# CDC PUBLIC HEALTH
POLICY INFORMATION BRIEF

## CDC's 6|18 Initiative:
State Improvements related to Tobacco Cessation* through Increased Collaboration between Medicaid and Public Health

### How 6|18 Accelerated Existing Public Health Program Efforts

The 6|18 Initiative was intended to facilitate collaboration between state public health and Medicaid agencies to increase reimbursement for, and uptake of, evidence-based interventions, including interventions related to tobacco cessation.[1] State teams received no additional funding but had access to technical assistance provided by Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), the Center for Health Care Strategies (CHCS), the Association of State and Territorial Health Officials, and the National Association of Medicaid Directors (NAMD). Financial support was provided to CHCS and ASTHO by the Robert Wood Johnson Foundation (RWJF).

State teams also participated in a technical support learning network with subject matter experts (SMEs), and shared information and experiences with other 6|18 state teams during and after the initiative period ended.[2] The 6|18 strategies are now integrated into CDC Programs, including the National and State Tobacco Control Program. We spoke to seven state teams and have highlighted what we learned. **Pages 5 and 6** provide a quick view of reported achievements by state.

*When CDC references tobacco in this document, we are referring to commercial tobacco and not the sacred and traditional use of tobacco by some American Indian communities.

### State Reported Policy-related Achievements:

- Removal of prior authorization requirements for FDA-approved cessation medications under Medicaid (NY, SC, CO,)
- Elimination of cost-sharing for FDA-approved cessation medications under Medicaid (CO)
- Allowing public health nurses to provide cessation counseling in rural areas for Medicaid beneficiaries (CO)
- Granting pharmacists authority to dispense all cessation medications and offer counseling to Medicaid beneficiaries (CO)
- Improving medication access in outlying and tribal areas through Indian Health Services (IHS) pharmacists (AK)
- Developed a standing order for pharmacists to dispense over-the-counter nicotine replacement therapies (NC)

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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## State Teams Outlined Their Achievements

Categories of state achievements: 1) data collection, monitoring, and analysis, 2) Medicaid coverage policy changes (aimed at increasing access and removing barriers), and 3) promotion to increase utilization of new or existing benefits.

### States Share Achievements Related to Data Collection, Monitoring, and Analysis

Public health and Medicaid staff worked together to gather information on state-specific Medicaid tobacco cessation coverage, including types of cessation counseling and medications covered, and barriers to accessing covered treatments (e.g., copayments or prior authorization requirements).[3] Medicaid sets policies for Medicaid enrollees receiving fee-for-service care but capitated Managed Care Organizations (MCOs), which cover the majority of Medicaid enrollees in many states, often establish their own operational policies for Medicaid. The majority of Medicaid beneficiaries in Minnesota, New York, Rhode Island, and South Carolina are covered by MCOs. Teams in these states worked together to survey MCOs about cessation coverage policies to identify areas for improvement. State teams in **Minnesota, New York, Rhode Island,** and **South Carolina** used this information to better understand current coverage and help bring coverage into alignment with current state law as needed. **Colorado** and **North Carolina** both reported where staff incorporated tobacco cessation-related objectives to assess MCO performance in the future. Five state teams discussed collecting and analyzing data to measure changes in Medicaid enrollees' utilization of cessation treatments. Teams used data sources such as Medicaid encounter or claims data **(New York, Rhode Island, Colorado),** all-payer claims data **(Minnesota),** actuarial analyses **(South Carolina),** or Quitline and digital media data **(Colorado, South Carolina). South Carolina** modified data sharing policies so public health staff could analyze Medicaid claims data. **Colorado** developed tobacco-related performance standards to assess newly created Medicaid Regional Accountable Entities, a new form of managed care entity in the state. **North Carolina** developed tobacco performance goals for its new managed care system.

## State Teams Reported Medicaid Coverage Policy Changes (Increasing Access and Removing Barriers)

**New York** and **Rhode Island** used survey data gathered from MCOs and data on Medicaid beneficiaries' use of tobacco cessation treatments to encourage MCOs to increase coverage of proven tobacco cessation treatment benefits and remove barriers that impede access.

