

BUILD A FINANCIAL INFRASTRUCTURE:

Health Plan
Benefits
and Provider
Reimbursement



Health Plan
Benefits and
Provider
Reimbursement
for the
Treatment of
Tobacco Dependence

April, 2003

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PACIFIC CENTER ON HEALTH AND TOBACCO
REPORT ON HEALTH PLAN BENEFITS AND PROVIDER REIMBURSEMENT

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PACIFIC CENTER ON HEALTH AND TOBACCO

REPORT ON HEALTH PLAN BENEFITS AND PROVIDER REIMBURSEMENT

Introduction

While there is no question that people who use tobacco face serious health consequences, many private and public health insurance plans and purchasers have lagged behind in making tobacco cessation programs a fully covered part of health plan benefits.

The good news is that, for those looking into rationales and procedures for integrating smoking cessation programs into health plans, there is clear guidance from both the Centers for Disease Control and Prevention, the Public Health Service, and the U.S. Preventive Services Task Force (USPSTF). The CDC has published two invaluable documents: the *Community Preventive Service Guidelines*¹ and *Best Practices for Comprehensive Tobacco Control Programs*.² The Public Health Service has published a comprehensive clinical practice guideline, *Treating Tobacco Use and Dependence*.³ The USPSTF has developed a list of approximately 50 preventive services found to be effective. These services have been analyzed and prioritized by Coffield et al. and published recently in the *American Journal of Preventive Medicine*⁴ (We will be referring to these documents throughout this report with the following abbreviations: CDC community preventive service guidelines, CDC best practices document, PHS clinical practice guideline, and Coffield article).

In order to help states put these guidelines into practice, the five western states of California, Oregon, Washington, Arizona, and Hawaii have formed a regional working group, the Pacific Center on Health and Tobacco, to collaborate on strategies for developing statewide tobacco cessation projects. The mission of the Pacific Center on Health and Tobacco (PCHT) is to promote widespread adoption of evidence-based methods for improving the availability and accessibility of tobacco cessation services within the Center membership states and to share our learning with other organizations and states.

Based on our experience, we think one of the reasons implementation has been difficult is the complexity of getting health plans, providers, purchasers of health insurance, and state agencies together to collaborate, define, and fulfill their respective roles. As members of the Pacific Center on Health and Tobacco, representatives from each of these groups are collaborating to better understand and define these roles and to devise strategies that can foster broader implementation.

PCHT members selected five topic areas for discussion and development:

- 1) Health plan benefits and reimbursement for cessation services;
- 2) Strategies for linking quitlines, cessation services, and health care;
- 3) Certification, training, and standards for cessation specialists and programs;
- 4) Vision and model for a comprehensive, statewide approach to cessation; and
- 5) Approaches for bridging disparities in cessation services.

In addition, a sub-committee of PCHT members and consultants has developed a report on strategic approaches for implementing comprehensive, statewide cessation programs.

This report addresses health plan benefits and provider reimbursement, which was chosen as the first topic because developing the resources and mechanisms to pay for tobacco cessation services, is a critical first step towards making them widely available and accessible.

This report divides the work of the PCHT on benefits and reimbursement into five sections:

- 1) Health plan benefits covering cessation services;
- 2) Approaches for reimbursing clinicians for providing cessation services;
- 3) Quality improvement;
- 4) Strategies for instigating and implementing these approaches in health care systems;
- 5) Case studies describing how public and private purchasers and health plans have developed benefits and reimbursement policies.

This report combines existing evidence-based recommendations with the applied experience and insight of the PCHT. It is intended to summarize what the members, consultants, and partners of the PCHT have learned that can help guide the planning and decision-making of member states and other groups who are working on this issue. As additional evidence-based information becomes available and our collective experience grows, this report will most certainly evolve. In the meantime, we believe that the existing evidence together with our collective experience is currently the best guide for improving our statewide cessation programs.

The Evidence Base

There is a substantial body of research clearly demonstrating that treating people for tobacco dependence is both clinically effective and cost-effective in comparison to other types of medical and disease prevention interventions. In developing their clinical practice guideline, the Public Health Service performed a meta-analysis of no less than 6,000 research articles. (See [http:// www.surgeongeneral.org/tobacco](http://www.surgeongeneral.org/tobacco) for the full text and references.) The Pacific Center founds its discussions and applied recommendations on the combined evidence base developed through the PHS clinical practice guideline, the CDC's community preventive service guidelines and best practices document, and the work of Coffield et al. A summary of the evidence base used by the PCHT can be found in Appendix A.

HEALTH PLAN BENEFITS

Evidence-Based Recommendations

As detailed in Appendix A, there is a substantial evidence base to guide those investigating why and how to integrate tobacco cessation services into health plan benefits. In brief, the PHS clinical practice guideline recommends that plans/purchasers include effective tobacco dependence treatments as part of the basic benefits package for all health insurance packages. The CDC's Community Preventive Service Guidelines recommend that health care systems provide tobacco-use cessation interventions that include telephone support, provider reminder systems alone or in conjunction with provider education programs; and that they reduce patient out-of-pocket costs. The CDC best practices document urges that health systems make the system changes recommended by the PHS cessation guidelines, cover treatment for tobacco use under both public and private insurance, and eliminate cost barriers to treatment for under-served populations, particularly the uninsured.

Collectively, these recommendations highlight an urgent need for health plans to cover tobacco cessation services. Yet, despite overwhelming research evidence that such interventions work and are cost-effective relative to other medical and disease prevention interventions, most health plans in the United States do not already include this benefit as part of their customer's insurance packages. In a recent survey of health plans, the Addressing Tobacco in Managed Care project found that only about one-third of health plans fully covered the recommended counseling programs and medication.⁵ The result is that thousands of tobacco users who would like help quitting don't have adequate access to effective treatment options — many other tobacco users fail to seek any services at all.

Adapted Recommendations of the PCHT

The PCHT supports all of the evidence-based recommendations. The PCHT has also agreed on a set of adapted recommendations for designing benefits based both on published recommendations⁶ and consensus among PCHT members. These are as follows:

1. The CDC and PHS guidelines should serve as the foundation for coverage decisions.
2. At least two of the three evidence-based smoking cessation treatments should be part of the standard benefit package for all purchasers and payers.
 - a. The definition of coverage and payment for treatment should include: 1) provider screening and brief intervention; 2) person-to-person interventions (telephone counseling, individual counseling, group counseling); and 3) pharmacotherapy.
 - b. Plans should strike a balance between less intensive treatments with the potential to reach large numbers of people, and more intensive treatments that have the potential to reach fewer numbers of people but are more likely to help someone stop using tobacco.
3. To reduce financial barriers to accessing services, co-payments for tobacco cessation treatment should be minimized and no greater than for other comparable services.
4. Access to benefits (via gatekeepers, etc.) should not be more restrictive than for other health plan benefits. Because tobacco dependence may require repeated treatment to be effective, access to benefits should not be restricted to a single lifetime course of treatment. The aim should be to create a reasonable benefit that does not reduce the overall impact of the treatment.
5. Health plans and purchasers should monitor the effectiveness of the services provided and periodically review new scientific research to ensure that cessation guidelines and the benefits packages derived from them are based on the latest evidence.

6. Health plans, providers and purchasers should all make an effort to publicize the effectiveness and availability of tobacco cessation treatment among their patient populations. They should also tailor counseling programs to appeal to different cultural groups.

Questions and considerations for health plans and purchasers

▶ *What is the rationale for linking counseling programs to pharmacotherapy?*

While tobacco cessation medications can relieve withdrawal symptoms when properly used, they do not "cure" tobacco dependence. Counseling programs play an important role in providing the social support and coping skills necessary to quit for good. When counseling programs are combined with the medications, cessation rates are higher and some health plans require participants to join the Free & Clear tobacco cessation program, a telephone-based counseling program, in order to receive coverage for nicotine gum, nicotine patches, or Zyban® (bupropion).

Other insurers do not require participation in counseling to access the pharmacy benefit because of the limited availability of programs and evidence that shows that the medications can still be effective in the absence of counseling programs. For example, Providence Health Systems of Oregon does not require members to participate in a counseling program in order to receive medication; however, the plan waives the pharmacy co-payment for members who are enrolled in an approved counseling program.

A new alternative that some plans are developing is a system that combines telephone-counseling programs with the use of medications. Telephone counseling programs have the capacity to reach large populations and some have developed systems to link their services with the use of medications. For example, MediCal, the California Medicaid program, issues vouchers through the California Smokers Helpline when their members enroll in the counseling program. These vouchers can be exchanged for over-the-counter medications.⁷

▶ *Should the benefit cover both over-the-counter (OTC) and prescription medications?*

Both the nicotine patch and nicotine gum are available over the counter. These products have been the most thoroughly tested for efficacy and have been found to be safe to use by most tobacco users. These products, along with the prescription nicotine nasal spray, nicotine inhaler, and Zyban®, are all approved by the Food and Drug Administration and are recommended as first-line medications for treating tobacco dependence. Covering both OTC and prescription medications in the benefit provides the most options for clinicians to use when making medication recommendations.

The cost of these medications varies considerably. The cost per day ranges from an estimated \$3.33 for Zyban®, \$4.00 for nicotine patches, \$5.40 for nicotine nasal spray, \$6.25-\$6.87 for nicotine gum, and \$10.94 for the nicotine inhaler.³ All of the medications are effective, but individuals will have more or less success with different medications. The PHS Quick Reference Guide for Clinicians offers clinical guidelines for prescribing pharmacotherapy for tobacco cessation. The PHS guideline also recommends combining the patch with a self-administered nicotine replacement therapy (either the nicotine gum or nicotine nasal spray) for people unable to quit with a single type of pharmacotherapy. Although the evidence supports providing the full range of medications to better tailor medication needs to the patient, some health plans do include cost as a criterion for deciding which medications to cover.

Many insurers do not cover OTC products at all. While covering only prescription medications limits the financial burden on the insurer, it also limits patients' access to some of the most effective and safe medications for tobacco cessation. This is of particular relevance to people living below the poverty level, who are

most likely to use tobacco and least able to pay out-of-pocket for OTC products.⁸ With this in mind, Oregon's managed care health plan for low-income residents, the Oregon Health Plan, makes OTC products available to members without requiring a co-payment.

► *What criteria should be used to determine which counseling programs should be covered?*

There is a consensus among PCHT members that the PHS guidelines should serve as the outcome measures criteria for determining which counseling programs should be covered. In general, the PHS guidelines outline a continuum of treatments, starting with brief counseling programs that are delivered by clinicians and follow the "5As" (see p. 42), and ending with more intensive and complex counseling programs that are usually delivered by trained specialists. The PHS recommendation is that all tobacco users receive at least the simpler, brief intervention delivered by clinicians and that any tobacco user who is willing to participate should be provided with the more intensive programs.

The discussion of coverage for counseling programs usually centers on the more intensive programs delivered by trained specialists. The PHS guidelines make the following recommendations about content and format for these programs:

Content: three types of counseling and behavioral therapies are recommended:

- 1) Providing smokers with practical counseling, including problem-solving skills;
- 2) Providing social support as part of treatment (good rapport with patient, non-judgmental support and encouragement);
- 3) Helping smokers obtain social support outside of treatment, including requesting support from friends and family and seeking support from groups, helplines, and other community resources.

Format: counseling can be delivered in a group, telephone, or individual format or a combination of these formats. It should be delivered in four to seven sessions of at least 20-30 minutes in duration that take place over at least two weeks, and preferably over more than eight weeks. The format should be tailored to the needs of specific populations or cultural groups.

The PHS guideline does not provide any recommendations about the qualifications of those providing the programs. There is a consensus among PCHT members that the quality of training for providers and specialists is an important indicator of the quality of the counseling program and should be included among the criteria used to determine which programs are reimbursed. The issue of training and certification of providers and specialists is the subject of a subsequent PCHT report.

The Tobacco-Free Coalition of Oregon's Health Systems Task Force has developed proposed standards and criteria for tobacco cessation programs and providers. This document can be found on the PCHT Website: www.paccenter.org. The Cessation and Training Evaluation Project of the Arizona Tobacco Education and Prevention Program (TEPP) has also developed standards and criteria for cessation programs and providers. This information can be found on the TEPP website: <http://www.tepp.org>.

