The Tobacco Dependence Treatment Support Landscape in Kansas

By

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Abstract

Background: Although tobacco control efforts have led to a marked reduction in tobacco use in the United States, tobacco consumption remains the top preventable cause of morbidity and premature mortality in this country. Health insurance coverage and tobacco dependence treatment in health care practices are systems that influence the state of tobacco.

Objective: To describe the tobacco dependence treatment service landscape in Kansas and identify gaps.

Methods: The three instruments used included the Kansas Environmental Scan for Tobacco Cessation Supports, the Kansas Health Plan Assessment, and the Tobacco Dependence Treatment Survey. Data collection occurred over different time periods between 2020 and 2022, and it involved insurance plan administrators and health care providers as well as research.

Results: *Kansas Environmental Scan for Tobacco Cessation Supports* – In Kansas, 16.2% (n=328,687) of the adult population smokes, and 24.4% (n=540,245) uses tobacco products. Fifty-five percent (n=1,538,700) of Kansans have coverage through an employer-based plan, 14% (n=396,400) are covered by Medicaid, and 9% (n=245,500) are uninsured. The Kansas Quitline served 1,028 tobacco users in 2020. Comprehensive tobacco cessation legislation was identified among the policies suggested to reduce tobacco use. *Kansas Health Plan Assessment* – The Kansas State Employee Health Plan (SEHP) reported offering comprehensive but not continuous tobacco dependence treatment coverage. *Tobacco Dependence Treatment Survey* – Among the Kansas health care providers surveyed regarding tobacco dependence treatment, reportedly 46% (n=55) had taken no related training, 68% (n=79) offered brief advice, 34% (n=39) prescribed FDA-approved cessation medication, 22% (n=25) provided related services to the uninsured, 19% (n=22) provided these services for free

to all patients, 11% (n=13) did not offer these services, 22% (n=25) did not accept insurance, and 67% (n=78) did not bill for these services.

Conclusion: This study suggests that many gaps remain in the tobacco dependence treatment landscape in Kansas. There are large gaps in health insurance coverage and in the capacity of providers to treat tobacco users.

Overview of Public Health Competencies Addressed by Project

Core Competencies Addressed

1. **MPH04** – Interpret results of data analysis for public health research, policy, or practice: This capstone involved interpreting the results of data collected through research and surveys for the benefit of public health research, policy, and practice.
2. **MPH13** – Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes: A diverse list of stakeholders was built and incorporated into the Kansas Environmental Scan for Tobacco Cessation Supports to help tobacco control advocates identify key organizations for partnership to improve public health outcomes related to tobacco use.
3. **MPH15** – Evaluate policies for their impact on public health and health equity: The Kansas Environmental Scan for Tobacco Cessation Supports outlined policies relevant to improving the tobacco dependence treatment infrastructure in Kansas, and the extent of their impact on public health and health equity was underscored.
4. **MPH19** – Communicate audience-appropriate public health content, both in writing and through oral presentation: A presentation of the results of the Tobacco Dependence Treatment Survey was created, and it was delivered to the Kansas Behavioral Health Tobacco Working Group on August 10th, 2021.
5. **MPH22** – Apply systems thinking tools to a public health issue: This capstone employed behavioral, causal, and structural systems thinking, and it applied structural systems thinking tools in the form of the Kansas Environmental Scan for Tobacco Cessation Supports to provide a picture of the tobacco dependence treatment support landscape in Kansas.

Public Health Management Competencies Addressed

1. **PHMC01** – Identify and interpret public health laws, regulations, and policies related to specific programs: The Policy section of the Kansas Environmental Scan for Tobacco Cessation Supports outlined the policies that could impact tobacco cessation, and these policies were discussed in this capstone in the context of the survey results as well as existing pertinent data.
2. **PHMC02** – Discuss the policy process for improving the health status of populations: This capstone elucidated the process by which the policies outlined in the Kansas Environmental Scan for Tobacco Cessation Supports could help increase tobacco cessation.
3. **PHMC03** – Identify the main components and issues of the organization, financing and delivery of health services and public health systems in the US: The factors associated with low utilization of evidence-based tobacco dependence treatment methods were identified by zooming in on health insurance coverage and on the clinical setting.
4. **PHMC06** – Apply leadership and systems thinking to understand the dynamics among public health, private enterprise, government, community-based, and healthcare organizations: This capstone took a systems-thinking approach in that it attempted to assess the tobacco dependence treatment capacity in Kansas by evaluating the different realms of influence in tobacco cessation across the state, namely, health insurance benefit coverage and the health care provider setting. The Kansas Environmental Scan for Tobacco Cessation Supports resulted from such an approach, for it encompassed the principal components associated with tobacco dependence and its treatment.

Acknowledgments

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Credit must also be given to Dr. Tresza Hutcheson for her advice as I started this work; to Mason Rohleder for his help on survey design; and to Dr. Nathalia Machado, Sara Prem, Kari Rinker, and members of the Kansas Department of Health and Environment Tristi Bond, Matthew Schrock, Mende Barnett, Steve Corbett, Carol Cramer, Suzanne Moore, Shannon Lines, and Melissa Warfield for their contributions to the Kansas Environmental Scan for Tobacco Cessation Supports. Lastly, I could not have tackled this project without the patience, love, understanding, and relentless support from my husband and my son, both of whom sacrificed precious family time so that I could work on and finish this final paper.

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Chapter 1: Background

Although tobacco control efforts over the past five decades have led to a marked reduction in tobacco use in the United States, tobacco consumption remains the top preventable cause of morbidity and premature mortality in this country and claims the lives of more than half a million individuals annually (National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2014). About one-fifth of the U.S. adult population (20.8%) consumed tobacco or tobacco-related goods in 2019, and most of these consumers (80.5%) used the combustible form of this addictive product (Cornelius et al., 2020). Since the dominant type of tobacco use is associated with combustible tobacco, surveillance data is often focused on this variable, and even more specifically on cigarette smoking, its most prevalent form (Cornelius et al., 2020). In 2019, 16.2% of Kansas adults reported smoking cigarettes whereas 14.0% of U.S. adults reported doing so (Centers for Disease Control and Prevention, 2017; Cornelius et al., 2020).

Tobacco-related products are harmful to human health because they contain numerous dangerous chemicals that, when inhaled or otherwise absorbed, can have adverse effects on every body organ and cause chronic diseases such as cancer, cardiovascular disease, diabetes, and pulmonary, macular, and immune/autoimmune diseases (Akter et al., 2017; Centers for Disease Control and Prevention, 2017; Cornelius et al., 2020; Degelman & Herman, 2017; Forey et al., 2011; National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2014; O'Keeffe et al., 2018; Roy et al., 2017; Thornton et al., 2005; U.S. Food and Drug Administration, 2020). Tobacco use can also be deleterious to reproductive health (CDC, 2010; Office on Smoking and Health [US], 2001). In addition, exposure to secondhand smoke (SHS) and/or thirdhand smoke (THS) is linked to adverse health outcomes, as well (Office on Smoking and Health [US], 2006; Ramírez et al., 2014). Further, smoking is at the root of most home fire deaths (Ahren, 2019). Finally, discarded

tobacco products represent a toxic and choking hazard to youth, and they pollute the environment (Dobaradaran et al., 2019; Hendlin, 2018; Kurmus & Mohajerani, 2020; Lerner et al., 2015; Stigler-Granados et al., 2019; Wang & Rostron, 2017).

From an economic perspective, tobacco-related costs amount to more than $300 billion yearly in the U.S. (i.e., $170 billion in medical expenditures and $156 billion in lost productivity; National Center for Chronic Disease Prevention and Health Promotion [US], 2014; U.S. Federal Trade Commission, 2019). In Kansas, the financial healthcare burden generated by tobacco use totals $1.12 billion (Campaign for Tobacco-Free Kids, 2022).

Tobacco cessation is beneficial to human health; it lowers the risk of premature mortality because it can reduce the risk of developing many of the afore-mentioned chronic diseases and negative reproductive health outcomes, and it attenuates the detrimental effects of these morbidities. Beyond the positive short- and long-term health and environmental ramifications of tobacco cessation, the latter is also reported to generate significant individual and societal cost savings (United States Public Health Service Office of the Surgeon General & National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2020).

Because tobacco and tobacco-related products contain the highly addictive substance nicotine, tobacco cessation proves extremely challenging and often requires numerous attempts (CDC, 2010; Chaiton et al., 2016; Dani & De Biasi, 2001; Lopez-Quintero et al., 2011; Office on Smoking and Health [US], 1988; United States Public Health Service Office of the Surgeon General & National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2020). Almost 70% of smokers report a desire to quit tobacco use, and more than half of them report attempting to quit smoking within the past year. However, approximately 7% of them report staying quit for a period of at least six months (Babb et al., 2017; United States Public Health Service Office of the Surgeon General & National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2020).

Since the 1980s and 1990s, many tobacco cessation methods and interventions have been created and implemented with different degrees of effectiveness across both treatment modes and tobacco use subgroups. Recommended strategies for successful tobacco cessation include individual, group, and telephone counseling as well as pharmacotherapy, with a combination of both methods proving more effective than single treatment approaches (Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff, 2008; United States Public Health Service Office of the Surgeon General & National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2020). Food and Drug Administration (FDA)-approved first-line medications comprise nicotine replacement therapy (NRT) products (i.e., gum, lozenges, transdermal patch, nasal spray, and oral inhaler) and the non-nicotine pharmacotherapies bupropion SR and varenicline. All these evidence-based tobacco dependence treatments are generally more effective, whether discretely or in certain combinations, than quitting efforts without them (Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff, 2008). Further, using short-acting NRT in conjunction with long-acting NRT (i.e., transdermal patch) can augment tobacco cessation success compared to leveraging only one form of this type of tobacco cessation aid (Lindson et al., 2019; United States Public Health Service Office of the Surgeon General & National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2020).

Despite the demonstrated effectiveness of tobacco dependence treatment counseling and pharmacotherapy treatment options and the requirement for insurance to cover them under the Patient Protection and Affordable Care Act (ACA), approximately one-third (31.2%) of adult smokers report using these treatment strategies, most of whom (93%) opting for tobacco dependence treatment medications (American Lung Association, 2020; Babb et al., 2017; Patient Protection and Affordable Care Act of 2010). This low tobacco dependence treatment utilization rate is likely partly driven by the following factors: a) the insufficient and inconsistent

use of appropriate referrals and tobacco dependence treatment interventions in the healthcare setting (given that 70% report visiting a physician annually); b) the underutilization of quitlines; c) the existence of non-ACA-compliant health plans; and d) the high proportion of smokers who lack insurance coverage (32.8%; American Lung Association, 2019; Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff, 2008; Bentz et al., 2006; Curry et al., 2008; Fiore & Jaén, 2008; Jamal et al., 2018; Holtrop et al., 2008; Kaufman et al., 2010; Seervai et al., 2019; United States Public Health Service Office of the Surgeon General & National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2020).

Among its objectives, Healthy People 2030 call for action toward a) a reduction in current tobacco use in adults as well as adolescents (TU-01 and TU-04, respectively), b) a rise in the percentage of adults who are advised to quit by medical providers (TU-12), c) a heightened use of counseling and tobacco dependence treatment pharmacotherapy (TU-13), d) increased past-year and successful smoking cessation attempts (TU-11 and TU-14/TU-15, respectively), and e) expanded Medicaid coverage of evidence-based tobacco dependence treatment (TU-16; Office of Disease Prevention and Health Promotion, [n.d.]). To advance toward these objectives, it is crucial to identify the tobacco dependence treatment supports that are currently available. In Kansas, the tobacco dependence treatment support landscape has not been fully documented. Therefore, this capstone aims to help bridge this gap and constitutes an attempt to describe the tobacco dependence treatment service landscape in Kansas.

Chapter 2: Methods

Three instruments were used to describe the tobacco dependence treatment service infrastructure in Kansas. These instruments included a state tobacco environmental scan (*Kansas Environmental Scan for Tobacco Cessation Supports*), an insurance carrier survey about tobacco dependence treatment benefits (*Kansas Health Plan Assessment*), and a tobacco cessation provider survey (*Tobacco Dependence Treatment Survey*).

Kansas Environmental Scan for Tobacco Cessation Supports

Participants

Individuals involved in populating the Kansas Environmental Scan for Tobacco Cessation Supports included all members of a Behavioral Health Tobacco Project work group (Dr. Elizabeth Ablah, Rick Cagan, Anne DiGiulio, Frederique Huneycutt, Dr. Nathalia Machado, and Dr. Kimber Richter) and Kansas Department of Health and Environment (KDHE) employees (Mende Barnett, Tristi Bond, Steven Corbett, Carol Cramer, Shannon Lines, Suzanne Moore, Matthew Schrock, and Melissa Warfield). The Behavioral Health Tobacco Project constituted an effort led by the National Alliance on Mental Illness (NAMI) Kansas and funded by the Kansas Health Foundation. It was designed to help expand health insurance coverage and increase access to evidence-based tobacco dependence treatment for individuals with mental illness and substance use disorders (Kansas Health Foundation, [n.d.]; NAMI Kansas, [n.d.]). Additional participants will be included in the future to keep this database updated. Anyone provided with a link to this instrument can view its data.

Instrument

The Kansas Environmental Scan for Tobacco Cessation Supports is a living database that stemmed from a document from the North American Quitline Consortium originally designed as a supplement of the first phase of a 2011 webinar series on building private-public partnerships (North American Quitline Consortium, [n.d.]). The scan's initial purpose was to prompt insurance entities to use quitlines. The original instrument can be found at

https://www.naquitline.org/resource/resmgr/PPP/State_Cessation_Coverage_Ass.doc.

The NAMI Kansas Director of the Behavioral Health Tobacco Project, Rick Cagan, elected to utilize this database template to capture the tobacco dependence treatment coverage landscape in Kansas. The spreadsheet was enhanced in May 2020 and then converted from Microsoft Word format to Microsoft Excel format in October 2020 (Appendix A). This instrument was composed of ten worksheets, which included an introduction to the document, state data on tobacco use and insurance coverage, a list of major insurance carriers, a list of the largest employers in the state, Kansas Medicaid information, Kansas Quitline statistics, a list of key stakeholders in Kansas together with their respective e-mail contact information, a list of relevant policies and policy efforts, resources for tobacco dependence treatment, and access to select data.

Procedures

This database was populated with data collected through online searches. Some data were also provided by members of the Behavioral Health Tobacco Project work groups as well as from individuals affiliated with KDHE and/or non-governmental health organizations (Kansas Department of Health and Environment, [n.d.]). Data collection started in October 2020 and is ongoing. The last revision of this document occurred on April 12th, 2022.

Kansas Health Plan Assessment (KHPA)

Participants

The Kansas Health Plan Assessment (KHPA) intended participants consisted of current administrators of active Kansas health insurance plans, including the state's health insurance plan, namely, the State Employee Health Plan (SEHP; KDHE, [n.d.]). Some of the health insurance companies prompted to participate in this assessment included Blue Cross Blue Shield® of Kansas, Blue Cross Blue Shield® of Kansas City, Aetna®, UnitedHealthcare® Insurance, Cigna® Health and Life Insurance, and Humana® Insurance. These companies were targeted because they were the ones identified, through data provided by the Kansas Insurance

Department, as holding the largest health insurance market share in Kansas (Van Aalst, 2017; R. Cagan, personal communication, November 11, 2021). Only one participant was allowed to complete this survey questionnaire per health insurance organization, but this participant was permitted to seek input from other employees within the associated organization.

Instrument

The Kansas Health Plan Assessment was developed by individuals from a Behavioral Health Tobacco Project work group as a joint effort between the American Lung Association, NAMI Kansas, and the University of Kansas School of Medicine (American Lung Association, [n.d.]; NAMI Kansas, [n.d.]; The University of Kansas School of Medicine, [n.d.]). This instrument aimed to assess tobacco dependence treatment service coverage, including coverage for all FDA-approved first-line tobacco dependence pharmacotherapy options and various recommended modes of counseling, associated with individual Kansas health insurance plans, and it included a total 81 questions (Appendix B). These questions were categorized as follows: premium surcharge and incentives; covered medication-assisted yearly quit attempts; covered tobacco cessation medications (i.e., varenicline, bupropion, and five forms of NRT – nicotine replacement patches, gum, lozenges, nasal spray, and inhalers); co-pay, prior-authorization, and limitations for covered tobacco cessation medications; allowed duration of quit attempt by covered tobacco cessation medication (30, 60, 90 days, Other); combination tobacco cessation pharmacotherapy; covered yearly counseling services and sessions (individual, group, telephone); co-pay and limitations for covered counseling services; reimbursement for Current Procedural Terminology (CPT) codes 99406 (individual tobacco dependence treatment counseling lasting between three minutes and 10 minutes) and 99407 (individual tobacco dependence treatment counseling lasting more than 10 minutes), and for tobacco dependence treatment office visits (such as the ones meeting the definition for code 99213 [Evaluation and Management lasting 20-29 minutes] or code 99214 [Evaluation and Management lasting 30-39 minutes]); types of providers allowed reimbursement for CPT codes

99406 and 99407 (i.e., Physicians; Nurses; Dentists; Pharmacists; Licensed Master Social Workers; Licensed Clinical Social Worker; Clinical Psychologist; Tobacco Treatment Specialist; Licensed Clinical Addiction Counselor; Certified Peer Specialist; Respiratory Therapist; Diabetes Educator; Other); and tobacco cessation counseling via telehealth (American Medical Association, 2019; Leone et al., 2016).

A skip logic was built into the survey so that participants could be presented with questions congruent with their previous answers. Once a participant completed the survey, its data was automatically submitted to the University of Kansas School of Medicine for analysis/interpretation and reporting.

