NEW YORK STATE | Department of Health

Smoking Cessation Benefit Utilization in New York State's Medicaid Managed Care Program 2015 - 2017

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Introduction

Smoking is the number one cause of preventable disease, disability, and death in the United States.[1] In New York State (NYS), smoking kills about 28,000 adults every year, and about 750,000 adult New Yorkers live with serious smoking-related illness. Despite adult smoking rates reaching record lows in the state, approximately 2.2 million adult New Yorkers still smoke. Smoking rates are highest among those with lower income, lower educational attainment, or mental illness. While the 2017 statewide smoking prevalence was estimated to be 14.1% among adults, it ranged from 10.3% in New Yorkers with income more than $50,000 to 21.2% in those with income less than $15,000.[2] The latter is comparable to the estimated smoking prevalence of 24.3% for the NYS Medicaid program statewide.[3] In total, New Yorkers spend $10.4 billion on tobacco-related health care costs annually, of which, Medicaid covers $3.3 billion.[4]

Due to the addictive properties of nicotine, quitting is difficult; therefore, both behavioral interventions (counseling) and pharmacotherapy are recommended to improve abstinence rates.[5] NYS Medicaid provides comprehensive coverage of smoking cessation pharmacotherapy agents (all seven approved classes of smoking cessation medication approved by the U.S. Food and Drug Administration) and smoking cessation counseling (SCC) for all Medicaid enrollees, without cost sharing, prior authorization requirements, or limit on quit attempts. Enrollees are allowed concurrent use of products (two or more medications at once). Medicaid also pays for over-the-counter nicotine patches, gum, and lozenges (with a prescription from a provider).

Those enrolled in Medicaid managed care (MMC) plans receive their pharmacotherapy benefits directly through their plans, with some variation by plan regarding which products are offered (generic equivalents for brand name medications). Cessation counseling, both Intermediate (3-10 minutes) and Intensive (greater than 10 minutes in individual or group setting), can be provided by office based practitioners, including dental hygienists, as well as by providers in Article 28 hospital outpatient departments, diagnostic and treatment centers, and federally qualified health centers.

The purpose of this report is to inform MMC plans, consumers, and stakeholders, about the prevalence of smoking and the use of tobacco cessation services among enrollees in mainstream MMC plans, HIV-Special Needs Plans (SNPs), and Health and Recovery Plans (HARPs). As administrators of health and pharmacy benefits, managed care plans are in a unique position to work with clinicians and enrollees to promote smoking cessation services through messaging, outreach, and case management. Quality improvement efforts should focus on increasing the use of these evidence-based tobacco cessation services and ultimately decreasing the prevalence of smoking.

Methods

Smoking prevalence rates and tobacco cessation service utilization in mainstream MMC plans and SNPs were calculated from 2015 to 2017, and in HARPs for 2017 (new plan type- first year with qualifying enrollment). Analyses were restricted to enrollees 18-64 years old. Individuals dually eligible for Medicaid and

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[1] 2014 Surgeon General's Report: The Health Consequences of Smoking- 50 Years of Progress. https://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/

[2] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2016. [accessed Oct 6, 2017]. URL: https://www.cdc.gov/brfss/brfssprevalence/index.html

[3] New York State BRFSS Brief: https://www.health.ny.gov/statistics/brfss/reports/docs/brfssbrief_smoking_1704.pdf

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

[5] U.S. Preventive Services Task Force Recommendation Statement. 2015 https://www.ncbi.nlm.nih.gov/pubmed/26389730

Medicare were excluded. Consistent with NYS QARR specifications, plan enrollment was assigned using an 11-month continuous enrollment criterion for each measurement year.[6]

Because the precise number of smokers in NYS Medicaid is not known, smoking 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 mainstream MMC, SNP, and HARP enrollees annually, alternating between an adult survey and child survey every other year. The adult CAHPS® survey asks enrollees if they now smoke cigarettes or use tobacco "every day", "some days", or "not at all". For this analysis, those who answered, "every day" or "some days" were considered smokers. The percent of identified adult smokers in each plan was held constant over two-year periods to account for off years when the child CAHPS® was administered. Smoking prevalence estimates were then applied to annual plan enrollment to obtain plan-specific estimates of the number of smokers in each plan. In these calculations, smoking prevalence estimates were adjusted to account for variation in smoking prevalence between NYC and the rest of state. This was achieved by applying regional CAHPS® smoking prevalence for each plan to regional plan enrollment, and adding the derived estimated number of smokers in each region, to obtain a regionally-weighted statewide plan estimate. Statewide plan-level prevalence rates were then calculated as the weighted estimated number of smokers divided by the total number of continuously enrolled non-dual adults in each plan.

Smoking cessation benefit utilization events were identified using Medicaid claims and encounters data. Pharmacotherapy products for smoking cessation were identified based on National Drug Codes (NDCs). The list of qualifying NDCs was compiled from NYS's Medicaid DataMart drug reference files, based on NYS-specific drug therapeutic codes 72142, 72143, 72144, 72145, 72146, 72147, 72148, and 72149, which are used to classify a given product as a smoking cessation agent. 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 it was prescribed for smoking cessation. SCC services were identified using procedure codes 99406/G0436, 99407/G0437, S9453, and D1320, corresponding to SCC lasting 3 to 10 minutes, greater than 10 minutes, counseling conducted in a non-physician provider class, and counseling provided by dental hygienists, respectively. Utilization was calculated as the proportion of distinct individuals who utilized a smoking cessation benefit during each year divided by the estimated number of smokers, within a given plan.