Additional Resources

- Public Health Service Clinical Practice Guideline and meta-analysis references: <http://www.surgeongeneral.gov/tobacco>
- CDC purchasing specifications for tobacco-use prevention and cessation: <http://www.gwhealthpolicy.org/newsps/tobacco>
- CDC best practices document: <http://www.cdc.gov/tobacco/bestprac.htm>

- PCHT Website: <http://www.paccenter.org>
- Agency for Healthcare Research and Quality: <http://www.ahrq.org>
- Addressing Tobacco in Managed Care: A Resource Guide for Health Plans: <http://www.aahp.org/atmc.htm> (click on "toolkit").
- Community Preventive Service Guideline: <http://www.cdc.gov/tobacco/comguide.htm>

PROVIDER REIMBURSEMENT

Evidence-Based Recommendations

The PHS guideline makes recommendations for clinicians and specialists working in a fee-for-service system and for salaried clinicians. These are:

- Adding tobacco dependence treatment as a reimbursable activity for fee-for-service providers;
- Informing fee-for-service clinicians and specialists that they will be reimbursed for using effective tobacco dependence treatments; and
- Adding tobacco dependence intervention to the job descriptions and performance evaluations of salaried clinicians and specialists.

Adapted Recommendations of the PCHT

The PCHT agrees with the PHS guideline and suggests the following two adaptations.

- Screening for tobacco use and advice to quit should be specified as part of standard care in capitated contracts with independent provider organizations (IPO's) and preferred provider organizations (PPO's) that are part of network models of managed care.
- Appropriate existing diagnostic and billing codes for treating tobacco dependence should be used when clinicians provide the more complex steps of the "5A's" (e.g. ICD-9 code 305.1 – tobacco dependence disorder).

Common Questions and Considerations

► *How has the delivery of the "5A's" been coded and billed?*

The "5A's" intervention, although brief compared to the lengthier and more complex interventions delivered by specialists, still demands that providers learn new skills and spend additional time with patients.

Most clinicians only get as far as the first 2 "A's" — screening their patients for tobacco use and advising them to quit.⁵ Some providers will also write prescriptions for the medications and suggest that their patients seek additional help. The first two steps of the "5A's" take less time and skill. They are not separately coded or billed for in either fee-for service or managed care systems.

The importance of delivering the remaining 3 "A's" was highlighted in a recent article extrapolating research data collected through Kaiser Permanente Northwest. In this article Jack F. Hollis suggested that if clinicians delivered minimal advice to 90 percent of the smokers they saw at least once over the course of a year, they would help an additional 283,500 smokers quit — over and above those who would quit on their own. He goes on to say that if clinicians increased the counseling to 10 minutes or more and/or follow-up to the half who were considering quitting, it would yield 756,000 clinician-generated long-term quitters a year.⁸

Reimbursement becomes an issue when clinicians take the extra time to help patients set a quit date, provide advice about how to quit, assist with pharmacotherapy, and either refer patients to additional cessation resources or assist patients directly. In a fee-for-service setting, these last three "A's" would be coded (ICD-9 –

305.1) and billed separately. In a capitated system, they would be coded separately and are sometimes reimbursed through incentive systems.

▶ *How have clinicians been reimbursed for providing tobacco cessation assistance?*

Several approaches are currently used for reimbursing clinicians for providing cessation services. The approach varies for fee-for-service insurers and managed health care plans using capitated contracts.

Fee-for-service

Generally, in fee-for-service insurance, clinicians are reimbursed for delivering cessation interventions when the counseling takes place in the context of tobacco-related conditions (e.g., pulmonary disease). In these cases, the encounter is coded for a particular medical condition and reimbursed accordingly.

Some health plans treat tobacco dependence as its own medical condition and reimburse directly for providing cessation counseling. For example, BlueCross BlueShield of Minnesota will reimburse clinicians for providing cessation counseling as a regular office visit. Office calls for medically appropriate, evidence-based treatment of tobacco use are billed to BlueCross with a diagnosis code of 305.1 (tobacco dependence disorder). The diagnosis applies to tobacco-dependent members who seek help quitting and is applied to the member's health care benefits.

In Oregon's Medicaid program, the Oregon Health Plan, the state directly reimburses fee-for-service clinicians for office visits for tobacco cessation. The diagnostic code used is 305.1 and billing codes currently used are HCPCS (Health Care Procedure Coding System) codes either for individual behavioral counseling (S9075) or group behavioral counseling (G9016).⁹

Capitated contracts

In a managed health care system, provision of tobacco cessation is considered part of the regular duties of clinicians and is typically included in the capitation rate. The expectation is that clinicians will screen patients, advise them to quit, write prescriptions, and encourage them to get help.

Some health plans have developed financial incentives for managed care clinicians to increase the provision of these services. For example, the Oregon-based Providence Health Systems developed a primary quality bonus that paid primary care providers to deliver preventive services. A small amount of the capitated payment (\$2 per member per month) was withheld and then paid to providers who meet pre-established performance measures.¹⁰

Another example is the Oregon-based plan, CareOregon. CareOregon provides managed care exclusively to Medicaid recipients. In order to increase emphasis on tobacco cessation, CareOregon is reimbursing clinicians for providing tobacco assistance. Like the fee-for-service codes, CareOregon uses the 305.1 diagnostic code for tobacco dependence and HCPCS codes for either individual counseling or group counseling (see Oregon office of Medical Assistance Programs case study).

► *How can providers code and bill for cessation services?*

There are several resources available to help with decisions about coding:

- A discussion of coding for tobacco dependence treatment and a list of possible codes can be found in Appendix B of the PHS guideline (pp 167-172).
The web link is: <http://www.surgeongeneral.gov/tobacco>
- A discussion of provider reimbursement and billing codes can also be found in the guide *Reimbursement for Smoking Cessation Therapy: A Healthcare Practitioner's Guide*, produced by the Professional Assisted Cessation Therapy (PACT) consortium.¹¹ This guide can be ordered by contacting RSi Communications, 690 Kinderkamack Road, Oradell, NJ 07649 (phone: 201-599-1500) or downloaded online at: <http://www.endsmoking.org> This document describes a variety of treatment and billing codes that can be used for tobacco dependence treatment, although many health plan policies do not always pay for these billing codes. The billing codes suggested fall under the general categories of preventive medicine treatments and psychiatric therapeutic procedures.
- Another resource, produced by the Tobacco-Free Coalition of Oregon Health Systems Task Force, is *Coding and Reimbursement for the Treatment of Tobacco Use: Recommended Standards and Guidelines for Payers and Clinicians*.¹² The authors of these recommendations found that the preventive medicine codes, such as those recommended in the PHS Guideline, are not reimbursed by any payer in Oregon. The service codes recommended in this document are the more clinically acceptable CPT and HCPCS codes. The Coding and Reimbursement document can be found at www.paccenter.org.

QUALITY IMPROVEMENT

Introduction

Quality improvement measures are gaining importance both as a means for increasing the quality of services delivered within health plans and for reporting the effective delivery of cessation services to purchasers of health care. Quality improvement measures are derived from evidence-based guidelines (e.g., PHS guideline) that establish quality of care standards. There are two national agencies that have established quality measures in health care, the National Committee on Quality Assurance and The Foundation for Accountability.

National Committee on Quality Assurance (NCQA)

The NCQA accredits health care organizations and has established clinical outcomes used as benchmarks for assessing the quality of health care, including tobacco cessation. The NCQA has translated these quality benchmarks into a health plan report card system using the Health Plan Employer Data and Information Set (HEDIS).¹³ HEDIS tobacco measures are obtained through a patient satisfaction survey. Although the response rate of smokers per health plan is modest, the HEDIS measure provides useful information about the delivery of cessation services within health care systems.

Included in the current HEDIS report card is a tobacco cessation measure – advice to quit. The advice to quit measure reports the percentage of adult current smokers who report that they received advice to quit from a health plan providers during the previous year. Two new tobacco measures, designed to collect information about the level of assistance to quit offered to tobacco users, are presently being considered by the NCQA. These new measures ask whether cessation medications were recommended and whether the health care provider discussed methods for quitting, other than using medications. These measures will be initiated in 2003 and reported publicly beginning in 2004.

The Foundation for Accountability (FAACT)

FAACT is a newer organization developing an alternative report card for health plans. The impetus for developing an alternative report card through FAACT grew out of a concern that HEDIS measures are influenced by health plans themselves and that they are more process oriented (e.g. services delivered) than outcome oriented (e.g. changes in health status). FAACT describes itself as "consumer driven and purchaser driven organization that will endorse, advocate, and promote a common set of patient-oriented measures of healthcare quality." FAACT gathers information through population surveys using questions derived from existing surveys – the CDC's Behavioral Risk Factor Survey and the National Health Interview Survey. Five questions are included to determine the proportion of patients reporting they received provider advice to quit smoking and five are included to determine the proportion of smokers who report quitting within the reporting period. The FAACT report card is still in its early stages of development and it is still too early to know how health plans, health care purchasers, and consumers will use this report card.¹⁴

The Purchaser Perspective

Employers are increasingly using the HEDIS report cards to make health care purchasing decisions. And, in an attempt to market themselves to purchasers, health plans are stepping up their efforts to establish systems to implement and track HEDIS measures. Plans include HEDIS measures in their quality improvement process to uncover problems and improve specific outcomes and then report the results to purchasers.

In this way, HEDIS measures have become the basis for improving the quality of health plan service delivery on behalf of the purchaser and provider service delivery on behalf of the health plan.¹⁴ Purchasers can negotiate the reporting of these quality measures as part of their contracts with health plans, making it possible to compare performance between health plans. Quality measures typically will include both patient satisfaction ratings and specific clinical outcome targets.

An example of a clinical outcome measure for tobacco cessation is the HEDIS advice to quit measure. Between 1996 and 1998, average percent reporting advice to quit among organizations reporting HEDIS measures was 66%. The 90th percentile benchmark for NCQA is 74.3%.¹⁵ Once baseline data is available, purchasers can then stimulate improvement on specific outcomes by negotiating target goals and putting a small percentage of the negotiated health care premiums at risk – payment that will be forfeited if the goals are not reached. The outcome targets then become performance guarantees.

For example, the Pacific Business Group on Health is a purchasing coalition that has established outcome targets in its contracts with health plans and uses these targets as performance guarantees. In 1996, PBGH negotiations with health plans put more than \$8 million at risk for meeting performance targets. Of that amount, nearly \$2 million or 23 percent of the premium at risk was refunded to PBGH by health plans for missed targets.¹⁵ The PBGH performance targets have prompted health plans to expand their capacity both to track and provide data on the quality of their tobacco cessation services.

Another approach to health plan accountability comes from the National Business Health Coalition (NBCH). The NBCH has developed a Request for Information (RFI) process that collects in-depth information on the process of health care delivery, including tobacco cessation. Health plans are asked for information on the provision of care and then receive feedback on their strengths and opportunities for improvement in the areas in which they have provided information. The RFI provides a standardized process nationally to improve the quality of care across health plans.

While the strategy of using HEDIS or other measures has substantial potential for holding health plans accountable for quality, the complex relationship between health plans and health care delivery creates difficulties. Most managed health care is delivered through a network model with individual clinics and clinicians providing services to multiple health plans. Dr. William Jessee from the AMA has reported that each physician in the U.S. participates in 9.1 health plans on average making providers accountable to multiple health plans. This, in turn, reduces the leverage of any single health plan to improve delivery-system performance.