Procedures

The instrument was created in the spring of 2020, using the cloud-based survey platform SurveyMonkey (SurveyMonkey, [n.d.]). The NAMI Kansas Director of the Behavioral Health Tobacco Project, Rick Cagan, identified contacts at Kansas health plans to be targeted as survey recipients. Mr. Cagan then sent e-mails to these contacts separately, explaining the purpose of the survey and inviting them to respond to it. A link to the survey was provided within the e-mail. Data collection began in October 2020 and, as of April 14, 2022, is ongoing.

Tobacco Dependence Treatment Survey

Participants

Participants in the Tobacco Dependence Treatment Survey comprised licensed behavioral health care providers in Kansas as well as other health care providers. The licensed behavioral health care providers were identified through a relevant contact list supplied by the Behavioral Sciences Regulatory Board (BSRB). All respondents were recruited via e-mail.

Instrument

The Tobacco Dependence Treatment Survey was developed using the cloud-based survey platform SurveyMonkey by individuals affiliated with the Behavioral Health Tobacco Project, and it included 13 questions (Appendix D). This instrument was meant to collect data

relative to the capacity of health care practices to provide evidence-based tobacco dependence treatment.

The associated questions aimed to gather information on the respondent and on the training completed by both the respondent and other employees in the organization. For training, respondents could select “Tobacco Treatment Specialist training,” “BTI-Brief Tobacco Intervention online training (KDHE),” and “Navigating the Reimbursement Maze – online Training for billing,” for example.

The survey also sought to assess the services offered relative to tobacco dependence treatment and user accessibility to tobacco dependence treatment services. For the services offered, respondents could choose the type of counseling offered as well as whether the provider prescribed or referred FDA-approved tobacco dependence treatment medications. For tobacco dependence treatment accessibility, selection options pointed to insurance status, program enrollment, and service area, for example.

Further, this questionnaire collected information on the cost of services to clients and the way payment was handled for services as well as the accepted types of insurance and the billing codes used for tobacco dependence treatment. For instance, this survey meant to determine whether services were free to all clients or only to clients based on criteria such as service area and enrollment status. If services were not free, respondents could select whether clients paid out of pocket or whether the insurance was billed. The insurance coverage options included both public insurance (i.e., KanCare [Kansas Medicaid], Medicare, and VA [Veterans Affairs]) and private insurance. Respondents could also write in other types of insurance, or they could indicate that no insurance was accepted by typing in “NA” (i.e., not applicable). The billing codes for tobacco dependence treatment included 99406 (individual counseling greater than 3 minutes), 99407 (individual counseling greater than 10 minutes), and S9453 (group counseling).

Additional questions sought to determine a) whether the respondent wished to receive more information on tobacco dependence treatment resources; b) whether the respondent had any concerns and/or questions; c) whether the respondent wished for the organization to be included in a listing of providers of tobacco dependence treatment; and d) what associated contact information to display in the listing, should the organization have agreed to be included in this directory.

Data from this collection effort was utilized to generate a directory of tobacco cessation service providers in Kansas that could be used by such entities as the Kansas Tobacco Quitline (KanQuit), Kansas Medicaid (KanCare), and Managed Care Organizations (MCOs), for example, as well as by individual tobacco users (KanCare Ombudsman Office, [n.d.]; Kansas Tobacco Quitline KanQuit, [n.d.]). The survey could be accessed via https://www.surveymonkey.com/r/7LY38CJ.

Procedures

Initially, a survey link was sent to approximately 8,000 licensed behavioral health care providers, whose contact information was pulled from a list obtained from the Behavioral Sciences Regulatory Board (BSRB). Subsequently, the survey was disseminated to a diverse set of medical care associations, such as the Association of Community Mental Health Centers of Kansas and addiction and primary care treatment associations, for further distribution to their members. Major health insurance plans also helped to broaden the survey reach by providing e-mail addresses for health care providers (Association of Community Mental Health Centers of Kansas, [n.d.]). Dissemination started in January 2020 and ended on December 31, 2020.

Statistical Analysis

The statistical analysis of the data was conducted using the 64-bit edition of the IBM Statistical Package for the Social Sciences (SPSS) software Release 27 for the Apple Macintosh computer. Univariate analyses were performed for all variables, providing results in the form of frequencies and percentages.

Chapter 3: Results

Kansas Environmental Scan for Tobacco Cessation Supports

State Data on Tobacco Use and Insurance Coverage Status: Regarding tobacco use in Kansas, 16.2% (n=328,687) of the adult population smokes, and 24.4% (n=540,245) uses tobacco products (Appendix A). In addition, an estimated 31.4% of Kansas adults with mental illness smoke. Regarding health insurance coverage, 55% (n=1,538,700) have coverage through an employer-based plan, 14% (n=396,400) are covered by Medicaid and 14% (n=396,600) by Medicare, 3% (n=89,993) are covered by an ACA exchange/direct-purchase plan, and 2% (n=64,100) have Tricare/Military. Nine percent (n=245,500) of Kansans are uninsured.

Medicaid: Kansas offered Medicaid benefits mostly through MCOs. The state has not passed a bill to expand Medicaid. No tobacco cessation services were carved out (i.e., these services are all provided by MCOs), and Medicaid offered an option, through its OneCare Kansas program, for long-term services and support, such as tobacco dependence treatment, for people with certain chronic conditions, including specific mental illnesses. OneCare Kansas connects all patient's providers to optimize patient care (KanCare, [n.d.]).

Major Health Insurance Plans: Eight major health insurance plans were identified as holding the largest share of the health insurance market. They included Blue Cross Blue Shield® of Kansas, Blue Cross Blue Shield® of Kansas City, BlueCross BlueShield Kansas Solutions, UnitedHealthcare® Insurance Company, Aetna® Life Insurance Company, Humana® Insurance Company, Cigna® Health and Life Insurance Company, and Aetna® Health.

Largest Employers: The 2020 Kansas Economic Report listed the 20 largest employers in the state (Kansas Department of Labor, 2020). Data on employment size among these employers could be gathered for only three organizations (i.e., Textron Aviation [n=12,458], Ascension Via Christi Hospitals Wichita [n=~10,000], and Unified School District (USD) 259 [n=~ 9,000]). Research Analyst Lindsay Allen, at the Labor Market Information Services of the

Kansas Department of Labor, confirmed that the number of employees per organization was considered confidential information and could not be disclosed by the agency. The Kansas Department of Labor could not release employer size ranking either. Contact information for the individuals responsible for managing employee benefits at these organizations could only be collected for four employers (i.e., State of Kansas, Textron Aviation, Ascension Via Christi Hospitals Wichita, and USD 259).

Quitline: In 2020, there were 3,715 direct calls to the Kansas Tobacco Quitline, KanQuit, which represented services to 1,028 Kansas tobacco users, or a treatment reach of about 30%. Among these tobacco users, 835 were referred to the Quitline, and 529 registered for web-based services. Of these KanQuit participants, 22% (n=224) were uninsured, 25% (n=258) had Medicaid, 28% (n=285) had Medicare, 22% (n=233) had private insurance, and 3% (n=29) had another type of insurance (North American Quitline Consortium, 2021).

KanQuit reported offering counseling support for everyone as well as two weeks of NRT for KanCare enrollees and four weeks of NRT for individuals qualifying for a behavioral health and substance abuse program. From a financial perspective, the KanQuit budget for State Fiscal Year 2020 was $172,501 and included funds for services (72.3%; $124,652), NRT (15.3%; $26,329), and promotion (12.5%; $21,520). These outlays translated into an amount spent per smoker of $0.45. The reported quit rate for individuals receiving KanQuit services in 2020 was 26.3% (T. N. Bond, personal communication, July 15, 2021; M. Schrock, personal communication, February 2, 2021).

Key Stakeholders/Targets for Partnership: In total, 67 key stakeholders associated with organizations across various sectors were identified who work to control tobacco and support tobacco dependence treatment. These sectors comprised government agencies, insurance and business groups, health care providers, advocacy organizations, health care foundations, and academic institutions. For example, government agencies included the Kansas Department of Health and Environment (KDHE), the Kansas Department of Aging and Disabilities Services

(KDADS), the Kansas Insurance Department (KID), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Further, the principal cancer, heart, lung, and mental health associations representing patient groups were listed within the advocacy organizations, and the University of Kansas School of Medicine and Wichita State University appeared within the key academic institutions, for instance.

Policies That Impact Tobacco Cessation: Policies shown to reduce tobacco use and boost tobacco prevention included comprehensive tobacco cessation legislation, tax increases on tobacco products, age restriction, funding allocation, flavor bans, smoke-free setting legislation, and regulation of the tobacco retail environment (ALA, 2020a). Legislation associated with comprehensive tobacco cessation included statutes on Medicaid expansion, Medicaid reimbursement rates, insurance coverage mandate, and the adoption of tobacco dependence treatment quality measures. Age restriction regulation included a law restricting the age of purchase, use, and possession (PUP) of tobacco products to individuals at least 21 years of age as well as the removal of PUP language from existing statutes. Funding legislation involved laws on protecting existing cessation/prevention funding, opposing securitization of tobacco settlement funds, and allowing for funds toward targeted counter-tobacco media campaigns. Smoke-free setting regulation encompassed state agencies, parks and other outdoor venues, school campuses, mass transit, and childcare facilities. Regulation of the tobacco retail environment included licensure regulation as well as content-neutral signage (E. Ablah, R. Cagan, A. DiGiulio, N. Machado, meeting, January 28, 2022).

Tobacco Dependence Treatment Resources: Two tobacco dependence treatment resources in Kansas were identified. First, the Kansas Support Groups web page (https://supportgroupsinkansas.org/support-groups), hosted by Wichita State University, provides tobacco dependence treatment resources for tobacco users or providers seeking to refer the latter to treatment (Kansas Support Groups, [n.d.]). Second, the Kansas Tobacco Dependence Treatment Provider Directory

(https://docs.google.com/spreadsheets/d/1dXm9xremZOQPhVEZnnvlnRUsrWZ86UYx/edit#gid=1867377745) includes the names of those providers in Kansas who reported in the tobacco dependence treatment survey disseminated in 2020 providing tobacco dependence treatment services and who elected to be listed (directory sample in Appendix F).

Select Data: Four sets of data were identified. They included data from the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA). They also included claims and self-assessment data.

HRSA collects health center data on tobacco dependence screening and treatment through the Uniform Data System (UDS) as reported by Federally Qualified Health Centers (FQHCs) and FQHC Look-alikes. These data cover patient characteristics, services provided, the use of services by patients, clinical processes, and health outcomes, among other data. Unlike FQHCs, FQHC Look-alikes do not receive funding under HRSA's Health Center Program (Health Resources and Services Administration, 2021). Only Kansas FQHC-reported data on tobacco dependence screening and treatment as well as smoking policies were included in the HRSA data set (K. Richter, personal communication, November 20, 2021/March 22, 2022). The HRSA data set was included because tobacco use identification and select psychopharmacological treatment interventions constitute evidence-based strategies recommended by the U.S. Preventive Services Task Force to help reduce tobacco use (Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff, 2008; United States Public Health Service Office of the Surgeon General & National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2020).

SAMHSA gathers self-reported data from mental health and substance use treatment facilities on tobacco dependence screening, counseling, FDA-approved pharmacotherapy, and tobacco-free campuses (Substance Abuse and Mental Health Services Administration, [n.d.]). These data stemmed from the National Survey of Substance Abuse Treatment Services (N-

SSATS) and the National Mental Health Services Survey (N-MHSS). These surveys collect data on the characteristics of substance use and mental health treatment facilities, respectively, and they are now combined under the National Substance Use and Mental Health Services Survey (N-SUMHSS) to alleviate the burden on both SAMHSA and respondents as well as to improve data quality (SAMHSA, [n.d.], 2018). The SAMHSA data set was included because individuals with mental illness are disproportionately impacted by tobacco use and face especially challenging barriers relative to cessation and tobacco dependence treatment (CDC, 2020; Lipari & Van Horn, 2017; Schroeder, 2016). This data set was also chosen because mental health and substance abuse treatment centers were reported to have particularly underutilized the recommended validated tobacco dependence treatment interventions (Friedman et al., 2008; Prochaska, 2010).

The claims data set includes KanCare, SEHP, and private insurance health care provider claims per year from 2013 to 2019 for treating patients with and without mental illness for tobacco dependence through counseling and FDA-approved medications. Claims data are composed of standardized billing codes that health care providers submit to insurance for reimbursement, and they reflect the tests, diagnoses, and interventions provided to patients as well as the medications filled/refilled by patients (Wilson & Bock, 2012). The claims data set was included because of the underutilization of evidence-based tobacco dependence treatment strategies in clinical settings and because individuals with mental illness and individuals on Medicaid (i.e., with low income) as well as individuals who lack insurance coverage have been found to use tobacco at higher rates than the general population (CDC, 2020; Cornelius et al., 2020; Curry et al., 2008; Fiore & Jaén, 2008; Jamal et al., 2018, Lipari & Van Horn, 2017; Schroeder, 2016; United States Public Health Service Office of the Surgeon General & National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2020).

The self-assessment data stemmed from an online survey developed by Kim Richter, Rick Cagan, and Dee Vernberg and maintained by the Kansas Department of Aging and Disabilities Services (KDADS). This survey was adapted from the Index for Tobacco Treatment Quality (ITTQ; Cupertino et al., 2013); it was completed by select behavioral health care organizations, and it assessed tobacco dependence treatment services before and after a mini-grant program aimed at improving tobacco treatment services. Specifically, it evaluated the extent to which these health care facilities had implemented aspects of the Kansas Tobacco Guideline for Behavioral Health Care (K. Richter, personal communication, November 20, 2021/March 22, 2022; Public Health Law Center & NAMI Kansas, 2018). This self-assessment data set was selected because tobacco dependence treatment interventions are underutilized in behavioral health care (Friedman et al., 2008; Prochaska, 2010).

Kansas Health Plan Assessment

One survey recipient contacted by Rick Cagan agreed to complete the Kansas Health Plan Assessment (KHPA). On October 13, 2021, the Senior Manager of Operations of the Kansas SEHP completed this questionnaire. Its completion provided a picture of the Kansas SEHP tobacco dependence treatment coverage. Results from this questionnaire follow (Appendix C).

Surcharges and Incentives: The Kansas SEHP reported having no premium surcharge for tobacco users and offering a reasonable alternative to a premium surcharge for tobacco users ("*credits/reward dollars for members who [completed] a tobacco cessation program. 6 points = $60, and [counted] towards the annual premium discount a member [might] earn*"). The plan also provided both an employer wellness incentive for non-tobacco users and a reasonable alternative to the non-tobacco user incentive through a Cerner's HealthQuest Rewards Program online course (Wichita State University, 2021).

Pharmacotherapy: The Kansas SEHP covered three (3) medication-assisted quit attempts per year. All FDA-approved tobacco cessation medications (i.e., varenicline,

bupropion, nicotine replacement patches, gum, lozenges, nasal spray, inhalers) were covered by this plan, and it allowed for combination pharmacotherapy for tobacco cessation. An enrollee filling out two different pharmacotherapies concurrently was considered as one quit attempt by the Kansas SEHP. The respondent indicated that there was no co-pay or other member financial requirement for any of these pharmacotherapies and that there were no prior authorization and no limitations for any of these medications expect for varenicline. When prompted to describe the limitations associated with varenicline, the respondent reported "Quit attempts per year." For varenicline, bupropion, and the nicotine replacement patches, gum, and lozenges, the respondent selected "0" for the specified duration in days of a quit attempt. For the nicotine replacement nasal spray and inhalers, the respondent selected "1" for the specified duration in days of a quit attempt.

Counseling: The Kansas SEHP covered individual, group, and contracted telephone counseling for tobacco cessation, with no co-pay or other cost sharing. The respondent indicated that 10 individual counseling sessions were allowed per plan year. No limitations were specified for group counseling or for contracted telephone counseling for tobacco cessation.

Billing/Reimbursement: The Kansas SEHP reportedly reimbursed providers who used CPT codes 99406 and 99407 for tobacco cessation. The respondent did not specify which of the listed providers could be reimbursed for tobacco dependence treatment billed under 99406 and 99407, nor did the respondent indicate which types of providers required additional certification or expertise to be able to bill for codes 99406 and 99407. In addition, the Kansas SEHP also covered office visits solely aimed at treating tobacco dependence, and reimbursement for counseling delivered via telehealth constituted a permanent benefit. Billing for counseling via telehealth did not require the use of coding modifiers.

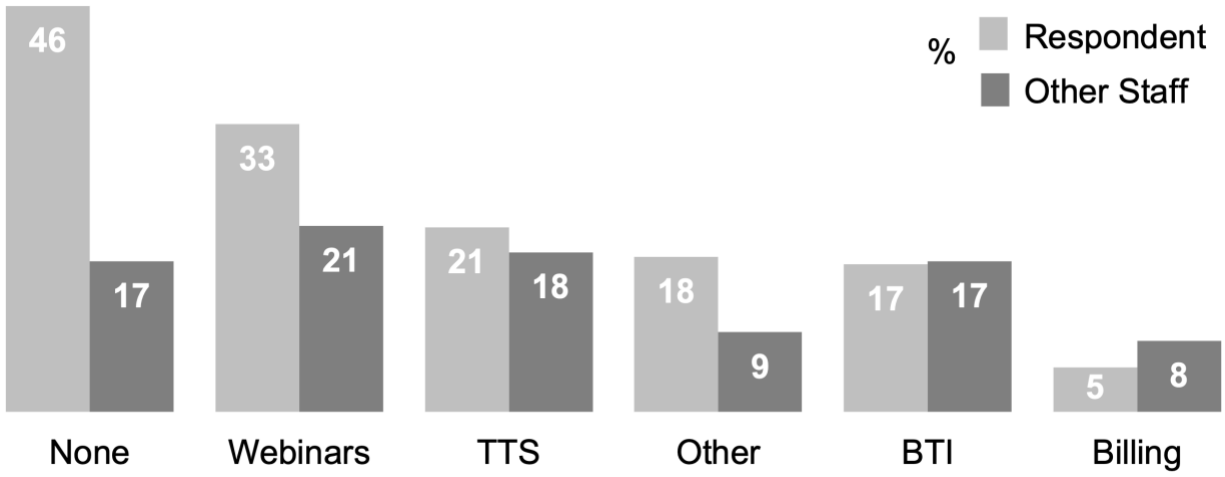
Tobacco Dependence Treatment Survey

In total, 126 respondents completed the Tobacco Dependence Treatment Survey. After removing duplicate entries, the survey generated 120 responses from distinct respondents, representing 116 organizations.

