What should state tobacco control programs know about state Medicaid agencies and the impact of ACA on their work?

Roundtable members representing state Medicaid agencies were quick to point out that Medicaid agencies will be different in different states. In some states, it is within a Department of Health and in others it may be called the Department of Welfare – and these two names represent two very different types of Medicaid agencies with very different histories, traditions and cultures. Tobacco control programs are urged to understand this.

Each Medicaid agency is unique, so state tobacco control programs must learn the language of their particular state's agency. The delivery of healthcare is very different from public health in the way that it is funded and the federal and state laws that dictate funding and service delivery. One Roundtable member noted that public health and healthcare delivery have different missions; public health is thinking about everybody and Medicaid is thinking about their specific population.

Lastly, one Roundtable member acknowledged, and others agreed, that ACA has been an incredible challenge for state Medicaid agencies, stating, "It has taken the air out of the room."

ACCELERATING PROGRESS ON UNDERSTANDING

1. State Medicaid directors and state health officials should encourage cross-training for key staff, especially considering the opportunities for collaborative partnerships resulting from the ACA.

2. State Medicaid directors and state health officials should encourage staff to take time to learn who the most appropriate liaisons are who can connect the right players with each agency and do what they can to facilitate those connections.

With opportunities such as the ACA and Medicaid Expansion, tobacco users should have more support and options to quit and stay quit than ever before – the question for us is, *how can we most effectively maximize the impact of the Affordable Care Act on access to, and coverage of, tobacco cessation for Medicaid enrollees?* Many of the challenges outlined by the Roundtable seem related to state variability and the need for a growing number of organizations (behavioral health, cessation, tobacco control, etc.) to better understand the roles and priorities of state Medicaid agencies *and* tobacco control programs with regard to healthcare reform and cessation. Clearly, harnessing the power and unique positions of both will be needed if we are to ensure that implementation of healthcare reform results in expanded access to, and utilization of, evidence-based cessation services.

ROUNDTABLE MEMBERS

State Agency Teams

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