Purchasers have three options to consider: (1) keep their focus on results and expect each plan to figure out how to improve provider performance; (2) contract directly with health care delivery systems; or (3) foster collaboration between plans and providers to develop common incentives for providers across plans.¹⁶

The Health Plan Perspective

Within health plans, quality improvement measures are aimed at holding providers, groups of providers, or clinics accountable for improving quality. Plans achieve this accountability by establishing specific performance targets and then making desired outcomes (e.g., HEDIS advice to quit measure) part of the job description of salaried providers or by specifying the service in the capitated contracts with clinics or provider groups. Data collected through tracking systems (e.g., electronic medical records, chart audits) are monitored by health plans, compared to pre-established targets, and then reported back to the providers or clinics. Whatever the method, the key is to establish baseline data for delivery of the “5As”, monitor progress towards established goals at least annually, provide feedback on progress towards goals, and consistently emphasize the important of reducing tobacco use as a goal of the organization.

The process of tracking and reporting itself has been found to help change provider behavior and lead to improved quality. For example, in 1994, Group Health Cooperative established tobacco performance measures and began collecting information through annual chart audits, 250 per clinic. Clinic-level data was generated and reported back to individual clinics. This feedback, although helpful, did not give feedback to individual providers and the reporting cycle was found to be too long to be very useful. Beginning in 1997, GHC began quarterly chart audits, which made reporting more timely although it still did not give feedback directly to providers.

In 1999, GHC embedded tobacco measures in the Treatment Record Form (TRF). The TRF is a paper form used by GHC providers to indicate diagnoses evaluated or lab work ordered at clinic visits. The TRF includes a "tobacco box" where providers check tobacco status: never used tobacco, currently use tobacco, recently quit using tobacco, advice to quit has been offered. Mandating documentation of tobacco identification and intervention using the TRF permits monthly monitoring and feedback of performance to individual providers. As a result of these changes, identification of tobacco status is now at 91% compared to 56% in 1994 and documentation of provider intervention is at 68% compared to 20% in 1994.^{17, 18}

Linking performance results to incentives, such as salary or performance bonuses, is another approach for improving quality. For example, in the Oregon-based Kaiser Permanente health plan, provider advice and referral is tracked through an electronic medical records system. This data is monitored, performance goals set, and feedback given to specific providers. Tobacco advice is also one of several performance measures included in the portion of payment put at risk. Targets are set at the beginning of the year and bonus payments are made or withheld based on these performance measures. The bonus payments are dispersed across the staff, making the incentive contingent on group rather than individual performance.¹⁹

In another example, the Minnesota-based HealthPartners health plan developed an outcome recognition program (ORP) targeting five preventive services including tobacco cessation. Medical groups achieving target rates in these areas were eligible for a financial bonus. In 1996-1997, the program resulted in an increase in the rates of identifying smokers from 49% to 56% and a 14% increase in the overall rate of counseling smokers.²⁰

IMPLEMENTATION STRATEGIES

Strategies for Implementing Reimbursement in Health Care Systems

The ultimate goal of any strategic effort is to make cessation benefits part of standard health care and to insure that tobacco users know what these benefits are and how they can be accessed. To that end, the most important role tobacco cessation advocates can play is to help employers who purchase health care and the insurers who provide health care build a sound business case for why treating tobacco dependence is important.

Key components of a sound business case will include:

- Either state specific or organization specific data on the extent of the problem
 - HEDIS data can be used to access the number of smokers in a health plan.
 - SAMMEC (Smoking Attributable Morbidity, Mortality and Economic Costs) data from your state health department or from the CDC can be used to estimate costs.
- Compelling business arguments for addressing the problem;
- Clear descriptions of the health benefits that follow tobacco cessation;
- Technical information to streamline the implementation process, and
- Specific case examples of similar organizations that have adopted reimbursement policies.

A sound business case includes as much information about *how* to implement reimbursement for cessation services as it includes information on *why* such services are necessary.

In this chapter, we outline the common implementation steps that must take place and the core concerns that must be addressed to help health care plans and purchasers take on the challenge of adding a new covered benefit. These sections are followed by several case examples.

Common Strategic Steps

Whether approached through a health plan or through purchasers, implementing a reimbursement system is a complex, multi-step process. Based on a review of case studies, interviews with industry experts, and the collective experience of PCHT members, we have identified five common strategic steps: leadership, coalition development, policy development, policy approval, policy implementation, evaluation and feedback.

1. **Leadership:** Whether inspired by patients, an ill family member, or motivated by common sense, there is generally one person within the organizational structure who serves as a catalyst for change. That "champion" is someone who has both the commitment to changing policy and the influence in the organization to begin the process of its initiation.
2. **Coalition development:** The champion begins to develop a coalition to support the policy change. There may be an existing coalition in the form of a standing committee or task force internal to the business or health insurance company. Or a new group may be drawn together for this purpose. In a state program or coalition, organizational staff can serve as catalysts, bringing key stakeholders together and facilitating discussions. Each of these key groups (businesses, insurers, health care providers, and state agencies) has separate as well as overlapping concerns. Understanding these concerns is critical to the success of the coalition.

3. **Policy development:** The key committee or coalition begins gathering information, usually cost and utilization data, and developing proposed policy changes. Outside consultants are often tapped to provide expert information and advice. Committee/coalition members will want to know what their colleagues in similar organizations are doing, what reimbursement policies they have in place, and how the policies are working. Representatives from key departments need to be included to make sure the proposed policy has been developed with broad input.
4. **Policy approval:** Once groundwork on the policy change has been completed, the proposal is brought before multiple departments and levels of the organization and/or other committees for approval. This often-lengthy process is essential not only to gain cooperation and approval from all aspects of the organization, but also to ensure that all-important implementation issues have been resolved.
5. **Policy implementation and evaluation:** A specific department or group is charged with oversight and monitoring of the implementation process and assists in the ongoing review and development of the policy. Steps will include promotion of the benefit, training, setting performance targets, tracking performance, providing feedback on performance, and developing information systems to support the policy change within the organization.

Addressing the Concerns of Purchasers

Overall, large employers that purchase health care would like to do what's right for their employees, but must consider the financial impact on their business. The most persuasive initial argument for purchasers is that adding this benefit will help their business and that there is a cost for not doing so. According to a recent article describing the experience of the Pacific Business Group on Health in expanding coverage for cessation, businesses have four primary considerations when deciding about cessation coverage.²¹

1. Importance and cost of tobacco use as a health concern
2. Effectiveness of available treatments
3. Cost-effectiveness of available treatments
4. Short-term costs

Importance and cost of tobacco use

Tobacco use remains a substantial public health problem and continues to be the number one preventable cause of disease and death in the country. Tobacco use carries an enormous cost that is not understood by most employers but its costs to employers can be estimated. Understandably, employers are most interested in data showing how tobacco use affects their specific employee population. It is estimated that a male smoker will have \$9,000 more in medical costs over his lifetime than a male nonsmoker, and female smokers will have over \$10,000.²² Employees who smoke are more likely to miss work and to be less productive on the job. The National Health Interview Survey estimates that men who smoke miss 3.9 more days of work a year than men who do not and women who smoke miss 2.1 more days of work than their nonsmoking peers.²³

Rates of productivity are also impacted by longer and more frequent breaks used for smoking. For example, a study of 300 airline reservation employees evaluating the impact of smoking status on productivity and absenteeism found that workplace productivity increases and absenteeism decreases among former smokers compared to current smokers.²⁴

Treatment effectiveness

With the publication of PHS clinical practice guideline, the effectiveness of treatment for tobacco dependence has been clearly documented. Using these guidelines as criteria, purchasers can design their health insurance contracts to ensure that these guidelines are followed and be more confident that the services they purchase will effectively assist their employees to quit.

Cost-effectiveness

Purchasers are interested in three questions related to cost-effectiveness: 1) What is the relative cost compared with other services? 2) What are the most cost-effective treatments? 3) What is the return on investment?

Cost-benefit data show that tobacco cessation treatments appear to be cost-neutral. That is, when all factors are taken into account, including all the costs and benefits to individuals, health plans, employees, and government, the costs invested in cessation treatment is nearly balanced with costs saved.²⁵ In a recent comparison of cost-effectiveness and disease prevention potential of 50 preventive services, providing screening and counseling for tobacco cessation was rated as a higher priority than all other preventive services (including screening for high blood pressure and mammography).⁴ Despite the high potential for preventing disease, treatment for tobacco dependence has one of the lowest delivery rates ($\leq 50\%$) compared to other preventative services (such as vaccinating children).

Purchasers are very interested in which treatments, among those that are effective, are the most cost-effective. While all cessation treatments are cost-effective, more intensive treatments (multiple counseling sessions and pharmacotherapy) are the most cost-effective because they significantly increase quit rates relative to the investment.²⁵

Purchasers are also very interested in their return on investment. Current data show that health care cost savings would more than pay for moderately priced, effective tobacco dependence treatment in 3-4 years.²⁶ Because tobacco use affects absenteeism and productivity, economic models based on employer costs show that worksite smoking cessation programs return one-third of their investment in the first year and return full investment after three years.²³

Short-term costs

There are immediate costs when a tobacco cessation benefit is initiated, and these costs need to be accounted for when considering a benefit change. One estimate from Group Health Cooperative is that the annual per member cost was \$4.92 or \$0.41 per member per month (based on data from seven employers and 90,005 enrollees). This per member cost is higher if the employee's covered dependents also participate.²⁷ To estimate total short-term costs, the initial development costs would also need to be added. An actuarial study conducted through California's Next Generation Alliance provides another estimate. This estimated benefit, including counseling and/or medications with a five percent use rate and no co-pay, would cost \$0.30 per member per month.²⁸

Addressing the Concerns of Health Plans

Health plans are primarily concerned about providing quality health care to their members while managing the cost. Part of the reason that treatment for tobacco cessation is not standard care across all health plans is the evolution of health insurance over time. According to a 1993 review article,²⁹ insurers said the primary barrier to including benefits for cessation treatment is that health insurance was originally designed to protect people against hospitalization costs, catastrophic illness, and to pay for medically necessary services. Tobacco cessation was and still is considered to be preventive rather than medically necessary. Furthermore,

until the introduction of evidence-based clinical practice guidelines, tobacco cessation treatments were perceived to have limited effectiveness. Because most employers are not aware of the costs of tobacco use to their business, requesting tobacco cessation benefits has not been a priority.

Treatment effectiveness/cost-effectiveness

With the growth of managed care and its emphasis on improving quality and controlling costs, health plans have given more attention to preventive services. We now know that treatments for tobacco cessation are effective. We also know that treatments are likely to be mostly cost neutral for health plans, although cost savings have been shown among pregnant women (by reducing some of the complications of pregnancy, e.g., premature and low birth weight babies)³⁰ and among people with cardiovascular disease (by decreasing heart attacks, especially secondary heart attacks).³¹ We also know that treatments for tobacco cessation are highly cost-effective and under-utilized compared to other preventive services such as mammography or colorectal screening.⁴

The strategic approach for working with health plans is to demonstrate that providing tobacco cessation treatment is highly cost-effective relative to all other preventive services, establish the cost of tobacco-related disease to the health plan, establish that a desirable goal of health care is to reduce health risks in the covered population, and that cessation services are a benefit that employers want to purchase.

Staying competitive

Providing tobacco cessation benefits can help health plans meet requirements for National Committee on Quality Assurance (NCQA) accreditation. These benefits are now also part of the Health Plan Employer Data and Information Set (HEDIS) report card system. Achieving NCQA accreditation and good scores on the HEDIS report card can help health plans compete in the marketplace.¹⁴

How to implement

Implementing a new benefit within a health plan is a complex process requiring many decisions at all levels of the plan. Health plans may also be reluctant to be the first to cover cessation and may be more receptive to work with multiple health plans in the same market. (To help with costing out implementation of a tobacco cessation benefit, consult Reimbursement for Smoking Cessation Therapy, A Healthcare Practitioners Guide pp. 40-42: <http://www.endsmoking.org>).

For health plans or groups of health plans who are implementing a benefit, these questions, taken from a recent article, outline key decision points and considerations for designing tobacco control systems and benefits in managed care.³²

Questions to ask before getting started:

1. What is driving the cessation benefits design? Health? Politics? Competition? Cost Reduction?
 - a. What exactly is covered? Pharmacology only? Which ones? How? Counseling?
What types – brief through intensive? How?
2. What is the scientific basis?
3. Are the right players at the table?
4. Is health plan senior sponsorship ready to remove roadblocks and release necessary resources?
5. What is the communications plan?
6. Can this be addressed in partnership with other health plans? With network providers?
With purchasers?

