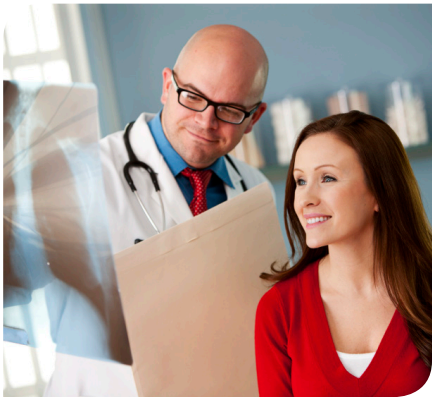
AMERICAN LUNG ASSOCIATION®

Approaches to Promoting Medicaid Tobacco Cessation Coverage: Promising Practices and Lessons Learned

People enrolled in Medicaid are twice as likely to smoke than those who have private insurance. Helping these individuals quit will save both lives and money. Five states, California, Massachusetts, Mississippi, Vermont, and Wisconsin, have successfully promoted their Medicaid tobacco cessation benefit and have shared their lessons learned. This document explores the promising practices these states used to encourage Medicaid enrollees in their states to quit.

Introduction

Smoking remains the leading preventable cause of death in the U.S. with Medicaid enrollees smoking at rates more than double those for adults with private health insurance or Medicare.[1] According to the Centers for Disease Control and Prevention (CDC), 29.1 percent of adults on Medicaid smoke compared with just 12.9 percent of adults on private insurance plans and 12.5 percent on Medicare.[2] Medicaid expenditures attributable to smoking total $39.6 billion annually, representing 15.2 percent of Medicaid expenditures nationwide.[3] Smoking-related diseases cost Medicaid programs an average of $833 million per state in 2013.[4]



Covering three forms of counseling (individual, group and telephone) and all Food and Drug Administration (FDA)-approved cessation medications is recommended by the US Public Health Service's ***Treating Tobacco Dependence: 2008 Update***[5]. Despite the clear guidelines, most state Medicaid programs do not cover all treatments proven effective in helping smokers quit. In addition, all but one state have at least one policy in place that makes it harder for a Medicaid member to access treatments that are covered.[6] Key provisions in the 2010 Patient Protection and Affordable Care Act (ACA) require coverage of all FDA-approved tobacco cessation medications for Medicaid enrollees. However, 20 states and the District of Columbia still do not cover all seven FDA-approved tobacco cessation medications for all their Medicaid enrollees. With one exception, all states that provide access to all seven FDA-approved medications still have barriers to treatment in place, such as copayments or prior authorization requirements.[6]

While the lack of comprehensive tobacco cessation coverage for Medicaid enrollees compounds disparities in the health consequences of tobacco use experienced by low-income Americans, inconsistent coverage across Medicaid populations and plans within each state adds another layer of complexity to efforts to help this population of smokers quit. This is especially true for health care providers who seek to refer Medicaid enrollees to cessation treatment. Variations in coverage and barriers across plans and populations (e.g., enrollees covered by fee-for-service Medicaid plans versus those covered under Medicaid Managed Care plans) can lead to confusion among enrollees and their providers. Providers who lack confidence that Medicaid patients they refer will receive adequate cessation assistance as a result of this confusion, may choose not to refer patients to treatment at all. In addition, they may make an incorrect referral, which may result in patients becoming frustrated and giving up on their quit attempts.

However, ensuring comprehensive coverage of evidence-based cessation treatments across a state's entire Medicaid population is only one piece of the puzzle. A Medicaid cessation benefit that is very generous on paper will not have an impact if it is not used. Finding ways to increase awareness and utilization of covered cessation treatments among Medicaid enrollees and their health care providers is also vital, whether the benefit is comprehensive or not[7]. Efforts to increase this awareness and use of covered cessation treatments have been an intentional focus of several state tobacco control programs over the past few years—a focus that runs parallel to ongoing efforts to improve cessation coverage.

