Medicaid Cessation Coverage Roundtable Report
September, 2014

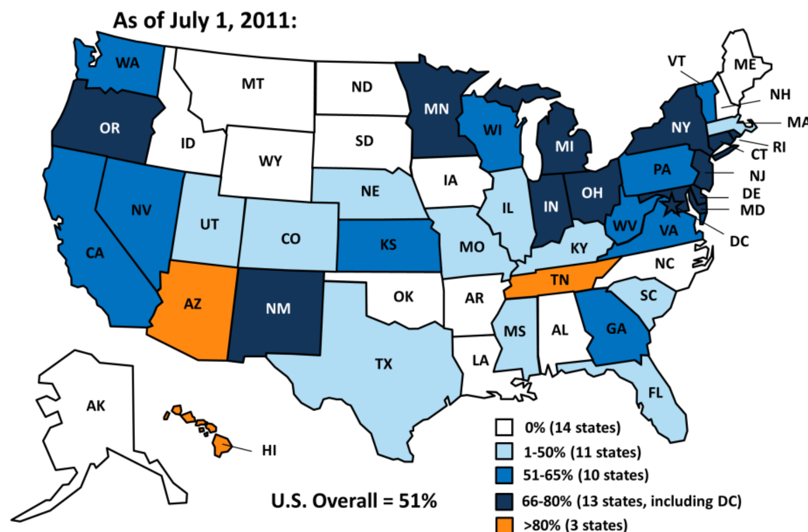
Medicaid Managed Care and Comprehensive Cessation Coverage: A Recommended Approach for State Tobacco Control Programs?

BACKGROUND

Medicaid, the largest health insurance provider in the U.S., is administered by the states within broad federal requirements and jointly funded by states and the federal government. Medicaid currently covers over 65 million Americans – more than 1 in every 5 – at least some time during the year[1] and over half of Medicaid beneficiaries nationally are enrolled in comprehensive managed care organizations (MCO) that contract with states to deliver Medicaid services (see figure from the Kaiser Family Foundation below).[2] It is important to note that this figure continues to rise as states expand managed care to include higher-need Medicaid populations and adults covered as part of the Medicaid expansion process.

Figure 6

Share of Medicaid Beneficiaries Enrolled in Comprehensive Risk-Based Managed Care Organizations



NOTE: Comprehensive risk-based managed care includes Health Insuring Organizations (HIOs), comprehensive commercial and Medicaid managed care organizations (MCOs), and Program of All-Inclusive Care for the Elderly (PACE).
SOURCE: *Medicaid Managed Care Enrollment Report, Summary Statistics as of July 1, 2011*, CMS, 2012.

In addition to MCOs, a smaller percentage of Medicaid beneficiaries are enrolled in Primary Care Case Management (PCCM) programs. States using the PCCM model continue to use the fee-for-service delivery system and payment structure but also pay primary care providers a small monthly fee to coordinate care for their Medicaid patients.

The Shift to Managed Care and Impact on Cessation

States have traditionally provided Medicaid benefits to enrollees using a fee-for-service system where healthcare providers are paid for each service they provide according to set payment rates. However, over the past 15 years, states have started to implement managed care so that enrollees receive their care from an organization under contract with the state (i.e., MCOs). Maintaining quality and accessibility of services, while at the same time working to contain costs, is at the heart of this ever-increasing shift from fee-for-service to managed care, though there is disagreement on the degree to which cost-savings have been realized by states as a result of the shift. In 2012, the Robert Wood Johnson Foundation (RWJF) published a synthesis of the evidence on whether states have saved money using managed care for their Medicaid populations and the degree to which those enrolled in managed care have better access to, and higher quality of, services compared to their fee-for-service counterparts. Overall, the RWJF findings showed little evidence of savings, mixed success in improving access and an undetermined impact on quality.

