American Lung Association.

A Guide to Assessing Tobacco Cessation Coverage in Health Plans

Overview

Smoking is the leading cause of preventable death and disease in the United States. Data continues to show that most people want to quit and we know what works to help smokers quit – the seven Food and Drug Administration (FDA) – approved medications and the three forms of counseling recommended by the U.S. Public Health Service Treating Tobacco Use and Dependence: 2008 update. Additionally, the 2020 Surgeon General's Report on Smoking Cessation concludes:

> *"Insurance coverage for smoking cessation treatment that is comprehensive, barrier-free, and widely promoted increases the use of these treatment services, leads to higher rates of successful quitting, and is cost-effective."*

The fragmentation of the U.S. healthcare system creates variation in coverage of treatments including tobacco cessation coverage. Commercial health plans insure the largest number of people in the U.S., both in the form of employer-sponsored coverage and the individual marketplace. Furthermore, over the last ten years, commercial health plans' role in public health coverage has grown significantly. Currently, over a third of Medicare enrollees are enrolled in a Medicare Advantage plan and the Congressional Budget Office projects that to increase to about 47% by 2029. And almost 80% of Medicaid members are covered by state-contracted externally operated managed care plans.

It is important for public health professionals to understand how health plans may (or may not) be addressing high burden, high cost public health conditions such as tobacco use. Because of the high prevalence of variation in plans, whether that be in the private market or as part of a public coverage program, assessing coverage can provide a foundation to develop relationships and improve coverage and, ultimately, health outcomes.

An important aspect of working with commercial health plans and managed care plans is understanding how they currently approach tobacco cessation coverage. This can guide efforts to identify areas of potential collaboration, including quality improvement initiatives, provider engagement and increased utilization of services. **This document supports state or local health departments seeking to access this information from health plans by providing guidance on how to frame questions in a manner that health plans will understand**. It also provides insight into ways to interpret and use health plan responses.

This assessment can help achieve the following purposes.

- Assess the **health plan's coverage** for tobacco cessation treatment (medications and counseling) (Assessment Area 1)
- Understand how the health plan supports **providers** to promote tobacco cessation (Assessment Area 2)
- Assess what **data and metrics** the health plan collects and/or reports to identify, incent, track, and monitor tobacco cessation services (Assessment Area 3)
- Determine how the health plan identifies, reaches out to, and supports its **members** who use tobacco (Assessment Area 4)
- Determine if the health plan has integrated or aligned tobacco cessation with efforts around **priority populations or other conditions** (Assessment Area 5)

Tier 1 Questions: All sections include baseline "Tier 1" questions that any state could pose.
Tier 2 Questions: In some instances, the section includes a set of Tier 2 questions after the Tier 1 questions. These questions are typically more nuanced or advanced than the Tier 1 questions. We recommend these questions for states that meet the following criteria:

- Already have a solid foundation of information
- Are comfortable with their understanding of the payer environment
- Are interested in probing a specific topic in greater depth
- Are not under significant time constraints

Because these Tier 2 questions will likely generate clarifying questions from health plans and may require responses from several different people within a health plan, we recommend that you not use these questions unless your health department meets these criteria and has a clear understanding of what it will do with the information received.

How To Use This Document

This document will allow public health to develop a customized tool to assess tobacco cessation coverage in health plans. In order to be successful, there are some key considerations to take account. Here are some ways to optimize this document.

First, **determine what types of plans you want to look at.** The U.S. health system is very fragmented. It would take massive resources (both in terms of money and staff time) to assess coverage in all health plans in a state and keep them up to date. We encourage you to pick a subset of plans to look at depending on what your end goal is. Here are some possible ideas:

- Medicaid Plans
- Plans offered in your state exchange (Healthcare.gov)
- Top 10 largest employers in the state

Remember, health insurance companies offer many different types of plans and coverage can be unique for each. It is important to identify the type of plan you want to collect coverage data for. If you are planning on analyzing these data, it might be important to collect coverage data from plans that have the same coverage requirements.

Once you have determined which plans you are going to look at, you should **determine what questions to ask the plans.** This document is extensive. There is more content than any given public health agency could work with or any health plan would be willing to answer. We recommend selecting one or two sections to use in your assessment. You can also pick a couple of questions from each section. Please note, since some of the topics overlap, there

may be some duplicative questions. **This document is intended to be a menu to pick and choose the questions you want to ask of health plans.**

Next, it is time to **identify your key partners and stakeholders**. This may include people from the Medicaid office or the Insurance Commissioner's office or other public health partners. It will most likely depend on what type of coverage you are looking to collect coverage data on.

It is not uncommon to circle back to the first two steps as you are finalizing your assessment and including new partners. It is important to identify what you are planning on using your data for and how that will best serve your organization's goals. **It is recommended to read through this document in its entirety before starting the process.**

This document includes five different sections, each with several questions. Each section provides background information and includes a stand-alone set of questions to send to health plans. Where appropriate, the document differentiates between questions and information specific to health plans serving Medicaid and those serving the private market (e.g., employers). From this point forward, we will refer to a Medicaid health plan as a Medicaid Managed Care Plan (MCP).

A background table precedes each set of questions. Below is a sample table that explains what information is provided in each column.

Topics to Assess	Purpose for Assessing	Possible Findings	Potential Follow-Up Actions	Background Information & Items for Technical Assistance (TA) Support
This section lists the topics that will be covered.	This section identifies the reasons you may be interested in gathering information on this topic, based in part on the kind of health plan initiative you are considering.	The information received from the health plan can point to many different findings. This section identifies the range of possible findings you may encounter.	Based on possible findings, this section suggests follow-up interventions or next steps. Interventions can be directed at health plans or other stakeholders (e.g., state Medicaid agencies, health insurance regulators, etc.).	This section identifies key terms you should be familiar with when having a conversation with health plan personnel. If you are not familiar with these topics, you may want to consider seeking TA from your colleagues in the Health Department or the Medicaid agency, the CDC, or other subject matter experts like the American Lung Association. In other instances, you may need to seek additional TA from consultants who understand public health, tobacco cessation strategies, and health insurance.

