

2017

TOOLKIT FOR IMPROVING CESSATION COVERAGE PROVIDED BY MEDICAID MCOs



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OVERVIEW

Purpose

In 2016, NAQC published recommended language for Medicaid Managed Care Organization (MCO) Request for Proposals (RFPs) to help guide state health departments and state Medicaid agencies with provision of comprehensive cessation services, including telephone counseling and medications, by MCOs (see Resource 3). This toolkit is complimentary, aiming to build capacity and maximize the use of that language in future MCO RFPs.

The guidance laid out below is based on the experiences of Michigan and Nevada, two states that have successfully changed Medicaid MCO RFP and contract language to include coverage for tobacco cessation. These examples provide insights and lessons learned, for other states to consider. It is important to note that ***no two states are the same***, and the unique policy, funding and political landscape for each state will be additional factors in determining how to navigate forward using the guidance below.

The target audiences for this toolkit are state quitline managers, state tobacco control program staff, and other stakeholders focused on improving access to and utilization of tobacco cessation treatment by Medicaid beneficiaries.

How to Use the Toolkit

The toolkit highlights seven steps to improving cessation coverage provided by Medicaid MCOs. While the steps are laid out in linear fashion, progress may not necessarily follow the sequential presentation of the steps. Users of this toolkit should revisit steps as needed, in order continue moving forward in their efforts, as well as identify and address new and emerging issues that may impact policy and program improvement efforts.

We have created templates for gathering key data, and provided links to case studies and reports from other states, which provide examples for how to use and present data to partners and stakeholders.

INTRODUCTION

Smoking-related diseases continue to be the leading cause of preventable death in the U.S. and the burden is especially severe among the poor and disenfranchised. Although the national smoking prevalence rate for adults has dropped to 15.1% (approximately 35 million individuals), the current rate for Medicaid enrollees has remained high at nearly double the national average (27.8%, approximately 11 million individuals) (7). It is estimated that the federal Medicaid program spends \$40 billion to treat smoking-related diseases each year compared to an estimated \$103 million to treat tobacco dependence (8).

Medicaid enrollees are a priority population for most state quitlines and accounted for 34% of tobacco users served by state quitlines in fiscal year 2016. In addition, 74% of state quitline report providing cessation medication to Medicaid enrollees, and the majority of those state quitlines (84%) pay all of the associated cost instead of the Medicaid program (13).

This toolkit is not intended to provide in-depth information on Medicaid and how Medicaid functions. However, Resource 1 in the Appendix of this toolkit provides basic information on Medicaid and links to key resources for more in-depth information on how Medicaid functions.

The Problem

State quitlines have long been engaged in efforts to improve access, awareness and utilization of quitline services, among priority populations like Medicaid enrollees. These efforts have focused on outreach to and education for health care providers, increasing referral capacity and targeted promotional campaigns; the

majority of which were paid for using funds from the state quitline budgets (14) (15). These efforts have been successful and, as noted above, Medicaid enrollees accounted for nearly a third of tobacco users served by state quitlines in fiscal year 2016.

The limiting factor to providing quitline services to Medicaid enrollees has been funding. In 2011, the federal Medicaid program began offering a new program called Federal Financial Participation (FFP), which provides a 50 percent match to states for the administrative costs (i.e., counseling) of quitline services for Medicaid enrollees (16). It should be noted, FFP specifically states that:

1. State quitlines cannot seek the administrative match for Medicaid enrollees covered by Managed Care Organizations (MCOs) unless quitline services have been specifically carved out from the MCO contract. In essence, FFP applies only to Medicaid enrollees covered under a Fee-for-Service (FFS) model of care delivery. Therefore, when a Medicaid MCO directs enrollees to the state quitline for telephone cessation counseling with no cost-sharing agreement or contract with the state quitline in place, the Medicaid MCO is essentially being paid by the state Medicaid agency for a service the Medicaid MCO is not providing.
2. State quitlines cannot include the cost of cessation medications in any cost allocations for FFP.

Today, 18 state quitlines are drawing down FFP. There are a variety of reasons for low participation in the FFP program, such as: 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 in some cases, the inability to direct the funds to the state quitline budget (17).

As a result, state quitlines have sought other avenues to increase funding for quitline services provided to Medicaid enrollees.

The Proposed Solution

A case can be made for Medicaid MCOs to provide a comprehensive cessation benefit, that includes access to quitline services, for all Medicaid enrollees. By doing so, Medicaid MCOs would be increasing access to evidence-based, cost effective cessation treatment. This has the potential to generate a positive return-on-investment for both the MCO and the state Medicaid agency.

To achieve this goal, state tobacco control programs and quitlines can partner with their state Medicaid agency to improve the Medicaid MCO RFP and contract language to include:

1. Coverage for tobacco cessation services to meet [US Preventive Services Task Force \(USPSTF\) guidelines](#) by including all 7 FDA-approved cessation medications, as well as individual, group and telephone counseling;
2. Access to covered cessation services by removing all co-pays and prior authorizations requirements (including stepped-therapy, a form of prior authorization), as required by the [Affordable Care Act \(ACA\)](#);
3. Proactively promotion of covered cessation services to Medicaid enrollees and health care providers.
4. Data sharing with state quitlines and state tobacco control programs on utilization of cessation services by Medicaid MCO enrollees.

The steps to achieving this change are described below and provide examples and templates to guide you through the process. Keep in mind, each partner brings a unique set of skills and knowledge to the table that will be needed to achieve the end goal.

- **State tobacco control programs and quitlines** bring the expertise of understanding current tobacco use and populations disproportionately impacted by tobacco use, the impact of tobacco use on health and health care costs, and information on evidence-based cessation services and systems change efforts to make evidence-based cessation a regular part of health care.
- **State Medicaid agencies** bring the knowledge and expertise of how Medicaid functions in the state, priorities of the state Medicaid, how RFP and contracting process work for Medicaid.