Training Completed: Forty-six percent (n=55) of the 120 respondents reported having completed no tobacco-related training. Webinars were the predominant form of training completed by respondents (33%, n=39), and training on billing was the least prevalent type of training completed by respondents (5%, n=6). Webinars were the predominant form of training completed by other staff at the organization (21%, n=25) and training on billing the least prevalent type of training completed by these employees (8%, n=9; Figure 1; Appendix E).

Figure 1

Training Completed by Respondent and Other Staff at the Organization



Note. TTS = Tobacco Treatment Specialist; BTI = Brief Tobacco Intervention online training (KDHE). Billing refers to online training workshop "Navigating the Reimbursement Maze." This tobacco dependence treatment workshop includes training on coverage, billing, and reimbursement.

Organizational Services Provided: Most of the 116 responding organizations (68.1%, n=79) reported offering brief advice (i.e., counseling under three minutes) to tobacco users and/or referring tobacco users to the Kansas Quitline, and 56% (n=65) and 47% (n=54) of them reported offering counseling lasting between three and 10 minutes and longer than 10 minutes, respectively. Nineteen percent (n=22) reported that group counseling was a service provided. Forty percent (n=46) reported referring to a prescriber for FDA-approved cessation medications, and 34% of them (n=39) reported prescribing or recommending these medications. Twenty-two percent (n=19) reported billing for the treatment of tobacco dependence, and 11% of them (n=13) reported not offering any of the services listed in the survey (Table 1).

Table 1

Types of Services Provided

Service Type	n	%
Brief advice (< 3 minutes)	79	68
Refer to Kansas Tobacco Quitline	79	68
Counseling (3-10 minutes)	65	56
Counseling (> 10 minutes)	54	47
Refer for medications	46	40
Prescribe or recommend medication	39	34
Billing for TDT	26	22
Group counseling	22	19
None of the above	13	11

Note. TDT = Tobacco Dependence Treatment.

Table 2

A Closer Look at Counseling

Counseling and Referral to Quitline	n	%
Individual counseling		
None	21	18
At least one form (brief advice, or counseling 3-10 minutes, or counseling > 10 minutes)	95	82
Only brief advice (< 3 minutes)	22	19
Group counseling	22	19
None and no individual counseling offered	19	16
Group counseling and at least one form of individual counseling offered	20	17
Group counseling and no form of individual counseling offered	2	2
Referral to Kansas Tobacco Quitline	79	68
None and no individual or group counseling offered	14	12
Refer to Quitline and no individual or group counseling	5	4

Note. Quitline = Kansas Tobacco Quitline, KanQuit.

Table 3

A Closer Look at Pharmacotherapy

Pharmacotherapy	n	%
Prescribe/recommend	39	34
Refer	46	40
Prescribe/recommend and/or refer, and at least one form of counseling offered	61	53
Prescribe/recommend and/or refer, and no form of counseling offered	3	3
Neither prescribe, nor refer	52	45
Neither prescribe, nor refer, and no form of counseling offered	16	14

Who Can Access Organizational Services: More than one-third (37%, n=43) of the organizations in the sample reported providing access to tobacco dependence treatment services to anyone, and 22% (n=25) reported providing access to these services to the uninsured. Twenty-one percent (n=24) reported offering these services to individuals with insurance, 16% (n=18) reported restricting these services to people in their service area, and 11% (n=13) reported offering the services to individuals already enrolled. Nineteen percent (n=22) reported not providing these services to anyone (Table 4).

Table 4

Who Can Access Tobacco Dependence Treatment Services

Service Accessibility	n	%
Other (a*ll inputs*)	54	47
Anyone	43	37
Available to uninsured	25	22
Available with insurance	24	21
No services provided*	22	19
Only people in service area	18	16
Only to already enrolled	13	11

Note. * “No Services Provided” was calculated based on the number of free-text responses equal to “NA” associated with selection “Other.”

How Clients Pay These Organizations: Forty percent of the organizations (n=46) reported billing insurance for services, 28% (n=32) reported having clients pay out of pocket, and 5% (n=6) reported providing a receipt for the client for subsequent filing with the insurance. Twenty-two percent (n=26) reported that they did not know how clients paid for services. Nineteen percent (n=22) reported not charging anyone for services, and 15% (n=17) reported subsidizing or not charging for these services when patients were uninsured. Ten percent (n=12) reported that services were free to the already enrolled, and 7% (n=8) reported that services were free to individuals in the organization's service area (Table 5).

Table 5

Payment for Services

How Clients Pay	n	%
Provider bills insurance	46	40
Out of pocket	32	28
I do not know	26	22
Free to all	22	19
Free or subsidized for uninsured	17	15
Free to already enrolled	12	10
Free to people in service area	8	7
Receipt provided to clients for insurance filing	6	5

Insurance Types Accepted: More than half of the organizations reported accepting private insurance (58%, n=67) and/or KanCare (57%, n=66). More than one-third (38%; n=44) reported accepting Medicare, and 5% (n=6) reported accepting another form of insurance. The insurance types reported as "Other" included "BCBSKS," "Beacon," "NaphCare," "ProviDrs, BCBS," and "Tricare." More than one-fifth (22%, n=25) reported not accepting any form of insurance (Table 6).

Table 6

Types of Insurance Accepted for Tobacco Dependence Treatment

Insurance Type	n	%
Private insurance	67	58
KanCare*	66	57
Medicare	44	38
Veterans Affairs (VA)	26	22
None	25	22
Other	6	5

Note. *KanCare corresponds to Kansas Medicaid.

Billing Codes Used: Most organizations (67%, n=78) reported that they had not billed for tobacco dependence treatment. Ten percent (n=12) reported having used billing code 99406 for counseling lasting between three and 10 minutes, and 8% (n=9) reported having used billing code 99407 for counseling lasting longer than 10 minutes. Of the 3% (n=3) that reported using other billing codes, two billing codes had been reportedly used: 90837 for 60-minute psychotherapy (ALA, 2021a) and 99213 for 15-minute outpatient evaluation and management for low-to-moderate-severity problems (American Academy of Pediatrics, 2022). None of the organizations reported having used billing code S9453 for group counseling (Table 7).

Table 7

Billing Codes Used for Treating Tobacco Dependence

Billing Code Used	n	%
Have not billed for TDT	78	67
99406 (3-10 minutes)	12	10
99407 (> 10 minutes)	9	8
Other	3	3
S9453 (group)	0	0

Note. 99406 and 99407 correspond to the billing codes for individual counseling.

TDT = Tobacco Dependence Treatment.

Chapter 4: Discussion

Kansas Environmental Scan for Tobacco Cessation Supports

Importance of State Data: The environmental scan for tobacco cessation supports included a section that provided current statistics on tobacco use among key groups in Kansas to help steer remedial efforts toward those most in need of an intervention. Such efforts are particularly needed in Kansas because of the disproportionate use of tobacco (Centers for Disease Control and Prevention, 2017). Population groups such as youth, pregnant individuals, people with behavioral illnesses, people with Medicaid, and those lacking insurance coverage were included in the scan because they are known to be disproportionally impacted by tobacco use and thus constitute tobacco use prevention and reduction or elimination intervention focus areas (National Center for Centers for Disease Control and Prevention, 2020; Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2014; Creamer et al., 2019; Prochaska et al., 2017).

Children and young adults are considered an especially at-risk population for tobacco use because of the impact that tobacco has on their developing bodies and because of the strong likelihood that they will be addicted to tobacco for a lifetime if they initiate tobacco use (National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2012). Similarly, pregnant individuals who use tobacco are targets of change in tobacco control efforts because tobacco has adverse effects on both their health and the health of the fetus (Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2014).

Adults with behavioral illness and/or with low income or no insurance coverage represent vulnerable populations because the rates of tobacco use in these cohorts are disproportionately greater than in the general population (Centers for Disease Control and Prevention, 2020). An appreciation of the distribution and nature of insurance coverage in Kansas is crucial because it can highlight who is eligible for tobacco dependence treatment

benefits and to what extent coverage is offered. In Kansas, these benefits are most generous for those with KanCare (i.e., 14% of Kansans; Kansas Hospital Association, [n.d.]). Tobacco dependence treatment benefits for those with private insurance (i.e., 74.8% of the Kansas population) can vary significantly. Variability in benefits can constitute a barrier because it can create confusion among providers as to which services and medications are covered (A. DiGiulio, interview, April 08, 2022; ALA, 2021c; U.S. Census Bureau, 2022). Under the ACA, comprehensive tobacco dependence treatment coverage includes no-cost access to individual, group, and phone counseling as well as all FDA-approved pharmacotherapy, and it features two quit attempts per year, with each attempt including a minimum of four counseling sessions and a 90-day supply of associated medications (Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff, 2008; Patient Protection and Affordable Care Act of 2010). Barriers to accessing these benefits include prior authorization requirements, duration limits, and cost sharing, for instance (Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff, 2008; Patient Protection and Affordable Care Act of 2010). The lack of health insurance represents another barrier to benefit access. One in 11 Kansans lacks insurance coverage (9%) and thus lacks tobacco dependence treatment insurance benefits (KHA, [n.d.]; U.S. Census Bureau, 2022).

Also important in the assessment of tobacco dependence treatment coverage is the availability of insurance coverage data on non-ACA compliant insurance plans (i.e., association health plans; short-term, limited-duration plans; Farm Bureau plans; Healthcare Sharing Ministries; and grandfathered insurance plans) because these plans are not required to cover tobacco dependence treatment aids (ALA, 2019; Blewett, 2019; National Conference of State Legislatures, 2020). However, such data could not be gathered readily or directly through a web search and may need to be obtained via such channels as the Kaiser Family Foundation (KFF) or the Kansas Insurance Department (KID). Further, this scan could be enhanced with the inclusion of data relative to other population subgroups disproportionately affected by

tobacco such as African Americans, Native Americans, Latinos, LGBTQ+, and rural Kansans (CDC, 2015).

A Need for Medicaid Expansion: Although Kansas enhanced its Medicaid benefits in 2018 relative to tobacco dependence treatment, the state has yet to pass Medicaid expansion legislation (CDC, 2022; Kaiser Family Foundation, 2022; The University of Kansas Cancer Center, 2018). This expansion would allow for an estimated 145,000 Kansans (including 113,000 uninsured) to receive health insurance coverage under Medicaid (The Commonwealth Fund, 2021); as such, it would allow this especially at-risk population to have access to cessation benefits and thus to increase its chances of quitting tobacco. By extension, this would help decrease the health and economic burden of tobacco on the Kansas population and coffers (CDC, 2014; Campaign for Tobacco-Free Kids, 2022).

Quitline Underutilization, Cost, and Quit Rates: Nationally, quitlines are reported to be underutilized, even though their quit rates have been shown to be above the reported general average quit rates (CDC, 2020; Kaufman et al., 2010). Quitlines have been demonstrated to be even more effective with the provision of a combination of counseling and NRT than with the sole provision of counseling (Swartz et al., 2005). The Kansas Quitline reflects this trend. There were 358,687 adult smokers in Kansas in 2019, and KanQuit reported providing services to 1,028 tobacco users -- 835 of whom through referrals -- and indicated a quit rate of 26.3% (North American Quitline Consortium, 2021; T. Bond, personal communication, January 18, 2022). Since 70% of tobacco users/smokers report a desire to quit using tobacco (CDC, 2020), if every adult Kansan using tobacco were to use KanQuit, tobacco dependence counseling services could be provided to 251,080 individuals as opposed to a small fraction of them (0.41%). Further, compared to the cost engendered by tobacco use, the cost of tobacco dependence treatment through KanQuit counseling is much lower, thus proving a strong investment. Indeed, in Kansas, the cost per tobacco user of KanQuit use is $0.45 or 0.014% of

the per-smoker healthcare cost ($3,122; Campaign for Tobacco-Free Kids, 2022; North American Quitline Consortium, 2021).

Underutilization of quitlines can stem from a variety of factors, including the lack of awareness of the existence or effectiveness of this tobacco dependent treatment resource by users and providers and the lack of consistent tobacco dependence identification and treatment workflows in health care practices (Clinical Practice Guideline for Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff, 2008; Curry et al, 2008; Kaufman et al., 2010). Therefore, more needs to be done to boost the utilization of this free telephone-based counseling system. Additionally, KanQuit does not share utilization data on the different population groups it serves, nor does it provide specialized materials for some of the population groups disproportionately impacted by tobacco, such as LGBTQ+, racial/ethnic groups, young adults, individuals with co-addictions, or people with mental illnesses (North American Quitline Consortium, 2021). Therefore, from an equity lens, it would be helpful to the tobacco control community if KanQuit disclosed usage data relative to these and other populations most negatively affected by tobacco and if it offered tailored material to these vulnerable cohorts as it does in certain other states.

Key Partner Engagement: A list of key partners was created because tobacco control interventions have been shown to be particularly effective with the participation of stakeholders from diverse sectors/backgrounds. These stakeholders could educate legislators on the need for specific legislative action (Center for Community Health and Development, 2022a-d; Minkler et al., 2012). Examples of such policies are indicated below. They could also help augment buy-in for this action and ensure proper implementation of various interventions. Moreover, key partners with expertise in the policy creation/change process can show tobacco control advocates how to navigate the complex legislative network and system effectively (CDC, 2014).

Policies That Help Reduce Tobacco Use and Boost Tobacco Prevention: In Kansas, contractual stipulations increasing KanCare reimbursement rates would likely incentivize

providers to offer tobacco dependence treatment (Clemens & Gottlieb, 2014). This would help reduce the underutilization of evidence-based treatment services and, in turn, would increase the number of tobacco users who receive these services and heighten their chances of quitting. In the same vein, legislation outlining performance standards in KanCare that aimed to require MCOs and providers to screen for tobacco use and offer tobacco dependence treatment would augment the pool of tobacco dependence treatment providers and capture a larger proportion of the tobacco user base for treatment. Moreover, within this legislation, including language broadening the list of KanCare counseling provider types, such as adding dentists, for instance, would increase the number of dependence treatment providers and, thereby, opportunities for treatment.

Furthermore, an insurance coverage mandate would require the improvement of benefits for private insurance and for SEHP to match KanCare tobacco cessation benefits, with no co-insurance, no co-payments, no deductibles, and no pre-authorization as well as the addition of coverage for cessation counseling via telehealth (ALA, 2020b). This regulation would broaden and ease access to tobacco dependence treatment services, thus positively impacting more tobacco users.

As of January 2021, Kansas ranked 34th in state excise taxes for cigarettes, with excise taxes representing $1.29 per cigarette pack (Boon, 2021; CDC, 2021). Tax increases result in increased costs to tobacco users. Since young adults, African Americans, Latinos, and low-income individuals have proven particularly sensitive to increased tobacco product prices, a rise in the price of these products can contribute to prevention efforts and lead to reduced morbidity, mortality, and healthcare costs (CDC, 1998; Ding, 2003; World Health Organization, 2008). Tax increases can also incentivize some tobacco users to quit (Bader et al., 2011). In Kansas, a $1.50 increase in taxes on cigarettes could result in 7,100 lives being saved (K. Rinker, personal communication, February 23, 2022; K. Rinker, testimony to the Kansas Legislature House Taxation Committee, January 25, 2022). Additionally, taxes on other tobacco products

have not been raised since 1972; bringing them to parity would help generate supplemental funds that could be leveraged toward tobacco dependence treatment and tobacco use prevention efforts (Testimony in Support of HB 2231, 2018). On the other hand, a price increase would inequitably impact low-income tobacco users because the cost of tobacco could become prohibitive, and tobacco users might forgo healthy products and services to be able to continue to use tobacco (Hirono & Smith, 2018).

Although Tobacco 21 (T21) has been passed at the Federal level (U.S. Food and Drug Administration, 2021), states are encouraged to pass similar legislation because it would a) help with Synar Amendment compliance as well as enforcement at the local and state levels, b) allow for stricter age restrictions, and c) provide an opportunity to include language/stipulations that would enhance tobacco control efforts (Substance Abuse and Mental Health Services Administration, 2021; Hill, 2020). For example, the removal of punitive consequences for the purchase, use, and possession (PUP) of tobacco products would prove beneficial because the assessment of related fines has not been shown to lead to tobacco cessation among underaged individuals (Wakefield & Giovino, 2003).

In its 2022 State of Tobacco Control, the American Lung Association indicates that Kansas should boost funding for tobacco control (ALA, 2022). The State of Kansas currently provides approximately $1 million in tobacco control funding, which represents only 9% of the funding level recommended by the CDC for the state (ALA, 2022). By contrast, the tobacco industry spends billions of dollars on promotion of its products, with most of these expenditures attributed to price discounts. In 2018, for instance, tobacco companies spent $8.4 billion on marketing in the U.S., 73.3% (or $6.155 billion) of which stemmed from price discounting (National Institute of Health, 2021; U.S. Federal Trade Commission, 2019).