Practical considerations:

1. Who is eligible? Fully insured only? What about self-insured groups? What about Medicaid?
How does any Medicaid benefit compare with the proposed health plan benefit?
2. Who pays and how much? Co-pays? Same as regular co-pays or different?
3. When is it available? Rolled out all at once or upon renewal?
4. Is there a cap on utilization? What is it and why?
5. What is the referral process that directs members to the full range of services offered?
6. How will implementation be monitored?
7. What evaluation data will be collected? What is the reporting capability? Can the health plan data systems track identification of tobacco users and capture encounter data?
8. How will the benefit be marketed?

CASE STUDIES: PURCHASERS

PACIFIC BUSINESS GROUP ON HEALTH: CALIFORNIA

The Pacific Business Group on Health (PBGH) is a nationally recognized, nonprofit coalition of employers dedicated to improving the quality of health care while moderating costs. PBGH's 45 member employers represent many of the largest in California, and purchase health insurance for more than three million employees, retirees, and dependents. The PBGH Negotiating Alliance, itself, purchases health benefits on behalf of a subset of PBGH's member employers, representing 410,000 employees, retirees, and dependents in 1999.

From 1994 until the recent expansion of coverage, the PBGH Negotiating Alliance had covered smoking cessation pharmacotherapy by prescription only but not over-the-counter purchase. The benefit also implicitly required behavioral interventions as an adjunct to use of pharmacotherapy, but did not explicitly cover the cost of these interventions. In addition, the benefit allowed health plans to control the use and costs of the benefit.

In 1998, PBGH's Negotiating Alliance began seriously considering the employer's role with respect to smoking cessation and its own smoking cessation benefit shortly after one of its prominent member employers elevated the issue of tobacco treatment in the context of PBGH's health benefits package. D'Ann Whitehead, Psy D, then Chevron's Manager of Health and Productivity and a longtime tobacco control advocate, was also serving as chair of the Next Generation California Tobacco Control Alliance's Managed Care Working Group. The Next Generation Alliance (NGA), a Robert Wood Johnson grantee, was focused on working with California's leading health plans, provider groups and employers in an effort to implement the PHS guideline for tobacco treatment statewide. Chevron represented a prominent employer for whom tobacco treatment was already recognized as a significant issue, by virtue of the company's employee population. Recognizing the potential influence PBGH might have on the issue of tobacco treatment in California, Whitehead and NGA staff met with PBGH staff and committee members two or three times to present NGA's goals and opportunities for PBGH to become involved.

PBGH responded almost immediately by recruiting a medical director as a representative to participate in NGA's Managed Care Working Group. Further, PBGH asked NGA to develop a detailed survey question to inquire about how closely California health plans were complying with the PHS guidelines. The PHS guidelines question was incorporated into PBGH's own survey of health plans, which yielded unclear results on the whole. Still, PBGH was able to glean that health plans were falling short of the standard of care detailed in the PHS guidelines. These results coupled with continued interest from member-employer, Chevron, prodded PBGH to take an active interest in improving compliance with the PHS guideline. In fact, not long after the survey came back, Whitehead joined PBGH's Quality Committee. Representing both Chevron and NGA's Managed Care Initiative, she took an active role in advocating for the role of employers in tobacco control as well as a sound smoking cessation policy.

In the summer of 1999, PBGH's Negotiating Alliance invited Jeff Harris, MD, MPH, from the CDC, to come to San Francisco to explore the issue of tobacco as a health problem, define the employer's role, and review the efficacy of its coverage of treatments to aid smoking cessation. Harris strongly recommended that PBGH expand insurance coverage of smoking-cessation treatments, citing the strong return on investment. In fact, Harris documented six recommendations and associated steps for PBGH, its member companies and the health plans with which they contracted:

1. Expand the PBGH Negotiating Alliance smoking cessation benefit to include over-the-counter pharmacotherapy and multiple counseling sessions.
2. Publicize the PBGH Negotiating Alliance smoking cessation benefit.
3. Measure and reward health plan performance on smoking cessation.
4. Assist health plans in delivery of smoking cessation pharmacotherapy and behavioral interventions.
5. Support further tobacco tax increases and increases in tobacco counter-marketing.
6. Publicize the California Smokers' Helpline.

Other key steps in the process by which the PBGH Negotiating Alliance determined the current cessation benefit included:

- Making the business case to help employers justify offering or expanding coverage.
- Discussion resolution of five questions:
 1. Should health insurance cover pharmacotherapy, behavioral interventions, or both, and should coverage for one be dependent on use of the other?
 2. Should over-the-counter pharmacotherapy be covered?
 3. How many courses of pharmacotherapy should be covered?
 4. Should out-of-pocket costs be eliminated?
 5. Can health plans be held accountable for delivering treatment to aid smoking cessation?

Based on these discussions and recommendations, PBGH expanded coverage in January 2000 to include over-the-counter pharmacotherapy as well as behavioral interventions such as smoking-cessation classes.

2000 Contract Language

PBGH requires the following elements in their contracts with health plans:

- Coverage for both prescription and OTC medications, with co-pay.
- Coverage for counseling programs run by trained specialists.
- Smoking cessation counseling sessions should not be deducted from the allowed number of mental health visits in a calendar year.
- Plans may link coverage of pharmacotherapy to participation in counseling.

"Coverage must be provided for effective smoking cessation drugs — nicotine replacement therapy, bupropion, or clonidine. Over-the-counter (OTC) nicotine-replacement therapy (i.e., nicotine patches and gum) is covered. The cost is prescription drug co-pay for a 30-34 day supply, and plans may limit coverage to four prescription fills per calendar year. Plans may impose utilization controls on OTC drugs (e.g., doctor prescription or mail order requirement)."

"Coverage must also be provided for smoking cessation behavioral interventions that may include at least four group counseling sessions for at least 30 minutes in length, or the plan's own program, if approved by PBGH. Trained specialists should conduct all counseling sessions. Smoking cessation counseling sessions are separate from the mental health benefit; use of the smoking cessation counseling sessions should not be deducted from the allowed number of mental health visits in a calendar year. Plans may require participation in smoking cessation behavioral interventions in order to access the pharmacy benefit. Health plan members may access this benefit through the health plan, PCP, or community resource."

ANALYSIS

PBGH has been progressive in developing effective contracts with health plans that meet most of the recommendations of PCHT and the PHS guideline. The new contract language includes coverage of both prescription and over-the-counter medications and counseling programs. The co-pay for cessation medications is the same as for other medications. Counseling sessions are separate from the mental health benefit and have a co-payment similar to other medical office visits. While the contract does not require health plans to link access to medications to participation in cessation counseling programs, it does permit participating health plans to make that requirement.

The PBGH has not addressed clinician reimbursement or accountability. However, the Negotiating Alliance did discuss ways in which health plan accountability for the delivery of tobacco cessation services could be measured without finding a satisfactory solution.¹⁶

OFFICE OF MEDICAL ASSISTANCE PROGRAMS: OREGON

The Office of Medical Assistance Programs (OMAP) is the state agency responsible for administering the Oregon Health Plan (OHP), which provides health services for Oregon Medicaid and other low income Oregonians. The Basic Health Care Package (or covered services provided through the OHP), is determined by the Health Services Commission (HSC) through a prioritized list process that is updated every two years. This list of health services is ranked by clinical effectiveness and value to society. The Legislature decided how much of the list to include in the Basic Health Care Package, and set a state health care budget. Of 743 conditions listed, 566 are funded. The prioritized list emphasizes prevention and education according to the United States Public Health Service's *Guide to Clinical Preventive Services*. In general, services that help prevent illness are nearer to the beginning of the list than services that treat illness after it occurs. In May of 1998, tobacco cessation was added as a covered service on line 186 of the 566 funded lines. This placement identifies the importance of tobacco cessation, and provides tobacco cessation services for OHP clients.

Currently, 72% of OHP clients receive health services through OHP contracted managed care plans, and 28% of OHP clients receive services through fee-for-service providers. Program content and process can vary dependent on whether an OHP member receives services on a fee-for-service basis or through a participating managed health care plan.

OHP Managed Care

Medical Directors of the OHP managed care plans (health and dental plans) and OMAP management meet monthly. A subcommittee to that group, the Project: **PREVENTION!** Task Force, was formed in 1996 to accelerate the rate of preventive services and develop system-wide prevention improvements for OHP clients. Decisions about statewide prevention initiatives are discussed in this forum and approved by the Medical Directors Group. These collaborative prevention initiatives are then designed, coordinated and monitored through the Project: **PREVENTION!** Task Force. In preparation for the inclusion of tobacco cessation as a covered benefit under the OHP, managed care plans, Department of Human Services staff, and other involved statewide partners encouraged the Task Force to consider implementation of the PHS Guideline on the short list of projects to be considered for the next Project: **PREVENTION!** initiative. In November 1997, the Project: **PREVENTION!** Task Force recommended tobacco cessation be the next focus of their coordinated statewide effort. Through the leadership of Dr. Tom Syltebo, Medical Director for Kaiser Permanente and chair of the Project: **PREVENTION!** Task Force, this recommendation was approved by the OHP Medical Directors Group.

Approaching tobacco cessation as a coordinated statewide effort by the OHP health and dental plans was an important step in promoting implementation throughout Oregon. Through a statewide collaboration, a synergistic effect increased the state's ability to build on this campaign in local county coalitions, media campaigns, and health systems. Health plans share the burden of the costs as members shift from one plan to another, and also in the benefits, as the effects of cessation initiated in one plan might be realized in another plan. Additionally, best practices identified by one plan could readily be shared with others, thereby accelerating the learning for all. The collaboration of the health plans also spurred an innovative approach to the purchase of cessation services. Working together, several plans collectively negotiated contracts with the contractor for Oregon's public telephone counseling service, Free & Clear, thereby reducing the unit cost of the service for each plan.

The OHP statewide tobacco cessation program was developed by the Project: PREVENTION! Task Force with technical support from the Oregon Health Division and the Tobacco-Free Coalition of Oregon. Three separate plans formed the template and direction for the program:

- 1) An *Implementation Plan* with goals and objectives, calling for adoption of the guidelines by all participating plans and steps for identifying measures for evaluation, training programs, and communication strategies;
- 2) An *Evaluation Plan* identifying common measures for chart audits and progress reports to compare implementation across the different participating health plans; and
- 3) Information *Dissemination Plan* to communicate with plans and plan members through mass mailings and outreach to a variety of audiences.

Oregon Tobacco Quit Line

A key link assisting in the implementation of the PHS Guideline is the Oregon Tobacco Quit Line. The Oregon Health Division, through its Tobacco Prevention and Education Program created an innovation in the delivery of services by establishing the Oregon Tobacco Quit Line as a clearinghouse and referral for health benefit information. In addition to providing initial telephonic cessation assistance, the Quit Line can identify the insurance benefits available to callers through their health plans and helps link them to these services. Since the contract for the Oregon Tobacco Quit Line is with the Free & Clear program, referring callers to Free & Clear is a seamless process for OHP members and others who have that benefit.

OMAP Contracts

Under the fee-for-service program, OMAP Rules describe coverage for tobacco cessation services (to be eligible for services, a documented quit date has to be established, the PHS guidelines are emphasized, and patient advice, counseling, pharmacotherapy, and telephonic counseling are identified) and billing requirements and limitations (medical therapy/brief counseling not to exceed 10 follow-up visits over 3 months). OMAP contracts with OHP managed care plans require the provision of tobacco cessation services that include education, counseling, and medications (without a co-pay). Health plans are also responsible for ensuring that the PHS guideline – the “5A’s” – are delivered by participating providers. Performance measures have been established and are monitored and regularly reported by OMAP staff, but there are no specific requirements for the content and format of the services. However, standards are set through the Project: PREVENTION! Task Force and all OMAP managed care contractors are required to comply with these standards.

Summary of Contract Language

OMAP has rules for fee-for-service providers and contracts for capitated health plans. The fee-for-service program makes no requirement for the linking of pharmacotherapy to counseling, however, some participating health plans make linking a requirement.