Throughout the assessment, there is space for you to specify what product line(s) the assessment is addressing. This typically looks like this: **__insert target__ population**

Before starting, consider the following important questions that will inform the content and fielding of your assessment:

1. Who will be sending the assessment to the health plans?
2. How will you distribute the assessment and what response mechanisms will be used?

Each of these three questions are explained more fully below.

Identify The Health Plan Product Line Or Type Of Health Plan You Are Interested In

Commercial health insurers, or payers, offer a mix of product lines drawn from the following options:

1. **Fully insured groups:** The insurance company carries all the insurance risk. These products are usually purchased by smaller employer groups (fewer than 100 lives).
2. **Self-insured groups:** The employer (or purchaser), not the insurance company, carries most of the risk; in this case, the health plan functions as an administrator that processes claims, ensures access to provider networks, and may or may not also provide services such as medical management, wellness, pharmacy coverage and behavioral health. The financial risk to the employer of bearing responsibility for all medical costs is offset by not having to pay for health plan costs such as profit margin, or state health insurance premium taxes. Self-insured employers are also generally exempt from state insurance regulation, as they are regulated by the U.S. Department of Labor. Many state and municipal governments are self-insured. These plans are typically utilized by large employers, however small employers are able to utilize these plans too.
3. **Medicaid managed care plans (MCPs) (may also be called Managed Care Organization (MCO):** This is the highest growth market for many commercial plans. States contract with the health plan to provide a specific set of benefits to Medicaid enrollees. These benefits may vary based on eligibility, with specific programs for pregnant women and children or disabled enrollees. Health plans covering Medicaid enrollees must follow state and federal rules.
4. **Medicare Advantage (MA):** The federal government contracts with insurance companies to provide Medicare Part A and Part B coverage to Medicare beneficiaries. Under Medicare Advantage, the insurer integrates Part A and Part B into one product and carries all the insurance risk. Over one in three people on Medicare (34%) was enrolled in a MA plan in 2019.

The product mix for each major commercial insurer varies across insurers and geographic regions; this mix also evolves over time due to market dynamics, including increased consolidation. For more information, see Appendix.

Because the purchaser/decision-maker, market dynamics and benefit designs vary across product line, health plans' responses to assessment questions will depend on what product line is being described. Throughout this document, we have primarily focused on the differences between *Medicaid* and *Commercial* plans, with commercial coverage including fully insured, self-insured and Affordable Care Act marketplace plans. We do not typically address Medicare because of its federal orientation (i.e., very few decisions can be made at the state level). **If you are interested primarily in the commercial market, we recommend that you choose a subset of health plans, such as the 10 largest employers in your state or plans offering coverage in your state's exchange. See the Appendix for a more detailed explanation of the difference between self-insured and fully insured coverage.**

You should specify your product line(s) and/or population(s) of interest in a cover letter accompanying the assessment.

Determine Who Will Send The Assessment

There are three options for sending the assessment. These have been classified based on quality of response from the plans with Option One being Gold, followed by Option Two - Silver and Option Three - Bronze.

Option One (Gold): Have the assessment issued by the health plans' regulating agency. Commercial plans and MCPs are often more responsive to requests from their regulating agency. This is typically the state insurance department/division for commercial plans and the state Medicaid agency for MCPs. Many states have found that MCP assessments sent by the state Medicaid agency generate dramatically higher response rates than assessments sent by state public health agencies. However, requests for information from a regulatory agency may make the plans anxious, which in turn may make the state regulators hesitant to conduct an assessment. The workload associated with sending and

managing an assessment and analyzing its results can also make the state regulating agency reluctant. The first barrier can be addressed by clearly communicating to the plans **WHY** the information being requested is important and **WHAT** will be done with the results. The second barrier can be addressed by having public health commit to helping the state agency manage the workload.

Option Two (Silver): Propose a joint release. On the commercial side it may be difficult to issue jointly unless the assessment focuses on interests shared by the insurance regulators and the state public health department such as pricing or coverage. Employer coalitions can also be a powerful ally, especially if the coalition is interested in using the results to inform its own initiatives and is willing to communicate the importance of the data to the health plans. Employer coalitions are likely to be more receptive to your overtures if you show them how they can use the assessment data to advance their goals. Employers often find a value-based approach to benefit design attractive (i.e., increasing health care quality and decreasing costs by using financial incentives to promote cost-efficient health care services and consumer choices). Similarly, partnering with the state health plan association can be an effective strategy, but you will need to ensure that the assessment can be distributed to all health plans, including plans that may not be association members. Such associations will also want to understand how the assessment's findings will be disseminated and used.

Option Three (Bronze): Have the assessment issued by the state public health department. If you are issuing the assessment on your own, you should develop the briefest assessment possible to meet your objectives and accompany it with a very clear cover letter spelling out **WHY** the information is being requested and **WHAT** it will be used for. Having higher-level state officials like the State Health Officer, State Public Health Director or the Director of the State Health Department sign the cover letter may catch the plans' attention. For example, the Utah Health Department's Tobacco Control Program generated a sufficiently robust response using this approach to feel confident that it had a generally accurate picture of levels of coverage among insurance carriers in Utah. Utah used the results to propose changes in state policies regarding access to the Utah Tobacco Quit Line for individuals with commercial coverage. However, unless the State Health Department has cultivated good relationships with the health plans in your state, this option may result in a lower response rate and is likely to require considerable follow up on your part to generate responses.