Background

Comprehensive tobacco cessation coverage increases quit attempts, use of proven cessation treatments, and successful quitting.[8] Evidence from Massachusetts indicates that a comprehensive, heavily promoted state Medicaid tobacco cessation coverage can be widely used, reduce smoking rates, improve health outcomes, and reduce health care costs.[9,10,11,12]

The following four ACA provisions have the potential to improve Medicaid cessation coverage.[13]

Affordable Care Act (ACA) Provisions Addressing Medicaid Cessation Coverage

1. Pregnant women in traditional (non-expansion) Medicaid (effective October 1, 2010): Requires Medicaid programs to cover a comprehensive cessation benefit for pregnant women without cost-sharing (Section 4107).
2. All Medicaid recipients in traditional (non-expansion) Medicaid (effective January 1, 2013): States that opt to cover effective clinical preventive services—including comprehensive tobacco cessation programs—for all Medicaid recipients without cost-sharing receive a one percent increase in their Federal medical assistance percentage for preventive services (Section 4106).
3. ACA Medicaid expansion recipients (effective January 1, 2014): Recipients eligible for Medicaid coverage in states that opt to expand Medicaid eligibility under the applicable ACA provision are entitled to cessation coverage without cost-sharing (Section 2001).
4. All Medicaid recipients in traditional (non-expansion) Medicaid (effective January 1, 2014): States must cover FDA-approved tobacco cessation drugs, and cost-sharing is allowed (Section 2502).

While cessation coverage for many Medicaid enrollees across the U.S. has improved[14], this coverage continues to vary widely by state. In addition, coverage can vary widely for Medicaid enrollees within a single state. Most state Medicaid agencies still impose at least some barriers to accessing treatments, such as step therapy, prior authorization, and limited treatment duration.

Even with the continued variability of covered benefits and the continued barriers to treatment in many states, there is important work to be done to improve awareness of the coverage that is available. This work, which is intended to increase consumer demand for and utilization of evidence-based cessation treatments, does not have to wait until a state has achieved comprehensive, barrier-free Medicaid cessation coverage.

Utilization of covered cessation treatments is driven by awareness of their availability and an understanding of how to access them. Efforts to encourage cessation among Medicaid smokers will be most effective if these smokers, their families and their health care providers have this awareness. While recognizing that state contexts vary widely, the suggestions below outline strategic considerations, promising practices and lessons learned for states to bear in mind as they seek to promote covered Medicaid treatments to increase their use.

Key Strategies For Promoting Medicaid Cessation Coverage

Cessation benefits are most likely to be used when smokers and their health care providers know which treatments are covered and how to access those treatments.[15] A recent study found that only about 10 percent of current adult smokers received cessation medications in 2013, with use of these medications varying widely across states. The study also found that Medicaid spent $103 million on cessation medications in 2013, which represents less than a quarter of one percent of the estimated cost to Medicaid of smoking-related diseases.[16]

Clearly there is a need to narrow the gap between the cessation benefits available to Medicaid smokers and their utilization of these benefits. Working closely with state Medicaid programs, state tobacco control programs can play an important role in promoting covered benefits to Medicaid smokers and the health care providers who serve them. In conversations with five states (Wisconsin, Massachusetts, Vermont, Mississippi and California), promotion to these two target audiences was found to go hand in hand, with this coordinated, comprehensive approach to promotion being seen as critical to success.

"We assumed that members weren't getting cessation medications because of strict drug benefit limitations. However, a careful review of the utilization data showed us that members were not maxing out on their drug benefit! The issue was more about providers not knowing the medication benefits for members and members not knowing what they have access to. Our promotional strategy then became about connecting the dots and empowering both."
—Mississippi Tobacco Control Program Staff

Wisconsin—Promoting the Benefit Widely

The Wisconsin experience illustrates the dual need for coverage and promotion. In 2001, less than two percent of Wisconsin's Medicaid enrollees were using their smoking cessation treatment benefit. According to Rob Adsit, MEd, Director of Education and Outreach at the University of Wisconsin School of Medicine and Public Health's Center for Tobacco Research and Intervention (UW-CTRI), many clinicians and health plans were unclear about the cessation benefits that were covered under the various Medicaid managed care plans, including recent improvements to benefits such as changes on the drug formulary and the removal of a requirement to enroll in counseling in order to receive cessation medications.

To increase awareness, dispel myths, and increase demand for use of cessation treatments by Medicaid enrollees, Wisconsin developed "Medicaid Covers It!," an educational campaign targeted at both health care providers *and* Medicaid enrollees. The campaign was a collaborative effort of three partners: UW-CTRI, the Wisconsin Medicaid Program, and the Wisconsin Department of Health Services. For each promotional goal, the partners made certain that there was a corresponding target, message, and communication method with measurable objectives for each activity.

