AME

Medicaid Tobacco Cessation Coverage in Oklahoma: A Case Study in Leveraging Systems and Partnerships

Comprehensive Tobacco Cessation Benefit:

- Nicotine patch
- Nicotine gum
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine inhaler
- Bupropion
- Varenicline
- Individual counseling
- Group counseling
- Phone counseling

Introduction

Oklahoma's adult smoking rate has historically been among the highest in the nation at 23.7 percent (the national rate is 19.0 percent).[1] However, major progress was announced in January 2013: the smoking rate for members of SoonerCare (Oklahoma's Medicaid program) saw a five percent drop from 48 percent in 2008 to 43 percent in 2013. In addition, the Oklahoma Tobacco Helpline has seen an 82 percent increase in the number of SoonerCare callers from 2009 to 2012, and nearly a doubling of calls in the last year alone.[2] These successes indicate that tobacco users on SoonerCare are interested in quitting, interested in using evidence-based treatments to do so, and can, in fact, be successful.

These are all reasons for Oklahoma to continue to work to ensure all Medicaid enrollees have easy access to a comprehensive tobacco cessation benefit. However, despite 2010 Patient Protection and Affordable Care Act (ACA) provisions that encourage coverage of evidence-based cessation treatments for Medicaid enrollees,[3] not all states have fully embraced this type of effort,[4] signifying a critical missed opportunity to reduce smoking-related death and disease among the nation's most vulnerable population, and to reduce ever-mounting smoking-attributed healthcare costs. A 2014 study showed that while many states are increasing coverage of cessation treatments, they are also increasing barriers to that coverage.[5]

Barriers to Accessing Cessation Benefits:

- Copays
- Prior authorization requirements
- Limits on length of treatment
- Limits on quit attempts per year or lifetime
- Requirements to try one treatment before another
- Requirements to enroll in counseling before receiving medication

The improved health and wellbeing of tobacco users on SoonerCare as a result of near-comprehensive[6] and almost barrier-free tobacco cessation coverage is a reflection of a solid foundation of long-term relationships across state agencies. Oklahoma's recipe for success is a collective commitment among partners to improve the health of the state, and the leveraging of institutional strengths to make continued improvements to cessation coverage.

GUIDE TO THE READER

Purpose

This case study explores Oklahoma's "real world" experience of designing and implementing near-comprehensive tobacco cessation coverage in SoonerCare (the Oklahoma Medicaid program) that has resulted in the successes noted above, as well as other promising outcomes. The roles of partners, the environmental and infrastructure support leveraged to bolster success, challenges faced and lessons learned are highlighted to guide and encourage those working toward comprehensive, barrier-free tobacco cessation coverage in Medicaid in other states.

Key Agencies and Acronyms

Oklahoma Health Care Authority (OHCA)

OHCA is the primary entity in the state of Oklahoma charged with administering and controlling costs of Oklahoma's Medicaid system, called SoonerCare, and ensuring that those who rely on state-purchased healthcare are served in a "progressive and positive system."[7] In this report OHCA is sometimes referred to as "the Medicaid Department."

Oklahoma Tobacco Settlement Endowment Trust (TSET)

In 2000, the Oklahoma Constitution was amended by a vote of the people to place a portion of each year's Master Settlement Agreement (MSA) payments into an endowment trust fund. The protection of MSA funds through TSET is unique among most states and has kept Oklahoma's tobacco control priorities safe from drastic state budget cuts being faced by tobacco control programs in many other states. In this report, TSET is sometimes referred to as "the Trust."

Oklahoma State Department of Health (OSDH)

OSDH is the primary public health agency in Oklahoma. OSDH's Center for the Advancement of Wellness works to reduce obesity and tobacco use in Oklahoma by working with communities, workplaces, schools and other groups to enact policy, environmental and social norm changes.[8] In this report, OSDH is sometimes referred to as "the Health Department."

Oklahoma Tobacco Helpline (OTH)

Launched in September 2003, the OTH is primarily funded by TSET, in partnership with OSDH, OHCA, Oklahoma Employees Group Insurance Division, and the Centers for Disease Control and Prevention.[9] In this report, OTH is sometimes referred to as "the Helpline."

