

Medicaid: A Tobacco Cessation Primer

Introduction:

The Medicaid population smokes at a rate almost two and a half times higher than the population with private insurance (24.5 percent vs. 10.5 percent).ⁱ This high smoking rate not only leads to disease and premature death, but costs the Medicaid program approximately \$39.6 billion per year (or about 15 percent of annual Medicaid spending).ⁱⁱ This is a problem that has been acknowledged – a Healthy People 2020 objective calls for comprehensive state coverage of evidence-based cessation treatments in Medicaidⁱⁱⁱ. Recognizing the high percentage of smokers in the Medicaid population, it is critical to reduce smoking in this population to see progress in the population at large. Comprehensive state Medicaid cessation coverage, combined with efforts to promote awareness of covered cessation treatments, has the potential to reduce smoking, smoking-related disease and health care expenditures among Medicaid enrollees.

The Centers for Disease Control and Prevention (CDC) [reports](#) data on state Medicaid programs' tobacco cessation coverage data. Additionally, CDC has brought state Medicaid programs and state public health programs together as part of the 6|18 Initiative in collaboration to improve state Medicaid tobacco cessation coverage and increase Medicaid enrollees' use of covered cessation treatments. Reducing tobacco use would be expected to save both lives and money. Currently only about 10 percent of smokers on Medicaid receive a prescription for a quit smoking treatment^{iv}, despite increases in coverage.

This document provides a basic overview of the Medicaid program. It is intended to provide public health professionals with information that will help them work with their state Medicaid program to implement tobacco cessation best practices.

History of the Medicaid Program

The Medicaid program was established by the Social Security Act of 1965. The program was originally designed to provide health coverage to blind and disabled people along with parents and children receiving public aid. Over the past half century, the program has grown to become the largest payor of healthcare in the United States – covering approximately 70 million people^v. Additional populations have been added to Medicaid coverage over the years, including income-eligible pregnant women and children. In 2014, states were given the option to expand Medicaid eligibility to all adults with incomes up to 138 percent of the federal poverty level (FPL), approximately \$28,676 a year for a family of three. By the end of 2018, 35 states and the District of Columbia had expanded their programs. The remaining states are able to expand their program if they choose to at any point.

The Federal-State Partnership

Medicaid is a program that is run and funded jointly by the states and the federal government. Each state receives a proportion of their state Medicaid funding, based on the actual healthcare expenses of the state Medicaid program from the federal government. This is called the Federal Medical Assistance Percentage or the FMAP. For the standard Medicaid* population, a state's FMAP is between 50 percent and 76 percent of a state's total Medicaid spending. The FMAP is

* Standard Medicaid population refers to the non- Medicaid expansion population. These individuals would have been eligible for Medicaid prior to Medicaid expansion.

determined by the state's per capita income, with a floor of 50 percent federal contributions. Additional special eligibility groups – such as children, pregnant women or expansion adults – can have a higher FMAP or federal matching percentage than that for the standard population. For example, for the Medicaid expansion population, the federal government initially had an enhanced FMAP of 100 percent, which slowly declines until 2020 when it hits 90 percent. The federal government can also set a higher FMAP for specific services that it wants to encourage can also have a higher FMAP. For example, states that cover all evidence-based preventive services with no cost-sharing can receive a one percentage point increase in their FMAP for these services for the standard Medicaid population. Currently there is no cap on how much the federal government can spend on state Medicaid programs.

Program Structure and Coverage Requirements

There is a saying, “if you know one Medicaid program, you know one Medicaid program.” As the saying suggests, there is a lot of variation in how Medicaid programs are structured and how they are governed.

The first way to structure a Medicaid program is fee-for-service (frequently referred to as FFS). This is when the state contracts directly with healthcare providers to pay for services that Medicaid enrollees use. The other way to structure the program is to contract with Managed Care Organizations (MCOs). This is when a MCO (a health insurance company with Medicaid patients) will take the financial risk for the patients' healthcare expenses. The state will contract with the MCO and the company will typically get a per-member per-month fee to manage their population's healthcare needs

Managed Care Organizations (MCOs) may not cover every service required by the state Medicaid program. In these instances, states will cover those required services for all Medicaid enrollees through the fee-for-service portion of the Medicaid program. These are referred to as wrap around services and are often services for high-need populations or more expensive services. It is very common for states to have a combination of MCO and fee-for-service coverage. Medicaid enrollees may be enrolled in an MCO based where the enrollee lives, or the state may let the enrollee choose their plan. Enrollees may also have the option of choosing either being enrolled in an MCO or in the fee-for-service program, depending on the state. There are some states that have 100 percent enrollment in fee-for-service and at least one state, Tennessee, that has a 100 percent enrollment in MCOs.^{vi} These variations are one reason why each state Medicaid program looks different.

