Leveraging the 6|18 Initiative to Support Public Private (Cost-Sharing) Partnerships

Background

The 6|18 Initiative is a program of the Centers for Disease Control and Prevention (CDC) which brings together public and private health care payers, purchasers and providers to improve health and control health care costs. The Initiative focuses on six high cost, high burden health conditions (tobacco use, asthma, diabetes, high blood pressure, inappropriate antibiotic use, and unintended pregnancies) and 18 evidence-based interventions that can prevent or control these six health conditions. Evidence-based interventions for tobacco use include increasing access to tobacco cessation treatments, removing barriers that impede access to covered tobacco treatments, and promoting increased use of covered treatment benefits by tobacco users.

The NAQC Public Private Partnership (PPP) initiative was established in 2011 with funding from the CDC. States involved in the PPP initiative participate in a peer learning environment and may receive one-on-one technical assistance and resources to increase their capacity to establish comprehensive partnerships with both private and public insurers to cover quitline services for their members. PPP member states work with Medicaid, the state as an employer, and private payors in order to achieve cost-sharing partnerships that cover quitline services as part of a comprehensive package of cessation services for their members.

The purpose of this case study was to explore and briefly describe how four states involved in NAQC’s PPP initiative leveraged their participation in CDC’s 6|18 Initiative to advance their Medicaid partnership goals.

Methods

Four states participating in NAQC’s PPP initiative were selected to be interviewed for this case study based on their past participation in the 6|18 Initiative (Indiana, Missouri, New Hampshire, and North Carolina). In August 2020, a group Zoom interview was conducted with representatives from Missouri, New Hampshire, and North Carolina and a separate individual interview was conducted with a representative from Indiana. The key takeaways from the interviews are described below.

Key Takeaways

What were a few of your PPP goals around tobacco use and cessation that 6|18 helped to support?

North Carolina leveraged 6|18 to support and work collaboratively with Medicaid during the transition of Medicaid from Fee-for-Service to Managed Care. Through 6|18 the tobacco control program and Medicaid agency gained a common understanding of the existing tobacco cessation coverage and the possibilities for coverage in the future. As a result of the 6|18 collaboration, the tobacco control staff worked with the Medicaid agency to gain agreement on requiring the Managed Care Organizations (MCOs) to contract for evidence-based quitline services, and specifically, to contract with the state Tobacco Control Program’s selected quitline services provider. The tobacco control staff provided subject matter expertise, including language for the Medicaid Request for Proposals (RFP) with the MCOs as well as assistance with onboarding and training the MCOs. The North Carolina team has continued to work together on other advancements, including group counseling, expanding the provider types that will be able
to bill for tobacco screening and treatment, as well as Medicaid coverage for pharmacotherapy for quitline participants. The North Carolina team credits 6|18 for helping the team to move these issues further, faster.

Through the 6|18 Initiative, a partnership was formed between the Indiana Department of Health (IDH) Divisions of Tobacco Prevention and Control (TPC), Chronic Disease, Primary Care and Rural Health, and Indiana Office of Medicaid Policy and Planning (OMPP). While some of the staff of these various divisions have had relationships on an individual or project basis, the 6/18 initiative convened the collaborative in an intentional and more focused way, which has expanded and strengthened those relationships. As a result, TPC staff routinely work with OMPP on projects such as reconciling data related to a quitline cost-sharing agreement, convening a summit to integrate tobacco dependence treatment reimbursement in behavioral health and primary care, and meeting with Medicaid MCO entities to educate on cessation services and discuss quitline utilization. Most recently the Indiana team has created a tobacco dependence treatment reimbursement workgroup to expand the provider types that are eligible to bill for Medicaid reimbursement and remove coding barriers that currently exist. The Indiana team continues to use the wealth of resources available through the 6|18 “CHCS Collab” online community, a private website for Medicaid and public health staff working on CDC’s 6|18 Initiative. This private website allows participants to collaborate on 6|18 action plans, track intervention progress, find and share resources, and communicate with state/territory teams or other teams participating in the 6/18 Initiative. It was developed by the Center for Health Care Strategies (CHCS), with support from the Robert Wood Johnson Foundation.