Tobacco-free campus policies serve as another lever toward tobacco use prevention and reduction/elimination (Gadomski et al., 2010; Ripley-Moffitt et al., 2010; Romano et al., 2019; Wray et al., 2021). Although Kansas prohibits smoking indoors in schools, government

and private worksites, childcare facilities, restaurants/bars, retail stores, and recreational/cultural buildings, casinos and tribal venues are excluded from this regulation. Additionally, e-cigarettes are not consistently present in the list of prohibited tobacco products across all associated policies. Further, there is no state-level legislation restricting the use of tobacco products on outdoor grounds such as public parks (ALA, 2022; R. Cagan, personal communication, October 28, 2021; E. Ablah, R. Cagan, A. DiGiulio, N. Machado, meeting, January 28, 2022).

Data That Highlight the Underutilization of Tobacco Dependence Treatment Methods: Compared to mental illness treatment facilities in the United States as a whole, Kansas mental illness treatment facilities were reported to screen for tobacco use, provide counseling, and offer non-nicotine medication at a lower rate, according to surveillance data analyzed by faculty at the University of Kansas Medical Center. Further, a much smaller proportion of mental health facilities (41%) in Kansas reported providing tobacco dependence treatment services than federally qualified health centers in Kansas (FQHCs; 87%) in 2019. Also, claims data suggested that tobacco dependence treatment counseling and medication were abysmally underutilized for all patients in Kansas insured by KanCare, SEHP, or individual and small-group private insurance plans, and utilization of these services was reported to be even lower among this patient cohort for people with mental illness than for those without mental illness. These findings underscore the need for boosted utilization of tobacco dependence treatment services, especially for those with behavioral and addiction illnesses (Clinical Practice Guideline Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff, 2008; Practice guideline for the treatment of patients with nicotine dependence, 1996).

Lack of Data Transparency: Data needed to populate the Kansas environmental scan for tobacco cessation supports was complicated/hindered by the lack of transparency regarding certain variables. For instance, the proportion of Kansans covered by the different health plans that are not required to comply with the ACA could not be determined. These health plans include grandfathered health plans, association health plans, short-term, limited-duration plans,

and Farm Bureau plans. In the same vein, there was no information online as to the different major health plan names and the number of Kansas residents they covered. Similarly, the Department of Labor declined to disclose the employer size of the top largest employers in Kansas, citing confidentiality. More transparency on the part of the various players in Kansas (e.g., health insurance companies, employers, non-ACA compliant plans providers, and government agencies) would work to provide a clearer, more precise picture of the health coverage landscape in the state and would thus allow for more targeted and effective tobacco control interventions.

Future of Environmental Scan: The Kansas Environmental Scan for Tobacco Cessation Supports is a living document that is intended to be a tool for those involved in counter-tobacco efforts to gain an overall picture of the tobacco dependence and treatment landscape in Kansas. Hosting, ownership, and management of this scan is currently being transitioned to the Tobacco Free Kansas Coalition (TFKC; S. Prem, personal communication, January 28, 2022; Tobacco Free Kansas Coalition, [n.d.]). This move could prove positively impactful because it will allow this document to have broad reach across the Kansas tobacco control community and thus visibility among many key stakeholders.

Kansas Health Plan Assessment

Importance of Surveying Health Insurance Plans and Transparency Issues: The Kansas Health Plan Assessment was meant to shed light on a) the tobacco dependence treatment benefits offered by health plans, b) the gaps that may exist in coverage, and c) the possible ACA compliance issues that may be present. However, the very act of seeking participation in the completion of this assessment proved laborious and almost fruitless, with only one health plan agreeing to complete the questionnaire. Outreach for participation in this assessment yielded one positive response from the Kansas SEHP and one negative response from Blue Cross Blue Shield® of Kansas. The Kansas SEHP covered 37,747 active state and non-state employees and direct-bill members as of January 2021 (Kansas Department of Administration,

Division of State Employee Health Benefits Plan, 2022). Blue Cross and Blue Shield® of Kansas served 986,924 members across all its plans as of December 31, 2020 (Blue Cross and Blue Shield of Kansas, [n.d.]). The latter health insurer declined to complete the survey on the basis that disclosure of certain benefit details would include proprietary information (V. Barnes, personal communication, November 11, 2021; S. N. Mickle, personal communication, January 12, 2022). The company did not indicate which specific survey questions were viewed internally as posing a risk to the company's market position. Their refusal to disclose benefit information is especially significant coming from Blue Cross Blue Shield® of Kansas because, along with Blue Cross Blue Shield® of Kansas City and BlueCross BlueShield Kansas Solutions, this health insurer holds a majority share of the insurance market in Kansas (Van Aalst, 2017).

With health insurers' reluctance to be transparent about their respective coverage benefits relative to tobacco dependence treatment, the tobacco control community is left with an incomplete picture of the coverage landscape in the state and thus with the inability to fully identify existing coverage gaps. Therefore, advocating for legislation toward greater transparency in this sector may be beneficial. Specifically, transparency would mean that all health insurance companies would be required to disclose detailed, de-identified plan benefit information relative to tobacco dependence treatment coverage together with associated reimbursement protocol requirements.

Kansas State Employee Health Plan (SEHP): The ability to collect benefit information on the Kansas SEHP is important a) because this plan covers a significant number of employees (n=37,747) and b) because statutes K.S.A. 40-2248 and K.S.A. 40-2249a require that a pilot be conducted in the Kansas SEHP, with a post-pilot report to the Kansas Legislature, before any changes can be made to mandated health insurance coverage benefits in Kansas (Kansas Department of Administration, Division of State Employee Health Benefits Plan, 2022; Mandated Health Benefits, 1990, 1999; R. Cagan, personal communication, March 24, 2022).

In 2018, Kansas enhanced Medicaid (KanCare) tobacco dependence benefits to include unlimited counseling sessions and an evidence-based combination of FDA-approved pharmacotherapy for up to four quit attempts per year, with 90 days per quit attempt and without pre-authorization or co-pay (The University of Kansas Cancer Center, 2018). Although the Kansas Health Plan Assessment revealed that the Kansas SEHP is compliant with ACA requirements, it does not align with the more generous tobacco dependence treatment benefits now included in KanCare. Indeed, the Kansas SEHP only allows for three instead of four quit attempts per year. This limitation leaves tobacco users with a gap in dependence treatment coverage, should they need to continue treatment past 39 weeks. Research suggests that it typically takes more than six quit attempts for those trying to end their dependence on tobacco to be successful (Chaiton et al., 2016).

Bringing the Kansas SEHP tobacco dependence treatment benefits to parity with the more generous benefits of KanCare would ensure continuity of care for tobacco users who want to quit and would heighten their chances of dependence treatment success. It would also set the stage for legislation to require all other private market plans to follow suit. Although Kansas House Bill No. 2129 introduced in the 2021 legislative session represented an attempt to align KanCare tobacco dependence treatment benefits with those of KanCare, the bill was not allowed to the floor for a vote (H.B. 2129, 2021). Per current discussions between tobacco control advocates and the administrators of the Kansas SEHP, the latter's reticence toward supporting such a bill stems from the concern that long-term use of nicotine-based tobacco dependence pharmacotherapy may be harmful (Kansas Department of Administration, Division of State Employee Health Benefits Plan, 2022). However, long-term use of such pharmacotherapy has been shown to be safe, especially compared to the risks associated with long-term tobacco use (Agency for Healthcare Research and Quality, 2012; Hartmann-Boyce et al., 2018).

Tobacco Surcharges Allowed in Kansas: Although the Kansas SEHP does not have any surcharge for tobacco users, other insurance plans in the private market may still charge tobacco users more than non-users. Indeed, the ACA allows for insurers to charge members up to 50% more, depending on their age, family size, physical location, and tobacco use (Patient Protection and Affordable Care Act of 2010). Research suggests that tobacco surcharges discourage tobacco users from enrolling in health insurance coverage and do not encourage these individuals to quit tobacco use (Friedman et al, 2016; Kaplan & Kaplan, 2020). In addition, surcharges may influence tobacco usage underreporting, whereby tobacco users report their tobacco usage status falsely to avoid surcharges (Pesko et al, 2017). This results in a missed opportunity for intervention at the provider level and, by extension, to a missed opportunity to decrease morbidity and mortality.

Surcharges were intended to shift the financial healthcare burden associated with tobacco-related chronic diseases from the general population to the individual tobacco users. However, private insurers are the only entities truly benefiting from these supplemental charges; they do not bear the brunt of the healthcare costs associated with treating these diseases. Indeed, most tobacco users develop such morbidities in older age, when they are then covered by Medicare.

Kansas decided to let carriers set the surcharge based on their claims experience, and no plan is set to lower the current tobacco rating ratio of 1.5:1 or prohibit this surcharge (V. Schmidt, personal communication, October 4, 2021). This rating ratio means that health insurers are allowed to charge tobacco users up to 50% higher premiums than they charge non-tobacco users. Considering the adverse effects generated by this supplemental charge to tobacco users, it is essential that tobacco control advocates continue to support legislation that will require all insurers to reduce or remove this additional burden on this target population.

Data Quality: Because some responses to the assessment by the administrators of the Kansas SEHP were ambiguous, it is difficult to draw a complete/detailed and accurate picture of

the Kansas SEHP coverage profile. For example, the specified duration in days of a quit attempt with NRT spray was indicated as "1." This response may have been unintentional on the part of the respondent because the latter may not have utilized the duration slider scale to respond properly or to respond at all. Ultimately, the assessment design must be enhanced to minimize the chances of non-responses or unintentional responses. Further, there is discordance between what the Kansas SEHP respondent reported for the provision of group counseling and what the American Lung Association database shows for the Kansas SEHP. Indeed, although the Kansas SEHP respondent reported providing group counseling services, the database of interest indicates no such provision (Appendix C; ALA, 2021b). Perhaps the Kansas SEHP respondent selected this response based on coverage for group counseling services in general, namely, not specific to tobacco dependence treatment. It is also possible that the information found in the American Lung Association's database is obsolete.

Tobacco Dependence Treatment Survey

The Tobacco Dependence Treatment Survey was meant to focus on tobacco dependence treatment service capacity at the provider level to determine what could be leveraged in this environment to impact tobacco cessation positively.

Treatment (Counseling): The proportion of facilities surveyed that reported offering counseling for tobacco dependence treatment lasting between three and 10 minutes or counseling lasting more than 10 minutes (56%; 47%) was higher than the proportion of facilities reporting offering tobacco dependence treatment counseling in Kansas as part of the National Survey of Substance Abuse Services (N-SSATS) 2017 data collection (34.5%). It was also higher than the proportion of facilities reporting offering tobacco dependence treatment counseling in Kansas as part of the National Mental Health Services Survey (N-MHSS) 2018 data collection (25.6%). At the national level, the 2017 N-SSATS and the 2018 N-MHSS revealed that 49.5% and 40.5% of facilities provided tobacco dependence treatment counseling,

respectively. However, these surveys were not specific on the form of reported counseling offered (SAMHSA, [n.d.], 2018).

Because the Tobacco Dependence Treatment Survey assessed two forms of tobacco dependence treatment counseling (i.e., individual and group counseling), it is important to consider the reported counseling services on a more granular level (Table 2). Doing so highlighted that 16% of providers (n=19) did not offer any type of counseling and that 18% of providers (n=21) did not offer any form of individual counseling (i.e., brief advice, counseling between three and 10 minutes, and counseling longer than 10 minutes). In addition, although most providers (68%, n=79) reported referring patients to the Kansas Tobacco Quitline, about one-third of the respondents reported not providing referrals to the Quitline, and 12% of providers reported offering neither any form of counseling, nor referrals to the Quitline. This echoes existing research on the matter (Holtrop et al., 2008; Kaufman et al., 2010; SAMHSA, [n.d.], 2018), and it is significant because tobacco dependence treatment counseling (whether in individual, group, or telephone format) constitutes an evidence-based method of tobacco dependence treatment that increases the chances of tobacco cessation success (Siu & U.S. Preventive Services Task Force, 2015).

Moreover, the proportion of providers who reported offering the lengthier type of individual counseling (longer than 10 minutes: 47%; n=54) is lower than the proportion of providers who reported offering individual counseling of shorter duration (between three and 10 minutes: 56%, n=65; under three minutes: 68%, n=79). This is important because the effectiveness of the tobacco dependence treatment counseling session has been shown to increase with the duration of this session (Clinical Practice Guideline for Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff, 2008; Siu & U.S. Preventive Services Task Force, 2015; United States Public Health Service Office of the Surgeon General, & National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2020). As a result, to help increase tobacco cessation in Kansas, relevant

interventions must be developed and implemented to influence more tobacco dependence treatment providers in Kansas to offer lengthier individual counseling sessions.

Treatment (Pharmacotherapy): One-third of the respondents reported prescribing FDA-approved tobacco cessation medications (34%), and less than half of the respondents reported referring to a prescriber for these medications (40%). Almost half of the providers surveyed reported neither prescribing nor referring to a provider for FDA-approved tobacco dependence treatment medications (45%, n=52), and 14% of providers (n=16) reported neither prescribing nor referring to a provider for FDA-approved tobacco dependence treatment medications, while reporting that no form of counseling was offered (Table 3). These survey findings are in line with existing research on tobacco dependence treatment practices in clinical care (Srivastava, 2019). The high percentage of providers who do not leverage these treatment strategies is a problem because tobacco cessation pharmacotherapy can be effective in helping tobacco users quit, and a combination of pharmacotherapy and behavioral therapy is more effective than either method alone (Siu & U.S. Preventive Services Task Force, 2015; United States Public Health Service Office of the Surgeon General & National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2020). Although some types of NRT products are available without a prescription, and while a referral to a tobacco quitline can lead to the recommendation or provision of NRT medications for individuals meeting certain criteria, the underleveraging of tobacco cessation pharmacotherapy by providers leaves tobacco users with reduced awareness and access to these proven tobacco cessation aids (Appendix A; M. Schrock, personal communication, February 11, 2021). Therefore, initiatives must be developed and implemented to encourage more providers in Kansas to prescribe tobacco cessation pharmacotherapy in their treatment protocol for tobacco users in an effort to help boost tobacco cessation among their patients.

Billing: The percentage of providers who reported providing billable individual tobacco dependence treatment counseling (56% [3-10 minutes]; 47% [> 10 minutes]) is greater than the

percentage of providers who reported billing for tobacco dependence treatment (22%). Although 56% of respondents reported offering tobacco dependence treatment counseling lasting between three and 10 minutes, only 10% of respondents reported using the associated billing code of 99406. Similarly, 47% of respondents reported offering tobacco dependence treatment counseling lasting longer than 10 minutes, yet only 8% of respondents reported using the associated billing code of 99407. In the same vein, 19% of respondents reported offering tobacco dependence treatment group counseling, yet none reported using the associated billing code of S9453. This indicates that many providers participating in the survey are not using appropriate billing codes for the treatment they offer patients. This is consistent with existing research illuminating the underutilization of tobacco dependence treatment billing codes by providers (Bloom et al., 2018).

This issue demands attention because it highlights the fact that providers have barriers to using tobacco dependence treatment billing codes. These barriers may be associated with the complexity of the coding system, the lack of awareness of these codes, or the low reimbursement rate attached to these codes (Asif et al., 2021; Leone et al., 2016; United States Public Health Service Office of the Surgeon General, & National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2020). This billing predicament also impacts surveillance of treatment, which impedes evaluation and may also have a detrimental effect on the willingness to provide tobacco dependence treatment counseling in clinical settings. On a larger scale, it results in suboptimal treatment methods being deployed and in reduced tobacco dependence treatment capacity, thus negatively affecting tobacco users. Therefore, changes to remove the barriers that prevent providers from using these tobacco dependence treatment billing codes must be implemented. They include a combination of policy (both at the state and organizational levels) and provider education initiatives. For example, organizational policies that require tobacco dependence treatment providers to complete training on billing together with government policies that require health

insurance payers to raise reimbursement rates for tobacco cessation treatment billing codes could prove beneficial.

Training: Considering that validated tobacco dependence treatment counseling and FDA-approved pharmacotherapy were recommended as effective evidence-based methods in boosting tobacco use quit rates, it is crucial for providers to receive appropriate training so that they can in turn provide effective counseling and be conversant with the different tobacco cessation medications available to clients (McDaniel et al., 2009; Siu & U.S. Preventive Services Task Force, 2015). Since almost half of all survey respondents (46%) reported receiving no training on treating tobacco dependence, there is a need for boosting the percentage of providers who receive such training. This finding on the lack of tobacco dependence treatment training is in line with existing research on the barriers to tobacco cessation in the clinical setting (Guydish et al., 2007; Kilgore et al., 2021; Koch & Breland, 2017; Okoli et al., 2020). Specifically, since 21% of respondents reported having had tobacco treatment specialist training and 17% reported having had brief tobacco intervention training, more providers need to be trained on brief tobacco intervention strategies such as those leveraging the 5A and 5R models. The 5A model is intended to guide providers through the brief tobacco intervention to help tobacco users quit. Its name stands for "Ask, Advise, Assess, Assist, Arrange," and it encapsulates the action steps that providers need to follow to optimize the interaction with patients who use tobacco. The 5R model can be utilized to assist providers in boosting the patient's motivation to quit tobacco use. Its name originates from the five topics that need to be covered in motivational counseling, namely, relevance, risks, rewards, roadblocks, and repetition (WHO, 2014).

Although one-third of respondents (33%) reported receiving tobacco dependence treatment training via webinars, this medium has not been shown to be as effective as in-person training relative to counseling tobacco users (Hudmon et al., 2014). Even though the COVID-19 pandemic has led to the creation of a plethora of online training options, providers could

leverage the online platform, specifically relative to brief tobacco intervention training, merely as a reinforcement to initial in-person training.

A small proportion of providers (5%) reported receiving training for billing "Navigating the Reimbursement Maze." This online training provides reimbursement advice specific to tobacco cessation counseling and medication. It is free of charge, lasts one hour, and can be accessed easily through the Kansas learning platform Kansas TRAIN via https://www.train.org/ks/course/1085269/. The low proportion of providers who reported having received this type of training is congruent with existing research, and it partly explains the low utilization rate of tobacco cessation billing codes for tobacco dependence treatment services (Bloom et al., 2018; Leone et al., 2016). Lastly, since the survey did not offer more selection options for training on billing, it is possible that respondents who did not select "Navigating the Reimbursement Maze – online training for billing" did receive another type of training that included detailed information on billing for tobacco dependence treatment.

