



Utilization of Smoking Cessation Benefits in Medicaid Managed Care, 2011-2015

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Introduction

According to the New York State Tobacco Control Program, smoking kills between 26,000 and 28,200 adults every year in New York State (NYS), making it the number one cause of disease and preventable death in NYS.¹ Despite NYS adult smoking rates reaching record lows, approximately 2.1 million adult New Yorkers still smoke,² and smoking rates among those with lower incomes, and lower educational attainment or mental illness, have not declined at the same pace.³ While the 2014 statewide smoking prevalence was estimated to be 14% among adults, it ranged from 10% in New Yorkers with income more than \$50,000 to 21% in those with income less than \$15,000.⁴ This is comparable to the 2015 estimated smoking prevalence rate of 28% within the NYS Medicaid program, and 24% within mainstream Medicaid managed care (MMC). In total, New Yorkers spend \$10.4 billion on tobacco-related health care costs annually, of which, Medicaid covers \$3.3 billion.⁵

The purpose of this report is to inform mainstream MMC plans, HIV-Special Needs Plans (SNPs), consumers, and stakeholders about the prevalence of smoking and use of tobacco cessation services within MMC and SNP health plans. As administrators of health and pharmacy benefits, MMC/SNP plans are in a unique position to work with both clinicians and members to impact the utilization of smoking cessation services through messaging, outreach, and case management. Quality improvement efforts should focus on increasing the use of evidence-based tobacco cessation services and ultimately decreasing the prevalence of smoking.

A previous report (January 2015) presented NYS smoking cessation utilization data from 2009 through 2013. The current report incorporates a refined methodology as to how enrollment and qualifying cessation events were identified and counted, providing updates to estimates for years 2011 through 2013, and expanding to include years 2014 and 2015.

Methods

These analyses describe trends in smoking prevalence and tobacco cessation service utilization in mainstream MMC plans and SNPs, from 2011 to 2015. Analyses were restricted to those enrollees 18-64 years old. Members enrolled in Medicaid FFS were excluded due to

¹ New York State Department of Health Statistics [online]. [Accessed August 18, 2016] URL: https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume8/n3_tobacco_leading_cause.pdf

² New York State Department of Health Statistics. http://www.health.ny.gov/prevention/tobacco_control/

³ New York State Department of Health Statistics [online]. [Accessed August 18, 2016] URL: https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume8/n2_adult_smoking_prevalence_in_2013.pdf

⁴ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed Jul 25, 2016]. URL: <http://wwwdev.cdc.gov/brfss/brfssprevalence/>.

⁵ New York State Department of Health Statistics [online]. [Accessed August 18, 2016] URL: http://www.health.ny.gov/prevention/tobacco_control/

limited data regarding smoking prevalence in the FFS population. Those individuals dually eligible for Medicaid and Medicare were also excluded. Plan enrollment was assigned using an 11-month continuous enrollment criteria for each measurement year, consistent with NYS QARR methodology.⁶

Utilization events were identified using Medicaid claims and encounter data. Pharmaceutical smoking cessation claims and encounters were identified based on National Drug Codes (NDCs) for smoking cessation agents. The list of qualifying NDCs was compiled from NYS's Medicaid Data Mart drug reference files, based on drug therapeutic codes 72142, 72143, 72144, 72145, 72146, 72147, 72148, and 72149, all specific to smoking cessation. Additionally, the NDC of any product categorized as a "smoking deterrent" was included. Bupropion, due to its use as both a smoking cessation agent and an antidepressant, was excluded from analyses, except for cases in which the drug's therapeutic code or categorization explicitly indicated that its formulary was for smoking cessation. Smoking cessation counseling services were identified using CPT and CDT procedure codes 99406, 99407 and D1320, corresponding to smoking cessation counseling lasting 3 to 10 minutes, greater than 10 minutes, and counseling provided by dental hygienists, respectively.

