State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

DATE: SEPTEMBER 3, 2014

POLICY LETTER 14-006

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: COMPREHENSIVE TOBACCO CESSATION SERVICES FOR MEDI-CAL MEMBERS; PREVENTING TOBACCO USE IN CHILDREN AND ADOLESCENTS

PURPOSE:
The purpose of this Policy Letter (PL) is to provide Medi-Cal managed care health plans (MCPs) with minimum requirements for comprehensive tobacco cessation services.

BACKGROUND:
Tobacco use is the leading preventable cause of death in the United States and Medi-Cal members have a higher prevalence of tobacco use than the general California population.[1]

Tobacco cessation services have been demonstrated to be both clinically effective and cost effective.[2] Research shows a return on investment of 3:1 for dollars spent on smoking cessation services in Medicaid populations.[3]
The Department of Health Care Services' (DHCS) Medi-Cal managed care contracts require MCPs to provide all preventive services identified as United States Preventive Services Task Force (USPSTF) grade "A" and "B" recommendations. The USPSTF recommends (grade A) that health care providers ask all individuals ages 18 and older about tobacco use and that providers offer cessation interventions to those who use tobacco products.

[1] UCLA Center for Health Policy Research, "California Health Interview Survey, 2011 to 2012," http://healthpolicy.ucla.edu/chis/design/Pages/questionnairesEnglish.aspx.
[2] 2008 US Public Health Service Clinical Practice Guideline, "Treating Tobacco Use and Dependence," http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html.
[3] Patrick, R. West K, Ku L, "The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts," PLOS One, January 6, 2012, http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0029665.

Augmented pregnancy tailored counseling should be offered to pregnant women who smoke.[4] Successful implementation strategies for primary care practice include instituting a tobacco user identification system, promoting clinician intervention, and dedicating staff to provide treatment. The USPSTF also recommends (grade B) that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.[5]

Additional federal guidance is contained in "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update" [6] which was sponsored by the U.S. Department of Health and Human Services, Public Health Service (USPHS). A summary is included in Attachment A.

REQUIREMENTS:

Tobacco Cessation Services
Effective November 1, 2014, MCPs shall implement and cover payment of the following tobacco cessation services:

1. Initial and annual assessment of tobacco use for each adolescent and adult member.

   MCPs must ensure that providers identify (initially and annually) all members (of any age) who use tobacco products and note this use in the member's medical record. MCPs must ensure that providers document the following:

   - A completed Individual Comprehensive Health Assessment, which includes the Individual Health Education Behavioral Assessment (IHEBA), for all new members within 120 days of enrollment per PL 08-003.[7] The Staying Healthy Assessment (SHA) is DHCS's IHEBA per PL 13-001 (Revised). Each age-appropriate SHA questionnaire asks about smoking status and/or exposure to tobacco smoke;[8]

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[4] United States Preventive Services Task Force, "Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults and Pregnant Women," http://www.uspreventiveservicestaskforce.org/uspstf09/tobacco/tobaccors2.htm.
[5] United States Preventive Services Task Force, "Primary Care Interventions to Prevent Tobacco Use in Children and Adolescents," http://www.uspreventiveservicestaskforce.org/uspstf/uspstbac.htm.
[6] Fiore MC, Jaén CR, Baker TB, et al. "Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline." Rockville, MD. U.S. Department of Health and Human Services. Public Health Service. May 2008.
[7] Previous MMCD PLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx.
[8] California Department of Health Care Services, "Staying Healthy Assessment," http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx#.

- Tobacco use status for every member at least once per year. Since the IHEBA must be reviewed or re-administered on an annual basis, smoking status can be re-assessed through the use of the SHA; and
- That they have asked tobacco users about tobacco use at every visit.