There are also a few states that provide premium assistance, so the Medicaid expansion population can purchase private health insurance on the state marketplaces set up under the Affordable Care Act. Those states also provide financial assistance to cover cost-sharing under the private plans.

Similar to how there is a lot of variation in how Medicaid programs pay for care, there is also variation in what services state Medicaid programs cover. Federal law requires state Medicaid programs to cover, as a floor, a limited number of services. These services include inpatient hospital services, physician services, laboratory services and transportation to medical care.

There are additional optional medical benefits that the federal government will help pay for if a state chooses to cover them. These benefits include prescription drugs, dental services and physical therapy. Additionally, a state can request that a benefit not listed be covered and the Secretary of Health and Human Services has the authority to approve the request. Examples include emergency services provided in non-Medicare certified hospitals and services provided in critical access hospitals.^{vii}

As the list of optional benefits suggests, states have a lot of discretion over how their Medicaid program is designed. States are also responsible for ensuring all MCOs are covering the appropriate services. Some states, like Kentucky, have state laws requiring the Medicaid program to cover various benefits.

To improve access to cessation treatments and increase use of these treatments, it is important to know how a specific Medicaid program functions. For example, a state with a large percentage of their Medicaid enrollees in MCOs might be successful in increasing use of cessation treatments with a tobacco-focused quality measure.

Finding Key Information

States are required to submit a State Plan to the Centers for Medicare and Medicaid Services (CMS). This plan details how the state will cover all mandatory benefits^{viii}, which optional benefits will be covered and which populations will be eligible for Medicaid. It also serves as an agreement between the state and the federal government that the state will follow the federal rules of the Medicaid program and the federal government will in turn provide the state Medicaid program with the allotted portion of federal funds.^{ix} When creating a state plan, it is assumed that all Medicaid enrollees will be covered through a fee-for-service program. Any variation from a standard fee-for-service program must be described in with a waiver or state plan amendment.

Mandatory Medicaid Benefits^{viii}:

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

States are able to, and sometimes required to, make changes to their Medicaid program. There are two ways to make changes to a state Medicaid program: a state plan amendment (SPA) and a waiver.

States can submit a SPA if they want to add or remove an optional service or change the way a particular benefit or population is covered. For example, a state can use a SPA to expand their Medicaid program eligibility to adults earning up to 138 percent of the

federal poverty level. States may also be required to submit a SPA if a new federal requirement is established. For example, the Affordable Care Act requires tobacco cessation treatment to be a covered service for pregnant women. States were required to submit a SPA to indicate to the federal government how they planned to meet this new requirement.^x

The other way for states to change their Medicaid program is through a waiver. There are two types of waivers: program waivers and demonstration waivers.

Program waivers can be either 1915(b) or 1915(c) waivers and typically make widespread programmatic changes. The 1915(b) waivers have been used to waive federal requirements that allow a state to set up a managed care program.[†] The 1915(c) waivers allow states to offer home- and community-based services on a limited basis.^{xi}

Demonstration waivers, also known as 1115 waivers give states extensive waiver authority to innovate and test new approaches to further the goals of the Medicaid program. These waivers have been used to create managed care programs, provide premium assistance for enrollees to purchase coverage in the state marketplace and to impose private insurance-like features, such as premiums. States receiving demonstration waivers are required to test the innovate approach to determine if the demonstration is successful.^{xii}

Tobacco Cessation

Affordable Care Act requires state Medicaid expansion enrollees (the newly enrolled, ACA-eligible adults up to 138 percent of FPL) to have a comprehensive tobacco cessation benefit and requires non-expansion enrollees to have access to all seven cessation medications. Data^{xiii} show that not all states meet these standards.

State tobacco control programs and public health agencies can use the information in this primer to work with their state Medicaid offices towards the common goal of helping Medicaid enrollees quit smoking. South Carolina provides a great example. The South Carolina public health agency recently collaborated with the South Carolina Medicaid Department to improve their Medicaid tobacco cessation benefit. The state now covers a comprehensive benefit for their Medicaid enrollees.^{xiv} Public health departments in other states can work with their Medicaid programs to review existing coverage or to promote awareness and use of cessation treatments that are already covered among Medicaid enrollees and their health care providers.

Medicaid enrollees smoke at a rate substantially higher than individuals insured by private insurance. Medicaid enrollees may also be less likely to have the means to access cessation treatment without the help of their health plan. It is important to partner with Medicaid to reduce the cost of smoking, both in terms of lives and dollars, in the low-income population.

Comprehensive Tobacco Cessation Benefit:

Seven Medications:

- NRT Gum (OTC*)
- NRT Patch (OTC)
- NRT Lozenge (OTC)
- NRT Inhaler
- NRT Nasal Spray
- Bupropion
- Varenicline

Three Forms of Counseling:

- Individual
- Group
- Phone

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[†] Federal requirements need to be waived to create provider networks and other characteristics of MCOs.

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