Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

For projects to be considered for inclusion in the Medicaid Transformation Project List, please provide the information requested in the template. We are looking for summarized information – **2-3 pages maximum per project**.
Please email completed templates by **January 15, 2016,** to MedicaidTransformation@hca.wa.gov with the subject **Medicaid Waiver Project**. Thank you for your interest and support.

Contact Information	*Ann Christian, CEO, Washington Council for Behavioral Health(WCBH)* *206.628.4608 ex 14; achristian@thewashingtoncouncil.org* *Organizations Involved in Developing Project:* • *WCBH Board of Directors and member community behavioral health organizations across the state* • *Molina Healthcare of Washington*
Project Title	***Smoking Cessation – Time to Move the Needle***
Rationale for the Project	

- ***Problem statement – why this project is needed.***

In general, the United States has seen a significant decline in smoking and other tobacco use among many populations. Because we know about the health effects of smoking and the high costs of tobacco-related diseases, there has been a national effort to increase screening and access to tobacco cessation treatment. Clinical data show, however, that public health strategies that have succeeded in reducing smoking in the general population may not be effective for remaining smokers.[1] Many of those remaining smokers are adults and youth with serious mental illness or substance use disorders (SUD). Numerous studies indicate that people with a behavioral health condition represent more than one-third of the total adult smokers in the US, and there is documentation showing higher rates of smoking in almost every type of behavioral health condition.[2] Around 45% of cigarettes sold in the United States are purchased by people with mental illness.[3]

Smokers with a co-occurring mental illness or SUD is a population that has been historically underserved, despite meeting all the criteria to be designated as a priority population, a designation that would lead to increased access to research funding and treatment resources. Although the three major conditions caused by tobacco use (cancer, cardiovascular disease, and respiratory disease) are prevalent among people with behavioral health conditions, there are very few policies aimed at reducing tobacco use among this population. Evidence suggests that this lack of attention may result from stigma surrounding people with mental illness, as no other population group showing similar health disparity has been so ignored.[4] Accordingly, it is important to note that there is no relationship between psychiatric diagnosis or symptom severity and a readiness to quit. Smokers with a behavioral health comorbidity are just as willing to quit as smokers in the general population.

Tailored approaches to tobacco cessation are needed in order to "move the needle" for this vulnerable population. Although Medicaid is the primary provider of health insurance for people with serious mental illness, reimbursement for tobacco treatment remains poor in most states and varies with respect to duration and copayments. In addition, people with behavioral health conditions are more likely to experience many factors that make it more challenging to quit, including behavioral symptoms that affect motivation and adherence, poverty, and other stressful living conditions. If these unique needs remain unaddressed, the disparity in smoking rates among people with mental illness or SUD compared to the general population, as well as the resulting medical costs, will continue to increase.

- ***Supporting research (evidence-based and promising practices) for the value of the proposed project.***

Numerous research shows that the availability of tobacco cessation services, which are both clinically and cost-effective, can reduce the health effects of smoking and their associated costs. In fact, according to the Centers for

Disease Control and Prevention (CDC), the risk of a heart attack drops significantly after one year of quitting. After two to five years, the chance of a stroke is about the same as a non-smoker's.[5] But research also shows that smoking rates among people with behavioral health conditions have plateaued.[6] Because tobacco use contributes significantly to this population's reduced life expectancy, intensive and tailored cessation services must be funded and implemented. For example, a recent article published last month in JAMA examines premature mortality among adults with schizophrenia in the Medicaid population.[7] Researchers concluded that because high risks of mortality were observed from diseases that implicate tobacco use as a key risk factor, greater efforts are needed to implement smoking cessation services in settings that treat patients with schizophrenia. Behavioral health providers, in particular, are well-suited to provide intensive tobacco treatment for this population because they are often the clinicians who know this population best, they are already serving the population, they have extensive experience in providing behavioral therapies.

- ***Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid beneficiaries.***

Medicaid expends at least 11% of its budget on tobacco-caused illnesses, which totals $22 billion nationwide.[8] A 2007 study highlighted in a CMS bulletin announcing new tobacco cessation services under the Affordable Care Act estimated that if all Medicaid beneficiaries who smoked stopped smoking, the Medicaid program would save $9.7 billion after five years.[9] Comprehensive tobacco cessation efforts can reduce the prevalence of smoking in high-risk populations, including people living with mental illness or SUD, thereby improving health outcomes for Medicaid enrollees. Such efforts would also reduce net costs to Medicaid.

