



# **TOBACCO CESSATION PILOT PROGRAM**

## **Report to the Texas Legislature**

**As Required by  
S.B. 10, 80<sup>th</sup> Legislature, Regular Session, 2007**



**Texas Health and Human Services Commission**

**September 2010**

## Table of Contents

<i>Executive Summary</i> .....	2
<i>Background</i> .....	3
<i>Current Texas Medicaid Tobacco Cessation Coverage</i> .....	3
<i>Pilot Overview</i> .....	4
<i>Pilot Outreach and Enrollment</i> .....	4
<i>Tobacco Cessation Counseling Interventions</i> .....	5
Face-to-Face Group Counseling Intervention.....	5
Telephonic Counseling Intervention.....	5
<i>Pilot Evaluation</i> .....	5
Pilot Results .....	6
Reported Use of Intervention Program to Quit Smoking .....	6
Tobacco Use.....	7
Use of Tobacco Cessation Medications.....	8
Provider Support .....	9
Members’ Demographic and Behavior-Related Information .....	9
<i>Next Steps: Texas Medicaid Tobacco Cessation Benefit</i> .....	14

## **Executive Summary**

Pursuant to S.B. 10, 80<sup>th</sup> Legislature, Regular Session, 2007, HHSC implemented a Medicaid tobacco cessation pilot program for STAR+PLUS members in the Bexar service area. The 2009 STAR+PLUS satisfaction survey identified smoking as a major problem for STAR+PLUS members. According to the survey, 34 percent of STAR+PLUS members statewide smoke.

Texas Medicaid currently covers tobacco cessation medications. Texas Medicaid does not currently cover tobacco cessation counseling. However, all Texans have access to telephone counseling services through the state's Quitline; a service provided by the Department of State Health Services (DSHS).

HHSC invited the Bexar service area STAR+PLUS managed care organizations (MCOs) to submit proposals for participation in the pilot. One of the MCOs, Superior, met the proposal criteria and submitted a proposal within the timeframe requested.

Eligible Superior health plan members enrolled in the pilot (i.e., the member used and wanted to quit tobacco) were randomly assigned to one of three groups prior to their enrollment in the pilot. These groups were the following:

- 1) A telephone intervention conducted by the American Cancer Society, who at the time of the study had a contract with DSHS to provide the State's Quitline services.
- 2) Face-to-face counseling conducted for Superior Health Plan by Nurtur (a Centene-owned Disease Management company).
- 3) A control group that was not offered any additional support, but not denied any support they would normally be entitled to (e.g., tobacco cessation medications).

In general, the total number of participants was divided evenly amongst the three groups.

The pilot also had an evaluation component. The University of Florida's Institute for Child Health Policy (ICHP) who is the State's External Quality Review Organization (EQRO) conducted the evaluation of the pilot. ICHP surveyed each health plan member up to 4 times throughout the 12-month period the member was enrolled in the pilot. ICHP first surveyed members upon enrollment in the pilot (i.e., the baseline survey) and then at 3, 6, and 12 months after enrollment.

In total, 334 members enrolled in the pilot. Members were able to access cessation services for a one-year period.

Thirteen members included in the evaluation completed at least one telephone counseling session with the American Cancer Society and at least one telephone evaluation survey with the University of Florida. Five individuals who are included in the evaluation completed the telephone intervention program. One member completed the telephone program two different times during the pilot period. Three members included in the

evaluation completed face-to-face counseling sessions with Nurtur. No one completed the program (i.e., no one completed the six face-to-face counseling sessions). Despite low levels of participation in the interventions, there was a large difference in smoking rates twelve months after enrollment in the pilot. Prior to enrollment in the pilot, the rate of tobacco use for all three groups ranged between 97 and 100 percent. STAR+PLUS members should only have been included in the pilot if they used tobacco, so it is unclear why the rate of tobacco use prior to enrollment was not 100 percent for everyone. Twelve months after enrollment, the control group had the highest percentage of smokers (83 percent), followed by the telephone intervention group (67 percent). The lowest percentage of smokers was found in the face-to-face intervention group (56 percent). The control group was the only group that saw an increase in the percentage of tobacco users between the second and third follow-up surveys.