STEPS TO IMPROVING CESSATION COVERAGE

The following section walks users through key steps in the process to changing the Medicaid MCO RFP and contract language. As stated previously, while the steps are laid out in linear fashion, progress may not necessarily follow the sequential presentation of the steps. Users of this toolkit should revisit steps as needed to continue to make progress, as well as address new and emerging issues that may impact policy and program improvement efforts.

Step 1: Building and Maintaining a Relationship with Medicaid

Key Take-Aways

- Find an advocate within your state Medicaid agency.
- Learn the language and priorities of Medicaid and your state Medicaid agency.
- Be a resource to your state Medicaid agency by gathering and sharing data on tobacco use and tobacco cessation.
- Meet your state Medicaid agency where they are at with addressing tobacco cessation.
- Create a timeline for your efforts to help you in working towards your defined goal, but be open to adjusting the timeline to meet the needs of your state Medicaid agency, or to capitalize on unanticipated opportunities.
- Provide examples of collaborations with Medicaid MCO from other states to demonstrate the possibilities for your state to explore and tailor to their needs.

For both Michigan and Nevada, their efforts began with building a relationship with an advocate within the state Medicaid agency. This relationship allowed both states to **“learn the language and priorities”** of Medicaid and how the state quitline and state tobacco control program could be supportive. This allowed Michigan and Nevada to infuse data on tobacco use and cessation, and information on the state quitline, into their conversations with the state Medicaid agency.

Both states approached their outreach to Medicaid **without** a set timeline for achieving their goal, thereby allowing them to develop the relationship, and capitalize on opportunities as they developed. In Michigan’s experience, this approach allowed the state to build off small improvements to achieve a larger policy change over time. In Nevada, the tobacco control program was able to capitalize on an unexpected opportunity to provide feedback on the state Medicaid agency’s internal quality improvement strategy and the role tobacco cessation could play; which opened the door for further dialogue and relationship development.

Michigan – Progress Over 10 Years

Efforts began in the early 2000's with a partnership between Michigan's Tobacco Control Program, Medicaid Office, and the Michigan Association of Health Plans which resulted in:

- Collaboration with the Michigan Association of Health Plans to assess and publish a list of cessation benefits by plan.
- Creation of a voluntary cost-sharing program to cover the expenses of Medicaid Quitline enrollees. 5 of 13 MCOs participated in the initial effort.
- Requirement for Medicaid MCOs to use a Department approved Quitline service. Currently 10 of 11 plans use the Michigan Tobacco Quitline.
- Established standard coverage of comprehensive tobacco dependence treatment, including access to quitline services for Medicaid MCO enrollees and coverage for all 7 FDA-approved medications without barriers.

Nevada – Capitalizing on Opportunity

The state tobacco control program began reaching out to the state Medicaid agency in early 2015 asking specific questions about cessation coverage for Medicaid enrollee, such as:

- Use of prior authorizations;
- Use of copays;
- How many quit attempts per year were covered;
- Coverage of individual, group and telephone counseling;
- Coverage for all FDA-approved cessation medications;
- If there were differences in the cessation benefit provided by Medicaid MCOs and Medicaid Fee-for-Services (FFS).

Staff from the state tobacco control program attended a public meeting on Nevada's Medicaid Quality Strategy in summer of 2015, during which they made public comments about tobacco cessation being included as a quality strategy. This resulted in:

- A connection with the state Medicaid agency staff after public meeting.
- An invitation for staff from the state Medicaid agency to attend the state tobacco control program's sustainability planning session;
- Staff from both state agencies discussed an upcoming MCO Request for Proposal (RFP) as a possible opportunity for collaboration.
- Internal and external partners helped the state tobacco control program craft draft proposed RFP language on tobacco cessation and navigate the MCO RFP process.
- State Medicaid reviewed and agreed to use proposed language for cessation benefit.

We acknowledge there may be barriers to building and maintaining a relationship with a partner organization; even if the partner organization is a sister state agency. For example, through NAQC's technical assistance on FFP/Medicaid Match, other states have experienced the following barriers while seeking partnerships with their state Medicaid agencies:

- Frequent staff turn-over within the state Medicaid agency. Making it difficult to develop and maintain a relationship with the agency.
- Confusion among state Medicaid staff about who was responsible for tobacco cessation benefits provided to Medicaid enrollees.
- Lack of response from state Medicaid agency staff to requests from state health department staff about tobacco cessation benefits.
- Perceived lack of support from leadership of the state tobacco control program and/or the state Medicaid agency. Without support and direction from leadership, staff within the state health department and state Medicaid agency did not feel empowered to seek FFP or address other Medicaid tobacco cessation benefit issues.

However, time and persistence are key to success. If outreach is not successful at first, keep trying.

Step 2: Gathering Essential Data and Information

Before reaching out to your state's Medicaid agency, it is important to know and document key data regarding the state quitline and Medicaid enrollees served by the state quitline, as well as information on current cessation benefits for Medicaid enrollees. These data and information can be used to create talking points and presentations to describe the scope of the issue, and to plan for meetings with the state Medicaid agency.

Resource 2 in the Appendices provides a template of tables you can use to document the data and information you have gathered. For each table in Resource 2 we have listed suggestions for questionnaires, surveys and data sources you can use to gather the data. For example, sources for data might include, but are not limited, to the:

- State quitline;
- State and national tobacco use surveillance data sets;
- State Medicaid agency website and publicly available documents; and
- State and national health plan quality measure data sets.

The questionnaires and surveys we list are examples and may need to be tweaked to fit the needs of your state. If you need to adjust a questionnaire or survey, we encourage you to reach out to a national technical assistance partner like NAQC, American Lung Association or the Center for Health Care Strategies, Inc., which have staff trained to assist you with adjusting the survey.

Finally, ***it is important to continually review and update data, as well as scan for new sources of data.*** Efforts to improve cessation coverage for Medicaid enrollees in your state will take time. As you work on this effort, be sure to review your data and information annually to ensure it is current. In addition, we encourage you to reach out to national technical assistance partners like NAQC, American Lung Association and the Center for Health Care Strategies, Inc. to see if there are any new national data or information on Medicaid and cessation that would be useful for your efforts.

