Case Study: The Effect of Expanding Cessation Coverage—The Massachusetts Medicaid Cessation Benefit

States can design and implement tobacco cessation benefits through Medicaid that are accessible, affordable, and that cover all evidence-based cessation treatments including counseling and medications.

The Massachusetts experience highlighted below shows that providing a broad cessation benefit through Medicaid can increase use of evidence-based cessation treatments, reduce smoking rates, improve health outcomes, and decrease medical costs over a short time period. The MassHealth cessation benefit had a major effect on all of these outcomes even though it was made available to a vulnerable, underserved, low-income population traditionally viewed as hard to reach. The lack of comprehensive Medicaid cessation coverage in most states represents a major missed opportunity to improve health outcomes in a vulnerable population while reducing health care costs.

The Health Burden and Costs of Tobacco Use

Smoking is the leading preventable cause of death in the United States. It kills about 480,000 Americans each year and causes more than 16 million people to suffer from disease and disability in the United States.[1] Annually, smoking costs the nation at least $130 billion in direct medical costs and more than $150 billion in lost productivity.[1] While smoking rates among the general population in the United States have declined in recent years,[2] they remain substantially higher among Medicaid beneficiaries[2] and smoking-related diseases are a major driver of Medicaid costs.[3]

Recommended Interventions

In the United States, about 70% of smokers want to quit and about 50% make a quit attempt each year.[4,5] However, less than 10% succeed, in part because of under use of proven cessation treatments.[4,5] Seven FDA-approved cessation medications along with individual, group, and telephone counseling have been shown to be effective in helping smokers quit.[4] While medication and counseling are each effective when used alone, they are more effective when used together.[4] In addition to being clinically effective, cessation treatments are also extremely cost-effective relative to other commonly used, routinely reimbursed medical interventions such as hypertension treatment and mammography.[4] Comprehensive coverage—meaning a combination of recommended medications and counseling that is covered by insurance with no cost-sharing required—increases the number of smokers who use these treatments, attempt to quit, and succeed in quitting.[4]

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Tobacco Cessation in Massachusetts

Smoking costs the Massachusetts Medicaid program, MassHealth, $1 billion annually in excess health care costs.[6] Adults with lower incomes (below $25,000 annually) are almost three times more likely to smoke than adults with higher incomes ($75,000 or more annually).[6] The 2006 MA Health Reform law specified that pregnant women and women with children younger than age 3 should be covered for smoking cessation benefits through Medicaid.[7] The two lead agencies, the Department of Public Health (DPH) and Medicaid, ultimately recommended a more comprehensive benefit that provided cessation coverage to all Medicaid beneficiaries, which was less complicated to administer than providing a benefit to only a subset of the Medicaid population that would require eligibility checks.[8] After several benefit design meetings and multiple cost projection analyses, this expanded benefit was recommended to and approved by both agency heads.[8]

The final benefit provides coverage of all FDA-approved cessation medications and individual and group counseling.[9,10]

Only seven states cover all FDA-recommended cessation treatments for all Medicaid enrollees[18] even though a recent study found that Medicaid recipients who lived in states with generous tobacco cessation coverage had the highest successful quit rates.[17]

Tobacco Cessation in Massachusetts, cont'd

MassHealth and DPH officials met on a weekly basis for more than a year to develop the components of the program along with its processes and expected outcomes.[11] At the program's inception, enrollees could obtain up to two, 90-day regimens of smoking cessation medications per year (90-days per quit attempt), which included the nicotine patch, gum, lozenge, bupropion, and varenicline.[10] The nicotine inhaler and nicotine nasal spray could be obtained with prior authorization. Medications could also be combined; for example, the patch and gum or the bupropion and patch. Medications were prescribed by a Medicaid provider for a nominal co-payment fee ($1-$3).[10]

Up to 16 counseling sessions were available per year in the form of individual or group counseling, and more could be provided with pre-authorization.[10] To provide greater accessibility to tobacco cessation counseling, a wide range of providers were authorized to provide these services including physicians, nurse practitioners, nurse midwives, registered nurses, physicians' assistants, and qualified tobacco cessation counselors (defined as someone who has completed at least 8 hours of training in tobacco cessation services from an accredited institute of higher education).[12] Independent nurse practitioners and independent nurse midwives could provide tobacco cessation counseling directly without being supervised by a physician.[12] If face-to-face counseling was unavailable, providers are encouraged to refer patients to the MA quit line and the QuitWorks telephone-based program operated by the Massachusetts DPH.[12]

The DPH also initiated a broad publicity and outreach campaign in conjunction with MassHealth to achieve a high usage rate among providers and consumers.[9,10] For providers, this included the development of fact sheets, detailed Frequently Asked Question [FAQs] with rate and billing codes, a pharmacotherapy pocket guide, and new intake and assessment protocols that were widely disseminated to health care systems and facilities.[13] Consumers were targeted with direct mailings, radio ads, transit ads,* and regular communications were sent to provider groups including medical associations and subspecialty groups.[13] DPH officials were trained and given access to MassHealth data to track benefit use and to provide feedback and special recognition to providers who were regularly referring patients to the program.[11]