The Affordable Care Act requires states to provide coverage for tobacco cessation services (including diagnostics, therapy, counseling, and pharmacotherapy) for pregnant women. Texas Medicaid currently provides coverage for certain prescription and over-the-counter medications used in the treatment of tobacco addiction. In addition, the DSHS Texas Quitline is available to all Texans. HHSC has begun implementation of this new tobacco cessation counseling benefit for pregnant women and will make providers aware of existing tobacco cessation drug therapy coverage and the availability of the DSHS Quitline for counseling services.

## **Background**

Medicaid enrollees smoke at a substantially higher rate than the general population. In 2007, 33 percent of adult Medicaid clients were smokers, compared to 20 percent of the general public<sup>1</sup>.

S.B. 10, 80<sup>th</sup> Legislature, Regular Session, 2007, required HHSC to develop and implement a pilot program in one area of the state that provided Medicaid clients with positive incentives to lead healthy lifestyles. Participation in tobacco cessation programs was one option highlighted in the legislation.

Pursuant to S.B. 10, HHSC implemented a Medicaid tobacco cessation pilot program for STAR+PLUS members in the Bexar service area. The 2009 STAR+PLUS satisfaction survey identified smoking as a major problem for STAR+PLUS members. According to the survey, 34 percent of STAR+PLUS members statewide smoke. The STAR+PLUS program serves clients who receive Supplemental Security Income (SSI) and SSI-related clients who have chronic and complex health conditions and who need both acute care and long-term services and supports.

## **Current Texas Medicaid Tobacco Cessation Coverage**

Texas Medicaid currently covers tobacco cessation medications. Managed care organization (MCO) members have access to unlimited medications; and tobacco cessation medications do not count against the three script limit for clients in Fee-For-

Service (FFS) and Primary Care Case Management (PCCM). Texas Medicaid does not currently cover tobacco cessation counseling. However, all Texans have access to telephone counseling services through the state's Quitline; a service provided by the Department of State Health Services (DSHS).

### **Pilot Overview**

HHSC invited the Bexar service area STAR+PLUS managed care organizations (MCOs) to submit proposals for participation in the pilot. One of the MCOs, Superior, met the proposal criteria and submitted a proposal within the timeframe requested.

Eligible Superior health plan members enrolled in the pilot (i.e., the member used and wanted to quit tobacco) were randomly assigned to one of three groups prior to their enrollment in the pilot. These groups were the following:

- 1) A telephone intervention conducted by the American Cancer Society, who at the time of the study had a contract with DSHS to provide the State's Quitline services.
- 2) Face-to-face counseling conducted for Superior Health Plan by Nurtur (a Centene-owned Disease Management company).
- 3) A control group that was not offered any additional support, but not denied any support they would normally be entitled to (e.g., tobacco cessation medications).

In general, the total number of participants was divided evenly amongst the three groups.

The pilot also had an evaluation component. The University of Florida's Institute for Child Health Policy (IHP) who is the State's External Quality Review Organization (EQRO) conducted the evaluation of the pilot.

In total, 334 members enrolled in the pilot. Members were able to access cessation services for a one-year period.

### **Pilot Outreach and Enrollment**

Tobacco users were identified through either a completed health risk assessment or a tobacco screening survey conducted by the University of Florida. Participation in the pilot was first extended to the 1,274 Superior Health Plan STAR+PLUS members who completed a risk assessment form and identified themselves as a tobacco user. Nurtur made a total of 2,717 calls to 1,274 members for an average of 2.13 calls per member. Prior to this first round of enrollment calls, notification letters were mailed to potential participants. These letters were written in English and Spanish and included information the STAR+PLUS enrollee could use to decide whether to participate in the pilot.

Because of the low number of members enrolled in the pilot following the first outreach effort, the project team attempted to expand the potential pilot population and include STAR+PLUS enrollees who did not complete a risk assessment form for Superior Health

Plan. In this effort, the University of Florida Survey Research Center (SRC) called 10,011 Superior Health Plan STAR+PLUS enrollees in Bexar County whose tobacco use status was unknown. The Survey Research Center completed 1,901 STAR+PLUS member screening calls; 635 of these (33 percent) members were considered eligible for enrollment. Eligible members were either tobacco users or had “unknown use status.” The contact information for eligible members was then provided to Nurtur through a secure server and Nurtur called these members to invite them to participate in the tobacco cessation pilot program. Nurtur made a total of 881 calls to 625 members for an average of 1.41 calls per member.

To further promote enrollment in the pilot, the University of Florida also designed and mailed brochures about the pilot to identified tobacco users. These were mailed near the end of the second round of enrollment calls.

