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Implementation of a Comprehensive Tobacco-Cessation Policy in Medicaid Managed Care Plans in California

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Introduction: In 2016, the California Department of Health Care Services issued All Plan Letter 16-014 to the Medi-Cal Managed Care Plans to provide information on requirements for comprehensive tobacco-cessation services. Researchers at the University of California, San Diego set out to: (1) examine Medi-Cal's Managed Care Plans' progress in implementing each section of All Plan Letter 16-014, (2) understand various factors related to implementation of the All Plan Letter, and (3) make recommendations to improve implementation.

Methods: Researchers surveyed health educators within California's 25 Medi-Cal Managed Care Plans to document each one's smoking-cessation services and policies in 2018. Data were collected for 24 of the 25 Medi-Cal Managed Care Plans (96%) via three methods, including: (1) a web-based survey, (2) an in-depth phone interview, and (3) collection of smoking cessation–relevant documents.

Results: Managed Care Plans demonstrate low levels of full implementation, with only one fully implementing all 20 provisions of the All Plan Letter. On average, Managed Care Plans implemented 13 of the 20 provisions. Managed Care Plans had highest implementation rates for provisions related to requirements for coverage of the seven U.S. Food and Drug Administration–approved medications for tobacco cessation, in which 12 (55%) fully implemented all related required provisions. Managed Care Plans had lowest implementation rates for provisions related to data collection, with only four (18%) fully implementing all three requirements.

Conclusions: Although All Plan Letter 16-014 was successful in creating more comprehensive and consistent benefits across Managed Care Plans, 95% of Managed Care Plans have not fully implemented it. Further guidance from the Department of Health Care Services and integration with the California Smokers' Helpline may be needed to achieve full implementation.

INTRODUCTION

California has the largest Medicaid program (Medi-Cal) in the U.S. with more than 12 million enrollees, 82% of whom receive their care through managed care plans (MCPs).[1,2] Medi-Cal enrollees smoke at higher rates (17.4%) compared with the privately insured Californians (9.2%), and thus face higher rates of tobacco-related morbidity and mortality.[3,4] Despite Medicaid coverage for effective smoking-cessation treatments, previous research has documented that only 7% of Medi-Cal smokers use covered cessation medications.[5]

In November 2016, the California Department of Health Care Services (DHCS) issued an All Plan Letter (APL 16-014) to the Medi-Cal MCPs detailing requirements to provide comprehensive tobacco-cessation services.[6] Modeled on evidence-based guidelines, the APL provided guidance on implementation of state and federal laws related to tobacco-cessation services.[7,8] To assist other states in implementing comprehensive tobacco-cessation services for their Medicaid managed care enrollees, this Research Brief summarizes progress in full APL 16-014 implementation, 2 years after its release.

METHODS

From September 2018 through February 2019, researchers at University of California, San Diego surveyed Medi-Cal's MCPs regarding smoking-cessation programs and policies as of 2018. Data were collected through a web-based survey application (Key Survey) and through online MCP drug formularies, provider manuals, and policies and procedures documents. Survey questions included items which assessed implementation of 20 provisions listed in APL 16-014 (Table 1). Given their key role in delivering tobacco-cessation services and training primary care providers

on tobacco cessation, health educators at each MCP served as the primary respondent and were encouraged to consult with respondents from other departments (i.e., pharmacy, quality improvement) where necessary. Upon completion of the survey, semi-structured follow-up interviews were conducted with survey respondents to clarify each survey response and ask about barriers to implementing required provisions.

Data were collected for 24 of the 25 Medi-Cal MCPs (96% response rate), representing 96% of the enrollment in California. One MCP administered the smoking-cessation programs for two other MCPs and was counted as one survey respondent (n=22). Two members of the research team coded responses into analysis categories for each MCP to assess full, partial, or no implementation of each APL provision. Any discrepancies were resolved by a third team member, referencing one of the MCP documents, or e-mailing the MCP respondent.

RESULTS

Table 1 presents the findings on Medi-Cal MCP implementation of APL 16-014 overall and weighted by MCP enrollment.[9] Approximately 2 years after its release, MCPs demonstrate low levels of full implementation, with only one MCP (5%) fully implementing all 20 provisions. On average, MCPs implemented 13 of the 20 APL provisions.

The APL provisions with the highest implementation were related to coverage of the seven U.S. Food and Drug Administration–approved medications to treat tobacco dependence. All 22 MCPs (100%) covered at least one medication without prior authorization for 90 days of treatment without cost sharing. Twenty-one MCPs (95%) reported covering medications without requiring

enrollment in counseling programs, whereas 14 MCPs (64%) reported covering medications without fail-first protocols (also referred to as step therapy). Eighteen MCPs (82%) covered all medications, with coverage for nicotine nasal spray and inhaler lacking in four MCPs (18%). Overall, 12 MCPs (55%) fully implemented all required tobacco-cessation medication provisions.

Implementation related to counseling requirements was inconsistent. Although 20 MCPs (91%) provided cessation information to their members who use tobacco and 18 MCPs (82%) provided access to counseling, only eight MCPs (36%) reported collaborating with county tobacco control programs, and four MCPs (18%) ensured that providers refer to the California Smokers' Helpline (a statewide free service that offers telephone cessation counseling). Overall, only one MCP (5%) fully implemented all six provisions related to counseling.

Provisions related to data collection had low levels of implementation, with only four MCPs fully implementing all three requirements (18%). These provisions included requirements to track individual utilization of tobacco-cessation interventions (64%), requiring primary care providers to institute a tobacco user identification system (55%), ensuring providers conduct initial and annual assessment of tobacco use for each member (27%), and tracking relevant Consumer Assessment of Healthcare Providers and Systems measures (27%).