The difference between the proportions of reported training completed by respondents and the proportions of reported training completed by other staff at the organization may be due to the nature of the respondent's position in the organization and/or to information bias. For example, in the case of completed Tobacco Treatment Specialist training, the proportion differential may be explained by the fact that respondents were individuals in leadership positions in the organization and, as such, may not have been the actual providers of tobacco dependence treatment. Data collected on other staff in the organization are likely not as reliable as data collected on respondents because of information bias. Gathering more reliable training data on others in the organization would require that respondents have access to a database within their respective organizations that captures these types of data.

Coverage and Accessibility: For most providers, tobacco dependence treatment services are reportedly predominantly available to select groups of individuals based on insurance, service area, and/or program enrollment. A large proportion of providers (79%) reported not

offering tobacco cessation services to the uninsured. Also, one-fourth of respondents reported having patients pay out of pocket for these services. This is significant because it overlooks a population group a) that is disproportionately negatively impacted by tobacco use, b) that is poorer than the general population, and c) that already tends to have a poorer health profile than groups with health insurance coverage (Call et al., 2014; Centers for Disease Control and Prevention, 2020; Dickman et al., 2017).

Additionally, the insurance plans reportedly accepted by providers underscore that large proportions of them do not accept private insurance plans (42%), Medicaid/KanCare (43%), or VA insurance (78%). This is noteworthy a) because individuals on Medicaid and people in the military have been shown to use tobacco at higher rates than the general population, and b) because private insurance plans cover the largest proportion of the population (Centers for Disease Control and Prevention, 2020; Keisler-Starkey & Bunch, 2021). Since access to tobacco dependence treatment services is shown to be especially lacking for those individuals disproportionally negatively impacted by tobacco use, policies must be adopted in Kansas at the state and organizational levels that improve access to tobacco dependence services for the uninsured and increase the proportion of providers who accept Medicaid, Medicare, VA, and private insurance plans.

Notwithstanding, the latter policy objective may not be as pressing or necessitated because there may not be as wide a gap in accepted insurance options by providers in Kansas as the results from the Tobacco Dependence Treatment Survey seem to indicate. Indeed, these results are discordant with results from both the N-SSATS and the N-MHSS data collections efforts. For the most part, the latter surveys revealed appreciably larger percentages of providers accepting these forms of health insurance coverage. This discrepancy may be due to the smaller sample size of the Tobacco Dependence Treatment Survey than the sample sizes associated with the N-SSATS and N-MHSS, respectively (SAMHSA, [n.d.], 2018).

Suggested Design Changes: This instrument would benefit from edits to questions and response options as well as backend modifications. For instance, the seventh option in Question 5 is missing the specification for the type of FDA-approved medication concerned, and it should read instead: "Referring to a prescriber for obtaining FDA-approved cessation medication." Also, within the same question, the option "Providing counseling greater than 3 minutes to help with tobacco quit attempts" should read instead: "Providing counseling between 3 and 10 minutes to help with tobacco quit attempts." Incidentally, a similar suggestion stands for the first option in Question 9 on billing codes used for counseling. Still within Question 5, option "Prescribing or recommending an FDA-approved cessation medication to quitting tobacco" could be changed to "Prescribing an FDA-approved cessation medication to quitting tobacco." Indeed, the terms "prescribing" and "recommending" have different implications for the tobacco user and thus for data interpretation. Additionally, the instructions in Question 6 prompt the respondent to input "NA" in the free-text box for selection option "Other" to indicate that no services are provided. However, this creates data clean-up issues for the analyst that could be avoided simply by the addition of a selection option "NA." Letting the respondent input "NA" in the free-text box for selection option "Other" also allows for contradictory responses to be provided within the same question, whereby the respondent could select an insurance type accepted while responding via "NA" that no insurance is accepted.

A similar suggestion relative to the response "NA" stands for Question 8. Furthermore, Question 8 included ambiguous language. The question could be reworded to read "Please indicate what types of insurance coverage you accept for providing tobacco dependence treatment" as opposed to "Please indicate what types of insurance coverage (including uninsured individuals) you are willing to accept for providing tobacco dependence treatment." Moreover, to facilitate the assembly of a provider directory, a skip logic could have prevented a negative response to Question 12 from allowing input of contact information in Question 13.

Lastly, an additional text box for the provision of county information would have ameliorated Question 13, and by extension, the provider directory of interest.

Limitations and Implications

Limitations: Limitations of this project merit consideration. First, both the Kansas Health Plan Assessment and the Tobacco Dependence Treatment Survey could benefit from design improvements. These design issues weakened data quality and created interpretation hurdles. Because both the Kansas Health Plan Assessment and the Tobacco Dependence Treatment Survey responses constituted self-reported data, they were subject to inaccuracies due to information bias. Also, neither the Kansas Health Plan Assessment nor the Tobacco Dependence Treatment Survey were designed to eliminate the risk of unintentional skipped questions completely. As well, because they stemmed from small sample sizes, results from the data collection associated with both survey instruments could not be generalized, and the data proved of more limited use than was intended initially through the development of these tools. For example, since the Kansas Health Plan Assessment was only completed by one participant, it was not possible to compare reported benefit coverage with other insurance plan types or to obtain reported benefit coverage on a diverse set of insurance plans. Lastly, data collection relative to the Kansas Environmental Scan for Tobacco Cessation Supports as well as the Kansas Health Plan Assessment was hindered by the lack of transparency on the part of various agencies and/or data online availability, as indicated in the discussion above.

Implications: Because most health-insured Kansans are enrolled in private health insurance plans and because these plans do not have to include continuous tobacco dependence treatment coverage (i.e., four quit attempts), it is crucial for the tobacco control community to work toward legislation that would boost this coverage to match the more generous coverage of KanCare. A first step in meeting this goal would be to influence the Kansas SEHP to align its tobacco dependence treatment benefits fully with those of KanCare. In addition, the need for Medicaid expansion in Kansas is a fortiori pressing because the

uninsured have higher rates of tobacco use than the general population. An expansion would allow this large, underserved group to have access to cessation benefits.

The evidence-based tobacco dependence treatment methods recommended by the U.S. Preventive Services Task Force and outlined in the Surgeon General Report on tobacco cessation are shown to be underutilized by the providers surveyed in this study (Clinical Practice Guideline for Treating Tobacco Use and Dependence 2008 Update Panel, Liaisons, and Staff, 2008; United States Public Health Service Office of the Surgeon General & National Center for Chronic Disease Prevention and Health Promotion [US] Office on Smoking and Health, 2020). Because this finding echoes existing surveillance data in Kansas and the United States, initiatives must be designed to augment the use of evidence-based counseling and FDA-approved tobacco cessation medication and to increase tobacco dependence treatment competency in the health care workforce in Kansas. Policies that would help toward these objectives include a) mandating increases in reimbursement rates for providers, b) requiring that screening and counseling for tobacco use dependence be part of the provider's patient care workflow protocol, c) expanding the list of types of providers allowed to offer tobacco dependence treatment, and d) demanding that health care facilities offer tobacco dependence treatment training (including education on billing for tobacco dependence treatment) to select employees.

Other legislation suggested to boost tobacco cessation in Kansas involves raising and reinforcing the tobacco tax and increasing funding for tobacco control initiatives to match the percentage recommended by the CDC. As well, requiring more transparency on the part of health insurers regarding benefit coverage could help those working in counter tobacco efforts identify, and thus work to rectify, the gaps that exist.

As shown in the Key Stakeholder section of the Kansas Environmental Scan for Tobacco Cessation Supports, Kansas counts many strong players that can be targeted for partnership in improving the tobacco dependence treatment support infrastructure in the state.

The Tobacco Scheming work group of the Behavioral Health Tobacco Project is an example of one such partnership and is at the root of the work presented in this paper. This work not only resulted in the creation of the Kansas Environmental Scan for Tobacco Cessation Supports, but it also led to the generation of a Kansas Tobacco Dependence Treatment Provider Directory. Both products represent tools that the tobacco control community can leverage henceforth in its efforts to strengthen the tobacco dependence treatment support landscape in Kansas, and as such they serve to help reduce tobacco-related morbidity and mortality in the population.

Chapter 5: Conclusion

The tools employed in this study allowed for a multifaceted view of the tobacco dependence treatment supports in Kansas. This study suggests that many gaps remain to be bridged to ensure that Kansans (especially those disproportionately impacted by tobacco use) receive optimal support to help them quit. These gaps were found both in health insurance coverage relative to tobacco dependence treatment and in the capacity for health care providers (particularly those in behavioral health) to leverage evidence-based psychopharmacological strategies to help increase the number of tobacco users who quit tobacco.

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Appendix A: Kansas Environmental Scan for Tobacco Cessation Supports

The following document is **designed to assist states in completing an environmental scan of tobacco dependence treatment coverage**. It complements the information presented during Phase I: Assessing and Building Support for Health Plan Coverage of Quitline Services of the 3-part Building Private-Public Partnerships webinar series. To view a copy of the archived webinar, visit: https://www.naquitline.org/events/EventDetails.aspx?id=139786
This document includes state data as well as information on major health insurance plans, large employers, the Kansas Quitline, Medicaid, key stakeholders/partners, policies, tobacco dependence treatment resources, and select data.
This document is also **viewable on Google Sheets** at: https://docs.google.com/spreadsheets/d/1dXm9xremZOQPhVEZnnvlnRUsrWZ86UYx/edit?usp=sharing&ouid=102823017809403463730&rtpof=true&sd=true

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STATE INFORMATION/DATA			
Item	Number/Percent	Resource URL	Notes
Total state population	2,913,314	https://www.census.gov/quickfacts/fact/table/KS	July 2019 estimates
Total adults	2,214,119	https://www.census.gov/quickfacts/fact/table/KS	Subtract under age 18 from total population
Smoking prevalence	16.20%	https://www.cdc.gov/brfss/brfssprevalence/index.html https://www.kdheks.gov/brfss/Survey2019/ct2019_currentsmok.html	Search for state, select Tobacco Use (Class), select Current Smoker Status (Topic), select the most current year available in the dropdown (crude prevalence; age-adjusted prevalence is 16.7 % for 2019)
Tobacco use prevalence	24.40%	Tristi Bond provided updated prevalence data from 2019 BRFSS and is working on updating the KDHE document	KDHE sourced from BRFSS: https://www.kdheks.gov/tobacco/download/Adult_Tobacco_Use_in_KS.pdf (from 2018 BRFSS: 23.6%)
Estimated number of adult smokers	358,687	https://www.cdc.gov/brfss/brfssprevalence/index.html	Total number of adults * smoking prevalence
Estimated number of pregnant smokers	3,056 (9.2%)	PRAMS Report 2019 (see page 51)	Self-reported among Kansas women with recent live births. For recent smoking rate, also see: https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/Smoking_pregnancy/state/KS
Estimated number of youth* smokers	8,746	https://www.cdc.gov/healthyyouth/data/yrbs/results.htm	5.8% *high school students report smoking. To determine high school student headcount, please see https://datacentral.ksde.org/report_gen.aspx

STATE INFORMATION/DATA			
Item	Number/Percent	Resource URL	Notes
Estimated number of youth* tobacco users	38,907	https://www.cdc.gov/healthyyouth/data/yrbs/results.htm	25.8% *high school students report using tobacco. To determine high school student headcount, please see https://datacentral.ksde.org/report_gen.aspx
Estimated proportion of adult smokers in the behavioral health population	31.40%	https://www.kdheks.gov/brfss/Survey2019/ct2019_currentsmok.html	2019: https://www.kdheks.gov/brfss/Survey2019/ct2019_currentsmok.html 37.5% of adults with AMI smoked in KS in 2011 NSDUH; https://www.samhsa.gov/data/sites/default/files/report_2738/ShortReport-2738.html; 2017 ~20% adults with AMI in KS, see https://www.samhsa.gov/data/sites/default/files/reports/rpt23238/NSDUHsaeMaps2018/NSDUHsaeMaps2018.pdf https://www.cdc.gov/tobacco/disparities/mental-illness-substance-use/index.htm https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm https://www.samhsa.gov/data/sites/default/files/report_2738/ShortReport-2738.html
Insurance Status		www.kff.org www.census.gov www.americashealthrankings.org www.healthinsurance.org	At KFF.org - health insurance coverage of the total population (state health facts, health coverage & uninsured, health insurance coverage of the total population)
Uninsured Population	245,500 (9%)	https://www.kha-net.org/DataProductsandServices/STAT/FinancesandCoverage/HealthInsuranceCoverage/	2018 Census shows 241,000 (10.1%) uninsured in 2018 (see https://www.census.gov/data-tools/demo/sahie/#/?s_statefips=20)

STATE INFORMATION/DATA			
Item	Number/Percent	Resource URL	Notes
Medicaid	396,400 (14%)	https://www.kha-net.org/DataProductsandServices/STAT/FinancesandCoverage/HealthInsuranceCoverage/	2018; for 2020 data see https://www.medicaid.gov/state-overviews/stateprofile.html?state=kansas 416,862 enrolled in Medicaid and CHIP as of Sep 2020
Medicare	396,600 (14%)	https://www.kha-net.org/DataProductsandServices/STAT/FinancesandCoverage/HealthInsuranceCoverage/	2018
Employer-based	1,538,700 (55%)	https://www.kha-net.org/DataProductsandServices/STAT/FinancesandCoverage/HealthInsuranceCoverage/	2018
ACA exchange plans	89,993 (3%)	https://insurance.ks.gov/documents/healthlife/health/2020-KID-Issue-Brief.pdf	2019
Private sector enrollees enrolled in self-insured plans	56.80%	https://www.kff.org/other/state-indicator/share-of-private-sector-enrollees-enrolled-in-self-insured-plans-2018/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D	
Non-group	173,400 (6%)	https://www.kha-net.org/DataProductsandServices/STAT/FinancesandCoverage/HealthInsuranceCoverage/	

STATE INFORMATION/DATA			
Item	Number/Percent	Resource URL	Notes
Tricare/Military	64,100 (2%)	https://www.kha-net.org/DataProductsandServices/STAT/FinancesandCoverage/HealthInsuranceCoverage/	2018
Association health plans (AHPs)			https://www.dol.gov/general/topic/association-health-plans and https://insurance.ks.gov/documents/healthlife/health/2019-KID-Issue-Brief.pdf and https://insurance.ks.gov/documents/healthlife/health/KID-Issue-Brief.pdf
Short-term, limited-duration plans			https://www.cms.gov/newsroom/fact-sheets/short-term-limited-duration-insurance-final-rule
Grandfathered plans			Check with Kaiser Family Foundation and Insurance Commissioner
Farm Bureau Plan			

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Note: May also want/need to understand the prevalence of smoking or e-cigarette use among vulnerable populations such as youth, pregnant women, people with behavioral health disorders. Also look at data by race and socioeconomic status/education for a deeper look at social determinants of health.

