

Trends in the Delivery and Reimbursement of Tobacco Dependence Treatment

The 2000 Public Health Service Clinical Practice Guideline summarizes effective, evidence-based treatment for tobacco dependence. Using this Guideline and other evidence-based reports, state and national initiatives have worked to implement evidence based treatment through a variety of health service delivery systems. As capacity develops to deliver treatment, trends in the delivery of treatment are emerging. An important factor in the delivery of services is the availability of reimbursement. A discussion of both service delivery and reimbursement trends offers a snapshot of where we are, where the gaps and opportunities exist, and where we need to go.

What does the PHS Guideline say about effective treatment?¹

- Brief treatment is effective (3 minutes or less) and all tobacco users should receive at least brief treatment.
- Treatment effectiveness increases with treatment intensity (e.g. minutes of contact) up to 90 minutes.
- Treatment lasting 8 sessions or more is the most effective.
- All clinicians should provide treatment.
- Treatments are more effective when delivered by multiple types of clinicians and delivery of treatment by multiple clinicians is encouraged.

What are the trends in brief treatment?

- Delivery of brief treatment is becoming more widespread and increasingly applied as a standard of care.
 - In a recent study published in the American Journal of Preventive Medicine on tobacco cessation services in nine HMO's, 90% of smokers reported being asked about smoking, 71% were advised to quit, 56% were assessed for willingness to quit, and 49% received assistance.²
- Quitlines deliver brief treatment in most states to all callers. Some quitlines also deliver intensive interventions depending on resources.³ (All tobacco users have access to the National Network of Tobacco Quitlines. The National Network provides assistance, information and referral to those callers in states with no state-run quitline and automatically routes other callers to their state's quitline.)
- Increasing the delivery of brief to moderate intensity treatment is realistic in inpatient and outpatient settings, especially with the ability to refer to quitlines for more support.⁴
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now requires hospitals to deliver brief treatment to patients admitted with heart attacks, heart disease, and pneumonia. These requirements are helping to get hospitals involved in delivering cessation services.⁵

What are the trends for intensive treatment?

- Based on the PHS Guideline, increasing options for intensive treatment (90 minutes over 8 or more sessions) would increase effectiveness and quit rates.
- Intensive treatment often addresses more complex medication needs, medical and mental health conditions, and individual circumstances.
- Barriers to increasing intensive treatment are cost, training and competencies of providers. Also, many tobacco users do not want to participate in more intensive treatment.¹ These barriers make intensive treatment less available.

- Although intensive treatment is less available than brief treatment, the trend is towards increasing availability of intensive treatment.
 - Some state tobacco control programs offer more intensive face-to-face and quitline services. (e.g. New Jersey, Massachusetts, Wisconsin, Arizona, Maine.)
 - In some states, quitlines and health plans partner to reach more tobacco users with intensive services (e.g. Minnesota).
 - Training programs for Tobacco Treatment Specialists are growing.⁶
 - The Association for the Treatment of Tobacco Use and Dependence (ATTUD) is developing national standards for tobacco treatment specialists including standards for providing intensive treatment.
 - The new Medicare benefit provides access to more intensive treatment.
 - Reimbursement for treatment is gradually increasing. For example, the percentage of health plans that provide full coverage for any type of pharmacotherapy tripled from 1997 to 2002.⁷

What is ATTUD?⁸

- Association for the Treatment of Tobacco Use and Dependence (ATTUD) promotes standards for trained tobacco treatment specialists.
- ATTUD defines the Tobacco Treatment Specialist as “a professional who possesses the skills and knowledge necessary to provide effective, evidence-based interventions for tobacco dependence across a range of intensities.”
- ATTUD supports standards as a way to:
 - Provide a benchmark for job performance and program evaluation
 - Define learning objectives for training programs
 - Provide guidance to consumers about evidence-based treatment.
 - Provide health insurers a basis for determining reimbursement.

What are the trends in reimbursement?