Because the precise number of smokers in Medicaid is not known, prevalence estimates were generated using Consumer Assessment of Healthcare Providers and Systems (CAHPS®)⁷ survey data. The CAHPS® survey is a member satisfaction survey administered to a random sample of MMC/SNP plan enrollees. The CAHPS® survey asks enrollees if they now smoke cigarettes or use tobacco "every day", "some days", or "not at all". For the purpose of this analysis, those who answered "every day" and "some days" were considered smokers. The adult CAHPS® survey is administered every other year. Thus, the percent of identified smokers in each plan was held constant over two year periods, and applied to the yearly changes in plan enrollment to obtain plan-specific prevalence estimates and the estimated number of smokers. Estimates were further adjusted to account for regional variation in smoking prevalence. This was achieved by calculating estimated regional (New York City and rest of state) smoking prevalence rates for each plan, when applicable. Statewide prevalence rates were then calculated by taking the average of regional plan prevalence rates weighted by regional plan enrollment.

Utilization rates were calculated as the proportion of unique enrollees who utilized a smoking cessation benefit during each year, divided by the estimated number of smokers within a given plan.

Results

Trended plan-specific smoking prevalence weighted rates from 2011-2015 are displayed in Table 1. Prevalence rates are based on CAHPS® data and are only available every other year.

⁶ New York State Department of Health, Managed Care Reports, QARR Report Series [online]. [Accessed August 18, 2016] URL:

http://www.health.ny.gov/health_care/managed_care/reports/quality_performance_improvement.htm#link3

⁷ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

High prevalence rates are noted among all plans over the five-year period. In 2015, the prevalence ranged from 14.7 to 38.8 percent in MMC plans, and 44.1 to 52.8 percent in SNPs.

Plan-specific trends in smoking cessation pharmaceutical utilization from 2011-2015 are displayed in Table 2. Overall, utilization of pharmaceutical benefits remained relatively flat over the five-year period, with a notable increase for many MMC plans between 2014 and 2015.

Table 1: Smoking Prevalence within New York State Medicaid Managed Care Health Plans, 2011-2015

	Year		
	2011/2012*	2013/2014*	2015
Medicaid Managed Care Plans (MMC)			
Affinity Health Plan	20.4%	15.1%	16.0%
CDPHP	45.2%	41.4%	32.2%
Excelsus BlueCross BlueShield	40.9%	39.5%	37.2%
Fidelis Care New York, Inc.	26.8%	26.5%	25.4%
HIP (EmblemHealth)	24.4%	20.6%	20.7%
HealthNow New York Inc.	41.2%	40.6%	38.8%
HealthPlus, an Amerigroup Company	15.6%	16.2%	17.6%
Healthfirst PHSP, Inc.	19.8%	14.0%	14.7%
Hudson Health Plan	27.0%	27.7%	22.8%
Independent Health	42.9%	37.0%	34.0%
MVP Health Care	45.3%	39.5%	29.0%
MetroPlus Health Plan	16.1%	16.7%	17.2%
Total Care, A Todays Options of New York Health Plan	44.7%	39.3%	37.5%
UnitedHealthcare Community Plan	15.5%	18.9%	19.2%
WellCare of New York	17.1%	17.4%	16.0%
YourCare Health Plan	39.2%	36.6%	38.4%
HIV Special Needs Plans (SNP)			
SNP- Amida Care	51.0%	49.7%	52.8%
SNP- MetroPlus Health Plan	46.0%	47.4%	44.1%
SNP- VNSNY CHOICE SelectHealth	NA	44.9%	41.4%

*The percent of identified smokers in each plan was held constant over two year periods since CAHPS® adult survey data is only available every other year.

NA – not available; plan not in operation in this time period.

Table 2: Smoking Cessation Pharmaceutical Benefit Utilization Rates within New York State Medicaid Managed Care Health plans, 2011-2015