Tip

Create a calendar with dates to review and update data, or reach out to national TA organizations for updates on national data and efforts in Medicaid and cessation. For example, review quitline utilization data at the end of each fiscal year or review HEDIS data for your state.

You will also need a copy of the Medicaid MCO “summary of coverage” or “coverage handbook”, including the pharmacy formulary. This will show you how the cessation benefit information is shared with enrollees.

Key Information you will Need from the “Summary of Coverage” or Survey of Medicaid MCOs on Cessation Benefits:

- Where in the “Summary of Coverage” is information on the cessation benefit located?
- Does the cessation benefit meet the standards of the comprehensive cessation benefit per the USPSTF and as laid out by the ACA?

2 quit attempts per year, with each quit attempt including:

- *4 cessation counseling sessions of at least 10 minutes provided via either telephone, group or individual counseling – with no cost-sharing or 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 cost-sharing or prior authorization requirements (note, stepped therapy is one type of prior authorization).*

If you cannot obtain a copy of the coverage provided by each Medicaid MCO in your state through public documents or websites, consider conducting a survey of the Medicaid MCOs. A survey will take more time and staff effort, but has the potential to yield more complete information. Here is an example of a tobacco cessation coverage questionnaire you can use or adjust to meet the needs of your state: [Oregon’s Survey of Medicaid MCOs’ Coverage of Cessation.](#)

Survey Tips

- Work with your state Medicaid agency to identify key/appropriate contact at each Medicaid MCO.
- Identify one staff person in the state tobacco control program responsible for sending out the survey/questionnaire and receiving the information from the MCOs, as well as the point of contact for any clarifying questions the MCOs may have.
- Identify one staff person in the state Medicaid agency as a point of contact for the state tobacco control program to reach out to if assistance is needed with contacting or receiving information from the MCOs.
- Give the Medicaid MCO's advance notice of the survey.
- Allow sufficient time for Medicaid MCO's to respond.
- Provide reminder(s) about the deadline to complete the survey.
- Allow staff time to follow-up with Medicaid MCO's to gather missing information or to clarify responses.

Step 3: Information on Medicaid MCO RFP and Contracts

You will also need information on the Medicaid MCO RFP and contracts process. This information may be publicly available, or you may need to work with your state Medicaid agency to obtain the information. If possible, request a copy of the current or most recent Medicaid MCO RFP. This will provide a higher level of accuracy in assessing what cessation services the state Medicaid agency required and where the services were placed in the RFP (i.e., as a preventive service or a “value added service”).

When working with your state Medicaid agency to ensure a comprehensive cessation benefit, including quitline services, is included in the Medicaid MCO RFP and final contract, placement of the cessation benefit language is a key issue.

Ensure that the comprehensive cessation benefit language is placed in the “*preventive services*” sections of the Medicaid MCO RFP; thereby making the comprehensive cessation services a *required service and including the cost of provision in the capitation and fees paid to the MCO*. The state Medicaid agency or Medicaid MCOs may suggest the comprehensive cessation services language be placed under the “*value-added services*”

section of the RFP; this would mean provision of cessation services is optional and MCOs would not be paid additional money to provide the service.

It is important for you to remain actively engaged with your state Medicaid agency throughout the development of the RFP, the RFP review process and contract execution to assist the state Medicaid agency with any questions they may receive from MCOs seeking clarification on the cessation benefit language, and to advocate the cessation benefit language be placed in the “preventive services” section of the RFP and final contract.

Key Information on Medicaid MCO RFP and Contract Process You Will Need to Know

- When is the next Medicaid MCO RFP set to be released?
- When does the development of the Medicaid MCO RFP occur?
- Who oversees the development of the Medicaid MCO RFP?
- How long are the Medicaid MCO contracts for? (i.e., 1 year, 3 years)
- Who oversees the Medicaid MCO contracts?
- Are there payment incentives tied to key performance measures built into the Medicaid MCO contracts (i.e., % of Medicaid enrollees diagnosed with hypertension that is being managed/controlled)?
- Where will the comprehensive cessation benefit language be placed in the final RFP and contract? (Note: the goal is for the cessation benefit language to be placed in the “preventive services” section and not the “value-added” section.)

Step 4: Analysis of Information and Formulating a Plan

Once you have gathered your data, you may find it helpful to work with partners to understand the data and information; partners may include the state Medicaid agency, other staff in the tobacco control program familiar with health care services and utilization data, as well as external partners that with expertise in cessation and Medicaid. After, develop a plan of action for addressing the gaps and working to improve the cessation benefit provided by Medicaid MCOs. This may mean addressing the “low hanging fruit” to start (e.g., working with the Medicaid MCOs to clearly document the current cessation benefit in an easily accessible manner for Medicaid enrollees and providers) while continuing to plan for larger efforts like changing the Medicaid MCO RFP and contract language to ensure a comprehensive cessation benefit, including quitline services, are provided.

Success may come in a step-wise manner with little wins leading to bigger changes; or it may come in a larger win due to an unexpected opportunity. Either way, take the improvement you can and make sure to circle back and assess the data to determine if additional improvements are needed.

Tip from Michigan and Nevada:

There is common ground among partners to improve quality and access. The data and information you gather will tell a story about tobacco use and cessation among Medicaid enrollees and the role Medicaid MCOs play in improving quality of care through access to and promotion of a comprehensive tobacco cessation benefit.

