Making Quitlines a Regular Part of Health Care under the Medicaid Program
November 2017

Context
The Patient Protection and Affordable Care Act (ACA), with its expansion of Medicaid and mandates for non-grandfathered private health plans and insurers to provide cessation treatment with no co-payments or prior authorizations has effectively “made” cessation a regular part of health care, at least on paper. However the role-out of this new law has not been without challenges. Because Medicaid benefits provided to enrollees under traditional eligibility rules (hereafter referred to as “traditional Medicaid”) have largely been exempted from some of the requirements of the ACA, its mandates vis-à-vis cessation treatment differ from those of the commercial sector.

Traditional Medicaid covers low-income and disabled individuals with specific eligibility thresholds varying from state to state. Under traditional Medicaid, all FDA-approved cessation medications are covered for adult enrollees, but require a prescription and may include cost-sharing. The ACA expands the cessation coverage for adult pregnant women enrolled in Medicaid by providing access to individual, group and telephone cessation counseling, and all FDA-approved cessation medications with no cost-sharing (1) (2).

Among states that opted to expand Medicaid, Medicaid expansion covers low-income or disabled persons whose incomes are up to 138 percent of the federal poverty level. The ACA requires non-grandfathered group and individual health plans, including Medicaid expansion, to provide A and B level evidence-based prevention services (as rated by the United States Preventive Services Task Force (USPSTF)) with no cost-sharing. In addition, the ACA allows non-grandfathered group and individual health plans to use “reasonable medical management techniques” to determine the quantity and frequency of the preventive service, if the USPSTF recommendation and guidance does not provide specifications for frequency or quantity (3).

On May 2, 2014, the federal government issued a Frequently Asked Question (FAQ) providing further guidance on the level of tobacco cessation benefit that would be considered “in compliance” with the ACA. The FAQ includes:

- Screening for tobacco use at every visit;
- Minimum of 2 quit attempts per year;
- 4 cessation counseling sessions of at least 10 minutes in duration provided via either telephone, group or individual counseling – with no prior authorization required;
- Coverage of all 7 FDA-approved cessation medications for a 90-day treatment supply when prescribed by a health care provider, with no prior authorization required (3).

For states that have chosen to expand Medicaid under the ACA, the differences in cessation benefits between traditional Medicaid and Medicaid expansion create the potential for a tiered system which may further increase health disparities for those under traditional Medicaid.

Goal
To encourage federal CMS and state Medicaid agencies to 1) assume responsibility for covering the cost
of evidence-based cessation services, including quitline services, and 2) promote these benefits to providers and members as a way to increase utilization.

**Importance of This Topic**
Medicaid is the largest healthcare insurer in the United States. Tobacco use has a devastating health impact on Medicaid enrollees as well as a significant financial impact on the Medicaid program. Improving cessation services offered through Medicaid is one of the most important actions we can take to improve the health of low income Americans and to decrease the prevalence of tobacco use. With a prevalence of 27.8 percent, the estimated number of Medicaid enrollees who smoke is over 11 million. As noted below, the Medicaid program spends over $40 billion annually on smoking-related diseases (6). By encouraging Medicaid to become responsible for covering the cost of cessation services, including quitlines, and promoting the availability of these services, the health status of Medicaid enrollees can be improved, and we will be better positioned to see continuing decreases in the prevalence of tobacco use.

**Existing Data**
The current smoking rate for Medicaid enrollees is 27.8 percent, nearly double the national average of 15.1 percent for adults (4). According to the FY2016 NAQC Annual Survey, state quitlines received over 1 million calls from people seeking services for themselves, or information for a family member, and over 180,000 referrals from healthcare providers. This translates to 409,419 unique individuals who either called or were referred to a state quitline for cessation services, and 353,154 unique tobacco users who received evidence-based cessation services (i.e., counseling and/or FDA-approved cessation medications) from state quitlines. Over 30% of the tobacco users treated by state quitlines had succeeded in quitting at 6 months (5). In FY2016, Medicaid enrollees accounted for 33.8 percent of tobacco users served by state quitlines, with proportions varying by state from a low of 5 percent to a high of 77 percent (5) (6). In addition, 74 percent of state quitlines report providing Nicotine Replacement Therapy (NRT) to quitline participants enrolled in Medicaid, with a median NRT supply of 4-weeks (range: 2-week to 12-week supply of NRT). Among the 74 percent of state quitlines that provided NRT to quitline participants enrolled in Medicaid, 83.7 percent paid the full costs of the NRT (5).