This project would also increase the efficiency and quality of care for Medicaid and other low-income populations by transforming service delivery. Currently, most tobacco cessation efforts are conducted in primary care settings rather than behavioral health settings. However, behavioral health providers, who regularly see patients with chronic mental health conditions or addiction issues, have many opportunities to intervene with smokers and to use motivational interventions for patients who have not yet expressed a desire to quit. This project would ensure that evidence-based tobacco cessation treatment, using combined behavioral health and pharmacy benefits, is fully covered.

Project Description

Which Medicaid Transformation Goals are supported by this project/intervention? Check box(es)

- ☐ Reduce avoidable use of intensive services
- X Improve population health, focused on prevention
- ☐ Accelerate transition to value-based payment
- X Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

- ☐ Health Systems Capacity Building
- X Care Delivery Redesign
- X Population Health Improvement – prevention activities

- ***Region(s) and sub-population(s) impacted by the project. Include a description of the target population (e.g., persons discharged from local jail facilities with serious mental illness and or substance use disorders).***

This project would be targeted, statewide, to all Medicaid adult and teen smokers with a serious mental illness and/or substance use disorder and receiving care in a community behavioral health setting.

- ***Relationship to Washington's Medicaid Transformation goals.***

A tobacco cessation initiative aimed at people with mental illness and SUD directly responds to Washington's Medicaid Transformation goal of improving population health with a focus on prevention and management of cardiovascular disease and smoking. A 2014 study showed that smoking accounts for half of the deaths among people with schizophrenia, bipolar disorder, and depression. Quitting tobacco has a greater impact on

cardiovascular risk than do changes in blood pressure, weight, physical activity, or lipids.[10]

- ***Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.***

Goals: The primary goal of this project would be to ensure that tobacco cessation treatment is fully covered by Medicaid for adult and teen enrollees diagnosed with a mental illness or substance use disorder. The covered treatment should also be of sufficient intensity and include evidence-based components proven to achieve smoking cessation among people with behavioral health conditions.

Interventions: Research indicates that brief interventions in primary care and/or quit lines have not been effective for people with mental illness or SUD. It also shows that either psychosocial or pharmacological treatments by themselves are only modestly effective in achieving long-term abstinence. Instead, effective smoking cessation interventions for persons this population include both pharmacotherapy (Nicotine Replacement Therapy-NRT, Wellbutrin/Bupropion, Chantix/Varenicline) and behavioral interventions (motivational, cognitive behavioral, behavioral medication management, etc.).[11] The intervention would be based in community behavioral health agencies and would actively coordinate care with primary care and other health providers involved in the patient's care.

Outcomes: We expect to show that combined pharmacologic and behavioral interventions improve smoking cessation outcomes in people with serious mental illness, including prolonged abstinence and in doing so have a positive impact on related medical conditions and life expectancy. Other states that have implemented comprehensive tobacco cessation programs within their Medicaid population have shown significant declines in hospitalizations for heart attacks and other acute coronary heart disease diagnoses.

- ***Links to complementary transformation initiatives - those funded through other local, state or federal authorities (such as the health home program and Early Adopter/Behavioral Health Organization regional purchasing) and/or Medicaid Transformation initiatives # 2 and 3.***

This project would support Healthier Washington's *Plan for Improving Population Health*, whose top two priority focus areas include cardiovascular disease and tobacco-free living, both of which would be directly impacted by this targeted smoking cessation intervention. Further, smoking cessation is also one of the top winnable battles identified by CDC Director, Dr. Tom Frieden; he has highlighted the special focus needed for people with mental illness in this CDC Vital Signs message.