With implementation of major coverage expansions and new enrollment standards as part of the Affordable Care Act (ACA), state Medicaid agencies have experienced a number of hotly-debated transitions over the past four years. State tobacco control programs know well how these transitions have challenged their ability to engage their state Medicaid agency partners in conversations about comprehensive tobacco cessation coverage, and implementation of the Centers for Medicare & Medicaid Services (CMS) quitline guideline. Additionally, state tobacco control programs often do not understand how to most effectively maneuver within the state Medicaid system, much less how to engage with the MCOs that are part of that system.

The result of stalled, interrupted or never-begun efforts to ensure comprehensive tobacco cessation coverage for *all* Medicaid enrollees is a hodgepodge of coverage among and within states, and decisions on cessation coverage that:

- are being made by each individual MCO plan;
- are less than comprehensive; and/or
- place limitations or requirements that restrict access to the benefit, such as annual limits, prior authorizations and copayments.

In the final meeting of the NAQC Roundtable, members discussed how the growing shift to managed care is impacting efforts to ensure comprehensive coverage for tobacco cessation and how one state, Michigan, has chosen to ensure standard coverage across MCOs through standard contract language, the challenges this approach has presented and lessons learned.

ROUNTABLE RATIONALE AND PURPOSE

The North American Quitline Consortium (NAQC) Medicaid Cessation Coverage Roundtable is a result of over two years of dialogue, technical assistance and resource development aimed at tobacco control programs working to secure cost-sharing partnerships with their state Medicaid agencies. The impetus of this early work was the June 2011 letter from CMS Director, Cindy Mann, to State Medicaid Directors announcing tobacco cessation telephone quitlines as allowable Medicaid administrative activities and thus, eligible for the 50 percent Federal Medicaid matching rate.[3]

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

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

- To provide **a forum for strategizing and sharing information** on both national and state Medicaid cessation policy priorities.

This final NAQC Roundtable report aims to bolster and inform state tobacco control programs on moving forward with efforts to improve cessation coverage to Medicaid enrollees in managed care plans and includes recommendations that NAQC believes will accelerate progress toward truly comprehensive and standard cessation coverage for all Medicaid enrollees, regardless of whether a person is covered by fee-for-service or managed care. With opportunities such as the CMS quitline guideline, the Affordable Care Act and Medicaid expansion, tobacco users should have more support and options to quit and stay quit than ever before – the question for us is: *How can we most effectively engage Medicaid MCOs to ensure standard, comprehensive cessation coverage for those enrolled in managed care?*

THE ROUNDTABLE'S VIEW

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

Why is Medicaid managed care a challenge for state tobacco control programs and comprehensive cessation coverage?

Competing priorities

It goes without saying that most state Medicaid agencies are currently focused on implementation of the Affordable Care Act, including Medicaid expansion. Even states that have chosen not to expand Medicaid are streamlining enrollment processes, making required changes to establishing eligibility requirements and preparing for potentially increasing enrollment.

Creating accountability

State Medicaid agencies struggle to establish and maintain accountability at the managed care plan level. Implementing minimum standards for tobacco use treatment is challenging. For example, in California there are 25 different MCOs that cover 58 counties. Of the 11 million people covered by Medicaid in California, 76% are in managed care. There are scores of contracts between the state Medicaid agency and MCOs and the state Medicaid agency and provider networks and they have been working for a few years to establish standard performance metrics to no avail. As stated by one roundtable member, "If you've seen one managed care plan, you've seen one managed care plan!

Ultimately, the managed care model is intended to save costs. These entities are expected to provide cost savings, thus the state Medicaid agencies who oversee these contracts need to balance the desire for various requirements and/or restrictions with the managed care plans' ability to manage their populations. For instance, one state Medicaid agency has started encouraging MCOs to get rid of prior-authorizations on cessation medications but expect that this "encouragement" will be an issue for the plans. MCOs view prior-authorizations as a tool to optimize patient outcomes by ensuring patients receive the most appropriate medications while reducing waste, error and unnecessary prescription drug use and cost.

Rules and guidance that are no longer relevant

According to one Roundtable member, CMS has rules that were wise at one time, but have become burdensome and antiquated especially considering advances in healthcare delivery. Telemedicine is one example, as is how CMS approaches over-the-counter medications. These limitations present serious problems for decreasing barriers to tobacco use treatment.