	Year				
	2011*	2012	2013	2014	2015
Medicaid Managed Care Plans (MMC)					
Affinity Health Plan	12.2%	11.0%	13.8%	13.5%	13.5%
CDPHP	16.9%	15.8%	17.1%	16.4%	20.0%
Excellus BlueCross BlueShield	17.6%	16.7%	17.7%	17.0%	19.1%
Fidelis Care New York, Inc.	13.7%	12.8%	12.5%	12.7%	14.3%
HIP (EmblemHealth)	8.3%	8.5%	9.7%	9.5%	10.4%
HealthNow New York Inc.	14.8%	14.3%	14.0%	13.2%	15.5%
HealthPlus, an Amerigroup Company	9.3%	8.8%	8.7%	9.1%	7.3%
Healthfirst PHSP, Inc.	10.2%	10.8%	15.5%	15.0%	13.7%
Hudson Health Plan	16.7%	16.9%	15.1%	14.3%	16.7%
Independent Health	15.1%	15.0%	15.6%	13.5%	16.9%
MVP Health Care	15.1%	10.6%	15.9%	17.3%	22.1%
MetroPlus Health Plan	12.6%	13.8%	14.1%	13.5%	12.3%
Total Care, A Todays Options of New York Health Plan	16.4%	16.7%	16.6%	15.0%	17.4%
UnitedHealthcare Community Plan	14.1%	12.2%	9.6%	10.3%	11.4%
WellCare of New York	12.7%	9.8%	8.0%	8.6%	8.3%
YourCare Health Plan	13.9%	13.9%	15.0%	14.9%	16.8%
HIV Special Needs Plans (SNP)					
SNP- Amida Care	35.3%	35.0%	33.4%	30.9%	29.1%
SNP- MetroPlus Health Plan	22.3%	22.2%	23.6%	22.5%	21.3%
SNP- VNSNY CHOICE SelectHealth	NA	NA	27.8%	27.3%	28.7%

*Managed Care’s Prescription Drug Benefit Carved-In (October 1, 2011).

NA – not available; plan not in operation in this time period.

Interestingly, rates declined slightly after the 2011 managed care carve-in of the pharmacy benefit, although some plans showed little change. Eleven of the 16 MMC plans had higher utilization of these benefits in 2015 than in 2011.

Table 3 describes plan-specific trends in the counseling benefit utilization rate. Rates of counseling benefit utilization demonstrate increased use within all plans, with seven plans doubling utilization since 2011 when Medicaid expanded coverage of smoking cessation counseling to all beneficiaries. Still, several plans witnessed a slight decline in utilization between 2014 and 2015.

Table 3: Smoking Cessation Counseling Benefit Utilization Rates within New York State Medicaid Managed Care Health Plans, 2011–2015

	Year				
	2011*	2012	2013	2014	2015
Medicaid Managed Care Plans (MMC)					
Affinity Health Plan	8.2%	14.9%	23.3%	24.4%	23.9%
CDPHP	7.7%	13.1%	10.7%	10.9%	12.7%
Excellus BlueCross BlueShield	8.4%	10.2%	10.9%	9.4%	11.2%
Fidelis Care New York, Inc.	10.7%	14.9%	16.4%	17.6%	18.5%
HIP (EmblemHealth)	7.8%	11.1%	14.3%	14.9%	13.8%
HealthNow New York Inc.	11.5%	13.2%	15.0%	15.4%	16.4%
HealthPlus, an Amerigroup Company	12.3%	15.5%	16.5%	18.1%	18.0%
Healthfirst PHSP, Inc.	6.6%	11.8%	20.5%	22.8%	23.4%
Hudson Health Plan	9.4%	17.5%	20.1%	21.0%	22.5%
Independent Health	7.8%	10.7%	13.6%	16.3%	18.2%
MVP Health Care	8.7%	11.2%	12.3%	9.5%	12.0%
MetroPlus Health Plan	5.9%	12.6%	15.9%	17.9%	15.6%
Total Care, A Todays Options of New York Health Plan	12.2%	12.2%	20.0%	21.1%	15.8%
UnitedHealthcare Community Plan	15.3%	17.1%	14.7%	14.3%	15.7%
WellCare of New York	10.7%	16.0%	16.4%	19.9%	22.4%
YourCare Health Plan	7.1%	10.8%	13.0%	15.1%	16.1%
HIV Special Needs Plans (SNP)					
SNP- Amida Care	17.8%	28.1%	31.3%	33.1%	32.0%
SNP- MetroPlus Health Plan	2.9%	11.2%	15.9%	18.7%	21.2%
SNP- VNSNY CHOICE SelectHealth	NA	NA	13.7%	15.3%	14.3%

* Medicaid expanded coverage of smoking cessation counseling to all Medicaid beneficiaries (April 1, 2011).