Medicaid enrollees also experience higher rates of behavioral health and chronic health conditions. For example, 55 percent have hypertension, 27 percent have diabetes, 26 percent have heart disease, 21 percent have a mental illness, 11 percent have COPD and 8 percent have asthma (7) (8). In 2015, it was estimated that over 65 percent of Medicaid enrollees had 2 or more chronic health conditions (7). State quitlines have developed specialized protocols to assist quitline participants who have chronic health and behavioral health conditions with quitting tobacco, and therefore are uniquely positioned to assist Medicaid enrollees (5) (9).

Analysis of the Centers for Medicare and Medicaid’s (CMS) 2013 Medicaid drug utilization files revealed that: 1) only 10% of Medicaid enrollees accessed cessation medications through their Medicaid benefits; and 2) CMS spent an estimated $103 million on cessation medications. This is less than 0.25 percent of the estimated $40 billion Medicaid spends on smoking-related diseases (10). Other studies have examined the utilization of cessation medications among pregnant women enrolled in Medicaid in Kansas and Maryland. Despite the ACA providing access to all 7 FDA-approved cessation medication with no cost-sharing, both studies found that utilization of the benefit remained low or unchanged from pre-ACA utilization levels (11) (12). A 2012 survey of obstetricians and gynecologist revealed that nearly 80% of those surveyed were unaware of the ACA’s coverage of cessation services for pregnant women enrolled in Medicaid (13). Despite low utilization of evidence-based cessation services among Medicaid enrollees, research has demonstrated that Medicaid enrollees want to quit smoking and are able to quit smoking when provided access to evidence-based cessation services (14).
Previous research by Patrick Richard and colleagues demonstrates the significant short term return-on-investment (ROI) for the Commonwealth of Massachusetts when the state improved the cessation benefit for Medicaid enrollees. Their 2011 ROI study found for every $1 spent on cessation there was an associated savings of $3.12 in medical expenses (15). In addition, a cost estimate study published in 2017 looked at the budget impact for health plans providing access to all FDA-approved cessation medications per the ACA. The study looked a commercial, Medicaid and Medicare health plans and found a per member per month (PMPM) cost increase would range from $0.06 PMPM to $0.10 PMPM, for Medicaid and commercial plans respectively. Thus the ACA requirement for cessation medications would have minor cost increases for health plans, and for Medicaid in particular (16). It should be noted, this study did not examine the cost for providing individual, group and telephone counseling, also required by the ACA; nor did the study take into account potential cost savings from reduced medical care due to enrollees engaging in cessation and/or quitting smoking.

Closing the Gaps
State quitlines have long been engaged in efforts to improve access, awareness and utilization of quitline services among priority populations, especially Medicaid enrollees. These efforts have focused on outreach to and education of health care providers, as well as increased referral and targeted promotional campaigns. Many of these efforts have been funded by state quitlines and/or state tobacco control programs (17) (18).

States also have engaged in a number of activities to encourage payment for quitline services from CMS and state Medicaid agencies. For example, in 2011 CMS announced a new program called Federal Financial Participation (FFP), which provides a 50 percent match to states for the administrative costs (i.e., counseling) of providing quitline services to Medicaid enrollees (19). It should be noted, CMS specifically excludes state quitlines from: 1) seeking FFP for Medicaid enrollees covered by Medicaid Managed Care Organizations (MCO), unless quitline services have been carved out of the Medicaid MCO contract, and 2) including the cost of cessation medications in any cost allocations for FFP. Today, 18 state quitlines (about one-third of all state quitlines) are drawing down FFP. The total amount of FFP received in FY2015 was $3.85 million (range: $18,600 to $2,002,638). The low participation in the FFP program is due to a variety of reasons including: the amount of time and effort needed to put FFP in place (on average 12 to 18 months); the low level of estimated match funds compared to the overall quitline budget; exclusion of the costs of medications and Medicaid enrollees covered by MCOs; and in some cases the inability to direct the funds to the state quitline budget (20).

Partly due to the limitations surrounding FFP, state quitlines have sought other avenues to ensure comprehensive cessation services including access to telephone counseling are provided to Medicaid enrollees and paid for by the Medicaid program. For example:

- In Minnesota, the state tobacco control program and state quitline, partnered to work with the state Medicaid agency and state legislature to have co-pays removed for all medications.
- In South Carolina, the state tobacco control program worked with state Medicaid agency and state legislature to have co-pays for all medications, and prior authorizations for cessation medications removed.
- In Arizona, the state quitline provides counseling services to all Medicaid enrollees, but assists the callers in connecting back with the state Medicaid agency for access to cessation medications because the state Medicaid agency provides a larger supply of NRT than the state quitline.