**This document will use the term State Health Department to generically reference the state entity responsible for overseeing tobacco. We recognize that in some cases there may be different names and organizational structures*

Assessment Owner Options

Gold	Silver	Bronze
State Regulator sends the assessment • **Medicaid:** State Medicaid Agency • **Commercial:** Department/Division of Insurance	Issue assessment jointly with regulator • **Commercial:** Consider also - state health plan association, employer coalition	State Health Department issues assessment • **Medicaid and Commercial:** Use highest possible signature on cover letter
Include content relevant to the regulator	Articulate value of information to external partner	Minimize content as much as possible
Offer to staff the assessment and analysis	Offer to staff the assessment and analysis	Plan on extensive follow up

Identify Your Distribution And Response Mechanism

As with the choice of the assessment owner, the key consideration in selecting the mechanism for distributing the assessment and collecting responses should be maximizing the volume and quality of responses. Emailing the assessment or providing an electronic link to an assessment tool allows the assessment to be easily distributed to the most appropriate respondent(s) within the health plan. If the assessment covers multiple topics, multiple entities within the health plan may need to contribute to the response. The more complicated a assessment is, the lower the response rate is likely to be. However, using an electronic mechanism to distribute the assessment and compile responses is a benefit. This approach also provides an opportunity to include links with further information and can also make it easier to analyze the assessment results.

This document does not explicitly suggest who the assessment should be sent to for completion. This decision depends on who is sending the assessment, the depth and breadth of the assessment owner's contacts within the health plan and the level of complexity of the assessment. In general, we recommend sending it to the person within the health plan with whom the assessment owner has the strongest relationship and who is the most likely to help distribute the assessment to the appropriate respondents. If there is no personal contact within the health plan, consider the chief medical officer, or the chief compliance officer. The chief executive officer is also an option, particularly if you have a high-level state executive signing the request letter. We recommend that you state in your cover letter/email that, while the recipient may forward the assessment to someone else within the health plan, you would like to be cc'd or notified regarding who ultimately receives the assessment. This will facilitate ongoing follow-up. Maintaining contact with both the initial person and any subsequent persons who receive the assessment is important so that it remains front of mind at the health plan. The cover letter should specify who will be following up with the health plan, particularly if one entity is sponsoring the assessment (e.g., the state Medicaid program) while a different entity is staffing the assessment (e.g., the state Health Department).

A Note On Follow-Up Actions Once You Get Your Assessment Results

Finally, rather than note it throughout the tables as a potential follow-up action, we are alerting you here that you may decide to reach out to the appropriate regulatory agency for answers to questions about compliance with benefit or access requirements, or to share the assessment results. For Medicaid MCPs, this agency is the state Medicaid program; for commercial plans and products, the responsible agency is the state insurance regulatory agency. For self-insured products, it is the employer that is regulated, not the health plan; regulation in this case is all federally-based.

Before initiating outreach on potential compliance issues, consider whether reaching out directly to the health plan first is more advisable, and whether the regulatory agency will be open to having you raise potential compliance issues that are under its oversight.
Factors to consider in making this decision include:

- The orientation of the regulatory agency to health plan compliance versus consumer protection
- The regulatory agency's level of staffing and of audit activity
- The nature of the relationship you wish to cultivate with health plans or MCPs

This may be an area where you consider requesting technical assistance before proceeding.

Tool For Assessing Health Plan Tobacco Cessation Coverage And Support

The following pages cover five assessment areas.

Health Plan Coverage for Tobacco Cessation

Health Plan Support of Providers to Promote Tobacco Cessation

Metrics the Health Plan Uses to Identify, Incent, Track, and Monitor Tobacco Cessation Services

Determining How the Health Plan Identifies, Reaches Out to, and Supports Members Who Use Tobacco

Integration and Alignment of Tobacco Cessation with Other Health Plan Priorities

Assessment Area 1 | Health Plan Coverage For Tobacco Cessation

Topics to Assess	Purpose for Assessing	Possible Findings	Potential Follow-Up Actions	Background Information & Items for Technical Assistance (TA) and Support
Health plan coverage for tobacco cessation: • Counseling • Medication • Access requirements (copays, authorizations, etc.) **Tier 2:** Health plan coverage differences by product line (HMO, PPO, Medicare, Medicaid, etc.)	• Determine gaps in coverage • Check compliance with federal and state regulations or guidance • Inform consumer outreach/ education	**Gaps are inconsistent** • Some plans have across-the-board better coverage • Some plans have gaps in prescription coverage; others in counseling • Gaps differ by product line (e.g., Medicaid versus insured) • Plans may offer comprehensive coverage but attach restrictions to access (e.g. prior authorization, step therapy etc.) **Gaps are nominal** • Coverage is good, but appears to be poorly utilized • Coverage is good, but barriers exist (e.g., cost-sharing, prior authorizations, etc.)	• Medicaid: Discuss results with Medicaid agency if non-compliance is identified • Commercial: Discuss results with state insurance regulatory agency if non-compliance is identified • Use aggregate results to work with health plans to illustrate gaps relative to their peers • Disseminate findings: The possibility of publicly disseminating findings would need to be stated in the assessment and may impact a plan's willingness to complete it • Educate gap plans on the evidence base for cessation coverage and ways to address gaps • If gaps are nominal, focus on increasing awareness and utilization	• Medicaid: What benefits the state Medicaid plan/MCP contract requires • Commercial: State insurance regulatory agency guidance, and state mandates • Health Insurance 101: Copayment, coinsurance, deductibles • Medical management: Various authorizations, step therapy, etc. • Difference in decision makers and action options for self-insured, insured, Medicaid, and Medicare product lines

Questions for Assessing Coverage

1. Please complete the table below regarding the FDA-approved tobacco cessation medications your plan covers for its **__insert target__population** (e.g., Medicaid, commercial etc.)