NA – not available; plan not in operation in this time period.

Table 4 describes plan-specific utilization rates among enrollees who had at least one claim/encounter for both counseling and pharmaceutical services from 2011-2015. Despite the increased efficacy of using both benefits in combination, by 2015, MMC health plan rates ranged from a low of 2.4% to a high of 5.8%, while SNP rates were only slightly higher (low of 5.4% and high of 9.6%). Overall, a small but consistent increase is observed for the 2011-2015 time-period.

Table 4: Smoking Cessation Combined Counseling and Pharmaceutical Benefit Utilization Rates within New York State Medicaid Managed Care Health Plans, 2011–2015

	Year				
	2011	2012	2013	2014	2015
Medicaid Managed Care Plans (MMC)					
Affinity Health Plan	2.1%	3.2%	4.4%	4.6%	4.4%
CDPHP	2.0%	3.8%	3.8%	4.0%	4.5%
Excellus BlueCross BlueShield	3.3%	3.3%	3.7%	3.5%	4.3%
Fidelis Care New York, Inc.	2.9%	3.4%	3.6%	3.8%	4.3%
HIP (EmblemHealth)	1.4%	1.8%	2.3%	2.4%	2.6%
HealthNow New York Inc.	3.3%	3.7%	3.9%	4.1%	4.5%
HealthPlus, an Amerigroup Company	2.3%	2.5%	2.6%	2.6%	2.4%
Healthfirst PHSP, Inc.	1.6%	2.7%	4.2%	4.6%	4.5%
Hudson Health Plan	2.9%	5.6%	6.1%	5.4%	5.8%
Independent Health	2.2%	3.3%	3.7%	3.6%	5.3%
MVP Health Care	2.9%	2.6%	3.6%	3.3%	4.5%
MetroPlus Health Plan	1.5%	3.2%	3.5%	3.7%	3.4%
Total Care, A Todays Options of New York Health Plan	3.2%	4.0%	5.7%	5.7%	4.7%
UnitedHealthcare Community Plan	3.4%	3.3%	2.6%	2.6%	2.7%
WellCare of New York	2.4%	2.9%	2.1%	3.0%	2.9%
YourCare Health Plan	2.3%	3.3%	3.9%	3.9%	5.2%
HIV Special Needs Plans (SNP)					
SNP- Amida Care	6.8%	11.4%	11.9%	12.4%	9.6%
SNP- MetroPlus Health Plan	1.3%	3.6%	5.6%	5.4%	5.4%
SNP- VNSNY CHOICE SelectHealth	NA	NA	4.7%	5.4%	5.7%

*Medicaid expanded coverage of smoking cessation counseling to all Medicaid beneficiaries (April 1, 2011), and smoking cessation pharmaceutical products were added to the Medicaid managed care prescription drug benefit package (October 1, 2011).

NA – not available; plan not in operation in this time period.

Table 5 describes plan-specific overall smoking cessation benefit utilization rates from 2011-2015. Driven by increases in the utilization of counseling benefits, the overall utilization rate demonstrates a steady annual increase between 2011 and 2015. In 2015, more than 30% of estimated smokers in three mainstream MMC plans and all SNPs used at least one of these benefits. All plans witnessed in excess of 20% of their estimated smokers utilizing at least one benefit; in 12 of the 16 mainstream MMC plans, and all three SNPs, the percentage of estimated smokers using at least one benefit was over 25%. Utilization was consistently higher among SNP enrollees, as more than 37% of estimated smokers used a benefit in 2015, with an average of over 40% (data not shown).