It may be helpful to develop a few fact sheets and reports that synthesize the data and information you have gathered and call out areas for improvement. These fact sheets and reports can be used by staff during meetings with partners to highlight the importance of improving tobacco cessation services provided to Medicaid enrollees. In addition, these fact sheets and reports can be made public via the state quitline website, and shared with the state quitline service provider to help facilitate an increased awareness of cessation benefits provided by Medicaid for quitline participants enrolled in Medicaid. Below we have listed some types of reports you may want to develop, along with some examples:

1. Fact Sheet on Quitline Services and Utilization by Medicaid enrollees that highlights:
 - a. Services provided by the quitline
 - b. Populations served by the quitline
 - c. Utilization and outcomes (if available) by population served
2. Calculate the ROI and develop a fact sheet.
 - a. [NAQC ROI Template for Public Private Partners](#)
 - b. Example: [Kentucky Fact Sheet on Quitline ROI](#)
 - c. Example: [Utah Fact Sheet on ROI for Tobacco Cessation](#)
3. Report on Medicaid MCO Cessation Benefits.
 - a. Example: [Kentucky of Medicaid MCO Cessation Benefit report](#)

As you gather and analyze the information on the Medicaid MCO RFP and contracting process, continue to work closely with your partners (i.e. state Medicaid, Medicaid MCOs and national TA providers) to:

- Understand the information gathered and determine if new data are available;
- Identify possible factors that could help incentivize change, or new areas for improvement; and
- Lay out a timeline for working towards change.

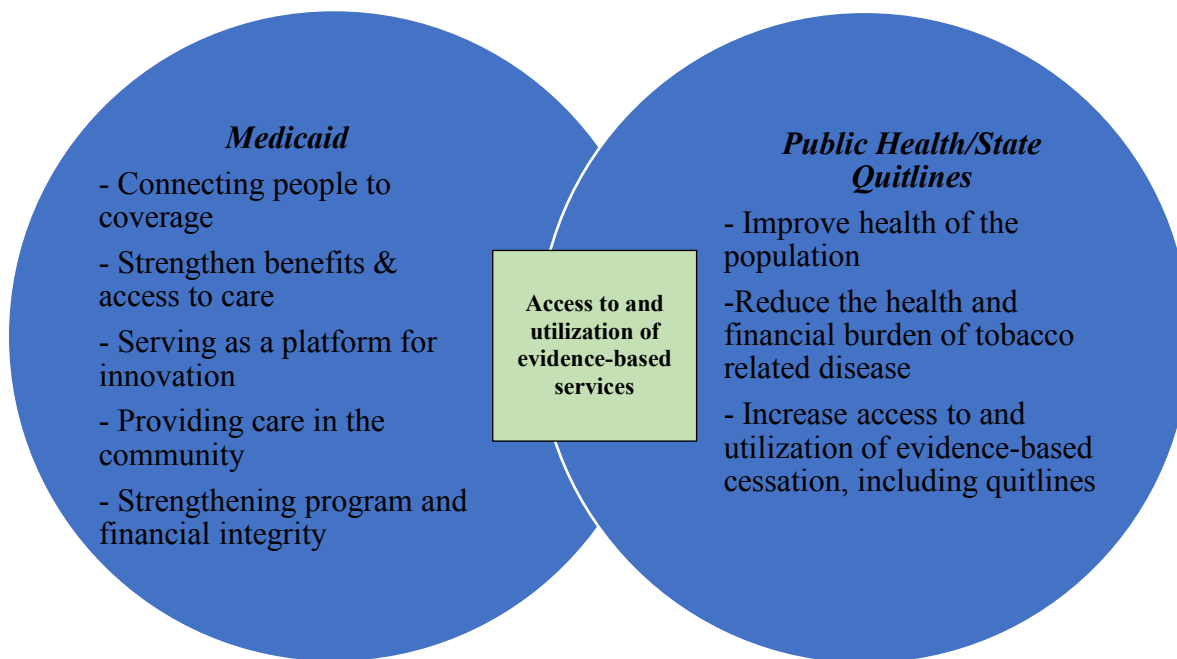
Step 5: Making the Case to Medicaid and Advocating for Change

Tobacco cessation has an “A” rating from the USPSTF, making it one of the most effective preventive services in health care. A recent study from the HealthPartners Institute found screening for tobacco use and encouragement of cessation among adults to be among the top three most effective clinical strategies for reducing burden and cost of preventable disease (18). In addition, a recent study of Medicaid enrollees in Minnesota demonstrated that Medicaid enrollees engage in quit attempts and are successful at quitting, and have even greater success when evidence-based cessation is offered proactively with no barriers (19).

In addition, research by Patrick Richard and colleagues demonstrated the significant short term return-on-investment (ROI) for the Commonwealth of Massachusetts when they improved the cessation benefit for their Medicaid enrollees. Their 2011 ROI study found for every \$1 spent on cessation there was an associated savings of \$3.12 in medical expenses (20). Finally, a recent cost estimate study examined the budget impact for public and private health plans to provide access to cessation medications with no cost-sharing at least twice per year, as laid out in the ACA. It found a nominal cost increase of \$0.01 Per Member Per Month (PMPM) for Medicaid. The study also found that over five years, Medicaid would see a 20.4% increase in smokers attempting to quit, and a 22.3% increase in smokers successfully quitting (21). Note, this study did not look at the budget impact of meeting the other requirements like individual, group and telephone counseling as laid out in the ACA; nor did the study factor in the cost savings health plans would realize due to members engaging in quit attempts and successfully quitting.

No matter the status of Medicaid expansion in your state, Medicaid and public health programs need to share the goal of ensuring the Medicaid MCO RFP and contractual language provides a comprehensive cessation benefit that is aligned with the [USPSTF](#), the [Clinical Practice Guideline for Treating Tobacco Use and Dependence, 2008 Update](#) and [ACA guidelines](#) on tobacco cessation.

In 2016, NAQC published recommend language for Medicaid MCO RFPs (see Appendix 2) to help guide state health departments and state Medicaid agencies. The recommended RFP language details a comprehensive cessation benefit, including telephone counseling and medications, promotion of the benefit to Medicaid enrollees and Medicaid health care providers, and sharing of key utilization that enables the state Medicaid agency and state tobacco control program to assess for reach and impact. While Medicaid and public health programs may not speak the same language, they do share common goals and common ground which can be the basis for taking mutually beneficial actions. Use the data you have gathered to make the case for policy and program improvements. See Step 4 for examples of ways you can use the data.