Results

Smoking prevalence estimates and the proportion of distinct (estimated) smokers using cessation services, by type of service and overall (use of either service), for each year, are presented consolidated into one table for each program: mainstream Medicaid (Table 1), SNPs (Table 2), and HARPs (Table 3).

Within mainstream MMC, smoking prevalence estimates declined across most plans (13 of 15) between 2015/16 and 2017. However, the range in smoking prevalence estimates in 2017 remained large (14.3% - 34.9%) narrowing only slightly from 2015/16 (14.7% - 38.8%). Median smoking prevalence in 2017 was 18.9%, down from 25.4% in 2015/16. This corresponded with an increase in the overall utilization of smoking cessation services for almost every plan (14 out of 15). Only two plans did not see an increase in the utilization

[6] Enrolled in a given MMC plan, SNP, or HARP for at least 11 of the 12 calendar months

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

of smoking cessation pharmacotherapy, however, utilization in one of those plans remained unchanged from 2015, and was the highest utilization of pharmacotherapy in 2017 (22.1%). Variation in overall utilization increased over the three years, ranging from 21.5% to 33.0% in 2015 (median = 27.9%), and 27.7% to 41.8% in 2017 (median = 33.9%) (Table 1).

Table 1. Smoking prevalence and cessation service utilization by category in mainstream MMC

	Prevalence		Pharmacotherapy			Counseling			Overall		
Plan Name	**2015/16**	**2017**	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
Affinity Health Plan	16.0%	16.8%	13.5%	13.5%	12.2%	23.9%	21.6%	21.7%	33.0%	30.8%	29.6%
CDPHP	32.2%	30.0%	20.0%	19.5%	20.9%	12.7%	13.7%	20.3%	28.2%	28.3%	35.0%
Empire BlueCross BlueShield HealthPlus	17.6%	15.1%	7.3%	8.6%	11.2%	18.0%	18.4%	21.8%	22.9%	24.0%	29.3%
Excellus BlueCross BlueShield	37.2%	31.3%	19.1%	19.3%	21.9%	11.2%	10.4%	13.2%	26.0%	25.4%	29.5%
Fidelis Care New York, Inc.	25.4%	18.9%	14.3%	15.3%	20.9%	18.5%	19.6%	28.0%	28.5%	29.9%	41.8%
HIP (Emblem Health)	20.7%	18.1%	10.4%	11.4%	12.1%	13.8%	16.3%	21.2%	21.5%	24.3%	29.1%
HealthNow New York Inc.	38.8%	34.9%	15.5%	16.8%	18.4%	16.4%	17.7%	22.1%	27.3%	29.2%	33.9%
HealthFirst PHSP, Inc.	14.7%	15.0%	13.7%	14.5%	14.2%	23.4%	25.4%	27.9%	32.6%	34.9%	36.6%
Independent Health's MediSource	34.0%	27.8%	16.9%	15.6%	20.1%	18.2%	16.4%	22.7%	29.8%	27.1%	35.7%
MVP Health Care	29.0%	20.8%	22.1%	15.6%	22.1%	12.0%	16.8%	22.4%	29.6%	27.4%	37.7%
MetroPlus Health Plan	17.2%	15.1%	12.3%	12.2%	13.0%	15.6%	16.8%	21.4%	24.6%	25.6%	30.3%
Molina Healthcare	37.5%	33.4%	17.4%	17.1%	19.9%	15.8%	18.5%	19.1%	28.6%	30.2%	32.4%
UnitedHealthcare Community Plan	19.2%	17.5%	11.4%	12.3%	13.8%	15.7%	17.3%	18.0%	24.3%	26.2%	27.7%
WellCare of New York	16.0%	14.3%	8.4%	11.0%	15.0%	22.4%	26.7%	32.5%	27.9%	33.2%	41.2%
YourCare Health Plan	38.4%	33.7%	16.8%	16.6%	19.9%	16.1%	17.1%	23.3%	27.7%	28.0%	35.2%

Within the three Medicaid SNPs, smoking prevalence estimates declined from 2015/16 (median= 44.1%) to 2017 (median = 41.6%). This corresponded with an overall increase in the use of smoking cessation benefits from a median of 37.3% in 2015 to 47.3% in 2017. However, while all SNPs had an increase in smoking cessation pharmacotherapy utilization, only one had an increase in SCC, and large differences in use of SCC was seen across plans. Variation in the overall use decreased slightly from 2015 (range= 37.0% to 51.4%) to 2017 (range = 46.2% to 58.2%) (Table 2).