The **Colorado** Medicaid program eliminated copayments for smoking cessation medications approved by the U.S. Food and Drug Administration (FDA) congruent with the 2015 United States Preventive Services Task Force (USPSTF) recommendations for behavioral and pharmacotherapy interventions for tobacco smoking cessation.[4]

Following this change, state Medicaid claims data indicated that utilization of these medications rose by about 60 percent.[5]

**More state achievements are outlined below in the state specific section.**

## States Describe Promotional Strategies to Increase Utilization of New or Existing Benefits

Promotional efforts were reported as a strategy used in six of the state teams to inform patients and providers about new benefits and encourage clinicians to screen patients for tobacco use and discuss tobacco cessation with their patients who reported smoking. Public health agencies and MCOs in some states developed educational materials and outreach campaigns for healthcare providers and Medicaid beneficiaries to increase awareness and use of covered tobacco cessation treatments.

**Educational materials** for providers highlighted the importance of helping patients quit smoking or using tobacco products, clarified what smoking and tobacco cessation treatments were covered, how to bill for them, and provided procedure or diagnostic codes for tobacco cessation-related counseling.

**Television and digital advertising campaigns** also included promotion. New York: 1) focused on Medicaid beneficiaries to spread the message that help quitting was available through Medicaid, and 2) promoted the Medicaid cessation benefits to healthcare providers. State conducted surveys of MCOs in New York indicated that providers in the state appreciated the information.

To reach diverse populations, South Carolina updated provider education materials to communicate recent Medicaid coverage changes. More state specific achievements are outlined below. North Carolina developed educational materials for physicians. Six out of the seven states interviewed promoted state Quitline cessation services or coverage to providers, Medicaid enrollees, or both. The education campaigns mentioned here and state Quitlines in these states were partly funded with state tobacco control program funding from CDC's Office on Smoking and Health (OSH). These achievements note only those states we interviewed during the 6|18 Initiative.

## ALASKA

Alaska Tobacco Prevention and Control Program

**Coverage**: Alaska Medicaid developed and started implementing a plan to eliminate copayments for FDA-approved tobacco smoking cessation medications and cessation-related office visits on an administrative basis.[5] Explored increasing access to tobacco cessation medications for Medicaid beneficiaries in outlying rural areas, who are often Alaska Natives, by using Indian Health Service (IHS) pharmacists. The state leveraged existing authorities by IHS to increase access.

Note: To qualify for Medicaid reimbursement, medications must be prescribed by a covered medical provider. This rule applies even to over-the-counter (OTC) nicotine replacement therapies (NRTs) like the nicotine patch, gum, or lozenge.

## COLORADO

Quit tobacco | Department of Public Health & Environment (colorado.gov)

**Data:** Public Health & Medicaid developed potential tobacco performance standards for Regional Accountable Entities. Evidence of increased use of Quitlines, greater Medicaid claims for counseling and medications.

**Coverage:** Removed Medicaid tobacco cost-sharing for cessation medications. Planning to remove prior authorization for varenicline. Worked with the State Board of Pharmacy to expand pharmacists' scope of practice to dispense all tobacco smoking cessation medications under a similar policy and offer cessation counseling. Additionally, public health nurses were authorized to provide tobacco cessation counseling to Medicaid beneficiaries in rural areas

**Promotion:** Public Health developed multi-mode media campaign for patients and providers to include educational materials and webinars to increase provider understanding of cessation medications and counseling. Colorado also developed a digital communications strategy aimed at Medicaid enrollees who smoked, which resulted in a substantial increase in Medicaid enrollee calls to the state Quitline. Find more information shared here: State Spotlight | Colorado: Increasing Use of Medicaid Tobacco Cessation Benefits (chcs.org).

## MINNESOTA

TFC—Tobacco Prevention and Control—Minnesota Department of Health (state.mn.us)

**Data:** Public Health & Clearway surveyed MCOs to clarify tobacco policies. They were planning to analyze state all payer claims database and CAHPS data.

**Coverage:** Minnesota state legislature approved policy changes eliminating copayments for tobacco smoking cessation services and requiring coverage of all FDA-approved medications shortly before the state started work on the 6|18 Initiative. Minnesota used findings from their MCO survey to discuss the recent legislative changes with MCOs and help bring them into compliance and to encourage cessation.

**Promotion:** Public Health promoted cessation medication use to patients and providers, developed public educational materials in ten languages and launched an outreach campaign to increase Medicaid enrollees' use of the state Quitline.