Be a resource for your state Medicaid agency. Be willing to do the leg work to reach out to internal and external partners for additional information and assistance to answer questions and concerns and provide guidance.

Examples

- Nevada assisted their state Medicaid agency in responding to questions from Medicaid MCOs on the new comprehensive cessation benefit during the Q&A period of the RFP process.
- Michigan gathered and shared relevant research on Medicaid and cessation.

Remember to celebrate the successes and congratulate your partners both privately and publicly. Acknowledging the collaboration and leadership of your partners is important. It is a way to thank them for their willingness to address a major policy issue and it is also a way to maintain and strengthen your relationship.

Finally, **reach out to internal and external partners like NAOC, American Lung Association and the Center for Health Care Strategies, Inc. for assistance with gathering data and information, or for assistance at any stage in your efforts to work with Medicaid.**

Tip from Michigan and Nevada:

“You do not have to have all the answers, but you do need to have people who can support you and find the answers.”

Step 6: Implementing and Educating About the Change

The work does not end when the state Medicaid agency agrees to add language for comprehensive cessation services to the Medicaid MCO RFP and contract language; in fact, it opens the door for a new chapter in the effort to improve access to and utilization of evidence-based quitlines and other cessation services.

Recent studies have examined the utilization of the expanded cessation benefit under the ACA for pregnant women enrolled in Medicaid and found that despite ACA-required access to all 7 FDA-approved cessation medications with no cost-sharing, utilization of the benefit remained low and unchanged from pre-ACA utilization levels (22) (23). In addition, a 2012 survey of obstetricians and gynecologist revealed that nearly 80% of those surveyed were unaware of the ACA’s requirement for cessation services provided to pregnant women enrolled in Medicaid (24). These studies demonstrate that improving a benefit does not translate to an increase in utilization of the benefit. To increase utilization, the Medicaid enrollees and their health care providers must be aware of the new benefit and how to access the benefit.

Both Michigan and Nevada found they needed to maintain their partnership with the state Medicaid agency to assist with implementation and education of the policy change. This was not a new effort, but rather a continuation of the state tobacco control program’s ongoing activity; proactively reaching out to see what assistance or information the state Medicaid agency needed. This included activities such as: gathering requested information and sharing in a timely manner; and developing talking points and documents the state Medicaid agency could use.

Key Implementation and Education Issue Both Michigan and Nevada Encountered:

- Working with Medicaid MCOs to ensure the tobacco cessation benefit is included as a “preventive service” and not a “value-added service”.
- Providing guidance to ensure Medicaid MCOs understand they cannot charge co-pays or require prior authorizations for Medicaid enrollees to access/utilize the benefit.
- Providing guidance to Medicaid MCOs on what telephone counseling is for tobacco cessation and a list of proven service providers.
- Educate Medicaid MCOs that they cannot promote the state quitline to members without a direct contract for service for their members.
- Verifying that Medicaid MCOs update all coverage handbooks and formularies to reflect the new cessation as a preventive service.
- Working with Medicaid MCOs to develop promotional materials to notify enrollees and health care providers of the new cessation benefit.
- Providing guidance to the Medicaid MCOs on how to submit data on utilization of telephone counseling services.

For Nevada, the issue of where the new language was placed in the RFP was of importance. Nevada advocated for the comprehensive cessation language to be placed under the “preventive services” sections of the Medicaid MCO RFP, thereby making the comprehensive cessation services a required service provided by the Medicaid MCOs. During the final review of the Medicaid MCO RFP language, the Nevada Medicaid agency decided to place the new comprehensive cessation services language under the “value-added services” section of the RFP. This meant the provision of cessation services was optional and MCOs would not be paid additional money to provide the service. As a result, none of the Medicaid MCOs in Nevada opted to provide a comprehensive cessation service to enrollees. Nevada continues to work with the Medicaid MCOs in their state to determine what cessation services will be provided and to advocate for comprehensive cessation services for Medicaid enrollees.

For Michigan, the low awareness of the comprehensive cessation benefit for Medicaid enrollees among Medicaid providers and Medicaid enrollees is a barrier to utilization of the benefit. Michigan was one of the first states to use the Medicaid MCO RFP and contract language to improve the cessation benefit for Medicaid enrollees in Michigan. The state tobacco control program proposed RFP and contract language that is aligned with the [USPSTF](#) for tobacco cessation and the [Clinical Practice Guideline for Treating Tobacco Use and Dependence, 2008 Update](#). Unfortunately, the language did not ensure:

- data sharing on utilization and outcomes for Medicaid enrollees who used the cessation benefit;
- promotion by the MCO of the new benefit to Medicaid enrollees or Medicaid providers.

As a result, Michigan continues to work with Medicaid MCOs to raise awareness of the cessation benefit among Medicaid providers and Medicaid enrollees.

Step 7: Assessing Wins and Identifying Future Efforts with Medicaid

It is important to take time to understand the impact of policy and program changes. You and your partners should develop a plan to assess the impact of your efforts. This can be done at any step in this process and could include:

- Scheduling time to gather feedback and perspective from partners at 3, 6 and 12 months post-implementation. This can help identify possible areas of concerns earlier rather than later and allows you and your partners to discussion possible solutions.
- Analyzing utilization data. For example, looking at changes in utilization data for the state quitline and quitline services provided by the MCO.
- Surveying Medicaid providers in your state to assess their level of awareness of the new benefit.
- Conducting a longitudinal study to examine the costs for provision of the comprehensive cessation benefit and for medical care associated with tobacco use to determine level of cost savings. This type of study may require outside funding.

Work with your partners and draw on the expertise of national technical assistance providers like NAQC, American Lung Association and the Center for Health Care Strategies, Inc. to help develop a plan to assess or evaluate your successes.