- ***Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project.***

There has been historic separation of the financing, organization, and delivery of Medicaid outpatient behavioral health treatment and pharmacy benefits. Additionally, tobacco prevention and control programs are generally administered by departments of health. Therefore, it will be important to have tobacco control programs and policy integrated with state behavioral health programs and policies. In order to develop an integrated approach to ensuring targeted tobacco cessation services to people with mental illness and SUD, we would need to engage:

- Health plans
- ACHs and local health departments that are implementing community-wide tobacco prevention and control
- Department of Health

Core Investment Components

- ***Proposed activities and cost estimates ("order of magnitude") for the project.***

  $212.00 X 8,600 participants = $1.82 million per year

- ***Best estimate (or ballpark if unknown) for:***
  - ***How many people you expect to serve, on a monthly or annual basis, when fully implemented.***

  Based on data from Missouri we estimate that 54% of the 80,000 adults age 18–59 use tobacco, or

approximately 43,000. Based on data from Massachusetts, about 20% of Medicaid individuals can be successfully engaged in a cessation program in a given year, or 8,600 in this model. (Our understanding, as noted previously in this proposal, is that persons with behavioral health disorders have equivalent desires to stop smoking as general Medicaid patients.)

- ***How much you expect the program to cost per person served, on a monthly or annual basis.***

The annual cost for both counseling and medication in Massachusetts was $183 per person in 2010 dollars. Updating to 2016 using 3% inflation per capita produces a participant cost of $212.

- ***How long it will take to fully implement the project within a region where it will have to be phased in.***

N/A; to be determined based on finalization of project model.

- ***The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.***

A 2012 study analyzed the ROI of a Medicaid tobacco cessation program in Massachusetts.[12] Although this effort was targeted to all smokers within Medicaid population, rather than only enrollees with a co-occurring mental illness or SUD, the findings are relevant. Every dollar spent on program costs, including medications, counseling, and promotion and outreach, for Medicaid smokers was associated with a reduction of $3.12 in Medicaid expenditures for cardiovascular hospital admissions. Updated to 2016 costs, the net savings would be $2.62 per dollar spent. Because cardiovascular disease is prevalent among people with behavioral health conditions, it follows that a similar ROI would be realized for a tobacco cessation program aimed at this population. The estimate of net savings would be $4.77 million per year.

Project Metrics

The state will monitor implementation of transformation projects at regional and statewide levels through process and outcome measures. Each project will require clearly defined outcomes that relate to the goals and specific process steps.

- ***Key process and outcome measures (and specific benchmark performance data if known) against which the performance of the project would be measured. Include priority measures sets described in the Waiver application*** **http://www.hca.wa.gov/hw/Documents/waiverappl.pdf** ***pages 46-47.***

Performance of the project could be measured by priority measures included in the waiver applications: Adult Tobacco Use, Medical Assistance with Smoking and Tobacco Use Cessation; Hospitalization for COPD, and Cardiovascular Disease measures.

- ***If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*****?**

At the start of the project, each participating clinic would determine the number of adult Medicaid patients who smoked during the previous period. Follow-up project performance measures would include the number of patients who engage in the smoking cessation intervention and the number who quit smoking (using a standard definition such as six months of abstinence).

[1] Williams, Jill M., MD, et al., *Smokers With Behavioral Health Comorbidity Should Be Designated a Tobacco Use Disparity Group*, American Journal of Public Health, Vol. 103, No. 9 (Sept. 2013).
[2] Williams et al. (2013).
[3] Grant, Bridget, PhD, et al., *Nicotine Dependence and Psychiatric Disorders in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions*, Archives of General Psychiatry, Vol. 61, 1107–1115 (2004); Lasser, Karen, MD, et al., *Smoking and Mental Illness: A Population-Based Prevalence Study*, JAMA, Vol. 284 (Nov. 2000).
[4] Williams et al. (2013).
[5] CDC
[6] Williams et al. (2013).

[7] Olfson, Mark, MD, MPH, et al., *Premature Mortality Among Adults with Schizophrenia in the United States*, JAMA Psychiatry, Vol. 72 (Oct. 2015).
[8] Centers for Medicare and Medicaid Services Bulletin, *New Tobacco Cessation Services* (Jun. 24, 2011).
[9] American Legacy Foundation, *Saving Lives, Saving Money II: Tobacco-Free States Spend Less on Medicaid* (2007).
[10] Williams, Jill M., MD, et al., *Tobacco Use and Mental Illness: A Wake-Up Call for Psychiatrists*, Psychiatric Services, Vol. 65, No. 12 (Dec. 2014).
[11] Bartels, Stephen, MD, MS, *Winnable Battles: Tobacco Use by Persons with Mental Illness and State Tobacco Strategic Plans*, National Council for Behavioral Health Presentation (2014).
[12] Richard, Patrick, et al., *The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts*, PLOS ONE, Vol. 7, Issue 1 (Jan. 2012).