These examples highlight ways states have reduced barriers Medicaid enrollees experience when trying to access evidence-based cessation services. While these efforts demonstrate progress, they do not ensure a comprehensive cessation benefit, including access to quitline services, is provided to Medicaid enrollees and paid for by the state Medicaid agency.
At a national level, both the CDC and the CMS have launched initiatives with the aim to improve populations health and reduce health care costs through health care delivery and payment transformation. CDC’s 6|18 Initiative is focused on helping states partner with health care payers, purchaser and providers to address the six most common health conditions that cost the most to treat, with 18 evidence-based strategies (21). In 2012, CMS launched the State Innovation Models (SIM) initiative which provides grants to states to develop, test and evaluate innovative reforms to health care delivery and payment models to improve the quality of care and health of Medicaid, CHIP and Medicare enrollees, while reducing costs. The SIM initiative is in its second round of funding, which requires grantees to focus on tobacco use, diabetes and obesity (22). Both the 6|18 and SIM initiatives have potential for new learnings and strategies that could help state tobacco control programs and quitlines partner with state Medicaid agencies to ensure a comprehensive cessation benefit, including access to quitline services, is provided to Medicaid enrollees and paid for by the state Medicaid agency.

As state Medicaid agencies have transitioned away from a traditional fee-for-service model towards an MCO model for covering enrollees, the MCOs have become responsible for improving health outcomes while containing costs. In 2015, 48 state Medicaid agencies used some form of managed care to provide services to enrollees and 39 state Medicaid agencies had contracts with MCOs. Kaiser Family Foundation estimates that currently 43 percent of Medicaid’s expenses are paid to MCOs (23). These changes demonstrate the commitment of CMS and state Medicaid agencies to improve health care and outcomes for Medicaid beneficiaries, while containing costs for the health care provided.

Two states (Michigan and Nevada) have leveraged this commitment to improved outcomes and cost-containment, working with their state Medicaid agencies to require MCOs to provide a comprehensive cessation benefit, including quitline services, and to promote that benefit to members and providers. The state of New York has taken a different path to improving access to quitline services for Medicaid enrollees. New York has worked closely with their state Medicaid agency to ensure comprehensive cessation services exist within all Medicaid MCOs and to begin triaging calls from the state quitline to the Medicaid MCOs. These two new approaches may become promising practices for reaching our goal.

Conclusions:
- The high prevalence of smoking among Medicaid enrollees continues and results in very high costs for treating smoking-related illness.
- Utilization of existing Medicaid cessation medication benefits by enrollees remains low.
- Medicaid enrollees continue to seek cessation services from state quitlines.
- State quitlines have sought a variety of avenues to reduce or eliminate barriers experienced by Medicaid enrollees seeking access to evidence-based cessation services.
- CMS and state Medicaid agencies are covering only a small proportion of the cost of quitline services delivered to Medicaid enrollees.

Next Steps for NAQC to Consider
To continue progress in improving cessation services provided to Medicaid enrollees and utilization of those services, NAQC should pursue the steps described below:
- Provide training and technical assistance to ensure that every state quitline has the basic skills needed to partner with its Medicaid agency, including: 1) an understanding of how Medicaid works at the state and national level; 2) familiarity with the “language” of Medicaid; 3) ability to develop and maintain relationships with a “champion” at the state Medicaid agency; 4) identifying the data important to Medicaid and knowing how to utilize and present it in a way that appeals to the state Medicaid agency; and 5) describing the importance of quality performance metrics (i.e., HEDIS) to Medicaid and helping states access these metrics.
- Advocate for the goal (stated above) within tobacco control (CDC, national partners) as well as nationally with HH/S/CMS and the National Association of State Medicaid Directors (NASMD).
- Monitor national initiatives like SIM and 6|18 for new information and strategies.
- Seek partnership with CDC on national efforts like 6|18 to provide technical assistance and expertise on comprehensive cessation benefits, including quitline services, to grantees and partners.
- Strengthen NAQC’s relationship with CMS and NASMD.
- Research and compile information on cessation services delivered to Medicaid enrollees by state quitlines and by others, especially Medicaid MCOs.
- Describe strategies and models used by states to successfully increase access to and utilization of quitline services. Provide training on these strategies and models.
- Monitor the experience in Michigan and Nevada (of including quitline services in Medicaid MCO contracts) and share the findings with other quitlines. Monitor the experience in New York as well (triaging quitline calls from Medicaid enrollees to their Medicaid MCOs).
- Develop resources and toolkits for states, quitline service providers, national organizations, state Medicaid agencies and other key stakeholders.