- Healthcare and corporate benefits leaders are increasingly more aware of the importance of covering treatment for tobacco dependence as a part of medical benefits. When smoking cessation assistance has been offered in the past, it has usually been included as part of a corporate wellness program. As the trend changes towards including tobacco dependence treatment as a medical benefit, reimbursement will also change.
- Centers for Medicare and Medicaid Services (CMS) now cover counseling and medications for Medicare recipients (see Medicare benefit page 4).
- National Business Group on Health supports tobacco dependence treatment benefits as more cost-effective than commonly covered disease prevention interventions.⁹
- America’s Health Insurance Plans (AHIP) advocates that tobacco cessation programs and services should be available to all health insurance plan members who want to quit.¹⁰
- Several leading employers and health plans are paying for telephone counseling and medications as part of their “claims expense” including:

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|---|--|
| ▪ State of South Carolina employees | ▪ Microsoft |
| ▪ Blue Cross and Blue Shield of Minnesota | ▪ Boeing |
| ▪ Washington Mutual | ▪ Lumenos (Consumer Directed Health Plan), a WellPoint Company |
- Some health insurers are also leaders; following the PHS Guideline recommendations:¹
 - Coverage for multiple counseling sessions including multiple quitline calls.
 - Coverage for medications including over-the-counter nicotine replacement.
 - Coverage for more than one course of treatment per year.

- Many other health insurers have only limited coverage.^{11,12}
 - A 2004 survey showed that less than one-third of employers offered comprehensive smoking-cessation programs¹³
 - Copays are often high.
 - Little coverage for person-to-person treatment; may only offer written or web-based only programs
 - May only offer referrals to existing community programs. Community programs can be a good option. But they are often not well attended and may be held too infrequently to serve the needs of many smokers seeking treatment.
- Many large health plans are not yet on board. Some that are either still waiting or in preliminary discussions are Aetna, Cigna, Humana, and many Blue Cross and Blue Shield organizations.

What are the next steps?

- CMS has increased access to treatment coverage and other health plans are likely to follow.
- Need to improve the CMS benefit so it stands as a quality model for other insurers.
 - Address lack of group or telephone counseling coverage
 - Address limits on professionals who can be reimbursed
- Need to enlist private employers and purchasers to get involved and cover their employees.
- With more reimbursement by public and private insurers, state tobacco control budgets can be used for publicly insured and uninsured.

What barriers prevent health insurers from covering tobacco dependence treatment?

- Health plans tend to resist new benefits as long as possible or are required to change by established national standard of care, landmark study, or legislation.
- Health plans want to keep prices down to stay competitive. With low demand from purchasers, there is low incentive for adding benefits which will increase prices.
- Health plans don't want to become the "smokers' health plan."
- Investment in benefit doesn't necessarily yield savings for health plan.¹⁴
- Cost-effective benefit structures are still being investigated.¹⁵
- The new Medicare benefit is expected to influence what other insurers cover.

What are the barriers preventing employers and purchasers from asking for coverage for tobacco dependence treatment?

- Many don't know what tobacco use costs their business or how a cessation benefit can help their employees and their costs. Purchasers often don't know what is and is not covered already in their health insurance plans. Education and information is needed.
- Health care costs have seen double digit increases over the last few years and employers are increasingly passing costs along to employees. Need to have a sound business rationale for adding a benefit.
- Little demand from employees so there is little attention given to this issue.

In this environment, how do we get health plans and big employers to pay for quitline services that are presently supported through the state program?

- Health plans and employers need to see their role in the big picture.
- State funds are really limited. Most of the tobacco settlement is not being spent on tobacco control, even less on tobacco cessation and quitlines.
- Quitlines are not set up to handle large employee groups. They are more of a safety net offering limited services for those without insurance. Also, they do not have the reporting capabilities employers need.
- Employers need to establish their own benefits for employees.

Medicare Benefit

Counseling

- Final decision in March 2005 to cover tobacco cessation counseling under Medicare Part B.
- Benefit covers:
 - Two cessation attempts a year
 - Maximum of four intermediate sessions (3-10 minutes) or intensive sessions (>10 minutes) each time with total of eight sessions per year.
- Beneficiaries eligible for the benefit are tobacco users with a disease or an adverse health effect linked to tobacco use or who are taking a therapeutic agent that is affected by tobacco use.
- Providers who can be reimbursed:
 - Any Medicare eligible provider (e.g. physicians, nurse practitioners, physicians assistants)
 - Services “incident to” treatment provided by Medicare eligible provider

Counseling Reimbursement

- Two “G” codes established under the Health Common Procedure Coding System (HCPCS):
 - G0375—Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. Short descriptor: Smoke/Tobacco counseling 3-10.
 - G0376—Smoking and tobacco use cessation visit, intensive, greater than 10 minutes. Short descriptor: Smoke/Tobacco counseling greater than 10.
- Medicare payments are made in Relative Value Units (RVU). The dollar value of RVU’s vary across states and organizations. G0375 is paid at .25 RVU and G0376 at .49 RVU.