## NEW YORK

The New York State Tobacco Control Program (NYS TCP)

**Data:** Medicaid surveyed 18 MCOs to identify where barriers such as prior authorization or other limits existed. Had prior analyses of claims and encounter data showing increases in Medicaid medication use and counseling.

**Coverage:** Changed coverage to include all FDA-approved tobacco smoking cessation medications, removed a two-course limit on medication use, and discontinued the need for prior authorization (except for brand name drugs where a generic equivalent was available). Public Health & Medicaid worked with MCOs to expand access to cessation services but did not require standardization.

**Promotion:** Continued media campaigns to increase awareness of Medicaid cessation services.

## NORTH CAROLINA

North Carolina Tobacco Prevention and Control Branch Home Page (ncdhhs.gov)

**Data:** Included tobacco cessation performance goals for MCOs.

**Coverage:** North Carolina moved to require all MCOs to contract with the public health Quitline for telephone cessation services. While CMS permits the use of Medicaid funds to cover the cost of counseling provided to Medicaid enrollees by Quitlines, most state Quitlines, both among case study states and nationally, do not receive Medicaid matching funds.[6,7] Explored policies that could be adopted with administrative authority. The Department of Health and Human Services shared plans (2018) to develop a standing order to permit pharmacists to dispense OTC NRTs to Medicaid beneficiaries.

**Promotion:** Developed educational materials and cessation training course for physicians.

## RHODE ISLAND

Tobacco Control Program: Department of Health (ri.gov)

**Data:** Surveyed MCOs about cessation coverage policies.

**Promotion:** Using findings from their MCO survey, Rhode Island developed matrix showing variation in cessation coverage policies across MCOs and shared it with providers to explain what was covered by each MCO plan. Medicaid worked closely with their State Innovation Model ( SIM) project to disseminate information about effective tobacco cessation methods to providers.

## SOUTH CAROLINA

Tobacco Cessation | SCDHEC

**Data:** Conducted MCO survey about cessation coverage policies prior to policy changes. Changed data sharing policies to increase access of public health staff to Medicaid data.

**Coverage:** South Carolina Medicaid provided matching funds to the statewide tobacco cessation Quitline, which is operated by the State Department of Health and Environmental Control. The state Medicaid program required comprehensive coverage for tobacco smoking cessation in both fee-for-service (FFS) and managed care plans, eliminated copayments, and removed requirements for prior authorization related to behavioral and pharmacotherapy interventions for smoking cessation. Changes were implemented administratively, without legislation.

**Promotion:** Updated provider guidance about policy changes. Medicaid provided 50% match for Public Health Quitline services.