MAJOR HEALTH INSURANCE PLANS			
Company Name	Health Plan Name	No. Members in State	Contact Information
BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.			BLUE CROSS AND BLUE SHIELD OF KANSAS, INC. NAIC No: 70729 President: MATTHEW D. ALL Secretary: SCOTT H. RAYMOND First Vice Chairman: Steven Marsh Vice President of Provider Relations and Medical Economics: Angie Strecker Controller: Pete DiDio Manager KS Health Data System: Deanna Karle Professional Relations Manager Credentialing: Linda Pracht Director, Professional Relations: Douglas Scott Type: KANSAS MUTUAL LIFE INSURANCE COMPANIES Address: 1133 TOPEKA BLVD. TOPEKA, KS 66629 Mailing Address: PO BOX 239 TOPEKA, KS 66629 Phone: 785-291-7000 or 800-432-0216 Other Phone (Pete DiDio): 785-291-8777 Other Phone (Deanna Karle): 785-291-8749 Other Phone (Linda Pracht): 785-291-7084 Other Phone (Douglas Scott): 785-291-8831 Other Phone (Angie Strecker): 785-291-8227 Email: pete.didio@bcbsks.com Email: doug.scott@bcbsks.com Email: Angie.Strecker@bcbsks

MAJOR HEALTH INSURANCE PLANS			
Company Name	Health Plan Name	No. Members in State	Contact Information
BLUE CROSS & BLUE SHIELD OF KANSAS CITY			BLUE CROSS & BLUE SHIELD OF KANSAS CITY NAIC No: 47171 Vice President, Chief Accounting & Investment Officer: Phil Bowling Address: ONE PERSHING SQUARE 2301 MAIN ST KANSAS CITY, MO 64108 Phone: 816-395-2477 Fax: 816-759-7099 Email: philip.bowling@bluekc.com
BLUECROSS BLUESHIELD KANSAS SOLUTIONS, INC.			BLUE CROSS AND BLUE SHIELD OF KANSAS CITY D/B/A BLUE-ADVANTAGE NAIC No: 95916 President: ERIN STUCKY Vice President, General Counsel, and Corporate Secretary: Mark A. Newcomer Type: HEALTH MAINTENANCE ORGANIZATIONS Address: 2301 MAIN ST KANSAS CITY, MO 64108 Phone: 816-395-2222 Fax: 816-395-2035 Email: mark.newcomer@bluekc.com

MAJOR HEALTH INSURANCE PLANS			
Company Name	Health Plan Name	No. Members in State	Contact Information
UNITEDHEALTHCARE INSURANCE COMPANY			UNITED HEALTHCARE INSURANCE COMPANY NAIC No: 79413 President: WILLIAM J. GOLDEN Secretary: THOMAS J. MCGUIRE Type: STOCK LIFE INSURANCE COMPANIES OF OTHER STATES Address: 185 ASYLUM AVENUE PO BOX 150450 HARTFORD, CT 06103 Phone: 877-832-7734 Fax: 860-702-5792 Midwestern States: UnitedHealthcare of Iowa, Kansas, Nebraska & Central Illinois CEO: Rob Broomfield Address: 9900 W 109th St Overland Park, KS 66210 VP UHC Network Management and Market Strategy (Kansas/NW Missouri): Ann Stafford Phone: 913-802-5630 Fax: 855-584-9750 Email: ann_m_stafford@uhc.com RVP, Provider Relations Service, Central Region: Tom Wicklund Phone: 913-681-7948 Email: thomas_d_wicklund@uhc.com Director Provider Relations & Service: Nancy A Battmer Phone: 913-802-5629 Email: nancy_a_battmer@uhc.com

MAJOR HEALTH INSURANCE PLANS			
Company Name	Health Plan Name	No. Members in State	Contact Information
AETNA LIFE INSURANCE COMPANY			Aetna/Coventry Greg Killinger Vice president/Network Market Head Kansas, Nebraska, Missouri, Iowa, Dakota's, N. Arkansas, S. Illinois 9401 Indian Creek Parkway, Suite 1300 Overland Park, KS 66210 Phone: 913-202-5227 Fax: 866-874-6407 gxkillinger@aetna.com Aetna Angela Coppola 11300 Tomahawk Creek Parkway Suite 300 Leawood, KS 66211-2670 Phone: 816-246-1156 Fax: 860-754-5808 Email: coppolaa@aetna.com

MAJOR HEALTH INSURANCE PLANS			
Company Name	Health Plan Name	No. Members in State	Contact Information
HUMANA INSURANCE COMPANY			HUMANA INSURANCE COMPANY NAIC No: 73288 President: BRUCE D. BROUSSARD Secretary: JOSEPH C VENTURA Tax Manager: Annette Richey Type: STOCK LIFE INSURANCE COMPANIES OF OTHER STATES Address: 1100 EMPLOYERS BLVD DE PERE, WI 54115 Phone: 920-336-1100 or 800-448-6262 General Administrative Address: 500 WEST MAIN STREET LOUISVILLE, KY 40202 Email: arichey@humana.com Mailing Address: PO BOX 740036 LOUISVILLE, KY 40201 Provider Engagement Consultant: Sheila Howard Phone: 913-217-3285 Email: showard12@humana.com
CIGNA HEALTH AND LIFE INSURANCE COMPANY			CIGNA HEALTH AND LIFE INSURANCE COMPANY NAIC No: 67369 President: JULIA HUGGINS Secretary: JILL STADELMAN Regional Director (TX): Kandice Sanaie Type: STOCK LIFE INSURANCE COMPANIES OF OTHER STATES Address: 900 COTTAGE GROVE RD BLOOMFIELD, CT 06002 Phone: 512-645-7961 or 860-226-4318 Fax: 215-761-5004 Email: Kandice.Sanaie@Cigna.com

MAJOR HEALTH INSURANCE PLANS			
Company Name	Health Plan Name	No. Members in State	Contact Information
AETNA HEALTH INC.			Aetna/Coventry Greg Killinger Vice president/Network Market Head Kansas, Nebraska, Missouri, Iowa, Dakota's, N. Arkansas, S. Illinois 9401 Indian Creek Parkway, Suite 1300 Overland Park, KS 66210 Phone: 913-202-5227 Fax: 866-874-6407 E-mail: gxkillinger@aetna.com Aetna Angela Coppola 11300 Tomahawk Creek Parkway Suite 300 Leawood, KS 66211-2670 Phone: 816-246-1156 Fax: 860-754-5808 Email: coppolaa@aetna.com

Table last revised: 01/30/22

Note: The following links can be used to find company information: (by company name)
http://towerii.ksinsurance.org/company/company.jsp?pagnam=companysearch
and (by NAIC number) http://towerii.ksinsurance.org/company/companyid.jsp?pagnam=companyidsearch
www.healthinsurance.org (overview of your state's insurance environment)
Health Coverage: State-to-State 2019 -- https://www.ahip.org/wp-content/uploads/StateDataBook_2019-FINAL.pdf and
https://www.beckershospitalreview.com/payer-issues/the-largest-commercial-insurers-in-each-state.html

LARGEST EMPLOYERS	No. of Employees	Benefits Director/Contact Information
Amazon.com Services, Inc.		
Dillon Companies		
Federal Government		
Garmin International		
Johnson County		
Kansas City, KS, USD 500		
Olathe, USD 233		
Shawnee Mission, USD 512		
Spirit Aerosystems, Inc.		
Sprint United Management Company		
State of Kansas		Janet Stanek (Director of Employee Health Plan) - janet.stanek@ks.gov
Stormont-Vail Healthcare		
Target Corporation		
Textron Aviation, Inc.	12,458	Jamie Rutledge (HR Director) - jrutledge@txtav.com
Tyson Fresh Meats, Inc.		
United Parcel Service		
University of Kansas Hospital Authority		
Via Christi Hospitals Wichita, Inc.	~10,000	Benefits are administered nationally through Ascension
Wal-Mart Associates, Inc.		
Wichita, USD 259	~9,000 (last we knew)	Sean Hudspeth (Chief HR Director) - shudspeth@usd259.net

Table last revised: 04/12/22

Note: Include state as an employer and search state employee website to find their benefits. Search in state's Department of Commerce, Department of Labor or similar. See page 9 of 2020 Kansas Economic Report (https://klic.dol.ks.gov/admin/gsipub/htmlarea/uploads/2020_Kansas_Economic_Report_v5_5.pdf) for 20 largest employers in alphabetical order.

QUITLINE CALLERS			
Variable	Number	Data Source	Notes
Number of direct calls to quitline	3,715	https://map.naquitline.org/profile.aspx?stateid=ks https://www.naquitline.org/page/2020survey	
Number of tobacco users receiving services	1,028	https://map.naquitline.org/profile.aspx?stateid=ks https://www.naquitline.org/page/2020survey	
Number of tobacco users registering for Web-based services	529	https://map.naquitline.org/profile.aspx?stateid=ks https://www.naquitline.org/page/2020survey	
Number of tobacco users referred to the quitline	835	https://map.naquitline.org/profile.aspx?stateid=ks https://www.naquitline.org/page/2020survey	

QUITLINE PARTICIPANTS BY INSURANCE STATUS			
Variable	Number/Percent/Value	Data Source	Notes
Uninsured	224 (22%)	Matthew Schrock at KDHE	
Medicaid	258 (25%)	Matthew Schrock at KDHE	
Medicare	285 (28%)	Matthew Schrock at KDHE	
TRICARE	0	Matthew Schrock at KDHE	Can refer to TriCare services
Total private/commercially insured	233 (22%)	Matthew Schrock at KDHE	Itemize insurance plans/carriers (e.g. Blue Cross/Blue Shield, Aetna, etc.) to identify those with highest utilization.
State employees	Not collected	Matthew Schrock at KDHE	
Other	29 (3%)	Matthew Schrock at KDHE	

QUITLINE SERVICES/UTILIZATION			
Variable	Number/Percentage/Value	Data Source	Notes
Populations/Sub-populations Served			Data on any subpopulations that are of interest to partners
Services Offered (such as telephone counseling, NRT, combo NRT, texting, web coaching)	Telephone, web, and text counseling support for all. 2 weeks of NRT (Medicaid enrollees), 4 weeks NRT (individuals qualifying for behavioral health and substance abuse program).	https://map.naquitline.org/profile.aspx?stateid=ks https://www.naquitline.org/page/2020survey	Identify services available to all. Specify any differences by subpopulation.
Total annual budget	$172,501	Matthew Schrock at KDHE	May include budgets for services, marketing/promotion, and evaluation, as appropriate for the partnership discussion. Note that the following provides general data on CDC funding:https://www.cdc.gov/tobacco/about/osh/program-funding/index.htm
Amount per smoker spent on services and medications	$0.45	https://map.naquitline.org/profile.aspx?stateid=ks https://www.naquitline.org/page/2020survey	May include services and medications only, or total budget
Reach and Quit Rate			Select your state and scroll down the profile page to the Quitline Metrics (https://map.naquitline.org/default.aspx; quit rate may not be available)
Quitline promotional reach	Not available for 2020	https://map.naquitline.org/profile.aspx?stateid=ks https://www.naquitline.org/page/2020survey	The number of people who connected, whether they received an evidence-based service or not. Was 0.51% based on 2019 NAQC survey results but not available for 2020.
Quitline treatment reach	0.30%	https://map.naquitline.org/profile.aspx?stateid=ks	The number of people who received at least one evidence-based service

QUITLINE SERVICES/UTILIZATION			
Variable	Number/Percentage/Value	Data Source	Notes
		https://www.naquitline.org/page/2020survey	
Quit rate	28.1% (a); 26.3% (b)	Tristi Bond	Per the NAQC calculation a) Conventional tobacco users b) Conventional tobacco users plus ENDS users

Table last revised: 04/12/22

Note: Information should be available through QL registration records or evaluation reports and is included in the NAQC Annual Survey.
If interested in partnering with Tribal Nations that are effectively self-insured, it will be important to assess utilization among their tribal members (those who have a CDIB card).
For State legislation that impacts cessation, check with the State Health Department, American Lung Association, American Cancer Society, and/or American Heart Association.

States may offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care plans, or both. Under the FFS model, the state pays providers directly for each covered service received by a Medicaid beneficiary. Under managed care, the state pays a fee to a managed care plan for each person enrolled in the plan. In turn, the plan pays providers for all the Medicaid services a beneficiary may require that are included in the plan's contract with the state.

- For a primer on Medicaid visit the Medicaid and CHIP Payment and Access Commission (MCPAC) at https://www.macpac.gov/medicaid-101/ and take special note of the section on Provider Payment and Delivery Systems at https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/
- General information on Medicaid in each state may be found at www.healthinsurance.org
- Additional Medicaid information in each state may be found at www.kff.org and www.lung.org

MEDICAID		
Questions	Answer	Description/Comments
Has the state expanded Medicaid under the Affordable Care Act (ACA)?	No	Note the year passed
Are any tobacco cessation services "carved out"?	No	Note the types of services and situations in which the services are carved out
Is the state Fee for Service, Managed Care, or Both?	Mostly MCO	Helpful for federal match or contract opportunity with MCO's https://www.healthinsurance.org/kansas-medicaid/ "As of 2018, nearly all (96 percent) of Kansas Medicaid enrollees were covered under the state's Medicaid managed care program." https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
Other issues		OneCare Kansas program includes a focus on tobacco dependence treatment or its target population https://www.kancare.ks.gov/consumers/onecare-ks-members

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Note: "Medicaid programs also may cover drugs sold without a prescription, commonly referred to as over-the-counter drugs, when prescribed by a physician or other authorized prescriber." - https://www.macpac.gov/wp-content/uploads/2015/09/Medicaid-Payment-for-Outpatient-Prescription-Drugs.pdf
For a summary of KanCare coverage see: https://okpxi30bv3m184y3670sw15d-wpengine.netdna-ssl.com/wp-content/uploads/sites/5/2018/12/BB_NAMI_PalmCard_2019.pdf
For tobacco cessation coverage available for Medicaid and the state employee plan, see

American Lung Association, State Tobacco Cessation Coverage Database: https://www.lung.org/policy-advocacy/tobacco/cessation/state-tobacco-cessation-coverage-database/states and https://www.lung.org/policy-advocacy/tobacco/cessation/state-tobacco-cessation-coverage-database/search

KEY STAKEHOLDERS/TARGETS FOR PARTNERSHIP		
Organization	Name/Title	Contact Information
GOVERNMENT AGENCIES		
City of Wichita (Tobacco Compliance)	Tom Vanatta (Public Health Sanitarian, Tobacco Control)	TVanatta@wichita.gov
Department of Health and Environment (KDHE)	Mende Barnett (Bureau of Health Promotion)	Mende.Barnett@ks.gov
Department of Health and Environment (KDHE)	Tristi Bond (Bureau of Health Promotion)	Tristi.Bond@ks.gov
Department of Health and Environment (KDHE)	Carol Cramer (Tobacco Use Prevention Program Manager)	carol.cramer@ks.gov
Department of Health and Environment (KDHE)	Sarah Fertig (Medicaid Director)	Sarah.Fertig@ks.gov
Department of Health and Environment (KDHE)	Matthew Schrock (Cessation Coordinator)	matthew.schrock@ks.gov
Department of Health and Environment (KDHE)	Melissa Warfied (Health Care Finance)	Melissa.L.Warfield@ks.gov
Department of Health and Environment (KDHE)	Caroline Wroczynski (Community Health Systems)	Caroline.Wroczynski@ks.gov
Department of Insurance (KID)	Vicki Schmidt (Insurance Commissioner)	vicki.schmidt@ks.gov
Department of Insurance (KID)	Linda Scott (Director of Information Technology)	linda.scott@ks.gov
Kansas Department of Aging and Disabilities Services (KDADS)	Kerrie Bacon (Medicaid/KanCare Ombudsman)	Kerrie.Bacon@ks.gov
Kansas Department of Aging and Disabilities Services (KDADS)	Andrew Brown (Commissioner)	andrew.brown@ks.gov
Kansas Department of Aging and Disabilities Services (KDADS)	Diana Marsh (Support Staff)	diana.marsh@kdads.ks.gov
Substance Abuse and Mental Health Services Administration (SAMHSA)	Kim Nelson (Regional Director)	Kimberly.Nelson@samhsa.hhs.gov
INSURANCE CARRIERS, BROKERS, ASSOCIATIONS & EMPLOYER GROUPS		
Aetna (Medicaid MCO)	Kim Jordan	jordan3@aetna.com
Kansas AFL-CIO	John Nave (Executive VP)	jnave@swbell.net

KEY STAKEHOLDERS/TARGETS FOR PARTNERSHIP		
Organization	Name/Title	Contact Information
Kansas AFL-CIO	Andy Sanchez (Secretary/Treasurer)	andy.sanchezs-t@swbell.net
Kansas Association of Medicaid Health Plans	Mary Bibler (Executive Director)	Mary.Bibler@kamhp.org
Kansas Business Group on Health	Shelley Duncan (Executive Director)	shelleyduncan@cphcp.com
Kansas Business Group on Health	Justin Moore, MD, FACP (Medical Director)	justin@doubleaarowmatabolism.com
Kansas Business Group on Health	Matt Thibault (Project Director)	mattthibault@med-soc.org
Kansas Farm Bureau Health Plans	Meagan Cramer (Director Communications and Marketing	cramerm@kfb.org
State Employee Health Plan	Pete Nagurny (Senior Manager - Plan Design, Fiscal & Data Management)	pete.nagurny@ks.gov
State Employee Health Plan	Paul Roberts (Senior Manager of Operations)	Paul.Roberts@ks.gov
Sunflower State Health Plan (Medicaid MCO)	Diana Erickson	Diana.N.Erickson@sunflowerhealthplan.com
United Healthcare (Medicaid MCO)	Sandra Berg	Sandra.berg@uhc.com
HEALTH CARE PROVIDER ASSOCIATIONS		
Association of Community Mental Health Centers of Kansas	Michelle Ponce	mponce@acmhck.org
Behavioral Health Association of Kansas	Stuart Little	stuartjlittle@mac.com
Community Care Network of Kansas	Alice Weingartner	aweingartner@communitycareks.org
CRO Network (Consumer Run Organizations)	c/o Darla Denton (Project Independence)	projectcro@yahoo.com
Kansas Academy of Family Physicians	Tara Remington Brown (CEO)	tremingtonbrown@kafponline.org
Kansas Academy of Family Physicians	Michelle Corkins (VP of Operations, Foundation Executive Director)	mcorkins@kafponline.org
Kansas Association of Addiction Professionals	Melissa Munoz	melissa@kearneyandassociates.com
Kansas Association of Local Health Departments	Dennis Kriesel	Dennis.kriesel@kalhd.org
Kansas Healthcare Collaborative	Michele Clark (Senior Director of Quality Initiatives and Special Projects)	mclark@khconline.org

KEY STAKEHOLDERS/TARGETS FOR PARTNERSHIP		
Organization	Name/Title	Contact Information
Kansas Healthcare Collaborative	Eric Cook-Wiens (Data and Measurement Director)	ecook-wiens@khconline.org
Kansas Healthcare Collaborative	Malea Hartvickson	MHartvickson@khconline.org
Kansas Hospital Association	Chad Austin (President and CEO)	caustin@kha-net.org
Kansas Hospital Association	Karen Braman (Senior VP Clinical and Strategic Initiatives)	kbraman@kha-net.org
Kansas Hospital Association	Audrey Dunkel (Vice-President Government Relations)	adunkel@kha-net.org
Kansas Hospital Association	Sally Othmer (Senior Director Data and Quality Reporting)	sothmer@kha-net.org
Kansas Hospital Association	Cindy Samuelson (Senior VP)	csamuelson@kha-net.org
Masonic Cancer Alliance (MCA)	Hope Krebill (Executive Director)	hkrebill@kumc.edu
Medical Society of Sedgwick County	Kim Neufeld (Tobacco Control Coordinator)	KimNeufeld@med-soc.org
Medical Society of Sedgwick County	Deanne M. Newland (Controller/HR Administrator)	deannenewland@med-soc.org
ADVOCACY ORGANIZATIONS		
American Cancer Society Cancer Action Network	Matt Prokop (Grassroots Manager)	matt.prokop@cancer.org
American Cancer Society Cancer Action Network	Stephanie Weiter (Associate Director, Development)	stephanie.weiter@cancer.org
American Cancer Society Cancer Action Network	Megan Word Legislative Director)	megan.word@cancer.org
American Heart Association	Kari RInker (Government Relations Director)	kari.rinker@heart.org
American Lung Association	Sara Prem (Director of Advocacy)	Sara.Prem@lung.org
Kansas Mental Health Coalition	Amy Campbell	campbell525@sbcglobal.net
Kansas Public Health Association	Brandon Skidmore (President)	bskidmore@sunflowerfoundation.org
NAMI Kansas	Rick Cagan (Behavioral Health Tobacco Project Director)	rcagan@namikansas.org