Fee for Service Rules

- When brief interventions are provided during a visit for other conditions, no additional billing is appropriate.
- Licensed providers who are enrolled with OMAP can be reimbursed \$10.00 per intensive tobacco cessation treatment.
- Treatment includes multiple encounters by individual, group, or telephone counseling.
- Reimbursement can be made for up to ten sessions over a three-month period per member, including telephonic counseling.
- Billing codes S9075 or G9016 (as appropriate); Diagnostic ICD-9 code: 305.1 Tobacco Dependence Disorder.

Capitated Contracts

Contracts covering managed care plans include preventive services based on the HSC prioritized list, and require that contractors also comply with the Project: **PREVENTION!** Task Force mission and objectives. In this way, the Task Force collectively sets the standards and participates in the quality improvement process for all the plans.

The following is the language that includes tobacco cessation in the 2000 OMAP contracts with participating health plans:

"Contractor shall provide Preventive Services, which are those services promoting health and/or reducing the risk of disease or illness included under OAR 410-141-0480, Oregon Health Plan Benefit Package of Covered Services, and OAR 410-141-0520, Prioritized List of Health Services. (Note: the specific treatment identified on the prioritized list is: Medical therapy/brief counseling not to exceed 10 follow-up visits over 3 months. ICD-9: 305.1; CPT 97780-97781, 99071, 99078, 99201-99215, 99372, BA330, BA331, BA332, BA333, BA334. Persons are eligible for this treatment if a documented quit date has been established.) Such services include, but are not limited to, periodic medical examinations based on age, sex and other risk factors; screening tests; immunizations; and counseling regarding behavioral risk factors."

"Preventive services screening and counseling content is based on age and risk factors determined by a comprehensive patient history. All necessary diagnosis and treatment services identified as a result of such screening must be provided by Contractor to the extent such services are Capitated Services. To the extent such services are not Capitated Services, but are Medical Case Management Services, Contractor must refer the OMAP Member to an appropriate Participating or Non-Participating Provider and manage and coordinate the services."

"For Preventive Care Services provided through any Subcontractors (including, but not limited to, Federally Qualified Health Centers, Rural Health Clinics and County Health Departments), Contractor shall require that all services provided to OMAP Members are reported to Contractor and are subject to Contractor's Medical Case Management and Record Keeping responsibilities."

"Contractors shall comply with the mission, objectives, and guidelines of Project: **PREVENTION!** as identified in Exhibit J of this Contract. This includes, but is not limited to, specific prevention projects, both at the Contractor and state levels, collection and measurement of data, and regular intervals of data submissions."

Examples of Benefits

The following are examples of the benefits offered by two health plans that provide services to the Oregon Health Plan.

Providence Health Plan

- Group programs 3 times per year; telephone counseling with Free & Clear – eligible to enroll one time per year.
- Nicotine gum, nicotine patches, or Zyban® offered, requires PCP authorization.
- No co-pay for OHP members.
- Referral from PCP not required.

CareOregon

- Group program at 3 sites in Portland metro area; individual counseling via provider throughout Oregon Tobacco Quit Line. Eligible for 10 sessions per 12 months.
- Telephone counseling with Free & Clear. Eligible to enroll once per 12 months.
- Nicotine gum, patches, nasal spray, inhaler, Zyban® provided without a co-pay. Eligible for two courses of treatment per year.
- PCP makes referrals but no prior authorization required.
- Reimburses providers \$10.00 for providing assistance, i.e., help patient set a quit date, prescribe medications as appropriate, refer to Oregon Tobacco Quit Line or in-house cessation program, two times per 12 months. Diagnostic code: 305.1; billing code: S9075.

Outcomes

The Oregon Office of Medical Assistance Programs is tracking changes in the delivery of cessation services in the Medicaid population as well as changes in smoking prevalence. The 2001 BRFSS data show that, compared to all Oregonians, more Medicaid clients reported being asked (78% vs. 72%) and advised (64% vs. 58%) about tobacco use, and 52% vs. 38% reported receiving assistance to quit from their health care providers. Changes in smoking prevalence are declining similar to statewide trends but at a somewhat slower rate. From 1996 to 2000, smoking rates for all Oregon adults decreased by 12% (from 23.4% to 20.7%) and by 9% for Medicaid clients (from 47.4% to 43.0%).

ANALYSIS

The Office of Medical Assistance Programs has established benefits that are consistent with PHS guidelines. They have extended tobacco cessation services to all recipients of Oregon's Medicaid program and the Oregon Health Plan. For fee-for-service providers, provider assistance, medications, and person-to-person counseling are covered. Managed care plans are required to provide the same services. Standards for services through managed care plans are encouraged through a prevention sub-committee of the Oregon Health Plan Medical Directors. Quality assurance is monitored through the OMAP office for both managed care plans and fee-for-service providers.

UNIFORM MEDICAL PLAN/PUBLIC EMPLOYEE BENEFITS BOARD (PEBB): WASHINGTON

The Uniform Medical Plan (UMP) is a state-administered, self-insured preferred provider plan that is one of several plans available to public employees and retirees through the Washington State Health Care Authority (HCA). HCA administers the UMP and the Public Employees Benefits Board (PEBB) establishes eligibility requirements and approves plan benefits of all participating health care organizations. All people covered under Public Employee Benefits Board (100,000 state and local government employees) are now eligible to receive cessation services. Specific requirements for these services are not specified but must be of at least \$250 in value. The PEBB chose to keep their contracts flexible because some of the participating plans already had a cessation benefit in place.

The UMP has defined their cessation benefit under the leadership of Dr. Andrew Brunskill, MD, BS, MPH, medical director of the UMP. His background as a pediatrician and personal belief in the importance of tobacco cessation motivated him to take the leadership in developing a cessation benefit for UMP members. He also believed that offering a cessation benefit would produce positive results for UMP a relatively small investment.

Development of the benefit began in 1998. The first step was to build a business case beginning with a review of Group Health Cooperative's (GHC) data showing reductions in tobacco use prevalence among its members following long-term investment in cessation services. Added to this was data from published medical studies demonstrating cost savings from cessation services offered to high-risk members (e.g. pregnant women). Once the business case was established, the two-year process of designing the cessation benefit was underway. Because of the small size of the UMP, the decision was made to contract out delivery of cessation services to Free & Clear. The tobacco cessation benefit has been in effect since December 2000.

The present UMP cessation benefit includes telephone-counseling services provided by Free & Clear. UMP made it a requirement in their contract for Free & Clear services that it will be given individual subscriber identification for enrollees so that UMP can cross match the people enrolling and their success by using UMP data on health care utilization and costs. The UMP is just starting to link this information to its utilization database and anticipates that this data will permit more precise evaluation of the benefit.

Summary of Current Benefit

- Covers \$250 lifetime benefit for telephone counseling services provided by Free & Clear
- Pharmacotherapy (nicotine replacement therapy or Zyban®) is covered if advised by the Free & Clear counselors.
- Prescriptions from the PCP are required for coverage under the prescription drug benefit. Authorized prescription drugs are not subject to the annual prescription drug deductible or the \$250 lifetime maximum.
- The plan pays 90% of the \$180 cost of the Free & Clear program (a \$18 co-pay) and 90% of the cost of authorized cessation medications.
- UMP ROI studies determine the parameters of the co-pay requirement.
- Preauthorization is not required.
- Benefit is not subject to an annual medical/surgical deductible.
- Members diagnosed with certain chronic medical conditions (such as diabetes, cardiovascular or pulmonary disease) and pregnant women (or women planning to become pregnant) may be eligible for 100% coverage of services and medications prescribed in conjunction with the tobacco cessation program.

ANALYSIS

The Uniform Medical Plan has developed a flexible benefit that includes both counseling and medications, as recommended by the PHS guideline. The UMP also makes special provisions for high-risk populations. However, the UMP limits reimbursement for cessation counseling to a \$250 lifetime maximum, which effectively limits members to one course of treatment through the Free and Clear Program. There is not yet any formal mechanism in place to require monitoring or reimbursing clinicians for tobacco cessation advice and referral. There have been efforts made to create a system to track utilization and other outcome data of the cessation benefit. Marketing this benefit has usually been limited to members identified as high-risk.

CASE STUDIES: HEALTH PLANS

PROVIDENCE HEALTH SYSTEMS: OREGON

The Providence Health System (PHS) in Oregon is an individual practice association health maintenance organization. In 1994, PHS made tobacco cessation a top priority in order to reduce overall cardiac morbidity and mortality. A task force made of key regional stakeholders was formed to develop a strategy to address tobacco cessation within PHS.

Prior to 1994, Providence™'s Heart Program, made up of representatives from the administration, health education department, the research and evaluation department, and the respiratory therapy department, met regularly to discuss strategies for reducing the occurrence of cardiovascular disease. Reducing tobacco use became a key risk reduction strategy. As the Heart Program began to address this issue, PHS underwent a change in organizational structure from one in which each hospital acted independently to a unified system. This move towards centralization was key to the development of PHS™' tobacco cessation program, making it applicable to all PHS members.

Each representative on the regional task force assisted in program development including literature review, program structure, communication strategies, administrative support to modify the benefit and provide coordination, and the details of the cessation service itself. The pharmacy department provided input to structure the pharmacy benefit. Under the leadership of Dr. Charles Bentz, the program also developed provider training and incentives, increasing its adoption throughout the PHS system. The entire process took about one year before implementation.

PHS has since targeted specific groups, including patients with coronary artery disease, diabetes, and asthma, added a hospital-based program through the respiratory care department, and translated cessation materials into Spanish and Russian. In addition to improving cessation services within the health system, the task force has been involved in community efforts with the Tobacco-Free Coalition of Oregon, collaborated with the Office of Medical Assistance Programs to help shape benefits for the Medicaid population, and addressed policy issues such as increasing the tobacco tax. PHS efforts to address tobacco cessation have led to its full accreditation from the National Committee for Quality Assurance.

PHS has a quality improvement system of training and feedback to help improve rates of tobacco cessation. Performance measures are tracked by using paper-based medical records in some clinics and the electronic medical record (EMR) system in others. A new EMR project, tracking provider advice and referral will be rolled out in 2002. This project will include 22 primary care EMR clinics, giving electronic feedback to providers about how they deliver the "5A's".

Summary of Current Benefits

- Includes group counseling, telephone counseling, intensive individual counseling (for those who have relapsed following group or telephone counseling), and medications.
- Health plan members: \$15 co-pay for counseling programs and a standard co-pay for medications.
- Providence does not require members to participate in counseling programs to access medication but does waive the medication co-pay when members are enrolled in an approved counseling program.
- Members attending group programs in the service delivery area receive a supply of their medication at no cost at each session. Members who are outside the service delivery area and are enrolled in an

approved program are reimbursed their medication co-pay. Members enrolled in the telephone-counseling program are mailed medication at no cost. Limits on access to the Providence Health Plan benefit vary by contract.

- Tobacco cessation is included as part of the required responsibilities of participating providers.

Outcomes

Since the beginning of Providence™'s Smoking Prevention Program in 1994, the overall prevalence of smoking among Providence Health Plan members has dropped from 20.4% in 1994 to 16.7% in 1999. In Providence Health Plan's (PHP) commercial population, smoking rates declined from 22.9% to 15.9%. Among Medicare members, smoking rates dropped from 12.0% to 8.9%. And, among Medicaid members, smoking rates decreased from 37.8% to 37.2%.

Providence has successfully increased physician rate of advice to quit smoking. In 1997, 59% of PHP members reported receiving advice to quit from their physician compared to 73% in 1999. Among members with two or more PCP visits in 1999, 56% reported getting advice every time they see a physician, compared to 48% in 1997. Providence has also increased readiness to quit among its members with 68% of smokers considering quitting in one month in 1999 compared to 52% in 1998 and 73% considering quitting in the next 6 months in 1999 compared to 66% in 1998.