Table 5: Total Smoking Cessation Benefit Utilization Rates within New York State Medicaid Managed Care Health Plans, 2011–2015

	Year				
	2011*	2012	2013	2014	2015
Medicaid Managed Care Plans (MMC)					
Affinity Health Plan	18.3%	22.6%	32.7%	33.3%	33.0%
CDPHP	22.6%	25.2%	24.0%	23.3%	28.2%
Excellus BlueCross BlueShield	22.8%	23.6%	24.9%	23.0%	26.0%
Fidelis Care New York, Inc.	21.5%	24.2%	25.4%	26.6%	28.5%
HIP (EmblemHealth)	14.7%	17.8%	21.7%	21.9%	21.5%
HealthNow New York Inc.	23.0%	23.8%	25.1%	24.4%	27.3%
HealthPlus, an Amerigroup Company	19.3%	21.7%	22.6%	24.7%	22.9%
Healthfirst PHSP, Inc.	15.3%	19.9%	31.8%	33.1%	32.6%
Hudson Health Plan	23.2%	28.8%	29.1%	30.0%	33.4%
Independent Health	20.7%	22.4%	25.5%	26.2%	29.8%
MVP Health Care	20.9%	19.1%	24.6%	23.4%	29.6%
MetroPlus Health Plan	16.9%	23.2%	26.6%	27.7%	24.6%
Total Care, A Todays Options of New York Health Plan	25.3%	25.0%	30.8%	30.3%	28.6%
UnitedHealthcare Community Plan	26.0%	26.0%	21.7%	22.0%	24.3%
WellCare of New York	21.0%	23.0%	22.3%	25.5%	27.9%
YourCare Health Plan	18.8%	21.4%	24.1%	26.1%	27.7%
HIV Special Needs Plans (SNP)					
SNP- Amida Care	46.3%	51.7%	52.8%	51.6%	51.4%
SNP- MetroPlus Health Plan	23.9%	29.8%	34.0%	35.8%	37.0%
SNP- VNSNY CHOICE SelectHealth	NA	NA	36.8%	37.1%	37.3%

*Medicaid expanded coverage of smoking cessation counseling to all Medicaid beneficiaries (April 1, 2011), and smoking cessation pharmaceutical products were added to the Medicaid managed care prescription drug benefit package (October 1, 2011).

NA – not available; plan not in operation in this time period.

An inherent limitation of analyses based on claims and encounter data is that only services that were billed for and prescriptions that were filled can be included in utilization counts; we do not know if a provider wrote a prescription that went unfilled, or if they recommended a strategy to quit smoking without formally completing (and billing for) smoking cessation counseling. In the 2015 adult CAHPS® survey, the majority of self-identified smokers (81%) reported they had been advised to quit smoking/using tobacco by their doctor or other health provider in the past six months. In addition, 64% reported that medication was recommended or discussed by a doctor or health provider to assist with tobacco cessation. A smaller proportion (56%) reported that their doctor or health provider discussed or provided methods and strategies other than medication to assist with tobacco cessation. While CAHPS® self-report of discussion of smoking cessation options with healthcare professionals was higher