2. FDA-approved tobacco cessation medications (non-pregnant adults of any age).
    - MCPs must cover all seven FDA-approved tobacco cessation medications: bupropion SR, Varenicline, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, and the nicotine patch for adults who smoke or use other tobacco products. At least one must be available without prior authorization;
    - MCPs must provide a 90-day treatment regimen of medications without other requirements, restrictions, or barriers;
    - MCPs must cover any additional medications once approved by the FDA to treat tobacco use;
    - While counseling is encouraged, MCPs may not require members to attend classes or counseling sessions prior to receiving a prescription for an FDA-approved tobacco cessation medication. Studies have shown that quit attempts are more likely to be successful when policies remove barriers to tobacco cessation treatment, including prior authorizations or limitations on treatments;[9] and
    - MCPs must cover a minimum of two separate quit attempts per year, with no mandatory break required between quit attempts.

3. Individual, group, and telephone counseling for members of any age who use tobacco products.
    - MCPs must ensure that individual, group, and telephone counseling is offered to members who wish to quit smoking, whether or not those members opt to use tobacco cessation medications;
    - MCPs must ensure that four counseling sessions of at least 10 minutes in duration are covered for at least two separate quit attempts per year without

[9] Centers for Disease Control and Prevention. State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Coverage — United States, 2008–2014, MMWR, March 28, Volume 63, Number 12.

prior authorization. MCPs must offer individual, group, and telephone counseling without cost to the members; and

- MCPs must ensure that providers refer members to the California Smokers' Helpline (1-800-NO-BUTTS), a free statewide quit smoking service operated by the University of California San Diego (see below) or other comparable quit line services. MCPs should encourage providers to use the "5 A's" model or other validated behavior change model when counseling patients.[10]

4. Services for pregnant tobacco users.

   At a minimum, MCPs must ensure that providers:

   - Ask all pregnant women if they use tobacco or are exposed to tobacco smoke; and
   - Offer all pregnant smokers at least one face-to-face counseling session per quit attempt. Face-to-face tobacco-cessation counseling services may be provided by or under supervision of a physician, legally authorized to furnish such services under state law. MCPs must also ensure that pregnant women are referred to a tobacco cessation quit line. These counseling services must be covered for 60 days after delivery plus any additional days up to the end of the month.

   Since smoking cessation medication is not recommended during pregnancy, MCPs should alert clinicians to refer to the tobacco cessation guidelines by the American College of Obstetrics and Gynecology before considering offering tobacco cessation medication during pregnancy. MCPs are encouraged to post these guidelines on their websites.

5. Prevention of tobacco use in children and adolescents.

   MCPs must ensure primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and

[10] Improving Chronic Illness Care, "5 A's Behavior Change Model, Adapted for Self-Management Support Improvement," http://www.improvingchroniccare.org/downloads/3.5_5_as_behaviior_change_model.pdf; and Agency for Healthcare Research and Quality, "Five Major Steps to Intervention (The "5A's)," http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.html.

adolescents. Anticipatory guidance as outlined in the American Academy of Pediatrics Bright Futures is recommended.[11]

6. Provider training.

MCPs shall use the USPHS "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update," which is one of the supporting documents to the USPSTF recommendations. MCPs are also encouraged to use any updates to inform and educate clinicians regarding effective strategies and approaches for providing tobacco cessation treatment for all populations, including specific recommendations for pregnant women. MCPs should encourage providers to implement these comprehensive tobacco use treatment recommendations.

MCPs should include tobacco cessation training with other provider trainings as required in DHCS contracts. These trainings must include:

- New requirements for comprehensive tobacco cessation member services included in this PL;
- Overview of the "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008;"
- How to use and adopt the "5 A's" or other validated model for treating tobacco use and dependence in the provider's clinic practice; and
- Special requirements for providing services for pregnant tobacco users.

MCPs should also inform providers about available online courses in tobacco cessation. Resources are listed in Attachment B.

Monitoring and Evaluation

MCPs must institute a tobacco user identification system in primary care practices, per USPSTF recommendations. In addition, MCPs should develop a system to monitor provider performance in implementing tobacco cessation interventions. Results should guide MCP and provider efforts to strengthen tobacco use screening and cessation interventions, and to determine if the prevalence of smoking decreases over time. At a minimum, measures for adults should include results from tobacco questions in the CAHPS survey.

[11] American Academy of Pediatrics Bright Futures, "Performing Preventive Services: A Bright Futures Handbook." https://brightfutures.aap.org/pdfs/Preventive%20Services%20PDFs/Anticipatory%20Guidance.PDF.