Medication Name	Covered?		Co-pay or other member financial requirements?		Are there limitations for use? (Number of quit-attempts per year? Lifetime? Duration limits?) If yes, describe.	Prior authorization or limitations (including step therapy, requirement to participate in counseling)?	
	Yes	*No*	*Yes*	*No*		*Yes*	*No*
Varenicline (Chantix)	☐	☐	☐	☐		☐	☐
Bupropion (Zyban, Wellbutrin)	☐	☐	☐	☐		☐	☐
Nicotine Replacement Therapy (*Over the counter)*	☐	☐	☐	☐		☐	☐
NRT Gum	☐	☐	☐	☐		☐	☐
NRT Patch	☐	☐	☐	☐		☐	☐
NRT Lozenge	☐	☐	☐	☐		☐	☐
Nicotine Replacement Therapy (*Prescription)*	☐	☐	☐	☐		☐	☐
NRT Nasal Spray	☐	☐	☐	☐		☐	☐
NRT Inhaler	☐	☐	☐	☐		☐	☐

2. Please complete the table below regarding USPSTF A-rated counseling services your plan covers for its **__ insert target__ population.**

Counseling Type	Covered?		Co-pay or other member financial requirements?		Any limitations (e.g., number of visits/year or types of providers)? Describe:
	Yes	*No*	*Yes*	*No*	
Individual	☐	☐	☐	☐	
Group	☐	☐	☐	☐	
Telephone • State Quit line	☐	☐	☐	☐	
Telephone • Contract w/ vendor	☐	☐	☐	☐	
Telephone • In-house	☐	☐	☐	☐	

3. Do members need to enroll in cessation counseling to receive cessation medications? ☐ Yes ☐ No

4. How many quit attempts per year does your plan cover for its **__insert target_population**?

5. *[Medicaid Question]* Please describe any differences in eligibility requirements or coverage for Medicaid expansion members versus previously eligible Medicaid members or any other Medicaid eligibility category.

6. Please describe any limitations on the types of providers that are able to provide cessation counseling?
   - Are there any billing considerations?

7. If telephonic counseling is provided in-house, please respond to the following:
   - Part of a general nurse call-line? ☐ Yes ☐ No
   - Staffed by counselors trained in tobacco cessation? ☐ Yes ☐ No
     - If yes, how many?

8. If telephonic counseling is provided by an external service provider, please provide the name of the service provider: _____

9. If telephonic counseling is provided by the state quitline, please respond to the following:
   - What state entity is reimbursed by the plan for these services?
     - ☐ Plan does not reimburse anyone for state quitline services
     - ☐ State quitline
     - ☐ State tobacco control program
     - ☐ Contracted service provider for the state quitline
     - ☐ Do not know

10. Are tobacco cessation services covered when delivered through telehealth?
    - Are there restrictions on the type of provider that can bill for the treatment?
    - Are there any location/ originating site requirements?

11. What codes CPT codes are covered?
    - What types of providers are able to bill the covered CPT codes for tobacco cessation counseling?

Topics to Assess	Purpose for Assessing	Possible Findings	Potential Follow-Up Actions	Background Information & Items for TA Support

Health plan support of providers to promote tobacco cessation
 	
Health plan financial incentives for providers to support tobacco cessation
 	
Tier 2:
Health plan payment or incentive variations by delivery system:
• Patient Centered Medical Homes (PCMH)
• Accountable Care Organizations (ACO)
	Work with providers to deliver clinical cessation services and/or promote other opportunities and venues for cessation services
	
	Identify providers with greatest incentive to identify and treat tobacco users (e.g., PCMH, ACO)
		• High level of passive support (e.g., newsletters, recommendation to screen), but no consistent mechanism for tracking effectiveness
		• Minimal level of patient-specific support or reporting
		• Statements supporting reimbursement, but:
		  ○ Very low volume of claims or limited ability to report claims volume
		  ○ Barriers exist for payment of claims (e.g., specific procedure and diagnosis code combination requirements such as a required diagnosis of a condition impacted by tobacco use)
		  ○ Expectation that screening and brief intervention are included as part of visit fee and not reimbursed separately
		• Product line provider reimbursement differences may impact providers' incentives to support wellness/ preventive care. For example:
		  ○ Providers who are paid a care management fee (e.g., PCMH) to support identifying gaps in care may be more motivated
			Limited Provider Engagement
			• Work with plans on cost-effective mechanisms to engage providers in promoting cessation
			• Commercial: Educate plans and employers on evidence that a value-based benefit design maximizes impact on both outcomes and cost savings/reductions
			• Medicaid: Educate Medicaid about value of maximizing utilization of cessation treatments; create provider outreach materials for Medicaid networks
			
			Payment
			• Feedback to plans that are not consistent on payment
			  ○ MCPs: Feedback through Medicaid agency
			  ○ Commercial: Feedback through employers, insurance regulators, state Medical Director (use highest-level channel available)
			• Use aggregate results to work with health plans to illustrate gaps relative to their peers
			• Educate health care providers regarding payment policies and protocols, including specific guidance on coding for each plan
				• For Medicaid and commercial payers:
				  ○ Provider reimbursement methodologies
				  ○ Providers' employment status (i.e., employed by health plan, employed by hospital, independent)
				  ○ EHRs used
				• PCMHs and ACOs – including market penetration, payment methodology
				• Reimbursement methodologies, including: Fee for service, capitation, DRG, per diem, shared savings, bundled payments
				• Pay for performance programs in place (e.g. plan-specific, National Quality Forum, etc.)

Topics to Assess	Purpose for Assessing	Possible Findings	Potential Follow-Up Actions	Background Information & Items for TA Support
		○ Providers who are capitated (e.g., HMO) with no quality rewards tied to tobacco may be less incented • Hospitals in risk-bearing ACOs may have increased motivation to identify and treat tobacco use • Hospitals receiving bundled payments may have greater motivation to partner with State Health Departments or community entities to provide tobacco cessation, but may or may not believe they should pay for it	**PCMH/ACOs** • Educate PCMH providers regarding payment/incentive programs which make tobacco cessation worth their effort • Provide TA to individual practices about practice transformation (e.g., changing intake flow to support tobacco screening) and use of registries and electronic health records (EHRs) to identify smokers, interventions for smokers that are not ready to quit, and quitline referrals • Provide information on tobacco cessation ROI to ACOs, PCMHs, and hospitals • Provide information on tobacco's impact on surgical complications, birth outcomes, or chronic diseases of importance to ACOs, PCMHs, hospitals, and providers	

Questions for Assessing Health Plan Support of Providers to Promote Tobacco Cessation

***Please note** that this section does not differentiate between providers serving different product lines for the health plan. It is extremely unlikely that a health plan would provide a different answer to the questions below for a commercial product versus an MCP. The exceptions to this are identified in the Tier Two questions.*