*MCO = Medicaid managed care organizations

## Lessons Learned from a set of State Public Health and Medicaid teams on 6|18 focused on Tobacco Cessation

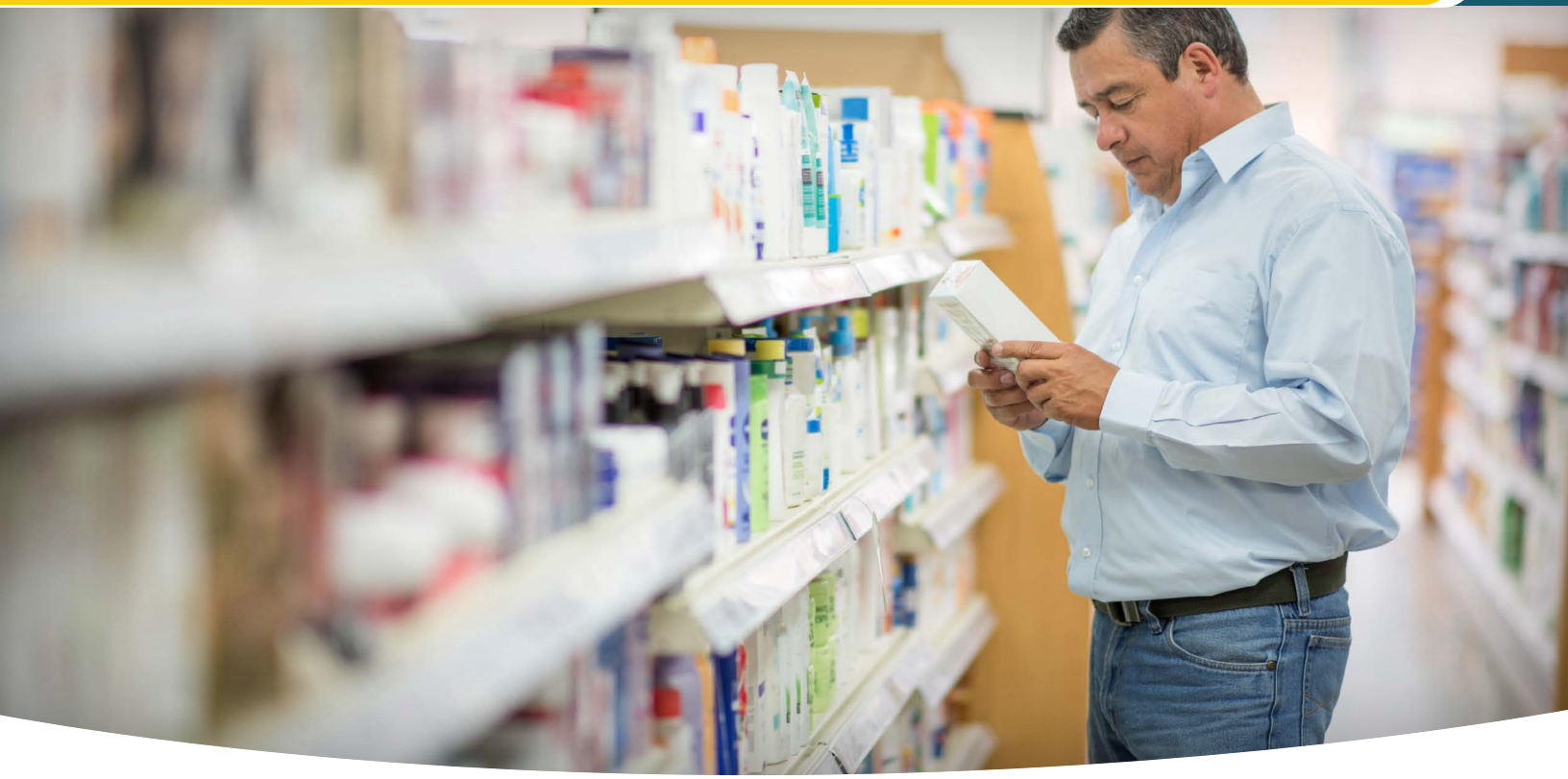
In 2018, representatives from state public health and Medicaid teams engaged in the CDC's 6|18 Initiative's 2016 and 2017 technical assistance cohorts (Alaska, Colorado, Rhode Island, and South Carolina, Minnesota, New York, and North Carolina) shared their experiences. Focus was given to describing state context, challenges, facilitating factors, and lessons learned when these states engaged in efforts to improve tobacco cessation. **Table 1** provides a summary of what state teams reported related to structural factors that influenced the partnership development and 6|18 policy achievements.

### State Context Before Joining the 6|18 Initiative

Medicaid initiatives in some states served as foundational to their 6|18 efforts, accelerating work toward common goals, including but not limited to their tobacco cessation coverage. **Alaska, Colorado, Rhode Island,** and **North Carolina** made efforts to expand, modify, or transition to Medicaid managed care systems. Alaska was in the process of implementing a redesign of their state Medicaid program, and both **Alaska** and **Colorado** were making changes to their Medicaid information technology (IT) systems. **Colorado, Minnesota, New York,** and **Rhode Island** had large CMS State Innovation Model (SIM) awards to test healthcare delivery system reforms, including value-based payment reforms, and **New York** had a major Medicaid Delivery System Reform Incentive Payment (DSRIP) Section 1115 waiver.[8]

### State Feedback and Reflections on Strengthening Relationships and Leveraging Resources

The 6|18 Initiative collaborations helped state public health and Medicaid agencies combine and leverage their skills and resources.[9] State teams shared their experiences from building cross agency relationships. Public health staff contributed subject matter expertise related to tobacco cessation, data analysis capacity and communication and promotion channels like campaigns promoting toll-free state tobacco Quitlines and educational materials for clinicians and the public. Medicaid staff contributed expertise in Medicaid policies, claims data and management, including understandings of benefit coverage and reimbursement policies, knowledge of billing codes and administrative changes, and the ability to communicate with managed care organizations (MCOs). State teams reported that working together through the 6|18 Initiative helped them navigate the areas of overlap and find opportunities to implement policies and strategies to help beneficiaries more easily access tobacco cessation benefits (e.g., removing prior authorization requirements or cost-sharing for FDA-approved cessation medications under Medicaid).