Table 2. Smoking prevalence and cessation service utilization by category in SNPs

	Prevalence		Pharmacotherapy			Counseling			Overall		
Plan Name	**2015/16**	**2017**	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
Amida Care	52.8%	47.3%	29.1%	33.0%	40.0%	32.0%	30.9%	31.1%	51.4%	52.4%	58.2%
Metro Plus Health Plan	44.1%	41.6%	21.3%	27.2%	28.7%	21.2%	20.9%	27.4%	37.0%	41.5%	47.3%
VNSNY Choice Health Plans	41.4%	38.0%	28.7%	35.6%	39.4%	14.3%	9.6%	11.9%	37.3%	42.1%	46.2%

In 2017, Medicaid HARP smoking prevalence ranged from 36.9% to 59.3% (median = 47.2%). Smoking cessation pharmacotherapy use ranged from 23.7% to 52.3% (median = 34.1%), and SCC use ranged from 16.9% to 38.3% (median = 32.3%). Overall use ranged from 40.0% to 69.4% (median = 53.5%).

Table 3. Smoking prevalence and cessation service utilization by category in HARPS, 2017

Plan Name	Prevalence	Pharmacotherapy	Counseling	Overall
Affinity Enriched Health	51.6%	23.7%	23.0%	40.0%
CDPHP	52.3%	34.1%	28.6%	50.7%
Empire BlueCross BlueShield HealthPlus	36.9%	33.7%	35.0%	56.7%
Excellus Health Plan, Inc.	54.2%	40.0%	16.9%	47.8%
Fidelis HealthierLife	47.9%	38.4%	33.1%	58.2%
HIP EmblemHealth Enhanced Care Plus	39.0%	27.6%	31.2%	49.6%
Healthfirst Personal Wellness Plan	39.3%	34.9%	37.2%	59.0%
Independent Health's MediSource Connect	46.2%	41.8%	38.3%	64.4%
MVP Harmonious Health Care Plan	47.2%	37.9%	27.0%	53.3%
MetroPlus Enhanced	47.8%	31.5%	33.8%	54.0%
TONY (Total Care Plus)	45.1%	52.3%	33.6%	69.4%
UnitedHealthcare Community-Wellness4Me	46.9%	33.5%	26.8%	50.0%
YourCare Options Plus	59.3%	33.7%	32.3%	53.5%

Discussion

Adult smoking prevalence in NYS's Medicaid managed care program declined from 2015/16 to 2017, coinciding with increased use of smoking cessation services. Differences in cessation service utilization are seen between plans, and programs (mainstream MMC, SNP, HARP).

The 2017 data are encouraging, as they reflect improvements following the December 2016 removal of: prior authorization requirements, restrictions on the number of yearly quit attempts, and restrictions on smoking cessation product formularies within NYS Medicaid. Also, 2017 was the implementation phase of strategies developed during the two-year smoking cessation Performance Improvement Projects (PIPs). However, it remains unclear what specifically is driving increased utilization of cessation services, as our findings only correlate with these programmatic changes. Further, we do not know the degree to which the increases in utilization of these services are driving down smoking prevalence.

This report offers the first look at smoking prevalence and cessation service utilization in HARPs, which became an approved plan type in 2016. While HARP populations appear to have the highest smoking prevalence of any MMC population in NYS, they also have the highest overall utilization of tobacco cessation services, with over half of estimated smokers using this benefit. These observations have face validity, as HARPs offer specialized services for Medicaid enrollees with alcohol or substance use issues.

Overall, both smoking prevalence and cessation service utilization are higher in SNPs and HARPS than mainstream MMC plans. However, SCC is used less frequently than pharmacotherapy in these populations, particularly in SNPs. Regardless, it appears that SCC utilization in the NYS Medicaid managed care program is

much higher than in other Medicaid programs nationally[8]. It is unclear what is specifically driving this relative success.

The analysis had several limitations. First, our estimates of smoking prevalence may be underestimated due to response bias, as they were derived from self-reported smoking status in a consumer survey. Service utilization rates may therefore be overestimated, as they are calculated from the number of actual cessation events divided by the estimated number of smokers. Regarding cessation service utilization, claims and encounter data only capture pharmacotherapy utilization (prescription and over-the-counter medication) when prescriptions are filled. Likewise, the analysis would have missed any clinical discussions about smoking cessation that did not meet NYS Medicaid's definition of an approved, billable, counseling session. Additionally, any cessation counseling that was provided in the absence of coding/billing would have been missed. Pharmacotherapy for smoking cessation that involved off-label use of bupropion products classified as antidepressants, would have also been missed. Finally, we were not able to exclude any pharmacotherapy or counseling that was used for cessation of non-smoking tobacco use.

Reducing smoking prevalence among smokers in NYS's Medicaid population continues to be a public health priority for the NYS Department of Health. Given the recommendations of the U.S. Preventative Services Task Force, that clinicians provide both counseling and pharmacotherapy for smoking cessation, future improvement efforts should focus on increasing concurrent use of services.

[8] Erin J Brantley, Jessica Greene, Brian K Bruen, Erika P Steinmetz, Leighton C Ku; Policies Affecting Medicaid Beneficiaries' Smoking Cessation Behaviors, *Nicotine & Tobacco Research*, , nty040, https://doi.org/10.1093/ntr/nty040