1. Does the plan recommend that clinicians screen adults for tobacco use at every visit? ☐ Yes ☐ No
2. How does the plan monitor that clinicians screen adults for tobacco use at every visit? (select all that apply)
   - ☐ Screening is not monitored
   - ☐ Extract data from EHR or EMR
   - ☐ Chart audit
   - ☐ Claims data
   - ☐ Clinician assessment
3. If the plan monitors screening, what percent of the plan's clinicians screen adults for tobacco use at every visit?
4. Which of the following methods does the plan use to improve providers' awareness of its tobacco cessation coverage, services, and policies? (select all that apply)
   - ☐ Provider contract
   - ☐ Provider manual
   - ☐ Provider newsletter
   - ☐ Provider portal
   - ☐ Provider relations staff
   - ☐ Tobacco-specific training for providers or staff on plan's cessation services
   - ☐ Paid media (e.g. radio, billboards, mass transit ads, etc.)
   - ☐ Other (please describe):
5. Which of the following kinds of patient support does the plan give to providers to support tobacco cessation? (select all that apply)
   - ☐ Member materials for provider use and distribution
   - ☐ Member-specific reports or reminders to screen
   - ☐ Member-specific reports or reminders to treat
   - ☐ Progress reports on members in tobacco cessation programs (independent of the provider's direct interventions)
6. Please complete the table below regarding how the plan reimburses its providers for cessation services delivered to members.

	Adults		Youth	
	Yes	*No*	*Yes*	*No*
Do you reimburse *outpatient providers* for cessation treatment and counseling services?	☐	☐	☐	☐
• Short to intermediate time counseling (beyond the basic office visit payment)	☐	☐	☐	☐
• Intensive counseling	☐	☐	☐	☐

• Group counseling	☐	☐	☐	☐
Do you reimburse *hospital-based* providers for cessation treatment and counseling services?	☐	☐	☐	☐
• Short to intermediate time counseling (beyond the basic office visit payment)	☐	☐	☐	☐
• Intensive counseling	☐	☐	☐	☐
• Group counseling	☐	☐	☐	☐

7. Are there any restrictions or requirements associated with submitting a bill for cessation treatment? ☐ Yes ☐ No
   If yes, please describe:_____
8. Approximately what percent of your providers have submitted claims for cessation services (not Rx)? Alternatively, what percent of your members have you received cessation service claims for?

Tier 2: Understanding Provider Support

The questions below focus on differences in provider support in more advanced delivery models such as patient centered medical homes (PCMH) or Accountable Care Organizations (ACO). This is a level of detail that may not be necessary unless the public health professional is interested in targeting alternative delivery or payment models or these models have wide market penetration in your targeted geographical area.

1. Which of the following activities does the plan support to help its providers engage in tobacco cessation (select all that apply)?
   - ☐ PCMH or practice redesign coaches who explicitly consider tobacco
   - ☐ Care managers who act on behalf of the provider to interact with members specifically on tobacco
   - ☐ Ability to refer to other plan-sponsored or -supported cessation interventions (e.g., quitline, plan wellness program, group classes offered by the plan)

2. Does the plan provide any financial incentives (beyond direct services reimbursement) to providers to do any of the following?

	Providers (non-PCMH)		PCMH providers		Hospitals		ACOs	
	Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
Conduct tobacco use screenings	☐	☐	☐	☐	☐	☐	☐	☐
Deliver cessation treatments to patients or refer patients to other cessation services	☐	☐	☐	☐	☐	☐	☐	☐
Improve any tobacco-related metrics	☐	☐	☐	☐	☐	☐	☐	☐

3. Does the plan structure any of its payment programs in a way that might provide an indirect incentive to engage in tobacco cessation?

	Providers (non-PCMH)		PCMH providers		Hospitals		ACOs	
	Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
Shared savings programs that might provide motivation to partner on tobacco cessation	☐	☐	☐	☐	☐	☐	☐	☐
Bundled payment programs that might provide motivation to partner on tobacco cessation	☐	☐	☐	☐	☐	☐	☐	☐

Assessment Area 3 | Metrics The Health Plan Uses To Identify, Incent, Track, And Monitor Tobacco Cessation Services

This section is slightly different from the other sections. This section addresses health plans' tobacco cessation metrics more generally than the other sections. While there are some references to the specific plan type or product line, there are also questions relating to the company as a whole. Metrics are often reported in this format.

Topics to Assess	Purpose for Assessing	Possible Findings	Potential Follow-Up Actions	Background Information & Items for Technical Assistance (TA) and Support
Plan metrics related to tobacco cessation: • Identification approaches and rates • Participation rates • HEDIS results • Quit rate methodology and results • Plan financial incentives for providers to support tobacco cessation • Plan quality initiatives related to tobacco cessation	Increase collection and utilization of data to monitor and support use of evidence-based cessation services	• Plan doesn't track or report identification of tobacco users or tobacco users' participation in cessation services • Plan has multiple separate sources of identification and participation data that are not integrated to provide a complete picture • Plan has integrated its different data sources or uses a common EHR system to support identification and participation • Plan has good participation rates but very poor identification rates, leading to a very small denominator of potential participants • Plan does not calculate quit rates or uses a methodology that is not credible • Plan has no financial incentives in place to support tobacco cessation • Plan has no quality initiatives related to tobacco cessation	• TA to health plans on improved identification methods • TA to health plans on increasing participation • TA to calculate quit rates in a more valid way • Use aggregate results to work with health plans to illustrate gaps relative to their peers • Commercial: Encourage plans to incorporate existing MIPS tobacco performance measures into plan performance indicators • Providers: Educate providers on tobacco measures that can be used to enhance MIPS reimbursement • Medicaid: Work with state Medicaid to implement a tobacco related quality improvement program (QIP) or performance improvement program (PIP) with MCPs	• Health Risk Assessments • Wellness programs via vendor vs. health plan • Self-insured plan options • HEDIS/CAHPS measures and limitations of the tobacco measures • EHR capabilities • EHR prevalence in geographical area of interest • Reasons members are reluctant to share tobacco use status • Quit rate calculation methodology • Medicaid: QIP/PIP methodology and requirements • ICD-10 codes and billing codes related to tobacco use and cessation services • MIPS (Merit-based Incentive Payment System) and MACRA (Medicare Access and CHIP Reauthorization Act) • Commercial: Reimbursement methodologies, including: Fee for service, capitation, DRG, per diem, shared savings, bundled payments