## What CDC Learned from States on Partnership

State teams reported that collaboration increased access to, and use of, evidence-based Tobacco Cessation interventions for Medicaid beneficiaries. Collaborations between public health and health care are key in addressing population health problems. We learned from states highlighted here that CDC's 6|18 Initiative helped strengthen partnerships between state public health and Medicaid agencies and this collaboration helped increase access to and use of evidence-based tobacco cessation interventions for Medicaid beneficiaries. An earlier case study report found that such collaborations had previously been rare, despite the importance of tobacco cessation to both entities in most states.[10]

Because the 6|18 Initiative did not provide funding (only customized technical assistance), agencies employed existing resources to develop and implement their action plans. Interview respondents noted that the support of CDC and CMS, combined with customized technical assistance (e.g., consultation with subject matter experts on strategies), encouraged agencies to work together toward shared goals. State teams explained that their collaborative update to processes included ensuring management buy-in and support, cultivation of staff-level relationships, and holding regular planning meetings that included staff across both agencies. State teams update to reported gaining a better understanding of the organizational differences, processes, and perspectives of the other agency noting that this was key to their success.

States also reported **continued collaborations** between public health and Medicaid agencies (even after their initial one-year timeframe ended). State teams reported that relationships developed through the 6|18 Initiative have the ability to help them address other areas of mutual interest, including other 6|18 Initiative conditions such as hypertension or diabetes, or other public health problems like substance use.

## Table 1: State Participant Reported Structural, Legislative, and Medicaid Policy Factors related to 6|18 Projects

| State and 6\|18 Project Period | Structural Factors and Existing Efforts | Other Medicaid Policy Factors |
|---|---|---|
| **Colorado** (2016–17) | ■ Public Health and Medicaid in separate agencies<br>■ Public Health and Medicaid had tobacco collaborations prior to the 6\|18 Initiative | ■ Medicaid expansion state<br>■ State Innovation Model grant<br>■ Medicaid staff busy with other priorities, including the Regional Accountable Entities initiative, a new managed care system. |
| **Minnesota** (2016–17) | ■ Public Health and Medicaid co-located in Department of Health and Human Services<br>■ Worked with Clearway Minnesota, a nonprofit tobacco control organization<br>■ Public Health and Medicaid had collaborated on tobacco issues before the 6\|18 Initiative.<br>■ Recent state legislation expanded scope of Medicaid tobacco cessation | ■ Medicaid expansion state<br>■ State Innovation Model grant |
| **New York** (2016–17) | ■ Public Health and Medicaid co-located in Department of Health<br>■ Extensive prior Public Health/Medicaid collaboration on tobacco<br>■ Recent efforts to increase cessation for behavioral health and fee-for-service patients<br>■ Strong agency leadership support | ■ Medicaid expansion state<br>■ State Innovation Model (SIM) grant<br>■ Delivery System Reform Incentive Payment waiver |
| **Rhode Island** (2016–17) | ■ Public Health & Medicaid in separate agencies | ■ Medicaid expansion state.<br>■ SIM grant<br>■ Developing a Medicaid accountable care system |
| **South Carolina** (2016–17) | ■ Public Health and Medicaid in separate agencies but are physically located in the same building<br>■ Sharing a car to attend 6\|18 meeting in Atlanta facilitated collaboration and plans<br>■ American Lung Association helped develop managed care organization survey | ■ Not Medicaid expansion state |
| **Alaska** (2017–18) | ■ Public Health and Medicaid co-located in Department of Health and Human Services<br>■ Strong agency leadership supporting cross agency collaboration<br>■ Had previous collaborations on other topics (Winnable Battles)<br>■ Selected 4 areas for 6\|18 initiatives, which required more energy<br>■ Medicaid offered training sessions (Medicaid 101) to inform public health staff | ■ Medicaid expansion began in 2015<br>■ Major state health reform implementation (Healthy Alaska)<br>■ Planning a managed care demonstration<br>■ New claims data base |
| **North Carolina** (2017–18) | ■ Medicaid and Public Health both in Department of Health and Human Services | ■ Not Medicaid expansion state<br>■ Shifting from fee for service to managed care |

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