The campaign's main provider audience was Medicaid-contracted providers. The campaign's planners recognized that these providers were not going to intervene if they were not sure that the cessation treatments they were recommending to their Medicaid patients would be covered. Campaign planners conducted focus groups with these providers to assess gaps in coverage-related knowledge. Promotional messages were drafted and circulated to providers for review and feedback before being finalized. Planners also recognized that, in addition to physicians, billing and coding staff, pharmacists and intake staff also needed to be educated about who which Medicaid enrollees had what benefit.

From 2005 to 2007, campaign planners examined whether the targeted educational campaign increased smoking cessation treatment utilization among Medicaid members. The team found that Medicaid claims for cessation medications increased from 1.5 percent of adult smokers at the beginning of the campaign to 4.4 percent at the end of the follow-up period. In addition, average monthly quitline registrations among Medicaid enrollees increased from 59 to 93, a statistically significant increase.[10,17]

Wisconsin Promotion Goals, Messages and Methods

Promotion Goal	Communication Message (target)	Communication Method
Increase awareness Increase utilization	"Wisconsin Medicaid has changed its tobacco cessation coverage. Now it is simpler, better." (health plans and clinicians) Medicaid covers tobacco dependence treatment medications and counseling (plus detailed information on writing scripts, coding, etc.)	Individual, targeted pieces for health care providers, pharmacists, mental health and substance abuse counselors and staff PowerPoint slides (sets for primary care and mental health/substance abuse counselors) Laminated reminder sheet for health care providers
Increase awareness Dispel myths Increase consumer demand Increase utilization	"If you are a Medicaid member, you can afford to quit." (consumers)	Articles for member newsletters Brochures and posters for patients in English and Spanish

Source: Adsit, Rob. Phone interview. 13 Jan. 2016.

California—Using Incentives

In 2011, California was one of ten states chosen to participate in a five-year grant project, Medicaid Incentives for the Prevention of Chronic Disease Program, created by the ACA and administered by the Centers for Medicare and Medicaid Services.[18] California's project, Medi-Cal Incentives to Quit Smoking (MIQS),

provided eligible Medi-Cal (the name for the California Medicaid program) smokers who wanted to quit with a $20 gift card if they called the California Smokers' Helpline (the state quitline) and engaged in counseling. They could also receive free nicotine patches delivered to their home (this is noteworthy, as Medicaid enrollees are typically required to access medications through Medicaid-approved pharmacies, which can pose a barrier to obtaining cessation medications for Medicaid callers to state quitlines and other Medicaid enrollees[19]). The MIQS team consists of staff from the California Department of Public Health, the California Department of Health Care Services, and the state quitline.

The MIQS project's promotional goal was to produce materials that educate *both* Medi-Cal enrollees and their health care providers on the incentive program and available cessation support. To achieve this goal, the partners developed a multi-tiered strategy, including face-to-face meetings with and presentations to health care providers and Medi-Cal managed care plans, out-of-home advertising, and in-office posters and postcards. The specific goal of the posters was to encourage health care providers to speak with their patients about their tobacco use and urge them to quit. The posters encouraged Medi-Cal patients who smoke to ask their provider about quitting and about the MIQS $20 gift card incentive. The idea was that, after a provider and patient have an initial conversation about quitting, the patient would take the postcard home, call the Helpline, enroll in quitline services, and receive the $20 gift card.

Posters and postcards were created in the languages in which the state quitline offers counseling: English, Spanish, Chinese, Korean, and Vietnamese. The materials included culturally appropriate photos and a Quick Response (QR) barcode that allowed people to scan and view on a smart phone an in-language web page that provides additional cessation information.

Three years ago, 50 percent of California Smokers' Helpline callers were Medicaid enrollees. Over the past three years, that percentage has climbed to between 70 and 80 percent, presumably in large part as a result of the collaborative MIQS promotional efforts.[20]

Promising Practices For Promoting Medicaid Cessation Coverage

Understanding the Medicaid Cessation Coverage Landscape

In conversations with state health officials, the need for baseline coverage data was emphasized. Understanding the coverage landscape is critical for identifying an appropriate promotion strategy, building the case for your promotion approach, lining up critical collaborators, and defining intended outcomes to measure.