Questions for Assessing Metrics the Health Plan Uses to Identify, Incent, Track, and Monitor Tobacco Services

1. Does your plan assess tobacco use status of its **__insert target__population** members? ☐ Yes ☐ No
2. If yes, how often (e.g., annually) is tobacco use status assessed?
3. Indicate which of the following mechanisms your plan uses to identify tobacco users (select all that apply):

	Used to identify tobacco users		If yes, tracked and able to be reported	
	Yes	*No*	*Yes*	*No*
Health Risk Assessment	☐	☐	☐	☐
Claims data • Medical • Pharmacy	☐	☐	☐	☐
Patient chart	☐	☐	☐	☐
Extracted from Provider EHRs	☐	☐	☐	☐
Disease or Care Management	☐	☐	☐	☐
Wellness vendor	☐	☐	☐	☐
Other (describe)	☐	☐	☐	☐

4. What percent of your **__ insert target population __** members have you identified as tobacco users?
5. What percent of your **__ insert target population __** members who use tobacco participated in a cessation service in the last reporting year?
6. Does your health plan track quit rates among members who use cessation benefits? ☐ Yes ☐ No
7. If yes (on #6), please describe your methodology
8. If yes (on #6), do you calculate separate quit rates for any of your different member populations?
    - Medicaid ☐ Yes ☐ No
    - Medicare ☐ Yes ☐ No
    - Individual ☐ Yes ☐ No
    - Group (fully) Insured ☐ Yes ☐ No
    - Self-Insured ☐ Yes ☐ No
9. Does your health plan measure the impact of a member quitting smoking on that member's use of other benefits (e.g., emergency room visits etc.)? ☐ Yes ☐ No
10. If yes, please specify what outcomes are measured and to whom the information is reported.

11. HEDIS/CAHPS Results: Please provide the most recent HEDIS results (specify year and specify Medicaid versus Commercial).

	HMO Results		PPO Results	
	Commercial	*Medicaid*	*Commercial*	*Medicaid*
HEDIS Medical Assistance with Smoking Cessation - Advising Smokers to Quit	☐	☐	☐	☐
HEDIS Medical Assistance with Smoking Cessation - Discussing Medications	☐	☐	☐	☐
HEDIS Medical Assistance with Smoking Cessation - Discussing Other Strategies	☐	☐	☐	☐

12. Does the plan provide any financial incentives (beyond direct services reimbursement) to providers to do any of the following?

	Providers (non-PCMH)		PCMH providers		Hospitals		ACOs	
	Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
Conduct tobacco use screenings	☐	☐	☐	☐	☐	☐	☐	☐
Deliver cessation treatments to patients or refer patients to other cessation services	☐	☐	☐	☐	☐	☐	☐	☐
Improve any tobacco-related metrics	☐	☐	☐	☐	☐	☐	☐	☐

13. Does the plan structure any of its payment programs in a way that might provide an indirect incentive to engage in tobacco cessation?

	Providers (non-PCMH)		PCMH providers		Hospitals		ACOs	
	Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
Shared savings programs that might provide motivation to partner on tobacco cessation	☐	☐	☐	☐	☐	☐	☐	☐
Bundled payment programs that might provide motivation to partner on tobacco cessation	☐	☐	☐	☐	☐	☐	☐	☐

14. Medicaid MCPs: Has the plan initiated or participated in any Quality Improvement Projects (QIP) or Performance Improvement Projects (PIP) related to tobacco cessation? ☐ Yes ☐ No

15. Commercial: Is tobacco a component of any of the plan's pay for performance, quality initiatives, or other performance programs? ☐ Yes ☐ No

Assessment Area 4 | Determining How The Health Plan Identifies, Reaches Out To And Supports Members Who Use Tobacco

Topics to Assess	Purpose for Assessing	Possible Findings	Potential Follow-Up Actions	Background Information & Items for Technical Assistance (TA) and Support
• How the health plan identifies tobacco users and promotes tobacco cessation to its members • Target populations **Tier 2:** Use of community cessation resources	Increase awareness and utilization of tobacco cessation services among tobacco users	• Passive (pull) outreach looks good, but no proactive (push) outreach • Information readily available about risks of tobacco use, but limited or no plan-specific information on cessation coverage or available cessation services • Limited connection to or awareness of community cessation resources • Awareness of but no targeted outreach to target populations	• Use aggregate results to work with health plans to illustrate gaps relative to their peers • TA to Case Management staff about evidence, plan programs, and additional community support • TA to communications team about promotion options • TA to quality team about expected increases in quits based on promotion of plan's tobacco cessation coverage to tobacco users • TA on specific outreach approaches for disparate populations or target disease conditions • Develop population- or disease-specific tobacco use and cessation fact sheets or other materials • Discuss any quitline programs available that explicitly serve the targeted populations or disease <u>Community Resources</u> • Build awareness of existing resources available to plans and/or providers (e.g., quitline, CDC educational materials)	• State policies regarding access to the tobacco quitline for Medicaid and insured individuals

Questions for Determining How the Health Plan Identifies, Reaches Out To, and Supports Members Who Use Tobacco

1. Does your plan assess the tobacco use status of its __ insert target population __ members? ☐ Yes ☐ No
2. If yes, how often (e.g., annually) is tobacco use status assessed?
3. Indicate which of the following mechanisms your plan uses to identify tobacco users:

	Used to identify tobacco users		If yes, tracked and able to be reported	
	Yes	No	Yes	No
Health Risk Assessment	☐	☐	☐	☐
Claims data • Medical • Pharmacy	☐	☐	☐	☐
Patient chart	☐	☐	☐	☐
Extracted from Provider EHRs	☐	☐	☐	☐
Disease or Care Management	☐	☐	☐	☐
Wellness vendor	☐	☐	☐	☐
Other (describe)	☐	☐	☐	☐

4. Please complete the table below indicating where your __insert target population __ members can find information about your plan's tobacco cessation benefits.