KEY STAKEHOLDERS/TARGETS FOR PARTNERSHIP		
Organization	Name/Title	Contact Information
NAMI Kansas	Sherrie Vaughn (Executive Director)	svaughn@namikansas.org
Oral Health Kansas	Kathy Hunt	Khunt@oralhealthkansas.org
Oral Health Kansas	Christi Wells	CNance@OralHealthKansas.org
Tobacco Free Kansas Coalition	Sara Prem (President)	Sara.Prem@lung.org
Tobacco Free Wichita Coalition	Shelley Rich (Tobacco Control Coordinator)	ShelleyRich@med-soc.org
QUITLINE SERVICE PROVIDER		
National Jewish Health	Lorena Rovero (Account Manager)	RoveroL@NJHealth.org
HEALTH CARE FOUNDATIONS		
Kansas Health Foundation	Natalie Olmsted (Program Officer)	nolmsted@khf.org
Sunflower Foundation	Billie Hall (President and CEO)	bhall@sunflowerfoundation.org
ACADEMIC INSTITUTIONS		
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Table last revised: 01/30/22

STATE AND LOCAL POLICIES THAT IMPACT TOBACCO CESSATION			
Name	Statute or Proposed Bill Number	Status	Notes
Comprehensive tobacco cessation			
Medicaid expansion			Lead by Alliance for Healthy Kansans.
Medicaid reimbursement rates			Counseling
Insurance coverage mandate			Expand benefits for commercial insurance and SEHP to match KanCare tobacco cessation benefits, with no co-ins/co-payments/deductibles/pre-auth. Need to add coverage for cessation counseling via telehealth.
State agency contract requirements with providers			
Adopt tobacco dependence treatment quality measures in KanCare to incentivize MCOs and providers to screen for tobacco use and to offer tobacco dependence treatment			For instance, increase the number of types of providers who are allowed to be reimbursed for the provision of tobacco dependence treatment services (e.g., add dentists as KanCare counseling providers for cessation treatment subject to the approval of adult dental benefits in KanCare by the Kansas Legislature).
Tax increase			
Tobacco tax	HB 2428	Has little chance of passing, considering the state's current revenue surplus	Increase tax on cigarettes. Tax to include electronic nicotine delivery systems (ENDS; tax on e-cigs currently taxed on volume). Raise tax to bring other tobacco products to parity. Bill may be tied to bill on food sales tax reduction/elimination.
Age restriction			
T21			Awaiting federal guidance on implementation at the state level. As of 10/21/21, 25 municipalities had passed a T21 ordinance in Kansas. See https://no-smoke.org/wp-content/uploads/pdf/T21.pdf and https://tobacco21.org/wp-content/uploads/2017/05/T21-Kansas-03-2019.pdf. For information on model T21 policies, see https://tobacco21.org/tobacco-21-model-policy/.

STATE AND LOCAL POLICIES THAT IMPACT TOBACCO CESSATION			
Name	Statute or Proposed Bill Number	Status	Notes
Synar compliance			https://www.samhsa.gov/synar
Remove punitive purchase, use, and possession (PUP) language			Removal of PUP language from legislation regarding age-restriction compliance would move the enforcement model from a punitive/disciplinary approach to a therapeutic/supportive approach toward cessation. To help implement this approach, a low-to-no cost training/group counseling program must be available for those underaged individuals who are found to be non-compliant.
Funding for tobacco control			
Protect existing cessation/prevention funding			Includes initiative to address SDOH and trauma-informed care.
Oppose securitization of tobacco settlement funds			
Include funding for media campaigns			
Flavor ban			
Ban all flavors, including menthol			
Smoke-free settings			
Tobacco-free campuses for all state agencies			
Tobacco-free parks			
Tobacco-free school campuses			
Tobacco-free transit			
Tobacco-free childcare providers/facilities			
Tobacco retail			
Tobacco retail licensing			Current proposal in Lawrence (Douglas County).

STATE AND LOCAL POLICIES THAT IMPACT TOBACCO CESSATION			
Name	Statute or Proposed Bill Number	Status	Notes
Content-neutral signage			

Table last revised: 04/12/22

Tobacco Dependence Treatment Resource	Resource Link
The Kansas Support Groups web page is another resource for those seeking tobacco dependence treatment or working to refer tobacco users to treatment.	http://supportgroupsinkansas.org/support-group To view tobacco dependence treatment resources and/or groups on this page, select "Tobacco Cessation" from the Category pull-down menu, and then click "Apply."
Tobacco Dependence Treatment Provider Directory	https://drive.google.com/file/d/122-TrLGIlAd_qbWceUTCThYqpnqGbOG0/view?usp=sharing

Table last revised: 01/16/22

ACCESS TO SELECT DATA			
Data Name	Data Description	Data Source/URL	Data Contact
HRSA data	HRSA collects data on tobacco interventions as reported by Federally Qualified Health Centers (FQHCs) in Kansas. Included are provider-reported data on the percentage who screen for tobacco use or provide tobacco dependence treatment at FQHCs in Kansas. Also shown are data for each individual FQHC. These data are also juxtaposed with SAMHSA data.	https://drive.google.com/file/d/1KDaoueau2rgMmVmEvGdGJBLAXyYkRfL8/view?usp=sharing	KU School of Medicine (Dr. Kim Richter; Dr. Nathalia Machado)
SAMHSA data	SAMHSA collects self-reported data from mental health and substance use treatment facilities which reflect engagement in several key areas: screening for tobacco use, cessation counseling, access to FDA-approved medications, and establishing tobacco-free campuses for treatment facilities.	https://drive.google.com/file/d/1qveuvP69sThXvr-dy4TkUcKParCeQdMH/view?usp=sharing	KU School of Medicine (Dr. Kim Richter; Dr. Nathalia Machado)
Claims data	Data are reported for claims based on tobacco cessation counseling codes (99406, 99407, S9075, S9453, G0436, G0437) and all FDA-approved cessation medications for KanCare, the State Employee Health Plan, and private insurance companies reporting to the Kansas Health Insurance Information System.	https://drive.google.com/file/d/1RL6ODUEkQWer4a2CARqePFwuLgrseEmJ/view?usp=sharing	KU School of Medicine (Dr. Kim Richter; Dr. Nathalia Machado)
Self-Assessment data	The Kansas Tobacco Guideline for Behavioral Health Care has a self-assessment checklist that is an online tool maintained on the KDADS website. The data available here are from 15 Community Mental Health Centers, addiction treatment facilities, one FQHC, and one Consumer Run Organization) that completed checklists before and after participating in a mini-grants program to improve tobacco treatment services. Beginning in 2021, all Community Mental Health Centers will complete Self-Assessments.	https://drive.google.com/file/d/1IE7DhsQXlKYccIIBxwr9aSmbc9UK_vIx/view?usp=sharing	KU School of Medicine (Dr. Kim Richter; Dr. Nathalia Machado)

Table last revised: 01/30/22

Appendix B: Kansas Health Plan Assessment

Kansas Health Plan Assessment

KANSAS HEALTH PLAN ASSESSMENT

This survey was designed to assess what health insurance carriers in Kansas cover regarding tobacco cessation treatment. This survey was developed by individuals from the University of Kansas School of Medicine, NAMI Kansas, and the American Lung Association.

Your compliance officer should complete this survey. For the purposes of this survey, please consider fully insured members (Exchange/state of Kansas employees) as the population served.

* 1. Name of person completing this assessment.

* 2. Name of organization.

* 3. Please provide your e-mail address and phone number in the event that we need to contact you to clarify any of your responses.

Email Address

Phone Number

* 4. Name of Health Plan represented in this assessment.

* 5. How many lives does this plan cover?

* 6. Is this plan a marketplace plan?

- ◯ Yes
- ◯ No
- ◯ I don't know

* 7. Role/Position of person completing this assessment.

* 8. Does the plan have a premium surcharge for tobacco users?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

* 9. Does the plan have a reasonable alternative to a premium surcharge for tobacco users?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

10. You have responded that your plan offers a reasonable alternative to a premium surcharge for tobacco users, please describe that reasonable alternative here:

11. Does the plan have an employer wellness incentive (e.g., something the employer offers) for non-tobacco users?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

12. Does the plan have a reasonable alternative to the non-tobacco user incentive?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

13. You have responded that your plan offers a reasonable alternative to the non-tobacco user incentive, please describe that reasonable alternative here:

14. How many **medication-assisted** quit attempts, per year, does your plan cover?

Kansas Health Plan Assessment

This next section of the survey asks a series of questions related to the following tobacco cessation medications:

- Varenicline, (Chantix)
- Bupropion
- Nicotine Replacement Patches
- Nicotine Replacement Gum
- Nicotine Replacement Lozenges
- Nicotine Replacement Nasal Spray
- Nicotine Replacement Inhalers

* 15. Is the tobacco-cessation medication varenicline, (Chantix), covered by your health plan?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

16. What is the specified duration (in days) of a quit attempt made with varenicline (Chantix)?

- ◯ 30
- ◯ 60
- ◯ 90
- ◯ I do not know
- ◯ Other (please specify)

17. Does varenicline (Chantix) require a co-pay or other member financial requirement?

- ◯ Yes
- ◯ No
- ◯ I do not know

18. Does varenicline (Chantix) require prior authorization for use?

- ◯ Yes
- ◯ No
- ◯ I do not know

19. Are there limitations for the use of varenicline (Chantix)?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

20. Your responses have indicated that there are limitations to the use of varenicline (Chantix). Please select the limitation/requirement that best describes your situation:

- [ ] Step Therapy
- [ ] Required to Participate in Counseling
- [ ] Other (please specify);
(for example: amount of cessation product per duration limit)

* 21. Is bupropion for tobacco cessation covered by your health plan?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

22. What is the specified duration (in days) of a quit attempt made with bupropion?

- ◯ 30
- ◯ 60
- ◯ 90
- ◯ I do not know
- ◯ Other (please specify)

23. Does bupropion require a co-pay or other member financial requirement?

- ◯ Yes
- ◯ No
- ◯ I do not know

24. Does bupropion require prior authorization for use?

- ◯ Yes
- ◯ No
- ◯ I do not know

25. Are there limitations for the use of bupropion?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

26. Your responses have indicated that there are limitations to the use of bupropion. Please select the limitation/requirement that best describes your situation:

- ☐ Step Therapy
- ☐ Required to Participate in Counseling
- ☐ Other (please specify);
  (for example: amount of cessation product per duration limit)

* 27. Are Nicotine Replacement Patches covered by your health plan?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

28. What is the specified duration (in days) of a quit attempt made with Nicotine Replacement Patches?

- ◯ 30
- ◯ 60
- ◯ 90
- ◯ I do not know
- ◯ Other (please specify)

29. Do Nicotine Replacement Patches require a co-pay or other member financial requirement?

- ◯ Yes
- ◯ No
- ◯ I do not know

30. Do Nicotine Replacement Patches require prior authorization for use?

- ◯ Yes
- ◯ No
- ◯ I do not know

31. Are there limitations for the use of Nicotine Replacement Patches?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

32. Your responses have indicated that there are limitations to the use of Nicotine Replacement Patches. Please select the limitation/requirement that best describes your situation:

- ☐ Step Therapy
- ☐ Required to Participate in Counseling
- ☐ Other (please specify);
  (for example: amount of cessation product per duration limit)

* 33. Is Nicotine Replacement Gum covered by your health plan?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

34. What is the specified duration (in days) of a quit attempt made with Nicotine Replacement Gum?

- ◯ 30
- ◯ 60
- ◯ 90
- ◯ I do not know
- ◯ Other (please specify)

35. Does Nicotine Replacement Gum require a co-pay or other member financial requirement?

- ◯ Yes
- ◯ No
- ◯ I do not know

36. Does Nicotine Replacement Gum require prior authorization for use?

- ◯ Yes
- ◯ No
- ◯ I do not know

37. Are there limitations for the use of Nicotine Replacement Gum?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

38. Your responses have indicated that there are limitations to the use of Nicotine Replacement Gum. Please select the limitation/requirement that best describes your situation:

- ☐ Step Therapy
- ☐ Required to Participate in Counseling
- ☐ Other (please specify);
  (for example: amount of cessation product per duration limit)

* 39. Are Nicotine Replacement Lozenges covered by your health plan?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

40. What is the specified duration (in days) of a quit attempt made with Nicotine Replacement Lozenges?

- ◯ 30
- ◯ 60
- ◯ 90
- ◯ I do not know
- ◯ Other (please specify)

41. Do Nicotine Replacement Lozenges require a co-pay or other member financial requirement?

- ◯ Yes
- ◯ No
- ◯ I do not know

42. Do Nicotine Replacement Lozenges require prior authorization for use?

- ◯ Yes
- ◯ No
- ◯ I do not know

43. Are there limitations for the use of Nicotine Replacement Lozenges?

- ◯ Yes
- ◯ No
- ◯ I do not know

44. Your responses have indicated that there are limitations to the use of Nicotine Replacement Lozenges. Please select the limitation/requirement that best describes your situation:

- [ ] Step Therapy
- [ ] Required to participate in counseling
- [ ] Other (please specify);
(for example: amount of cessation product per duration limit)

* 45. Is Nicotine Replacement Nasal Spray covered by your health plan?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

46. What is the specified duration (in days) of a quit attempt made with Nicotine Replacement Nasal Spray?

- ◯ 30
- ◯ 60
- ◯ 90
- ◯ I do not know
- ◯ Other (please specify)

47. Does Nicotine Replacement Nasal Spray require a co-pay or other member financial requirement?

- ◯ Yes
- ◯ No
- ◯ I do not know

48. Does Nicotine Replacement Nasal Spray require prior authorization for use?

- ◯ Yes
- ◯ No
- ◯ I do not know

49. Are there limitations for the use of Nicotine Replacement Nasal Spray?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

50. Your responses have indicated that there are limitations to the use of Nicotine Replacement Nasal Spray. Please select the limitation/requirement that best describes your situation:

- ☐ Step Therapy
- ☐ Required to Participate in Counseling
- ☐ Other (please specify)
  (for example: amount of cessation product per duration limit)

* 51. Are Nicotine Replacement Inhalers covered by your health plan?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

52. What is the specified duration (in days) of a quit attempt made with Nicotine Replacement Inhalers?

- ◯ 30
- ◯ 60
- ◯ 90
- ◯ I do not know
- ◯ Other (please specify)

53. Do Nicotine Replacement Inhalers require a co-pay or other member financial requirement?

- ◯ Yes
- ◯ No
- ◯ I do not know

54. Do Nicotine Replacement Inhalers require prior authorization for use?

- ◯ Yes
- ◯ No
- ◯ I do not know

55. Are there limitations for the use of Nicotine Replacement Inhalers?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

56. Your responses have indicated that there are limitations to the use of Nicotine Replacement Inhalers. Please select the limitation/requirement that best describes your situation:

- ☐ Step Therapy
- ☐ Required to Participate in Counseling
- ☐ Other (please specify);
  (for example: amount of cessation product per duration limit)

* 57. Do you cover combination pharmacotherapy for tobacco cessation?

- ◯ Yes
- ◯ No
- ◯ I do not know

58. If an enrollee fills a prescription for two different pharmacotherapies at the same time, would this be considered **ONE** or **MORE THAN ONE** quit attempt?

- ◯ ONE
- ◯ MORE THAN ONE
- ◯ I do not know

Kansas Health Plan Assessment

This next section of the survey asks a series of questions related to counseling services for tobacco cessation provided by your health plan.

* 59. Are individual counseling services for tobacco cessation covered by your health plan?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

60. Do individual counseling services for tobacco cessation require a co-pay or other member financial requirement?

- ◯ Yes
- ◯ No
- ◯ I do not know

61. How many counseling sessions for tobacco cessation are included (per quit attempt) as a benefit for individuals covered under your plan?

62. Are there any limitations to individual counseling services for tobacco cessation?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

63. Your responses have indicated that there are limitations to the use of individual counseling services for tobacco cessation. Please describe those limitations here:

* 64. Are group counseling services for tobacco cessation covered by your health plan?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

65. Do group counseling services for tobacco cessation require a co-pay or other member financial requirement?

- ◯ Yes
- ◯ No
- ◯ I do not know

66. Are there any limitations to group counseling services for tobacco cessation?

- ◯ Yes
- ◯ No
- ◯ I do not know

67. Your responses have indicated that there are limitations to the use of group counseling services for tobacco cessation. Please describe those limitations here:

* 68. Are telephone counseling services for tobacco cessation covered by your health plan?

- ◯ Yes. In-House telephone counseling services for tobacco cessation are covered by the health plan. (The plan uses in-house counselors or coaches to provide cessation support to members.)
- ◯ Yes. Contracted telephone counseling services for tobacco cessation are covered by the health plan. (The plan contracts with another organization to provide cessation support to members.)
- ◯ No.
- ◯ I do not know

Kansas Health Plan Assessment

69. Do In-house telephone counseling services for tobacco cessation require a co-pay or other member financial requirement?

- ◯ Yes
- ◯ No
- ◯ I do not know

70. Are there any limitations to In-house telephone counseling services for tobacco cessation?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

71. Do contracted telephone counseling services for tobacco cessation require a co-pay or other member financial requirement?