Methodology

This case study is built upon extensive review of key documents, reports and articles appearing in online publications. Sources for data on Medicaid include American Lung Association data, the Kaiser Family Foundation website and key published articles related to the Medicaid population and tobacco use. Key-informant interviews were conducted with representatives from the OHCA, TSET, OSDH and the University of Oklahoma Health Sciences Center.

Audience

The primary audience for this case study is state tobacco prevention and control and state Medicaid agency staff. Secondary audiences include the greater public health community, healthcare systems and decision makers.

BACKGROUND

According to the Centers for Disease Control and Prevention (CDC), Oklahoma ranks 45th in the United States for adult smoking prevalence,[10] meaning the state has one of the highest smoking rates in the nation. Approximately 6,200 Oklahomans die each year from tobacco related causes.[11] Oklahoma's adult smoking rate in 2012, while lower than the 26.1 percent in 2011, was 23.7 percent compared to 19.0 percent nationally.[12] For Oklahoma Medicaid enrollees, the adult smoking prevalence rate jumps to 43 percent.[13]

The importance of supporting Medicaid smokers specifically in quitting is well documented. Not only are rates of smoking much higher among Medicaid enrollees than those of the general population (30.1 percent versus 18.1 percent),[14] Medicaid enrollees are by definition low-income, and therefore less able to pay for tobacco cessation treatments themselves. There are also critical cost-savings to be realized by covering evidence-based treatments for this population of smokers. Medicaid expenditures attributable to smoking total nearly $40 billion annually, representing about 15 percent of all expenditures.[15] Smoking-related diseases cost Medicaid programs an average of $833 million per state in 2013.[16]

Surprisingly, despite these and other compelling data, most state Medicaid plans do not cover all treatments proven effective in helping smokers quit, and all states have at least one policy in place that makes it ***harder*** for a Medicaid enrollee trying to quit to access treatments that are covered.[17] Only two states, Indiana and Massachusetts, provide comprehensive coverage for all Medicaid enrollees.[18] An additional seven states cover all cessation treatments except phone counseling for all Medicaid enrollees: Connecticut, Maine, Minnesota, North Dakota, Ohio, Pennsylvania, and Vermont.[19] Clearly, an exploration of state efforts to successfully expand coverage and decrease barriers to accessing that coverage is necessary.

Oklahoma's Medicaid tobacco cessation benefit went into effect in 2006 and began as coverage of specific cessation medications, eventually expanding to the full range of FDA-approved cessation medications, including over-the-counter nicotine replacement therapies, and individual and quitline counseling. It was soon after the benefit started that the Medicaid Department first sat down with the Trust and the Health Department to be more deliberate about applying evidence-based practices to coverage. Nearly nine years and many iterations of coverage later, Oklahoma's Medicaid population has access to near-comprehensive and almost barrier-free tobacco cessation coverage, and tobacco use rates in this population are decreasing.

"This is a story of years and years of taking baby steps. We started with return-on-investment data and showed Medicaid the results. They were then worried about how much coverage would cost, so we encouraged an incremental approach. Don't be afraid to put stopgaps in if your partners are worried about the money. Or, open it wide up and put stopgaps in later. The OHCA is under tremendous pressure to save money, and thankfully the science has advanced to show how cessation works to do just this. The Massachusetts study helped. Don't be afraid to find creative ways to make the system work for you. Oklahoma's approach is a great marriage between the science of cessation and the science of Medicaid!"
—OSDH (Health Department)

BUILDING BLOCKS FOR SUCCESS

Systems Thinking

Since 2008, the Trust, the Medicaid Department and the Health Department have worked together on a "systems approach" to cessation, with the Trust playing a lead role as a primary funder of Medicaid systems-based improvement efforts. Taking a systems approach allows for quick identification of underlying causes of an issue needing change and where to work to most effectively address it. Solutions that address as many problems as possible are identified, and, once the underlying structure is understood, the most appropriate leverage points to effect change within the system are clear.