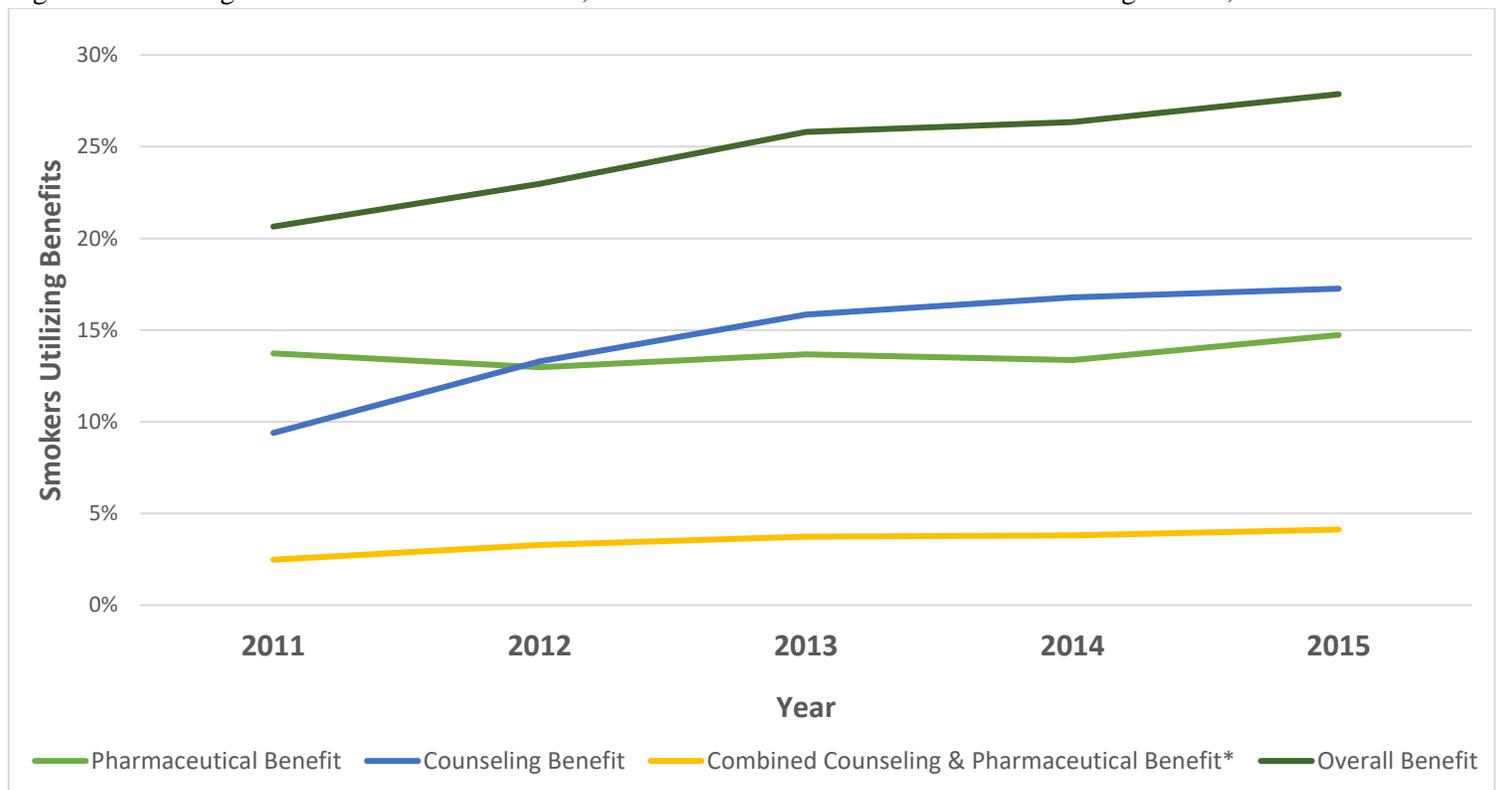
than the service utilization indicated in the analysis of Medicaid claims and encounter data, it is important to note that the CAHPS® questions do not inquire about prescriptions given, nor do they indicate if the discussion qualified as an approved smoking cessation counseling session.

Conclusion

Despite efforts to control the use of tobacco in New York State, tobacco use remains highly prevalent among enrollees in the New York State Medicaid program. Expansion of the Medicaid benefit package has led to increased access to counseling and pharmaceutical services, yet only a minority of enrolled smokers are utilizing these benefits. Plan by plan comparison reveals variation in rate of utilization. Most plans have demonstrated improved utilization since 2011.

Looking at the data at the program level reveals several trends that warrant further consideration. Figure 1 describes smoking cessation benefit utilization across all mainstream MMC plans from 2011 to 2015. Over this five-year period, the smoking cessation pharmaceutical benefit utilization rate remained relatively stable, with a slight decline observed after the 2011 managed care carve-in of the smoking cessation pharmacy benefit, and with a

Figure 1: Smoking Cessation Benefit Utilization, New York State Mainstream Medicaid Managed Care, 2011-2015