- ◯ Yes
- ◯ No
- ◯ I do not know

72. Are there any limitations to contracted telephone counseling services for tobacco cessation?

- ◯ Yes
- ◯ No
- ◯ I do not know

Kansas Health Plan Assessment

73. Your responses have indicated that there are limitations to In-house telephone counseling services for tobacco cessation, please describe those limitations here:

74. Your responses have indicated that there are limitations to contracted telephone counseling services for tobacco cessation, please describe those limitations here:

Kansas Health Plan Assessment

75. Which CPT codes for tobacco cessation does your plan reimburse for?

- ☐ 99406
- ☐ 99407
- ☐ Other (please specify)
- ☐ None of the above

76. Please select the providers who can be reimbursed for tobacco cessation counseling.

	These providers can be reimbursed for tobacco cessation counseling for 99406 or 99407.
Physicians	☐
Nurses	☐
Dentists	☐
Pharmacists	☐
Licensed Master Social Workers	☐
Licensed Clinical Social Worker	☐
Clinical Psychologist	☐
Tobacco Treatment Specialist	☐
Licensed Clinical Addiction Counselor	☐
Certified Peer Specialist	☐
Respiratory Therapist	☐
Diabetes Educator	☐

Other (please specify)

77. What type of providers require additional certification/expertise to bill for codes 99406 or 99407?

78. Does your plan reimburse for office visits (e.g., 99213, 99214) for the sole purpose of treating tobacco?

- ◯ Yes
- ◯ No
- ◯ I do not know

79. Do you cover tobacco cessation counseling when delivered via telehealth?

- ◯ Yes; Permanently/Anytime
- ◯ No
- ◯ Conditionally (e.g., During pandemic)
- ◯ I do not know

If you selected 'Conditionally', please describe:

80. Are there any additional coding modifiers that need to be included when billing for tobacco cessation counseling via telehealth?

- ◯ Yes
- ◯ No
- ◯ I do not know

If 'Yes', please describe:

81. Please share anything else you think is relevant to your insurance coverage regarding the treatment of tobacco.

Appendix C: Kansas Health Plan Assessment: State Employee Health Plan

Kansas Health Plan Assessment: Responses From State Employee Health Plan

Question Category	Question	Response From SEHP
Respondent Information and Plan Type		
	Name of person completing this assessment.	Paul Roberts
	Name of organization.	State of Kansas Employee Health Plan
	Name of Health Plan represented in this assessment.	State Employee Health Plan (SEHP)
	Role/Position of person completing this assessment.	Senior Manager of Operations
Premium Surcharge and Incentives		
	Does the plan have a premium surcharge for tobacco users?	No
	Does the plan have a reasonable alternative to a premium surcharge for tobacco users?	Yes
	You have responded that your plan offers a reasonable alternative to a premium surcharge for tobacco users, please describe that reasonable alternative here:	We provide credits/reward dollars for members who take a tobacco cessation program. 6 points = $60, and counts toward the annual premium discount a member may earn.
	Does the plan have an employer wellness incentive (e.g., something the employer offers) for non-tobacco users?	Yes
	Does the plan have a reasonable alternative to the non-tobacco user incentive?	Yes
	You have responded that your plan offers a reasonable alternative to the non-tobacco user incentive, please describe that reasonable alternative here:	The program is offered through our HealthQuest wellness program and is an online course and coaching approach
Non-nicotine Medication		
	How many medication-assisted quit attempts, per year, does your plan cover?	3

Kansas Health Plan Assessment: Responses From State Employee Health Plan

Question Category	Question	Response From SEHP
Varenicline		
	Is the tobacco-cessation medication varenicline, (Chantix), covered by your health plan?	Yes
	What is the specified duration (in days) of a quit attempt made with varenicline (Chantix)?	0
	Does varenicline (Chantix) require a co-pay or other member financial requirement?	No
	Does varenicline (Chantix) require prior authorization for use?	Yes
	Are there limitations for the use of varenicline (Chantix)?	Yes
	Your responses have indicated that there are limitations to the use of varenicline (Chantix). Please select the limitation/requirement that best describes your situation: *Step Therapy, Required to Participate in Counseling, Other (please specify – for example: amount of cessation product per cessation limit)*	Quit Attempts per year
Bupropion		
	Is bupropion for tobacco cessation covered by your health plan?	Yes
	What is the specified duration (in days) of a quit attempt made with bupropion?	0
	Does bupropion require a co-pay or other member financial requirement?	No
	Does bupropion require prior authorization for use?	No
	Are there limitations for the use of bupropion?	No
	Are Nicotine Replacement Patches covered by your health plan?	Yes
	What is the specified duration (in days) of a quit attempt made with Nicotine Replacement Patches?	0
Nicotine Replacement Therapy (NRT)		
Patches		
	Do Nicotine Replacement Patches require a co-pay or other member financial requirement?	No
	Do Nicotine Replacement Patches require prior authorization for use?	No
	Are there limitations for the use of Nicotine Replacement Patches?	No

Kansas Health Plan Assessment: Responses From State Employee Health Plan

Question Category	Question	Response From SEHP
Gum		
	Is Nicotine Replacement Gum covered by your health plan?	Yes
	What is the specified duration (in days) of a quit attempt made with Nicotine Replacement Gum?	0
	Does Nicotine Replacement Gum require a co-pay or other member financial requirement?	No
	Does Nicotine Replacement Gum require prior authorization for use?	No
	Are there limitations for the use of Nicotine Replacement Gum?	No
Lozenges		
	Are Nicotine Replacement Lozenges covered by your health plan?	Yes
	What is the specified duration (in days) of a quit attempt made with Nicotine Replacement Lozenges?	0
	Do Nicotine Replacement Lozenges require a co-pay or other member financial requirement?	No
	Do Nicotine Replacement Lozenges require prior authorization for use?	No
	Are there limitations for the use of Nicotine Replacement Lozenges?	No
Nasal Spray		
	Is Nicotine Replacement Nasal Spray covered by your health plan?	Yes
	What is the specified duration (in days) of a quit attempt made with Nicotine Replacement Nasal Spray?	1
	Does Nicotine Replacement Nasal Spray require a co-pay or other member financial requirement?	No
	Does Nicotine Replacement Nasal Spray require prior authorization for use?	No
	Are there limitations for the use of Nicotine Replacement Nasal Spray?	No
Inhalers		
	Are Nicotine Replacement Inhalers covered by your health plan?	Yes

Kansas Health Plan Assessment: Responses From State Employee Health Plan

Question Category	Question	Response From SEHP
	What is the specified duration (in days) of a quit attempt made with Nicotine Replacement Inhalers?	1
	Do Nicotine Replacement Inhalers require a co-pay or other member financial requirement?	No
	Do Nicotine Replacement Inhalers require prior authorization for use?	No
	Are there limitations for the use of Nicotine Replacement Lozenges?	No
Combination Pharmacotherapy		
	Do you cover combination pharmacotherapy for tobacco cessation?	Yes
	If an enrollee fills a prescription for two different pharmacotherapies at the same time, would this be considered ONE or MORE THAN ONE quit attempt?	One
Counseling		
Individual		
	Are individual counseling services for tobacco cessation covered by your health plan?	Yes
	Do individual counseling services for tobacco cessation require a co-pay or other member financial requirement?	No
	How many counseling sessions for tobacco cessation are included (per quit attempt) as a benefit for individuals covered under your plan?	10
	Are there any limitations to individual counseling services for tobacco cessation?	No
Group		
	Are group counseling services for tobacco cessation covered by your health plan?	Yes
	Do group counseling services for tobacco cessation require a co-pay or other member financial requirement?	No
	Are there any limitations to group counseling services for tobacco cessation?	No

Kansas Health Plan Assessment: Responses From State Employee Health Plan

Question Category	Question	Response From SEHP
Telephone		
	Are telephone counseling services for tobacco cessation covered by your health plan?	Yes. Contracted telephone counseling services are covered by the health plan. (The plan contracts with another organization to provide cessation support to members.)
	Do contracted telephone counseling services for tobacco cessation require a co-pay or other member financial requirement?	No
	Are there any limitations to contracted telephone counseling services for tobacco cessation?	No
Billing Codes and Telehealth		
	Which CPT* codes for tobacco cessation does your plan reimburse for?	99406, 99407
	Please select the providers who can reimburse for tobacco cessation counseling and identify which, if any, of these providers require additional certification/expertise to bill for codes 99406, 99407.	[Respondent skipped this question]
	Which kind of providers require additional certification/expertise to bill for codes 99406 or 99407?	[Respondent skipped this question]
	Does your plan reimburse for office visits (e.g., 99213, 99214) for the sole purpose of treating tobacco?	Yes
	Do you cover tobacco cessation counseling when delivered via telehealth?	Yes. Permanently/Anytime
	Are there any additional coding modifiers that need to be included when billing for tobacco cessation counseling via telehealth?	No
Additional Comments		
	Please share anything else you think is relevant to your insurance coverage regarding the treatment of tobacco.	[Respondent skipped this question]

Note. The questions included in the version of the Kansas Health Plan Assessment that was completed by the State of Kansas Employee Health Plan (SEHP) do not include all the questions that are included in the current version of this assessment (April 2021) because this instrument was refined after it was piloted by the Kansas SEHP. For example, this assessment now includes "How many lives does the plan cover?" and "Is this a Marketplace Plan?" The current version of the instrument also asks the respondent to provide an e-mail address and phone number in case any response needs a clarification (see Appendix B).

SEHP = State Employee Health Plan

CPT = Current Procedural Terminology.

Code 99407 = Tobacco dependence treatment counseling lasting between three and 10 minutes.

Code 99406 = Tobacco dependence treatment counseling lasting longer than 10 minutes.

Code 99213 = Evaluation and Management lasting 20-29 minutes.

Code 99214 = Evaluation and Management lasting 30-39 minutes.

Appendix D: Tobacco Dependence Treatment Survey

Tobacco Dependence Treatment Survey

The Behavioral Health Tobacco Project is a collaboration led by NAMI Kansas with support from the Kansas Health Foundation. The Project involves a broad array of behavioral health and primary care providers and their associations. The focus of the Project is to reduce tobacco use by individuals with behavioral health conditions.

This survey is designed to collect essential information about the capacity of health care practitioners to provide evidence-based tobacco dependence treatment. We will use this information to publish a directory of providers. The Kansas Tobacco Quitline, KanCare MCOs, and other entities may use the directory to provide referrals for tobacco treatment.

Some of the questions ask about training that providers in your facility may have taken. Training for providing tobacco treatment is recommended, because most health care providers - including physicians, nurses, and qualified mental health professionals - are able to offer and bill for tobacco dependence counseling within the scope of their practice - without any special training.

Thank you for your participation.

* 1. Name:

* 2. Name of Provider Organization - Enter NA if you are responding as an individual provider.

3. Title/Position/Credential (if applicable)

* 4. Indicate any training related to treating tobacco dependence that you or other staff in the organization have taken.

	I have taken this training	Other staff in the organization have taken this training
Tobacco Treatment Specialist training	☐	☐
BTI -Brief Tobacco Intervention online training (KDHE)	☐	☐
Webinars	☐	☐
Navigating the Reimbursement Maze - online training for billing	☐	☐
Other training - Please specify in comment field	☐	☐
No training has been taken	☐	☐

Please specify other training

* 5. Which of the following services are you or your organization able to provide? Please check all that apply.

- ☐ Providing brief advice (less than 3 minutes) to encourage tobacco quit attempts
- ☐ Providing counseling (greater than 3 minutes) to help with tobacco quit attempts
- ☐ Providing counseling (greater than 10 minutes) to help with tobacco quit attempts
- ☐ Providing group counseling, including tobacco cessation groups
- ☐ Billing for treatment of tobacco dependence
- ☐ Prescribing or recommending an FDA-approved cessation medication for quitting tobacco
- ☐ Referring to a prescriber for obtaining FDA-approved medications
- ☐ Referring patients to the Kansas Tobacco Quitline
- ☐ None of the above

Comments

* 6. How do tobacco users access your tobacco treatment services? Please check all responses that apply. Indicate NA in Other option if no services are provided.

- [ ] Anyone is able to access services
- [ ] Services are only available to individuals in our service area
- [ ] Services are only available to individuals already enrolled in our program
- [ ] Services are available for individuals with insurance coverage
- [ ] Services are available for uninsured individuals
- [ ] Other criteria (please specify)

* 7. How do clients pay for services? Please check all responses that apply.

- [ ] Services are free to all comers
- [ ] Services are free to clients in our service area
- [ ] Services are free to clients already enrolled in our services
- [ ] Clients pay out of pocket
- [ ] Provider bills insurance for services provided
- [ ] Agency provides free or subsidized services for the uninsured
- [ ] Receipts are provided for services for clients to file with insurance
- [ ] I don't know how services are paid for

Comments:

* 8. Please indicate what types of insurance coverage (including uninsured individuals) you are willing to accept for providing tobacco dependence treatment.

- [ ] KanCare (Kansas Medicaid)
- [ ] Private insurance
- [ ] Medicare
- [ ] VA
- [ ] Other (please specify other insurance accepted or NA if no insurance is accepted)

* 9. If you have billed for treating tobacco dependence, please list the billing codes used.

- [ ] 99406 - Individual Counseling - Greater than 3 minutes
- [ ] 99407 - Individual Counseling - Greater than 10 minutes
- [ ] S9453 - Group counseling
- [ ] We have not billed for tobacco dependence treatment
- [ ] Other (please specify)

10. If you would like to receive additional information and resources related to supporting tobacco dependence treatment, please enter your email address here.

11. Please let us know if you have concerns or questions that we can address.

* 12. Would you or your organization like to be included in a list of Kansas providers who offer treatment for tobacco dependence? Directory listings will be previewed with respondents prior to publication.

- ( ) Yes
- ( ) No

Comment:

13. Please provide your contact information if you wish to be included in the provider listing. Individuals who provide treatment with no organizational affiliation may leave line 2 blank.

Name	
Organization	
Address	
Address	
City/Town	
State	
Zip Code	
E-Mail address	
Phone Number	

Appendix E: Types of Tobacco Dependence Treatment Training Completed

Types of Tobacco Dependence Treatment Training Completed

	Training Type	n	%
By Respondent			
	None	55	46
	Webinars	39	33
	Tobacco Treatment Specialist	25	21
	Other	21	18
	Brief Tobacco Intervention	20	17
	Billing	6	5
By Other Staff			
	Webinars	25	21
	Tobacco Treatment Specialist	21	18
	Brief Tobacco Intervention	20	17
	None	20	17
	Other	11	9
	Billing	9	8

Note. Billing refers to online training workshop “Navigating the Reimbursement Maze.” This tobacco dependence treatment workshop includes training on coverage, billing, and reimbursement. Brief Tobacco Intervention refers to Brief Tobacco Intervention online training (KDHE).

Appendix F: Sample Kansas Tobacco Dependence Treatment Provider Directory

Kansas Tobacco Dependence Treatment Provider Directory

Revised: March 27, 2022

This directory was created using the data from a tobacco dependence treatment survey first disseminated in 2020 as a joint effort between the University of Kansas School of Medicine and NAMI Kansas, with support from the Kansas Health Foundation. The survey aimed to determine the capacity of Kansas health care practitioners to provide evidence-based tobacco dependence treatment. The Directory includes providers in many counties throughout Kansas; it is meant to be used by health care providers and other entities for referral for tobacco dependence treatment as well as by patients seeking such treatment.

The Directory is divided into three columns and sorted in alphabetical order by county (left column) and then by organization name (center column). In addition to listing address and phone number information, many organizations also provide the name of a practitioner who specifically handles tobacco dependence treatment within the facility. Tobacco Treatment Specialist (TTS) training is also indicated when applicable. Information on tobacco dependence treatment services, free access when applicable, and accepted insurance is shown in the right column.

Individual counseling, when noted, refers to counseling over three minutes.
"Cessation Meds (Prescribe)" means that pharmacotherapy for tobacco dependence can be prescribed.
"Cessation Meds (Refer)" denotes that pharmacotherapy for tobacco dependence can only be obtained indirectly through referral to a prescriber.

The **Kansas Tobacco Support Groups** web page is another resource for those seeking tobacco dependence treatment or working to refer tobacco users to treatment. This page is located at *http://supportgroupsinkansas.org/support-groups*. To view relevant resources, select "Tobacco Cessation" from the Category pull-down menu and then click "Apply."

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Kansas Tobacco Dependence Treatment Provider Directory

Revised: March 27, 2022

County	*Organization and Tobacco Dependence Treatment Provider*	*Tobacco Dependence Treatment Services and Payment/Insurance Accepted*
Barton	**Heart of Kansas Family Health Care, Inc.** 1905 19th St Great Bend, KS, 67530 (620) 792-5700	**Tobacco Dependence Treatment Services:** Counseling (Individual) Cessation Meds (Prescribe) **Insurance Accepted:** KanCare, Medicare, VA, Private Insurance
Barton	**St. Francis Ministries** 1508 Main St Great Bend, KS, 67530 Myers, Deborah (620) 617-4504	**Tobacco Dependence Treatment Services:** Counseling (Individual) **Insurance Accepted:** KanCare, Private Insurance
Brown	**Hiawatha Community Hospital Family Practice** 300 Utah Hiawatha, KS, 66434 Bigham, Bryon (785) 742-2161	**Tobacco Dependence Treatment Services:** Counseling (Individual) Cessation Meds (Prescribe) **Insurance Accepted:** KanCare, Medicare, VA, Private Insurance
Butler	**South Central Mental Health Counseling Center (SCMHCC)** 221 W King St Andover, KS, 67002-8964 Mukwindidza, Susan (TTS Trained) (316) 733-5047	**Insurance Accepted:** KanCare, Medicare, VA, Private Insurance
Cherokee	**Spring River Mental Health and Wellness** 6610 SE Quakervale Rd Riverton, KS, 66770 Biondo, Emily (TTS Trained) (620) 848-2300	**Tobacco Dependence Treatment Services:** Counseling (Individual) **Insurance Accepted:** KanCare, Private Insurance

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