From fiscal year (FY) 2007 to 2009, approximately 75,000 smokers (40% of MassHealth smokers) participated in the program.[10] MassHealth spent about $20 million on medications and counseling, and the DPH spent $558,500 on promotion and outreach.[14]
The program resulted in the following outcomes:

- ***Reduced smoking prevalence:***
  Using the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS) data, smoking prevalence was examined in the MassHealth population from 1999–2008. **The smoking rate among MassHealth beneficiaries decreased from 38% in 2006 to 28% in 2008, representing a 26% decline in the first 2.5 years.**[10]

- ***Reduced hospitalizations:***
  Using MassHealth claims data, DPH researchers compared the probability of hospitalization before and after use of the pharmacotherapy benefit among MassHealth beneficiaries. Researchers examined diagnoses by looking at cardiovascular group codes, respiratory group codes, and other conditions. **There was a 46% decrease in hospitalizations for heart attacks and a 49% decrease in hospitalizations for other acute heart disease diagnoses among users of the pharmacotherapy benefit.** There were no significant decreases in hospitalizations for respiratory and other diagnoses.[15]

- ***Return on investment:***
  Using program costs and savings attributable to the reduction of cardiovascular admissions among Medicaid beneficiaries, researchers calculated the return on investment (ROI) associated with the tobacco cessation benefit. During FY 2007–2009, annual program costs—including pharmacotherapy, counseling, and outreach—totaled about $183 per participant, while annual hospital savings were estimated at $571 per participant. **Every $1 in program costs was associated with $3.12 in medical savings for cardiovascular conditions alone, for a $2.12 ROI to the Medicaid program for every dollar spent.**[14]

Since the benefit was instituted, certain changes have been made to ensure its continued availability and sustainability. The initial co-pay of $1–$3, which was the standard price for a prescription benefit through MassHealth, was increased to $3.65 in 2011 to reflect current charges.[16] Over-the-counter medications, such as the patch and gum, are no longer restricted to a 90-day supply and can now be provided to support as many quit attempts as the consumer makes annually.[8]

*A new FDA-approved cessation medication, varenicline (Chantix), was released by Pfizer and heavily promoted in Massachusetts at the same time that the campaign occurred. Other pharmaceutical manufacturers also promoted cessation medications during this period. These promotional efforts were not linked to the public health campaign.

Summary

Several key features of the Massachusetts Tobacco Cessation Program contributed to its success.

- ***Passage of the state health reform law:***
The passage of the Massachusetts health reform law acted as a catalyst for the expansion of tobacco cessation coverage to all MassHealth beneficiaries.

- ***Built on existing infrastructure and partnerships:***
MassHealth and the DPH established a close partnership that predated the benefit, laying the groundwork for close collaboration in implementing and promoting the new cessation coverage. Existing referral and quit line infrastructure was used to expand the benefit to MassHealth participants.

- ***Reduced barriers to utilization:***
To maximize access to cessation treatments, counseling or prior authorization was not required to receive most medications; billing for smoking cessation counseling was allowed on the same day as a medical visit for another purpose; and there was a nominal copayment fee.

- ***Provided broad coverage:***
The benefit covered a range of evidence-based cessation treatments, including all FDA-approved medications and individual and group counseling.

- ***Engaged providers and consumers:***
A major effort was made to promote the benefit to Medicaid providers and beneficiaries through tailored communication channels.

- ***Documented impact:***
Systems were put in place in advance to monitor and document benefit use and its effect on smoking rates, health outcomes, and medical costs in the state's Medicaid population.

The passage of the Patient Protection and Affordable Care Act represents a major opportunity to offer evidence-based tobacco cessation benefits to all smokers, regardless of their type of health insurance.

The Act requires non-grandfathered health insurance plans to cover without cost sharing all preventive services that have received "A" or "B" ratings from the US Preventive Services Task Force (USPSTF), which includes the following tobacco cessation services:

- Screening for tobacco use
- Tobacco cessation counseling and all FDA-approved tobacco cessation medications [†]

The Affordable Care Act also requires state Medicaid programs to provide comprehensive smoking cessation coverage to pregnant women and bars these programs from excluding FDA-approved cessation medications from coverage.[20]

State officials should be well-versed in their state's essential health benefit, as it will govern which tobacco cessation services are covered by small group and individual plans, plans in state marketplaces, and Medicaid expansion plans.[18] While insurers are allowed to charge tobacco users higher premiums—up to a 50% higher rate than they charge to non-tobacco users—smokers in plans in the group market can avoid the higher premiums if they participate in a cessation program. States also have the legal authority to prohibit this higher rate or place a lower ceiling on the permitted premium increase.[19,20]

State public health officials can be valuable partners in smoking cessation efforts.

Public health departments can develop and target educational campaigns to consumers and providers using social and traditional media, printed and online materials, and other outreach approaches conducted by staff or contractors. In addition, they can provide specific, evidence-based recommendations on how to make cessation programs effective and analyze data to track cessation use and health outcomes. State public health and health care leaders are strongly encouraged to examine opportunities for structuring evidence-based tobacco cessation programs for maximum effect.

[†] Specific guidance on cessation services required under ACA is available at http://www.dol.gov/ebsa/faqs/faq-aca19.html under Q5.

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