Medicaid's Maternal and Child Health Unit is where, in 2008, the first formal partnership between the key agencies began. During a meeting of the state's Perinatal Advisory Task Force in which the Health Department was invited to give an overview of cessation activities in the state, Medicaid was made aware of the Trust's mission to fund systems-change efforts. A subsequent Trust grant to Medicaid to work with prenatal care providers to implement evidence-based clinical systems-change strategies was the beginning of a strong working relationship that also resulted in the hiring of a full-time Medicaid employee dedicated to this work. Over time, the focus of this position has changed from prenatal provider systems change to state-level partner engagement on cessation.

"Systems level changes are the lesson here. If you do not force yourself to look at big picture changes that you must dedicate resources to, you will not change the health of your state."
—OSDH (Health Department)

TACTIC

The structure of state Medicaid agencies varies. However, all Medicaid agencies are required by federal law to cover a comprehensive set of benefits and services for children known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) programs. All Medicaid agencies have an EPSDT coordinator, and this is a great person to start with when trying to identify potential champions. While EPSDT coordinators have a specific set of duties assigned to them, they are often public-health minded supporters, are linked to the medical division within the agency, and understand that addressing tobacco use is key to the health and wellbeing of children.

Aside from historic, trusted and respected relationships among layers of leadership within the key agencies, strategy to craft Medicaid agency infrastructure that makes the focus on cessation permanent has been highly successful and methodically implemented in Oklahoma. By leveraging administrative matching rates (costs incurred by states in administering the Medicaid program that are matched by the federal government at a 50 percent rate), the Trust now funds four positions responsible for identifying and fostering internal Medicaid cessation champions, incorporating wellness and cessation efforts into existing opportunities within the Medicaid agency ("in-reach" vs. outreach), and working with Medicaid providers.

This strategy to leverage administrative matching funds is also used to support the SoonerQuit for Women mass media campaign. This campaign, which is targeted to the Medicaid population, has played an important role in increasing the Helpline's reach to Medicaid enrollees.[20] Capitalizing on administrative matching funds has gone a long way, with not a single dollar coming from the state Medicaid budget, but from the Trust—funds intended for supporting tobacco users in quitting.

"We made the decision that if we were focusing on systems-level change, it had to come from within…We knew we needed to stick our nose to the ground, learn the language of insurance, how they make decisions and where they decide to take risks…Partnerships get the door open, and you have to have partners who are willing to listen. However, you better come in that door with the business case to support your innovation. This is what sets us apart—someone has to know the mechanism to operationalize this, and that person is inside Medicaid."
—TSET (the Trust)

TACTIC

Embed someone within the network you want to change! Hire a person who knows that system well and who can translate cessation into the system's language and agenda. How can we make the most of a system on behalf of cessation when we don't even know where the essential leverage points are?

Cross-Agency Work Group

After seeing data reported in the March 28, 2014 Morbidity and Mortality Weekly Report on tobacco cessation[21] the Medicaid and Health Departments launched a joint work group with the aim to improve access to tobacco cessation treatments among Medicaid enrollees by December 31, 2014. Over the course of multiple planning sessions, the agencies identified and prioritized several potential approaches for achieving this objective. The two strategies chosen by the group were to:

- **Remove barriers to obtaining tobacco cessation medications and counseling.** At this time, barriers to obtaining cessation treatments among Medicaid enrollees included prior authorization for medications, copayments, a requirement to enroll in counseling in order to receive cessation medications, duration limits, and annual limits on quit attempts. The work group decided to focus first on elimination of copayments and prior authorization for all cessation medications covered by Medicaid. Steps included:
  - Identify the appropriate channels for internal policy change
  - Collaborate with Medicaid's Health Policy Unit
  - Review and analyze available data to assess utilization and possible budget impacts
  - Determine if cost savings would be sufficient to pursue an administrative policy change process
  - Obtain leadership approval

  Medication copayments and prior authorization were officially eliminated on September 1, 2014, the date set by the Health Policy Unit. While it is too early to begin analyzing claims data to assess the impact of the change, the state's work group will focus on this assessment in 2015.
- **Increase the number of referrals to the Oklahoma Tobacco Helpline and increase the rates of enrollment in quitline counseling resulting from referrals.**[22] The work group created an automated referral database to improve the referral process to the Helpline and trained Medicaid Population Care Management (PCM) staff to integrate the new referral system into daily work processes. In four months, referrals to the Helpline were only slightly increased, as clients tended to want to work directly with case managers on quitting. However, the referral process has been incorporated into PCM processes, outreach and training.