Variability in benefits

Roundtable members agree that there needs to be better alignment among plans on the definition for comprehensive coverage, and that the great variability in what is covered by different MCOs in a state is an issue for providers and consumers.

To address this challenge and support promotion of cessation benefits by providers, Michigan created a grid that is completed by each plan as part of their annual compliance review. How did the state Medicaid agency get each plan to provide the information? It actually became a competition among the plans – no plan wants to be the only one on the grid lacking information!

MassHealth, the Massachusetts Medicaid agency, also developed a tobacco cessation benefits webpage that describes the services available and has a section specifically for providers: http://www.mass.gov/eohhs/provider/insurance/masshealth/masshealth-tobacco-cessation-benefits.html

ACCELERATING PROGRESS ON ASSESSING CURRENT CHALLENGES

1. Simply stated, there are very real priorities for state Medicaid agencies that tobacco control must be aware of and any efforts to engage this critical partner must take these priorities into account. How? Return-on-investment is critical for MCOs and thus, the state Medicaid agency staff who manage those contracts. Share tools, resources, and information that

can support her/him in making the case for tobacco control to the MCOs they manage, especially truly comprehensive coverage. Consider tactics that make their work easier!

2. For many state Medicaid agencies, the only quality metric they can point to for tobacco treatment is the **Healthcare Effectiveness Data and Information Set** (**HEDIS**). NAQC encourages movement toward a national tobacco treatment benchmark for all plans serving the Medicaid population that goes beyond the HEDIS tobacco measures.
3. Medicaid agencies operate in a highly regulated environment of federal and state laws. While many of these laws protect the health and safety of enrollees or prevent fraud, some (e.g., telehealth and pre-authorization for OTC medications) appear to undercut innovation and quality care. NAQC encourages state Medicaid agencies and CMS to review these rules and consider eliminating them or excluding quitlines and cessation medications from them.

What strategies have been used to successfully engage MCOs in comprehensive cessation coverage?

Members of the Roundtable noted three strategies that seem to be most effective: a top-down approach in which leadership at the Medicaid agency and MCO level agree on the importance of comprehensive coverage and mandate that it occur; state legislation; and directive from CMS or HHS. One Roundtable member noted that legislation and directive from the federal level makes a huge difference in the ability to move more quickly toward full implementation – it makes something a priority in the midst of many competing demands.

When, and if, insurance codes are being worked on is a time for possible progress as well, i.e., making comprehensive cessation an essential health benefit. However, no one on the Roundtable has experience with this strategy.

ACCELERATING PROGRESS ON STRATEGIES TO ENGAGE MCOs

1. There seems to be great variation between states in the entity that has “jurisdiction” over managed care plans, “enforcement” around cessation coverage more broadly, and how states are coordinating cessation coverage for Medicaid expansion plans and traditional, fee-for-service Medicaid. What state entity or entities *should* be responsible for coordinating and ensuring cessation

coverage for all covered lives? How can tobacco control programs become an integral part of these discussions, if they aren't already?

2. Tools, resources and opportunities for states to share experiences and approaches related to their work with Medicaid managed care are needed to build knowledge of successful approaches.

The Michigan Story

In 2004, the Michigan quitline was just over one year old and contracting with a small, in-state service provider that also happened to be providing services for a few of Michigan's MCOs. At the same time, the Medicaid Director started taking notice of HEDIS scores that were at 66.2% for asking about tobacco use and wanted to see improvement. Soon after, voluntary cost-sharing for 50% of quitline services between Medicaid MCOs and the tobacco control program was implemented.

In 2008, the Chief Medical Executive was focused on tobacco treatment and had a great relationship with the Medicaid Director. Together with staff from both agencies, they started to change contract language for MCOs, a process that took approximately eight months. Contracts required MCOs to have a quitline for all enrollees and though it did not require a partnership with the state quitline, the contract did require that the tobacco control program approve the quitline that was being used to fulfill the requirement. The quitline had to offer proactive services, utilize motivational interviewing and allow for review of treatment protocols by the tobacco control program.