ANALYSIS

Providence Health Systems has developed a comprehensive tobacco cessation benefit that meets the PHS and PCHT recommendations. Providence's tobacco program includes several types of counseling programs and cessation medications. The co-payments required of members are modest and can be waived as an incentive to participate in approved programs. Providence considers tobacco cessation an integral part of the clinician's responsibilities and continues to develop systems that monitor and report on how consistently clinicians deliver advice to quit.

GROUP HEALTH COOPERATIVE: WASHINGTON

Group Health Cooperative (GHC) is a consumer-governed health organization with nearly 600,000 members. It has a 20-year track record of consciously attempting to improve the quality of preventive care for its members.

In 1992, GHC's Committee on Prevention led by Tim McAfee, MD, MPH, Bruce Davis, MD, Associate Medical Director, and Robert S. Thompson, MD, Director, Department of Preventative Care, set about establishing a set of prevention priorities. After looking at census data, state economic indicators, and information about GHC members, the committee decided to make tobacco cessation services its number one priority. Through their research, they found that nearly 500 GHC members lost their lives due to tobacco use, and tobacco-related illness cost the plan \$18 million dollars every year. It soon became clear that tobacco cessation services not only had the potential to improve the quality of life for the largest number of members, but it also made good economic sense.

In 1990, a group of physicians, nurses, planners, and researchers formed the Tobacco Use Subcommittee on Prevention. This subcommittee, led by Dr. McAfee, began meeting regularly to discuss what GHC could do, in an organized way, about tobacco use. The Committee on Prevention, which had the author-

ity to make wide-ranging policy changes, sponsored this work. The subcommittee's work led to the formation of a detailed plan that embodied most of the elements of the National Cancer Institute's "4A's" model for clinical smoking control. The plan also closely resembled the Agency for Health Care Policy and Research tobacco cessation guideline published in 1996 (now the PHS guideline). It called for systematic identification, advice, assistance, and follow-up for all tobacco users at all encounters within its system. It also called for the provision of coverage for tobacco cessation services, as well as legislative and other community efforts. In the next two years, this agenda was adopted by the developing quality improvement infrastructure at GHC. As decreasing the prevalence of tobacco use became GHC's number one prevention priority, it made identification of patient tobacco status and provision of tobacco cessation advice part of the standard services required of all clinicians.

Implementation

One of the first steps to implementing the new policy was to generate buy-in at the clinical level using the newly developed Tobacco Roadmap. The subcommittee educated the clinician groups about the importance of helping their patients stop using tobacco. The committee identified a cessation champion at every clinic in order to make this work visible and valued. Clinicians were trained on how to use the new system, which included changes in the patient chart, such as naming tobacco use as a vital sign and adding tobacco use to the "problem" list. They also instituted rewards for following the new system, including annual recognition of high-achieving clinics. Over time, they instituted annual performance targets for clinician groups, which established highly visible indicators of how well tobacco cessation was integrated into routine visits.

GHC has successfully implemented systemic changes in a large health system through a quality improvement process that did not depend on an infusion of research dollars. The second success has been maintaining improvements over time. For example, based on internal research findings showing that members might use tobacco cessation services more if they were free. The co-pay amount required of members decreased incrementally each year and in 1997, GHC decided to provide 100 percent coverage for the Free & Clear program. The subsequent increase in Free & Clear enrollment clearly validated that choice.

GHC has outlined their three basic prerequisites for successful implementation. First, keep at it – it takes years to change provider and system behavior. Second, clearly identify individuals at different levels of the organization accountable for specific, measurable outcomes and keep them informed about how they and the areas they are accountable for are doing. This includes the CEO, the medical director, as well as clinic managers who have been charged with ensuring that all patients have their tobacco use status noted, and individual medical assistants, nurses, pharmacists, and physicians. Third, keep changes simple and offload time-consuming tasks (Offloading complex tasks was deeply appreciated by GHC practitioners.).

Quality Assurance

Measurement and reporting has been very important to the ongoing success of the GHC program. It has been assisted by tying measurement of tobacco use to existing measurement systems whenever possible. This includes regular chart audits, system satisfaction surveys, and clinic practice reports. In the future, GHC is planning to embed key tobacco indicators within their new automated systems. All of these measurements are used to report on the results of the program and to develop program improvements and policy changes.

Summary of Current Benefit

- Free & Clear telephone counseling and group programs
- 100% coverage — free to all members

- Limited to one course of behavioral treatment a year – telephone or group counseling (tobacco users who relapse are judged on a case-by-case basis for extension of this benefit)
- Limited to one course of nicotine gum, nicotine patches, or Zyban® (subject to pharmacy co-pay, e.g. \$10) per year while enrolled in the program
- Referral from PCP not required

Outcomes

In 2000, GHC estimated that approximately 15% of enrollees, or about 45,000 members, smoke. According to 1999 HEDIS data, Group Health Cooperative is rated among the nation's top 10 percent of all health care plans in advising smokers to quit. From a random sample of members who smoke or recently quit in 1999, 77% of GHC's members report being advised by their health care provider to stop smoking.

The one-month quit rate for Free and Clear is 30%. Once GHC started offering the fully covered benefit in 1996, overall enrollment in Free and Clear jumped from 1,300 to 3,500, or 2.8% of its smokers, within that year. By 1999, 7.2% of GHC smokers had enrolled in Free and Clear. Enrollment also increased in the Medicare population from 132 in 1997 to 234 in 1999 (about 6% of Free and Clear enrollees).

ANALYSIS

GHC has made a significant effort to help its members stop using tobacco and meets the criteria of the PHS guideline. Tobacco cessation advice is part of routine office visits and clinicians are held accountable for these services with provider performance reports and other incentives. Participation in Free & Clear is 100 percent covered, though members must make a \$10 co-payment for cessation drugs. Coverage for drugs is contingent upon participation in Free & Clear.

KAISER PERMANENTE NORTHWEST: OREGON

Kaiser Permanente Northwest, a unified staff model health maintenance organization, has a long-standing tobacco cessation program offered to Kaiser Permanente (KP) members and to the community. While this program is not technically part of member benefits, it is offered through the Health Education Department at a substantially discounted rate to members.

The program was developed through the Kaiser Center for Health Research (CHR) by the research team working on tobacco cessation. In the late '70s, the CHR was a research site for the national Multiple Risk Factor Intervention Trial (MRFIT). Part of the MRFIT project included tobacco cessation, which prompted the CHR research team to develop a state-of-the-art tobacco cessation program. In the early 1980s, Kaiser began to develop a new health education department and hired a new regional health educator. An early responsibility of the regional health educator was to initiate a health promotion campaign for employees, including tobacco cessation. Within the same time period, the health education department began discussions that led to establishing smoke-free policies within KP facilities. Before the smoke-free policy was put into effect, the CHR tobacco cessation program was incorporated into the health education department and then offered to employees.

Initially, there was a significant co-payment for classes, as much as \$100, and many members had to pay the cost in full. An additional attendance deposit was also required. As the Health Education Department expanded, the tobacco cessation program was also expanded and began to be offered at a discounted rate to KP members. After the introduction of tobacco cessation medications, the Health Education Department negotiat-

ed with the KP pharmacy to dispense these medications nearly at cost for employees and members enrolled in the tobacco cessation classes.

Implementation

Kaiser has also initiated system-wide implementation of the PHS guideline. Members often access services through the PCP, specialist, or medical assistant, who administers the “5 A's”. The patient’s chart is flagged as a current tobacco user and the clinician ties the cessation advice to the member’s current symptoms or chronic condition for a more personal cessation advice message. The advice is documented, and if the member is interested in talking further with someone about cessation, an electronic message is sent to the health education department for follow-up.

Quality Assurance

KP has an electronic medical records system that tracks provider advice and referral. This data is monitored, performance goals are set, and feedback is given to specific providers by the Health Systems department. Tobacco advice is also one of several performance measures included in the portion of staff incentive payment. Targets are set at the beginning of the year and bonus payments are made or withheld based on these performance measures. The bonus payments are dispersed across the staff, making the incentive contingent on group rather than individual performance. Oversight for quality control of the clinic intervention is handled by the tobacco subgroup of the larger prevention committee.

Summary of Current Benefit

- Members pay a \$35 fee for either phone counseling or classes. There is also a refundable attendance deposit of \$35 for the classes.
- Members pay out-of-pocket for the medications when they are dispensed. Members who complete the classes are refunded the \$35 deposit and the cost of the medications except for their standard medication co-pay.
- A referral is not necessary for members to attend classes.
- Access to medications is contingent on a prescription and enrollment in classes.

ANALYSIS

Kaiser has a long, well-researched, and successful experience providing tobacco cessation assistance to its members. The service is considered a health education program and health plan benefit (differentiated fees for members and non-members). The program meets the basic PHS guideline recommendations and contains all three elements recommended by the PCHT: person-to-person counseling (classes and telephone counseling), medications, and provider advice and referral. The cost to members is the standard co-pay within KP, reflecting its position as a medical service. The cost for the medications is limited to the co-pay for KP medications. However, the entire cost for medications is paid up front by the member and is refunded (minus the co-pay) only upon enrollment and successful completion of the program. Given that the average cost for medications is hundreds of dollars, this requirement may discourage some members from accessing services. KP does provide services to the Oregon Medicaid population and is required by contract to waive co-payments, making this program more accessible to KP’s low-income members.

BLUECROSS BLUESHIELD OF MINNESOTA

BlueCross' 1994 lawsuit against the tobacco industry and the resulting settlement in 1998 required BlueCross to develop a plan for the new revenue. As part of the plan, a goal of a 30% reduction in member tobacco use rate within ten years was established. A new internal center, the Center for Tobacco Reduction and Health Improvement, was established to manage and implement the plan. Directed by Dr. Marc Manley, the Center has instigated the development of new policies for cessation benefits within BlueCross BlueShield.

The Center's first step was to assess the scientific literature and the 1996 Smoking Cessation Clinical Practice Guideline (now the PHS guideline). These sources provided the scientific support for an internal cessation benefit group to recommend pharmacy benefit changes. Beginning in September 1998, BlueCross began to cover cessation pharmacotherapies (nicotine patch, nicotine gum and bupropion SR (Zyban®) with a physician's prescription.

The scientific literature and the original clinical cessation guideline outlined provider concerns about lack of reimbursement as a barrier to providing cessation treatment. At the same time, some members who wanted to access their pharmacy benefit for cessation medications discovered that the office visit necessary to get their prescriptions was not covered under their medical benefit. This obvious gap in coverage prompted further discussion within the Center about reimbursing office visits specifically for tobacco cessation.

A 1999 baseline survey of 10,000 BlueCross members provided information regarding rates of clinician advice to quit. A team from the Center, customer service, provider service, and pharmacy benefit management retrospectively analyzed 12 months of tobacco-related claims and assessed patterns of clinical visits and coding. A new policy for reimbursing providers was developed and proposed by the team and then brought before multiple internal committees for discussion. When all of the details about the policy and its implementation had been resolved, Dr. Manley presented the policy to the internal group of key leadership for approval and then to the CEO for final approval.

The new policy made significant changes in the claims processing system. Under the new policy, office calls for medically appropriate, evidence-based treatment of tobacco use could be billed with a diagnosis code of 305.1 (Tobacco Dependence Disorder). The new policy applies to members seen as outpatients with the chief complaint of tobacco use and a desire to quit using tobacco. BlueCross applies the health care benefits the member has available for a medical illness to his or her claim. If tobacco use is discussed during the patient's preventive or wellness exam, it is considered as part of the preventive exam. The member's wellness or preventive benefit is applied to these services during processing.

The reimbursement policy change was closely followed by the launch of a smoking cessation counseling service, which offers a series of stop smoking counseling sessions by telephone or by mail. Members access this no-cost service directly without a referral, although a prescription is still needed to access the pharmacy benefit.

Reimbursement Policy Implementation

Implementation of the provider reimbursement policy included internal and external communications plans that clearly and repeatedly described the policy change and its few limitations (for example, BlueCross is prohibited by law from changing the benefits provided to certain groups).