Cross-Agency Work Group Members

Oklahoma State Department of Health

- Cessation Systems Program Consultant
- Project Manager, Center for Health Innovation and Effectiveness
- Tobacco Use Prevention Manager

Oklahoma Health Care Authority (Medicaid)

- SoonerQuit Grant Manager
- Policy Development Coordinator
- Medical Director
- Senior Planning Coordinator
- Case Management Supervisor
- Planning Coordinator
- Health Promotion Manager
- Statistician
- Research Analyst

"It has been one of the most productive work groups I've been on. It was also a work group that was created by leadership from both agencies and put at the top of the priority list. If we had other projects going on, those were pushed aside temporarily in order to complete the work group's objectives."
—OHCA (Medicaid)

Data, Data, Data

Evaluation planning is about anticipating what you want to achieve by expanding coverage and engaging evaluators and data experts from the very beginning of a change initiative. For Oklahoma, it was critical to define why specific data, especially cost-related data, was being collected, who was collecting it, and how it would be reported to internal and external stakeholders. While the Medicaid Department wanted to support enrollees in quitting, it also did not want to break the bank by expanding and promoting a cessation benefit. It was the responsibility of the work group members and the Trust to show at every step how utilization of the benefit would actually stretch Medicaid's financial capacity to support the benefit. In summary, data were needed early on to ease the concern that the state Medicaid program would go broke as a result of expanded coverage with reduced barriers.

In addition to cost data and utilization data, the University of Oklahoma Health Sciences Center evaluates two key programmatic areas using Helpline data: the Medicaid media campaign and efforts to increase fax referrals to the Helpline from clinics serving a high volume of Medicaid enrollees. The number of Helpline calls from Medicaid enrollees is tracked and analyzed for increases in utilization and for trends to inform media buys and ad placement. These data have been especially helpful in garnering support for Medicaid-specific Helpline promotion and systems intervention by providing real-time results of Helpline utilization linked with internal Medicaid activities to promote the Helpline.

The Medicaid Department has also been working to promote the Helpline through fax referrals from targeted clinics. The Helpline data are helpful in tracking clinics' and providers' referrals and, again, linking results with internal programmatic efforts.

Helpline data are shared with Medicaid quarterly in a dashboard format and the evaluator, Oklahoma Tobacco Research Center, works with Medicaid on how to communicate findings back to their decision-makers and how to frame the results for their partners.

Medicaid staff realized fairly quickly that once the medications benefit was in place, they needed to ensure monthly monitoring of counseling enrollment and medication utilization rates in order to sustain success. They needed to promote the robust benefit so that enrollees would be aware of it and want to use it, but also have hard data to report to internal stakeholders showing that the benefit was not going to "break the bank." The Medicaid Department's medical director has been a key ally in connecting with internal players such as the pharmacy director and public information officers to share data, analyses and trends.

TACTIC

When building your evaluation plan, do not rely too heavily on helpline/quitline data. Helpline data goes a long way toward informing program staff, but can result in staff being unable to look beyond what the quitline can provide. There are many other important indicators and outcomes to monitor. Working with evaluators outside of your program can help guide you toward these.

CHALLENGES TO SUCCESS

Knowing How to Speak "Insurance"

The Health Department and the Trust struggled with figuring out the intricate details of how insurance works. They knew best practices for tobacco control, but were in a foreign land when it came to creating and implementing a cessation insurance benefit. One of their first lessons was learning just how influential a role actuaries play within insurance providers (whether public or private) and that, when it comes to cessation, actuaries routinely overestimate the number of people who will use cessation treatments to try to quit. For both agencies, this became a critical leverage point for education.