Source of Information	Includes information about the health risks of tobacco use		Describes resources or suggestions for how to quit	
	Yes	*No*	*Yes*	*No*
Plan website	☐	☐	☐	☐
Member portal	☐	☐	☐	☐
Open enrollment materials	☐	☐	☐	☐
Certificate of coverage	☐	☐	☐	☐
Member newsletter	☐	☐	☐	☐
Health/wellness materials	☐	☐	☐	☐
Other (describe)	☐	☐	☐	☐

5. Please complete the table regarding whether and how you promote or "push" information about cessation benefits to your __insert target population__ members based on the following possible identification points. Triggers refer to the information that precipitates sending information to the member. For example, an indication of tobacco use on the member's health risk assessment (HRA) might be a trigger for sending material about cessation benefits.

	Yes	No	If yes, triggers:	If yes, form of outreach or push:
Health Risk Assessment (HRA)	☐	☐		
Maternity/Prenatal	☐	☐		
Behavioral health program(s)	☐	☐		
Care management program(s)	☐	☐		
Complex case management program(s)	☐	☐		
Substance use program(s)	☐	☐		
Other (describe)	☐	☐		

6. Please use the table below to describe any special efforts and resources in place to meet the tobacco dependence treatment needs of high-risk populations:

	Special efforts and resources are in place to meet unique tobacco dependence treatment needs		
	Yes	*No*	*If yes, describe*
Populations known to have tobacco use rates higher than the general population (e.g., Native Americans, African-Americans, LGBTQ, etc.)	☐	☐	
Non-English-speaking members	☐	☐	
Individuals with limited formal education and limited health literacy	☐	☐	
Individuals with mental health conditions	☐	☐	
Individuals with substance use conditions	☐	☐	
Individuals who are pregnant	☐	☐	

7. Does your plan refer **__insert target population __** members to the state tobacco quitline? ☐ Yes ☐ No

Tier 2: Understanding Member Identification and Support

1. Does your plan recommend or refer **__insert target population __** members to other community tobacco cessation resources? ☐ Yes ☐ No
2. If yes, please use the table below to describe the resources, how referrals are made and documented, and any follow-up protocols. If none exist, please leave cell blank.

Community Resource (list)	Referral Process	Referral Documentation	Follow-Up Protocol

3. How often does your plan update the availability of community-based resources? Is there any assessment of quit rates, member satisfaction, or other quality metrics for members referred to these resources? If so, please explain.

Assessment Area 5 | Integration And Alignment Of Tobacco Cessation With Other Health Plan Priorities

Topics to Assess	Purpose for Assessing	Possible Findings	Potential Follow-Up Actions	Background Information & Items for Technical Assistance (TA) and Support
Plan cessation strategies for disparate populations: • Racial/ethnic • Low SES • Low education • Disabled • LGBTQ Plan integration of tobacco cessation with other conditions: • Chronic diseases • Behavioral health and substance use • Infant mortality/ birth outcomes	Integrate, leverage, and/ or reduce duplication between public health programs, commercial plan programs, and/ or Medicaid MCP initiatives targeting populations at special risk for tobacco use or with comorbidities adversely impacted by tobacco	• Entity is prioritizing another population or disease area • Is NOT willing to integrate tobacco cessation • IS willing to integrate tobacco cessation (while not explicitly prioritizing tobacco) • May discover an area of quality focus that could be expanded to include tobacco ***NOTE:*** *This section is likely to produce very different results for Medicaid versus commercial populations. Make sure to specify which population you are interested in, but don't rule out asking about this for both these populations, since there could be an opportunity for applying learnings from Medicaid populations to commercial populations and vice versa.*	• Use aggregate results to work with health plans to illustrate gaps relative to their peers • Develop population- or disease-specific tobacco use and cessation fact sheets or other materials • Discuss any quitline services specific to the population or disease (e.g., Asian language quitline) • Provide TA on addressing tobacco use within the specific population or relative to the specific disease • Medicaid: Because of tobacco's impact on many diseases, addressing tobacco cessation initiatives in Quality Improvement Projects (QIP) or Performance Improvement Projects (PIP) may provide meaningful interventions and results, even in the absence of a direct tobacco cessation QIP or PIP • Commercial: Because of tobacco's impact on many diseases, Quality improvement initiatives addressing these diseases may be enhanced by including a tobacco component, even in the absence of a direct tobacco initiative ***NOTE:*** *Follow-up actions will likely differ between Medicaid and commercial populations. If a plan has robust programs in its MCP line but not in its commercial line, the focus may be on extending some of the most applicable components to its commercial line (e.g., to behavioral health, chronic disease, etc.).*	• Disparate populations • Disease management • HEDIS • Quality Improvement Program/ Performance Improvement Program (QIP/ PIP) methodology and requirements (Medicaid/Medicare Advantage/other) • ICD-10 codes and billing codes related to tobacco use and cessation services

Questions for Assessing If and How the Health Plan Has Aligned or Integrated Tobacco Cessation with Other Priority Programs

1. Please complete the table below regarding any programs specifically targeting any of the following demographics or disease conditions for your **__insert target population __** members.