Although the policy allows reimbursement for the History of Tobacco Use (V15.82) code with office visits, BlueCross chose to emphasize the Tobacco Dependence Disorder (305.1) code in its communications to providers. The policy of BlueCross is to treat tobacco use as a chronic disease and the 305.1 diagnosis code is more in alignment with other chronic illness coding. In addition, the V15.82 code is ambiguous in description;

e.g., the code could be used to describe a person who had a past history of tobacco use but was currently not using tobacco. Therefore, a decision was made to use the code 305.1 *without* V15.82 to provide more accurate information regarding current tobacco use in the population.

BlueCross sought to both inform clinicians of the reimbursement policy change and hold them accountable for implementing processes that would support the clinical cessation guidelines. A "Quick Points" bulletin distributed to all network providers, outlined the policy and claims processing changes and emphasized the role of primary care physicians in providing brief but effective interventions for all tobacco users at every clinical visit.

Additional communications included a press release and lead articles in BlueCross' "Provider Press" and "Quality Improvement Provider Press." Center for Tobacco Reduction & Health Improvement Executive Director Dr. Marc Manley described the policy change in a feature article in "Minnesota Physician" and in presentations to the Minnesota Medical Association and to local tobacco control advocates.

BlueCross provides a wide range of insurance products to nearly 2 million people, in the midst of a highly competitive market. In making this policy change, BlueCross provides evidence that health plans can and should reimburse clinicians for the treatment of tobacco dependence, just as they do for other chronic illnesses. In fact, U.S. Surgeon General Dr. David Satcher held up BlueCross as a "shining example" when he released the updated guideline. Dr. Mark Banks, CEO of BlueCross, shared the podium with Dr. Satcher as a positive example for other health plans to emulate.

BlueCross is evaluating the effect of this policy change and is considering extension of the policy to other settings. BlueCross will assess the scientific literature, conduct its own survey of tobacco cessation provider processes, and monitor claims utilization. This information, plus cost-effectiveness considerations, will guide decisions to expand the policy and/or enhance communications.

Summary of Current Benefit

- All FDA-approved medications are covered (patches, gum, nasal spray, inhaler, and Zyban®) with the usual pharmacy co-pay and a physician's prescription. Over-the-counter medications are also included.
- All BlueCross fully insured members are eligible.
- Telephone counseling or mail-based counseling (BluePrint for Health) is available at no cost. A prescription is still necessary to access the pharmacy benefit.
- Tobacco users can make appointments with their health care provider to receive assistance to stop smoking. These clinic visits are considered part of routine medical care and are covered as part of a BlueCross member's existing coverage.

ANALYSIS

BlueCross BlueShield of Minnesota is a national leader in establishing tobacco cessation benefits for its members. BlueCross meets all the PHS recommended guidelines for benefits including medications, counseling and provider reimbursement. The impetus for BlueCross to develop cessation benefits came from their progressive action to bring a liability suit against the tobacco industry. When the suit was settled, BlueCross as an organization continued their leadership in tobacco control by establishing the Center for Tobacco Reduction and Health Improvement, which develops and manages the tobacco programs, including development of the cessation benefit. The Center is collecting data and monitoring the implementation of the cessation benefit through a continuous quality improvement process and plans to refine their reporting and communication strategies accordingly.

PACIFICARE HEALTH SYSTEM: CALIFORNIA

In March 1995, PacifiCare introduced the StopSmoking program. This program provided all PacifiCare members access to cessation services through telephone support, printed materials and medications. The cessation services offered to PacifiCare members are defined by the organization as a value-added service rather than a cessation benefit. These services are not filed as a benefit according to CMS (Centers for Medicare and Medicaid Service), but are instead integrated into PacifiCare's Health Improvement and Disease Management programs and the preventative health guidelines (reviewed by NCQA once a year).

The StopSmoking Program was run internally for several years until January 1, 2002 when, due to the recent shifts in the tight health care market, it was contracted out to the Free & Clear program. Free & Clear manages enrollment, sending out printed materials, telephonic support, recommendations for pharmacological therapy and reporting. PacifiCare maintains the pharmacy component and promotional efforts to the providers or other external partners.

The driving force behind changing the prevention program's protocol within PacifiCare was the Health Improvement and Disease Management department. There was no formal process to generate the initial creation of the StopSmoking program. Regular program meetings usually included proposals to further develop and expand PacifiCare's health improvement programs and project operations. The development of the tobacco cessation program was included in this process.

The project manager of the Health Improvement and Disease Management programs assembled the necessary background materials illustrating best practices for addressing tobacco use and dependence. He also constructed an outline for the pharmacology component of the cessation program. Program planning meetings included a review of current literature and the evolution of the program's design. Program staff spent roughly a year developing the components of the StopSmoking program. After completion of the program's design and implementation framework, PacifiCare's medical directors gave their approval to add the contracted service to the Health Improvement and Disease Management programs.

According to PacifiCare, the Stop Smoking Program has three purposes:

1. Improve long-term quit rates;
2. Reduce health care costs; and
3. Improve member satisfaction with health plan and health care services.

Summary of Current Benefit (Value Added Service)

- Program (Free & Clear) has five to six telephone sessions over one year.
- Program fee is \$20 for PacifiCare members, \$20 for Secure Horizons (fees vary by state)
- Cessation medications, nicotine patches (NicodermCQ®) or Zyban®, are available to most participants.
- Participants must be enrolled in Free & Clear and obtain a prescription from their physician to be eligible for one of the medications.
- \$20 co-payment for 30-day supply of either medication with a 90-day maximum per enrollment year.

Outcomes

PacifiCare has offered their StopSmoking program to all its members for almost six years and is now offering the Free & Clear telephone-counseling program. The overall program's one-year "quit" rates have been documented consistently above 30%.

From 1996 through February 2002, total enrollment in the StopSmoking program was 3,839. The California 1-year quit rate as of December 2002 was 34%. In 2002, total enrollment for California members in the Free & Clear program was 809.

ANALYSIS

PacifiCare has made a significant effort to help its members stop using tobacco and meets the basic requirements of the PHS guidelines. PacifiCare has a system for communicating with providers about program enrollees that helps track program participants. PacifiCare does not have an enterprise-wide system to identify and assist tobacco users. However, members in their Disease Management programs (CHF, CAD, COPD, Diabetes, and ESRD) are asked about smoking status. Any identified tobacco users are given a coupon to waive the enrollment fee to encourage members with chronic conditions to participate in the program. For other members, providers give out the program's contact information to interested patients and the patient is responsible for making contact.

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APPENDIX A

SUMMARY OF EVIDENCE BASE USED BY THE PCHT

Public Health Service Clinical Practice Guideline

The PHS clinical practice guidelines make the following recommendations:

1. Tobacco dependence is a chronic condition that often requires repeated intervention. However, effective treatments exist that can produce long-term or even permanent abstinence.
2. Because effective tobacco dependence treatments are available, every patient who uses tobacco should be offered at least one of these treatments:
 - a. Patients *willing* to try to quit tobacco use should be provided with treatments identified as effective.
 - b. Patients *unwilling* to try to quit tobacco use should be provided with a brief intervention designed to increase their motivation to quit.
3. It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user seen in a health care setting.
4. Brief tobacco dependence treatment is effective, and every patient who uses tobacco should be offered at least brief treatment.
5. There is a strong dose-response relationship between the intensity of tobacco dependence counseling and its effectiveness. Treatments involving person-to-person contact (via individual, group, or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (e.g., minutes of contact).
6. Three types of counseling and behavioral therapies were found to be especially effective and should be used with all patients attempting tobacco cessation:
 - a. Provision of practical counseling (problem solving/skills training);
 - b. Provision of social support as part of treatment (intra-treatment social support); and
 - c. Help in securing social support outside of treatment (extra-treatment social support).
7. Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients attempting to quit smoking.
 - a. Five first-line pharmacotherapies were identified that reliably increase long-term smoking abstinence rates:
 - i. Bupropion SR
 - ii. Nicotine gum
 - iii. Nicotine inhaler
 - iv. Nicotine nasal spray
 - v. Nicotine patch
 - b. Two second-line pharmacotherapies were identified as efficacious and may be considered by clinicians if first-line pharmacotherapies are not effective:
 - i. Clonidine
 - ii. Nortriptyline
 - c. Over-the-counter nicotine patches are effective relative to placebo, and their use should be encouraged.

8. Tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. As such, insurers and purchasers should ensure that:
- All insurance plans include as a reimbursed benefit the counseling and pharmacotherapeutic treatments identified as effective in this guideline.
 - Clinicians are reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic conditions.

The "5A's"

The PHS guidelines summarize the clinical implementation of treatment for tobacco dependence as the "5A's":

<i>ASK</i>	about tobacco use; i.e., identify and document tobacco use status for every patient at every visit.
<i>ADVISE</i>	to quit; i.e., using a clear, strong and personalized manner, urge every tobacco user to quit.
<i>ASSESS</i>	willingness to make a quit attempt; i.e., ask if the tobacco user is willing to make a quit attempt at this time.
<i>ASSIST</i>	in quit attempt; i.e., for patients willing to make a quit attempt, use counseling and pharmacotherapy to help them do so.
<i>ARRANGE</i>	follow-up; i.e., schedule follow-up contact, preferably within the first week after the quit date.

CDC Community Preventive Service Guidelines

The following are strategies recommended for health care systems by the CDC's Task Force on Community Preventive Services, 2000:

- Health care systems are strongly recommended to provide multi-component tobacco-use cessation interventions that include telephone support and provider reminder systems plus provider education programs with or without patient education.
- Health care systems are recommended to reduce patient out-of-pocket costs for effective cessation therapies.

CDC Best Practices Document

The following are the CDC's best practice recommendations for states:

- Establish population-based counseling and treatment programs, such as cessation helplines.
- Make the system changes recommended by the PHS cessation guidelines.
- Cover treatment for tobacco use under both public and private insurance.
- Eliminate cost barriers to treatment for under-served populations, particularly the uninsured.

Summary: Priorities Among Recommended Clinical Preventive Services

Coffield AB, et al. *Am J Prev Med* 2001;21(1)

Assessing adults for tobacco use and providing tobacco cessation counseling is second in priority only to vaccinating children as a prevention service with a high proportion of potential disease and injury prevention at high cost-effectiveness. Assessing adolescents for tobacco use and providing an anti-tobacco message or advice to quit is the fifth priority.

Both assessing adults for tobacco use and providing cessation counseling and assessing adolescents for tobacco use and providing an anti-tobacco message or advice to quit are high priority preventive services with less than 50% delivery rate. Both of these preventive services are high-priority opportunities for improving health and reducing costs.

APPENDIX B: BACKGROUND ON CLINICIAN REIMBURSEMENT

▶ *What are the methods for reimbursing clinicians?*

There are three general ways in which clinicians are reimbursed for providing health care: fee-for-service, salary, and through capitated contracts. In a fee-for-service system, clinicians provide treatment directly to patients and then bill the patient's insurance company for payment. Other clinicians receive a base salary — from large medical groups, hospital organizations, or a health maintenance organization (HMO) — for which they are expected to provide a pre-negotiated range of services. Yet other clinicians enter into contracts with large insurance purchasers that establish a "capitation rate" or amount that the clinician will be paid for each member per month covered under the contract. These provider groups usually have contracts with multiple purchasers.

▶ *Why is coding important?*

All encounters in health care are documented and given codes specifying the diagnosis and codes specifying the nature of the visit and any procedures and treatments that were provided.⁷ These codes are used for billing, reimbursement, and quality assurance. The coding system is how health care organizations keep track of each patient encounter, how those services are paid for, and how often the services are being offered and utilized. Establishing standardized codes for tobacco cessation services and medications is critical to helping more health care organizations integrate them into their standard benefits package.

▶ *How does coding differ by the type of insurance coverage?*

Fee-for-service

In fee-for-service health care, fees for each treatment and procedure are determined by the insurer, linked to the code, and paid accordingly. Insurers vary in what treatments and procedures they will pay for, even if a diagnosis is present and an appropriate treatment code is listed. If clinicians provide a treatment that does not have a code or is not reimbursed by the patient's insurer, the clinician is not paid for that service. Since this is often the case for tobacco cessation, clinicians typically do not provide more than the basic standard of care - screening and advice - to help patients stop using tobacco. For clinicians to provide the full range of services, it will be necessary for insurers to both create a policy to reimburse clinicians for assisting tobacco users to quit and to develop appropriate codes for the documentation and billing system.