Actuaries must determine how much a benefit will cost in order to establish the impact of increased coverage on the overall budget, as well as the degree to which the investment in the benefit will be returned. As Health Department and Trust staff worked to understand how return-on-investment (ROI) figures were being determined by Medicaid, they learned that a cessation benefit utilization rate of 20 percent was predicted—an unheard of utilization rate to tobacco control professionals, who know that it takes a comprehensive mass media campaign to drive 5 to 6 percent increases in call volume to quitlines. Information on the factors that drive people to make a quit attempt and the full story of behavior change were critical context for actuaries to have as they developed ROI information. The Health Department had a "warehouse of epi support" to assist Medicaid with projecting utilization and could draw on the experience of what it takes to drive calls to the quitline to support this education effort.

TACTIC

While educating the actuaries to ensure proper calculation of return on investment, the critical role of partnerships was also in play. The Health Department was working with the Medicaid medical director, a person with the ear of leadership, to show why Health Department data was more relevant and useful to cessation benefit utilization than data from internal experts the medical director works with every day.

"Get someone to help you understand insurance. It is a different world and a different language. Don't wait to get them to the table! They know what drives decisions and the data that matters. I would like to have skipped the couple of years we took to learn this lesson."
—OSDH (Health Department)

TACTIC

Barriers to accessing cessation medications serve two primary functions for state Medicaid agencies: cost containment and reduction of misuse or overuse. Therefore, utilization data, the evidence base on effective cessation treatments, and everything else used to make the case for decreasing barriers to medications coverage MUST address the concern that opening up access to medications will "blow the budget."

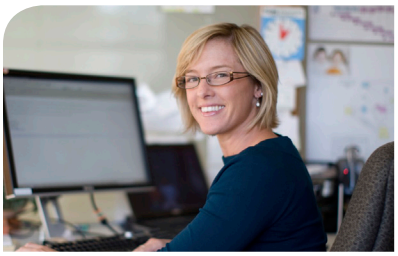
LESSONS SHARED

"Agency leadership—leadership that is visionary and interested in truly serving the public's needs—that is the gold ticket."
—OSDH (Health Department)

Strong Leadership at Every Level

Mid-level to executive-level leadership with direct knowledge and understanding of cessation goals has been immensely helpful to the success of Oklahoma's efforts to increase coverage and decrease barriers to access. Through Medicaid structural and reporting changes over time, the staff at the center of this successful effort have, at times, reported to the agency director and medical director. In fact, for the past several years they reported to the Director of Communication, Outreach and Reporting, who now serves as the Medicaid CEO, and who was already an ally. In addition, the entire structure of Medicaid is very flat, or non-hierarchical, which facilitates access to executive staff and a less formal approach to working with other state agencies.

There have also been long-standing relationships between the Trust's Executive Director, and executive level leadership within Medicaid and the Health Department. Many of these leaders share social work backgrounds and understand the importance of addressing tobacco-related health disparities among low socio-economic-status communities, including persons enrolled in Medicaid. As noted by multiple key informants, while these partnerships, which have spanned over 15 years, have been essential to moving cessation forward, they are not the only essential piece of the puzzle.



"You simply can't ride on the coattails of "partnerships" until the very end. You MUST be able to make the business case. Unfortunately for public health, this is a skill set we lack."
—OSDH (Health Department)

A Less-Specific Policy

There is some specificity to the Oklahoma Medicaid cessation coverage policy. For example, for counseling to be covered, a provider must use the 5 A's protocol,[23] and only cessation medications approved by the FDA are covered. However, the official policy does not specify all aspects of the benefit, and that has been an advantage. As a result of less specificity around existing barriers to treatment, there has not been a need for formal policy changes to decrease coverage barriers. The latter work has all been done administratively, including the removal of prior authorizations and copayments for medications.

Don't Forget Promotion and Tracking

Anytime you are working to improve coverage, it is important to remember that outreach and promotion related to the improved or new coverage is an essential step that should follow on the heels of implementation. After all, the enhanced benefit will not be a success unless those who need it are aware of it and use it. In addition, be sure to promote the benefit, not only to Medicaid enrollees, but also to healthcare providers who serve the Medicaid population. These two very different audiences will require different messages and different messengers.