Even with the significant step of changing Medicaid MCO RFP and contract language to provide a comprehensive cessation benefit, including quitline services, both Michigan and Nevada have identified future efforts to undertake with their state Medicaid agencies. These future efforts include:

- Continuing to develop marketing and educational campaigns to increase awareness of the new cessation benefit among health care providers and Medicaid enrollees.

- Working with the state Medicaid agency and other interested partners to evaluate the new comprehensive cessation benefit provided by Medicaid MCOs.
- Exploring ways to assist Medicaid MCOs with providing access to group counseling.
- Exploring ways to improve Medicaid reimbursement for tobacco counseling. For example, increasing the amount providers are reimbursed for assessing for tobacco use and providing cessation counseling, or expanding the type of health care professionals that can bill for counseling to include Tobacco Treatment Specialists or other allied health professionals.
- Exploring ways for Medicaid to fully reimburse the state quitline for providing counseling and NRT to Medicaid enrollees. For example, the use of standing orders to overcome the prescription requirement for all medications paid for by Medicaid (including over-the-counter medications like nicotine replacement therapy).

As you move forward with your efforts, draw on the examples from Michigan and Nevada and learn from their successes and challenges. Please keep us informed of your successes and challenges and of ways we may make this toolkit more helpful to your collaborations with the state Medicaid agency and your efforts to improve cessation services and coverage, including access to quitlines, for Medicaid enrollees.

CONCLUSION

The information presented in this toolkit is meant to guide you through a process to ensure the Medicaid MCO RFP and contractual language provides a comprehensive cessation benefit, including quitlines, that is aligned with the [USPSTF](#), the [Clinical Practice Guideline for Treating Tobacco Use and Dependence, 2008 Update](#) and [ACA guidelines](#) on tobacco cessation . We have highlighted the successes of and lessons learned from two states, Michigan and Nevada, and provided templates and examples for you to use. We cannot emphasize enough that ***no two states are the same***, and the unique policy, funding and political landscape for each state will be additional factors in determining how to navigate forward using the guidance from this toolkit.

As you move forward with your efforts, please reach out to NAQC with questions. We are here to help.

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This toolkit will be updated with information and guidance as needed. If you have information you would like to share with NAQC on your efforts to work with Medicaid MCOs please reach out to **Maria Rudie**, Research Manager (mrudie@naquitline.org).

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APPENDICES

Resource 1

Medicaid: Background and Strategic Consideration

Medicaid is a complicated program, structurally, functionally and politically. This overview is intended to provide a general grounding in the overall structure and function of Medicaid to better position you to use the information and guidance laid out in the toolkit. In addition to the brief overview of Medicaid provided here, we strongly encourage you to review information from:

- Center for Medicare and Medicaid (CMS): [Medicaid webpage](#);
- Kaiser Family Foundation: [Medicaid webpage](#);
- [Center for Health Care Strategies, Inc: Population Health and Prevention webpage](#);
- Your state's Medicaid agency website.

Medicaid is the largest health insurance program in the United States. It covers individuals (adults and children) who are low-income or disabled. Enrollment in Medicaid fluctuates from month to month, mainly due to income changes that impact eligibility of individuals and families. It is estimated that Medicaid covers 74 million adults and children in the United States, or 1 in 5 people (1) (2).

Medicaid is operated under a federal-state partnership that is funded by matching federal and state dollars. The federal government sets a minimum threshold for health benefit requirements, provides oversight and applies a funding formula to determine the amount of federal funds provided to each state (ranging from 50% to 75% of matching state funds). The states administer the Medicaid program and provide funding from the state budget. As administrators, states are able to further refine or enhance eligibility requirements for their state, what services are covered, how health care is delivered, and how health care providers are paid (1) (2).

There are two eligibility groupings for Medicaid:

- Traditional Medicaid: This covers low-income and disabled individuals with specific eligibility thresholds varying from state to state (1).
- Medicaid expansion: This covers low-income or disabled childless adults, with incomes up to 138 percent of the federal poverty level. It is made possible by subsidies from the federal government via the Affordable Care Act (ACA). Expansion of Medicaid is optional for states, and as of January 2017, 32 states, including the District of Columbia, have chosen to expand Medicaid under the ACA (1) (3).

Health Care is delivered to Medicaid enrollees via two main models:

- Fee-for-Service (FFS): FFS allows Medicaid enrollees to choose a health care provider from a list of approved providers. The health care provider is paid per service they provide based on a set reimbursement rate and there is no incentive or requirement for the health care provider to coordinate the overall health care of the individual. In essence, the Medicaid enrollee is responsible for managing and coordinating their health care within the list of approved health care providers (2).
- Managed Care Model: This model is where a group or network of providers are responsible for the provision and management of care and have a financial stake in it. There are a variety of managed care models including: MCOs, Primary Care Case Management (PCCM), Prepaid Inpatient Health Plan (PIHP) and Prepaid Ambulatory Health Plan (PAHP). For the purposes of this toolkit, we will focus on MCOs (4).

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. Among the 39 states with Medicaid MCO contracts, 21 states had at least 75% of their Medicaid enrollees covered by an MCO (5) (6). Kaiser Family Foundation estimates that for state's fiscal years 2015 and 2016, 43% of Medicaid's expenses were paid to MCOs; that percentage is expected to grow over time (6).

Although the national smoking prevalence rate for adults has dropped to 15.1% (approximately 36.5 million individuals), the current rate for Medicaid enrollees has remained high at nearly double the national average (27.8%, approximately 11 million individuals) (7). It is estimated that the federal Medicaid program spends nearly \$40 billion to treat smoking-related diseases each year, compared to an estimated \$103 million to treat tobacco dependence (2; 21).

Under traditional Medicaid, all seven FDA-approved cessation medications are covered for all adult enrollees, but require a prescription and may include cost-sharing, prior authorization, and other barriers. The ACA did expand the cessation coverage for adult pregnant women covered by traditional Medicaid to provide access to individual, group and telephone cessation counseling, and all FDA-approved cessation medications with no cost-sharing (9) (10).