State experience shows that it is vital to collect Medicaid cessation coverage data before developing a promotion plan. Additional data necessary to inform strategy development include the Medicaid population's smoking prevalence; the proportion of the Medicaid population in fee-for-service versus managed care; and the number of Medicaid managed care plans). For example, if only 10 percent of your state's Medicaid population falls under fee-for-service, it might be appropriate to concentrate promotion efforts on Medicaid enrollees in managed care. Please see the appendix for a tool to assist with creating a promotion strategy.

"It is a fair amount of work to engage Medicaid-contracted HMOs, and you have to think about this up front. Use the data to determine your target audience and the best distribution strategy for that audience. Promoting to Medicaid-contracted providers takes buy-in from the HMOs, as they have the direct communication link with the Medicaid-contracted providers… you have to know who has this link!"

Wisconsin Tobacco Control Program

Collaboration and Partnership

An important distinction between collaboration and partnership is that people collaborate and organizations/systems partner. This distinction is highlighted in efforts to promote Medicaid cessation coverage. Examples of both approaches were evident in every state that shared their experiences about promotion. It is imperative for state tobacco control program staff to collaborate closely with state Medicaid agency staff (and, if necessary, Medicaid managed care plan staff) on developing and implementing promotional strategies. However, in order to share organizational resources (e.g., utilization data and provider lists), partnership at the organizational level, whether formal and informal, is also critical.

"You must have a handle on your baseline data! Don't waste time without knowing your plans first!"

California Department of Health Care Services Staff

About Medicaid Managed Care Plans

When partners from one state's Medicaid agency and the state tobacco control program came together to conduct a survey of more than a dozen Medicaid managed care plans to learn more about the specific cessation benefits being offered by each plan, they learned that actual contract language was very vague and that the cessation benefits were less than robust. In addition, compliance was lacking. Every plan was in a different place. Some plans did not know their patients' smoking rates. Now, this state is seeking to put in place a standardized benefit across all plans and the entire Medicaid population, thus addressing important coverage disparities. However, while it pursues this goal, the state continues to promote its existing Medicaid managed care cessation coverage to health care providers who serve Medicaid enrollees.

Vermont—Holistic Approach

The Vermont Department of Health developed a marketing strategy in partnership with their state Medicaid agency partner. The strategy, which includes systems change, data sharing and audience-appropriate promotion, resulted in a 57 percent increase in Medicaid registrants' calls to the state quitline and a 117 percent increase in completed coaching calls from January 2013 to August 2015.[21] The strategy has also led to increased online cessation and in-person group counseling registrations.[17]

The marketing strategy took a holistic approach by including systems change and data sharing in their promotion efforts:

- Systems change: The state expanded cessation counseling to all enrollees by activating three CPT codes for tobacco cessation and moving from using one type of NRT to using two types of NRT.
- Data sharing: Organizations began regular sharing and collaborative review of CPT codes by provider type, NRT utilization, provider referrals to the quitline, and hospital admissions for four related health conditions.
- Audience-appropriate promotion: Primary research resulted in changes to strategy (e.g., optimizing the website for mobile phones after learning that this population largely relies on mobile phones) and to messaging (e.g., personal stories through testimonials and rebranding the statewide network of quit counselors to VT Quit Partners). Providers were targeted with

"We've learned from different populations of smokers. There is distrust of some systems—this is especially true for Lesbian, Gay, Bisexual and Transgendered (LGBT) and Native American enrollees. There are different channels for promotion, and these are the channels they trust. You have to use community-specific promotional channels that they are already using."

California Department of Health Care Services Staff

mailings that provided information on the CPT codes, and a new section on 802Quits.org is dedicated to provider support.[22]

The importance of audience-appropriate promotion was noted in several conversations with state tobacco control staf, especially when promoting directly to Medicaid enrollees.

Mississippi—The Value of Collaboration and Partnership

In 2012, Mississippi's Tobacco Advisory Council (a legislatively-mandated advisory council of partners, subcontractors, and other organizations appointed by state and university officials[23]) proposed that the state Medicaid program exclude cessation medications from its monthly drug limitation. The Council cited recent studies and evidence related to return on investment and cost savings generated by reducing barriers to accessing cessation medications. However, because it did not involve the Medicaid program in the development of the proposal, the Council missed a key piece of information: the fact that Medicaid program has drug limitations. As a result, the proposal failed. Since then, a Medicaid partner (the Associate Director of Medicaid) has joined the workgroup and is assisting in the development of a revised proposal.[24] Including Medicaid in the process ensures that the effort employs the correct operational strategy and language.

