Tobacco Dependence Treatment for Kentucky Medicaid Recipients: The MCO Perspective

POLICY BRIEF

SUMMARY

Kentuckians and people of lower socio-economic status (SES) continue to bear the burden of chronic tobacco dependence and its negative effects even though national tobacco use rates have steadily declined.[1] Adults below the poverty line are 50% more likely to smoke than those of higher SES.[2] Kentuckians have a smoking prevalence of 25% compared to the national rate of 17.1%.[3] Although common tobacco treatment interventions (nicotine replacement, behavioral interventions) are cost-effective and often covered by Medicaid, they are widely under-utilized. Promoting the consistent use of evidence-based cessation methods with individuals of lower SES has the potential to significantly reduce chronic tobacco dependence and subsequent negative health outcomes.[2]

There are few Kentucky Medicaid providers who specialize in tobacco treatment despite the fact that tobacco dependence is a chronic, relapsing condition. It is essential that evidence-based strategies are used to treat tobacco dependence in order to achieve the best outcomes.

The study aim was to explore the capacity for delivery of tobacco treatment with Kentucky's Medicaid recipients and the systems factors that facilitate or inhibit delivery of evidence-based tobacco treatment from the perspective of Kentucky's managed care organizations (MCOs).

WHAT DID RESEARCHERS DO?

We conducted focus group interviews with 14 clinically and/or financially focused professionals from the five MCOs serving Kentucky in 2018. The purpose of the interviews was to elicit stakeholders' views about delivery of tobacco treatment and the facilitators and barriers to providing tobacco treatment with their members. Interview transcripts were coded and analyzed using standard qualitative research protocols.

WHAT DID THE MCOS SAY?

- Tobacco use assessed at least annually
- Telephone quitline (1-800-QUIT-NOW) referral most commonly used intervention
- Lack of standardized quality measure priorities, practices, and resources including billing information
- Office Managers the gatekeepers to Medicaid providers

"We always have goals of helping members get to the point of being ready to quit and then we're advocating for them with the providers to see what they can do."
— Focus Group Participant

THE CASE FOR TREATING TOBACCO DEPENDENCE

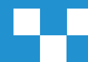
Tobacco use is the single most preventable cause of death and disease.

Medicaid recipients consistently use tobacco at higher rates than the general population.

Tobacco's health effects cost KY Medicaid an estimated $590 million annually*

Treating tobacco dependence saves lives and money.

*www.tobaccofreekids.org/problem/toll-us/Kentucky



BREATHE

Bridging Research Efforts and Advocacy Toward Healthy Environments

THEMES FROM FOCUS GROUP INTERVIEWS

Capacity for Delivery of Tobacco Treatment

Tobacco use is assessed at least annually as part of the Health Risk Assessment (HRA); there is variation in asking about "smoking" versus "tobacco use."

Telephone quitline referral is the most often used intervention; standardized processes are not used to assess effectiveness of quitline referral.

All MCOs use the HEDIS reporting system; they differ in how quality measure priorities are determined.

Current trainings prioritize motivational interviewing for frontline staff (e.g., case managers).

Integration of tobacco treatment into chronic disease and special population management is needed; there is interest in standardized strategies and resources.

Facilitator

MCOs are sensitive to relationships with providers and members.

Barriers

There are time constraints and competing priorities.

There is lack of centralized, evidence-based tobacco treatment resources, including billing information which could facilitate consistent provider and member engagement.

Office Managers are gatekeepers to providers which can impact opportunities for direct communication.

NEXT STEP

Survey office managers and Medicaid providers to assess capacity for tobacco treatment and training needs.

Further Reading

[1]Brantley EJ et al. (2018) Policies affecting Medicaid beneficiaries' smoking cessation behaviors. Nicotine Tob Res.

[2]Dahne J et al. (2017) State tobacco policies as predictors of evidence-based cessation method usage: Results from a large, nationally representative dataset, Nicotine Tob Res.

[3]Centers for Disease Control and Prevention (2017). BRFSS Prevalence and Trends Data.

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POLICY RECOMMENDATIONS

To improve public health, lower health care costs, and facilitate tobacco treatment, based on the **5 A's Model** of tobacco treatment, we recommend:

1. Standardize comprehensive tobacco use assessment on the HRA, regardless of MCO:
   a. **Ask:** Past 30-day use of any tobacco product
   b. **Advise** to quit using scripted language
2. Develop and disseminate protocols and resources for MCOs and providers that:
   a. **Assess** readiness to quit using a standardized measure
   b. Offer treatment during every patient contact unless the tobacco user opts-out; **Assist & Arrange** easy access to tobacco treatment (medications, counseling, and follow up)
   c. Close the feedback loop by systematically sending quit line utilization data to MCOs and providers
   d. Incorporate consistent tobacco treatment into chronic disease and special population management
3. Facilitate access to an enhanced, ideally centralized bank of tobacco treatment resources for all MCOs and providers
4. Incentivize standardized training in evidence-based tobacco treatment for front-line staff and providers

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