	Target Program		Tobacco Component Embedded in Target Program		
	Yes	*No*	*Yes*	*No*	*If yes, describe*
Racial/Ethnic	☐	☐	☐	☐	
Low SES	☐	☐	☐	☐	
Low Education	☐	☐	☐	☐	
Disabled	☐	☐	☐	☐	
LGBTQ	☐	☐	☐	☐	
Other	☐	☐	☐	☐	
Disease Conditions					
Pregnancy/Infant Mortality	☐	☐	☐	☐	
Behavioral Health/Substance Use	☐	☐	☐	☐	
Chronic Conditions (identify)	☐	☐	☐	☐	
Other (describe)	☐	☐	☐	☐	

2. **Medicaid MCPs:** Has the plan initiated or participated in any Quality Improvement Projects (QIP) or Performance Improvement Projects (PIP) and included tobacco cessation interventions? ☐ Yes ☐ No
   If yes, please describe: _____

3. **Commercial:** Is tobacco a component of any of the plan's pay for performance, quality initiatives, or other performance programs? ☐ Yes ☐ No
   If yes, please describe: _____

4. **Commercial:** Is the plan considering any new quality initiative, rapid improvement initiatives, or other performance programs for next year?
   If yes, please describe: _____

Appendix | Health Plan Product Line Considerations

	Medicare Advantage (MA)	Medicaid Managed Care Plan (MCP)	Fully Insured	Self-insured
Definitions	• A Medicare product offered by a private health plan that provides integrated Medicare Part A and Medicare Part B coverage. Can also be referred to as Medicare Part C. • Funding: Members pay a flat monthly premium to the MA company, in addition to any applicable copays and deductibles. Federal government provides majority of funding via Medicare program. • 1 in 3 Medicare recipients.	• A health plan that receives a set monthly payment (capitation) from a state Medicaid agency. A risk-based MCP assumes all financial risk for providing the agreed upon services. • Funding: State government with Federal match. • 81% of state Medicaid recipients. • Fastest growth market for commercial carriers.	• A product that covers the cost of an insured individual's medical and surgical expenses. Aside from member responsibilities such as copays and deductibles, the insurer assumes all risk for providing services – even if the cost of the services exceeds the premium. • Funding: Employer plus member responsibilities (e.g., premium contribution, deductible, copays). • Employer groups tend to be small (95% of employers with fewer than 50 employees use fully insured plans).	• A plan in which the employer assumes the financial risk for providing health care benefits to its employees. Often paired with an administrative services relationship with a health plan or third-party administrator to adjudicate claims and manage provider networks. • Funding: Employer plus growing share paid by member. • 63% of covered workers are in a self-insured health plan. The percent of workers in self-insured plans increases with the size of the company (17%: 3-199 workers, 83%: > 200 workers).

	Medicare Advantage (MA)	Medicaid Managed Care Plan (MCP)	Fully Insured	Self-insured
General Background	• This population is fairly stable, so, barring changes in the external market, members don't change plans a lot. • Benefits must at least match regular Medicare benefits, but can be enhanced. Changes to benefits must be approved by Medicare (CMS). • Proposed changes must be able to demonstrate viability with the senior population, e.g., long-term benefits are less attractive, but quality of life benefits are very attractive. • Medicare uses a star rating system for MA plans. Stars are highly coveted and widely promoted as a differentiator.	• Very unstable market. • Benefits must at least meet both state and federal requirements, Benefits are outlined in the State Plan (which vary from state to state). Proposed changes that require amending the State Plan are difficult due to political and legislative requirements. • Most states with a Managed Care System also have a Medicaid waiver to allow for the structure of the Managed Care System. • Changes that can be managed either internally by the MCP or in partnership with the State Medicaid agency but without State Plan amendments are preferred by states. • Time horizon for ROI is critical. State Plan changes typically require 1-year ROI to be approved; MCPs often have 3-year contracts, so the horizon to show ROI for non-State Plan changes is a bit longer.	• Benefits must meet state requirements (which vary from state to state) and federal requirements (e.g., ACA, Mental Health Parity and Addiction Equity Act (MHPAEA)). • For most commercial plans, one year is the standard horizon for ROI unless the benefit provides clear market advantages from a non-ROI perspective. For groups like Kaiser and other integrated systems with longer client relationships, the ROI horizon is viewed more expansively.	• Health plans bear no cost for any extra service unless they are also selling the employer a Disease Management program. • Must make proposed changes compelling to the employer's consultant or administrative partner by framing them as providing added value to employers or a differentiator in marketing themselves to employers. No public health lens, so business case must be tied to productivity, employee retention, value, etc. • Bureau of Labor Statistics indicates that the median tenure for all wage and salary workers was 4.2 years in January 2016. The median tenure for public sector wage and salary workers was 7.7 years. This extends the window for showing ROI.

	Medicare Advantage (MA)	Medicaid Managed Care Plan (MCP)	Fully Insured	Self-insured
• **Customer** • **Regulator** • **Financial Stability**	• **Customer**: Individual Medicare retirees; more women than men; range of cognitive and physical ability. • **Regulator:** Federal government. • **Financial Stability**: Funds come from members and federal government. Annual rate announcements by the federal government, coupled with risk adjusters, dictate financial value for MA plans. Rates and risk adjusters can vary year to year and region to region.	• **Customer:** State Medicaid Agency is the primary business customer, but in a multi-MCP state, MCPs must also compete to attract Medicaid recipients. • **Regulator:** State Medicaid agency, State Insurance Department, Federal government at a macro level. • **Financial Stability**: On average, 57% of funds come from Federal government, the rest from state government. Although currently a fast-growth market for commercial, the current uncertainty about federal funding coupled with the fact that new growth is concentrated primarily in higher risk segments such as long-term services and supports may render this market less attractive to MCP carriers.	• **Customer:** Employers, individuals if on Exchange. • **Regulator:** State Insurance Department. • **Financial Stability**: Declining market due to shift to self-insurance. Plan holds the most control due to small size and weak market leverage of small employer business base. Customers are very price-sensitive, leading to high turnover.	• **Customer:** Large employers, but lower and lower thresholds for size to self-insure. Broker or benefit consultant is a key partner (driver in many cases) for the business decisions. • **Regulator:** Limited federal regulation - ERISA, HIPAA. • **Financial Stability**: Fairly stable because employers don't want to shift vendors frequently due to cost of disruption. Primary reasons to self-insure are financial: no state premium tax, no reserve requirements, no payment for the profit margin health plans build into their premiums, fewer regulatory restrictions (e.g., state mandated benefits).

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