Remember, Medicaid covers a wide range of benefits to its enrollees. As a major payer, Medicaid provides financing for safety-net hospitals, health centers, nursing homes, and community-based long-term care.[25] For some states it may be important to leverage external conveners or policy change efforts (e.g., a payment and delivery system reform or a quality improvement initiative) to bring public health and Medicaid together to focus on tobacco.

"Medicaid comes when they are called…their mission is not tobacco, but they will do what is required."
—State Tobacco Control Program Staff

Finding the Right Person

Who in a state Medicaid program should you talk with about promoting cessation benefits to enrollees and providers? In Vermont, there are three positions within the state Medicaid agency of particular importance to the ongoing collaborative marketing strategy:

1. Director of Operations—knows how things work in practice within the system of ICD-9, ICD-10 and CPT codes and how to change codes to make sure that codes are appropriate and be reimbursed.
2. Director of Pharmacy—especially interested in cost and what the data shows as probability that providers would use the new billing codes. This

position is a key ally in accessing utilization data.

3. Medicaid Medical Director—can engage in direct outreach to providers. In Vermont, the Medicaid Medical Director personally signed a letter to Medicaid providers stating that expanding access to coverage was the right thing to do.

Engaging those with decision-making authority in collaboratively developing promotional and policy-related strategies is important. Most often, people in these positions are dialed in to the current short- and long-term goals of the state Medicaid program and the state legislature. They can help ensure that the work you are trying to do is in alignment with those agendas.

Evaluate Impact

While a few of the states whose work is featured in this document either have not yet started their evaluation efforts or are in the process of publishing results and are therefore unable to share details about these efforts. However, all agreed that evaluation of the impact of promotion—primarily by looking at utilization data—is critical and another instance in which having a strong partnership with Medicaid pays off. Tobacco control programs can measure changes to reach and service utilization for quitlines using their own data, but they will need access to Medicaid data in order to measure changes in utilization of counseling and medications.

A published evaluation of Wisconsin's promotion campaign found statistically significant increases in pharmacotherapy claims and quitline registrations among Medicaid enrollees during the evaluation period.[10] This study may be helpful in identifying possible data sources for measuring utilization of treatments, as well as in illustrating the limitations of certain data sources. Based on the Massachusetts experience, critical questions to ask when developing an evaluation plan for a new promotion initiative include:

- Are Medicaid enrollees aware of the cessation coverage they have? Has this awareness changed over time?
- Do they understand how to access these covered benefits? Has this understanding changed over time?
- How many Medicaid enrollees utilize their cessation benefits and what benefits do they use?
- Are there changes in the rate of smoking among Medicaid enrollees or among those who use the benefits?[26]

State tobacco control programs typically track the type of health insurance status of state quitline callers, including whether they are Medicaid enrollees. Some state quitlines also try to track callers' insurance coverage by specific health plans, but callers are not always able to provide this information. Not having plan-specific quitline enrollment and utilization data can be a barrier when trying to work with Medicaid managed care plans to leverage support for expanding coverage and promotion, as well as when working to evaluate promotion efforts.

"A plan for evaluating the difference all of this effort will make is important from the very beginning—to you and to Medicaid."

Massachusetts Tobacco Control Program Staff

Policy is still important

While promoting covered treatments is a prerequisite to improving their utilization, improving Medicaid cessation coverage remains important as well. As stated by one state tobacco control staff person, "If the benefit is a bad one, it doesn't matter how much you promote it."

Changes in policy often take time. Vermont's tobacco control program initially found it difficult to initiate conversations with the state Medicaid agency. In opening this dialogue, the program took a collaborative, data-driven approach that acknowledged the state Medicaid agency's past efforts to help Medicaid smokers quit. Maintaining a steadfast, long-view focus on policy change, the program helped contextualize the data for their Medicaid partner and provide a full picture from which to begin developing policy-based solutions. It helped that the state tobacco control program was able to show Medicaid what public health was doing with public health dollars to reach and serve this population.[17]

"We said to our Medicaid partners, 'We'll bring the data that we have on Medicaid smokers and maybe you'll be interested in seeing it. It would be great to piece together your policy changes over the last few years to see the positive impact they have had on getting people to try to quit.'"