DISCUSSION

Despite high levels of tobacco dependence treatment coverage, MCPs fell short in implementation related to counseling services and monitoring of tobacco use behavior and

treatment utilization. Lack of compliance with APL 16-014 is driven by multiple factors such as the nature of the requirements, technical limitations, and a lack of prioritization.

The language used to describe APL requirements served as a barrier to full implementation for some MCPs. For example, with tobacco-cessation drug coverage, many MCPs were not clear that using fail-first protocols was not allowed for any of these drugs. In addition, the use of the phrase "MCP shall ensure providers…" was also interpreted by some as "MCPs shall require" and by others as "MCPs shall require, monitor, and enforce." DHCS may want to issue further guidance on these and other points of confusion.

The MCPs also reported technical limitations in implementing the APL. Owing to infrastructure challenges, MCPs are not consistently requiring contracted providers to have tobacco user identification systems and are not able to measure overall smoking rates to track progress of smoking-cessation initiatives. This presents a serious challenge to treating tobacco dependence among the majority of Medi-Cal MCPs, and MCPs may want to invest in infrastructure to address challenges for measuring rates of tobacco use and other diseases.

Finally, full implementation of the APL provisions is also driven by prioritization of treating tobacco use. Respondents at MCPs with lower levels of implementation reported frustration in the lack of prioritization of treating tobacco dependence by MCP leadership. MCPs are subject to many requirements, of which tobacco is just one small part. As DHCS does not audit the MCPs on each individual provision in APL 16-014, MCP leadership can opt to prioritize other practices that they are audited on.

Although improvements in the provision of tobacco dependence treatments by MCPs have occurred in the past 2 decades, MCPs continue to fall short in implementing practices to provide comprehensive tobacco-cessation services as outlined in APL 16-014.[10] Whereas the results weighted by MCP enrollment indicate that implementation of APL items was positively influenced by enrollment, future research should examine other organizational and environmental factors that may either promote or prevent full adoption of the APL.

Limitations

These results are part of an academic research project and are not to be interpreted as results from a formal audit of compliance with DHCS Medi-Cal policy. As DHCS audits do not specifically address smoking-cessation benefits, this paper represents the only information publicly available on the extent to which MCPs have fully implemented APL 16-014. In addition, these results represent policies in place in 2018, and it is possible that individual MCP policies have been updated since the completion of this study.

CONCLUSIONS

Although APL 16-014 was successful in creating more consistent cessation benefits across MCPs, 95% of MCPs have not yet achieved full implementation. DHCS may need to re-evaluate the items in the APL and prioritize those that are of highest benefit, taking into account MCPs' current resource and infrastructure limitations. In addition, strengthening connections to existing state- and county-level resources and the California Smokers' Helpline may be needed to achieve full implementation of APL 16-014 among all Medi-Cal MCPs.

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Table 1. Summary of Overall Implementation of APL 16-014 Sections 1-8 (n=22[a])

Topic	Provision	Implementation rate (%)	Implementation rate weighted by enrollment (%)[b]
Medications	Cover at least one FDA-approved tobacco cessation medication without prior authorization	100	100
Medications	Require 90-day treatment regimen of medications without co-pay	100	100
Medications	Do not require enrollment in counseling program to access tobacco cessation medications	95	99
Counseling	Provide information to members using tobacco	91	97
Medications	Cover all seven FDA-approved tobacco cessation medications for adults	82	96
Pregnant users	Require providers to ask all pregnant beneficiaries if they use tobacco or are exposed to tobacco	82	95
Counseling	Ensure individual face-to-face, group, and telephone counseling are offered at no cost to beneficiaries	82	91
Pregnant users	Require providers to offer all pregnant tobacco users at least one face-to-face tobacco cessation counseling per quit attempt	77	92
Counseling	Encourage providers to use the “5 A’s”	73	85
Medications	Do not use stepped-care or fail-first protocols	64	86
Data	Shall track individual utilization data of tobacco cessation interventions	64	65
Children and adolescents	Require providers to provide interventions to prevent initiation	59	78
Counseling	Encourage providers to use the Helpline’s web referral or e-referral system	55	65
Data	Require primary care practices to institute a tobacco user identification system	55	51
Provider training	Conduct tobacco cessation trainings for providers	45	70

Counseling	Collaborate with county tobacco control programs to identify group counseling resources	36	38
Pregnant users	Ensure pregnant beneficiaries who use tobacco are referred to a tobacco cessation quitline	36	45
Data	Ensure contracted providers conduct initial and annual assessment of tobacco use for each beneficiary	27	29
Data	Shall track CAHPS tobacco survey items	27	40
Counseling	Ensure providers refer beneficiaries who use tobacco to the CA Smokers' Helpline (or other comparable service)	18	26
	Fully implemented all 20 provisions	5	–
	Average number of provisions implemented (out of 20)	13	–

[a]One MCP administers the health education benefit for two other MCPs; thus, the number of respondents is 22. The combined enrollment for all three were used to weight the responses in Table 1.
[b]MCP responses were weighted by multiplying each response (1 or 0) by the number of Medicaid enrollees in each MCP and dividing by the total Medicaid enrollment across all MCPs (9,696,645) to represent the % of enrollees who were in MCPs with the selected policy in place (MCP enrollment ranged from 6,009 to 2,066,390, with an average enrollment of 440,757).

APL, All Plan Letter; FDA, Food and Drug Administration; CAHPS, Consumer Assessment of Healthcare Providers and Systems; CA, California; MCP, Managed Care Plan.