### **Tobacco Cessation Counseling Interventions**

Participants assigned to one of the counseling groups were asked to set a quit date. Once they set a date, they began the intake process for receiving services. Both the telephone and face-to-face counseling participants received culturally appropriate education, motivation, and support services to reduce the risk of tobacco-related health conditions, such as high blood pressure, heart disease, and certain cancers by promoting cessation of all tobacco products. Counselors worked with members to develop and implement individualized quit plans.

Components of the counseling programs included the following.

- Orientation, including a description of the cessation program.
- Assistance in developing a quit plan.
- Quit date preparation.
- Identification of trigger situations.
- Stress management strategies.
- Weight management strategies.
- Discussion of printed education materials.
- Education on prescription and over-the-counter medications.

### **Face-to-Face Group Counseling Intervention**

Nurtur conducted the face-to-face counseling on behalf of Superior Health Plan. This intervention was designed to provide members with six, one-hour, face-to-face sessions over a period of six weeks. To accommodate members’ schedules, meeting times were scheduled during day and evening hours, and also on Saturdays. Moreover, as a reminder Nurtur called members prior to the meeting times and also called members who missed scheduled meetings. The group sessions were scheduled at facilities throughout San Antonio.

## **Telephonic Counseling Intervention**

The American Cancer Society through its partnership with DSHS provided telephone counseling services to pilot members. Clients referred to telephone counseling set up appointments with counselors who called participants when it was time for their session. The American Cancer Society called members at least 4 to 5 times to complete the cessation program; each call lasted for approximately 15 to 30 minutes.

## **Pilot Evaluation**

As the state's EQRO, ICHP measures the performance and cost-effectiveness of the Medicaid program and participating managed care organizations (MCOs). As part of the EQRO activities for state fiscal year 2008-2009 and 2009-2010, the University of Florida evaluated the success of the Medicaid STAR+PLUS tobacco cessation pilot program.

ICHP surveyed each health plan member up to 4 times throughout the 12-month period the member was enrolled in the pilot. ICHP first surveyed members upon enrollment in the pilot (i.e., the baseline survey) and then at 3, 6, and 12 months after enrollment. Survey questions focused on the participant's tobacco use, tobacco cessation activities, weight changes, use of health-care services, mood, sleep, and alcohol use as they attempted to quit using tobacco products. Members enrolled in all three groups received incentives for answering the evaluation-related surveys. For each survey completed, participants received a \$15 gift card.

## **Pilot Results**

Two hundred and thirty-eight participants completed the baseline survey, and were therefore followed over the 12-month pilot period. Table 1 provides more detailed information on the number of follow-up surveys completed by participants. Most participants completed at least one follow-up survey and many completed all of the follow-up surveys.

**Table 1. Number of surveys completed by participating STAR+PLUS members**

<b>Surveys</b>	<b>Surveys completed (N)</b>
Baseline only	48
1 follow-up survey	46
2 follow-up surveys	77
3 follow-up surveys	67
Total participating members	238

## Reported Use of Intervention Program to Quit Smoking

Thirteen members included in the evaluation completed at least one telephone counseling session with the American Cancer Society and at least one telephone evaluation survey with the University of Florida. Five individuals who are included in the evaluation completed the intervention program. One member completed the program two different times during the pilot period.

Three members included in the evaluation completed face-to-face counseling sessions with Nurtur. No one completed the program (i.e., no one completed the six face-to-face counseling sessions).