Chronic Disease Prevention Chief, Vermont

Conclusion

Promoting covered tobacco cessation treatments to Medicaid smokers and the health care providers who serve them is a prerequisite to increasing awareness and use of these treatments, which in turn is a prerequisite to reducing smoking rates in this population. To be effective, these promotions require close coordination between state tobacco control programs and state Medicaid agencies.

In reviewing promotions conducted in several states, two primary approaches emerge: direct promotion to Medicaid enrollees and promotion to health care providers who serve this population. In undertaking promotional efforts of both these types, state tobacco control programs are faced multiple challenges. Some of these challenges include a population that is often unaware that covered services exist and how to access them, and that may have trouble navigating the Medicaid system; providers who may be confused by variations in cessation coverage and barriers between fee-for-service and managed care and among different managed care plans and who may think that Medicaid smokers are not interested in quitting or able to quit; and the need to maneuver through complex systems and government bureaucracies while developing relationships with new partners or rebuilding previous relationships due to turnover of key personnel.

The promising practices emerging from conversations with state tobacco control program staff offer include the following key learnings:

- Take time to understand the Medicaid coverage landscape *before* deciding on a promotional strategy.
  - Review your state's cessation coverage and barriers to access care.
  - Make note of any inconsistencies in coverage before promoting care.
  - Determine what plans have the most tobacco users.
- Building and sustaining close relationships with key allies in the state Medicaid agency helps ensure that promotional plans align with that agency's organizational priorities and strategic objectives.

- Leadership partnering at the organizational level allows access to critical data, shared staffing, mutual support, and internal expertise.
- Developing a plan for evaluating the impact of promotional efforts in collaboration with partners ensures that progress is measured against shared goals.

Methodology

The promising practices in this document are built on an extensive review of key documents, reports and articles appearing in online publications, as well as promotional documents and collateral materials used by state tobacco control programs in their promotional efforts. Sources for data on Medicaid include the Kaiser Family Foundation website and published studies related to the Medicaid population and tobacco use. Conversations were held with representatives from state tobacco control programs in California, Massachusetts, Mississippi, Vermont, and Wisconsin.

Acknowledgements

The American Lung Association would like to thank Tamatha Thomas-Haase, Rob Adsit, Rebecca Brookes, Anna Landau, Jessica Safier, Vickie Tucker, Rhonda Williams, and Amy Winter for their willingness to share their wisdom with others working hard to address tobacco-related health and coverage disparities.

References

1 US Department of Health and Human Services. The health consequences of smoking—50 years of progress: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 2014. Available at http://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf

2 Jamal A, Homa, D, O'Connor E, Babb S, Caraballo R, Singh T, Hu S, King, B. Current Cigarette Smoking Among Adults — United States, 2005–2014. MMWR Morb Mortal Wkly Rep 2015; 64(44);1233-1240. Retrieved 2.9.16 from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6444a2.htm?s_cid=mm6444a2_w

3 Xu X, Bishop EE, Kennedy SM, Simpson SA, Pechacek TF. Annual healthcare spending attributable to cigarette smoking: an update. Am J Prev Med 2015;48(3):326-333.

4 Armour BS, Finkelstein EA, Fiebelkorn IC. State-level Medicaid expenditures attributable to smoking. Prev Chronic Dis 2009;6(3):A84. Smoking attributable Medicaid costs are updated from 2004 to 2014 dollars, using the Medical Consumer Price Index. Retrieved 12.18.15 from http://www.cdc.gov/pcd/issues/2009/jul/08_0153.htm

5 US Public Health Service. Treating tobacco use and dependence: 2008 update. Clinical practice guideline. Rockville, MD: US Department of Health and Human Services, US Public Health Service; 2008. Available at http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html

6 American Lung Association. Cessation Coverage Database. Retrieved 4.26.16.

7 Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs — 2014. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

8 US Public Health Service. Treating tobacco use and dependence: 2008 update. Clinical practice guideline. Rockville, MD: US Department of Health and Human Services, US Public Health Service; 2008. Available at http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html

9 Richard P, West K, Ku L. The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts. (2012) PLoS ONE 7(1): e29665. Retrieved 2.5.16 from http://dx.plos.org/10.1371/journal.pone.0029665

10 Land T, Warner D, Paskowsky M, et al. Medicaid coverage for tobacco dependence treatments in Massachusetts and associated decreases in smoking prevalence. PLoS One 2010;5:e9770.