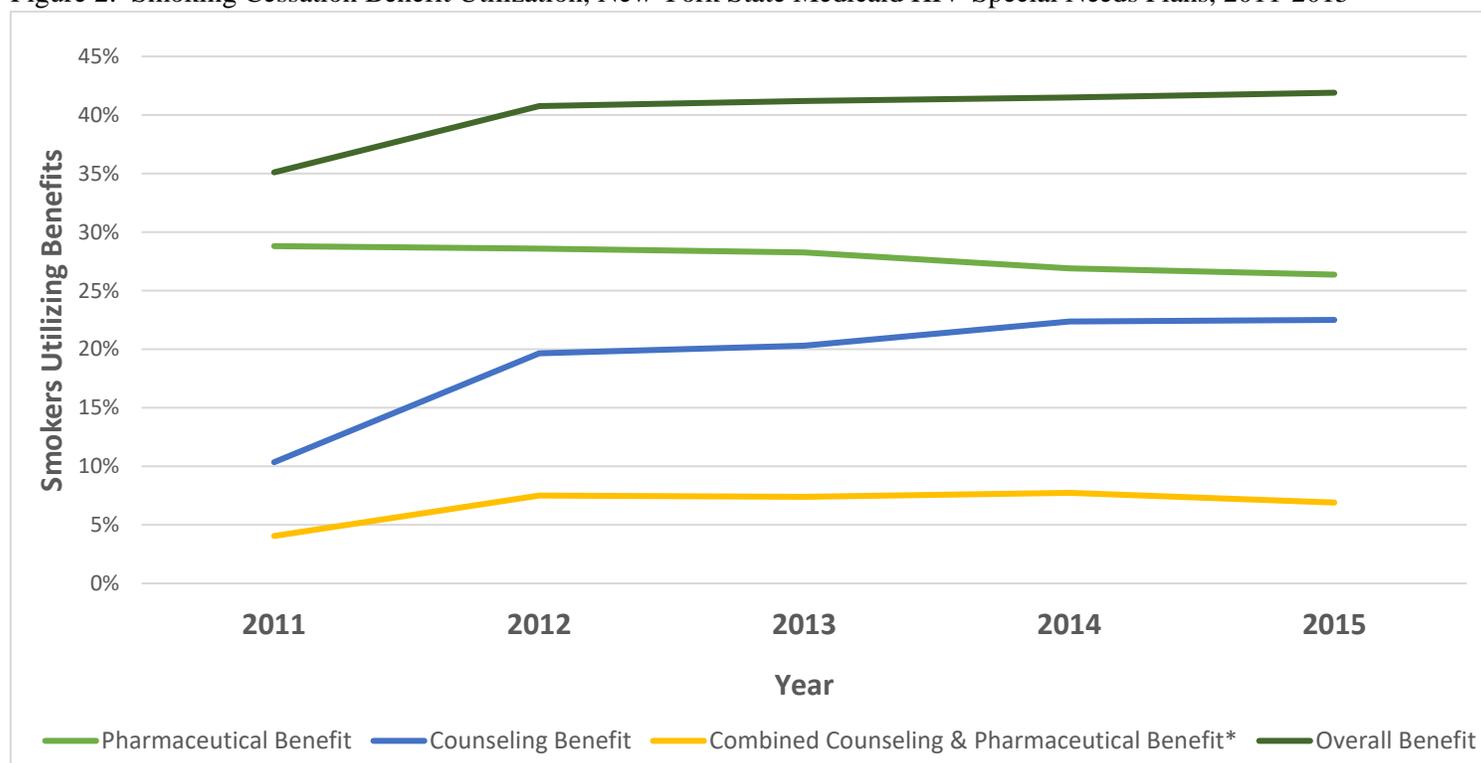


*Includes the subset of enrollees who had at least one claim/encounter for both counseling and pharmaceutical services.

slight increase from 2014 to 2015. Smoking cessation counseling utilization rates have increased, as did the rate of enrollees receiving a combination of smoking cessation counseling and pharmaceutical benefits. Increased utilization of the smoking cessation counseling benefit appears to be driving increases in the overall utilization rate. However, despite observed increases, over two thirds of estimated smokers in mainstream MMC plans, are not utilizing smoking cessation benefits.

Figure 2 describes the trends in smoking cessation benefit utilization in HIV-Special Needs Plans from 2011 to 2015. Overall utilization of smoking cessation benefits is higher within this population than in MMC, however, there has been little to no increase in utilization since 2012. Within the SNP population, pharmaceutical smoking cessation benefit utilization remains higher than cessation counseling.

Figure 2: Smoking Cessation Benefit Utilization, New York State Medicaid HIV-Special Needs Plans, 2011-2015



*Includes the subset of enrollees who had at least one claim/encounter for both counseling and pharmaceutical services.

We welcome suggestions and comments on this publication. Please contact us at:

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