**References and Resources**


10. **Medicaid Tobacco Cessation: Big Gaps Remain In Efforts To Get Smokers To Quit.** Leighton Ku, Brian K Bruen, Erika Steinmetz and Tyler Bysshe. 1:62-70, s.l. : Health Affairs, 2016.


Appendix 1: Michigan’s Medicaid MCO RFP Language
This language was inserted into the “Covered Services” section of the state Medicaid agency’s RFP for MCO.

A. Tobacco Cessation Treatment
   1. Contractor must not place prior authorization requirements on tobacco cessation treatment or limit the type, duration or frequency of tobacco cessation treatments included in this section.
   2. Contractor must provide tobacco cessation treatment that includes, at a minimum, the following services:
      a. Intensive tobacco cessation treatment through an MDHHS-approved telephone quit-line.
      b. Individual tobacco cessation counseling/coaching (separate from the 20 outpatient mental health visits covered by the Contractor) in conjunction with tobacco cessation medication or without
      c. Non-nicotine prescription medications
      d. Prescription inhalers and nasal sprays
      e. The following over-the-counter agents
         i. Patch
         ii. Gum
         iii. Lozenge
      f. Combination therapy – the use of a combination of medications, including but not limited to the following combinations
         i. Long-term (>14 weeks) nicotine patch and other nicotine replacement therapy (gum or nasal spray)
         ii. Nicotine patch and inhaler
         iii. Nicotine patch and bupropion SR

Appendix 2: Nevada’s Medicaid MCO RFP Language

A. Tobacco Cessation Treatment
   1. Screening for tobacco use at every visit; and
   2. For those who currently use tobacco products, provide at least two quit attempts per year of which each attempt includes at a minimum:
      a. Effective counseling as defined by U.S. Public Health Services Clinical Practice Guideline on Tobacco Dependence Treatment:
         i. Intensive tobacco cessation counseling services through a telephone quit-line vendor approved by the state Department of Public and Behavioral Health
         ii. Individual tobacco cessation counseling/coaching (separate from the XX outpatient mental health visits covered by the Contractor)
         iii. Group tobacco cessation counseling/coaching (separate from the XX outpatient mental health visits covered by the Contractor).
      b. FDA approved cessation medications:
         i. All FDA approved tobacco cessation medications, both prescription and over-the-counter medications.
         Treatment regimen should cover a minimum of 90 days.
ii. Combination therapy – the use of a combination of medications, including but not limited to the following combinations – should be allowed:
   (1) Long-term (>14 weeks) nicotine patch and other nicotine replacement therapy (gum or nasal spray)
   (2) Nicotine patch and inhaler
   (3) Nicotine patch and bupropion SR

3. Contractor must not place “stepped-therapy” requirements on tobacco cessation treatment.

4. Contractor must not place prior authorization requirements on tobacco cessation treatment or limit the type, duration or frequency of tobacco cessation treatments included in this section.

5. Contractor must not place cost-sharing requirements on tobacco cessation treatments included in this section.

6. Contractor should amend policies, evidences of coverage, formularies and/or drug brochures as necessary to ensure that insureds are given complete information about the coverage of tobacco cessation items and services.
   a. There should be no riders for these preventive services. All preventive services should be part of the main policy and have no cost-sharing tied to use of preventive services.

7. Contractor will partner with the Division of Public and Behavioral Health to, at a minimum:
   a. Promote the full Tobacco Cessation Benefit to Medicaid recipients.
      i. Gain input from the Division of Public and Behavioral Health on promotional materials provided to Medicaid recipients. Provide reports on promotional activities at least biannually.
   b. Partner with Division of Public and Behavioral Health to triage Medicaid MCO beneficiaries who call the state run quitline (1-800-QUIT-NOW) back to the Medicaid MCO run quitline.
   c. Provide aggregate NAQC MDS data, via the selected telephone quit-line approved vendor, to the Division of Public and Behavioral Health, per data sharing agreement, at least biannually.
   d. The approved MCO quitline vendor must be a member of NAQC.