**Table 2. Intervention-reported use of assistance to quit smoking**

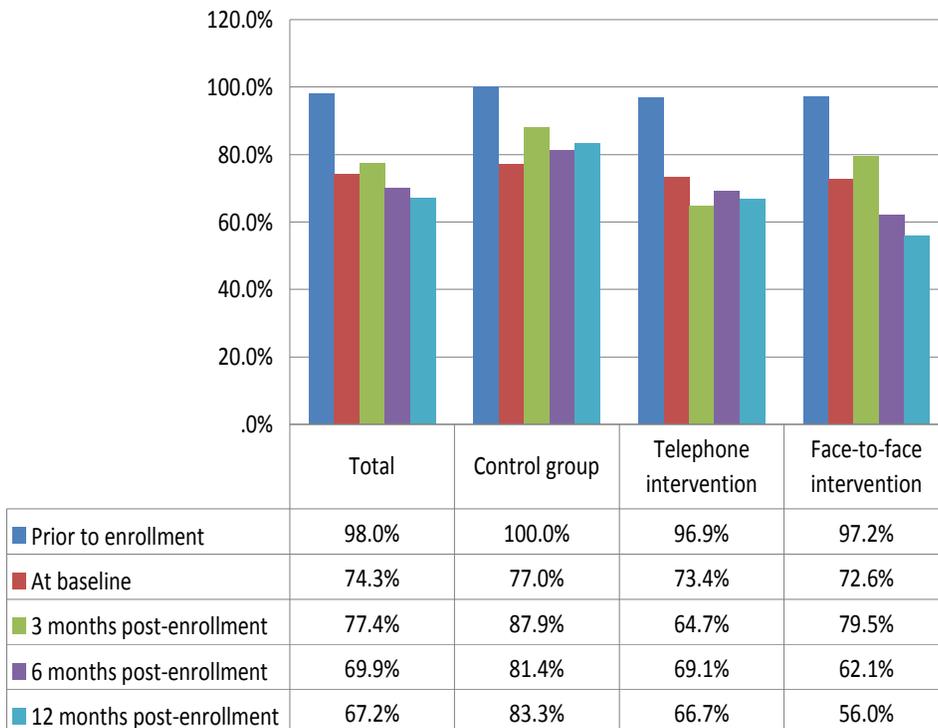
<b>Intervention group</b>	<b>At any time during the pilot period (N)</b>
Control group (N=48)	0
Telephone intervention (N=54)	13
Face-to-face intervention (N=55)	3

## Tobacco Use

The main outcome being measured by this evaluation was whether participants quit using tobacco products. The baseline survey asked STAR+PLUS enrollees about their tobacco use prior to their enrollment in the pilot as well as their current tobacco use; the three follow-up surveys asked only about current tobacco use. Tobacco use included: cigarettes, pipes, cigars, snuff, and chewing tobacco. Respondents rarely reported use of tobacco products other than cigarettes, especially on a daily basis. Participants were also asked to report any household tobacco use. Around one-quarter of respondents reported household cigarette use. Reported household use of other types of tobacco products was extremely low.

**Figure 1** below demonstrates tobacco use by intervention group at five points in time: (1) prior to enrollment in the pilot; (2) at the baseline interview; (3) at the first follow-up interview approximately three months after enrollment in the pilot; (4) at the second follow-up six months after enrollment; and (5) at the third follow-up twelve months after enrollment.

**Figure 1. Total tobacco use prior to enrollment, at baseline, and at three, six, and twelve months post-enrollment**



Despite low levels of participation in the interventions, there was a large difference in smoking rates twelve months after enrollment in the pilot. Prior to enrollment in the pilot, the rate of tobacco use for all three groups ranged between 97 and 100 percent. STAR+PLUS members should only have been included in the pilot if they used tobacco, so it is unclear why the rate of tobacco use prior to enrollment was not 100 percent for everyone. Twelve months after enrollment, the control group had the highest percentage of smokers (83 percent), followed by the telephone intervention group (67 percent). The lowest percentage of smokers was found in the face-to-face intervention group (56 percent). The control group was the only group that saw an increase in the percentage of tobacco users between the second and third follow-up surveys.

ICHP performed statistical tests to compare the difference between the percentages of cigarette smokers and tobacco users in the three pilot groups. At twelve months, ICHP found that the telephone intervention did not have an impact on clients. The face-to-face intervention did, however, impact members and, as a result, there were significantly fewer cigarette smokers in the face-to-face intervention group when compared to the control group.

### **Use of Tobacco Cessation Medications**

All STAR+PLUS members had access to the use of tobacco cessation medications, which is the standard of care for Superior STAR+PLUS members. In all groups, the percentage of respondents reporting medication use was variable, but usually around 14 to 15 percent.

### **Provider Support**

The Agency for Health Care Policy and Research recommends that primary care physicians identify smokers, treat every smoker with a cessation or motivational intervention, offer nicotine replacement therapy except in special circumstances, and schedule follow-up contacts after cessation.<sup>2</sup> All STAR+PLUS members who visited their doctor's office in the last six months were asked to estimate how frequently: (1) their doctors or other health providers advised them to quit using tobacco products, (2) their providers recommended or discussed medication to quit, and (3) their providers recommended or discussed other methods or strategies to quit smoking.