Medications

- Medicare beneficiaries may be eligible for coverage for stop smoking medications beginning January 1, 2006 through the new Medicare pharmacy benefits.
- The benefits are provided through many pharmacy plans and these will vary in their coverage.

Practical implications:

- Most Medicare beneficiaries who use tobacco will be eligible for this benefit. The requirement that beneficiaries have adverse health effects related to tobacco use is broad and include symptoms such as cough.
- The providers who are able to bill for this services are mostly limited to those who can already bill through Medicare *Professionals offering groups or telephone counseling are not yet included.* No other specific training or credentials are required for reimbursement.
- Other providers may be reimbursed if services are incident to treatment by Medicare eligible providers.
- Reimbursement rates are low.

References

- ¹Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence: Clinical Practice Guideline*. Rockville, MD: U.S.Department of Health and Human Services, Public Health Service; June 2000. *JAMA* June 28, 2000. 283; 24:3245-3253. Full document available at <http://www.surgeongeneral.gov/tobacco>
- ²Quinn, VP, Stevens, VJ, Hollis, JF, et al. Tobacco-Cessation Services and Patient Satisfaction in Nine Non-profit HMOs. *Am J Prev Med* 2005; 29(2).
- ³North American Quitline Consortium: <http://www.naquitline.org/>
- ⁴Susan Swartz, MD, Center for Tobacco Independence (Maine). *Provider Intervention and Reimbursement*. Conference call presentation, Tobacco Cessation Leadership Network: November 15, 2005.
- ⁵For information on the Joint Commissions performance measures, visit <http://www.jcaho.org/gov/pms/core+measures>
- ⁶For more on training programs, visit Tobacco Cessation Leadership Network website, Cessation Resources and Tools: <http://www.tcln.org>.
- ⁷McPhillips-Tangum C, Bocchino C, Carreon R, Erceg C, Rehm B. Addressing tobacco in managed care: results of the 2002 survey. *Prev Chronic Dis* 2004 Oct . http://www.cdc.gov/pcd/issues/2004/oct/04_0021.htm.
- ⁸Association for the Treatment of Tobacco Use and Dependence: <http://www.attud.org/>
- ⁹Center for Prevention and Health Services. *Reducing the Burden of Smoking on Employee Health and Productivity*. Issue Brief: Volume 1, Number 5. Available at http://www.businessgrouphealth.org/prevention/smoking_cessation.cfm
- ¹⁰America's Health Insurance Plans' public health and prevention statements of support: <http://www.ahip.org/>
- ¹¹Schauffler HH. Defining benefits and payments for smoking cessation treatments. *Tob Control* 1997;6:Suppl:S81-S85.
- ¹²Curry, Susan J.; Grothaus, Louis C.; McAfee, Tim; Pabiniak, Chester. Use and Cost Effectiveness of Smoking-Cessation Services under Four Insurance Plans in a Health Maintenance Organization. *New England Journal of Medicine*. 339(10):673-679, September 3, 1998.
- ¹³Furhman, *Wall Street Journal*, 4/26/05. Reference to 2004 Benefits Survey Report of the Society for Human Resource Management. Article Date: 28 Apr 2005 : <http://www.medicalnewstoday.com/medicalnews.php?newsid=23516>
- ¹⁴Barendregt JJ, Bonneux L, van der Maas PJ. The health care costs of smoking. *N Engl J Med* 1997;337:1052-1057.
- ¹⁵Halpin, HA. *The Effectiveness and Costs of Different Benefit Decisions for Treating Tobacco Dependence*. Results from a Randomized Trial. Presented at the 2005 Annual SRNT Meeting, Prague, Czech Republic.

Other TCLN Resources

For more information about health insurers, employers, and training, see http://www.tcln.org/cessation_resources_and_tools.

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