The ACA requires Medicaid expansion to provide evidence-based prevention services, rated as A or B level by the United States Preventive Services Task Force (USPSTF), with no cost-sharing. Tobacco cessation treatment is an A level preventive service (11). The Department of Health and Human Services issued a Frequently Asked Question (FAQ) providing the following guidance on the level of tobacco cessation benefit that would be considered "in compliance" with the ACA:

- Screening for tobacco use at every visit;
- Minimum of 2 quit attempts per year and with each quit attempt:
 - 4 cessation counseling sessions of at least 10 minutes provided via either telephone, group or individual counseling – with no prior authorization and no cost-sharing 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 and no cost-sharing required (11).

According to CMS, coverage for the adult expansion population must be offered through an alternative benefit plan (ABP). For states that have chosen to expand Medicaid, these states generally have expanded coverage in one of two ways:

- By extending traditional Medicaid coverage to the Medicaid expansion population. This essentially means there is "parity" between the traditional Medicaid and expansion Medicaid population for health benefits.
- By creating a benefit package that is not aligned with the state's traditional Medicaid state plan and using managed care for the expansion population. This means the benefits for the two eligibility groups are different and managed separately.

Please note, states can also provide subsidies to the Medicaid expansion population, which are used to purchase coverage offered in the state or federally facilitated marketplace created by the Patient Protection and Affordable Care Act (ACA).

This means, for the 32 states, including the District of Columbia, that have chosen to expand Medicaid under the ACA, the ACA requirements do not always apply to the Medicaid expansion population. For the 19 states

that have chosen ***not*** to expand Medicaid, there is no federal requirement to provide a comprehensive cessation benefit as laid out by the ACA; although states can choose to provide a cessation benefit greater than that required by CMS for traditional Medicaid.

In addition, there is no guidance from CMS specific to Medicaid MCO RFP or contract language that would ensure the provision of a comprehensive cessation benefit, as laid out by the ACA, for the Medicaid expansion population. A 2016 survey of cessation services covered by states that expanded Medicaid found a lack of compliance with ACA requirements (12). Some state tobacco control programs and quitlines have reported through NAQC that Medicaid MCOs use “reasonable medical management” to determine tobacco cessation benefits.; In some cases the Medicaid MCOs are directing enrollees to the state quitline for access to telephone counseling. When a Medicaid MCO directs enrollees to the state quitline for telephone cessation counseling with no cost-sharing agreement or contract with the state quitline in place, the Medicaid MCO is essentially being paid by the state Medicaid agency for a service the Medicaid MCO is not providing.

The results are continued barriers such as co-pays, prior authorizations (including stepped-therapy), access to a limited number of FDA-approved cessation medications, limits on number of quit attempts, and no access to group counseling or telephone counseling. The concern is that these barriers may continue to contribute to health disparities for a population disproportionately impacted by tobacco.

Resource 2

Data Gathering Tool: Key Quitline Budget and Utilization Data and Medicaid Enrollment Data

The following tables are designed to help you identify and document data needed to understand the current utilization of the state quitline by Medicaid enrollees, the effectiveness and ROI of the state quitline, the make-up of state Medicaid health plans and current enrollment, and finally the current cessation coverage required by the state Medicaid agency and offered by health plans for Medicaid enrollees the health plans cover.

You can use this data to create talking points and presentations to describe the scope of the issue, and to plan for meetings with the state Medicaid agency; but we recommend that the tables below should be viewed as internal documents for your use only.

For each table below we have listed suggestions for questionnaires, surveys and data sources you can use to gather the data. The questionnaires and surveys we list are examples and may need to be tweaked to fit the needs of your state. If you need to adjust a questionnaire or survey, we encourage you to reach out to a national technical assistance partner like NAQC, American Lung Association or the Center for Health Care Strategies, Inc., who can assist you with adjusting the survey.

A final note, when gathering data, be it utilization and budget data from the quitline or enrollment data for Medicaid, seek data from the same and most recent fiscal year possible from all of the data sources so that you are looking at the same timeframe for all data and information.

Section 1: State Quitline Budget

Fiscal Year	Quitline Budget	Amount
Data Source: Current state tobacco control program budget documents		
	Total Quitline Budget	\$
	Sum of Quitline Services & Medications Budgets*	\$

*The sum of the Quitline Services & Medications Budgets are used to determine Spending per Smoker. Spending per smoker is a key quitline metric established by the NAQC members to provide a uniform measure for amount of money spent per participant on evidence-based cessation services.

Section 2: Utilization and Outcomes of Quitline Services*

*This data should be captured for the same fiscal year as the budget data

Fiscal Year	Call Volume to State Quitline	Number
Data Sources:		
<ul style="list-style-type: none"> • Monthly or annual quitline utilization report(s) from quitline service provider • Most recent quitline evaluation report or NAQC Annual Survey for national quit rate data 		
	Total number of people who called the state quitline	

Fiscal Year	Enrollment in Services	Number
Data Source: Monthly or annual quitline utilization report(s) from quitline service provider		
	Total number of people enrolled in services	

Fiscal Year	Received Services	Number
Data Sources: Monthly or annual quitline utilization report(s) from quitline service provider		
	Total number of people who received Counseling and/or Cessation Medications (evidence-based cessation	

	services)	
	Among the Total number of people who received Counseling and/or Cessation Medications, the Total number who were Medicaid enrollees	

Quit Rates*

Data Sources: Most recent quitline evaluation report or NAQC Annual Survey for national quit rate data

Date Evaluation was conducted	(mm/dd/yy to mm/dd/yy):
Evaluation Response Rate**	(i.e., 50.0%)
Overall Quit Rate for people served by the quitline**	(i.e., 20.9%):
Quit Rate for Medicaid Beneficiaries served by the quitline***	(i.e. 20.9%):

*Quitline Evaluations are not conducted based on a fiscal year. Please use evaluation data that most closely aligns with the fiscal year for the budget and utilization data reported.