Salaried or capitated contracts

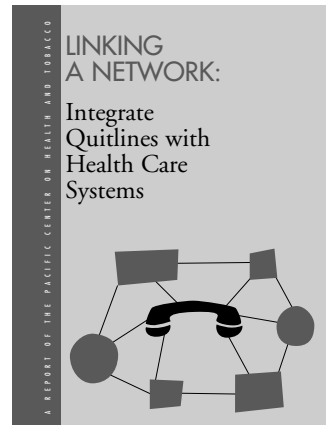
In capitated contracts, clinicians are paid for providing the services specified as part of their job (as salaried clinicians) or in their contracts. Codes are used in these systems, entered into an administrative database, and used to monitor whether the specified services have been delivered and to evaluate the quality of care. In order to prompt clinicians to take the time to provide assistance to tobacco users above the standard of care, managed care systems will sometimes use incentives. Managed care systems often withhold a part of the capitated amount negotiated for delivering services and then use this withheld amount to offer a bonus to either individual clinicians or to clinical groups for meeting certain performance goals. Delivery of the "5A's" has been included as a performance goal in some health systems. The codes used to document these encounters are entered into an administrative database and used as the basis for determining whether the goals have been met.

APPENDIX C: REPORTS AND RESOURCES

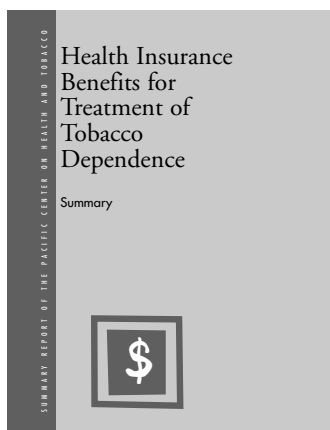
The PCHT has developed a series of reports and resources, available on our website, to help implement a comprehensive statewide tobacco cessation program. Here is a selection:



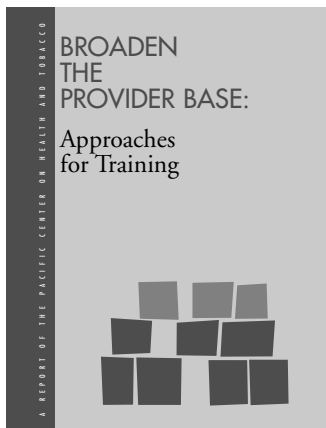
COMPREHENSIVE STATEWIDE TOBACCO CESSATION
The PCHT rationale, vision, and model for a comprehensive, state-based approach to tobacco cessation.



LINKING A NETWORK:
Integrate Quitlines with Health Care Systems. Describes the rationale and case studies for linking quitlines and health care delivery systems together.

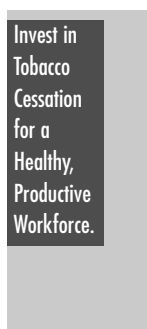


HEALTH INSURANCE BENEFITS FOR TREATMENT OF TOBACCO DEPENDENCE:
At-a-glance summary from the "Build a Financial Infrastructure."
This summary is intended to help guide discussions with employers and purchasers, and can be tailored to each state.



BROADEN THE PROVIDER BASE:
Approaches for Training. Outlines the benefits and approaches to provider and specialist training and discusses the pros and cons of certification.

Coming up:
BRIDGING GAPS: Outreach to Diverse Groups



INVEST IN TOBACCO CESSATION FOR A HEALTHY, PRODUCTIVE WORKFORCE:
A brief summary for employers that can be tailored to each state, outlining the business case for tobacco cessation benefits.



PCHT Website:
www.paccenter.org

APPENDIX D: PCHT MEMBERSHIP

ARIZONA

Myra Muramoto, MD, MPH
University of Arizona
College of Family and Community Medicine
Arizona Health Sciences Center
1450 N. Cherry Avenue.
Tucson, AZ 85719
(520) 626-1086
myram@u.arizona.edu

Tim Connolly, RN, MN
University of Arizona
College of Family and Community Medicine
Arizona Health Sciences Center
1450 N. Cherry Avenue.
Tucson, AZ 85719
(520) 626-1084
tconnoll@u.arizona.edu

Bob Leischow, MPH
Arizona Department of Health Services
Tobacco Education and Prevention Program
1740 W. Adams, #203-S
Phoenix, AZ 85007
(602) 364-0845
(602) 364-0844 (fax)
bleisch@hs.state.az.us

Pamela Powers, MPH
Arizona's Smokers Helpline
2302 E. Speedway, Ste 202
Tucson, AZ 85712-0482
(520) 318-7212 x 203
(520) 318-7222 (fax)
pjp@u.arizona.edu

CALIFORNIA

Traci Verardo
Next Generation California Tobacco Control Alliance
980 Ninth Street, Suite 370
Sacramento, CA 95814
(916) 554-0390
(916) 554-0399 (fax)
traci.verardo@tobaccofreealliance.org

Beau Carter
Integrated Healthcare Association
45 Quail Court, Suite 205
Walnut Creek, CA 94596
(925) 746-5100, ext. 19
(925) 746-5103 (fax)
bcarter@iha.org

Larry Dickey, MD, MSW, MPH
Office of Clinical Preventive Medicine
CA Department of Health Services
714 P Street, Rm. 1492
Sacramento, CA 95814
(916) 657-1493
(916) 657-3089 (fax)
ldickey@dhs.ca.gov

Scott Thomas, PhD
Bay Area Community Resource Project
171 Carlos Drive
San Rafael, CA 94904
(415) 444-5580 ext. 327
(415) 444-5598 (fax)
sthomas@bacr.org

Christopher Anderson
California Smokers' Helpline
Dept. of Family and Preventive Medicine
University of California, San Diego
9500 Gilman Dr. MC 0905
La Jolla CA 92093-0905 USA
(858) 713-1526
(858) 713-1599 (fax)
cmanderson@ucsd.edu

HAWAII

Clifford Chang, MPH, CHES
American Cancer Society
Coalition for a Tobacco Free Hawaii
245 N. Kakui Street, Suite 201
Honolulu, HI 96817
(808) 595-7500
(808) 595-7502 (fax)
cchang@cancer.org

OREGON

Wendy Bjornson, MPH
Tobacco Cessation Projects
Oregon Health Sciences University/
Tobacco-Free Coalition of Oregon
1425 NE Irving, #100
Portland, OR 97232
(503) 236-0361
(503) 872-9336 (fax)
Wendy_Bjornson@qwest.net

Elizabeth Laws, MPA
Tobacco Cessation Projects
Oregon Health Sciences University/
Tobacco-Free Coalition of Oregon
1425 NE Irving, #100
Portland, OR 97232
(503) 236-0361
(503) 872-9336 (fax)
Elizabeth_Laws@qwest.net

Jennifer Reeves
Tobacco Cessation Projects
Oregon Health Sciences University/
Tobacco-Free Coalition of Oregon
1425 NE Irving, #100
Portland, OR 97232
(503) 236-0361
(503) 872-9336 (fax)
Jennifer_Reeves@qwest.net

Dawn Robbins
Tobacco Cessation Projects
Oregon Health Sciences University/
Tobacco-Free Coalition of Oregon
1425 NE Irving, Ste 100
Portland, OR 97232
503-236-0361
503-872-9336
Dawn_Robbins@qwest.net

Nancy Clarke
Department of Human Services Health Division
800 NE Oregon St., #730
Portland, OR 97232
(503) 731-4273
(503) 731-4082 (fax)
nancy.g.clarke@state.or.us

WASHINGTON

Tim McAfee, MD, MPH
Group Health Cooperative of Puget Sound
Center for Health Promotion
12401 E. Marginal Way S.
Tukwila, WA 98168
(206) 988-7919
(206) 988-7900 (fax)
mcafee.t@ghc.org

Karen Krueger, RN, MN, MBA
WA State Dept. of Health
Chronic Disease and Reduction Unit
P.O. Box 47855
Olympia, WA 98904-7855
(360) 236-3611
(360) 236-3646 (fax)
karen.krueger@doh.wa.gov

Tamatha Thomas-Haase
WA State Dept. of Health
Chronic Disease and Reduction Unit
P.O. Box 47855
Olympia, WA 98904-7855
(360) 236-3722
(360) 236-3646 (fax)
tamatha.thomas-haase@doh.wa.gov

Sara Tift, MBA
Group Health Cooperative of Puget Sound
Center for Health Promotion
4969 N.E. Avalon Lane
Bainbridge, WA 98110
(206) 855-9508
(206) 855-9508 (fax)
stift@bainbridge.cnchost.com

Ken Wassum
Group Health Cooperative of Puget Sound
Center for Health Promotion
12401 E. Marginal Way S.
Tukwila, WA 98168
(206) 988-7938
(206) 988-7900 (fax)
wassumk@ghc.org

CENTERS FOR DISEASE CONTROL AND PREVENTION

Corrine Husten, MD, MPH
Centers for Disease Control and Prevention
Office on Smoking and Health
4770 Buford Hwy NE
Mail Stop K-50
Atlanta, GA 30341
(770) 488-5703
(770) 488-5848 (fax)
cch5@cdc.gov

Abby Rosenthal, MPH
Centers for Disease Control and Prevention
Office on Smoking and Health
4770 Buford Hwy NE
Mail Stop K-50
Atlanta, GA 30341
(770) 488-5159
(770) 488-5848 (fax)
alr7@cdc.gov

Micah Milton, MPH
4770 Buford Hwy NE Mailstop K-50
Atlanta, GA 30341
(770) 488-5728
(770) 488-5848 (fax)
mmilton@cdc.org

CENTER FOR TOBACCO CESSATION

Linda Bailey, J.D., M.H.S.
Center for Tobacco Cessation/Cancer & Science
Trends/American Cancer Society
901 E Street, NW, Suite 500
Washington, D.C. 20004-2037
(202) 585-3200
(202) 661-5750 (fax)
linda.a.bailey@cancer.org

Elizabeth Edsall, MSc
Center for Tobacco Cessation/Cancer & Science
Trends/American Cancer Society
901 E Street, NW, Suite 500
Washington, D.C. 20004-2037
(202) 585-3217
(202) 661-5750 (fax)
elizabeth.edsall@cancer.org

CONSULTANTS

Jane Ross, MBA, MPH
California Department of Education
1430 N. Street, Suite 6408
Sacramento, CA 95814
(916) 319-0200
Janebro@aol.com

Cyndi Lewis
Center for Tobacco Free Kids
PO Box 326
LaConner WA 98257
(360) 466-9208
(419) 793-5604 (fax)
clewis@tobaccofreekids.org

Beth Ewy, MPH, CHES
Division of Preventive and Behavioral Medicine,
University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655
(508) 856-2935
(508) 856-3840 (fax)
beth.ewy@umassmed.edu

Lori Pbert, Ph.D
Division of Preventive and Behavioral Medicine,
University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655
(508) 856-3515
(508) 856-3840 (fax)
lori.pbert@umassmed.edu

Ed Lichtenstein PhD.
Oregon Research Institute
715 Franklin Blvd.
Eugene, OR 97403
(541) 484-2123
(541) 484-1108 (fax)
ed@ori.org

Claryse Kami Nunokawa
Hawaii Community Foundation
1164 Bishop Street, 8th floor
Honolulu, HI 96813
(808) 566-5543
(808) 521-6286 (fax)
cnunokawa@hcf-hawaii.org

Maia Rogers, MPP, MPH
Health Policy Analyst
8070 E. Cedar Ave
Denver, CO 80230
(720) 236-5433
(425) 675-9975
malaya@attglobal.net



OHSU Smoking Cessation Research & Policy Center
3181 SW Sam Jackson Park Rd CR115 • Portland, OR 97239
503-418-5479 • fax 503-494-5407 • email: lawse@ohsu.edu • www.paccenter.org