Among tobacco users with an office visit, between 65 and 73 percent were advised to quit smoking during at least one office visit in the last six months. This is considerably greater than the HHSC quality of care measure (i.e., Performance Indicator Dashboard) standard of 28 percent for state fiscal year 2008.<sup>3</sup>

### **Members' Demographic and Behavior-Related Information**

The intent of the evaluation was to capture pilot participants' tobacco use and cessation activities for 12 months. However, additional information was also collected to determine if there were any changes in participants' weight, sleep patterns, alcohol use, and depression as they attempted to quit using tobacco. Demographic information was collected during the baseline survey.

- *Race/Ethnicity:* There were more Hispanic enrollees and fewer Black, non-Hispanic enrollees in this pilot than can be found in the STAR+PLUS state-wide estimates. This may be due to the pilot being confined to a limited geographic area (i.e., Bexar County). Fifty-one percent of the participants in this pilot were Hispanic; 24 percent were White, non-Hispanic; 17 percent were Black, non-Hispanic; and 8 percent were Other, non-Hispanic.
- *Education:* Nearly half (48 percent) of the pilot participants had less than a high school education and 23 percent had any college education. (These percentages are nearly identical to state-wide estimates for STAR+PLUS enrollees.)
- *Body Mass Index:* The average female in the pilot was obese. The average male in the pilot was overweight.
- *Health Care Use:* Members enrolled in the STAR+PLUS program have complex health-care needs and, therefore, require close contact with the health care system. A

high percentage (between 76 and 79 percent) of participating pilot members had at least one visit to a health care provider in the six months prior to their interview.

- *Alcohol Use:* In general, 25 to 29 percent of all pilot participants reported having at least one alcoholic drink in an average week. There was a slight increase in overall alcohol consumption as the pilot progressed, however, this trend basically disappeared when the overall rates were broken down by pilot group, with the exception of the control group. Over the pilot period, the use of any alcohol increased among members in the control group from 15 percent at the baseline survey to 20 percent 12 months later. Over this same period, use of alcohol by members in the telephone group increased from 29 to 30 percent; and in the face-to-face group from 30 to 32 percent.
- *Depression:* At the baseline survey, 49 percent of respondents reported symptoms indicative of major depression. Twelve months later, 36 percent reported similar symptoms. This decrease is probably attributable to the likelihood that members with more symptoms of depression were less likely to continue to participate.
- *Sleep quality:* Members reported significant problems with sleep quality.

#### **Next Steps: Texas Medicaid Tobacco Cessation Benefit**

S.B. 10 required that HHSC provide recommendations on the continuation or expansion of the pilot program. Based on the low participation rates in the Bexar program in spite of considerable outreach, HHSC does not recommend that this particular pilot be continued or expanded at this time. However, HHSC will be providing additional tobacco cessation services to pregnant women in Medicaid based on the new federal requirement to do so.

The Affordable Care Act requires states to provide coverage for tobacco cessation services (including diagnostics, therapy, counseling, and pharmacotherapy) for pregnant women. Pregnant women may be more motivated to quit tobacco use than other populations and, therefore, interventions targeted at pregnant women may be more successful than results found in the STAR+PLUS pilot.

Medicaid coverage for pregnant women is limited to services recommended with respect to pregnant women in the “Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline,” approved by the Secretary of Health and Human Services, and furnished by or under the supervision of a physician or other authorized health care professional. Cost-sharing may not be imposed for counseling and pharmacotherapy for clients up to 150 percent of the Federal Poverty Level (FPL).

As noted in this report, Texas Medicaid currently provides coverage for certain prescription and over-the-counter medications used in the treatment of tobacco addiction. In addition, the DSHS Texas Quitline is available to all Texans. HHSC has begun implementation of this new tobacco cessation counseling benefit for pregnant women and

will make providers aware of existing tobacco cessation drug therapy coverage and the availability of the DSHS Quitline for counseling services.

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<sup>1</sup> Centers for Disease Control and Prevention. State Medicaid Coverage for Tobacco-Dependence Treatments – United States, 2007. *MMWR* 2009;58:1199 -1204.

<sup>2</sup> The Smoking Cessation Clinical Practice Panel Staff. 1996. “The Agency for Health Care Policy and Research Smoking Cessation Clinical Practice Guideline.” *Journal of the American Medical Association* 275 (16):1270–1280.

<sup>3</sup> HHSC. 2007. “Chapter 10.1.1: Performance Indicator Dashboard, Version 1.3.” *Uniform Managed Care Manual*. Available at <http://www.hhsc.state.tx.us/Medicaid/UMCM/>.