California Smokers' Helpline
The Public Health Service Guideline recommends the use of tobacco quit lines in addition to services offered by clinicians and health systems. The California Smokers' Helpline (1-800-NO-BUTTS) is a free statewide quit smoking service operated by the University of California San Diego's Moore's Cancer Center.[12] The Helpline offers self-help materials, referral to local programs, and one-on-one telephone counseling to quit smoking. Helpline services have been proven in clinical trials to double a smoker's chances of successfully quitting. Services are available in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), and specialized services are available for teens, pregnant women, and tobacco chewers. The Helpline also provides information for friends and family members of tobacco users.

For more information about the Helpline, contact the Communications and Partner Relations Department at:

California Smokers' Helpline
9500 Gilman Drive, Mail Code #0905
La Jolla, CA 92093-0905
(858) 300-1010
cshoutreach@ucsd.edu

For questions about this PL, contact your Medi-Cal Managed Care Division Contract Manager.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Acting Deputy Director
Health Care Delivery Systems

Attachments

[12] Additional information is available at: UC San Diego's Moore's Cancer Center, http://cancer.ucsd.edu/.

Attachment A: Summary of "2008 US Public Health Services Guidelines: Treating Tobacco Use and Dependence" and Additional Background

For the general population (nonpregnant adults):

1. Because tobacco dependence is a chronic condition that often requires repeated intervention, multiple attempts to quit may be required. At least two quit attempts per year should be covered;

2. While counseling and medication are both effective in treating tobacco use when used alone, they are more effective when used together; and

3. While individual, group, and telephone counseling are effective in treating tobacco use, effectiveness increases with treatment intensity.

   Note that federal guidance for implementation of the Patient Protection and Affordable Care Act (ACA) recommends the following coverage for each cessation attempt:

   i. Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling, and individual counseling) without prior authorization; and

   ii. All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

For pregnant women:

1. Because of the serious risk of smoking to the pregnant smoker and fetus, whenever possible, pregnant smokers should be offered tailored one-on-one counseling that exceeds minimal advice to quit; and

2. Pharmacotherapy is not recommended for pregnant women because there is insufficient evidence on the safety and effectiveness of pharmacotherapy in pregnant women.

   Note that the ACA (Section 4107) authorizes coverage of counseling and pharmacotherapy for tobacco cessation for pregnant women. American Academy of Obstetricians and Gynecologists recommends clinical interventions and strategies for pregnant women who smoke. (American Congress of Obstetricians and Gynecologists, "Smoking Cessation During Pregnancy: Committee Opinion," available at:

http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Smoking_Cessation_During_Pregnancy)

For children and adolescents:

1. Counseling is recommended for adolescents who smoke, because it has been shown to be effective in treating adolescent smokers; and

2. Counseling in a pediatric setting of parents who smoke has also shown to be effective and is recommended. Secondhand smoke can be harmful to children.

   Note that coverage of medically necessary tobacco cessation services, including both counseling and pharmacotherapy, is mandatory for children up to age 21 under Medicaid's Early and Periodic Screening, Diagnostic and Treatment benefit. This benefit includes the provision of anticipatory guidance and risk-reduction counseling regarding tobacco use.

Attachment B: Provider Trainings and Resources

Overview of the "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update" (SDL # 11-007): http://bphc.hrsa.gov/buckets/treatingtobacco.pdf.

Continuing Medical Education (CME)-accredited training on tobacco cessation and behavioral health: https://cmecalifornia.com/Activity/1023974/Detail.aspx.

Other cessation trainings: http://www.centerforcessation.org/training.html.

University of California San Francisco's (UCSF) Smoking Cessation Leader Center's tools and resources: http://smokingcessationleadership.ucsf.edu/Resources.htm

UCSF's Smoking Cessation Leadership Center Webinars for CME/Continuing Education Unit credit: http://smokingcessationleadership.ucsf.edu/Webinarscme.htm.

California Smokers' Helpline/Center for Tobacco Cessation: http://centerforcessation.org/training.html.

Medical Incentive to Quit Smoking Project: http://www.nobutts.org/migs/.