Under the new contract agreements, cost-sharing at 50% was offered to MCOs choosing to use the existing state quitline and 11 of 13 MCOs signed agreements with the tobacco control program and two secured their own quitline service. The contracts with MCOs also required coverage of two FDA-approved nicotine replacement therapies (NRT) and one prescription cessation medications.

In 2014, the tobacco control program started meeting with Medicaid staff managing the MCOs to review contract requirements related to medication and group cessation counseling (for which there are currently no billable codes) to determine if and how requirements for coverage could be strengthened. This work continues in the very busy midst of implementation of Medicaid expansion in Michigan!

*As a note of success, in 2013 the HEDIS scores for Medicaid MCOs was 79% for asking about tobacco use; 45% for discussing cessation strategies; and 52% for discussing cessation medications.

<u>Lessons learned and remaining challenges</u>

- This has been a 10 year work-in-progress involving many different people, many different roles and quite a bit of staff turnover. Tobacco control staff work primarily with state Medicaid staff managing the MCOs, though they have presented directly to MCOs on occasion. Examples of other critical staff positions to include in this effort have been:
  - Public information officers
  - Quitline service providers
  - MCO Medical Directors
  - MCO Quality Improvement Officers

- Michigan has always had tiered quitline services. If a caller has commercial insurance, they are directed to their plan for cessation services and not served by the state quitline. This approach has served them well in their work with Medicaid, as no one wants to pay for something that you offer to everyone for free.

- Initially there were a lot of medical directors pushing back on the quitline requirement, as they did not want their patients getting help through a quitline – only a physician. This sentiment required a lot of education.

- Promotion of the quitline is limited and there is work to be done to increase awareness of the benefit and its utilization.

- There are still a few holes in coverage, as Michigan placed either/or language in the contracts and there are repercussions to this approach to be aware of.

- Prior authorization remains a barrier to services. In fact, there is one MCO that simply denies everything on prior authorization and this leads to patient and provider frustration.

- Medicaid expansion is the priority for all Medicaid staff at the moment.

- Currently, the cessation benefit Michigan offers to people covered by Medicaid managed care is better than the benefit offered to those on fee-for-service. This is presenting a challenge and in the coming months will need to be addressed.

ACCELERATING PROGRESS ON COMPREHENSIVE COVERAGE FOR MEDICAID MANAGED CARE

1. Find the right person(s) within the state Medicaid agency to get the work done, rather than trying to work directly with MCOs to implement comprehensive coverage.
2. Legislation is a key tactic that should be considered.
3. There is a need for supportive leadership and other infrastructure support such as knowledgeable operations/contract staff and a smaller number of MCOs that increase the likelihood of success.
4. Rome was not built in a day. There is a need for small steps and incremental change that will have lasting impact.
5. Respect the "managed" part of managed care. They do want to do the right thing but are running a business that is at its core about cost-savings to the state.
6. Think carefully about possibly long-term implications of making compromises when determining contract language/requirements to standardize benefit coverage.

ROUNDTABLE MEMBERS

State Agency Teams

California

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Michigan
Kim Hamilton, Manager, Plan Management Section, Managed Care Plan Division, Bureau of Medicaid Program Operations and Quality Assurance, Medical Services Administration, Department of Community Health

Centers for Disease Control and Prevention
Steve Babb, MPH, Public Health Analyst, Tobacco Cessation Unit, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion

Centers for Medicare & Medicaid Services
Observer: *Stephen Cha, MD, MHS,* Chief Medical Officer, Center on Medicaid and CHIP Services
Additional representatives from CMS will join meetings as needed for specific discussion topics.

American Lung Association
Jennifer Singleterry, *MA*, Director, National Health Policy

National Council for Behavioral Health
Laira Roth, Senior Policy Associate

Guest Speaker
Karen S. Brown, MPA
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[3] Centers for Medicare and Medicaid Services. June 24, 2011. New Medicaid Tobacco Cessation Services. Retrieved from http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd11-007.pdf