11 Land T, Rigotti NA, Levy DE, et al. A longitudinal study of Medicaid coverage for tobacco dependence treatments in Massachusetts and associated decreases in hospitalizations for cardiovascular disease. PLoS Med 2010;7:e1000375.

12 Richard P, West K, Ku L. The return on investment of a Medicaid tobacco cessation program in Massachusetts. PLoS One 2012;7:e29665.

13 McAfee T, Babb S, McNabb S, Fiore MC. Helping smokers quit—opportunities created by the Affordable Care Act. N Engl J Med 2015;372:5-7. Available at http://www.nejm.org/doi/pdf/10.1056/NEJMp1411437

14 Singleterry J, Jump Z, Lancet E, Babb S, MacNeil A, Zhang L. State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Coverage — United States, 2008– 2014. MMWR Morb Mortal Wkly Rep 2014; 63(12);264-269. Retrieved 5.10.16 from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6312a3.htm

15 Keller, PA, et al. Increasing Consumer Demand Among Medicaid Enrollees for Tobacco Dependence Treatment: The Wisconsin "Medicaid Covers It" Campaign." American Journal of Health Promotion: 2011, Vol. 25, No. 6, 393-395.

16 Ku L, Bruen B, Steinmetz E, Bysshe T. Medicaid Tobacco Cessation: Big Gaps Remain in Efforts to Get Smokers to Quit. Health Aff January 2016 vol. 35 no. 1 62-70. Retrieved 2.5.16 from http://content.healthaffairs.org/content/35/1/62.short

17 Adsit, Rob. Phone interview. 13 Jan. 2016.

18 Ku L, Zauche D, Forbes E. Saving Money: The Massachusetts Tobacco Cessation Medicaid Benefit. A Policy Paper. Partnership for Prevention. Retrieved 2.20.16 from http://www.prevent.org/data/images/roi%20policy%20paper_a.pdf

19 North American Quitline Consortium. Barriers to Medicaid Payment for Quitline Services – Status and Solutions. Retrieved 2.10.16 from http://www.naquitline.org/?page=medicaid#Q08

20 Safier, Jennifer. Phone interview. 11 Jan. 2016.

21 Brookes, Rebecca. Effectively Reaching the Medicaid Population with Tobacco Cessation. Poster presentation. American Public Health Association Annual Meeting. Delivered November, 2015.

22 Williams, Rhonda and Brookes, Rebecca. Phone interview. 26 Jan. 2016.

23 2010 Mississippi Code. TITLE 41 - PUBLIC HEALTH. Chapter 113 - Tobacco Education, Prevention and Cessation Program. Retrieved 2.10.16 from https://law.resource.org/pub/us/code/ms/ms.xml.2010/2010/title-41/113/41-113-9/index.html

24 Winter, Amy and Tucker, Vickie. Phone interview. 28 Jan. 2016.

25 Paradise J. Medicaid Moving Forward. Issue Brief. The Henry J. Kaiser Family Foundation. Retrieved 1.17.16 from http://kff.org/health-reform/issue-brief/medicaid-moving-forward/

26 Ku L, Zauche D, Forbes E. Saving Money: The Massachusetts Tobacco Cessation Medicaid Benefit. A Policy Paper. Partnership for Prevention. Retrieved 2.20.16 from http://www.prevent.org/data/images/roi%20policy%20paper_a.pdf

Appendix: Crafting a Promotion Strategy

Coverage-Related Data Necessary for Crafting Promotion Strategy

The specific coverage data is critical to creating accurate promotion materials. The data collected should be able to answer the following questions:

Data Needed:	Your strategy to collect the data:
What cessation benefit is offered? Does it differ between Fee-for-Service and Managed Care plans or between Managed Care Plans?	
What are the barriers to accessing cessation treatments in each plan?	
What is the tobacco use prevalence for the Medicaid population? If available, what is the prevalence by plan membership?	
What is the utilization of counseling by plan?	
What is the utilization of pharmacotherapy by plan?	
What data do you need that you do not have access to?	

Other Resources:

In addition to coverage data, there any many resources available to states. The American Lung Association has many resources at www.lung.org/cessationta or by contacting CessationTA@lung.org.