Similar to the other states interviewed, the Missouri tobacco control staff had existing relationships with Missouri Medicaid prior to 6|18, however, they credit 6|18 as a catalyst for obtaining greater buy-in from leadership of both agencies as well as strengthening and focusing the relationships among the partners and elevating the issue within Medicaid. The Missouri Medicaid program recently moved to require the MCOs to cover the tobacco identification and treatment for behavioral health, as this was previously carved out of the MCO responsibilities. Missouri is currently leveraging the 6|18 partnership to implement the American Lung Association’s new health insurance assessment with Medicaid MCOs to gain a better understanding of what the MCOs are currently providing and identify priorities for future partnership efforts. They intend to work on increasing utilization of the benefits and quitline services among Medicaid members and providers. The resources provided through 6|18 have helped the Missouri team gain access to a larger network of their peers to better understand what other states have accomplished within what is allowed by the Centers for Medicare and Medicaid Services (CMS). The training support and technical assistance from 6|18, in combination with other national the partners, has demonstrated collaboration at the federal level, and provided the state team with a solid foundation, accountability and encouragement to advance their goals.

For New Hampshire, 6|18 served as a catalyst to create a department-wide team of tobacco control and Medicaid staff where previous efforts had not been as successful. As a result, during a contracting opportunity between Medicaid and the MCOs, the team prioritized tobacco cessation and worked collaboratively to create the MCO contract requirements. The relationship has grown stronger over time, as Medicaid guides the tobacco program to work with the MCOs within a contractual framework. The tobacco program is enhancing MCO cessation benefits and is now revisiting care manager workflow. A plan-do-study-act cycle to pilot with one MCO offers the plan member a warm transfer from the care manager to a quit coach or an on-line referral to a quit coach. There are performance outcomes under development with MCO quality teams that will provide feedback about member utilization of quitline services. The team credits the 6|18 initiative and the teamwork among the national partners such as NAQC’s Public Private Partnership and the American Lung Association’s technical assistance, for providing the support and guidance to encourage the team’s success and progress.
In what ways did 6|18 support your efforts to set up public private partnerships around tobacco cessation and quitlines?

The four states agreed that 6|18 set the tone for intentional, collaborative work. Although states had some relationships in place prior to 6|18, 6|18 served as a catalyst, pushing progress forward faster than would have occurred otherwise and deepening relationships to the next level to include leadership as well. Ultimately this resulted in “wins.”

The 6|18 Initiative helped to:

| Secure leadership support and access to key decision makers and leaders | 6|18 secured organizational support and, in some cases, in-person access to key decision makers and leaders. Leadership support was mentioned as important to receiving consistent information and to sustaining accomplishments (or wins). |
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| Elevate the issue of tobacco use | Although everyone is aware tobacco use is an issue, it can sometimes take a back seat to other issues. 6|18 elevated tobacco use so it could be prioritized and focused upon. |
| Establish credibility | Working collaboratively with certain partners and leaders provided instant credibility. |
| Expand networks and improve access to resources | 6|18 was described as convening the state staff from public health and Medicaid who each had networks of partners, providers, and stakeholders, thus, providing access to expanded networks of possibilities and resources. |
| Create accountability and build momentum on projects | 6|18 held partners accountable and helped move them forward. Accountability was particularly helpful when relationship-building faced barriers and were slow to progress on their own. Increased accountability led to increased wins. |
| Build consistent relationships | With 6|18, key partners were meeting on a regular basis, providing consistency both in terms of talking regularly as well as receiving uniform information. |
| Build trust | Once trust was built among those involved, it was easier to move into action as partners simply needed to ask for what they needed and would receive it. |

What supports sustainability of the leveraged results?

Even though 6|18 has ended for some of the states interviewed, they were confident in their ability to sustain their efforts based on stronger relationships, collaborative plans, and shared accomplishments. To foster sustainability, the PPP participants who were interviewed advised that the relationships provided a strong foundation for moving forward as a team to accomplish their future goals. Each team developed a strategy and continued to work on it together over time, allowing it to be fluid enough to change when there’s a need to do so. They make an effort to meeting regularly, follow-up and remain intentional and focused. Having small wins along the way serves to bolster interest and support.

[THAT’S THE HEART AND ESSENCE OF 6|18. BRINGING PEOPLE AND SYSTEMS TOGETHER, MAKING SURE THAT YOU’RE COLLABORATING AND TALKING TO EACH OTHER. FROM THAT, YOU DISCOVER HOW MUCH MORE YOU CAN DO WHEN YOU DO IT TOGETHER.]

[Regina Smith, Indiana]
What if 6|18 didn’t exist anymore? What lessons learned could be applied by state tobacco control programs to further partnerships on their own?

Regardless of participation in 6|18, it’s important for any state to do a self-examination, answering questions such as, “What are our objectives? What are the missing pieces? Should we be working collaboratively? Who needs to be at the table?” It’s a good idea to do a readiness assessment as well: “Are we ready to do that?”

One state recommended using a “press box perspective” or pulling back your perspective far enough to take in a broader view of the whole field, beyond your single department or program. See how all the puzzle pieces align and fit together so you can work in an integrative manner. Then you can more easily see how the right people and systems can help you.

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