"It doesn't mean you have anything just because you have the benefit in place! It needs to be used to be meaningful. There was a lot of work focused on promotion and utilization right after our "win" that I didn't anticipate."
—OHCA (Medicaid)

Take Time to Strategize

The Trust and Health Department carefully considered the right message to convince Medicaid of the need for improved coverage of and access to cessation treatments. Their message called attention to all of the costs associated with smoking by Oklahoma Medicaid enrollees and focused on convincing the Medicaid Department that, with a few changes that were in their full control, healthcare costs could be significantly reduced. As one partner expressed it, "We gave them the steering wheel to their car, and let them determine how fast and where to go."

The next step was to secure and support an internal champion. For Oklahoma, this was the Medicaid medical director—an ambassador who spoke both the language of Medicaid and the language of the cessation evidence base. Identifying the right champion within a Medicaid agency requires homework and getting to the root of formal and informal power within the institution. It is about so much more than the organizational chart!

WHAT COMES NEXT?

Further Decreasing Barriers

Creating sustainable cessation coverage through administrative policy changes has been an extremely successful strategy, though the work is not yet complete, according to the Medicaid Department. Using the March, 2014 MMWR report, State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Coverage—United States, 2008–2014, to guide priorities, two barriers to treatment were removed in 2014. In 2015, efforts will continue the commitment to improve coverage of and access to cessation treatments. Specifically, the Medicaid team will work to remove the copayment currently required to receive counseling, even though most Medicaid enrollees are exempt from having to pay this copayment under the current billing system. This change can be made through an administrative mechanism due to its small budgetary impact.

"Board meetings, medical and drug utilization review meetings—you should be at all meetings that are open to the public. Listen and learn! You have to care about what they are doing—not just what you want them to do! You need to invest time in learning Medicaid 101. There isn't a single Medicaid agency out there that isn't under pressure to save money. Cessation is it!"

Additionally, Medicaid will review the possibility of removing duration limits on all cessation medications with the exception of varenicline (an exception resulting from the Director of Pharmacy's concerns about the side effects of this medication). It has set a goal of having limits removed by the end of the fiscal year. Currently, all medications are available to Oklahoma Medicaid members for 180 days.

Further Exploring Data

With seven years of tobacco cessation treatment coverage and seven years of data compiled, it is critical to review these data to learn more about successes, challenges, and opportunities for improvement. A complete evaluation of the cessation benefit that links Helpline data and Medicaid benefit utilization data to tell a fuller story of cost savings, utilization, and outcomes is on the horizon, though systematic review of claims data is not in place just yet.

Increasing Access Points to Cessation

While Oklahoma Medicaid cessation coverage has included medications and counseling since 2006, it was not until just a few years ago that Medicaid began trying to expand this benefit. Over time, the list of approved counseling provider types has expanded, first by adding public health nurses/RNs who work in tribal facilities, and most recently by adding licensed clinical social workers who are Mayo-certified tobacco treatment specialists. Creating as many access points to cessation counseling as possible remains a key goal.

CLOSING REFLECTIONS

Over the past five years, Oklahoma has made significant progress in improving the health and well-being of tobacco users enrolled in Medicaid as a result of near-comprehensive and near barrier-free tobacco cessation coverage. This success reflects a solid foundation of long-term relationships across state agencies and a collaborative commitment among Medicaid, the Trust and the Health Department to address high smoking prevalence rates and mounting healthcare costs through improved coverage, reduced barriers to treatment, and targeted and tailored promotion of the Medicaid cessation benefit.

Oklahoma's success stands as an inspiration to other state Medicaid programs and Health Departments to make a commitment to (1) implementing systems- and policy-based interventions to decrease prevalence; (2) making the business case for expanding coverage using data that "speaks" specifically to the needs and challenges of individual state Medicaid agencies; and (3) creatively leveraging all possible funding sources to build and sustain cessation infrastructure within state Medicaid agencies.

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