**NAQC's [Calculating Quit Rates, 2015 Update](#) issue paper, recommends best practices for quitline evaluations. For example, use of random sampling and response rates of 50% or higher.

*** Some quitlines conduct evaluations that oversample specific populations to better understand the reach and impact of the quitline among that population. If your quitline has evaluation data specific to Medicaid enrollees it is recommended that you review that outcome data and consider sharing it with your state Medicaid agency.

Section 3: Cost per Quitline Participant

Cost per Quitline Participant	Amount
Sum of Quitline Services & Medications Budgets/Total # of Quitline Participants	\$

Cost to Serve Medicaid Enrollees	Amount
Total # of Medicaid Enrollees Service by Quitline x Cost per Participant*	\$

*This dollar amount provides states with a key talking point for engagement with state Medicaid agencies. Quantifying the cost for evidence based cessation services provided by the state quitline. This amount coupled with the Quit Rate achieved, can be used to an ROI calculation.

Section 4: Return on Investment

Use NAQC's: [Calculating the Return on Investment: Employee Tobacco Cessation Coverage Utilizing Telephonic Counseling and Medication](#) to calculate and estimated ROI.

Section 5: State Medicaid

Medicaid Enrollees	
Data Sources: state Medicaid website, Kaiser Family Foundation Medicaid page, Centers for Medicare and Medicaid (CMS)	
Total number of people enrolled in Medicaid in your state	(i.e. 10,000):
Estimated percentage of Medicaid enrollees who are Current Tobacco Users	i.e., 27.8%):
CMS Core Measure: National Quality Forum #0028: % of patients aged 18 years or older who were screened for tobacco use at least once during the two-year measurement period AND who received	

cessation counseling intervention if identified as a tobacco user.	
State specific quality measures on: <ul style="list-style-type: none"> • Screening for tobacco use • Counseling on cessation • Provision of cessation medication • Referral to cessation resources (i.e. state quitline) 	

Type of system used to deliver services to Medicaid beneficiaries	Yes/No	Number of Medicaid Enrollees
Data Sources: State Medicaid website, Kaiser Family Foundation page on Medicaid		
Fee for Service (FFS): This is where there is no coordination of care for Medicaid members and the state Medicaid agency has established fee levels for covered services and pays participating providers directly for each service delivered to Medicaid beneficiaries (source Kaiser Family Foundation)		
Managed Care Organization (MCO): This is when health plans contract with state to provide comprehensive Medicaid benefits to enrolled Medicaid beneficiaries for a preset per-member-per-month capitated payment (Source: Kaiser Family Foundation)		

Medicaid MCO Plans and Tobacco Cessation Coverage	
Data Sources: State Medicaid website, State Medicaid staff contact, Medicaid MCO plan summary of coverage/benefits	
Example Survey: Oregon Health Plan – MCO Tobacco Cessation Service Survey	
Do the Medicaid MCO/RBMC plans include tobacco cessation coverage?	
Are you able to obtain a copy of the current cessation benefit language?	
Is the cessation benefit listed as a “preventive service”? Note: The goal is to have cessation covered and listed as a preventive health service	
Does Medicaid MCO provide a comprehensive cessation benefit? <ul style="list-style-type: none"> • 2 quit attempts per year and for each 	

<p>quit attempt;</p> <ul style="list-style-type: none">• 4 cessation counseling sessions of at least 10 minutes provided via either telephone, group or individual counseling – with no prior authorization and no cost-sharing 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 and no cost-sharing required, (note, stepped-therapy is a form of prior authorization)	
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Resource 3

NAQC Recommended Language for Comprehensive Cessation Benefits in Medicaid MCO RFPs *September 2016*

Located:

http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/medicaid/medicaid_mco_language2017.pdf



I. Tobacco Cessation Treatment

- A. Screening for tobacco use at every visit; and
- B. For those who currently use tobacco products, provide at least two quit attempts per plan year of which each attempt includes at a minimum:
 1. Effective counseling as defined by U.S. Public Health Services Clinical Practice Guideline on Tobacco Dependence Treatment:
 - a. Intensive tobacco cessation counseling services through a telephone quit-line vendor approved by the state Department of Public and Behavioral Health
 - b. Individual tobacco cessation counseling/coaching (separate from the XX outpatient mental health visits covered by the Contractor)
 - c. Group tobacco cessation counseling/coaching (separate from the XX outpatient mental health visits covered by the Contractor).
 2. FDA approved cessation medications:
 - a. All FDA approved tobacco cessation medications, both prescription and over-the-counter medications. Treatment regimen should cover a minimum of 90 days.
 - b. Combination therapy – the use of a combination of medications, including but not limited to the following combinations – should be allowed:
 - 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
 3. Contractor must not place “stepped-therapy” requirements on tobacco cessation treatment.
 4. Contractor must not require physician prescription for issuance of Over-the-Counter FDA approved cessation medications included in the tobacco cessation benefit
 5. 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.
 6. Contractor must not place cost-sharing requirements on tobacco cessation treatments included in this section.
 7. Contractor should amend policies, evidences of coverage, formularies and/or drug brochures as necessary to ensure that beneficiaries are given complete information about the coverage of tobacco cessation items and services.
 8. Contractor will partner with the Division of Public and Behavioral Health to, at a minimum:
 - a. Promote the full Tobacco Cessation Benefit to Medicaid MCO beneficiaries.
 - b. Gain input from the Division of Public and Behavioral Health on promotional materials provided to Medicaid MCO beneficiaries.
 - c. Provide reports on promotional activities at least biannually.
 - d. 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.

- e. Provide aggregate North American Quitline Consortium (NAQC) MDS data, utilization and outcomes via the selected telephone quit-line approved vendor, to the Division of Public and Behavioral Health, per data sharing agreement, at least biannually.
- f. The approved MCO quitline vendor must be a member of North American Quitline Consortium (NAQC)